State of Tennessee

2014 Update to the

State Health Plan

Division of Health Planning
Tennessee Department of Health

TN Department of Health

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Foreword

Where We Find Ourselves Now

Tennessee's State Health Plan, completed annually at the direction of the General Assembly and endorsed by Governor Bill Haslam, is part of an ongoing effort to accelerate Tennessee's progress towards becoming one of the nation's ten healthiest states. We acknowledge that we have not, in 25 years of America's Health Rankings, ever been out of the bottom 10 states and that our most current ranking of 45th is far from our vision of Tennessee in the top tier of this established health index. One can legitimately argue with the components and weightings of the index. Similarly, one may argue with the components and weighting of the World Health Organization's years-old ranking of the United States as 37th worldwide or the 2014 Commonwealth Fund's ranking of the U.S. health system as 11th of 11 developed economies. Yet, it is more difficult to dispute the majority of the facts that are components of these rankings. The infant mortality rate, for example, is what it is.

It is also not a mystery what is driving the illnesses that steal the years from our lives and the life from our years. In Tennessee, we call them "the Big Three," and they result from our deeply programmed drives toward the embracing of comfort and avoidance of discomfort. They lead to the behaviors that are the health challenges of our time, both in Tennessee and much of the developed world. They are: 1) tobacco and nicotine addiction, 2) too much caloric intake and weight, and 3) too little physical activity. To these three, in Tennessee and many other states, we must add "plus One": substance abuse. Substance abuse has been led over the last decade by abuse of prescription opioids and benzodiazepines. The principles we focus on in this State Health Plan are each very important; yet, it is difficult to argue that we are 45th as an entire state because we are so much lacking in four out of the five Principles for Achieving Better Health: Health Access, Healthcare Efficiency, Healthcare Quality, and Health Workforce. It is the remaining Principle's focus, our Un-Healthy Lives, that is the major culprit.

Since the late 1960s, after accepting a societal responsibility for the care of the nation's elderly, disabled, and poor, the United States has steadily increased health care spending, ever upward. The United States spends more each year in terms of absolute dollars ($9,255 per person) and as a percentage of GDP (17.4% or $2.9T)[1] than any other nation in the world. If our health sector alone were a national economy, it would be the 6th largest in the world today, while caring for less than 4.5% of the world's population.

Despite an abundance of resources focused on health care, our "system" is not producing "health" for our population. Improving our health, then, is not a matter of resources; it is a matter of how we choose to use them. Do we put up a fence around a metaphoric cliff to prevent people from falling,

[1] Source: United States Department of Health and Human Services, CMS 2013. Retrieved from http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/index.html

or do we buy another ambulance and crew to rescue and care for them when they do? If we have the resources to do both, why are there so many gaps in the fence? We can and must do better. The continuing and future costs of expensive care are eroding public and private budgets and family disposable incomes. Patching the gaps in these "fences" with less expensive prevention options that improve health seems preferable.

The 2014 State Health Plan's Focus on "Health"

The State Health Plan and its updates are a guide to protecting, promoting, and improving the health of people in Tennessee. This Plan provides information to understand past efforts and to move towards a goal that begins to focus on better health approaches. It aspires to serve as a working blueprint to drive activities focused on measurable improvements in the lives of all people in Tennessee.

Since 2009, the State Health Plan has been a force for improvement in the health of our population. We have seen it through bright spots like the reduction in our infant mortality rate, the lowest ever, and the increase in the use of vaccinations. However, chronic challenges persist, including high rates of tobacco use and nicotine addiction (almost 1 in 4 adults), excess weight (2 in 3 of us), sedentary living (1 in 3 of us), and drug misuse and abuse (more than 1 in 20 of us). The situation for Tennessee's under-18 population is no less serious: Too many children smoke (1 in 5), are overweight or obese (4 in 10), and do not get enough physical activity (7 in 10). These unhealthy behaviors lead to a greater prevalence of chronic diseases and disparities in death rates that continue to be roadblocks to good health statewide. To date, there has not been a significant cultural shift in our state's population that would result in placing more value on long-term optimal personal health instead of immediate behaviors that have poor health outcomes. This is not a surprise; this is a very difficult cultural shift that goes against the grain of millennia of human adaptation. We are a state populated by historically hardy and genetically "thrifty" stock. Our forebears were very good at surviving periods of want, and our culture developed over generations that defined "caring" and kindness in gestures like serving wonderful foods and delicious beverages or offering a walker a ride. We quite naturally shuffle away from redefining what "caring" might mean when, until just the last few decades, it has meant a better chance at "health."

For these reasons, this 2014 Plan adopts a new definition of health developed by the members of the Goal Teams (listed in Appendix D). This definition recognizes that each individual has a state of "optimal health" that permits him or her, throughout all stages of life, to attain a high-quality life free of preventable disease, preventable disability, and preventable injury.

The difference between "health" and "optimal health" is simple: The former is a condition of adequacy; the latter is a superior condition, achieved when we as individuals are able to maintain ourselves at or near our highest quality of health, given our individual uniqueness and abilities, to do the things in our lives that we want and love to do, maximizing our physical and mental capacities, experiencing life free of preventable disease, disability, and injury, and enjoying prosperity however we conceive of it, whether along spiritual, relational, economic, or other lines.

Put more simply, it is having the health to do what we want to, when we want to, as we want to – for as long as we are given. And people in Tennessee have the resources within our grasp to enjoy optimal health – abundant recreational opportunities, numerous sources of locally produced healthy foods, access to disease prevention and health care for the vast majority (though too many are still left out), cultural pride, joy and abundance in our musical traditions, stunning scenery, and an environment with a very pleasant four-season climate. Nevertheless, optimal health requires more than access to resources; it requires using those resources and using them wisely while avoiding behaviors that cause immediate and long term negative health impacts.

The Important Roles of Health Care and Valuing Health in Improving the State's Population Health

We know health *care* alone is usually more about fixing a problem – or preventing it from getting worse – than it is about preventing it in the first place. It follows that health care, while extremely important to each of us as individuals and as a society collectively, is not the primary driver of significant improvements in population health. This 2014 State Health Plan is structured around this fundamental concept and sets goals and objectives to help move indicator needles – for example, premature death – in the right directions. For some that means moving from unhealthy to healthy; for others it's going from healthy to optimally healthy.

The aforementioned recent review by the Commonwealth Fund of the health systems in 11 of the world's most advanced economies ranked the U.S. 11th overall; the United Kingdom was 1st, despite spending less than half as much per person. The United Kingdom was number one among these nations in the areas of "quality," "effectiveness," "safety," and "patient-centeredness" of care, and while not number one in "timeliness of care," it still bested the United States. But importantly – and perhaps surprising to many – when it came to the overall health ranking of the two respective populations, i.e., the healthiness of their lives, the U.S. was 11th while the U.K. only 10th.

To make significant improvements, we need to encourage our entire society to value *health* as well as *health care*. In other words, we need to build a *culture of health* and create a *climate of health* where each of us, no matter where we are starting from, can achieve optimal health.

This culture of health must include changes to our health care services system, which currently is not well incentivized to promote individual healthy behaviors, good health, or population health improvement. While the United States has some of the world's finest and most effective health care services, the mix of care is not well integrated, consistently accessible, or affordable in the long run, even to a nation with the world's best economy. In short, our system focused on *care* is not getting good value for the dollar, nor is it achieving an optimal health vision for the nation.

The concept of an episode of care currently begins with a problem and ends with an outcome. But a person's life and health supersede both. To contribute to promoting optimal health across Tennessee, we need to work to move our incentives "upstream" and

engage the best efforts of our health care system earlier in our lifecycle and, to the extent possible (and what is possible will grow with research, knowledge, and understanding), before disease develops and throughout a lifecycle focused on optimal health rather than absence of disease and injury. The health care system then becomes more "system-like:" Providers integrate more up front preventive features into the continuum of care and payers reward the value of health maintained rather than the volume of sickness care delivered.

Why is Seeking Optimal Health So Hard?

The challenges of our time are new, different, and on a larger scale than previously have been faced in human history. The Big Three plus One are rooted in those same human challenges. Our struggle with them comes down to our very nature, how we are "wired" to survive. Everyone has to eat and most of us seek to be efficient in our movements. We are genetically "programmed" to seek to eat more (especially if it is sweet, salty, meaty, and varied) and to do less. For too many, there is also the issue of food security, the constant fear that there will not be enough, that we have to get it while we can, and that the more and the cheaper, the better. It is absolutely *counter to daily natural impulses*, our core "programming," to moderate eating and increase physical activity. We can get around this core programming with a temporary fix, but it takes *will power.* And will power is experimentally proven to be of short and exhaustible duration in most settings.

Thus, because of our core programming, obesity and inactivity in many ways are even harder to combat than tobacco use. And we've worked hard to reduce tobacco use. Despite fifty years of campaigning against tobacco use through the United States Surgeon General's warnings – with the clear knowledge of the harms of cancer and heart disease, billions of dollars spent, millions prematurely dead, companies successfully sued, and policies making it much harder and costlier to smoke – we still have, nationally, nearly one-in-five people smoking, down from a little over two-in-five. Tobacco, with the nicotine in it, is highly addictive and can also be socially compelling, but *no one has to use it. Everyone has to eat.*

So yes, we struggle with our programming, but we also understand that to get and stay healthy, fit, and vigorous can be rewarding in itself. This approach can be aided by personal responsibility and individual motivation, but for many people in Tennessee, there are disparities in opportunities available to pursue healthy lifestyles. And the pursuit of a healthy lifestyle for adults, let alone developing children, is hard. We are bombarded every day with stimuli – advertisements, smells, sights and people urging us to indulge, to feast, to enjoy ourselves because, of course, it is yummy, it is time together, and we "deserve it." A recent advertisement observed "*You can stop ANYTIME YOU WANT! Well, sort of, you've gotta eat…right?*"

Beyond personal choice, there are strong tendencies tied up in our genes that are turned on or off before we are born and early in our childhood, which very strongly impact how we deal with the Big Three plus One. These influencers in our lives and environment interact with our nervous systems, our other organs, and even, we are learning, with the

microorganisms that live in and on each of us, to play a powerful role in our choices to do what we do. They also make it hard, in the reality of our present environment (very unlike that of our ancestors), to do what is best for our health.

The Role of the State Health Plan

The Big Three plus One and the health risks and diseases they create are not just a public health or health care challenge. Government, community, and business leaders certainly have a role to play in fostering individual and community actions that lower barriers to healthy living, limit and eliminate disparities, and promote good health. Professionals can describe the challenges, create paths and programs to improve them, but to address them will take time, technological advances, improved scientific understanding, and, most challenging, culture change with "all hands on deck." We can hope for a magic bullet, like vaccines were and are for childhood diseases, but hope is not a sufficient response to these clear and ongoing harms**.**

State government can be a powerful facilitator for greater attention to these issues at the state and local levels. Most state government departments have some role in protecting, promoting, and improving health, as do local governments, mayors, county executives, and other elected and appointed officials, from planning to parks to public works.

This edition of the State Health Plan for the first time will emphasize the importance of health protection, promotion, and prevention *before* there is a health problem rather than merely to detect a problem that already exists. The Department of Health views this approach as the best way to accelerate improvements in population health, while still recognizing the role health care plays in maintaining and improving individual health.

Our present reality is not set in stone – it can change.

A state health rank of 45 is not just our number. Unless we work to change it, it is our future. The Big Three plus One are crucial factors in our national health ranking. We have to partner and engage to achieve a Tennessee that is really, truly healthier. Optimal personal health will require reducing current tobacco use, reducing obesity and improving physical activity, and preventing and treating substance abuse. The long term health of our state also requires attention to the health of our children as our future. Each of these problems will affect our children's adulthood, threatening our state's finances, making our state less attractive to economic development and jobs, and creating conditions where our kids may live shorter lives than we do. This is not merely a government problem, a health sector problem, a personal or a family problem – this is all hands on deck. This Plan, along with the work of many other hands and organizations, seeks to begin creating the consensus and basis for action that amplifies the pitch of this call. All hands on deck!

John J. Dreyzehner, MD, MPH, FACOEM
Tennessee Commissioner of Health

Introduction: What is "Health?"

We know healthcare alone cannot make major improvements in population health.* To make significant improvements, we need to understand what "being healthy" and "staying healthy" mean, and how to encourage our entire society to value health. In other words, we need to build a culture of health. The 2014 State Health Plan is structured around this basic concept.

The first edition of Tennessee's State Health Plan in 2009 adopted the World Health Organization's definition of health as an initial step for creating the foundation of the plan: "a state of complete physical, mental, and social well-being, and not merely the absence of disease." This 2014 edition moves away from that definition. "Health" should not be limited to a state of "complete…well-being," but must encompass the idea that each individual has a state of "optimal health" that permits him or her, throughout all stages of life, to attain a high-quality life free of preventable disease, disability, and injury. The State Health Plan sets goals and objectives to guide the population as a whole in reaching that optimal state of health.

It is important to understand that the health of people in Tennessee is not dependent only on the individual and the health care provider, but on every entity, public and private, affecting one's health. Health is the common denominator, connecting groups, both inside and outside of government, that do not traditionally think about their role as impacting health but that, in fact, help create social and physical environments that promote good health.

Our current health care system does not yet systematically extend beyond providers' walls to the places where our health is most impacted: where we live, learn, work, worship, and play. We are increasingly aware that our health can be unduly and unequally influenced by many factors beyond basic access to health care, including education, income, race and ethnicity, location, housing, transportation, and clean air and water. Our state government can be a primary motivator in recognizing how other agencies, along with the two departments charged with health and mental health/substance abuse policies and programs, can and should include in their strategic plans a focus on improving health.

Personal responsibility plays an important role in getting and staying healthy, but too many people in Tennessee still do not have access to an equal measure of choices and opportunities to pursue healthy lifestyles. Government has a role to play in fostering individual and community actions that lower barriers to healthy living, help eliminate disparities, and promote good health.

In this State Health Plan, we begin, for the first time, to stress the importance of "health protection and promotion" as the best way to accelerate improvements in population health while still recognizing the role health care plays in improving individual health. Goals and Priorities for Consideration are included with this emphasis, as well as an initial set of Objectives, focusing on the primary health concerns in Tennessee.

* "Health" refers to all aspects of health, including but not limited to: physical health, social health, and behavioral health.

Executive Summary

Why a State Health Plan?

Tennessee is one of the least healthy states in America. In 2013, America's Health Rankings ranked Tennessee the 42nd healthiest state out of the 50 states. Recognizing the need for the state to coordinate its efforts to improve the health of people in Tennessee, in 2004 the General Assembly passed Public Chapter 942, which created the Division of Health Planning and charged it with developing a State Health Plan.

History of the State Health Plan

In 2009, the first edition of the State Health Plan was developed and published as a document to begin a comprehensive and participatory health planning process to coordinate efforts to improve the health of people in Tennessee. The 2010 edition of the State Health Plan was the result of an extensive public process that gathered the input of many key stakeholders, health experts, and people in Tennessee through regional meetings and collaborative efforts. It outlined key determinants of health, adopted as its framework Five Principles for Achieving Better Health (drawn from policy set forth in TCA § 68-11-1625(b), see Appendix A), and developed the first set of Goals for Achieving Better Health. Subsequent editions identified key strategies for improving the health of people in Tennessee and reported on the ongoing status for specific health outcomes and determinants.

Purpose of this Edition

This 2014 edition of the State Health Plan retains the Five Principles for Achieving Better Health Framework, but expands the principles to promote an emphasis on health protection and primary prevention. The Plan makes significant revisions to the 2010 Plan's Goals, broadening them to be aspirational ones that aim for an ideal state, allowing more innovation and creativity in developing Objectives.

Importantly, for the first time, the 2014 edition of the State Health Plan identifies an initial set of Objectives for 2015 for improving the health of people in Tennessee. **This 2014 edition concentrates on Objectives based on the TDH Strategic Plan and corroborated by the public process. These Objectives emphasize primary prevention**

initiatives that focus on healthy weight and nutrition, tobacco use prevention, infant mortality, immunizations, substance abuse, and unintended pregnancies. Literally hundreds of ideas were proposed for other Objectives during the public input process; these ideas have been grouped into Priorities for Consideration under each Goal for future consideration.

By statute, the State Health Plan is intended "to involve and coordinate functions with such State entities as necessary to ensure the coordination of State health policies and programs." The majority of ideas for Objectives suggested through the public process do, indeed, require the involvement of other state agencies, not just the Tennessee Department of Health (TDH). This edition notes Priorities for Consideration that will require collaboration with these other agencies and anticipates that the development of Objectives from these Priorities for Consideration will be work that continues into the 2015 edition of the State Health Plan and into the future.

The Planning Model: Public Input for the Updated Edition

This current edition of the State Health Plan is the result of an extensive public planning process (Appendix B). The overall strategy was to draw upon the knowledge of those with professional expertise as well as the common sense and personal experiences of the public.

The Five Principles for Achieving Better Health, their Goals and Objectives

The State Health Plan uses the framework of the Five Principles for Achieving Better Health, first set forth in the 2010 edition, to set Goals and Objectives to improve the health of people in Tennessee. The Five Principles include:

1. **Healthy Lives**: The purpose of the State Health Plan is to improve the health of people in Tennessee.
2. **Access**: People in Tennessee should have access to health care and the conditions to achieve optimal health.
3. **Economic Efficiencies**: Health resources in Tennessee, including health care, should be developed to address the health of people in Tennessee while encouraging value and economic efficiencies.

4. **Quality of Care**: People in Tennessee should have confidence that the quality of care is continually monitored and standards are adhered to by providers.
5. **Workforce**: The state should support the development, recruitment, and retention of a sufficient and quality health workforce.

This Framework is discussed in further detail on page 12 and in Appendix B.

Moving from a Health Care to a Population Health Focus

In this edition of the State Health Plan, we emphasize the importance of "health protection and promotion" as the best way to accelerate improvements in population health while still recognizing the role health care plays in improving individual health. A participatory process assisted in identifying population health Goals and Priorities for Consideration for Tennessee with an emphasis on primary prevention of the health conditions and behaviors that significantly impact the people in Tennessee.

Certificate of Need Standards and Criteria

Tennessee's Certificate of Need (CON) program seeks to deliver improvements in access, quality, and cost effectiveness through orderly growth management of the state's health care system. This edition of the State Health Plan contains updates to the standards and criteria for Nursing Home Services, Hospice Services, Home Health Services, and the Discontinuance of Obstetrical Services.

2015 Update of the State Health Plan

This 2014 edition of the State Health Plan provides a collective vision for protecting, promoting, and improving the health of people in Tennessee and the performance of our health system. The Department of Health recognizes that this work requires effective coordination among state departments, state agencies, and many other stakeholders. With the 2015 edition, the Division of Health Planning will work to develop these collaborations to establish measurable Objectives that align with the priorities and programs of these other departments and stakeholders.

Preface to the 2014 Update of the State Health Plan

Why a State Health Plan?

Tennessee is one of the least healthy states in America. In the America's Health Rankings report released in December 2013, Tennessee ranked 42nd out of the 50 states. The America's Health Rankings report analyzes a wide variety of health outcomes and determinants from each state to develop the rankings. The outcomes and determinants for Tennessee are shown in Appendix E. Significant poor rankings include: adult smoking (47th), diabetes (46th), infant mortality (47th), cardiovascular deaths (44th), cancer deaths (45th), adult physical inactivity (45th), preventable hospitalizations (46th), and violent crime (50th). More information on America's Health Rankings may be found at http://www.americashealthrankings.org/reports/annual, and on Tennessee's performance at http://www.americashealthrankings.org/TN.

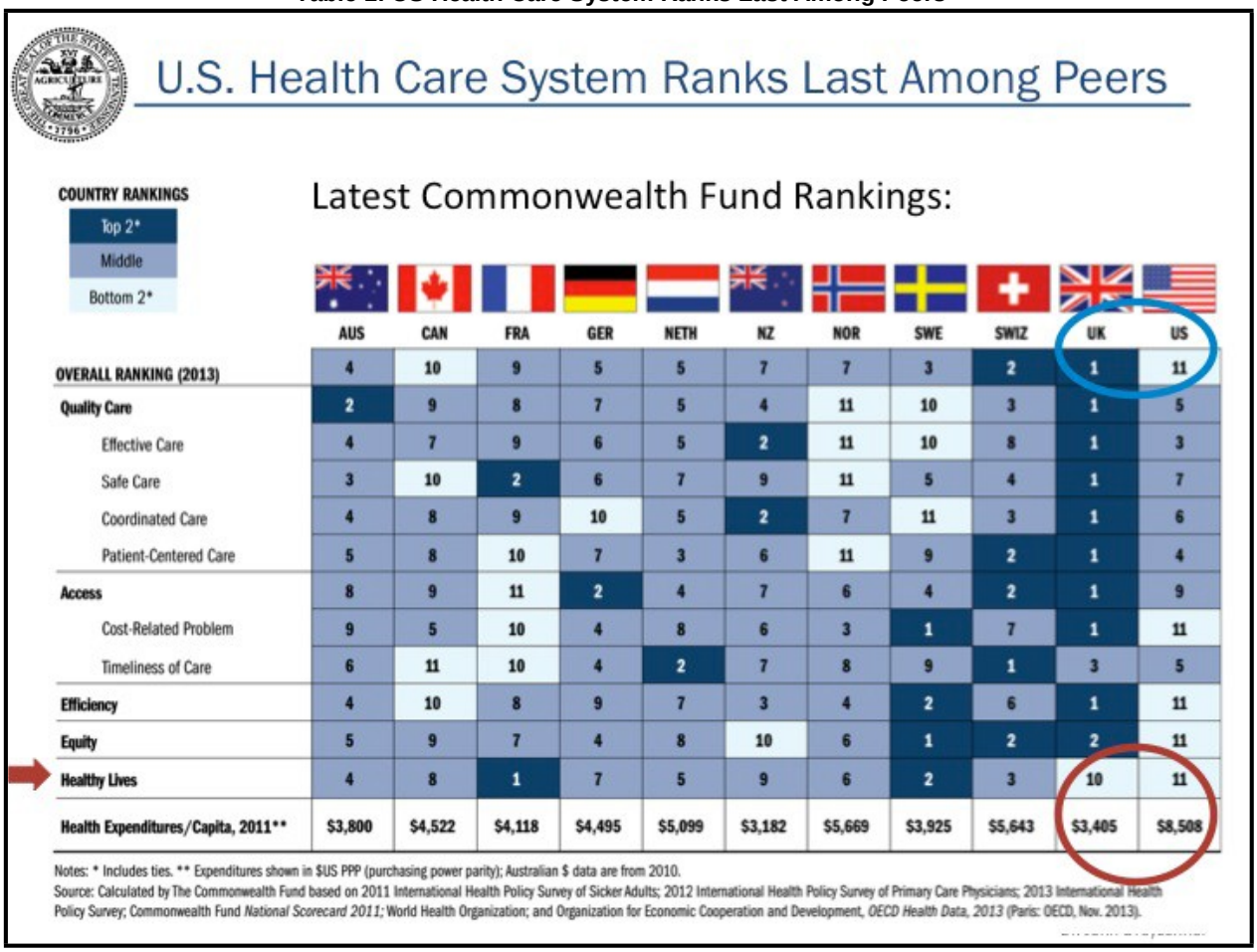
Recognizing the need for the state to coordinate its efforts to improve the health of people in Tennessee, in 2004 the General Assembly passed Public Chapter 942, which created the Division of Health Planning and charged it with developing a State Health Plan to be approved and adopted by the Governor. The law states that the State Health Plan:

- "shall include clear statements of goals, objectives, criteria and standards to guide the development of health care programs administered or funded by the state of Tennessee through its departments, agencies or programs;"
- is to be considered "as guidance by the Health Services and Development Agency when issuing certificates of need;" and
- "shall guide the state in the development of health care programs and policies and in the allocation of health care resources in the state."

The 2010 edition of the State Health Plan focused primarily on health care systems and providers. While successful at providing quality health care, compared to other nations the US health care system ranks low as shown in the below chart in terms of cost, efficiency, and equity of care; most importantly, it ranks worst in the category of "healthy lives". However, note that the highest ranking health care

system, that of the United Kingdom, also ranks near the bottom for health of its population. France ranks 9th overall, yet its population health ranks 1st. This comparison suggests that investments and interventions in health care may not lead to healthy populations and that primary protection initiatives could have a more direct impact than health care systems on population health.

Table 1: US Health Care System Ranks Last Among Peers



U.S. Health Care System Ranks Last Among Peers

COUNTRY RANKINGS
Top 2*
Middle
Bottom 2*

Latest Commonwealth Fund Rankings:

	AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US
OVERALL RANKING (2013)	4	10	9	5	5	7	7	3	2	1	11
Quality Care	2	9	8	7	5	4	11	10	3	1	5
Effective Care	4	7	9	6	5	2	11	10	8	1	3
Safe Care	3	10	2	6	7	9	11	5	4	1	7
Coordinated Care	4	8	9	10	5	2	7	11	3	1	6
Patient-Centered Care	5	8	10	7	3	6	11	9	2	1	4
Access	8	9	11	2	4	7	6	4	2	1	9
Cost-Related Problem	9	5	10	4	8	6	3	1	7	1	11
Timeliness of Care	6	11	10	4	2	7	8	9	1	3	5
Efficiency	4	10	8	9	7	3	4	2	6	1	11
Equity	5	9	7	4	8	10	6	1	2	2	11
Healthy Lives	4	8	1	7	5	9	6	2	3	10	11
Health Expenditures/Capita, 2011**	$3,800	$4,522	$4,118	$4,495	$5,099	$3,182	$5,669	$3,925	$5,643	$3,405	$8,508

Notes: * Includes ties. ** Expenditures shown in $US PPP (purchasing power parity); Australian $ data are from 2010.
Source: Calculated by The Commonwealth Fund based on 2011 International Health Policy Survey of Sicker Adults; 2012 International Health Policy Survey of Primary Care Physicians; 2013 International Health Policy Survey; Commonwealth Fund *National Scorecard 2011;* World Health Organization; and Organization for Economic Cooperation and Development, *OECD Health Data, 2013* (Paris: OECD, Nov. 2013).

As shown by the chart on the following page, numerous factors contribute to population health status including individual behaviors, culture, the environment, economic and social determinants, and genetics.

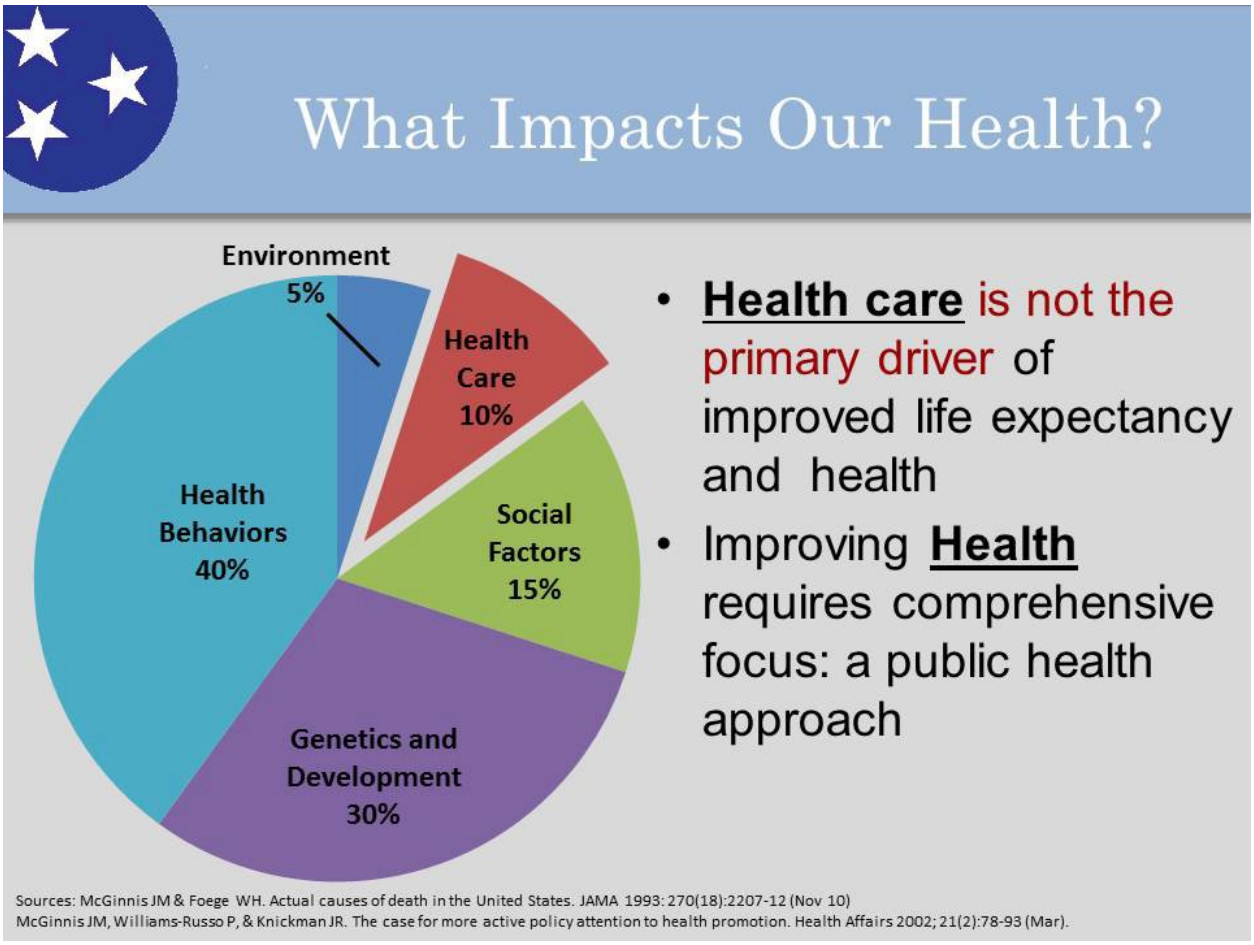


Figure 1: What Impacts Our Health?

As shown in the chart, health care impacts 10% of our health and longevity; 30% is impacted by genetics, over which we have little or no influence. Therefore, to achieve significant population health improvements in Tennessee, the State Health Plan must shift its primary focus to the areas of physical environment, healthy behaviors, and social factors, which together account for 60% of the impact on our health. Objectives established in the 2014 State Health Plan consider these factors and create a new framework for future action that will more closely align the Plan with protection, promotion, and improvement actions that will result in long term population level changes.

The Public Process for Developing the 2014 State Health Plan

Based on the suggestions and findings of earlier editions, this current edition of the State Health Plan is the result of an extensive public process that gathered the input of many key stakeholders, health experts, and people in Tennessee through local and regional meetings and other collaborative efforts. This edition augments the Five Principles for Achieving Better Health by revising the Goals for each principle, by setting specific TDH Objectives, and by acknowledging the need for collaboration with other agencies and communities in developing further Objectives. The public process undertaken to accomplish this update is outlined in Appendix B. The overall strategy was to draw upon the knowledge of those with professional expertise as well as the common sense and personal experiences of the public.

Tennessee Department of Health Objectives for 2015

The Tennessee Department of Health has prioritized improvements in certain health outcomes, health determinants, and health improvement-related programs, which are incorporated here into the State Health Plan. The SMART Objectives included as part of this 2014 Update are those for which TDH is taking the lead. This year's Objectives also serve as a starting point for the 2015 update of the State Health Plan, for which TDH will initiate collaborations with other departments and stakeholders to develop Objectives on which those departments and stakeholders are taking the lead.

The 2014 Tennessee Department of Health Objectives were developed based on the TDH Strategic Plan. Each Objective listed here will be incorporated into the 2015 update under a Goal and its Principle. For the sake of clarity and ease of alignment, the Goal and Principle to which the Objective belongs are stated here.

1. Annually, Tennessee's placement in America's Health Rankings improves better than the national average for:
    a. Smoking
    b. Physical Inactivity
    c. Obesity

    This Objective measures **Principle 1, Healthy Lives, Goal 1b**:
    People in Tennessee – including adults, children, youth, families, and communities – understand and practice behaviors that promote and maintain good health.

    Potential Supportive Stakeholder Communities: State Government, Education, Health Care Payers, Health Care Providers, Mental Health Providers, Transportation, Environment, and many more.

2. Primary Prevention Initiatives (PPI)

   a. By 2016, replicate 10 successful/effective primary prevention projects that have been completed by a TDH team.

      This Objective measures **Principle 1, Healthy Lives, Goal 1a:**
      People in Tennessee have the necessary support and opportunities for healthy living.

      Potential Supportive Stakeholder Communities: Education, Economic Development, Agriculture, others.

   b. By 2016, 33% of pregnant female participants successfully complete nicotine abstinence programs (e.g., Baby and Me, CEASE, Smart Moms) to reduce preterm and low birth weight births.

      This Objective measures **Principle 2, Access, Goal 2a:**
      People in Tennessee understand, have access to, and practice health protection activities.

      Potential Supportive Stakeholder Communities: Education, Health Care Payers

   c. By 2016, the average number of tobacco cessation-funded activities per county increases from 0 to 3.

      This Objective measures **Principle 2, Access, Goal 2b:**
      Communities support healthy lifestyles.

      Potential Supportive Stakeholder Communities: Education, Health Care Payers

3. By 2016, morphine equivalents prescribed in Tennessee decrease by 5%.

   This Objective measures **Principle 4, Quality of Care, Goal 4b:**
   The health system encourages healthy behaviors and delivers safe and effective care.

Potential Supportive Stakeholder Communities: State Government, Mental Health and Substance Abuse, Safety, Health Care Payers.

4. By June 30, 2015, implement an electronic health record project in a single rural and single Metro TDH department.

   This Objective measures **Principle 3, Economic Efficiencies, Goal 3e:** *Tennessee's health system encourages the exploration of new technologies, health care delivery models, and other transformative opportunities.*

   Potential Supportive Stakeholder Communities: State and Local Government

5. For the TDH, by September 30, 2016, implement an electronic health record statewide.

   This Objective measures **Principle 5, Workforce, Goal 5d:** *Health delivery is maximized through workforce efficiency without compromising quality.*

   Potential Supportive Stakeholder Communities: State Government, Local Government, Health Care Providers.

Primary Prevention Initiatives to Target Population Health Improvement

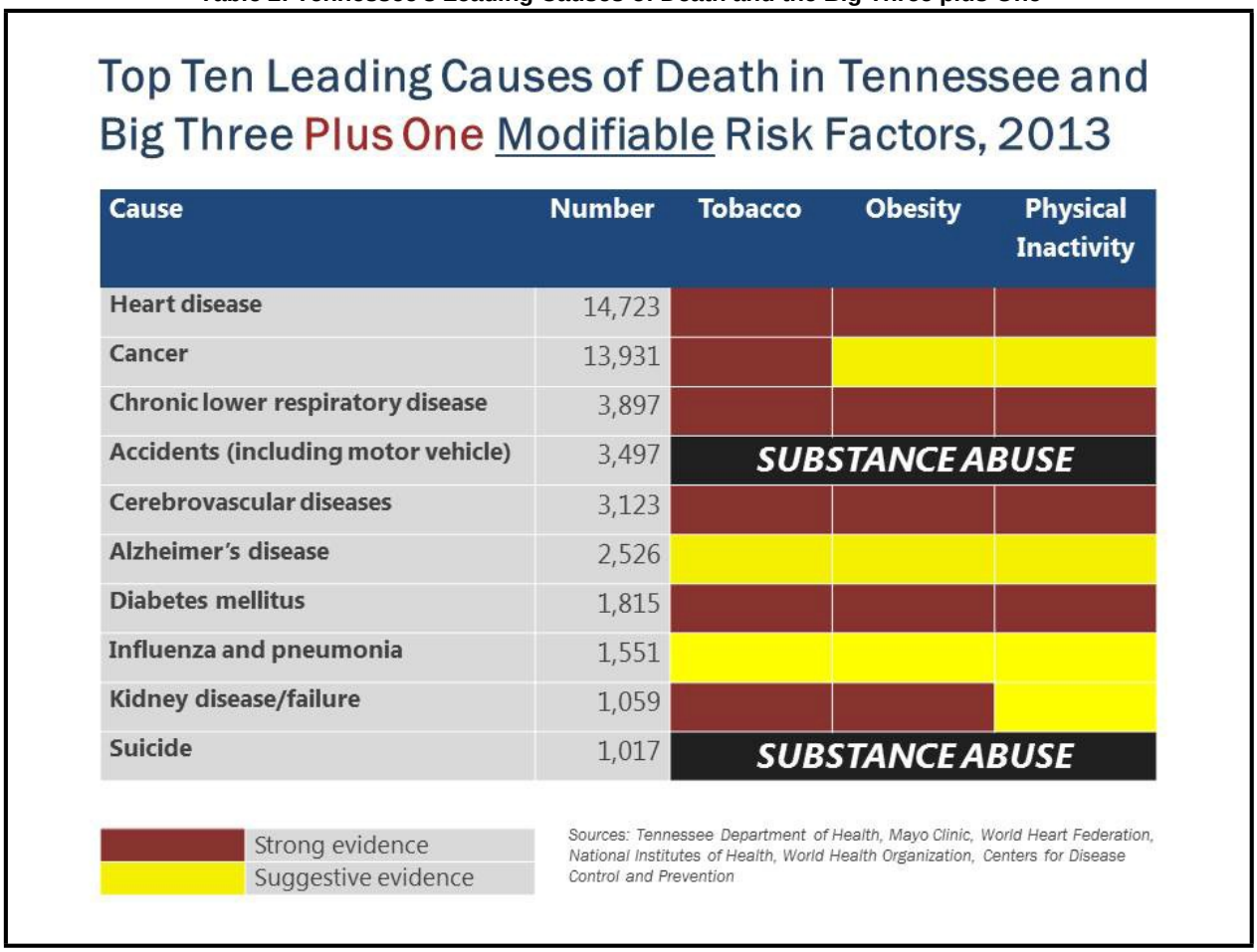
Analysis of Tennessee's health rankings and measures has resulted in the understanding that four behavioral factors greatly impact a majority of the causes of excessive deaths in the state. These four behaviors include smoking, obesity, physical inactivity, and substance abuse. These "Big Three plus One" have become a target of department-wide primary prevention interventions and a focal point for departmental interactions with community partners, including other state departments. The figure below shows how Tennessee ranked on America's Health Rankings in 2014 for each of the Big Three plus One.

Figure 2: Tennessee's "Big Three plus One"

The Big Three plus One directly influence at least six of the top ten leading causes of death in Tennessee, and also directly influence other public health threats, such as heart disease, cancer, and diabetes. Overall, the Big Three plus One influence two-thirds of the factors that contribute to Tennessee's overall rank in America's Health Rankings. Focusing our health protection work on reducing tobacco use and substance abuse, lowering the rate of obesity, and increasing the physical activity of people in Tennessee is the best way to accelerate improvements in our overall population health.

The chart below shows how the Big Three plus One impact the top ten leading causes of death in Tennessee. Evidence strongly shows six causes of death are influenced by them, while it suggests that the other four are as well.

Table 2: Tennessee's Leading Causes of Death and the Big Three plus One



Top Ten Leading Causes of Death in Tennessee and Big Three Plus One Modifiable Risk Factors, 2013

Cause	Number	Tobacco	Obesity	Physical Inactivity
Heart disease	14,723	■	■	■
Cancer	13,931	■	■	■
Chronic lower respiratory disease	3,897	■	■	■
Accidents (including motor vehicle)	3,497	SUBSTANCE ABUSE		
Cerebrovascular diseases	3,123	■	■	■
Alzheimer's disease	2,526	■	■	■
Diabetes mellitus	1,815	■	■	■
Influenza and pneumonia	1,551	■	■	■
Kidney disease/failure	1,059	■	■	■
Suicide	1,017	SUBSTANCE ABUSE		

■ Strong evidence
■ Suggestive evidence

Sources: Tennessee Department of Health, Mayo Clinic, World Heart Federation, National Institutes of Health, World Health Organization, Centers for Disease Control and Prevention

According to America's Health Rankings, nearly 25% of adults in Tennessee smoked as of 2013. Only 10.5% of the adults in the top performing state in the nation smoke. Also in 2013, 12.5% of seniors in Tennessee smoke, ranking the state 49th in this measure. Additionally, according to the Campaign for Tobacco Free Kids (http://www.tobaccofreekids.org/), in 2013 15.4% of Tennessee high school students smoked, compared to 15.7% nationally.

America's Health Rankings also found that 31.1% of adults in Tennessee in 2013 were obese or morbidly obese, compared to 20.5% of the adults in the top performing state. However, 26.3% of seniors in Tennessee in 2013 were obese, making the state

24th in this measure. Also in 2013, 35.3% of Tennessee children ages 10-17 were obese, ranking Tennessee 44th as compared to the national percentage of 30.6.

Also according to America's Health Rankings, the percentage of adults in Tennessee in 2013 who reported doing no physical activity (such as running, golf, calisthenics, gardening, or walking) other than their regular job in the last 30 days was 28.6%, as opposed to 16.2% for the best ranking state. Also in 2013, 32.2% of seniors in Tennessee reported no physical activity for this measure, ranking the state 39th.

To make a significant impact on these rankings and Tennessee's overall ranking, it is important to accelerate our progress. For this reason, TDH has set the objective to improve faster than the national average in each of these rankings annually.

There is also an increasing recognition that in addition to the Big Three, substance abuse is a significant driver of Tennessee's poor rank relative to the rank of other states. Substance abuse is recognized as contributing to multiple of the leading causes of death in Tennessee, including suicide and accidents (e.g., motor vehicle accidents). Recognizing this relationship, TDH has implemented several strategies for reducing substance abuse and its related effects. This focus can be seen in the TDH objective to decrease morphine equivalents prescribed in Tennessee.

As shown in the following chart, TDH data analysis also indicates that there are a number of areas for which Tennessee experiences health disparities regarding the Big Three.

Table 3: Health Disparities and the Big Three

	Race	Gender	Location	Education
Tobacco Use				
Obesity				
Physical Inactivity				

TDH data analyses specifically show disparities such as:

> Tobacco: There is a clear association between lower educational achievement and smoking prevalence – people with less than a high school education smoke at a rate three times higher than do college graduates. The same pattern holds when comparing income levels with smoking. The rural percentage of use in 2012 in Tennessee (26.6%) is higher than the urban percentage of use (21.1%). Data also show that more men than women smoke in Tennessee, with whites in greater proportion than blacks.
>
> Obesity: In Tennessee, black non-Hispanics have a higher obesity prevalence rate (40.7%) than do white non-Hispanics (29.6%) in 2012. Black non-Hispanic females in both rural and urban counties had the highest rate of obesity among racial/gender groups in 2012 at 43.3% and 48.6%, respectively. There is an association between higher obesity and lower educational achievement levels.
>
> Physical Inactivity: While Tennessee's physical activity levels have improved recently, the percentage of inactivity is over 40% higher than the national figure, among the worst in the nation. There is a clear association between lower educational attainment and less physical activity. Black non-Hispanics in both rural and urban counties had higher "no physical activity" prevalence rates when compared to white non-Hispanics, and urban black non-Hispanics had a much lower rate of physical activity than did white non-Hispanics. Additionally, males were more likely to engage in physical activity (65.3%) than were females (60.5%) in 2013 in Tennessee.

Clearly, rural people in Tennessee as well as black non-Hispanics experience significant health disparities, including higher incidence of disease and disability, increased mortality rates, lower life expectancies, and higher rates of pain and suffering. Other disparities that can be difficult to quantify but also impact people in Tennessee include disparities in veterans' health, senior health, behavioral health, and others. TDH is also interested in looking at disparities regarding substance abuse. To improve Tennessee's health ranking, emphasis needs to be placed on reducing and eliminating health disparities.

Framework for the State Health Plan

Understanding the Five Principles for Achieving Better Health and the Interactive Role State Government Departments Play in Improving the Health of People in Tennessee

The following Five Principles for Achieving Better Health, based on the statutory policy statement shown in Appendix A, serve as the framework for the State Health Plan.

Principle 1: Healthy Lives

The purpose of the State Health Plan is to improve the health of people in Tennessee.

Each person's health is the result of the interaction of individual behaviors, social factors, the environment, health care, and our genetic endowment. The State Health Plan serves to facilitate the collaboration of state agencies and stakeholders to improve health with respect to these factors, focusing particularly on behaviors, social factors, and the environment.

Principle 2: Access

People in Tennessee should have access to health care and the conditions to achieve optimal health.

Many elements impact one's access to optimal health and health care, including existing health status, employment status, income level, the built environment, geography, and culture. The State Health Plan can establish Objectives for providing and/or promoting access, offer policy direction for improving access, and serve a coordinating role to expand opportunities for improving and maintaining health and access to health care.

Principle 3: Economic Efficiencies

Health resources in Tennessee, including health care, should be developed to address the health of people in Tennessee while encouraging value and economic efficiencies.

The State Health Plan should work to identify health protection and promotion programs and activities that improve community and individual health, reduce health care costs, improve health outcomes per dollar spent (i.e., "Value"), and encourage innovation.

Principle 4: Quality of Care

People in Tennessee should have confidence that the quality of care is continually monitored and standards are adhered to by providers.

This Principle has been expanded to encompass a broader concept of the health system that addresses improving health through better behaviors and a larger community of participants who help individuals in their health journeys. This Principle also includes the concept that health care providers are held to certain professional standards by the state's licensure system and that quality of care can be improved through adoption of best practices and data-driven evaluation.

Principle 5: Workforce

The state should support the development, recruitment, and retention of a sufficient and quality health workforce.

The concept of who impacts our health has also been expanded for this update of State Health Plan. It is important that the state help communities develop a comprehensive approach to improving and maintaining health that includes not only health care providers, but others in the community who impact individuals' health prior to need for a licensed provider. It is also important that the state continue to work to ensure the availability of a sufficient, qualified health workforce, taking into account issues including: the number of providers at all levels and in all specialty and focus areas; the number of professionals in teaching positions; the capacity of medical, nursing, allied health, and other educational institutions; state and federal laws and regulations impacting capacity programs; and adequate availability of funding.

The State Health Plan: "Connecting the Dots"

As can be seen in this document, many state agencies' programs and plans can and do impact the health of people in Tennessee. Within the Department of Health, there are many offices and divisions with which important collaborations are in progress. Below are examples of collaborations besides those within TDH, which reinforce the importance of developing partnerships among state agencies to improve our health.

- **The Governor's Health and Wellness Foundation** is a non-profit corporation that leads a statewide initiative to improve the lives of people in Tennessee by encouraging three specific behaviors: daily exercise, healthy eating habits, and smoking cessation. It is implementing its comprehensive plan with the *Healthier Tennessee* campaign.
- **The Department of Mental Health and Substance Abuse Services** plans for and promotes the availability of comprehensive services to promote mental health and substance abuse prevention, early intervention, treatment, habilitation, and rehabilitation services and support programs.
- **The Health Services and Development Agency** oversees the *Certificate of Need* program.
- **The Bureau of TennCare** (Tennessee's Medicaid program) provides health care for over 1.2 million people in Tennessee.
- **The Department of Corrections** provides health care for prisoners.
- **The Department of Economic and Community Development**, through its *Three Star Program*, provides incentives to Tennessee communities to make improvements in five areas that have been identified as critical to ensuring community success, including *Health and Welfare*.
- **The Department of Environment and Conservation** (TDEC) protects and improves the quality of Tennessee's air, land, and water through programs and initiatives that protect human health and the environment and support economic development and quality of life through education, outreach and effective enforcement of state and federal environmental laws. TDEC also manages the award-winning Tennessee State Parks system — with 54 state parks hosting more than 25 million visits each year.
- **The Department of Human Services** provides food and nutrition education as well as access to immunizations and other key services.

- **The Department of Children's Services** provides case management services to some of our state's most vulnerable population, including managing their health-related resources.
- **The Department of Intellectual and Developmental Disabilities** assists with needed care for those with intellectual disabilities.
- **The Department of Education** provides a *Conditions for Learning* initiative that includes several programs including the Coordinated School Health Program designed to improve the health of school-aged children.
- **The Department of Transportation** designs and maintains roads that allow people in Tennessee to access health care services and provides multimodal transportation grants to communities, which help improve and maintain health through biking and walking.
- **The Department of Labor and Workforce Development** ensures that an adequate supply of health care providers and other health-related workers are trained and employed.

Furthermore, in addition to managing and administering direct service programs, state government has a number of other roles. Health improvement could be impacted by considering how to increasingly leverage multiple roles as policy makers, regulators, purchasers, and grantors to expand capacity and breadth. State government departments are increasingly recognizing their roles as leaders and facilitators in educating the people of Tennessee about protecting and promoting personal and population health.

Where we live, work, worship, and play are key elements in being healthy. It is important that those agencies of our state government that affect our lives, our employment, and our recreational opportunities collaborate and consider health when making new policies and plans. Along with these stakeholders within state government, there are also many important community stakeholders whose work aligns with the State Health Plan through programs and initiatives that are having a significant impact on the health of people in Tennessee.

The 2014 State Health Plan Goals were developed with this cooperative attitude in mind. Using the Five Principles for Achieving Better Health, the State Health Plan will serve as a blueprint and a guide to "connect the dots" between the different stakeholders in developing a comprehensive and collaborative approach to help people in Tennessee reach their optimal health.

Goals for the Five Principles for Achieving Better Health

Introduction

After the Goal Teams re-drafted the Goals for the State Health Plan, several meetings were held to assess and revise the draft Goals and 12 meetings, including nine public ones, were held to learn what people in Tennessee would like to see accomplished to improve population health. They provided their thoughts for each Goal under each of the Five Principles for Achieving Better Health. These ideas were then assessed and collated to form Priorities for Consideration that will be used to develop future Objectives in collaboration with other state agencies and departments, stakeholders and communities.

The Priorities for Consideration were assessed by a state government leadership committee to rate the issue's importance based on concerns such as potential impact on the population, availability of resources for addressing the issue, and current interests of the people in Tennessee. The conclusions of this committee, as well as further input from department and community stakeholders, will help shape the Objectives for future editions of the State Health Plan.

Within TDH there are many experts, offices, and divisions with whom and with which important collaborations are already in progress, and with whom and with which more collaborations will develop as the Objectives are shaped. These offices and divisions include, but are not limited to, the Office of Minority Health and Disparities Elimination, the Office of Rural Health and Health Access, the TDH Hospital Discharge Data System, the TDH Ambulatory Surgical Treatment Center and Outpatient Diagnostic Center Data Systems, the TDH Health Facilities Licensure Survey System, the Tennessee Traumatic Brain Injury Registry, the Tennessee Cancer Registry, the Division of Family Health and Wellness, the Office of Oral Health Services, and many others.

Principle 1: Healthy Lives

"The purpose of the State Health Plan is to improve the health of people in Tennessee."

Background

Our health is affected by many factors such as what we do, where we live, the people that live around us, our income, our education, and the genes we inherited from our parents. The State Health Plan focuses on goals that support opportunities for improvement in health at both the individual and at the community level.

The Goal Team members' discussions led to a consensus on the importance of health prevention activities and the reduction of onset of chronic diseases for all people in Tennessee throughout their lives. They also agreed on the need for communities to provide opportunities to be healthy for all people in Tennessee and the importance of educating consumers on how to be healthy. The public's ideas showed nearly universal agreement with the idea of promoting health protection and healthy living, with special emphasis statewide on the importance of being able to understand and practice healthy behaviors. Also deemed critical were reducing health disparities and providing opportunities for all state agencies to understand how they impact population health.

Goals

The Goals in this section of the report are not only related to each other, but also provide a foundation for the Goals of the other four Principles for Achieving Better Health.

Goal 1a. People in Tennessee have the necessary support and opportunities for healthy living.

Priorities for Consideration:

1. *Education* – Studies show a direct correlation between higher levels of education and better health.

2. *Infrastructure* – The importance of linking sidewalks, bicycle paths, walking trails, and mass transportation in improving the level of physical activity of a population is gaining national attention.

3. *Availability and Preferences for Healthy Food* – The lack of availability of affordable, nutritious food often results in consumption of high fat, nutritionally bereft options – and sometimes a preference for these options – which contributes to obesity, heart disease, diabetes, and low energy levels.

Potential Collaborators: Healthier Tennessee, Department of Education, Department of Transportation, the built environment community (e.g., land use and community planners, architects, local government), Tennessee Housing and Development Authority, local housing authorities, local governments, and the Tennessee Obesity Task Force

Goal 1b. People in Tennessee – including adults, children, youth, families, and communities – understand and practice behaviors that promote and maintain good health.

Priorities for Consideration:

1. *Physical Activity/Obesity* – In 2013, Tennessee ranked 45th in adult physical inactivity and 40th in adult obesity. It is estimated that nearly 40% of students in grades kindergarten, 2nd, 4th, 6th, and 8th enrolled in Tennessee public schools during the 2013-2014 school year were either overweight or obese.

2. *Tobacco Cessation* – In 2013, Tennessee ranked 47th among the 50 states in the percentage of its adult population who smoked.

3. *Workplace Wellness Programs* – Building workplace "cultures of health" that encourage and support healthy lifestyles and help prevent chronic disease may help improve population health.

4. *Leading Causes of Death* – Rates for Tennessee's 10 leading causes of death are worse than the national rates (table below)

Top 10 Leading Causes of Death for Tennessee Residents per 100,000 people 2010, 2011, and 2012 with Rates and 2011 U.S. Comparison

Sources: Tennessee Department of Health, Office of Policy, Planning and Assessment, Division of Health Statistics; and United States Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics Vital Statistics Reports, Preliminary Data, 2011

Table 4: Tennessee's Top Ten Leading Causes of Death (2010-12)

Leading Cause	Number			Rate			U.S. 2011 Rate (Rank)
	2010	2011	2012	2010	2011	2012	
Total Resident Deaths	59,201	60,104	61,164	932.9	872.6	947.4	806.5
1. Heart Diseases	14,489	14,154	14,245	228.3	204.3	220.6	191.4 (1)
2. Cancer	13,514	13,461	13,633	212.9	187.6	211.2	184.6 (2)
3. Chronic Lower Respiratory Diseases	3,525	3,647	3,658	55.5	52.5	56.7	46.0 (3)
4. Accidents and Adverse Effects	3,472	3,400	3,302	54.7	52.0	51.1	39.4 (5)
5. Cerebrovascular Disease and Stroke	3,178	3,206	2,991	50.1	47.3	46.3	41.1 (4)
6. Alzheimer Disease	2,428	2,578	2,416	38.3	39.3	37.4	27.2 (6)
7. Diabetes	1,678	1,737	1,823	26.4	24.8	28.2	23.5 (7)
8. Pneumonia and Influenza	1,347	1,421	1,469	21.2	21.8	22.0	17.2 (8)
9. Suicide (previously No. 10)	932	938	956	14.7	14.1	14.8	12.3 (10)
10. Kidney Disease (previously No. 9)	974	814	930	15.3	11.8	14.4	10.8 (9)

5. *Teenage Birth Rate* – Teenage pregnancy and childbearing can bring substantial social and economic costs with immediate and long-term impacts on teen parents and their children.

6. *Child Behavioral Health* – Good behavioral health significantly impacts overall and lifetime good health; these impacts can be seen as early as childhood.

7. *Infant Mortality* – In 2014, Tennessee ranked 41st in infant mortality (the death of an infant before his or her first birthday), with 7.3 deaths per 1,000 live births; this compares with ranking 47th in 2013, with 8 deaths per 1,000 live births.

8. *Neonatal Abstinence Syndrome (NAS) Births* – NAS is associated with an increased risk of complications in the neonatal period and higher costs to the healthcare system.

9. *Immunizations, Physical Examinations, and Health Screenings for Awareness and Early Detection* – When combined with personal and community health education, these primary prevention initiatives contribute significantly to health protection.

Potential Collaborators: Healthier Tennessee, Department of Education, Early Childhood Wellness Initiatives, Taskforce on Aging and Disability, Department of Mental Health and Substance Abuse Services

Goal 1c. Health disparities between and among populations, as well as the underlying causes of these disparities, are eliminated.

Priorities for Consideration:

1. *Veterans Issues* – The physical and behavioral health concerns of Tennessee's more than 525,000 veterans can differ significantly from those of the general population.

2. *Health Disparities Elimination* – Certain Tennessee populations – defined by parameters such as race, ethnic background, gender, educational achievement, income level, and geography – often experience poorer health due to limited or inadequate availability of information regarding healthy lifestyles, prevention measures, and health care.

3. *Children in Poverty* – In 2013, Tennessee ranked 42nd in the nation with 26.3% of people under 18 years of age living in poverty. Poverty can create ill-health because it forces affected people to live in environments that may make them sick, often without decent shelter, clean water, or adequate sanitation.

4. *Behavioral Health* – People with behavioral health issues often experience poorer health determinants and outcomes than the public in general.

Potential Collaborators: Tennessee Department of Veterans Affairs, Healthier Tennessee, Taskforce on Aging and Disability, Tennessee Department of Mental Health and Substance Abuse Services

Goal 1d. Individuals and communities have and utilize tools and resources to manage and improve health.

Priorities for Consideration:

1. *Physical Activity in Schools* – Regular physical activity during childhood and adolescence positively impacts health, weight control, and reduction of anxiety and stress.

2. *Health Literacy* – An individual's capacity to obtain, process, communicate, and understand basic health information and services is key to making appropriate health decisions.

3. *Healthy Food in Schools* – Many children consume at least half of their meals at school, and for some, food served at school is their primary source of food.

4. *Physicals* – This primary prevention initiative contributes to lifetime health protection, from childhood (e.g., the Early Periodic Screening, Diagnosis, and Treatment Program and school physicals) through adulthood.

5. *Nutrition/Physical Activity Programs for Seniors* – Tennessee's population that is over 65 years of age is higher than the national average, yet in 2013 Tennessee ranked in the bottom 10 states on almost all senior health and well-being measures.

6. *Mobile Access to Health Care Providers* – Availability of better transportation options can impact people's access to health care providers.

7. *Safe Routes to School* – Safe Routes to School is a national and international movement to reverse the decline in children

walking and bicycling to schools, and thus may increase levels of physical activity.

8. *Workshops for Self-Management of Chronic Disease*– More information and assistance on chronic disease self-management may improve how well people in Tennessee care for themselves.

9. *Value and Availability of Palliative Care*– Increasing awareness of the availability of palliative care programs, which provide specialized medical care focusing on relief from the symptoms, pain, and stress of a serious illness, can help communities and individuals take better advantage of such services.

Potential Collaborators: Department of Education (e.g., the Tennessee School Nutrition Program), Healthier Tennessee, Department of Mental Health and Substance Abuse Services (including Prescription for Success), Early Childhood Wellness Initiatives, and Commission on Aging

Goal 1e. State and local decision makers consider the impacts of health policy and health systems on both individual and community health.

Priorities for Consideration:

1. *Certificate of Need*– Health policy and health systems plans will be considered by the Health Services and Development Agency when making Certificate of Need decisions because these considerations are directly related to two of the three criteria (Need and Orderly Development) necessary to approve a Certificate of Need. The HSDA is charged with using the goals, objectives, criteria, and standards in the State Health Plan as guidelines when determining whether Certificate of Need criteria have been met.

2. *Community Development*– Cross-sector collaborations in planning and developing communities can help improve local population health and reduce health disparities.

3. *Local Fitness Programs and Facilities* – Availability of fitness programs and facilities can help improve health and reduce health disparities, especially in underserved communities.

4. *Collaborative Health Education* – Partnerships with schools, as well as other health providers and voluntary organizations, at all levels and with local communities, can assist in providing more and better information on healthy behaviors and primary prevention.

5. *Built Environment* – "Walkable" and "livable" communities can help improve health and reduce health disparities.

6. *Funding for Preventive Health Activities* – Funding health protection and primary prevention programs at the local level can assist in improving communities' health.

7. *County Plans to Improve Population Health* – Coordination among local government, state government, health and wellness councils, and providers, especially regarding Community Health Needs Assessments, can measure the impact of health programs and initiatives on a community. Plans can address general goals for change or focus on single health conditions and their related issues.

8. *State Government "Health in All Policies"* – "Health in All Policies" is a strategy to assist leaders and policymakers in integrating considerations of health and well-being during the development, implementation, and evaluation of policies and services, thus resulting in a coordinated, collaborative approach to improving health.

Potential Collaborators: Health Services and Development Agency, Tennessee Department of Economic and Community Development (Three Star Program), Built Environment Community, Healthier Tennessee, Tennessee Promise (The Tennessee Student Assistance Corporation and local non-profit partners), Local Communities, the Bureau of TennCare

Principle 2: Access to Care

"People in Tennessee should have access to health care and the conditions to achieve optimal health."

Background

Many elements impact one's access to optimal health and health care, including existing health status, employment status, income level, the built environment, geography, and culture. Gaining entry into the health system and gaining access to sites of care are equally important access issues.

The Goal Team members' discussions led to a consensus on the importance of people in Tennessee living healthy lives and of communities supporting activities to do so. Connected to this concept was the agreement that health and health care needs should affirmatively be measured and address and that people in Tennessee have access to appropriate services. The ideas received focused on health education, the identification of local health needs, and access to specific types of care.

Goals

Access to the conditions and opportunities to achieve better health and to health care involves many factors. The goals and objectives of this section address issues of access on several levels.

Goal 2a. People in Tennessee understand, have access to, and practice health protection activities.

Priorities for Consideration:

1. *Community Health Literacy* – Access to information on health protection and primary prevention programs at the local level can help improve health and reduce health disparities.

2. *School Health Education* – Education provided in schools on healthy eating, nutrition, health education, and prescription

drugs can impact healthy behaviors developed in childhood that may persist throughout life.

Potential Collaborators: Healthier Tennessee, the Bureau of TennCare, Department of Education

Goal 2b. Communities support healthy lifestyles.

Priorities for Consideration:

1. *Violent Crime* – In 2013, Tennessee ranked last among the 50 states in its rate of violent crime offenses. The available evidence shows that both direct and indirect exposures to violence have serious health consequences for a community.

2. *Access to Nutritious Food* – Greater community support for access to nutritious food can help improve health and reduce health disparities.

3. *Affordable Public Transportation* – Access to affordable transportation to health care providers can impact whether individuals seek appropriate care, especially services that promote health protection and primary prevention.

4. *Integrated Interdepartmental Efforts* – Coordination and collaboration among state departments can provide additional resources to communities to support healthy lifestyles. (e.g., the Department of Economic and Community Development's Three Star Program encourages collaboration across departments and provides incentives to communities).

5. *Best Practices for Healthy Community* – Access to definitions and essential elements of a healthy community can help communities develop their own plans of action to support healthy lifestyles.

Potential Collaborators: Local communities, Tennessee Department of Economic and Community Development, Safety community, Department of Agriculture

Goal 2c. Tennessee's health and health care needs and opportunities are clearly defined, measured, reported, and addressed.

Priorities for Consideration:

1. *Identification of Local Health Needs and Opportunities*– A baseline assessment of health needs and opportunities is a solid beginning to improving access to better health.

2. *Support of Community/Local Health Department Partnerships* – Partnerships between community stakeholders as well as the local health department can help identify and address local health needs and opportunities.

3. *Adverse Childhood Event*s – Certain childhood mistreatment and negative experiences are major risk factors for the leading causes of adult chronic disease and related deaths. Identifying and reporting on these events may assist in reducing adult chronic disease and related deaths.

Potential Collaborators: The Bureau of TennCare, Department of Mental Health and Substance Abuse Services, local communities

Goal 2d. People in Tennessee are able to obtain appropriate quality health care services to meet their needs.

Priorities for Consideration:

1. *Access to Health Insurance* – Access to health insurance impacts the ability of people in Tennessee to obtain health care services.

2. *Access to Behavioral Health Services* – Access to behavioral health services impacts the ability of people in Tennessee to address their overall health needs.

3. *Access to Health Care Providers and Primary Care Networks* – Access to health care providers and primary care networks impacts the ability of people in Tennessee to obtain appropriate health care services and primary care.

4. *Veterans' Care* – Access to appropriate health care services that address the physical and behavioral health concerns specific to Tennessee's veterans impacts the health of that population.

5. *Health and Dental Clinics* – Access to appropriate health and dental clinics impacts people's ability to obtain appropriate services, especially for underserved populations.

6. *Behavioral Health/Substance Abuse Services in Prisons* – For those people in Tennessee who are incarcerated, access to behavioral health and substance abuse services in prisons can impact how well they adjust to release from prison.

7. *Home and Community-Based Health* – Access to home and community-based services can help improve people's care experience and health.

8. *Team-Based Care* – Access to team-based care can help improve people's care experience.

Potential Collaborators: The Bureau of TennCare, Taskforce on Aging and Disability, Department of Mental Health and Substance Abuse Services, local communities, Health Services and Development Agency

Principle 3: Economic Efficiencies

"Health resources in Tennessee, including health care, should be developed to address the needs of people in Tennessee while encouraging value and economic efficiencies."

Background

While Economic Efficiencies in previous editions of the State Health Plan has focused on efficiency in the health care system, the 2014 edition aims to expand such concepts of efficiency to health protection and primary prevention as well as health care. Therefore, the goals for this principle reflect not only value in the health care system, but also the value of people in Tennessee understanding and engaging in health protection.

The Goal Team members' discussions led to a consensus that access to understandable and usable information about health and the health care system impacts how effectively patients engage in health protection and with the health care system. The Goal Teams also discussed Tennessee's position at the forefront of health care payment reform, particularly regarding payment based on value rather than volume. Understanding and improving the value of health resources was also a common element of Goal Team discussions, as was the importance of transformational technologies and opportunities.

Goals

Economic Efficiency is not only about efficient, quality health care; it is also about individuals' understanding of the efficiency of their optimal health. The goals and objectives in this section reflect efficiency at both of these levels.

Goal 3a. Individuals and communities in Tennessee recognize the long-term efficiency and effectiveness of health protection.

Priorities for Consideration:

1. *Primary Prevention* – Individuals' access to and engagement in primary prevention activities and wellness programs may show recognition of the efficiency and effectiveness of health protection.

2. *Insurance Plans* – Promotion of wellness programs may increase health protection activities among health plan beneficiaries.

3. *Community Engagement with Healthier Tennessee* – Expanded community involvement in Healthier Tennessee can help improve involvement in health protection activities in those communities.

4. *Three Star Program* – Participation by communities in the Department of Economic and Community Development's Three Star Program can impact involvement in health protection activities in those communities.

Potential Collaborators: Three Star Program, Home and Community-Based Health Protection and Care, Taskforce on Aging and Disability

Goal 3b. Health and health care information – including cost and quality – are readily available, transparent, and understandable.

Priorities for Consideration:

1. *Data Availability* – Availability of data is key to transparency and the understanding of program and policy impacts.

2. *Reductions of Data Lag* – Directly related to No. 1 above, reducing the time between data gathering and data reporting is also key to transparency, as well as to generating understandable information.

3. *Primary Prevention Return on Investment (ROI)* – To effectively understand and communicate the ROI of primary prevention initiatives, it is important to gather and analyze appropriate data.

4. *Controlled Substance Monitoring Database (CSMD)* – Collaboration throughout Tennessee and with other states is key to the success of the CSMDB. Evidence continues to accumulate that prescription drug monitoring programs help reduce diversion of controlled substances, improve clinical decision-making, and assist in other efforts to curb the prescription drug abuse epidemic.

5. *Electronic Medical Records (EMR)* – EMR is a powerful tool for improving appropriate and effective sharing of health information.

Potential Collaborators: Prescription for Success, Division of Health Care Finance and Administration

Goal 3c. The value of health and health care resources is continually measured, reported, and improving.

Priorities for Consideration:

1. *Provider Effectiveness* – Measuring appropriate health care utilization can impact the value of health care resources.
2. *Emergency Department (ED) Visits* – Measuring and reporting on ED visits in order to develop better ways to direct individuals to the appropriate level of care can impact the value of health care resources.
3. *Health Impact Analysis* – Measuring, assessing, and reporting the outcomes of state health policy initiatives can help in understanding the value of utilization of health and health care resources in Tennessee.
4. *Return on Investment (ROI)* – Developing trusted ways to measure and report on the ROI for state health programs can help in improving the value of health and health care resources in Tennessee.
5. *Academic Partnerships* – State partnerships with non-state health researchers can help expand our resources to measure and assess health outcomes data and report on the success of programs.
6. *Transitions of Care* – Improving care coordination for patients between and among providers can positively impact patient health.

Potential Collaborators: County Level Priorities, Three Star Program, Healthier Tennessee, Health Services and Development Agency (CON)

Goal 3d. Payments to health care providers reward high-value care. Health care providers will receive new information and rewards for high quality and efficient care. The State will lead payment reform by example with the TennCare, CoverKids, and state employee insurance programs, and will work with provider, payer, employer, and patient stakeholders so that changes to the payment and delivery system are widely adopted and aligned.

Priorities for Consideration:

1. *Monetary Incentives to Primary Care Providers* – Value-based purchasing should increase the value of primary care.
2. *Transparency of the Patient Care Outcomes of Providers* – Such transparency can help patients choose providers.
3. *Prevalence of Value-based Purchasing* – Prevalence of value-based purchasing can be used as a measure of how many people in Tennessee are impacted by health payment reform. Medicare is already engaged in structuring reimbursement using this practice.
4. *Implementation of Payment Reform Initiatives for Provider-Patient Communication* – Initiatives that encourage providers to communicate with patients can help improve the value of care provided.
5. *Implementation of Payment Reform Initiatives across the Commercial Insurer Spectrum* – Implementing such initiatives across commercial insurers can impact how many people in Tennessee are affected by value-based payment reform.

Potential Collaborators: The Bureau of TennCare, Finance and Administration (Benefits Administration), health insurance companies

Goal 3e. Tennessee's health system encourages the exploration of emergent technologies, health care delivery models, and other transformative opportunities.

Priorities for Consideration:

1. *Health Information Exchange (HIE)* – Expansion and interoperability of HIE technology impacts how patients and providers in Tennessee track and share a patient's records.
2. *Electronic Medical Records (EMR)* – Support and expansion of EMR capabilities impacts how patients and providers in Tennessee track health status, healthcare use, and health outcomes within a patient's records.
3. *Emergent Technologies* – Because technological opportunities are ever-changing, it is important that there be flexibility in the State Health Plan so that such opportunities can be incorporated into future Objectives.
4. *Health Care Delivery Model (Rural Hospital)* – Transformative opportunities for rural hospitals should be explored – including delivery models for both financial stability and a mix of services (including preventive care and chronic disease maintenance) – with community providers and the residents they serve.

Potential Collaborators: Home and Community-Based Health Protection and Care, EMR, Telemedicine, Community Health Workers/Care Transitions, the Bureau of TennCare

Principle 4: Quality of Care

"People in Tennessee should have confidence that the quality of care is continually monitored and standards are adhered to by providers."

Background

Much like Economic Efficiencies, Quality of Care is no longer only a health care focus, but also a health protection focus. Regarding the Goals for Quality of Care, this shift represents a greater emphasis on healthy behaviors and patient-centered care.

The Goal Team members' discussions led to a consensus that safe, effective, and evidence-based care is important in any consideration of quality. They also felt it was of equal importance that the health system emphasizes healthy behaviors and measures both the quality of treatment and the quality of preventive care in community as well as practice settings. They also agreed that patient access to information on quality of providers is paramount. In addition, they noted that patients and providers should be partners in achieving successful outcomes.

Goals

Quality of Care includes aspects such as safety and effectiveness as well as an emphasis on promoting healthy behaviors. The goals in this section address aspects of quality on several levels.

Goal 4a. Providers and patients are partners in health protection and achieving successful outcomes, as agreed upon by both the patient and provider

Priorities for Consideration:

1. *Behavioral Health* – Behavioral health screenings can be an important factor in achieving successful patient outcomes.

2. *Senior Health* – The Governor's Taskforce on Aging and Disability has recently released a Strategic Plan regarding seniors' health protection as well as issues impacting seniors' health.

3. *Patient-Centered Practices* – Patient education and patient-centered practices are important to a successful partnership between patients and providers in achieving successful health outcomes.

Potential Collaborators: Healthier Tennessee, Home and Community-Based Health Protection and Care, Conditions for Learning (DOE), Department of Mental Health and Substance Abuse Services (Prescription for Success), Taskforce on Aging and Disability

Goal 4b. The health system encourages healthy behaviors and delivers safe and effective care.

Priorities for Consideration:

1. *Americans with Disabilities Act (ADA)* – Availability of a transition plan for people with disabilities impacts the delivery of safe and effective care.

2. *Substance Abuse/Addiction* – Increased monitoring and regulation of opioid use for pain management is key to encouraging healthy behaviors, delivering safe and effective care, and impacting substance abuse and addiction.

3. *Primary Care* – Primary care that integrates preventive and treatment services can impact delivery of safe and effective care.

4. *Wellness Plans and Information* – Expansion of wellness programs and campaigns can encourage healthy behaviors.

5. *Elective Deliveries* – Tracking medical justification for elective deliveries impacts the delivery of safe and effective care in this area.

Potential Collaborators: Healthier Tennessee, Built Environment, Three Star Program, Prescription for Success, County Level Priorities, Controlled Substance Monitoring Database, Early Childhood Wellness Initiatives, Health Services and Development Agency

Goal 4c. The health system uses evidence-based practices and minimizes unnecessary variation in procedures.

Priorities for Consideration:

1. *Pain Control* – Effective monitoring of addictive pain control medication at the patient and system-wide levels can help improve policymaking and increase the safe prescription of these medications.
2. *Quality of Health Care Services* – Consistent measurement of health care quality among health insurers and provider organizations based on national guidelines is key to implementing evidence-based practices and minimizing unnecessary variation.
3. *Data Collection* – Increased effective data collection serves as the foundation for evidence-based practices.
4. *Improved Outcomes* – Using evidence-based quality metrics to direct practice and minimize unnecessary variation can improve outcomes.
5. *Schools for Health Professionals* – Incorporating training on quality of care practices and metrics into schools for health professionals can help increase evidence-based practices and minimize unnecessary variation.

Potential Collaborators: The Bureau of TennCare, Controlled Substance Monitoring Database, Department of Mental Health and Substance Abuse Services

Goal 4d. The public has access to user-friendly, actionable, and accurate information on the quality of providers.

Priorities for Consideration:

1. *Information Access* – Access to user-friendly information can help improve the public's understanding of measures of provider quality.
2. *Community Report Card* – Availability of a community health care/quality report card on the community's health system can offer the public access to user-friendly, actionable, and accurate information on provider quality.
3. *Department of Health Website* – An interactive quality of care website can provide the public access to user-friendly, actionable, and accurate information on provider quality.

Potential Collaborators: Health Facilities Licensure, Health Professionals Licensure, Behavioral Health Licensure

Principle 5: Health Workforce

"The state should support the development, recruitment, and retention of a sufficient and quality health workforce."

Background

Our concept of who impacts our health has broadened since the 2010 State Health Plan. The state should help communities approach health in ways that are open to a more comprehensive set of those who can improve and maintain health, including but also beyond health care providers. The state should continue to work to ensure the availability of a sufficient, qualified health workforce, taking into account issues including: the number of providers at all levels and in all specialty and focus areas; the number of professionals in teaching positions; the capacity of medical, nursing, allied health, and other educational institutions; state and federal laws and regulations impacting capacity programs; and adequate availability of funding.

The Goal Team members placed a new emphasis on health protection and primary prevention and expanded the concept of who impacts health improvements beyond that of licensed health care professionals. Interest was expressed in ensuring the health workforce is culturally attuned to local communities and that the primary care workforce is maximized while maintaining the provision of high quality services.

The Priorities for Consideration strongly reflected a desire for home and community-based health protection and care while ensuring that an expanded health workforce understands and is able to communicate with local residents. As well, that workforce should reflect the particular needs of a community. Much interest was expressed in the use of technological improvements in the delivery of care.

Goals

Health Workforce includes aspects such as promoting wellness through primary care, equipping a sufficient workforce with appropriate knowledge and cultural skills, and maximizing the efficiency of the workforce. This section addresses aspects of health workforce on several levels.

Goal 5a. Tennessee's health system emphasizes and promotes wellness through the focus of its workforce on health protection and primary care.

Priorities for Consideration:

1. *Primary Prevention and Primary Care* – An increased emphasis on the provision of primary prevention and primary care are key to the wellness of people in Tennessee.
2. *Community Involvement* – Local businesses and faith communities can promote wellness by connecting with local health and health management classes.
3. *Healthier Tennessee* – This health protection and primary prevention initiative of the Governor's Health and Wellness Foundation promotes wellness throughout the state.

Potential Collaborators: Healthier Tennessee, Taskforce on Aging and Disability, local communities, Department of Economic and Community Development

Goal 5b. Tennessee's health workforce is well-equipped to care for the health needs of patients and communities.

Priorities for Consideration:

1. *Patient Awareness* – Equipping providers to help their patients be more engaged in protecting and managing their health can help improve health outcomes.
2. *Continuing Education* – Additional continuing medical education standards for health care professionals can ensure these professionals are adequately equipped to address patients' needs.
3. *Other Professional Education* – Cultural competency programs in medical schools, programs to train religious leaders in health protection, and training for all health profession students in broader models of care can help these providers care for patients.

4. *Community Care Transitions* – Ensuring that providers have a plan in place to address community care transitions is important to helping them provide the care that their patients need.

5. *Recruitment into Health Professions Programs* – Programs that teach school-age children (particularly rural and inner city children) awareness of health-related occupations can help develop Tennessee's future health workforce.

Potential Collaborators: Tennessee Promise, Three Star Program, Controlled Substance Monitoring Database, Prescription for Success, Health Services and Development Agency, Department of Education

Goal 5c An adequate† health workforce is recruited and retained to engage in the needs of the surrounding community.

Priorities for Consideration:

1. *Primary Care Providers* – While Tennessee ranked 18th in its number of primary care physicians in 2013, this rank does not reflect the uneven distribution of providers throughout the state.

2. *Incentives for State/Rural Provider Practice* – Increasing the number of programs that provide incentives for practice (e.g., financial, educational, etc.) can help attract health professionals to areas with a high need for providers.

3. *Cultural Competency* – Ensuring that health care workers can communicate with and understand their local patients will help address the health care needs of a community.

4. *Health System Education* – Community educators can assist local residents in understanding the health care system and thus help address the needs of the community.

Potential Collaborators: The Bureau of TennCare, Taskforce on Aging and Disability, Department of Mental Health and Substance Abuse Services, local communities, Health Services and Development Agency

† "Adequate" includes, but is not limited to, sufficiency of number, training, and cultural competence.

Goal 5d. Health delivery is maximized through workforce efficiency without compromising quality.

Priorities for Consideration:

1. *Community Health Liaison* – Community health workers who act as liaisons between residents and health care and insurance companies can encourage proper navigation and use of health services to help improve outcomes.

2. *Scope of Practice* – Increasing the number of primary care providers and their ability to practice with appropriate oversight can help improve the efficiency of primary care provision.

3. *Midwives* – Appropriately increasing the use of midwives can help improve the care of obstetrical patients.

4. *Partnerships Among Providers* – Improved collaboration among providers as well as with local health departments and academic center educational partnerships can help maximize the effectiveness of the health care workforce.

5. *Technology* – Appropriate use of technology can help maximize provision of care without compromising patient safety.

Potential Collaborators: Local communities, Provider Professional Associations, the Bureau of TennCare, Department of Mental Health and Substance Abuse Services

Certificate of Need
Standards and Criteria

Why Certificate of Need

In the 1970s, the federal government urged states to control rising health care costs by managing the growth of health care services and facilities through health planning and a certificate of need process. Tennessee established its Certificate of Need program in 1973. In 1974, the federal government enacted the National Health Planning and Resources Development Act, which, among other things, provided federal funds to assist with state health planning. The Act was repealed in 1987, resulting in the loss of federal funds. However, most states, including Tennessee, retained a form of CON, realizing a well-run CON program is one of very few methods state planners have to control health care costs, ensure quality, and ensure access to health care for all people in Tennessee. CON standards and criteria were developed, with significant revisions occurring in the 1990s and again in 2000. In 2004, the Division of Health Planning was created with one of its many responsibilities being the development of revised standards and criteria for the CON program.

All current CON Standards and Criteria, including recent updates, can be found at: http://www.tn.gov/hsda/.

Past, Current, and Future Revisions

In 2009, the Division revised the original CON standards for:

- Positron Emission Tomography Services
- Cardiac Catheterization Services

In 2010, the Division updated the CON standards for:

- Open Heart Surgical Services
- External Shock Wave Lithotripsy Services

In 2011, the Division updated the CON standards for:

- Magnetic Resonance Imaging Services
- Megavoltage Radiation Therapy Services

In 2012, the Division updated the CON standards for:

- Ambulatory Surgical Treatment Centers
- Hospice Services

This 2014 Edition of the State Health Plan updates the CON standards for:

- Nursing Home Services
- Hospice Services
- Home Health Services
- Discontinuation of Obstetrical Services

These 2014 revisions and their corresponding rationale statements are included on the following pages. Future updates will contain updated revisions of other CON Standards and Criteria. The new revisions replace the versions found in the "Guidelines for Growth" of the Health Services and Development Agency; as required by statute, these revisions and the entire 2014 Update to the State Health Plan have been reviewed by the agency members and staff.

Nursing Home Services

Certificate of Need Standards and Criteria

STATE OF TENNESSEE

STATE HEALTH PLAN

CERTIFICATE OF NEED STANDARDS AND CRITERIA

FOR

NURSING HOME SERVICES

The Health Services and Development Agency (HSDA) may consider the following standards and criteria for applications seeking to provide nursing home services as defined by Tennessee Code Annotated (TCA) Section 68-11-201(28). Rationale statements are provided for standards to explain the Division of Health Planning's (Division) underlying reasoning and are meant to assist stakeholders in responding to these Standards and to assist the HSDA in its assessment of certificate of need (CON) applications. Existing providers of nursing home services are not affected by these Standards and Criteria unless they take an action that requires a new CON for such services.

These Standards and Criteria are effective immediately upon approval and adoption by the governor. However, applications to provide nursing home services that are deemed complete by the HSDA prior to the approval and adoption of these Standards and Criteria shall be considered under the Guidelines for Growth, 2000 Edition.

NOTE: TCA Section 68-11-1622 states that the HSDA "shall issue no certificates of need for new nursing home beds, including the conversion of hospital beds to nursing home beds or swing beds," other than a designated number of such beds per fiscal year, "to be certified as Medicare skilled nursing facility (SNF) beds…." Additionally, this statute states that the number of Medicare SNF beds issued under this section shall not exceed the allotted number of such beds per applicant. The applicant should also specify in the application the skilled services to be provided and how the applicant intends to provide such skilled services.

NOTE: An applicant that is not requesting a CON to add new nursing home beds shall have its application reviewed by the HSDA staff and considered by the HSDA pursuant to TCA Section 68-11-1609.

Rationale: This Note is included to assist potential applicants in understanding the distinction in the law between a CON application for new Medicare skilled nursing facility beds (including the conversion of hospital beds to nursing home beds or swing beds) and a CON application that does not propose new beds.

Definitions

Nursing Home: Shall have that meaning set forth in Tennessee Code Annotated Section 68-11-201(28) or its successor.

Occupancy Rate: The number of patient days divided by the product of the number of licensed beds and the number of days in the calendar year. The Tennessee Department of Health (TDH) reports nursing home utilization data, including occupancy rates, on its website at: http://health.state.tn.us/statistics/CertNeed.shtml

Service Area: The county or counties represented on an application as the reasonable area in which a nursing home intends to provide services and/or in which the majority of its service recipients reside.

Standards and Criteria

1. **Determination of Need**.

   The need for nursing home beds for each county in the state should be determined by applying the following population-based statistical methodology:

   Need = .0005 x population 65 and under, plus
   .012 x population 65-74, plus
   .060 x population 75-84, plus
   .150 x population 85 +

   Rationale:
   The Division has analyzed the existing Guidelines for Growth compared with the statewide utilization percentages as well as occupancy rates from the nursing home Joint Annual Reports (JARs) for 2012 and has determined that grounds to update the percentages are not sufficient to justify revision of the formula. While input from stakeholders supports that the existing formula is adequate to address statewide nursing home need at present, stakeholder input further suggests that this formula may require re-evaluation based on the impact of factors such as patient participation in the TennCare CHOICES program authorized by the Long Term Care Community Choices Act of 2008, the change in Nursing Facility Level of Care Criteria for TennCare recipients in 2012, and other reimbursement and policy changes. The Division will assess the adequacy of the formula as circumstances concerning nursing homes develop.

County utilization does, of course, differ among the counties' age cohorts, and depends largely upon the availability of nursing home services as well as the availability of reimbursement for those services. The Division believes the criterion regarding the Average Daily Census of existing nursing homes in a Service Area, set forth in No. 4 will help balance any need "overstatements" that the formula might calculate.

Research published by the Henry J. Kaiser Family Foundation in 2013 (http://kff.org/medicaid/fact-sheet/overview-of-nursing-facility-capacity-financing-and-ownership-in-the-united-states-in-2011/) shows that a majority of people over the age of 65 will need long-term care services for an average of three years, and 20 percent of people will need more than five years of services. The percentage of the population over the age of 65 is expected to increase as the "baby boom" generation ages, and specifically the number of people 85 and older is expected to grow significantly. Tennessee's population projections are in-line with those reported nationally, if not slightly higher, for these age groups. How best to determine sufficient capacity to accommodate long-term care user choice in both institutional and community-based settings will continue to be a challenge for policy makers.

The Division recognizes that, increasingly, nursing homes are impacted by the decreases in reimbursement rates, the focus on shorter stays, and the encouragement by policies for nursing care to be provided elsewhere in the community or in the home. The result has been an overall decline in occupancy rates and an increase in the level of care required by nursing home patients.

As requested by stakeholders, the Division commits to making available to applicants a standard chart of the results of the need formula for each county as data are verified, finalized, and made available by the TDH.

2. **Planning horizon:** The need for nursing home beds shall be projected two years into the future from the current year.

   Rationale: The current Guidelines for Growth use a two year planning horizon; after consideration of the impact of a three year planning horizon, the Division believes a three year planning horizon has the potential to overstate need.

3. **Establishment of Service Area**: A majority of the population of the proposed Service Area for any nursing home should reside within 30 minutes travel time from that facility. Applicants may supplement their applications with sub-county level data that are available to the general public to better inform the HSDA of granular details and trends; however, the need formula established by these Standards will use the latest available final JAR data from the Department of Health. The HSDA additionally may consider geographic, cultural, social, and other aspects that may impact the establishment of a Service Area.

Rationale: The current Guidelines for Growth also state that a majority of the population of a service area should reside within 30 minutes travel time. In many cases it is likely that a proposed nursing home's service area could draw much more significantly from a specific area of a county. However, utilization data—which are critical to the need formula—are available from the Department of Health only at the county level. When available, the Division would encourage the use of sub-county level data that are available to the general public (including utilization, demographics, etc.) to better inform the HSDA in making its decisions. Because nursing home patients often select a facility based on the proximity of caregivers and family members, as well as the proximity of the facility, factors other than travel time may be considered by the HSDA.

4. **Existing Nursing Home Capacity**: In general, the Occupancy Rate for each nursing home currently and actively providing services within the applicant's proposed Service Area should be at or above 90% to support the need for any project seeking to add new nursing home beds within the Service Area and to ensure that the financial viability of existing facilities is not negatively impacted.

   When considering replacement facility or renovation applications that do not alter the bed component within the Service Area, the HSDA should consider as the primary factor whether a replacement facility's own occupancy rate could support its economic feasibility, instead of the occupancy rates of other facilities in the Service Area.

   Rationale: The words "In general" are specifically included in this Standard because several factors contribute to the ability of existing nursing homes to meet need, including in particular the designation of beds by payer mix and the specific services provided. Private insurance, Medicaid (TennCare), and Medicare reimburse services at different rates and for different purposes and lengths of stay. An applicant may be able to make a case for licensed beds if, for example, specific ancillary services or bed types are lacking in a proposed Service Area, whether or not all nursing homes in a Service Area have Occupancy Rates at or above 90%. A preference should be provided to an applicant wishing to provide Medicaid (TennCare) beds. The Division is of the opinion that the following types of applications seek to increase/alter the number of nursing home beds within a Service Area:

   a. An applicant seeks to add new nursing home beds;
   b. An applicant seeks to relocate an existing facility to a new Service Area;
   c. An applicant seeks to establish a new facility not currently operating (i.e., does not seek a replacement of an existing, operating facility); and
   d. An applicant seeks to take a single existing licensed facility and divide its bed component into more than one licensed facility (this last application type should not be viewed as merely a replacement of an existing facility, and usually requires legislation authorizing this division of beds).

5. **Outstanding Certificates of Need:** Outstanding CONs should be factored into the decision whether to grant an additional CON in a given Service Area or county until an outstanding CON's beds are licensed.

   Rationale: This Standard is designed to ensure that the impact of a previously approved CON for the provision of nursing home services in a given service area is taken into consideration by the HSDA.

6. **Data:** The Department of Health data on the current supply and utilization of licensed and CON-approved nursing home beds should be the data source employed hereunder, unless otherwise noted.

   Rationale: Using one source for data is the best way to ensure consistency across the evaluation of all applications. The Division believes the TDH's data should be relied upon as the primary source of data for CON nursing home services applications.

7. **Minimum Number of Beds**: A newly established free–standing nursing home should have a sufficient number of beds to provide revenues to make the project economically feasible and thus is encouraged to have a capacity of least 30 beds. However, the HSDA should consider exceptions to this standard if a proposed applicant can demonstrate that economic feasibility can be achieved with a smaller facility in a particular situation.

   Rationale: Quality of care is impacted by the relationship between facility size and the appropriate staffing of the facility. Assuming appropriate staffing exists, the HSDA should consider each applicant's circumstances individually regarding facility size. The Division's research in Tennessee indicates that 90-120 licensed beds may be an optimal range for ensuring both economic feasibility and the delivery of quality care. However, exceptions to this general range are certain to arise.

   Two examples of such circumstances could be: 1) When a newly proposed facility is planned in conjunction with an existing continuum of services, such as the development of a continuing care campus or other type of multiple service provider, in which case a smaller number of beds may be justified; and 2) If the existing resources in a sparsely populated rural area are not sufficient and new nursing homes are needed, a smaller facility may be justified as compared to a larger facility. The State Health Plan encourages the HSDA to evaluate such applications carefully to ensure that they propose to provide services adequately to a broad population.

8. **Encouraging Facility Modernization**: The HSDA may give preference to an application that:
   a. Proposes a replacement facility to modernize an existing facility.
   b. Seeks a certificate of need for a replacement facility on or near its existing facility operating location. The HSDA should evaluate whether the

replacement facility is being located as closely as possible to the location of the existing facility and, if not, whether the need for a new, modernized facility is being impacted by any shift in the applicant's market due to its new location within the Service Area.

c. Does not increase its number of operating beds.

In particular, the HSDA should give preference to replacement facility applications that are consistent with the standards described in TCA §68-11-1627, such as facilities that seek to replace physical plants that have building and/or life safety problems, and/or facilities that seek to improve the patient-centered nature of their facility by adding home-like features such as private rooms and/or home-like amenities.

Rationale: The aging of nursing home facilities is an increasing concern within the industry. This standard seeks to provide support for an existing nursing home to modernize/update its facilities.

9. **Adequate Staffing:** An applicant should document a plan demonstrating the intent and ability to recruit, hire, train, assess competencies of, supervise, and retain the appropriate numbers of qualified personnel to provide the services described in the application and that such personnel are available in the proposed Service Area. However, when considering applications for replacement facilities or renovations of existing facilities, the HSDA may determine the existing facility's staff would continue without significant change and thus would be sufficient to meet this Standard without a demonstration of efforts to recruit new staff.

10. **Community Linkage Plan:** The applicant should describe its participation, if any, in a community linkage plan, including its relationships with appropriate health care system providers/services and working agreements with other related community services to assure continuity of care. If they are provided, letters from providers (including, e.g., hospitals, hospice services agencies, physicians) in support of an application should detail specific instances of unmet need for nursing home services.

    Rationale: Coordinated, integrated systems of care may not be in place in much of rural Tennessee, and therefore this language has been deleted. Additionally, the Division recognizes that nursing homes may not be the primary drivers of community linkage plans, and the Division does not mean to suggest that an applicant should develop one itself; instead it should provide information on its participation in a community linkage plan, if any. However, the Division recognizes that hospitals, particularly rural ones, often encounter difficulties in discharge planning to nursing homes due to a lack of available beds. CON applications for new nursing home beds should therefore also provide letters from hospitals, hospice service agencies, physicians, or any other appropriate providers, to provide evidence of unmet need and the intent to meet that need.

11. **Access:** The applicant should demonstrate an ability and willingness to serve equally all of the Service Area in which it seeks certification. In addition to the factors set forth in HSDA Rule 0720-11-.01(1) (listing the factors concerning need on which an application may be evaluated), the HSDA may choose to give special consideration to an applicant that is able to show that there is limited access in the proposed Service Area. However, an applicant should address why Service Area residents cannot be served in a less restrictive and less costly environment and whether the applicant provides or will provide other services to residents that will enable them to remain in their homes.

12. **Quality Control and Monitoring:** The applicant should identify and document its existing or proposed plan for data reporting, quality improvement, and outcome and process monitoring systems, including in particular details on its Quality Assurance and Performance Improvement program as required by the Affordable Care Act. As an alternative to the provision of third party accreditation information, applicants may provide information on any other state, federal, or national quality improvement initiatives. An applicant that owns or administers other nursing homes should provide detailed information on their surveys and their quality control programs at those facilities, regardless of whether they are located in Tennessee.

    Rationale: This section supports the State Health Plan's Principle No. 4 for Achieving Better Health regarding quality of care. Typically, nursing homes are not accredited by the Joint Commission or other accrediting bodies; applicants instead are asked and encouraged to provide information on other quality initiatives. The intent of this alternative is to permit the applicant to show its commitment to, as well as its performance regarding, quality control and improvement. Surveys and quality control programs at sister facilities may provide an indication of future quality performance at the applicant's proposed facility and are relevant to the HSDA's assessment of the application.

13. **Data Requirements:** Applicants should agree to provide the TDH and/or the HSDA with all reasonably requested information and statistical data related to the operation and provision of services at the applicant's facility and to report that data in the time and format requested. As a standard of practice, existing data reporting streams will be relied upon and adapted over time to collect all needed information.

14. **Additional Occupancy Rate Standards:**

    a. An applicant that is seeking to add or change bed component within a Service Area should show how it projects to maintain an average occupancy rate for all licensed beds of at least 90 percent after two years of operation.

b. There should be no additional nursing home beds approved for a Service Area unless each existing facility with 50 beds or more has achieved an average annual occupancy rate of 90 percent. In determining the Service Area's occupancy rate, the HSDA may choose not to consider the occupancy rate of any nursing home in the proposed Service Area that has been identified by the TDH Regional Administrator as consistently noncomplying with quality assurance regulations, based on factors such as deficiency numbers outside of an average range or standards of the Medicare 5 Star program.

c. A nursing home seeking approval to expand its bed capacity should have maintained an occupancy rate of 90 percent for the previous year.

Rationale: The Division believes reducing the occupancy rates from 95 to 90 percent in numbers 14b and 14c more accurately reflects overall occupancy in the state, and also would take into consideration some increasing vacancy rates that current nursing homes may be experiencing due to decreasing admissions overall and increasing patient turnover due to short-stay patients.

Hospice Services

Certificate of Need Standards and Criteria

STATE OF TENNESSEE

STATE HEALTH PLAN
CERTIFICATE OF NEED STANDARDS AND CRITERIA

FOR

RESIDENTIAL HOSPICE SERVICES AND HOSPICE SERVICES

The Health Services and Development Agency (HSDA) may consider the following standards and criteria for applications seeking to provide Residential Hospice and Hospice services. Existing providers of Residential Hospice and Hospice services are not affected by these standards and criteria unless they take an action that requires a new certificate of need (CON) for Residential Hospice and/or Hospice services.

These standards and criteria are effective immediately upon approval and adoption by the Governor of the State Health Plan updates for 2014. Applications to provide Residential Hospice and/or Hospice services that were deemed complete by HSDA prior to this date shall be considered under the Certificate of Need Standards and Criteria included in the State Health Plan updates for 2012.

Because of the unique nature of hospice services, the Division commits to reviewing these standards annually.

Definitions Applicable to both Residential Hospice Services and Hospice Services

1. **"Deaths**" shall mean the number of all deaths in a Service Area less that Service Area's number of reported homicide deaths, suicide deaths, and accidental deaths (which includes motor vehicle deaths), as reported by the State of Tennessee Department of Health. The number of reported infant deaths includes neonatal and post neonatal deaths and is reported separately under the respective cause of death; therefore, in order to prevent overlap, the number of infant deaths is not included discretely.

2. "**Residential Hospice"**[1] shall have that meaning set forth in Tennessee Code Annotated Section 68-11-201 or its successor.

3. **"Hospice"** shall refer to those hospice services not provided in a Residential Hospice Services facility.

4. **"Total Hospice"** shall mean Residential and Hospice Services combined.

STANDARDS AND CRITERIA APPLICABLE TO TOTAL HOSPICE

1. **Adequate Staffing:** An applicant should document a plan demonstrating the intent and ability to recruit, hire, train, assess competencies of, supervise, and retain the appropriate numbers of qualified personnel to provide the services described in the application. Importantly, the applicant must document that such qualified personnel are available for hire to work in the proposed Service Area. In this regard, an applicant should demonstrate its willingness to comply with the general staffing guidelines and qualifications set forth by the National Hospice and Palliative Care Organization.

   Rationale: Health care professionals, including those who provide hospice services, are not uniformly located across the state, and rural areas showing some need for hospice services may not have a qualified hospice workforce. The Division believes that granting a CON for the provision of health care services without evidence that the applicant has a qualified workforce readily available to provide quality care to patients is not, in fact, providing access to quality health care.

2. **Community Linkage Plan:** The applicant should provide a community linkage plan that demonstrates factors such as, but not limited to, relationships with appropriate health care system providers/services and working agreements with other related community services assuring continuity of care focusing on coordinated, integrated systems. Letters from physicians in support of an application should detail specific instances of unmet need for hospice services.

3. **Proposed Charges:** The applicant should list its benefit level charges, which should be reasonable in comparison with those of other similar facilities in the Service Area or in adjoining service areas.

4. **Access:** The applicant must demonstrate an ability and willingness to serve equally all of the Service Area in which it seeks certification. In addition to the factors set forth in HSDA Rule 0720-11-.01(1) (listing the factors concerning need on which an application

[1] The Division recognizes the Guidelines for Growth's statement that "the purpose of residential hospice facilities is not to replace home care hospice services, but rather to provide an option to those patients who cannot be adequately cared for in the home setting." The Division also recognizes that Residential Hospice and Hospice providers may in fact provide the same services.

may be evaluated), the HSDA may choose to give special consideration to an applicant that is able to show that there is limited access in the proposed Service Area.

5. **Indigent Care:** The applicant should include a plan for its care of indigent patients in the Service Area, including:

    a. Demonstration of a plan to work with community-based organizations in the Service Area to develop a support system to provide hospice services to the indigent and to conduct outreach and education efforts about hospice services.
    b. Details about how the applicant plans to provide this outreach.
    c. Details about how the applicant plans to fundraise in order to provide indigent and/or charity care.

6. **Quality Control and Monitoring:** The applicant should identify and document its existing or proposed plan for data reporting, quality improvement, and outcome and process monitoring system. Additionally, the applicant should provide documentation that it is, or intends to be, fully accredited by the Joint Commission, the Community Health Accreditation Program, Inc., the Accreditation Commission for Health Care, another accrediting body with deeming authority for hospice services from the Centers for Medicare and Medicaid Services (CMS) or CMS licensing survey, and/or other third party quality oversight organization. The applicant should inform the HSDA of any other hospice agencies operating in other states with common ownership to the applicant of 50% or higher, or with common management, and provide a summary or overview of those agencies' latest surveys/inspections and any Department of Justice investigations and/or settlements.

    Rationale: This information will help inform the HSDA about the quality of care the applicant's common ownership and/or management provides in other states and the likelihood of its providing similar quality of care in Tennessee.

7. **Data Requirements:** Applicants should agree to provide the Department of Health and/or the Health Services and Development Agency with all reasonably requested information and statistical data related to the operation and provision of services and to report that data in the time and format requested. As a standard of practice, existing data reporting streams will be relied upon and adapted over time to collect all needed information.

8. **Education:** The applicant should provide details of its plan in the Service Area to educate physicians, other health care providers, hospital discharge planners, public health nursing agencies, and others in the community about the need for timely referral of hospice patients.

RESIDENTIAL HOSPICE SERVICES

DEFINITIONS

9. **"Service Area"** shall mean the county or contiguous counties represented on an application as the reasonable area in which a health care institution intends to provide Residential Hospice Services and/or in which the majority of its service recipients reside. A radius of 50 miles and/or a driving time of up to 1 hour from the site of the residential hospice services facility may be considered a "reasonable area;" however, full counties shall be included in a Service Area. Only counties with a Hospice Penetration Rate that is less than 80 percent of the Statewide Median Hospice Penetration Rate may be included in a proposed Service Area.

10. **"Statewide Median Hospice Penetration Rate" (SMHPR)** shall mean the number equal to the Hospice Penetration Rate (as described in the following Need Formula) for the median county in Tennessee.

ADDITIONAL SPECIFIC STANDARDS AND CRITERIA FOR RESIDENTIAL HOSPICE SERVICES

Note that, while a "need formula" is set forth below, the decision to approve a CON application hereunder should be determined by the cumulative weight of all standards and criteria, including those set forth earlier herein.

11. **Need Formula:** The need for Residential Hospice Services should be determined by using the following Hospice Need Formula, which should be applied to each county in Tennessee:

    A / B = Hospice Penetration Rate

    Where:

    A = the mean annual number of Hospice unduplicated patients served in a county for the preceding two calendar years as reported by the Tennessee Department of Health;

    and

    B = the mean annual number of Deaths in a county for the preceding two calendar years as reported by the Tennessee Department of Health.

    Note that the Tennessee Department of Health Joint Annual Report for Hospice defines "unduplicated patients served" as "number of patients receiving services on day one of reporting period plus number of admissions during the reporting period."

Need is established in a county (thus, enabling an applicant to include it in the proposed Service Area) if its Hospice Penetration Rate is less than 80% of the Statewide Median Hospice Penetration Rate; further, existing Residential Hospice Services providers in a proposed Service Area must show an average occupancy rate of at least 85%.

The following formula to determine the demand for additional hospice service recipients should be applied to each county included in the proposed service area, and the results for each county's calculation should be aggregated for the proposed service area:

(80% of the SMHPR – County Hospice Penetration Rate) x B

Rationale: The use of an SMHPR is a methodology employed by many states; the Division paid particular attention to the Kentucky model (which employs an 80% rate), as Kentucky's population is similar geographically and culturally to that of Tennessee. The Division considered ranges from 70-85%, but felt that the results of rates lower than 80% were too restrictive. Only three additional counties showed need using the 85% rate as opposed to the 80% one, and those had low single-digit-need numbers. Thus, the 80% rate is proposed. The Division believes that using the median county rate supports the view that rural counties cannot quickly reach the higher penetration rates of Tennessee's metropolitan areas. The underlying purpose is to help encourage orderly growth by using an SMHPR that ratchets upward across the state as hospice providers strive to exceed 80% of the median county's hospice penetration rate. Thus, utilization should continue to increase, albeit gradually, and provide the opportunity in the underutilizing counties for more hospice services by agencies that can expect a market to exist for those services.

12. **Types of Care:** An applicant should demonstrate whether or not it will have the capability to provide general inpatient care, respite care, continuous home care, and routine home care to its patients. If it is not planning to provide one or more of these listed types of care, the applicant should explain why.

13. **Continuum of Care Regarding the Expansion from Non-Residential Hospice Services:** An applicant for Residential Hospice Services that provides Hospice Services should explain how the Residential Hospice Services will maintain or enhance the Hospice Services' continuum of care to ensure patients have access to needed services. An applicant should provide assurances that it understands and will comply with any existing Medicare reimbursement requirements (e.g., the provision of different levels of hospice care, including any total patient care day allowances) and evidence that there are a sufficient number of potential hospice service recipients that will enable it to so comply.

    Rationale: Currently[2]**,** Medicare pays nearly 90% of all hospice claims. The Medicare hospice benefit produces an incentive to recruit as many new patients as possible and to keep them on the service as long as possible. Unlike other segments of the health care

[2] As of January 9, 2015

industry, where revenues and costs can vary widely, Medicare pays a set daily rate for each person in hospice care, with higher allowances for patients that require more attention.

As part of its interest in ensuring that hospice programs serve only patients who are eligible and appropriate for hospice care, Medicare limits the total number of days of inpatient care (the sum of general inpatient care (GIP) and inpatient respite care days) for which a hospice may be reimbursed. The cap is set at 20 percent of the hospice's total patient care days. The Department of Health and Human Services' Office of Inspector General (OIG), in a May 3, 2013, memo to Marilyn Tavenner, Acting Administrator for Centers for Medicare & Medicaid Services (CMS), stated that CMS staff "have expressed concerns about possible misuse of GIP" by hospice programs and noted a $2.7 million settlement with a hospice program for allegedly having billed for GIP when patients actually received routine home care (which has a lower reimbursement rate). "Long lengths of stay and the use of GIP in inpatient units need further review to ensure that hospices are using GIP as intended and providing the appropriate level of care. OIG is committed to looking into these issues further and will conduct a medical record review that will assess the appropriateness of GIP provided in different settings." The Division adds the above requirement as a way to ensure that the HSDA and applicants understand the importance that an applicant provide hospice services appropriately. The Division believes that the HSDA, through its application of appropriately developed CON standards and criteria, can serve an important role in reducing opportunities for Medicare/Medicaid fraud and abuse in Tennessee.

14. **Assessment Period:** After approval by the HSDA of a residential hospice services CON application, no new residential hospice services CON application – whether for the initiation of services or for the expansion of services – should be considered for any county that is added to or becomes part of a Service Area until JAR data for residential hospice services can be analyzed and assessed by the Division to determine the impact of the approval of the CON.

    Assessment Period Rationale: This Standard is designed to ensure that the impact of the provision of hospice services as a result of the approval of a new CON is accounted for in any future need calculations for a Service Area.

HOSPICE SERVICES

DEFINITIONS

15. **"Service Area"** shall mean the county or contiguous counties represented on an application as the area in which an applicant intends to provide Hospice Services and/or in which the majority of its service recipients reside.

16. **"Statewide Median Hospice Penetration Rate" (SMHPR)** shall mean the number equal to the Hospice Penetration Rate (as described below) for the median county in Tennessee.

ADDITIONAL SPECIFIC STANDARDS AND CRITERIA FOR HOSPICE SERVICES

Note that, while a "need formula" is set forth below, the decision to approve a CON application hereunder should be determined by the cumulative weight of all standards and criteria, including those set forth earlier herein.

17. **Need Formula:** The need for Hospice Services should be determined by using the following Hospice Need Formula, which should be applied to each county in Tennessee:

    A / B = Hospice Penetration Rate

    Where:

    A = the mean annual number of Hospice unduplicated patients served in a county for the preceding two calendar years as reported by the Tennessee Department of Health;

    and

    B = the mean annual number of Deaths in a county for the preceding two calendar years as reported by the Tennessee Department of Health.

    Note that the Tennessee Department of Health Joint Annual Report of Hospice Services defines "unduplicated patients served" as "number of patients receiving services on day one of reporting period plus number of admissions during the reporting period."

    Need should be established in a Service Area as follows:

    a. For a hospice that is initiating hospice services:

        i. The Hospice Penetration Rate for the entire proposed Service Area is less than 80% of the SMHPR;

    AND

        ii. There is a need shown for at least 100 total additional hospice service recipients in the proposed Service Area, provided, however, that every county in the Service Area shows a positive need for additional hospice service recipients.

    Preference should be given to applications that include in a proposed Service Area only counties with a Hospice Penetration Rate that is less than 80% of the SMHPR; however,

an application may include a county or counties that meet or exceed the SMHPR if the applicant provides good reason, as determined by the HSDA, for the inclusion of any such county and: 1) if the HSDA finds that such inclusion contributes to the orderly development of the healthcare system in any such county, and 2) the HSDA finds that such inclusion is not intended to include a county or counties that meet(s) or exceed(s) the SMHPR solely for the purpose of gaining entry into such county or counties. Letters of support from referring physicians in any such county noting the details of specific instances of unmet need should be provided by the applicant.

b. For a hospice that is expanding its existing Service Area:

    i. There is a need shown of at least 40 additional hospice service recipients in each of the new counties being added to the existing Service Area.

Taking into account the above guidelines, the following formula to determine the demand for additional hospice service recipients should be applied to each county, and the results should be aggregated for the proposed service area:

(80% of the Statewide Median Hospice Penetration Rate – County Hospice Penetration Rate) x B

Rationale – 17a: The Division believes that hospice services in Tennessee are under-utilized, most likely as a result of community and societal norms and a need for more education to the general public on the benefits of hospice. Consequently, the Division believes that hospice services should be encouraged, within reason, in Tennessee and that providing broader opportunities for these services will help educate the public as to their value. Under 17a, the ability to include within a Service Area a county that meets or exceeds the SMHPR should assist in the grouping of counties within a Service Area, thus providing more hospice services opportunities, provided that there is no detriment to the orderly development of the healthcare system as a result.

The Tennessee Hospice Association and other stakeholders provided information that 120 hospice service recipients is a larger than necessary number to ensure economic sufficiency of a hospice that is initiating hospice services. Consensus opinion appears to agree that 100 hospice service recipients is a sufficient number.

Rationale – 17b: Other states provide for the ability of an existing hospice to expand its Service Area where positive need is shown at 40-50% of the criterion required for a new hospice to institute services, thus a number of 40 additional hospice service recipients is suggested. Existing agencies are presumed to have the infrastructure in place for such expansion.

18. **Assessment Period:** After approval by the HSDA of a hospice services CON application, no new hospice services CON application – whether for the initiation of

services or for the expansion of services – should be considered for any county that is added to or becomes part of a Service Area until JAR data for hospice services can be analyzed and assessed by the Division to determine the impact of the approval of the CON.

Assessment Period Rationale: This Standard is designed to ensure that the impact of the provision of hospice services as a result of the approval of a new CON is accounted for in any future need calculations for a Service Area.

Additional Comments and Rationale Statements for Revised and Updated Standards and Criteria for Hospice Services

Definitions

Deaths: The Division of Health Planning patterns its need formula off the Kentucky certificate of need formula that takes into account all deaths, instead of using a type of cancer death weighted formula that appeared in the Guidelines for Growth. Cancer patient utilization of hospice services has lessened in relation to non-cancer patients, while the utilization of hospice services continues to grow.

Residential Hospice and Hospice: The Division recognizes that residential hospice services and hospice services are able to perform the same level of services and has thus not distinguished between the need for hospice services based on the two types of service providers. However, certain standards and criteria, such as service area, provide for a difference in consideration of an application.

Standards and Criteria

Quality of Care: Providing for adequate and qualified staffing is an important part of providing quality care to patients, and is one of the State Health Plan's Principles for Achieving Better Health. A community linkage plan that assures continuity of care also falls within this Principle. Letters from physicians in support of an application should detail specific instances of unmet need for hospice services. Quality improvement, data reporting, and outcome and process monitoring fall under this Principle as well, as does accreditation/quality oversight of the hospice service program. Finally, it should be noted that Medicare currently requires all four levels of hospice care for reimbursement (which also supports the third Principle regarding Economic Efficiencies).

Access: The second Principle for Achieving Better Health in the State Health Plan focuses on access to care. Accordingly, the applicant must demonstrate an ability and willingness to serve equally all of the Service Area in which it seeks certification and provide a plan for its care of indigent patients. As well, in addition to the factors set forth in HSDA Rule 0720-11-.01(1) (listing the factors concerning need on which an application may be evaluated), the

HSDA may choose to give special consideration to an applicant that is able to show that there is limited access in the proposed Service Area. The revisions to the need formula in 17b are meant to encourage the provision of hospice services in counties that otherwise do not meet the need formula, thus providing better access for the community.

Economic Efficiencies: The third Principle for Achieving Better Health focuses on encouraging economic efficiencies in the health care system. The new standards and criteria provide that the applicant's proposed charges should be reasonable in comparison with those of other similar facilities in the Service Area or in adjoining service areas. Educating the health care community on hospice services also falls within this Principle; the education component also addresses the fifth Principle of recruiting, developing, and retaining a sufficient qualified health care workforce.

Data Needs: The Division recognizes that hospice patients known as "general inpatients" receive hospice services in locations other than their homes, such as nursing homes and hospitals, and that these patients are not separately identified on the Joint Annual Report. The Division aims to correct this omission in the future to better account for the total utilization of hospice services.

NOTE: A previously proposed standard providing for the showing of an "unmet demand" has been deleted, for the following three reasons: 1) The Division believes that an unintended consequence of that proposed standard would have been the preclusion of a new, non-county-contiguous hospice agency ever to develop a Service Area from those counties and receive a CON to serve them; 2) After review of hospice utilization data for the past three JARs, the Division has learned that, in counties that showed a positive need of less than 40 under the existing need formula, existing hospice agencies met substantially all (if not all) of the positive need of additional hospice service recipients, providing evidence that the orderly development of hospice services in such counties currently exists; and 3) the Division recognizes that the HSDA already has the inherent authority to determine, based on evidence provided, that there is a need for expansion of hospice services into adjacent counties beyond that shown by the need formula.

Home Health Services

Certificate of Need Standards and Criteria

STATE OF TENNESSEE

STATE HEALTH PLAN
CERTIFICATE OF NEED STANDARDS AND CRITERIA

FOR

HOME HEALTH SERVICES

The Health Services and Development Agency (HSDA) may consider the following standards and criteria for applications seeking to provide home health services. Rationale statements for each standard are provided following the standard. Existing providers of home health services are not affected by these standards and criteria unless they take an action that requires a new certificate of need (CON) for such services.

These standards and criteria are effective immediately upon approval and adoption by the Governor. However, applications for certificates of need to provide home health services that are deemed complete by HSDA prior to the approval and adoption of these standards and criteria by the Governor shall be considered under the Guidelines for Growth, 2000 Edition.

Definitions

Home Health Service: "Home health service" is defined by Tennessee Code Annotated § 68-11-201. This definition is included in HSDA Rule 0720-9-.01. As set out in the statute, home health services include skilled nursing care; physical, occupational, or speech therapy; medical social services; home health aid services; and the provision of certain medical supplies and medical appliances. For the purposes of these standards and criteria, a "home health service" shall be performed by a "home care organization." Please see Note 1 for information regarding Professional Support Services and Personal Support Services.

Home Care Organization: "Home care organization" is defined by Tennessee Code Annotated § 68-11-201 and includes an entity that provides home health services.

Service Area: Refers to the county or contiguous counties in which the applicant intends to provide home health services.

Joint Annual Reports (JARs): The JARs prepared and submitted by home care organizations shall be identified by the Health Services and Development Agency (HSDA) as the primary source of data regarding home health services performed in Tennessee. The Tennessee Department of Health (TDH) maintains the JARs and is responsible for generating reports utilizing TDH data as required by the Certificate of Need program.

Private Duty Services: Refers to those skilled nursing and CNT services under physician orders provided in the home or community setting.

Intermittent Care Services: Refers to those nursing services provided by an RN or an LPN, therapist, social worker, or aide under physician orders that are normally no more than one visit per day of a maximum duration of two hours.

Standards and Criteria

1. **Determination of Need:** In a given county, 1.5 percent of the total population will be considered as the need estimate for home health services in that county. This 1.5 percent formula will be applied as a general guideline, as a means of comparison within the proposed Service Area.

   Rationale: After much effort, the Division has determined that limitations of the data obtained from the current JAR form do not permit a revision of the Need formula, and that there are no more accurate data sources available. Consequently, it has at this time decided to retain the current Need formula from the Guidelines for Growth, and has repeated it herein. The Division commits to working with stakeholders to assess the data needs of the HSDA, the TDH, and stakeholders and to revise the JAR form accordingly. Once sufficient data are collected, a review of the Need formula will be undertaken.

   The existing Need formula is admittedly a conservative one. The Division's research regarding Medicare-Medicaid fraud and abuse in the home health services industry supports a conservative Need formula. In 2012, the Government Accountability Office reported that 40% of all fraud convictions initiated by a group of Medicaid fraud-control units were for home health services — the biggest category of providers convicted through the Medicaid units' efforts. The Centers for Medicare and Medicaid Services (CMS) states that home health agencies offer services and supplies "vulnerable to fraud."

2. The need for home health services should be projected three years from the latest available year of final JAR data.

Note: The Division recognizes that a home care organization can be established within a 12-15 month period of time, and that ideally a one year planning horizon would be used. However, in this instance a three-year planning horizon is used because final JAR data lag significantly behind the current date. Final 2012 JAR data became available in May 2014, thus providing data for need to be projected in 2015 but not for any other future full calendar year. Should a change occur that enables TDH to provide final JAR data significantly earlier, the Division would propose a change in the planning horizon.

3. The use rate of existing home health agencies in each county of the Service Area will be determined by examining the latest utilization rate as calculated from the JARs of existing home health agencies in the Service Area. Based on the number of patients served by home health agencies in the Service Area, an estimation will be made as to how many patients could be served in the future.

   Rationale: This Standard is carried over from the Guidelines for Growth.

4. **County Need Standard:** The applicant should demonstrate that there is a need for home health services in each county in the proposed Service Area by providing documentation (e.g., letters) where: a) health care providers had difficulty or were unable successfully to refer a patient to a home care organization and/or were dissatisfied with the quality of services provided by existing home care organizations based on Medicare's system Home Health Compare and/or similar data; b) potential patients or providers in the proposed Service Area attempted to find appropriate home health services but were not able to secure such services; c) providers supply an estimate of the potential number of patients that they might refer to the applicant.

   Rationale: This Standard seeks to promote State Health Plan Principle 2 concerning Access to Care. The Division believes that if the Need formula is not met, a pattern of problems with referring patients successfully to home care organizations should be demonstrated by the applicant. If no such pattern can be established, there is likely not a need for a new home care organization.

5. **Current Service Area Utilization:** The applicant should document by county: a) all existing providers of home health services within the proposed Service Area; and b) the number of patients served during the most recent 12-month period for which data are available. To characterize existing providers located within Tennessee, the applicant should use final data provided by the JARs maintained by the Tennessee Department of Health. In each county of the proposed Service Area, the applicant should identify home health agencies that have reported serving 5 or fewer patients for each of the

last three years based on final and available JAR data. If an agency in the proposed Service Area who serves few or no patients is opposing the application, that opponent agency should provide evidence as to why it does not serve a larger number of patients.

Rationale: From comments expressed by many stakeholders, the Division is aware that a home care organization may be licensed to provide services in a county/Service Area but may serve few or no patients there. The Division believes this situation may unreasonably impede the expansion of home health services in a county/Service Area and that any such home care organization that is opposing an application should provide evidence that supports its low market penetration.

6. **Adequate Staffing:** Using TDH Licensure data, the applicant should document a plan demonstrating the intent and ability to recruit, hire, train, assess competencies of, supervise, and retain the appropriate numbers of qualified personnel to provide the services described in the application and document that such personnel are available to work in the proposed Service Area. The applicant should state the percentage of qualified personnel directly employed or employed through a third party staffing agency.

   Rationale: This Standard seeks to promote State Health Plan Principle 5 concerning a sufficient and quality health care work force. Home care organization workers do not necessarily need to live in the county in which they work. However, in the short-term, the number of possible workers in a general area is unlikely to change quickly. In order to promote economic efficiencies and access to health care through reduced personnel cost, applicants should demonstrate that they have a plan to recruit sufficient workforce in the general area within reasonable commuting distance of the proposed Service Area. Moreover, the applicant should present its long-term plans to ensure an adequate supply of quality home care workers is available to meet future needs.

7. **Community Linkage Plan:** The applicant should provide a community linkage plan that demonstrates factors such as, but not limited to, referral arrangements with appropriate health care system providers/services (that comply with CMS patient choice protections) and working agreements with other related community services assuring continuity of care focusing on coordinated, integrated systems. A new provider may submit a proposed community linkage plan.

   Rationale: This Standard seeks to promote State Health Plan Principles 3 and 4 concerning Economic Efficiencies and Quality of Care, respectively. In order to promote economic efficiencies and the quality of health care provided in Tennessee, applicants should demonstrate that they have

established relationships with other health care providers that will ensure a continuity of care for their patients.

8. **TennCare Managed Care Organizations (MCOs) and Financial Viability:** Given the time frame required to obtain Medicare certification, an applicant proposing to contract with the Bureau of TennCare's MCOs should provide evidence of financial viability during the time period necessary to receive such certification. Applicants should be aware that MCOs are under no obligation to contract with home care organizations, even if Medicare certification is obtained, and that Private Duty Services are not Medicare certifiable services. Applicants who believe there is a need to serve TennCare patients should contact the TennCare MCOs in the region of the proposed Service Area and inquire whether their panels are open for home health services, as advised in the notice posted on the HSDA website, to determine whether at any given point there is a need for a provider in a particular area of the state; letters from the TennCare MCOs should be provided to document such need. See Note 2 for additional information.

   Applicants should also provide information on projected revenue sources, including non-TennCare revenue sources.

   Rationale: This Standard seeks to promote State Health Plan Principle 3 concerning Economic Efficiencies. This Standard further seeks to promote the orderly development of the health care system by bringing to the forefront issues concerning Medicaid/Medicare certification.

9. **Proposed Charges:** The applicant's proposed charges should be reasonable in comparison with those of other similar agencies in the Service Area or in adjoining service areas. The applicant should list:

   a. The average charge per visit and/or episode of care by service category, if available in the JAR data.
   b. The average charge per patient based upon the projected number of visits and/or episodes of care and/or hours per patient, if available in the JAR data.

   Rationale: This Standard seeks to promote State Health Plan Principle 3 concerning Economic Efficiencies through greater marketplace transparency.

10. **Access:** In concert with the factors set forth in HSDA Rule 0720-11-.01(1) (which lists those factors concerning need on which an application may be evaluated), the HSDA may choose to give special consideration to an applicant that is able to show that there is limited access in the proposed Service Area for groups with special medical needs such as, but not limited to, medically fragile children, newborns and their mothers, and HIV/AIDS

patients. Pediatrics is a special medical needs population, and therefore any provider applying to provide these services should demonstrate documentation of adequately trained staff specific to this population's needs with a plan to provide ongoing best practice education. For purposes of this Standard, an applicant should document need using population, service, special needs, and/or disease incidence rates. If granted, the Certificate of Need should be restricted on condition, and thus in its licensure, to serving the special group or groups identified in the application. The restricting language should be as follows: CONDITION: Home health agency services are limited to (*identified specialty service group*); the expansion of service beyond (*identified specialty service group*) will require the filing of a new Certificate of Need application. Please see Note 3 regarding federal law prohibitions on discrimination in the provision of health care services.

Rationale: This Standard seeks to promote State Health Plan Principle 2 concerning Access to Care.

11. **Quality Control and Monitoring:** The applicant should identify and document its existing or proposed plan for data reporting (including data on patient re-admission to hospitals), quality improvement, and an outcome and process monitoring system (including continuum of care and transitions of care from acute care facilities). If applicable, the applicant should provide documentation that it is, or that it intends to be, fully accredited by the Joint Commission, the Community Health Accreditation Program, Inc., the Accreditation Commission for Health Care, and/or other accrediting body with deeming authority for home health services from CMS.

    Rationale: This Standard seeks to promote the State Health Plan Principle 4 concerning Quality of Care. The Division recognizes that certain home care organizations are certified by CMS but are not necessarily accredited by the entities listed above.

12. **Data Requirements:** Applicants should agree to provide the Department of Health and/or the Health Services and Development Agency with all reasonably requested information and statistical data related to the operation and provision of services and to report that data in the time and format requested. As a standard of practice, existing data reporting streams will be relied upon and adapted over time to collect all needed information.

    Rationale: This Standard seeks to promote accurate health planning through the availability of accurate and timely data.

Notes

1. Professional Support Services and Personal Support Services: It should be noted that an entity providing either "professional support services," as defined by TCA § 68-11-201 (regarding nursing and occupational, physical, or speech therapy services provided to individuals with mental retardation or developmental disabilities pursuant to a contract with the state agency financially responsible for such services), or "personal support services," as set forth in the Rules of the Department of Mental Health and Substance Abuse Services Office of Licensure Chapter 0940-05-38 (regarding self-care assistance, household assistance, personal assistance to access community activities, and education services), does not require a Certificate of Need in order to be licensed by the appropriate department to perform its services.

2. TennCare Medicare Certification: As of the effective date of these standards and criteria, the Rules of the Bureau of TennCare ("TennCare"), the state of Tennessee's Medicaid program, require that any applicant for a Certificate of Need to provide home health services that desires to contract with TennCare's MCOs become Medicare-certified. The process of becoming Medicare-certified can take several months if an agency does not meet Medicare "deemed certified" status through accreditation by national accrediting organizations.

It should be noted that as of the effective date of these standards and criteria, Private Duty Services do not qualify as a Medicare reimbursable service. Thus, an entity that applies for a Certificate of Need should not apply to provide only Private Duty Services if it intends to try to contract with the MCOs as it will not be able to receive Medicare certification. Additionally, applicants should contact TennCare for specific information regarding the ability to contract with MCOs. On the Health Services and Development Agency website (http://www.tn.gov/hsda/) an informational letter is available entitled "Are you thinking about applying for a CON to provide Home Health or Private Duty Nursing Services in Tennessee?"

3. Services not to be Discriminatory in Nature: Some past applications have endeavored to provide home health services to specific populations. It should be noted that federal law prohibits health care providers from providing health care services that discriminate against any population in the areas of race, color, national origin, disability, or age. This prohibition is enforced by the Office for Civil Rights to ensure that eligible persons have equal access to quality health care regardless of race, color, national origin, disability, or age.

Discontinuance of Obstetrical Services

Certificate of Need Standards and Criteria

STATE OF TENNESSEE

STATE HEALTH PLAN

CERTIFICATE OF NEED STANDARDS AND CRITERIA

FOR

DISCONTINUANCE OF OBSTETRICAL SERVICES

The Health Services and Development Agency (HSDA) may consider the following standards and criteria for applications seeking to discontinue obstetrical services. Existing providers of obstetrical services are not affected by these standards and criteria unless they take an action that requires a new certificate of need (CON) for the Discontinuance of Obstetrical Services.

These standards and criteria are effective immediately upon approval and adoption by the Governor of the State Health Plan updates for 2014. Applications to discontinue obstetrical services that were deemed complete by the HSDA prior to this date shall be considered under the Guidelines for Growth.

Definitions

1. **"Obstetrical Services**" shall mean those services provided by a hospital pertaining to the care and treatment of women in childbirth during the period before and after delivery of their babies (including labor, delivery, and recovery) and the care of their newborns.

2. **"Service Area"** shall mean the county or contiguous counties from which the applicant's hospital draws its obstetrical patients.

3. **"Level I, Level II, Level III, and Level IV hospital"** shall mean those hospitals that provide the specific level of perinatal services set forth in Tennessee Code Annotated 68-1-802 regarding perinatal care. The Department of Health *Guidelines for Regionalization, Hospital Care Levels, Staffing and Facilities* may be found in the Reports and Publications section of the Perinatal Regionalization Program webpage at: http://health.state.tn.us/MCH/PRP.shtml

Standards and Criteria

1. Applicants should provide the following information based on final and available Tennessee Department of Health (TDH) data:

   a. The number of women by county who used obstetrical services at the applicant's hospital as well as the number of live births at the hospital during each 12 month period of the previous 36 months. Also, an estimate of the number, by county, of obstetrical patients projected for the next 12 months who will be affected by the proposed discontinuance based on births and obstetrical patient volume trends in the Service Area, including the estimated number of such obstetrical patients who are beneficiaries of TennCare.

   b. An assessment of the characteristics of the women who used obstetrical services at the applicant's hospital during each 12 month period of the previous 36 months, including their age and county of residence and including the number of obstetrical patients who were beneficiaries of TennCare by age group, as well as a list of existing obstetrical and other providers' practices in the Service Area that would be impacted should the application be approved.

   c. In each county of the Service Area, the number of females aged 15-44 and the fertility rate for each 12 month period of the previous 36 months.

   d. Information on the number of practicing obstetricians and other providers, listed separately, who performed deliveries at the applicant's hospital and in the Service Area for each 12 month period of the past 36 months; the sufficiency of the obstetrical staff at the hospital for the same time period; and whether, in the applicant's opinion, the number of deliveries at the hospital currently allows for maintenance of competent staff.

   e. The distance in miles and approximate travel time from the applicant's hospital to alternate sites to establish how far patients in need of obstetrical services would have to travel to obtain these services should the service be discontinued at the applicant's hospital, as well as an assessment of whether these alternate sites have sufficient capacity to absorb these patients.

   f. The modes of transportation that obstetrical patients would use to travel to alternate sites to obtain obstetrical services should the service be discontinued at the applicant's hospital.

   g. Data on patients' average labor and delivery costs at the applicants' hospital versus patients' average labor and delivery costs at the alternate sites and a financial analysis of the applicant's hospital based on the impact of discontinuance of obstetrical services. The applicant should also address how the continuance of obstetrical services would impact the financial viability of the hospital.

h. Information for the hospital for each 12 month period of the previous 36 months regarding the following statistics: (1) percentage per live births of premature births; and (2) percentage per live births of low birth weight births.

i. Documentation of the recruitment and retention plan that was initially put into place as well as a discussion of why it failed, including duration and costs of these efforts. If shortage or instability of professional workforce is cited as justification for discontinuance of obstetrical services, the applicant should provide a five year history of counts and composition of physicians and obstetrical service hospital staff and document the recruitment and retention plan(s) in place for the service.

Rationale: The decision to permit the discontinuance of obstetrical services can have serious far-ranging patient impact, and determining the implications of discontinuance necessarily requires the consideration of a broad range of issues. The provision of obstetrical services is critically important to the population health of a community as well as to that community's ability to attract and retain women of child-bearing age. Therefore, the Division believes an applicant should document historical trends in demand (e.g., a decline in the number of women who have used obstetrical services at its hospital) and consider the impact discontinuance of the service would have on women in the Service Area who can be expected in the future to require these services.

The State Health Plan's Principles for Achieving Better Health must all be balanced in the consideration of an application to discontinue obstetrical services. In particular, Principle No. 2, "Access," informs the requirement that the preceding information be provided to help the HSDA better assess the current Need for obstetrical services in the Service Area and how discontinuing them would impact the community's future access to these services. The State Health Plan's Principle No. 3, "Economic Efficiencies," informs the need to include data on patients' costs as well as impact on obstetrical providers' practices and hospital finances as measures to meet HSDA's statutory charge to ensure the Financial Feasibility of an application. For example: How might patient costs increase? What is the likely financial impact on local providers? Can the hospital financially continue to provide obstetrical services? To assess the State Health Plan's Principle No. 4, "Quality of Care," data should be presented that documents the hospital's contributions to perinatal outcomes and outlines how quality and outcomes would be improved by the proposal to discontinue obstetrical services. Proposals to discontinue services should address the State Health Plan's Principle No. 5, "Workforce," by documenting and describing efforts to maintain adequate hospital staffing and whether the proposal would impact existing obstetrical service providers currently using the hospital.

2. Applicants should present a plan for obstetrical care for the Service Area to be shared with the local health department, local emergency services, the local Board of Health or Advisory Committee, and the local health council that includes:

   a. Information based on final and available TDH data for each county in the Service Area for each 12 month period of the previous 36 months regarding the following statistics: (1) rate per live births of neonatal mortality during the first 28 days of life; (2) rate per live births of maternal mortality*; (3) percentage of live births of women receiving adequate prenatal care; and (4) percentage of live births of women receiving prenatal care by trimester (1, 2, 3, or no prenatal care).

   b. Documentation of consultation with the regional neonatal and/or obstetrical director and/or outreach educator/coordinator for the regional perinatal center. The list of and contact information for these coordinators may be obtained by calling the TDH Director of Perinatal, Infant, and Pediatric Care at 615-741-0377; the information may also be found at: http://health.tn.gov/MCH/PRP.shtml#2.

   c. For the Service Area, a community linkage plan that assures that adequate, accessible, and quality services are available through orderly pathways to and/or agreements with other hospitals for the provision of appropriate obstetrical and neonatal services (based on the Department of Health *Guidelines for Regionalization, Hospital Care Levels, Staffing and Facilities)*. This plan should include documentation that TennCare and/or Medicare patients can receive obstetrical services at the Alternate Delivery Sites. An applicant may find additional information from TDH at http://health.tn.gov/MCH/PRP.shtml#3.

   d. Information based on final and available TDH data on the charges at Alternate Delivery Sites as compared to those of the applicant's hospital for:
      i. obstetrical services and infant care, and
      ii. C-sections and episiotomies

   e. Documentation of discussions with each local health department in the Service Area to assure awareness of the proposal to discontinue services. The health departments and hospital should develop a plan for provision of important non-clinical supplementary services that contribute positively to good pregnancy and infant outcomes (e.g., WIC, breastfeeding counseling, referrals for home-based intervention programs, etc.) to women in the Service Area who are planning to use the hospital's obstetrical services. A list by county of the local health departments and their contact information can be found at: http://health.state.tn.us/localdepartments.htm

* These data will only reflect those mothers who die at the hospital immediately after giving birth.

f. Planned communications to inform the community as a whole and women of child-bearing age of the proposed discontinuance to ensure that the Service Area residents are aware of the proposal to discontinue obstetrical services, should the application be approved. Such communications may include public meetings in conjunction with the local health department, Public Service Announcements on the radio and/or television, ads in local newspapers, etc., as well as having information available on Alternate Delivery Sites.

g. A plan that documents the hospital's continuance and training to be prepared for emergency deliveries, as well as availability of emergency department equipment and services at the hospital, that ensures the ability to provide obstetrical and neonatal patients and infants less than one year of age with appropriate emergent care.

h. Documentation of communication with emergency transportation agencies.

i. Documentation of communication with TennCare MCOs (including the applicant's responses to any concerns expressed by TennCare) regarding the discontinuance of obstetrical services and alternate sites.

Rationale: Approval for withdrawal of hospital obstetrical services from a CON-granted Service Area was deemed of such significance that the General Assembly requires a Certificate of Need for the action. The hospital has a responsibility to prepare a plan for action that assures that the health of the Service Area's women and infants will not be compromised by the action. The plan includes multiple components. Through development of the plan, the hospital affirms its responsibility to the health of its Service Area's population as part of its license to operate and original Certificate of Need. A plan should require consultation with regional perinatal coordinators, local health departments, emergency service organizations, and TennCare MCOs. The impact on providers who practice obstetrical and neonatal care in the Service Area should be considered. The public (particularly women of child-bearing age) who expect to use the hospital should be engaged and any opinions reported prior to HSDA review of an application for discontinuance of obstetrical services. The objective of an overall plan should focus on protecting the health of the Service Area through a community linkage plan that is guided by the Department of Health's *Guidelines for Regionalization, Hospital Care Levels, Staffing and Facilities.*

Appendices

Appendix A: Health Services and Planning Policy Statement

Appendix B: Process to Identify Goals and Strategies – Engaging the Public

Appendix C: Survey and Survey Results

Appendix D: Goal Team Members

Appendix E: Tennessee Health Rankings 2013

Appendix A: *Statutory Authority for the State Health Plan*

The Division of Health Planning was created by action of the Tennessee General Assembly and signed in to law by Governor Phil Bredesen (TCA § 68-11-1625). It is charged with creating a State Health Plan. The text of the law follows.

a. There is created the state health planning division of the department of finance and administration. It is the purpose of the planning division to create a state health plan that is evaluated and updated at least annually. The plan shall guide the state in the development of health care programs and policies and in the allocation of health care resources in the state.

b. It is the policy of the state of Tennessee that:
    1. Every citizen should have reasonable access to emergency and primary care;
    2. The state's health care resources should be developed to address the needs of Tennesseans while encouraging competitive markets, economic efficiencies and the continued development of the state's health care industry;
    3. Every citizen should have confidence that the quality of health care is continually monitored and standards are adhered to by health care providers; and
    4. The state should support the recruitment and retention of a sufficient and quality health care workforce.

c. The planning division shall be staffed administratively by the department of finance and administration in a manner that the department deems necessary for the performance of the planning division's duties and responsibilities, which may include contracting for the services provided by the division through a private person or entity.

d. The duties and responsibilities of the planning division include:
    1. To develop and adopt a State Health Plan, which must include, at a minimum, guidance regarding allocation of the state's health care resources;
    2. To submit the State Health Plan to the Health Services and Development Agency for comment;

3. To submit the State Health Plan to the Governor for approval and adoption;
4. To hold public hearings as needed;
5. To review and evaluate the State Health Plan at least annually;
6. To respond to requests for comment and recommendations for health care policies and programs;
7. To conduct an ongoing evaluation of Tennessee's resources for accessibility, including, but not limited to, financial, geographic, cultural, and quality of care;
8. To review the health status of Tennesseans as presented annually to the Division by the Department of Health and the Department of Mental Health and Developmental Disabilities;
9. To review and comment on federal laws and regulations that influence the health care industry and the health care needs of Tennesseans;
10. To involve and coordinate functions with such State entities as necessary to ensure the coordination of State health policies and programs;
11. To prepare an annual report for the General Assembly and recommend legislation for its consideration and study; and
12. To establish a process for timely modification of the State Health Plan in response to changes in technology, reimbursement and other developments that affect the delivery of health care.

Appendix B: *Process to Identify Goals and Strategies – Engaging the Public*

The goals and objectives presented in the 2014 State Health Plan are a synthesis of research, data, and public input. Engaging the public – the professionals in the health care arena as well as interested citizens – was key to achieving a plan that legitimately represents valid issues of concern to people in Tennessee.

Engaging the public in a meaningful way with limited resources called for a creative, iterative approach. The Division modified the approach it used successfully in 2010, designing the multiple-step, year-long process described more fully below. The design builds on data collected in 2010 that first helped define Tennessee's health concerns, and augmented the data with professional and public input to arrive at Goals and Objectives.

As shown on the following page (Figure 1), the overall strategy was to balance public input by drawing upon the knowledge of those with professional expertise, while rounding this out with the common sense and personal experiences of the public at large.

Step 1: State Government Experts

From January 2014 through March 2014, Division staff met with TDH experts to determine if existing reports and plans fit within the State Health Plan, to identify the significant health issues currently being addressed by the state, and to identify measures to use to evaluate health outcome trends. For these meetings, the Division asked attendees to consider:

- Which parts of the plan were particularly relevant for their own work
- What they (or others in their area) were doing to tackle any of the issues identified
- What they would emphasize as priority areas, and
- Whether they saw critical concerns in the future that the next State Health Plan should address.

Other state experts were also consulted, including those in the Department of Mental Health and Substance Abuse Services and the Bureau of TennCare. During the meetings, the Division heard not only what the state experts

considered to be a main focus for action to improve health for people in Tennessee, but also ideas about what was working well and concerns about change needed.

Step 2: Goal Teams

In February and March 2014, Division staff identified experts who could contribute specific knowledge and expertise regarding each of the Plan's guiding principles. These experts were invited to be part of small interdisciplinary goal teams to review the 2010 State Health Plan Goals and to offer suggested revisions to them. They also suggested subject matter areas for Priorities for Consideration. Appendix D lists these members.

During April 2014, four day-long work sessions were held in Nashville, where each Goal Team was asked to:

- Agree upon 5-7 recommended goals for the 2014 State Health Plan regarding a specific principle (Access, Economics, Quality or Workforce)
- Propose 5-7 recommended goals for the Plan that would support the improvement of the health of people in Tennessee (Principle 1, Healthy Lives), and
- Identify subject matter areas for other meeting attendees to use in developing Priorities for Consideration, with particular emphasis on their own focus principle.

To the benefit of the Division staff, each of the goal teams wanted to continue working on the development of the goals and strategies beyond the work sessions. Thus, they have been used as a sounding board for further iterations of the goals and strategies through conference calls and email correspondence.

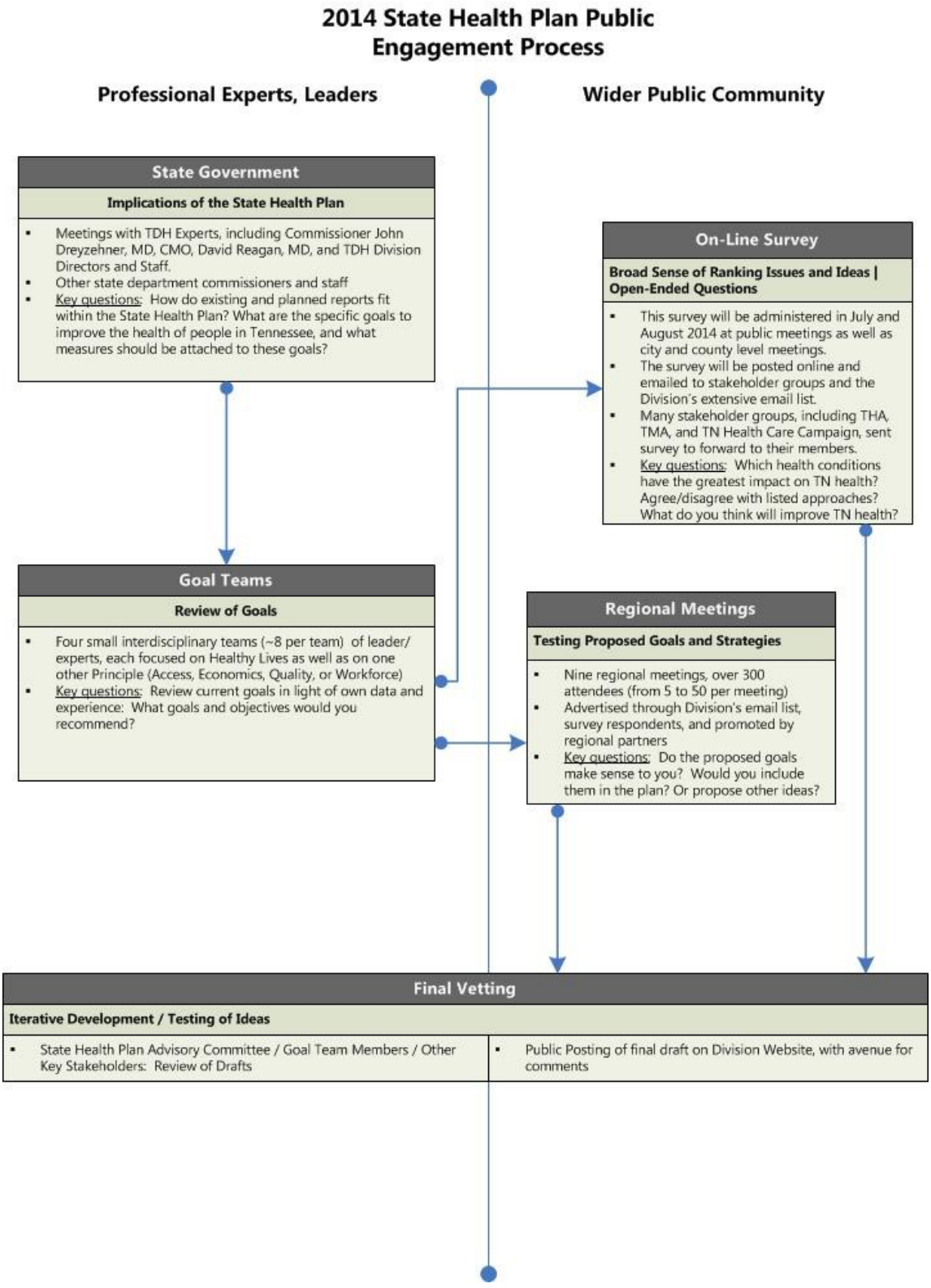


Figure 3: 2014 State Health Plan Public Engagement Process

Step 3: Meetings with Regional and Metro Health Councils, Local Health Departments, Minority Health Grantees, and the Rural Health Association of Tennessee

In addition to the experts who participated in the Goal Team meetings, the Division received input from other expert stakeholders, including: the Mid-Cumberland, Northeast, and South Central Regional Health Councils; health councils representing Knoxville, Memphis, and Nashville; staff of the Lincoln and Scott County Health Departments; grantees of the Office of Minority Health and Disparities Elimination; and members of the Rural Health Association of Tennessee. These meetings served to elicit:

- Input regarding the goals developed through the Goal Team meetings
- Suggestions regarding potential objectives for the Plan, and
- General feedback on the Plan framework, focus, and future aims.

These expert stakeholder meetings were instrumental in refining the Goals for the 2014 update and in developing the Priorities for Consideration. The meetings also reinforced the shift in direction for the 2014 Plan as well as for future updates.

Step 4: Regional Meetings

In many respects, all of the previous steps were the foundation for the main outreach effort, that of holding public meetings around the state. During the months of July and August 2014, the Division staff convened nine different meetings to obtain public input on the draft goals and promising strategies.

Arrangements were made with public universities and other community partners in each of the areas to serve as co-hosts of these meetings. The co-hosts not only provided the meeting spaces and, in some cases, students to support the effort, they also reached out to their colleagues in the area to help promote the events. Meetings were held as shown below in Table 1:

Table 5: Summary of Regional Meetings

July 22, 2014, Memphis	University of Tennessee Health Science Center, Student Alumni Center, Schreier Auditorium
July 24, 2014, Nashville	Tennessee State University, Avon Williams Campus, Room 354
July 25, 2014, Knoxville	University of Tennessee, Howard Baker Center for Public Policy, Toyota Auditorium
July 28, 2014, Johnson City	East Tennessee State University, D.P. Culp University Center, Forum Room
July 31, 2014, Dyersburg	Dyersburg State Community College, Campus Activities Building, FCNB Auditorium
August 6, 2014, Cookeville	Tennessee Technological University, Nursing and Health Services Building, Room 260
August 12, 2014, Jackson	Jackson State Community College, Science Building, Frank Dodson Science Auditorium
August 20, 2014, Murfreesboro	Patterson Community Center
August 25, 2014, Chattanooga	Erlanger Hospital, Probasco Auditorium

Along with the local promotional efforts, the Division sent notice of the meetings to its extensive mailing list and posted the details on the TDH website. Again, based on similar public meeting efforts, these meetings surpassed expectations.

The two-hour public meetings were designed as work sessions to accomplish the most detailed part of the public process, the development of Priorities for Consideration based on ideas participants developed using the SMART model (Specific, Measureable, Actionable, Relevant, and Time-Based). In doing so, the Division also received:

- Feedback regarding the proposed common goals – what the State of Tennessee should emphasize in order to improve the health of people in Tennessee, and
- A better understanding of local and regional health concerns.

After a brief introduction of the purpose of the meeting, the attendees were divided into small groups of 5-8 people and given approximately 90 minutes to review the proposed goals and to develop SMART Objectives for each of the Five Principles, which have served as the basis for the Priorities for Consideration that will inform collaborations for the 2015 State Health Plan. Worksheets were provided so that all of these ideas could be recorded. Each of the groups then had an opportunity to report out one key highlight from their group's discussion.

While many of the attendees felt two hours was too short for this intensive work, they also acknowledged that if the meeting had been longer, they would have been less likely to attend. Contact information for additional thoughts was included on the agenda, and a handful of attendees took advantage of this opportunity.

On the map below, a star marks a community where at least one public or stakeholder meeting was held:

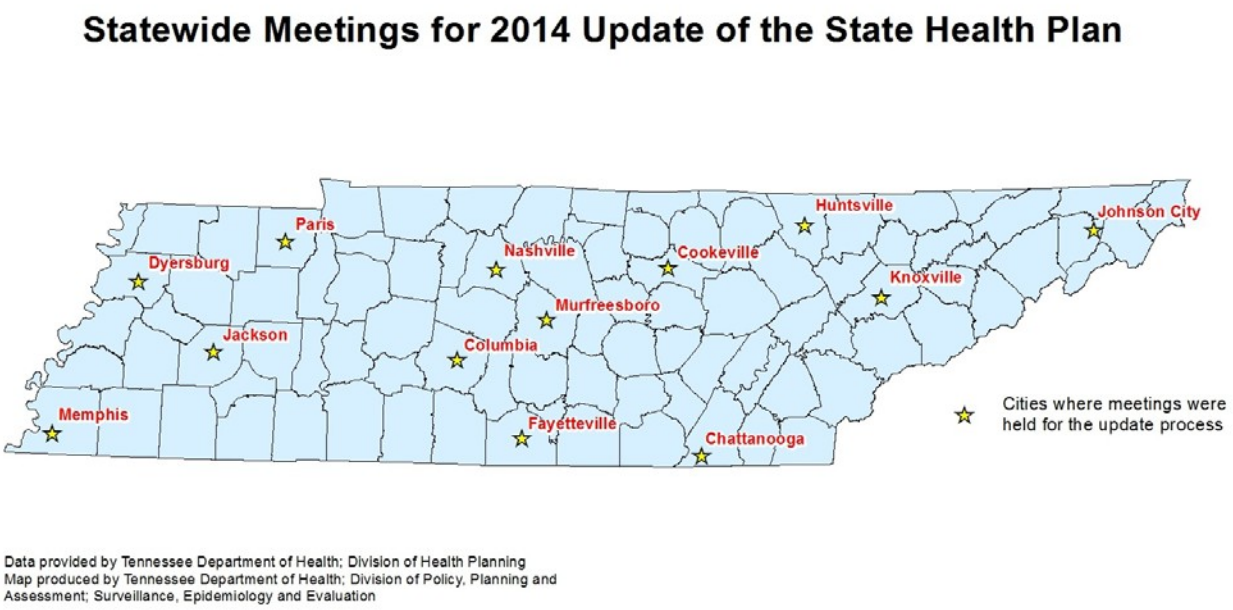


Figure 4: Map of Statewide Meetings for 2014 Update of the State Health Plan

Step 5: Online Survey

Drawing upon on-going research as well as the urgent matters identified by the TDH experts and the Goal Teams, Division staff created an on-line survey. The survey was designed to take less than 20 minutes for those with limited time, but to still provide enough time to cover the major health concerns and allow ample opportunity for those who wanted to devote more time to weigh in with open-ended questions.

The results of course cannot be portrayed as a scientific representation of what people in Tennessee "actually" consider to be the most important health issues or the most promising approaches for improvement. However, the results must be seriously considered as representing what might be termed, "informed constituents." The comments revealed considerable thought and expertise.

As discussed in Appendix C, the online survey was sent to an estimated 2,000 people throughout Tennessee. The survey was completed by residents of 91 of the 95 counties throughout Tennessee. Appendix C also summarizes what people in Tennessee rated as priorities for the next State Health Plan.

Final vetting of the draft Goals and Objectives, as well as Priorities for Consideration, involved the staffs of various state departments and agencies, legislative staff members, the Health Services and Development Agency staff, and a Final Review Team including the following (or their representatives):

Senator Becky Massey

Senator Rusty Crowe

Representative Bob Ramsey

Representative Harold Love, Jr.

Comptroller Justin Wilson

Doug Varney, Commissioner of the Department of Mental Health and Substance Abuse Services

Larry Martin, Commissioner of Finance and Administration

Darin Gordon, Deputy Commissioner, Bureau of TennCare

Will Cromer, Director of Policy and Research, The Governor's Office

Rick Johnson, Governor's Foundation for Health and Wellness

The vetted draft was then submitted to the Health Services and Development Agency for comment, as required by statute, before submitting to Governor Haslam for approval and adoption.

Appendix C: *Survey and Survey Results*

People across Tennessee had the opportunity to participate in an online survey to voice their opinions regarding their concerns surrounding issues of health and health care. Responses were received from 91 of the 95 counties in Tennessee. The survey as well as the overall public process resulted in revisions to the State Health Plan's Goals to clarify their intent. In addition, Goals 1b, 1c, and 1d were combined to become Goal 1b; a new Goal 1e was added; Goals 3a and 3b were combined to become Goal 3a; and Goal 5e was moved to become Goal 3e.

On the first section of the survey, respondents were asked to rate a list of potential objective subject areas for each of the Five Principles for Achieving Better Health based how important the respondent felt it is for State Health Plan to address that subject area. The rating scale ranged from 1 (low importance) to 5 (high importance); the potential objective subject areas were listed in no particular order. The respondents were informed that if they felt unfamiliar with a subject area or felt it did not apply to them, that they may choose not to rate it. Following is a visual summary of the questions and responses.

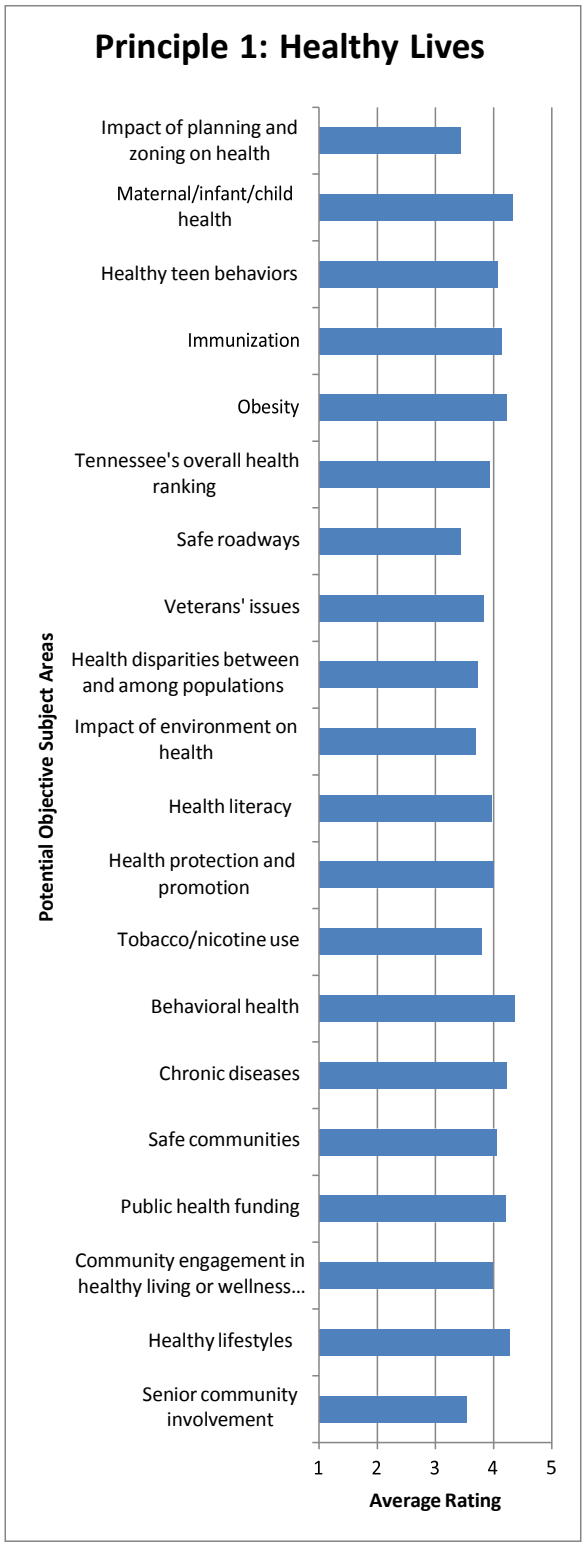


Figure 5: Survey Ratings, Principle 1 Potential Objective Subject Areas

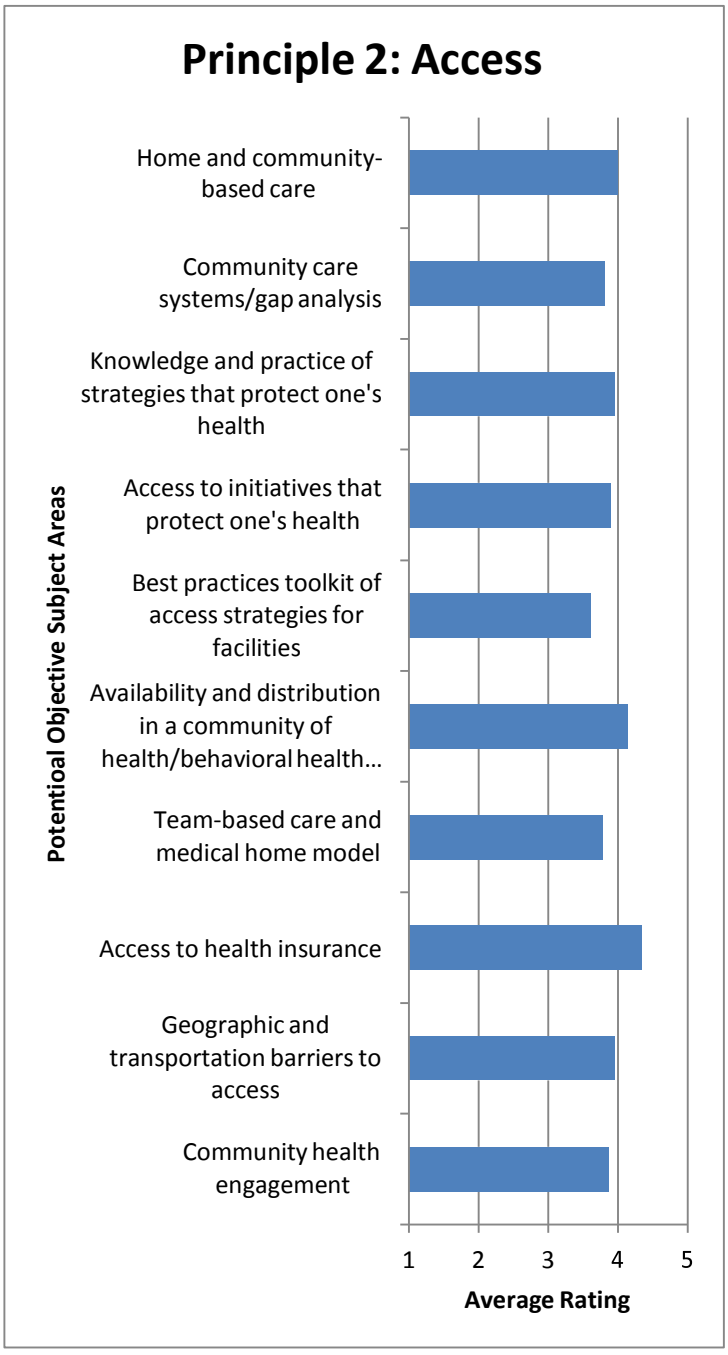


Figure 6: Survey Ratings, Principle 2 Potential Objective Subject Areas

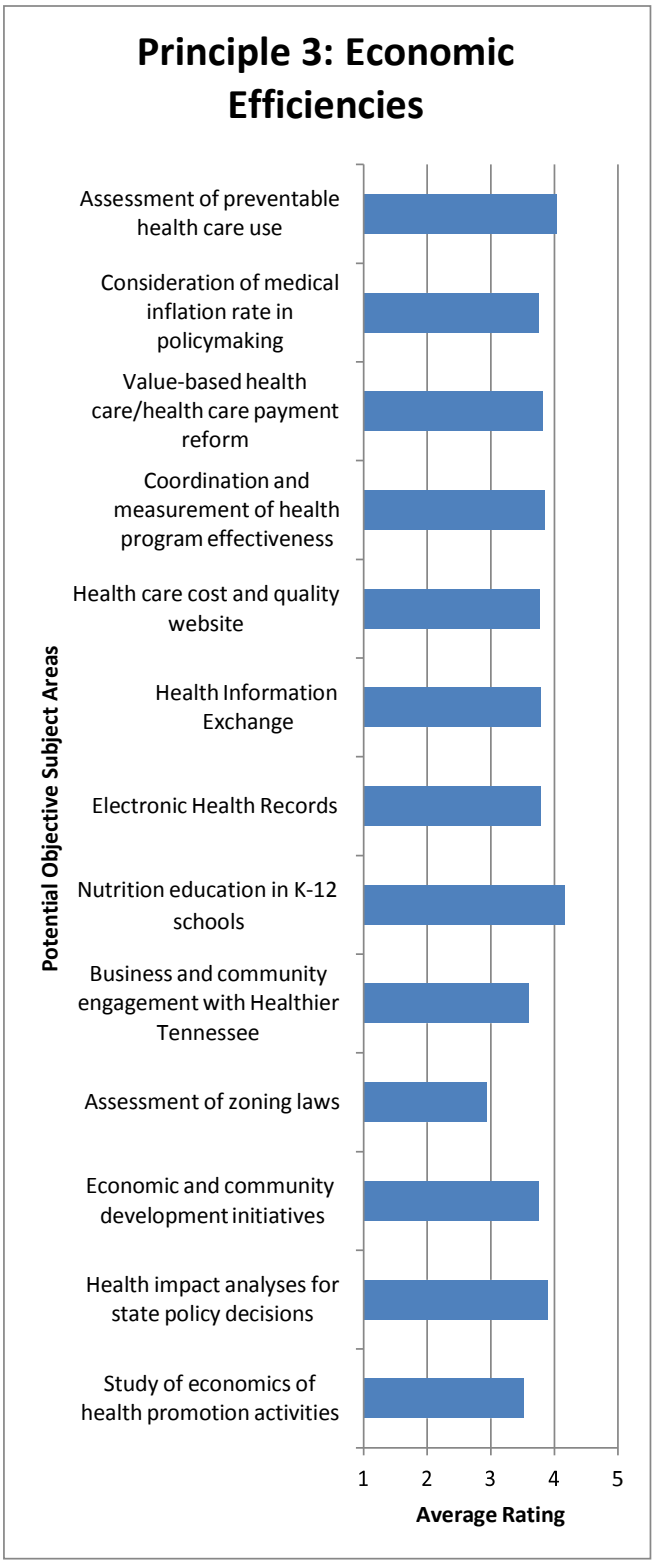


Figure 7: Survey Ratings, Principle 3 Potential Objective Subject Areas

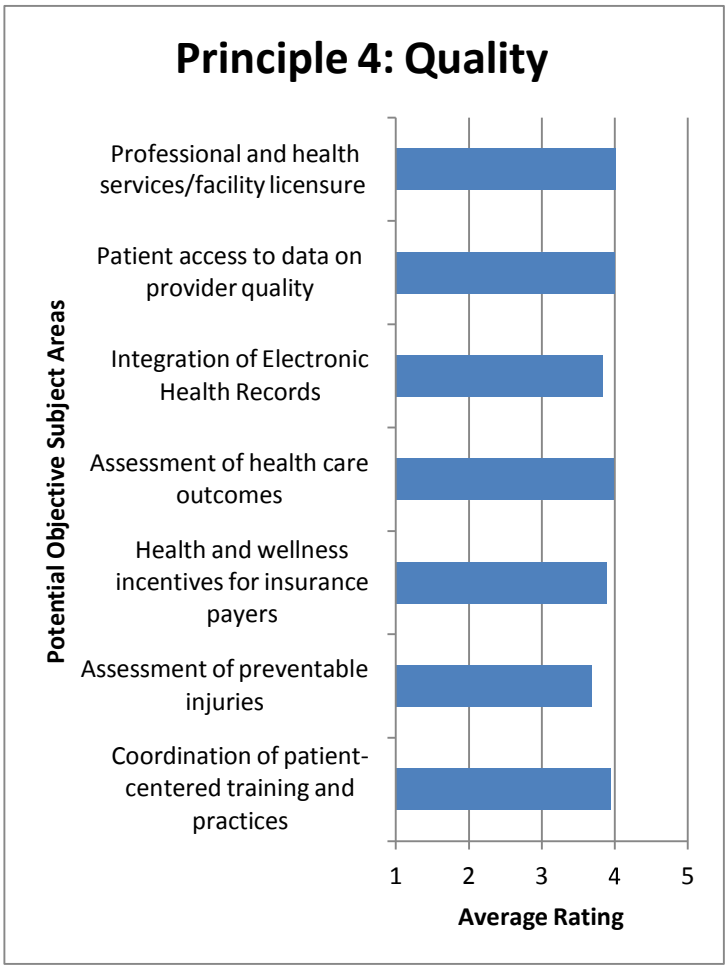


Figure 8: Survey Ratings, Principle 4 Potential Objective Subject Areas

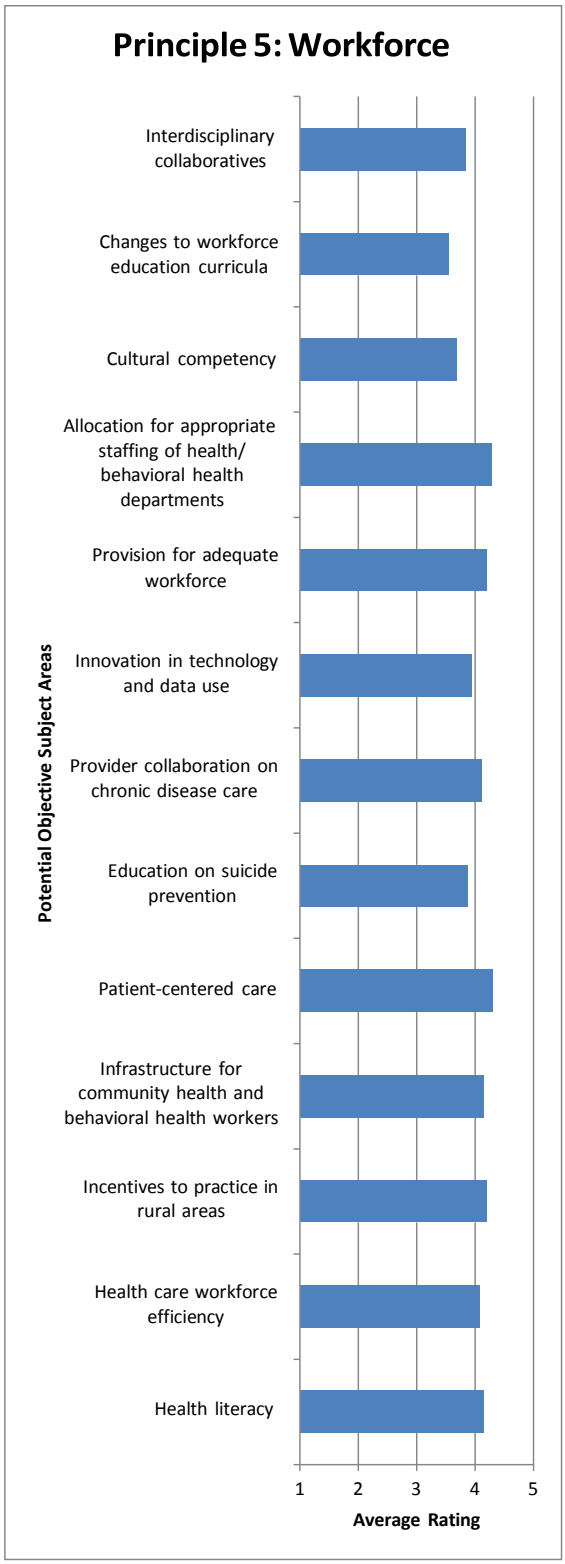


Figure 9: Survey Ratings, Principle 5 Potential Objective Subject Areas

On the second section of the survey, respondents were asked to rate revised Goals for each of the Five Principles for Achieving Better Health based on how relevant they felt each Goal is to its Principle. The rating scale ranged from 1 (low relevance) to 5 (high relevance). Following is a visual summary of the questions and responses.

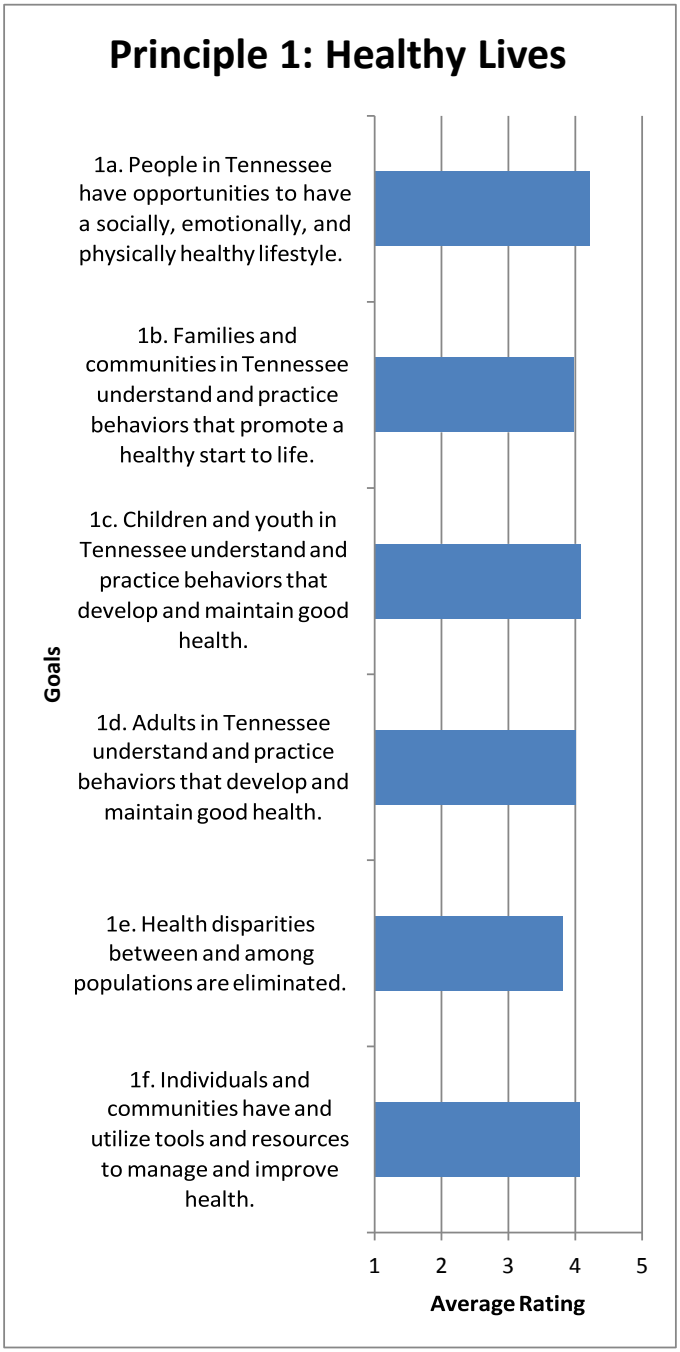


Figure 10: Survey Ratings, Principle 1 Goals

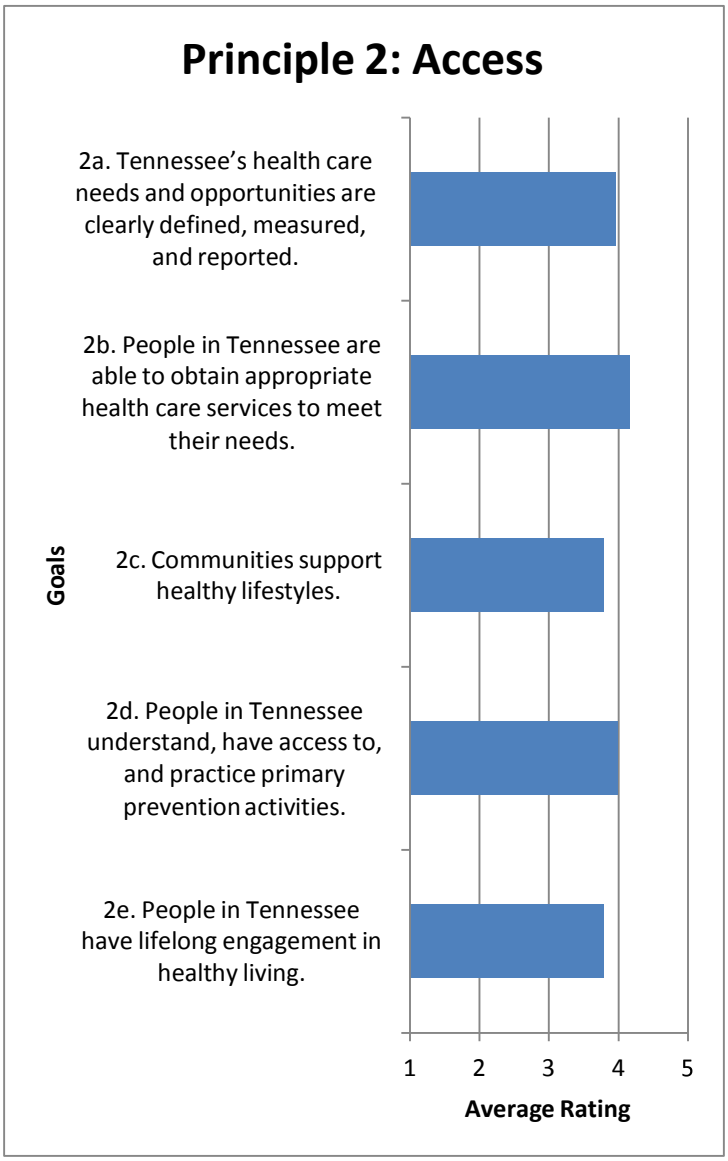


Figure 11: Survey Ratings, Principle 2 Goals

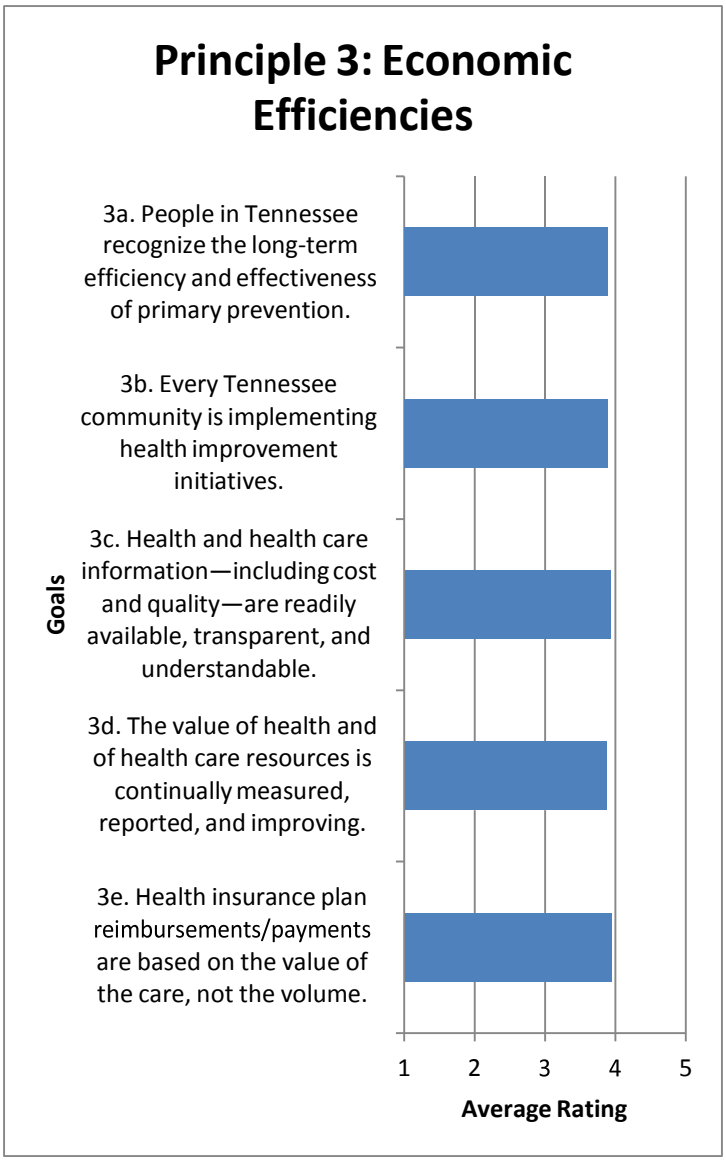


Figure 12: Survey Ratings, Principle 3 Goals

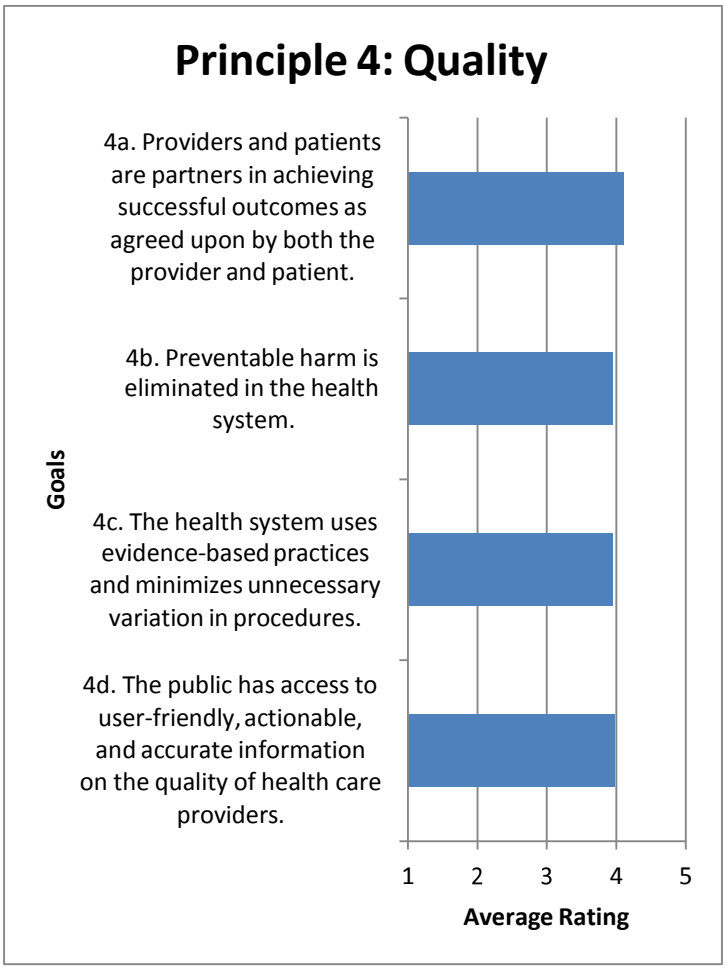


Figure 13: Survey Ratings, Principle 4 Goals

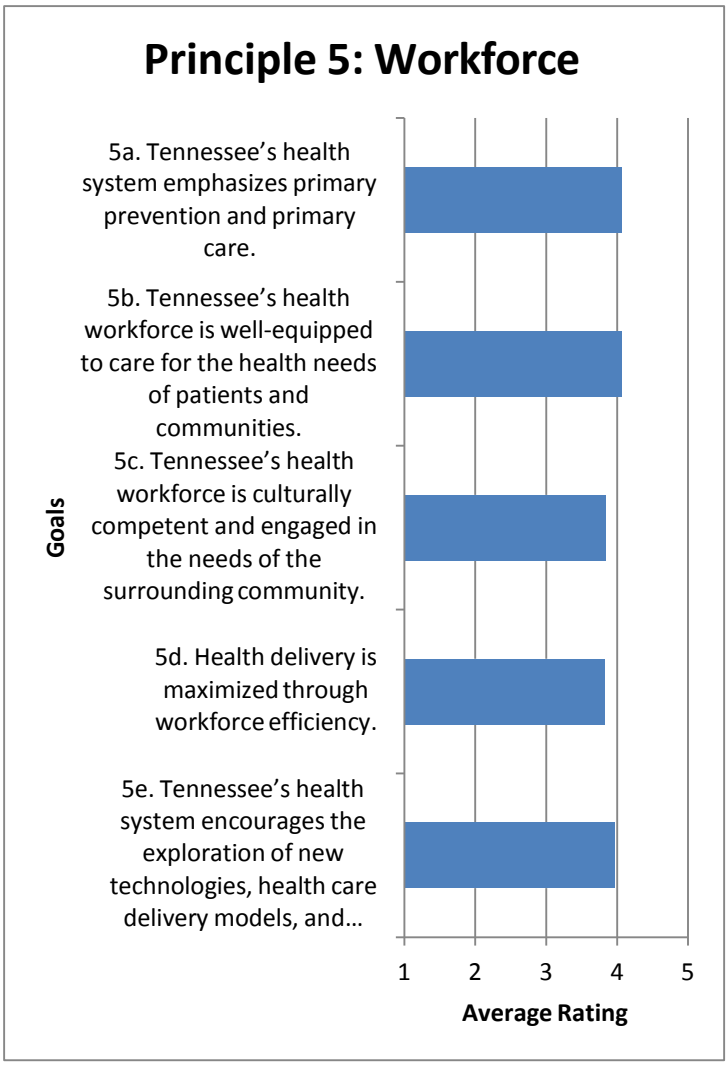


Figure 14: Survey Ratings, Principle 5 Goals

State Health Plan 2014

State Health Plan 2014 Survey, Part One

The Division of Health Planning in the Tennessee Department of Health is significantly updating the State Health Plan. One valuable source of input for the update is this survey; it should take about 20 minutes to complete. ***Please complete this survey by Friday, September 19, 2014.*** *We appreciate your time in sharing your thoughts and feedback.*

The State Health Plan, which was first developed in 2009, is organized around the Five Principles for Achieving Better Health. With these Principles as a foundation, we are working to develop Measurable Objectives to track and measure Tennessee's health progress. Your responses will help us prioritize what the Measurable Objectives should address.

For each of the Five Principles, we have compiled in no particular order a list of possible objective subject areas. **Please rate how important it is from 1 (low importance) to 5 (high importance) for the State Health Plan to address these subject areas.** If you are unfamiliar with a subject area or it does not apply to you, you may choose not to rate it. If there are additional subject areas you feel are not included, please list those suggestions in the text box that follows each list.

Principle 1, Healthy Lives: The purpose of the State Health Plan is to improve the health of people in Tennessee.

	Please rate importance for State Health Plan to address subject area (1 = low, 5 = high)		Please rate importance for State Health Plan to address subject area (1 = low, 5 = high)
Senior community involvement		Impact of environment on health	
Healthy lifestyles		Veterans' issues	
Community engagement in healthy living/wellness action		Health disparities between and among populations	
Public health funding		Safe roadways	
Safe communities		Immunization	
Chronic diseases		Obesity	
Behavioral health (mental health disorders/substance abuse disorders)		Health literacy (understanding health issues and communicating with providers)	
Tobacco/nicotine use		Healthy teen behaviors	
Health protection and promotion		Maternal/infant/child health	
Tennessee's overall health ranking		Impact of planning and zoning on health	

Are there other subject areas regarding *Principle 1: Healthy Lives* you feel are not listed? If so, please list them here.

_____

_____

Principle 2, Access: People in Tennessee should have access to health care and the conditions to achieve optimal health.

	Please rate importance for State Health Plan to address subject area (1 = low, 5 = high)		Please rate importance for State Health Plan to address subject area (1 = low, 5 = high)
Community health engagement		Best practices toolkit of access strategies for facilities	
Geographic and transportation barriers to access		Access to initiatives that protect one's health	
Access to health insurance		Knowledge and practice of strategies that protect one's health	
Team-based care and medical home model		Community care systems/gap analysis	
Availability and distribution in a community of health/behavioral health services and providers		Home and community-based care	

Are there other subject areas regarding *Principle 2: Access* you feel are not listed? If so, please list them here.

_____

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_____

Principle 3, Economic Efficiencies: The state's health resources, including health care, should be developed to address the health of people in Tennessee while encouraging value and economic efficiencies.

	Please rate importance for State Health Plan to address subject area (1 = low, 5 = high)		Please rate importance for State Health Plan to address subject area (1 = low, 5 = high)
Study of economics of health promotion activities		Health impact analyses for state policy decisions	
Health Information Exchange		Health care cost and quality website	
Economic and community development initiatives		Coordination and measurement of health program effectiveness	
Assessment of zoning laws		Nutrition education in K-12 schools	
Business and community engagement with Healthier Tennessee		Consideration of medical inflation rate in policymaking	
Value-based health care/health care payment reform		Assessment of preventable health care use	
Electronic Health Records			

Are there other subject areas regarding *Principle 3: Economic Efficiencies* you feel are not listed? If so, please list them here.

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_____

Principle 4, Quality: People in Tennessee should have confidence that the quality of health care is continually monitored and standards are adhered to by health care providers.

	Please rate importance for State Health Plan to address subject area (1 = low, 5 = high)
Coordination of patient-centered training and practices	
Assessment of preventable injuries	
Health and wellness incentives for insurance payers	
Assessment of health care outcomes	
Integration of Electronic Health Records	
Patient access to data on provider quality	
Professional and health services/facility licensure	

Are there other subject areas regarding *Principle 4: Quality* you feel are not listed? If so, please list them here.

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Principle 5, Workforce: The state should support the development, recruitment, and retention of a sufficient and quality health workforce.

	Please rate importance for State Health Plan to address subject area (1 = low, 5 = high)		Please rate importance for State Health Plan to address subject area (1 = low, 5 = high)
Health literacy (understanding health issues and communicating with patients)		Innovation in technology and data use	
Health care workforce efficiency		Provision for adequate workforce	
Incentives to practice in rural areas		Cultural competency	
Infrastructure for community health and behavioral health workers		Allocation for appropriate staffing of health/behavioral health departments	
Provider collaboration on chronic disease care		Changes to workforce education curricula	
Education on suicide prevention		Interdisciplinary collaboratives	
Patient-centered care			

Are there other subject areas regarding *Principle 5: Workforce* you feel are not listed? If so, please list them here.

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The Measurable Objectives will be written in a SMART (Specific, Measurable, Achievable, Relevant, Time-bound) format. Please suggest any SMART objectives here; for each SMART objective you suggest, please categorize it by the associated subject area(s) and Principle.

For example:

Idea: XYZ County works to reduce its rate of diabetes.

SMART Objective: By December 31, 2020, the rate of diabetes in XYZ County is reduced by 10%.
Principle: Principle 1, Healthy Lives
Subject Area(s): Chronic disease, obesity

We would also like your input on the term "health"; currently, we define “health” as a person’s physical, social, and behavioral health (which includes mental health and substance abuse disorders). Are there other aspects of health that you feel should be included?

State Health Plan 2014 Survey, Part Two

Next, for each of the Principles in the State Health Plan, we would like your input on the revised draft Goals. These revised Goals have been developed based on input from across the state. For clarity, the structure of how the Principles, Goals, and Measurable Objectives fit together in the State Health Plan is illustrated below:

- Principle 1: *Healthy Lives*. The purpose of the State Health Plan is to improve the health of people in Tennessee.
    - Goal 1a: People in Tennessee have opportunities to have a socially, emotionally, and physically healthy lifestyle.
        - **Measurable Objectives**
    - Goal 1b: Families and communities in Tennessee understand and practice behaviors that promote a healthy start to life.
        - **Measurable Objectives**
    - Goal 1c...
- Principle 2: *Access*...

It may be helpful to consider how the Goals would impact and improve the health of your community as well as the health of the state overall. **Please rate how relevant from 1 (low relevance) to 5 (high relevance) each Goal is to its Principle.** To capture additional thoughts and input, after each Principle we have included text boxes where you can write comments.

Principle 1, Healthy Lives: The purpose of the State Health Plan is to improve the health of people in Tennessee.

	Please rate relevance of Goal to its Principle (1 = low, 5 = high)
Goal 1a. People in Tennessee have opportunities to have a socially, emotionally, and physically healthy lifestyle.	
Goal 1b. Families and communities in Tennessee understand and practice behaviors that promote a healthy start to life.	
Goal 1c. Children and youth in Tennessee understand and practice behaviors that develop and maintain good health.	
Goal 1d. Adults in Tennessee understand and practice behaviors that develop and maintain good health.	
Goal 1e. Health disparities between and among populations are eliminated.	
Goal 1f. Individuals and communities have and utilize tools and resources to manage and improve health.	

Additional thoughts or comments regarding *Principle 1: Healthy Lives* Goals:

Principle 2, Access: People in Tennessee should have access to health care and the conditions to achieve optimal health.

	Please rate relevance of Goal to its Principle (1 = low, 5 = high)
Goal 2a. Tennessee's health care needs and opportunities are clearly defined, measured, and reported.	
Goal 2b. People in Tennessee are able to obtain appropriate health care services to meet their needs.	
Goal 2c. Communities support healthy lifestyles.	
Goal 2d. People in Tennessee understand, have access to, and practice primary prevention activities.	
Goal 2e. People in Tennessee have lifelong engagement in healthy living.	

Additional thoughts or comments regarding *Principle 2: Access* Goals:

Principle 3, Economic Efficiencies: The state's health resources, including health care, should be developed to address the health of people in Tennessee while encouraging value and economic efficiencies.

	Please rate relevance of Goal to its Principle (1 = low, 5 = high)
Goal 3a. People in Tennessee recognize the long-term efficiency and effectiveness of primary prevention.	
Goal 3b. Every Tennessee community is implementing health improvement initiatives.	
Goal 3c. Health and health care information—including cost and quality—are readily available, transparent, and understandable.	
Goal 3d. The value of health and of health care resources is continually measured, reported, and improving.	
Goal 3e. Health insurance plan reimbursements/payments are based on the value of the care, not the volume.	

Additional thoughts or comments regarding *Principle 3: Economic Efficiencies* Goals:

Principle 4, Quality of Care: People in Tennessee should have confidence that the quality of health care is continually monitored and standards are adhered to by health care providers.

	Please rate relevance of Goal to its Principle (1 = low, 5 = high)
Goal 4a. Providers and patients are partners in achieving successful outcomes as agreed upon by both the provider and patient.	
Goal 4b. Preventable harm is eliminated in the health system.	
Goal 4c. The health system uses evidence-based practices and minimizes unnecessary variation in procedures.	
Goal 4d. The public has access to user-friendly, actionable, and accurate information on the quality of health care providers.	

Additional thoughts or comments regarding *Principle 4: Quality* Goals:

Principle 5, Workforce: The state should support the development, recruitment, and retention of a sufficient and quality health workforce.

	Please rate relevance of Goal to its Principle (1 = low, 5 = high)
Goal 5a. Tennessee's health system emphasizes primary prevention and primary care.	
Goal 5b. Tennessee's health workforce is well-equipped to care for the health needs of patients and communities.	
Goal 5c. Tennessee's health workforce is culturally competent and engaged in the needs of the surrounding community.	
Goal 5d. Health delivery is maximized through workforce efficiency.	
Goal 5e. Tennessee's health system encourages the exploration of new technologies, health care delivery models, and other transformative opportunities.	

Additional thoughts or comments regarding *Principle 5: Workforce* Goals:

Please share a practical example of how the State Health Plan could be helpful to you in your efforts to make Tennessee a healthier place to live, work, and play.

_____
_____
_____
_____
_____

Please tell us anything else you would like us to know about what the State Health Plan should address:

_____
_____
_____
_____
_____

If you would like to receive further updates on the State Health Plan, please submit your email here:

_____

For data collection purposes, please indicate in what county you reside.*(required)

_____

Thank You!

Thank you for taking this survey. Your response is very important to us. We appreciate your involvement in updating the State Health Plan and look forward to releasing the finalized Plan in the near future.

Appendix D: *Goal Team Members*

The following is a list of the goal team members who participated in the state health planning process.

Access

Rae Bond – Executive Director of the Medical Foundation of Chattanooga and director of Project Access
Micah Cost – Tennessee Pharmacists Association Director of Professional Affairs
Eric Harkness – TDH Health Policy Advisor
Leslie Humphreys – TDH Assistant Commissioner of Community Health Services
Rebecca Johns-Wommack – Executive Director, Tennessee Obesity Task Force
Bridget Jones – Executive Director, Cumberland Region Tomorrow
Yvonne Madlock – Director, Shelby County Department of Health
Jessie Reid – Program Director, TDH Office of Rural Health
Cindy Siler – Deputy Director, Tennessee Rural Partnership
Kathy Wood-Dobbins – CEO, Tennessee Primary Care Association

Quality

Mary Layne Van Cleave – EVP, COO, Tennessee Hospital Association
Terri Crutcher – Assistant Professor and Assistant Dean at Vanderbilt School of Nursing
Bridget McCabe, MD – Director, TDH Office of Quality Improvement
Jim Shulman – Executive Director, Tennessee Commission on Aging and Disability
Allison Thigpen – Research & Policy Analyst, Tennessee Commission on Aging and Disability
Eric Harkness – TDH Health Policy Advisor
Dawn Fitzgerald – CEO, QSource

Economic Efficiencies

Martha Buchanan, M.D. – Director, Knox County Health Department
Brooks Daverman – Director, Strategic Planning and Innovation Group, Tennessee Division of Health Care Finance and Administration
Eric Harkness – TDH Health Policy Advisor
Melanie Hill – Executive Director, Tennessee Health Services and Development Agency
Rosalind Kurita – TDH Health Policy Advisor
Laurie Lee – Executive Director, Employee Benefits, State of Tennessee
Robert Snyder, M.D. – Medical Director, Division of Workers' Compensation, Tennessee Department of Labor and Workforce
Cristie Travis – CEO, Memphis Business Group on Health
Larry Van Horn – Associate Professor of Management (Economics) Executive Director of Health Affairs, Owen Graduate School of Management, Vanderbilt University

Workforce

Jo Edwards – Adams Chair of Excellence in Health Care Services, Director, Center for Health and Human Services, Middle Tennessee State University
Bill Jolley – VP, Rural Health Issues, Tennessee Hospital Association
Patrick Lipford – Director, TDH Office of Rural Health
Marthagem Whitlock – Assistant Commissioner, Tennessee Department of Mental Health and Substance Abuse Services
Eric Harkness – TDH Health Policy Advisor
Carole Myers – Associate Professor, College of Nursing, University of Tennessee

Appendix E: *Tennessee Health Rankings 2013*

Table 6: Tennessee Health Rankings 2013

DETERMINANTS	2013		NO. 1
BEHAVIORS	Value	Rank	STATE
Smoking (Percent of adult population)	24.9	47	10.6
Binge Drinking (Percent of adult population)	11.3	3	10.2
Drug Deaths (Deaths per 100,000 population)	15.7	40	5.0
Obesity (Percent of adult population)	31.1	40	20.5
Physical Inactivity (Percent of adult population)	28.6	45	16.2
High School Graduation (Percent of incoming ninth graders)	80.4	21	91.4
COMMUNITY & ENVIRONMENT			
Violent Crime (Offenses per 100,000 population)	644	50	123.0
Occupational Fatalities (Deaths per 100,000 workers)	5.5	36	1.9
Infectious Disease (Combined score Chlamydia, Pertussis, Salmonella*)	-0.20	21	-0.90
Chlamydia (Cases per 100,000 population)	490.1	37	140.6
Pertussis (Cases per 100,000 population)	1.7	5	0.7
Salmonella (Cases per 100,000 population)	16.6	34	6.6
Children in Poverty (Percent younger than 18 years)	26.3	42	9.7
Air Pollution (Micrograms of fine particles per cubic meter)	10.1	36	5.3
POLICY			
Lack of Health Insurance (Percent without health insurance)	13.6	22	4.0
Public Health Funding (Dollars per person)	$85	23	$225
Immunization–Children (Percent aged 19 to 35 months)	73.1	10	80.2
Immunization–Adolescents (Percent aged 13 to 17 years)	58.5	36	82.0
CLINICAL CARE			
Low Birthweight (Percent of live births)	9	41	6.0
Primary Care Physicians (Number per 100,000 population)	122.4	18	196.1
Dentists (Number per 100,000 population)	50.9	36	85.6
Preventable Hospitalizations (Number per 1,000 Medicare enrollees)	80.8	46	27.4
ALL DETERMINANTS	-0.35	42	0.70
OUTCOMES			
Diabetes (Percent of adult population)	11.9	46	7.0
Poor Mental Health Days (Days in previous 30 days)	4	30	2.8
Poor Physical Health Days (Days in previous 30 days)	4.6	45	2.9
Disparity in Health Status (By educational attainment**)	27.0	11	19.7
Infant Mortality (Deaths per 1,000 live births)	8	47	4.4
Cardiovascular Deaths (Deaths per 100,000 population)	309.3	44	186.9
Cancer Deaths (Deaths per 100,000 population)	214.5	45	141.3
Premature Death (Years lost per 100,000 population)	9,440	43	5,493
ALL OUTCOMES	-0.23	43	0.33
OVERALL	-0.58	42	0.92