



**STATE OF TENNESSEE
DIVISION OF HEALTH PLANNING
STATE HEALTH PLAN ADVISORY COMMITTEE MEETING MINUTES**

Centennial Medical Center
October 23, 2008

Present:

Joe Armstrong - House of Representatives, Chair of the House Health and Human Resources Committee

Craig Becker - Chief Executive Officer, Tennessee Hospital Association

Wilma Carney - Assistant to Senator Rusty Crowe, Chair of the Senate General Welfare, Health, and Human Resources Committee (representing Senator Crowe)

Brooks Daverman – Health Quality Analyst, Division of Health Planning, State of Tennessee

Bruce Duncan - Assistant Vice President, National HealthCare Corporation

Rita Geier (Via Telephone) - Senior Fellow for Public Health, Howard H. Baker Center for Public Policy, University of Tennessee-Knoxville

M.D. Goetz, Jr. - Commissioner of Finance and Administration, State of Tennessee

Darin Gordon - Deputy Commissioner of TennCare, State of Tennessee

Albert J. Grobmyer, III, MD – Tennessee Medical Association

Eric Harness – Planning and Research Coordinator, Division of Health Planning, State of Tennessee

Melanie Hill – Executive Director, Health Services and Development Agency

Arthur Maples – President, American Health Planning Association; Director, Government Operations & Strategic Analysis, Baptist Memorial Health Care Corp.

Jeff Ockerman – Director, Division of Health Planning, State of Tennessee

Emily Passino, Ph.D. – Senior Management Consultant, Office of Consulting Services, Finance & Administration, State of Tennessee

Linda Penny – Legislative Liaison, Office of the Comptroller of the Treasury, State of Tennessee

Debbie Shahla – Director, Division of Planning and Policy, Department of Mental Health and Developmental Disabilities, State of Tennessee

Jim Shulman – Deputy Commissioner, Department of Health, State of Tennessee
(representing Commissioner Susan R. Cooper, MSN, RN)

Faye Weaver – Assistant to the Comptroller of the Treasury, State of Tennessee
(representing Comptroller John G. Morgan)

Marthagem Whitlock – Assistant Commissioner, Division of Planning and Policy,
Department of Mental Health and Developmental Disabilities, State of Tennessee
(representing Commissioner Virginia Betts)

Marilyn Talbot, Recorder

PURPOSE

To kick off the State Health Plan Advisory Committee; to discuss the framework for the State Health Plan, and to get input on the Certificate of Need process.

Welcome, Opening Remarks and Introductions

Director of Health Planning Jeff Ockerman called the meeting to order at 10:12 a.m. in 3 Tower Classroom. After a welcome from Tom Herron, Chief Executive Officer of Centennial Medical Center, and Micki Slingerland, Centennial's Chief Operating Officer, Jeff Ockerman thanked the participants and press representatives for coming to the meeting. The participants introduced themselves and briefly stated how they became involved in the field of healthcare.

Mr. Ockerman explained that the purpose of this meeting of the State Health Plan Advisory Committee is to provide a broad visioning discussion to assist the staff of the Division of Health Planning in its development of the initial framework of the State Health Plan. There will be many opportunities for public input as the State Health Plan is developed for the participants and other stakeholders to work on details.

Overview – Vision for the Future/Reflections

Mr. Ockerman presented an overview of the Division of Health Planning, the State Health Plan, and the Advisory Committee. (See Attachment #1.)

The Division's staff has initially identified three primary components for the State Health Plan: (1) a comprehensive health planning data warehouse; (2) reports on public and private health initiatives; and (3) the review, updating, and maintenance of the State Health Plan, including Certificate of Need standards and criteria. Mr. Ockerman expanded on the status of the creation of the Health Planning Data Warehouse and said that planned key features include: (1) Ability to track key indicators of health and the health care system in Tennessee (population level data—not patient level data); (2)

Ability easily to analyze information from currently fragmented sources; and (3)
Capacity to collect current data on health initiatives and to measure their effectiveness.

Strategies regarding reports on public and private health initiatives include: (1) Recognition of areas of needed action, creation of reports, and offering manageable, specific strategies; (2) Identification of overlapping programs and opportunities for collaboration; and (3) Enabling the measurement of program effectiveness through the Health Planning Data Warehouse. The Division has learned to be a bridge builder between departments and agencies that do not have the time or the opportunity to interact with each other.

Mr. Ockerman stated that progress made on the Certificate of Need standards and criteria would be reported later during the meeting. Mr. Ockerman concluded his presentation with comments on the Advisory Committee's role, including those of providing guidance for the development of the State Health Plan framework and asking questions regarding the components, the priorities, and how best to engage and collaborate with stakeholders. In the future, the Advisory Committee will be asked to identify successes and omissions.

Emily Passino then requested feedback from the participants regarding their vision for the State Health Plan; comments are summarized below:

<u>Hopes and Concerns</u>
Coordination between state departments – elimination of silos
Setting health priorities
Coordination among all State health providers
Guidance for the Certificate of Need process, to include concrete focus
Big State goals leading to standards
Avoid interfering with department programs while providing guidance and criteria
Priorities, focus, and consistency
Healthier Tennesseans
Process—mechanism to be more proactive
Limited number of priorities

The next category Dr. Passino presented for consideration was, “Who cares?” – who has a stake in the State Health Plan? Discussion produced the following groups:

<p style="text-align: center;"><u>Who Cares?</u></p> <p style="text-align: center;">Plan should be a top down guide for citizen, providers, and the community</p> <p style="text-align: center;">Elected officials who referee for friction between parties</p> <p style="text-align: center;">Health agencies</p> <p style="text-align: center;">Providers</p> <p style="text-align: center;">Higher Education—those who educate providers</p> <p style="text-align: center;">Business purchasers of healthcare</p> <p style="text-align: center;">Taxpayers</p> <p style="text-align: center;">Citizens</p>
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Building the State Health Plan

Brooks Daverman, Health Quality Analyst with the Division of Health Planning reported that developing a draft for the proposed State Health Plan Framework began with a survey of other state health plans and examples. Those plans fit into one of four categories: (1) Coordinating Documents; (2) Medical facilities plans; (3) Single Subject Reports; and (4) Healthy People 2010.

Mr. Daverman presented the Division’s proposed concept of a Coordinating Document, which includes CON standards and criteria, policy goals, references to other plans and single subject reports for details, and a minimum annual update. Single subject reports would be released on an as-needed basis, and would include quality of care, health care workforce, and geographic access.

Dr. Passino stated a summary proposition for guidance and for comment by the participants: The State Health Plan will include a section for CON and another for State policy. It will not be a 500-page document—it will have links to other documents and other departments. It will be updated continually with supplemental reports. The plan will describe our goals and the supplemental reports will set out proposals to accomplish them.

Dr. Passino asked participants for their comments on this summary proposition.

Commissioner Goetz asked whether it is an inventory or prioritization. Rita Geier added that she believes where there is policy, criteria is necessary. It was agreed that state agencies should review their programs against the State Health Plan, and that there

should be measurable criteria for state health plan goals, with meaningful data collected towards those criteria.

Dr. Passino described the five major policy areas of the State Health Plan, based on the enacting legislation for the Health Planning Division, as follows:

1. Healthy Lives,
2. Quality of Care,
3. Access,
4. Economic Efficiency, and
5. Healthcare Workforce.

(These descriptions reflect the statutory principles of the State Health Plan listed on slides Nos. 11 and 12 in Attachment #1). Each area will include key elements, and priority issues and initiatives. Discussion ensued regarding elements that touch each goal.

Several issues arose regarding the goal areas for the State Health Plan. Rita Geier noted that we rank 15th in primary care physicians per capita (in the United Health Foundation Report); however, our health outcomes are not as good as that ranking. Considerable discussion ensued regarding access—both economic and geographic access, especially in rural areas. Commissioner Goetz added that if we are going to frame all of the goals by geographic area, we need to take this idea into consideration from a planning point of view. Discussion continued regarding access versus availability. Tennessee has availability (as reflected in the rankings), but it does not necessarily have access (as reflected in the outcomes). One possible goal would be to get the State into the top quartile of the national health rankings during the next four years. Discussion ensued regarding the process necessary to move this type of goal from an aspiration to a standard. Several examples were cited, among which were home health agencies and their ranking within the national health rankings.

Dr. Passino requested participants to write down what they would consider to be priority issues or initiatives for the various goal areas and put their ideas on the chart at the front of the room over lunch to answer the question, “What are priority issues and initiatives that should be addressed by the State Health Plan in each of these areas?”

After lunch, Dr. Passino commented on the number of rich ideas that were placed on the chart. She said that the results will be typed up and made available for further comments and additions, particularly from Rita Geier who was participating via telephone. (See Table 1, next page).

Table 1: Goal Areas for TN State Health Plan: Priority Issues and Initiatives

HEALTHY LIVES	QUALITY OF CARE	ACCESS	ECONOMIC EFFICIENCY	HEALTH CARE WORKFORCE
KEY ELEMENTS	KEY ELEMENTS	KEY ELEMENTS	KEY ELEMENTS	KEYELEMENTS
<ul style="list-style-type: none"> • Patient Compliance • Information – Education – Prevention • Life Expectancy (2010) • Personal behaviors, responsibilities • Disparities, Technology, Access 	<ul style="list-style-type: none"> • Quality metrics, e.g., CMS “Never Events” • Range of provider metrics • Survey of facilities • Licensure for base level standards • Evidence-based medicine • Continuing Education • Disparities, Technology, Access 	<ul style="list-style-type: none"> • Distance – Healthcare “sheds” (like water sheds) • Economic • Practical convenience • To primary care • Connections to known needs • Transportation • Disparities, Technology 	<ul style="list-style-type: none"> • Rational approach to rationalize resources • Resource allocation • CON Infrastructure • “Built it and they come” (whether needed or not) • Consider everyone’s best interest • Utilization concerns • Evidence-based medicine • Financial sustainability • Don’t perpetuate the BAD • Disparities, Technology, Access 	<ul style="list-style-type: none"> • Teaching, Training • Recruiting / retaining talent • Provision (delivery) beyond old model (e.g., nurse practitioners) • Tied to facilities • Allied health positions, nurses, primary care physicians, pharmacists – having teachers to teach • Disparities, Technology, Access
PRIORITY ISSUES & INITIATIVES	PRIORITY ISSUES & INITIATIVES	PRIORITY ISSUES & INITIATIVES	PRIORITY ISSUES & INITIATIVES	PRIORITY ISSUES & INITIATIVES
<ul style="list-style-type: none"> • Health benchmarks by category • Identify top 5 chronic / health issues for TN • Healthy Lives: 2010 measures to benchmark progress • Pilot program on 	<ul style="list-style-type: none"> • Measure results of treatment at patient level • Develop a single quality factor • Outcomes (for example, readmissions) • Tie quality to CON, continued licensure 	<ul style="list-style-type: none"> • Safety Net • Uniform quality standards • Promote access for all age groups of society • Patient centered • More community based 	<ul style="list-style-type: none"> • Align physician/ hospital incentives • Maximize resources • Measures: (1) need, (2) redundancy • Volume • Relate to effectiveness, 	<ul style="list-style-type: none"> • Adequate distribution of specialties across state • Incentive for primary care; increase primary care providers • Incentives; incentives to work in TN • Guidance Counseling

HEALTHY LIVES	QUALITY OF CARE	ACCESS	ECONOMIC EFFICIENCY	HEALTH CARE WORKFORCE
<ul style="list-style-type: none"> • impacting major health issues (obesity, cancer) • Understand Tennesseans' health issues • Measurable results • Measure outcomes 	<ul style="list-style-type: none"> • Establish state goals on critical health indicators • Clear guidelines 	<ul style="list-style-type: none"> • primary care programs • Integrate types of health care • Communication • Shortage of nurses, surgeons (open heart) • Directed assistance • Access to health insurance for <u>all</u> • Identify areas of need by providers, facilities, services, etc. • Impact across state boundaries • Support new service delivery options 	<ul style="list-style-type: none"> • productivity • Determine what we will pay for and what setting • Safety Net 	<ul style="list-style-type: none"> • Identify providers, sources for training to determine areas of need • Increase cross training • Quality of work life • Issues re health care works transferring to TN • Utilize existing workforce labor network • More information for public

Dr. Passino reminded the participants that the first iteration of the Plan be a short document with a broad statement and overview. She asked the participants to think about how the state health plan will be used, and what would make the document meaningful and useful.

Bruce Duncan suggested that we take a look at what we have in front of us, adding that health care is changing very fast. We need to set up a system for better health care to try to improve our numbers.

Following further discussion regarding how State departments and agencies would participate in the State Health Plan, Mr. Ockerman explained how the statutes set out the State Health Plan adoption process. Once a plan is drafted it is sent out for comment to the Health Services and Development Agency (and, as well, to the public). Then, once comments have had the chance to be included in the State Health Plan draft, it is sent to the Governor for approval and adoption. After the adoption, state agencies' and departments' participation should occur.

Commissioner Goetz called attention to some of the things the Committee has been able to do today. Much of the flow from this type of approach in terms of what we do internally should have all agencies and departments (insurance, health care agencies, education, legislative, etc.) moving in the same direction, flowing from the Plan and continuing discussion through a consistent message.

Certificate of Need

Dr. Passino asked Eric Harkness, Planning and Research Coordinator for the Division of Health Planning, to give an overview of Certificate of Need (CON) in Tennessee. Mr. Harkness presented the statutory definition of a CON and the three statutory criteria of need, economic feasibility, and orderly development of adequate and effective health care. He provided a brief history for the CON process and then he explained the areas covered by the CON process.

Mr. Harkness also discussed the traditional rationales given for the CON process: it promotes competition within a regulated framework (health care is not subject to the same market forces that drive other economic sectors) and it restricts the uncontrolled proliferation of medical facilities that can increase medical costs, threaten the quality of health care, and decrease access by destabilizing major health care providers. He then discussed how new ideas about the CON process might better be used to support safety net providers, other essential community services, and the maintenance of quality standards, such as volume standards.

Reporting on national CON activity, Mr. Harkness reported that all but 14 states have some form of a CON process. Attempts have been made recently to eliminate or reform

CON laws in several states, and the CON process is under fire from the U.S. Department of Justice and the Federal Trade Commission.

In Tennessee, the CON process by law is a component of the State Health Plan. Specific standards and criteria need to be updated and maintained over time by the health planning process, which can also help identify goals and priorities for the CON process.

Mr. Harkness called attention to the “Health Planning Decision Support System” (HPDSS) document in the handouts, explaining that this is a project charter for the centralized health care data warehouse. Page No. 5 of the document provides a list of all of the services, facilities, etc. governed by the CON process.

Dr. Passino asked if we still need the CON process in Tennessee and if so, why? Discussion ensued and the participants concluded that the CON process is needed to protect public versus private resources, reinforce and support State initiatives such as TennCare, even the playing field, and provide rational allocation of resources (even though there are reservations about revisiting what requires a CON). The general consensus was that if structured correctly, a CON process will provide for the following:

- Follow-up and accountability
- Objective quality standards
- Conditions attached to a granted CON to ensure accountability for promises made by applicants during the process
- Some flexibility and balance
- Meet demands (for example, competitive bids to address what is identified)
- Confidence in the State Health Plan (fair, objective, assessment of what State needs)

Dr. Passino requested input to define “need” for a CON. Participants agreed that this would include access for all. It would emphasize current, hard data and avoid subjective data. There should be a standard accepted source for key information, not competing sources. It would include two goals: (1) to use new data mart, and (2) to have the ability for more granular data. The criteria would need to be validated.

Dr. Passino asked whether there were particular CON categories deserving of greater priority than others in the revisions of the standards and criteria. There was general agreement that the standards and criteria for ambulatory surgical treatment centers and for diagnostic centers needed immediate attention and that the rules for diagnostic treatment center data reporting need to be developed.

In leading the closing discussion, Mr. Ockerman stated that the process being undertaken by the Division of Health Planning is a more extensive and participatory one than had

been anticipated, but that it will result in a better State Health Plan due to the collaboration with stakeholders. He cautioned that a problem with previous efforts to change CON standards and criteria was the inherent need to arrive at consensus when, in fact, consensus is not necessarily possible or preferable for all situations; the statute setting out the process for creating the State Health Plan avoids this problem.

Darin Gordon requested that the State Health Plan include a review of the Joint Annual Report methodology, timing, and purpose. Craig Becker added that the Tennessee Hospital Association does a review of the Joint Annual Report content each year.

Mr. Gordon also mentioned that there are a number of studies that agencies are required by law to complete even though there is no need or audience for these reports any longer and the State Health Plan should take this concern into consideration. Mr. Shulman stated that the Health Department has reviewed all of the reports it is responsible for to ensure that there is a good reason for doing them.

Going Forward

In closing, Mr. Ockerman thanked the participants for attending and being a part of this process. He stated that Dr. Passino and her staff will summarize today's work, which will be sent to the participants and to the HSDA for posting on its website. After the start of the New Year, the Division plans to request input from stakeholders in a series of public meetings around the state regarding the State Health Plan framework as well as its more specific topics.

Mr. Ockerman reported that he anticipates convening the group quarterly.

The meeting adjourned at 1:55 p.m.

Attachments:

1. Attachment 1, Overview of Health Planning, 10-23-08.pdf
2. Attachment 2, Designing a State Health Plan, 10-23-08.pdf
3. Attachment 3, Certificate of Need Background, 10-23-08.pdf