

State of Tennessee

2010 Tennessee State Health Plan

Division of Health Planning



2010

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Executive Summary

Why a State Health Plan?

Tennessee is one of the least healthy states in America. In one recent report, Tennessee ranks as the 44th healthiest state out of the 50 states.¹ Numerous factors contribute to the health status of Tennesseans including individual behaviors, culture, the environment, economic and social determinants, and genetics. Recognizing the need for the state to coordinate its efforts to improve the health of Tennesseans, in 2004, Public Chapter 942 passed by the General Assembly created the Division of Health Planning in the Department of Finance and Administration and charged it with developing a State Health Plan.

Purpose of the First Edition

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 Tennesseans' efforts to improve our health. The 2009 State Health Plan then 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), (Appendix A).

The Planning Model: Public Input for the Updated Edition

Based on the suggestions and findings of the first edition, the 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 Tennesseans through regional meetings and collaborative efforts. (Appendix B). The overall strategy was to balance public input by drawing upon the wisdom of those with professional expertise as well as common sense and personal experiences.

The Five Principles for Achieving Better Health

The 2010 State Health Plan recognizes the poor health of our state population as compared to those of other states. Regarding the Five Principles for Achieving Better Health, the State Health Plan has outlined goals and strategies that support health policies and programs at the individual, community, and state level that will help improve the health status of Tennesseans. In addition to goals and strategies, we support and strongly encourage the use of data and evidence-based practices and the reporting of program outcomes to guide Tennessee programs and policies.

We also recognize the importance of personal responsibility in achieving better health outcomes and encourage all Tennesseans to take action to improve their health. It must be noted that in

2010 the federal government enacted the Patient Protection and Affordable Care Act, which aims to reform health insurance, reduce health care costs, and improve the health of Americans. Recognizing the important relationship of economics and health, The State Health Plan in this edition and future editions will seek to integrate these changes if and as they occur.

As discussions around health care, costs and quality continue at the national level, the State Health Plan will continue to review and endorse goals and strategies that improve the quality of care of Tennesseans as well as promote evidence-based practices and policies centered on improving quality while controlling costs. If national and statewide trends continue and as the population of Tennessee ages, in the near future there will be a health care workforce shortage throughout the state. The State Health Plan will continue to promote policies and practices that support funding and opportunities to train and maintain a workforce that can meet the health needs of Tennesseans.

Certificate of Need Standards and Criteria

Tennessee's Certificate of Need (CON) program seeks to deliver improvements in access, quality, and cost savings 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 ESWL (lithotripsy) and home health services and for open heart surgery. Standards and criteria will be tied to the State Health Plan's overarching goals and priorities.

Finally, we hope that this edition of the 2010 State Health Plan and future editions will assist the next state administration by providing a collective vision for coordination among state departments and agencies to work to improve the health of Tennesseans and the performance of our health system.

State Health Plan Introduction

This chapter serves as an introduction to the Tennessee 2010 State Health Plan including the origins, formation, process and future goals.

Why a State Health Plan?

The Beginnings of a State Health Plan

Tennessee is one of the least healthy states in America. In one recent report, Tennessee ranks as the 44th healthiest state out of the 50 states,¹ an improvement from its 48th position in 2008. Though rankings may be considered to be relative, the state's health status is also reflected in the below average life expectancy of our population. Tennesseans are expected to live on average 3 years less than the average US citizen (75 years as compared to 78 years) and 2 more infants die per every 1,000 infants born (Approximately 9 deaths per 1,000 live births as compared to 7 deaths per 1,000 live births) as compared to the US average.^{2, 3}

Numerous factors contribute to the health status of Tennesseans including individual behaviors, culture, the environment, economic and social determinants, and genetics. Tennessee's lack of an integrated system of health care also contributes to poor health outcomes.

The Commonwealth Fund, a respected national health care think tank, ranked Tennessee's health system performance 39th in 2009 – an improvement from 41st in 2007 – based on benchmarks for 38 indicators of access, quality, costs, and health outcomes.

Recognizing the need for the state to coordinate its efforts to improve the health of Tennesseans, in 2004, Public Chapter 942 passed by the General Assembly created the Division of Health Planning in the Department of Finance and Administration and charged it with developing a State Health Plan. This 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, and considered as guidance by the Health Services and Development Agency when issuing certificates of need....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.”⁴

The 2009 State Health Plan – the First Edition

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 Tennesseans' efforts to improve our health. It first adopted the World Health Organization (WHO)'s definition of health as an initial step for creating the foundation for the State Health Plan: "a state of complete physical, mental, and social well being, and not merely the absence of disease." The 2009 State Health Plan then 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), and set out health focus areas of health for the State of Tennessee. It also provided the process and methods from which this second edition of the State Health Plan was developed. More information on this policy statement, the procedure for annual approval and adoption of the State Health Plan, and other matters appear in Appendix A.

The Framework for Tennessee's Comprehensive State Health Plan

Five Principles for Achieving Better Health

The following Five Principles for Achieving Better Health serve as the basic framework for the State Health Plan.

1. Healthy Lives

The purpose of the State Health Plan is to improve the health of Tennesseans.

Every person's health is the result of the interaction of individual behaviors, society, the environment, economic factors, and our genetic endowment. The State Health Plan serves to facilitate the collaboration of organizations and their ideas to help address health at these many levels.

2. Access to Care

Every citizen should have reasonable access to health care.

Many elements impact one's access to health care, including existing health status, employment, income, geography, and culture. The State Health Plan can provide standards for reasonable access, offer policy direction to improve access, and serve a coordinating role to expand health care access.

3. Economic Efficiencies

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 system. The State Health Plan should work to identify opportunities to improve the efficiency of the state's health care system and to encourage innovation and competition.

4. Quality of Care

Every citizen should have confidence that the quality of health care is continually monitored and standards are adhered to by health care providers. Health care providers are held to certain professional standards by the state’s licensure system. Many health care stakeholders are working to improve their quality of care through adoption of best practices and data-driven evaluation.

5. Health Care Workforce

The state should support the development, recruitment, and retention of a sufficient and quality health care workforce. The state should consider developing a comprehensive approach to ensure the existence of a sufficient, qualified health care workforce, taking into account issues regarding 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 funding.

The State Health Plan: “Connecting the Dots”

Since health is defined as “a state of complete physical, mental, and social well being, and not merely the absence of disease,” it is important to realize that the health of Tennesseans is not dependent only upon the individual and the health care provider, but on every entity, public and private, that affects one’s physical, mental, and social well being. In a State Health Plan Advisory Committee meeting regarding the audience for the State Health Plan, Commissioner of Health Susan Cooper stated, “Who should *not* be using this document?” leading the group to the central point that “health is the thread that connects all the silos” both inside and outside of government. Health is the common denominator, connecting groups that do not traditionally think about their roles as impacting health.

Since our health is the product of where “we live, work, and play,” all areas of state government potentially affect our individual health and the overall health of our state and individuals’ health may be affected simultaneously by more than one government agency. Several government departments are traditionally associated with helping Tennesseans maintain or improve their health. The Department of Health works to promote and improve the health and well-being of Tennesseans by preventing problems that contribute to disease and injury. The Department of Mental Health and Developmental Disabilities provides services, support and advocacy for persons of all ages who have mental illness, serious emotional disturbance, or substance abuse disorders. The Governor’s Office of Children’s Care Coordination works through several initiatives to reduce the rates of infant mortality and improve the health of Tennessee’s children. But in addition, there are many other state agencies whose work impacts the health of Tennesseans.

As a sampling:

- The Department of Corrections is responsible for the provision of health care for prisoners.
- The Department of Environment and Conservation provides and maintains trails, parks and other recreational activities that can help us be healthy.
- 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 Division of Intellectual Disabilities assists with needed care for those with intellectual disabilities.
- The Department of Education oversees the Coordinated School Health Program that introduces our children to healthy habits and food choices.
- The Department of Transportation designs and maintains roads that allow us to access health care services and maintain health through biking or walking.
- The Department of Labor and Workforce Development ensures that an adequate supply of health care providers and health-related staff are trained and employed.

Furthermore, in addition to administering direct service programs, state government has a number of other roles, including:

- | | |
|---|---|
| <ul style="list-style-type: none">• Policy Maker• Regulator [Enforcer/Licenser]• Grantor• Employer | <ul style="list-style-type: none">• Leader/Facilitator• Educator• Public Health• Purchaser
[Health Plans, Cover Tennessee, TennCare] |
|---|---|

Where we live, work, 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. With this cooperative attitude in mind, we hope that, 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 government agencies in developing a comprehensive and collaborative approach to help Tennesseans reach their full potentials to be healthy.

The 2010 State Health Plan

Based on the suggestions and findings of the first edition, this current (second) 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 Tennesseans through regional meetings and collaborative

efforts. This edition augments the Five Principles for Achieving Better Health by developing goals and strategies for each principle and, in some cases, providing examples of successful programs. The process is outlined in Appendix B.

As shown on the following page (Figure 1), the overall strategy was to balance public input by drawing upon the wisdom of those with professional expertise as well as common sense and personal experiences.

The Future

The Division of Health Planning staff will continue to seek public and expert input to develop appropriate goals and strategies that will improve the health status of Tennesseans and that will reflect best practices that are effective and relevant at the individual, local, and state level. We acknowledge the limitations of the 2010 State Health Plan with regards to evidence-based programs and policies that have already been implemented in areas throughout the state. We seek to include more programs and policies in future editions as well as incorporate changes at the federal level that may affect the health of Tennesseans and/or the state's health care system. We also look forward to utilizing the Division's all payer claims database to guide us in our assessment and understanding of the health needs of Tennesseans. We encourage the support of evidence based practices and policies and hope that this edition of the 2010 State Health Plan and future editions will provide a collective vision for coordination among state departments and agencies to work to improve the health of Tennesseans and the performance of our health system.

2010 State Health Plan Public Engagement Process

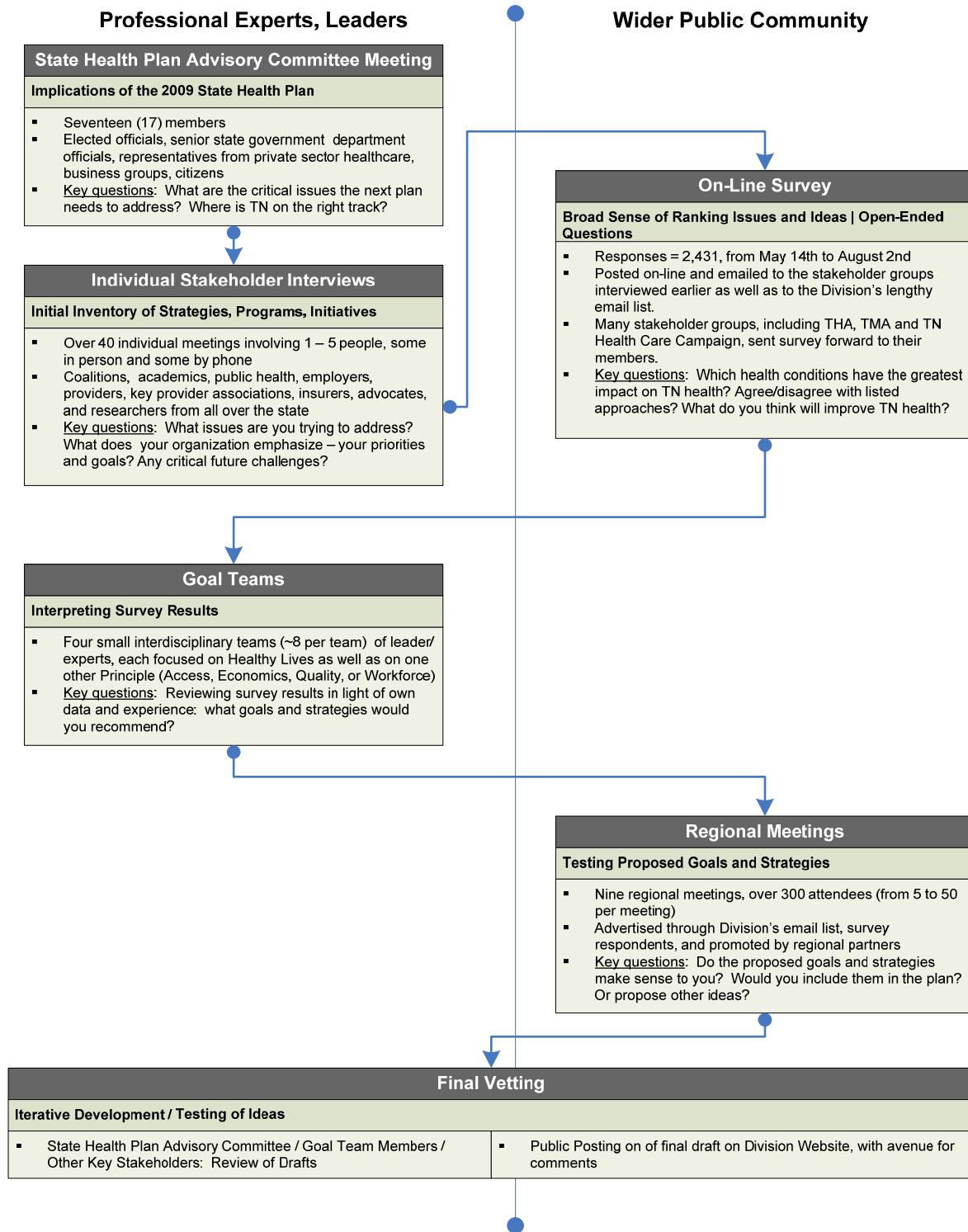


Figure 1. Public Engagement Process

The Five Principles for Achieving Better Health

Principle 1: Healthy Lives

“The purpose of the State Health Plan is to improve the health of Tennesseans.”

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 received from our parents. According to the US government’s Healthy People 2010 plan, some of the leading indicators that affect individual health are: Physical Activity, Obesity, Tobacco and Substance Use, Mental Health, Environmental Quality, and Immunizations.⁵ Given this information, the State Health Plan focuses on goals and strategies that provide opportunities that allow for improvement in these areas at both the individual and at the community level. The description of the current health status of Tennesseans is intended to provide an overview of how the citizens of Tennessee fare in these areas and to initiate dialogue as to how we may improve.

Status of Tennesseans

In *America’s Health Rankings*, an annual report published by the United Health Foundation, Tennessee ranks as the 44th healthiest state out of the 50 states.¹ Though rankings may be considered to be relative, the state’s poor health status is also reflected in the below average life expectancy of our population. Tennesseans are expected to live on average 3 years less than the average US citizen (75 years as compared to 78 years) and 2 more infants die per every 1,000 infants born (approximately 9 deaths per 1,000 live births as compared to 7 deaths per 1,000 live births) as compared to the US average.^{2,3}

“It is very discouraging to read report after report of the poor health of Tennesseans.”

-Survey Respondent

How we “live, learn, work, and play” affects our physical and mental health.⁶ As a population, Tennesseans aren’t physically healthy. The lifestyles of Tennesseans are a major determinant of our below-average health, especially in areas such as physical activity, obesity, and smoking. While 23 percent of Americans reported no physical activity within the past month, over 30 percent of Tennesseans stated that they had not been physically active within the same time period. 67 percent of Tennesseans report being overweight or obese compared to the national average of 63 percent and over 1 out of every 10 Tennesseans has been diagnosed with diabetes.⁷ Though our rates of smoking have decreased slightly since 1999, in 2009 over 1 in 5 Tennesseans still classify themselves as smokers.⁷

<u>Leading Cause</u>	<u>Number</u>	<u>Rate</u>
Total Resident Deaths	58,555	952.9
Heart Diseases	14,636	238.2
Cancer	13,108	213.3
Chronic Lower Respiratory Diseases	3511	57.1
Stroke and Cerebrovascular Disease	3294	53.6
Accidents and Adverse Effects	3220	52.4
Alzheimer's Disease	2415	39.3
Diabetes	1733	28.2
Pneumonia and Influenza	1419	23.1
Suicide	965	15.7
Kidney Disease	900	14.6

Top 10 Leading Causes of Death for Tennessee Residents per 100,000 people, 2008

Source: Tennessee Department of Health, Office of Policy, Planning and Assessment, Division of Health Statistics

Not only is our physical health suffering, our mental health is suffering. Though the number of Tennesseans who are considered binge drinkers is only 1 in 50 people, significantly less than the national average of 1 in 20 people, the mental health of Tennesseans is poorer than that of the national average.⁷ Almost 1 in 10 Tennesseans have recently experienced an episode of depression compared to less than 1 in 12 Americans.⁸

Many Tennesseans are aware of their lack of good health. In a 2009 survey, over 20 percent of Tennesseans said that their health was fair or poor as compared to the national average of almost

"Mental health is fundamental to overall health. Mental illnesses and substance abuse disorders are real and diagnosable diseases for which prevention works, for which a variety of effective treatments exist, and from which recovery is not only possible but expected."

-Virginia T. Betts Commissioner of Mental Health and Developmental Disabilities

15 percent.⁷

Input of Tennesseans

Mirroring the health data reported above, the top three health conditions considered by the Division of Health Planning survey respondents (Appendix C) to have the greatest impact on the health of Tennesseans were:

1. Obesity and overweight (79%);
2. Heart attack, stroke, high blood pressure, and cardiovascular disease (71%); and
3. Diabetes (63%).

Also felt to be important were alcoholism and drug abuse; cancer, health disparities; mental health disorders; asthma and chronic lung diseases; and infant mortality, low birth weight, and premature births (respondents could choose up to five health conditions for this question).

Respondents were also asked what different institutions could do to improve the health of Tennesseans. The most popular government initiative was increasing areas where people can walk and exercise, such as parks, sidewalks, and bike lanes. Reducing teen access to tobacco, alcohol, and other drugs was also a popular government initiative, as was outreach to mothers and mothers-to-be who are at high risk for infant and/or maternal mortality. Business initiatives most supported by survey respondents were the offering of health insurance coverage and of wellness programs to employees. Tennessee's Coordinated School Health program was not a listed option on the survey, but more people wrote in this program than any other strategy, signaling strong support for and recognition of the program. The other top school strategies in the survey were increasing sidewalks, crosswalks, and crossing guards so children have a safe way to walk to school, and increasing mental health counselors in schools.

When the Goal Team members considered the survey results in light of their own professional experience and knowledge, their discussions led to a consensus on the importance of prevention and reduction of risks for chronic diseases, not just for adults but for children as well. They also agreed on the need to provide opportunities to be healthy for all Tennesseans and the importance of educating consumers on how to be healthy. The resulting proposed goals considered by the people participating in the regional meetings showed virtually universal agreement with the idea of prevention, with special emphasis statewide on the importance of taking personal responsibility for one's health. Also deemed critical were child and maternal health, the reduction of the use of unhealthy products, and the importance of engaging individuals and families in decisions about health care.

Goals and Strategies

Health starts “where we live, learn, work, and play” and many factors outside the health care system impact our health.⁶ The goals in this section of the report are not only related to each other, but also provide a foundation for the other principles for achieving better health.

Healthy Mental and Physical Lifestyles

Maintaining good physical and mental health is essential to reducing the risk for several chronic diseases; adequate levels of physical activity and good nutrition are key elements to achieving health in these areas. In a study released by The Task Force on Community Preventive Services (TFCPS), several evidenced-based recommendations were suggested to improve physical activity in members across all age levels in the community.⁹ The TFCPS also provided recommendations for healthy indoor and outdoor environments, good nutrition, and opportunities for good social interaction as means to maintain good physical and mental health. This goal reflects these recommendations as a means to achieve better health.

Goal 1A. Make it easier for Tennesseans to have a mentally and physically healthy lifestyle.

Promising Strategies:

- Implement the statewide physical activity and nutrition plan, “Eat Well, Play More, a Comprehensive Plan to Reduce Obesity and Chronic Disease in Tennessee,” and support the Tennessee Obesity Task Force and other local and state programs that emphasize increased physical activity and good eating habits, e.g. the Tennessee Department of Health’s GetFitTN Program.
- Support a healthy environment in the workplace, e.g. Tennessee Occupational Safety and Health Act TCA 50-3-101, Tennessee Executive Order 69 regarding providing healthy items for sale in vending machines located on state property.
- Assure a healthy environment, both indoors and outdoors, e.g. Tennessee Department of Mental Health and Developmental Disabilities’ Creating Homes Initiative and the Community Supportive Housing program.
- Support statewide coalitions and programs that address chronic disease, e.g. The Tennessee Cancer Coalition, the Tennessee Department of Health’s Project Diabetes and Disease Management Programs provided through TennCare’s managed care organizations.
- Implement programs and policies that encourage increased recreational activity, e.g. the Tennessee Department of Environment and Conservation’s “Tennessee 2020: Vision for Parks, People and Landscapes” public health strategies.
- Implement transportation health initiatives, e.g. the Tennessee Department of Transportation’s “Safe Routes to School” program, other federal “Safe, Accountable, Flexible, Efficient Transportation Equity Act: A Legacy for Users” initiatives, and the Nashville Metropolitan Planning Organization Regional Bicycle and Pedestrian Study.

- Support programs that encourage good mental hygiene and prevention of suicide, e.g. the Tennessee Suicide Prevention Network.
- Increase awareness in all areas of state and local government of the health effects of programs not directly intended to impact health, e.g. programs designed to increase education graduation levels, jobs, and a safe environment.

Maternal and Infant Health

Good maternal and infant health is essential to maintaining a healthy population. Many factors contribute to good maternal and infant health, such as ensuring access to prenatal and postnatal care, providing preventive and childcare services, and promoting access to care in vulnerable or at risk populations.¹⁰

Goal 1B. Improve maternal and infant health to promote a healthy start to life.

Promising Strategies:

- Promote healthy behaviors in pregnant women such as, but not limited to, smoking cessation e.g. TennCare coverage of smoking cessation agents, Tennessee Department of Mental Health and Developmental Disabilities’ Women and Pregnant Women Substance Use Program, and the Governor’s Office of Children’s Care Coordination Women’s Health Initiative.
- Encourage a collaborative effort to reduce infant mortality e.g. the Governor’s Office of Children’s Care Coordination Infant Mortality and Prematurity Prevention Initiatives, such as the Centering Pregnancy Program.
- Support coordinated care programs for high risk pregnancies e.g. Maternity management services delivered through TennCare’s managed care organizations.
- Encourage the following of the United States Public Health Service’s recommendations for the use of folic acid supplementation in women of child-bearing age.¹¹
- Encourage evidence-based home visitation program for pregnant women and new mothers, e.g. Nurses for Newborn Foundation, the Tennessee Department of Health’s Help Us Grow program.
- Implement Tennessee Department of Health’s Maternal and Child Health strategies.
- Implement strategies that promote breast feeding, e.g. “Eat Better Play More” strategies.

Healthy Children

As one survey respondent stated, “Our children are the best investment we can make in preventing long term health issues and empowering them to make healthier choices.” We can help our children develop and maintain good health on many levels. Decreasing rates

of obesity through encouraging good nutrition and physical activity are essential to promoting healthy lifestyles in children. Providing safe environments that promote good mental health and discourage violent behavior are also key components in starting healthy habits in childhood that are reflected in this goal.¹²

Goal 1C. Start healthy habits in childhood.

Promising Strategies:

- Fully fund the Tennessee Department of Education’s Coordinated School Health program and promote its implementation in a way that encourages good eating and physical activity habits and promote monitoring and evaluation of local implementations.
- Facilitate the opportunity for more children to walk safely to school.
- Consider funding or collaborating with existing programs that promote healthy eating habits and/or physical activity, e.g. The University of Tennessee Agricultural Extension programs, the Tennessee Department of Human Services’ State Nutrition Action Plan nutrition education program; Bradley County’s Coordinated Approach to Children’s Health program.
- Support policies and programs that encourage children to spend time outside, e.g. Tennessee’s Children’s Outdoor Bill of Rights endorsed by Resolution by the Tennessee General Assembly.
- Maintain high rates of immunizations for infants and children, e.g. the Tennessee Department of Health and the Tennessee Department of Education initiatives, the Tennessee Office of eHealth Initiatives’ electronic immunization records, the Bureau of TennCare programs, immunization requirements for children enrolled in the Tennessee Department of Human Services licensed childcare facilities, and the Families First program.
- Improve nutrition, mental health, and physical activity in pre-school and early childhood development facilities e.g. TDOH Gold Sneaker Initiative and the Tennessee Department of Mental Health and Developmental Disabilities’ Early Connections Network.
- Continue efforts to increase well child and preventive care visits, e.g. TennCare’s efforts to increase well child visit rates.
- Encourage an educational setting that promotes mental health and a safe, non-violent environment, e.g. school-based Mental Health Liaison programs, Tennessee Department of Mental Health and Developmental Disabilities’ Violence and Bullying Prevention Program, Memphis City and Shelby County Anti-Bullying policies, the TDOH Rape Prevention Education Program, and Project HEROES.

Tobacco and Alcohol Use

Tobacco is a significant source of death and disability and has been proven to cause diseases such as cancer, heart disease, and lung disease.¹³ For every person who dies from a smoking-related illness, 20 more people will be adversely affected by illness.¹⁴ Likewise, excessive alcohol consumption is also a major cause of death and disability and one of the top three leading causes of preventable death in the United States.¹⁵ Policies relating to encouraging cessation and reducing environmental exposure to secondhand smoke are recommended by the CDC Task Force for Community Preventive Services (TFCPS) regarding tobacco. To reduce the negative health effects of alcohol, limiting the hours and days of sale of alcohol as well as enforcement of laws that prohibit sales to minors are recommended by the TFCPS.

Goal 1D. Reduce tobacco, alcohol, and substance use disorders.

Promising Strategies:

- Expand proven legislative initiatives, e.g. expand the Tennessee's Non-Smoker's Protection Act to cover all workplaces, expand the tobacco sales tax increase of 2007.
- Promote use of smoking cessation programs, e.g. the TDOH Tennessee Tobacco Quit Line, health benefit designs that support smoking cessation programs, and grants to local governments for tobacco cessation programs.
- Support programs that reduce access to tobacco products for youth, e.g. the TDOH (?) Tobacco Access Reduction Program.
- Support programs that encourage the reduction of binge drinking and substance use behaviors in adolescents, e.g. Tennessee's Partnerships for Success projects, the Tennessee Prevention Network, the Governor's Office of Children's Care Coordination's Substance Abuse Collaborative.
- Promote the use of programs that provide treatment and counseling for substance use disorders, e.g. the Tennessee Department of Mental Health and Developmental Disabilities' Alcohol and Drug Abuse Treatment programs, Community Treatment Collaborative, Co-occurring Disorders Treatment Initiative, Higher Education Initiative.
- Promote the use of Screening, Brief Intervention, and Referral to Treatment in primary care settings.
- Support community-based environmental strategies to limit access to substances and foster a culture and environment that reduces the prevalence and or likelihood of tobacco, alcohol, and substance use, e.g. Community Anti-Drug Coalitions.

Health Literacy

The US Department of Health and Human Services defines health literacy as “The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.”¹⁶ Poor health literacy is associated with worse health outcomes, increased costs, and a difficult time managing chronic diseases.¹⁷

Goal 1E. Increase health literacy so that individuals and their families are better prepared to take personal responsibility for managing their health and making decisions about health care.

Promising Strategies:

- Study the feasibility and effects of implementing nationally-recognized projects that encourage increased health literacy and personal responsibility e.g. Project Achieve (CDC funded).
- Support initiatives that increase understanding about health and health literacy, e.g. Health Educators, the Tennessee Department of Education’s Coordinated School Health program, and the University of Tennessee Agriculture Extension Service.
- Encourage programs that help individuals understand mental illness, e.g. the Tennessee Department of Mental Health and Developmental Disabilities’ Building Recovery of Individual Dreams and Goals through Education and Support program (“BRIDGES”) and the Family Support Program

Ensuring the Opportunity to be Healthy for Everyone

Our beliefs, values, and perspectives as well as the beliefs, values, and perspectives of those around us define our culture, influence how we live, and ultimately affect our health. Our culture and status in life can make it easier or more difficult to be healthy. Providing care that addresses the cultural needs of the individual such as the provision of interpreters, providing disease management that is culturally appropriate, and providing personnel who can help patients navigate the health care system are strategies that have been shown to address the root causes of health disparities related to the patient care process and other health variables.¹⁸ This goal provides strategies to help lower the barriers to ensure that everyone has an opportunity to be healthy.

Goal 1F. Reduce barriers to becoming healthy for everyone.

Promising Strategies:

- Educate health care professionals in cultural competency issues to eliminate barriers in communication and cultural insensitivity when teaching vulnerable populations (from “Eat Better, Play More”).

- Educate families/members of vulnerable populations to choose healthier lifestyle resources within their socio-economic conditions and identify community organizations and resources that will promote these choices (from “Eat Better, Play More”).
- Ensure compliance with federal guidelines in healthcare centers for the provision of adequate language services for limited English proficiency patients.
- Increase the availability and accessibility of home and community based services to elderly and disabled individuals in order to prevent and/or delay the need for nursing facility care, e.g. the Bureau of TennCare’s CHOICES in Long-Term Care program and the Tennessee Department of Human Services’ Homemaker Program.
- Encourage local faith-based organizations to promote, in a coordinated manner, mental and physical health in their communities, e.g. the Tennessee Department of Health’s Faith-Based Health Initiative and Emotional Fitness Centers.
- Increase community-based, culturally appropriate care, e.g. JustCare Family Network.
- Support programs that foster good mental and physical health for the homeless, the elderly, foster children, children of abuse or trauma, and other vulnerable populations, e.g. Projects for Assistance in Transition from Homelessness, Adult Protective Services, Juvenile Court Ordered Mental Health Evaluation Services, and the Governor’s Office of Children’s Care Coordination Centers of Excellence.
- Ensure opportunities to maintain health in those populations with mental illness and other co-occurring disorders, e.g. HIV/AIDS Early Intervention Services Program.

Conclusion

The 2010 State Health Plan recognizes the poor health of our state population as compared to those of other states and as defined by the aforementioned health determinants. In this edition, we have endeavored to outline goals and strategies that support health policies and programs at the individual, community, and state level that will help improve the health status of the Tennesseans. We also support and strongly encourage the use of data and evidence-based practices and the reporting of program outcomes to guide Tennessee programs and policies. We also recognize the importance of personal responsibility in achieving better health outcomes and encourage all Tennesseans to take action to improve their health. Future editions of the State Health Plan will work to support and create evidence-based strategies that continue to facilitate improvement of the health of Tennesseans and encourage collaboration of local and state organizations.

“If every Tennessean just did one thing to take one small step on their journey to personal health, we would see great changes.” –Susan Cooper, Commissioner of Health.

Tennessee Public Health Association Conference 2010

Principle 2: Access to Care

“Every citizen should have reasonable access to health care”

Background

According to the Institute of Medicine, having access to health care means “the timely use of personal health services to achieve the best health outcomes.”¹⁹ In the 2009 National Health Disparities Report (NHDR), attaining good access requires:²⁰

- Gaining entry into the health care system
- Getting access to sites of care where patients can receive needed services
- Finding providers who meet the needs of individual patients and with whom patients can develop a relationship based on mutual communication and trust.

The State Health Plan Advisory Committee took particular interest in the policy area of ensuring that all Tennesseans have “reasonable access” to health care. While the statutory policy statement refers only to emergency and primary care, this broader focus in the State Health Plan reflects the areas of priority that are described by the NHDR. Some of these areas discussed by the Advisory Committee include:

- Economic access – how the financial/insured status of the individual impacts access to health care
- Disparities/inequalities in access to health care
- Access to emergency and primary care
- Geographic access – the distance one has to travel to receive comprehensive care; also, a regional analysis of health care “watersheds” – the clusters of comprehensive health care services that draw patients in from outlying areas
- How to obtain and analyze data for the purpose of understanding the impact of access impacts known health care needs
- The impact of access to transportation on access to health care
- The role of technology, such as telemedicine, in meeting health care access needs

Status of Tennesseans

For most Tennesseans, having health insurance is a key element of access to health care. Those without insurance can face major barriers to accessing health care as outlined by the NHDR. According to the United Health Foundation's *America's Health Rankings* report, 15 percent of all Tennesseans are uninsured, ranking Tennessee 30th out of 50 states in the percent of the population who is uninsured.²¹

Access to health care also involves having the right services available within a geographic region, having adequate transportation, and having the service available at the right time. The Health Services and Resources Administration designates areas that may have a shortage of primary medical care, dental or mental health providers as Health Provider Shortage Areas (HPSAs) and areas where residents may have a shortage of personal health services as Medically Underserved Areas (MUAs).²² Every county in Tennessee has an HPSA and/or an MUA designation.

The size and geographic distribution of Tennessee's health care workforce is clearly a major element of access. Health care workforce issues are covered separately in on page 39.

Input of Tennesseans

How do Tennesseans define "reasonable access to health care?" While many of the respondents to the Division of Health Planning's online survey (see Appendix C) felt that every type of health care should be a part of reasonable access, virtually everyone agreed that reasonable access should include primary and preventative care, followed closely by emergency care and maternity/prenatal care. Mental health care, care for chronic diseases, oral and dental care, and long term care for the elderly and disabled also received significant support in the survey.

Survey respondents felt that the top three considerations in determining whether a person has reasonable access to care were

According to the Current Population Survey, Tennesseans obtained insurance through the following means:

- **Employer-based:** 48 percent.
- **TennCare and CoverKids:** 17 percent of Tennesseans have TennCare (Tennessee's Medicaid program) or CoverKids (Tennessee's Children's Health Insurance Program).
- **Medicare:** 14 percent of Tennesseans have Medicare; (National average is 12 percent).
- **Individual:** 5 percent of Tennesseans directly purchase insurance as an individual, (equal to the national average).
- **Other Insurance:** 2 percent of Tennesseans have some other form of public health insurance (Slightly higher than the national average).

Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2008 and 2009 Current Population Survey (CPS: Annual Social and Economic Supplements)
<http://www.statehealthfacts.org/profileind.jsp?cmprgn=1&cat=3&rgn=44&ind=125&sub=39H>.

- The price of health care services,
- The distance a person must travel to get to a service provider; and
- The transportation options available.

Tennesseans in both rural and urban areas expressed concern regarding geographic access issues in the State Health Plan surveys and at the regional meetings. Rural Tennesseans are concerned about maintaining local primary care services and specialty care services within a reasonable driving distance. Urban areas tend to have more specialists, but the adequacy of “safety-net providers” who treat the majority of uninsured or publicly insured patients is a concern. Both rural and urban areas agree that lack of access to vehicular transportation is a major barrier to

“If people do not have fair and adequate access to preventive medicine or health care, we are failing our fellow citizens.”

-Survey Respondent

health care access. In rural areas van transportation services available to eligible TennCare recipients through their managed care organizations is a solution, whereas a solution in urban areas is often accessing health care facilities by bus or other public transportation. Regional meeting participants also voiced support for telemedicine initiatives as a way to increase their access to health care professionals.

The Goal Team members agreed that primary care services should be geographically convenient, delivered within a reasonable time frame, and culturally effective (addressing language and cultural nuances). They also agreed that access to health insurance doesn’t necessarily equate to access to health care and expressed concern that electronic medical records initiatives may not speed the health care delivery process or save money.

Goals and Strategies

Access to care involves many factors. The goals and strategies of this section address issues of access on several levels.

Access to Primary Mental and Physical Care

Access to primary care is associated with more equal health outcomes for diseases such as heart disease and cancer.²³ However, according to a report released by the US Health Resources and Services Administration (HRSA),²² as of September 30, 2009, nationally there is a shortage of primary care, dental, and mental health providers with about 65 million people living in regions without adequate primary care, 49 million people living in regions without adequate dental care, and 80 million people living in regions without adequate mental health care. Many Tennesseans live in these regions as previously defined at the beginning of this chapter. Access to care also involves providing the appropriate workforce and ensuring that policies and programs are in place to allow workforce members to practice at the full extent of their level of training.²⁴

Goal 2A. Ensure all Tennesseans have access to primary mental and physical care, including preventive care and oral care.

Promising Strategies:

- Expand points of service for primary and preventive care, including school-based clinics and community health centers including federally qualified health centers, e.g. the Tennessee Department of Mental Health and Developmental Disability's Medically-Monitored Crisis Detoxification Units, the Tennessee Department of Health's School-Based Dental Prevention program
- Encourage local medical societies and other health care professionals to offer services to those without means to pay e.g. the Chattanooga Project Access, the Knoxville Area Project Access, Bridges to Care in Nashville, and the Dispensary of Hope in Murfreesboro.
- Expand access to mental health, substance use disorder and oral health services and consider their integration into primary care e.g. Behavioral Health Safety Net of TN, Crisis Stabilization Units, the Tennessee Department of Mental Health and Developmental Disabilities' Wellness Recovery Program, and Cherokee Health Systems.
- Utilize Physician Assistants, Advanced Practice Nurses and other non-physician health care providers where appropriate.
- Increase the availability of non-emergency care at night and on the weekends.
- Ensure that adequate inpatient mental health care services exist, e.g. the Tennessee Department of Mental Health and Developmental Disabilities' Regional Mental Health Institutes

Overcoming the Barrier of Geography

According to a report released by the Commonwealth Fund, many states are using telemedicine to provide care by specialists and primary care providers to rural areas and as a primary means to reduce geographic disparities. These services are usually reimbursed by Medicaid and some states require reimbursement by private insurers as well.²⁵ Though Federally Qualified Health Centers use telemedicine, currently no Tennessee law exists that regulates the reimbursement of telemedicine services.²⁶

Goal 2B. Ensure that geography is not a barrier to critical health care services.

Promising Strategies:

- Promote widespread use of and reimbursement for telemedicine services in rural areas and urban areas, e.g. Regional Mental Health Institute Telemedicine Project and Federally Qualified Health Centers.

- Support expansion of adequate transportation services for the elderly, handicapped, and economically disadvantaged who have medical needs, e.g. transportation to medical services available under the TennCare program, the Upper Cumberland Human Resources Agency, and the Tennessee Department of Transportation programs.
- Utilize mobile units of health care when appropriate, e.g. Tennessee Department of Mental Health and Developmental Disabilities’ Mobile Crisis Response Services

Access to Health Insurance

In a study funded by the Agency for Healthcare Research and Quality that looked at the relationship of health insurance to the utilization of health services and overall health, it was found that those with health insurance used more health care services and had better health outcomes than those who did not.²⁷

Goal 2C. Expand access to affordable, quality health insurance.

Promising Strategies:

- Extend the outreach approach currently used to reach potential enrollees of CoverTennessee to reach all currently underinsured or uninsured Tennesseans to help match their circumstances to appropriate health insurance options.
- Expand Centers for Medicare and Medicaid programs using available federal funding from the Patient Protection and Affordable Care Act to the maximum fiscal capacity.
- Support a “no-wrong-door” approach to eligibility determination for insurance services by encouraging communication across data systems and identifying opportunities for shared efficiencies across state agencies.

Ensuring everyone has Access to Care

According to a national study released by the National Association of Community Health Centers and The Robert Graham Center, of those without a usual source of care (USC), 32% are uninsured and 21% are low income (meaning that the majority of the population who do not report a USC have insurance and are not in poverty). In addition, 9% of *all* Medicare beneficiaries without other sources of insurance lack a USC. Out of 31 million people who describe their health as “fair” or “poor,” 4 million have not established a continuous healing relationship with a provider.²⁸

52% of those without a Usual Source of Care lack health insurance
 24% are of low income,
 23-32% are members of racial and ethnic minority groups

Goal 2D. Overcome barriers to access to health care across populations and communities.

Promising Strategies:

- Lower barriers to access to prenatal care.
- Increase support for in-home health care for the elderly and the disabled.
- Ensure that facilities that acquire a Certificate of Need (CON) comply with relevant CON standards and criteria such as providing services to uninsured and publicly insured patients.
- Ensure that populations with significant barriers to health care are included in health access plans and have appropriate access to needed health services, e.g. the Tennessee Division of Intellectual Disabilities' Dental Board and Volunteer State Health Plan

Conclusion

The Division of Health Planning is currently gathering data and reports concerning the areas of access listed above, though it is likely that the current availability of data is not sufficient to provide a comprehensive analysis of all potential strategies. As, and if they are implemented, the health reforms relating to access to care proposed by the federal government as outlined by The Patient Protection and Affordable Care Act will be reflected in current and future editions of the State Health Plan as it seeks to coordinate the efforts of state and local agencies to provide adequate access to healthcare for the citizens of Tennessee.

Principle 3: Economic Efficiencies

“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 system.”

Background

America’s health care system is one of the most innovative and technologically advanced in the world. It is also the most expensive in the world.²⁹ In fact, the U.S. spends more than double the per capita average of the industrialized countries that make up the Organization for Economic Development and Cooperation (OECD),³⁰ and Tennessee’s per capita spending is even higher than the US national average. Despite high costs, America’s health outcomes are worse than those of many other industrialized countries on many measures; further, health outcomes in Tennessee tend to be worse than those of other states.³¹ Many recognize that our health care system is broken and that “its costs are unsustainable and endanger our nation” and provides “inconsistent quality.”³² Thus, providing economic efficiencies in health care is a primary concern for state policy makers. Given the inefficiency and fragmentation in the health care delivery system in the United States, as well as the generally acknowledged increases in health care costs, the state health planning process should explore opportunities to improve care while containing cost growth in Tennessee.

Status of Tennesseans

Health care is a major expense in our state. Tennesseans individually spend, on average, \$5,464 annually on health care — \$200 more per person per year than the national average.³³ In 2004, Tennessee claimed the second highest spending in the nation per capita on prescription and over-the counter drugs and other medical nondurables (\$983/person).³⁴ However, despite this high level of spending, Tennessee ranks 46th worst out of the 50 states for the percentage of adults with Diabetes Mellitus Type 2 and ranks 45th worst in the nation in cardiovascular disease prevalence.³⁵ As seen in previous sections, Tennesseans fare worse than their counterparts in other states in many other areas of health as well.

“How do you determine the true cost of health care?”

-Survey Respondent

In addition to Tennesseans spending more than most people on health care, health care programs consume 51 percent of the state government expenses (by comparison, education represents 28 percent of state government expenses).³⁶ Tennessee’s per capita health care spending is also growing faster than the national average, at 7.4 percent for Tennessee compared to 6.7 percent for the U.S.³⁷ Thus, holding back the growing cost of health care and finding cost effective ways to promote health of Tennesseans are primary concerns for state policy makers.

Input of Tennesseans

In the Division of Health Planning on-line survey (see Appendix C), mirroring the actual health data reported above, the top ideas for improving economic efficiency in health care were:

1. Reduce the use of emergency departments for non-emergency situations (80%)
2. Emphasize prevention in health care services (79%).

Other issues of importance to survey respondents were tort reform and increasing the use of electronic medical records and e-prescribing. Tort reform came up in every regional meeting across the state, and it was one of the most controversial issues. The issue of taking personal responsibility for one's health, in terms of utilizing preventive care measures, often appeared in the regional meeting comments as a way of reducing the costs of health. East Tennessee meeting participants, more so than those at other regional meetings, expressed hope that telemedicine and other use of technology would help lower the cost of care.

When the Goal Team members considered the survey results in light of their own professional experience and knowledge, they focused on the concept of "economic efficiency" as including:

- Balancing competitive markets, health systems and economic efficiencies
- Focusing on health care system resources (provider and investment building as well as in people)
- Acknowledging that we have finite resources
- Lowering costs | spending more wisely | getting better value for money spent
- Helping the efficiencies of the overall system while providing for patients

They also agreed that economic efficiency is a function of consumption, which in turn is driven by factors such as wellness and accountability of patients and providers. The Goal Team members acknowledge that the state has several leverage points, including its position as an employer, as a grant recipient and provider, as the licensing authority for health care professionals and providers, as a regulator, and as a granter of certificates of need.

Goals and Strategies

Providing affordable yet effective care requires addressing issues of economics on several levels. The following goals and strategies are the result of the consideration of the complexity of these issues and their interrelatedness.

Efficiency and Quality

Efficiency and quality are both necessary components to providing affordable yet safe and effective health care. Efficiency is one of the aims outlined by the Institute for Health Care

Improvement in their 2001 report to promote the quality of health care and to help close the gap between the health care people expect and the health care they actually receive.³⁸

Goal 3A. Improve the efficient use of health care resources without sacrificing quality.

Promising Strategies:

- Promote best practices and programs that reduce inefficient resource use in e.g., diagnostic testing, hospital re-admissions, the use of the emergency departments.
- Support and strengthen current efforts to enforce and uphold licensure and inspection activities of state agencies, e.g. the licensure programs of the Department of Health and the Department of Mental Health and Developmental Disabilities.
- Facilitate the use of appropriate medical technology that allows for safe and efficient care, e.g. the Office of eHealth Initiatives' Internal Health Council programs

Effective Prevention

As Benjamin Franklin said, “An ounce of prevention is worth a pound of cure.” In an article in the American Journal of Public Health, an emphasis on prevention was shown to be a feasible way to control overall health care costs long term.³⁹ The US Preventive Services Task Force (USPSTF), “convened by the Public Health Service to rigorously evaluate clinical research in order to assess the merits of preventive measures, including screening tests, counseling, immunizations, and preventive medications,” publishes several recommended screenings that are considered the “gold standard” in clinical preventive care. This goal emphasizes strategies to increase prevention in the current health care setting.

Goal 3B. Emphasize prevention for long-term efficiency and effective use of health care resources.

Promising Strategies:

- Continue to promote and increase immunization rates among children.
- Support Grade A and B recommendations of the US Preventive Task Force for all ages and encourage increased regular screenings during primary care visits.
- Promote screening, early detection, and follow-up care for physical, mental and substance use disorders, and oral health care e.g. Early and Periodic Screening, Diagnosis, and Treatment, depression screening.

Transparency of Cost

Well-coordinated care can improve efficiency and reduce costs for both providers and consumers. Groups such as Accountable Care Organizations (ACOs) are proposed as one way of attempting to improve the transparency of and reducing health care costs.⁴⁰

Goal 3C. Make it easier for both patients and providers to have information about the price paid of health care services and their relationship with safety and effectiveness

Promising Strategies:

- Use Tennessee's all payer claims database, as approved by and under the oversight of the Tennessee Health Information Committee, to create resources for providers and patients, informing them of the average price paid of common health care services.
- Create accountable care organizations where groups of local primary care physicians, specialists, and hospitals can be held accountable for the cost and quality of care and encourage collaboration with local health organizations.
- Promote the use of organizations that monitor and disseminate information regarding the price of health care services e.g. Memphis Business Group on Health.

Collaborative Care

In a report by the Institute of Medicine, shared information between individuals and providers as well as cooperation and communication between health care providers and institutions were listed as important components to improving overall quality of care and as a means of reducing health care costs.⁹

Goal 3D. Facilitate collaboration and innovation in health care delivery, payment, and incentives for individuals and providers.

Promising Strategies:

- Study other successful models of integrated, multi-disciplinary healthcare systems.
- Creating incentives for health care providers and patients to select procedures that have demonstrated effectiveness.
- Consider supporting request for information services, e.g. eValue8.
- Emphasize interdisciplinary educational opportunities for students who are studying health care professions.

Electronic Health Records (EHR)

In an article in *Health Affairs*, it was concluded that the adoption of EHR could provide significant savings in the areas of safety, efficiency, and health benefits.⁴¹

Goal 3E. Enable widespread, meaningful use of electronic health records in order to increase gains in health care productivity, quality, and safety.

Promising Strategies:

- Ensure the safe and secure electronic exchange of appropriate and accurate health information, e.g. programs of the Tennessee Office of eHealth Initiatives, the Health Information Partnership of Tennessee initiatives.
- Promote use of EHR among health care providers and health care facilities, e.g. Tennessee Regional Extension Center Initiatives, TennCare's HER Provider Incentive Program, the Tennessee Web-based Information Technology System, the Tennessee Division of Intellectual Disabilities Electronic Health Records.
- Encourage communication of information across systems, e.g. the Tennessee Office of eHealth Initiatives' Regional Health Information Organizations, Tennessee Department of Mental Health and Developmental Disabilities shared EMR technology collaborative discussions, Tennessee health information exchanges.
- Increase the use of e-Prescribing, so that clinicians, patients and pharmacists have timely, complete, actionable information regarding a patient's medications.

Tort Reform

Some prevention is not cost-saving, but still represents a better value for the health care dollars spent compared with reactively treating disease. According to an article by Paul Rubin and Joanna Shepherd of Emory University, several types of tort reforms (caps on noneconomic damages, caps on punitive damages, and product liability reform) are associated with a decrease in the accidental death rates of patients.⁴²

Goal 3F. Support tort reform in a manner that ensures the safe and appropriate practice of medicine.

Promising Strategies:

- Continue to promote and assess the impact of the 2008 tort reform law, SB 2001, to independently assess the validity of a filed malpractice suit performed by the plaintiff before proceeding to trial.
- Study the effects of tort reform in reducing the number of accidental deaths and injuries of Tennessee's citizens. Encourage decision makers to include all key stakeholders in re-structuring the current tort system in a way that reduces unnecessary medical practices without compromising patient protection.

Conclusion

Providing health care that is economically efficient yet safe and effective is a complex issue. This edition of the State Health Plan seeks to provide a foundation by listing goals and strategies that address this issue on several levels. It must be noted that in 2010 the federal government enacted the Patient Protection and Affordable Care Act, which aims to reform health insurance, reduce health care costs, and improve the health of Americans. Recognizing the important relationship of economics and health, The State Health Plan in this edition and future editions will seek to integrate these changes if and as they occur.

"Health is not a partisan issue." Phil Bredesen. Governor of Tennessee.

Tennessee Public Health Association Conference 2010

Principle 4: Quality of Care

“Every citizen should have confidence that the quality of health care is continually monitored and standards are adhered to by health care providers.”

Background

The issue of the quality of health care provided in the United States has received increased attention in recent years. The Institute of Medicine, a science-based non-profit organization with a mission to advise the nation on health matters, defines “high quality care” as care that is:

- **Safe** – avoiding injuries to patients from the care that is intended to help them;
- **Effective** - providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding under use and overuse, respectively);
- **Patient-centered** – providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions;
- **Timely** – reducing waits and sometimes harmful delays for both those who receive and those who give care;
- **Efficient** – avoiding waste, including waste of equipment, supplies, ideas, and energy; and
- **Equitable** – providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.³⁸

Having an adequate number of physicians and providing health care does not, by itself, ensure quality of care. In a study published in the New England Journal of Medicine (NEJM), the average American received only half of the medical care processes he or she needed.⁴³ In another study in the NEJM, patient outcomes were not necessarily better – and were sometimes worse – in regions with a very large supply of physicians.⁴⁴ In the new National Health Care Quality Strategy and Plan, the elements of benchmarks and plans specific to agencies, meaningful use of health information technology, and strategies to align public and private payers are all cited as key provisions to ensure that quality health care is delivered.⁴⁵ As one can see, providing quality care is a complex issue involving many facets of the health care system.

Status of Tennesseans

Although there are many examples of the provision of high quality health care in Tennessee, Tennessee has room for improvement. The number of hospitalizations that could have been avoided, which is an outcome indicating not the quality of care in a hospital but instead the ability of the overall health care system to reach out to people, help them manage their diseases, and avoid problems leading to hospitalization. From 2006 to 2007, Tennessee had approximately 7,500 hospital admissions per 100,000

“Comprehensive and creative changes will have to be made to our system. We must begin to consider new ways to care for people, better ways to teach people to care for themselves.”

-Survey Respondent

Medicare recipients that may have been avoided by higher quality in the overall health care system as determined by Medicare. This rate compares unfavorably with a median state 2006/2007 rate of approximately 6,300 per 100,000.⁴⁶ Hospital readmissions measure the quality of the hospital, the follow-up care patients receive, and coordination between all types of providers. In Tennessee, almost 19 percent of Medicare recipients who are discharged from a hospital are readmitted within 30 days, compared with a 17.5 percent median state.⁴⁶

Health care quality is also reflected in adherence to evidence-based procedures. For example in 2007, the proportion of Tennessee diabetics over age 40 who received important screenings such as HbA1C, foot, and eye exams was close to the national average, and none of these measures substantially changed when compared with Tennessee’s results in 2001. The percentage of adults over the age of 18 who had their blood cholesterol checked annually was at the national average, while the percentage of women who received important cancer screenings such as pap smears and mammograms was rated as better than the national average.⁴⁷

Input from Tennesseans

In the Division of Health Planning online survey (Appendix C), the top ideas for improving health care quality were:

1. Encourage health care providers to communicate with patients in ways patients will understand.
2. Increase the use of medical records that prompt health care providers when a recommended treatment is indicated and alert providers to potential problems.

When the Goal Team members considered the survey results in light of their own professional experience and knowledge, they referred to the Institute of Medicine Guidelines set forth at the beginning of this section as the framework for creating draft goals. They also discussed the importance of building partnerships (public-private, as well as among government agencies and as among private sector groups) to achieve quality goals. They encouraged building on what they termed our “Southern strengths” – our local communities and our faith-based communities. The Goal Team members also expressed concerns over whether state and private sector entities

are able to access all available federal funds to help measure quality of care and discussed the tension between the state's pertinent roles of regulation/enforcement and provision of leadership/incentives in this area.

As a group, the regional meeting participants expressed quality in terms of the need for better communications between providers and patients, both having providers express medical language in words the patients understand and in terms of more basic communication through use of the same language. They also endorsed the idea of better coordination of care among different providers as well as the other goals set forth herein.

Goals and Strategies

Safe and Effective Health Care

Efficiency is one of the aims outlined by the Institute for Health Care Improvement in their 2001 report to promote the quality of health care, to increase safety and effectiveness, and to help close the gap between the health care people expect and the health care they actually receive.³⁸

Goal 4A. Ensure that health care delivery is safe and effective.

Promising Strategies:

- Create incentives for health care providers and patients to select procedures that have demonstrated effectiveness.
- Continue to increase the number of health plans accredited by the National Committee for Quality Assurance (NCQA) that report a full set of Health Care Effectiveness Data and Information Set data, e.g. the Bureau of TennCare managed care organizations.
- Endorse plans that reduce health care related errors, e.g. the Tennessee Department of Health's "Healthcare-Associated Infections" plan and the Centers for Medicaid and Medicare Services Care Transitions program.
- Ensure that providers and facilities acquire and maintain adequate licensure and accreditation, e.g. the Tennessee Department of Mental Health and Developmental Disabilities' licensure procedures, the Joint Commission, and the Tennessee Department of Health's licensure and accreditation procedures.

Patient-Centered Care

"Patient centeredness" is defined by the Institute of Medicine as: "Health care that establishes a partnership among practitioners, patients, and their families (when appropriate) to ensure that decisions respect patients' wants, needs, and preferences and that patients have the education and support they need to make decisions and participate in their own care," and is seen as an important component to improving quality of care.⁴⁸

Goal 4B. Create a patient-centered health-care system.

Promising Strategies:

- Support the work of regional collaboratives, e.g. Healthy Memphis Common Table, CareSpark, Midsouth eHealth Alliance, and Shared Health.
- Encourage geographic areas of Tennessee that have not begun a regional collaborative to begin one.
- Encourage the establishment of or conversion to Federally Qualified Health Centers.

Providing Information

In the previously-mentioned report from the Institute of Medicine, *Crossing the Quality Chasm*, transparency in health care and patient access to information, including information about providers was seen as a means to foster quality care.¹

Goal 4C. Ensure the public has access to user-friendly, actionable, and accurate information on the quality of health care providers.

Promising Strategies:

- Where appropriate, encourage/support others' reporting of guides to quality of hospitals and professionals, e.g. Memphis Business Group on Health Leapfrog Hospital Survey results.
- Encourage insurers to provide provider quality information to members and cost/payment information if available.
- Research availability of and means to provide this type of information to the public.

Using the Evidence

The IOM report, as well as many other studies, also supports evidence-based decision making and making good use of data to ensure appropriate and effective care is delivered.

Goal 4D. Increase the use of evidence-based practice in the health care decisions of providers and patients.

Promising Strategies:

- Consider utilizing Agency for Health Care Research and Quality and other evidence-based practice models to promote the acquisition and dissemination of new evidence-based practices.
- Encourage providers and organizations to continue to utilize evidence-based practices e.g. Illness Management and Recovery Program and the Tennessee Department of Mental Health and Developmental Disabilities' evidence-based curriculum.

- Encourage state departments and health agencies to develop a series of “Best Practice” guidelines that are distributed to local agencies, e.g. the Tennessee Department of Mental Health and Developmental Disabilities’ Best Practice Guidelines.

Coordinating Care

The patient-centered medical home is endorsed by many national health care groups such as the American Academy of Pediatrics, the American Academy of Family Physicians, the American College of Physicians, and the American Osteopathic Association as a means of coordinating care across many disciplines and provider levels.⁴⁹ According to these four groups, a medical home encompasses the following:

- “1. An ongoing relationship with a *personal physician* trained to provide first contact, continuous, and comprehensive care.
2. A *team of other individuals at the practice* led by the personal physician to collectively take responsibility for the ongoing care of patients.
3. An approach to care that *covers the whole person*, so that the personal physician is responsible for providing all of the patient’s health care needs or for arranging care with specialists as needed.
4. *Care is coordinated and/or integrated* across the entire health care system, including hospitals, nursing homes, home health agencies, and other care settings, to ensure that patients receive the care they need when and where they need and want it.
5. *Quality and safety* are key features and entail the use of evidence-based medicine and clinical decision-support tools to guide decision-making, physician commitment to continuous quality improvement; involving patients in decision-making; the use of health information technology where possible to support optimal patient care, performance measurement, patient education, and enhanced communication.”

Goal 4E. Ensure patients receive well-coordinated mental, substance use disorder, and physical health care across all providers, settings, and levels of care.

Promising Strategies:

- Implement models of care for chronic disease that are integrated and comprehensive, e.g. the Robert Wood Johnson Foundation’s “The Chronic Care Model”
- Ensure that all Tennesseans have access to a patient-centered medical home.
- Encourage health care providers to communicate effectively with patients.
- Use telemedicine to provide care and communicate information when appropriate.
- Promote the integration of physical and behavioral health at the payer level, e.g. the Bureau of TennCare’s program.
- Implement medical technology that encourages the sharing of necessary information for patient care

Conclusion

As discussions around health care, costs and quality continue at the national level, the State Health Plan will continue to review and endorse goals and strategies that improve the quality of care of Tennesseans as well as promote evidence-based practices and policies centered on improving quality.

Principle 5: Health Care Workforce

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

Background

Having access to individuals who work in health care is an essential component to improving the health of individuals and communities. Because our aging population will have increasing healthcare needs, it is anticipated that Tennessee, as well as the United States, will experience a shortage in our health care workforce. The extent of this shortage, and how it will impact the health of Tennesseans, is an issue for further research and discussion. However, the anticipated retirement of a large number of providers and workforce professionals as well as the increasing health needs of the aging Baby Boom generation indicate that the topic should be addressed sooner rather than later.

A wide array of professionals provide health care to our population, and ensuring there are sufficient numbers of these different types of professionals is essential to the provision of quality care. The health care workforce includes a wide variety of professionals, from doctors, nurses, and dentists to allied health workers, public health officials and many others; each category faces

“Prevention is the first step in health care and education goes right along with having a healthy community.”

-Survey Respondent

unique challenges, including the need for greater higher education resources, the impending retirement of existing professionals, and the distribution of professionals throughout the state. Further, most jobs in the health services industry require postsecondary vocational training or a Bachelor’s or higher degree, placing increased importance on the state’s public and private education systems.⁵⁰

This State Health Plan recommends that the state consider developing a comprehensive approach to ensuring the existence of a sufficient, qualified health care workforce, taking into account the following issues:

- 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, dental, allied health, and other educational institutions;
- State and federal laws and regulations impacting the capacity and funding of programs and the needs of current workforce members.
- The collaboration and consideration of all health professions in creating practices and policies to address workforce issues.

Status of Tennesseans

Through the Workforce Investment Act, workforce training efforts in Tennessee provided over 16,000 new health care workers over the past 3 years, representing approximately 18 percent of all of the Workforce Investment Act training conducted in the state at an investment of over 60 million dollars.⁵¹ In 2009 almost 7,000 workers were trained for the health sciences. This number represents 19.5 percent of trainees across all industry sectors.

Physicians

A report from the Council on Graduate Medical Education predicts that by the year 2020 the United States will experience an overall 10 percent shortfall in the number of physicians, and in particular raises the concern of a potential shortage of generalists/primary care physicians.⁵² Tennessee compares well with the remaining states in the overall number of primary care physicians practicing in the State. Tennessee has approximately 122 actively practicing primary care physicians per 100,000 people, compared with 120 primary care physicians per 100,000 people nationally.⁵³ However, 20 percent of Tennessee's physicians are over the age of 60 and thus nearing retirement age. The Rural Partnership in its 2008 Demand Assessment reported, "Primary care physicians continue to be in greatest demand," raising the critical issue of the disproportional primary care workforce distribution within the state.⁵⁴ It should be noted that the presence of more physicians does not necessarily translate into better care. As reported by a study published by The New England Journal of Medicine, patient outcomes are not necessarily better – and are sometimes worse – in regions with a very large supply of physicians.⁴⁴ Consequently, ensuring that physicians receive proper initial training and that they have the opportunity to participate in ongoing quality enhancement efforts are as important as ensuring an adequate number of physicians.

Nursing

Nurses fill a wide range of roles in the health care system. In addition to providing direct clinical care, nurses are also better able to perform many administrative and support services than non-clinically trained personnel.⁵⁵ For the near future, Tennessee is predicted to have sufficient associate degree nurses as a result of efforts made by stakeholders comprising the Nursing Education Master Plan Steering Committee.⁵⁶ However, it is predicted that by 2020 Tennessee will have a shortage of 15,000 registered nurses.⁵⁶ The shortage of BSN and MSN graduates is also critical. High level bachelors (BSN) and master's degree (MSN) graduates comprise the nursing faculty pipeline, meaning that without more of these higher degree nurses, a sufficient number of new nurses may not be trained and brought into the workforce.

Dentists

In the US there are over 141,000 dentists.⁵⁷ However, 49 million people still lack adequate access to dental care in 4,230 areas and less than ten percent of dentists regularly provide care to these areas.⁵⁸ Out of the 95 counties in Tennessee, 86 of them are designated as partially or

totally lacking adequate access to dental care.⁵⁹ Currently, Tennessee has 3,530 dentists who are licensed to practice dentistry or approximately 56 dentists per 100,000 people, lower than the national average of 60 dentists per 100,000 people.⁶⁰ The number of dentists per 100,000 people has been declining since 2000 and this trend is anticipated to continue. Some states have applied for federal grants to improve the workforce shortage of oral health care providers, and Tennessee currently participates in the loan repayment program.⁶¹

Allied Health Workforce

The effective functioning of the health care system depends on having appropriate numbers of allied health professionals to provide essential services to the public. Allied health professionals encompass a very broad set of disciplines and functions, including rehabilitation professions, medical assisting, emergency medical professions, medical imaging, clinical laboratory services, dental services, and health information management. In 2010, The Center for Health and Human Services at Middle Tennessee State University updated its report Allied Health in Tennessee: A Supply and Demand Study, which examines the supply and demand for various health care personnel in the state.⁶² As stated in the report's Executive Summary, from 1997-2007, "Tennessee has experienced a significant increase" in the number of allied health and health science baccalaureate graduates. Associate degrees awarded in the allied health and health sciences increased 29 percent in Tennessee (as compared to 19 percent nationally). According to the study, "These increases have reduced the demand in some occupational areas but have only slightly addressed the fast-growing demands in others." Areas that do not meet the supply demand ratio include: respiratory therapy, health information administration, physical therapy assisting, nursing assisting, laboratory services, occupational therapy assisting, physician assisting, recreation therapy, and dental hygiene.

Public Health Workforce

Critical to the health of Tennesseans is the existence of an adequate public health workforce. Public health professionals focus on improving health outcomes in their states through a wide variety of activities, ranging from HIV/AIDS counseling, testing, and surveillance to bioterrorism and emergency preparedness.⁶³ Tennessee's average age of a state public health employee was over 48 years in 2008, over the national average of 47. The percentage of these Tennessee state employees who are eligible to retire within five years is approximately 48 percent, significantly higher than the 29 percent average of the 28 states reporting this data.⁶⁴

Input from Tennesseans

In the Division of Health Planning online survey (see Appendix C) and in regional meetings across the state, the most popular ideas for supporting a sufficient health care workforce were all within the education realm, showing a preference for creating a health care workforce from Tennessee’s population over making efforts to recruit providers from out of state. The top workforce ideas in the survey were:

1. Providing financial assistance to medical, nursing, and allied health students who agree to work in Tennessee health care shortage areas upon graduation.
2. Providing debt relief for health care professionals to practice in shortage areas.
3. Developing programs to encourage young Tennesseans to become health care professionals.

When the Goal Team members considered the survey results in light of their own professional experience and knowledge, they agreed upon the need to develop “medical homes” for consumers that also integrate specialist services and an interdisciplinary complement of services. They also identified the need to provide community-based care and recognized the need to provide access to specialist care and mental health care to the state’s rural populations. The Goal Team members noted the need to develop our healthcare workforce “from the ground up,”

Goals and Strategies

Setting appropriate goals and strategies that allow for the State of Tennessee to meet the supply demand ratio of health care professionals is essential to ensure that adequate health care is provided to Tennessee’s citizens. It is also important to consider all the professions that contribute to making a sufficient workforce when implementing programs and strategies.

Improve Workforce Capacity in Geographic Shortage Areas

The Human Resource Service Agency has shown that some federal programs, such as the Medicare Health Professional Shortage Area Bonus Payment and the National Health Service Corps Loan Repayment programs are effective in bringing health care providers to health shortage areas by providing monetary incentives to those who agree to practice in areas of need.³⁸

Goal 5A Improve work force capacity for primary care professionals, especially in geographic shortage areas.

Promising Strategies:

- Create incentives such as tuition debt relief for newly-licensed physicians to practice in health shortage areas, e.g. National Health Service Corp Program, the Tennessee Department of Health’s Health Access Incentive and Health Access Community Initiative programs.

- Continue support for programs and services that increase medical students' and residents' exposure to rural areas, e.g. The Rural Partnership (TRP) Rural Rotation Project, the Area Health Education Centers Program.
- Increase support to other university-community partnerships, e.g. the ETSU Community-academic preceptor group, The Rural Health Partnership.
- Support technological advances that provide more access to health care providers, e.g. telemedicine, the Tennessee Regional Extension Center for Health Information Technology.
- Study federal programs that award grant money to boost workforce capacity for oral health professionals.

Develop a Sufficient Workforce for the Future

Encouraging students to select careers in areas of health care where critical shortages are expected is seen as an effective and necessary means of replacing the current aging health care workforce and meeting the supply/demand needs of the future.⁶⁵

Goal 5B. Develop a sufficient health care workforce for the future by motivating and preparing today's students.

Promising Strategies:

- Promote health careers among middle and high school students through potentially productive programs giving enough support and funding to make the efforts statewide, e.g. Race to the Top, the Science, Technology, Engineering, and Math disciplines, Health Occupations Students of America, the Area Health Education Centers.
- Develop and provide financial incentives to students at the undergraduate and graduate levels of study considering a career in health care and who agree to work in Tennessee health shortage areas upon graduation.
- Provide meaningful community-based educational experiences in geographic shortage areas throughout the state for medical and other health care students, e.g. Tennessee Primary Care Association Student/Resident Experiences and Rotations in Community Health program, the Tennessee Hospital Association Agenda-21 Program, the Cherokee Health Systems Graduate Psychology Program.
- Increase funding for medical residency positions in needed medical fields.
- Continue to encourage community-academic partnerships that expose students to different aspects of health care e.g. Tennessee Department of Mental Health and Developmental Disabilities' partnerships, the Tennessee Interdisciplinary Health Policy Program

Retrain and Upgrade the Current Workforce

Echoing the perspectives of many health care reform leaders, the Centers for American Progress report encourages training of current health care professionals to promote interdisciplinary collaboration and recognizes the importance of having a workforce that is culturally competent.⁷⁴

Goal 5C. Retrain and upgrade the skills of the current workforce.

Promising Strategies:

- Assure the health care workforce is trained to provide high quality and culturally competent care.
- Continue already-existing workforce training programs, e.g. State-wide programs funded through the Workforce Reinvestment Act, Tennessee Department of Health Provider Trainings, East Tennessee State University's Public Health Training Center, the Tennessee Regional Extension Center's eHealth workforce training initiatives.
- Support already-existing programs such as the Rural Preceptors Training and Rural Opportunity Curriculum provided through TRP and partners.
- Encourage the maintenance of certifications and licensure as well as continuing education opportunities.

Conclusion

If national and statewide trends continue and as the population of Tennessee ages, in the near future there will be a health care workforce shortage throughout the state. The State Health Plan will continue to promote policies and practices that support funding and opportunities to train and maintain a workforce that can meet the health needs of Tennesseans.

Certificate of Need Standards and Criteria

Introduction

Open Heart Surgery Services

Open Heart Surgery Services Rationale

ESWL Services

ESWL Services Rationale

Certificate of Need Standards and Criteria Revisions

Why Certificate of Need

Certificate of Need (CON) laws were developed from the federal Health Planning Resources Development Act" of 1974. The aim of CON programs is to help control health care facility costs and allow for meaningful planning of new services and facilities. Under the authority of TCA Title 68, Chapter 11, Part 1, the Tennessee Health Planning and Resource Development Act of 1987, Tennessee has developed a set of guidelines for CON Standards and Criteria. These original CON Standards and Criteria can be found at the Health Services and Development Agency's "Guidelines for Growth" document located at:

<http://health.state.tn.us/statistics/PdfFiles/Guidelines%20for%20Growth.pdf>

Past, Current, and Future Revisions

In 2009, the Division of Health Planning revised the original CON standards for Positron Emission Tomography Services and Cardiac Catherization Services. In 2010, the Division of Health Planning updated the CON standards for:

- Open Heart Surgery Services
- External Shock Wave Lithotripsy Services

These revisions and the corresponding rationale statement are included on the following pages. Future editions will contain updated revisions of other CON Standards and Criteria. The new revisions replace the older versions found in the HSDA "Guidelines for Growth."



STATE OF TENNESSEE

STATE HEALTH PLAN
CERTIFICATE OF NEED STANDARDS AND CRITERIA

FOR

OPEN HEART SURGERY SERVICES

The Health Services and Development Agency (HSDA) may consider the following standards and criteria for applications seeking to provide open heart surgery services. Rationale statements for each standard are provided in an appendix. Existing providers of open heart surgery 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 proposed standards and criteria will become effective immediately upon approval and adoption by the governor. However, applications to provide open heart surgery services that are deemed complete by HSDA prior to the approval and adoption of these standards and criteria shall be considered under the Guidelines for Growth, 2000 Edition.

Definitions

Open Heart Surgery: Open heart surgery is any surgery where the chest is opened and surgery is performed on the heart muscle, valves, arteries or other heart structures. The term “open” refers to the chest, not the heart itself. The heart may or may not be opened, depending on the type of surgery. A heart-lung machine (also called cardiopulmonary bypass) is usually used during conventional open heart surgery.

The following procedures also are considered open heart surgery:

- Procedures being performed on the heart through smaller incisions
- Procedures being performed that are done with the heart still beating, such as
 - Minimally invasive direct coronary artery bypass (MIDCAB)
 - Robot assisted coronary artery bypass (RACAB)
 - Off pump coronary artery bypass surgery (OPCAB)

Open Heart Surgery Service: An organized surgical program that serves inpatients of a hospital that has a suitable operating room or suite of operating rooms, equipment, staff,

intensive care unit, and all support services required to perform open heart surgery. The open heart surgery service shall be located in an acute care hospital that is licensed by the State of Tennessee and that has an authorized therapeutic cardiac catheterization service.

Open Heart Surgery Case: A “case” shall mean one visit to an operating room by one open heart surgery patient, regardless of the number of procedures performed during that visit.

Adult: Refers to any patient or open heart surgery service treating a patient 15 years of age or older.

Pediatric: Refers to any patient or open heart surgery service treating a patient less than 15 years of age.

Service Area: Refers to the county or counties represented by an applicant as the reasonable area to which the applicant intends to provide open heart surgery services and/or in which the majority of its current service recipients reside.

Hospital Discharge Data System (HDDS): The HDDS shall be identified by the Health Services and Development Agency (HSDA) as the primary source of data regarding open heart surgeries performed in Tennessee. The HDDS receives information from the institutional paper claim form (as of the date of this document, the UB-04 form) on all inpatient discharges and other selected patient visits from Tennessee hospitals. Each form contains information on patient diagnoses, procedures performed on the patient, charges for services provided, and selected patient demographics. The Tennessee Department of Health maintains the HDDS and is responsible for generating reports utilizing its data as required by the Certificate of Need program.

Patient Origin Study: A study undertaken by an applicant seeking to provide open heart surgery services to determine the geographic distribution of the residences of the patients served by its existing services. Such studies help define patient catchment and medical trade areas and are useful in locating and planning the development of new services.

Standards and Criteria

1. **Determination of Need:** The need for open heart surgery services is determined by applying the following formula to four age ranges of the population and summing the result of each calculation. The applicant should apply this formula to the following age ranges: 0 through 14; 15 through 44; 45 through 64; and 65 and above. The formula serves to derive the number of open heart surgery cases which may be needed in a proposed service area.

$$N = U \times (P + O).$$

where:

N = number of cases needed in a service area;

U = latest available Tennessee use rate (number of cases performed per 1,000 population in the state as determined by the Tennessee Department of Health);

P = projection of population (in thousands) of each age range in the service area as determined by the Tennessee Department of Health for Tennessee; and

O = the projection of out-of-state population (in thousands) of each age range in the service area as determined by the U.S. Census Bureau for non-Tennessee counties

In addition, the applicant should submit a patient origin study to document the applicant's general patient catchment area and the volume of cases referred to other specialty services currently provided by the applicant.

The need for open heart surgery services shall be projected three years into the future from the current year. The need for pediatric and adult open heart surgery services shall be projected separately.

2. **Minimum Volume Standard:** The applicant should demonstrate that the proposed service utilization will be a minimum of 200 adult surgery cases per year by its third year of operation for adult open heart surgery services. The applicant should demonstrate that the proposed service utilization will be a minimum of 100 pediatric open heart surgery cases per year by its third year of operation for pediatric open heart surgery services. Annual volume shall be measured based upon a two-year average which shall begin at the conclusion of the applicant's first year of operation.
3. **Current Service Area Utilization:** The applicant should document that all existing providers of open heart surgery services within the proposed service area and within a 50 mile radius each performed at least 300 adult open heart surgery cases per year (or 130 pediatric open heart surgery cases per year) during the most recent 12 month period for which data are available. To characterize existing providers located within Tennessee, the applicant should use data provided by the Hospital Discharge Data System (HDDS) maintained by the Tennessee Department of Health. To characterize providers located outside of Tennessee, the applicant should use publicly available data, if available, and describe in its application the methodology these providers use to count volume.

In addition, the applicant should provide the HSDA with a report of patient destination for open heart surgery services based on the most recent 12 months of publicly reported data. This report should list all facilities that provided open heart services to residents of the service area and the number of open heart cases performed on residents of the service area for each facility. The Tennessee Department of Health will assist applicants in generating this report utilizing the HDDS.

4. **Orderly Development of Applicant's Cardiac Care Services:** The applicant should document that it has operated a fully functioning therapeutic cardiac catheterization laboratory for at least one year and that this laboratory complies with the minimum volume standards set forth in the Standards and Criteria for Cardiac Catheterization Services. The applicant should also document the number of heart surgery cases and—if applicable—cardiac catheterization cases that have been referred out of the hospital during the most recent three year period of available data.
5. **Adverse Impact on Existing Providers:** A new open heart surgery program should not be approved if the new program will cause the annual caseload of existing programs within the service area to drop below 300 adult cases or 130 pediatric cases. The patient origin study conducted for Standard 2, an analysis of patient origin data collected for Standard 4, and the referral data documented for Standard 5 should be used to determine whether such an adverse impact on existing providers is likely to occur.
6. **Open Heart Surgery Continuum of Care:** The applicant should document that it will provide the following resources to properly support an open heart surgery program based upon projected volume levels. Included in such documentation should be a letter of support from the applicant's governing board of directors documenting the full commitment of the applicant to develop and maintain the facility resources, equipment, and staffing to provide a full continuum of open heart surgery care and supportive services. The applicant should also document the financial costs of maintaining these resources and its ability to sustain them to ensure quality treatment of patients in the open heart surgery continuum of care.
 - a) Access to specialists as required in the areas of Interventional Cardiology, Renal, Nephrology, Pulmonary Medicine, Neurology, Infectious Disease, and Endocrinology;
 - b) At least one dedicated open heart surgery Operating Room;
 - c) Operative services—available 24 hours per day, seven days per week for emergent cases—including Perfusion, Cardiac Anesthesia, and a specially trained Cardiac Operating Room Team;
 - d) Support services, including Blood Bank, Patient Dialysis, Respiratory Therapy, and Physical Therapy;

- e) Post-Operative care that includes a Cardiovascular Intensive Care Unit/Open Heart Recovery Unit, a Cardiac Step-Down Unit, and Cardiac Rehabilitation; and
 - f) Ventricular Assist Device (VAD) capabilities.
7. **Adequate Staffing:** The applicant should document a plan for recruiting and maintaining a sufficient number of professional and technical staff to provide the services listed in Standard 7. The applicant should also document an ongoing educational plan for all staff included in the open heart surgery program.
 8. **Staff and Service Availability for Emergent Cases:** The applicant should document the capability to mobilize surgical and medical support teams rapidly (within 30 minutes) for emergency cases 24 hours per day, seven days per week. The applicant should also address staff availability and Operating Room space availability for emergencies during peak operating hours.
 9. **Treatment of Pediatric Patients:** Open heart surgery on pediatric patients may not be limited to pediatric facilities. However, a facility treating pediatric patients should have a pediatric cardiac surgeon, specialized pediatric staff, and offer services in the continuum of care as noted in Standard 7 for pediatric patients; additionally, such an applicant should document its intention to comply with the American Academy of Pediatrics' Guidelines for Pediatric Cardiovascular Centers.
 10. **Minimum Physician Requirements to Initiate a New Service:** The applicant should document the availability of, or present a plan for recruiting, at least two qualified cardiac surgeons certified by the American Board of Thoracic Surgery. For adult open heart surgery services, a qualified cardiac surgeon will have performed a minimum of 200 adult open heart surgery cases in the two years prior to the application. For pediatric open heart surgery services, a qualified cardiac surgeon will have performed a minimum of 100 pediatric open heart surgery cases in the two years prior to the application. In both adult and pediatric open heart surgery services programs, at least one cardiac surgeon should have a minimum of five years of cardiac surgical experience.
 11. **Maintenance of Physician Skill:** The applicant should establish processes to ensure that its adult open heart surgeons will perform at least 100 adult open heart surgery cases annually across all practice locations and/or that its pediatric open heart surgeons will perform at least 50 pediatric open heart surgery cases annually across all practice locations.
 12. **Clinical Guidelines:** The applicant should agree to document ongoing compliance with the most recently published *Guidelines for Coronary Artery Bypass Graft Surgery* adopted by the American College of Cardiology and the American Heart Association. Where providers are not in compliance, they should maintain appropriate documentation stating the reasons for noncompliance and

the steps the provider is taking to ensure quality. As of the adoption of these Standards and Criteria, the latest edition may be found here under the heading “Guidelines”: <http://www.acc.org/qualityandscience/clinical/topic/topic.htm>.

13. **Licensure:** Open heart surgeries should only be performed in acute care hospitals that are licensed by the State of Tennessee.
14. **Accessibility:** The maximum travel time to hospitals providing open heart surgery services should be within a one-way driving time of 90 minutes for at least 90 percent of the population of Tennessee.
15. **Elective Surgery:** The applicant should document that elective open heart surgery services will be available within two weeks from the date of the patient’s decision to undergo surgery.
16. **Quality Control and Monitoring:** The applicant should identify and document its intention to participate in a data reporting, quality improvement, outcome monitoring, and peer review system which benchmarks outcomes based on national norms. The system should provide for peer review among professionals practicing in facilities and programs other than the applicant hospital. Demonstrated active participation in the STS National Database is encouraged and shall be considered evidence of meeting this standard.
17. **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.

CERTIFICATE OF NEED STANDARDS AND CRITERIA

FOR

OPEN HEART SURGERY SERVICES

Rationale

1. **Determination of Need.** This formula was developed through responses to the Questionnaire and refined through comments received on the Proposed Standards. In combination with the patient origin study, the formula is designed to yield an estimated number of open heart surgery patients the applicant will serve based upon population trends and the applicant's medical catchment area. The patient origin study will also help verify the applicant's proposed service area.

The Division had considered applying a multiplier to the formula to account for a general decreasing trend in the state's open heart use rate. The Division believes such a multiplier is not necessary at this time but will continue to monitor the use rate over time and is open to modifying this position.

2. **Minimum Volume Standard.** An open heart surgery program is capital and staff intensive. Therefore, to ensure that the proper staff and resources will be available to support a quality open heart surgery program, the Division seeks to ensure that it will have sufficient volume to financially support the program. In addition, in general, research suggests that higher volume open heart surgery programs tend to have better risk adjusted outcomes. Therefore, this standard is in alignment with the State Health Plan's principles of economic efficiency and quality.

Respondents to the Questionnaire and Proposed Standards generally agreed that the minimum volume standards were at an appropriate level.

3. **Current Service Area Utilization.** This Standard supports Standards 2 and 5 by asking the applicant to demonstrate that a sufficient number of potential open heart patients reside within the applicant's service area and that the potential redistribution of patients in the service area will not adversely affect the quality of care provided by existing providers. Respondents to the Questionnaire and the Proposed Standards agreed that this Standard is reasonable.
4. **Orderly Development of Applicant's Cardiac Care Services.** Because providing open heart surgery services is such a resource intensive endeavor, the Division takes the position that it is not appropriate for a brand new hospital to provide the service. Instead, the Division believes that the hospital should demonstrate its capability to administer an open heart surgery program through successful management of less intensive cardiac services. In addition, graduating from a therapeutic cardiac catheterization service to an

open heart surgery program will help provide an initial base of patients. Respondents to the Questionnaire and the Proposed Standards agreed that this Standard is reasonable.

5. **Adverse Impact on Existing Providers.** For the reasons stated in the rationale for Standard 2, the Division believes that causing an existing open heart surgery program's volume to drop below a certain threshold will affect the economic viability and quality of that program. Respondents to the Questionnaire and Proposed Standards generally agreed that this Standard is reasonable, though many suggested lowering the volume threshold from 350 to 300, which the Division has done for this Final Standard.
6. **Open Heart Surgery Continuum of Care.** The Division seeks to ensure that applicants to provide open heart surgery services have fully planned for the programmatic and financial implications of maintaining a successful program. In addition, a commenter on the Proposed Standards suggested adding a statement to this Standard to help ensure that the applicant's board of directors fully understands the resource commitment to maintain a successful program.
7. **Adequate Staffing.** State Health Plan Principle for Achieving Better Health Number 5 reads, "The state should support the development, recruitment, and retention of a sufficient and quality health care workforce." This Standard asks the applicant to support this principle through providing the HSDA with a well thought out staffing recruitment and educational plan.
8. **Staff and Service Availability for Emergent Cases.** Respondents to the Questionnaire and Proposed Standards agreed that providers of open heart surgery cases should be prepared to quickly provide surgical services in an emergency situation.
9. **Treatment of Pediatric Patients.** In certain circumstances, it may be appropriate for a hospital other than a children's hospital to provide open heart surgery services to a pediatric patient. Respondents to the Questionnaire and Proposed Standards generally agreed that this Standard is reasonable. Additionally, one commenter recommended including a statement regarding intention to comply with the American Academy of Pediatrics' Guidelines for Pediatric Cardiovascular Centers, which the Division has included in the Final Standard.
10. **Minimum Physician Requirements to Initiate a New Service.** Respondents to the Questionnaire and Proposed Standards agreed that hospitals should not initiate new open heart surgery programs with an inexperienced medical staff. Respondents agreed that the minimum thresholds set by this Standard are reasonable.
11. **Maintenance of Physician Skill.** The issue of ongoing accountability to the CON Standards and Criteria for successful CON applicants is not yet resolved. However, currently the CON program does have the authority to ensure proper planning is in place before a new service is initiated. This Standard seeks to ensure that applicants have established procedures that will result in its open heart surgeons having an adequate volume of cases to maintain a high level of quality and practice, regardless of the

surgeon's actual practice locations. Respondents to the Questionnaire and Proposed Standards agreed that this Standard is reasonable.

12. **Clinical Guidelines.** This Standard mimics a similar standard in the Standards and Criteria for the Initiative of Cardiac Catheterization Services. It also supports State Health Plan Principle Number 4: "Every citizen should have confidence that the quality of health care is continually monitored and standards are adhered to by health care providers." Respondents to the Questionnaire and Proposed Standards agreed that this Standard is reasonable.
13. **Licensure.** Practicing open heart surgery in a facility not monitored by an official accreditation/licensure process harms patient confidence in the quality of care. Respondents to the Questionnaire and Proposed Standards agreed that this Standard is reasonable.
14. **Accessibility.** This Standard supports State Health Plan Principle Number 2: "Every citizen should have reasonable access to health care." Respondents to the Questionnaire and Proposed Standards agreed that this Standard is reasonable.
15. **Elective Surgery.** This Standard was adopted by the Guidelines for Growth, 2000 Edition, and is maintained in these Final Standards. Respondents to the Questionnaire and Proposed Standards agreed that this Standard is reasonable.
16. **Quality Control and Monitoring.** This Standard supports State Health Plan Principle Number 4: "Principle for Achieving Better Health Number 4: "Every citizen should have confidence that the quality of health care is continually monitored and standards are adhered to by health care providers." Respondents to the Questionnaire and Proposed Standards agreed that this Standard is reasonable, though some commenters asked that the Division specifically mention the STS National Database as the ideal quality monitoring system, which the Division has included in this Final Standard. The Division hopes that, eventually, every open heart surgery program in Tennessee will participate in the STS National Database, however the Division does not believe it is appropriate to mandate participation in the program.
17. **Data Requirements.** This Standard seeks to improve quality through transparency in accordance with accepted rules, regulations, and contracts. Respondents to the Questionnaire and Proposed Standards agreed that this Standard is reasonable.



STATE OF TENNESSEE
STATE HEALTH PLAN
CERTIFICATE OF NEED STANDARDS AND CRITERIA

FOR

**EXTRA-CORPOREAL SHOCK WAVE
LITHOTRIPSY SERVICES**

The Health Services and Development Agency (HSDA) may consider the following standards and criteria for applications seeking to provide extra-corporeal shock wave lithotripsy (ESWL) services. Rationale statements for each standard are provided in an appendix. Existing providers of ESWL 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 proposed standards and criteria will become effective immediately upon approval and adoption by the governor. However, applications to provide ESWL 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.

Definitions

Lithotripsy: Lithotripsy is defined as the pulverization of urinary stones by means of a lithotripter. Extracorporeal lithotripsy is lithotripsy that occurs outside the body. Extracorporeal shock wave lithotripsy is the non-invasive procedure that uses shock waves to pulverize urinary stones, which can then be expelled in the urine. An emitter is placed in contact with the patient relative to where the stone is located and the shock waves are focused on the stone, which is shattered by the force.

Procedure: A “procedure” is the single provision of ESWL services as reported by its ICD9 code or the ESWL services facility’s internal financial code that corresponds to the ESWL services CPT code.

Service Area: Refers to the county or counties represented by an applicant for ESWL services as the reasonable area to which the applicant intends to provide ESWL services and/or in which the majority of its current service recipients reside.

Standards and Criteria

1. **Determination of Need:** The need for ESWL services is determined by applying the following formula:

$$N = (U \times P) + O$$

N = number of ESWL services procedures needed in a Service Area;

U = latest available Tennessee use rate (number of procedures performed per 1,000 population in the state as determined by the Tennessee Department of Health);

P = projection of population (in thousands) in the service area as determined by the Tennessee Department of Health for Tennessee counties and the United States Census Bureau for non-Tennessee counties; and

O = the number of out-of-state resident procedures performed within the applicant's Service Area in the same time frame used to determine U based upon publically reported data. The applicant should document the methodology used to count volume in out-of-state resident procedures and, if different from the definition of "procedure" described in these standards and criteria, should distinguish out-of-state procedures from in-state cases.

The need shall be based upon the Service Area's current year's population projected three years forward.

2. **Minimum Volume Standard:** Applicants proposing to acquire and operate an ESWL services unit must project a minimum utilization of at least 250 procedures per year by the third year of operation, based on full-time use of an ESWL unit. The applicant must also document and provide data supporting the methodology used to project the patient utilization. An application to provide ESWL services on a part-time basis shall convert its projected use to that of a full-time equivalent ESWL unit.

3. **Current Service Area Utilization:** The applicant should document that all existing providers of ESWL services within the proposed Service Area each performed at least 300 ESWL procedures per year during the most recent 12 month period for which data are available. The utilization by ESWL units that operate on a part-time basis shall be converted to that of a full-time equivalent ESWL unit. To characterize existing providers located within Tennessee, the applicant should use data provided by the Health Services and Development Agency. To characterize providers located outside of Tennessee, the applicant should use publicly available data, if available, and describe in its application the methodology these providers use to count volume.

In addition, the applicant should provide the HSDA with a report of patient destination for ESWL services based on the most recent 12 months of publicly reported data. This report should list all facilities that provided ESWL services to residents of the proposed Service Area and the number of ESWL procedures performed on residents of the Service Area for each facility. The Tennessee Department of Health will assist applicants in generating this report utilizing the HDDS.

4. **Adverse Impact on Existing Providers:** An application for ESWL services should not be approved if the new program will cause the annual caseload of existing ESWL programs within the Service Area to drop below an average of 300 procedures. The utilization by ESWL units that operate on a part-time basis shall be converted to that of a full-time equivalent ESWL unit. The patient origin study conducted for Standard 2, an analysis of patient origin data collected for Standard 3, and the referral data documented for Standard 3 should be used to determine whether such an adverse impact on existing providers is likely to occur.
5. **Adequate Staffing and Services:** The applicant should document a plan for recruiting and maintaining a sufficient number of qualified professional and technical staff to provide the ESWL services and must document the following:
 - a. The existence of an active radiology service and an established referral urological practice;
 - b. The availability within 90 minutes' drive time of acute inpatient services for patients who experience complications; and
 - c. The fact that all individuals using the equipment meet the training and credentialing requirements of the American College of Surgeons' Advisory Council for Urology.

The applicant should also document an ongoing educational plan for all staff included in the ESWL services program.

6. **ESWL Equipment:** Only applications that provide for the provision of ESWL services using equipment that has been approved by the United States Food and Drug Administration for clinical use shall be approvable.

7. **Quality Control and Monitoring:** The applicant should identify and document its intention to participate in a data reporting, quality improvement, outcome monitoring, and peer review system that benchmarks outcomes based on national norms. The system should provide for peer review among professionals practicing in facilities and programs other than the applicant.
8. **Data Requirements:** Applicants should agree to provide the Department of Health and/or the HSDA 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.
9. **Transfer and/or Affiliation Agreements:** If an applicant is not a designated Level 1 trauma center, an applicant must document an acceptable plan for the development of transfer and/or affiliation agreements with hospitals in the service area (this criterion does not preclude the development of transfer agreements with facilities outside the applicant's Service Area).
10. **Access:** 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:
 - a. That is offering the service in a medically underserved area as designated by the United States Health Resources and Services Administration;
 - b. That documents that the service area population experiences a prevalence and/or incidence of urinary stones or other clinical conditions applicable to extra-corporeal shock wave lithotripsy services that is substantially higher than the State of Tennessee average; or
 - c. That is a "safety net hospital" as defined by the Bureau of TennCare Essential Access Hospital payment program.

CERTIFICATE OF NEED STANDARDS AND CRITERIA

Extra-Corporeal Shock Wave Lithotripsy Services

Definitions for “Lithotripsy,” “Procedure,” and “Service Area” are provided in the standards and criteria.

Rationale

- 1. Determination of Need:** The formula for determination of need is based on a state utilization rate formula for ESWL services, rather than one unit per 250,000 people. Data available in the future may enable the need determination to be based on regional utilization rates. The need determination also takes into account out-of-state residents’ utilization of Tennessee-based ESWL services. Need is based upon population projected three years forward, instead of the current four years provided by the Guidelines for Growth, reflecting the comparatively low capitalization requirements to institute ESWL services.
- 2. Minimum Volume:** Based on the responses to the Questionnaire and the comments at the public meeting, it appears that a reasonable minimum annual volume projection for an ESWL unit by its third year of operation is 250 procedures, which allows for future growth in services (the former Guidelines for Growth also required a projection of 250 procedures). An application to provide ESWL services on a part-time basis is converted to a full-time equivalent ESWL unit projected use.
- 3. Current Service Area Utilization:** Converting part-time ESWL unit utilization numbers to full-time equivalents, the average number of ESWL procedures performed by ESWL units in Tennessee in 2009 was 589. The Questionnaire responses and the public meeting comments showed strong and reasonable interest in ensuring greater accessibility to ESWL services statewide, as is contemplated by the State Health Plan’s Principle No. 2 for Achieving Better Health (“Every citizen should have reasonable access to health care”). This standard states that each existing Service Area ESWL unit should have performed at least 300 procedures in the most recent 12 month period in order for an application to show need for ESWL services in the Service Area. This standard also requires an applicant to provide patient origin data analysis.
- 4. Adverse Impact:** This standard suggests that existing ESWL programs in a Service Area should not drop below a projected annual utilization number of 300 procedures as a result of the granting of an application to provide ESWL services. The utilization by ESWL units that operate on a part-time basis shall be converted to that of a full-time equivalent ESWL unit.
- 5. Staffing/Services:** Availability of acute inpatient services within a 90 minute drive time has been added, replacing the current undefined “proximity” guideline, thus providing a

more definite access-to-care standard. The Guidelines for Growth referenced the “American Lithotripsy Society,” which no longer exists. That reference has been replaced by one to the “American College of Surgeons’ Advisory Council for Urology.”

6. **Equipment:** This standard reflects the one in the former Guidelines for Growth.
7. **Quality:** This standard reflects the connection to the State Health Plan’s Principle No. 4 for Achieving Better Health, “Every citizen should have confidence that the quality of health care is continually monitored and standards are adhered to by health care providers.”
8. **Data:** The ability to measure improvements in access to care and in cost of care can only be discerned by having access to necessary data. This standard reflects the continuing need for accurate data.
9. **Transfer Agreements:** This standard differs from the Guidelines for Growth in providing that an applicant that is a Level 1 Trauma Center need not provide a transfer and/or affiliation agreement.
10. **Access:** To ensure reasonable access to ESWL services in underserved areas, as is contemplated by the State Health Plan’s Principle No. 2 for Achieving Better Health (“Every citizen should have reasonable access to health care”), the HSDA may choose to give special consideration to applicants that meet these particular conditions.

Appendices A-G

Appendix A: Health Services and Planning Policy Statement

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

Appendix C: Survey Results

Appendix D: Stakeholders Contributing to Development of Plan

Appendix E: State Health Plan Advisory Committee Members

Appendix F: State Task Forces and Specific Issue Plans

Appendix G: Strategic Program Examples

APPENDIX A

Health Services and Planning Act Policy Statement

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 strategies presented in the 2010 State Health Plan are a synthesis of research, data and public input, further vetted by the State Health Plan Advisory Committee. 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 Tennesseans.

Engaging the public in a meaningful way with limited resources called for a creative, iterative approach. With the advice of its Advisory Committee and the Finance & Administration Office of Consulting Services, the Division designed the multiple-step process described more fully below. The design recognizes that while quantitative certainty, as might have been possible with a scientifically stratified random survey sample, might have been desirable, it was not feasible; thus the data collected were balanced by rich, qualitative methods.

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

Step 1: State Health Plan Advisory Committee Meeting

Comprising a stimulating range of perspectives (See Appendix E), the thirteen members of this advisory committee include state government leaders (the chairs of the General Assembly Senate and House health committees, the comptroller, cabinet members for health, mental health, and finance departments, and the directors of TennCare, HSDA, and eHealth) as well as private sector members (representing long term care, health insurance, hospitals, physicians, health planners, public policy and business).

Together these experts reviewed the health status of Tennesseans as presented in the 2009 State Health Plan and discussed the implications found therein for the goals and strategies Tennessee might establish. The committee agreed it was critical to engage the public in these discussions, and offered support and suggestions for this outreach.

Step 2: Individual Stakeholder Interviews

From January 2010 through April 2010, Division staff held dozens of meetings with a wide range of knowledgeable stakeholders (See Appendix D), including leaders of provider groups (clinicians, pharmacists, hospitals, clinics), universities, community action groups, insurance, business, medical centers, state agencies, collaboratives and regional health councils.

2010 State Health Plan Public Engagement Process

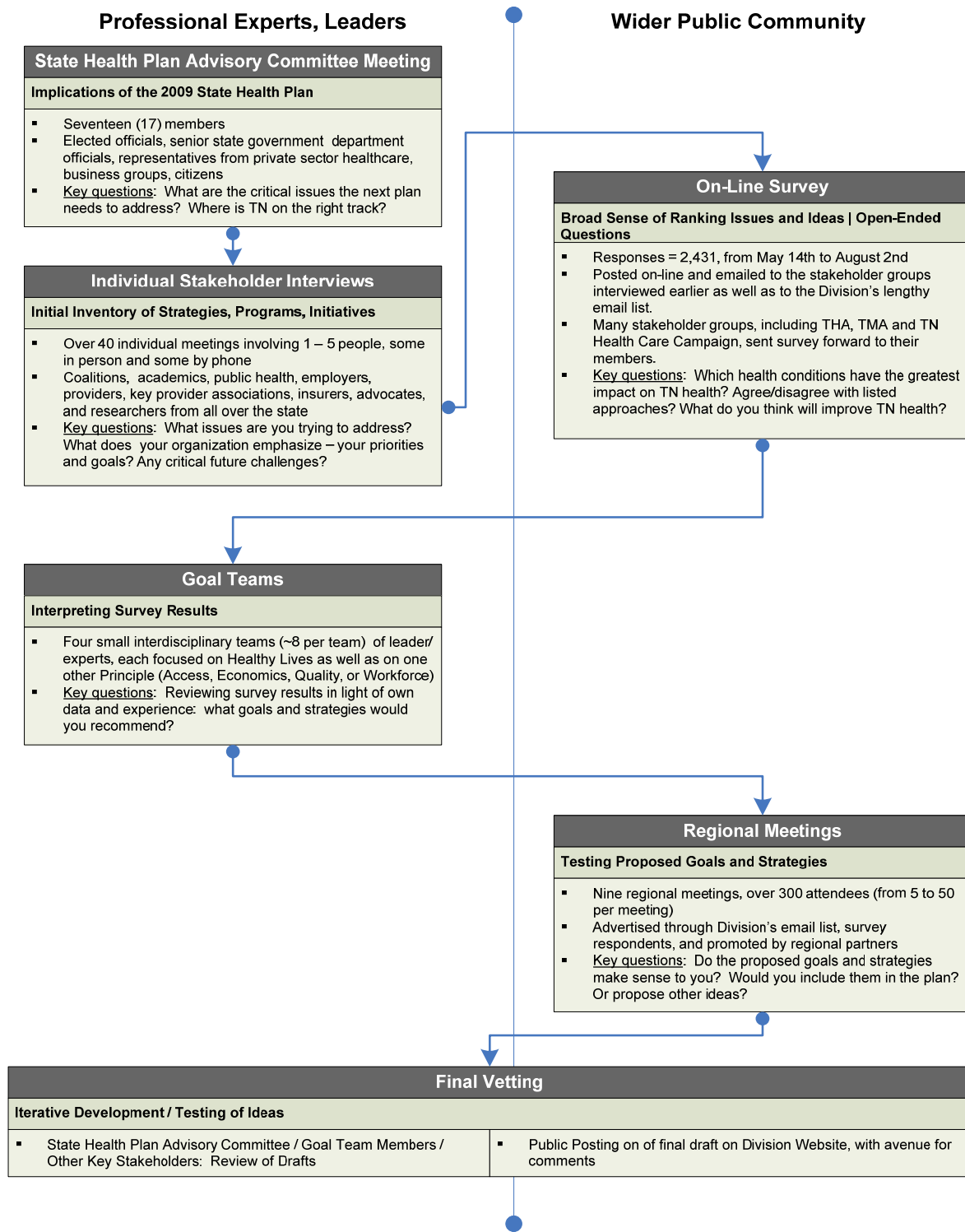


Figure 2. Public Engagement Process

For these meetings, the Division first sent each participant a 6-page summary of the 2009 State Health Plan organized along the Five Principles for Achieving Better Health, asking them 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.

During the meetings, the Division heard not only what the stakeholder considered to be a main focus for action to improve Tennessee health, but also ideas about what was working well and concerns about change needed.

Step 3: On-Line Survey

Drawing upon on-going research as well as the urgent matters identified by the State Health Plan Advisory Committee and the inventory of strategies, programs, and initiatives identified during the individual stakeholder interviews, Division staff created an on-line survey. The survey was designed to take less than 15 minutes for those with limited time, but to still cover the major principles and allow ample opportunity for those who wanted to devote more time to weigh in with open-ended questions.

Based on similar surveys, the Division set a goal of getting 1,000 Tennesseans to participate. The recipients were encouraged to forward the survey to their staff, members, colleagues, and others. As shown in Appendix D, thanks largely to the active participation of the stakeholders interviewed prior to the survey, during the weeks the survey was open (from May 14th through August 2nd), nearly 2,500 citizens, representing every county in Tennessee, took the time to share their views regarding what the next State Health Plan should include.

The results of course cannot be portrayed as a scientific representation of what Tennesseans “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, with very few resembling the hot-head rants typically found on-line after, for example, a news story on health care.

Step 4: Goal Teams

Individuals identified through the stakeholder interviews who could contribute specific knowledge and expertise regarding each of the plan’s guiding principles, were invited to be part of small interdisciplinary goal teams to help analyze the survey results. Nominations were also sought from the Institute of Public Health. Appendix D lists these members.

During early June, four day-long work sessions were held in Nashville, where each group was asked to:

- Agree upon 5-7 recommended goals for the 2010 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 Tennesseans (Principle 1, Healthy Lives), and
- Identify promising strategies to accomplish these goals, with particular emphasis on their own focus principle.

To the gratification 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 also used as a sounding board for further iterations of the goals and strategies through conference calls and email correspondence.

Step 5: 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 month of July, the Division Director convened nine different meetings to obtain public input on the draft goals and promising strategies.

Working with the University of Tennessee at Knoxville Howard Baker Center for Public Policy, arrangements were made with public universities in each of the areas to serve as co-hosts of these meetings. The co-hosts not only provided the meeting spaces and, in many 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 1: Summary of Regional Meetings

- Murfreesboro, July 9, 10:00 am – 12:00 pm. MTSU.
- Cookeville, July 12, 10:00 am - 12:00 pm. Tennessee Tech University.
- Nashville, July 13, 10:00 am – 12:00 pm. Tennessee State University.
- Chattanooga, July 14, 10:00 am -12:00 pm, University of Tennessee at Chattanooga.
- Jackson, July 15, 1:00 pm – 3:00 pm. Tennessee Technology Center.
- Martin, July 16, 1:00 am – 3:00 pm. The University of Tennessee at Martin.

- Memphis, July 20, 10:00 am – 12:00 pm. University of Tennessee Health Science Center.
 - Knoxville, July 23, 2:00 pm – 4:00 pm. University of Tennessee.
 - Johnson City, July 26, 1:00 pm – 3:00 pm. East Tennessee State University.
-

Along with the local promotional efforts, the Division sent notice of the meetings to everyone who had indicated an interest in these meetings through the on-line survey, and posted the details on the Division website. Again, based on similar public meeting efforts, these efforts surpassed expectations.

The two-hour public meetings were designed as work sessions to accomplish two things:

1. To get feedback regarding the proposed common goals – what the State of Tennessee should emphasize in order to improve the health of Tennesseans, and
2. To understand local and regional promising strategies – specific programs or initiatives that are improving the health of Tennesseans.

After the director's brief introduction of the purpose of meeting, the attendees were divided into small groups of 7-9 people and given approximately 90 minutes to critique the proposed goals and to identify things that might help move the state forward. Worksheets were provided so that all of these thoughts 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 further thoughts was included on the agenda, which a handful of attendees took advantage of.

Final vetting of the draft involved various state departments and agencies, the stakeholder groups identified above who were involved during the public engagement phase, and interested people from the public, who could view the final draft on the division's webpage at <http://tn.gov/finance/healthplanning/> and submit comments.

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

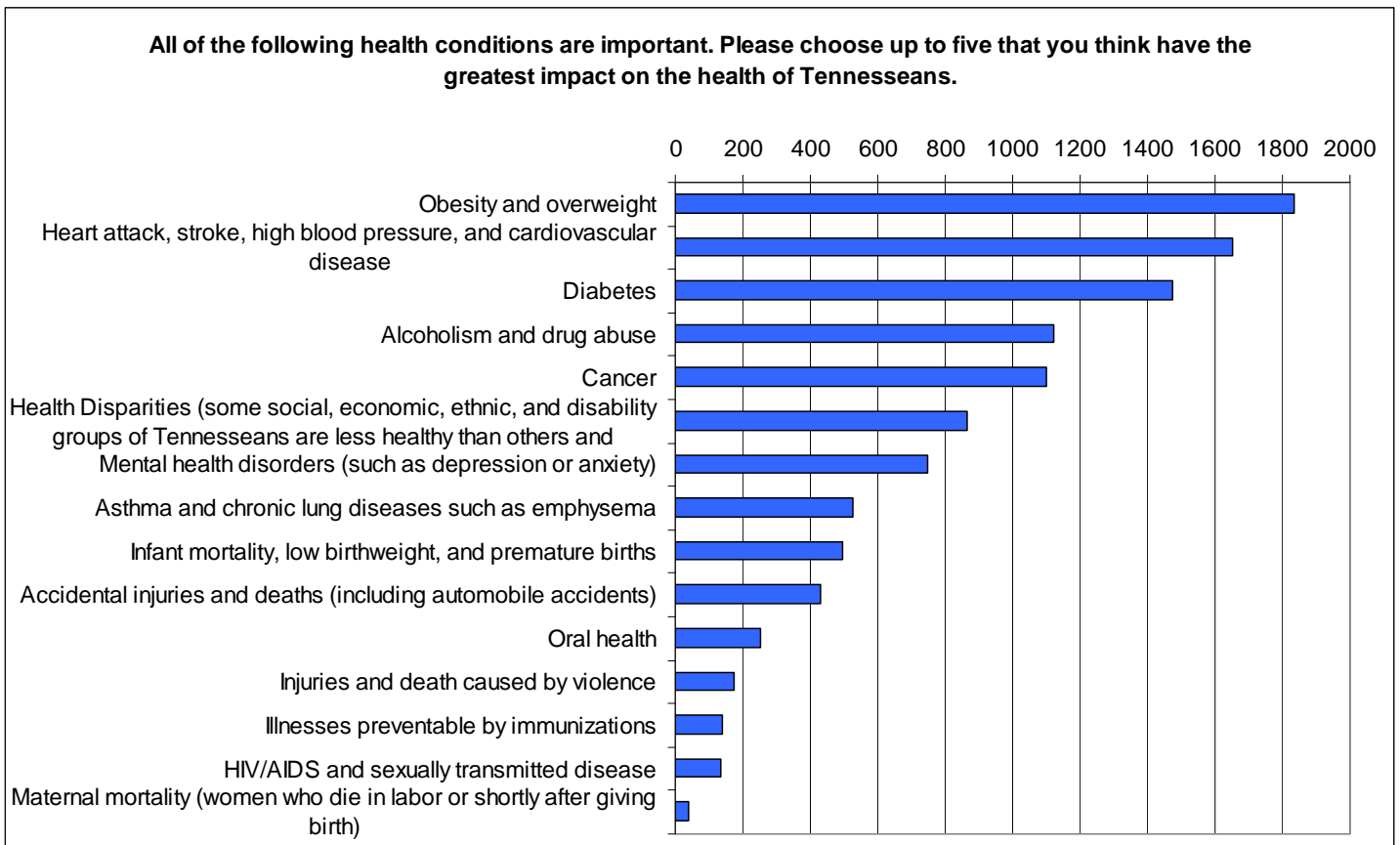
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Appendix C

Survey Results

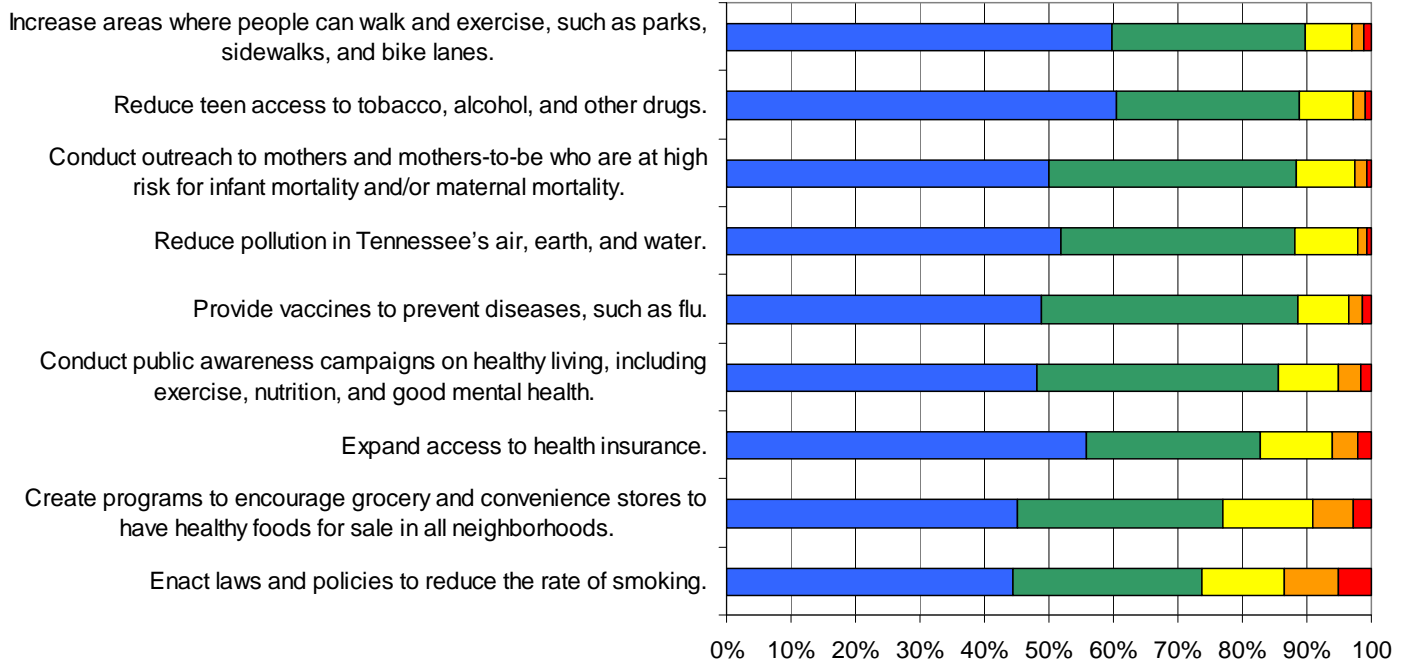
Tennesseans had the opportunity to participate in an online survey to voice their opinions regarding their concerns surrounding issues of health care. During the three month period that the survey was made available, 2431 completed responses were received. The following is a visual summary of the questions and responses.

Health Conditions Thought to be Most Important to Tennesseans

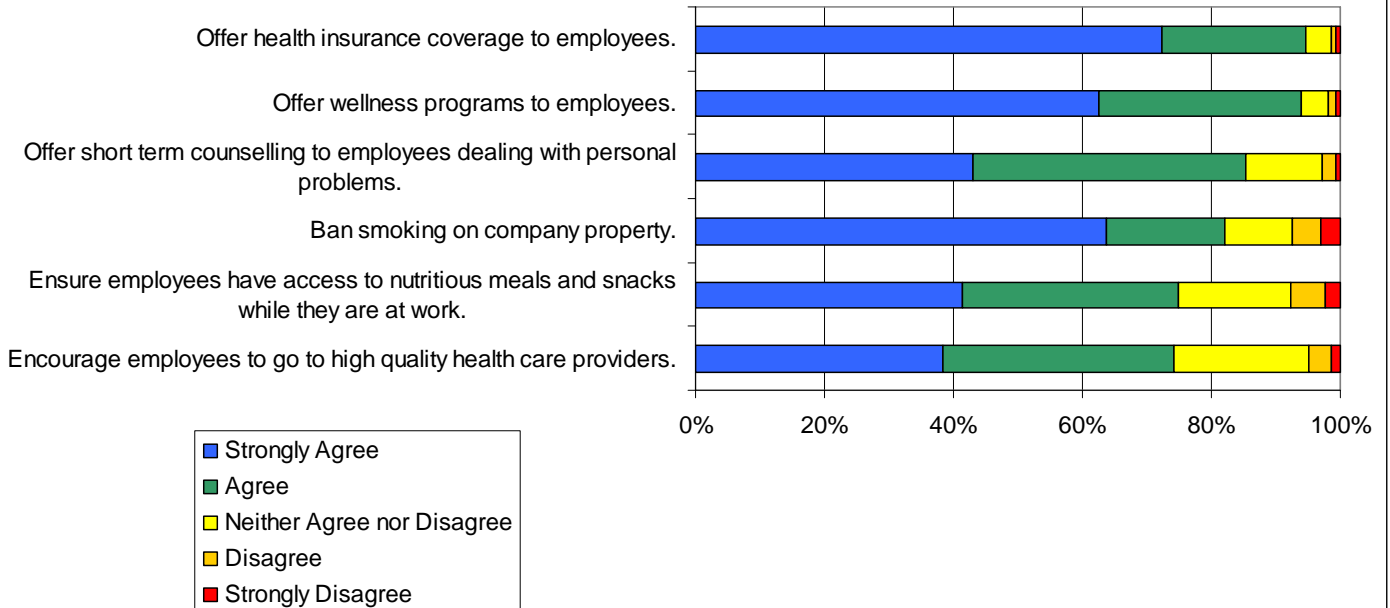


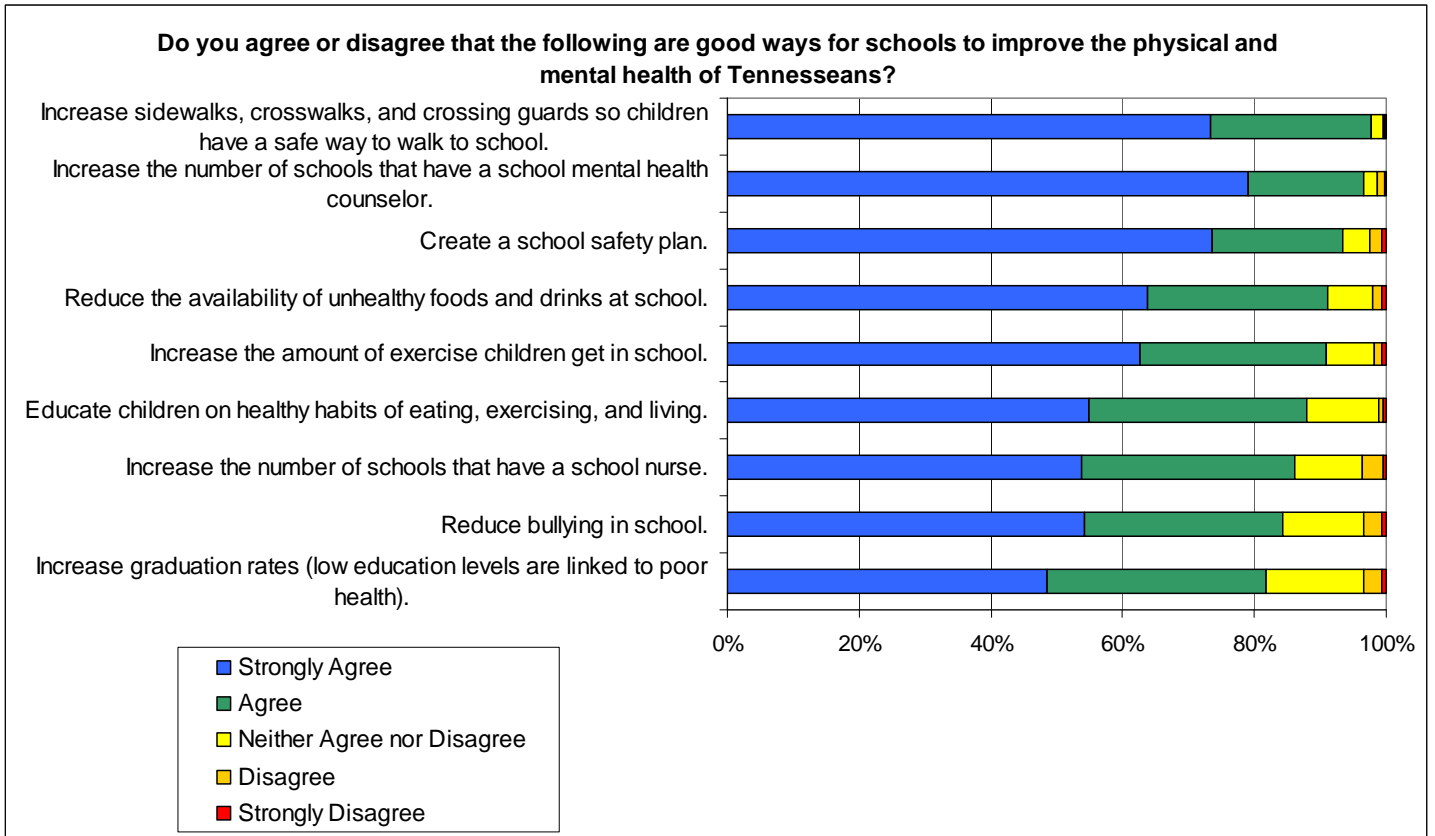
Healthy Lives: The Purpose of the State Health Plan is to improve the health of Tennesseans.

Do you agree or disagree that the following programs are good ways for state and city governments to improve the physical and mental health of Tennesseans?

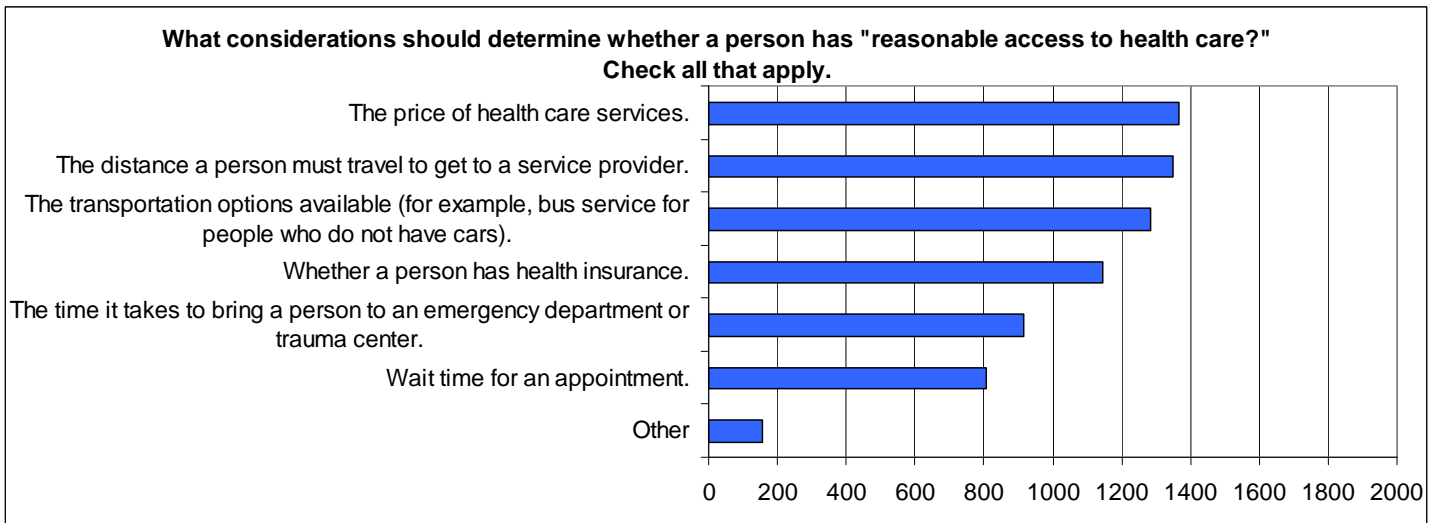
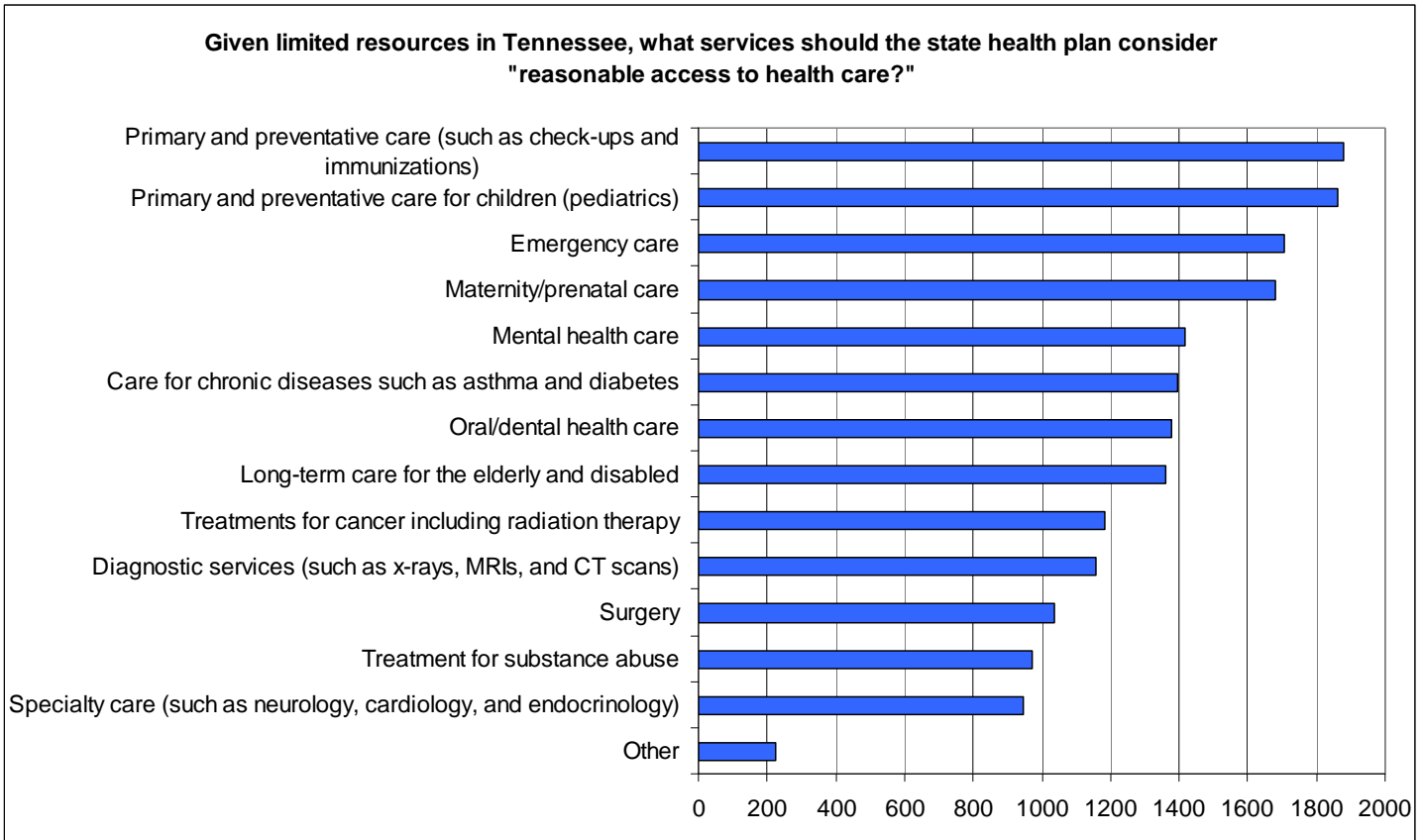


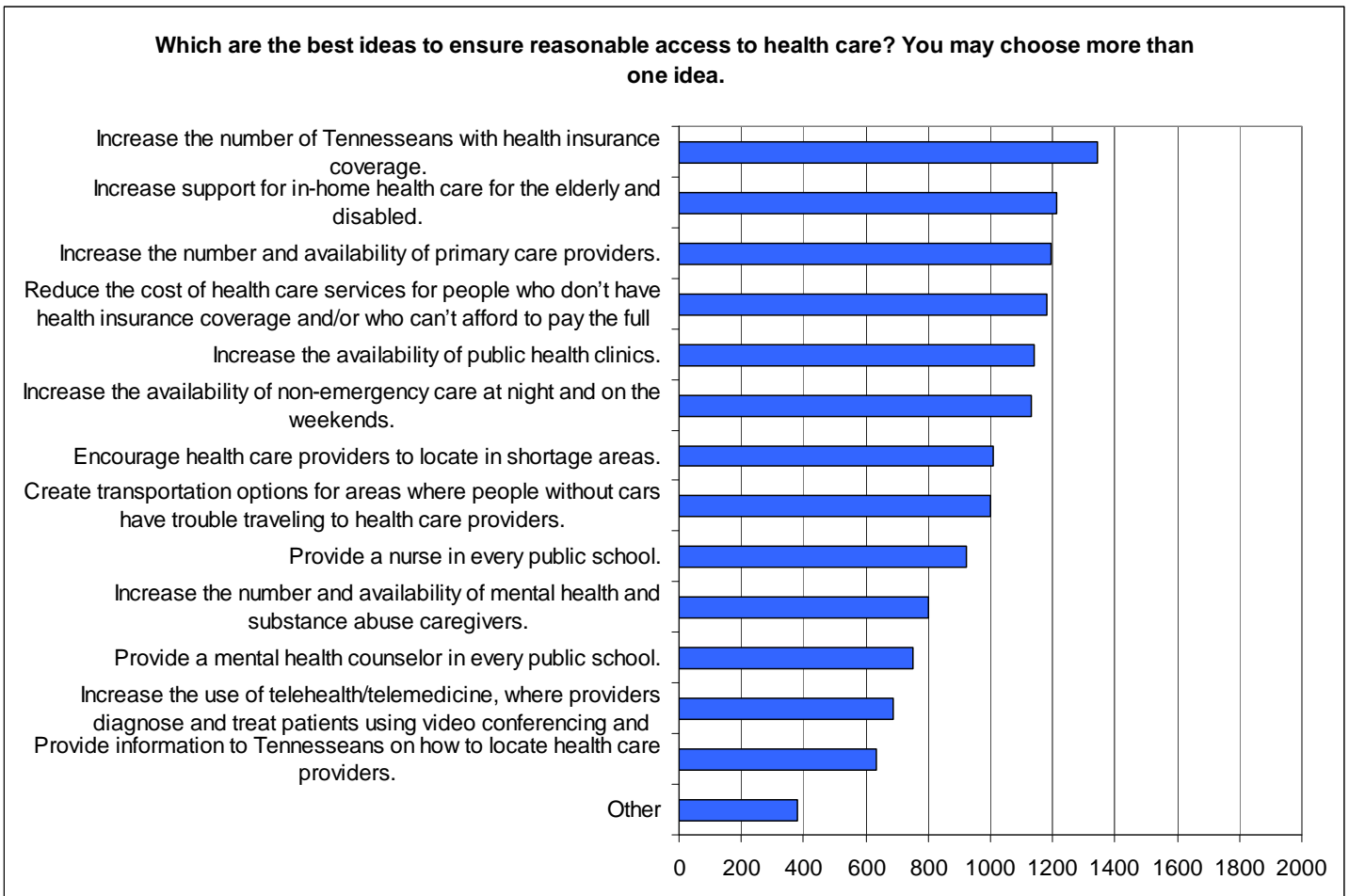
Do you agree or disagree that the following are good ways for businesses to improve the physical and mental health of Tennesseans?



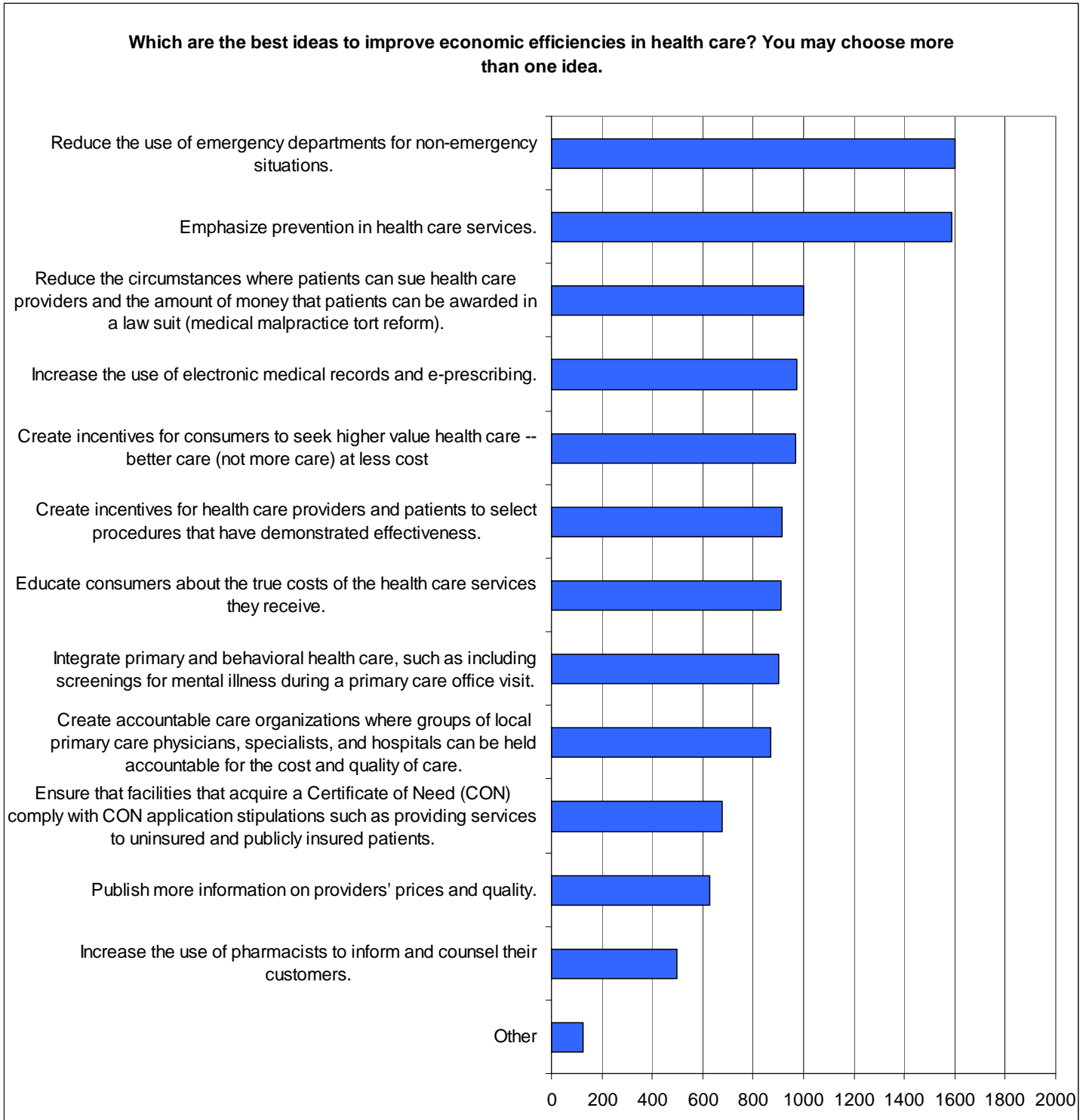


Access: Every citizen should have reasonable access to health care.



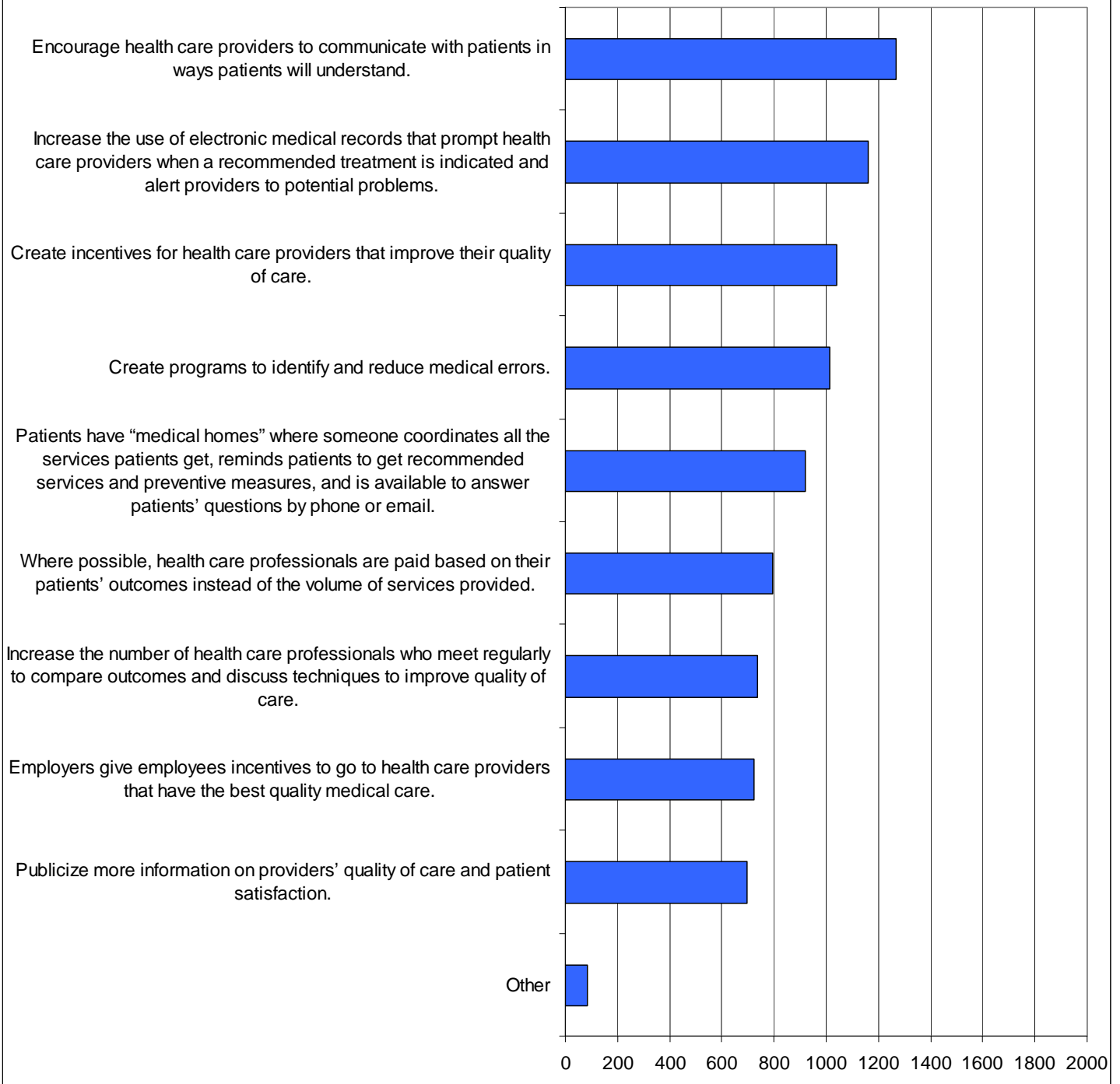


Economic Efficiencies: The state's health care resources should be developed to address the needs of Tennesseans while encouraging competitive markets, economic efficiencies, and the continued development of the state's health care system.

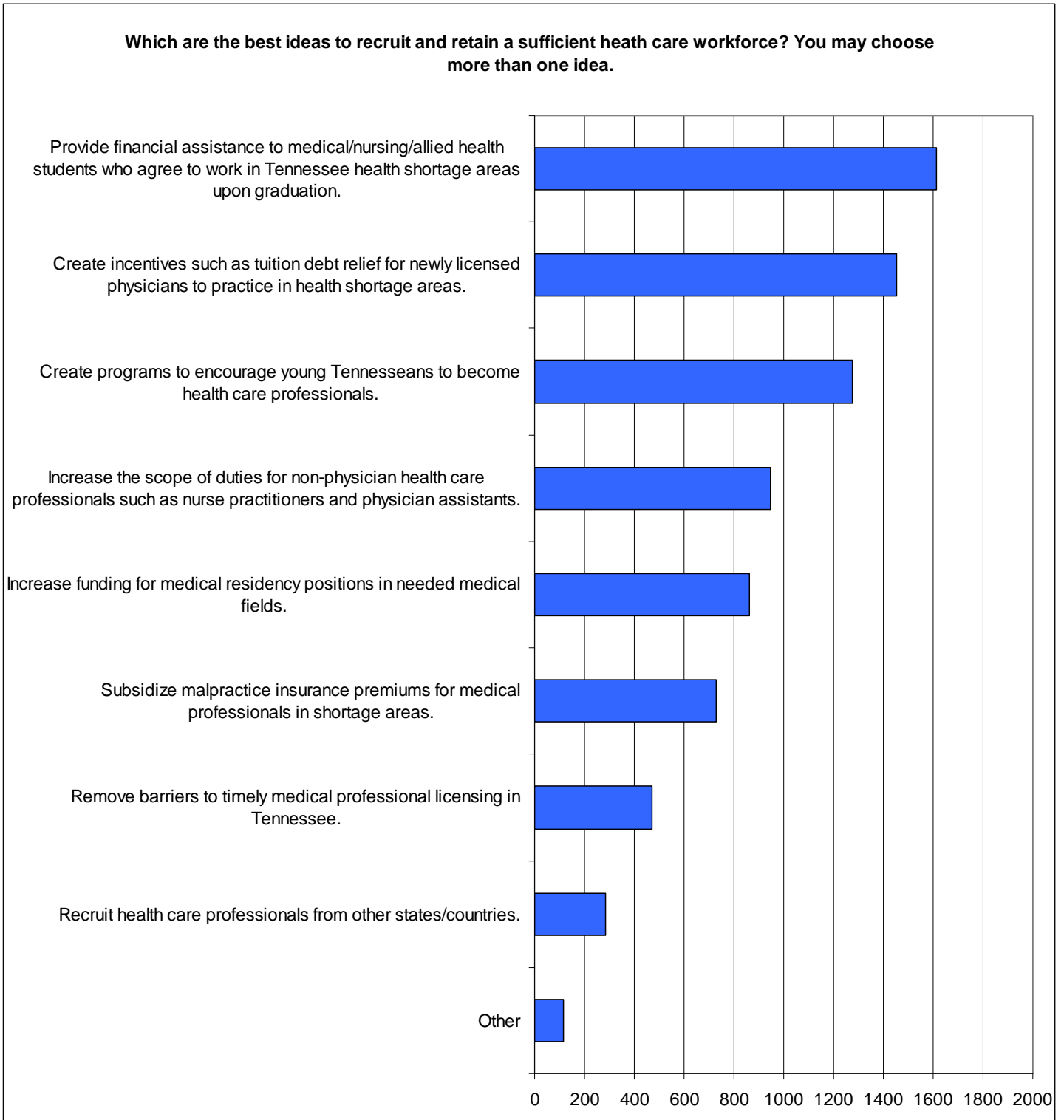


Quality of Care: Every citizen should have confidence that the quality of health care is continually monitored and standards are adhered to by health care providers.

Which are the best ideas to improve the quality of health care? You may choose more than one idea.



Health Care Workforce: The state should support the recruitment and retention of a sufficient and quality health care workforce.



Appendix D

Stakeholders Contributing to Development of Plan

List of Entities Interviewed

The Division of Health Planning interviewed the following entities in spring 2010 as part of its public engagement campaign to develop the 2010 Tennessee State Health Plan:

- BlueCross BlueShield of TN
- Cherokee Health System
- Cigna Health Insurance
- Community Progress Committee (Wilson County)
- Department of Education
- Department of Environment and Conservation
- Department of Finance and Administration - Benefits Administration/CoverTN
- Department of Health Regional Health Councils
- Deputy Governor John Morgan
- Erlanger Health System
- ETSU College of Public & Allied Health / TN Institute of Public Health
- Governor's Office of Children's Care Coordination
- Hamilton County Medical Society
- Health Information Partnership of TN
- Healthcare 21 Business Coalition
- Healthy Memphis Common Table
- Mountain States Health Alliance
- MTSU Center for Health and Human Services
- Rural Health Association of Tennessee
- Rural Health Collaborative
- Tennessee State University College of Health Sciences
- TN Association for Home Care
- TN Association of Mental Health Organization
- TN Business Roundtable
- TN Commission on Children and Youth
- TN Health Care Association
- TN Health Care Campaign
- TN Hospital Association
- TN Medical Association
- TN Nurses Association
- TN Obesity Task Force
- TN Pharmacists Association
- TN Primary Care Association
- TN Trauma Center Association
- TriStar Health System
- University of Tennessee - Health Science Center
- University of Tennessee - Knoxville
- UT Medical Center
- Vanderbilt University School of Medicine

List of Goal Team Members

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

Access

Bill Huskey	<i>Health Policy Coordinator, Tennessee Primary Care Association</i>
Dick Blackburn	<i>Executive Director, Tennessee Association of Mental Health Organizations</i>
LaTonya Ellis	<i>Director, Tennessee General Assembly Health Equities Commission</i>
Laura Beth Brown	<i>President, Vanderbilt Home Care Services, Inc</i>
Micah Cost	<i>Director of Professional Affairs, Tennessee Pharmacists Association</i>
Michael Warren	<i>Medical Director, Governor's Office of Children's Care Coordination</i>
Rae Bond	<i>Director, Medical Foundation of Chattanooga; Director, Project Access</i>
Veronica Gunn	<i>Chief Medical Officer, Tennessee Department of Health</i>

Economic Efficiencies

Bill Southwick	<i>CEO, HealthMark Partners, Inc</i>
Jean Young	<i>Assist. VP, Information Services, Tennessee Hospital Association</i>
Cristie Travis	<i>CEO, Memphis Business Group on Health</i>
David Mirvis	<i>Professor of Preventive Medicine, University of Tennessee Health Science Center</i>
Joe Winick	<i>Sr VP, Strategic Planning and Business Development, Erlanger Health System</i>
Manoj Jain	<i>Medical Director of Quality, Q Source</i>
Melanie Hill	<i>Executive Director, Tennessee Health Services and Development Agency</i>
Susie Baird	<i>Director of Policy, Bureau of TennCare</i>

Quality

Bart Perkey	<i>Director of Health Services Access, Metro Nashville-Davidson County Department of Health</i>
Chris Clarke	<i>Sr. VP, Tennessee Hospital Association</i>
John Couzins	<i>EQRO Director, Q Source</i>
Laura Beerman	<i>Technical Writer, Q Source</i>
Dennis Freeman	<i>CEO, Cherokee Health Systems, Inc.</i>
Tere Hendricks	<i>Acting State Registrar and Director of Vital Records, Director of Health Statistics, Tennessee Department of Health</i>
Mary Layne Van Cleave	<i>EVP and COO, Tennessee Hospital Association</i>
Renee Frazier	<i>CEO, Healthy Memphis Common Table</i>
Tom Lundquist	<i>Vice President of Performance Measurement and Improvement of Health Care Services, BlueCross BlueShield of Tennessee</i>

Workforce

Bill Jolley	<i>VP, Tennessee Hospital Association</i>
Carole R. Myers	<i>Assistant Professor, University of Tennessee College of Nursing</i>
Cathy Taylor	<i>Assistant Commissioner, Tennessee Department of Health</i>
Charlotte Burns	<i>CEO, Hardin Medical Center</i>
Cindy Siler	<i>CEO, The Rural Partnership</i>
Jo Edwards	<i>Director, Center for Health and Human Services, Middle Tennessee State University</i>
Marthagem Whitlock	<i>Assistant Commissioner, Tennessee Department of Mental Health and Developmental Disabilities</i>
Patti Scott	<i>Chair, School Health Task Force, Tennessee Nurses Association</i>
Peter Buerhaus	<i>Director, Center for Interdisciplinary Health Workforce Studies, Institute for Medicine and Public Health, Vanderbilt University Medical Center</i>
David Seaberg	<i>Dean, University of Tennessee College of Medicine Chattanooga</i>

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Appendix E

State Health Plan Advisory Committee

The Advisory Committee for the State Health Plan is comprised of Tennessee state elected officials, state government department and agency stakeholders, representatives from specific healthcare and business groups, and the public. The Committee is purposefully kept to a limited number in order to encourage the discussion of broad topics of interest and an analysis of the framework of the State Health Plan from a statewide policy level.

The Advisory Committee meets in October of each year. At the first meeting on October 23, 2008, the Advisory Committee gave new direction for the initial framework of the State Health Plan. At the second meeting, on October 29, 2009, The Advisory Committee provided guidance on how to make the 2010 SHP useful and effective as a guide for the state's investment and resources. Members of the Advisory Committee are consulted on particular issues as they arise.

The members of the Advisory Committee are:

State Government Members:

- Chair of the Senate General Welfare, Health, and Human Resources Committee – Senator Rusty Crowe
- Chair of the House Health and Human Resources Committee – Representative Joe Armstrong
- Comptroller of the Treasury – Justin P. Wilson
- Commissioner of Finance and Administration – Dave Goetz
- Commissioner of Health – Susan R. Cooper
- Commissioner of Mental Health and Disabilities – Virginia Trotter Betts
- Deputy Commissioner of Finance and Administration and Director of the Bureau of TennCare – Darin J. Gordon
- Executive Director, Health Services and Development Agency – Melanie Hill
- Director, Office of e-Health Initiatives – Will Rice
- Executive Director, Health Equities Committee-LaTonya Ellis

Non-state Government Members:

- American Health Planning Association – Arthur Maples, president; Baptist Memorial Hospital (Memphis)
- Long term care – Bruce Duncan, Assistant Vice President, National HealthCare Corp. (Murfreesboro)
- Health Insurance – David Locke, BlueCross BlueShield of Tennessee (Chattanooga)
- Tennessee Hospital Association – Mary Layne Van Cleve, COO (Nashville)
- Tennessee Medical Association – Albert J. Grobmyer, III, MD (Memphis)
- Public Policy – Rita Geier, Senior Fellow for Public Health, the Howard H. Baker Center for Public Policy, UT-Knoxville (Knoxville)
- Business – Cristie Travis, Memphis Business Coalition on Health (Memphis)

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Appendix F

State Task Forces and Specific Issue Health Plans

The following are state planning task forces that have or are developing strategic plans concerning specific health issues. These plans will inform the development of the State Health Plan, and, through discussions with these task forces and relevant stakeholder groups, the Division of Health Planning may incorporate these plans into the State Health Plan.

Infections Task Force

The Department of Health created the Infections Task Force in response to Public Chapter 323 (2005). The Task Force studies healthcare-acquired infections and makes recommendations to the Department of Health. The latest available report from the Task Force may be found here: <http://health.state.tn.us/Downloads/MRSAreport307.pdf>.

Adult Emergency Oral Health Task Force

Public Chapter 998 (2008) directed the Department of Health to convene a task force to “develop a statewide strategy for the provisions of adult emergency oral health care, utilizing public and private sector resources.” The task force produced an initial report with short and long-term recommendations in early 2009 and plans to continue meeting. The report may be found here: <http://health.state.tn.us/Downloads/adultemoralhealth08.pdf>.

The Tennessee Alzheimer’s Disease Task Force

Public Chapter 566 (2007) created the Tennessee Alzheimer’s Disease Task Force, “the public welfare requiring it.” The Task Force was “directed to assess the current and future impact of Alzheimer’s disease on Tennesseans; to examine the existing industries, services, and resources addressing the needs of persons with Alzheimer’s disease, their families, and caregivers; and to develop a strategy to mobilize a state response to this public health crisis.” The Task Force’s Final Report, prepared by the Tennessee Commission on Aging and Disability, is available here: <http://www.tennessee.gov/comaging/documents/ataskforce.pdf>

The Tennessee Cervical Cancer Elimination Task Force

Public Chapter 921 (2006) created the Tennessee Cervical Cancer Elimination Task Force as a subcommittee of the Tennessee Comprehensive Cancer Control Coalition. The Task Force has established a goal of eliminating cervical cancer by 2040. The group’s report, the Cervical Cancer Prevention Plan, is available here: <http://health.state.tn.us/Downloads/CervicalCancerPreventionPlan.pdf>.

Tennessee Veterans Task Force (TMHDD)

The Tennessee Veterans task force is a collaboration of the Tennessee Department of Mental Health and Development Disabilities and a number of veterans and mental health groups. The task force focuses on expanding and strengthening the system of care for active duty service members and returning veterans and their families by convening trainings, compiling resources, and identifying gaps with an emphasis on building long-term system capacity. More information on the task force may be found here:

http://www.tennessee.gov/mental/A&D/A_D_veterans.html.

Tennessee Obesity Task Force

In 2008 the Department of Health convened a work group to develop a strategic plan addressing obesity and related health problems in Tennessee.

Tobacco Use Prevention, Control, and Cessation Strategic Plan

In 2008, the Department of Health Tobacco Use Prevention and Control Program (TUPCP) convened stakeholders from across the state to form a Strategic Planning Work Group to establish a five-year plan for a comprehensive statewide tobacco control initiative for the period 2009-2013. The plan aims to “change social norms to reduce and eliminate the burden of tobacco-related death and illness for all people and communities of Tennessee.” More information on the TUPCP may be found here:

<http://health.state.tn.us/healthpromotion/index.html>.

Tennessee Office of eHealth Initiatives

The Tennessee Office of eHealth Initiatives under the Department of Finance and Administration serves as the single coordinating authority for the exchange of eHealth information in Tennessee. It collaborates with private and public sector health care stakeholders through the statewide eHealth Advisory Council, established by Governor Bredesen in 2006. The Advisory Council is currently transitioning into a new body as the State of Tennessee prepares for changes in the eHealth landscape brought by the federal Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009.

<http://www.tennesseeanytime.org/ehealth/>

Appendix G

Strategic Program Examples

Healthy Lives

Eat Well, Play More, a Comprehensive Plan to Reduce Obesity and Chronic Disease in Tennessee www.eatwellplaymoretn.org

The primary focus of this five-year plan is to “create policy and environmental changes in the places where people live, work, learn, play and pray” through “comprehensive efforts to address obesity and other chronic diseases through a variety of nutrition and physical activity strategies that reduce the barriers to daily physical activity and access to healthy foods.”

Tennessee Department of Health GetFitTN Program www.getfittn.com

GetFitTN is a statewide program to address the rising epidemic of Type 2 diabetes and risk factors that lead to diabetes, like obesity. This initiative is aimed at educating both adults and children that lifestyle changes like increasing physical activity and having a healthier diet can delay or prevent Type 2 diabetes.

Tennessee Executive Order 69 <http://www.state.tn.us/sos/pub/execorders/exec-orders-bred69.pdf>

An executive order promoting healthy food and beverage options in executive branch state public properties.

Creating Homes Initiative <http://state.tn.us/mental/recovery/CHIpage.html>

A TDMHDD strategic plan to partner with Tennessee communities to educate, inform and expand quality, safe, affordable and permanent housing options for people with mental illness.

Community Supportive Housing <http://www.state.tn.us/mental/recovery/housing6.html>

A statewide initiative that supplements supportive housing providers in order to allow people with a history of mental illness or co-occurring substance use disorder who have very low income to have access to safe, affordable, supportive housing.

Tennessee Comprehensive Cancer Control Coalition http://health.state.tn.us/CCCP/TCCC_Plan.pdf

The Tennessee Comprehensive Cancer Control Coalition (TCCCC) aims to “to measurably reduce the burden of cancer on the citizens of Tennessee by implementing a collaborative statewide plan driven by data, science, capacity and outcomes.”

Tennessee Department of Health Project Diabetes

<http://health.state.tn.us/projectdiabetes.htm>

Project Diabetes is a statewide initiative that focuses on education, prevention, and treatment programs for diabetes and obesity through community and public-private partnerships as well as promoting policies and programs at the individual and community level.

Tennessee 2020: Vision for Parks, People, and Landscapes

<http://www.tn.gov/environment/recreation/plan/>

Tennessee 2020 is a 10 year plan that outlines goals and serves as a means for the state to work with communities to maintain and address issues related to recreational assets. It documents the most critical needs facing conservation and recreational infrastructure.

Tennessee Department of Transportation “Safe Routes to School” Program

<http://www.tdot.state.tn.us/bikeped/saferoutes.htm>

This is a federally funded program that aims to improve safety for children and the community and provide opportunities to increase physical activity through biking and walking.

Safe, Accountable, Flexible, Efficient Transportation Equity Act: A Legacy for Users

<http://www.fhwa.dot.gov/safetealu/summary.htm>

SAFETEA-LU is a federal program that promotes more efficient and safe transportation programs by focusing on transportation issues of national significance, while allowing state and local transportation groups flexibility for solving transportation problems in their communities.

Nashville Metropolitan Planning Organization Regional Bicycle and Pedestrian Study

http://nashvillempo.org/regional_plan/walk_bike/regional_study09.aspx

This study intends to “help establish a strategic vision for improving walking and bicycling opportunities in the greater Nashville region,” which will guide future transportation initiatives, projects, and funding.

Tennessee Suicide Prevention Network

<http://tspn.org/>

This is a statewide coalition of agencies, advocates and consumers that oversees the implementation of strategies to “eliminate/reduce the incidence of suicide across the life span, to reduce the stigma associated with suicide and educate communities throughout the state about suicide prevention and intervention.”

Tennessee Department of Mental Health and Developmental Disabilities’ Women and Pregnant Women Substance Use Program

http://state.tn.us/mental/A&D/treat_serv.html

This program provides treatment and recovery support services (residential, intensive outpatient, and outpatient treatment) for women with dependent children and pregnant women who have a substance use disorder.

Governor’s Office of Children’s Care Coordination Women’s Health and Infant Mortality Initiatives

615-741-5192

The GOCCC Women's Health and Infant Mortality Initiatives fund evidence-based programs to improve women's health during pregnancy and infant health during the first year of life in an effort to improve birth and infant outcomes in Tennessee.

Nurses for Newborns

<http://www.nfnf.org/tennessee.php>

This program provides funding for registered nurses to make home visits to new and pregnant mothers to provide health-care assessments, education and positive parenting skills in effort to prevent infant mortality and child abuse/neglect.

Tennessee Department of Health Help Us Grow Up Successfully program

<http://health.state.tn.us/MCH/index.html>

This is a home visiting program that coordinates additional services for pregnant and postpartum women up to two years and children ages birth through five years to ensure the health and well-being of children.

Tennessee Coordinated School Health

<http://tennessee.gov/education/schoolhealth/>

This is a statewide program designed to connect health (physical, emotional and social) with education. This eight component coordinated approach improves students' health and their capacity to learn through the support of families, communities and schools working together.

University of Tennessee Agricultural Extension programs

<http://utextension.tennessee.edu/Pages/default.aspx>

A statewide program that works with farmers, families, youth, and communities to deliver educational programs and research-based information to citizens throughout the state of Tennessee.

Tennessee Department of Human Services’ State Nutrition Action Plan

<http://fcs.tennessee.edu/tncep/default.htm>

The goal of this program is to “improve the likelihood that persons eligible for the SNAP will make healthy food choices within a limited budget and choose physically active lifestyles.”

Coordinated Approach to Children's Health

<http://www.timesfreepress.com/news/2010/sep/24/program-aims-help-students-beat-obesity/>

An evidence-based program delivered through the Coordinated School Health program in Bradley County.

Tennessee Children's Outdoor Bill of Rights

<http://www.tnwconservation.org/images/pdf/sjr0705.pdf>

This bill of rights was implemented to increase the likelihood that children will have meaningful experiences in nature through activities such as playing outside, walking in the woods, growing a garden, and visiting a farm.

Gold Sneaker Initiative

<http://health.state.tn.us/goldsneaker.htm>

An initiative to establish physical fitness, nutrition, and other health guidelines for licensed childcare facilities.

Families First Program

http://state.tn.us/humanserv/adfam/afs_tanf.html

This program provides temporary cash benefits to families who have children, and are experiencing financial difficulties and who agree to follow a personal responsibility plan that involves health and education components for the children and a work/training program for adults.

School-based Mental Health Liaison Programs

http://www.tennessee.gov/mental/specialpops/sp_child_care.html

This program provides mental health professionals to work in schools by providing a liaison service between the school and children's families and information to assist with navigation of the mental health system and with the goal of promoting school success and in assuring that children with emotional disturbances remain in regular classrooms.

Violence and Bullying Prevention Program

<http://state.tn.us/mental/index.html>

This is a TDMHDD program designed for youth in grades four and five in six Tennessee counties. The focus of the program is to enhance resiliency, and improve impulse control and anger management.

Project HEROES

<http://www.johnsoncitypress.com/News/article.php?ID=81888>

An initiative through a partnership between Johnson City schools and Frontier Health to assist in case management, early intervention, counseling and communication of students with mental health issues.

Tennessee Department of Health Rape Prevention Education Program

<http://health.state.tn.us/healthpromotion/#ViolenceSexualAssaultPrevention>

This program provides education to middle and high school youth through the local health departments across the state. The seven rape crisis centers provide training to professionals and community education.

Tennessee Non-Smoker's Protection Act

<http://health.state.tn.us/smokefreetennessee/>

This Act makes it illegal to smoke in all enclosed public places within the State of Tennessee with a few exceptions. The smoking ban applies, but is not limited to: restaurants, educational facilities, hotels, retail stores, sports arenas, and child care facilities.

Tennessee Tobacco Quit Line

<http://health.state.tn.us/tobaccoquitline.htm>

The Tennessee Tobacco QuitLine is a “toll-free telephone service that provides personalized support for Tennesseans who want to quit smoking or chewing tobacco.”

Tennessee's Partnerships for Success

<http://csap.samhsa.gov/grants/partnerships.aspx>

http://state.tn.us/mental/A&D/treat_serv.html

The project aims to decrease binge drinking and prevent the onset and progression of substance abuse among 14-25 year olds as well as “strengthen prevention capacity and infrastructure at the state and county levels.”

Tennessee Department of Mental Health and Developmental Disabilities Alcohol and Drug Abuse Treatment program

http://state.tn.us/mental/A&D/treat_serv.html

A statewide program that provides alcohol and drug abuse treatment for DUI offenders.

Community Treatment Collaborative

<http://tennessee.gov/mental/A&D/bopp/txservicesguidelines.pdf>

An initiative to prevent at risk parole and probation violators with co-occurring disorders or substance abuse issues from returning to prison.

Co-occurring Disorders Treatment Initiative

<http://www.state.tn.us/mental/A&D/cod/index.html>

This program provides training and assistance to licensed alcohol and drug abuse treatment agencies to receive certification to deliver co-occurring substance use and mental health disorders treatment.

Community Anti-Drug Coalitions

<http://www.cadcat.org/>

Coalitions conduct environmental strategies that aim to: “limit access to substances, change the culture and contexts within which decisions about substance use are made, and/or reduce the prevalence of negative consequences associated with substances.”

Tennessee Department of Mental Health and Developmental Disabilities Wellness Recovery Program

<http://news.tennesseeanytime.org/node/6048>

This program educates those with a mental illness or co-occurring disorder of mental illness and substance abuse about mental illness and treatment through a peer-led course on mental illness, mental health treatment, and self-help skills.

TennCare CHOICES in Long-Term Care program

<http://www.tn.gov/tenncare/CHOICES/>

This program is for long-term care home and community based services such as a nursing home and activities of daily living.

Tennessee Department of Human Services Homemaker Program

http://tn.gov/humanserv/adfam/afs_hp.html

Through a referral from Adult Protective Services, this program allows vulnerable adults to remain in their homes by providing personal care services through a network of community agencies.

Tennessee Department of Health Faith-Based Health Initiative

<http://health.state.tn.us/dmhde/faith.shtml>

The goals of this initiative are to: reduce health disparities throughout the through the “It’s About Time! Initiative,” identify opportunities and sustain relationships between public health and faith communities for active collaborations, and connect Department of Health resources with faith communities to promote healthy practices.

Emotional Fitness Centers

www.emotionalfitnesscenter.org

This is a “public, private, faith-based mental health pilot program that will address utilization disparity and under-utilization of mental health services in Memphis, Tennessee and the surrounding area by removing the stigma often associated with mental health services in minority communities.”

JustCare Family Network

http://state.tn.us/mental/specialpops/sp_child_sysCare.html

This network is a public-private partnership that aims “to offer an effective approach to delivering mental health services and system transformation through an enhanced culturally competent, family-driven and coordinated system of care,” for children and youth ages 5-19 especially African-American youth in the juvenile justice system.

Projects for Assistance in Transition from Homelessness

http://state.tn.us/mental/recovery/path_description.html

This is a federal grant program to assist people who are homeless and who are diagnosed with mental illness and co-occurring disorders through community-based outreach, mental health, substance abuse, case management, and other support services as well as limited housing services.

Adult Protective Services

http://www.tennessee.gov/humanserv/adfam/afs_aps.html

Adult Protective Services staff investigate reports of abuse, neglect (including self-neglect) or financial exploitation of adults who are unable to protect themselves due to a physical or mental limitation.

Juvenile Court Ordered Mental Health Evaluation Services

<http://www.tennessee.gov/mental/policy/forensic3.html>

This program allows for the mandate a mental health evaluation for youth who are referred to juvenile court for delinquency who have been charged with a felony-level offense. These evaluations identify whether the child is mentally ill or developmentally disabled, if any services are recommended and where they may be found, whether the child meets commitment criteria, and any other specific court-related issues ordered (e.g. competence to stand trial).

Governor's Office for Children's Care Coordination Centers of Excellence

615-741-5192

Centers of Excellence for Children in State Custody (COEs) are a “statewide network of tertiary care academic medical centers and provider agencies with expertise in children’s physical and behavioral health” that focus on “improving the comprehensive well-being of children in or at risk of coming into state custody” through “evaluation and consultation services for children who are victims of abuse and trauma as well as training in evidence-based practices for mental health providers.”

HIV/AIDS Early Intervention Services Program

http://state.tn.us/mental/A&D/treat_serv.html

This program is designed to educate consumers with a substance use disorder or co-occurring disorder in healthy choices that prevent HIV infection or its spread. HIV rapid testing is also offered as well as medical and psychosocial supports if the test is positive.

Access to Care

Medically-Monitored Crisis Detoxification Units

http://state.tn.us/mental/A&D/treat_serv.html

These units provide comprehensive short-term alcohol and drug detoxification services including evaluation and withdrawal management, observation, monitoring, and treatment 24 hours, seven days a week. Patients are referred upon discharge to treatment providers and follow-up care.

Tennessee Department of Health School-Based Dental Prevention Program

<http://health.state.tn.us/oralhealth/schoolbased.html>

This statewide, school based preventive dental targets children in grades kindergarten through eighth in schools with 50% or more free and reduced lunch. Screenings, referrals and follow-up care are provided as well as health education and preventive sealants.

Behavioral Safety Net of TN

<http://www.state.tn.us/mental/safetynet.html>

This service is designed to “meet basic medication and treatment needs of individuals and includes assessment, evaluation, diagnostic, therapeutic intervention, case management, pharmacologic management, labs related to medication management, and pharmacy assistance and coordination.”

Crisis Stabilization Units

http://www.state.tn.us/mental/recovery/crisis_serv.html

These units provide walk-in and short-term stabilization services 24-hours, seven days a week, for individuals with mental health and substance abuse issues through “assessment, triage, medication management, and group and individual therapy as well as opportunities for clients to work with a wellness recovery consumer specialist.”

Tennessee Department of Mental Health and Developmental Disabilities Regional Mental Health Institute Initiatives

<http://tennessee.gov/mental/mhs/mhs2.html>

The TDMHDD operates Regional Mental Health Institutes (RMHIs) to admit persons in need of inpatient psychiatric services regardless of ability to pay.

Regional Mental Health Institute Telemedicine Project

<http://tennessee.gov/mental/mhs/mhs2.html>

This project aims to “expedite the assessment process, avoid unnecessary transportation to RMHIs of individuals who do not meet criteria for emergency involuntary admission, and eliminate the current assessment wait time for law enforcement upon arrival at an RMHI.”

Upper Cumberland Human Resources Agency

<http://www.uchra.com/transportation.html>

This transit system provides “public transportation to rural residents of all ages, giving first priority to elderly, handicapped and economically disadvantaged with medical needs while providing deviated, fixed route and demand-response service.”

Dispensary of Hope

<http://dispensaryofhope.org/>

A non-profit venture that provides access to affordable medications for those patients without other means to purchase them.

Mobile Crisis Response Services

<http://www.recoverywithinreach.org/treatment/consumerrights/mobilecrisis>

This service ensures that Tennesseans have access to behavioral health services 24 hours a day, 7 days a week and can be provided over the phone or face to face to any location that has been deemed safe for both the individual and responders involved. Telehealth services are in use to assist with the provision of this service in several Tennessee locations.

CoverTennessee

<http://www.covertn.gov/>

This program is “a partnership between the state, employers and individuals that makes health care coverage affordable for the state's working uninsured.”

Tennessee Division of Intellectual Disabilities Dental Board

<http://www.state.tn.us/dids/>

Volunteer State Health Plan

<http://www.state.tn.us/dids/>

Economic Efficiencies

Tennessee Department of Health licensure requirements

<http://health.state.tn.us/licensure/>

Provides licensure requirements and services to health care facilities.

Tennessee Department of Mental Health and Developmental Disabilities licensure

<http://state.tn.us/mental/licensure/licensure.html>

TDMHDD licenses agencies that provide mental health, mental retardation, alcohol and drug, and personal support services in order to ensure the safety of these services and protect individuals against unlicensed providers, unsafe environments, inadequate training of personnel, physical and mental abuse and any acts deemed detrimental to the treatment and general welfare of persons.

US Preventive Task Force Recommendations

<http://www.uspreventiveservicestaskforce.org/>

The USPSTF conducts scientific evidence reviews of a broad range of clinical preventive health care services (such as screening, counseling, and preventive medications) and develops recommendations for primary care clinicians and health systems. These recommendations are published in the form of "Recommendation Statements."

Tennessee All-Payer Claims Database

<http://www.tn.gov/finance/healthplanning/dataWarehouse.shtml>

In response to a law Tennessee is creating an all payer claims database, which may be used by the state of Tennessee to: improve patient healthcare and healthcare coverage, identify health and healthcare needs, determine the capacity of existing healthcare resources, evaluate the effectiveness of intervention

programs, review costs among various treatment settings and providers, and provide information on healthcare providers' quality of care.

Tennessee Health Information Committee

<http://www.tn.gov/finance/healthplanning/THICfirstmeeting.shtml>

A committee composed of stakeholders from different groups to guide the development of Tennessee's All Payer Claims database.

Tennessee Health Information Exchanges

<http://news.tnanytime.org/ehealth/advancingHIE.html>

A system established to: “give clinicians vital, secure, decision-ready information at the point of care; empower patients to take charge of their health decisions by having their own health information available; and leverage the capabilities within HIE to benefit public health in general.”

eValue8

<http://evaluate8.org/>

An evidence based request for information tool used to measure the quality and performance of health care vendors.

Office of eHealth Initiatives Internal Health Council programs

<http://www.tennesseeanytime.org/ehealth/IHC.html>

The purpose of the Internal Health Council “is to guide the state’s policies, priorities and programs related to Health Information Exchange and Health IT.” This council is comprised of cabinet members from state departments and agencies involved with health IT and/or the electronic exchange of health information.

Health Information Partnership of Tennessee initiatives

<http://www.hiptn.org/>

A public-private partnership to improve the health of people served in Tennessee by sharing of appropriate health information through local and regional Health Information Exchanges, as well as in areas not yet covered by exchange.

Quality of Care

TennCare Managed Care Organizations

<http://www.tn.gov/tenncare/pro-mcos.html>

TennCare services are provided through managed care entities which vary from region to region.

Tennessee Department of Health Healthcare-Associated Infections plan

<http://health.state.tn.us/Ceds/HAI/index.htm>

A statewide plan to manage the coordination and collaboration of stakeholders and facilities to prevent or control healthcare-associated infections.

Healthy Memphis Common Table

<http://healthymemphis.org/>

The Healthy Memphis Common Table is a non-profit organization whose mission is “to mobilize Greater Memphis to achieve excellent health for all.” They are a regional health and healthcare improvement collaborative comprised of individuals, organizations, and coalitions.

Carespark

<http://carespark.com/dev/>

CareSpark is a regional non-profit coalition of healthcare, business and community leaders whose mission is to “improve the health of the region through the collaborative use of health information for the residents of east Tennessee and southwest Virginia.” This is accomplished through a system that provides secure exchanges of information among health care providers and facilities.

Midsouth eHealth Alliance

<http://www.midsoutheha.org/>

MidSouth eHealth Alliance (MSEHA) is a non-profit initiative that provides an electronic exchange of health information for physicians to improve the quality, safety, and efficiency of health care.

Centers for Medicaid and Medicare Services Care Transitions program

<http://www.cms.gov/QualityImprovementOrgs/downloads/CAREFSUpdate062509.pdf>

A program that aims to “reduce readmissions following hospitalization and to yield sustainable and replicable strategies to achieve high-value health care for sick and disabled Medicare beneficiaries.”

Shared Health

<http://www.sharedhealth.com/>

Shared Health® uses the secure exchange of medical information and online decision support tools provided to health care providers to improve the efficiency and quality of patient care while maintaining or improving costs.

Memphis Business Group on Health

<http://www.memphisbusinessgroup.org/>

Memphis Business Group on Health is a coalition of member employers that provides best practice sharing, market data, and other tools to help members manage the cost and quality of health benefits for their employees as well as making value-based purchasing decisions.

Illness Management and Recovery Program

<http://tmhca-tn.org/about/>

This evidence-based practice emphasizes utilizing information learned about mental illness through practical application by the development of personal goals.

Tennessee Department of Mental Health and Developmental Disabilities Best Practice Guidelines

<http://www.tennessee.gov/mental/omd/omdbpg.html>

These guidelines promote quality care for children and adolescents by establishing uniform treatment options and the best use of multidisciplinary treatment resources as well as identifying and providing treatment for youth with severe mental illness and/or severe emotional disorders.

Robert Wood Johnson Foundation “The Chronic Care Model”

<http://www.improvingchroniccare.org/>

A model derived from Improving Chronic Illness Care that provides a summary of the basic elements for improving care in health systems at the patient, practice organization, and community levels.

Healthcare Workforce

National Health Service Corp Program

<http://nhsc.bhpr.hrsa.gov/about/>

The National Health Service Corps, provides scholarship and loan repayment programs to recruit medical, dental, and mental health providers to meet the need for health care providers in Health Professional Shortage Areas in the U.S.

Tennessee Department of Health’s Health Access Incentive

<http://health.state.tn.us/rural/haip.html>

This initiative provides incentives in the form of grants to health care providers who agree to serve for three years in an area of health care shortage.

Health Access Community Initiative program

<http://health.state.tn.us/rural/haip.html>

This initiative provides funds for underserved communities to recruit or retain health professionals.

The Rural Partnership’s Rural Rotation Project

<http://theruralpartnership.com/about/>

Provides opportunities for students and residents to gain exposure to serving in a rural area in Tennessee.

Area Health Education Centers Program

<http://www.mmc.edu/education/medical/ahec/index.htm>

The mission of this program is “to improve the supply and distribution of health care professionals-with an emphasis on primary care-in urban and rural Tennessee to increase the provision of and access to culturally appropriate, quality health care and decrease disparities among disadvantaged and underserved populations.”

ETSU Community-Academic Partnership

<http://www.etsu.edu/kellogg/>

This partnership connects East Tennessee State University to local communities (Rogersville and Mountain City, TN) in order to facilitate academically-based service and learning opportunities for students and community members.

Race to the Top

<http://www2.ed.gov/programs/racetothetop/index.html>

A government funded program that assists in preparing students to succeed in college and the workplace. It establishes parameters and standards to measure student performance as well as recruits effective teachers and turns around low-achieving schools.

Science, Technology, Engineering, Math program

<http://www.state.tn.us/sos/pub/execorders/exec-orders-bred68.pdf>

Through the Department of Education, this program is charged with “promoting and expanding the teaching and learning of science, technology, engineering and mathematics (STEM) education in K-12 public schools across Tennessee.”

Tennessee Primary Care Association Student/resident Experiences and Rotations in Community Health program

<http://www.tnpca.org/displaycommon.cfm?an=1&subarticlenbr=96>

Health care students and residents have the opportunity to learn in a community-based practice in an underserved area. SEARCH students gain primary care training experience working with patients in underserved urban and rural areas at Community Health Centers throughout Tennessee.

Tennessee Hospital Association Agenda-21 Program

<http://www.tha.com/agenda21/index.htm>

Agenda 21 is a twelve-week paid summer internship for “minority students pursuing a degree of concentration in health services management, public policy, healthcare financial management, or healthcare administration.” Students have senior management staff mentors and gain first-hand experience of the operations and management issues.

Tennessee Department of Mental Health and Developmental Disabilities community-academic partnerships

These partnerships are in conjunction with several schools, including Vanderbilt University, Middle Tennessee State University, Fisk University, University of Tennessee Health Science Center, and Meharry Medical College. These relationships provide educational activities, internships, and clinical rotations for a variety of mental healthcare professionals that allow students to become aware of opportunities available in the public mental health sector.

Tennessee Interdisciplinary Health Policy Program

<http://www.tennessee.gov/mental/omd/omdTIHPP.html>

The Tennessee Interdisciplinary Health Policy Program by provides monthly internships where medical, law, and pharmacy students can participate as a group in a government agency-sponsored program to learn the value of a multi-disciplinary approach to health care policy development.

Tennessee Department of Health Provider Trainings

<http://health.state.tn.us/providers.htm#training>

East Tennessee State University Public Health Training Center

<http://www.johnsoncitypress.com/News/article.php?ID=81540>

East Tennessee State University, partnering with Meharry College of Medicine, the University of Memphis, and the University of Tennessee, is preparing to launch a Tennessee Long-Distance Internet Facilitated Educational Program for Applied Training in Health to provide regional public health training events for local and state health officials.

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