

# DIVISION OF HEALTH PLANNING

## 2013 ANNUAL REPORT



State of Tennessee  
Department of Health

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Commissioner John J. Dreyzehner, MD, MPH

# DIVISION OF HEALTH PLANNING 2013 ANNUAL REPORT

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## FROM THE COMMISSIONER OF HEALTH

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This past year, the Division of Health Planning accomplished a variety of objectives, falling into three main areas:

1. Updating the State Health Plan and revising critical Certificate of Need program area standards and criteria;
2. Supporting and advising the Department of Health on a wide variety of initiatives, including the impact of the Affordable Care Act on local health departments; and the more than 800,000 citizens directly served by department healthcare programs; as well as the impact on other state safety net providers with outreach and a key stakeholder meeting; and
3. Providing and participating in opportunities for coordinated action among the Department of Health, TennCare, Department of Mental Health and Substance Abuse Services and other state agencies.

The 2013 Update to the State Health Plan focuses on providing current information on the health status of Tennesseans, including the Administration's efforts to reduce obesity and substance abuse, the state's improvement over the past five years in specific health outcomes and determinants and the TDH's additional emphasis on health protection and security, including primary prevention, as well as updating Certificate of Need standards and criteria. In accordance with statutory authority, the 2013 Update will be presented to Governor Bill Haslam this spring for his approval and adoption.

In 2014, The Division of Health Planning will undertake a statewide public process to update the Goals and develop Objectives in the State Health Plan. The Division will also continue its work coordinating and leveraging relevant state programs and services to optimize health outcomes and value for Tennesseans and to improve the effectiveness of our health care system.

This Annual Report provides a summary of these efforts and other work we accomplished in calendar year 2013 and what we plan to accomplish in 2014. We look forward to working to implement the State Health Plan and to completing a comprehensive update to the State Health Plan.

John J. Dreyzehner, MD, MPH  
Commissioner  
Department of Health

## INTRODUCTION AND OVERVIEW

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The development and continual updating of a comprehensive plan – the State Health Plan – is critical for success in improving health outcomes and the value of health care delivered. “Health outcomes” for the purposes of health planning includes the health of individuals as well as of the general population and the State Health Plan has a particular focus on reducing obesity and substance abuse. The plan also embraces the notion of “value,” ensuring that investments in improving health are wisely targeted and stresses the importance of primary prevention in improving the health of Tennesseans.

The responsibility for improving the health of Tennesseans is housed among multiple state departments and agencies – each with its own statutory responsibilities, plans and strategies to meet them. The Division of Health Planning was created by statute to ensure that relevant programs and services across state government are coordinated and leveraged to optimize health outcomes and value for Tennesseans.<sup>1</sup>

Last year, Tennessee’s ranking remained at 42nd in the nation in health status,<sup>2</sup> although 14 specific areas showed improving trends over time (please see Appendix B). TDH has set a vision for Tennessee to reach the top ten in this national ranking. However, despite our improvements, Tennessee’s ranking still means Tennesseans compare poorly on many important indicators of quality of life and life expectancy. Tennessee’s comparatively overall poor health also represents a costly burden on every business, city, county and taxpayer in Tennessee. Because the economic cost of poor health is so large, improving health outcomes and health value in Tennessee offers the potential for a significant return on investment.

We are fortunate in Tennessee to have a number of government programs and non-governmental organizations dedicated to the improvement of health quality and health care cost containment. These groups make important contributions independently and should make an even greater impact by working collaboratively.

The state’s role in promoting the health of Tennesseans is multi-pronged. The state is the public health authority and provider of critical health services and primary prevention activities through the Department of Health, the Department of Mental Health and Substance Abuse Services and the Department of Intellectual and Developmental Disabilities. The state is also the prison health authority, the provider and coordinator of children’s care programs, the facilitator for advancement in health information technology and the grantor of certificates of need for specific health care services and facilities. In addition, the state is a major purchaser of health insurance, the licensor and regulator of health and health insurance services, an employer/health insurance purchaser, a provider and the

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<sup>1</sup> See Appendix A for a full discussion of the roles and duties set forth by the enabling statute.

<sup>2</sup> United Health Foundation’s America’s Health Rankings, found at <http://www.americashealthrankings.org>

promoter of Tennessee's health care industry. Finally and importantly, the state is a driving force behind improving the education levels of its residents, a factor well connected to improved health status later in life.

A comprehensive plan is necessary to coordinate these many roles and to bring to the table Tennessee's many health and health care stakeholders. Through a central, comprehensive State Health Plan, Tennessee can assess gaps and coordinate efforts to reach the goals it sets out.

## DIVISION OF HEALTH PLANNING ACCOMPLISHMENTS, 2013

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2013 was the year for the fourth update to the State Health Plan that was developed in 2009, fulfilling our primary statutory obligation. The 2013 update provides updated information, including some important trending data, on the health of Tennesseans and updated standards and criteria for two Certificate of Need program areas. The Division in 2013 also advised the Department of Health on a wide variety of programs and initiatives, including the probable impact of the Affordable Care Act on its operations and coordinated several opportunities for collaboration among the Department of Health and other state agencies.

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### The 2013 Update to the State Health Plan

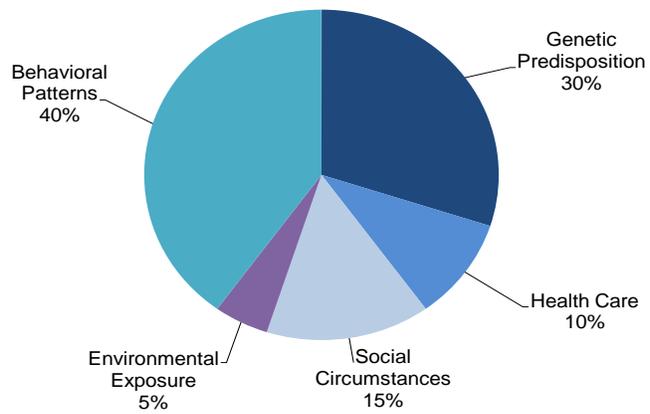
The 2013 Update to the State Health Plan reports on the health status of Tennesseans, including the Administration's efforts to reduce obesity and substance abuse and the TDH's additional emphasis on primary prevention and revises two Certificate of Need program area standards and criteria.

Most gains in human health as reflected in broad population health measures of life expectancy and infant mortality have resulted from protective measures taken prior to onset of disease or injury. On these measures, the United States is a significant health outlier. By any measure—absolute, percentage of GDP, per capita—we spend more money on health care than any other nation in the world. Incredibly, we also have the poorest collective health status of any developed nation: an infant mortality rate of 6 per 1000 live births (ranking the US 37th in the world) and a life expectancy of 79.8 (ranking the US 35th in the world).

The health status of Tennesseans is worse than that of the residents of most other states. At the same time, health care is a relatively small element of the determinants of a population's health. According to an often-cited study, health care accounts for 10 percent of a population's health.<sup>3</sup>

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<sup>3</sup> McGinnis JM and Foege WH. Actual causes of death in the United States. JAMA 1993; 270(18) 2207-12 (Nov 10). McGinnis JM, Williams-Russo P, & Knickman JR. The case for more active policy attention to health promotion. Health Affairs 2002; 21(2):78-93 (Mar).



Source: Schroeder, Steven. "We Can Do Better – Improving the Health of the American People." NEJM. September 2007. Adapted from McGinnis et.al.

In 2013, Tennessee's national health status ranking, comprised of measurements of outcomes and determinants, remained at 42<sup>nd</sup>. Importantly, Tennessee has gradually improved over time in 14 critical outcomes and determinants of health (set out in Appendix B). To address the goal of improving the health of Tennesseans, the identification of specific outcomes and determinants that negatively impact these rankings is essential; the TDH has begun the process of this work and of identifying other state agencies that are critical to implementation of changes that will improve Tennessee's ranking. As real health disparities in health status of populations and places are identified, action to address them will be necessary to overall population health improvement. An improved understanding of the underlying personal behaviors, place-based conditions and service issues that affect these outcomes will identify differences and disparities needed to be changed to improve these rankings. These actions, taken across state departments, will end up addressing the State Health Plan's remaining Principles to Achieving Better Health of access, resources, quality and workforce.

Prior to the Governor's approval and adoption, as required by law the 2013 Update to the State Health Plan will be reviewed by the Health Services and Development Agency (HSDA) for inclusion of its comments. The Division is submitting the 2013 Update to the State Health Plan to Governor Haslam for approval and adoption, as required by statute, this spring.

The framework for the State Health Plan is based upon the Five Principles for Achieving Better Health identified by an Advisory Committee and taken from the statutory policy statement:

1. The purpose of the State Health Plan is to improve the health of Tennesseans;
2. Every citizen should have reasonable access to health care;
3. 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;
4. Every citizen should have confidence that the quality of health care is continually monitored and standards are adhered to by health care providers; and
5. The state should support the development, recruitment and retention of a sufficient and quality health care workforce.

As required by statute, the Division has established with the Governor's Office a process for timely modification of the State Health Plan in response to changes in

technology and reimbursement, as well as other developments that affect the delivery of health care and the improvement of the health status of Tennesseans. This process anticipates annual preparation of modifications to the State Health Plan for approval and adoption by the Governor and provides for the ability by the Division of Health Planning to prepare modifications on an ad hoc basis.

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## Reviewing and Revising Certificate of Need Standards

With the advice of the HSDA, stakeholders and the general public, in 2013 the Division revised the CON standards and criteria for Home Health Services and Nursing Home Services. These revised standards and criteria are included in the 2013 Update to the State Health Plan. The Division followed an extensive public process for each revision, discussed below. The Division is currently revising the standards and criteria for Mental Health Residential Treatment Facilities and is in the research stage for preparing revisions to the standards and criteria for Nonresidential Substitution-based Treatment Centers for Opiate Addiction and for the Discontinuance of Obstetrical Services. The following table shows the progress made in revising the CON standards and criteria since 2009.

**Table 1: Status and Schedule for revising CON category standards and criteria**

| Category   | Status                                    |
|--|---|
| 1. Positron Emission Tomography (PET) Services                               | Completed, 2009                           |
| 2. Cardiac Catheterization Services  | Completed, 2009                           |
| 3. Open Heart Surgery Services   | Completed, 2010                           |
| 4. ESWL (Lithotripsy)  | Completed, 2010                           |
| 5. Magnetic Resonance Imaging  | Completed, 2011                           |
| 6. Megavoltage Radiation Therapy Services                                    | Completed, 2011                           |
| 7. Ambulatory Surgical Treatment Centers                                     | Completed, 2012                           |
| 8. Hospice Services  | Completed, 2012                           |
| 9. Home Health Services  | Included in 2013 State Health Plan Update |
| 10. Nursing Home Services  | Included in 2013 State Health Plan Update |
| 11. Mental Health Residential Treatment Facilities                           | Under revision                            |
| 12. Nonresidential Substitution-based Treatment Centers for Opiate Addiction | Researching                               |
| 13. Discontinuance of Obstetrical Services                                   | Researching                               |

## The Public Process for Revising CON Program Area Standards and Criteria:

The Division has established the following thorough and transparent process for revising CON program area standards and criteria:

1. The Division staff researches the issues, paying particular attention to national professional standards and other states' CON standards. The Health Services and Development Agency staff provides additional resources in this process, including research and information on specific issues encountered with recent CON applications.
2. Division staff members conduct interviews with as broad a range of stakeholders as is possible (e.g., for-profit, non-profit, urban, rural, hospital-based, non-hospital-based, etc.) to gain additional expert insight.
3. From the interviews, additional questions are developed and distributed to stakeholders for responses.
4. The responses to the questions are used to develop a draft of revised standards and criteria. This draft is sent out to stakeholders for comment, including the Health Services and Development Agency.
5. Division staff members conduct a public hearing on the draft revisions.
6. Revised standards and criteria are then finalized and included in the draft update to the State Health Plan for eventual approval and adoption by the Governor.

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## Other Health Planning Division Activities

The Division works collaboratively with many health and health care related entities inside and outside state government. For example, in 2013:

- Division staff analyzed the Affordable Care Act and advised the TDH on its impact on TDH local health departments
- Division staff worked with TDH School Based Dental Prevention Program and TennCare to assess the impact of the state's Dental Sealants Program
- The Division's Director served as a board member for the Tennessee Institute of Public Health.
- The Division's Director served on the Tennessee Hospital Association's Workforce Advisory Committee
- Division staff coordinated the development of the Population Health discussion and researched the adequacy of the number of physicians, nurses and mid-level professionals for a TennCare SIMs grant application
- Division staff members participated on the Tennessee Obesity Task Force
- The Division's Director was appointed by the Governor to serve on the state Mental Health and Substance Abuse Services Task Force

- The Division planned and hosted a multi-day inter-agency Evidence-Informed Health Policy Workshop
- The Division's Director spoke at the Tennessee Rural Health Association annual meeting and staff worked with the TDH Division of Rural Health and The Rural Partnership to align their recruitment efforts.

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## Future Work

During 2014, the Division will undertake a public process to update the State Health Plan, focusing on creating a state agency-wide document for improving the health of Tennesseans, focusing on primary prevention. This update will 1) determine which existing Goals should be the focus of the state's efforts to improve the health status of Tennesseans and 2) develop measurable Objectives for those Goals. The process has the following components:

1. Create Goal Teams of experts and stakeholders to review Goals and develop proposed Objectives;
2. Meet with certain Local Health Departments to receive input on local population health issues;
3. Hold Regional Health Council meetings to receive input on Goals and Objectives;
4. Develop and send an electronic survey to the public at large; and
5. Hold Regional Public meetings in each Congressional District to receive public input on Goals, proposed Objectives and other matters.

Additionally, the Division will continue to promote the State Health Plan's policy priorities, goals and strategies, incorporating this work with a new emphasis on the economics of primary prevention. Further, the Division will continue its work revising Certificate of Need program area standards and criteria and developing health status trend analyses.

## Appendix A

### About the Division of Health Planning:

#### Primary Roles

The Division of Health Planning was created by action of the Tennessee General Assembly and signed into law in 2004 (TCA § 68-11-1625). It is charged with three primary roles:

- Creating a State Health Plan that:
  - guides state health care programs and policies and
  - guides the allocation of state health care resources
- Providing policy guidance to:
  - Respond to requests for comment and recommendations for health care policies and programs and
  - Review and comment on federal laws and regulations
- Assessing health resources and outcomes to:
  - Conduct an ongoing evaluation of Tennessee's resources for accessibility (financial, geographic, cultural and quality) and
  - Review the health status of Tennesseans

#### Additional Duties:

The Division has the following additional specific duties set out by statute:

- Regarding the State Health Plan:
  1. To submit the State Health Plan to the Health Services and Development Agency for comment;
  2. To submit the State Health Plan to the Governor for approval and adoption;
  3. To hold public hearings as needed;
  4. To review and evaluate the State Health Plan at least annually;
  5. 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.
- Other statutory duties are:
  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; and
11. To prepare an annual report for the General Assembly and recommend legislation for its consideration and study.

## Appendix B Tennessee's Improving Health Trends

### Tennessee's Improving Trends

Shown in the following chart are fourteen health determinants and outcomes in which Tennessee has shown gradual improvement over the past five years. However, even with these improvements, Tennessee still lags behind most of the rest of the country in many of these areas, as well as others (source: America's Health Rankings 2013). Statistically significant improvements are shown in *Italics*.

|                                    | Measure                             | Definition   | TN Rank | TN Value | Change 2009-13 |
|------------------------------------|-------------------------------------|--|---------|----------|----------------|
| <b>Determinants</b>                |                                     |  |         |          |                |
| <b>Behaviors</b>                   |                                     |  |         |          |                |
|                                    | <b>Obesity</b>                      | Percentage of population over age 18 estimated to be obese, with a body mass index (BMI) of 30 or higher.  | 35      | 29.2%    | ↓ 0.1%         |
|                                    | <b>High School Graduation</b>       | Percentage of incoming ninth graders who graduate in four years from a high school with a regular degree.  | 24      | 77.4%    | ↑ 11.9%        |
| <b>Community &amp; Environment</b> |                                     |  |         |          |                |
|                                    | <b>Violent Crime</b>                | Number of murders, rapes, robberies and aggravated assaults per 100,000 population.  | 47      | 613      | ↓ 78           |
|                                    | <b>Occupational Fatalities</b>      | Number of fatalities from occupational injuries per 100,000 workers.   | 36      | 5.4      | ↑ 0.3          |
|                                    | <b>Air Pollution</b>                | Average exposure of the general public to particulate matter of 2.5 microns or less in size (PM2.5).   | 37      | 10.4     | ↓ 2.9          |
| <b>Policy</b>                      |                                     |  |         |          |                |
|                                    | <b>Lack of Health Insurance</b>     | Percentage of the population that does not have health insurance privately, through their employer, or the government.   | 23      | 13.9%    | ↓ 1.1%         |
|                                    | <b>Public Health Funding</b>        | State funding dedicated to public health as well as federal funding directed to states by the Centers for Disease Control and Prevention and the Health Resources and Services Administration. | 21      | \$83     | ↑ \$1.75       |
| <b>Clinical Care</b>               |                                     |  |         |          |                |
|                                    | <b>Low Birthweight</b>              | Percentage of babies weighing less than 2,500 grams (5 pounds, 8 ounces) at birth.   | 42      | 9%       | ↓ 0.6%         |
|                                    | <b>Primary Care Physicians</b>      | Number of primary care physicians (including general practice, family practice, OB-GYN, pediatrics and internal medicine) per 100,000 population.  | 20      | 120.4    | ↑ 1.4          |
|                                    | <b>Preventable Hospitalizations</b> | Discharge rate among the Medicare population for diagnoses that are amenable to non-hospital based care.   | 46      | 83.4     | ↓ 11.1         |
| <b>Outcomes</b>                    |                                     |  |         |          |                |
|                                    | <b>Infant Mortality</b>             | Number of infant deaths (before age 1) per 1,000 live births.  | 45      | 8.1      | ↓ 0.8          |
|                                    | <b>Cardiovascular Deaths</b>        | Number of deaths due to all cardiovascular diseases, including heart disease and strokes, per 100,000 population.  | 44      | 310.4    | ↓ 28.8         |
|                                    | <b>Cancer Deaths</b>                | Number of deaths due to all causes of cancer per 100,000 population.   | 45      | 204      | ↓ 0.5          |
|                                    | <b>Premature Death</b>              | Number of years of potential life lost prior to age 75 per 100,000 population.   | 43      | 9513     | ↓ 198          |



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