

Tennessee Rural Health Care Task Force

Improving Rural Health Care Across Tennessee



June 2023

Acknowledgement

Governor Lee,

On behalf of the Tennessee Rural Health Care Task Force, we first want to express our gratitude for your support in establishing this Task Force and recognizing the importance of addressing the health care needs of our State's rural communities. Over the past 12 months, we have had the privilege of leading a diverse and dedicated group of 34 Task Force members representing a broad array of stakeholders, including public and private organizations, State agency representatives, and legislators who have demonstrated unwavering commitment to the work of the Task Force and dedication to improving health and health outcomes in rural Tennessee.

From the outset, we were faced with the difficult challenge of addressing the unique health care needs of rural Tennessee. However, with the invaluable insights of the Task Force members, we are proud to present these high impact recommendations which, if implemented, will significantly improve health access and outcomes for rural Tennesseans.

Through rigorous research, analysis, and collaboration, we have identified key areas for policy and funding investment in this comprehensive set of recommendations that we believe will have a lasting impact on the health care landscape in our State. From addressing high priority access to care challenges, enhancing workforce development efforts, and supporting community-driven initiatives to improve social drivers of health, we believe that our recommendations will help to ensure that rural communities across Tennessee have access to the health care services they need and deserve.

As we conclude our work, we would like to once again express our sincere gratitude for your leadership and support in establishing the Rural Health Care Task Force. We would also like to extend our thanks to each individual Task Force member for their tireless efforts and time they have devoted to the health and wellbeing of rural Tennesseans.

Sincerely,



Morgan McDonald, MD, FAAP, FACP

Task Force Co-Chair



David Dill

Task Force Co-Chair

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Executive Summary

Tennessee's rural communities face unique health care challenges that impact both physical and behavioral health. Rural Tennesseans often experience diminished access to care, in part due to limited availability of health care facilities, long travel times to receive care, workforce shortages for high-demand health care professions, and a high cost of health care.^{1,2} Rural community members also experience distinct social and environmental obstacles which can contribute to poor health outcomes, including mental health challenges, obesity, and substance misuse.³

In recent years, Tennessee has prioritized programs and resources to improve rural health care, including the Health Care Modernization Task Force, Healthy Smiles Initiative, Tennessee Rural Hospital Transformation Act of 2018, Tennessee Broadband Accessibility Act, and the Small and Rural Hospital Readiness Grant Program.^{4,5,6,7} Relying on data to drive outcomes, the State has also expanded access to dental services for all adults receiving TennCare (i.e., Medicaid) benefits and extended postpartum benefit coverage to 12 months following the end of a pregnancy.^{8,9} Through these initiatives and others, the State's public and private partners underscored the importance of health care in rural communities and the need for future investment.

Recognizing the opportunity to build upon these initiatives, Governor Bill Lee established the Tennessee Rural Health Care Task Force ("Task Force"), led as a public-private partnership originating in the Tennessee Department of Health (TDH). Governor Lee charged the Task Force to develop a set of recommendations including innovative programs, policy and funding opportunities, and legislative agenda considerations, which will holistically improve rural health care across Tennessee.

Tennessee Rural Health Care Task Force Overview

The Task Force, chaired by TDH's former Interim Commissioner, Dr. Morgan McDonald, and Lifepoint Health's Chairman and Chief Executive Officer (CEO), David Dill, convened from May 2022 to June 2023. The Co-Chairs implemented a collaborative approach to identify focus areas and develop recommendations by engaging 34 diverse public and private

¹ *Tennessee Health Workforce Projections: 2021-2035*. Tennessee Hospital Association. 2022. <https://secure.tha.com/files/workforce/Tennessee-Health-Workforce-Projections-Report.pdf>

² *State-Level Projections of Supply and Demand for Behavioral Health Occupations: 2016-2030*. U.S. Department of Health and Human Services Health Resources and Services Administration Bureau of Health Workforce National Center for Health Workforce Analysis. 2018. <https://bhwh.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/state-level-estimates-report-2018.pdf>

³ Preliminary 2022 TDH County Health Assessment Data.

⁴ Lee Administration Health Care Modernization Task Force Formed. Department of Finance & Administration. 2019. <https://www.tn.gov/finance/news/2019/10/8/lee-administration-health-care-modernization-task-force-formed.html>

⁵ *Healthy Smiles Initiative. Improving Dental Access Across Tennessee*. 2021. https://wpln.org/wp-content/uploads/sites/7/2022/02/Healthy-Smiles-Initiative-Nov21_final.pdf

⁶ Rural Hospital Transformation Plans. Transparent Tennessee. 2020. <https://www.tn.gov/transparenttn/state-financial-overview/open-ecd/openecd/tneecd-performance-metrics/openecd-rural-community-development-quick-stats/rural-hospital-transformation-plans.html#:~:text=Originating%20from%20the%20Tennessee%20Rural,services%20in%20rural%20Tennessee%20communities>

⁷ Gov. Lee Announces \$10 Million in Small and Rural Hospital Readiness Grants. Office of the Governor. 2020. <https://www.tn.gov/governor/news/2020/4/6/gov-lee-announces--10-million-in-small-and-rural-hospital-readiness-grants.html>

⁸ Dental Services. Division of TennCare. [Dental Services \(tn.gov\)](https://www.tn.gov/tenncare/dental-services)

⁹ Medicaid Pregnancy and Postpartum Benefits. Division of TennCare. [Medicaid Pregnancy and Postpartum Benefits \(tn.gov\)](https://www.tn.gov/tenncare/medicaid-pregnancy-and-postpartum-benefits)

stakeholders to participate in the Task Force, including health care providers, community-based health centers and clinics, academic institutions, insurers, rural employers, retail corporations, health care associations, non-profit organizations, members from the General Assembly, and State agency representatives. Each stakeholder provided their unique perspective on strategies to improve rural health care across Tennessee.

While the Task Force recognized the numerous challenges impacting rural communities, Task Force members used recent rural health care trends and their collective knowledge of challenges facing rural Tennesseans to identify three priority areas that have downstream impacts on all rural Tennessee communities: Access to Care, Workforce Development, and Social Drivers of Health. The Co-Chairs created three workgroups to align with these priority areas and assigned Task Force members based on their respective areas of expertise, as shown in **Figure 1**. The Co-Chairs designated leads for each workgroup:

- Access to Care: Libby Thurman (CEO, Tennessee Primary Care Association [TPCA]),
- Workforce Development: Andrew Burnett (Vice President of Workforce Strategies and Rural Health, Tennessee Hospital Association [THA]), and
- Social Drivers of Health: Jacy Warrell (CEO, Rural Health Association of Tennessee [RHAT]).

Figure 1. Rural Health Care Task Force Membership

#	Name	Title	Organization
Task Force Co-Chairs			
1	Dr. Morgan McDonald	Former Interim Commissioner; National Director of Population Health	TN Department of Health; Milbank Memorial Fund
2	David Dill	Chairman and CEO	Lifepoint Health
Access to Care Workgroup			
3	Libby Thurman (Workgroup Lead)	CEO	Tennessee Primary Care Association
4	Michael Banks	CEO	Haywood County Community Hospital
5	Elizabeth Foy	Chief of Staff	TN Department of Health
6	Rep. Ron M. Gant	Representative	State of TN General Assembly
7	Alan Levine	Chairman, President, and CEO	Ballad Health
8	Jeff Parrish	State Counsel and Field Director	U.S. Senator Marsha Blackburn
9	Brad Smith	Chairman and CEO	Main Street Health
10	Stephen Smith	Deputy Commissioner and Director	TN Division of TennCare
11	Dr. Cathleen Suto	OB/GYN	Dayspring Health
12	Dr. Phil Wenk	CEO	Delta Dental of Tennessee
13	Dr. Eboni Winford	Director of Research and Health Equity	Cherokee Health Systems

#	Name	Title	Organization
Workforce Development Workgroup			
14	Andrew Burnett (Workgroup Lead)	Vice President of Workforce Strategies and Rural Health	Tennessee Hospital Association
15	Rep. Rebecca Alexander	Representative	State of TN General Assembly
16	Scott Barber	CEO	Dyersburg Hospital - West TN Healthcare
17	Dr. James Haynes	Dean, College of Medicine	University of Tennessee College of Medicine - Chattanooga
18	Amy Johnson	Interim Vice President of Academic Affairs and Student Success	Dyersburg State Community College
19	Dr. Paul Juarez	Professor and Director, Health Disparities Research Center of Excellence	Meharry Medical College
20	Leslie Meehan	Interim Deputy Commissioner of Population Health	TN Department of Health
21	Sabrina Parker	CEO	Helping Hands Middle & West Tennessee
22	John Rutledge	Former President and CEO	American Physician Partners
23	Sen. Bo Watson	Senator	State of TN General Assembly
24	Marie Williams	Commissioner	TN Department of Mental Health & Substance Abuse Services
25	Dr. Randy Wykoff	Dean, College of Public Health	East Tennessee State University
Social Drivers of Health Workgroup			
26	Jacy Warrell (Workgroup Lead)	CEO	Rural Health Association of Tennessee
27	Cristina Cáceres	Director of Community Resources	Centro Hispano de East TN
28	Cherrell Campbell-Street	Deputy Commissioner	TN Department of Human Services
29	Kevin Corkern	Health and Wellness Regional Senior Director	Walmart Stores
30	Dr. Kimberly Lamar	Assistant Commissioner - Office of Health Disparities Elimination	TN Department of Health
31	Dr. Lisa Piercey	Former Commissioner; CEO	TN Department of Health; Tristela Strategies, LLC
32	Rachel Powers Selbe	Deputy Assistant Commissioner	TN Department of Economic & Community Development
33	Sen. Shane Reeves	Senator	State of TN General Assembly
34	Dr. Andrea Willis	Senior Vice President & Chief Medical Officer	BlueCross BlueShield of Tennessee

Recommendation Development

The Access to Care, Workforce Development, and Social Drivers of Health workgroups met monthly from September 2022 to May 2023 to develop evidence-based recommendations that would improve rural communities' access to preventive and comprehensive health care services, promote equitable, efficient, and effective health care delivery, and improve health outcomes for rural Tennesseans. The workgroups:

- Identified key focus areas based on a review of state and national rural health care data, trends, and industry knowledge,
- Reviewed programs, approaches, and innovative policies impacting rural health care from Tennessee and other states,
- Engaged in robust discussion to refine potential policy, programmatic, and legislative opportunities to address existing gaps,
- Leveraged membership expertise to consider and develop approaches that provide a comprehensive perspective on potential rural health solutions, and
- Collaborated with subject matter experts outside of the Task Force (e.g., Tennessee State agencies, experts from agencies in other states, academic institutions, non-profit organizations) to understand the current landscape and needs and make informed and realistic recommendations.

The Task Force, as a collective, reviewed, discussed, and refined workgroup recommendations for inclusion in this report. The Task Force acknowledges that ongoing evaluation of each proposed and implemented recommendation will be critical. For all proposed recommendations, the Task Force recommends the State establish key performance indicators and measures of success with associated timeframes to continuously evaluate effectiveness.

The remainder of this report outlines each recommendation by workgroup, including background, recommended actions, intended impact, potential next steps, and proposed budget (if applicable).

Rural Health Care Task Force Recommendations

Figure 2 provides a summary of Task Force recommendations by workgroup. The sections that follow provide additional detail on each recommendation. **Appendix A** includes a high-level summary of proposed budget by workgroup.

Figure 2. Summary of Rural Health Care Task Force Recommendations

Access to Care Workgroup	
1	<p>Center of Excellence: Leveraging public and private investments, establish a Center of Excellence (CoE) for rural communities and providers (including hospitals, outpatient facilities, long term care, dental and behavioral health centers) to provide and/or coordinate operational and strategic technical assistance, background implementation research, and advocacy efforts to expand service line delivery, evaluate alternative payment models, or transition services to better meet rural community needs.</p> <p>Total Proposed Budget (5-Year): \$5,030,000</p>
2	<p>CoE Planning and Implementation Grants: Establish Planning and Implementation Grant funding for the CoE to disburse to rural communities and/or providers to supplement technical assistance services provided through the CoE.</p> <p>Total Proposed Budget (5-Year): \$7,000,000</p>
3	<p>Health Insurance Coverage: Improve access to health insurance coverage through the following initiatives:</p> <p>3.1 Assess opportunities to address gaps in insurance status, and</p> <p>3.2 Identify existing coverage sources and educate rural Tennesseans about available options.</p> <p>Total Proposed Budget (5-Year): Not Applicable (Policy Recommendation)</p>
4	<p>Specialty Care: Increase access to specialty care in rural communities through the following initiatives:</p> <p>4.1 Provider-to-Provider E-Consult Program for rural primary care providers (e.g., Local Health Departments [LHDs], Federally Qualified Health Centers [FQHCs], Community Behavioral Health providers, Community and Faith-Based Organizations, Regional Health Care Delivery Systems, Rural Health Clinics [RHCs]) to improve access to specialty consultation, and</p> <p>4.2 Tennessee Department of Health Project Access Specialty Incentive Pilot Program to incentivize additional high-need specialty providers (e.g., cardiology, psychiatry, general surgery) to deliver in-person services for rural communities.</p> <p>Total Proposed Budget (5-Year): \$5,250,000</p>
5	<p>Scope of Practice: Continue to evaluate evidence and opportunity for specific scope of practice changes that may improve accessibility for rural Tennesseans.</p> <p>Total Proposed Budget (5-Year): Not Applicable (Policy Recommendation)</p>

6	<p>Rural Telemedicine Program: Pilot a Rural Telemedicine Program that establishes telemedicine infrastructure and platforms in Safety Net Clinics and develops additional Health Insurance Portability and Accountability Act (HIPAA) compliant telemedicine sites to enhance access to telemedicine capabilities in rural communities.</p> <p>Total Proposed Budget (1-Year): \$66,900</p>
Workforce Development Workgroup	
7	<p>Rural Health Care Apprenticeship Programs: Bolster and expand existing rural health and behavioral health care registered apprenticeship programs, enhance non-State apprenticeship programs, and identify opportunities to develop new “apprenticeship-like” programs for high-demand health care professions.</p> <p>Total Proposed Budget (5-Year): \$39,423,650</p>
8	<p>Rural Health Care Training Programs: Provide longitudinal, recurring State funding to expand or develop:</p> <ul style="list-style-type: none"> 8.1 Rural health care preceptorship and rotation programs, 8.2 Rural training tracks, accelerated medical training opportunities, and fellowships, 8.3 Rural residency programs which prioritize placement in rural communities, and 8.4 Continuing Education / Continuing Medical Education Courses. <p>Total Proposed Budget (5-Year): \$22,491,250</p>
9	<p>Rural Health Care Pathway Programs: Expand current health care, behavioral health, and dental health pathway programs by:</p> <ul style="list-style-type: none"> 9.1 Increasing early exposure to health care careers, 9.2 Increasing transition opportunities into health science education and health care careers, and 9.3 Improving health care career advancement programs (e.g., LPN to RN, EMT to RN). <p>Total Proposed Budget (5-Year): \$67,745,244</p>
10	<p>Rural Loan Repayment: Expand existing loan repayment programs to incentivize rural providers (e.g., psychiatric, primary care, pediatric, women’s health physicians, NPs, RNs, counselors, and therapists) to practice in rural areas.</p> <p>Total Proposed Budget (5-Year): \$5,799,750</p>
11	<p>Community Health Workers: Support the work of State agencies, non-profit organizations, academic institutions, and the Community Health Worker (CHW) professional association in implementing and sustaining evidence-supported CHW work to improve health outcomes and provide a broad means of entry into other health professions.</p> <p>Total Proposed Budget (4-Year): \$4,000,000</p>

Social Drivers of Health Workgroup

12 **SDOH Planning Grants and Implementation Funds:** Support County Health Councils (CHCs) to improve food security, transportation, and substance misuse / mental health condition prevention through establishment of Rural County Planning Grants, expansion of Collaborative Action for Resilience and Equity (CARE) Grants, and implementation of private partner development support.

Total Proposed Budget (5-Year): \$33,000,000

13 **Closed-Loop Referral System Supports:** Support rural providers in addressing the social drivers of health experienced by their patients, including preparing for and implementing TennCare’s Closed Loop Referral System.

Total Proposed Budget (3-Year): \$9,600,000

Access to Care

Recommendation 1: Center of Excellence

Leveraging public and private investments, establish a Center of Excellence (CoE) for rural communities and providers (including hospitals, outpatient facilities, long term care, dental and behavioral health centers) to provide and/or coordinate operational and strategic technical assistance, background implementation research, and advocacy efforts to expand service line delivery, evaluate alternative payment models, or transition services to better meet rural community needs.

Total Proposed Budget (5-Year): \$5,030,000

Many rural communities have inadequate and variable access to core health care services (e.g., Obstetrics and Gynecology [OB/GYN], dental, behavioral health, primary care, specialty care), worsened by facility closures in recent years. Nearly 97% of Tennessee counties are designated as a primary care professional shortage area, 98% of counties include a dental care professional shortage area, and 100% of counties include a mental health care professional shortage area, which restricts access to care.¹⁰ Local health care facility options are also often unavailable, driven by recent facility closures in rural areas (e.g., OB/GYN / birthing centers, nursing homes, hospitals).^{11,12,13} Meanwhile, the health care landscape, facility operations, clinical needs, and federal and state opportunities and regulation are changing rapidly. Individual rural health care facilities often do not have the administrative infrastructure to maximize strategic and operational opportunities to expand access to care.

Rural communities have unique needs, and the Task Force recognizes there is not a “one-size-fits-all” solution to improve access to care in rural communities. New or enhanced models of care delivery such as Rural Emergency Hospitals and “hub and spoke” obstetric and dental practice models have arisen in recent years, but rural communities and facilities

Service Variability and Rural Facilities in Tennessee:

- 13 rural hospitals have closed since 2010 ¹⁴
- 22 Counties do not have a hospital ¹⁴
- 55 Counties do not have birthing facilities ¹⁵
- Over 50% of Tennessee rural hospitals lack maternity care ¹⁶
- 10 obstetric facilities closed within the past ten years ¹⁷

¹⁰ Data Downloads: Shortage Areas. Health Resources & Services Administration. 2023. <https://data.hrsa.gov/data/download#SHORT>

¹¹ Information provided by Tennessee Department of Health.

¹² Rural Hospital Viability A Look at Alternative Models for Rural Hospitals. Tennessee Hospital Association. <https://tha.com/focus-areas/small-and-rural/rural-hospital-viability/>

¹³ Rural Hospital Closures. University of North Carolina The Cecil G. Sheps Center for Health Services Research. 2023. <https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/>

¹⁴ Rural Hospital Viability A Look at Alternative Models for Rural Hospitals. Tennessee Hospital Association. <https://tha.com/focus-areas/small-and-rural/rural-hospital-viability/>

¹⁵ Information provided by Tennessee Department of Health.

¹⁶ *The Crisis in Rural Maternity Care*. Center for Healthcare Quality & Payment Reform. 2023.

https://ruralhospitals.chgpr.org/downloads/Rural_Maternity_Care_Crisis.pdf

¹⁷ Information provided by Tennessee Department of Health.

often do not have the resources to strategically evaluate and implement these models. To help address these challenges and promote access to care solutions tailored to local communities, the Task Force recommends establishing a Center of Excellence (CoE), steered by relevant agencies and subject matter experts, to provide ongoing and as-needed technical assistance to rural communities and providers.

Operating Model and Mission Statement

The Task Force recommends developing the CoE through a public-private partnership, leveraging one of two potential models:

1. As a new, standalone entity, or
2. Built into an existing entity (e.g., academic business and policy partners such as East Tennessee State University Center for Rural Health and Research, Meharry Medical College [Meharry], University of Tennessee [UT] Health Sciences Center) through legislative designation or a competitive procurement process open to all qualified organizations.

The CoE's proposed mission is to "promote health and access to care for rural communities through targeted technical assistance, expertise, and advocacy." The CoE should harness collective wisdom from a diverse background of subject matter experts to support rural communities and providers. The Task Force recommends leveraging the public-private partnership model to help secure necessary staff with relevant experience and expertise to effectively support rural communities. To ensure success, the CoE will need to have commitment from State and private sector advisors, a focus on recruitment of industry and policy experts, and the ability to pay market salaries for that expertise.

The Task Force recommends that the State partner with private industry (e.g., health systems, philanthropic foundations, and rural employers) to provide supplementary funding to staff and sustain the CoE. The State may consider leveraging a quasi-governmental structure (i.e., supported by a direct recurring appropriation and industry but managed independently) to support program administration and operation.

Governance

The Task Force recommends establishing a Steering Committee to provide strategic counsel, oversight, governance, and operational parameters to the CoE. The Steering Committee should establish technical assistance eligibility guidelines and requirements for receiving grant funding (outlined in Recommendation 2). The Steering Committee should additionally establish clear reporting guidelines and monitoring standards for the CoE as a potential recipient of State funding. The CoE should have authority to evaluate technical assistance and funding requests without engaging the Steering Committee but may leverage the Steering Committee to review requests as needed.

The Steering Committee may consist of:

- Representatives from relevant State of Tennessee entities (e.g., Tennessee Departments of Health, Economic and Community Development, Labor and Workforce Development, Mental Health and Substance Abuse Services, TennCare, Intellectual and Developmental Disabilities, and the Health Facilities Commission),
- Representation from the Tennessee General Assembly
- Health care industry leaders,
- Academic institutions (e.g., public universities, Tennessee Board of Regents [TBR] colleges),
- Non-profit associations / organizations (e.g., THA, RHAT, TPCA, Tennessee Charitable Care Network), and
- Rural employers and other private sector entities (e.g., internet service providers) as needed.

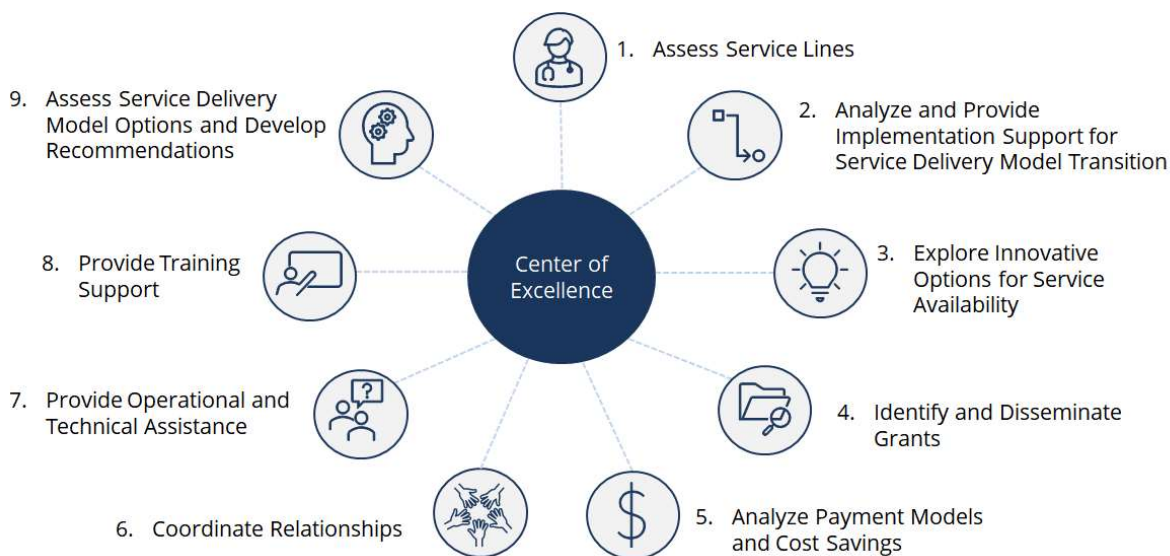
Proposed Technical Assistance Activities

CoE technical assistance may include direct strategic, operational, and administrative support, such as:

- Facilitating service line assessments for rural health care facilities and providers (e.g., behavioral health, urgent care, OB/GYN and/or dental “hub and spoke”),¹⁸
- Payment model assessments,
- Delivery model / payment model transition supporting enhanced service availability and viability, and
- Operational and financial advising.

The CoE may engage federal and State payers (e.g., Medicare, Medicaid) to assist with implementation of innovative payment model change and service line transition, as needed. **Figure 3** shows the proposed technical assistance that the CoE may provide.

¹⁸ Service line refers to the operation, governance, and delivery of health care services to patients with certain diagnoses, specialty groups, or within a similar geographic service location.

Figure 3. Proposed CoE Technical Assistance

The CoE will promote access to care through:

1. Assessing rural health care facility and provider service lines to identify “core” service expansion opportunities and/or partnerships that promote “core” service delivery, including:
 - a. Primary care,
 - b. Behavioral health care,
 - c. Emergency services,
 - d. Maternal health care,
 - e. Oral health services / dental care, and
 - f. Outpatient services (e.g., urgent care, community health centers).
2. Analyzing and providing implementation support to communities and providers considering service delivery model transition (e.g., evaluation of service delivery model impact in a community, administrative / operational planning),
3. Exploring innovative options to enhance service availability in rural communities (e.g., “hub and spoke” model for dental health care services),¹⁹
4. Scanning for available grants and disseminating application information to communities and providers (i.e., encourage collaboration and partnerships for application),

¹⁹ Dental hub and spoke models leverage facilities that provide a full array of service offerings and smaller facilities or units that offer a limited subset of services to a community. For example, Tennessee may continue to leverage academic partnerships with to allow dental students to provide routine of services at “spokes” and direct more intense care to the hub. The CoE may serve as an extension providing technical assistance to match students to geographies.

5. Analyzing alternative payment model opportunities, potential cost savings, and overall budget neutrality to support financial sustainability for key service lines in rural areas (e.g., OB/GYN, dental services, chronic disease management),
6. Coordinating relationships between rural clinics and urban labor and delivery sites to improve OB/GYN service availability in rural communities,
7. Providing ongoing operational and technical assistance to promote consistent coverage for rural populations, create sustainable funding mechanisms for entities, and evaluate outcomes to identify additional service offerings and alignment across communities,
8. Providing necessary functional and administrative training / resources to rural health care leaders and community officials,²⁰ and
9. Assessing viable alternative service delivery model transition options (e.g., Rural Emergency Hospital Designation) and developing recommendations for General Assembly review and consideration.

CoE expertise should be readily accessible to all rural communities and providers and deliver technical assistance “in-house” whenever possible. The CoE may coordinate access to additional subject matter experts, when needed, through Planning and Implementation Grant funding (as identified in Recommendation 2).

Recommendation 2: CoE Planning and Implementation Grants

Establish Planning and Implementation Grant funding for the CoE to disburse to rural communities and/or providers to supplement technical assistance services provided through the CoE.

Total Proposed Budget (5-Year): \$7,000,000

The Task Force recognizes that there may be instances where rural communities and providers may need additional planning support beyond the CoE’s in-house capabilities and/or funding to support implementation efforts (e.g., service line changes, alternative payment model implementation, service delivery model transition).

To supplement the CoE and support implementation efforts, the Task Force recommends developing two grant programs for the CoE to administer, outlined in **Figure 4**.

Figure 4. CoE Grant Programs

Grant Program	Description
<p>Planning Grant Total Annual Budget: \$400,000 per year for five years</p>	<p>Funding to support complex technical assistance needs that exceed CoE staff expertise and/or capacity. The CoE would distribute funding to the rural community or</p>

²⁰ Identified as a need in rural communities per the Governor’s Rural Task Force Report in 2016 (<https://tnced.com/wp-content/uploads/2018/10/rtf-final-10102016.pdf>)

Grant Program	Description
	provider and coordinate access to additional subject matter experts (i.e., third-party entity).
Implementation Grant Total Annual Budget: \$1,000,000 per year for five years	Funding to implement the service line changes, alternative payment models, or service delivery models identified through technical assistance.

The Planning and Implementation Grant programs should:

- Be available to all rural communities and facilities that meet defined eligibility requirements (e.g., meets the definition of “rural”),
- Operate independently (i.e., Planning Grant is not required for receipt of an Implementation Grant),
- Build upon technical assistance and viable solutions identified through Recommendation 1, and
- Receive ongoing oversight from the Steering Committee including continuous monitoring and outcome reporting.

Recommendation 3: Health Insurance Coverage

Improve access to health insurance coverage through the following initiatives:

- 3.1 Assess opportunities to address gaps in insurance status, and
- 3.2 Identify existing coverage sources and educate rural Tennesseans about available options.

Total Proposed Budget (5-Year): Not Applicable (Policy Recommendation)

Health insurance is linked to improved access to care and health outcomes.^{21,22} Individuals without health insurance experience significant barriers in accessing care for behavioral health and substance abuse, chronic health conditions, pediatric visits, and key preventive services.²³ Likewise, insurance coverage is necessary for the financial stability of health care facilities, and states with higher rates of uninsured populations have had higher rates of hospital closures. According to a recent report by the Center for Healthcare Quality and Reform, 21 (44%) of Tennessee’s rural hospitals were at risk of closing as of October 2022 due to financial losses and lack of financial reserves.²⁴

Tennessee is in the bottom 10 states for health insurance coverage, with nearly 15% of its working age adults 18-65 years old going without health insurance.²⁵ Over 80% of

²¹ *The Oregon Experiment — Effects of Medicaid on Clinical Outcomes*. The New England Journal of Medicine. 2013.

<https://www.nejm.org/doi/full/10.1056/nejmsa1212321>

²² *The Health and Healthcare Impact of Providing Insurance Coverage to Uninsured Children: A Prospective Observational Study*. BMC Public Health. 2017.

<https://bmcpublihealth.biomedcentral.com/articles/10.1186/s12889-017-4363-z>

²³ Access to Health Services. Healthy People 2023. Office of Disease Prevention & Health Promotion. 2023. <https://health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/access-health-services>

²⁴ *631 Hospitals at Risk of Closure, State by State*. *Becker's Hospital Review*. 2023. <https://www.beckershospitalreview.com/finance/631-hospitals-at-risk-of-closure-state-by-state.html>

²⁵ 2023 Scorecard on State Health System Performance. <https://www.commonwealthfund.org/publications/scorecard/2023/jun/2023-scorecard-state-health-system-performance>

uninsured Tennesseans reported cost to be the most significant reason for not having insurance.²⁶ Residents of rural counties lack health insurance at higher rates than urban counties.²⁷ Of those who are uninsured, a 2023 Kaiser Family Foundation analysis showed that approximately 124,000 adults in Tennessee are currently in the insurance “coverage gap” (<100% federal poverty level [FPL]), meaning that they face challenges accessing health insurance because their income is higher than the Medicaid income requirement but below 100% FPL, deeming them ineligible for Affordable Care Act Marketplace subsidies for insurance.^{28,29}

Further, the Task Force understands lack of insurance coverage may be a contributing factor to health care workforce shortages. According to Georgetown University, the health care and social assistance services industries are within the top ten most common professions for low-wage, uninsured adults in Tennessee.³⁰

Tennessee has taken actions within recent years to improve access to health, including:

- Expanding access to maternal care and postpartum care by increasing eligibility for expecting moms to 250% of the Federal Poverty Level (FPL), extending coverage for women one year after birth of a child, and adding a lactation consultant benefit,
- Offering dental benefits to all TennCare adult members,
- Establishing the Katie Beckett Program for children with disabilities who do not qualify for Medicaid due to income eligibility thresholds, and
- Providing continuous 12-month eligibility for low-income children through TennCare.^{31,32,33}

Current insurance options offered in Tennessee include employer-sponsored insurance, Medicaid, Medicare, Children’s Health Insurance Program, CoverKids, CoverRx, and federal marketplace options through the Affordable Health Care Act.^{34,35,36} The State also delivers health care services to uninsured Tennessee adults ages 19-64 through primary care, dental, and behavioral health Safety Nets, however nine counties do not have primary care

²⁶ *The Impact of TennCare: A Survey of Recipients, 2022*. The University of Tennessee Knoxville, Haslam College of Business. 2022.

<https://haslam.utk.edu/publication/the-impact-of-tenncare-a-survey-of-recipients-2022/>

²⁷ Rates of Uninsured Fall in Rural Counties, Remain Higher Than Urban Counties. United States Census Bureau. 2019.

<https://www.census.gov/library/stories/2019/04/health-insurance-rural-america.html>

²⁸ How Many Uninsured Are in the Coverage Gap and How Many Could be Eligible if All States Adopted the Medicaid Expansion? Kaiser Family Foundation. March 2023.

<https://www.kff.org/medicaid/issue-brief/how-many-uninsured-are-in-the-coverage-gap-and-how-many-could-be-eligible-if-all-states-adopted-the-medicaid-expansion/>

²⁹ *2020 Income, Poverty, Health Insurance Coverage, and Education in Tennessee’s 95 Counties*. The Sycamore Institute. 2022. https://www.sycamoreinstitutenet.org/wp-content/uploads/2022/06/2022_06_22-FINAL-2020-ACS-County-Estimates-of-Income-Poverty-Insurance-and-Education.pdf

³⁰ *A Profile of Tennessee’s Low-Wage Uninsured Workers*. Georgetown University Health Policy Institute. Center for Children and Families. 2021.

<https://ccf.georgetown.edu/2021/05/17/a-profile-of-tennessees-low-wage-uninsured-workers/>

³¹ *The Budget*. Fiscal year 2023-2024. State of Tennessee. 2023. <https://www.tn.gov/content/dam/tn/finance/budget/documents/2024BudgetDocumentVol1.pdf>

³² Dental Services. Division of TennCare. <https://www.tn.gov/tenncare/members-applicants/dental-services.html>

³³ *Katie Beckett Program Update: A Joint Report to the Tennessee General Assembly*. Division of TennCare. Department of Intellectual & Developmental Disabilities.

2022. <https://www.tn.gov/content/dam/tn/tenncare/documents/KBAAnnualReport22.pdf>

³⁴ State Health Care Snapshots: Tennessee. KFF. <https://www.kff.org/statedata/election-state-fact-sheets/tennessee/>

³⁵ How can I get health care if I don’t qualify for TennCare? Division of TennCare. <https://www.tn.gov/tenncare/members-applicants/how-can-i-get-health-care-if-i-don-t-qualify-for-tenncare.html>

³⁶ Health Insurance Information. Department of Commerce & Insurance. <https://www.tn.gov/commerce/insurance/consumer-resources/health-insurance-information.html>

Safety Net providers, 37 counties do not have dental Safety Net providers, and 22 counties do not have access to a behavioral health Safety Net provider.^{37,38}

The State should evaluate current opportunities to increase insurance coverage to improve both health care access and health outcomes for Tennessee residents. This should include an evaluation of current opportunities and associated costs and benefits to the State for different approaches to this problem. The Task Force recognizes there are additional opportunities the State can explore to mitigate coverage gaps for uninsured Tennesseans, some of which are included in **Figure 5**.

Figure 5. Opportunities to Mitigate Coverage Gaps for Uninsured Tennesseans

Opportunity	Description
<p>1. Subsidies for Businesses to Cover Part-Time Workers</p>	<p>The State may provide subsidies to employers, especially those within the health care and service industry, to offer insurance coverage for part-time employees. This may incentivize employees and help mitigate labor shortages.</p>
<p>2. Enhanced Medicaid Coverage</p>	<p>The State may consider extending eligibility for Medicaid coverage with enhanced federal funding.</p>
<p>3. Short Term Duration Insurance Plans</p>	<p>Short term duration insurance plans are available to individuals who are uninsured, or experience a gap in insurance coverage, and provide temporary / limited coverage for less than one year.³⁹</p>
<p>4. Health Reimbursement Arrangements</p>	<p>Health Reimbursement Arrangements are offered through employers and provide tax-free reimbursements to employees for certain health services up to a capped amount.⁴⁰</p>
<p>5. Employer-Based Services for Health Care Providers</p>	<p>Businesses may pursue additional innovative opportunities, like direct contracting with health care providers (i.e., “direct-to-employer / direct-to-provider” models) to provide health services to their employees. In this model, employers partner with a health system to deliver services to employees which allows for greater cost control by the employer and enhances patient coordination.⁴¹</p>
<p>6. Targeted Population-Based Approaches</p>	<p>The State may consider implementing innovative initiatives to reach populations who are at risk of falling into the coverage gap (e.g., incarcerated adults). For example, in 2023, California launched a Justice-Involved Initiative to provide continuous Medicaid coverage for three months during the transition period after incarceration and re-entry into the community.⁴²</p>

³⁷ Tennessee Governor’s Rural Opportunity Summit. 2023. <https://www.tn.gov/content/dam/tn/ruralsummit/documents/Health.pdf>

³⁸ Tennessee Uninsured Adult Healthcare Safety Net 2022 Annual Report. 2022. <https://www.tn.gov/content/dam/tn/health/program-areas/division-of-health-disparities-elimination/documents/Uninsured%20Adult%20Healthcare%20Safety%20Net%20Annual%20Report%202022%20FINAL.pdf>

³⁹ Understanding Short-Term Limited Duration Health Insurance. KFF. 2018. <https://www.kff.org/health-reform/issue-brief/understanding-short-term-limited-duration-health-insurance/>

⁴⁰ Health Reimbursement Arrangement (HRA). HealthCare.gov. [https://www.healthcare.gov/glossary/health-reimbursement-account-hra/#:-:text=Health%20Reimbursement%20Arrangements%20\(HRAs\)%20are.funds%20and%20owns%20the%20arrangement](https://www.healthcare.gov/glossary/health-reimbursement-account-hra/#:-:text=Health%20Reimbursement%20Arrangements%20(HRAs)%20are.funds%20and%20owns%20the%20arrangement)

⁴¹ A Pathway for Coordinated, Affordable Employer-Sponsored Health Care. Duke University Margolis Center for Health Policy. 2021. [Duke Margolis Integrated Pain Management PCC](https://www.duke.edu/margolis-center-for-health-policy/a-pathway-for-coordinated-affordable-employer-sponsored-health-care)

⁴² Justice-Involved Initiative. Medi-Cal Transformation. CA.Gov, DHCS. 2023. <https://www.dhcs.ca.gov/CalAIM/Justice-Involved-Initiative/Pages/home.aspx>

To further understand the viability of these options and others in improving access to health care coverage, the Task Force recommends the State assess opportunities to address gaps in insurance status, identify all existing coverage sources, and educate rural Tennesseans about available options.

3.1 Insurance Gap Assessment:

The Task Force recommends completing a comprehensive assessment of insurance coverage and gaps. The assessment should seek opportunities to minimize gaps in insurance coverage and promote access to care (e.g., opportunities to cover individuals below 100% FPL). For rural Tennesseans who may be eligible for coverage, the Task Force recommends identifying opportunities and educating rural Tennesseans about currently available insurance coverage options.

The Task Force recommends the following activities as part of the insurance gap assessment:

- Review existing coverage options to identify current gaps (e.g., no affordable insurance options available, poor health outcomes) and potential “high priority” populations,
- Determine opportunities to address existing coverage gaps in rural communities (e.g., short-term duration insurance plans, expanded use of individual coverage Health Reimbursement Arrangements), and
- Identify and pursue opportunities to mitigate coverage gaps.

3.2 Coverage Option Identification and Community Member Education:

The Task Force recognizes that uninsured rates are often higher in rural communities and individuals below 100% FPL usually have full or part time jobs where employer-sponsored health insurance is not offered to them or accessible (e.g., health care professionals who are not eligible for subsidies).^{43,44} 2021 U.S. Census Data shows that 49% of families below 100% FPL had at least one worker.⁴⁵ There may be an opportunity to use existing resources (e.g., Community Navigators) to educate community members about available options (e.g., federal marketplace).⁴⁶ These include:

- Identifying existing sources of health insurance coverage available within rural communities (e.g., low deductible federal marketplace plans),
- Implementing insurance options to address gaps identified by the assessment (i.e., Recommendation 3.1) for uninsured populations with potential coverage options, and

⁴³ 2022 Advocacy Priorities. Rural Health Association of Tennessee. 2022. <https://www.tnruralhealth.org/assets/2022%20Advocacy%20Goals.pdf>

⁴⁴ What is the Medicaid “Coverage Gap” and Who Does it Affect? HealthInsurance.org. <https://www.healthinsurance.org/faqs/what-is-the-medicaid-coverage-gap-and-who-does-it-affect/>

⁴⁵ POV-05. Primary Families by Number of Working Family Members and Family Structure. United States Census. 2022. <https://www.census.gov/data/tables/time-series/demo/income-poverty/cps-pov/pov-05.html>

⁴⁶ Rates of Uninsured Fall in Rural Counties, Remain Higher Than Urban Counties. United States Census Bureau. 2019. <https://www.census.gov/library/stories/2019/04/health-insurance-rural-america.html>

- Providing targeted education on available coverage options through Community Advisors / Navigators (i.e., educating individuals between 100-138% FPL on low deductible federal marketplace plans).

Recommendation 4: Specialty Care

Increase access to specialty care in rural communities through the following initiatives:

- 4.1 Provider-to-Provider E-Consult Program for rural primary care providers (e.g., Local Health Departments [LHDs], Federally Qualified Health Centers [FQHCs], Community and Faith-Based Organizations, Community Behavioral Health providers, Regional Health Care Delivery Systems, Rural Health Clinics [RHCs]) to improve access to specialty consultation, and
- 4.2 Tennessee Department of Health Project Access Specialty Incentive Pilot Program to incentivize additional high-need specialty providers (e.g., cardiology, psychiatry, general surgery) to deliver in-person services for rural communities.

Total Proposed Budget (5-Year): \$5,250,000

Quality primary care cannot exist independent from specialist access. While primary care is essential for acute care, preventive care, and chronic disease management, primary care practices rely on specialty providers for diagnosis and management of a myriad of common conditions such as cancer or orthopedic injury that otherwise keeps patients out of work. Rural communities often lack access to specialty providers, leading to long travel times for rural patients seeking specialty services.^{47,48} Additionally, health care professionals in rural communities can feel geographically isolated from additional clinical supports, leading to primary care burn out and relocation. Uninsured patients face even greater challenges and must resort to an inconsistent charity care system in Tennessee, if care can be found at all.⁴⁹

The Task Force recognizes the need for additional specialty services in rural communities and the challenges with recruiting and retaining specialists in rural areas. To improve access to specialty care, the Task Force recommends implementing:

- A provider-to-provider e-consult platform at rural provider locations, and
- A pilot program to provide incentive payments that help expand existing specialty provider rotation programs (i.e., Project Access).

4.1 Provider-to-Provider E-Consult Program:

E-consults allow primary care providers and specialists to collaborate regarding the treatment of a patient using a shared platform (e.g., electronic health record, web-based

⁴⁷ Rural Access to Health Care Services Request for Information. Health Resources & Services Administration. 2019. <https://www.hrsa.gov/rural-health/rfi-rural-health-care-access>

⁴⁸ Study: Rural Residents Travel about Twice as Far to Hospital on Average. American Hospital Association. 2018. <https://www.aha.org/news/headline/2018-12-14-study-rural-residents-travel-about-twice-far-hospital-average>

⁴⁹ Recruitment and Retention for Rural Health Facilities. Rural Health Information Hub. 2022. <https://www.ruralhealthinfo.org/topics/rural-health-recruitment-retention>

platform) without a face-to-face visit.⁵⁰ E-consult platforms can help connect rural patients and providers to specialty services, which reduces wait times for patients and improves a provider's ability to coordinate and deliver patient care.^{51,52} E-consult capabilities have also been shown to reduce the costs for specialty services for the patient, allowing for a more cost-effective approach to service delivery.⁵³

The Task Force recommends providing access to an e-consult platform for rural primary care providers (e.g., LHDs, FQHCs, Community and Faith-Based Clinics, Certified Community Behavioral Health Clinics, RHCs) across the State. This e-consult platform should include "real-time" one-on-one e-consults between rural primary care providers and specialists to seek clinical guidance and expertise, improve access to specialty care in geographically isolated communities, and avoid unessential referrals.⁵⁴

Given the support that TDH currently provides safety net and rural clinics, the Task Force recommends that TDH competitively contract with an e-consult vendor to support this program. The vendor should be responsible for addressing potential barriers including specialty provider network development, electronic medical record interoperability between various provider sites, and provider training. The Task Force suggests allocating \$800,000 per year for five years to hire an e-consult vendor and support platform implementation based off similar procurement efforts.

4.2 Specialty Provider Rotation Program:

To improve access to specialty care in rural communities, the Task Force recommends implementing a specialist incentive pilot for TDH's Project Access program, which leverages non-profit entities across the State to coordinate with local Tennessee Medical Association chapters and connect uninsured patients with health care services (e.g., specialty care, comprehensive care management, diagnostic services, preventive care).

Specifically, the Task Force recommends allocating up to \$250,000 per year to Project Access to incentivize additional high-need specialty providers (e.g., cardiology, psychiatry, general surgery) to deliver in-person services in rural communities. Additional budget details for the five Project Access regions are shown in **Figure 6**.

⁵⁰ *Electronic consultations (e-consults) to improve access to specialty care: A systematic review and narrative synthesis*. Journal of Telemedicine and Telecare. 2015. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4561452/>

⁵¹ Best Practice Guide: Telehealth for Emergency Departments. U.S. Health & Human Services. 2021. <https://telehealth.hhs.gov/providers/telehealth-for-emergency-departments/e-consults/>

⁵² Rural Access to Health Care Services Request for Information. Health Resources & Services Administration. 2019. <https://www.hrsa.gov/rural-health/rfi-rural-health-care-access>

⁵³ *Reduced Cost Of Specialty Care Using Electronic Consultations For Medicaid Patients*. HealthAffairs. 2018. <https://www.healthaffairs.org/doi/10.1377/hlthaff.2018.05124>

⁵⁴ Best Practice Guide: Telehealth for Emergency Departments. U.S. Health & Human Services. 2021. <https://telehealth.hhs.gov/providers/telehealth-for-emergency-departments/e-consults/>

Figure 6. Project Access Specialty Incentive Pilot

Expected Number of Specialty Visits per Year	200 per region
Number of Project Access Regions	5
Proposed Specialty Incentive per Visit	\$250
Total	\$250,000 per year for five years

Recommendation 5: Scope of Practice

Continue to evaluate evidence and opportunity for specific scope of practice changes that may improve accessibility for rural Tennesseans.

Total Proposed Budget (5-Year): Not Applicable (Policy Recommendation)

The Task Force recognizes there is often limited provider availability in rural communities, including physicians, dentists, advanced practice providers, behavioral health professionals, and other related health care professions. Modifying scope of practice may allow certain providers to practice at the top of their license, assist with meeting physician and dental workforce demands, produce health care cost savings, and promote access to care.^{55,56,57}

The Tennessee General Assembly and relevant advocacy groups have convened a number of times in recent years around scope of practice for certain professions (e.g., expansion of NP substance use treatment prescription authority at FQHCs, number of collaboration sites for advanced practice RNs (APRNs) and physician assistants (PAs), and temporary pandemic related scope of practice and student allowances by executive order).^{58,59} There have also been several expansions of multi-state compact recognitions by the health practice boards in recent years to allow physicians, nurses, and other health practitioners from other states to practice in Tennessee.^{60,61,62}

The Task Force examined scope of practice literature and found varying results regarding the impact of scope of practice expansion on access to care and health outcomes. For example, the Task Force reviewed a study published in 2018 that assessed patient outcome

⁵⁵ *Expanding Scope of Practice After Covid-19*. Conference Summary. University of Pennsylvania School of Nursing and Leonard Davis Institute of Health Economics. 2021. <https://ldi.upenn.edu/wp-content/uploads/2021/06/PennLDI-PennNursing-Expanding-Scope-of-Practice-After-COVID-19-Brief.pdf>

⁵⁶ *Benefits of Less Restrictive Regulation of Advance Practice RNs in Florida*. Nursing Outlook, ScienceDirect. 2018.

<https://www.sciencedirect.com/science/article/abs/pii/S002965541830201X>

⁵⁷ *Nurse practitioners' workforce outcomes under implementation of full practice authority*. National Library of Medicine. PubMed Central. 2021.

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7581487/>

⁵⁸ Board of Nursing. Tennessee Department of Health. 2022. <https://www.tn.gov/health/health-program-areas/health-professional-boards/nursing-board/nursing-board/legislative.html>

⁵⁹ Executive Order by The Governor. No 83. An Order to Facilitate the Continued Response to COVID-19. 2021. <https://publications.tnsosfiles.com/pub/execorders/exec-orders-lee83.pdf>

⁶⁰ Participating Jurisdictions. NCSBN. 2023. <https://www.nursecompact.com/>

⁶¹ Board of Medical Examiners. TN Department of Health. <https://www.tn.gov/health/health-program-areas/health-professional-boards/me-board/me-board/applications.html#:~:text=%E2%96%BA%20The%20Interstate%20Medical%20Licensure.for%20obtaining%20multiple%20state%20licenses>.

⁶² Physical Therapy Licensure Compact. TN Department of Health. <https://www.tn.gov/health/health-program-areas/health-professional-boards/pt-board/pt-board/physical-therapy-licensure-compact.html>

data from 503 Rural Health Clinics in eight southeastern states to examine the impact of NP regulations on rural population health outcomes.⁶³ The study found no statistical difference in patient outcomes between reduced and restricted scope of practice states. Other studies support that states that restrict scope of practice do not improve quality of care.⁶⁴

The Task Force recommends the State consider whether modifying scope of practice in various fields (e.g., dental, behavioral health) can increase access to care for rural communities in a meaningful way while maintaining quality of care.

The Task Force recommends identifying an objective research entity (e.g., academic institution) to review research results and determine actionable steps for potential scope of practice expansion while considering:

- Access to care,
- Quality metrics,
- Health outcomes,
- Licensing barriers,
- Cost savings,
- Impact on different patient populations (e.g., private insurance, Medicaid, uninsured),
- Potential scope of practice modifications for specific scenarios (e.g., dental telehealth oversight, psychiatric admissions), and
- Safety and quality of care considerations in rural communities.

The research entity should collect stakeholder feedback from key partners and identify actions for potential scope of practice and licensure waiver modifications based on evaluation findings.

Recommendation 6: Rural Telemedicine Program

Pilot a Rural Telemedicine Program that establishes telemedicine infrastructure and platforms in Safety Net Clinics and develops additional Health Insurance Portability and Accountability Act (HIPAA) compliant telemedicine sites to enhance access to telemedicine capabilities in rural communities.

Total Proposed Budget (1-Year): \$66,900

Rural Tennesseans often face barriers (e.g., transportation, broadband, cell service availability, platform knowledge) accessing provider-based and/or in-home telemedicine services.⁶⁵ Despite ongoing substantial investment and significant action from the State,

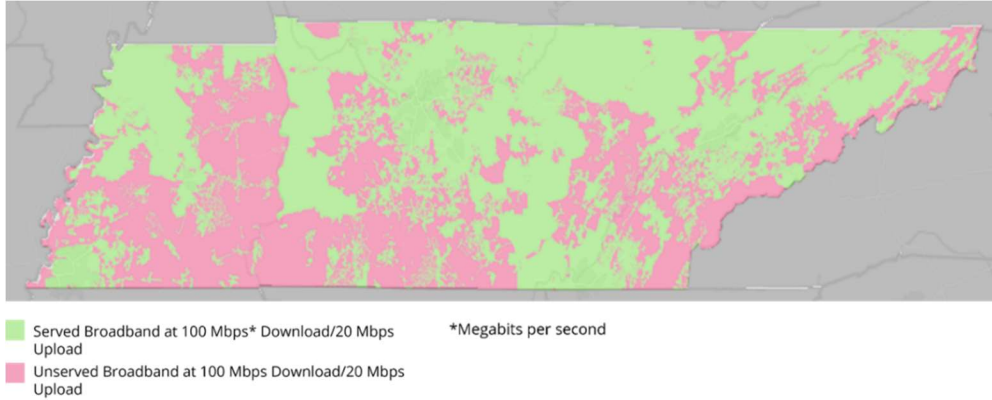
⁶³ *Impact of Nurse Practitioner Practice Regulations on Rural Population Health Outcomes*. PubMed. 2018. <https://pubmed.ncbi.nlm.nih.gov/29914051/>

⁶⁴ *Association of State-Level Restrictions in Nurse Practitioner Scope of Practice with the Quality of Primary Care Provided to Medicare Beneficiaries*. PubMed. 2019. <https://pubmed.ncbi.nlm.nih.gov/28906171/>

⁶⁵ *The Association of Broadband Internet Access and Telemedicine Utilization in rural Western Tennessee: an observational study*. BMC Health Services Research. 2021. <https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-021-06746-0#Sec3>

telemedicine is not currently a viable option in all communities given differing levels of broadband infrastructure (as identified in **Figure 7**) and cellular service.⁶⁶

Figure 7. TN Department of Economic & Community Development Broadband Accessibility Map, November 2022⁶⁷



The Task Force recognizes that additional telemedicine infrastructure and community-based telemedicine sites are being implemented and could help enhance access to necessary primary, specialty, and behavioral health care services.⁶⁸ The Task Force recommends implementing a one-year pilot program within three Safety Net Clinics and three community-based sites (e.g., library) to improve access to telemedicine and health care services within rural communities.

Rural communities have varied levels of telemedicine infrastructure, and the program should provide targeted support for communities to address existing barriers (e.g., operational workflows, broadband accessibility, varying cell phone service availability, and education). The Task Force recommends contracting with a telemedicine vendor to help the State implement the Rural Telemedicine Program. In **Figure 8**, the Task Force outlines potential activities for the State and the telemedicine vendor.

Figure 8. Potential Rural Telemedicine Program Activities

State Activities	Telemedicine Vendor Activities
<ul style="list-style-type: none"> • Create Rural Telemedicine Program and hire a vendor to support implementation. • Review and monitor telemedicine reimbursement mechanisms. • Consider opportunities to expand cell service availability in rural communities to support access to home-based telemedicine services (e.g., boosters). 	<ul style="list-style-type: none"> • Implement telemedicine infrastructure and platforms in pilot Safety Net Clinics. • Confirm telemedicine vendor service offerings, broadband capacity, and operational tactics for integration with provider workflows.

⁶⁶ Tennessee has made several investments in expanding broadband accessibility through the American Rescue Plan, Tennessee Broadband Accessibility Act, and the Department of Economic & Community Development which provides emergency funds and broadband grants to communities.

⁶⁷ Tennessee Broadband Accessibility Map. Tennessee Department of Economic & Community Development. 2022.

<https://gis.connectednation.org/portal/apps/webappviewer/index.html?id=415548aa14c4471ea6dfbd9f051cd232>

⁶⁸ Telehealth Use in Rural Healthcare. Rural Health Information Hub. 2021. <https://www.ruralhealthinfo.org/topics/telehealth>

State Activities	Telemedicine Vendor Activities
<ul style="list-style-type: none"> Conduct continuous evaluation to determine impact on access to care and health outcomes. 	<ul style="list-style-type: none"> Implement additional HIPAA compliant telemedicine sites (e.g., community library) in pilot communities. Provide implementation support (i.e., hands-on assistance for providers) to enhance telemedicine infrastructure.

Additional Considerations

The Task Force understands some health systems are currently implementing telemedicine in schools and emergency rooms and using mobile applications to connect patients with providers from any location. The Task Force recommends the State explore future opportunities to build upon existing technology. Such opportunities may include potential pilot programs to address emergency room telemedicine, school-based telemedicine, and other innovative methods to use telemedicine (e.g., emergency medical services use of audio-visual telemedicine to connect with a physician).

The Task Force recognizes transportation challenges will remain a barrier in rural communities when accessing in-person or virtual services. To address these challenges and enhance access to additional telemedicine sites, the Task Force suggests the State continue to monitor opportunities to expand existing transportation options (e.g., Tennessee Association of Human Resource Agencies medical transportation services, TennCare Non-Emergency Medical Transportation Services) in rural communities.⁶⁹

⁶⁹ The Tennessee Association of Human Resource Agencies provides transportation services, including Rural Public Transit, to assist rural community members with getting to their medical appointments.

Workforce Development

Recommendation 7: Rural Health Care Apprenticeship Programs

Bolster and expand existing rural health and behavioral health care registered apprenticeship programs, enhance non-State apprenticeship programs, and identify opportunities to develop new “apprenticeship-like” programs for high-demand health care professions.

Total Proposed Budget (5-Year): \$39,423,650

Current and future Statewide health care workforce supply inadequacies include registered nurses (RNs), mental health / substance abuse social workers, social / human service assistants, licensed practical / vocational nurses, clinical laboratory technologists / technicians, respiratory therapists, and medical records and health information technicians.^{70,71,72} Additionally, students often face several barriers (e.g., limited financial support and training opportunities) related to health care education and employment.⁷³

Registered apprenticeship and non-State (i.e., not directly supported by Tennessee Department of Labor and Workforce Development [TNLWD]) apprenticeship programs can help address rural and Statewide health care workforce supply inadequacies by providing training

Registered apprenticeship programs are non-degree, work-based learning models while **non-State apprenticeship programs** are competency-based models.^{74,75}

Both include supervised on-the-job training, education, and increasing wages.

opportunities for professions that do not require a degree. There are 739 existing apprentices in the 57 registered health care apprenticeship programs available in Tennessee, many of which do not address the highest-need health care professions stated previously.⁷⁶ The type and number of apprentices needs to be significantly increased.

Apprentices benefit from these programs through free on-the-job training and related education to prepare for post-apprenticeship employment.⁷⁷ Though employers are responsible for paying for apprenticeship training costs, employers often observe a

⁷⁰ *Tennessee Health Workforce Projections: 2021 – 2035*. Tennessee Hospital Association. 2022. <https://secure.tha.com/files/workforce/Tennessee-Health-Workforce-Projections-Report.pdf>

⁷¹ *A Snapshot of Occupational Dynamics Associated with TAMHO Member Organizations*. Tennessee Association of Mental Health Organizations. 2023.

⁷² *Tennessee's In Demand Occupations to 2026*. Tennessee Department of Labor and Workforce Development.

<https://www.tn.gov/content/dam/tn/workforce/documents/jobs-and-education/InDemandOccupationsto2026.pdf>

⁷³ *Barriers to College and Health Care Careers Among US Students from a Rural Community*. Society of Teachers of Family Medicine. 2019.

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7205084/>

⁷⁴ Work-based learning is an approach where students build on classroom-based instruction to develop employability skills that prepare them for success in postsecondary education and future careers (Work-Based Learning. TN Department of Education. [https://www.tn.gov/education/educators/career-and-technical-education/work-based-learning.html#:~:text=Work%2Dbased%20learning%20\(WBL\),postsecondary%20education%20and%20future%20careers](https://www.tn.gov/education/educators/career-and-technical-education/work-based-learning.html#:~:text=Work%2Dbased%20learning%20(WBL),postsecondary%20education%20and%20future%20careers)).

⁷⁵ Competency-based education is defined as an innovative, student-centric approach to post-secondary learning, that promotes open access and improves opportunities by removing barriers for adult learners in Tennessee. Competency-based education is designed for equitable student achievement by mastering clearly defined real-world competencies based on workforce needs, minimizing the time from enrollment to employment. (Competency-Based Education. Tennessee Board of Regents. <https://www.tbr.edu/academics/competency-based-education>).

⁷⁶ Information provided by Tennessee Department of Labor and Workforce Development.

⁷⁷ What is an Apprenticeship. ApprenticeshipTN. <https://www.tn.gov/apprenticeship/what-is-an-apprenticeship/what-is-an-apprenticeship.html>

positive return on investment after the apprenticeship program.⁷⁸ These programs allow students to meet their financial obligations while pursuing additional training and education related to their desired profession.

The Task Force recommends leveraging existing Tennessee structures that oversee rural apprenticeships to bolster, support, and expand registered apprenticeship and non-State apprenticeship opportunities in rural communities. Specifically, the Task Force recommends recruiting health care industry specific staff withing TNLWD, adding additional high demand apprenticeship pathways, funding non-State experienced apprenticeship entities (e.g., TNLWD, RHAT), and allocating financial and technical resources to rural sponsoring entities (e.g., academic institutions, workforce agencies) and rural employers (e.g., health care facilities) to expand existing TNLWD health care apprenticeship programs or non-State apprenticeship programs. Financial supports may assist:

- Rural sponsoring entities to provide the necessary training, course credits, and certifications, and
- Apprentices to cover ancillary costs that pose barriers to many students (e.g., transportation, childcare, supplies, scrubs, certification fees, examination fees, annual background checks, bi-annual drug screens).

Additionally, the Task Force recommends convening TNLWD, health care associations, and accrediting bodies to determine new, eligible apprenticeship programs for health care professions that are in high demand. The Task Force recommends developing and/or exploring potential apprenticeship programs to implement training opportunities aligned with the professions outlined in **Figure 9**.

Figure 9. Proposed Professions for Inclusion in Apprenticeship Programs

TNLWD Registered Apprenticeship Programs	Non-State Apprenticeship Programs	Potential New "Apprenticeship-Like" Programs*
<ul style="list-style-type: none"> • Certified Nursing Assistant (CNA) • Dental Assistant • Diagnostic Imaging Specialist • Emergency Medical Technician (EMT) • Health Support Specialist • Home Health Aide • Licensed Practical Nurse (LPN) Resident • Medical Assistant • Medical Equipment Repairer • Medical Records and Health Information Technician • Neurodiagnostic Technologist • Pharmacy Assistant • Pharmacy Technician • Surgical Technician 	<ul style="list-style-type: none"> • Behavioral Health Technician • CNA • Clinical Laboratory Technologists / Technicians • Dental Laboratory Technician • Electrocardiogram (EKG) Technician • Community Health Worker • Medical Assistant • Peer Counselor • Public Health Professional 	<ul style="list-style-type: none"> • Counselor • RN • Respiratory Care Therapist • Social and Human Services Assistant • Therapist

*Note: Unlike traditional apprenticeship programs, degree apprenticeship programs will require coordination with State licensing boards.

⁷⁸ Do Employers Earn Positive Returns to Investments in Apprenticeship? Abt Associates and Urban Institute. 2022. https://wdr.doleta.gov/research/FullText_Documents/ETAOP2022-36_AAI_ROI_Final_Report_508_9-2022.pdf

While traditional apprenticeship programs are for non-degree requiring professions, several states have implemented “apprenticeship-like” programs for degreed and licensed health professions. Such a program would require close coordination between health professions schools, employers, and licensing boards so that individuals can assume incremental responsibility commensurate with the coursework they have mastered.⁷⁹

Recommendation 8: Rural Health Care Training Programs

Provide longitudinal, recurring State funding to expand or develop:

- 8.1 Rural health care preceptorship and rotation programs,
- 8.2 Rural training tracks, accelerated medical training opportunities, and fellowships,
- 8.3 Rural residency programs which prioritize placement in rural communities, and
- 8.4 Continuing Education / Continuing Medical Education Courses.

Total Proposed Budget (5-Year): \$22,491,250

Rural rotation exposure in training or residency is positively associated with choosing rural practice.⁸⁰ However, students, clinicians, and training facilities often face several barriers related to receiving or implementing rural training opportunities, including:

- Low supply of preceptors necessary to train, educate, and supervise students,
- Insufficient health care training opportunities in rural settings, and
- An expensive and burdensome administrative process to implement new Graduate Medical Education (GME) programs in rural areas.⁸¹

The Task Force recommends addressing these barriers by promoting additional rural training opportunities, including funding for preceptorships, rotations, fellowships and training tracks, and residencies, as defined in **Figure 10**.

Figure 10. Rural Training Program Definitions

Training Program	Definitions
Preceptorships	A short-term relationship between a student as novice and an experienced staff person as the preceptor who provides individual attention to the students’ learning needs and feedback regarding performance; based on student level, students experience relative independence in making decisions, setting priorities, management of time, and patient care activities. ⁸²
Rotations	A period in which a health professions student in the clinical part of their education passes through various ‘working’ services, usually in one to four-month blocks. ⁸³

⁷⁹ Alabama Board of Nursing, Student Nurse Apprentice. <https://www.abn.alabama.gov/apprentice/>

⁸⁰ *Recruiting Rural Healthcare Providers Today: A Systematic Review of Training Program Success and Determinants of Geographic Choices*. Journal of General Internal Medicine. 2018. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5789104/>

⁸¹ Per Rural Health Care Task Force Workforce Development Workgroup meeting discussions. GME Programs are hospital training programs (e.g., internships and residencies) for physicians following formal training and program completion at an accredited medical school.

⁸² Segen’s Medical Dictionary. Retrieved June 1, 2023, from <https://medical-dictionary.thefreedictionary.com/preceptorship>

⁸³ McGraw-Hill Concise Medical Dictionary of Modern Medicine. Retrieved June 12, 2023, from <https://medical-dictionary.thefreedictionary.com/clinical+rotation>

Training Program	Definitions
Rural Training Tracks	A program offering medical residents or health professions students the opportunity to gain experience in both urban and rural areas, with over 50% of the education and training taking place in a rural area. ⁸⁴
Fellowships	The training a doctor embarks upon to become a specialist in their chosen field. During training, the learning physician — also known as a fellow — works closely with a specialist to deepen their knowledge and experience of the subspecialty they are interested in. ⁸⁵
Residencies	A period of at least one year and often three to seven years of on-the-job training, usually postgraduate, that is part of the formal educational program for health care professionals. ⁸⁶

Preceptors provide students with vital clinical education which trains the next generation of health care professionals. Programs such as rotations, fellowships, and residencies can increase trainees' exposure to rural lifestyle and medical practice to improve in-state retention rates and physicians / providers per capita.⁸⁷

The Task Force recommends providing longitudinal, recurring State funding to new and existing rural health care training programs available through Tennessee medical schools, training sites, and/or providers (including behavioral health), and/or Area Health Education Center (AHEC) to address existing primary care and behavioral health shortages in rural communities.

8.1 Rural Health Care Preceptorship and Rotation Programs

The Task Force recommends providing a recurring annual investment to implement and support new preceptorship programs across the State's rural areas.

Rural Preceptorship program funding should include stipends for:

- Nursing Preceptorships (e.g., RNs, APRNs),
- Behavioral Health Preceptorships (e.g., therapists, social workers, counselors),
- Physician Preceptorships (e.g., allopathic and osteopathic physicians),
- Host institutions to develop preceptorship memoranda of understanding or affiliation agreements, preceptor training, and related expenses, and
- Adjunct faculty, clinical assistants, associate professors, and part-time faculty who may serve as preceptors.

Rural Rotation program funding should support staff and trainees' transportation, housing, travel, and medical malpractice expenses, including but not limited to:

- The Tennessee AHEC Scholars Program for medical school students, and

⁸⁴ Rural Track Program Designation – Overview. Accreditation Council for Graduate Medical Education. <https://www.acgme.org/initiatives/medically-underserved-areas-and-populations/rural-tracks/>

⁸⁵ What is a fellowship-trained doctor? Medical University of the Americas. 2021. <https://www.mua.edu/resources/blog/what-is-a-medical-fellowship>

⁸⁶ Medical Dictionary. Retrieved June 1, 2023, from <https://medical-dictionary.thefreedictionary.com/residency>

⁸⁷ *Recruiting Rural Healthcare Providers Today: A Systematic Review of Training Program Success and Determinants of Geographic Choices*. Journal of General Internal Medicine. 2018. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5789104/>

- Tennessee Center for Health Workforce Development (TCWD) for medical school students and medical residents.

The Task Force recommends implementing this pool of funding as an annual drawdown available to all training sites to implement and support preceptorship and rotation programs as defined above.

8.2 Rural Training Tracks, Accelerated Medical Training Opportunities, and Fellowships

The Task Force recommends increasing the number of rural training tracks, accelerated medical training opportunities, and rural fellowships available across the State (including allopathic and osteopathic physicians, APRNs, and behavioral health professionals).

Specifically, the Task Force recommends the State:

- Expand rural family medicine training tracks to increase the number of rural training opportunities,
- Build on the successful Middle Tennessee program, expand accelerated medical training opportunities (i.e., “3+3+3 Training Programs”) in academic institutions in East and West Tennessee, where students complete their undergraduate degree in three years, medical degree in three years, and family medicine residency in three years,
- Expand Rural Family Medicine – OB/GYN Fellowship Programs to increase access to maternal health care services in rural areas, and
- Implement an APRN-focused “Rural Health Entrepreneur Fellowship” to support APRNs (e.g., Nurse Practitioners [NPs], psychiatric NPs, pediatric NPs, nurse midwives) in skill and knowledge development. This program should provide APRNs with the clinical and business knowledge to develop and implement a rural health clinic in high-need communities. The Task Force recommends evaluating this program and identifying opportunities to extend to other provider types pending results and impact.

8.3 Rural Residency Programs available through Tennessee Medical Schools, Nursing Programs, and Provider Locations

The Task Force recommends providing one-time funding (i.e., a pool of start-up funds) that supports the development of new rural residency programs. The Task Force recognizes that new GME hospitals may require supplementary funding to cover expenses between GME program initiation and eventual reimbursement (i.e., federal funding).

The Task Force recommends providing this funding to accredited allopathic and osteopathic physician residency programs that:

- Primarily train residents in rural training sites for greater than 50% of their total time in residency, and
- Focus on producing physicians who will ultimately practice in rural communities.

8.4 Continuing Education / Continuing Medical Education Courses

The Task Force recommends providing recurring funding to the Tennessee AHEC program to support ongoing training of rural health care professionals' preceptors through virtual continuing education / continuing medical education courses. Ongoing training provides additional skill development among rural health care providers and provides an additional participation incentive.

Recommendation 9: Rural Health Care Pathway Programs

Expand current health care, behavioral health, and dental health pathway programs by:

- 9.1 Increasing early exposure to health care careers,
- 9.2 Increasing transition opportunities into health science education and health care careers, and
- 9.3 Improving health care career advancement programs (e.g., LPN to RN, EMT to RN).

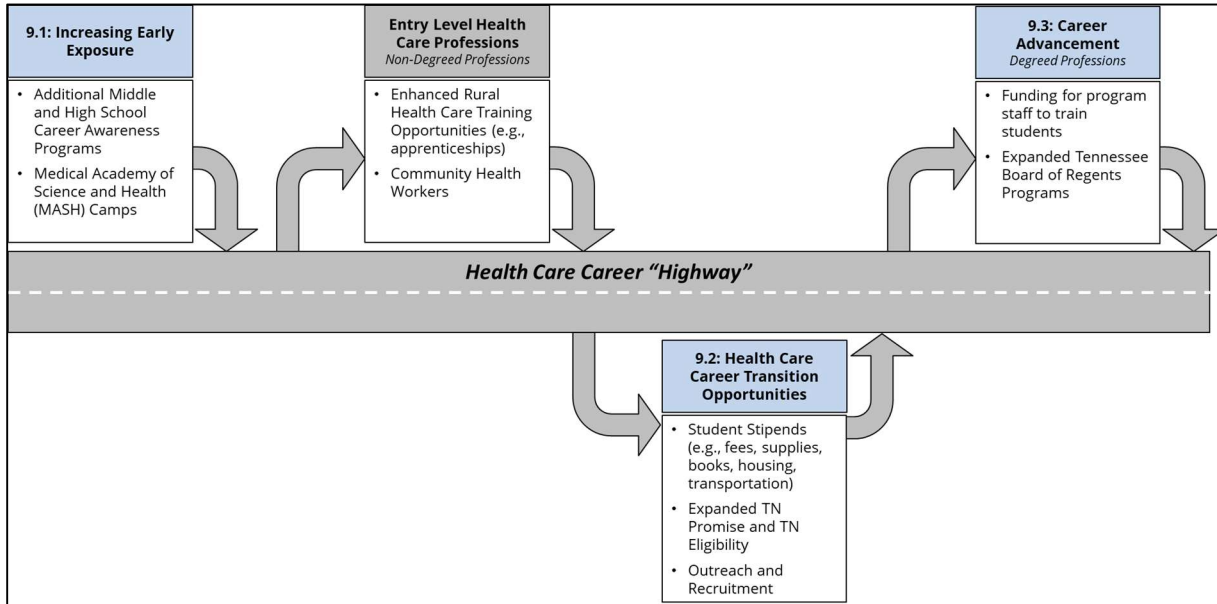
Total Proposed Budget (5-Year): \$67,745,244

Individuals from rural communities are most likely to stay or return to rural communities in their health care profession.⁸⁸ Training and recruiting rural students and then providing an opportunity for employment is an evidence-based strategy for growing the workforce in rural areas. The Task Force acknowledges the importance of developing strong, defined career pathway programs to enhance the health care workforce in rural communities. There are several successful, existing pathway programs available through Tennessee Promise, Tennessee Reconnect, TCWD, AHEC program, HOSA – Future Health Care Professionals, and various TBR colleges that have capacity and demand to expand if funded to do so. The Task Force recommends the State support and expand these programs to engage individuals from early education throughout their professional careers.

The Task Force recommends a series of actions and policies to enhance opportunities to enter and transition into health care, behavioral health, and dental health professions as outlined in **Figure 11**. The Task Force identified these actions as various “on and off ramps” of a “health care highway”, meeting individuals where they are to support their progression and goals throughout their respective health care careers.

⁸⁸ *Recruiting Rural Healthcare Providers Today: A Systematic Review of Training Program Success and Determinants of Geographic Choices*. Journal of General Internal Medicine. 2018. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5789104/>

Figure 11. Building “On and Off Ramps” for the Health Care Career “Highway”



The Task Force recommends supporting rural health care pathway programs by expanding post-secondary funding for education (e.g., books), increasing rural recruitment and enrollment rates among rural youth and non-traditional students (e.g., through social media marketing campaigns to address financial and social stigmas), and increasing program completion rates (e.g., through student stipends). Expanding current pathway programs and building new pathway programs can help attract new students (e.g., young adults, middle-aged adults, military personnel with health care experience) into health care professions, provide additional supports to students to assist in completion of post-secondary education and obtain the necessary licensures, and help address existing workforce shortages.

The Task Force recommends expanding existing Tennessee career pathway programs by increasing youth exposure to health care careers, increasing transition opportunities into health science education and health care professions, and improving professional advancement programs. More detail is included in **Figure 12**.

Figure 12. Recommendations to Expand Career Pathway Programs

Recommendation Overview	Recommendation Detail
9.1 Increasing Exposure to Health Care Careers	
Expanded Youth Programming to Increase Career Awareness	Expand and increase the connectedness of programs to provide health care career programming and support to increase middle school, high school, and college students’ awareness of the wide variety of health care professions (e.g., respiratory care therapists,

Recommendation Overview	Recommendation Detail
	<p>clinical laboratory technologists / technicians, psychiatrists, mental health counselors, psychologists, RNs, physicians).</p> <p>Provide recurring funding to organizations (e.g., AHEC, HOSA) to increase career awareness offerings such as hosting annual Statewide career fairs, conducting education career webinars, providing clinical shadowing opportunities, and developing resource libraries for students interested in health care occupations.</p>
Medical Academy of Science and Health (MASH) Camps	<p>Conduct a pilot MASH Camp to socialize students to a variety of health care professional opportunities. Evaluate MASH Camp to determine effectiveness in rural post-secondary enrollment in health sciences.</p>
9.2 Increasing Transition Opportunities into Health Science Education and Health Care Careers	
Post-Secondary Education and Personal Living Expense Stipends	<p>Provide additional stipends for post-secondary education related costs (e.g., licensure fees, examination fees, supplies, books) and personal living expense costs (e.g., childcare, housing, transportation) to recent high school graduates, non-traditional students (i.e., working professionals) and/or other students committed to serving in rural areas.</p>
Targeted Health Care Education Outreach	<p>Develop additional outreach programs to recruit rural working professionals to pursue health care education and explore health care career advancement opportunities.</p>
Expanded Tennessee Promise and Tennessee Reconnect	<p>Implement a policy to expand Tennessee Promise and Tennessee Reconnect eligibility to Tennessee ages 19 – 23, already hold a certificate or Associate’s degree, including students in bridge programs (e.g., certified nursing assistant [CAN] to LPN, LPN to RN), and/or are seeking additional education for a high-demand health care profession.</p>
9.3 Improving Health Care Career Advancement Programs	
Faculty Salary Incentives	<p>Provide competitive salary and sign-on bonus incentives for faculty at rural Tennessee colleges and Tennessee Colleges of Applied Technology (TCATs).</p>
New Career Pathway Programs	<p>Develop career pathway programs with documented agreements (i.e., articulation agreements) between academic institutions regarding students’ transferable course credits to promote health care career progression, including:</p> <ul style="list-style-type: none"> • TCAT Pre-Practical Nursing Programs, • TCAT Practical Nursing Programs,

Recommendation Overview	Recommendation Detail
	<ul style="list-style-type: none"> Community College Associate of Applied Science in Nursing Programs, and TCAT Associate of Occupational Technology (AOT) in Surgical Technologist Programs.
<p>New and Existing Health Care Bridge Programs</p>	<p>Increase grant funding to establish new and maintain existing health care bridge programs at rural academic institutions including:</p> <ul style="list-style-type: none"> Certificate to Licensure Programs (e.g., CNA to LPN), Community College Paramedic to RN Programs, Community College LPN to RN Programs and, Public University Associate Degree of Nursing to RN Programs.

Additional Considerations

The Task Force recognizes the opportunity for the State to further engage the federal government to explore opportunities to expand the health care workforce pipeline. The Task Force recommends the State explore opportunities to engage with federal partners to evaluate potential policies to improve health care career pathways that address existing needs in rural communities. For example, the Task Force acknowledges that there may be an opportunity to expand international work visa policies to recruit health care professionals (e.g., nursing aides) to work in high-need rural community settings such as nursing homes, clinics, or hospitals.

Recommendation 10: Rural Loan Repayment Programs

Expand existing loan repayment programs to incentivize rural providers (e.g., psychiatric, primary care, pediatric, women’s health physicians, NPs, RNs, counselors, and therapists) to practice in rural areas.

Total Proposed Budget (5-Year): \$5,799,750

Licensed health care professionals often face financial barriers, such as:

- Substantial student loan debt, especially among health professions that require four-year education and graduate-level education, and
- Required loan payments prior to receiving loan repayment funding.^{89,90,91}

The existing Tennessee State Loan Repayment Program (TSLRP) is bound by federal regulations (e.g., loan repayment amount, health professional shortage area [HPSA] site

⁸⁹ Student Debt: Ensuring Medical School Remains Affordable. Association of American Medical Colleges. <https://students-residents.aamc.org/advocacy/student-debt-ensuring-medical-school-remains-affordable>

⁹⁰ Dental Student Debt. American Student Dental Association. 2022. <https://www.asdanet.org/index/get-involved/advocate/issues-and-legislative-priorities/Dental-Student-Debt>

⁹¹ Per Rural Health Care Task Force Workforce Development Workgroup meeting discussions.

placements). Therefore, the Task Force recognizes the opportunity to potentially modify or expand other existing loan repayment programs without the parameters of federal regulation to incentivize rural practice. Specifically, the Task Force recommends providing funding to expand loan repayment programs available through non-State, non-profit organizations to recruit and retain providers in rural communities.

The Task Force recommends leveraging a non-State, non-profit entity to manage a loan repayment program and distribute \$1,000,000 in awards annually in exchange for a commitment to serve in rural communities for the following provider types:

- Physicians,
- NPs (including psychiatric NPs, pediatric NPs),
- RNs,
- Licensed Clinical Social Workers,
- Counselors, and
- Therapists.

In addition, the Task Force recommends the State evaluate potential opportunities to adjust existing loan repayment programs to incentivize providers to serve in rural communities:

- Monitor the new State Family Medicine Loan Repayment Program (SB781) and identify opportunities to expand / augment, if deemed successful,⁹²
- Increase awareness of available loan repayment programs,
- Increase loan repayment amount (while considering potential tax implications and federal restrictions) compared to existing loan repayment programs,
- Prioritize rural site placements (based on workforce demand),
- Prioritize professionals with demonstrated commitment to live and/or work in rural communities,
- Customize loan repayment amounts based on level of education, time of service, and student loan amount (if deemed to be beneficial),⁹³
- Increase flexibility of allowable professions, and
- Allow applications earlier in career placement pathway.

Lastly, the Task Force recommends advocating to Health Resources and Services Administration (HRSA) the need to revisit HPSA scoring to assure providers can be placed in the highest need clinics.

⁹² Tennessee General Assembly, Senate Bill 781. 2023. <https://www.capitol.tn.gov/Bills/113/Bill/SB0781.pdf>

⁹³ Tennessee Health Workforce Projections: 2021 – 2035. Tennessee Hospital Association. 2022. <https://secure.tha.com/files/workforce/Tennessee-Health-Workforce-Projections-Report.pdf>

Recommendation 11: Community Health Workers

Support the work of State agencies, non-profit organizations, academic institutions, and the Community Health Worker (CHW) professional association in implementing and sustaining evidence-supported CHW initiatives to improve health outcomes and provide a broad means of entry into other health professions.

Total Proposed Budget (4-Year): \$4,000,000

CHWs are lay public health workers who are often from the community they serve, which positions them to provide culturally appropriate health education and community-specific care coordination. Hundreds of research articles have evaluated the impact of CHWs on health outcomes and cost of care.⁹⁴ Several Tennessee organizations currently use CHWs, with varying roles and responsibilities (e.g., advocacy, case management, care coordination, navigation, and peer education) and are implementing pilot programs to determine CHW effectiveness in their various roles. While some CHWs are sustained through reimbursement models, others rely on one-time funding sources (e.g., grants).⁹⁵

CHWs face several barriers related to their profession, including:

- Inconsistent roles, responsibilities, training / education requirements,
- Lack of sustainable funding sources to reimburse CHW services, and
- Undefined pathways for further health care career advancement.^{96,97,98}

As outlined in **Figure 13**, the Task Force recommends three policies for the State to advance existing CHW initiatives, including active programs from State agencies, non-profit organizations, and academic institutions. The Task Force recognizes that the CHW profession is still evolving, and the Task Force recommends the State evaluate results from ongoing pilot programs to determine if and/or how to best incorporate CHWs and necessary infrastructure (e.g., education, training, career advancement opportunities, sustainable funding mechanisms) into rural communities to improve health care coordination and health outcomes.

⁹⁴ *Community Health Workers: Evidence of Their Effectiveness*. Association of State and Territorial Health Officials. <https://www.astho.org/globalassets/pdf/community-health-workers-summary-evidence.pdf>

⁹⁵ *Tennessee Community Health Workers Report*. TN Community Health Worker Collaborative. 2018. https://www.meharry-vanderbilt.org/meharry-vanderbilt/sites/default/files/CHW%20Report_FINAL%20draft_1%2028%2019.pdf

⁹⁶ *Community Health Worker Career Gateways, Requirements, Pathways, and Barriers*. National Association of Community Health Workers. 2021. https://nachw.org/wp-content/uploads/2022/08/chw_career_4.pdf

⁹⁷ *Tennessee Community Health Workers Report*. TN Community Health Worker Collaborative. 2018. https://www.meharry-vanderbilt.org/meharry-vanderbilt/sites/default/files/CHW%20Report_FINAL%20draft_1%2028%2019.pdf

⁹⁸ Per Rural Health Care Task Force Workforce Development Workgroup meeting discussions.

Figure 13. Policy Recommendations to Enhance Existing CHW Infrastructure

CHW Infrastructure	Policy Recommendations
Education, Training, and Potential Certification	Support ongoing State initiatives to align courses and training materials with most effective CHW roles / responsibilities and determine whether a formal State certification process could benefit the CHW profession. Increase CHW training to entry-level individuals who are from the community they hope to serve.
CHW Career Pathways	Define CHW career advancement opportunities including supervisory pathways and pathways to other clinical health professions (e.g., nursing, behavioral health professional, allied health professional).
Potential Payment Models	Monitor results of ongoing State initiatives to support best opportunities for CHW reimbursement across various payers (e.g., private insurance, Medicaid, employee benefit). Sustain CHW encounters for the uninsured population via encounter reimbursement from the TDH Uninsured Adult Safety Net Fund.

In addition, the Task Force recognizes that multiple entities (i.e., Meharry, TBR, and Vanderbilt University) currently receive grant funding from HRSA to administer CHW training programs and the funding expires in 2025. The Task Force recognizes the importance of this funding and recommends that TDH distribute \$1,000,000 annually (beginning in 2026) in competitive grants to further expand and sustain training, staffing, and student tuition for CHW programs.

Social Drivers of Health (SDOH)

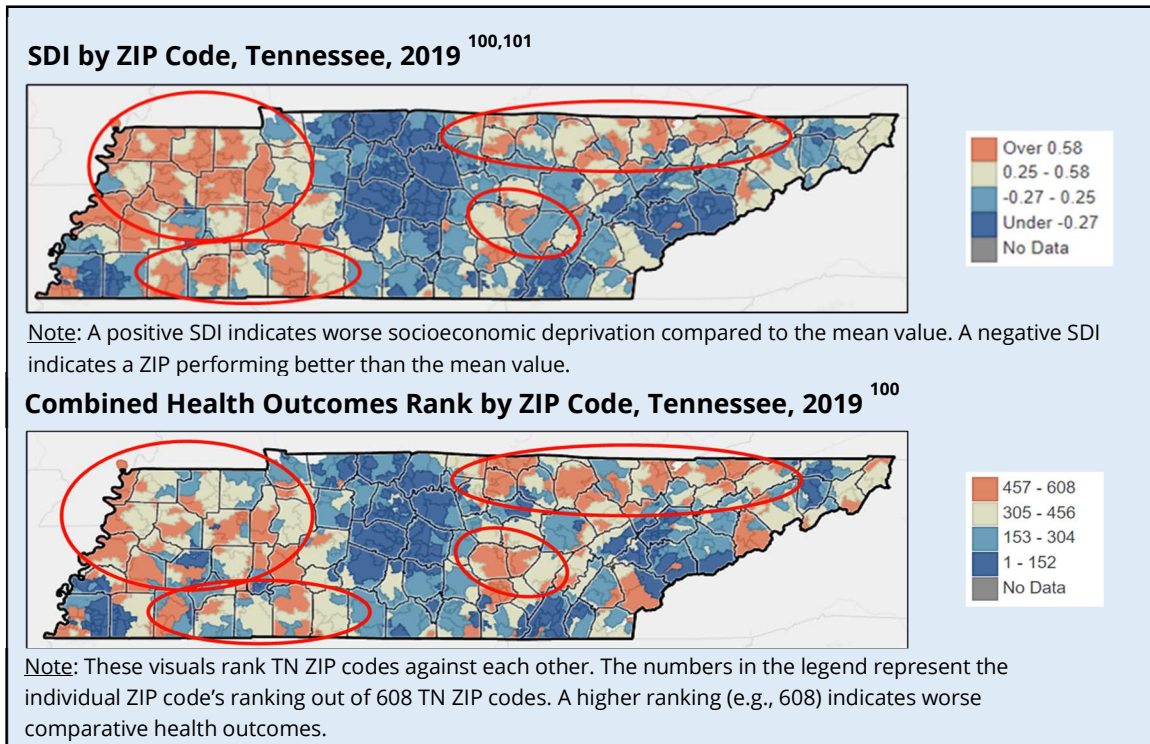
Recommendation 12: SDOH Planning Grants and Implementation Funds

Support County Health Councils (CHCs) to improve food security, transportation, and substance misuse / mental health condition prevention through establishment of Rural County Planning Grants, expansion of Collaborative Action for Resilience and Equity (CARE) Grants, and implementation of private partner development support.

Total Proposed Budget (5-Year): \$33,000,000

SDOH are the conditions in which people live, work, play, and worship that can impact their health and well-being. These include employment, opportunities for education, access to transportation, nutritious food options, freedom from discrimination and stigma, stable housing, and opportunities for meaningful social interaction and connection, among others. Social drivers account for nearly 50% of health outcomes.⁹⁹ This association is readily apparent in Tennessee’s rural communities, where worse performance on the Socioeconomic Deprivation Index (SDI) overlap with worse outcomes across several regions of the State (e.g., rural West Tennessee, Northeast Tennessee), as depicted in **Figure 14**.^{100,101}

Figure 14. SDI and Combined Health Outcomes Rank by Zip Code – 2019



⁹⁹ Addressing Social Determinants of Health: Examples of Successful Evidence-Based Strategies and Current Federal Efforts. Assistant Secretary for Planning and Evaluation; Department of Health and Human Services. <https://aspe.hhs.gov/reports/sdoh-evidence-review>

¹⁰⁰ Explore TN Health. Tennessee Hospital Association and Hospital Industry Data Institute. 2022. <https://exploretnhealth.org/>

¹⁰¹ Socioeconomic Deprivation Index is a measurement accounting for income, education, employment, housing, household characteristics, transportation, and demographics within a community.

The Task Force understands the need to enhance services that assist those who are most vulnerable and could benefit from additional community-based supports. To improve health outcomes, the Task Force recommends that the State meaningfully invest in community-based decisions to impact social drivers and the State provide a means for private investment into those community established priorities for intervention.

The Task Force reviewed data and potential interventions for a host of social drivers of health in rural communities. Ultimately, the Task Force recognized that communities know their own challenges and solutions and recommends that the State build upon established community level engagement that has shown success in some counties and then drive investment to those priority areas. The Task Force identified County Health Councils (CHCs), which

bring together diverse community leaders from multiple sectors, as an existing entity in each rural Tennessee county that can lead social driver improvements.

Every three years, CHCs conduct a

County Health Assessment (CHA) and develop a resulting Community Health Improvement Process (CHIP) to identify and establish shared priorities and set a shared action agenda to address the highest priority health needs (e.g., substance misuse, mental health, obesity) in their community. CHCs have received additional short-term support in the last two to three years that has been met with significant rural community interest and participation.

Through the CHC process, communities are engaged in evaluating local level data provided by the Department of Health and thinking as upstream as possible to address community and social drivers of local health outcomes.

When considering potential social drivers that could lead to improved health and access to care, the Task Force identified food insecurity, lack of transportation, substance misuse, and mental health to be among the most pressing and impactful for rural communities. More specifically, these social drivers significantly impact the lives of rural Tennesseans Statewide:



1. Food Security: 13% of Tennessee households were food insecure in 2021 and 11% of Tennesseans reported food insufficiency from July to August 2022.^{102,103}
2. Transportation: Between 2.2% (Jefferson County) and 17.9% (Lake County) of homes in TDH-defined non-urban counties do not have access to a vehicle.¹⁰⁴
3. Substance Misuse / Mental Health: 80% of rural or partially rural CHCs completing a CHA in 2022 identified misuse as a health priority, and 63% identified Mental Health as a priority.¹⁰⁵

The Task Force recognizes the need for strong public-private partnerships to assist small community-based organizations and local governments to grow and sustain resources, such as grants, technical support, capacity-building, community development, and strategic planning.¹⁰⁶

The Task Force recommends supporting rural communities by sustaining public health infrastructure in the CHCs and by establishing a non-government technical assistance provider to provide an infrastructure for private partner engagement and investment and provide additional community level technical planning assistance. To ignite innovation, the Task Force proposes funding for the establishment and continuation of two grant programs along with technical assistance support:

1. Rural County Planning Grants
2. Collaborative Action for Resilience and Equity (CARE) Grants

CHC Success Story

Beginning in 2014, the **Trousdale County Health Council** evaluated their county health data and identified obesity and physical inactivity as major health challenges. They partnered with the Trousdale County Schools Office of Coordinated School Health to implement a joint community health and active living initiative that they named “#1 for Life.”

Through this program, Trousdale County Health Council implemented new physical fitness classes and other initiatives to improve community health.

By 2020, over 2,750 persons had participated in various activities, with many reporting positive changes, including one young adult losing over 100 pounds.

Trousdale County’s health outcomes have improved since program implementation according to the Robert Wood Johnson County Health Rankings. **From 2011 to 2021, Trousdale County’s ranking for Health Outcomes (compared to other Tennessee Counties) improved from 85th to 30th. Their ranking for Length of Life improved from 88th to 16th.**

The Trousdale County Health Council stated the change in rankings is a direct reflection of their work through the “#1 for Life” initiative.

Source: Rural Health Association of Tennessee

¹⁰² Food Insecurity in Tennessee. America’s Health Rankings; United Health Foundation. 2022. https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/food_insecurity_household/state/TN

¹⁰³ Data Dashboard #1: Mapping Food Insecurity. Food Research & Action Center. <https://frac.org/mappingfood19>

¹⁰⁴ National Environmental Public Health Tracking Network. Centers for Disease Control and Prevention. <https://ephtracking.cdc.gov/DataExplorer/>

¹⁰⁵ Information provided by the Tennessee Department of Health.

¹⁰⁶ *Building Partnerships with Philanthropies: Emerging Strategies for Rural Communities*. The Walsh Center for Rural Health Analysis. 2019. <https://www.norc.org/content/dam/norc-org/pdfs/Rural%20Philanthropy%20Toolkit%20Practice%20Brief%20Brief%20APRIL2019.pdf>

Rural County Planning Grants

The Task Force recommends providing Planning Grants to up to 30 rural CHCs (or their fiduciary partners) each year. Providing Planning Grant funding to a cohort of approximately 30 counties annually would allow all rural CHCs to receive funding once every three years (i.e., Cohort 1, Cohort 2, Cohort 3). Planning Grant applicants should be required to develop a capacity building plan for the period of one year, develop support from non-government and business sector partners, and complete an initial readiness assessment that attests to ability to responsibly manage State dollars.

Spending priorities of Planning Grants should be based on a community-level process for determining rural county needs and identification of multi-sector partners (i.e., partners from various industries) to assist the rural community. These Planning Grants should support community capacity building that can lead to further funding opportunities through private sector funders and/or CARE Grant Implementation Funds (see below).

Based on current, community-driven priorities identified through the CHA process and the cross-sector data demonstrating health impact, the Task Force strongly recommends that CHCs use this grant funding to develop a research-based plan to address key SDOH, including:

1. Food Security,
2. Transportation, and
3. Substance Misuse / Mental Health Condition Prevention.

The Task Force recommends that Planning Grant application and approval be a prerequisite to receive CARE Grant funding.

CARE Grant – Seed Implementation Funds

The Task Force recommends providing recurring funding to support the existing CARE Grant program, a competitive grant program that provides implementation funds to CHCs. The Task Force recommends making new CARE Grants available to CHCs that performed successfully in the Planning Grant phase, wherein the CHC developed a solution to address a social driver, including:

1. Food Security,
2. Transportation, and
3. Substance Misuse / Mental Health Condition Prevention.

The Task Force recommends the following requirements for CARE Grant applicants:

2022 CARE Grant Spotlight: Perry County Community Center Youth Services Hub

Grant Funding: \$440,000

Initiative Overview:

- Create an “all-inclusive brick and mortar hub for organizations serving the mental health needs of Perry County youth.”
- Transform Community Center into office spaces, classrooms, common areas, and community kitchens.
- Develop “One-stop shop” programming for youth, including after-school activities, mental health support, cooking classes, and tutoring.



Supported by U.S. Congressman Mark Green, State Representative Kirk Haston, Perry County Mayor John Carroll, and Linden Mayor Wess Ward

1. Demonstration of proper governance structure and financial management systems needed to successfully implement the grant,
2. Demonstration of at least two community-based organizations and / or private sector partners and two public partners (e.g., CHC member organizations including schools, health departments, and local government) who have committed to collaboratively implement research-based solutions to address a SDOH identified during the Planning Grant phase,
3. Successful completion of Planning Grant report, and
4. Demonstration of clear understanding of community need, a proposal of a research-based solution to address the need, and what the expected community impact could be.

The Task Force recommends competitive advantage be given to applicants who:

1. Propose a collaborative, multi-county intervention.
2. Describe how the CARE Grant may assist the CHC in building upon Planning Grant activities.
3. Demonstrate a match of funds, such as from a for-profit partner, private foundation, or in-kind match from a local community-based organization.

Rural County Planning Grant and CARE Grant Funding Cycle

Each CHC would operate on a three-year planning (Rural County Planning Grant) and implementation (CARE Grant) cycle per the graphic in **Figure 15**.

Figure 15. Rural County Planning Grant and CARE Grant Timeline

Program Year	Cohort 1	Cohort 2	Cohort 3
Year 1 (FY 2025)	Planning Grant		
Year 2 (FY 2026)	Implementation	Planning Grant	
Year 3 (FY 2027)		Implementation	Planning Grant
Year 4 (FY 2028)	Planning Grant		
Year 5 (FY 2029)	Implementation	Planning Grant	

The Task Force recommends establishing a minimum (\$50,000) and maximum (\$200,000) funding amount for CARE Grant recipients (to be requested and justified in the application). In addition to the proposed CARE Grant funding, the Task Force expects CHCs to secure private investment to build capacity and promote sustainability.

Figure 16 depicts the proposed Rural County Planning Grant and CARE Grant funding cycle aligned with the timeline above.

Figure 16. Proposed Rural County Planning Grant and CARE Grant Funding by FY

	FY 2025	FY 2026	FY 2027	FY 2028	FY 2029
Cohort 1 Planning	\$1,500,000			\$1,500,000	
Cohort 2 Planning		\$1,500,000			\$1,500,000
Cohort 3 Planning			\$1,500,000		
Cohort 1 Implementation		\$3,000,000	\$3,000,000		
Cohort 2 Implementation			\$3,000,000	\$3,000,000	
Cohort 3 Implementation				\$3,000,000	\$3,000,000
Total Grant Funding	\$1,500,000	\$4,500,000	\$7,500,000	\$7,500,000	\$4,500,000

To maintain oversight and thorough understanding of the use of funding and impact on the community, the Task Force recommends TDH develop and implement short- and long-term performance metrics. The Task Force recommends TDH use performance metrics data to measure program impact and potential sustainability considerations.

Technical Assistance (TA) and Partner Development Support

The Task Force recommends providing annually recurring funding to support TDH positions and a contract with a private partner to provide infrastructure to promote private

sector investment for the community projects, technical assistance, and sustainability assistance to CHCs as defined in **Figure 17**.

Figure 17. Proposed Technical Assistance and Partner Development Support

TA Partner Organization	Purpose and Proposed Role
<p>TDH Staff Positions</p>	<p>TDH was awarded federal funding to invest in CHC infrastructure in FY22. Over 50 counties chose to use TDH's support to bring community partners together via a CHA/CHIP process. The Task Force recommends building on the success of this initial investment by establishing permanent positions to continue and expand support for local CHCs and manage grant funding provided to rural counties and their partners. This assistance should include programmatic leadership and local, community-based assistance for CHCs initiating and/or conducting their CHA. This would include ongoing education on SDOH, leading drivers of morbidity and mortality, and a "menu of options" (i.e., potential initiatives for communities to select and implement) for research-based interventions.</p>
<p>Private Technical Assistance Partner</p>	<p>This investment would promote public-private collaboration between local and State government, private businesses, and community-based organizations in the CHC process. The partner should collaborate with TDH (i.e., the grant-making entity) in supporting the CHCs through the Planning Grant and CARE grant process, including:</p> <ul style="list-style-type: none"> • Providing direct technical assistance (e.g., grant identification / writing / execution, project planning, policy development, financial management), • Developing and maintaining a list of pre-vetted partners to support research-based solutions that address SDOH, • Vetting potential private partners to ensure capabilities and interests align with the intent and objective of the grant program, • Serving as a referral and matching partner between CHCs, corporations, foundations, community-based organizations, which offer innovative solutions in addressing mental and behavioral health, food security, and transportation, and • Recruiting business sector investment to support the implementation and sustainability of the CHCs.

The Task Force intends for TDH to have the autonomy to determine the specifics (e.g., application process, reporting structure) of the Grant programs, but recommends leveraging and expanding existing processes and infrastructure that have demonstrated success. Where possible, the Task Force recommends encouraging CHCs to build upon existing efforts and avoid duplication of efforts.

The Task Force recognizes there may be additional opportunities to incentivize communities to achieve health outcome improvements. The Task Force recommends TDH

identify and pursue potential opportunities to incentivize rural communities to improve SDOH in addition to those outlined in this recommendation.

Lastly, the Task Force recommends TDH conduct annual evaluations, as well as an evaluation at the end of the five-year period, to determine the impact of this program on rural communities and health outcomes.

Recommendation 13: Closed-Loop Referral System Supports

Support rural providers in addressing the social drivers of health experienced by their patients, including preparing for and implementing TennCare’s Closed Loop Referral System.

Total Proposed Budget (3-Year): \$9,600,000

At the time of the report, TennCare is actively procuring support “for the design, development, implementation, and operation of a public, cloud-based Closed-Loop Referral System” that aims to enhance non-medical service coordination for providers and patients across Tennessee.¹⁰⁷ The Closed-Loop Referral System will coordinate access to necessary supports for rural community members across the State. The Task Force recognizes the benefit of this platform for patients and providers and the need to deliver assistance to rural providers who may not have the capacity to successfully implement without support. The Task Force intends for this recommendation and resulting actions to provide additional support to rural providers to effectively implement the Closed-Loop Referral System platform and enhance non-medical service coordination to improve the SDOH for rural patients.

The Task Force recommends that the State coordinate support for rural providers (e.g., safety net clinics, rural health clinics, hospitals, independent practices) to enhance the SDOH screening process and resource coordination, including preparing for and implementing TennCare’s Closed-Loop Referral System. Providers and communities would benefit from additional implementation support over a three-year implementation period (FY 2025 – FY 2027) to allow providers and communities the flexibility to implement when they are prepared to do so.

Specifically, the Task Force recommends the State provide the following resources to support rural providers in preparing for and implementing the Closed-Loop Referral System:

- Tailored resources (e.g., small grants) for rural provider groups to support training, office workflow, system roll-out, community linkages, baseline technology improvements, and/or upstream SDOH interventions, and
- Investment in community-based organizations and agencies serving rural communities to increase capacity for and effectiveness of referrals.

¹⁰⁷ Upcoming Procurements. Division of TennCare. 2023. <https://www.tn.gov/tenncare/information-statistics/upcoming-procurements.html>

Oral Health: Sustaining 2021 Healthy Smiles Initiatives

Rural communities face dental access to care barriers attributed to insurance factors, income, and geographic location. The American Dental Association Health Policy Institute reports nearly 22% of low-income Tennesseans believe the appearance of their teeth can affect job interviews and 70% of Tennesseans report cost as a contributing factor for not visiting the dentist.¹⁰⁸ Elderly rural patients face heightened challenges with an increased risk of gum disease, tooth decay, and limited access to providers.¹⁰⁹

The State convened the Healthy Smiles Initiative Dental Workgroup in 2021 to identify recommendations that enhance oral health services across Tennessee. In addition to the Access to Care, Workforce Development, and Social Drivers of Health recommendations, the Task Force requests the State provide recurring funding to sustain these dental initiatives including:

- **Smile on 65+:** This funding would support charitable clinics and FQHCs in providing oral health care and case management services to adults ages 65+,
- **Prosthodontic Grant Program:** This funding would support the cost of dentures for working age Tennesseans (18 – 64 years of age) seen in charitable care clinics,
- **Dental Loan Repayment Program:** Making permanent the expanded loan repayment programs for dental hygienists, dental assistants, and dentists in rural and underserved areas, and
- **Dental School Class Size:** Make permanent the non-recurring State investment in dental school class size at Meharry, University of Tennessee, and Lincoln Memorial University schools of dentistry.¹¹⁰

¹⁰⁸ *Oral Health and Wellbeing in Tennessee*. American Dental Association Health Policy Institute. <https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/oralhealthwell-being-statefacts/Tennessee-Oral-Health-Well-Being.pdf>

¹⁰⁹ Addressing Rural Seniors' Unmet Needs For Oral Health Care. HealthAffairs. <https://www.healthaffairs.org/content/forefront/addressing-rural-seniors-unmet-needs-oral-health-care>

¹¹⁰ Healthy Smiles Initiative. Improving Dental Access Across Tennessee. 2021. https://wpln.org/wp-content/uploads/sites/7/2022/02/Healthy-Smiles-Initiative-Nov21_final.pdf

Summary and Conclusion

We applaud Governor Lee for commissioning the Rural Health Care Task Force and creating the opportunity for thoughtful and evidence informed recommendations to improve the health and well-being of rural Tennesseans who have increasing challenges to access health and health care.

The need to invest in solutions for rural Tennesseans is urgent. The pace of facility and service line (e.g., obstetrics) closures further threatens the health of Tennessee residents and business investment opportunities while needs such as behavioral health are skyrocketing. Furthermore, a high rate of uninsured residents creates significant barriers to access care, weakens the financial viability of health care, dental and behavioral health facilities, and diminishes the health of the available work force and their families. Lack of workforce availability is particularly acute in rural health care across all types of care needed, driving up the cost and decreasing the availability, safety, and quality of all types of care. Meanwhile, the environment in which rural Tennesseans live, work, play and worship is one of its greatest strengths and yet those living more remotely often have the least economic, education, transportation, and nutrition resources needed for optimal health. While the health care landscape will continue to rapidly evolve, Tennessee residents and policy makers will have to quickly adapt and create opportunities for those who need it most with innovative ideas and technologies (e.g., artificial intelligence).

Rather than simply recap the challenges to health and health care access in Tennessee, this report offers actionable opportunities to significantly improve the health of Tennesseans for generations. Although the Task Force membership consisted of state and national policy and business experts, members have also carefully examined what is and is not working across the country and within our State and have spent countless hours talking with rural community members and providers, businesses, and experienced agency program managers. This has resulted in practical and high yield recommendations in three key areas:

- Access to Care
- Workforce Development
- Social Drivers of Health

Many of these recommendations, such as expanding CHCs with public-private partnerships, improving provider to provider specialist telehealth access, and expanding apprenticeships and rural training are proven to work in rural Tennessee and are “shovel ready” with the dedication of funding from State, Federal, or private sector sources. Other recommendations, such as the Center of Excellence, will require ongoing commitment and collaboration by State agencies, industry partners, and rural communities, and would result in substantial and perpetual benefit to rural health care providers by harnessing operational and policy expertise for all communities and facilities. Policy recommendations such as closing the insurance gap, evaluating scope of practice, and addressing the

educational support need between Tennessee Promise and Tennessee Reconnect will take deliberation and action. Some of these recommendations, particularly regarding workforce development, will take a significant financial investment by the State to raise, recruit, and retain health professionals of all types for immediate and future needs. A common thread in our recommendations is to leverage the resources and expertise of private sector through various partnerships. We believe that this approach is optimal because it brings in additional resources to rural communities and allows for the flexibility to tailor programs to the unique needs and priorities of each community.

The high-impact recommendations in this report provide a comprehensive road map to transform the health care landscape in our State by improving access to health care, providing communities resources to address key drivers of health outcomes, and training and sustaining health care professionals for rural Tennesseans for years to come. Improvements in health and health care access have ripple effects, leading to better opportunities for Tennesseans in education and economic mobility, resulting in stronger communities.

Task Force members have contributed significant time, energy, and expertise to this process thanks to Governor Lee's charge. The Task Force also extends its gratitude to the Guidehouse team for its assistance in research, facilitation, and recommendation development support. Together, we are grateful for the opportunity to develop these recommendations and pave a historic path forward to improving rural health care in our State.

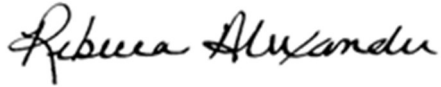
Appendix A: Five-Year Rural Health Care Task Force Budget Request

Figure 18 outlines the five-year budget request for each recommendation, by workgroup.

Figure 18. Five-Year Rural Health Care Task Force Budget Request

	FY 2025	FY 2026	FY 2027	FY 2028	FY 2029	Five-Year Total
Total Budget Request	<u>\$38,428,962</u>	<u>\$39,664,842</u>	<u>\$43,164,842</u>	<u>\$40,574,074</u>	<u>\$37,574,074</u>	<u>\$199,406,794</u>
Access to Care	<u>\$3,522,900</u>	<u>\$3,456,000</u>	<u>\$3,456,000</u>	<u>\$3,456,000</u>	<u>\$3,456,000</u>	<u>\$17,346,900</u>
1: Center of Excellence (CoE)	\$1,006,000	\$1,006,000	\$1,006,000	\$1,006,000	\$1,006,000	\$5,030,000
2: CoE Planning and Implementation Grants	\$1,400,000	\$1,400,000	\$1,400,000	\$1,400,000	\$1,400,000	\$7,000,000
3: Health Insurance Coverage	N/A	N/A	N/A	N/A	N/A	N/A
4: Specialty Care	\$1,050,000	\$1,050,000	\$1,050,000	\$1,050,000	\$1,050,000	\$5,250,000
5: Scope of Practice	N/A	N/A	N/A	N/A	N/A	N/A
6: Rural Telemedicine Program	\$66,900	\$0	\$0	\$0	\$0	\$66,900
Workforce Development	<u>\$28,706,062</u>	<u>\$27,008,842</u>	<u>\$27,508,842</u>	<u>\$28,118,074</u>	<u>\$28,118,074</u>	<u>\$139,459,894</u>
7: Rural Health Care Apprenticeship Programs	\$6,384,730	\$8,259,730	\$8,259,730	\$8,259,730	\$8,259,730	\$39,423,650
8: Rural Health Care Training Programs	\$5,398,250	\$3,898,250	\$4,398,250	\$4,398,250	\$4,398,250	\$22,491,250

	FY 2025	FY 2026	FY 2027	FY 2028	FY 2029	Five-Year Total
9: Rural Health Care Pathway Programs	\$15,763,132	\$12,690,912	\$12,690,912	\$13,300,144	\$13,300,144	\$67,745,244
10: Rural Loan Repayment Programs	\$1,159,950	\$1,159,950	\$1,159,950	\$1,159,950	\$1,159,950	\$5,799,750
11: Community Health Workers	\$0	\$1,000,000	\$1,000,000	\$1,000,000	\$1,000,000	\$4,000,000
Social Drivers of Health	<u>\$6,200,000</u>	<u>\$9,200,000</u>	<u>\$12,200,000</u>	<u>\$9,000,000</u>	<u>\$6,000,000</u>	<u>\$42,600,000</u>
12: County Health Councils SDOH Grant Programs	\$3,000,000	\$6,000,000	\$9,000,000	\$9,000,000	\$6,000,000	\$33,000,000
13: Closed-Loop Referral System Supports	\$3,200,000	\$3,200,000	\$3,200,000	\$0	\$0	\$9,600,000



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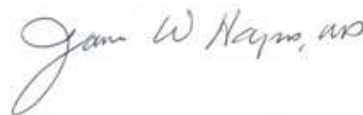
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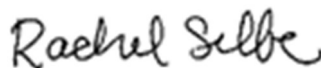
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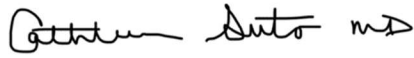
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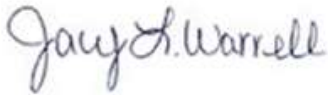
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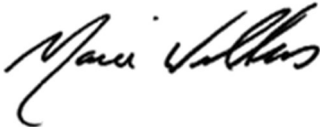
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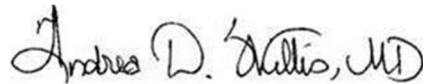
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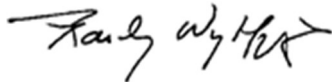
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