Maternal and Child Health Services Title V Block Grant

Tennessee

FY 2022 Application/ FY 2020 Annual Report

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I. General Requirements

I.A. Letter of Transmittal

August 12, 2021

Grants Management Officer
Division of State and Community Health
Maternal and Child Health Bureau
Health Resources and Services Administration
5600 Fishers Lane, Room 18-31
Rockville, MD 20857

Dear Grants Management Officer,

Tennessee's Title V MCH Block Grant application and report are enclosed.

Please contact me directly if further information is needed.

Sincerely,

Tobi Adeyeye Amosun, MD, FAAP
Director, Division of Family Health and Wellness
Tennessee Department of Health

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I.B. Face Sheet

The Face Sheet (Form SF424) is submitted electronically in the HRSA Electronic Handbooks (EHBs).

I.C. Assurances and Certifications

The State certifies assurances and certifications, as specified in Appendix F of the 2021 Title V Application/Annual Report Guidance, are maintained on file in the States' MCH program central office, and will be able to provide them at HRSA's request.

I.D. Table of Contents

This report follows the outline of the Table of Contents provided in the *"Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms,"* OMB NO: 0915-0172; Expires: January 31, 2024.

II. Logic Model

Please refer to figure 4 in the "Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms," OMB No: 0915-0172; Expires: January31, 2024.

III. Components of the Application/Annual Report

III.A. Executive Summary

III.A.1. Program Overview

Introduction to Tennessee's MCH/Title V Program

The Tennessee MCH/Title V Program is housed within the Tennessee Department of Health's (TDH) Division of Family Health and Wellness (FHW). This division is responsible for the TDH's maternal and child health, chronic disease and health promotion, and supplemental nutrition programs. The FHW Division Director also serves as the MCH/Title V Director, therefore all programs within FHW are under the control of the MCH/Title V Director. This makes for strong integration and collaborative bonds between the MCH/Title V and all other FHW programs.

Needs Assessment

At the beginning of a new five-year grant cycle, states are required to conduct a comprehensive needs assessment to identify priority needs of women, infants, children, adolescents and their families; as well as determine the capacity of the health system to meet those needs. During the years between the comprehensive needs assessments, states are expected to conduct on-going needs assessments in order to identify any significant changes in needs and capacity.

TDH conducted the comprehensive needs assessment for the 2021-2025 cycle during 2019 and 2020 in conjunction with over 100 stakeholders. Key components included:

- Quantitative analysis of key indicators; including descriptive statistics stratified by race, ethnicity, and geography
- Qualitative data collection and analysis; including focus groups, key informant interviews, and open-ended surveys
- Structured process for choosing priorities based on the data complied
- Capacity assessment of current and potential programming for each identified priority

As a part of the ongoing needs assessment, the state hosts MCH stakeholder meetings twice each year. These meetings are open to anyone, and effort is made to extend the invitation broadly. During the meetings, participants are asked to consider the progress made on performance measures during the past year, and then based on that evaluation make recommendations for the next year's action plan.

Needs and Priorities

States are required to identify at least one priority in each of the population health domains, except for the Cross-cutting/Systems Building domain which is optional. There are a total of six domains:

- Women's and Maternal Health
- Perinatal and Infant Health
- Child Health
- Adolescent Health
- Children with Special Health Care Needs
- Cross-cutting/Systems Building

As a result of the Needs Assessment, TDH identified priority needs for the MCH population for the 2021-2025 grant cycle. These priorities include:

- Increase family planning
- Decrease pregnancy-associated mortality
- Increase breastfeeding
- Decrease infant mortality
- Increase prevention and mitigation of Adverse Childhood Experiences (ACEs)
- Decrease overweight and obesity (among children)
- Decrease tobacco and e-cigarette use (among adolescents)
- Increase medical home
- Improve transition from pediatric to adult care
- Improve mental health

Program Planning

The MCH/Title V Program is managed within FHW. This division includes sections for:

- Reproductive and Women's Health
- Perinatal, Infant, and Pediatric Care
- Early Childhood Initiatives
- Supplemental Nutrition (including WIC)
- Injury Prevention and Detection
- Chronic Disease Prevention and Health Promotion
- Children and Youth with Special Health Care Needs

The variety of content areas in FHW pairs well with the identified priorities. Therefore, each FHW section (including both program an epidemiology staff) leads at least one priority. Teams are responsible for developing and reporting on the action plan and corresponding measures. This is done in conjunction with the MCH Stakeholder Group. This group was formed during the 2015 needs assessment and has met twice a year since then. The group reviews the action plan and measurement progress, then suggests changes for the coming year. They also partner with the MCH/Title V Program to complete the activities outlined in the action plan and work towards the objective for each measure. This is all done under the guidance of the MCH/Title V Director who oversees all aspects of program planning.

Performance Reporting

The epidemiology staff for each priority team takes the lead on tracking and reporting on each measure. The MCH Block Grant coordinator facilitates the tracking and visualization of all measures among all priority teams. This enables everyone (MCH/Title V Director, MCH Block Grant coordinator, priority teams, and MCH Stakeholder Group) to view the overall progress made among all priorities.

Assuring Comprehensive, Coordinated, Family-Centered Services

The MCH/Title V Program assures comprehensive and coordinated services in a number of ways. Core services such as WIC, family planning, breast and cervical cancer screening, preventive care for children (EPSDT and immunizations), health promotion, community outreach and the care coordination services of Help Us Grow Successfully (HUGS) and Children's Special Services (CSS) are offered in all county health departments. Rural

health departments report to regional office and to the Community Health Services (CHS) division of the state health department. Metro health departments are independent and accountable to local governments but operate closely via contract with TDH. This organizational structure assures that MCH/Title V and other state and federal funds are administered comprehensively to all 95 counties and that program fidelity is maintained via direct management or contract. Regular communication occurs with the Regional Leadership Team (metro and regional directors and CHS leadership), the Medical Leadership Team (metro and regional health officers), Nursing Leadership Team (metro and regional nursing leads), and the MCH regional directors to assure multi-directional transmission of key information and provide opportunities for sharing of ideas. Other core MCH/Title V services such as newborn screening provide services to the entire state but are centrally located at the state lab to assure excellent communication between the lab and the FHW clinical follow up team for lead, genetic disorders, hearing loss, and congenital heart disease.

The MCH/Title V Program continues to work with families to assure comprehensive coordinated family-centered services by providing education around the importance of receiving services in a patient-centered medical home, and how to partner with providers in the decision-making process. The program provides the “Partnering with your Provider Booklet” statewide for distribution at community events, as well as medical providers for distribution in their practices. Staff has also collaborated with the Bureau of TennCare, the state Medicaid agency, in their Primary Care Transformation Strategy “Patient-Centered Medical Home”. There are currently over 81 participating provider organizations in over 400 locations, covering over 37% of the TennCare population.

For the MCH/Title V CYSHCN program specifically, staff include a dedicated Family/Youth Engagement and Involvement Director whose primary responsibility is to work with Family Voices to ensure opportunities for family and youth training on patient centered medical homes, transition and policy/advocacy. Title V funds have also been used to expand the division contract with family voices to provide consultation and training for all programs within FHW. In addition, several programs continue to expand their own advisory and family groups to better inform programs and services. For example, the Perinatal Advisory Committee (PAC) and Genetics Advisory Committee have always been open meetings, and recently family representatives have been sought out to attend those meetings. Likewise, the family planning program has 13 required community and client advisory boards in each rural and metro region. Additional input from reproductive justice groups has also been sought to review program guidelines and messaging around contraception and neonatal abstinence syndrome. Furthermore, in the comprehensive redesign of the CSS, HUGS, and Community Outreach programs into the streamlined Community Health Access and Navigation in Tennessee (CHANT) program has incorporated family engagement in the design process to assure that the needs of children and families are being met appropriately.

Partnerships

The strength of MCH/Title V lies in its partnerships. In addition to the intentional engagement of families and customers listed above, TDH has pursued partnerships of all types using the collective impact framework. The descriptions below are not exhaustive and serve as examples of the myriad of partners valued by the agency and the division.

For example, a multitude of local, state, and national partnerships have emerged statewide regarding the opioid crisis and prevention of neonatal abstinence syndrome. In 2019, this resulted in the second consecutive year to year decline (26% from 2017) in cases reported to the NAS surveillance system since 2013. The NAS subcabinet met regularly from 2013-19 with representatives from TDH, Department of Mental Health and Substance Abuse (TDMHSA), Department of Education (DOE), Department of Children's Services (DCS), TennCare, Department of Human Services (DHS) and several others to review NAS surveillance data and research and to plan interventions together. TDH has partnered with the PAC, regional perinatal centers, rural hospitals, Tennessee Hospital Association and the Tennessee Initiative for Perinatal Quality Care (TIPQC) to share best practice and information

regarding treatment of drug exposed mothers and infants. TDH is partnering closely with TennCare, TIPQC, and TDMHSAS in the multi-state Opioid Use Disorder, Maternal Outcomes, and Neonatal Abstinence Syndrome Initiative (OMNI) Learning Community. Much of this work has centered on supporting TIPQC in the roll out of maternal and neonatal quality bundles in the care of substance exposed mothers and infants. In addition, TDH has partnered with local drug coalitions, law enforcement, multiple state agencies and insurance companies to fund and promote medication take back sites in all 95 counties. The response to the opioid epidemic has been complex and growing, involving legislative action, law enforcement, regulation education, prevention messaging, and treatment.

Infant mortality reduction efforts have likewise relied extensively on partnerships. For example, DOE, DCS, EMS entities, the medical community, and the judicial system have been critical to maintaining the Child Fatality Review. Local review teams in all judicial districts serve on a volunteer basis and are essential to determining cause of death for infants and children. This data guides the priorities for the upcoming years, and the local review teams serve as bodies to dissemination information to local communities as well. Given the lack of improvement in the infant mortality rate in the state, the infant mortality strategic plan was revised during 2019 with the assistance of numerous partners including Tennessee Chapter of the American Academy of Pediatrics (TNAAP), TIPQC, the PAC, academic partners such as Vanderbilt University and Children's Hospital, the Children's Hospital Alliance of Tennessee, the Tennessee Breastfeeding Coalition, federally qualified health centers, MCH directors statewide, and community advocacy groups.

Obesity is likewise a complex problem requiring a multi-dimensional approach and many partnerships. DOE and the Office of Coordinated School health partner in both data collection and programming for schools across the state. Obesity has also been a priority for the Governor's Children's Cabinet and the state agencies represented. Recognizing the importance of the built environment and culture change for obesity prevention, TDH has partnered with the Department of Environment and Conservation to promote state parks via the Park Rx and rewards program, the promotion of youth activity clubs, and training state park restaurants to become Responsible Epicurean Agricultural Leadership (REAL) food certified. TDH also coordinates with Governor's Foundation for Health and Wellness to promote Healthier Community designation and Healthier Tennessee business initiatives. Academic partners such as Middle Tennessee State University, East Tennessee State University, and Vanderbilt have also been critical for data analysis and program implementation across the state for efforts in both obesity reduction and tobacco prevention. The Department of Human Services has been instrumental in training childcare facilities and assuring the inclusion of the seven Gold Sneaker policies regarding physical activity, nutrition, and tobacco were included in the star rating system for centers.

III.A.2. How Federal Title V Funds Complement State-Supported MCH Efforts

MCH/Title V federal funds are essential to meet state and local needs in a manner that is intentional, flexible and accountable. States are held accountable for planning and progress in priority areas and must report how both state and federal funds are spent. A needs assessment occurs every five years and is updated annually by review of available data and input of stakeholders. Similarly, the action plan to address the needs with available state and federal resources and a wide range of partners is revised annually. Tennessee has consistently met both maintenance of effort and state funding match requirements of the federal MCH/Title V block grant, ensuring that both funding sources are utilized for MCH needs. The flexibility of the block grant is particularly critical to meet emerging needs when obtaining needed funding from annual appropriation cycles can be significantly delayed. Examples in recent years include the Zika response when MCH funded infrastructure for newborn screening had to be utilized for case management and core MCH programs such as family planning were critical for prevention. Additional CDC funds were used to enhance birth defects surveillance, a primary driver of infant mortality which is an MCH/Title V priority. MCH and SSDI funds have been used to supplement birth defects efforts so that additional infrastructure and care coordination built with Zika funds could be sustained and expanded.

III.A.3. MCH Success Story

In 2020 the Centers for Disease Control and Prevention (CDC) led an Action Learning Collaborative focused on building emergency preparedness and response (EPR) capacity for maternal and infant health. In order to officially join the collaborative states were required to have representatives from both MCH and EPR programs participate. Unfortunately, Tennessee did not have the capacity to meet this requirement due to the ongoing COVID-19 pandemic and the strain it placed on EPR program capacity. However, MCH/Title V Program funded staff decided to use their time to push the work forward as much as possible utilizing materials from the Action Learning Collaborative. Specifically, staff worked through the Public Health Emergency Preparedness and Response Checklist for Maternal and Infant Health during Public Health Emergencies. The checklist included four strategies:

1. Integrate MCH considerations into state EPR plans
2. Develop strategies to gather epidemiologic/surveillance data on women of reproductive age and infants, to guide action
3. Establish/promote EP communications about target population with clinical partners, public health and governmental partners, and with the general public
4. Identify public health programs, interventions, and policies to protect/promote health and prevent disease and injury in emergencies among maternal and infant populations

Progress was made on each strategy in the following ways.

1. Through connections made with EPR staff a MCH/Title V representative will now participate in the regular EPR planning process.
2. PRAMS and BRFSS data were analyzed to understand emergency preparedness of the MCH population in Tennessee.
3. The insights gathered from the PRAMS and BRFSS data were used to develop a MCH EPR checklist for families. The checklist covered what to include in an emergency plan, what supplies to always have, and which documents to have ready to go and where to store them. This checklist is currently available on the state website, copies are being printed to be distributed by WIC, Family Planning, and CSS programs, and there are plans to include it in the Welcome Baby mailer that is sent to the parents of all infants born in Tennessee.
4. A telehealth option was established for family planning visits.

Overall working through this process helped build a better infrastructure for MCH EPR activities moving forward. There is still much progress to be made in planning for the special needs of the MCH population during disasters, but this work has laid a solid foundation. The MCH/Title V Program will continue to push this work forward in the coming years.

III.B. Overview of the State

Demographics, Geography, Economy, and Urbanization

Tennessee spans approximately 500 miles east to west, 110 miles north to south, and is bordered by 8 other states. The state, comprised of 95 counties, is geographically, politically, and constitutionally divided into three Grand Divisions: East, Middle, and West. East Tennessee, comprised of 35 counties, is characterized by mountains and rugged terrain. This region contains Knoxville and Chattanooga (the 3rd and 4th largest cities in the state) as well as the "Tri-Cities" of Bristol, Johnson City, and Kingsport located in the extreme northeastern most part of the state near the boarders to Virginia and North Carolina. Middle Tennessee consists of 39 counties, has the largest land area, and is characterized by rolling hills and fertile stream valleys. Middle Tennessee is the least densely populated of the three Grand Divisions, yet houses Nashville, the state's capitol and largest city. West Tennessee, bordered by the Mississippi River on the west and the Tennessee River on the east, contains 21 counties. This region has the smallest land area and is the least populous of the three Grand Divisions, yet contains the second most populous city in the state – Memphis. Outside greater Memphis, the region is mostly agricultural.

Tennessee's population is estimated to be 6.7 million. Compared to the United States, Tennessee is less racially and ethnically diverse with a smaller foreign born and non-native English-speaking population. The state has slightly higher rates of homeownership and health insurance coverage. However, the state sees slightly worse rates of high school graduates, employment, and poverty. The tables below compare Tennessee to the US as a whole on many different factors.[1]

Race	Tennessee (%)	United States (%)
White alone	77.3	72.2
Black alone	16.8	12.7
Two or more races	2.2	3.4
Asian alone	1.8	5.6
Some other race alone	1.8	5.0
American Indian and Alaska Native alone	0.3	0.9
Native Hawaiian and Other Pacific Islander alone	0.1	0.2

Ethnicity	Tennessee (%)	United States (%)
Hispanic	5.5	18.3
Non-Hispanic	94.5	81.7

Nativity and Language	Tennessee (%)	United States (%)
Foreign born	5.1	13.7
Language other than English spoken at home	7.3	21.9

Socioeconomic Factors	Tennessee (%)	United States (%)
High school graduates or higher	87.8	88.3
Employment rate	57.7	59.8
Homeownership rate	66.2	63.9
Poverty rate among children under 18	22.3	18.0
Health Insurance	10.1	8.9

Health Status of Tennessee's MCH Population

In 2019, according to America's Health Rankings, Tennessee ranked 44th in the nation for overall health.[2] Historically Tennessee has ranked in the bottom ten states for this overall measure. Unfortunately, the state ranks poorly on several key MCH, chronic disease, and social determinates of health indicators, including:

- Smoking (46th)
- Violent Crime (48th)
- Physical Distress (48th)
- Mental Distress (45th)
- Diabetes (45th)
- Physical Inactivity (47th)
- Cardiovascular deaths (45th)
- Infant mortality (43rd)
- Preventable hospitalizations (43rd)
- Teen births (42nd)
- Children in poverty (42nd)
- Low birthweight (41st)

However, the state also ranks well on a few MCH, chronic disease, and social determinates of health indicators, including:

- Childhood immunizations (2nd)
- High school graduation (3rd)
- Excessive drinking (8th)

Based on America's Women and Children Report, a sub report of America's Health Rankings Report, Tennessee ranked in the lowest quintile at 41st overall in 2019. When the population is broken down into women, infants, and children, slight improvements are observed. Although infants still rank in the lowest quintile at 46th, women and children saw a slight ranking improvement to the second to lowest quintile at 35th and 30th respectively.[3]

State Health Agency Roles, Responsibilities, and Priorities

Tennessee's MCH initiatives are housed within the Tennessee Department of Health (TDH), the cabinet-level public health agency. The mission of TDH is to protect, promote, and improve the health and prosperity of people in Tennessee. The Department has a strategic plan that focuses on prevention and access to health and healthcare services. TDH is currently prioritizing four prevention initiatives: tobacco use, obesity, substance abuse, and adverse childhood experiences (ACEs).

Within TDH, MCH/Title V is administered by the Division of Family Health and Wellness (FHW). This Division manages the Department's portfolio of programs and initiatives related to Maternal and Child Health, Chronic Disease Prevention and Health Promotion, and Supplemental Nutrition. FHW is responsible for programmatic implementation of core public health services within 95 local health departments (ie. family planning, breast and cervical cancer screening, Children's Special Services, WIC) in addition to health promotion activities (tobacco prevention, lead prevention and case follow up, etc.) as well as management of programs external to the department such as Evidence Based Home Visiting and expanding systems capacity for priorities spanning from perinatal care to diabetes prevention programs.

Public health efforts in Tennessee have long been focused on the MCH population. All of the current TDH priorities relate to the MCH population, and TDH is committed to improving the health and well-being of the MCH population across the life course.

State Systems of Care for Underserved and Vulnerable Populations

As of July 2020, Tennessee has 16 Critical Access Hospitals designated to preserve access to local primary and emergency health services. These hospitals are located in rural counties with less healthy populations that demonstrate higher rates of obesity, diabetes, preventable hospitalizations, cardiovascular deaths and cancer deaths as compared to state and national benchmarks. Additionally, these hospitals are located in rural counties with fewer physicians and with a higher proportion of patients who live in poverty and a higher Medicaid population. They have 25 beds or less, and are more than 35 miles from the next nearest hospital.

As of July 2020, 90 of Tennessee's 95 counties are federally designated as either whole or partial-county Health Professional Shortage Areas (HPSAs) for Primary Care (based on either the low-income population or geography). This is up from 89 counties in May 2017. All but two of the state's 95 counties are designated as federal Dental HPSAs and all but four counties are designated as federal Mental Health HPSAs. Ninety of the state's 95 counties are designated as either whole or partial-county Medically Underserved Areas (MUA). TDH facilitates state funding for Federally Qualified Health Centers as well as Faith and Charitable Care Centers as has strong relationships with both the Tennessee Primacy Care Association (FQHCs) and Tennessee Charitable Care Network (faith-based clinics) which has facilitated grants and population health planning among the entities.

The distribution of primary care providers varies across the state. A map with health resource shortage areas for obstetrics and pediatrics can be found in the Supporting Documents section. As of July 2020, the following counts of full-time or part-time, actively licensed providers were available through the TDH Division of Health Licensure and Regulation [4]:

Specialty	Actively Licensed Physicians
General Practice	2727
Obstetrics and Gynecology	1441
Family Medicine	3273
Pediatrics	425

There are 60 birthing hospitals and centers in Tennessee (hospitals/centers with >50 deliveries/year). This is down from 68 in 2016.[5] There are five regional perinatal centers, and TDH works closely with these networks of hospitals to implement measures to assure care and delivery at the appropriate level of care.

TDH works closely with TennCare, the state's Medicaid agency. TennCare provides health care for approximately 1.3 million Tennesseans and operates with an annual budget of approximately $12 billion. TennCare members are primarily low-income pregnant women, children and individuals who are elderly or have a disability. TennCare covers approximately 20 percent of the state's population, 50 percent of the state's births, and 50 percent of the state's children. TennCare is a critical and valuable partner in serving Tennessee's MCH population. [10] More description of this agency and the partnership between the agencies is found in the description of the Health Care Delivery System in the State Action Plan Narrative Overview.

Children's Special Services (CSS, Tennessee's state MCH/Title V CYSHCN program) is a critical gap-filling program supported by federal and state MCH funds. It serves as both a payor of last resort for Children and Youth with Special Health Care Needs as well as a care coordination entity for these families. Founded in 1919, CSS is governed by state code. While CSS is core to CYSHCN services in Tennessee, CYSHCN priorities for this vulnerable population expand beyond the program to include broad family and stakeholder engagement particularly in the areas of pediatric to adult transition and patient centered medical home, as determined by the state needs assessment. CYSHCN staff have also coordinated some efforts at behavioral health integration, though this has largely taken place within health care delivery facilities, particularly FQHCs and safety net mental health centers.

State Statutes and Other Regulations Impacting MCH/Title V

Numerous state laws and regulations impact the operation of MCH/Title V program services in Tennessee. Many of the laws provide TDH authority to operate programs such as Family Planning, CSS, evidence-based home visiting, fetal infant mortality review (FIMR), child fatality review (CFR), maternal mortality review or teen pregnancy prevention. Child fatality review and, more recently, maternal mortality review legislation provide funding and legal authority to enhance data gathering to inform action.

Some state laws mandate specific activities or services related to the MCH population. For example, laws mandate that infants receive screening for metabolic/genetic conditions, critical congenital heart disease, and congenital hearing loss. Others mandate coverage for services such as hearing screening or hearing aids.

Other laws provide basic protections for the MCH population. These include Tennessee's child passenger restraint law (which was the first such law passed in the nation), as well as laws which require prophylactic eye antibiotics for infants, prohibit female genital mutilation, require schools to test for lead in water, and prohibit smoking in most public places.

Several laws establish committees that advise TDH on specific programs or services. These include the Children's Special Services Advisory Committee (services for children and youth with special health care needs), Perinatal Advisory Committee (perinatal regionalization), and the Genetics Advisory Committee (newborn screening and follow-up).

In addition to laws passed by the General Assembly, many programs and services related to the MCH population operate under rules and regulations promulgated by the TDH and approved by the Attorney General, Secretary of State, and Government Operations Committee of the General Assembly. Often these rules contain more detailed information on program operations than the law that established a particular program or service. Examples include rules related to newborn screening, operation of the CSS program, and operation of the child safety fund (funding from child safety seat violations used to fund purchase of additional child safety seats for distribution in local communities).

A list of MCH-related laws is included in the Supporting Documents section.

[1] Data Profiles. Tennessee 2018. https://data.census.gov/cedsci/profile?g=0400000US47&hidePreview=true&tid=ACSDP1Y2018.DP02&vintage=2018
[2] America' Health Rankings. 2019. https://www.americashealthrankings.org/explore/annual/state/ALL
[3] America's Health Rankings. 2019 Health of Women and Children Report. https://www.americashealthrankings.org/learn/reports/2019-health-of-women-and-children-report/findings-state-rankings
[4] Tennessee Department of Health. Division of Health Disparities. Healthcare Provider Census.
[5] Tennessee Department of Health, Division of Vital Records and Statistics, Office of Health Statistics. Birth Statistical System

III.C. Needs Assessment
FY 2022 Application/FY 2020 Annual Report Update

This application year (FY2022) is the second year of the FY2021-2025 grant cycle. During interim years of the grant cycle, an ongoing needs assessment is conducted as a way of continuously monitoring and assessing the needs of the MCH population as well as the capacity of the system to meet those needs. The ongoing needs assessment is considered an annual follow up to the comprehensive needs assessment that is completed every five years in conjunction with the beginning of a new grant cycle. The process and findings of the most recent comprehensive needs assessment, completed in 2020, have been described previously. An explanation of Tennessee's ongoing needs assessment is described below.

Ongoing Needs Assessment Activities

The Tennessee MCH/Title V Program has multiple mechanisms for continually assessing health needs and system capacity. The main mechanism is through meetings of the MCH Stakeholder Group and the Tennessee MCHB Grantees.

During the planning of the 2015 comprehensive Needs Assessment, it was decided that a MCH Stakeholder Group was needed to provide feedback and partnership to Tennessee's MCH/Title V Program. This group was formed and has continued to meet twice a year in-person since its inception. However due to the ongoing COVID-19 pandemic the meetings have been virtual since 2020. It is an open group and anyone is welcome to join at any time. Special effort is made to invite those who serve the MCH population, as well as parents (including parent of CYSHCN, foster parents, and grandparents) and youth. During the meetings, the group reviews progress on the NOMs, SOMs, NPMs, SPMs and ESMs. At the fall meeting, after the progress report on the past year is presented the stakeholders discuss how they can partner together to meet the goals set for the coming year. At the spring meeting, a progress report as well as a draft action plan is presented for the coming year. The stakeholders then discuss what revisions should be made to the action plan based on the progress made thus far. After the meeting the FHW staff make edits to the plan based on the stakeholders' feedback.

The Tennessee MCHB Grantees group was formed after the August 2015 federal/state MCH/Title V Program review when staff identified the need to intentionally connect with all other MCHB grantees in Tennessee. Tennessee's MCH/Title V Program annually request an updated list of grantees from MCHB, and then uses that list to invite all grantees to attend two in person meetings per year. Most recently the list included Healthy Start Initiative – Eliminating Racial/Ethnic Disparities, two Leadership Education in Neurodevelopmental and Related Disorders Training Programs, Emergency Medical Services for Children, State Implementation Grants for Improving Services for Children and Youth with Autism Spectrum Disorder, Family Professional Partnership/CSHCN, Maternal and Child Environmental Health Network, Universal Newborn Hearing Screening and Intervention, and the Maternal and Child Health Nutrition Training Program. These meetings have also been held virtually since 2020 due to the COVID-19 pandemic. The gathering of this group provides an opportunity to align the programs in Tennessee so that the MCH population's needs are supported. During non-pandemic times the meetings are held directly before the MCH Stakeholder Group meeting so that grantees can stay and provide input to the MCH Block Grant as well.

In addition to these intentional activities, ongoing needs assessment occurs through other mechanisms throughout the year. A variety of MCH stakeholders are represented on various departmental advisory committees (Genetics, Perinatal, and Children's Special Services Advisory Committees). These subject matter experts (which include family members) advise the Department on program/policy issues and also identify emerging issues that warrant further consideration/action. Regular meetings are also held with other state and local agencies, advocacy groups,

professional organizations, health service delivery professionals, and other partners to share data and gather input on current activities. Lastly there is regular interaction between TDH Central Office staff and those staff in regional and local health departments. Through routine conference calls or in- person site visits, Central Office staff hear firsthand about “on the ground” issues and needs in communities across the state.

Changes in Health Status and Needs

The information below is based on the National Outcome and Performance Measures for this grant, which are established in the federal grant guidance. For this analysis Tennessee only used federally available data. Therefore, the data discussed may not be the only or the most recent data available. For example, NAS rates for the state noted below worsened according to hospital discharge data, but real time surveillance data showed an improvement for 2020 NAS rates.

Women’s/Maternal Health

Over the past several years, teen births as well as pregnancy smoking and postpartum depression have been decreasing in Tennessee. However, more infants are being born with Neonatal Abstinence Syndrome (NAS) and the rate of severe maternal morbidity continues to worsen.

Perinatal/Infant Health

Several perinatal and infant health measures have seen improvements over the past few years particularly infant mortality measures. These measures include neonatal mortality, post-neonatal mortality, pre-term mortality, sudden infant death syndrome mortality and overall infant mortality. On a related note, the state also continues to see improvements in safe sleep practices. However, other improvements have stalled such as low birth weight and preterm birth.

Child Health

This domain has several indicators showing improvement including breastfeeding, vaccinations, secondhand smoke exposure and insurance status. Unfortunately, there was no change in child mortality nor children who are overweight or obese.

Adolescent Health

The measures for this domain show little improvement. Adolescent mortality is increasing, specifically suicide, and exceeds the national rate. On the positive side motor vehicle deaths are decreasing. Unfortunately, they are still above the national rate.

Children and Youth with Special Healthcare Needs (CYSHCN)

Medical home shows an improvement and is above the national percentage. But transition and systems of care are going in the wrong direction.

Changes in MCH/Title V Program Capacity

In August a CDC/CSTE (Council of State and Territorial Epidemiologists) Epidemiology Fellow joined FHW and will be with the division for roughly two years. During that time the fellow will help operationalize the cross-cutting priority

of health equity. Implementing this work in a consistent way has been a challenge over the last two years. It will be helpful to have someone designated to lead the effort and facilitate the operationalizing of this priority.

The COVID-19 pandemic has put a strain on the public health workforce and the MCH workforce is no exception. As the pandemic draws on it continues to place professional and personal pressure on each staff member. From a professional standpoint staff have been stretched to cover duties such as COVID-19 surveillance, emergency response, and vaccination rollout. This has impacted staff differently based on role. Some staff have been asked to take on duties directly related to the pandemic, while others have been asked to cover the duties of those who have been reassigned to pandemic duties. A pandemic of this magnitude puts a strain on the entire public health system. For MCH/Title V services that has meant moving from in person services to telephonic and virtual means. The transition was not without difficulty and some downtime, but all services have been restored in a new format. This change has impacted program service numbers, some have gone up while others have gone down. MCH/Title V staff continue to troubleshoot to meet the needs of the MCH population.

Partnerships and Collaborations

Tennessee's MCH/Title V program continues to partner with numerous entities at the federal, state, and local level to serve the legislatively defined MCH populations and to expand the capacity and reach of the state MCH/Title V and CYSHCN programs.

The MCH/Title V CYSHSN program has a staff member responsible for Family/Youth Engagement and Involvement whose primary responsibility is to work with Family Voices to ensure opportunities for family and youth training on patient centered medical homes, transition and policy/advocacy. MCH/Title V funds have also been used to expand the division contract with family voices to provide consultation and training for all programs within FHW. In addition, several programs continue to expand their own advisory and family groups to better inform programs and services, including recruitment of regular parent participants in the Perinatal Advisory Committee and Genetics Advisory Committee. Likewise, in the comprehensive redesign of the CSS, HUGS, and Community Outreach programs into the streamlined Community Health Access and Navigation in Tennessee (CHANT) program has incorporated family engagement in the design process to assure that the needs of children and families are being met appropriately.

Operationalization of Five-Year Needs Assessment Process and Findings

The MCH/Title V Program operationalizes the Needs Assessment (both Five-Year and Ongoing) in two main ways: priority setting and priority monitoring. Both assessments include the review of quantitative, qualitative, and program capacity data. The core objective of the Five-Year Needs Assessment is to identity priorities. The Ongoing Needs Assessment complements this by monitoring changes in health needs that may warrant changes to priorities, as well as how effective the action plan activities are on improving health. By monitoring progress, the program is able to identify which activities are most effective and which are not. Based on this information the activities are continued, retired, or replaced. Both the Five-Year and Ongoing Needs Assessment are critical to the effectiveness of this program.

Changes in Organizational Structure and Leadership

In the fall of 2019, the FHW Director (Dr. Morgan McDonald) took on an interim role of Deputy Commissioner for Population Health. The following spring that became a permanent role. This left the FHW Director role empty. An interim MCH/Title V Director was named in spring of 2020, until a new director could be hired. The new director, Dr. Amosun, joined the department in spring of 2021. Dr. Amuson is a pediatrician who will also serve as the new

MCH/Title V Director.

Five-Year Needs Assessment Summary
(as submitted with the FY 2021 Application/FY 2019 Annual Report)

III.C.2.a. Process Description

Purpose and Requirements

At the beginning of each five-year grant cycle the state is required to conduct a comprehensive needs assessment. The assessment must include both quantitative and qualitative data analysis, with the goal of identifying the health needs of Tennessee women, infants, children, adolescents and their families. The capacity of the health system to meet the needs identified must also be evaluated. Then based on all the information gathered the state must choose priorities to focus on for the new grant cycle. At least one priority must be identified for each population domain, and no more than 10 priorities in total.

Population Domains:

- Women's and Maternal Health
- Perinatal and Infant Health
- Child Health
- Adolescent Health
- Children and Youth with Special Health Care Needs (CYSHCN)
- Cross-Cutting *(Optional)*

Framework

For the assessment the main framework used was the Public Health Planning Cycle described in the federal guidance for this grant. The steps of the process are described below.

Public Health Planning Cycle:

1. Engage stakeholders
2. Assess needs and identify desired outcomes and mandates
3. Examine strengths and capacity
4. Select priorities
5. Set performance objectives
6. Develop an action plan
7. Seek and allocate resources
8. Monitor progress for impact on outcomes
9. Report back to stakeholders

The state supplemented the Public Health Planning Cycle framework with one from the Needs Assessment in Public Health: A Practical Guide for Students and Professionals book. This framework consisted of detailed linear stages that provided a slightly more detailed approach to both planning and implementing the assessment. The stages in this framework are described below.

Stages in Needs Assessment Process

1. Start-up Planning Stage
2. Operational Planning Stage
3. Data Stage
4. Needs Analysis Stage
5. Program and Policy Development Stage
6. Resource Allocation Stage

Planning and Implementation

Start-up Planning Stage

The 2020 comprehensive needs assessment was led by the MCH Block Grant Coordinator, which is a full-time permanent position supervised by the MCH/Title V Director. The coordinator is responsible for gathering all information needed for the annual grant application and report, which in 2020 included the comprehensive needs assessment.

To complete the assessment teams were established for each required population domain. All staff within FHW was assigned to a domain team. This was done by appointing each FHW senior leader to the domain that most closely aligned with the programs they lead for the division. Their program staff and epidemiologists were also assigned to the same domain. Therefore, each domain team consisted of at least one (but many times multiple) FHW senior leader, program staff, and epidemiologist. This created multidisciplinary teams where each member contributed specific expertise to fulfill different roles on the team. The table below shows FHW section assignment by domain.

Population Domain	FHW Section(s)
Women/Maternal	Reproductive and Women's Health
Perinatal/Infant	Perinatal, Infant and Pediatric Care Supplemental Nutrition Injury Prevention and Detection
Child	Early Childhood Initiatives
Adolescent	Chronic Disease Prevention and Health Promotion
CYSHCN	Children and Youth with Special Health Care Need

All work for this grant is done in partnership with stakeholders. The formal stakeholder group was established during the 2015 comprehensive needs assessment. This group has continued to meet in person twice a year since then. It is open to anyone who has a stake in the health of women, infants, children, adolescents and their families in Tennessee. Stakeholders were engaged throughout the 2020 comprehensive needs assessment process. Stakeholder involvement will be described where applicable in the stages below.

Operational Planning Stage

The assessment formally began in October 2018 with the FHW needs assessment planning meeting. This meeting was attended by all FHW senior leaders, program staff and epidemiologists. At the meeting the MCH Block Grant coordinator reviewed the federal requirements, timeline, 2015 comprehensive needs assessment methodology, and roles and expectations of staff for the 2020 assessment. The group discussed what worked well during the last assessment and which areas needed to change for this assessment. Based on this conversation it was decided that fewer health topics would be covered in order to take a deeper look at each one. This would allow the data on each topic to be stratified by geography and racial/ethnic groups. It was also decided that focus groups would be utilized as a qualitative method because they provided such in-depth insight into areas that are multifaceted and therefore difficult to understand and impact.

In January of 2019 epidemiologists from each domain team met to discuss how to analyze and present the quantitative data in a consistent way across all domains. It was decided that there were three perspectives to cover for each topic. The first was comparing state level data to national data. The second was showing the geographic distribution across the state through a map rendering. The third was to compare race and ethnic groups to check for any disparities. Then the overall findings from these perspectives would be summarized in a data interpretation section. A template was created and utilized to gather each of these elements. However, for some topics the data was not collected in a way that allowed it to be broken down into each of these perspectives. When this happened, the epidemiologists made substitutions based on what was available.

Data Stage

Each domain team was asked to develop a list of roughly 10 health topics that most impact the population domain. These lists were presented to stakeholders on a webinar in February of 2019. The stakeholders provided feedback on the lists; topics were added based on the feedback. The final lists included the topics below.

Women's and Maternal Health Topics

- Well Woman Care/Preconception Care
- Cervical Cancer Prevention and Early Detection
- Contraception Access
- Pregnancy Intent
- Prenatal Care
- Maternal Mortality
- Opioid Use
- Teen Pregnancies/Births
- Sexual/Domestic Violence
- Human Trafficking

Perinatal and Infant Health Topics

- Infant Mortality
- Safe Sleep
- Birth Defects
- Premature Birth and Low Birth Weight Infants
- Breastfeeding
- Newborn Screening
- Access to Timely Prenatal Care
- Unintended Pregnancy
- Prenatal Smoking
- Perinatal Depression

Child Health Topics

- Neonatal Abstinence Syndrome (NAS)
- Adverse Childhood Experiences (ACEs)
- Developmental Screening
- Childhood Obesity and Nutrition
- Dental Care/Dental Home
- Well Child Visits/Medical Home
- Child Injury
- Bullying/Suicide
- Lead Exposure

Adolescent Health Topics

- Physical Activity
- Nutrition
- Youth Nicotine Exposure
- Human Papilloma Virus (HPV) vaccination
- Obesity
- Mental Health – Depression, ACEs
- Substance Abuse
- Sexual Behaviors – Unintended Pregnancies
- Intentional Injury – Teen Violence, Human Trafficking, Suicide
- Unintentional Injury – Motor Vehicle Collisions

CYSHCN Topics

- Transition from Pediatric to Adult Care
- In Home Assistance and Respite Care
- Birth Defects
- Medical Home
- Access to Care
- Rural Health Challenges
- Decision Making (patient/family/provider partnership)
- Youth Involvement in Care
- Access to Coverage
- Early Intervention and Screening

With final lists of topics, the epidemiologists started pulling together data on each one and utilized the template to display the data. All the quantitative data was then presented at the spring stakeholder meeting in April of 2019, which is held in-person. The stakeholders where asked to help identify areas that were unclear or gaps that could be filled in with qualitative data. Based on their feedback each domain team selected a topic(s) to explore with qualitative data.

After the meeting the epidemiologists led their teams in choosing which methodology would work best for the topic. The methods included focus groups, key informant interviews, and open-ended surveys. Each team worked together to develop the data collection instruments. The table below depicts all the qualitative topics and methods used.

	Women/Maternal	Perinatal/Infant	Child	Adolescent	CYSHCN
Focus Groups	• Reproductive service access and utilization	• Breastfeeding and safe sleep	• General health and parenting	• Tobacco • General health	• Medical home • Dental care • Mental health • Respite care needs
Key Informant Interviews	• Human trafficking	• Breastfeeding and postpartum depression			• Medical home, dental home, mental health, and respite care
Open-ended Surveys					• Dental home, mental health, and respite care

During the summer of 2019 four interns were trained to help implement the qualitative methods. To prepare for data collection the interns created many documents including: informed consent forms, participant demographic forms, focus group flyers, key informant interview scripts, and participant thank you letters. To recruit participants, partner organizations were identified based on desired participants. Partner organizations were asked to help recruit participants, and for focus groups a space to hold meeting. All key informant interviews were conducted over the phone. The tables below describe the partner organizations and participants by qualitative method and topic covered.

Focus Groups		
Domain	**Topic(s)**	**Partner Organization/Participants**
Women's/Maternal	Reproductive Service Access and Utilization	TDH Regional Health Department community members
Perinatal/Infant	Breastfeeding and Safe Sleep	Head Start parents
Child	General Health and Parenting	Head Start parents
Adolescent	Tobacco	TDH Youth Tobacco Summit participants
Adolescent	General Health	DOE Coordinated School Health
CYSHCN	Medical Home	TDH Youth Summit participants
CYSHCN	Dental Home	TDH Youth Summit participants
CYSHCN	Mental Health	TDH Youth Summit participants
CYSHCN	Respite Care	TDH Youth Summit participants

Key Informant Interviews		
Domain	**Topic(s)**	**Participant(s)**
Women's/Maternal	Human Trafficking	Law Enforcement Agents Non-Profits Serving Survivors
Perinatal/Infant	Breastfeeding and Safe Sleep	Pediatricians Obstetricians Family Medicine Practitioners
CYSHCN	Medical Home, Dental Home, Mental Health, and Respite Care	Neonatologists Developmental Pediatricians Genetic Counselor Audiologist and Speech Pathologist

Open Ended Survey		
Domain	**Topics**	**Participants**
CYSHCN	Dental Home, Mental Health, and Respite Care	CHANT Care Coordinators

Once all the data was collected the interns and epidemiologist worked together to analyze it. Data visualizations were created to present the information at the fall stakeholder meeting. Which was used to inform the prioritization process.

Needs Analysis Stage

In October of 2019 FHW senior leaders, program staff and epidemiologists met to design a priority setting process. At this meeting the prioritization process used for the last comprehensive needs assessment in 2015 was reviewed. Based on the discussion it was decided that a prioritization matrix would be utilized again because of the level of objectivity it brings to the process. This method allows each potential priority to be considered against multiple criteria. The criteria are chosen based on what is most important to the group. To identify criteria for the 2020 assessment the group considered what factors could be evaluated based on the data that had been gathered. It was decided that severity, prevalence, and level of inequality could be assessed. The last criteria chosen was readiness. This was a more subjective criteria that required respondents to give their opinion on the readiness of the state (and community) to address the issue.

The matrix was administered at the fall stakeholder meeting. During this meeting each domain team presented the quantitative, qualitative, and capacity assessment data compiled for that domain. The teams then facilitated a discussion on the data. Feedback on each potential priority was then collected by asking everyone (including TDH staff) to fill out the matrix. The matrix and scores are available in the Supporting Documents section of this grant.

In November of 2019 the MCH Block Grant Coordinator analyzed the data collected through the prioritization matrix and shared the results with each team. Each team then met to discuss the results and identify which potential priority should be

recommended as the priority for the new grant cycle. In January of 2020 all domain teams met as one group to finalize the priorities. Each domain team recommended a priority and provided an explanation of why it should be chosen based on data gathered and stakeholder feedback. The MCH Block Grant Coordinator also recommended priorities for the Cross-Cutting domain based on topics that were identified as issues in all the domains. All recommendations were discussed, and the priorities were finalized at this meeting.

Program and Policy Development Stage

Once the priorities were chosen each FHW senior leader was entrusted to lead one priority. Their program staff and epidemiologists were also assigned to the same priority. Therefore, each priority team consists of a FHW senior leader, program staff, and epidemiologist(s). This again created multidisciplinary teams where each member contributed specific expertise to fulfill different roles on the team. The table below shows FHW section assignment by domain and priority.

Population Domain	Priority	FHW Section
Women/Maternal	Family Planning	Reproductive and Women's Health
	Pregnancy-Associated Mortality	Injury Prevention and Detection
Perinatal/Infant	Breastfeeding	Supplemental Nutrition
	Infant Mortality	Perinatal, Infant and Pediatric Care
Child	Obesity	Chronic Disease Prevention and Health Promotion
	Adverse Childhood Experiences (ACEs)	Early Childhood Initiatives
Adolescent	Tobacco and E-cigarette Use	Chronic Disease Prevention and Health Promotion
CYSHCN	Medical Home	Children and Youth with Special Health Care Needs
	Transition	Children and Youth with Special Health Care Needs

During the spring and summer of 2020 each priority team developed an action plan. The plans detailed what will be done to impact the priority in a positive way. The grant requires that the action plans have a two-tier structure; this consist of grouping activities into broader overarching strategies. The action plan structure is shown below. There are no maximum number of strategies or activities.

Action Plan Structure:

- Strategy 1
  - Activity 1
  - Activity 2
- Strategy 2
  - Activity 1
  - Activity 2

Another requirement is that measurements be developed to assess the impact of the action plan. Therefore, teams developed measures following the 3-tiered measurement framework in the grant guidance. There are three types of measurements that relate to one another.

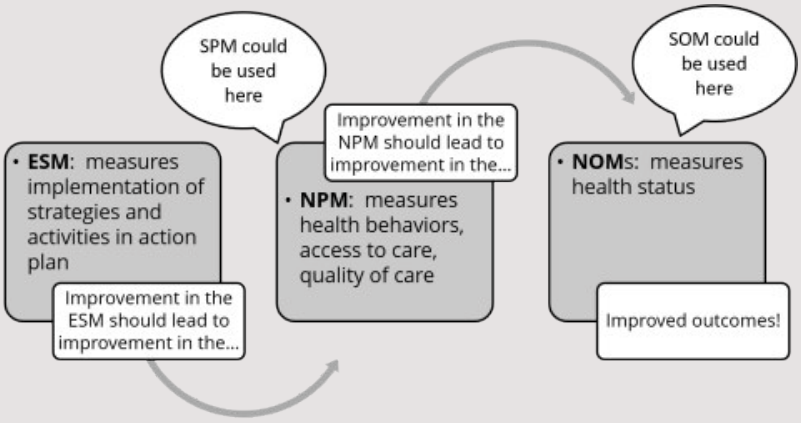
Types of Measures:

- National Outcome Measures (NOMs) or State Outcome Measures (SOMs)
- National Performance Measures (NPMs) or State Performance Measures (SPMs)
- Evidence-based or –informed Strategy Measures (ESMs)

The NPMs and NOMs are listed in the grant guidance. Each NPM is linked to one or more NOMs; this linkage is also provided in the guidance. States must choose at least one NPM for each population domain, and by extension the corresponding NOMs. State may create SPMs to address any priorities that have not been fully addressed through the NPMs. States may also create SOMs to mirror the national framework. The state must create at least one ESM for each

NPM. ESMs measure the process of implementing the action plan. Tennessee chose to create ESMs for each activity planned. The state also chose to create SPMs and SOMs where needed.

Relationship Between Measures:



It should be noted that the action plans and measures were developed during the COVID-19 pandemic. During this time many staff were temporarily reassigned to the pandemic response. This decreased capacity which caused it to take much longer to create the plans and measures. Staff also transitioned from working in the office (at least a day a week) to working completely from home. This new virtual work format required a lot of adjustment to create efficient and effective teams.

Due to the COVID-19 pandemic the fall stakeholder meeting was held virtually, typically it is held in person. Each priority team was given 30 minutes to present their action plan and discuss it with stakeholders. The stakeholders were also provided with each priority team lead's contact information so that feedback could be submitted after the meeting. The teams revised and finalized the action plans based on stakeholder feedback.

Resource Allocation Stage

Once the priorities were finalized the resource allocation stage could begin. The goal for this stage was to align funding with the priorities for the new grant cycle. To do this all currently funded initiatives were categorized by the priorities for the new grant cycle. If a current initiative didn't fit into one of the priorities it was set aside. The initiatives set aside were evaluated as to whether the initiative should continue (with funding from other source) or be discontinued. Lastly the distribution of funds across the domains was compared to evaluate the spread.

III.C.2.b. Findings

III.C.2.b.i. MCH Population Health Status

MCH Population Health Status

To assess the population health status for each domain the state used both quantitative and qualitative data. Both the quantitative and qualitative data can be found as an attachment in the Supporting Documents section of this document.

III.C.2.b.ii. Title V Program Capacity

III.C.2.b.ii.a. Organizational Structure

Tennessee's MCH/Title V and CSHCN program is housed in the Division of Family Health and Wellness (FHW), within the Tennessee Department of Health (TDH). This department serves as the state health agency. It is a cabinet level agency within the executive branch of the state government and is led by a commissioner who is appointed by the governor. The structure of TDH includes a central office, 13 regional offices, and at least one local health department/clinic in each county. The administration of Tennessee's MCH/Title V and CSHCN program resides in the central office. Within this office program staff work closely with regional staff, non-profit partners and other state agencies to implement program activities.

III.C.2.b.ii.b. Agency Capacity

The Tennessee Department of Health's mission is to promote, protect, and improve the health and prosperity of people in Tennessee. The agency accomplishes this through provision of core public health services. Public health services are evolving into gap filling functions providing direct services to those who do not have public or private insurance and into population based, infrastructure and enabling services that support an integrated health care system to meet citizen needs. Services are provided in all counties through local and metropolitan health departments and private nonprofit agencies. These services include medical examinations, screening and treatment for sexually transmitted diseases, preventive health exams, screening for anemia, WIC, EPSDT, dental services, immunizations, education and counseling. Services are provided by nurse practitioners, physicians, certified nurse midwives, public health nurses, licensed practical nurses, nurse aides, educators, and counselors. No charges are made to clients at or below the federal poverty level. TennCare and other insurance are charged as appropriate.

TDH is comprised of local health departments that play a vital role in protecting many aspects of the public's health including instances of emerging infectious diseases, chronic diseases, bioterrorism, and natural disasters. As threats have increased and become more complex, the local health department role has expanded and demands new and different skills for its workforce. In order to have the capacity to address the roles of local health departments and the consequential workforce challenges to be public health ready, the Department focuses on systems integration, prevention, and access to health care that includes a strong population education and upstream health improvement component. Ongoing training and support for public health leadership development is provided for the Department's employees. Accountable baseline federal funding for all local health departments is provided to have the workforce to provide essential services in public health as well as a strategic system-wide effort to increase the production, recruitment, and retention of the public health workforce that is sufficient, competent, and diverse.

III.C.2.b.ii.c. MCH Workforce Capacity

Title V-funded MCH and CSHCN staff work in multiple capacities within the Tennessee Department of Health (Central Office, 7 Rural Regional Offices and 6 Metro Offices, and local health departments in all 95 counties).

State-level program planning is provided by individual program directors, in consultation with Tennessee's MCH/Title V Director and senior leadership within FHW. MCH program directors gather monthly for a Program Management meeting, during which staff outline program goals and objectives, map program activities to state priority measures, discuss opportunities for linkages between MCH programs, and work through challenges common across programs. The Program Management meetings also provide an opportunity for ongoing professional development among the Central Office MCH workforce. These monthly meetings also provide an opportunity to familiarize staff with Departmental operations, procedures and policies. FHW staff development is also incorporated into monthly administration meetings and less formal monthly staff lunch and learn sessions. Bi-monthly staff meetings bring all FHW staff together to celebrate successes, share key information, and develop strategy for key division and department priorities. All FHW central office staff are provided opportunities to participate in professional development activities over the course of their annual performance review. All central office FHW staff have participated in ACEs training and health disparities training which include implicit bias training and cultural competencies. ACEs training has been provided statewide to both regional and local staff. A Health Equity Toolkit has been developed that includes resources and education around health disparities, cultural biases in order to provide awareness and education to all FHW staff with plans to distribute the toolkit department wide.

FHW has employed 14 epidemiologists (including five doctoral-level epidemiologists). The epidemiologists provide broad support for data analysis and program evaluation across the Division and specialized support in program areas such as home visiting, chronic disease prevention and health promotion, injury prevention and detection, reproductive and women's health, newborn screening, childhood lead poisoning prevention, and children and youth with special healthcare needs. FHW hosted a CSTE (Council of State and Territorial Epidemiologists) Applied Epidemiology Fellow in 2013-15 (Julie Traylor). Ms. Traylor continues to lead the five-year MCH/Title V Needs Assessment and is now a full-time state employee, serving as Tennessee's MCH Block Grant and SSDI Grant Coordinator. FHW matched a CDC MCH Epi Assignee in December of 2017 to help build surge capacity for MCH epidemiology-related issues. She has considerably expanded the Division and the Department's capacity. She has spearheaded data quality initiatives with vital records, provided mentoring

structure for division epidemiologists, expanded capacity for analytics in maternal mortality, among many other initiatives. She has also instituted a well-attended journal club as well as publications work group with participants from across the Division. TDH continues to employ her to assist with MCH related priority areas conducting surveillance and research department wide.

Additional data analysis support is provided through a number of collaborative relationships. The SSDI grant (managed by FHW) provides funding support for staff in the Department's Office of Policy, Planning, and Assessment as well as funding for the MCH block grant coordinator and for the birth defects data infrastructure The SSDI grant also provides funding for Digital Library access to FHW and TDH staff. Initial training was provided to FHW staff in an all staff gathering, and additional training has been initiated to further develop skillsets in literature searches and evidence evaluation. FHW also receives data support through the Department's Division of Quality Improvement. The Office of Performance Management has also provided support in LEAN process implementation for women's health and CYSHCN.

Tennessee's MCH/Title V Program continues to partner with the University of Tennessee at Knoxville (UTK), a HRSA-MCHB grant recipient, to provide cultural competency training to health department staff. Since March 2012, selected Department of Health staff in all 13 regions continue to participate in the half-day training provided by UTK annually. The workshop takes an in-depth look at individual cultural competence. It is specifically designed to increase awareness, knowledge, and skills in dealing with clients, patients, and co-workers whose world view is different from one's self. The emphasis is on the health-related professions. The first round of training focused on regional and Central Office Leadership and subsequent sessions (ongoing) have been provided training front-line service delivery staff.

Several professional development have been provided and were made available in multiple sites across the state. These trainings include health equity, ACEs, Implicit Bias, reproductive life plan, maternal depression, and breastfeeding promotion and support. Tobacco Cessation including addressing tobacco use with families, strategies for engaging the family and connecting families with local resources is provided throughout the state. Professional development resources that align with both requirements for Infant Mental Health Endorsement and the National Family Support Competency Framework are available on line through the Institute for the Advancement of Family Support Professionals and Achieve on Demand. The Department of Health has taken a leadership role in the Building Strong Brains through Tennessee's ACEs Initiative and has increased the knowledge of ACEs throughout the state. Staff members in each region have been trained in the standardized ACEs curriculum that shares key information about the brain science behind ACEs, the importance of safe and nurturing relationships during early childhood, and strategies for reducing the impact of ACEs. Knowledge dissemination is the first step in ensuring that all health department services are ACEs informed. The Department of Health continues to expand understanding of ACEs and further explore how we can ensure that ACEs are considered as we make program, policy, and procedure decisions.

FHW staff are also encouraged to take advantage of external workforce development activities. Tennessee has successfully trained staff on CHANT with programmatic rollout in all Regions of the State. Navigating the complex system of health and social services can be challenging for many individuals and families, and depending on individual needs and medical diagnoses, care may involve a number of programs, providers, and personnel. To overcome these challenges, the Tennessee Department of Health streamlined three public health programs, Help Us Grow Successfully (HUGS), Children's Special Services (CSS) and Tenncare Kids Community Outreach into one integrated model of care coordination, the Community Health Access and Navigation in Tennessee (CHANT). CHANT teams provide enhanced patient-centered engagement, navigation of medical and social services referrals, and *impact* pregnancy, child and maternal health outcomes. Some staff participate in LEAD Tennessee, a statewide, 12-month development initiative which includes six one-day summits of intense, personally tailored, high impact learning focused on twelve core leadership competencies. The goal of LEAD Tennessee is to increase the state's leadership bench strength by providing agencies with a continuous pipeline of motivated and prepared leaders that share a common language and mindset about great leadership. Julie Traylor, MCH Block Grant Coordinator is participating in this program which promotes valuable components for both new and experienced directors.

MCH/Title V funding is used to support ongoing training of local and regional health department staff who provide services to the MCH population. Examples include an annual professional development conference for CYSHCN care coordination

staff and an annual “Spring Update” training session for women’s health and family planning staff. MCH staff have also been instrumental in planning the annual in-person conference for state public health educators to develop capacity in the health department priorities of tobacco prevention, physical activity promotion, obesity reduction, and prevention of opioid use. Tennessee has also utilized MCH/Title V funding to support the broader MCH workforce outside of public health. For example, Title V/MCH funding supports an mPINC technical assistance web site for hospitals and pays for 20 hours of lactation continuing education for interested members of the care team. FHW also supports CLC training and certification for staff across the state who work in breastfeeding.

FHW routinely hosts student interns from a variety of training levels (undergraduate, graduate, and post-graduate). Products of recent or current trainees include: Investigation of pediatric opioid overdose with publication of relevant infographics for key stakeholders. Development of an online overview of health equity approaches in all fifty states. Literature synthesis for statewide provider, payer, and advocate groups which have developed to address the recurrent prematurity prevention initiatives of17-OHP utilization and access to immediate post-partum long acting contraception Educational materials on preventing unintended pregnancy for adolescents and adolescent health care providers Development of "one key question" outreach to providers encouraging them to act to reduce unintended pregnancy Mapping of tobacco retailers in relation to school and engaging youth in tobacco prevention activities Focus groups to gain understanding of decision making of minority fathers regarding breastfeeding initiation

III.C.2.b.iii. Title V Program Partnerships, Collaboration, and Coordination

Maternal and Child Health and Women's Health (part of the Division of Family Health and Wellness) staff at the central office, regional offices, and local health department levels are involved in numerous collaborative efforts within the Department with various programs, other governmental departments and agencies, and organizations and agencies outside government (universities, school systems, city/county government, hospitals, and nonprofit agencies such as March of Dimes, American Cancer Society, American Heart Association, Arthritis Foundation, Tennessee Suicide Prevention Network, State Minority Health Task Force, Family Voices, The Tennessee Disability Coalition, and the Council for Developmental Disabilities). MCH has always had a strong collaborative relationship with metropolitan health departments in the state. Since these entities have separate boards of health, the state's role is to provide needed service, focused funding, training and continuing education and participation as a partner in all planning and system change initiated to improve the public's health. The six designated metro health departments receive funds through the state's contractual system. Staff in Metro Health Departments who provide MCH services are regularly included in conference calls, quarterly meetings, in-service training and planning meetings about MCH programs and services. The MCH Director holds monthly conference calls with all regional MCH Coordinators; the agenda includes updates from the central office, regional updates, topical presentations on MCH programs, and information on specific MCH performance and priority measures. Metro Regional Directors participate as active partners with rural Regional Directors in public health planning and new initiatives. The primary difference between these two entities is that metros report to boards of health and the mayor, while rural regional directors report to the Department.

Examples of collaborative efforts: TennCare/Medicaid: The Childhood Lead Poisoning Prevention Program has a cost-sharing protocol with TennCare for cases when an environmental investigation is conducted for a lead poisoned child on Medicaid. CSS requires that all children applying for the CSS program apply for TennCare; assists families in locating a medical home, specialists and related service providers within the managed care organizations' (MCO) provider networks; keeps TennCare informed of underserved areas and works with the MCOs to identify out-of-network providers for CSHCN. CSS participates in TennCare advocates' meetings to keep informed of changes and uses the network of state, regional, and local CSS staff for disseminating information. This route also allows direct interaction between CSS staff and parents to ensure parental understanding of the changes and improve transition of services. CSS also helps families file appeals for denied medically necessary services.

All local health departments are providing outreach, advocacy, and EPSDT screenings for TennCare enrollees and referring patients to their medical home as applicable. The clinics refer patients who may be eligible to TennCare. The family planning program informs patients who test positive for pregnancy about TennCare's presumptive eligibility benefit and refers eligible patients to the agency for application. Department of Children's Services (DCS) is responsible for the children in state custody. The Department of Health is providing the EPSDT screenings for all these children. MCH gets referrals from DCS

for home visits. DCS staff are involved on teams reviewing cases for the Child Fatality Review program. MCH staff is invited to attend the multidisciplinary teams to case manage clients. CSS regional coordinators work with the DCS Regional Health Unit nurses to coordinate health services for CSHCN in state custody.

Collaborations are occurring between the Child Fatality Review Program (housed in MCH) and DCS. The MCH Director meets regularly with senior leadership from DCS to discuss opportunities for primary prevention of child maltreatment. Local DCS staff have for many years participated on the local child fatality review teams, and state DCS leadership has participated on the state team. MCH staff are members of the Children's Justice Task Force and the Child Sex Abuse Task Force, whose members are from many state government departments and community organizations. The Children's Justice Task Force focuses on the welfare of children reported to have been abused or neglected and is charged with identifying existing problems and recommending solutions. The Child Sex Abuse Task Force is responsible for assisting DCS in developing a plan for better coordination and integration of the goals, activities and funding for detection, intervention, prevention and treatment of child sexual abuse. MCH has a staff member who is an associate member of the TN Child Abuse Prevention Advisory Committee. The committee focuses on statewide efforts to prevent child abuse. The Family Planning Director represents the Department of Health in a collaborative effort with the Tennessee Bureau of Investigation and the Departments of Human Services, Children's Services, Intellectual and Developmental Disabilities, and Mental Health to establish a system of identification and service delivery for human trafficking victims.

Department of Human Services (DHS): DHS houses the Division of Vocational Rehabilitation, TN Services for the Blind and Visually Impaired and the TN Technology Access Project. These programs work in collaboration with the CSS program. The Deaf/Blind Coordinator has participated on the Newborn Hearing Screening (NHS) Task Force since 1997. DHS offices serve as the place of application for Medicaid and TennCare. DHS provides CSS proof that CSS applicants have applied to TennCare. MCH has collaborated with DHS since 1996 to build a statewide network of child care resource centers which include a child care health consultant. Services provided include: technical assistance and consultation, training, and lending resource library materials and are available to all child care providers in the State. MCH through its Early Childhood Comprehensive Systems Program and its Child Care Resource Centers assists DHS in providing technical assistance for state regulated day care centers.
Department of Education (DOE): Central Office MCH staff collaborate routinely with the Office of Coordinated School Health (OCSH), which is housed within the Department of Education. There is also increasing collaboration between regional TDH staff and regional CSH staff. In early 2012, TDH Regional MCH Directors provided an overview of MCH-related services at regional CSH meetings. Feedback from both MCH and CSH staff indicated that the meetings were useful for sharing program information and building local connections. MCH staff in collaboration with CSH recently organized an Adolescent Institute for Adolescent Health and Adolescent Pregnancy Prevention Coordinators, CSH Professionals, Health Educators, and Abstinence Education Grant Program Staff. Institute workshops addressed: childhood obesity, asthma, the importance of breakfast, physical activity, vision, aggression and violence, ADHD and teen pregnancy and parenting. The Department of Education, Division of Special Education, is the lead agency for the IDEA Part C TN Early Intervention System (TEIS) for infants and toddlers birth to 3 identified with or having a potential for a developmental delay. TEIS has been an active collaborator with the CSS program since 1990 and with Newborn Hearing Screening (NHS) since 1996. The programs coordinate referral and care coordination activities on infants and children requiring services from both agencies. An MCH staff person serves on the State IDEA Interagency Coordinating Council. TEIS staff serve on the NHS Task Force. TEIS works closely with the NHS program to provide tracking, follow-up and intervention services for infants referred for or identified with a hearing loss after hospital hearing screening. An MCH staff member serves on the Part C (Early Intervention) Monitoring Review Committee. CSS central office and regional office staff participate in Early Intervention Administrators' Forums which include various agencies and promote interagency linkages at the program administrators' level. Local CSS staff participate in meetings for individual CSHCN with DOE Part C and Part B personnel in developing coordinated care plans to insure the coordination of services.

Head Start: A staff person representing Head Start and Early Head Start is an active member of the TEIS State Interagency Coordinating Council; MCH works through this committee with Head Start. The DOE Head Start Collaboration Officer is a member of the Childhood Lead Poisoning Prevention Program and the Early Childhood Comprehensive Systems Advisory Committees. These committees include state agency staff and advocates for children and who meet regularly. The Newborn Hearing Screening Program, in collaboration with the National Center on Hearing Assessment and Management (NCHAM),

works with 3 Early Head Start agencies across the state to implement the Early Childhood Hearing Outreach (ECHO) initiative to provide training on hearing screening, follow-up and reporting. The MCH Director also liaisons with the Director of the State Head Start Collaboration on an as-needed basis. For example, the two collaborated to clarify policies related to EPSDT screening and worked with Head Start staff and community health care providers to promote better understanding and compliance with policies.

Mental Health/Developmental Disabilities: Staff are active members of the Child Fatality Review program at both local and state levels. MCH staff work collaboratively with the Department of Mental Health/Developmental Disabilities (TDMHDD) to assure that appropriate mental health services are accessed for children with special health care needs. CSS includes an assessment of a child's psychosocial development and refers CSHCN and family members to local mental health centers or other local mental health providers if appropriate. Mental health and socialemotional development are one of the five critical areas being addressed in the Early Childhood Comprehensive Systems, and TDMHDD staff participate on the Advisory Committee. The TDH Injury Prevention and Detection Director serves as a member of the Tennessee Suicide Prevention Network and works with a state intradepartmental committee and the state suicide prevention advisory committee. The committee has developed a state plan to address youth suicide prevention.

Social Security Administration (SSA): MCH staff provide information on MCH programs to parents of CSHCN who have applied for SSI. The CSS program coordinates referral of children whose names are received from the SSA. The parent or guardian is sent information about possible services available to their child from state programs (CSS, Mental Health, Mental Retardation, TEIS, and the regional genetics centers, HUGS, Traumatic Brain Injury, Hematology/Sickle Cell Centers, Department of Mental Health and Developmental Disabilities, Department of Intellectual Disabilities, TEIS, and Special Education).

Tennessee Bureau of Investigation (TBI): TBI staff are active members of the Child Fatality Review program at both local and state levels. CSS staff work with Corrections staff to get wheelchair ramps and custom made furniture for CSHCN constructed at no cost to families.

Child Fatality Review: The Child Fatality Review process is a statewide network of multidisciplinary, multi-agency teams in the 31 judicial districts to review all deaths of children 18 and younger. Members of each local team include: Department of Health regional health officer; Department of Human Services social services supervisor; Medical Examiner; prosecuting attorney appointed by the District Attorney General; local law enforcement officer; mental health professional; pediatrician or family practice physician; emergency medical services provider or firefighter; juvenile court representative; and representatives of other community agencies serving children. Members of the State Child Fatality team include: Department of Health commissioner; Attorney General; Department of Human Services commissioner; Tennessee Bureau of Investigation director; physician (nominated by Tennessee Medical Association); physician credentialed in forensic pathology; Department of Mental Health and Developmental Disabilities commissioner; Department of Education commissioner; judiciary member nominated by the Supreme Court Chief Justice; Tennessee Commission on Children and Youth chairperson; two members of the Senate; and two members of the House of Representatives. The state child fatality team is collaborating with several agencies to implement prevention initiatives.

The Injury Prevention Program is collaborating with the Tennessee Department of Education and the trauma centers to implement the Battle of the Belt Program, an educational intervention to increase seatbelt usage among high school students. The Department of Health is collaborating with the Department of Children's Services, the Tennessee Commission on Children and Youth, the Department of Human Services, UT Extension, the Department of Education and Prevent Child Abuse Tennessee to distribute safe sleep materials.

Childhood Lead Poisoning Prevention Program: Collaborating agencies include: a) University of Tennessee Extension Service which provides social marketing to develop and distribute information on childhood lead poisoning to health departments and extension agents, and surveillance system assistance to analyze child blood lead level data and assist staff, partners and health care providers regarding medical case-management of children with elevated levels; and b) Tennessee Department of Environment and Conservation to conduct environmental investigations.

Adolescent and Young Adult Health: The adolescent health director provides educational presentations and resources to adolescent health coordinators and the advisory committee through quarterly teleconferences. The director serves on several committees designed to improve the quality of life for youth and provide educational opportunities for youth and adults including the intra-departmental committee of the Tennessee Suicide Prevention Network; the local and state Disproportionate Minority Contact and Confinement (DMCC) committees; the Tennessee Commission for Children and Youth (TCCY)/Mid-Cumberland committee; and the Tennessee Alliance for Drug Endangered Children (TADEC). The Adolescent & Young Adult Health director assists in coordinating activities of the Department's annual Child Health Week with Mental Health and Developmental Disabilities, the TENNderCare program, and community partners. Additional collaborations for the Adolescent & Young Adult Health director include coordinating a committee from throughout the Family Health and Wellness Division (FHW).

Asthma Management: State of Tennessee Asthma Task Force (STAT) members, in conjunction with Early Childhood Comprehensive Systems, the TennCare Bureau and the Department of Education, developed and are implementing a comprehensive state plan to reduce the burden of asthma among Tennesseans. The plan includes surveillance and epidemiology; public awareness and education; medical management; and environmental management components. The program director currently collaborates with STAT nurses to make educational presentations across the state to medical providers, educators, parents, and youth. STAT plans to target preschool children, school-aged children, and adults 30 and older. MCH also sponsors children to attend summer asthma and diabetes camps. The 10 Child Care Resource and Referral (CCR&R) Centers were provided with asthma tool kits for use with parents and child care providers. A nurse consultant was funded to provide training and technical assistance to the staff at CCR&Rs on health related issues of young children in group care including asthma management. Print material on prevention of tobacco/smoking exposure was developed and circulated to child health related programs across the state.

Federally Qualified Health Centers: Community Health Centers are located in medically underserved areas of the state. These community health centers provided primary health care, dental and mental health services to more than 280,400 patients. Referral systems exist between those community health centers and health departments located within the same county. Community Health Centers in TN are community-based public and private nonprofit corporations that provide comprehensive primary health care services to all people regardless of the patient's ability to pay for those services. They are located in medically underserved areas of the state, both rural and urban. These sites provide primary health care, mental health care and dental services to over 361,000 people per year.

Early Periodic Screening, Diagnosis, and Treatment Program (EPSDT): Since July 2001, local health department clinics have assisted TennCare by providing EPSDT screenings to TennCare enrollees. The TennCare Program previously had difficulty in achieving desired EPSDT screening rates and partnered with the Department to improve these rates.

Autism Spectrum Disorders and Other Neurodevelopmental Disorders: TDH actively participates on the TN Autism Summit Team (led by the Tennessee Disability Coalition) and has been actively involved in the development of the Autism State Plan. TDH has also partnered with staff from the TN Chapter of the AAP and the CDC Act Early Champion to develop a pilot protocol for autism spectrum disorder (ASD) screening in local health departments. The Early Childhood Initiatives section of MCH successfully applied for funding from AMCHP to co-brand CDC materials on ASDs and developmental screening. These materials will be distributed through a number of venues including early childhood home visits. Developmental screening (using the PEDS and Ages and Stages tools) is conducted in all local health departments as part of EPSDT screenings. Staff in all thirteen regions were trained on the appropriate administration and scoring of these tools; staff also received guidance on making appropriate referrals and talking for families about suspected delays.

Folic Acid Education Campaign: Women's Health and Nutrition staff (central and regional offices) are partnering with the March of Dimes, Girl Scouts, and members of the state folic acid council to educate the citizens of TN on the need for folic acid. Staff developed and implemented many of the statewide activities. The Women's Health director serves on the state council. The family planning program provides vitamins with folic acid to patients of reproductive age who receive program services. MCH staff are currently partnering with the March of Dimes and a health education consultant on a grant to use text messaging and web technology to educate college women on important lifestyle issues.

HIV/AIDS/STD (Communicable Diseases Section/Department of Health): There is strong collaboration between the staff of the Women's Health and HIV/AIDS/STD sections. Family planning staff make referrals for HIV counseling and testing and educate clients regarding all STDs including HIV/AIDS. With the integration of services at the local levels and the multiple functions performed by staff in the clinics, staff are very familiar with these programs. The Infertility Prevention Program (screening for chlamydia, treatment, and data analysis) is a joint project of Family Planning, STD, and the State Laboratory. Although federal support for the regional project has ended, Tennessee is continuing screening and treatment for Chlamydia.

The Tennessee Breast and Cervical Cancer Early Detection Program (TBCCEDP): This program provides breast and cervical cancer screening, diagnosis and treatment to uninsured women over age 50. About 14,000 women are screened annually and enrolled in TennCare, if necessary, for treatment. The program accepts referrals of any age from family planning for diagnostics. The program accepts any referrals of eligible symptomatic women.

Office of Nursing: MCH central office nursing staff routinely provide program updates at the quarterly statewide Nursing Directors' meetings. They also serve as consultants to answer health questions related to their respective programs i.e., Family Planning, SIDS, Lead Poisoning Prevention, Home Visiting, etc.

Women Infants and Children: CSS makes direct referrals to WIC on all clients under 5 or mothers of CSHCN who are pregnant. CSS purchases special formula if they need amounts above the allowed allocations under the WIC program. CSS also assists in obtaining special foods for children with PKU.

Division of Population Health Assessment: Staff collaborate with Health Statistics on dissemination of data releases and special reports, data collection for the joint Annual Report of Hospitals, data collection for the Region IV Women and Infant Health Data Indicators Project, and other MCH data projects. Staff coordinate on data matching and reports for the newborn hearing screening program and on the SSDI grant. The SSDI competitive grant was approved for TN but the time period was shortened to three years. SSDI funds will be used to maintain the Health Information Tennessee site which provides the most current state information through a web based application that can be customized by the user. Grant funds will also be used to develop system wide understanding and application of the life course theory as required by the funding source.

Tennessee Adolescent Pregnancy Prevention Program: Tennessee's adolescent pregnancy prevention efforts encompass two different strategies--the Tennessee Adolescent Pregnancy Prevention Program (TAPPP) and the Abstinence Education Program. TAPPP councils operate in four of the six metropolitan areas and in 6 of the 7 rural regions. The 10 Coordinators serve as the community contacts/resource persons for adolescent pregnancy issues. All council memberships are broadly representative of the surrounding community, and include Girl Scouts, March of Dimes, Department of Human Services, Department of Children's Services, community based youth serving organizations, hospitals, local businesses, schools, universities, adoption service agencies, faith-based organizations, juvenile justice agencies, media representatives, and regional and local health councils. Each council participates in a wide range of activities, depending on local priorities and resources, including conferences, parenting and adolescent health fairs, workshops, legislative briefings, and training for professionals. TAPPP councils operate in three of the six metro areas. Each Metro and Regional Health Department utilizes health educators to implement a wide range of activities, depending on local priorities and resources, including educational classes, teen pregnancy and parenting events, conferences, adolescent health fairs, workshops, legislative briefings, and training for professionals. The TN State Department of Health Program Director for Adolescent Pregnancy Prevention and Abstinence Programs and TAPPP Coordinators participate in quarterly conference calls to discuss regional program updates, upcoming events and effective collaborations for future community activities. The Department of Health/MCH is the current recipient of the Pregnancy Assistance Fund (PAF) grant. The PAF grant was transferred to the Department of Health on July 1, 2011. Services consist of access to prenatal care, well child clinical services, a standardized tracking system for program participants, a Baby Store incentive program to purchase needed child care items, and educational information and resources.

Tennessee Primary Care Association (TPCA): Department staff work with the TPCA primarily through the Office of Health Access, Regional and Local Health Councils, and the Women's Health Advisory Committee. The state's Breast and Cervical Screening Program is partnering with TPCA and member organizations to explore the options for developing a training

mechanism for community health workers and patient navigators across systems.

March of Dimes: MCH staff began partnering with March of Dimes many years ago and support the organization's work on decreasing and preventing prematurity, decreasing infant mortality and enhancing the newborn screening program. Staff also support the March of Dimes programs by serving on various local and state committees. The Department is partnering with the March of Dimes, TN Hospital Association, and TIPQC on an initiative to reduce early elective deliveries. Products of the collaborative have included a new website, a letter issuing a challenge to hospitals (attached to this section), social media, presentations, and articles.

Tennessee Chapter, American Academy of Pediatrics (TNAAP): TDH staff participate in quarterly meetings with representatives from TennCare and the Tennessee Chapter of the American Academy of Pediatrics (TNAAP). MCH Block Grant funds have been used to sponsor TNAAP educational events and the Division Director routinely attends TNAAP board meetings and functions to provide updates on state-level MCH activities. Universities: FHW collaborates regularly with university partners across the state on project implementation, evaluation, and consultation. Examples of such collaboration include: program evaluation training for FHW staff by faculty from four Tennessee universities (UT Knoxville, University of Memphis, Tennessee State University, and East TN State University).

III.C.2.c. Identifying Priority Needs and Linking to Performance Measures

Through the needs assessment and prioritization process, described previously, the following priorities were chosen for the FY21-25 grant cycle. The prioritization process included utilizing a prioritization matrix, where potential priorities were scored against multiple criterion. A breakdown of the scores for each potential priority can be found in the Supporting Documents section.

There were two topics that bubbled up across all the domains: mental health and health equity. It was decided that these would not be placed in the Cross-Cutting Domain but would instead be incorporated into all priorities.

Maternal and Women's Health

Family Planning

This priority was chosen because the team felt that it impacted most of the potential priorities on the prioritization matrix. Pregnancy and parenthood affect so many areas of health. It was felt that focusing on this priority would broadly impact many areas of women's health.

Pregnancy-Associated Mortality

Maternal mortality was ranked 3rd on the prioritization matrix for this domain. Although it was not at the very top, once again it was felt that work around this priority would impact most of the other potential priorities. The priority was renamed to pregnancy-associated mortality to be more specific.

Perinatal and Infant Health

Breastfeeding

Breastfeeding was the top ranked potential priority for this domain. This is a health behavior that impacts many areas of health. The state has seen a lot of success in this area, particularly around initiation. The team would like to build on that success and work to improve duration for even more improved outcomes.

Infant Mortality

Infant mortality came in 2nd on the prioritization matrix, just behind breastfeeding. While the state has seen

an improvement in this area, the state rate remains well above the national average. Infant mortality is a measure of population health and the quality of health care. Therefore, the team felt that it should continue to be a priority for this domain.

Child Health

Overweight/Obesity

This was ranked 2nd through the prioritization matrix. Overweight/obesity continue to be an issue within the state that once again affects many other areas of health. Therefore, the team decided to continue with this priority.

Adverse Childhood Experiences (ACEs)

ACEs were the top ranked potential priority on the prioritization matrix for this domain. This is also a priority area for the state in general, due to the impact these events have on health later in life. Therefore, the team chose to continue with this priority.

Adolescent Health

Tobacco and E-cigarette Use

Exposure to nicotine (to encompass combustible and e-cigarettes) ranked 2nd only to mental health in the prioritization matrix. Since this health behavior is common in the state and has health implications that impacts smokers and non-smokers (through second-hand smoke exposure) the team decided on continue with this priority. Mental health bubbled up in each domain and is therefore being incorporated into each priority.

Children with Special Health Care Needs

Medical Home

This priority was chosen because the team felt that it could address many of the top ranked potential priorities through this one priority. There has been work done around in this area in the past but there is still room for improvement.

Transition from Pediatric to Adult Care

Transition from pediatric to adult care is especially important for children with special health care needs. They have more health care needs than the general population, and therefore need access to providers. This was chosen as a priority since it is critical to their care that the transition be a smooth one.

III.D. Financial Narrative

	2018		2019	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$12,749,682	$11,817,625	$12,750,000	$11,449,081
State Funds	$30,000,000	$14,525,370	$32,000,000	$14,002,061
Local Funds	$0	$0	$0	$0
Other Funds	$0	$14,278,869	$0	$0
Program Funds	$4,400,000	$2,180,291	$2,881,646	$1,853,003
SubTotal	$47,149,682	$42,802,155	$47,631,646	$27,304,145
Other Federal Funds	$158,886,385	$134,695,633	$174,823,962	$119,705,038
Total	$206,036,067	$177,497,788	$222,455,608	$147,009,183

	2020		2021	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$12,750,000	$9,115,297	$11,800,000	
State Funds	$14,000,000	$10,802,455	$14,000,000	
Local Funds	$0	$0	$0	
Other Funds	$0	$0	$0	
Program Funds	$2,100,000	$2,331,656	$1,900,000	
SubTotal	$28,850,000	$22,249,408	$27,700,000	
Other Federal Funds	$159,282,034	$115,089,592	$139,734,625	
Total	$188,132,034	$137,339,000	$167,434,625	

	2022	
	Budgeted	Expended
Federal Allocation	$11,800,000	
State Funds	$12,100,000	
Local Funds	$0	
Other Funds	$0	
Program Funds	$1,200,000	
SubTotal	$25,100,000	
Other Federal Funds	$153,475,117	
Total	$178,575,117	

III.D.1. Expenditures

The Division of Administrative Services within TDH is responsible for all fiscal management. Division staff uses Edison which is the State of Tennessee's Enterprise Resource Planning (ERP) system for budgeting, collection of revenues and distribution of expenditures. Computer generated cumulative expenditure and receipt plan analysis, transaction listings and spending/receipt plans are available statewide on-line for all MCH programs. This information can be accessed by both central and regional office staff. Financial audits are the responsibility of the Comptroller's Office. All departments, offices and programs within state government are subject to frequent audits. Contract agencies are also audited frequently. MCH program staff provide site visits and program monitoring at contract agencies in order to assure compliance with the contract's scope of services. Fiscal monitoring of contract agencies is the responsibility of TDH's Internal Audit staff.

The Tennessee MCH/Title V Program met all legislative requirements regarding the spending of grant funds. This includes a maintenance of effort in the amount of $13,125,024 set by the state in 1989. This figure is based on the amount the state was spending on maternal and child health programs in 1989. The state is required to continue to contribute at least this amount to the program in order to receive this federal grant. The state is on track to meet the maintenance of effort amount for the FY2020 award. The state is also required to match the federal dollars. For every four federal dollars the state receives, the state must contribute three dollars. For the FY2020 award Tennessee has used $9,115,297 of the federal allocation so far, therefore the required match on that amount is $6,836,472.75. The state has met that amount. The last requirement is that at least 30% of federal grant funds are spent on preventive and primary care for children, 30% on children with special health care needs, and no more than 10% on administrative cost. Tennessee has met these thresholds for the FY2020 award.

It also should be noted that none of the services paid by the grant were reimbursable by other agencies (namely Medicaid) or providers. This is assured through eligibility determination processes for programs such as CSS as well as regular communication with TennCare regarding the reimbursement services of the MCOs. Any unobligated balance noted in the report will be used to support program activities through the end of FY2021.

The FY2020 federal award and state match MCH/Title V Program dollars supported programs across the health domains as illustrated below. Some of the programs span multiple domains, and therefore are repeated among the domains.

Federal Funds				
Women's/Maternal	Perinatal/Infant	Child Health	Adolescent Health	CSHCN
Breast and Cervical Cancer Screening Program Family Planning Program Primary Care Women's Health Services (local health department)	Child Fatality Review and Prevention Program Genetic Centers Newborn Screening Follow Up	Child Fatality Review and Prevention Program Primary Care Child Health Services (local health department)	Family Planning Program	Children's Special Services (Tennessee's MCH/Title V CSHCN Program) Genetic Centers Lead Poisoning Prevention Program Newborn Screening Follow Up

State Match Funds				
Women's/Maternal	Perinatal/Infant	Child Health	Adolescent Health	CSHCN
Maternal, Infant, and Early Childhood Home Visiting Program	Maternal, Infant, and Early Childhood Home Visiting Program	Child Health and Development Program Healthy Start (Tennessee program, not federal Healthy Start) Lead Poisoning Prevention Program Maternal, Infant, and Early Childhood Home Visiting Program	Adolescent Pregnancy Prevention Lead Poisoning Prevention Program	

Estimates of the reach of the MCH/Title V program in terms of population served is listed on Form 5a and 5b. The program has the widest reach among pregnant women and infants less than 1 year old categories through the work of the perinatal centers and newborn screening. The children 1-22 years of age, CSHCN, and others categories have a much smaller reach. These numbers are estimates in that deduplication is not possible between programs.

III.D.2. Budget

Tennessee state law requires all departments to submit a complete financial plan and base budget request for the ensuing fiscal year that outlines proposed expenditures for the administration, operation and maintenance of programs. Budget guidelines are prepared annually by the Department of Finance and Administration. The Department's Budget Management Office, in cooperation with all programs, is responsible for the preparation of the budget documents. The base budget request becomes law after it is approved by the General Assembly and signed by the Governor. A work program budget is then developed for each program.

TDH uses a cost allocation system for the local health departments. Costs are allocated using two specific methods, the direct cost allocation method and the resource based relative value method (RBRVS). The direct cost allocation method is used when costs can be directly allocated to one or more programs. Any cost can be directly allocated when coded correctly on the appropriate accounting document. Direct cost allocation is used primarily for costs that arise from administrative support staff in the Department's central and regional offices and for selected contract expenditures. The RBRVS cost allocation method is used to allocate costs which cannot be directly allocated to one or more programs. These costs arise from the delivery of direct health or patient care services in local health departments. RBRVS adds weighted encounter activities using relative value units and allocates costs based on the percentage of activity for each program. RBRVS is a federally approved cost allocation method for TDH. RBRVS is linked at the service delivery level to AS 400 computers at the regional and central offices.

Program encounter data are entered at local health departments for direct patient care services using Current Procedural Terminology (CPT) codes and program codes. Relative value units assigned to each procedure code allow a proportionate amount of cost to be associated with each procedure. RBRVS provides quarterly cost allocation reports to central and regional office staff. These reports are used to monitor and manage expenditures, determine cost for services provided, and allocate resources as needed.

The maintenance of effort requirement for maternal and child health programs in Tennessee was established in 1989. This requirement specifies that the state must, at minimum, continue to fund Tennessee MCH program efforts using state funds at the level it was in 1989. At that time Tennessee calculated its maintenance of effort to be $13,125,024.28. This calculation was based on an analysis of 15 months of expenditures for the program, adjusted for differences between the state and federal fiscal years, as well as adjustments for accrued liabilities. The state is also required to match every four federal dollars received with three state dollars. TDH fully supports using state funds to meet the maintenance of effort and match requirements in support of MCH program activities. TDH monitors its maintenance of effort and state match annually and has met requirements in all reporting years.

Tennessee fully utilizes Maternal and Child Health Block Grant funding within the 24-month allowable timeframe and meets all targeted maintenance and match requirements set forth in the grant regulations.

The Tennessee MCH/Title V Program is not proposing major changes to the reported budget for this year. The budget will mirror that of the FY2020 expenditures. This budget aligns with Tennessee's priorities for the grant. Federal dollars are used to extend the reach of state dollars. The federal allocation allows Tennessee to serve more of the maternal and child population.

The MCH/Title V director leverages other federal dollars from the programs listed below which are under the director's control.

Other Federal Grants

- Birth Defects and Developmental Disabilities
- Commodity Supplemental Food Program (CSFP)
- Comprehensive Suicide Prevention*
- Diabetes, Heart Disease & Stroke Prevention & Management Program (1815)
- Early Hearing Detection and Intervention (EHDI) State Programs*
- Emerging Issues in Maternal and Child Health*
- Injury Prevention and Control
- Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants
- National Breast and Cervical Cancer Early Detection Program (NBCCEDP)
- National Comprehensive Cancer Control Program (NCCCP)
- Preventing Maternal Deaths: Supporting Maternal Mortality Review Committees*
- Preventive Health Services Block Grant
- Rape Prevention and Education (RPE) Program
- Sexual Risk Avoidance Education (SRAE)
- State and Local Healthy Homes and Childhood Lead Poisoning Prevention Programs (CLPPPs)
- State Systems Development Initiative (SSDI)
- Sudden Death in the Young (SDY) Registry
- The Loving Support Peer Counseling Program (Breastfeeding)
- Title X Family Planning
- Tobacco Control Programs
- Traumatic Brain Injury
- Universal Newborn Hearing Screening and Intervention
- Women, Infants, and Children (WIC)

*Denote grants added since last year.

All programs of the TDH must be free from discrimination. TDH's non-discrimination policy is as follows: Title VI of the Civil Rights Act of 1964 requires that federally assisted programs be free of discrimination. In accordance with Federal civil rights laws, the Tennessee Department of Health does not tolerate harassment and discrimination based upon any protected class including race, color, national origin, sex, age, disability or reprisal or retaliation, in any program or activity conducted or funded by TDH. Such harassment and discrimination constitutes misconduct which undermines the integrity of the employment relationship and is subject to disciplinary action, up to and including dismissal.

III.E. Five-Year State Action Plan

III.E.1. Five-Year State Action Plan Table

State: Tennessee

Please click the links below to download a PDF of the Entry View or Legal Size Paper View of the State Action Plan Table.

State Action Plan Table - Entry View

State Action Plan Table - Legal Size Paper View

III.E.2. State Action Plan Narrative Overview

III.E.2.a. State Title V Program Purpose and Design

The purpose of the MCH/Title V Program is to broadly support and improve the health of the maternal and child population in Tennessee. This is done by identifying priority needs and working with partners to leverage program capacity to meet those needs, which ultimately improves health outcomes for women, infants, children, and families across the state. Tennessee's MCH/Title V Program works to convene MCH stakeholders at least twice a year, so that all programs serving these populations can be strategically aligned statewide. This strategic alignment is imperative for utilizing resources efficiently and assuring the greatest impact.

The MCH Block grant works within a life course framework, operationalized by the population health domains below. Through these domains the MCH population is subdivided into time periods that represent important stages in life. States are required to choose at least one priority within each domain, ensuring that priorities are spread across the life course.

Population Health Domains:

- Women/Maternal Health
- Perinatal/Infant Health
- Child Health
- Adolescent Health
- Children with Special Health Care Needs (CYSHCN)
- Cross-cutting/Life Course

Utilizing information gathered through the comprehensive needs assessment, the Tennessee Title V/MCH program identifies priority areas and then assembles teams to work on each area. Each FHW senior leader, and their program/epidemiology staff, are entrusted to lead one priority. The teams are responsible for developing action plans, measuring success, implementing the plans and reporting on progress. All of this is done in collaboration with stakeholders at multiple touchpoints throughout the year.

III.E.2.b. State MCH Capacity to Advance Effective Public Health Systems

III.E.2.b.i. MCH Workforce Development

Title V-funded MCH and CSHCN staff work in multiple capacities within TDH (Central Office, 7 Rural Regional Offices and 6 Metro Offices, and local health departments in all 95 counties).

State-level program planning is provided by individual program directors, in consultation with Tennessee's MCH/Title V Director and senior leadership within FHW. MCH program directors gather monthly for a Program Management meeting, during which staff outline program goals and objectives, map program activities to state priority measures, discuss opportunities for linkages between MCH programs, and work through challenges common across programs. The Program Management meetings also provide an opportunity for ongoing professional development among the Central Office MCH workforce. These monthly meetings also provide an opportunity to familiarize staff with Departmental operations, procedures and policies. FHW staff development is also incorporated into monthly administration meetings and less formal monthly staff lunch and learn sessions. Bi-monthly staff meetings bring all FHW staff together to celebrate successes, share key information, and develop strategy for key division and department priorities.

MCH/Title V funding is used to support ongoing training of local and regional health department staff who provide services to the MCH population. Examples include an annual professional development conference for CYSHCN care coordination staff and an annual "Spring Update" training session for women's health and family planning staff. MCH staff have also been instrumental in planning the annual in-person conference for state public health educators to develop capacity in the health department priorities of tobacco prevention, physical activity promotion, obesity reduction, and prevention of opioid use. Tennessee has also utilized MCH/Title V funding to support the broader MCH workforce outside of public health. For example, Title V/MCH funding supports an mPINC technical assistance website for hospitals and pays for 20 hours of lactation continuing education for interested members of the care team. FHW also supports CLC training and certification for staff across the state who work in breastfeeding promotion.

Some staff participate in LEAD Tennessee, a statewide, 12-month development initiative which includes six one-day summits of intense, personally tailored, high impact learning focused on twelve core leadership competencies. The goal of LEAD Tennessee is to increase the state's leadership bench strength by providing agencies with a continuous pipeline of motivated and prepared leaders that share a common language and mindset about great leadership.

Since 2016, TDH has partnered with the Public Health Information Access Project through the National Library of Medicine (NLM). This partnership provides TDH staff with full-text access to over 240 peer-reviewed journals (including MCH-related journals). Additionally, a partnership with East Tennessee State University facilitates inter-library loan access to other articles not available through the NLM project. MCH/Title V Program funds are used to support the NLM project. MCH/Title V program staff have been instrumental in developing workforce development opportunities in the use of the public health library and teaching of literature reviews for both FHW and TDH.

Due to the ongoing COVID-19 pandemic most all meetings have been held virtually since March of 2020. This new situation has called for developing new skills, namely, how to collaborate in a virtual setting. Seeing this gap in skill, MCH/Title V Program staff developed and hosted a training on "How to Host an Engaging Virtual Meeting". Staff used the Harvard Business Review's "Running Virtual Meetings" book to develop the training. It covered technology considerations but focused how to create an engaging online environment and run a smooth meeting. The impetus for this training was to improve engagement at the virtual MCH stakeholder meeting, however since most FHW support multiple program those programs also benefited. It was well received and improved virtual meeting

engagement and morale overall.

In May of 2021 a new position was established in FHW for a Director of Strategic Development. This position is responsible for developing staff knowledge and skills as well as fostering partnerships with other MCH population serving agencies. The director surveyed division staff to identify topic areas for development. The survey results ranged from developing leadership skills to learning new data analysis software. Over the coming year the MCH/Title V Program is planning to offer development opportunities on a wide range of topics gathered from the survey. Participation will be voluntary in order to garner genuine interest.

In 2020 and 2021 special effort has been made to provide professional development specifically to FHW epidemiologists. This included purchasing software licenses and training for Tableau, a data visualization software. Program staff were also welcomed to join the training, but most participants were epidemiologists. The training took place over six months. The group used eLearning modules to work through the class together. The only requirement to participate was to create a dashboard that was beneficial to an FHW program, resulting. This training resulted in several MCH related dashboards. The second cohort of staff to be trained will begin this fall. There is also planned training on how to use SQL in SAS next year, which will allow epidemiology staff to use large, linked datasets available within the department. This will be funded through both the MCH/Title V Program and the Emerging Issues in MCH grant.

III.E.2.b.ii. Family Partnership

FHW recognizes the vital nature of parental involvement throughout our division in program development, implementation, and evaluation. The Division has a longstanding collaborative relationship with Tennessee Family Voices, beginning with an enhanced effort to integrate parent and youth input in all aspects of MCH and FHW services. Advances have been made over the past few years to further involvement of parents in planning, programming and implementing Tennessee's Title V Programs. Family members have attended and participated in Tennessee's Block Grant Review since 2015 and have attended the AMCHP meeting as a Family Delegate and part of the Tennessee delegation since 2013.

TDH continues to partner with Family Voices and provides funds to ensure the Parent-to-Parent mentoring program can continue to provide parent matching, mentoring and build skill and capacity for parents to be active, engaged partners in their child's health. The CSHCN Program has implemented a number of activities in partnership with Family Voices to further expand parent involvement including development of training and leadership opportunities. Significant accomplishments include:

- Youth, parents and family members participate in youth and parent led training and workshops that include training on partnering in decision-making, self-advocacy, transition and reinforcing expectations with their health care provider for comprehensive and coordinated care.

- TDH contracts with Family Voices to hire parent and youth consultants to assist with the coordination of family and youth activities and the coordination of the youth advisory committee.

FHW collaborated with Family Voices and LEND to create the Youth Advisory Committee (YAC). Currently there are thirteen active members who continue to meet and focus on several priorities, i.e., self-advocacy, funding opportunities, transition – speaking to your provider and member recruitment and retention. The Family Voices' Youth Consultant and the FHW CYSHCN Integrated System of Services Coordinator have primary responsibility for this committee and continue to engage LEND participants who assist with planning and facilitating meetings. YAC participants and their parents received training on "telling your story" and "speaking to your elected officials". Youth and parents attended Disability Day on the Hill and participated in legislative forums individually and in groups. One specific issue that was addressed by this group and the AMCHP family delegate was Tennessee's Katie Beckett Waiver – a request for a Medicaid waiver program to provide medical treatment for children with disabilities whose families would otherwise not qualify for TennCare, the state's Medicaid program. This legislation passed and funds were allocated for FY20. Family members worked with the State's Medicaid program to develop the Katie Beckett guidelines. Parents of the youth involved have volunteered to serve in an advisory capacity to Family Health and Wellness.

Through the newborn hearing screening grant, TDH contracts with Family Voices to conduct the Parent Empowerment Access and Resources (PEARS) program. PEARS is dedicated to directly supporting families, their infants and toddlers who are identified with any degree of hearing loss by offering them the opportunity to talk to or meet face-to-face with a Parent Guide. PEARS provides a strong foundation in supporting families without bias regarding communication modes or methods as well as functional understanding of supports and services available to families and their children. Parents also serve on the newborn hearing screening and follow-up task force.

Family representatives routinely attend and participate in the Genetics Advisory Committee (GAC) and Children's Special Services (CSS) Advisory Committee meetings and the Tennessee Birth Defects Advisory Committee (TNBDSS). The GAC meetings focus on the state's newborn screening and follow-up program, and members advise the Department on program operations and the addition of screening tests to the state's testing panel. The CSS

Advisory Committee meetings focus on issues related to the management and operation of the CSS program (Tennessee's Title V CSHCN Program) as well as broader issues impacting all CYSHCN. The Birth Defects meetings focus on prevalence, trends and preventive measures for birth defects and infant mortality.

In 2019, TDH partnered with Family Voices to host focus groups with families of CYSHCN as part of the five-year Title V Needs Assessment and participated in all activities related to the Needs Assessment and the block grant development. The Family Voices Director and former AMCHP Family Scholar and Delegate partners with the CYSHCN Director to co-chair the stakeholder meetings during which key MCH stakeholders provide input on the selection of priority areas and national performance measures. Family members continue to participate on the MCH Block Grant Stakeholder group for children and youth with special health care needs and the other seven domains. Family Voices staff continue to work with families on issues related to violence in the Injury and Prevention section of FHW.

Family members have continued to participate in the annual statewide professional development training for Children's Special Services staff. Parents spoke about how Tennessee's Title V CSHCN program had impacted their family and provided care coordinators and administrative staff with guidance on how to engage families and partner in the care of their child with special health care needs. This was particularly impactful for the 100th anniversary of the CSS program.

During FY18, the CYSHCN staff developed a state-wide youth workgroup comprised of multiple state departments and local agencies that target youth with special health care needs ranging from 14-24 years of age. Agencies in this work group include Departments of Health, Education, Mental Health and Substance Abuse Services, Intellectual and Developmental Disabilities, Human Services (Vocational Rehabilitation), Labor (Workforce and Development), Children's Services, TN Voices and Family Voices. This group initially met to strategize around recruitment and retention of members, however realized that many of them have the same requirements and concerns regarding youth engagement and involvement. The workgroup meets monthly in which agency and youth council updates, new projects and effective advice are shared. In July, 2019, the workgroup held the first ever statewide Youth Summit focusing on youth/family engagement and involvement. The summit included youth and families from all departments; and chose *"Advocating for U(s)" as the theme*. Youth from each of these groups were integral in planning the summit and facilitated break-out sessions. The summit provided opportunities for the attendees to learn tools for transition to adulthood and tips on how to navigate systems of care, including mental and behavioral health, successfully.

Family Voices staff, members of the Youth Workgroup, parents of CYSHCN and youth are all active participants in the MCH Block Grant process. Members of each group participated in the Five-Year Needs assessment, helped to choose the CYSHCN priority, assisted in developing the CYSHCN logic model, strategies, activities, ESMs, NPMs, SPMs, NOMs, and SOMs. TDH was intentional in providing opportunities for all to participate, there were meetings held during the normal working hours and meetings held at night and on the weekend to ensure that youth and family members would be able to participate. These initiatives led to a well thought-out process with invaluable input from all participants.

The CYSHCN program continues to work towards system building for all children and have created partnerships with numerous interdisciplinary stakeholders, including TEIS, evidence based home visiting, the TN Council on Developmental Disabilities, TN Department of Labor and Workforce Development, TN AWARE, the Council on Children's Mental Health, Family Voices, Tennessee Voices for Children, LEND, TN Disability Pathfinders, Vocational Rehabilitation, Tennessee Commission on Children and Youth, and several employment programs and task forces for children with and without disabilities. The CYSHCN program also continues working towards improving the quality of care across systems, the department's newly formed CHANT program will increase opportunities for engagement, navigation and resource referral for all children and families. Collaborative efforts

with TennCare, TNAAP and other public health programs are aimed at building systems and improving quality of care across systems. The CYSHCN program also promotes program and policy change for system building and is engaged in the Division's efforts around creating optimal health for all and works to ensure health equity is included in CYSHCN, Division, and Departmental policies and procedures.

III.E.2.b.iii. MCH Data Capacity

III.E.2.b.iii.a. MCH Epidemiology Workforce

FHW wholehearted recognizes the value of using data to understand population health in order to implement programs that meet the health needs of the MCH population. As a division, significant investments have been made to increase data analysis capacity over the last decade. In 2010 there were zero epidemiologists within the division, now there are nineteen including one CDC Senior Maternal and Child Health Epidemiology Program Assignee and one CDC/CSTE Applied Epidemiology Fellow. All nineteen epidemiologists are full time staff members who support individual programs, or multiple programs, within the division as well as Tennessee's Title V/MCH Program. The MCH/Title V Program is what links all of the work within the division together, therefore it is a collaborative division-wide effort led by our Division Director/Title V Director.

Roles and Responsibilities

The epidemiologists provide broad support for data analysis and program evaluation across FHW and specialized support in each section including reproductive and women's health, supplemental nutrition, injury prevention and detection, early childhood initiatives, chronic disease prevention and health promotion, perinatal infant and pediatric care, and children and youth with special healthcare needs. The specific programs within those sections include:

Reproductive and Women's Health

- Family Planning
- Perinatal Regionalization
- Presumptive Eligibility
- Sexual Risk Avoidance Education
- Rape Prevention and Education
- Breast Cancer Screening Program

Perinatal Infant and Pediatric Care

- Newborn Metabolic Screening
- Newborn Hearing Screening
- Childhood Lead Poisoning Prevention

Supplemental Nutrition

- WIC
- WIC Loving Support Program
- Commodity Supplement Nutrition Program

Injury Prevention and Detection

- Infant Mortality Reduction
- Child Fatality Review
- Maternal Mortality Review
- Traumatic Brain Injury
- General Injury Prevention
- Suicide Prevention

Early Childhood Initiatives

- Home Visiting

- Healthy Start (state program, not federal healthy start)
- CHANT
- NAS

Chronic Disease Prevention and Health Promotion
- Gold Sneaker
- Preventive Health and Health Services Block Grant
- Tobacco
- Project Diabetes
- Diabetes, Heart Disease, and Stroke (1815)
- Comprehensive Cancer

Children and Youth with Special Healthcare Needs
- CSS

In regard to MCH/Title V Program responsibilities specifically. There is a programmatic and epidemiology lead for each priority. All other epidemiologists are assigned to a priority as additional support staff. They fill in as needed and broaden the bandwidth for data analysis work around each priority. This allows for more in-depth and therefore richer understanding of the health needs and programmatic impacts for each priority. They have a very active role in the comprehensive and ongoing needs assessment as well as state measure development and tracking for the annual action plan and report.

Funding Structure

Most epidemiologists are paid through federal grants within their specific sections based on the individual programs they support. However, for many a portion of their salary comes from the MCH/Title V Program. The MCH/Title V Program has one full time coordinator/epidemiologist devoted solely to it and the SSDI grant.

Levels of Education and Training

Of the nineteen epidemiologists, four hold terminal degrees in epidemiology or statistics. The others possess master's degrees in either epidemiology, biostatistics, or health policy. As a group there is a combined forty-five years of experience working in the field of epidemiology.

Training and Development

Although the epidemiology capacity has increased significantly since 2010 there is always a need for more support. In almost every grant that is applied for within the division an epidemiology role is included in the proposal. The understanding that an epidemiologist's perspective and guidance is needed is well seeded within the division. This practice is expected to continue.

Over the last two years a portion of the SSDI grant has been used to support training opportunities for FHW epidemiologists. This included data visualization training on Tableau software which resulted in the creation of nine data dashboards. In the coming years the hope is to expand training opportunities to increase SAS and ArcGIS skills among staff. The SAS training would focus on advanced analyses using linked datasets and longitudinal data. The ArcGIS training would include learning the advanced analysis features of the upgraded ArcGIS software.

III.E.2.b.iii.b. State Systems Development Initiative (SSDI)

The SSDI grant complements the MCH Block grant by setting aside funds for MCH data infrastructure. This ensures that grantees have MCH data collection and analysis capacity. Grantees are then able to leverage this capacity to make data informed decisions, particularly in regards to program planning. This in turn facilitates the creation of effective programs, which leads to health improvements in the MCH population.

The SSDI grant supports direct, consistent, electronic, and timely access to data by coordinating with the Division of Vital Statistics within TDH. The SSDI coordinator and MCH/Title V Director maintain the data sharing relationship between the two divisions. This relationship enables FHW epidemiologists to have access to many vital record datasets. As data sharing issues arise, they are discussed and resolved in a way that addresses the needs and concerns of both divisions.

All FHW epidemiologists have direct, consistent, electronic, and timely access to:

- Vital Records Birth
- Vital Records Death
- Vital Records Birth-Death Linked
- Vital Records Fetal Death
- Youth Risk Behavior Surveillance System (YRBSS)
- Behavioral Risk Factor Surveillance System (BRFSS)
- Pregnancy Risk Assessment Monitoring System (PRAMS)
- Hospital Discharge
- Induced Termination of Pregnancy
- Population Estimation

The FHW epidemiologists who work with in the programs below have direct consistent, electronic, timely access to these datasets:

- Patient Tracking and Billing Management Information System (direct care in LHDs)
- Women, Infants, and Children (WIC)
- Newborn Bloodspot Screening
- Newborn Hearing Screening
- Evidence-Based Home Visiting
- Healthy Start (Tennessee specific program)
- Tobacco Quitline
- Baby and Me Tobacco Free
- Neonatal Abstinence Syndrome Surveillance
- Child Fatality Review
- Maternal Mortality Review
- Traumatic Brain Injury Registry
- Tennessee Birth Defects Registry
- Children’s Special Services (Title V CSHCN program)
- Childhood Lead Screening

If FHW epidemiologists outside of these programs need to access this data, they can do so by coordinating with the epidemiologist for that program.

By ensuring access to MCH data, FHW epidemiologists are able to analyze and present information which

programs can then use to make data informed decisions. For example, access to MCH data allows for population assessment, program development, and progress monitoring of the MCH Block grant Action Plan. At the beginning of each grant cycle FHW epidemiologists and program staff complete a needs assessment which provides data on the MCH population. FHW staff and other stakeholders use this data to select priorities for the upcoming grant cycle. Once the priorities are chosen an action plan is developed (i.e. program development) to impact each priority. Lastly FHW epidemiologists assist in developing process and outcome measures to measure the impact of the Action Plan on the health of the MCH population. Progress is monitored on each measure by FHW staff and other stakeholders at the bi-annual public MCH stakeholder meetings. Based on measurement performance FHW staff and stakeholders revise the Action Plan as needed to improve health impact.

The SSDI grant also supports key MCH data priority needs. For example, the SSDI coordinator has been supporting the building of the birth defects surveillance system for the state. This includes how birth defect data is collected, transferred and stored within systems. The coordinator is available for data enhancement activities throughout the division as they arise and time permits. In 2021-2022 the SSDI coordinator will be involved in the integration of birth data into the Integrated Data System at TDH. This system already includes death data hospital discharge, and controlled substance monitoring database data. The addition of birth data will allow FHW epidemiologists to better understand topics longitudinally, such as infant and maternal risk factors and outcomes among pregnant women who use opioids. Information such as this could be used to better serve the needs of the MCH population in general.

Over the last two years a portion of the SSDI grant has been used to support training opportunities for FHW epidemiologists. This included data visualization training on Tableau software which resulted in the creation of nine data dashboards. A list of dashboard topics is below.

Tableau Dashboards

- Baby & Me Tobacco Free
- CHANT
- Child Fatality and Infant Mortality
- FHW Expenditure Tracker
- Lead in Water Testing in Tennessee Public Schools
- Monitoring Suicidal Behavior in TN
- NAS
- Neonatal Levels of Care
- SARS-CoV-2 Child

III.E.2.b.iii.c. Other MCH Data Capacity Efforts

Pregnancy Risk Assessment Monitoring System (PRAMS)

The MCH/Title V Program coordinator and CDC Senior Maternal and Child Health Epidemiology Program Assignee to Tennessee represent FHW on the PRAMS Steering Committee which is housed within TDH's Division of Population Health Assessment. Most recently the FHW representatives provided input to the PRAMS program on which topics should be added or removed for the new phase of the questionnaire. This work will directly affect MCH data available to MCH programs on the health-related experiences of new mothers.

Emerging Issues in Maternal and Child Health Grant

The division applied for an was awarded the Emerging Issues in Maternal and Child Health for FY2022 from MCHB. FHW will use this grant to facilitate the addition of birth data to the TDH Integrated Data System (IDS) housed within the Office of Informatics and Analytics (OIA) at TDH. It will also support the training of FHW epidemiology staff on how to use the system. This will enhance epidemiologists' skills around using large linked longitudinal datasets.

The IDS currently includes data from the vital records death file, hospital discharge, and controlled substance monitoring database data. Adding birth data will allow FHW epidemiologists to conduct analysis to understand the emerging issue of opioid and substance use disorder among pregnant and postpartum women throughout the state. Currently in Tennessee the leading cause of pregnancy-associated death was overdose, and about one-third (34%) of all pregnancy-associated deaths had substance use disorder as a contributing factor to death. Decreasing pregnancy-associated mortality is a MCH/Title V Program priority. There is an unmet need to understand the non-fatal impact of the opioid and substance use disorder crisis among pregnant and postpartum women to identify upstream opportunities for prevention and intervention. This grant will help meet that need and prioritizes sustainability to address the needed technological and workforce infrastructure so TDH can identify and address future emerging maternal and child health issues.

National Survey for Children's Health Oversample

The MCH/Title V Program has partnered with Tennessee COVID-19 Health Disparities Initiative to fund an oversample of the state for the National Survey of Children's Health. The goal is to collect enough data that indicators can be stratified by race and ethnicity. It is important to have this information to better understand where health disparities exist so they can be addressed and eliminated. Currently the sample size for the state is too small to allow this stratification for all measures.

Key Challenges

A key challenge faced when trying to improve the use of MCH data is funding to build data infrastructure. The SSDI grant is helpful in this area but it is small amount of money when it comes to data projects. It cost money to hire staff with the skills and expertise to build and analyze MCH information systems, not to mention the systems themselves.

III.E.2.b.iv. MCH Emergency Planning and Preparedness

As discussed in the MCH Success Story section this is an area of development for Tennessee's MCH/Title V Program. Staff have connected with the state's Emergency Planning and Response team mostly around Continuity of Operations Planning (COOP) for MCH related programs such as CSS, WIC etc. FHW leadership has contact with EPR leadership but a stronger connection between program staff from both areas is needed. Based on ongoing MCH/Title V program needs assessment efforts and lessons learned from previous emergency responses, infrastructure gaps were identified in the overall relationship between the two teams. Moving forward the goal is to have more regular touchpoints and collaborative planning sessions with the state EPR team, as well as a more developed internal FHW infrastructure for emergency planning and response that goes beyond COOP planning. This will include designating an MCH EPR lead in FHW who can take responsibility for this effort.

The state does have a written EOP that is reviewed annually, that does consider some special populations such as pregnant women, however the populations need to be expanded. The MCH/Title V Director has been consulted in the planning and development of the State's EOP; however, they are not part of the Incident Management Structure. Currently, the CDC Senior Maternal and Child Health Epidemiology Program Assignee typically takes the lead on emerging MCH issues from a data assessment and surveillance standpoint. But there is a need for other tasks to be completed such as coordination and communication. These are areas of development for the MCH EPR lead.

III.E.2.b.v. Health Care Delivery System

III.E.2.b.v.a. Public and Private Partnerships

Tennessee's modern efforts at health reform began in 1994 with the introduction of TennCare, Tennessee's Medicaid program. Given the significant overlap in priority population and the opportunity for population health improvement, TDH partners extensively with the agency. The TennCare program operates under a Section 1115 waiver from the Centers for Medicare and Medicaid Services (CMS) in the United States Department of Health and Human Services. Unlike traditional fee-for-service Medicaid, TennCare is an integrated, full-risk, managed care program.

TDH has developed arrangements whereby traditional public health services, including family planning, STI screening and treatment, EPSDT, and tuberculosis screening and treatment are provided in county health departments and generally reimbursed without a primary care provider referral. TDH has current Participating Provider Agreements with all three TennCare (Medicaid) MCO plans (Amerigroup, BlueCare, United Healthcare Community Plan), DentaQuest (TennCare dental), Magellan (TennCare pharmacy), Humana (private insurance), Cigna (private insurance), Aetna (private insurance), Oscar Health Plan (ACA marketplace), Bright Healthcare (ACA marketplace), Medicare (flu/pneumonia credentialed in all county health departments and all Federally Qualified Health Centers are credentialed part A providers), and Blue Cross Blue Shield of Tennessee (ACA marketplace and private insurance). Traditional public health services (i.e., family planning, STI screening and treatment, EPSDT, tuberculosis screening and treatment, vaccines) are billable to these third-party plans. In most cases, these services are available to third party plan members without a primary care provider referral.

TDH continues to partner with the TennCare MCOs to set up an electronic portal for referral of pregnant women who smoke to connect them with cessation counseling and incentives which are billable services reimbursed by the MCOs. TDH was able to prove efficacy of this model with state tobacco prevention funds and then partner with the MCOs to sustain this important public health intervention as a billable service. This has been a significant achievement for TDH, TennCare, and the MCOs.

Over the past five years, the Department has greatly expanded its ability to bill third party insurance by negotiating contracts with carriers. Nonetheless, the state has been significantly impacted by increasing premiums in the federally run health insurance marketplace. There are three marketplace plans in the state, and increasingly only one plan is offered in any given area. State and federal discussions are rapidly evolving and have the potential to dramatically affect insurance coverage and access for Tennesseans.

Partnership

The scope of MCH/Title V partnership with TennCare extends far beyond reimbursement for MCH services in local health departments. The agencies partner together in multiple population health priorities. For example, TennCare partially funds infant mortality reduction initiatives through MCH/Title V programs such as group prenatal care pilots, FIMR teams, safe sleep promotion, and training in long-acting reversible contraception insertion. TennCare representatives routinely participate in the Perinatal Advisory Committee to discuss issues such as delivery at appropriate levels of care, implementation of the LOCATe tool, NAS management, and back transport policies. TennCare, TDH, and the MCOs also meet at least quarterly with the Tennessee Chapter of the American Academy of Pediatrics to coordinate efforts around EPSDT, immunizations, PCMH, and emerging population health priorities. In addition, the MCH/Title V director meets regularly with TennCare in context such as the NAS subcabinet, TIPQC, and on an ad hoc basis. TennCare has intentionally included input from TDH and the MCH/Title V Program regarding the implementation of its episodes of care model for payment reform. TennCare funding also supports TDH outreach efforts and partially supports the HUGS care coordination services, and TDH has worked extensively with TennCare and the MCOs to align service delivery via CHANT. The agencies collaborate on multiple other MCH related efforts

such as lead screening and EPSDT outreach. There has been ongoing joint action to minimize barriers to contraception and particularly voluntary long acting reversible contraception in the immediate post-partum period, co-authorship of the legislatively mandated diabetes report, co-authorship of a 2017 legislatively mandated report on neonatal abstinence syndrome, joint work around maternal mortality reduction initiatives, and support for the perinatal quality collaborative roll out of its quality bundles for substance exposed mothers and neonates.

New Innovative Health Care Delivery Models

TennCare is seeing positive results from several changes it has made to how health care is paid for and delivered in Tennessee. The state's innovative programs are resulting in improvements in the care of TennCare members, as well as significant programmatic savings. Tennessee's Health Care Innovation Initiative is moving from paying for volume to paying for value. The mission is to reward health care providers for high quality and efficient treatment of medical conditions and help maintain member's health over time. Tennessee is leading by example through the TennCare program and Tennessee state employee's benefits administration in hopes other stakeholders are asked to join in statewide payment and delivery system reform.

The Tennessee Health Care Innovation Initiative has three strategies, primary care transformation, episodes of care, and long-term services and supports. Primary care transformation focuses on the role of the primary care provider in promoting the delivery of preventive services and managing chronic illnesses over time. The initiative has developed an aligned model for Patient Centered Medical Homes (PCMH), Tennessee Health Link for TennCare members with the highest behavioral health needs as well as a shared care coordination tool that allows providers to identify and track the closure of gaps in care linked to quality measures. Episodes of care focus on the health care delivered in association with acute health care events such as a surgical procedure or an inpatient hospitalization. Episodes encompass care delivered by multiple providers in relation to a specific health care event. The long-term services and supports (LTSS) component focuses on improving quality and shifting payment to outcomes-based measures for the QuILTSS program and for enhanced respiratory care.

MCH/Title V Funding for Gap-Filling Health Care Services to MCH Populations

Tennessee continues to use MCH/Title V funding to provide gap-filling services to MCH populations. Examples include:

Children's Special Services: MCH/Title V funding supports care coordination as well as reimbursement for direct services (inpatient/outpatient hospitalizations, physician office visits, laboratory testing, medications, supplies, durable medical equipment, and therapies). Payment for medical services is available for children with a chronic physical diagnosis whose family income is at or below 200% of the federal poverty level. in 2017, CSS has piloted increasing the income eligibility to 225% of federally poverty level in one region successfully.

Breast and Cervical Cancer Screening: MCH/Title V funding is used to support screening and diagnostic services for uninsured or underinsured women at or below 250% of the federal poverty level. This funding augments other federal funding (CDC) as well as dedicated state appropriations and funding from the Susan G. Komen Foundation.

Family Planning: MCH/Title V funding augments federal Title X funding, state appropriations, and patient billing collections. In CY2018, 77% of individuals served through the program were at or below 100% of the federal poverty level and 97% were at or below 250% of the federal poverty level.

EPSDT: MCH/Title V funding provides funding for EPSDT visits for uninsured children in local health departments.

Likewise, children seen in WIC, immunization clinic, or adolescents in family planning clinics are offered EPSDT services if desired by the family in cooperation with TennCare to increase screening rates across the state. TDH provided 5.2% (43,359) of TennCare EPSDT visits in the state in FFY 2018. TennCare, TDH, and the MCOs share data to outreach to target counties to increase adherence to the AAP periodicity schedule. TDH is enhancing efforts to connect EPSDT visits to the medical home via CHANT pathways.

III.E.2.b.v.b. Title V MCH – Title XIX Medicaid Inter-Agency Agreement (IAA)

Outreach and Enrollment

TDH has undertaken several efforts to assist clients seeking services in public health departments to access public insurance or insurance available through the health insurance marketplace. In the 89 rural counties, there are at least two (and in many cases more) options for obtaining assistance with Medicaid and ACA insurance enrollment. TDH clinic management staff can provide clients with information (verbal and written) about how to access enrollment assistance for these plans.

A map was developed in 2014-15 that indicated the locations of state agencies and partners across the state who could assist with insurance enrollment and outreach. The map and list of referral sources was shared with both local and regional health department leadership. Local staff have this map and resource listing as a tool to assist patients in finding navigator and application assistance services.

Clinical Application Coordinators (CACs) are also available in 16 counties (Stewart County, Gibson County and all 14 counties of the Upper Cumberland Region) as well as in metro health departments. These CACs provide outreach and on-site enrollment services in communities across the state for marketplace plans. Additionally, the TDH Breast and Cervical Cancer Screening Program (partially funded by Tennessee's MCH/Title V Program) and the Ryan White HIV/AIDS Program each have one CAC in each rural region to assist with outreach and on-site enrollment efforts. Care coordinators for CSS also assist with enrollment through the marketplace and with appeals for third-party payer denials.

In all clinic sites, TDH staff provides presumptive eligibility (PE) determination for Medicaid for pregnant women and for individuals diagnosed with breast or cervical cancer. TDH has begun including a checklist for those who qualify for Presumptive Eligibility or CoverKids (Tennessee's SCHIP) enrollment. This checklist includes in simple terms what Medicaid could request to prevent their coverage from being dropped after the Presumptive period ends. The checklist includes how to sign up and use TennCare Connect so the applicant can manage their Medicaid coverage and contact information on their own. Several health departments provide lists of resources available locally for pregnant women, but this varies by county and region. Central Office reviews equity data from enrollments to determine which communities or groups are being underserved and working to provide services and outreach to those underserved groups and communities.

During FY2021 TDH served 8,273 presumptive eligibility and CoverKids applicants. TDH conducts routine training with local staff on changes in the Medicaid enrollment process to ensure that eligible persons can be served.

Healthcare Financing

TennCare services are offered through managed care entities. Medical, behavioral and Long-Term Services and Supports are covered by "at-risk" Managed Care Organizations (MCOs). All of TennCare's MCOs have recently been ranked among the top 100 Medicaid health plans in the country. The care provided by TennCare's MCOs is assessed annually by the National Committee for Quality Assurance (NCQA) as part of the state's accreditation process.[1] In addition to the MCOs, there is a Pharmacy Benefits Manager for coverage of prescription drugs and a Dental Benefits Manager for coverage of services to children under age 21.

Policy Waivers and State Plan Amendments

A Katie Beckett Waiver program was signed into Tennessee state law in May 2019. TennCare subsequently

submitted an amendment request to the Centers for Medicare and Medicaid Services (CMS) to implement the program in September 2019. CMS approved the request in November of 2020. The program was made available to families that same month. Within two months 849 referrals were received; 600 were received the first day. As of January 2021, 290 children have been enrolled in the program.

The Katie Beckett Program helps kids in Tennessee with disabilities and complex medical needs under the age of 18. The Katie Beckett Program provides care for children under the age of 18 with disabilities and complex medical needs whose parent's income may make them ineligible for Medicaid.

Katie Beckett Part A assists children in Tennessee with the most significant disabilities or complex medical needs. A child must meet "institutional" level of care but want to receive care in the home. Children in Part A receive full Medicaid Benefits and also can get up to $15,000 in nonmedical services called home and community-based services. A child must have private insurance, and a premium may be required based on the family's income.

Katie Beckett Part B is for children in Tennessee who have disabilities and complex medical needs who do not qualify for care in a medical institution. They meet "at risk" level of care. Children in Part B do not receive Medicaid. Families get up to $10,000 a year in services to care for their child. Families can spend the money in Part B in any or all of 5 different ways: a card to pay for medical expenses, paying for a child's private insurance premium, getting paid back for certain services including non-traditional therapies, hiring your own staff to provide respite and supportive home care or having a community provider for services.

Due to the ongoing COVID-19 pandemic a new law addressing telemedicine was enacted in August of 2020 and will remain in place through April 2022. This new law requires health insurers to cover virtual care the same way they would in-person care. Specifically, the new law establishes payment and reimbursement parity between telehealth and in-person visits, removes geographic requirements on original service location and expands the list of healthcare providers who are permitted to provide telehealth services most notably, to include drug addiction counselors. These changes remove many barriers to care and help to reduce possible transmission of COVID-19 infection through person-to-person contact.

Title V/Title XIX Joint Policy Making

MCH/Title V Director and direct supervisor meeting monthly with Title XIX's Chief Medical Officer to discuss joint efforts and brainstorm solutions common challenges. Regular meetings also occur for joint workgroups addressing EPSDT, CHANT, and PE. Over the last year these meetings have produced formal contracts between the two agencies to address the health department's role in EPSDT services for children, care coordination for families including CSHCN (CHANT), immunization outreach, data sharing, and additional support for presumptive eligibility and care coordination for pregnant women.

[1] https://www.tn.gov/tenncare/information-statistics/annual-reports.html

III.E.2.c State Action Plan Narrative by Domain

State Action Plan Introduction

The purpose of the MCH/Title V Program is to broadly support and improve the health of the maternal and child population in Tennessee. This is done by identifying priority needs and working with partners to leverage program capacity to meet those needs, which ultimately improves health outcomes for women, infants, children, and families across the state. Tennessee's MCH/Title V Program works to convene MCH stakeholders at least twice a year, so that all programs serving these populations can be strategically aligned statewide. This strategic alignment is imperative for utilizing resources efficiently and assuring the greatest impact.

The MCH Block grant works within a life course framework, operationalized by the population health domains below. Through these domains the MCH population is subdivided into time periods that represent important stages in life. States are required to choose at least one priority within each domain, ensuring that priorities are spread across the life course.

Population Health Domains:

- Women/Maternal Health
- Perinatal/Infant Health
- Child Health
- Adolescent Health
- Children with Special Health Care Needs (CYSHCN)
- Cross-cutting/Life Course

Utilizing information gathered through the comprehensive needs assessment, the Tennessee Title V/MCH program identifies priority areas and then assembles teams to work on each area. Each FHW senior leader, and their program/epidemiology staff, are entrusted to lead at least one priority. The teams are responsible for developing action plans, implementing the plans, reporting on progress, and measuring success. All of this is done in collaboration with stakeholders at multiple touchpoints throughout the year.

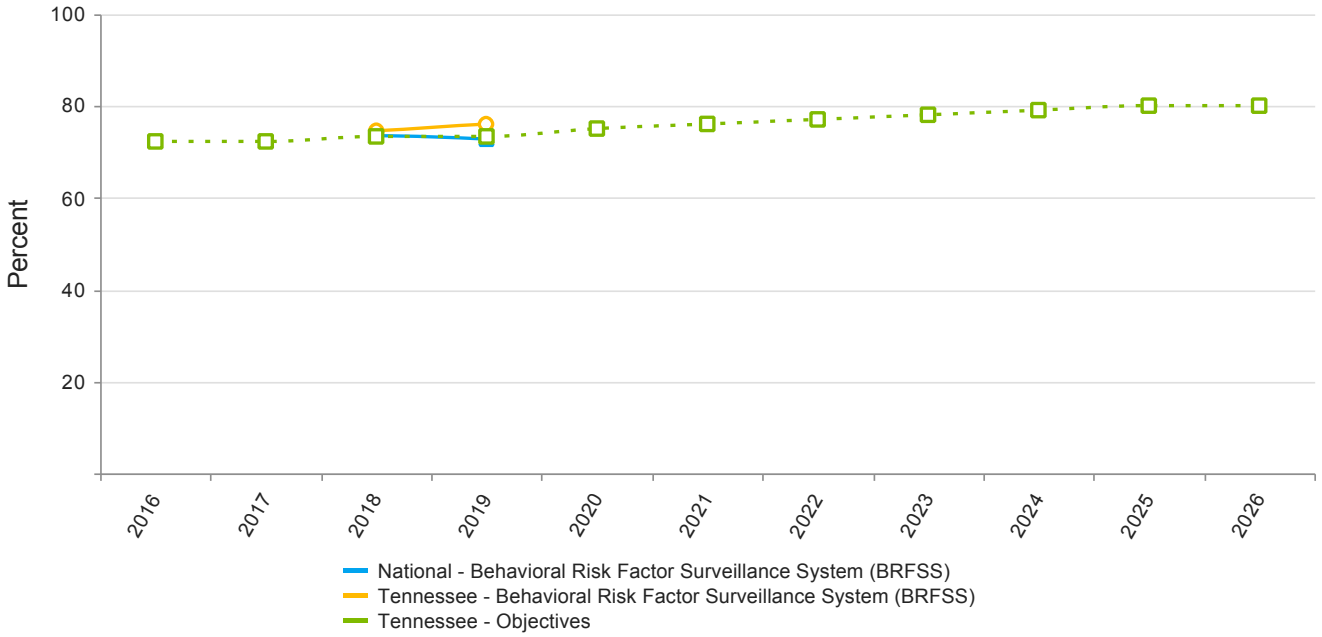
Women/Maternal Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations	SID-2018	79.4	NPM 1 NPM 14.1
NOM 3 - Maternal mortality rate per 100,000 live births	NVSS-2015_2019	26.4	NPM 1 NPM 14.1
NOM 4 - Percent of low birth weight deliveries (<2,500 grams)	NVSS-2019	9.2 %	NPM 1 NPM 14.1
NOM 5 - Percent of preterm births (<37 weeks)	NVSS-2019	11.2 %	NPM 1 NPM 14.1
NOM 6 - Percent of early term births (37, 38 weeks)	NVSS-2019	28.6 %	NPM 1 NPM 14.1
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2018	6.8	NPM 1 NPM 14.1
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2018	6.9	NPM 1 NPM 14.1
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2018	4.5	NPM 1 NPM 14.1
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2018	2.4	NPM 1 NPM 14.1
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2018	216.7	NPM 1 NPM 14.1
NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2018	153.6	NPM 14.1
NOM 10 - Percent of women who drink alcohol in the last 3 months of pregnancy	PRAMS-2019	4.8 %	NPM 1
NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations	SID-2018	14.6	NPM 1
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2018_2019	87.9 %	NPM 14.1
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2019	23.7	NPM 1
NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth	PRAMS-2019	15.5 %	NPM 1

National Performance Measures

NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year
Indicators and Annual Objectives



Federally Available Data					
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective					75
Annual Indicator				74.6	76.0
Numerator				875,792	897,415
Denominator				1,174,631	1,180,193
Data Source				BRFSS	BRFSS
Data Source Year				2018	2019

Previous NPM-1 BRFSS data for survey years 2015, 2016 and 2017 that was pre-populated under the 2016, 2017 and 2018 Annual Report Years is no longer displayed since it is not comparable with 2018 survey data.

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	76.0	77.0	78.0	79.0	80.0	80.0

Evidence-Based or –Informed Strategy Measures

ESM 1.1 - Create pre/posttests to assesses provider knowledge of and confidence using PATH (Parenthood/Pregnancy Attitude, Timing, and How important is pregnancy prevention).

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	Yes	Yes	Yes	Yes	Yes

ESM 1.2 - Percent of family planning encounters that occur via telehealth

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	0.4	0.8	1.6	3.2	6.4

ESM 1.3 - Number of women receiving patient navigation for women's health services

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	250.0	250.0	250.0	250.0	250.0

ESM 1.4 - Percent of birthing hospitals receiving training by TIPQC or THA

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	63.0	66.0	69.0	72.0	75.0

ESM 1.5 - Percent of birthing hospital providers trained reporting a change in knowledge

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	77.0	79.0	81.0	83.0	85.0

ESM 1.6 - Percent of non-clinical members participating in the action group

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	45.0	47.0	49.0	50.0	50.0	50.0

ESM 1.7 - Percent of postpartum women with positive screenings for depression (using a validated screening tool) who will receive resources/education or referrals for professional services

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	95.0	97.0	98.0	100.0	100.0

ESM 1.8 - Percent of recommendations with who/what/when components

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	75.0	79.0	84.0	89.0	94.0	98.0

State Performance Measures

SPM 1 - Percent of new mothers whose pregnancy was intended

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		51.6	49.9	49.9	62
Annual Indicator	51.6	54.1	50.6	51.5	47.2
Numerator					
Denominator					
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2013	2014	2015	2017	2018
Provisional or Final ?	Final	Final	Provisional	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	62.0	63.0	63.0	64.0	64.0	65.0

SPM 2 - Percent of facilities implementing patient safety recommendations

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	12.5	12.5	20.5	20.5	25.0	25.0

SPM 3 - Number of community level recommendations implemented

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	10.0	10.0	20.0	20.0	25.0	25.0

State Outcome Measures

SOM 1 - Rate of pregnancy-associated mortality to live birth

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	95.6	93.2	90.0	89.5	88.2	87.0

SOM 2 - Rate of pregnancy-related mortality to live births

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	25.6	24.2	23.5	22.0	20.5	19.0

State Action Plan Table

State Action Plan Table (Tennessee) - Women/Maternal Health - Entry 1	
Priority Need	
Decrease pregnancy-associated mortality	
NPM	
NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year	
Objectives	
Increase the percent of women, ages 18-44, with a preventive medical visit in the past year from 70% on October 1, 2020 to 82% on September 30, 2025.	
Strategies	
Increase surveillance of maternal deaths	
ESMs	Status
ESM 1.1 - Create pre/posttests to assesses provider knowledge of and confidence using PATH (Parenthood/Pregnancy Attitude, Timing, and How important is pregnancy prevention).	Active
ESM 1.2 - Percent of family planning encounters that occur via telehealth	Active
ESM 1.3 - Number of women receiving patient navigation for women's health services	Active
ESM 1.4 - Percent of birthing hospitals receiving training by TIPQC or THA	Active
ESM 1.5 - Percent of birthing hospital providers trained reporting a change in knowledge	Active
ESM 1.6 - Percent of non-clinical members participating in the action group	Active
ESM 1.7 - Percent of postpartum women with positive screenings for depression (using a validated screening tool) who will receive resources/education or referrals for professional services	Active
ESM 1.8 - Percent of recommendations with who/what/when components	Active

NOMs

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

NOM 3 - Maternal mortality rate per 100,000 live births

NOM 4 - Percent of low birth weight deliveries (<2,500 grams)

NOM 5 - Percent of preterm births (<37 weeks)

NOM 6 - Percent of early term births (37, 38 weeks)

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

NOM 9.1 - Infant mortality rate per 1,000 live births

NOM 9.2 - Neonatal mortality rate per 1,000 live births

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

NOM 10 - Percent of women who drink alcohol in the last 3 months of pregnancy

NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

State Action Plan Table (Tennessee) - Women/Maternal Health - Entry 2

Priority Need

Increase family planning

SPM

SPM 1 - Percent of new mothers whose pregnancy was intended

Objectives

Increase the percentage of mothers whose pregnancy was intended from 62% on October 1, 2020 to 64% on September 30, 2025.

Strategies

Increase knowledge, awareness, and usage of reproductive life plans through PATH across the state of Tennessee

Increase rural access to family planning services through telehealth

Increase access to women’s health services by addressing and eliminating barriers to care through client navigation

State Action Plan Table (Tennessee) - Women/Maternal Health - Entry 3

Priority Need

Decrease pregnancy-associated mortality

SPM

SPM 2 - Percent of facilities implementing patient safety recommendations

Objectives

Increase the percent of facilities implementing patient safety recommendations from 24% on October 1, 2020 to 33% on September 30, 2025.

Strategies

Increase evidence-based education at hospitals on topics identified by the Maternal Mortality Review Committee (MMRC)

State Action Plan Table (Tennessee) - Women/Maternal Health - Entry 4

Priority Need

Decrease pregnancy-associated mortality

SPM

SPM 3 - Number of community level recommendations implemented

Objectives

Increase the percent of community level recommendations implemented from 10 on October 1, 2020 to 25% on September 30, 2025.

Strategies

Increase access to services through community agency involvement to improve maternal health outcomes

State Action Plan Table (Tennessee) - Women/Maternal Health - Entry 5

Priority Need

Decrease pregnancy-associated mortality

SOM

SOM 2 - Rate of pregnancy-related mortality to live births

Objectives

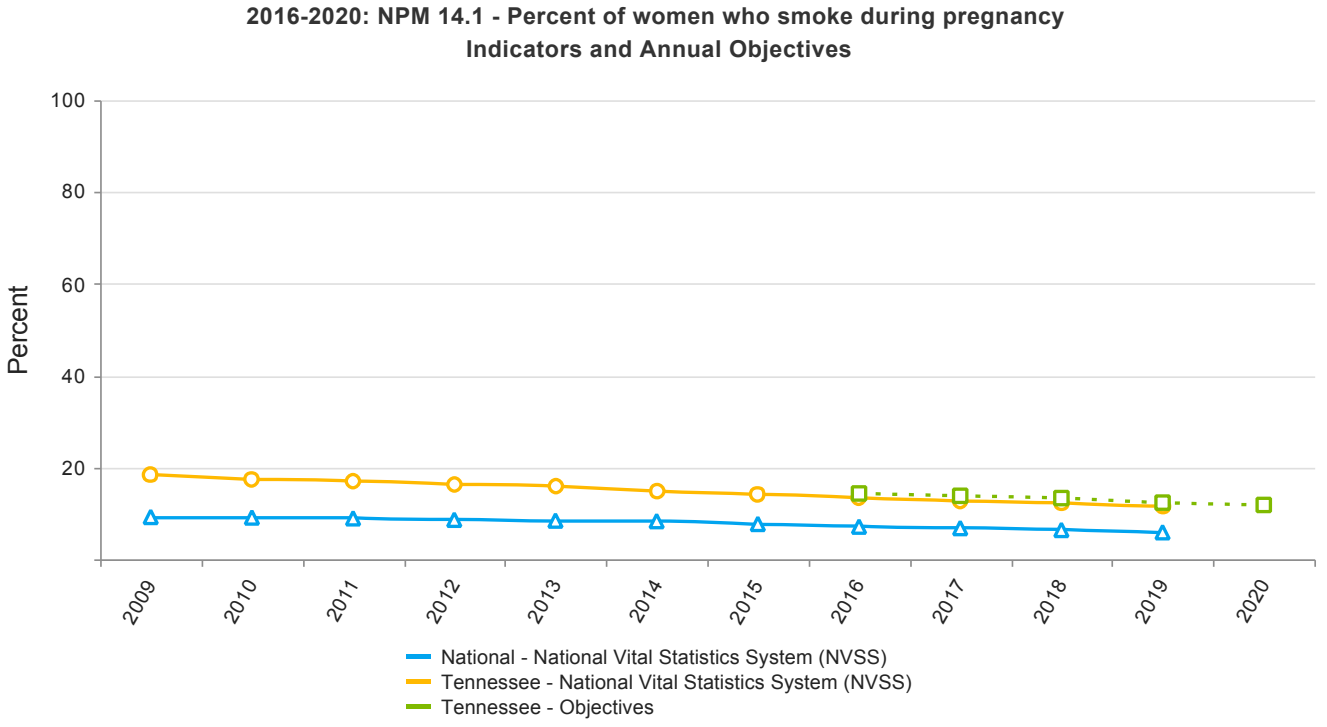
Decrease the rate of pregnancy-related mortality to live births from 25.6 per 100,000 live births on October 1, 2020 to 20.5 per 100,000 live births on September 30, 2025.

Strategies

Increase evidence-based education at hospitals on topics identified by the Maternal Mortality Review Committee (MMRC)

State Action Plan Table (Tennessee) - Women/Maternal Health - Entry 6
Priority Need
Decrease pregnancy-associated mortality
SOM
SOM 1 - Rate of pregnancy-associated mortality to live birth
Objectives
Decrease pregnancy-associated mortality from 51 on October 1, 2020 to 42 on September 30, 2025.
Strategies
Increase access to services through community agency involvement to improve maternal health outcomes

2016-2020: National Performance Measures



Federally Available Data					
Data Source: National Vital Statistics System (NVSS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	14.4	13.9	13.4	12.4	11.9
Annual Indicator	14.3	13.4	12.8	12.2	11.5
Numerator	11,577	10,771	10,318	9,797	9,239
Denominator	80,953	80,306	80,363	80,177	80,213
Data Source	NVSS	NVSS	NVSS	NVSS	NVSS
Data Source Year	2015	2016	2017	2018	2019

2016-2020: Evidence-Based or –Informed Strategy Measures

2016-2020: ESM 14.1.1 - Number of reproductive-aged female tobacco users (15-44 years) who received online or phone counseling services through the Tennessee Tobacco Quitline.

Measure Status:			**Active**	
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			800	880
Annual Indicator	624	599	567	372
Numerator				
Denominator				
Data Source	Tennessee Tobacco QuitLine Report	Tennessee Tobacco QuitLine Report	Tennessee Tobacco QuitLine Report	Tennessee Tobacco QuitLine Report
Data Source Year	FFY2017	FFY2018	FFY2019	FFY2020
Provisional or Final ?	Final	Final	Final	Final

PRIORITY: Improve utilization of preventive care for women of childbearing age.

Interpretation of Performance Data on NOMs, NPMs, SPM and ESMs:

NPM 1 The percent of women with a last year preventive medical visit in calendar year 2019 was 76.0%, which exceeds the FY2019-2020 goal of 73.3% (i.e. the goal was met). Although this percentage was higher compared to that reported during the first year of the block grant (69.6% for calendar year 2015), based on overlapping confidence intervals this change was not statistically significant. This measure has remained steady since the beginning of the grant period.

SPM 3 The percent of women with an unintended pregnancy in calendar year 2018 was 47.2%, which is lower than the FY2018-2020 goal of 49.9% (i.e. the goal was met). Although this percentage was lower compared to that reported during the first year of the block grant (51.6% for calendar year 2013), based on overlapping confidence intervals this change was not statistically significant. This measure has remained steady since the beginning of the grant period.

ESM 1.1 In state fiscal year 2020, there were 22 press releases, PSAs and/or social media messages promoting preventive health care visits for women of reproductive age. This was 2 more than the goal of 20.

ESM 1.2 In state fiscal year 2020, there were 11 clinician webinars/trainings that include discussions on how to increase preventive care visits among women. This was 9 more than the goal of 2.

ESM 1.3 In state fiscal year 2020, there were 2 site-level family planning utilization reports distributed, which met the goal for this measure.

ESM 1.4 In state fiscal year 2020, there were no region-level pregnancy-related service utilization reports distributed. Due to staff reassignments and updated clinic priorities related to COVID, reports were temporarily suspended. However, the goal for this measure was met in each of the previous grant years. In addition, previous reports showed that staff were continuing to ensure that a high percentage of pregnancy test recipients receive FP services.

Accomplishments and Challenges (based on FY2020 Action Plan)

Strategy 1: Increase general awareness of the importance of preventive health care visits for women of childbearing age.

Activity 1a: Promote National Women's Health Week in May and continue to promote preventative heath care for women throughout the year through press releases, social media, and/or public service announcements.

Report 1a: Many Women's Health Week activities in 2020 were postponed due to COVID. However, the Reproductive & Women's Health team continued to plan for 2021's events. TDH is partnering with The Art's & Business Council to have local artists create a unique, inspired graphic to help promote Women's Health Week. RWH began working on a

toolkit including press releases, social media messages and other marketing tools. A "Free Pap Day" is also being planned in collaboration with external partners, TBCSP and Family Planning.

Activity 1b: Collaborate with Family Health and Wellness internal partners to cross message the importance of women's health preventive care.

Report 1b: Collaboration with Family Health and Wellness internal partners is ongoing. The Tennessee Breast & Cervical Screening Program (TBCSP) teamed up with Tobacco Prevention to provide individuals calling the Quitline with cancer screening recommendations and the importance of preventative care. TBCSP also partnered with Comprehensive Cancer and Tobacco Prevention to create a marketing campaign called TN Pink and Pearl Campaign. This campaign focused on promoting breast cancer and lung cancer screening for women.

Activity 1c: Capture the promotion of preventive health outreach to women done by the Reproductive and Women's Health Programs through REDCap.

Report 1c: Outreach activities continue to be tracked utilizing REDCap. In 2020, REDCap was updated to better capture evidence-based outreach and to better align with program initiatives. Quarterly results are shared with all programs within RWH.

Activity 1d: Work with Parish Nurses to incorporate preventative care messages for women in church bulletins.

Report 1d: Due to COVID-19 and shifting priorities, we were unable to work with Parish Nurses. However, RWH has continued to partner with the Faith-Based Initiatives in Disparities Elimination to promote women's health including the importance of annual preventive visits and recommended cancer screenings. The creation of bulletin inserts is ongoing.

Activity 1e: Initiate an evidence-based intervention (patient reminders, provider reminders or provider feedback) in at least one health system.

Report 1e: TDH partnered with Church Health System in Memphis, TN to initiate evidence-based interventions. Church Health implemented both provider reminders and provider feedback that helped to encourage providers to ensure that patients completed all recommended screenings.

Strategy 2: Engage primary care providers on the importance of promoting preventive health care for women of childbearing age.

Activity 2a: Provide training for providers in both public and private settings discussing the importance of preventive health visits and how to leverage missed opportunities to increase provision of preventive health during acute care visits using the following strategies: (1) provide preventive health visit during sick visit and detail how to properly code the visit for reimbursement; (2) schedule preventive health visit during sick visit; (3) encourage evening and weekend appointments for preventive care in addition to acute care which is often available.

Report 2a: Family planning has a focused mission of "Optimal Health" to promote health across the reproductive lifespan. A fundamental aspect of achieving this mission involves the integration of optimal health into our FP initiatives in collaboration within our agency and with community partners (A Step Ahead, Court systems, Jail initiatives, Substance abuse prevention, etc.). Training of health care providers is ongoing.

Activity 2b: Promote the use of the PATH Method (Pregnancy Attitudes Timing and How important is preventing pregnancy) as a way for providers to fully support women's preventive reproductive health needs using the following strategies: (1) incorporate The PATH Method into electronic health records; (2) continue to include documentation of the use of the PATH Method as part of Family Planning site visit chart reviews; (3) partner with other Public Health Programs (WIC, Home Visiting, Primary Care, STD) to incorporate the PATH Method into their client screening/history.

Report 2b: Family Planning (FP) facilitated the opportunity for all FP staff to attend the NCNTC annual Title X training (8/2020) and were enrolled in the PATH training hosted by Patti Cason. The PATH Method has been incorporated in health department EHR (EPI/CPRS) and all staff have been trained in the appropriate use and documentation.

Activity 2c: Increase access to Family Planning services by collaborating with STD staff to provide family planning counseling, education and methods to all STD clients seen at local health departments.

Report 2c: Family Planning continues to collaborate with the STD programs to promote women's health by meeting monthly. Best practices, programmatic updates and current initiatives are shared by all programs in attendance.

Strategy 3: Continue to provide high-quality women's health services through local health departments in all 95 counties.

Activity 3a: Provide in-house preventive care services to women at all health departments, and when necessary provide referrals to community health clinics if a needed preventive health service is not available at the local health department.

Report 3a: During 2020, many of the local health departments were operating under their emergency plans. While some health departments were unable to provide preventive care services during this time, all patients needing services were referred to community health clinics. Family planning services were not interrupted and telehealth was offered as well.

Activity 3b: Maintain memoranda of understandings between local health departments and community health clinics to facilitate referral for primary care services not available at local health departments.

Report 3b: The TN Department of Health has 17 MOU/participating provider agreements with various health plans, and more than 40 agreements for outside FP service providers across the

state. The Prenatal Presumptive Eligibility(PE) Program is also working with TennCare and FQHC's to expand PE enrollment services.

Activity 3c: Create quarterly site-level reports for Family Planning clinics and Breast and Cervical Screening Program clinics assessing client demographic trends for use in targeting outreach activities and promoting Family Planning clinic utilization and preventive reproductive health services and recommended breast and cervical cancer screenings.

Report 3c: Family Planning has created a "Friendly Clinic Survey" assessment tool to identify areas that individual clinics can address in order to improve their teen, male and LGBTQ+ friendliness. The surveys were completed in every local health department by April 2020 . The results from this survey will guide innovations and initiatives to improve the "friendliness" of the FP sites. Family Planning has also collaborated with the Middle Tennessee Trans Task Force (TTF) and provided education about services available in the local health departments. TTF members have agreed to provide feedback, from their unique lens, and participate in program, survey, and "friendly" implementation efforts in TN.

TBCSP has assessed state-wide and programmatic data by race, ethnicity and location. Targeted providers and health systems are being recruited to help fill in gaps of service.

Activity 3d: Improve access to FP services by streamlining documentation requirements in health department EHR.

Report 3d: The RWH's Clinical Trainer has routine meetings with the health department's EHR team, Community Health Services, and nursing staff to streamline and de-duplicate efforts in documentation. EHR telehealth templates have also been created within the system in an effort to streamline.

Strategy 4: Provide pregnancy-related services to women of childbearing age.

Activity 4a: All local health department clinics will offer basic prenatal services, which includes pregnancy testing, presumptive eligibility determination for Medicaid, WIC, counseling, information, and referral for medical care.

Report 4a: Despite the ongoing pandemic, all local health departments continued to offer pregnancy-related services. FP services are considered "essential services" and continued to be provided during the emergency implementations. These activities shifted from in-person to virtual or telephonic. These services are ongoing.

Activity 4b: Distribute vitamins with folic acid and provide folic acid education to non-pregnant women through local health departments.

Report 4b: All female FP clients are offered and encouraged to take folic acid regardless of pregnancy intention.

Activity 4c: Track the number of pregnant women enrolled in presumptive eligibility for TennCare and compare with Family Planning pregnancy test reports.

Report 4c: PE numbers are compared with positive pregnancy tests on an ongoing basis. Trends are tracked and documented for targeted outreach and program improvement.

Activity 4d: Provide education information, community resources and linkages to healthcare services to pregnant and parenting teens at community events, including: Teaching Teens Outstanding Parenting Skills (T-TOPS) programs, Teen Life Mazes and Incredible Baby Showers.

Report 4d: Family Planning collaborates with SRAE/TAPPP to provide FP education and services. All FP sites have a list of all community services including parenting skills, community resources, mental health resources, etc. available at all sites. Many outreach events were cancelled due to COVID restrictions.

PRIORITY: Increase Family Planning Service Access and Utilization

Objective SPM 1 Increase the percentage of mothers whose pregnancy was intended from 62% on October 1, 2020 to 64% on September 30, 2025.

The following strategies and activities are planned for *October 1, 2021 to September 30, 2022*:

Strategy 1: Increase knowledge, awareness, and usage of reproductive life plans through PATH across the state of Tennessee

Supporting Evidence for Strategy 1: A reproductive life plan (RLP) is a set of personal goals about having or not having children which is based on everyone's own values, goals, and resources. Family planning providers play a key role in helping both women and men to reflect on their reproductive intentions, to complete a RLP and to access appropriate services to meet their RLP goals.[i]

PATH is a client-centered approach to assess parenthood/pregnancy, attitude, timing and the importance of pregnancy prevention. PATH can be used with any gender, sexual orientation or age. PATH is designed to facilitate listening and efficient client-centered conversations about preconception care, contraception and fertility as appropriate. PATH training is critical to ensuring a skilled family planning workforce that is able to provide client-centered, non-coercive, and culturally competent services. [ii]

Activity 1a: Facilitate PATH trainings with various internal and external partners including TPCA, TPHA, colleges and universities, rural health clinics, federally qualified health centers etc.

Activity 1b: Provide community outreach and education surrounding the importance of a reproductive life plan and birth spacing to faith-based communities and community partners.

Activity 1c: Create pre and post PATH training evaluations to identify gaps in learning.

Activity 1d: Increase assessment with PATH with non-family planning clients within TDH.

Strategy 2: Increase rural access to family planning services through telehealth

Supporting Evidence for Strategy 2: TDH seeks to ensure that minority communities, individuals residing in underserved rural and urban areas, and individuals with disabilities can reap the benefits of telehealth by overcoming barriers. These barriers can include taking time off work, transportation, childcare and confidentiality among others. Telehealth has the potential to help clients overcome these barriers and improve access to care.[iii]

Activity 2a: Promote Family Planning Telehealth services through key stakeholders and community partners using flyers, posters, social media posts and other identified promotional materials.

Activity 2b: Create, disseminate and evaluate a client satisfaction survey to identify areas for program improvement.

Activity 2c: Continue to expand telehealth services in additional rural health regions by providing additional education and training to key staff.

Activity 2d: Establish partnerships with health clinics at colleges and universities to refer clients for telehealth family planning services.

Strategy 3: Increase access to women's health services by addressing and eliminating barriers to care through client navigation

Supporting Evidence for Strategy 3: There are many health inequities surrounding women's health, obstetrics and gynecology. Client navigation can support efforts to address barriers to care and help to reduce these disparities.[iv]

Activity 3a: Develop a scope of service for client navigation contracts that at a minimum identify target or priority populations and expectations of contracted organization.

Activity 3b: Contract with health departments, community clinics, healthcare facilities or Federally qualified health centers to secure women's health client navigators.

Activity 3c: Update the navigation tracking tool in REDCap to ensure accurate tracking of clients' barriers and resolutions.

Activity 3d: Provide navigation services according to identified scope while identifying and addressing disparities in care.

Planned Partnerships:

- Rural and Metro health departments
- Community Health Services within TDH
- FQHCs/rural health clinic
- Colleges and Universities
- Title X
- NFPRHA
- RHNTC
- Faith-based community
- TPCA
- TPHA
- A Step Ahead
- TIPQC
- TennCare
- AMCHP
- ASTHO
- STD/HIV Program

Contextual Factors:

- Ongoing COVID-19 Pandemic

- Access to Technology
- National Program Guidelines and Policies
- Political Environment
- Socioeconomic Factors

Assumptions:

- State and Federal funding will be secure throughout the program period
- PATH training will be adopted and used in the way we intended
- Professionals will be motivated to attend trainings and implement what they have learned
- Staff with the necessary skills and abilities can be recruited, hired and retained.
- Continuation of essential health services
- Medical leadership buy-in
- Continued support of increased access to care

PRIORITY: Decrease Pregnancy-Associated Mortality

Objective NPM 1 Increase the percent of women, ages 18-44, with a preventive medical visit in the past year from 70% on October 1, 2020 to 82% on September 30, 2025.

Objective SPM 2 Increase the percent of facilities implementing patient safety recommendations from 24% on October 1, 2020 to 33% on September 30, 2025.

Objective SPM 3 Increase the percent of community level recommendations implemented from 10 on October 1, 2020 to 25% on September 30, 2025.

The following strategies and activities are planned for *October 1, 2021 to September 30, 2022*:

Strategy 1: Increase surveillance of maternal deaths

Supporting Evidence for Strategy: Moderate evidence to suggest maternal mortality review provides comprehensive information on causes of death, preventability, contributing factors, and leads to actions improving maternal deaths.

Activity 1a: Identify pregnancy-associated deaths and facilitate state Maternal Mortality review Committee meetings. The Committee will identify age, race and place for each death reviewed to identify disparities.

Activity 1b: Through the Maternal Mortality Review Committee, determine the relatedness of all deaths to pregnancy, contributing factors, cause(s) of death, and preventability of all deaths. For each pregnancy-related death determine age, race and place of death to identify disparities. For each pregnancy-related death, the MMRC will determine the cause as specified by PMSS.

Activity 1c: Develop recommendations for preventing subsequent maternal deaths based upon MMRC findings and for inclusion in the Maternal Mortality annual report and

dissemination to relevant stakeholders quarterly. These recommendations include reference to specific disparities, contributing factors, and cause(s) of death identified in the reviews.

Strategy 2: Increase evidence-based education at hospitals on topics identified by the Maternal Mortality Review Committee (MMRC)

Supporting Evidence for Strategy: *Moderate*. Provider education, such as continued medical educational opportunities appear to be effective.

Activity 2a: Contract with Tennessee Hospital Association (THA) and Tennessee Initiative for Perinatal Quality Care (TIPQC) to provide training to birthing hospitals on top causes leading to maternal death as identified by the MMRC. Birthing hospitals in the grand region of the state with the highest disparities will be given top priority for training.

Strategy 3: Increase access to services through community agency involvement to improve maternal health outcomes

Supporting Evidence for Strategy: Moderate: There is evidence to suggest that expanded insurance coverage is effective.

Activity 3a: Convene a maternal health task force, with a minimum of 25 members, quarterly to highlight innovative and best practices for preventing maternal death. The task force will include membership from the Office of Minority Health and Disparities Elimination to represent vulnerable populations.

Activity 3b: Fund a minimum of 3 community agencies to implement MMR leading contributing factors related to substance abuse, domestic violence assessment and mental health referral and treatment. Proposals will be evaluated on how well they are addressing at-risk populations.

Activity 3c: Increase the number of women of childbearing age participating in family planning and well woman visits by expanding and promoting telehealth to better reach those people in areas at risk for pregnancy-associated deaths.

Activity 3d: Increase the number of women applying for presumptive eligibility by implementing an outreach plan and collaborating with a community partners to reach vulnerable populations.

Planned Partnerships: TIPQC, THA, Maternal Health Action Team Members, Maternal Mortality Review Committee, Family Planning, Presumptive Eligibility

Contextual Factors:

- TIPQC and THA have a long-standing history of providing statewide education to providers.
- TIPQC only has capacity to assist hospitals with implementing one AIM bundle at a time
- Funding of agencies is competitive and dependent upon agencies applications for funding.

Assumptions:

- Training healthcare providers will improve maternal outcomes.
- Increasing enrollment in family planning will improve health before pregnancy.

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[i] American College of Obstetricians and Gynecologists' Committee on Health Care for Underserved Women. Committee Opinion No. 654: Reproductive Life Planning to Reduce Unintended Pregnancy. Obstet Gynecol. 2016 Feb;127(2):e66-9. doi: 10.1097/AOG.0000000000001314. PMID: 26942389.

[ii] Hipp, S.L., Chung-Do, J. and McFarlane, E., 2019. Systematic review of interventions for reproductive life planning. Journal of Obstetric, Gynecologic & Neonatal Nursing, 48(2), pp.131-139. (mixed)

[iii] Polinski JM, Barker T, Gagliano N, Sussman A, Brennan TA, Shrank WH. Patients' Satisfaction with and Preference for Telehealth Visits. J Gen Intern Med. 2016;31(3):269-275. doi:10.1007/s11606-015-3489-x

[iv] McKenney, K. M., Martinez, N. G., & Yee, L. M. (2018). Patient navigation across the spectrum of women's health care in the United States. *American journal of obstetrics and gynecology*, *218*(3), 280–286. https://doi.org/10.1016/j.ajog.2017.08.009

Perinatal/Infant Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2018	6.8	NPM 3
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2018	6.9	NPM 3 NPM 4 NPM 5
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2018	4.5	NPM 3
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2018	2.4	NPM 4 NPM 5
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2018	216.7	NPM 3
NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2018	153.6	NPM 4 NPM 5

National Performance Measures

NPM 3 - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)
Indicators and Annual Objectives

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	84.5	84.5
Numerator		
Denominator		
Data Source	Birth Statistical System	Birth Statistical System
Data Source Year	2020	2020
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	85.0	85.5	86.0	86.5	87.0	87.0

Evidence-Based or –Informed Strategy Measures

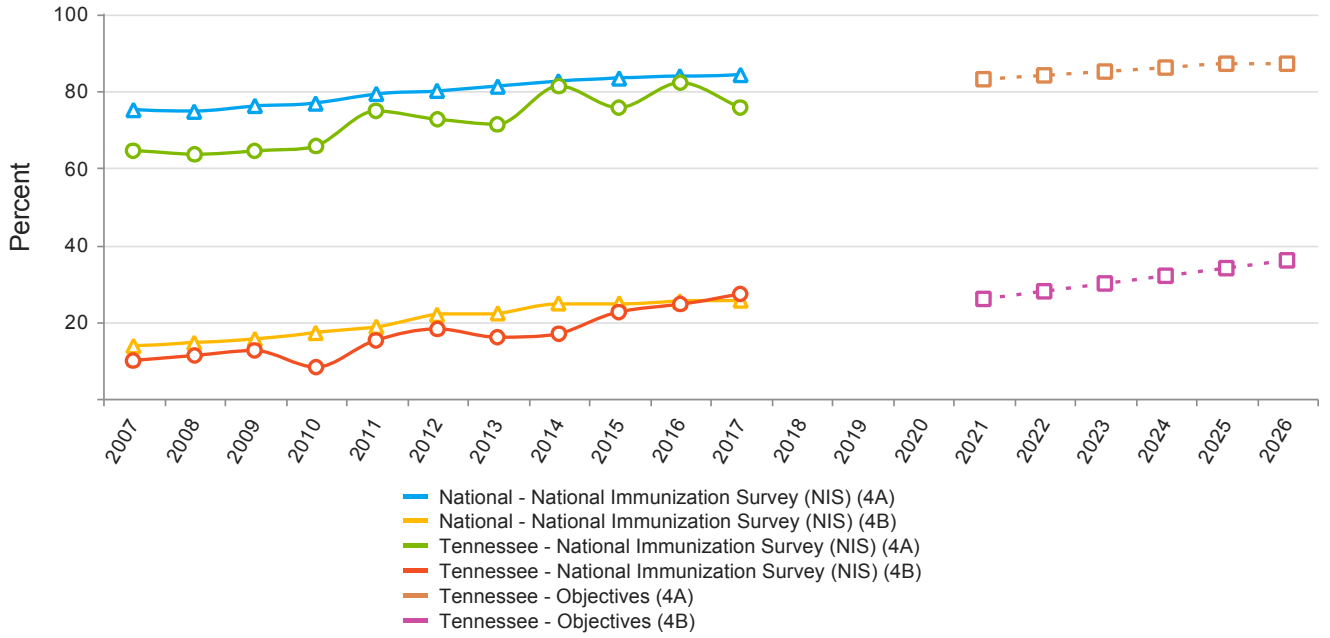
ESM 3.1 - Percent of Tennessee birthing hospitals participating in perinatal quality collaborative projects

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	33.0	33.0	33.0	33.0	33.0	33.0

NPM 4 - A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months Indicators and Annual Objectives



NPM 4A - Percent of infants who are ever breastfed

Federally Available Data		
Data Source: National Immunization Survey (NIS)		
	2019	**2020**
Annual Objective		
Annual Indicator	82.2	75.8
Numerator	63,360	53,802
Denominator	77,089	70,947
Data Source	NIS	NIS
Data Source Year	2016	2017

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	83.0	84.0	85.0	86.0	87.0	87.0

NPM 4B - Percent of infants breastfed exclusively through 6 months

Federally Available Data		
Data Source: National Immunization Survey (NIS)		
	2019	**2020**
Annual Objective		
Annual Indicator	24.5	27.2
Numerator	18,257	19,012
Denominator	74,506	69,987
Data Source	NIS	NIS
Data Source Year	2016	2017

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	26.0	28.0	30.0	32.0	34.0	36.0

Evidence-Based or –Informed Strategy Measures

ESM 4.1 - Number of credentialed lactation professionals within WIC

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	166.0	176.0	186.0	196.0	206.0	216.0

ESM 4.2 - Breastfeeding Welcomed Here (BFWH)-designated businesses with ideal workplace lactation policies

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	0.0	0.0	0.0	0.0	0.0	0.0

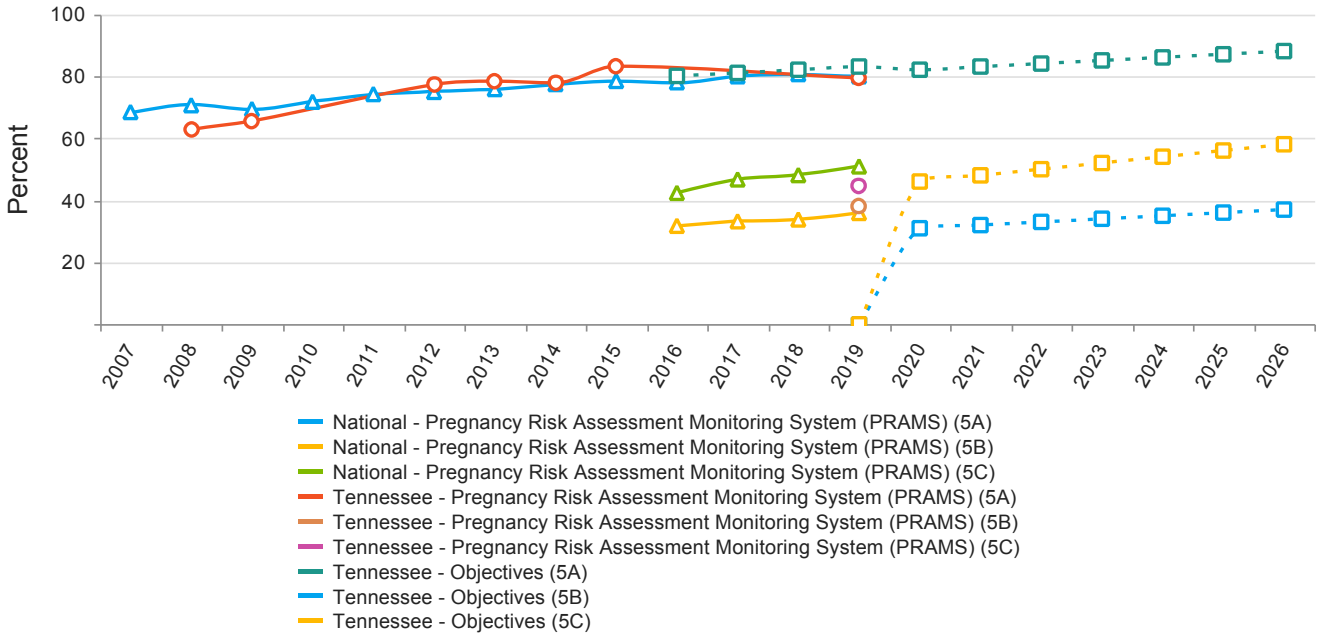
ESM 4.3 - Recognition process implemented for Breastfeeding Welcomed Here (BFWH)-designated businesses

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	Yes	Yes	Yes	Yes	Yes	Yes

NPM 5 - A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding
Indicators and Annual Objectives



NPM 5A - Percent of infants placed to sleep on their backs

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	80	81	82	83	82
Annual Indicator	78.0	83.0	83.0	83.0	79.4
Numerator	58,899	63,387	63,387	63,387	59,805
Denominator	75,553	76,381	76,381	76,381	75,369
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2014	2015	2015	2015	2019

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	83.0	84.0	85.0	86.0	87.0	88.0

NPM 5B - Percent of infants placed to sleep on a separate approved sleep surface

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2020
Annual Objective	31
Annual Indicator	37.9
Numerator	27,572
Denominator	72,769
Data Source	PRAMS
Data Source Year	2019

State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			0	31
Annual Indicator	0	0	0	
Numerator				
Denominator				
Data Source	No data source	No data source	No data source	
Data Source Year	No data	No data	No data	
Provisional or Final ?	Final	Final	Final	

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	32.0	33.0	34.0	35.0	36.0	37.0

NPM 5C - Percent of infants placed to sleep without soft objects or loose bedding

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2020
Annual Objective	46
Annual Indicator	44.8
Numerator	32,496
Denominator	72,533
Data Source	PRAMS
Data Source Year	2019

State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			0	46
Annual Indicator	0	0	0	
Numerator				
Denominator				
Data Source	No data source	No data source	No data source	
Data Source Year	No data	No data	No data	
Provisional or Final ?	Final	Final	Final	

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	48.0	50.0	52.0	54.0	56.0	58.0

Evidence-Based or –Informed Strategy Measures

ESM 5.6 - Percent of hospitals receiving national recognition or implementing approved safe sleep policy

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	100.0	100.0	100.0	100.0	100.0	100.0

ESM 5.7 - Number of diaper bags with safe sleep educational materials distributed

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	663.0	676.0	690.0	704.0	718.0	732.0

State Performance Measures

SPM 4 - Percent of newborns who initiated breastfeeding

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		80	82	84	80.7
Annual Indicator	78.2	79.8	80.9	80.8	82.6
Numerator					
Denominator					
Data Source	TDH PPA - Birth Statistical System	TDH PPA - Birth Statistical System	TDH PHA - Birth Statistical System	TDH PHA - Birth Statistical System	TDH PHA - Birth Statistical System
Data Source Year	CY2015	CY2016	CY2017	CY2017	CY2017
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	81.2	81.7	82.2	82.7	83.2	83.7

SPM 5 - Percent of safe sleep diaper bag recipients who reported making a behavioral change in their infant sleep practices because of the items included in the bag

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	47.0	50.0	52.0	55.0	57.0

State Action Plan Table

State Action Plan Table (Tennessee) - Perinatal/Infant Health - Entry 1	
Priority Need	
Increase breastfeeding	
NPM	
NPM 4 - A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months	
Objectives	
Increase the percent of infants who were ever breastfed from 83% on October 1, 2020 to 84% on September 30, 2025.	
Strategies	
Cultivate a diverse community of professional lactation support through education and training opportunities across health care disciplines	
ESMs	**Status**
ESM 4.1 - Number of credentialed lactation professionals within WIC	Active
ESM 4.2 - Breastfeeding Welcomed Here (BFWH)-designated businesses with ideal workplace lactation policies	Active
ESM 4.3 - Recognition process implemented for Breastfeeding Welcomed Here (BFWH)-designated businesses	Active
NOMs	
NOM 9.1 - Infant mortality rate per 1,000 live births	
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	
NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	

State Action Plan Table (Tennessee) - Perinatal/Infant Health - Entry 2

Priority Need

Decrease infant mortality

NPM

NPM 5 - A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Objectives

Increase the percent of infants placed to sleep on their backs from 82% on October 1, 2020 to 87% on September 30, 2025.

Increase the percent of infants placed to sleep on a separate approved sleep surface from 31% on October 1, 2020 to 36% on September 30, 2025.

Increase the percent of infants placed to sleep without soft objects or loose bedding from 46% on October 1, 2020 to 56% on September 30, 2025.

Strategies

Reduce infant sleep-related deaths, with outreach focused on regions with the highest infant mortality rates, the highest reported number of sleep-related deaths, and the widest racial disparity among sleep-related deaths (West TN, Shelby and Davidson)

ESMs	Status
ESM 5.6 - Percent of hospitals receiving national recognition or implementing approved safe sleep policy	Active
ESM 5.7 - Number of diaper bags with safe sleep educational materials distributed	Active

NOMs

NOM 9.1 - Infant mortality rate per 1,000 live births

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

State Action Plan Table (Tennessee) - Perinatal/Infant Health - Entry 3

Priority Need

Decrease infant mortality

NPM

NPM 3 - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

Objectives

Increase the percent of VLBW infants born in a hospital with a Level III+ NICU from 84.5% on October 1, 2020 to 87% on September 30, 2025.

Strategies

Improve perinatal health outcomes through quality improvement and regionalization efforts

ESMs	Status
ESM 3.1 - Percent of Tennessee birthing hospitals participating in perinatal quality collaborative projects	Active

NOMs

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

NOM 9.1 - Infant mortality rate per 1,000 live births

NOM 9.2 - Neonatal mortality rate per 1,000 live births

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

State Action Plan Table (Tennessee) - Perinatal/Infant Health - Entry 4

Priority Need

Increase breastfeeding

SPM

SPM 4 - Percent of newborns who initiated breastfeeding

Objectives

Increase the percent of Tennessee newborns who initiate breastfeeding from 80.6% on October 1, 2020 to 83.2% on September 30, 2025.

Strategies

Re-enforce lactation policies that positively influence breastfeeding practices in the workplace

State Action Plan Table (Tennessee) - Perinatal/Infant Health - Entry 5

Priority Need

Decrease infant mortality

SPM

SPM 5 - Percent of safe sleep diaper bag recipients who reported making a behavioral change in their infant sleep practices because of the items included in the bag

Objectives

Increase the percent of safe sleep diaper bag recipients who reported making a behavioral change in their infant sleep practices because of the items included in the bag from 43% on October 1, 2020 to 55% on September 30, 2025.

Strategies

Reduce infant deaths due to prematurity and low birthweight by reducing infant exposure to tobacco

PRIORITY: Reduce infant mortality.

Interpretation of Performance Data on NOMs, NPMs, SPM and ESMs:

NPM 5a The percentage of mothers who reported most often laying their infant to sleep on their back was 78%, based on 2017 PRAMS data. Tennessee did not meet its target of 84% for this measure. To note, however, though the PRAMS data used for this measure has historically been staggered back by three years, more recent data for 2018 is now available. The 2018 data shows that 81% of Tennessee mothers reported most often laying their baby to sleep on their back, a three percentage point increase from the 2017 figure. Because of the delays in the availability of PRAMS data, the performance data for this measure does not reflect the effect of the more recent activities Tennessee has implemented to increase the practice of safe sleep behavior. For example, the diaper bag project which supplies families with materials and education to aid in safe sleep and has been shown to be effective in achieving behavioral change was first introduced summer of 2018 and expanded in 2020. The lack of timeliness in the PRAMS data used to access performance for this measure prevents us from seeing the impact of this and other more recent projects Tennessee has worked on during FFY 2020.

NPM 5b The percentage of mothers who reported placing their infant to sleep on a separate sleep surface was 31%, based on 2017 PRAMS data. Tennessee narrowly missed meeting its target of 34% for this measure. The 2018 PRAMS data shows that 30% of mothers placed their infant to sleep on a separate surface, consistent with the 2017 estimate. The same limitations noted above for NPM 5a apply for this measure. Because of the significant delay in availability, the data reported here do not reflect any potential impact of the projects implemented over the past several years. The safe sleep diaper bag, for example, has been distributed to nearly 2,000 families as of this report and evaluation data shows that the most common behavioral change families made because of the items in the bag was putting their infant to sleep alone on a separate sleep surface. Due to the promising data from this and other safe sleep projects, we hope to see the percentage for this measure improve as more recent data is released.

NPM 5c The percentage of mothers who reported placing their infant to sleep without soft objects or loose bedding was 42%, based on 2017 PRAMS data. Tennessee surpassed its goal of 36% for this measure. The 2018 PRAMS data for this measure shows further improvement, with 44% of mothers reporting placing their infant to sleep without soft objects or loose bedding for this year. Though we have exceeded our goal for this measure, encouraging caregivers not to have soft bedding or toys in the crib continues to be a priority in our activities and we expect to see this number continue to improve in years to come.

ESM 5.1 During FY 2020, a total of 277,331 safe sleep materials were distributed to community partners and families to educate on infant safe sleep. Tennessee surpassed its goal of distributing 240,000 materials, despite the limitations of the pandemic restrictions which interfered with several of the main methods of distribution (daycares, churches, businesses, etc.). As Tennessee has an average of approximately 80,000 resident births each year, our goal of 240,000 was chosen with the intention of reaching each infant through three different avenues (e.g. at the birthing hospital, at day care, and at a church service) so that caregivers have several opportunities to receive the information. Our Year 5 performance shows that we are

achieving this objective with over 37,000 materials to spare.

ESM 5.2 In FY 2020, the Child Fatality Review teams reviewed 100% of infant deaths that occurred in calendar year 2019. Tennessee has consistently met its goal for this measure of reviewing 100% of infant deaths.

ESM 5.3 The percentage of very low birthweight infants delivered at level 3 and 4 facilities was 83%, based on provisional data for calendar year 2020. Tennessee narrowly missed its goal of 85% for this measure. Though Tennessee's performance has remained fairly consistent on this measure over the past five years, we have made some methodological changes to improve the validity of the data. This calculation now includes non-birthing hospitals in the denominator and assigns care levels using CDC LOCATe responses instead of reports from perinatal regional coordinators. These changes are not expected to cause a major shift in the data but could explain the very slight decrease noted for Year 5.

ESM 5.4 In FY 2020, 100% of newborns with a positive metabolic screen received definitive follow-up to definitive diagnosis and clinical management. Tennessee has consistently met its goal of 100% for this measure.

ESM 5.5 A total of 38,609 individuals received services from the Tennessee Adolescent Pregnancy Prevention Program (TAPPP) in FY 2020. Tennessee did not achieve its goal of serving 47,000 individuals in this time period. In previous years, Tennessee has met or exceeded the objective for this measure, so we suspect that the decrease seen in FY 2020 stems from two factors. The first is the changes to the reporting system made in April 2020 which altered the categories of activities reported and the way participation is captured. We anticipated a moderate decrease due to this change. Second, and likely much more impactful, was the pandemic and the resulting closures. The majority of individuals served by TAPPP in FY 2020 received these services prior to mid-March 2020, reflecting the limitations to this program imposed by the stay-at-home orders.

Accomplishments and Challenges (based on FY2020 Action Plan)

Strategy 1: Educate parents and caregivers on safe sleep.

Activity 1a: Disseminate safe sleep flyers, magnets, door hangers, posters, educational flipcharts and *Sleep Baby Safe and Snug* board books to hospitals, daycares, Department of Children's Services, businesses, churches, generational caregivers and other agencies serving families with infants.

Report 1a: From October 2019 until September 2020 277,331 safe sleep materials were distributed to community partners and families to educate on infant safe sleep. Every child born in Tennessee receives a *Sleep Baby Safe and Snug* board book.

Activity 1b: Increase the total number of educational materials distributed through the Direct On Scene Education (DOSE) program with first responders and housing agencies from 1900 to 2300 by September 30, 2020. Through this activity, first responder agencies and local housing authorities will be provided with packets of safe sleep information and access to portable cribs

for families that do not have a safe sleep environment for their infant child.

Report 1b: 2,140 DOSE kids were reported distributed through September 30, 2020. This does not meet the goal due to a slowdown of kit distribution because of COVID-19.

Activity 1c: Increase the number of safe sleep floor talkers placed in stores, clinics, health departments, daycares and other agencies from 1400 to 1700 by September 30th, 2020.

Report 1c: 1,666 floor talkers have been placed through September 30th, 2020. Hospitals are the primary recipient of the floor talkers, with health departments and childcare centers also requesting the floor talkers. This goal was short due to there being limited access to retail stores during COVID-19.

Activity 1d: Increase the number of WIC parents completing the new safe sleep educational module from 1200 to 1400 by September 30, 2020.

Report 1d: From October 1, 2019 thought September 30, 2020 842 families completed the Safe Sleep educational module on wichealth.org. This brings the total to 2,042 parents that have completed the module. This goal was met and surpassed for the year.

Activity 1e: Increase the number of non-birthing hospitals providing safe sleep education from 3 to 10 by September 30th, 2020.

Report 1e: As of September 30th, 2020, there are 7 non-birthing hospitals providing safe sleep education to families. Five of the facilities are children's hospitals. This goal was not met due to focus of non-birthing hospitals turning focus to COVID-19 responses. Hospitals that were already participating continued to provide education to families.

Activity 1f: Disseminate Spanish and English safe sleep crib card to a minimum of 40 birthing hospitals by September 30th, 2020.

Report 1f: As of September 30, 2020, 35 birthing hospitals and one children's hospital are utilizing the crib cards. All of the birthing hospitals are offered the crib card. The largest birthing facilities in the state use the cards.

Activity 1g: Evaluate program fidelity with initial roll out of Community Health Access and Navigation in Tennessee (CHANT) program.

Report 1g: The diaper bag project started with CHANT in 2020. Families are provided standard safe sleep education and materials including a sleep sack to facilitate safe sleep. The initial CHANT program evaluation found that 55% of families change their infant sleep behavior based on this information.

Strategy 2: Review infant deaths through multidisciplinary teams to enhance data collection.

Activity 2a: Provide necessary documents to 34 child fatality review (CFR) teams and 4 fetal and infant mortality review (FIMR) teams to review all infant deaths and collect data on circumstances

surrounding these deaths.

Report 2a: All child deaths for 2019 were reviewed and entered into the CFR database by September 20, 2020. Notifications of all child deaths were sent to the local teams monthly. The 4 FIMR teams were given notification of fetal deaths through vital records and local hospitals. Autopsy reports and medical records were provided as requested.

Activity 2b: Provide training to the local CFR teams through quarterly new member webinars and annual in-person education.

Report 2b: Quarterly new member webinars were hosted in November, March, and July. A virtual conference was held in May of 2020 for all CFR team members.

Activity 2c: Provide data quality reports to the local CFR teams to enhance the quality of data collected.

Report 2c: Data quality reports were provided to local teams monthly starting in January. The frequency increased as the deadline to have data entered approached September.

Activity 2d: Provide death scene investigation training to first responders to educate on information to be gathered at the scene of an infant death. Training will be provided in-person and online for firefighters, police, EMS and medical examiners. If needed, agencies will be provided with a doll for doll reenactments.

Report 2d: Death Scene Investigation training was held in December 2019 in Hamilton County. The current online training was emailed to local first responders in Spring 2020 due to not being able to meet in person. Plans to develop a virtual classroom for DSI were started in September 2020 with a launch date for late winter. Agencies that requested a doll received one.

Activity 2e: Improve the percentage of agencies represented at local child fatality review meetings.

Report 2e: It was reported in September 2020 that nearly all agencies required to participate in local child fatality meetings increased participation. The only agency that had decrease participation was local law enforcement. Local child fatality teams reported virtual meetings facilitated the increase in participation because members were not having to travel.

Strategy 3: Support quality improvement and regionalization efforts to improve perinatal outcomes.

Activity 3a: Fund the statewide perinatal quality improvement collaborative to engage obstetrics, neonatal, and pediatric stakeholders in applying quality improvement methodologies related to perinatal outcomes.

Report 3a: The Department of Health continued to contract with Vanderbilt to coordinate the work of the Tennessee Initiative for Perinatal Quality Care (TIPQC). Under the direction of the Oversight Committee, hospital teams have created and implemented new quality improvement projects, continued with existing projects, collected data to track progress

and outcomes, attended learning sessions, and participated in the annual educational conference.

During calendar year 2020, TIPQC wrapped up Wave 1 of its first ever dual-arm quality improvement project, addressing opioid use disorder and opioid exposure in newborns. The Safe to Sleep project launched in March 2020, with a total of 1571 crib audits having been conducted by the 13 participating teams; and a severe maternal hypertension QI project is currently under development with 7 pilot teams.

Activity 3b: Provide technical assistance to the Regional Perinatal Centers. The five Regional Perinatal Centers will provide perinatal care for high- risk pregnant women and newborns if no other appropriate facility is available to manage significant high-risk conditions. Funding from the state (Medicaid) is used to provide consultation and referral for facilities and health care providers within the respective perinatal region, professional education for hospital staff and for other health care providers within the region, and maternal-fetal and neonatal transport.

Report 3b: Throughout the year, MCH staff have continued to work closely with the five Regional Perinatal Centers and the Perinatal Advisory Committee. In state fiscal year 2020, the five Centers provided direct care for 5,077 high-risk neonates and 18,820 high-risk maternal patients, and 6,797 hours of education and training were provided to staff at community hospitals to help them prepare for recognizing and treating complex medical conditions.

Updates were made to the perinatal social workers educational objectives, regionalization and transportation guidelines, and a new document was created to prepare EMS and non-delivering hospital staff for providing care to high-risk pregnant women and newborns in emergent situations.

Activity 3c: Coordinate the Perinatal Advisory Committee meetings and address with members findings from implementation of CDC's Level of Care Assessment Tool (LOCATe) in birthing facilities statewide and key information related to access to perinatal care especially in rural areas.

Report 3c: The Perinatal Advisory Committee met five times during the federal fiscal year (October 10, 2019, January 8, 2020, April 29, 2020, July 8, 2020, and August 26, 2020). Highlights for the federal fiscal year included: analysis of LOCATe survey responses and discussion of results, maternal mortality, pilot testing process to streamline requests to MCOs for back transport, update on implementation of the AIM OUD/OEN bundle, an analysis of deliveries occurring at non-birthing hospitals, newborn screening implementation of SMA screening and the OZ tracking system, and analysis of the impact of COVID-19 on pregnant women and neonates.

Strategy 4: Provide follow-up for abnormal newborn screening results.

Activity 4a: FHW staff will provide follow-up on all abnormal newborn screening results and unsatisfactory tests. Referrals are made to the genetics and sickle cell centers across the state. Access to genetic screening, diagnostic testing and counseling services is available at three

comprehensive and two satellite Genetic Centers and two comprehensive and two satellite Sickle Cell Centers for individuals and families who have or who are at risk for genetic disorders.

Report 4a: All babies born in Tennessee are required to be screened for metabolic conditions, hearing, and CCHD by the birthing facility. All newborn screening test results which are abnormal or unsatisfactory are sent to the follow-up staff for action. Providers are contacted and referrals made to the tertiary centers across the state for confirmation testing, counseling, and long-term follow-up. During this past calendar year, the State monitored screening for Spinal Muscular Atrophy (SMA), the newest condition added to the newborn screening panel during the prior year. During the state fiscal year, the education nurse held 1 BLS/Heart Saver class, conducted 17 hospital virtual site visits, 3 primary care physician trainings, and 2 hospital educational sessions.

Activity 4b: The newborn screening follow-up program will identify infants who did not have a metabolic screen by linking newborn screening data to birth certificate files. A report of those infants will be sent to the birthing hospital for review and follow-up.

Report 4b: The program epidemiologist has a weekly and monthly process in place to match the birth file from the Office of Vital Records (OVR) with records in the Newborn Screening Database to identify babies born in the state without documentation of receiving newborn screening – i.e. dried blood spot, hearing loss and critical congenital heart disease. The quality improvement (QI) nurse sends an individualized report to each birthing hospital detailing the babies with missing screening results. Hospitals are asked to report results back to the state or to identify the reason(s) why a screening test did not occur. A summative report on completeness and timeliness of newborn screening is also prepared for birthing hospitals.

Activity 4c: FHW staff will plan and facilitate three face-to-face meetings of the Genetics Advisory Committee, to include completion of processes and procedures for adding spinal muscular atrophy (SMA) to the State's newborn screening panel.

Report 4c: The Genetics Advisory Committee met three times during this past federal fiscal year (November14, 2019, April 23, 2020, and August 27, 2020).

Much of the work centered on laboratory and follow-up procedures for adding SMA to the newborn screening panel, including creating procedures, validating tests, determining appropriate follow-up to prepare for implementation in January 2020, the convening of a CCHD work group to address false negatives, implementation of the OZ system, determining TSH cut-offs, and COVID's impact on the newborn hearing screening program.

Strategy 5: Reduce unintended pregnancies.

Activity 5a: The Family Planning Program will provide comprehensive family planning services, including medical examinations, laboratory tests, education and counseling, and contraceptive supplies.

Report 5a: Family Planning is considered an “essential service” and was continued throughout the year during COVID-19. Services were reduced and many consultation services were done via telephone and telehealth. Due to the unique circumstances during the year family planning services dropped 26%.

Activity 5b: The TN Adolescent Pregnancy Prevention Program (TAPPP) will work with local health departments that choose to pilot implementation of evidence-based strategies outlined in the Teen Birth Vital Sign guidelines.

Report 5b: Knox County TAPPP is working on plan to help create teen friendly spaces in Women’s Health Center to make environment more welcoming to teens.

Knox & Sullivan TAPPP received resources including medically accurate brochures, TPP promotional materials, and information on We Think Twice campaign for youth. Campaign provides resources that advocate for youth voice.

Activity 5c: Communicate researched informed benefits of delaying the onset of sexual encounters or returning to a sexually risk-free status.

Report 5c: Knox and Sullivan TAPPP received handouts and pamphlets, medically accurate and age appropriate, for use in clinical or program spaces. Information covered risk reduction, risk avoidance, STD’s, healthy relationships, and benefits of abstaining.

PRIORITY: Increase Breastfeeding Initiation and Duration

Objective NPM 4 Increase the percent of infants who were ever breastfed from 83% on October 1, 2020 to 84% on September 30, 2025.

Objective SPM 6 Increase the percent of Tennessee newborns who initiate breastfeeding from 80.6% on October 1, 2020 to 83.2% on September 30, 2025.

The following strategies and activities are planned for *October 1, 2021 to September 30, 2022*:

Strategy 1: Cultivate a diverse community of professional lactation support through education and training opportunities across health care disciplines

Supporting Evidence for Strategy: Health care providers who identify as racial or ethnic minorities are more likely to provide care to underserved populations and group diversity is shown to improve task related outcomes.[i],[ii] While physicians feel they received adequate education on lactation, patients report they do not receive sufficient information from their primary care physician. However, additional skill targeted education with health care providers is shown to improve knowledge, attitudes, and confidence related to lactation support.[iii],[iv] Increased breastfeeding rates for practices have also been documented.[v] Increased presence of lactation counselors and other supports are shown to increase breastfeeding duration through the first year of life.[vi],[vii] Staff training in advanced lactation provides community-wide lactation counseling through the local health departments and increases the access to lactation support across the state. Increased referral and use of the hotline are an added layer of access, especially in those areas with little access to lactation professionals.[viii]

Activity 1a: Advertise the 20-hour lactation curriculum to health care providers that serve in communities with low breastfeeding engagement

Activity 1b: Provide advanced lactation training to WIC public health nutritionists and nursing staff within local health departments, focusing on areas with limited community breastfeeding support professionals

Activity 1c: Re-establish connection between birthing hospitals and Tennessee Breastfeeding Hotline services to ensure lactation support at discharge

Strategy 2: Re-enforce lactation policies that positively influence breastfeeding practices in the workplace

Supporting Evidence for Strategy: Within the community, partnerships are vital to create system and environmental change.[ix],[x] **"**Effective workplace breastfeeding interventions activate three mechanisms: 1) awareness of the intervention, 2) changes in workplace culture, manager/supervisor support, co-worker support and physical environments, and 3) provision of time.**"** [11] By systematically evaluating and addressing the barriers to workplace accommodations TDH will improve workplace support in areas with low access to supports[xi],[xii] and promote those businesses with best practices[10].

Activity 2a: Assess workplace lactation policies for businesses with BFWH designation

Activity 2b: Acknowledge BFWH-designated businesses that have established lactation workplace policies for employees

Activity 2c: Promote Breastfeeding Welcomed Here (BFWH) designation in rural areas and among minority-owned businesses

Planned Partnerships:

- Department of Economic & Community Development
- Tennessee State University
- Meharry Medical College
- Eastern Tennessee State University
- Tennessee Hospital Association
- Tennessee County Health Councils
- TDH Office of Minority Health
- Local area Chamber of Commerce

Contextual Factors:

- Competing or supporting initiatives sponsored by other agencies.
- Socioeconomic factors of the target audience.
- The motivations and behavior of the target population.
- Social norms and conditions that either support or hinder your outcomes in reaching disparate populations, such as the background and personal experiences of participants.

Assumptions:

- Funding will be secure throughout the course of the project.
- Professionals, businesses, and families will be encouraged to attend learning sessions.
- Staff with the necessary skills and abilities are dedicated to fulfilling the strategies and activities.
- Partnerships or coalitions are encouraged to address each strategy and participate in activities.
- Policy adoption can lead to individual behavior change.

PRIORITY: Decrease Infant Mortality

Objective NPM 3 Increase the percent of VLBW infants born in a hospital with a Level III+ NICU from 84.5% on October 1, 2020 to 87% on September 30, 2025.

Objective NPM 5a Increase the percent of infants placed to sleep on their backs from 82% on October 1, 2020 to 87% on September 30, 2025.

Objective NPM 5b Increase the percent of infants placed to sleep on a separate approved sleep surface from 31% on October 1, 2020 to 36% on September 30, 2025.

Objective NPM 5c Increase the percent of infants placed to sleep without soft objects or loose bedding from 46% on October 1, 2020 to 56% on September 30, 2025.

Objective NPM 14.2 Decrease the percent of women who smoke during pregnancy from 10.9% on October 1, 2020 to 8.4% on September 30, 2025.

Objective SPM 5 Increase the percent of safe sleep diaper bag recipients who reported making a behavioral change in their infant sleep practices because of the items included in the bag from 43% on October 1, 2020 to 55% on September 30, 2025.

The following strategies and activities are planned for *October 1, 2021 to September 30, 2022*:

Strategy 1: Reduce infant sleep-related deaths, with outreach focused on regions with the highest infant mortality rates, the highest reported number of sleep-related deaths, and the widest racial disparity among sleep-related deaths (West TN, Shelby and Davidson)

Supporting Evidence for Strategy 1: There is emerging evidence to suggest hospitals implementing a safe sleep policy will reduce sleep-related deaths. There is also emerging evidence to suggest educating caregivers will change their behavior.

Activity 1a: Increase the percent of birthing hospitals recognized as a National Cribs for Kids certified hospital or with an approved safe sleep policy.

Activity 1b: Improve infant caregiver safe sleep behaviors through the education provided by the safe sleep diaper bag project in Evidence Based Home Visiting Programs and care coordination (CHANT) programs.

Strategy 2: Improve perinatal health outcomes through quality improvement and regionalization efforts

Supporting Evidence for Strategy 2: A 2017 review of three online databases (Johns Hopkins University) showed moderate evidence for continuing education of hospital providers plus state guidelines/policy. TIPQC projects educate hospital providers. Tennessee has had regionalization guidelines in place for decades for all levels of perinatal care and for both obstetrics and neonatal care.

Activity 2a: Support quality improvement collaborative projects for hospitals regarding care for high risk maternal and/or neonatal patients.

Strategy 3: Reduce infant deaths due to prematurity and low birthweight by reducing infant exposure to tobacco

Supporting Evidence for Strategy 3: AMCHO considers the Baby and Me Program as a best practice/evidence-based model. Details from three states including Tennessee are included on the AMCHP Innovation Station website.

Activity 1a: Support tobacco cessation among women of childbearing age or individuals living with an infant < 1 year by providing nicotine replacement therapy (NRT) to individuals through the local health departments.

Activity 2b: Promote enrollment in Baby and Me Tobacco Free to reduce smoking during pregnancy.

Assumptions:

- Partnership with TIPQC can effectively address problems or reach into areas we cannot.
- Past experiences with QI projects shows ability to succeed.
- Perinatal collaborations across the country continue to show improvement in birth outcomes through their projects.
- Training healthcare providers will improve birth outcomes.

Continuing Partnerships:

- TIPQC
- Birthing hospitals
- Health care providers
- Regional Perinatal Centers
- TDH Smoking Cessation Program

Contextual Factors:

- TIPQC has a long-standing history of creating, promoting and implementing quality improvement projects with Tennessee birthing hospitals.
- TIPQC projects only work with birthing hospitals and their health care providers and only reach indirectly into the community health care providers.

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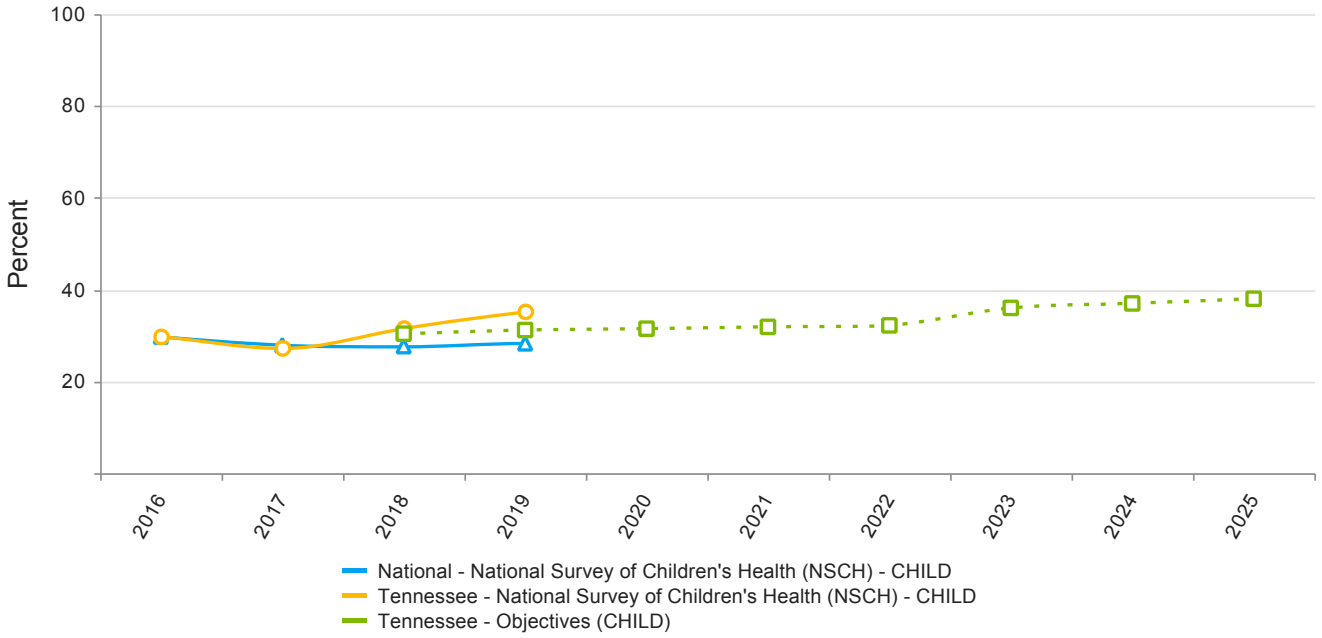
Child Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)	NSCH	Data Not Available or Not Reportable	NPM 6
NOM 15 - Child Mortality rate, ages 1 through 9, per 100,000	NVSS-2019	20.7	NPM 7.1
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000	NVSS-2019	42.0	NPM 7.1
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000	NVSS-2017_2019	15.9	NPM 7.1
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000	NVSS-2017_2019	12.0	NPM 7.1
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2018_2019	87.9 %	NPM 6 NPM 8.1
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	NSCH-2018_2019	20.4 %	NPM 8.1
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	WIC-2018	15.2 %	NPM 8.1
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	YRBSS-2019	20.9 %	NPM 8.1

National Performance Measures

NPM 8.1 - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day
Indicators and Annual Objectives



Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CHILD					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			30.4	31.2	31.5
Annual Indicator		29.6	27.3	31.5	35.2
Numerator		152,452	140,812	163,612	176,434
Denominator		514,521	516,001	519,562	500,965
Data Source		NSCH-CHILD	NSCH-CHILD	NSCH-CHILD	NSCH-CHILD
Data Source Year		2016	2016_2017	2017_2018	2018_2019

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	31.9	32.2	36.0	37.0	38.0	40.0

Evidence-Based or –Informed Strategy Measures

ESM 8.1.1 - Percent of physical education teachers receiving professional development related to 50% of PE class time spent in moderate to vigorous physical activity

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	5.0	15.0	25.0	35.0	45.0	55.0

ESM 8.1.2 - Percentage of TN counties in which trainings related to mental health and physical health have occurred

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	10.0	20.0	30.0	40.0	50.0

ESM 8.1.3 - Number of Gold Sneaker certified childcare facilities

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	700.0	850.0	950.0	1,000.0	1,050.0	1,100.0

ESM 8.1.4 - Percent of LHD primary care clinics writing HPHP prescriptions annually

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	25.0	40.0	55.0	65.0	70.0

ESM 8.1.5 - Number of Healthy Parks Healthy Person prescriptions written

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	125.0	250.0	350.0	450.0	550.0	650.0

ESM 8.1.6 - Percentage of TN counties with completed built environment projects

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	20.0	30.0	40.0	50.0	60.0	70.0

ESM 8.1.7 - Percent of eligible venues offering the Double Up Food Bucks Program

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	35.0	45.0	55.0	65.0	75.0	85.0

ESM 8.1.8 - Percent of staff with an increase in ACEs and TIC knowledge as evidenced by post training evaluation

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	80.0	80.0	80.0	80.0	80.0

ESM 8.1.9 - Percent of families with improved protective factors score

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	50.0	52.0	54.0	56.0	58.0	60.0

ESM 8.1.10 - Percent of families enrolled in CHANT care coordination who partially or fully complete pathways identified

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	41.0	42.0	43.0	44.0	45.0	46.0

State Performance Measures

SPM 6 - Percent of schools with at least 50% physical education class time spent in moderate to vigorous physical activity

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	10.0	20.0	30.0	40.0	50.0	60.0

SPM 7 - Rate of Double Up Food Bucks purchases per SNAP recipient

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	0.0	0.0	0.0	0.0	0.0

SPM 8 - Percent of children with two or more ACEs

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		27.5	27.5	24	23
Annual Indicator	27.5	27.5	24.6	24.1	23
Numerator					
Denominator					
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2011_2012	2011_2012	2016	2017	2018
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	22.5	22.0	21.6	21.2	21.0	20.4

SPM 9 - Percent of substantiated child maltreatment cases among families served by home visiting programs

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	0.3	0.4	0.3	0.2	0.2	0.2

SPM 10 - Percent of caregivers who experience intimate partner violence and do not receive professional support services among families served by home visiting

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	7.0	5.0	4.0	3.5	3.0	2.5

State Outcome Measures

SOM 3 - Percent of public school 6th graders who are overweight or obese

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	43.3	42.9	42.6	42.2	41.9	41.9

SOM 4 - Percent of WIC recipients aged 2-4 years who are overweight or obese

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
2022	2023	2024	2025	2026
Annual Objective	15.0	14.0	13.0	12.4	12.0

State Action Plan Table

State Action Plan Table (Tennessee) - Child Health - Entry 1	
Priority Need	
Decrease overweight and obesity among children	
NPM	
NPM 8.1 - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day	
Objectives	
Increase the percentage of children ages 6-11 years who are physically active at least 60 minutes per day from 31.5% on October 1, 2020 to 40.0% on September 30, 2022.	
Strategies	
Support school-based efforts to promote physical activity and good nutrition	
ESMs	Status
ESM 8.1.1 - Percent of physical education teachers receiving professional development related to 50% of PE class time spent in moderate to vigorous physical activity	Active
ESM 8.1.2 - Percentage of TN counties in which trainings related to mental health and physical health have occurred	Active
ESM 8.1.3 - Number of Gold Sneaker certified childcare facilities	Active
ESM 8.1.4 - Percent of LHD primary care clinics writing HPHP prescriptions annually	Active
ESM 8.1.5 - Number of Healthy Parks Healthy Person prescriptions written	Active
ESM 8.1.6 - Percentage of TN counties with completed built environment projects	Active
ESM 8.1.7 - Percent of eligible venues offering the Double Up Food Bucks Program	Active
ESM 8.1.8 - Percent of staff with an increase in ACEs and TIC knowledge as evidenced by post training evaluation	Active
ESM 8.1.9 - Percent of families with improved protective factors score	Active
ESM 8.1.10 - Percent of families enrolled in CHANT care coordination who partially or fully complete pathways identified	Active

NOMs

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

State Action Plan Table (Tennessee) - Child Health - Entry 2

Priority Need

Decrease overweight and obesity among children

SPM

SPM 6 - Percent of schools with at least 50% physical education class time spent in moderate to vigorous physical activity

Objectives

Increase the percentage of public schools with at least 50% physical education class time spent in moderate to vigorous physical activity from 10% on October 1, 2020 to 60% on September 30, 2025.

Strategies

Promote Gold Sneaker voluntary recognition program for licensed childcare centers

State Action Plan Table (Tennessee) - Child Health - Entry 3

Priority Need

Decrease overweight and obesity among children

SPM

SPM 7 - Rate of Double Up Food Bucks purchases per SNAP recipient

Objectives

Increase the rate of Double Up Food Bucks purchases per SNAP recipient in the targeted counties. (new program therefore no baseline to set objectives)

Strategies

Promote policy, systems, and environmental change (PSE) strategies to increase physical activity and promote access to healthy food and beverages

State Action Plan Table (Tennessee) - Child Health - Entry 4

Priority Need

Increase prevention and mitigation of Adverse Childhood Experiences (ACEs)

SPM

SPM 8 - Percent of children with two or more ACEs

Objectives

Decrease the percent of children with two or more ACEs from 23% on October 1, 2020 to 21% on September 30, 2025.

Strategies

Increase knowledge and practice of ACE and Trauma Informed Care (TIC)

State Action Plan Table (Tennessee) - Child Health - Entry 5

Priority Need

Increase prevention and mitigation of Adverse Childhood Experiences (ACEs)

SPM

SPM 9 - Percent of substantiated child maltreatment cases among families served by home visiting programs

Objectives

Decrease the percent of investigated child maltreatment cases among families served by home visiting programs from 3.3% on October 1, 2020 to 3.0% on September 30, 2025.

Strategies

Ensure a strong start for children by promoting a healthy parent-child attachment through implementation of home visiting programs throughout the 95 counties of Tennessee

State Action Plan Table (Tennessee) - Child Health - Entry 6

Priority Need

Increase prevention and mitigation of Adverse Childhood Experiences (ACEs)

SPM

SPM 10 - Percent of caregivers who experience intimate partner violence and do not receive professional support services among families served by home visiting

Objectives

Decrease the percent of caregivers who experience intimate partner violence and do not receive professional support services among families served by home visiting programs from 8.0% on October 1, 2020 to 3.0% on September 30, 2025.

Strategies

Intervene to lessen immediate and long-term harms by linking families to health and social services

State Action Plan Table (Tennessee) - Child Health - Entry 7

Priority Need

Decrease overweight and obesity among children

SOM

SOM 3 - Percent of public school 6th graders who are overweight or obese

Objectives

Decrease the percent of public school 6th graders who are overweight or obese from 43.3% on October 1, 2020 to 41.9% on September 30, 2025.

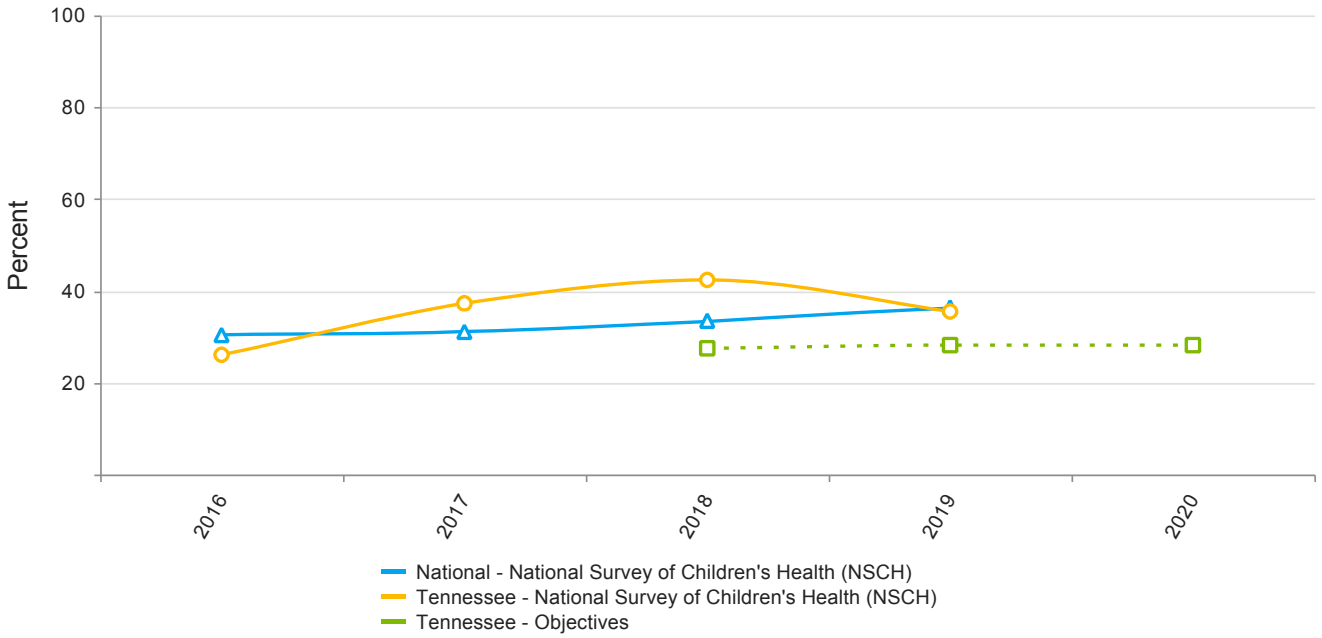
Strategies

Partner with healthcare providers to promote physical activity counseling during well-child visits

State Action Plan Table (Tennessee) - Child Health - Entry 8
Priority Need
Decrease overweight and obesity among children
SOM
SOM 4 - Percent of WIC recipients aged 2-4 years who are overweight or obese
Objectives
Decrease the percent of WIC recipients ages 2-4 years who are overweight or obese
Strategies
Partner with healthcare providers to promote physical activity counseling during well-child visits

2016-2020: National Performance Measures

2016-2020: NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year
Indicators and Annual Objectives



Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			27.5	28.2	28.2
Annual Indicator		26.2	37.2	42.4	35.6
Numerator		53,746	72,782	77,114	69,012
Denominator		205,002	195,708	181,726	193,946
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018	2018_2019

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

2016-2020: Evidence-Based or –Informed Strategy Measures

2016-2020: ESM 6.1 - Number of unique page views to the Developmental Milestones and Developmental Screenings kidcentraltn.com sites

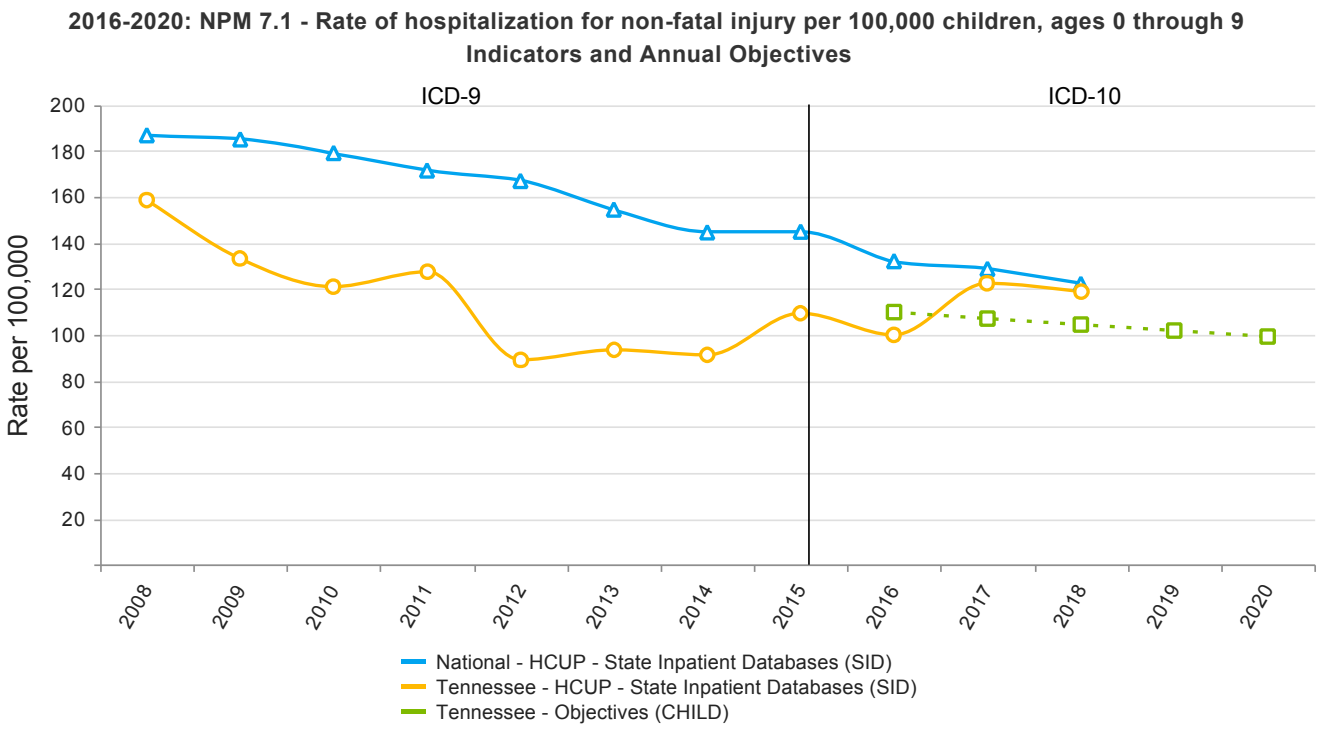
Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			800	1,200	1,200
Annual Indicator	979	953	1,167	510	3,739
Numerator					
Denominator					
Data Source	TDH FHW Early Childhood Section Program Data	TDH FHW Early Childhood Section Program Data	TDH FHW Early Childhood Section Program Data	TDH FHW Early Childhood Section Program Data	TDH FHW Early Childhood Section Program Data
Data Source Year	FFY2016	FFY2017	FFY2018	FFY2019	FFY2020
Provisional or Final ?	Final	Final	Final	Final	Final

2016-2020: ESM 6.2 - Number of health department nurses trained in the START Autism and MCHAT-R/F program

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective				485	
Annual Indicator	450	526	576	627	695
Numerator					
Denominator					
Data Source	TDH CHS Program Data	TDH CHS Program Data	TDH CHS Program Data	TDH CHS Program Data	TDH CHS Program Data
Data Source Year	FFY2016	FFY2017	FFY2018	FFY2019	FFY2020
Provisional or Final ?	Final	Final	Final	Final	Final

2016-2020: ESM 6.3 - Percent of Developmental Screenings performed across the state for participants enrolled in an Evidence-Based Home Visiting Program

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		90	90	91	92
Annual Indicator	89.2	76.1	86.7	71	66.5
Numerator					
Denominator					
Data Source	TDH FHW Early Childhood Section Program Data	TDH FHW Early Childhood Section Program Data	TDH FHW Early Childhood Section Program Data	TDH FHW Early Childhood Section Program Data	TDH FHW Early Childhood Section Program Data
Data Source Year	FFY2016	FFY2017	FFY2018	FFY2019	FFY2020
Provisional or Final ?	Final	Final	Final	Final	Final



Note: ICD-10-CM beginning in 2016; previously ICD-9-CM with 2015 representing January - September

Federally Available Data					
Data Source: HCUP - State Inpatient Databases (SID)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	109.8	107	104.4	101.8	99.2
Annual Indicator	109.1	109.1	100.1	122.6	118.7
Numerator	893	672	823	1,009	972
Denominator	818,595	615,938	822,424	822,681	818,914
Data Source	SID-CHILD	SID-CHILD	SID-CHILD	SID-CHILD	SID-CHILD
Data Source Year	2014	2015	2016	2017	2018

2016-2020: Evidence-Based or –Informed Strategy Measures

2016-2020: ESM 7.1.1 - Number of parents and caregivers receiving car seat education

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective				2,875	2,900
Annual Indicator	2,836	2,098	2,136	2,525	1,603
Numerator					
Denominator					
Data Source	TDH FHW Injury Prevention Section Program Data	TDH FHW Injury Prevention Section Program Data	TDH FHW Injury Prevention Section Program Data	TDH FHW Injury Prevention Section Program Data	TDH FHW Injury Prevention Section Program Data
Data Source Year	FFY2016	FFY2017	FFY2018	FFY2019	FFY2020
Provisional or Final ?	Final	Final	Final	Final	Final

2016-2020: ESM 7.1.2 - Number of counties that adopt Count It! Drop It! Lock It! educational programs

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			48	93	
Annual Indicator	36	61	93	95	95
Numerator					
Denominator					
Data Source	TDH FHW Injury Prevention Section Program Data	TDH FHW Injury Prevention Section Program Data	TDH FHW Injury Prevention Section Program Data	TDH FHW Injury Prevention Section Program Data	TDH FHW Injury Prevention Section Program Data
Data Source Year	FFY2016	FFY2017	FFY2018	FFY2019	FFY2020
Provisional or Final ?	Final	Final	Final	Final	Final

2016-2020: ESM 7.1.3 - Percent of families who receive injury prevention education through the AAP checklist among families participating in Evidence Based Home Visiting programs

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		85	87	89	91
Annual Indicator	81	36	46	54	60
Numerator					
Denominator					
Data Source	TDH FHW Early Childhood Section Program Data	TDH FHW Early Childhood Section Program Data	TDH FHW Early Childhood Section Program Data	TDH FHW Early Childhood Section Program Data	TDH FHW Early Childhood Section Program Data
Data Source Year	FFY2016	FFY2017	FFY2018	FFY2019	FFY2020
Provisional or Final ?	Final	Final	Final	Final	Final

PRIORITY: Increase the number of infants and children receiving a developmental screen.

Interpretation of Performance Data on NOMs, NPMs, SPM and ESMs:

NPM 6 This percentage of parent completed developmental screening tools continued to increase. There was a 3.6% increase from FY2019.

ESM 6.1 In Year 5, the number of unique page views to developmental screening and developmental milestone information on KidCentralTN website improved to 3,739 from 510 in Year 4. This improvement can possibly be explained by more promotion of developmental information available on KidCentralTN by collaborating early childhood agencies. It also must be noted that the site's vendor may have had greater accessibility to retrieve this data; in the previous reporting year, the vendor was establishing their deployment practice as the website had been managed by another vendor.

ESM 6.2 The number of Tennessee Department of Health nurses who received START Autism and MCHAT-R/F training increased to a total of 695 since the beginning of this measurement, which surpassed the Year 5 objective of 611. The training administrator made the training available via the web, making it more accessible for healthcare professionals.

ESM 6.3 Screening for developmental delays in children enrolled in evidence-based home visiting in Tennessee (TNEBHV) uses a validated (ASQ-3) parent-completed tool within the AAP-defined age groups (9, 18 and 24 months). The percentage of children enrolled in TNEBHV who were screened for developmental delays in FFY 20 declined to 66.5%. This may be explained, in part, by the impact of COVID19 pandemic reducing the availability of services.

Accomplishments and Challenges (based on FY2020 Action Plan)

Strategy 1: Target families and caregivers in education efforts regarding the importance of developmental screening.

Activity 1a: Develop and utilize outreach materials to educate caregivers about the importance of screening and early intervention services that are available.

Report 1a: Opportunities to educate families may have been diminished due to Covid-19. ASQ trainings are currently being provided to CHANT staff in an effort to enhance skills to educate families.

Activity 1b: Conduct Child Find activities to educate caregivers about the importance of screening and early intervention services that are available.

Report 1b: This activity was not able to be completed.

Activity 1c: Promote linkage between early identification and services to ensure concerns are addressed between families and their care provider.

Report 1c: TDH Early Childhood Initiatives continues to partner with the TN Young Child Wellness Council, which fosters collaboration among child serving stakeholders and programs, including TN Early Intervention Services (TEIS).

Strategy 2: Partner with child serving agencies and medical providers in receiving continued training in order to conduct developmental screening and how to refer for needed early intervention services

Activity 2a: Revise and renew contract with the Department of Human Services to promote trainings in child development and developmental screenings through the Child Care Resource and Referral (CCR&R) Network.

Report 2a: TDH contracted with CCR&R for childcare quality coaches to provide trainings to childcare workers in the ASQ, emergency preparedness, First Aid, CPR, Talk With Me Baby, ACEs, and Protective Factors.

Activity 2b: Continue to partner with the Tennessee Chapter of the American Academy of Pediatrics to provide training on the Modified-Checklist for Autism in Toddlers, Revised (M-CHAT R) and ASQ-3 screening tools to all local health department regions, including CHANT and EBHV staff, as well as pediatricians to ensure continuity in screening practices. Information will also be shared about children with special health care needs services that are available and how to make a referral to those provider agencies.

Report 2b: ASQ trainings are currently being provided to CHANT staff in an effort to enhance skills to educate families.

Strategy 3: Increase coordination and collaboration between child's medical home and child serving agencies.

Activity 3a: Promote the Medical Home model with an emphasis on incorporating developmental and behavioral screening, reimbursement methods, and referral pathways.

Report 3a: EBHV programs complete assessments, including the ASQ-3 and ASQ-SE, with enrolled families and refer to providers as needed. EBHV also collects information on medical homes, educates on the importance of medical homes, and refers as appropriate. Additionally, EBHV programs track immunization to ensure up to date.

Activity 3b: Identify data tracking system for children who have been screened across child serving sectors.

Report 3b: Early Childhood Initiatives continues to partner with the TN Young Child Wellness Council (TNYCWC). TNYCWC meetings had to be held virtually due to the Covid-19 pandemic. Meetings of the TNYCWC Data Subcommittee to discuss a child-serving system-wide data system was put on hold.

Activity 3c: Gather information on interagency processes between child serving agencies and medical home providers to understand the referral process across the state.

Report 3c: The CHANT referral pathway has been fully implemented.

PRIORITY: Reduce the burden of injuries among children.

Interpretation of Performance Data on NOMs, NPMs, SPM and ESMs:

NPM 7.1 The rate of hospitalizations for non-fatal injury among children ages 0 to 9 years old was 123.0 per 100,000 children, a 3% increase from FY2020's rate of 119.1 Thus, the priority did not meet its FY2020 objective of reducing the rate of hospitalizations for non-fatal injury to 99.2 injuries per 100,000 children. Please note that the data reported for FY2020 are 2019 Hospital Discharge Data System data, the latest year of available hospitalization data.

ESM 7.1.1 The number of parents and caregiving receiving car seat education in FY2020 was 1603, a 37% decrease from FY2019 figures. The actual performance for this priority was 45% less than the targeted FY2020 objective of 2900 individuals.

ESM 7.1.2 In FY2020, all 95 Tennessee counties adopted the Count It, Lock It, Drop It™ Educational program. For this priority, TN met and exceeded its FY2020 objective of 93 counties adopting the program.

ESM 7.1.3 In FY2020, 60% of families participating in the Evidence-Based Home Visiting Program received injury education through the AAP checklist. This actual performance for FY2020 was 31% points less than the objective for the year. Nonetheless, FY2020's performance represented a 6% point increase in the proportion of families that received injury education in FY2019.

Accomplishments and Challenges (based on FY2020 Action Plan)

Strategy 1: Promote the use of child safety seats.

Activity 1a: Provide funding and technical assistance to community agencies to purchase and distribute car seats. Agencies will ensure seats are installed correctly when distributing them to caregivers.

Report 1a: From October 1, 2019 to September 30, 2020, TDH provided $103,114 to 27 agencies, who purchased 1,528 child safety seats, infant only seats, and booster seats for distribution. Agencies conduct education while ensuring that seats are properly installed. Each agency is required to have a certified child safety seat technician on staff.

Activity 1b: Disseminate a child safety seat infographic to promote the correct use of car seats to parents and caregivers.

Report 1b: An infographic titled "The Road to Crash Prevention" was disseminated which contained general safe driving information along with child safety seat education. Over 1,000 infographics were sent to 31 Child Fatality Review teams for local distribution to providers and stakeholders

Strategy 2: Promote safe storage of medications.

Activity 2a: Promote safe storage and disposal of medications through the Count It, Lock It, Drop It™ initiative and TN Together.com website. The goal of Count It, Lock It, Drop It™ is to increase the number of individuals tracking medication, securing medication in a locked medicine box, and utilizing medicine drop boxes. Staff will partner with Count It, Lock It, Drop It™ to educate 35 injury prevention partners about safe storage and disposal of medication and promote the TN Together website.

Report 2a: As of September 30th, 2020, all 95 counties have implemented the Count It! Lock It! Drop It! ™ program that includes education and securing medication in locked medicine boxes. A total of 106 (one hundred and six) groups in Tennessee are conducting the program with multiple programs in some counties. A total of 356 drug drop boxes are available for use throughout TN and an online map of sites can be found at http://tdeconline.tn.gov/rxtakeback/

Activity 2b: Staff will attend a minimum of 5 meetings with opioid partners by September 30, 2020 to promote safe storage of medications to improve Count It, Lock It, Drop It™ efforts.

Report 2b: TDH partnered with Count It! Lock It! Drop It! staff and the Tennessee Department of Environment and Conservation (TDEC) to promote safe storage of medications. TDEC staff are active members of the state Injury Community Implementation Group and have promoted CDL to over 100 injury prevention partners at these meetings. CDL staff also served on the Committee for Pediatric Emergency Care Injury Prevention Subcommittee and promoted safe storage to those partners. CDL staff have also partnered with TDH Opioid Epidemic Response team to help local health departments and local coalitions to implement and improve CLD efforts.

Activity 2c: Continue to utilize Title V funding to support (in part) the operation of the Tennessee Poison Center.

Report 2b: TDH provided $279,532 in Title V funding to support a portion of the operation of the Tennessee Poison Center. TDH meets regularly with TPC to align priorities and address emerging issues such as unintentional pediatric opioid ingestions.

Strategy 3: Provide injury prevention education to parents and caregivers.

Activity 3a: Discuss injury prevention topics with a minimum of 83% of eligible families served through TDH evidence-based home visiting programs. Topics to be discussed include child safety seat use, safe sleep, drowning, smoke detector use, carbon monoxide detector use, and gun storage.

Report 3a: Sixty-percent (60%) of parents enrolled in evidence-based home visiting (EVHB) programs received education/counseling on the AAP Checklist. During FY19, the IVP manager presented to home visitors at the Tennessee Home Visiting Summit in Chattanooga. He shared state injury data relevant to the APP Safety Checklist and encouraged home visitors to utilize the AAP Safety Checklist to educate parents and caregivers to decrease injury risk in the home.

Activity 3b: Complete a child injury data report and distribute to home visiting staff and partners.

Report 3b: EVHB grantees received the annual agency specific Performance Measurement Report which include data on 1) the percentage enrolled in TDH funded home visiting that had a DCS investigation, 2) rate of injury related emergency department visits and 3) percent of infants whose parents use safe sleep practices. This is important both to inform grantees and partners but also to legislators and other stakeholders interested in evaluation of service impact.

Activity 3c: Develop and distribute an injury prevention infographic on to 300 stakeholders.

Report 3c: Infographics (n=3,000) were updated with 2018 child fatality data and distributed for suicide, safe sleep and motor vehicle crashes to local community stakeholders including, medical providers, childcare providers, and other agencies who serve families with at-risk children. Child injury fatality data was also included on the Child Fatality Review dashboard and the link was shared with injury prevention partners. See link Workbook: Child Fatality Dashboard (tn.gov)

PRIORITY: Reduce the number of children who are overweight/obese.

Interpretation of Performance Data on NOMs, NPMs, SPM and ESMs:

Overall, among child health and primary prevention measures that promote healthy weight among children, Tennessee (TN) continues to experience modest improvement in some indicators, while other indicators have seen stable or less beneficial trends as follows:

NPM 8.1 Combined 2018-2019 data from the National Survey of Children's Health show that over one-third of children ages 6-11 meet physical activity guidelines (35.2%). This rate exceeds the Year 5 target objective of 32.3% and represents a steadily increasing trend since Year 2. The increase is likely due to more statewide programming and new laws leading to enhanced opportunities for physical activity.

SPM 2 Breastfeeding initiation among newborns remained relatively steady at 80.6% in 2019 (Year 5) compared to 80.8% in 2018 (Year 4). This rate was somewhat below expectations, although the rate has increased moderately from 78.2% in 2015 (Year 1). Tennessee continues to engage with community-based partners, health care providers, and lactation care providers in WIC to promote breastfeeding efforts.

ESM 8.1.1 The number of Gold Sneaker-certified childcare facilities increased substantially (83.7%) from 306 in 2019 to 562 in 2020 due primarily to the November 2018 redesign of the initiative's policies and certification process in partnership with the Tennessee Department of Human Services. The redesign required all existing Gold Sneaker facilities to apply for recertification. Since then, certifications have increased at the fastest rate ever due to Gold sneaker being included as a requirement in DHS's coveted 3-Star Quality Rating for childcare centers. The total number of certified facilities now exceeds the number that existed prior to the redesign (i.e., 519 in 2018).

ESM 8.1.2 The average number of monthly calls to the TN Breastfeeding Hotline declined moderately from 475 in 2019 to 414 in 2020. The ongoing decline from 519 in 2018 is most likely due to decreased promotion with birthing hospitals and the increased availability of information through social media or online websites for breastfeeding families. Also, TBH's call volume might have been impacted by an overall decrease in hotline media promotion since 2018, the transition to an out-of-state vendor from an in-state hospital-based provider, and the social media presence of more community-based providers/advocates.

ESM 8.1.3 The number of TN Baby Friendly-designated birthing hospitals declined from six in 2019 to four in 2020. Since achieving a high of six hospitals in 2018, TN has had difficulty maintaining Baby Friendly hospitals likely due to the rigor and extensive cost of attaining and maintaining the designation. As an alternative, TDH created BEST (Breastfeeding, Early Elective Delivery Reduction, and Safe Sleep for Tennessee Babies) to celebrate hospital efforts to reduce infant deaths. Fourteen hospitals received the BEST Award for 2020, which includes a requirement for breastfeeding initiation rates.

Accomplishments and Challenges (based on FY2020 Action Plan)

Strategy 1: Continue the Gold Sneaker voluntary recognition program for licensed childcare centers (recognizing that overweight/obese preschoolers are more likely to grow up to be overweight/obese children).

Activity 1a: Recruit a minimum of 50 childcare facilities statewide by educating facility directors about the benefits of Gold Sneaker certification.

Report 1a: From January 1, 2019, to September 30, 2020 a total of 562 licensed Tennessee childcare providers obtained Gold Sneaker certification.

Activity 1b: Provide technical assistance to 100% of the childcare facilities to help in the development and implementation of policies related to physical activity, nutrition, and tobacco exposure.

Report 1b: Technical assistance is provided during Gold Sneaker training with information from an array of online complimentary resources available to assist in implementation of policies, as well as the Gold Sneaker Certification User Guide which provides step-by-step guidance to complete the Gold Sneaker Certification. Certified providers also receive a toolkit and resource package of age-appropriate materials further designed to implement policies. On-going technical assistance is provided upon request.

Activity 1c: Collaborate with the Department of Human Services to implement the Gold Sneaker Three Star requirement and to continue exploring the possibility of adding Gold Sneaker requirements to childcare licensing standards.

Report 1c: The Tennessee Department of Health (TDH) worked with the Tennessee Department of Human Services to provide recommendations for including Gold Sneaker policies as part of the state's minimum licensing standards for licensed child care providers in Tennessee. Recommendations were made based on national best practices and the

CDC's high-impact obesity prevention standards for early care and education.

Activity 1d: Develop a process evaluation to assess Gold Sneaker facilities in the implementation of the revised policies.

Report 1d: The Tennessee Department of Health and the Tennessee Department of Human Services continue to collaborate to determine an appropriate rubric to assess Gold Sneaker certified providers.

Activity 1e: Host a minimum of 1-2 Gold Sneaker Advisory Group meetings to assist in the ongoing certification and evaluation processes for Gold Sneaker facilities.

Report 1e: The Tennessee Department of Health Central Office maintains contact with and hosted a meeting for the Gold Sneaker Advisory Committee in July 2020 whereby an update on the number of certifications was provided along with the certification process and resources available for providers and trainers. Committee members discussed the Tennessee Department of Human Services collaboration and newly revised online training (2020). Members also discussed readily available data sets related to health equity measures in the Gold Sneaker population.

Activity 1f: Provide a minimum of 1-2 Gold Sneaker trainings for public health educators and 2-4 trainings with DHS staff statewide, and other partners as requested.

Report 1f: From October 1, 2019 to September 30, 2020, The Gold Sneaker Initiative Program Director conducted three Gold Sneaker "train-the-trainer" sessions for local health educators, nutritionists and health promotion staff enabling them to offer Gold Sneaker certification training to licensed Tennessee child care providers. Additionally, the Initiative Program Director conducted three Gold Sneaker trainings to licensed child care directors and educators assisting them in meeting the initial step toward Gold Sneaker certification. Providers also received assistance to complete the online Gold Sneaker Certification Application.

Strategy 2: Increase support for breastfeeding initiation and duration by 2% (recognizing the impact of breastfeeding on long-term health risk for children).

Activity 2a: Promote breastfeeding among the general population through public outreach efforts (e.g., Breastfeeding Welcomed Here outreach to employers and businesses, Tennessee Hospital Association, Tennessee Breastfeeding Coalition, and Primary Prevention Initiatives).

Report 2a: During FY20, there were 29 new Breastfeeding Welcome Here (BFWH) locations established. Overall, there are 1244 BFWH sites statewide.

Activity 2b: Enhance the awareness and utilization of the Breastfeeding Hotline among the general public, providers, and new families (e.g., hotline magnets and/or other promotional material in the "Welcome Baby" mailer).

Report 2b: The Tennessee Breastfeeding Hotline (TBH) was heavily promoted statewide among

hospitals by the Tennessee Hospital Association (THA), breastfeeding coordinators and experts within regional and county health departments, breastfeeding peer counselors and nutrition educators within WIC clinics, and TDH's early childhood initiatives for healthy infant development (e.g. Welcome Baby). During FY20, there were approximately 5,000 calls made to the hotline.

Activity 2c: Collaborate with THA to provide technical assistance to birthing hospitals pursuing Baby-Friendly designation or the adoption of other hospital policies to improve breastfeeding practices (e.g. Best for Babies recognition).

Report 2c: Ongoing upon request. No additional Baby–Friendly designations were pursued in FY2020. Best for Babies awardees must show 82% initiation rate or a 5% increase of initiation in the prior year. For FY20 there were 14 BEST awards and for FY19 there were 18 birthing hospitals recognized.

Activity 2d: Partner with the Tennessee Breastfeeding Coalition and other local coalitions to maintain a repository of resources for lactation support and breastfeeding advocacy which would be freely accessible and public facing to build continuity of care in communities and statewide.

Report 2d: Contacts for lactation support were collected through coalition and stakeholder meetings via RedCap survey. The Tennessee Breastfeeding Coalition received training regarding collecting, building out, and updating community resources utilizing a format established by the Pennsylvania Resource Organization for Lactation Consultants and collected information at stakeholder meetings via Google survey. State-wide resource development is ongoing.

Strategy 3: Support the Office of Coordinated School Health in school-based efforts to promote physical activity and good nutrition.

Activity 3a: Utilize Title V funding to support a State School Nurse Consultant to be housed in the Department of Education, Office of Coordinated School Health.

Report 3a: The State School Nurse Consultant developed a school-based and school-linked clinic toolkit that districts can use for either implementing or sustaining a school health clinic. School health clinic best practices resources were shared with Lead Nurses and Coordinated School Health Coordinators. Additionally, the School Nurse Consultant worked to update the Tennessee Health Screening Guidelines.

Activity 3b: Collaborate with the Office of Coordinated School Health, state, regional and local health departments that are focusing on obesity-related primary prevention to increase by 25, the number of physical activity clubs that promote lifelong physical activity.

Report 3b: During the reporting period, TDH was informed of 273 physical activity clubs. Activity clubs included: Go Girl Go, Journey Pure, Marathon in a Month, 5Ks, Bike/Walk Cleveland, Play n Learn Mommy and Me, Healthy U, Fab 5 physical activity lessons and After School Mile Club.

Activity 3c: Provide resources (toolkits) to schools planning to implement a run club, physical activity club or other CSPAP activity. Promote resources through webinars, conference calls, group trainings, and other avenues, as they arise.

Report 3c: A free downloadable run club toolkit was placed on the TN website, so school and health department staff interested in establishing a run club had the opportunity to receive guidance and resources. TDH Central Office staff also provided the toolkit to regional Health Promotion Directors to distribute to PHEs at the local level.

Activity 3d: Collaborate with the Office of Coordinated School Health, Health Educators, and before/after school programs to provide resources and tools that promote a healthy nutrition environment.

Report 3d: As part of the Project Diabetes program, fourteen (14) school and community projects included objectives addressing access to healthy food and beverages. These objectives included installation of water bottle refill stations in schools along with the ReThink your Drink campaign to reduce the consumption of sugar-sweetened beverages. Students in more than 44 schools led their peers to sign a pledge to drink fewer sugary beverages and more water. Also, access to healthy foods increased through the Double Up Food Bucks initiative at farmers markets in East Tennessee offering the ability to double buying power on fresh fruits and vegetables.

PRIORITY: Reduce the number of children exposed to adverse childhood experiences.

Interpretation of Performance Data on NOMs, NPMs, SPM and ESMs:

SPM 1 The percent of children reporting 2 or more ACEs continued to decrease from previous years. There was a decline of 3.7% from 24.1% FY2019 to 20.4% in FY2020 in TN.

ESM for SPM 1.1 *This ESM was retired in FY 16,Year 2.*

ESM for SPM 1.2 This ESM was retired in FY19.

ESM for SPM 1.3 The percent of new primary caregivers that were screened for ACEs in FY20 increased. There was an 8.9% increase from 69.9 in FY19 to 78.8 in FY20.

Accomplishments and Challenges (based on FY2020 Action Plan)

Strategy 1: Increase general awareness of adverse childhood experiences (ACEs) in the community.

Activity 1a: Under the leadership of the Title V Program staff, develop and disseminate a Tennessee ACEs Briefs aligned with TDH priorities.

Report 1a: The ACE brief is in progress. A team was gathered to compose both research and data for the brief and graphics have been added. The brief is being approved and then will be distributed to the public.

Activity 1b: Review and update ACEs information included in Welcome Baby booklets to increase parents' understanding of ACEs and strategies to protect their child, and promote the concept of resilience in an accessible way.

Report 1b: ACEs section in Welcome Baby version 3.0 has been updated and the reading level has been reduced to a Fleisch-Kincaid level of 6.4. This version of the book is not yet approved by Ms. Walker.

Activity 1c: Explore alternate ways to educate parents and other caregivers on ACEs, with a focus on non-English speakers. This will include translation of new Welcome Baby packet into Spanish, and possibly Arabic.

Report 1c: With the new version 3.0 of Welcome Baby, info-graphics were used as much as possible to be able to reach non-English speaking families. A Spanish version of the 3.0 version of WB is currently being pursued as well as an electronic/web version of the book to bring to a wider audience. This version of the book is not yet approved by Ms. Walker.

Activity 1d: Provide ongoing leadership to Building Strong Brains, Tennessee's ACEs Initiative formed in 2015.

Report 1d: The Building Strong Brains Committee continues to bring partnerships together to collaborate on the work of training for trainers and disseminating media information to be public. Strategic planning in light of the pandemic has begun to align goals and priorities within the different child serving sectors.

Activity 1e: Provide ACEs training update/refresher training to the 34 Child Fatality Review teams during their annual meeting.

Report 1e: The format of the Annual Meeting changed and held virtually due to Covid-19 with limited time.

Strategy 2: Explore intervention opportunities to mitigate ACEs impact

Activity 2a: With the BSB interagency steering committee, facilitate a Community of Practice with BSB Innovation grantees on grassroots actions to mitigate ACEs.

Report 2a: Startup of the BSB Community of Practice was delayed due to Covid-19 pandemic response, as well as leadership transitions. Additionally, existing grants were only renewed for 1-year.

Activity 2b: Explore resources to assist EBHV state/federal funded grantees and local health department CHANT teams in conducting a self-assessment on the presence of trauma informed practices in their programs, policies and procedures.

Report 2b: A trauma informed self-assessment evaluation has been identified for use. It has yet to be presented, along with the trauma informed training that goes along with it.

Strategy 3: Collect Tennessee-specific data on ACEs and utilize that data to inform program and policy decisions.

Activity 3a: Continue to collect and disseminate Tennessee specific data such as from Evidence-Based Home Visiting Programs, and compare to state and nationally representative data sources such as BRFSS and NSCH. Disseminate findings to appropriate stakeholders serving these populations.

Report 3a: A white paper on Tennessee ACEs has been completed and is currently under review for dissemination.

PRIORITY: Decrease Overweight and Obesity Among Children

Objective NPM 8.1 Increase the percentage of children ages 6-11 years who are physically active at least 60 minutes per day from 31.5% on October 1, 2020 to 40.0% on September 30, 2025.

Objective SPM 6 Increase the percentage of public schools with at least 50% physical education class time spent in moderate to vigorous physical activity from 10% on October 1, 2020 to 60% on September 30, 2025.

Objective SPM 7 Increase the rate of Double Up Food Bucks purchases per SNAP recipient in the targeted counties. (new program therefore no baseline to set objectives)

The following strategies and activities are planned for *October 1, 2021 to September 30, 2022*:

Strategy 1: Support school-based efforts to promote physical activity and good nutrition

Supporting Evidence for Strategy 1: Physical Activity: Enhanced School-Based Physical Education: Enhanced school-based physical education (PE) involves changing the curriculum and course work for K-12 students to increase the amount of time they spend engaged in moderate- or vigorous-intensity physical activity during PE classes.[i]

Activity 1a: Collaborate with DOE to develop and implement strategies to provide professional development to physical education teachers pertaining to engaging students in moderate-to-vigorous-physical activity 50% or more of physical education class time.

Activity 1b: Collaborate with DOE to provide professional learning opportunities that connect mental health and physical health for PHEs and Health Councils, and youth (ie trauma-informed care, Youth Mental Health 1st Aid training, Movement is Medicine).

Strategy 2: Promote Gold Sneaker voluntary recognition program for licensed childcare centers

Supporting Evidence for Strategy 2: Center-based early childhood education programs (ECE) aim to improve educational outcomes that are associated with long-term health as well as social- and health-related outcomes. Economic evidence indicates there is a positive return on investment in early childhood education. The benefits from students' future earnings gains alone exceed program costs. If targeted to low-income or racial and ethnic minority communities, ECE programs are likely to reduce educational achievement gaps, improve the health of these student populations, and promote health equity.[ii]

Activity 2a: Host 1-2 technical assistance training for health promotion staff statewide in using the TrainTN system for Gold Sneaker certification training for licensed daycares.

Activity 2b: Provide a minimum of 1-2 trainings that address implementation practices of Gold Sneaker policies for public health educators, daycare staff, TN Department of Human Services staff, and Child Care Resource & Referral Center staff, and other partners statewide.

Strategy 3: Partner with healthcare providers to promote physical activity counseling during well-child visits

Supporting Evidence for Strategy 3: Physical Activity: Family-Based Interventions. Family-based interventions combine activities to build family support with health education to increase physical activity among children.[iii]

TDH will focus on increasing provider referrals from TDH clinics in the West region, as electronic health records show referrals from the West region are low as compared to other TDH regions, and app usage in the West is less when compared to other regions of the state. This approach will also address health equity, as the West region of the state has a higher percentage of African Americans, as compared to other regions (not including Metro Health Departments).

Activity 3a: Provide training for 5 health provider champions on how to incorporate the use of the Healthy Parks Healthy Person park prescription portal to increase family-based physical activity.

Activity 3b: Promote the use of the Healthy Parks Healthy Person park prescription program and app by PHNs, WIC staff, and other health providers in 10 additional local health departments with an emphasis in west Tennessee.

Strategy 4: Promote policy, systems, and environmental change (PSE) strategies to increase physical activity and promote access to healthy food and beverages

Supporting Evidence for Strategy 4: Physical Activity: Creating or Improving Places for Physical Activity. In these types of interventions, worksites, coalitions, agencies, and communities work together to change local environments to create opportunities for physical activity. Changes can include creating or improving walking trails, building exercise facilities, or providing access to existing facilities.[iv]

Activity 4a: Support and provide technical assistance to at least 5 local communities who set a goal to increase physical activity through the construction of walking and nature trails.

Activity 4b: Collaborate with non-profits in east Tennessee to increase access to fresh fruit and vegetables for SNAP recipients through the Double Up Food Bucks program.

Planned Partnerships: Partners employing PSE strategies are funded through Project Diabetes, a state funded grant initiative.

Contextual Factors: 1) economic/fiscal outlook; 2) political and social influences; 3) legislation and policies (facilitators or barriers); 4) COVID variants; 5) product marketing supporting poor nutrition or sedentary lifestyles; 6) SES, racial/ethnic, geographic disparities; 7) overall trends toward sedentary behavior (e.g., screen time) and less healthy diets (e.g., fast food).

Assumptions: 1) Funding will be secured throughout the course of the project. Children who learn and practice good physical activity and nutrition habits will maintain these habits for life. 2) Professionals will be motivated to attend workshops (e.g., HPHP, GS, etc.) and implement lessons learned. 3) Evidenced-based program implementation as well as polices and regulations promoting nutrition/PA will lead to healthy behaviors and a

reduction in obesity.

PRIORITY: Increase Prevention and Mitigation of Adverse Childhood Experiences (ACEs)

Objective for SPM 8 Decrease the percent of children with two or more ACEs from 23% on October 1, 2020 to 21% on September 30, 2025.

Objective for SPM 9 Decrease the percent of investigated child maltreatment cases among families served by home visiting programs from 3.3% on October 1, 2020 to 3.0% on September 30, 2025.

Objective for SPM 10 Decrease the percent of caregivers who experience intimate partner violence and do not receive professional support services among families served by home visiting programs from 8.0% on October 1, 2020 to 3.0% on September 30, 2025.

The following strategies and activities are planned for *October 1, 2021 to September 30, 2022*:

Strategy 1: Increase knowledge and practice of ACE and Trauma Informed Care (TIC)

Supporting Evidence for Strategy 1: The variety of sectors can make a difference in preventing ACEs by impacting the various contexts and underlying risks that contribute to violence and adversity and by supporting safe, stable, nurturing relationships and environments for all children while taking a trauma informed approach to prevent ACEs.
Centers for Disease Control and Prevention (2019). Preventing Adverse Childhood Experiences: Leveraging the Best Available Evidence. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. https://www.cdc.gov/violenceprevention/pdf/preventingACES.pdf

Activity 1a: Develop and implement online TIC training for TDH staff, including those in the CHANT and EBHV programs. Through this training TDH staff and CHANT and EBHV programs will be able to integrate trauma informed practices into their work with families, mitigating the impact of ACEs.

Activity 1b: Provide ACE and TIC refresher training for child fatality teams as part of their ongoing training. This training will provide information and insight to teams on the impact of ACEs and trauma and assist in understanding the impact on social determinants of health.

Strategy 2: Ensure a strong start for children by promoting a healthy parent-child attachment through implementation of home visiting programs throughout the 95 counties of Tennessee

Supporting Evidence for Strategy 2: Effective home visiting models have demonstrated many benefits for children and parents. Early childhood home visitation can prevent ACEs by providing information, caregiver support, and training about child health, development, and care to families in their homes to build a safe, stable, nurturing and supportive home environment. Children participating in a home visiting program have better cognitive and language development, better academic achievement, fewer behavioral problems, lower rates of substance use, and fewer arrests, convictions, and parole violations by age 19. Home visiting is

associated with better pregnancy outcomes, improved parenting practices, reductions in the use of welfare and other government assistance, greater employment, lower rates of substance use, and reduced exposure to intimate partner violence.
Centers for Disease Control and Prevention (2019). Preventing Adverse Childhood Experiences: Leveraging the Best Available Evidence. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. https://www.cdc.gov/violenceprevention/pdf/preventingACES.pdf

Activity 2a: Teach positive parenting skills through home visitation in partnership with local EBHV implementing agencies. This will include encouraging social-emotional learning and parent-child relationship whose instability has been exacerbated by the COVID-19 global pandemic.

Activity 2b: Provide health education through EBHV home visiting programs in counties throughout Tennessee. Communicating the importance of children having a medical home to parents promotes high quality and culturally effective integrated care.

Activity 2c: Provide supportive care and additional services to families and children through EBHV home visitation. By connecting families with concrete services and knowledge of parenting and child development improve protective factors which mitigate or prevent ACEs.

Strategy 3: Intervene to lessen immediate and long-term harms by linking families to health and social services

Supporting Evidence for Strategy 3: Traumatic events in childhood can be emotionally painful or distressing and can have effects that persist for years. Factors such as the nature, frequency and seriousness of the traumatic event, prior history of trauma, and available family and community supports can shape a child's response to trauma. Creating and sustaining safe, stable, nurturing relationships and environments for all children and families can prevent ACEs and help all children reach their full health and life potential.
Centers for Disease Control and Prevention (2019). Preventing Adverse Childhood Experiences: Leveraging the Best Available Evidence. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. https://www.cdc.gov/violenceprevention/pdf/preventingACES.pdf

Activity 3a: Screen and assess families for enrollment in CHANT to identify health and social needs that have long term impact on families and children. By identifying the needs of families immediate, priority services can be provided to families.

Activity 3b: Provide referrals to families for identified health care and social service needs. Identifying which of the sixteen pathways of care families have identified as needs increase the protective factors within a family by providing concrete services at the time identified.

Activity 3c: Assist families in navigating the healthcare and social services system through the CHANT care-coordination model. Aiding in navigating any of the sixteen pathways, including obtaining a medical home or an EPSDT, is solution focused as barriers and other obstacles are addressed. Through this family resiliency is increased as a strategy to eliminate and mitigate ACEs the family might have experienced.

Planned Partnerships: TDH maintains and continues formal partnerships with the Tennessee Council on Children and Youth (TCCY)/Building Strong Brains (BSB) Committee; Home Visiting Leadership Alliance (HVLA); Young Child Wellness Council (YCWC); and Regional and Metro Health Departments.

Contextual Factors:

- TDH will demonstrate leadership in promoting ACE mitigation factors.

Assumptions:

- Partners will be informed about ACES and implement trauma informed care practices in their work. Families will demonstrate positive interactions with their children.

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[i] The Community Guide; https://www.thecommunityguide.org/findings/physical-activity-enhanced-school-based-physical-education
[ii] The Community Guide; https://www.thecommunityguide.org/findings/promoting-health-equity-through-education-programs-and-policies-center-based-early-childhood
[iii] The Community Guide; https://www.thecommunityguide.org/findings/physical-activity-family-based-interventions
[iv] The Community Guide; https://www.thecommunityguide.org/findings/physical-activity-creating-or-improving-places-physical-activity

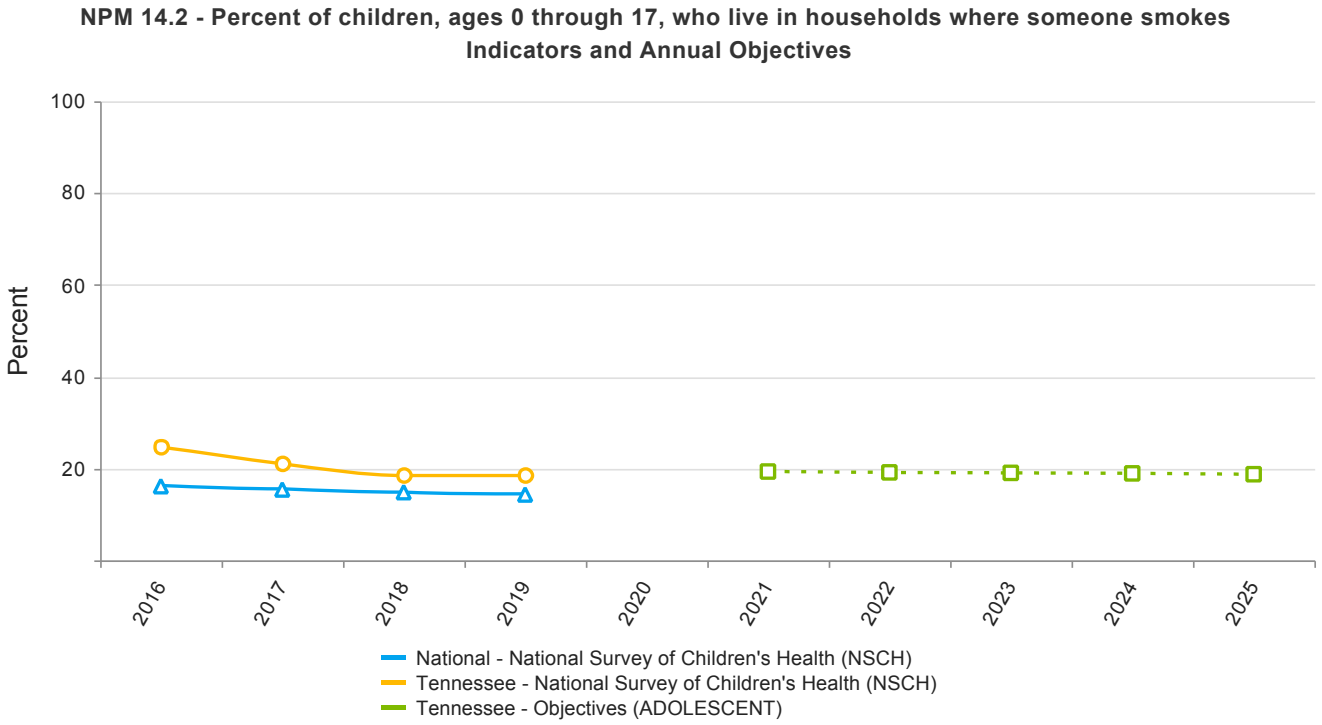
Adolescent Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations	SID-2018	79.4	NPM 14.2
NOM 3 - Maternal mortality rate per 100,000 live births	NVSS-2015_2019	26.4	NPM 14.2
NOM 4 - Percent of low birth weight deliveries (<2,500 grams)	NVSS-2019	9.2 %	NPM 14.2
NOM 5 - Percent of preterm births (<37 weeks)	NVSS-2019	11.2 %	NPM 14.2
NOM 6 - Percent of early term births (37, 38 weeks)	NVSS-2019	28.6 %	NPM 14.2
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2018	6.8	NPM 14.2
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2018	6.9	NPM 14.2
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2018	4.5	NPM 14.2
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2018	2.4	NPM 14.2
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2018	216.7	NPM 14.2
NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2018	153.6	NPM 14.2
NOM 15 - Child Mortality rate, ages 1 through 9, per 100,000	NVSS-2019	20.7	NPM 7.2
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000	NVSS-2019	42.0	NPM 7.2
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000	NVSS-2017_2019	15.9	NPM 7.2
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000	NVSS-2017_2019	12.0	NPM 7.2
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2018_2019	87.9 %	NPM 8.2 NPM 14.2

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	NSCH-2018_2019	20.4 %	NPM 8.2
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	WIC-2018	15.2 %	NPM 8.2
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	YRBSS-2019	20.9 %	NPM 8.2

National Performance Measures



NPM 14.2 - Adolescent Health

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			29	23.8	
Annual Indicator		24.9	21.1	18.6	18.6
Numerator		362,200	311,958	276,334	271,871
Denominator		1,457,726	1,478,634	1,485,841	1,464,986
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018	2018_2019

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	19.4	19.2	19.1	19.0	18.8	18.7

Evidence-Based or –Informed Strategy Measures

ESM 14.2.1 - Number of tobacco-free sports teams

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	79.0	81.0	83.0	85.0	88.0	90.0

ESM 14.2.2 - Number of social media posts promoting text-based cessation services

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	6.0	12.0	12.0	24.0	24.0	24.0

ESM 14.2.3 - Number of anti-tobacco social media posts

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	6.0	12.0	12.0	24.0	24.0	24.0

ESM 14.2.4 - Number of youth who attend the state anti-tobacco conference trainings

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	75.0	300.0	300.0	350.0	400.0	450.0

ESM 14.2.5 - Number of ambassadors recruited

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	26.0	26.0	26.0	26.0	26.0	26.0

State Performance Measures

SPM 11 - Percent of high school students currently using cigarettes

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	6.4	5.8	5.3	4.8	4.3	3.8

SPM 12 - Percent of high school students currently using e-cigarettes

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	18.0	17.9	17.8	17.8	17.7	17.6

SPM 13 - Number of adolescents enrolled in cessation program

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	0.0	20.0	50.0	100.0	120.0	150.0

State Outcome Measures

SOM 5 - Percent of adults reporting Chronic obstructive pulmonary disease (COPD)

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	9.3	9.2	9.1	9.0	8.9	8.8

SOM 6 - Percent of adults reporting cardiovascular disease

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	5.3	5.3	5.3	5.2	5.2	5.2

SOM 7 - Age-adjusted mortality rate from tobacco-attributable cancers among Tennesseans aged 35+

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	176.4	171.4	166.4	161.3	156.3	141.3

State Action Plan Table

State Action Plan Table (Tennessee) - Adolescent Health - Entry 1	
Priority Need	
Decrease tobacco and e-cigarette use among adolescents	
NPM	
NPM 14.2 - Percent of children, ages 0 through 17, who live in households where someone smokes	
Objectives	
Decrease the percent of children, ages 0 through 17, who live in households where someone smokes from 19.5% in 2019 to 18.8% in 2025.	
Strategies	
Promote anti-tobacco youth led initiatives	
ESMs	Status
ESM 14.2.1 - Number of tobacco-free sports teams	Active
ESM 14.2.2 - Number of social media posts promoting text-based cessation services	Active
ESM 14.2.3 - Number of anti-tobacco social media posts	Active
ESM 14.2.4 - Number of youth who attend the state anti-tobacco conference trainings	Active
ESM 14.2.5 - Number of ambassadors recruited	Active

NOMs

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

NOM 3 - Maternal mortality rate per 100,000 live births

NOM 4 - Percent of low birth weight deliveries (<2,500 grams)

NOM 5 - Percent of preterm births (<37 weeks)

NOM 6 - Percent of early term births (37, 38 weeks)

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

NOM 9.1 - Infant mortality rate per 1,000 live births

NOM 9.2 - Neonatal mortality rate per 1,000 live births

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

State Action Plan Table (Tennessee) - Adolescent Health - Entry 2

Priority Need

Decrease tobacco and e-cigarette use among adolescents

SPM

SPM 11 - Percent of high school students currently using cigarettes

Objectives

Decrease the percentage of high school students currently using cigarettes, from 7.1% in 2019 to 4.3% in 2025.

Strategies

Promote anti-tobacco youth led initiatives

State Action Plan Table (Tennessee) - Adolescent Health - Entry 3

Priority Need

Decrease tobacco and e-cigarette use among adolescents

SPM

SPM 12 - Percent of high school students currently using e-cigarettes

Objectives

Decrease the percentage of high school students currently using e-cigarettes from 22.1% in 2019 to 17.7% in 2025.

Strategies

Build partnerships with coalitions across the state

State Action Plan Table (Tennessee) - Adolescent Health - Entry 4

Priority Need

Decrease tobacco and e-cigarette use among adolescents

SPM

SPM 13 - Number of adolescents enrolled in cessation program

Objectives

Increase the number of adolescents enrolled in cessation programs, from 0 in 2019 to 125 in 2025.

Strategies

Promote youth tobacco cessation services

State Action Plan Table (Tennessee) - Adolescent Health - Entry 5

Priority Need

Decrease tobacco and e-cigarette use among adolescents

SOM

SOM 5 - Percent of adults reporting Chronic obstructive pulmonary disease (COPD)

Objectives

Decrease percent of adults reporting Chronic Obstructive Pulmonary Disease (COPD) from 9.3% in 2019 to 8.8% in 2025.

Strategies

Promote anti-tobacco youth led initiatives

State Action Plan Table (Tennessee) - Adolescent Health - Entry 6

Priority Need

Decrease tobacco and e-cigarette use among adolescents

SOM

SOM 6 - Percent of adults reporting cardiovascular disease

Objectives

Decrease percent of adults reporting cardiovascular disease from 5.3% in 2019 to 5.2% in 2025.

Strategies

Promote youth tobacco cessation services

State Action Plan Table (Tennessee) - Adolescent Health - Entry 7

Priority Need

Decrease tobacco and e-cigarette use among adolescents

SOM

SOM 7 - Age-adjusted mortality rate from tobacco-attributable cancers among Tennesseans aged 35+

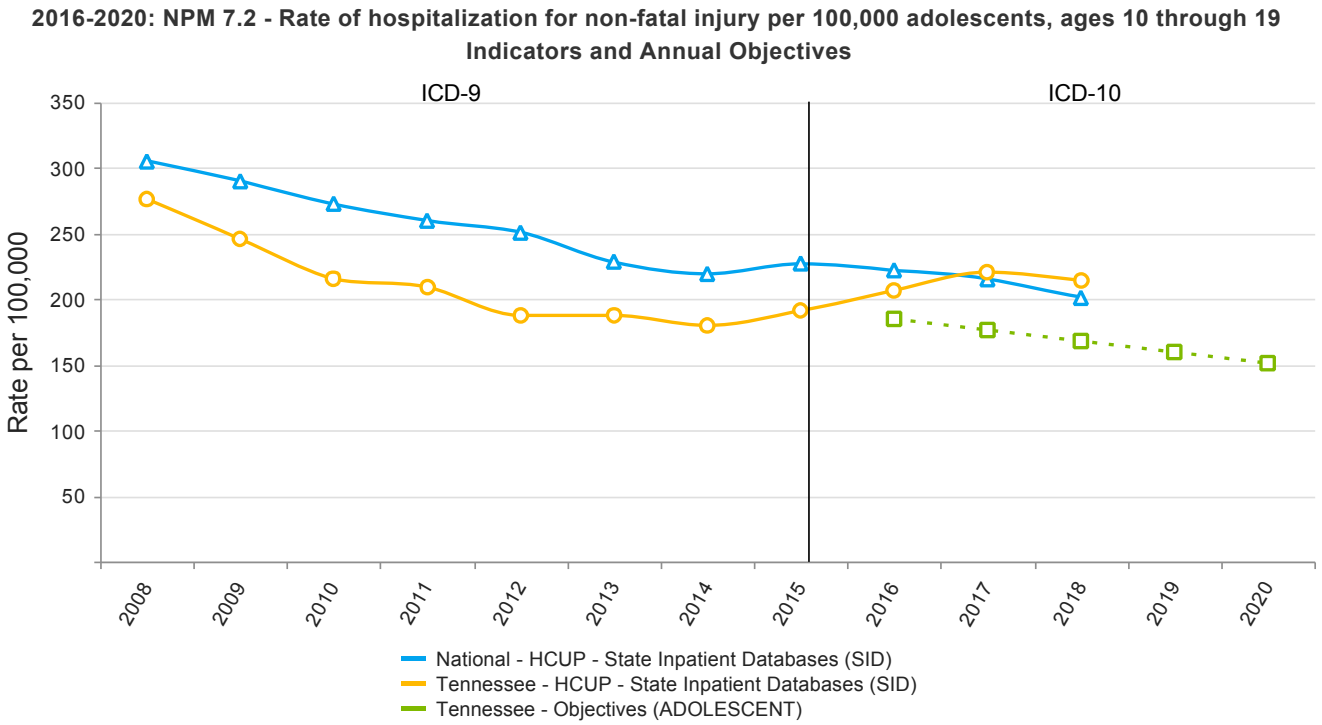
Objectives

Decrease the age-adjusted mortality rate from tobacco-attributable cancers among Tennesseans ages 35+ from 176.4 in 2019 to 141.3 in 2025.

Strategies

Build partnerships with coalitions across the state

2016-2020: National Performance Measures



Note: ICD-10-CM beginning in 2016; previously ICD-9-CM with 2015 representing January - September

Federally Available Data					
Data Source: HCUP - State Inpatient Databases (SID)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	184.8	176.4	168	159.6	151.2
Annual Indicator	207.7	191.6	206.3	220.7	213.9
Numerator	1,746	1,206	1,738	1,877	1,830
Denominator	840,564	629,323	842,341	850,432	855,439
Data Source	SID-ADOLESCENT	SID-ADOLESCENT	SID-ADOLESCENT	SID-ADOLESCENT	SID-ADOLESCENT
Data Source Year	2014	2015	2016	2017	2018

2016-2020: Evidence-Based or –Informed Strategy Measures

2016-2020: ESM 7.2.1 - Number of schools in the top ten crash rate counties (among ages 15-18) that conduct evidence-informed teen safe driving programming

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	
Annual Objective				59	
Annual Indicator	46	43	48	53	
Numerator					
Denominator					
Data Source	ReduceTNCrashes.org Safe Driving Report	ReduceTNCrashes.org Safe Driving Report	ReduceTNCrashes.org Safe Driving Report	ReduceTNCrashes.org Safe Driving Report	Reduce Safe
Data Source Year	FFY2016	FFY2017	FFY2018	FFY2019	
Provisional or Final ?	Final	Final	Final	Final	

2016-2020: ESM 7.2.2 - Number of drug disposal bins installed statewide

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective				326	341
Annual Indicator	206	236	311	350	356
Numerator					
Denominator					
Data Source	TN Depart of Environmental and Conservation Report	TN Depart of Environmental and Conservation Report	TN Depart of Environmental and Conservation Report	TN Depart of Environmental and Conservation Report	TN Depart of Environmental and Conservation Report
Data Source Year	FFY2106	FFY2017	FFY2018	FFY2019	FFY2020
Provisional or Final ?	Final	Final	Final	Final	Final

2016-2020: ESM 7.2.3 - Number of press releases, social media posts and presentations about adolescent falls

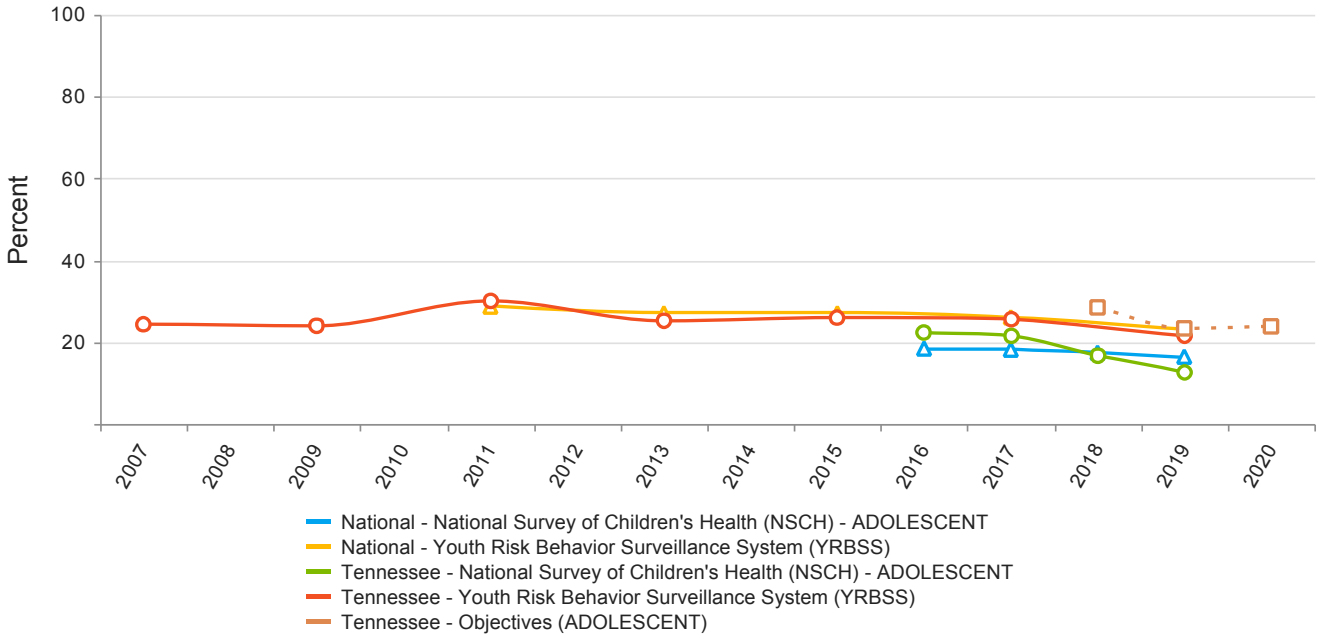
Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective				7	7
Annual Indicator	8	9	22	16	11
Numerator					
Denominator					
Data Source	TN Depart of Environmental and Conservation Report	TN Depart of Environmental and Conservation Report	TN Depart of Environmental and Conservation Report	TN Depart of Environmental and Conservation Report	TN Depart of Environmental and Conservation Report
Data Source Year	FFY2106	FFY2017	FFY2018	FFY2019	FFY2020
Provisional or Final ?	Final	Final	Final	Final	Final

2016-2020: ESM 7.2.4 - Number of suicide-related articles, social media posts and trainings provided by TDH

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective				20	22
Annual Indicator	11	19	28	28	71
Numerator					
Denominator					
Data Source	TDH FHW Injury Prevention Section Program Data	TDH FHW Injury Prevention Section Program Data	TDH FHW Injury Prevention Section Program Data	TDH FHW Injury Prevention Section Program Data	TDH FHW Injury Prevention Section Program Data
Data Source Year	FFY2016	FFY2017	FFY2018	FFY2019	FFY2020
Provisional or Final ?	Final	Final	Final	Final	Final

2016-2020: NPM 8.2 - Percent of adolescents, ages 12 through 17 who are physically active at least 60 minutes per day

Indicators and Annual Objectives



Federally Available Data					
Data Source: Youth Risk Behavior Surveillance System (YRBSS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	26.9	27.7	28.5	23.4	23.9
Annual Indicator	25.9	25.9	25.6	25.6	21.6
Numerator	70,480	70,480	73,476	73,476	60,692
Denominator	272,118	272,118	286,547	286,547	281,239
Data Source	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT
Data Source Year	2015	2015	2017	2017	2019

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - ADOLESCENT					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			28.5	23.4	23.9
Annual Indicator		22.4	21.5	16.9	12.7
Numerator		107,989	105,885	85,908	61,844
Denominator		481,757	491,600	509,523	488,141
Data Source		NSCH-ADOLESCENT	NSCH-ADOLESCENT	NSCH-ADOLESCENT	NSCH-ADOLESCENT
Data Source Year		2016	2016_2017	2017_2018	2018_2019

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

2016-2020: Evidence-Based or –Informed Strategy Measures

2016-2020: ESM 8.2.1 - Number of Physical Activity Clubs in K-12 schools

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective				234	259
Annual Indicator	47	111	209	253	256
Numerator					
Denominator					
Data Source	TDH FHW Chronic Disease Program Data	TDH FHW Chronic Disease Program Data	TDH FHW Chronic Disease Program Data	TDH FHW Chronic Disease Program Data	TDH FHW Chronic Disease Program Data
Data Source Year	FFY2016	FFY2017	FFY2018	FFY2019	FFY2020
Provisional or Final ?	Final	Final	Final	Final	Final

2016-2020: ESM 8.2.2 - Number of school gardens in Tennessee public schools

Measure Status:				**Active**
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			451	476
Annual Indicator	337	426	348	348
Numerator				
Denominator				
Data Source	DOE - Farm to School Program	DOE - Farm to School Program	DOE - Farm to School Program	DOE - Farm to School Program
Data Source Year	FFY2017	FFY2018	FFY2019	FFY2020
Provisional or Final ?	Final	Final	Final	Final

2016-2020: ESM 8.2.3 - Number of Healthy Parks Healthy Person app users

Measure Status:			**Active**	
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			2,935	
Annual Indicator	1,661	2,853	4,928	8,787
Numerator				
Denominator				
Data Source	TDEC Healthy Parks Healthy Person App	TDEC Healthy Parks Healthy Person App	TDEC Healthy Parks Healthy Person App	TDEC Healthy Parks Healthy Person App
Data Source Year	FFY2017	FFY2018	FFY2019	FFY2020
Provisional or Final ?	Final	Final	Final	Final

PRIORITY: Reduce the burden of injury among adolescents.

Interpretation of Performance Data on NOMs, NPMs, SPM and ESMs:

NPM 7.2 For adolescents and youth aged 10 to 20, there was a 4% decrease in rate of hospitalization for injury among this age group between FY2019 and FY2020 (227.5 vs. 217.4 per 100,000 population). Please note that the data reported for FY2020 are 2019 Hospital Discharge Data System data, the latest year of available hospitalization data.

ESM 7.2.1 TDH reached 64 high schools in counties with high rates of motor vehicle crashes. This performance exceeded the targeted objective of FY2020 of reaching 61 schools, and surpassed FY2019's performance by 21%.

ESM 7.2.2 The total number of disposal bins installed statewide was 356 in FY2020. The latest performance represents 15 more installed bins than the FY2020 objective and 2% higher than FY2019 figures

ESM 7.2.3 With 11 press releases, social media posts, and presentations, TDH exceeded its FY2020 goal of having seven social awareness presentations about adolescent falls.

ESM 7.2.4 Lastly, TDH promoted suicide-related messaging, social media, and training in FY2020. The actual performance for this priority (n=71) was more than three times its objective (n=22) in FY2020 and 154% higher than the number of suicide prevention programming in FY2019.

Accomplishments and Challenges (based on FY2020 Action Plan)

Strategy 1: Increase implementation of evidence based or evidence informed activities related to motor vehicle safety in schools.

Activity 1a: In the ten counties with the highest teen motor vehicle crash rates, increase the number of schools that utilize ReduceTNCrashes.Org to conduct a teen safe driving program from 43 to 53.

Report 1a: A total of 64 schools participated in teen safe driving programs sponsored by TDH or ReduceTNCrashes.Org, with a majority of those residing in the counties with the highest teen motor vehicle crash rates, crash counts, emergency department visits or rates (i.e. high teen crash risk). Staff promoted Reduce TN Crashes and other evidence-based programs such as Checkpoints Parent-Teen Driving Agreements and TN Battle of the Belt Seatbelt Competition to Tennessee school-based driver education program directors.

Activity 1b: Partner with 15 organizations to conduct the Checkpoints™ program to increase the number of teen/parent driving agreements.

Report 1b: A total of 20 schools and organizations conducted the Checkpoints program. Ten of those schools were in Williamson County with other schools and organizations located

throughout the state. The groups conducted the evidence-based Checkpoints™ program, completing over 1,100 parent-teen driving agreements to address teen driving risks. This year, we provided take-home classes and virtual training to address COVID-19. Williamson County provided the program virtually to parents and teens with success. Teen crash data from the Tennessee Department of Homeland Security for Williamson County where all public schools participate continues to see a reduction in teen crashes for 16 & 17 year old drivers since the program began with a 2.9% reduction in teen crashes from 2017-2018 and a 2.3% reduction in 2019-2020.

Activity 1c: Partner with schools to provide Graduated Driver's License education to 2,500 teens and caregivers.

Report 1c: A total of 2,650 individuals received Graduated Driver's License education with over 2,300 students and family members via the Checkpoints Parent-Teen Driving Agreement education program. Also, 350 Checkpoints Parent-Teen Driving booklets were distributed to schools for teen safe driving education.

Strategy 2: Increase awareness of proper storage and disposal of medications.

Activity 2a: Promote safe storage and disposal of medications through the Count it, Lock it, Drop™ it initiative. The goal of Count It, Lock It, Drop It™ is to increase the number of individuals tracking medication, securing medication in a locked medicine box, and utilizing medicine drop boxes. Staff will partner with Count It, Lock It, Drop It™ to educate 35 injury prevention partners about safe storage and disposal of medication and promote the TN Together website.

Report 2a: As of September 30th, 2019, all 95 counties have implemented the Count It! Lock It! Drop It! program that includes education and securing education in locked medicine boxes. A total of 106 (one hundred and six) groups in Tennessee are conducting the program with some multiple programs in some counties. This sustainability and increase in this program has been a success story for our local partners. Through a partnership with the Tennessee Department of Environment and Conservation, we have placed a total of 356 drug disposal drop boxes throughout the state. These programs all partner together to promote drug take back days and other prescription drug abuse prevention programs.

Activity 2b: Staff will attend a minimum of 5 meetings with opioid partners by September 30, 2020 to promote safe storage of medications to improve Count It, Lock It, Drop It™ efforts.

Report 2b: TDH partnered with Count It! Lock It! Drop It! staff and the Tennessee Department of Environment and Conservation (TDEC) to promote safe storage of medications. TDEC staff are active members of the state Injury Community Implementation Group and have promoted CDL to over 100 injury prevention partners at these meetings. CDL staff also served on the Committee for Pediatric Emergency Care Injury Prevention Subcommittee and promoted safe storage to those partners. CDL staff have also partnered with TDH Opioid Epidemic Response team to help local health departments and local coalitions to implement and improve CLD efforts.

Activity 2c: Continue to utilize Title V funding to support (in part) the operation of the Tennessee Poison Center

Report 2c: TDH provided $279,532 in Title V funding to support a portion of the operation of the Tennessee Poison Center. TDH meets regularly with TPC to align priorities and address emerging issues such as unintentional pediatric opioid ingestions

Strategy 3: Increase general awareness of the causes of adolescent hospitalizations due to falls.

Activity 3a: Increase the number of youth sports leagues or schools that apply for Safe Stars recognition from 28 to 40 by September 30, 2020.

Report 3a: A total of 42 state partners helped promote Safe Stars to organizations and schools that included state agencies, hospitals, colleges, professional sports organizations, and athletic associations. A total of 68 organizations and/or schools applied for Safe Stars recognition via the web site portal and a total of 35 organizations were recognized as Safe Stars Gold Star Status and one as Bronze status as of Sept 30, 2020. At the time of this report, 44 total organizations are recognized. Funding for automated external defibrillators (AEDs) was also utilized to provide AEDs for qualifying organizations. Finally, TDH staff presented Safe Stars to over 150 coaches and health educators at regional Department of Education conferences.

Activity 3b: Collaborate with TDH Office of Communications and other stakeholders to integrate routine social media postings (e.g. Facebook, Twitter) around activities that place adolescents at risk for falls (such as sports).

Report 3b: A total of 11 social media fall prevention messages and/or presentations were posted on Tennessee Department of Health Twitter and Facebook sites during the grant period. Injury prevention staff also presented Safe Stars concussion prevention program information to three regional Department of Education conferences for over 150 coaches and physical/health education instructors to reduce concussion in sports.

Activity 3c: Promote the CDC Mild Traumatic Brain Injury (mTBI) Guidelines to 200 healthcare providers by September 30, 2020.

Report 3c: The Department partnered with the Tennessee Disability Coalition BrainLinks program to provide 497 Toolkits for Healthcare Providers that include CDC mTBI Guidelines as well as research, references, and training for providers, patients and families. BrainLinks also provided 394 Toolkits to school nursed and 77 CDC Pediatric mTBI Guideline supplemental documents to partners. TDH continued to promote Safe Stars and Return to Learn/Return to play Guidelines education to schools. The Safe Stars Initiative youth sports rating system rates schools on sports safety policy practice. To date, there are 44 schools and/or organizations recognized as Safe Star groups.

Strategy 4: Increase early identification and awareness of suicide attempts among youth.

Activity 4a: Analyze suicide attempt data weekly reported in ESSENCE to identify areas with increased

suicide attempts and work with partners to develop a response plan.

Report 4a: TDH conducts weekly syndromic surveillance of suicide-related emergency department visits in children under 18 across Tennessee, including visits for suicide attempt, intentional self-harm, and/or thoughts of suicide. The visits are monitored using the Electronic Surveillance System for the Early Notification of Community-Based Epidemics (ESSENCE) software, a database which collects discharge diagnosis data on emergency department visits in 95% of hospitals across the state. A model for rapid prevention response using surveillance data from ESSENCE was developed by TDH in partnership with state and local partners to help target prevention efforts within areas of the state showing increased emergency department visits for suicide-related behavior in children under 18. The plan includes increasing awareness of suicide and providing information about suicide prevention resources, services, and programs available within a county seeing increases of suicide-related visits in near real time.

Activity 4b: Conduct quarterly suicide prevention stakeholder meetings with a minimum of 20 participants to determine gaps in services and develop recommendations to address needs.

Report 4b: From October 2019 to September 2020, the Suicide Prevention Stakeholder Task Force Team convened five times to discuss suicide prevention programming across the state, including information on suicidal ideation, suicide attempts and death, at-risk populations, suicide prevention practices in behavioral and healthcare organizations and within educational institutions ,and suicide response protocols. The task force team also advised on 32 recommendations for improvement of mental health and suicide prevention programming and services which were included in TDH's 2020 Suicide Prevention Annual Report.

Activity 4c: Partner with community agencies to increase the number of trainings for youth impactors on Question, Persuade Refer (QPR).

Report 4c: TDH staff members and external partners throughout the state were provided QPR suicide prevention gatekeeper trainings to help better identify and support individuals at-risk for suicide. This year, QPR trainings were provided to those that work with sexual and intimate partner violence survivors, CHANT staff, evidence-based home visitors, traumatic brain injury coordinators, and local health department staff. Finally, through our work with the Child Safety Learning Collaborative, QPR trainings were offered to youth impactors throughout the state in partnership with TSPN. Through this partnership, 5,402 youth impactors across the state were trained in QPR.

Activity 4d: Disseminate a suicide prevention infographic to schools and community agencies.

Report 4d: A suicide prevention infographic (1,000) that included updated data and referral sources was provided to Tennessee Suicide Prevention Network partners to educate schools and other stakeholders. Staff also partnered with the Tennessee Suicide Prevention Network (TSPN) and the Department of Education to present information about TSPN, Question Persuade, Refer Training, and Youth Mental Health First Aid to schools and other youth provider organizations throughout the state.

Activity 4e: Post social media messages on Facebook and Twitter during suicide prevention awareness month.

Report 4e: A total of forty-four (44) social media suicide prevention messages were posted on Tennessee Department of Health Twitter and Facebook sites during the grant period that included: TN Statewide Crisis Line, Suicide Prevention Lifeline, World Suicide Prevention Day, Suicide Warning Signs, Men's Health and Suicide Prevention, Suicide Prevention Crisis Text Line, and Suicide Awareness Day.

PRIORITY: Reduce the number of adolescents who are overweight/obese.

Interpretation of Performance Data on NOMs, NPMs, SPM and ESMs:

Overall, Tennessee (TN) continues to experience mixed progress in child health and primary prevention indicators that promote healthy weight among adolescents as follows:

NPM 8.2 Combined 2018-2019 data from the National Survey of Children's Health show that the proportion of adolescents (ages 12-17) in TN meeting physical activity guidelines has decreased to 12.7%, which is a four-year low and the largest yearly percent decline. Although all year to year comparisons are not statistically significant, the trend still represents a steady decline from 22.4% in Year 2. Any actual decline is most likely due to the ongoing trend toward a more sedentary lifestyle within this age group and fewer physical activity opportunities in high schools.

ESM 8.2.1 The number of physical activity clubs for K-12th graders has grown to 256 in FY2020 compared to just 47 in FY2016. However, there was only a slight increase of three clubs in Year 5, which undoubtedly reflects the impact of COVID-19. The overall four-year increase is due in part to the inclusion of these clubs in many County Primary Prevention Plans in TN. Although there has been much interest in these groups in the past, little is known about the types and duration of physical activity that they promote and the extent to which middle and high school students are participating in these clubs.

ESM 8.2.2 The number of school gardens in TN public schools in FY2020 remained the same as in FY2019 (i.e., 348). The COVID-19 pandemic and related school closures and restrictions undoubtedly impeded any expansion in the past year. However, there was actually a decrease of 78 gardens in FY 2019 due to substantial non-COVID related barriers to sustaining these facilities (e.g., summer vacation and turnover in students, staff, and faculty). Given these barriers as well as COVID-19, it was a success that school gardens did not decline any further during FY2020. Overall, the current number of school gardens is slightly higher than the 337 that were reported in FY2017.

ESM 8.2.3 The number of Healthy Parks Healthy Person app users continued to experience exponential growth from 4928 in FY2019 to 8787 in FY2020. This represents over a five-fold increase in users since FY2017. The tremendous expansion highlights the effectiveness of valuable incentives and extensive promotional efforts from the TN Department of Environment and

Conservation as well as the innate popularity of this method to increase physical activity in parks.

Accomplishments and Challenges (based on FY2020 Action Plan)

Strategy 1: Support the Office of Coordinated School Health in school-based efforts to promote physical activity and good nutrition.

Activity 1a: Utilize Title V funding to support a State School Nurse Consultant to be housed in the Department of Education, Office of Coordinated School Health.

Report 1a: The State School Nurse Consultant developed a school-based and school-linked clinic toolkit that districts can use for either implementing or sustaining a school health clinic. School health clinic best practices resources were shared with Lead Nurses and Coordinated School Health Coordinators. Additionally, the School Nurse Consultant worked to update the Tennessee Health Screening Guidelines.

Activity 1b: Provide a minimum of 2 trainings that promote tools, resources, and strategies that promote healthy Encourage collaboration between the Office of Coordinated School Health, state, regional and local health departments that are focusing on obesity-related primary prevention.

Report 1b: On the TDH Health Promotion Quarterly Call, CSH staff provided training to approximately 75 TDH Health Promotion staff, including: Health Promotion Directors, PHEs and Tobacco Coordinators to promote tools, resources and strategies that encourage physical activity, healthy behaviors and good nutrition. The Annual CSH Institute, which convenes approximately 100 CSH Coordinators, TDH Health Promotion staff and other school personnel, provided multiple sessions on physical education, school nutrition guidelines and obesity-related primary prevention activities.

Activity 1c: Provide a minimum of 2 trainings that promote evidence-based practices designed to increase physical activity before, during and after school.

Report 1c: During the reporting period, CSH in collaboration with TDH staff conducted two TN Physical Education (PE) Virtual Professional Development (PD) trainings for PE teachers and Public Health Educators (PHEs). The PDs included childhood related topics, including but not limited to: Getting Students Back to Playing Games, Mindful Movement, Safe Stars (Sports Safety Program), Ways to Align Physical Activity with Academics, Model Sports Safety Program and Kids Heart Challenge. Training attendees were invited from 1127 LEAs (Pre-K through grade 12) and county health departments from all 95 counties.

Activity 1d: Implement 1-2 strategies that increase access to healthier food and beverage options before, during, and after school.

Report 1d: As part of the Project Diabetes program, fourteen (14) school and community projects focused on access to healthy food and beverages. These projects included installation of water bottle refill stations in schools along with the ReThink your Drink campaign to

reduce the consumption of sugar-sweetened beverages. Students in more than 44 schools led their peers to sign a pledge to drink fewer sugary beverages and more water. Also, access to healthy foods increased through the Double Up Food Bucks initiative at farmers markets in East Tennessee offering the ability to double buying power on fresh fruits and vegetables

Adolescent Health - Application Year

PRIORITY: Decrease Tobacco and E-cigarette Use Among Adolescents

Objective NPM 14.2 Decrease the percent of children, ages 0 through 17, who live in households where someone smokes from 19.5% in 2019 to 18.8% in 2025.

Objective SPM 11 Decrease the percent of high school students currently using cigarettes, from 7.1% in 2019 to 4.3% in 2025.

Objective SPM 12 Decrease the percent of high school students currently using e-cigarettes from 22.1% in 2019 to 17.7% in 2025.

Objective SPM 13 Increase the number of adolescents enrolled in cessation programs, from 0 in 2019 to 125 in 2025.

The following strategies and activities are planned for *October 1, 2021 to September 30, 2022*:

Strategy 1: Promote anti-tobacco youth led initiatives

Supporting Evidence for Strategy 1: The tobacco epidemic will not end without preventing initiation among young people, it is critical that programs engage youth in tobacco control efforts. Youth can be powerful allies to help communicate the impact of tobacco use on young people, implement effective tobacco control strategies, and shift social norms around tobacco use in their communities. (CDC Best Practice User Guide: Youth Engagement in Tobacco Prevention and Control, 2019)

Activity 1a: Promote tobacco-free sports, and increase the number of teams taking the pledge to be tobacco-free athletes

Activity 1b: Host annual TNSTRONG Youth Summit to engage and educate adolescents and adolescent leaders on the dangers of using tobacco products, and tobacco control interventions

Activity 1c: Promote anti-tobacco messaging via social media

Strategy 2: Promote youth tobacco cessation services

Supporting Evidence for Strategy 2: Close to 95 percent of smokers try their first cigarette before the age of 21. Nicotine is highly addictive and can harm brain development in youth. People who start using tobacco at an early age are more likely to develop an addiction than those who start at a later age, and kids who use vapor products are more likely to go on to smoke cigarettes. (American Lung Association. 2020.Helping Teens Quit: Teen Tobacco Cessation and Education Resources. https://www.lung.org/quit-smoking/helping-teens-quit)

Activity 2a: Engage partner organizations serving at risk adolescents to screen for tobacco use and refer to federally funded services when available

Activity 2b: Promote youth cessation programs via social media

Strategy 3: Build partnerships with coalitions across the state

Supporting Evidence for Strategy 3: Coalitions are a type of partnership that have successfully promoted policy change despite an often unfavorable cultural and legislative climate for their work. Partnerships and coalitions work to raise awareness of the importance of environments free of commercial tobacco, educate about the impact of tobacco prices, create health communications campaigns, and promote cessation. (CDC Best Practice User Guide: Partnerships in Tobacco Prevention and Control, 2021.)

Activity 3a: Increase partnerships with anti-drug and tobacco coalitions statewide

Planned Partnerships: The Tobacco Control Program will partner with anti-drug coalitions for community education, tobacco-free policies, promotion of youth prevention and cessation programs, and implementation of youth cessation programs. Additionally, the program plans to partner with organizations that serve at-risk youth to refer to cessation services.

Contextual Factors: Adolescent tobacco and e-cigarette use is heavily influenced by contextual factors including tobacco industry marketing and policy interference, partner organization participation, state legislation, political and social norms and influences, tobacco-use disparities, staff capacity, and program funding.

Assumptions: The success of the Tobacco Control Program's efforts rely on a number of key assumptions including: funding will be secure throughout the course of the project; youth trained in peer-to-peer intervention and tobacco control strategies will utilize these skills to effect change in their respective communities; partner organizations engaged and trained on tobacco control strategies will implement associated activities in their respective workplans; youth who are in environments or institutions with strong tobacco-free policies are less likely to experiment with and use tobacco products, including e-cigarettes; and cessation programs including text-to-quit services will be effective among youth who use tobacco products, including e-cigarettes.

Children with Special Health Care Needs

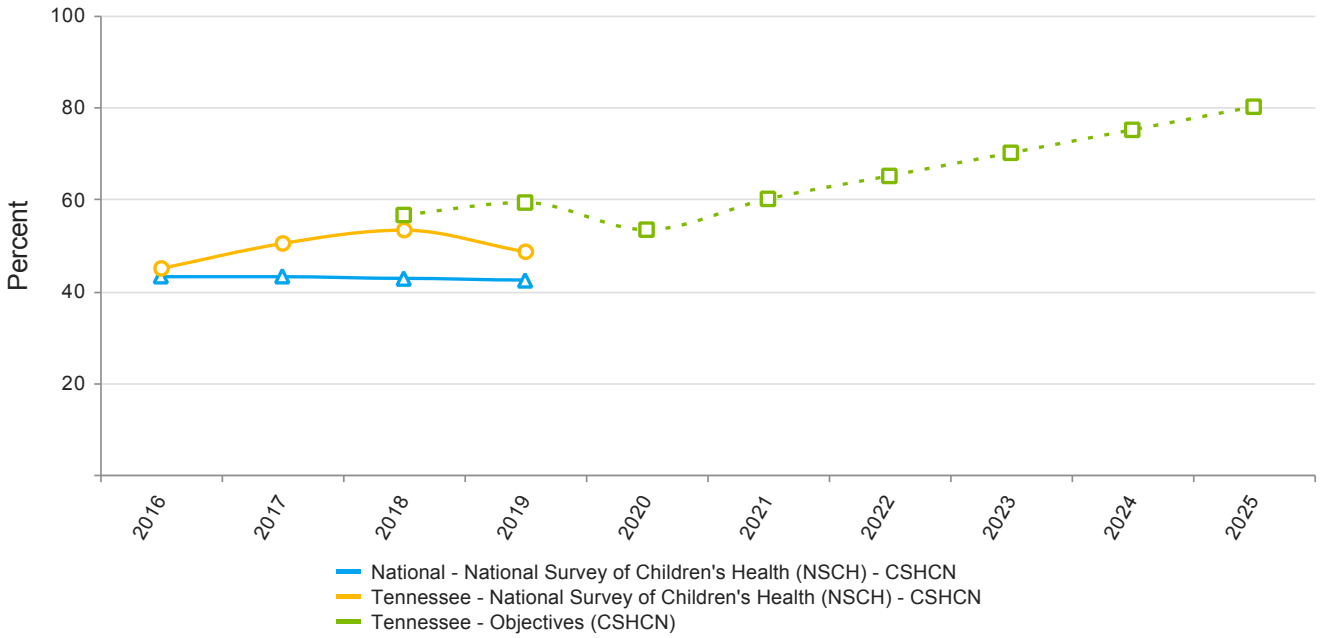
Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	NSCH-2018_2019	17.2 %	NPM 11 NPM 12
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH-2018_2019	42.7 %	NPM 11
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2018_2019	87.9 %	NPM 11
NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year	NSCH-2018_2019	3.2 %	NPM 11

National Performance Measures

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Indicators and Annual Objectives



NPM 11 - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			56.5	59.2	53.3
Annual Indicator		44.8	50.4	53.3	48.5
Numerator		125,986	143,840	164,583	157,666
Denominator		281,120	285,167	308,848	325,137
Data Source		NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017	2017_2018	2018_2019

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	60.0	65.0	70.0	75.0	80.0	85.0

Evidence-Based or –Informed Strategy Measures

ESM 11.5 - Number of CYSHCN who receive CHANT/CSS care coordination

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	2,500.0	3,000.0	3,500.0	4,000.0	4,500.0	5,000.0

ESM 11.5 - Percent of providers adopting medical home approach

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	40.0	55.0	65.0	75.0	85.0

ESM 11.6 - Number of families provided education and resources on importance of medical home access and utilization

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	600.0	700.0	800.0	900.0	1,000.0	1,100.0

ESM 11.6 - Percent of providers reporting increased knowledge on systems of care

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	20.0	30.0	40.0	50.0	60.0

ESM 11.7 - Number of families receiving referrals to their child's primary care provider

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	375.0	400.0	425.0	450.0	475.0	500.0

ESM 11.7 - Percent of providers who report an increase in their knowledge of available resources

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	25.0	50.0	75.0	100.0	100.0

ESM 11.8 - Percent of CHANT families who schedule an annual visit with their child's primary care provider

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	25.0	35.0	45.0	55.0	65.0	75.0

ESM 11.8 - Percent of families who report an increase in access and utilization of resources

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	35.0	40.0	50.0	60.0	70.0

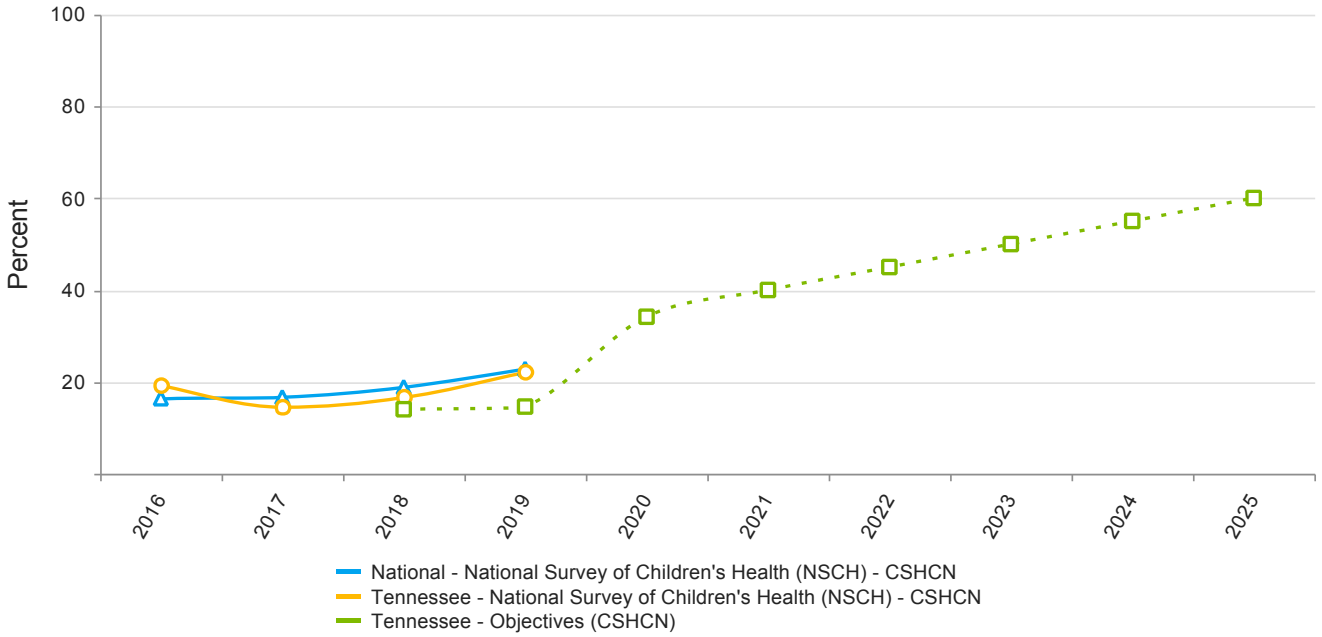
ESM 11.9 - Percent of CYSHCN receiving CHANT care coordination who receive medical home education

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	75.0	85.0	95.0	100.0	100.0

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care
Indicators and Annual Objectives



NPM 12 - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			14.1	14.7	34.2
Annual Indicator		19.2	14.4	16.6	22.2
Numerator		16,734	17,666	26,590	30,583
Denominator		87,214	122,975	159,749	137,839
Data Source		NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017	2017_2018	2018_2019

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	40.0	45.0	50.0	55.0	60.0	65.0

Evidence-Based or –Informed Strategy Measures

ESM 12.5 - Number of transition resource kits disseminated

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	150.0	300.0	600.0	1,200.0	2,400.0	2,400.0

ESM 12.6 - Number of youth with special health care needs trained as mentors

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	25.0	35.0	45.0	55.0	65.0	75.0

ESM 12.7 - Number of parents and youth with special health care needs who receive leadership and self-advocacy training

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	50.0	75.0	100.0	125.0	150.0	175.0

State Performance Measures

SPM 14 - Number of CYSHCN receiving care in a medical home

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	800.0	850.0	900.0	950.0	1,000.0	1,050.0

SPM 15 - Percent of providers with increased knowledge on medical home and care coordination

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	25.0	35.0	50.0	65.0	75.0	85.0

SPM 16 - Percent of providers reporting improved system of care for CYSCHN

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	35.0	50.0	65.0	75.0	85.0

SPM 17 - Percent of families who complete an annual visit with their primary care provider

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	50.0	65.0	80.0	95.0	100.0

SPM 18 - Percent of youth reporting with increased knowledge on transition resources and services

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	55.0	70.0	85.0	100.0	100.0

SPM 19 - Precent of YSHCN served by CHANT and YAC who complete an annual transition plan

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	75.0	85.0	95.0	100.0	100.0

SPM 20 - Precent of youth leaders participating in advisory councils providing resources to other youth

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	40.0	50.0	60.0	70.0	80.0

State Action Plan Table

State Action Plan Table (Tennessee) - Children with Special Health Care Needs - Entry 1	
Priority Need	
Increase medical homes among children with special healthcare needs	
NPM	
NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home	
Objectives	
Increase the percent of children with special health care needs 0-17 who have a medical home from 53.3% on October 1, 2020 to 80% on September 30, 2025.	
Strategies	
Create a shared vision for integrating and improving CYSHCN system of care	
ESMs	Status
ESM 11.5 - Number of CYSHCN who receive CHANT/CSS care coordination	Active
ESM 11.5 - Percent of providers adopting medical home approach	Active
ESM 11.6 - Percent of providers reporting increased knowledge on systems of care	Active
ESM 11.6 - Number of families provided education and resources on importance of medical home access and utilization	Active
ESM 11.7 - Number of families receiving referrals to their child’s primary care provider	Active
ESM 11.7 - Percent of providers who report an increase in their knowledge of available resources	Active
ESM 11.8 - Percent of families who report an increase in access and utilization of resources	Active
ESM 11.8 - Percent of CHANT families who schedule an annual visit with their child's primary care provider	Active
ESM 11.9 - Percent of CYSHCN receiving CHANT care coordination who receive medical home education	Active

NOMs

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year

State Action Plan Table (Tennessee) - Children with Special Health Care Needs - Entry 2

Priority Need

Improve transition from pediatric to adult care among children with special health care needs

NPM

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care

Objectives

Increase the percent of adolescents with special health care needs 12-17 who received services necessary to make transitions to adult health care from 34.2% on October 1, 2020 to 60% on September 30, 2025.

Strategies

Inform, educate and link YSHCN, families and providers to available transition resources and services, and how to access those services

ESMs	Status
ESM 12.5 - Number of transition resource kits disseminated	Active
ESM 12.6 - Number of youth with special health care needs trained as mentors	Active
ESM 12.7 - Number of parents and youth with special health care needs who receive leadership and self-advocacy training	Active

NOMs

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

State Action Plan Table (Tennessee) - Children with Special Health Care Needs - Entry 3

Priority Need

Increase medical homes among children with special healthcare needs

SPM

SPM 14 - Number of CYSHCN receiving care in a medical home

Objectives

Increase the number of CYSHCN receiving care in a medical home from 800 on October 1, 2020 to 1050 on September 30, 2025.

Strategies

Create a shared vision for integrating and improving CYSHCN system of care

State Action Plan Table (Tennessee) - Children with Special Health Care Needs - Entry 4

Priority Need

Increase medical homes among children with special healthcare needs

SPM

SPM 15 - Percent of providers with increased knowledge on medical home and care coordination

Objectives

Increase the percent of providers with increased knowledge on medical home and care coordination from 25% on October 1, 2020 to 85% on September 30, 2025.

Strategies

Inform and educate families and providers to promote systems change

State Action Plan Table (Tennessee) - Children with Special Health Care Needs - Entry 5

Priority Need

Increase medical homes among children with special healthcare needs

SPM

SPM 16 - Percent of providers reporting improved system of care for CYSCHN

Objectives

Increase the percent of providers reporting improved system of care for CYSHCN from 35% on October 1, 2020 to 85% on September 30, 2025.

Strategies

Identify and disseminate resources on medical home best practices in Tennessee to inform and educate families and providers on care-coordination benefits

State Action Plan Table (Tennessee) - Children with Special Health Care Needs - Entry 6

Priority Need

Increase medical homes among children with special healthcare needs

SPM

SPM 17 - Percent of families who complete an annual visit with their primary care provider

Objectives

Increase the percent of families who complete an annual visit with their primary care provider from 50% on October 1, 2020 to 100% on September 30, 2025.

Strategies

Inform and provide coordination for CHANT families on medical home and care coordination benefits

State Action Plan Table (Tennessee) - Children with Special Health Care Needs - Entry 7

Priority Need

Improve transition from pediatric to adult care among children with special health care needs

SPM

SPM 18 - Percent of youth reporting with increased knowledge on transition resources and services

Objectives

Decrease the percent of youth reporting with increased knowledge on transition resources and services from 55% on October 1, 2020 to 100% on September 30, 2025.

Strategies

Promote successful transition through educational opportunities and self-advocacy training

State Action Plan Table (Tennessee) - Children with Special Health Care Needs - Entry 8

Priority Need

Improve transition from pediatric to adult care among children with special health care needs

SPM

SPM 19 - Precent of YSHCN served by CHANT and YAC who complete an annual transition plan

Objectives

Decrease the precent of YSHCN served by CHANT and YAC who complete an annual transition plan from 75% on October 1, 2020 to 100% on September 30, 2025.

Strategies

Inform, educate and link YSHCN, families and providers to available transition resources and services, and how to access those services

State Action Plan Table (Tennessee) - Children with Special Health Care Needs - Entry 9

Priority Need

Improve transition from pediatric to adult care among children with special health care needs

SPM

SPM 20 - Precent of youth leaders participating in advisory councils providing resources to other youth

Objectives

Decrease the precent of youth leaders participating in advisory councils providing resources to other youth from 40% on October 1, 2020 to 80% on September 30, 2025.

Strategies

Promote successful transition through educational opportunities and self-advocacy training

PRIORITY: Increase the number of children (with and without special healthcare needs) who have a medical home.

Interpretation of Performance Data on NOMs, NPMs, SPM and ESMs:

NPM 11 In 2018-2019, 50.8% of Tennessee children, with and without special healthcare needs, reported to be having a medical home, a slight dip from 2017-2018 (51.2%). However, it is slightly higher than the national average of 47.7% in 2018-2019.

ESM 11.1 687 providers were trained and provided information on medical home implementation during FY2020. The objective of 780 was not met, and the number trained was actually lower than FY2019. This decrease has been attributed to the COVID-19 Pandemic. Most of the previous year's provider training has been held in-person. The pandemic required all planned in-person training be canceled and it was somewhat of a challenge to recruit participants virtually.

ESM 11.2 600 families received patient centered medical home training. The objective of 665 was not met, this can be attributed to the COVID-19 Pandemic. All in-person training was cancelled. While many of our families were able to participate virtually, the lack of broadband and access to equipment prevented some families from participating.

ESM 11.3 During FY 2020, 75% of children served by the CSS program reported receiving care in a medical home, an increase from last year's 70.5%.

ESM 11.4 During FY2020 there were a total of 107 infants referred from the TNBDSS program to the CSS program. Of those referred 31 were actually enrolled in the CSS Program.

Accomplishments and Challenges (based on FY2020 Action Plan)

Strategy 1: Support primary care providers in implementing a medical home approach to care.

Activity 1a: CYSHCN staff will partner with Family Voices to support practices and provide opportunities to develop and implement family engagement policies.

Report 1a: The CYSHCN staff continue to partner with Family Voices and seek opportunities for development and implementation of family engagement policies. Family members are included in the YAC meetings. they were included in the Youth Engagement Summit and will have breakout sessions in the upcoming youth conference. CYSHCN staff are working with the youth coordinator and family consultant at Family Voices to develop additional opportunities for family members to participate in policy development around family engagement.

Activity 1b: CYSHCN staff will identify and provide educational resources to practices seeking medical home certification.

Report 1b: The CYSHCN section provided information on NCQA certification and medical home educational material to 225 providers identified through the TN Birth Defects surveillance

system and to an additional 125 certified TennCare Patient Centered Medical Home Providers. TNAAP has conducted training and CYSHCN continues to notify vendors and other providers when the training is taking place. One challenge is that many small providers do not have the capacity to meet all of the requirements for NCQA certification. To offset this barrier, TNAAP continues to provide training and assistance. Providers are encouraged to meet as many of the requirements as possible. While this may not provide actual certification, the practice may still be recognized as a medical home. TennCare continues to certify patient centered medical homes.

Activity 1c: CYSHCN staff will partner with The Tennessee Birth Defects Surveillance System (TNBDSS) to monitor the percentage of infant pediatricians enrolled in the state's Patient Centered Medical Home initiative. Informational packets that support the adoption of medical home principles into medical practices will be distributed to all infant providers listed in the reporting database.

Report 1c: The CYSHCN staff have identified several educational resources and have mailed out over 225 packages of medical home educational material. The program is scheduled to mail out at least 1000 additional packages over the next quarter to all licensed pediatric providers in Tennessee. One challenge to this activity is identifying those that are seeking certification. Since the program does not have the ability to generate this information, some providers that are already certified have and will receive the resources also. A major challenge for FY2020 is related to the COVID-19 Pandemic. Staff have worked remotely since March 2019. There were challenges with printing and mailing.

Strategy 2: Increase general awareness of the importance of a medical home approach to care.

Activity 2a: CYSHCN staff will maintain the electronic Medical Home Toolkit as a resource for providers and families.

Report 2a: The medical home tool kit is active and is located on the MCH website at: https://www.tn.gov/health/health-program-areas/mch/mch-mh.html. The program continues to update and add resources as they are developed.

Activity 2b: CYSHCN staff will continue to partner with Family Voices to coordinate and refer families to the Parent to Parent program and to provide families with information and support on accessing ongoing, comprehensive care in a medical home.

Report 2b: Referrals are provided to Family Voices through the TN Birth Defects Program and the Children's Special Services Program. During this past fiscal year, there were 106 referrals received and 17 family matches made. Over 300 Partnering with your Doctor Booklets were provided to families being served through the CHANT care coordination process. The CHANT medical home pathway provides resources and referrals to families. Family Voices has been able to secure additional funding for the Parent to Parent Mentoring program which provides an opportunity for serving a greater number of families statewide.

Activity 2c: CYSHCN staff will continue to partner with Family Voices to provide workshops and resources

for families that include health advocacy, resources, system navigation, and partnering in the decision-making process.

Report 2c: CYSHCN continues to partner with Family Voices to conduct workshops and resources. All workshops have been virtual since March 2020. Challenges occurred when the Family Voices offices sustained damage in the tornadoes of March 2020. Staff were required to work remotely and conduct all family activities virtually. The monthly YAC meetings provide opportunities for parents and care givers to share and receive resources as requested. Training and resources on policy development, health advocacy, system navigation and tele-health have been provided.

Activity 2d: CYSHCN staff will continue to partner with Tennessee Chapter of the American Academy of Pediatrics, Tennessee Academy of Family Physicians, Family Voices, Tennessee Voices for Children and the Department of Mental Health and Substance Services to provide educational opportunities on the availability of behavioral health resources.

Report 2d: CYSHCN staff collaborate with the organizations and agencies listed to provide educational resources and opportunities on behavioral health. The Statewide Transition Work Groups has partnered with the Department of Mental Health and Substance Abuse Services and the Youth Advisory Leadership Council to ensure that resources and training is provided on behavioral and mental health services. The YAC chose behavioral and mental health as a priority during the Title V Needs Assessment and were instrumental in ensuring that activities and strategies for the ensuing 5-years will focus on service delivery, and resources for youth with mental health diagnoses.

Strategy 3: Link families to medical homes through Children's Special Services, Tennessee's Title V CYSHCN program.

Activity 3a: Provide training and care coordination resources to assist families to identify and access medical homes.

Report 3a: CHANT care coordinators state-wide have received training and are assisting families to identify and access medical home resources. Between October 1, 2019 and September 30, 2020, there were 7259 families who triggered the medical home pathway. 1,469 actually started the pathway and 677 families completed the medical home pathway. All Medicaid eligible families receive information and resources about medical homes. Any family that indicates they are unaware of their medical home or primary care provider are assisted with locating who the provider is and making appointments. CHANT and CSS families are provided copies of the *Partnering with Your Doctor* booklet and are given additional information on the importance of receiving care in the medical home.

Activity 3b: Utilize the results of the CSS program participant satisfaction survey to increase medical home utilization.

Report 3b: The CSS program participant satisfaction survey has not been conducted. Families are encouraged and receive assistance in making appointments with their medical home

provider. Referrals are provided for any family that indicates they do not have a medical home. The challenge for this activity has been administering the medical home utilization survey to CSS family participants. The program is working with the CHANT team to develop a survey and mechanism to distribute it electronically. Challenges have occurred because many of the families do not have access to computers and are unable to access and complete surveys on their cell phones. With the COVID-19 Pandemic and face to face visit cancelled, many challenges and barriers occurred that prevented completion of this activity.

Activity 3c: CSS staff will work with Medicaid to identify patient-centered medical homes and provide referral and resources to connect families to primary and specialty care providers implementing the CHANT patient centered medical home pathway.

Report 3c: CSS staff partner with Medicaid (TennCare Bureau) and families to assist with identifying patient-centered medical home providers. Families receiving services through the CSS program or CHANT care coordination are referred to primary care and specialty providers. CHANT care coordination is now available statewide and all families who indicate they do not have a medical home or specialty provider are assisted in determining their primary care provider and referrals for specialty providers are made as needed.

Activity 3d: CSS staff will work with TNBDSS program to ensure that all infants and families identified through the birth defects reporting system are linked to appropriate supportive services.

Report 3d: The TNBDSS referred 107 infants during FY2020. Those referrals were made to the CSS program, the Tennessee Early Intervention Services and Family Voices. The CSS program enrolled 31 infants, TEIS enrolled 17 and Family Voices enrolled 41. The program determined these numbers were significantly lower than what was expected and has developed a mechanism to work with the Individual programs to identify barriers or challenges that prevent the referred families from receiving services.

PRIORITY: Increase the number of children (with and without special healthcare needs) who receive services necessary to make transitions to adult health care.

Interpretation of Performance Data on NOMs, NPMs, SPM and ESMs:

NPM 12 In 2018-2019, 22.8% Tennessee children aged 12-17, with and without special healthcare needs, reported receiving services necessary to make transitions to adult health care. This is higher than what was reported in 2017-2018, i.e. 17.3%.

ESM 12.1 The number of individuals with and without special health care needs on the CYSHCN Advisory Council (YAC) increased to 23 in FY 2020, which almost doubled the number for FY2019. This number surpassed the targeted goal of 15. The widened outreach of CYSHCN staff to include the LEND program in Memphis,
Tennessee, the local LEND program and Family Voices along with the statewide child serving agency team that looks at transition for specific agency requirements and on a holistic basis

may have contributed to the increased recruitment and retention of YAC members.

ESM 12.2 380 providers received technical assistance and information on transition for youth and young adults with and without special health care needs. This was a drop from the number for FY2019, however this number surpassed the FY2020 goal of 265.

ESM 12.3 Among children 14+ served by the CSS program in FY 2020, 45% of them had a transition plan in place, a relatively large drop from 54.4% in FY 2019. This trend continued from previous years since the CSS program was integrated into the CHANT. This decrease in the number could also be contributed to the COVID-19 Pandemic response in that many of the CHANT teams were reassigned to work in the COIVD response for testing and vaccinations.

ESM 12.4 The number of parents and children who have completed the Transition Readiness tool is 0 for FY 2020. The program initially planned to use the Got Transition Tool, however, were asked to create a separate tool that was germane to the program requirements. That tool is still in development and has not been launched to the team. Delays can be attributed to the COVID-19 Pandemic and resources being pulled for response.

Accomplishments and Challenges (based on FY2020 Action Plan)

Strategy 1: Identify adult medical home practices to provide care for youth and young adults with special health care needs.

Activity 1a: CYSHCN staff will collaborate with the National Center for Medical Home Implementation and utilize "Got Transition" to provide technical assistance to the CYSHCN program and providers on developing transition policies.

Report 1a: CYSHCN staff continue to collaborate and seek assistance from the National Center for Medical Home Implementation and Got Transition and now the National Resource Center for Patient and Family-Centered Medical Home Implementation. Tennessee has worked with Got Transition to ensure that TN data is included in the national transition data and updates this information as necessary.

Activity 1b: CYSHCN staff will partner with two local Federally Qualified Health Centers to increase transition from pediatric providers to adult providers.

Report 1b: CYSHCN staff have held a preliminary conversation with staff at Matthew Walker Comprehensive Health Center to develop a partnership and transition initiative. Staff will met with the medical Director to determine how best to implement a transition pilot project within the FQHC. Noted challenges to this activity include the fact that many of the children and youth are already seeing an adult provider and there is not an opportunity to receive a referral from a pediatric provider. This activity was also delayed because of COVID-19 Pandemic – staff at the FQHC were unable to fully explore how to carry out this option and we decided to wait until we are able to meet with families again in a face-to face environment.

Strategy 2: Incorporate health care transition planning into written plans of care for children with special

health care needs.

Activity 2a: CYSHCN staff will continue to work with the Tennessee Chapter of the American Academy of Pediatrics (TNAAP) to ensure policies and processes for transition planning and preparation are available to pediatric providers.

Report 2a: TNAAP continues to provide training to pediatric providers around transition. Videos and training material developed in conjunction with the CYSHCN program are available on TNAAP's website and providers continue to access the training material. Without dedicated funding, it is somewhat difficult to continue to update and provide current resources, material and training opportunities. This activity has expanded to include a partnership with our state Medicaid office and TNAAP that provides opportunities for us to collaborate and provide services related to transition and address social determinants of health.

Activity 2b: CSS care coordinators will work with families to develop (and renew annually) a transition plan for all program participants starting at age 14.

Report 2b: CHANT care coordinators are responsible for conducting annual transition planning with all youth and young adults aged 14-21. The completion rate for the state fiscal year was 45% which was below the 85% projected state completion rate and significantly below the 54.4% for FY 2019. It is believed that challenges to meeting this goal included rolling out CHANT, new staff unfamiliar with required procedures for CSS Transition and the COVID-19 Pandemic response of many CHANT team members being reassigned to cover the COVID-19 response with testing and providing vaccines.

Activity 2c: CYSHCN staff will develop a youth and parent/guardian Transition Readiness Assessment tool.

Report 2c: The CYSHCN program initially planned to administer the Got Transition readiness assessment tool. After meeting with Got Transition, it was determined that the program needed to develop a state specific transition readiness assessment tool that will be administered to all CSS participants age 12-13 and their parent(s)/caregiver(s). Challenges to meeting this activity include epidemiologist previously assigned to project taking new job. CYSHCN staff are now working with CHANT Epi and others to develop electronic tool that can be administered between to youth and their parents/caregivers. Initial questions have been developed, the program was unable to test the tool based on CHANT team members being pulled to COVID-19 response.

Activity 2d: CSS program staff will work with youth and parents/guardians to ensure completion of the Transition Readiness Assessment tool beginning at age 12.

Report 2d: The Transition Readiness Assessment tool has been developed in draft form, but it has not been issued to field staff to administer to youth and families.

Strategy3: Support youth participation in the transition process.

Activity 3a: CYSHCN program staff will collaborate with Family Voices and LEND to recruit and retain

members to serve on a youth advisory group.

Report 3a: CYSHCN staff continue to lead the youth advisory efforts with Family Voices and LEND. The Youth Advisory Council has increased from 14 members to 23. The Council is youth driven and holds quarterly meetings that include presentations on medical home, transition, advocacy, system navigation and policy development. The Council also hosts social activities at local gaming venues and restaurants in an effort to build connections and relationships. During the pandemic, the youth decided to meet weekly and have continued to meet and provide opportunities to discuss the issues they are facing due to the pandemic restrictions and not being able to attend school in person, as well as their mental and behavioral health issues

Activity 3b: In conjunction with Family Voices, CYSHCN will provide training and conferences for youth and families with special health care needs regarding transition to adult health care providers.

Report 3b: CYSHCN was unable to convene for the second Youth Transition Conference due to COVID-19 Pandemic. While the conference could not be held, the YAC continued to hold monthly meetings and received training on topics regarding transition and medical homes. The team continued to plan for the second conference and will host that conference during the Spring 2021. This conference will be facilitated by youth and will provide an opportunity for participants to complete an actual transition plan. This conference will include national subject matter experts and also provide sessions for parents/legal guardians care givers.

Activity 3c: CYSHCN staff will actively encourage youth participation in policy and advocacy opportunities.

Report 3c: The Youth Advisory Council has participated in several virtual quarterly meetings that provided presentations and interactive sessions on self-advocacy. Each year prior to Disability Days on the Hill, the Youth Advisory Council participates in a role-play activity that includes mock interactions with elected officials. This year while the visits with the legislators were virtual, the youth continued to meet with their legislators and tell their stories while soliciting support for legislation that is of interest to them, others with disabilities and their families.

Activity 3d: CYSHCN will collaborate with the LEND program at the Boling Center in West Tennessee to replicate the youth advisory council in other areas of the state.

Report 3d: The CYSHCN program is still working out logistics to host a youth advisory council at the Boling Center. Meetings have been held with the Boiling Center Director and information shared with the youth in the Memphis/Shelby County area. Because all meetings during this fiscal year have been virtual, logistics for attendance has not been a challenge. Activities are scheduled that include all youth regardless of where they reside in the State. Because the meetings are virtual, they can and have been scheduled as early or as late as the youth need in order to have a robust attendance. This has also contributed to the increase in membership.

PRIORITY: Increase CYSHCN Medical Home Access and Utilization

Objective for NPM 11 Increase the percent of children with special health care needs 0-17 who have a medical home from 53.3% on October 1, 2020 to 80% on September 30, 2025.

Objective for SPM 14 Increase the number of CYSHCN receiving care in a medical home from 800 on October 1, 2020 to 1050 on September 30, 2025.

Objective for SPM 15 Increase the percent of providers with increased knowledge on medical home and care coordination from 25% on October 1, 2020 to 85% on September 30, 2025.

Objective for SPM 16 Increase the percent of providers reporting improved system of care for CYSHCN from 35% on October 1, 2020 to 85% on September 30, 2025.

Objective for SPM 17 Increase the percent of families who complete an annual visit with their primary care provider from 50% on October 1, 2020 to 100% on September 30, 2025.

The following strategies and activities are planned for *October 1, 2021 to September 30, 2022*:

Strategy 1: Create a shared vision for integrating and improving CYSHCN system of care

Supporting Evidence for Strategy 1: "Creating an effective system of care for children and youth with special health care needs (CYSHCN) is one of the most challenging and pressing roles for state health leaders. In the United States, 9.4 million children, or almost 13 percent, have special health care needs. A major challenge for families of CYSHCN is accessing an often-fragmented system of care." Models-of-Care-for-CYSHCN.pdf (amchp.org). The National Child Health Survey reports in the 2018-2019 combined survey only 48.5% Tennessee children with special health care needs report receiving care that meets the medical home criteria of coordinated, ongoing, comprehensive care within a medical home.

Activity 1a: Sponsor learning collaborative to help improve service coordination and CYSHCN linkage for minority and other disparate populations to providers and community-based services.

Activity 1b: Promote access to equitable and more efficient health care for disparate populations by partnering with TennCare, TNAAP, TPCA, TAFP, Office of Minority Health and Disparity Elimination and Family Voices to host a Statewide Medical Home Conference.

Activity 1c: Identify and provide technical assistance including information on medical home disparities to non-Medicaid providers seeking to implement a medical home approach to care.

Strategy 2: Inform and educate families and providers to promote systems change

Supporting Evidence for Strategy 2: All children should receive comprehensive coordinated care in a medical home environment that is a collaboration between the family and the provider and provides medical

care and support, care coordination and resources. This strategy will increase knowledge of families and providers and promote systems change. The National Child Health Survey reports in the 2018-2019 combined survey only 48.5% Tennessee children with special health care needs report receiving care that meets the medical home criteria of coordinated, ongoing, comprehensive care within a medical home.

Activity 2a: Target minority and disparate families and providers by geographic location and promote medical home implementation through education, training and resources.

Activity 2b: Identify and provide resources and referrals to minority and disparate families and geographically targeted providers on dental home, behavioral/mental health care coordination, respite care and family engagement practices.

Strategy 3: Identify and disseminate resources on medical home best practices in Tennessee to inform and educate families and providers on care-coordination benefits

Supporting Evidence for Strategy 3: Care coordination can be critical for linking families and CYSHCN to needed medical, developmental, behavioral, educational, and social services, and for providing community-based resources and emotional support. works. The National Care Coordination Standards for CYSHCN indicates "Care coordination for CYSHCN is based on the premise of health equity, that all children and families should have an equal opportunity to attain their full health potential, and no barriers should exist to prevent children and their families from achieving this potential and that care coordination should address the full range of social, behavioral, environmental, and health care needs of CYSHCN." (https://www.nashp.org/national-care-coordination-standards-for-children-and-youth-with-special-health-care-needs/#toggle-id-2) The National Child Health Survey reported in the 2018-2019 combined survey results that 23.6% of CYSHCN in Tennessee did not receive needed care coordination.

Activity 3a: Create and disseminate medical home toolkit to families and providers including information on health equity and disparities.

Activity 3b: Create and disseminate care coordination toolkit including information on diverse populations and geographic locations to health care providers and CHANT care coordinators.

Activity 3c: Promote health equity in the medical home and provide care coordination and medical home referrals to families receiving services through the Children's Special Services Program.

Activity 3d: Provide education and resources to Children's Special Services authorized vendors.

Strategy 4: Inform and provide coordination for CHANT families on medical home and care coordination benefits

Supporting Evidence for Strategy 4: Access to a pediatric medical home is associated with increased quality of care, improved health outcomes, and decreased unmet medical needs for children and youth, including children and youth with special health care needs. Research shows that access to and utilization of a pediatric medical home is associated with the following:
Increased provision of preventive services for children, including - Increased likelihood of having anticipatory guidance provided; Increased likelihood of being seen by a primary care clinician within the last year; Increased rates of childhood immunizations; Increased rates of well-child visits; Increased likelihood to have

had height, weight, and blood pressure checked; Decreased amount of outpatient sick visits; Decreased rate of inappropriate use of antibiotics; and Improved health outcomes and health status (https://medicalhomeinfo.aap.org/overview/Pages/Evidence.aspx) The National Child Health Survey reports in the 2018-2019 combined survey only 48.5% Tennessee children with special health care needs report receiving care that meets the medical home criteria of coordinated, ongoing, comprehensive care within a medical home.

Activity 4a: Provide education and resources on importance of care in the medical home.

Activity 4b: Increase family referrals to primary care providers.

Activity 4c: Encourage families to schedule appointments with their primary care provider.

Activity 4d: Promote annual health care visit in the medical home

Planned Partnerships: The CYSHCN Team currently partners and plans to continue partnering with TNAAP, TN Chapter of Family Physicians, Federally Qualified Health Care Centers, local health departments, Family Voices, the State of TN child serving agencies, i.e., Department of Intellectual and Developmental Disabilities, TN Council on Developmental Disability, Tennessee Commission on Children and Youth, Tennessee Council on Mental Health, the Department of Mental Health and Substance Abuse Services, and the local hospital family advisory groups.

Contextual Factors: During the past several years, Tennessee has experienced a drastic decline in the number of rural hospitals. With the closing of the hospitals, this also caused many providers to relocate their practices, which created barriers to access and care for families and especially families with special health care needs as many areas lack pediatric providers. Rural transportation is also a major issue (to urban areas). Some families do not have access to insurance and are not eligible for Medicaid. Other barriers include adult providers not accepting Medicaid; non-expansion of Medicaid, internet and broadband access; COVID-19 restrictions.

Assumptions: The status of health care will improve for CYSHCN; Increase capacity of youth to achieve their maximum quality-of-life potential; increase the number of CYSHCN who receive coordinated services in a Medical Home; Increase family and youth knowledge regarding resources in their community and access to said resources; Increase provider and community knowledge on medical home, transition, and resources; Create new resources in an electronic version with regular updates scheduled.

PRIORITY: Transition from Pediatric to Adult Care

Objective for NPM 12 Increase the percent of adolescents with special health care needs 12-17 who received services necessary to make transitions to adult health care from 34.2% on October 1, 2020 to 60% on September 30, 2025.

Objective for SPM 18 Decrease the percent of youth reporting with increased knowledge on transition resources and services from 55% on October 1, 2020 to 100% on September 30, 2025.

Objective for SPM 19 Decrease the precent of YSHCN served by CHANT and YAC who complete an annual transition plan from 75% on October 1, 2020 to 100% on September 30, 2025.

Objective for SPM 20 Decrease the precent of youth leaders participating in advisory councils providing resources to other youth from 40% on October 1, 2020 to 80% on September 30, 2025.

The following strategies and activities are planned for *October 1, 2021 to September 30, 2022*:

Strategy 1: Inform, educate and link YSHCN, families and providers to available transition resources and services, and how to access those services

Supporting Evidence for Strategy: All youth with special health care needs should receive services necessary to make transitions to adult health care work and independence. As youth age, transition from parent supervised patient controlled care to independent patient-centered care is vital for growth and development. The National Child Health 2018-2019 combined survey indicates that 77.8% children and youth with special health care needs aged 12-17 in Tennessee did not receive the services necessary for transition to adult health care https://www.childhealthdata.org/browse/survey/results?q=7777&r=44&g=807

Activity 1a: Provide available resources by age and geographic location for YSHCN and families – inclusive, but not limited to, medical home, dental home, behavioral/mental health services and transition.

Activity 1b: Develop and disseminate a state-wide YSHCNs transition resource kit including resources for disparate and minority populations.

Activity 1c: Provide training for families, youth, partners and providers on all aspects of transition.

Strategy 2: Promote successful transition through educational opportunities and self-advocacy training

Supporting Evidence for Strategy: Youth and parents who receive leadership training are able to provide mentoring and peer to peer support to other parents and youth with special health care needs. Trained parents and YSHCN are better equipped to become **self**-advocates and participate in the decision-making process and policy development. The National Child Health 2018-2019 combined survey indicates that 77.8% children and youth with special health care needs aged 12-17 in Tennessee did not receive the services necessary for transition to adult health care. https://www.childhealthdata.org/browse/survey/results?q=7777&r=44&g=807

Activity 2a: Recruit and retain YAC council members ensuring diverse representation including race, ethnicity, age and gender.

Activity 2b: Train YAC members from diverse populations to mentor other YSHCN in the community.

Activity 2c: Provide learning opportunities (leadership training – ex. Peer-to-Peer support program, talking to legislators, taking control of your healthcare) for youth.

Planned Partnerships: CYSHCN will continue our collaborative efforts and partnering with Family Voices, TNAAP, TPCA, TAFP, State Transition Work Group, Vocational Rehabilitation, Transition TN, the Youth Advisory Committee

Contextual Factors: Issues that may interfere with efficient transition to adult health care include the perspectives of stakeholders, age limits on pediatric service, complexity of health conditions, a lack of experienced healthcare professionals in the adult arena, and health care financing for chronic and complex conditions. Adult providers do not

accept Medicaid. As youth age, they may lose their Medicaid coverage and are not able to afford private insurance.

Assumptions: The status of health care will improve for YSHCN; Increase capacity of youth to achieve their maximum quality-of-life potential; Increase the number of YSHCN who receive coordinated services in a Medical Home; Increase family and youth knowledge regarding resources in their community and access to said resources; Increase provider and community knowledge on medical home, transition, and resources; Increase YSHCN leadership opportunities and continuity of care throughout adulthood.

Cross-Cutting/Systems Building

State Performance Measures

SPM 21 - Percent of women who reported 14+ days of poor mental health in the past month

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	18.2	17.8	17.4	17.0	16.6

SPM 22 - Percent of children who had difficulties obtaining mental health care among those who received or needed care during the past 12 months, age 3-17 years

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	25.0	24.0	23.0	22.0	21.0

State Outcome Measures

SOM 8 - Percent of pregnancy-associated deaths in which mental health conditions was a contributing factor

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	25.0	24.0	23.0	22.0	21.0

State Action Plan Table

State Action Plan Table (Tennessee) - Cross-Cutting/Systems Building - Entry 1
Priority Need
Improve mental health
SPM
SPM 21 - Percent of women who reported 14+ days of poor mental health in the past month
Objectives
Decrease the percent of women who reported 14+ days of poor mental health in the past month from 18.6% on October 1, 2020 to 15% on September 30, 2025.
Strategies
Screen and refer women to mental health treatment and resources

State Action Plan Table (Tennessee) - Cross-Cutting/Systems Building - Entry 2

Priority Need

Improve mental health

SPM

SPM 22 - Percent of children who had difficulties obtaining mental health care among those who received or needed care during the past 12 months, age 3-17 years

Objectives

Decrease the percent of those who experienced difficulties obtaining mental health care among those who received or needed care during the past 12 months, age 3-17 years from 25% on October 1, 2020 to 22% on September 30, 2025.

Strategies

Provide training and resources to support positive mental health

State Action Plan Table (Tennessee) - Cross-Cutting/Systems Building - Entry 3

Priority Need

Improve mental health

SOM

SOM 8 - Percent of pregnancy-associated deaths in which mental health conditions was a contributing factor

Objectives

Decrease the percent of pregnany-associated deaths in which mental health conditions was a contributing factor from 20% on October 1, 2020 to 14% on September 30, 2025.

Strategies

Provide training and resources to support positive mental health

Cross-Cutting/Systems Builiding - Annual Report

No content was entered for the Cross-Cutting/Systems Building - Annual Report in the State Action Plan Narrative by Domain section.

Cross-Cutting/Systems Building - Application Year

PRIORITY: Improve Mental Health

Objective SPM 21 Decrease the percent of women who reported 14+ days of poor mental health in the past month from 18.6% on October 1, 2020 to 15% on September 30, 2025.

Objective SPM 22 Decrease the percent of those who experienced difficulties obtaining mental health care among those who received or needed care during the past 12 months, age 3-17 years from 25% on October 1, 2020 to 22% on September 30, 2025.

The following strategies and activities are planned for FY22 (October 1, 2021 to September 30, 2022):

Strategy 1: Screen and refer women to mental health treatment and resources

Supporting Evidence for Strategy: The US Preventive Services Task Force (USPSTF), American College of Obstetricians and Gynecologists (ACOG), and other women's health organizations recommend that pregnant and postpartum women be assessed for risk of depression so that they can receive intervention before symptoms arise.

Activity 1a: Conduct mental health screenings among women enrolled in Community Health Access and Navigation in TN (CHANT) and Evidence Based Home Visiting (EBHV).

Activity 1b: Connect women with mental health needs identified through screening to resources

Strategy 2: Provide training and resources to support positive mental health

Supporting Evidence for Strategy: Evidence suggests that school-based gatekeeper training is effective in improving participants' knowledge, skills, self-efficacy and likelihood to intervene. Question, Persuade, Refer (QPR) Gatekeeper Training is designed to teach participants how to recognize the warning signs of someone who may be contemplating suicide and question them about whether or not they are suicidal; how to offer hope to an individual experiencing a suicidal crisis and persuade them to get help; and how to refer an individual having a suicidal crisis for help in order to save their life**.**

Healthy Parks Healthy Person TN's Park Prescription Program promotes spending time outdoors to improve physical and mental health.

Activity 2a: Support Question, Persuade, Refer (QPR) Gatekeeper Training for teachers and other school personnel

Activity 2b: Promote mental health benefits of park prescription program in health department clinics

Planned Partnerships: TN Department of Mental Health and Substance Abuse Services (TNDMHSAS); Tennessee Commission on Children and Youth (TCCY); Young Child Wellness Council (YCWC); Regional and Metro Health Departments; TN Chapter of the American Academy of Pediatrics (TNAAP); Pediatric Providers, Mental Health Providers, and Hospitals; Families and Youth Self-Advocates; Schools

Contextual Factors:

- Patient/client barriers in access to programs, primary care, and behavioral healthcare
- Readiness of collaborative partners
- Financial resources

Assumptions:

- Women and families will enroll in EBHV and CHANT
- Healthcare providers, teachers, and counselors will participate
- Stakeholders will be engaged
- Families and youth will be open to support

III.F. Public Input

Public Comment – During Report/Application Development

Tennessee's MCH/Title V Program offers three main mechanisms for the public to provide feedback on the annual application/report. The first is through participating in in-person stakeholder meetings that are held twice each year. These meetings are open to the public, with special effort being made to reach out to those serving the MCH population as well as parents (including parents of CYSHCN, foster parents, and grandparents). During the meetings, participants evaluate the progress made on action plan measures. At the fall meeting, that evaluation is utilized to identify partnership opportunities between the Tennessee MCH/Title V Program and the other stakeholders/organizations that will help to achieve measurable progress. At the spring meeting the information is used to develop the action plan for the coming year. Both meetings have an average of 100 stakeholders in attendance.

The second opportunity to provide feedback is through membership or public participation in advisory committees. The division convenes multiple advisory committees commissioned by Tennessee statute including: Genetics Advisory Committee (focused on newborn screening), Perinatal Advisory Committee (focused on perinatal health and the regionalization system), Children's Special Services Advisory Committee and Birth Defects Registry Advisory Committee (focused on the MCH/Title V CYSHCN program). Committee members are appointed by the Department of Health Commissioner or the Governor and provide topic-specific expertise to the respective committees. Furthermore, these meetings are subject to the State's Open Meetings Law and are open for attendance by members of the general public. The MCH/Title V director and program staff are in regular communication with committee members, members of the public, and members of the General Assembly on topic areas of interest to those committees. In addition to these long standing committees, the MCH/Title V CYSHCN program established a youth advisory committee in 2017, and sections of the Division operate advisory committees for grants such as the Preventive Health and Health Services Block Grant.

Lastly ongoing feedback is gathered through FHW program staff. Program staff seek input throughout the year from representatives of local and regional health departments, and by extension, their clients and communities. Regional MCH Directors are convened via conference call every other month. On each call, all central office program representatives and regional MCH Directors are offered the opportunity to present updates for their program/region. These highlights focus on information that increases understanding and collaborative efforts between programs, as well as updates that affect all MCH programs. Additionally, Central Office program staff regularly visit each of the Department's 13 regions to individually meet with front- line program staff. The visits are separate from required monitoring visits, and are aimed to provide opportunities for Central Office staff to see firsthand the unique needs of Tennessee communities and to understand how state-level staff can best support front-line staff.

Public Comment Process – After Report/Application Submission

Each year the application/report is uploaded to the state website where it is accessible to all. Contact information for the MCH/Title V Director is also included. The public is directed to contact the director with any input, making commenting available at all times.

III.G. Technical Assistance

Tennessee's MCH/Title V Program is not requesting any technical assistance at this time.

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - IAA MOU Letter and All Contracts.pdf

V. Supporting Documents

The following supporting documents have been provided to supplement the narrative discussion.

Supporting Document #01 - MCH Related Legislative Mandates.pdf

Supporting Document #02 - Tennessee Provider Ratios.pdf

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - Tennessee Organizational Charts.pdf

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Tennessee

	FY 22 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 11,800,000	
A. Preventive and Primary Care for Children	$ 3,658,000	(31%)
B. Children with Special Health Care Needs	$ 5,310,000	(45%)
C. Title V Administrative Costs	$ 1,062,000	(9%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 10,030,000	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 12,100,000	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 1,200,000	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 13,300,000	
A. Your State's FY 1989 Maintenance of Effort Amount $ 13,125,024		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 25,100,000	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS(Subtotal of all funds under item 9)	$ 153,475,117	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 178,575,117	

OTHER FEDERAL FUNDS	FY 22 Application Budgeted
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 100,000
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 118,452,235
US Department of Agriculture (USDA) > Food and Nutrition Services > Commodity Supplemental Food Program (CSFP)	$ 795,865
US Department of Agriculture (USDA) > Food and Nutrition Services > The Loving Support Peer Counseling Program (Breastfeeding)	$ 1,493,654
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Injury Prevention and Control	$ 250,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Tobacco Control Programs	$ 1,386,832
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventive Health and Health Services Block Grant	$ 2,551,850
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Breast and Cervical Cancer Early Detection Program (NBCCEDP)	$ 2,482,515
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	$ 726,122
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 8,125,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 245,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Sudden Death in the Young (SDY) Registry	$ 225,453
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State and Local Healthy Homes and Childhood Lead Poisoning Prevention Programs (CLPPPs)	$ 401,646
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Traumatic Brain Injury	$ 300,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Comprehensive Cancer Control Program (NCCCP)	$ 362,629

OTHER FEDERAL FUNDS	FY 22 Application Budgeted
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventing Maternal Deaths: Supporting Maternal Mortality Review Committees	$ 450,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Birth Defects and Developmental Disabilities	$ 349,214
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 160,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	$ 9,933,118
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Sexual Risk Avoidance Education (SRAE)	$ 1,482,069
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Diabetes, Heart Disease & Stroke Prevention & Management Program (1815)	$ 2,273,138
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Comprehensive Suicide Prevention	$ 750,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal and Child Health Federal Consolidated Programs	$ 178,777

	FY 20 Annual Report Budgeted		FY 20 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 12,750,000		$ 9,115,297	
A. Preventive and Primary Care for Children	$ 3,829,336	(30%)	$ 2,818,656	(30.9%)
B. Children with Special Health Care Needs	$ 4,152,956	(32.6%)	$ 3,993,304	(43.8%)
C. Title V Administrative Costs	$ 1,028,890	(8.1%)	$ 703,857	(7.8%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 9,011,182		$ 7,515,817	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 14,000,000		$ 10,802,455	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0		$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0		$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 2,100,000		$ 2,331,656	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 16,100,000		$ 13,134,111	
A. Your State's FY 1989 Maintenance of Effort Amount $ 13,125,024				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 28,850,000		$ 22,249,408	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.				
10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9)	$ 159,282,034		$ 115,089,592	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 188,132,034		$ 137,339,000	

OTHER FEDERAL FUNDS	FY 20 Annual Report Budgeted	FY 20 Annual Report Expended
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 100,000	$ 100,000
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 117,727,979	$ 84,411,092
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Sexual Risk Avoidance Education (SRAE)	$ 2,033,318	$ 1,215,265
US Department of Agriculture (USDA) > Food and Nutrition Services > Commodity Supplemental Food Program (CSFP)	$ 977,643	$ 815,679
US Department of Agriculture (USDA) > Food and Nutrition Services > The Loving Support Peer Counseling Program (Breastfeeding)	$ 1,172,613	$ 1,200,818
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Injury Prevention and Control	$ 250,000	$ 220,578
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Tobacco Control Programs	$ 1,939,783	$ 1,342,345
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventive Health and Health Services Block Grant	$ 2,513,815	$ 2,478,859
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Breast and Cervical Cancer Early Detection Program (NBCCEDP)	$ 2,086,375	$ 2,433,717
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	$ 979,267	$ 502,010
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Zika Maternal and Child Health Services Program	$ 600,000	$ 179,767
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	$ 19,791,112	$ 9,106,938
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 7,830,000	$ 8,285,000

OTHER FEDERAL FUNDS	FY 20 Annual Report Budgeted	FY 20 Annual Report Expended
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 316,551	$ 285,305
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Sudden Death in the Young (SDY) Registry	$ 238,216	$ 174,677
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State and Local Healthy Homes and Childhood Lead Poisoning Prevention Programs (CLPPPs)	$ 475,362	$ 384,729
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Traumatic Brain Injury	$ 250,000	$ 303,521
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Diabetes, Heart Disease & Stroke Prevention & Management Program (1815)		$ 1,401,416
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Tobacco Use Prevention Public Health Approaches for Ensuring Quitline Capacity		$ 247,876

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**1.FEDERAL ALLOCATION**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: The federal allocation is unknown when the budget is originally submitted with the application. Therefore, the budget is created based on an estimate. In FY2020 the estimate was higher than the actual allocation. Due to this many budget categories had to be adjusted, including this line item.	
2.	**Field Name:**	**Federal Allocation, A. Preventive and Primary Care for Children:**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: The federal allocation is unknown when the budget is originally submitted with the application. Therefore, the budget is created based on an estimate. In FY2020 the estimate was higher than the actual allocation. Due to this many budget categories had to be adjusted, including this line item.	
3.	**Field Name:**	**Federal Allocation, C. Title V Administrative Costs:**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: The federal allocation is unknown when the budget is originally submitted with the application. Therefore, the budget is created based on an estimate. In FY2020 the estimate was higher than the actual allocation. Due to this many budget categories had to be adjusted, including this line item.	
4.	**Field Name:**	**3. STATE MCH FUNDS**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: The federal allocation is unknown when the budget is originally submitted with the application. Therefore, the budget is created based on an estimate. In FY2020 the estimate was higher than the actual allocation. Due to this many budget categories had to be adjusted, including this line item.	
5.	**Field Name:**	**6. PROGRAM INCOME**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: The federal allocation is unknown when the budget is originally submitted with the application. Therefore, the budget is created based on an estimate. In FY2020 the estimate was higher than the actual allocation. Due to this many budget categories had to be adjusted, including this line item.	

Data Alerts: None

Form 3a
Budget and Expenditure Details by Types of Individuals Served

State: Tennessee

I. TYPES OF INDIVIDUALS SERVED

IA. Federal MCH Block Grant	FY 22 Application Budgeted	FY 20 Annual Report Expended
1. Pregnant Women	$ 1,143	$ 0
2. Infants < 1 year	$ 935,723	$ 818,162
3. Children 1 through 21 Years	$ 3,839,974	$ 2,626,671
4. CSHCN	$ 3,549,305	$ 2,688,306
5. All Others	$ 2,411,855	$ 2,278,301
Federal Total of Individuals Served	$ 10,738,000	$ 8,411,440

IB. Non-Federal MCH Block Grant	FY 22 Application Budgeted	FY 20 Annual Report Expended
1. Pregnant Women	$ 141,570	$ 97,338
2. Infants < 1 year	$ 763,510	$ 722,026
3. Children 1 through 21 Years	$ 3,248,850	$ 3,166,449
4. CSHCN	$ 1,629,870	$ 1,137,469
5. All Others	$ 6,316,200	$ 5,679,173
Non-Federal Total of Individuals Served	$ 12,100,000	$ 10,802,455
Federal State MCH Block Grant Partnership Total	$ 22,838,000	$ 19,213,895

Form Notes for Form 3a:

None

Field Level Notes for Form 3a:

1.	**Field Name:**	**IA. Federal MCH Block Grant, 3. Children 1 through 21 years**
	Fiscal Year:	**2022**
	Column Name:	**Application Budgeted**
	Field Note: The discrepancy between the amount budgeted for Children 1-21 Years on Form 3a and the amount budgeted for Preventive and Primary care for Children (Form 2, Line 1A) is due to classification of particular programs that span multiple populations. For example, family planning funds are used, in part, to serve children age 1-22 but also serve other populations (and therefore are not counted in the "Preventive and Primary Care for Children" category on Form 2).	
2.	**Field Name:**	**IA. Federal MCH Block Grant, 4. CSHCN**
	Fiscal Year:	**2022**
	Column Name:	**Application Budgeted**
	Field Note: The discrepancy between the amount budgeted for CSHCN on Form 3a and the amount budgeted for for CSHCN (Form 2, Line 1A) is due to classification of particular programs that span multiple populations. For example, child health funds are used, in part, to serve CSHCN but also serve infant and child populations (and therefore are not counted in the "CSHCN" category on Form 2).	
3.	**Field Name:**	**IA. Federal MCH Block Grant, 3. Children 1 through 21 years**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: The discrepancy between the amount expended for Children 1-21 Years on Form 3a and the amount expended for for Preventive and Primary care for Children (Form 2, Line 1A) is due to classification of particular programs that span multiple populations. For example, family planning funds are used, in part, to serve children age 1-22 but also serve other populations (and therefore are not counted in the "Preventive and Primary Care for Children" category on Form 2).	
4.	**Field Name:**	**IA. Federal MCH Block Grant, 4. CSHCN**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: The discrepancy between the amount expended for CSHCN on Form 3a and the amount expended for for CSHCN (Form 2, Line 1A) is due to classification of particular programs that span multiple populations. For example, child health funds are used, in part, to serve CSHCN but also serve infant and child populations (and therefore are not counted in the "CSHCN" category on Form 2).	

Data Alerts:

- Children 1 through 21 Years, Application Budgeted does not equal Form 2, Line 1A, Preventive and Primary Care for Children Application Budgeted. A field-level note indicating the reason for the discrepancy was provided.
- CSHCN, Application Budgeted does not equal Form 2, Line 1B, Children with Special Health Care Needs, Application Budgeted. A field-level note indicating the reason for the discrepancy was provided.
- Children 1 through 21 Years, Annual Report Expended does not equal Form 2, Line 1A, Preventive and Primary Care for Children, Annual Report Expended. A field - level note indicating the reason for the discrepancy was provided.
- CSHCN, Annual Report Expended does not equal Form 2, Line 1B, Children with Special Health Care Needs, Annual Report Expended. A field-level note indicating the reason for the discrepancy was provided.

Form 3b
Budget and Expenditure Details by Types of Services

State: Tennessee

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY 22 Application Budgeted	FY 20 Annual Report Expended
1. Direct Services	$ 1,062,000	$ 820,092
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 328,052	$ 253,347
B. Preventive and Primary Care Services for Children	$ 279,200	$ 215,587
C. Services for CSHCN	$ 454,748	$ 351,158
2. Enabling Services	$ 6,716,560	$ 5,188,981
3. Public Health Services and Systems	$ 4,021,440	$ 3,106,224
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 299,725
Physician/Office Services		$ 230,433
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 70,307
Dental Care (Does Not Include Orthodontic Services)		$ 5,433
Durable Medical Equipment and Supplies		$ 45,687
Laboratory Services		$ 46,155
Other		
CSS Food		$ 122,352
Direct Services Line 4 Expended Total		$ 820,092
Federal Total	$ 11,800,000	$ 9,115,297

IIB. Non-Federal MCH Block Grant	FY 22 Application Budgeted	FY 20 Annual Report Expended
1. Direct Services	$ 437,750	$ 437,093
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 56,846	$ 56,853
B. Preventive and Primary Care Services for Children	$ 758	$ 8
C. Services for CSHCN	$ 380,146	$ 380,232
2. Enabling Services	$ 9,551,367	$ 8,902,923
3. Public Health Services and Systems	$ 2,110,883	$ 1,462,439
4. Select the types of Non-Federally-supported "Direct Services", as reported in II.B.1. Provide the total amount of Non-Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 97,497
Physician/Office Services		$ 64,041
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 113,430
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 47,746
Laboratory Services		$ 59,571
Other		
CSS Food		$ 54,808
Direct Services Line 4 Expended Total		$ 437,093
Non-Federal Total	$ 12,100,000	$ 10,802,455

Form Notes for Form 3b:

None

Field Level Notes for Form 3b:

None

Form 4
Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated

State: Tennessee

Total Births by Occurrence: 85,045 **Data Source Year: 2020**

1. Core RUSP Conditions

Program Name	(A) Aggregate Total Number Receiving at Least One Valid Screen	(B) Aggregate Total Number of Out-of-Range Results	(C) Aggregate Total Number Confirmed Cases	(D) Aggregate Total Number Referred for Treatment
Core RUSP Conditions	84,735 (99.6%)	1,431	180	180 (100.0%)

Program Name(s)				
3-Hydroxy-3-Methyglutaric Aciduria	3-Methylcrotonyl-Coa Carboxylase Deficiency	Argininosuccinic Aciduria	Biotinidase Deficiency	Carnitine Uptake Defect/Carnitine Transport Defect
Citrullinemia, Type I	Classic Galactosemia	Classic Phenylketonuria	Congenital Adrenal Hyperplasia	Critical Congenital Heart Disease
Cystic Fibrosis	Glutaric Acidemia Type I	Glycogen Storage Disease Type II (Pompe)	Hearing Loss	Holocarboxylase Synthase Deficiency
Homocystinuria	Isovaleric Acidemia	Long-Chain L-3 Hydroxyacyl-Coa Dehydrogenase Deficiency	Maple Syrup Urine Disease	Medium-Chain Acyl-Coa Dehydrogenase Deficiency
Methylmalonic Acidemia (Cobalamin Disorders)	Methylmalonic Acidemia (Methylmalonyl-Coa Mutase)	Mucopolysaccharidosis Type 1	Primary Congenital Hypothyroidism	Propionic Acidemia
S, ßeta-Thalassemia	S,C Disease	S,S Disease (Sickle Cell Anemia)	Severe Combined Immunodeficiences	Spinal Muscular Atrophy Due To Homozygous Deletion Of Exon 7 In SMN1
ß-Ketothiolase Deficiency	Trifunctional Protein Deficiency	Tyrosinemia, Type I	Very Long-Chain Acyl-Coa Dehydrogenase Deficiency	X-Linked Adrenoleukodystrophy

2. Other Newborn Screening Tests

Program Name	(A) Total Number Receiving at Least One Screen	(B) Total Number Presumptive Positive Screens	(C) Total Number Confirmed Cases	(D) Total Number Referred for Treatment
2-Methyl-3-hydroxybutyric aciduria	84,735 (99.6%)	28	0	0 (0%)
2-Methylbutyrylglycinuria	84,735 (99.6%)	1	0	0 (0%)
3-Methylglutaconic aciduria	84,735 (99.6%)	28	0	0 (0%)
Argininemia	84,735 (99.6%)	1	0	0 (0%)
Biopterin defect in cofactor biosynthesis	84,735 (99.6%)	7	2	2 (100.0%)
Biopterin defect in cofactor regeneration	84,735 (99.6%)	7	2	2 (100.0%)
Carnitine acylcarnitine translocase deficiency	84,735 (99.6%)	31	0	0 (0%)
Methylmalonic acidemia with homocystinuria	84,735 (99.6%)	3	1	1 (100.0%)
Citrullinemia, type II	84,735 (99.6%)	8	0	0 (0%)
Carnitine palmitoyltransferase type I deficiency	84,735 (99.6%)	2	0	0 (0%)
Carnitine palmitoyltransferase type II deficiency	84,735 (99.6%)	31	0	0 (0%)
2,4 Dienoyl-CoA reductase deficiency	84,735 (99.6%)	1	0	0 (0%)
Glutaric acidemia type II	84,735 (99.6%)	34	0	0 (0%)
Galactoepimerase deficiency	84,735 (99.6%)	54	1	1 (100.0%)
Galactokinase deficiency	84,735 (99.6%)	54	0	0 (0%)
Benign hyperphenylalaninemia	84,735 (99.6%)	7	2	2 (100.0%)

Program Name	(A) Total Number Receiving at Least One Screen	(B) Total Number Presumptive Positive Screens	(C) Total Number Confirmed Cases	(D) Total Number Referred for Treatment
Isobutyrylglycinuria	84,735 (99.6%)	33	0	0 (0%)
Medium/short-chain L-3-hydroxyacl-CoA dehydrogenase deficiency	84,735 (99.6%)	28	0	0 (0%)
Malonic acidemia	84,735 (99.6%)	28	0	0 (0%)
Hypermethioninemia	84,735 (99.6%)	1	0	0 (0%)
Short-chain acyl-CoA dehydrogenase deficiency	84,735 (99.6%)	34	1	1 (100.0%)
Tyrosinemia, type II	84,735 (99.6%)	38	0	0 (0%)
Tyrosinemia, type III	84,735 (99.6%)	38	0	0 (0%)
Various other hemoglobinopathies	84,735 (99.6%)	12	8	8 (100.0%)
T-Cell related lymphocyte deficiencies	84,735 (99.6%)	45	2	2 (100.0%)
Hyperornithinemiahyperammonemia-homocitrullinemia	84,735 (99.6%)	0	0	0 (0%)
Non-ketotic hyperglycinemia	84,735 (99.6%)	30	0	0 (0%)
Carbamoyl phosphate synthetase I deficiency	84,735 (99.6%)	0	0	0 (0%)
Ornithine transcarbamylase deficiency	84,735 (99.6%)	0	0	0 (0%)

3. Screening Programs for Older Children & Women

None

4. Long-Term Follow-Up

Tennessee's Newborn Screening Follow-Up has a case management section which provides short-term follow up to monitor all cases with abnormal tests through to confirmatory testing and treatment initiation. The State contracts with tertiary specialty centers to assure follow-up and confirmatory testing for all infants with abnormal screens. The centers are required, by contract, to report the results (whether disease was confirmed) back to the State, and for cases in which disease was confirmed, the center reports the date on which treatment was started. Currently, the State does not monitor confirmed diagnosed infants beyond notification of diagnosis and treatment initiation by the contracted tertiary specialty center. However, the State provides infrastructure funding at each center to support long-term treatment, genetic testing for vulnerable individuals, and education/outreach.

Form Notes for Form 4:

None

Field Level Notes for Form 4:

None

Data Alerts: None

Form 5
Count of Individuals Served by Title V & Total Percentage of Populations Served by Title V

State: Tennessee

Annual Report Year 2020

Form 5a – Count of Individuals Served by Title V (Direct & Enabling Services Only)

		Primary Source of Coverage				
Types Of Individuals Served	(A) Title V Total Served	(B) Title XIX %	(C) Title XXI %	(D) Private / Other %	(E) None %	(F) Unknown %
1. Pregnant Women	11,480	54.0	0.0	12.0	34.0	0.0
2. Infants < 1 Year of Age	28,852	32.0	0.0	1.0	67.0	0.0
3. Children 1 through 21 Years of Age	160,285	35.0	0.0	14.0	51.0	0.0
3a. Children with Special Health Care Needs 0 through 21 years of age^	4,956	0.0	0.0	0.0	100.0	0.0
4. Others	116,507	9.0	0.0	8.0	83.0	0.0
Total	317,124					

Form 5b – Total Percentage of Populations Served by Title V (Direct, Enabling, and Public Health Services and Systems)

Populations Served by Title V	Reference Data	Used Reference Data?	Denominator	Total % Served	Form 5b Count (Calculated)	Form 5a Count
1. Pregnant Women	80,450	Yes	80,450	100.0	80,450	11,480
2. Infants < 1 Year of Age	86,066	Yes	86,066	100.0	86,066	28,852
3. Children 1 through 21 Years of Age	1,769,434	Yes	1,769,434	39.0	690,079	160,285
3a. Children with Special Health Care Needs 0 through 21 years of age^	399,429	Yes	399,429	3.0	11,983	4,956
4. Others	4,979,965	Yes	4,979,965	9.0	448,197	116,507

^Represents a subset of all infants and children.

Form Notes for Form 5:

None

Field Level Notes for Form 5a:

1.	**Field Name:**	**Pregnant Women Total Served**
	Fiscal Year:	**2020**
	Field Note: The majority of this count comes from women's health services in local health departments, including family planning.	
2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2020**
	Field Note: The majority of this count comes from TennCare (Medicaid) outreach efforts, well child visits in local health departments (mostly for TennCare enrollees), and general child health services in local health departments.	
3.	**Field Name:**	**Children 1 through 21 Years of Age**
	Fiscal Year:	**2020**
	Field Note: The majority of this count comes from TennCare (Medicaid) outreach efforts, as well as general child health services and reproductive health services in the local health departments.	
4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age**
	Fiscal Year:	**2020**
	Field Note: This count comes fro Children's Special Services, Tennessee's MCH/Title V Children with Special Health Care Needs program, in local health departments.	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2020**
	Field Note: The majority of this count comes from women's health services in the local health department.	

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women**
	Fiscal Year:	**2020**

Field Note:
This percentage is based on how many pregnant women were served through multiple programs during the reporting year. At this time de-duplication between programs is not possible therefore the percentage may be an overestimation.

Programs that serve this population include: Healthy Start (not the federal program), Home Visiting, Child Health and Development, Help Us Grow Successfully, Diabetes Prevention, Tobacco QuitLine, Local Health Department Services, Perinatal Centers, WIC, and Maternal Mortality Review.

2.	**Field Name:**	**InfantsLess Than One Year**
	Fiscal Year:	**2020**

Field Note:
This percentage is based on how many infants were served through multiple programs during the reporting year. At this time de-duplication between programs is not possible therefore the percentage may be an overestimation.

Programs that serve this population include: Healthy Start (not the federal program), Home Visiting, Child Health and Development, Help Us Grow Successfully, Poison Control, Birth Defect Follow Up, Local Health Department Services, Perinatal Centers, Newborn Metabolic Screening, Newborn Hearing Screening, WIC, SIDS, Sudden Death in the Young, Child Fatality Review and Prevention, Fetal Infant Mortality Review, Infant Mortality Reduction Initiative, and Child Safety Fund.

3.	**Field Name:**	**Children 1 Through 21 Years of Age**
	Fiscal Year:	**2020**

Field Note:
This percentage is based on how many children age 1-21 were served through multiple programs during the reporting year. At this time de-duplication between programs is not possible therefore the percentage may be an overestimation.

Programs that serve this population include: Healthy Start (not the federal program), Home Visiting, Child Health and Development, Help Us Grow Successfully, Diabetes Prevention, Poison Control, Chronic Disease, Tobacco QuitLine, Birth Defect Follow-Up, Local Health Department Services, Abstinence Education, Family Planning, Adolescent Pregnancy Prevention, Rape Prevention, Breast and Cervical Cancer Detection, Lead Poisoning Prevention, WIC, Unexplained Child Death, Sudden Death in the Young, Child Fatality Review and Prevention, Injury Surveillance and Prevention, Child Safety Fund and Traumatic Brain Injury.

4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age**
	Fiscal Year:	**2020**

Field Note:
This percentage is based on how many children with special health care needs were served through multiple programs during the reporting year. At this time de-duplication between programs is not possible therefore the percentage may be an overestimation.

Programs that serve this population include: Children Special Services, Birth Defect Follow-Up, Lead Poison Prevention, Genetics, Newborn Screening Follow-Up, and Newborn Hearing Follow Up.

5.	**Field Name:**	**Others**

Fiscal Year: **2020**

Field Note:
This percentage is based on how many other individuals were served through multiple programs during the reporting year. At this time de-duplication between programs is not possible therefore the percentage may be an overestimation.

Programs that serve this population include: Healthy Start (not the federal program), Home Visiting, Child Health and Development, Help Us Grow Successfully, Diabetes Prevention, Health Promotion, Poison Control, Chronic Disease, Tobacco QuitLine, Local Health Department Services, Abstinence Education, Family Planning, Adolescent Pregnancy Prevention, Rape Prevention, Breast and Cervical Cancer Detection, Genetics, WIC, Epilepsy, and Traumatic Brain Injury.

Data Alerts: None

Form 6
Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: Tennessee

Annual Report Year 2020

I. Unduplicated Count by Race/Ethnicity

	(A) Total	(B) Non-Hispanic White	(C) Non-Hispanic Black or African American	(D) Hispanic	(E) Non-Hispanic American Indian or Native Alaskan	(F) Non-Hispanic Asian	(G) Non-Hispanic Native Hawaiian or Other Pacific Islander	(H) Non-Hispanic Multiple Race	(I) Other & Unknown
1. Total Deliveries in State	88,027	60,217	16,684	8,366	162	1,861	243	0	494
Title V Served	88,027	60,217	16,684	8,366	162	1,861	243	0	494
Eligible for Title XIX	44,465	26,326	11,579	5,590	94	536	113	0	227
2. Total Infants in State	90,523	59,283	16,231	8,894	0	0	0	0	6,115
Title V Served	42,392	31,196	6,795	3,899	42	210	36	0	214
Eligible for Title XIX	52,973	26,644	16,426	7,655	0	0	0	2,248	0

Form Notes for Form 6:

None

Field Level Notes for Form 6:

None

Form 7
State MCH Toll-Free Telephone Line and Other Appropriate Methods Data

State: Tennessee

A. State MCH Toll-Free Telephone Lines	2022 Application Year	2020 Annual Report Year
1. State MCH Toll-Free "Hotline" Telephone Number	(615) 741-7353	(615) 741-7353
2. State MCH Toll-Free "Hotline" Name	Family Health and Wellness	Family Health and Wellness
3. Name of Contact Person for State MCH "Hotline"	Tobi Amosun	Tobi Amosun
4. Contact Person's Telephone Number	(615) 532-4131	(615) 532-4131
5. Number of Calls Received on the State MCH "Hotline"		0

B. Other Appropriate Methods	2022 Application Year	2020 Annual Report Year
1. Other Toll-Free "Hotline" Names	Tennessee Breastfeeding Hotline	Tennessee Breastfeeding Hotline
2. Number of Calls on Other Toll-Free "Hotlines"		4,969
3. State Title V Program Website Address	www.kidcentraltn.com	www.kidcentraltn.com
4. Number of Hits to the State Title V Program Website		128,753
5. State Title V Social Media Websites	www.facebook.com/TNDeptofHealth	www.facebook.com/TNDeptofHealth
6. Number of Hits to the State Title V Program Social Media Websites		9,999,999

Form Notes for Form 7:

None

Form 8
State MCH and CSHCN Directors Contact Information

State: Tennessee

1. Title V Maternal and Child Health (MCH) Director	
Name	Tobi Adeyeye Amosun, MD, FAAP
Title	Director, Division of Family Health and Wellness
Address 1	710 James Robertson Parkway
Address 2	8th Floor
City/State/Zip	Nashville / TN / 37243
Telephone	(615) 253-4131
Extension	
Email	jacqueline.johnson@tn.gov

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Jacqueline Johnson, MPA
Title	Section Chief, Children and Youth with Special Healthcare Needs
Address 1	710 James Robertson Parkway
Address 2	7th Floor
City/State/Zip	Nashville / TN / 37243
Telephone	(615) 741-0361
Extension	
Email	jacqueline.johnson@tn.gov

3. State Family or Youth Leader (Optional)	
Name	Tori Goddard
Title	Family Leader
Address 1	200 Paul Drive
Address 2	
City/State/Zip	Mt Juliet / TN / 37122
Telephone	(615) 335-7800
Extension	
Email	torigoddard@yahoo.com

Form Notes for Form 8:

None

Form 9
List of MCH Priority Needs

State: Tennessee

Application Year 2022

No.	Priority Need	Priority Need Type (New, Revised or Continued Priority Need for this five-year reporting period)
1.	Increase family planning	New
2.	Decrease pregnancy-associated mortality	New
3.	Increase breastfeeding	New
4.	Decrease infant mortality	Continued
5.	Decrease overweight and obesity among children	Continued
6.	Increase prevention and mitigation of Adverse Childhood Experiences (ACEs)	Continued
7.	Decrease tobacco and e-cigarette use among adolescents	Revised
8.	Increase medical homes among children with special healthcare needs	Revised
9.	Improve transition from pediatric to adult care among children with special health care needs	Continued
10.	Improve mental health	New

Form Notes for Form 9:

None

Field Level Notes for Form 9:

None

Form 9 State Priorities – Needs Assessment Year – Application Year 2021

No.	Priority Need	Priority Need Type (New, Revised or Continued Priority Need for this five-year reporting period)
1.	Increase family planning	New
2.	Decrease pregnancy-associated mortality	New
3.	Increase breastfeeding	New
4.	Decrease infant mortality	Continued
5.	Decrease overweight and obesity among children	Continued
6.	Increase prevention and mitigation of Adverse Childhood Experiences (ACEs)	Continued
7.	Decrease tobacco and e-cigarette use among adolescents	Revised
8.	Increase medical homes among children with special healthcare needs	Revised
9.	Improve transition from pediatric to adult care among children with special health care needs	Continued

Form Notes for Form 9:

None

Field Level Notes for Form 9:

None

Form 10
National Outcome Measures (NOMs)

State: Tennessee

Form Notes for Form 10 NPMs, NOMs, SPMs, SOMs, and ESMs.

Baseline will be established in FY2022

NOM 1 - Percent of pregnant women who receive prenatal care beginning in the first trimester

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	74.6 %	0.2 %	58,240	78,098
2018	75.6 %	0.2 %	56,759	75,035
2017	74.8 %	0.2 %	56,693	75,746
2016	74.2 %	0.2 %	51,493	69,385
2015	74.2 %	0.2 %	55,756	75,125
2014	74.2 %	0.2 %	56,654	76,364
2013	71.6 %	0.2 %	54,489	76,103
2012	70.4 %	0.2 %	53,419	75,885
2011	69.9 %	0.2 %	51,605	73,832
2010	70.6 %	0.2 %	52,663	74,579
2009	69.5 %	0.2 %	54,058	77,795

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 1 - Notes:

None

Data Alerts: None

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	79.4	3.4	562	70,742
2017	79.7	3.4	558	70,014
2016	73.8	3.4	480	65,006
2015	90.8	4.4	439	48,340
2014	90.9	3.8	587	64,567
2013	106.2	4.0	709	66,787
2012	96.1	3.8	635	66,091
2011	89.5	3.6	627	70,040
2010	82.2	3.5	572	69,591
2009	76.6	3.3	556	72,589
2008	76.1	3.2	570	74,884

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 2 - Notes:

None

Data Alerts: None

NOM 3 - Maternal mortality rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015_2019	26.4	2.6	107	404,709
2014_2018	24.9	2.5	101	405,861

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 3 - Notes:

None

Data Alerts: None

NOM 4 - Percent of low birth weight deliveries (<2,500 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	9.2 %	0.1 %	7,356	80,283
2018	9.3 %	0.1 %	7,471	80,473
2017	9.2 %	0.1 %	7,409	80,813
2016	9.3 %	0.1 %	7,431	80,084
2015	9.2 %	0.1 %	7,460	81,384
2014	9.0 %	0.1 %	7,297	81,441
2013	9.1 %	0.1 %	7,307	79,962
2012	9.2 %	0.1 %	7,377	80,318
2011	9.0 %	0.1 %	7,176	79,554
2010	9.0 %	0.1 %	7,179	79,451
2009	9.2 %	0.1 %	7,539	82,172

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 4 - Notes:

None

Data Alerts: None

NOM 5 - Percent of preterm births (<37 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	11.2 %	0.1 %	8,993	80,340
2018	11.1 %	0.1 %	8,911	80,541
2017	11.1 %	0.1 %	8,962	80,847
2016	11.3 %	0.1 %	9,085	80,340
2015	11.0 %	0.1 %	8,959	81,538
2014	10.8 %	0.1 %	8,780	81,497
2013	11.1 %	0.1 %	8,826	79,691
2012	11.2 %	0.1 %	8,961	79,807
2011	11.1 %	0.1 %	8,729	78,903
2010	11.4 %	0.1 %	8,988	78,936
2009	11.3 %	0.1 %	9,231	81,518

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 5 - Notes:

None

Data Alerts: None

NOM 6 - Percent of early term births (37, 38 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	28.6 %	0.2 %	22,962	80,340
2018	27.9 %	0.2 %	22,468	80,541
2017	27.6 %	0.2 %	22,338	80,847
2016	27.2 %	0.2 %	21,868	80,340
2015	26.6 %	0.2 %	21,662	81,538
2014	26.1 %	0.2 %	21,293	81,497
2013	26.2 %	0.2 %	20,856	79,691
2012	27.8 %	0.2 %	22,149	79,807
2011	28.9 %	0.2 %	22,784	78,903
2010	30.1 %	0.2 %	23,721	78,936
2009	31.5 %	0.2 %	25,645	81,518

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 6 - Notes:

None

Data Alerts: None

NOM 7 - Percent of non-medically indicated early elective deliveries

Data Source: CMS Hospital Compare

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019/Q1-2019/Q4	2.0 %			
2018/Q4-2019/Q3	2.0 %			
2018/Q3-2019/Q2	2.0 %			
2018/Q2-2019/Q1	2.0 %			
2018/Q1-2018/Q4	2.0 %			
2017/Q4-2018/Q3	2.0 %			
2017/Q3-2018/Q2	2.0 %			
2017/Q2-2018/Q1	2.0 %			
2017/Q1-2017/Q4	2.0 %			
2016/Q4-2017/Q3	2.0 %			
2016/Q3-2017/Q2	2.0 %			
2016/Q2-2017/Q1	2.0 %			
2016/Q1-2016/Q4	2.0 %			
2015/Q4-2016/Q3	2.0 %			
2015/Q3-2016/Q2	1.0 %			
2015/Q2-2016/Q1	2.0 %			
2015/Q1-2015/Q4	2.0 %			
2014/Q4-2015/Q3	2.0 %			
2014/Q3-2015/Q2	2.0 %			
2014/Q2-2015/Q1	2.0 %			
2014/Q1-2014/Q4	3.0 %			
2013/Q4-2014/Q3	3.0 %			
2013/Q3-2014/Q2	3.0 %			
2013/Q2-2014/Q1	4.0 %			

Legends:

NOM 7 - Notes:

None

Data Alerts: None

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	6.8	0.3	555	81,028
2017	6.8	0.3	549	81,276
2016	6.8	0.3	555	81,107
2015	6.4	0.3	521	81,958
2014	6.8	0.3	554	81,875
2013	7.0	0.3	558	80,281
2012	7.2	0.3	582	80,674
2011	7.4	0.3	595	79,909
2010	6.6	0.3	524	79,743
2009	6.8	0.3	561	82,469

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 8 - Notes:

None

Data Alerts: None

NOM 9.1 - Infant mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	6.9	0.3	556	80,751
2017	7.3	0.3	591	81,016
2016	7.4	0.3	594	80,807
2015	7.0	0.3	568	81,685
2014	6.9	0.3	561	81,602
2013	6.8	0.3	544	79,992
2012	7.2	0.3	582	80,371
2011	7.4	0.3	592	79,588
2010	7.9	0.3	626	79,495
2009	8.0	0.3	657	82,211

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.1 - Notes:

None

Data Alerts: None

NOM 9.2 - Neonatal mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	4.5	0.2	361	80,751
2017	4.6	0.2	372	81,016
2016	4.2	0.2	343	80,807
2015	4.1	0.2	335	81,685
2014	4.3	0.2	349	81,602
2013	4.2	0.2	333	79,992
2012	4.3	0.2	349	80,371
2011	4.6	0.2	365	79,588
2010	4.6	0.2	368	79,495
2009	4.8	0.2	396	82,211

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.2 - Notes:

None

Data Alerts: None

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	2.4	0.2	195	80,751
2017	2.7	0.2	219	81,016
2016	3.1	0.2	251	80,807
2015	2.9	0.2	233	81,685
2014	2.6	0.2	212	81,602
2013	2.6	0.2	211	79,992
2012	2.9	0.2	233	80,371
2011	2.9	0.2	227	79,588
2010	3.2	0.2	258	79,495
2009	3.2	0.2	261	82,211

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.3 - Notes:

None

Data Alerts: None

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	216.7	16.4	175	80,751
2017	201.2	15.8	163	81,016
2016	211.6	16.2	171	80,807
2015	189.8	15.3	155	81,685
2014	230.4	16.8	188	81,602
2013	193.8	15.6	155	79,992
2012	209.0	16.1	168	80,371
2011	214.9	16.5	171	79,588
2010	245.3	17.6	195	79,495
2009	255.4	17.7	210	82,211

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.4 - Notes:

None

Data Alerts: None

NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	153.6	13.8	124	80,751
2017	149.4	13.6	121	81,016
2016	153.5	13.8	124	80,807
2015	153.0	13.7	125	81,685
2014	111.5	11.7	91	81,602
2013	123.8	12.5	99	79,992
2012	164.2	14.3	132	80,371
2011	154.5	14.0	123	79,588
2010	171.1	14.7	136	79,495
2009	153.3	13.7	126	82,211

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.5 - Notes:

None

Data Alerts: None

NOM 10 - Percent of women who drink alcohol in the last 3 months of pregnancy

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	4.8 %	1.1 %	3,631	76,202
2015	5.5 %	1.0 %	4,299	78,404
2014	5.8 %	1.1 %	4,524	77,863
2013	4.8 %	1.0 %	3,677	77,144
2012	6.7 %	1.1 %	5,139	77,036
2009	5.6 %	1.1 %	4,474	79,825
2008	3.4 %	0.8 %	2,774	81,407

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

NOM 10 - Notes:

None

Data Alerts: None

NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	14.6	0.5	995	68,374
2017	16.2	0.5	1,099	67,827
2016	18.0	0.5	1,134	63,143
2015	16.9	0.6	793	46,904
2014	15.3	0.5	959	62,637
2013	12.5	0.4	815	65,309
2012	8.9	0.4	584	65,480
2011	6.0	0.3	414	69,570
2010	5.4	0.3	375	69,409
2009	4.3	0.2	311	72,741
2008	3.0	0.2	225	75,307

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 11 - Notes:

None

Data Alerts: None

NOM 12 - Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner. (DEVELOPMENTAL)

Federally available Data (FAD) for this measure is not available/reportable.

NOM 12 - Notes:

None

Data Alerts: None

NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

Federally available Data (FAD) for this measure is not available/reportable.

NOM 13 - Notes:

None

Data Alerts: None

NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	13.1 %	1.4 %	183,494	1,400,701
2017_2018	13.7 %	1.6 %	189,299	1,379,241
2016_2017	10.7 %	1.5 %	149,356	1,391,773
2016	8.9 %	1.6 %	124,646	1,402,272

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 14 - Notes:

None

Data Alerts: None

NOM 15 - Child Mortality rate, ages 1 through 9, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2019	20.7	1.7	154	742,209
2018	22.3	1.7	165	739,940
2017	23.3	1.8	173	741,775
2016	23.2	1.8	172	741,404
2015	18.3	1.6	135	739,432
2014	20.6	1.7	152	738,611
2013	21.1	1.7	156	738,334
2012	22.4	1.7	166	739,838
2011	20.0	1.7	147	736,697
2010	22.0	1.7	163	740,978
2009	20.0	1.7	148	738,731

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 15 - Notes:

None

Data Alerts: None

NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2019	42.0	2.2	359	855,582
2018	44.9	2.3	384	855,439
2017	43.5	2.3	370	850,432
2016	39.9	2.2	336	842,341
2015	39.8	2.2	335	840,920
2014	36.7	2.1	309	841,738
2013	35.5	2.1	299	841,885
2012	40.3	2.2	340	844,247
2011	37.1	2.1	315	848,300
2010	38.2	2.1	327	856,127
2009	42.4	2.2	363	855,924

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.1 - Notes:

None

Data Alerts: None

NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017_2019	15.9	1.1	203	1,274,577
2016_2018	15.3	1.1	195	1,272,255
2015_2017	15.5	1.1	197	1,267,849
2014_2016	15.1	1.1	191	1,262,485
2013_2015	14.1	1.1	177	1,259,614
2012_2014	15.5	1.1	195	1,260,128
2011_2013	16.9	1.2	214	1,267,375
2010_2012	18.9	1.2	243	1,285,474
2009_2011	19.2	1.2	250	1,302,264
2008_2010	21.7	1.3	285	1,312,853
2007_2009	28.1	1.5	368	1,307,973

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.2 - Notes:

None

Data Alerts: None

NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017_2019	12.0	1.0	153	1,274,577
2016_2018	13.2	1.0	168	1,272,255
2015_2017	12.4	1.0	157	1,267,849
2014_2016	11.2	0.9	142	1,262,485
2013_2015	10.1	0.9	127	1,259,614
2012_2014	9.8	0.9	123	1,260,128
2011_2013	8.7	0.8	110	1,267,375
2010_2012	7.8	0.8	100	1,285,474
2009_2011	7.8	0.8	102	1,302,264
2008_2010	7.2	0.7	94	1,312,853
2007_2009	7.1	0.7	93	1,307,973

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.3 - Notes:

None

Data Alerts: None

NOM 17.1 - Percent of children with special health care needs (CSHCN), ages 0 through 17

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	21.6 %	1.5 %	325,137	1,505,049
2017_2018	20.6 %	1.6 %	308,848	1,502,862
2016_2017	19.1 %	1.5 %	285,900	1,494,648
2016	19.0 %	1.9 %	282,585	1,488,549

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.1 - Notes:

None

Data Alerts: None

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	17.2 %	2.7 %	55,932	325,137
2017_2018	13.3 %	2.5 %	41,061	308,848
2016_2017	17.2 %	3.0 %	49,083	285,167
2016	20.7 %	4.5 %	58,242	281,120

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.2 - Notes:

None

Data Alerts: None

NOM 17.3 - Percent of children, ages 3 through 17, diagnosed with an autism spectrum disorder

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	3.3 %	0.7 %	41,516	1,243,702
2017_2018	3.0 %	0.6 %	37,557	1,253,631
2016_2017	2.0 %	0.6 %	24,820	1,232,350
2016	1.8 %	0.8 %	21,252	1,212,557

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.3 - Notes:

None

Data Alerts: None

NOM 17.4 - Percent of children, ages 3 through 17, diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	10.5 %	1.2 %	128,774	1,222,343
2017_2018	10.6 %	1.3 %	131,344	1,234,743
2016_2017	10.2 %	1.3 %	124,036	1,217,529
2016	10.1 %	1.6 %	121,186	1,201,276

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.4 - Notes:

None

Data Alerts: None

NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	42.7 %	5.3 %	82,660	193,489
2017_2018	40.6 %	5.6 %	84,514	207,992
2016_2017	41.7 %	6.2 %	69,811	167,435
2016	48.7 %	7.9 %	71,834	147,604

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 18 - Notes:

None

Data Alerts: None

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	87.9 %	1.3 %	1,319,049	1,500,238
2017_2018	88.7 %	1.4 %	1,326,928	1,495,696
2016_2017	89.7 %	1.3 %	1,336,207	1,488,972
2016	89.2 %	1.6 %	1,326,511	1,486,938

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 19 - Notes:

None

Data Alerts: None

NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

Data Source: WIC

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	15.2 %	0.2 %	6,693	44,025
2016	14.6 %	0.2 %	7,457	51,157
2014	14.9 %	0.2 %	8,083	54,429
2012	15.3 %	0.2 %	8,130	53,033
2010	16.0 %	0.2 %	9,126	57,153
2008	14.7 %	0.2 %	7,596	51,616

Legends:

Indicator has a denominator <50 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	20.9 %	1.4 %	57,059	273,316
2017	20.5 %	1.2 %	56,429	275,401
2015	18.6 %	1.0 %	49,124	263,806
2013	16.9 %	0.9 %	41,957	248,583
2011	15.2 %	0.8 %	40,424	266,111
2009	15.7 %	1.0 %	42,186	267,892
2007	16.8 %	0.9 %	45,330	269,544
2005	14.4 %	1.3 %	37,410	259,109

Legends:

Indicator has an unweighted denominator <100 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	20.4 %	2.4 %	130,946	642,532
2017_2018	16.7 %	2.5 %	111,281	666,245
2016_2017	15.6 %	2.3 %	98,467	631,225
2016	19.2 %	2.8 %	111,864	583,745

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 20 - Notes:

None

Data Alerts: None

NOM 21 - Percent of children, ages 0 through 17, without health insurance

Data Source: American Community Survey (ACS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	4.9 %	0.3 %	74,160	1,510,670
2018	4.7 %	0.3 %	70,287	1,509,769
2017	4.2 %	0.3 %	62,707	1,505,959
2016	3.5 %	0.3 %	52,909	1,502,677
2015	4.3 %	0.3 %	63,432	1,493,057
2014	5.2 %	0.3 %	77,115	1,493,436
2013	5.7 %	0.4 %	84,902	1,492,149
2012	5.6 %	0.4 %	83,030	1,492,012
2011	5.8 %	0.4 %	86,513	1,489,552
2010	5.3 %	0.3 %	79,838	1,499,117
2009	5.8 %	0.3 %	85,685	1,489,741

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 21 - Notes:

None

Data Alerts: None

NOM 22.1 - Percent of children who have completed the combined 7-vaccine series (4:3:1:3*:3:1:4) by age 24 months

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	69.0 %	4.4 %	56,000	81,000
2015	73.9 %	3.6 %	62,000	84,000
2014	63.8 %	4.2 %	54,000	84,000
2013	71.2 %	4.0 %	59,000	83,000
2012	66.4 %	4.5 %	55,000	83,000
2011	70.1 %	3.7 %	58,000	82,000

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate >1.2

Estimates with 95% confidence interval widths >20 or that are inestimable might not be reliable

NOM 22.1 - Notes:

None

Data Alerts: None

NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza

Data Source: National Immunization Survey (NIS) – Flu

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2020	63.7 %	1.7 %	904,896	1,420,559
2018_2019	62.1 %	1.8 %	883,469	1,423,801
2017_2018	61.5 %	2.1 %	867,500	1,411,591
2016_2017	57.4 %	2.0 %	799,927	1,393,844
2015_2016	61.8 %	1.9 %	865,797	1,400,513
2014_2015	61.8 %	2.0 %	871,825	1,409,807
2013_2014	60.2 %	2.0 %	836,358	1,390,019
2012_2013	56.4 %	2.3 %	789,668	1,400,851
2011_2012	50.4 %	2.7 %	695,541	1,379,253
2010_2011	56.6 %	3.8 %	777,299	1,373,320
2009_2010	48.9 %	3.9 %	617,746	1,263,285

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or because the relative standard error is >0.3.

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.2 - Notes:

None

Data Alerts: None

NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	61.9 %	3.7 %	263,805	425,944
2018	62.3 %	3.5 %	265,046	425,286
2017	56.1 %	3.4 %	238,814	425,789
2016	55.3 %	3.4 %	235,979	426,750
2015	48.7 %	3.3 %	207,308	425,570

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate > 1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.3 - Notes:

None

Data Alerts: None

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2019	89.1 %	2.4 %	379,649	425,944
2018	90.7 %	1.9 %	385,687	425,286
2017	89.4 %	2.0 %	380,743	425,789
2016	89.3 %	2.2 %	381,010	426,750
2015	79.7 %	2.7 %	339,136	425,570
2014	86.0 %	2.3 %	363,547	422,685
2013	80.0 %	2.7 %	338,276	422,624
2012	77.4 %	3.2 %	325,269	420,423
2011	67.6 %	3.2 %	283,974	420,127
2010	58.7 %	3.2 %	243,261	414,201
2009	48.0 %	3.1 %	199,390	415,570

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate > 1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.4 - Notes:

None

Data Alerts: None

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	79.3 %	3.0 %	337,888	425,944
2018	85.2 %	2.5 %	362,229	425,286
2017	75.0 %	3.1 %	319,476	425,789
2016	76.3 %	3.0 %	325,708	426,750
2015	76.7 %	2.9 %	326,284	425,570
2014	74.0 %	3.0 %	312,756	422,685
2013	67.8 %	3.1 %	286,448	422,624
2012	69.4 %	3.4 %	291,733	420,423
2011	63.3 %	3.3 %	265,999	420,127
2010	50.6 %	3.2 %	209,556	414,201
2009	52.1 %	3.1 %	216,515	415,570

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate >1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.5 - Notes:

None

Data Alerts: None

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	23.7	0.3	4,918	207,809
2018	25.3	0.4	5,258	207,756
2017	26.6	0.4	5,516	207,240
2016	28.0	0.4	5,766	206,065
2015	30.6	0.4	6,267	204,782
2014	33.2	0.4	6,756	203,551
2013	34.8	0.4	7,105	204,285
2012	38.4	0.4	7,910	205,905
2011	40.8	0.4	8,497	208,285
2010	43.5	0.5	9,254	212,929
2009	48.4	0.5	10,378	214,436

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 23 - Notes:

None

Data Alerts: None

NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	15.5 %	2.1 %	11,792	75,888
2015	15.4 %	1.6 %	12,063	78,110
2014	13.6 %	1.6 %	10,620	78,096
2013	18.1 %	1.8 %	13,695	75,835
2012	17.2 %	1.6 %	13,157	76,677

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

NOM 24 - Notes:

None

Data Alerts: None

NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	3.2 %	0.9 %	47,687	1,490,019
2017_2018	2.4 %	0.7 %	35,789	1,499,644
2016_2017	1.8 %	0.5 %	26,301	1,484,581
2016	2.1 %	0.8 %	30,908	1,471,004

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 25 - Notes:

None

Data Alerts: None

Form 10
National Performance Measures (NPMs)

State: Tennessee

NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Federally Available Data					
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective					75
Annual Indicator				74.6	76.0
Numerator				875,792	897,415
Denominator				1,174,631	1,180,193
Data Source				BRFSS	BRFSS
Data Source Year				2018	2019

Previous NPM-1 BRFSS data for survey years 2015, 2016 and 2017 that was pre-populated under the 2016, 2017 and 2018 Annual Report Years is no longer displayed since it is not comparable with 2018 survey data.

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	76.0	77.0	78.0	79.0	80.0	80.0

Field Level Notes for Form 10 NPMs:

None

NPM 3 - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	84.5	84.5
Numerator		
Denominator		
Data Source	Birth Statistical System	Birth Statistical System
Data Source Year	2020	2020
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	85.0	85.5	86.0	86.5	87.0	87.0

Field Level Notes for Form 10 NPMs:

None

NPM 4A - Percent of infants who are ever breastfed

Federally Available Data		
Data Source: National Immunization Survey (NIS)		
	2019	**2020**
Annual Objective		
Annual Indicator	82.2	75.8
Numerator	63,360	53,802
Denominator	77,089	70,947
Data Source	NIS	NIS
Data Source Year	2016	2017

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	83.0	84.0	85.0	86.0	87.0	87.0

Field Level Notes for Form 10 NPMs:

None

NPM 4B - Percent of infants breastfed exclusively through 6 months

Federally Available Data		
Data Source: National Immunization Survey (NIS)		
	2019	**2020**
Annual Objective		
Annual Indicator	24.5	27.2
Numerator	18,257	19,012
Denominator	74,506	69,987
Data Source	NIS	NIS
Data Source Year	2016	2017

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	26.0	28.0	30.0	32.0	34.0	36.0

Field Level Notes for Form 10 NPMs:

None

NPM 5A - Percent of infants placed to sleep on their backs

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	80	81	82	83	82
Annual Indicator	78.0	83.0	83.0	83.0	79.4
Numerator	58,899	63,387	63,387	63,387	59,805
Denominator	75,553	76,381	76,381	76,381	75,369
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2014	2015	2015	2015	2019

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	83.0	84.0	85.0	86.0	87.0	88.0

Field Level Notes for Form 10 NPMs:

None

NPM 5B - Percent of infants placed to sleep on a separate approved sleep surface

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2020
Annual Objective	31
Annual Indicator	37.9
Numerator	27,572
Denominator	72,769
Data Source	PRAMS
Data Source Year	2019

State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			0	31
Annual Indicator	0	0	0	
Numerator				
Denominator				
Data Source	No data source	No data source	No data source	
Data Source Year	No data	No data	No data	
Provisional or Final ?	Final	Final	Final	

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	32.0	33.0	34.0	35.0	36.0	37.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
Data will be available from PRAMS next year.

NPM 5C - Percent of infants placed to sleep without soft objects or loose bedding

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2020
Annual Objective	46
Annual Indicator	44.8
Numerator	32,496
Denominator	72,533
Data Source	PRAMS
Data Source Year	2019

State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			0	46
Annual Indicator	0	0	0	
Numerator				
Denominator				
Data Source	No data source	No data source	No data source	
Data Source Year	No data	No data	No data	
Provisional or Final ?	Final	Final	Final	

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	48.0	50.0	52.0	54.0	56.0	58.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
Data will be available from PRAMS next year.

NPM 8.1 - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CHILD					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			30.4	31.2	31.5
Annual Indicator		29.6	27.3	31.5	35.2
Numerator		152,452	140,812	163,612	176,434
Denominator		514,521	516,001	519,562	500,965
Data Source		NSCH-CHILD	NSCH-CHILD	NSCH-CHILD	NSCH-CHILD
Data Source Year		2016	2016_2017	2017_2018	2018_2019

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	31.9	32.2	36.0	37.0	38.0	40.0

Field Level Notes for Form 10 NPMs:

None

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			56.5	59.2	53.3
Annual Indicator		44.8	50.4	53.3	48.5
Numerator		125,986	143,840	164,583	157,666
Denominator		281,120	285,167	308,848	325,137
Data Source		NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017	2017_2018	2018_2019

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	60.0	65.0	70.0	75.0	80.0	85.0

Field Level Notes for Form 10 NPMs:

None

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			14.1	14.7	34.2
Annual Indicator		19.2	14.4	16.6	22.2
Numerator		16,734	17,666	26,590	30,583
Denominator		87,214	122,975	159,749	137,839
Data Source		NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017	2017_2018	2018_2019

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	40.0	45.0	50.0	55.0	60.0	65.0

Field Level Notes for Form 10 NPMs:

None

NPM 14.2 - Percent of children, ages 0 through 17, who live in households where someone smokes - Adolescent Health

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			29	23.8	
Annual Indicator		24.9	21.1	18.6	18.6
Numerator		362,200	311,958	276,334	271,871
Denominator		1,457,726	1,478,634	1,485,841	1,464,986
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018	2018_2019

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	19.4	19.2	19.1	19.0	18.8	18.7

Field Level Notes for Form 10 NPMs:

None

Form 10
National Performance Measures (NPMs) (2016-2020 Needs Assessment Cycle)

State: Tennessee

2016-2020: NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			27.5	28.2	28.2
Annual Indicator		26.2	37.2	42.4	35.6
Numerator		53,746	72,782	77,114	69,012
Denominator		205,002	195,708	181,726	193,946
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018	2018_2019

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Field Level Notes for Form 10 NPMs:

None

2016-2020: NPM 7.1 - Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9

Federally Available Data					
Data Source: HCUP - State Inpatient Databases (SID)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	109.8	107	104.4	101.8	99.2
Annual Indicator	109.1	109.1	100.1	122.6	118.7
Numerator	893	672	823	1,009	972
Denominator	818,595	615,938	822,424	822,681	818,914
Data Source	SID-CHILD	SID-CHILD	SID-CHILD	SID-CHILD	SID-CHILD
Data Source Year	2014	2015	2016	2017	2018

Field Level Notes for Form 10 NPMs:

None

2016-2020: NPM 7.2 - Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19

Federally Available Data					
Data Source: HCUP - State Inpatient Databases (SID)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	184.8	176.4	168	159.6	151.2
Annual Indicator	207.7	191.6	206.3	220.7	213.9
Numerator	1,746	1,206	1,738	1,877	1,830
Denominator	840,564	629,323	842,341	850,432	855,439
Data Source	SID-ADOLESCENT	SID-ADOLESCENT	SID-ADOLESCENT	SID-ADOLESCENT	SID-ADOLESCENT
Data Source Year	2014	2015	2016	2017	2018

Field Level Notes for Form 10 NPMs:

None

2016-2020: NPM 8.2 - Percent of adolescents, ages 12 through 17 who are physically active at least 60 minutes per day

Federally Available Data					
Data Source: Youth Risk Behavior Surveillance System (YRBSS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	26.9	27.7	28.5	23.4	23.9
Annual Indicator	25.9	25.9	25.6	25.6	21.6
Numerator	70,480	70,480	73,476	73,476	60,692
Denominator	272,118	272,118	286,547	286,547	281,239
Data Source	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT
Data Source Year	2015	2015	2017	2017	2019
Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - ADOLESCENT					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			28.5	23.4	23.9
Annual Indicator		22.4	21.5	16.9	12.7
Numerator		107,989	105,885	85,908	61,844
Denominator		481,757	491,600	509,523	488,141
Data Source		NSCH-ADOLESCENT	NSCH-ADOLESCENT	NSCH-ADOLESCENT	NSCH-ADOLESCENT
Data Source Year		2016	2016_2017	2017_2018	2018_2019

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Field Level Notes for Form 10 NPMs:

None

2016-2020: NPM 14.1 - Percent of women who smoke during pregnancy

Federally Available Data					
Data Source: National Vital Statistics System (NVSS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	14.4	13.9	13.4	12.4	11.9
Annual Indicator	14.3	13.4	12.8	12.2	11.5
Numerator	11,577	10,771	10,318	9,797	9,239
Denominator	80,953	80,306	80,363	80,177	80,213
Data Source	NVSS	NVSS	NVSS	NVSS	NVSS
Data Source Year	2015	2016	2017	2018	2019

Field Level Notes for Form 10 NPMs:

None

Form 10
State Performance Measures (SPMs)

State: Tennessee

SPM 1 - Percent of new mothers whose pregnancy was intended

Measure Status:	Active				
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		51.6	49.9	49.9	62
Annual Indicator	51.6	54.1	50.6	51.5	47.2
Numerator					
Denominator					
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2013	2014	2015	2017	2018
Provisional or Final ?	Final	Final	Provisional	Final	Final

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	62.0	63.0	63.0	64.0	64.0	65.0

Field Level Notes for Form 10 SPMs:

None

SPM 2 - Percent of facilities implementing patient safety recommendations

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	12.5	12.5	20.5	20.5	25.0	25.0

Field Level Notes for Form 10 SPMs:

None

SPM 3 - Number of community level recommendations implemented

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	10.0	10.0	20.0	20.0	25.0	25.0

Field Level Notes for Form 10 SPMs:

None

SPM 4 - Percent of newborns who initiated breastfeeding

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		80	82	84	80.7
Annual Indicator	78.2	79.8	80.9	80.8	82.6
Numerator					
Denominator					
Data Source	TDH PPA - Birth Statistical System	TDH PPA - Birth Statistical System	TDH PHA - Birth Statistical System	TDH PHA - Birth Statistical System	TDH PHA - Birth Statistical System
Data Source Year	CY2015	CY2016	CY2017	CY2017	CY2017
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	81.2	81.7	82.2	82.7	83.2	83.7

Field Level Notes for Form 10 SPMs:

None

SPM 5 - Percent of safe sleep diaper bag recipients who reported making a behavioral change in their infant sleep practices because of the items included in the bag

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	47.0	50.0	52.0	55.0	57.0

Field Level Notes for Form 10 SPMs:

None

SPM 6 - Percent of schools with at least 50% physical education class time spent in moderate to vigorous physical activity

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	10.0	20.0	30.0	40.0	50.0	60.0

Field Level Notes for Form 10 SPMs:

None

SPM 7 - Rate of Double Up Food Bucks purchases per SNAP recipient

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	0.0	0.0	0.0	0.0	0.0

Field Level Notes for Form 10 SPMs:

None

SPM 8 - Percent of children with two or more ACEs

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		27.5	27.5	24	23
Annual Indicator	27.5	27.5	24.6	24.1	23
Numerator					
Denominator					
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2011_2012	2011_2012	2016	2017	2018
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	22.5	22.0	21.6	21.2	21.0	20.4

Field Level Notes for Form 10 SPMs:

None

SPM 9 - Percent of substantiated child maltreatment cases among families served by home visiting programs

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	0.3	0.4	0.3	0.2	0.2	0.2

Field Level Notes for Form 10 SPMs:

None

SPM 10 - Percent of caregivers who experience intimate partner violence and do not receive professional support services among families served by home visiting

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	7.0	5.0	4.0	3.5	3.0	2.5

Field Level Notes for Form 10 SPMs:

None

SPM 11 - Percent of high school students currently using cigarettes

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	6.4	5.8	5.3	4.8	4.3	3.8

Field Level Notes for Form 10 SPMs:

None

SPM 12 - Percent of high school students currently using e-cigarettes

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	18.0	17.9	17.8	17.8	17.7	17.6

Field Level Notes for Form 10 SPMs:

None

SPM 13 - Number of adolescents enrolled in cessation program

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	0.0	20.0	50.0	100.0	120.0	150.0

Field Level Notes for Form 10 SPMs:

None

SPM 14 - Number of CYSHCN receiving care in a medical home

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	800.0	850.0	900.0	950.0	1,000.0	1,050.0

Field Level Notes for Form 10 SPMs:

None

SPM 15 - Percent of providers with increased knowledge on medical home and care coordination

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	25.0	35.0	50.0	65.0	75.0	85.0

Field Level Notes for Form 10 SPMs:

None

SPM 16 - Percent of providers reporting improved system of care for CYSCHN

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	35.0	50.0	65.0	75.0	85.0

Field Level Notes for Form 10 SPMs:

None

SPM 17 - Percent of families who complete an annual visit with their primary care provider

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	50.0	65.0	80.0	95.0	100.0

Field Level Notes for Form 10 SPMs:

None

SPM 18 - Percent of youth reporting with increased knowledge on transition resources and services

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	55.0	70.0	85.0	100.0	100.0

Field Level Notes for Form 10 SPMs:

None

SPM 19 - Precent of YSHCN served by CHANT and YAC who complete an annual transition plan

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	75.0	85.0	95.0	100.0	100.0

Field Level Notes for Form 10 SPMs:

None

SPM 20 - Precent of youth leaders participating in advisory councils providing resources to other youth

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	40.0	50.0	60.0	70.0	80.0

Field Level Notes for Form 10 SPMs:

None

SPM 21 - Percent of women who reported 14+ days of poor mental health in the past month

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	18.2	17.8	17.4	17.0	16.6

Field Level Notes for Form 10 SPMs:

None

SPM 22 - Percent of children who had difficulties obtaining mental health care among those who received or needed care during the past 12 months, age 3-17 years

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	25.0	24.0	23.0	22.0	21.0

Field Level Notes for Form 10 SPMs:

None

Form 10
State Outcome Measures (SOMs)

State: Tennessee

SOM 1 - Rate of pregnancy-associated mortality to live birth

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	95.6	93.2	90.0	89.5	88.2	87.0

Field Level Notes for Form 10 SOMs:

None

SOM 2 - Rate of pregnancy-related mortality to live births

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	25.6	24.2	23.5	22.0	20.5	19.0

Field Level Notes for Form 10 SOMs:

None

SOM 3 - Percent of public school 6th graders who are overweight or obese

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	43.3	42.9	42.6	42.2	41.9	41.9

Field Level Notes for Form 10 SOMs:

None

SOM 4 - Percent of WIC recipients aged 2-4 years who are overweight or obese

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	15.0	14.0	13.0	12.4	12.0

Field Level Notes for Form 10 SOMs:

None

SOM 5 - Percent of adults reporting Chronic obstructive pulmonary disease (COPD)

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	9.3	9.2	9.1	9.0	8.9	8.8

Field Level Notes for Form 10 SOMs:

None

SOM 6 - Percent of adults reporting cardiovascular disease

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	5.3	5.3	5.3	5.2	5.2	5.2

Field Level Notes for Form 10 SOMs:

None

SOM 7 - Age-adjusted mortality rate from tobacco-attributable cancers among Tennesseans aged 35+

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	176.4	171.4	166.4	161.3	156.3	141.3

Field Level Notes for Form 10 SOMs:

None

SOM 8 - Percent of pregnancy-associated deaths in which mental health conditions was a contributing factor

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	25.0	24.0	23.0	22.0	21.0

Field Level Notes for Form 10 SOMs:

None

Form 10
Evidence-Based or –Informed Strategy Measures (ESMs)

State: Tennessee

ESM 1.1 - Create pre/posttests to assesses provider knowledge of and confidence using PATH (Parenthood/Pregnancy Attitude, Timing, and How important is pregnancy prevention).

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	Yes	Yes	Yes	Yes	Yes

Field Level Notes for Form 10 ESMs:

None

ESM 1.2 - Percent of family planning encounters that occur via telehealth

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	0.4	0.8	1.6	3.2	6.4

Field Level Notes for Form 10 ESMs:

None

ESM 1.3 - Number of women receiving patient navigation for women's health services

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	250.0	250.0	250.0	250.0	250.0

Field Level Notes for Form 10 ESMs:

None

ESM 1.4 - Percent of birthing hospitals receiving training by TIPQC or THA

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	63.0	66.0	69.0	72.0	75.0

Field Level Notes for Form 10 ESMs:

None

ESM 1.5 - Percent of birthing hospital providers trained reporting a change in knowledge

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	77.0	79.0	81.0	83.0	85.0

Field Level Notes for Form 10 ESMs:

None

ESM 1.6 - Percent of non-clinical members participating in the action group

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	45.0	47.0	49.0	50.0	50.0	50.0

Field Level Notes for Form 10 ESMs:

None

ESM 1.7 - Percent of postpartum women with positive screenings for depression (using a validated screening tool) who will receive resources/education or referrals for professional services

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	95.0	97.0	98.0	100.0	100.0

Field Level Notes for Form 10 ESMs:

None

ESM 1.8 - Percent of recommendations with who/what/when components

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	75.0	79.0	84.0	89.0	94.0	98.0

Field Level Notes for Form 10 ESMs:

None

ESM 3.1 - Percent of Tennessee birthing hospitals participating in perinatal quality collaborative projects

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	33.0	33.0	33.0	33.0	33.0	33.0

Field Level Notes for Form 10 ESMs:

None

ESM 4.1 - Number of credentialed lactation professionals within WIC

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	166.0	176.0	186.0	196.0	206.0	216.0

Field Level Notes for Form 10 ESMs:

None

ESM 4.2 - Breastfeeding Welcomed Here (BFWH)-designated businesses with ideal workplace lactation policies

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	0.0	0.0	0.0	0.0	0.0	0.0

Field Level Notes for Form 10 ESMs:

None

ESM 4.3 - Recognition process implemented for Breastfeeding Welcomed Here (BFWH)-designated businesses

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	Yes	Yes	Yes	Yes	Yes	Yes

Field Level Notes for Form 10 ESMs:

None

ESM 5.6 - Percent of hospitals receiving national recognition or implementing approved safe sleep policy

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	100.0	100.0	100.0	100.0	100.0	100.0

Field Level Notes for Form 10 ESMs:

None

ESM 5.7 - Number of diaper bags with safe sleep educational materials distributed

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	663.0	676.0	690.0	704.0	718.0	732.0

Field Level Notes for Form 10 ESMs:

None

ESM 8.1.1 - Percent of physical education teachers receiving professional development related to 50% of PE class time spent in moderate to vigorous physical activity

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	5.0	15.0	25.0	35.0	45.0	55.0

Field Level Notes for Form 10 ESMs:

None

ESM 8.1.2 - Percentage of TN counties in which trainings related to mental health and physical health have occurred

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	10.0	20.0	30.0	40.0	50.0

Field Level Notes for Form 10 ESMs:

None

ESM 8.1.3 - Number of Gold Sneaker certified childcare facilities

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	700.0	850.0	950.0	1,000.0	1,050.0	1,100.0

Field Level Notes for Form 10 ESMs:

None

ESM 8.1.4 - Percent of LHD primary care clinics writing HPHP prescriptions annually

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	25.0	40.0	55.0	65.0	70.0

Field Level Notes for Form 10 ESMs:

None

ESM 8.1.5 - Number of Healthy Parks Healthy Person prescriptions written

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	125.0	250.0	350.0	450.0	550.0	650.0

Field Level Notes for Form 10 ESMs:

None

ESM 8.1.6 - Percentage of TN counties with completed built environment projects

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	20.0	30.0	40.0	50.0	60.0	70.0

Field Level Notes for Form 10 ESMs:

None

ESM 8.1.7 - Percent of eligible venues offering the Double Up Food Bucks Program

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	35.0	45.0	55.0	65.0	75.0	85.0

Field Level Notes for Form 10 ESMs:

None

ESM 8.1.8 - Percent of staff with an increase in ACEs and TIC knowledge as evidenced by post training evaluation

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	80.0	80.0	80.0	80.0	80.0

Field Level Notes for Form 10 ESMs:

None

ESM 8.1.9 - Percent of families with improved protective factors score

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	50.0	52.0	54.0	56.0	58.0	60.0

Field Level Notes for Form 10 ESMs:

None

ESM 8.1.10 - Percent of families enrolled in CHANT care coordination who partially or fully complete pathways identified

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	41.0	42.0	43.0	44.0	45.0	46.0

Field Level Notes for Form 10 ESMs:

None

ESM 11.5 - Number of CYSHCN who receive CHANT/CSS care coordination

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	2,500.0	3,000.0	3,500.0	4,000.0	4,500.0	5,000.0

Field Level Notes for Form 10 ESMs:

None

ESM 11.5 - Percent of providers adopting medical home approach

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	40.0	55.0	65.0	75.0	85.0

Field Level Notes for Form 10 ESMs:

None

ESM 11.6 - Number of families provided education and resources on importance of medical home access and utilization

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	600.0	700.0	800.0	900.0	1,000.0	1,100.0

Field Level Notes for Form 10 ESMs:

None

ESM 11.6 - Percent of providers reporting increased knowledge on systems of care

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	20.0	30.0	40.0	50.0	60.0

Field Level Notes for Form 10 ESMs:

None

ESM 11.7 - Number of families receiving referrals to their child's primary care provider

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	375.0	400.0	425.0	450.0	475.0	500.0

Field Level Notes for Form 10 ESMs:

None

ESM 11.7 - Percent of providers who report an increase in their knowledge of available resources

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	25.0	50.0	75.0	100.0	100.0

Field Level Notes for Form 10 ESMs:

None

ESM 11.8 - Percent of CHANT families who schedule an annual visit with their child's primary care provider

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	25.0	35.0	45.0	55.0	65.0	75.0

Field Level Notes for Form 10 ESMs:

None

ESM 11.8 - Percent of families who report an increase in access and utilization of resources

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	35.0	40.0	50.0	60.0	70.0

Field Level Notes for Form 10 ESMs:

None

ESM 11.9 - Percent of CYSHCN receiving CHANT care coordination who receive medical home education

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	75.0	85.0	95.0	100.0	100.0

Field Level Notes for Form 10 ESMs:

None

ESM 12.5 - Number of transition resource kits disseminated

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	150.0	300.0	600.0	1,200.0	2,400.0	2,400.0

Field Level Notes for Form 10 ESMs:

None

ESM 12.6 - Number of youth with special health care needs trained as mentors

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	25.0	35.0	45.0	55.0	65.0	75.0

Field Level Notes for Form 10 ESMs:

None

ESM 12.7 - Number of parents and youth with special health care needs who receive leadership and self-advocacy training

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	50.0	75.0	100.0	125.0	150.0	175.0

Field Level Notes for Form 10 ESMs:

None

ESM 14.2.1 - Number of tobacco-free sports teams

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	79.0	81.0	83.0	85.0	88.0	90.0

Field Level Notes for Form 10 ESMs:

None

ESM 14.2.2 - Number of social media posts promoting text-based cessation services

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	6.0	12.0	12.0	24.0	24.0	24.0

Field Level Notes for Form 10 ESMs:

None

ESM 14.2.3 - Number of anti-tobacco social media posts

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	6.0	12.0	12.0	24.0	24.0	24.0

Field Level Notes for Form 10 ESMs:

None

ESM 14.2.4 - Number of youth who attend the state anti-tobacco conference trainings

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	75.0	300.0	300.0	350.0	400.0	450.0

Field Level Notes for Form 10 ESMs:

None

ESM 14.2.5 - Number of ambassadors recruited

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	26.0	26.0	26.0	26.0	26.0	26.0

Field Level Notes for Form 10 ESMs:

None

Form 10
Evidence-Based or -Informed Strategy Measures (ESMs) (2016-2020 Needs Assessment Cycle)

2016-2020: ESM 1.1 - Number of press releases, PSAs and/or social media messages promoting preventive health care visits for women of reproductive age

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			9	20	20
Annual Indicator	6	46	21	21	22
Numerator					
Denominator					
Data Source	TDH FHW Womens Health Section Program Data	TDH FHW Womens Health Section Program Data	TDH FHW Womens Health Section Program Data	TDH FHW Womens Health Section Program Data	TDH FHW Womens Health Section Program Data
Data Source Year	FFY2016	FFY2017	2017	2018	2019
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

Field Note:
FY2018 performance based on data from 7/1 through 12/31 2017

2016-2020: ESM 1.2 - Number of webinars for providers on increasing preventive care visits among women in their clinics

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective				2	
Annual Indicator	0	7	22	33	11
Numerator					
Denominator					
Data Source	TDH FHW Womens Health Section Program Data	TDH FHW Womens Health Section Program Data	TDH FHW Womens Health Section Program Data	TDH FHW Womens Health Section Program Data	TDH FHW Womens Health Section Program Data
Data Source Year	FFY2016	FFY2017	2017	2018	2019
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

Field Note:
FY2018 performance based on data from 7/1 through 12/31 2017

2016-2020: ESM 1.3 - Number of site-level family planning utilization reports distributed to local health departments

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		4	4	2	2
Annual Indicator	0	2	2	2	2
Numerator					
Denominator					
Data Source	TDH FHW Womens Health Section Program Data	TDH FHW Womens Health Section Program Data	TDH FHW Womens Health Section Program Data	TDH FHW Womens Health Section Program Data	TDH FHW Womens Health Section Program Data
Data Source Year	FFY2016	FFY2017	2017	2018	2019
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

Field Note:
FY2018 performance based on data from 7/1 through 12/31 2017

2016-2020: ESM 1.4 - Number of region-level pregnancy-related service utilization reports distributed to regional health departments

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		4	4	2	2
Annual Indicator	4	4	2	2	2
Numerator					
Denominator					
Data Source	TDH FHW Womens Health Section Program Data	TDH FHW Womens Health Section Program Data	TDH FHW Womens Health Section Program Data	TDH FHW Womens Health Section Program Data	TDH FHW Womens Health Section Program Data
Data Source Year	FFY2016	FFY2017	2017	2018	2019
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

Field Note:
FY2018 performance based on data from 7/1 through 12/31 2017

2016-2020: ESM 5.1 - Number of safe sleep educational material distributed

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective				80,000	240,000
Annual Indicator	226,881	257,694	317,334	311,629	277,331
Numerator					
Denominator					
Data Source	TDH FHW Injury Prevention Section Program Data	TDH FHW Injury Prevention Section Program Data	TDH FHW Injury Prevention Section Program Data	TDH FHW Injury Prevention Section Program Data	TDH FHW Injury Prevention Section Program Data
Data Source Year	FFY2016	FFY2017	FFY2018	FFY2019	FFY2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 5.2 - Percent of infant deaths to be reviewed by child fatality review teams

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		100	100	100	100
Annual Indicator	100	100	100	100	100
Numerator					
Denominator					
Data Source	TDH FHW Injury Section Program Data - CFR Report	TDH FHW Injury Prevention Section Program Data	TDH FHW Injury Prevention Section Program Data	TDH FHW Injury Prevention Section Program Data	TDH FHW Injury Prevention Section Program Data
Data Source Year	CY2016	CY2017	CY2018	CY2019	CY2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 5.3 - Percent of VLBW (Very Low Birth Weight) infants being delivered at Level III or IV birthing facilities

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		80	80	85	85
Annual Indicator	84	85	85	84	83
Numerator					
Denominator					
Data Source	TDH PPA - Birth Statistical System	TDH PPA - Birth Statistical System	TDH PHA - Birth Statistical System	TDH PHA - Birth Statistical System	TDH PHA - Birth Statistical System
Data Source Year	FFY2016	FFY2017	FFY2018	FFY2019	FFY2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 5.4 - Percent of newborns with a positive metabolic screen who receive follow-up to definitive diagnosis and clinical management

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		100	100	100	100
Annual Indicator	100	100	100	100	100
Numerator					
Denominator					
Data Source	TDH FHW Perinatal Health Section Program Data	TDH FHW Perinatal Health Section Program Data	TDH FHW Perinatal Health Section Program Data	TDH FHW Perinatal Health Section Program Data	TDH FHW Perinatal Health Section Program Data
Data Source Year	CY2016	CY2017	CY2018	CY2019	CY2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 5.5 - Number of individuals served by the Tennessee Adolescent Pregnancy Prevention Program (TAPPP)

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective				46,500	47,000
Annual Indicator	45,881	47,159	55,583	47,597	38,609
Numerator					
Denominator					
Data Source	TDH FHW Womens Health Section Program Data	TDH FHW Womens Health Section Program Data	TDH FHW Womens Health Section Program Data	TDH FHW Womens Health Section Program Data	TDH FHW Womens Health Section Program Data
Data Source Year	FFY2015	FFY2016	FFY2017	FFY2018	FFY2019
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 6.1 - Number of unique page views to the Developmental Milestones and Developmental Screenings kidcentraltn.com sites

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			800	1,200	1,200
Annual Indicator	979	953	1,167	510	3,739
Numerator					
Denominator					
Data Source	TDH FHW Early Childhood Section Program Data	TDH FHW Early Childhood Section Program Data	TDH FHW Early Childhood Section Program Data	TDH FHW Early Childhood Section Program Data	TDH FHW Early Childhood Section Program Data
Data Source Year	FFY2016	FFY2017	FFY2018	FFY2019	FFY2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
The data collection system changed in 2019, numbers may not be comparable to previous years.

2016-2020: ESM 6.2 - Number of health department nurses trained in the START Autism and MCHAT-R/F program

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective				485	
Annual Indicator	450	526	576	627	695
Numerator					
Denominator					
Data Source	TDH CHS Program Data	TDH CHS Program Data	TDH CHS Program Data	TDH CHS Program Data	TDH CHS Program Data
Data Source Year	FFY2016	FFY2017	FFY2018	FFY2019	FFY2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 6.3 - Percent of Developmental Screenings performed across the state for participants enrolled in an Evidence-Based Home Visiting Program

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		90	90	91	92
Annual Indicator	89.2	76.1	86.7	71	66.5
Numerator					
Denominator					
Data Source	TDH FHW Early Childhood Section Program Data	TDH FHW Early Childhood Section Program Data	TDH FHW Early Childhood Section Program Data	TDH FHW Early Childhood Section Program Data	TDH FHW Early Childhood Section Program Data
Data Source Year	FFY2016	FFY2017	FFY2018	FFY2019	FFY2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 7.1.1 - Number of parents and caregivers receiving car seat education

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective				2,875	2,900
Annual Indicator	2,836	2,098	2,136	2,525	1,603
Numerator					
Denominator					
Data Source	TDH FHW Injury Prevention Section Program Data	TDH FHW Injury Prevention Section Program Data	TDH FHW Injury Prevention Section Program Data	TDH FHW Injury Prevention Section Program Data	TDH FHW Injury Prevention Section Program Data
Data Source Year	FFY2016	FFY2017	FFY2018	FFY2019	FFY2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 7.1.2 - Number of counties that adopt Count It! Drop It! Lock It! educational programs

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			48	93	
Annual Indicator	36	61	93	95	95
Numerator					
Denominator					
Data Source	TDH FHW Injury Prevention Section Program Data	TDH FHW Injury Prevention Section Program Data	TDH FHW Injury Prevention Section Program Data	TDH FHW Injury Prevention Section Program Data	TDH FHW Injury Prevention Section Program Data
Data Source Year	FFY2016	FFY2017	FFY2018	FFY2019	FFY2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 7.1.3 - Percent of families who receive injury prevention education through the AAP checklist among families participating in Evidence Based Home Visiting programs

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		85	87	89	91
Annual Indicator	81	36	46	54	60
Numerator					
Denominator					
Data Source	TDH FHW Early Childhood Section Program Data	TDH FHW Early Childhood Section Program Data	TDH FHW Early Childhood Section Program Data	TDH FHW Early Childhood Section Program Data	TDH FHW Early Childhood Section Program Data
Data Source Year	FFY2016	FFY2017	FFY2018	FFY2019	FFY2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 7.2.1 - Number of schools in the top ten crash rate counties (among ages 15-18) that conduct evidence-informed teen safe driving programming

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	
Annual Objective				59	
Annual Indicator	46	43	48	53	
Numerator					
Denominator					
Data Source	ReduceTNCrashes.org Safe Driving Report	ReduceTNCrashes.org Safe Driving Report	ReduceTNCrashes.org Safe Driving Report	ReduceTNCrashes.org Safe Driving Report	Reduce Safe
Data Source Year	FFY2016	FFY2017	FFY2018	FFY2019	
Provisional or Final ?	Final	Final	Final	Final	

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 7.2.2 - Number of drug disposal bins installed statewide

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective				326	341
Annual Indicator	206	236	311	350	356
Numerator					
Denominator					
Data Source	TN Depart of Environmental and Conservation Report	TN Depart of Environmental and Conservation Report	TN Depart of Environmental and Conservation Report	TN Depart of Environmental and Conservation Report	TN Depart of Environmental and Conservation Report
Data Source Year	FFY2106	FFY2017	FFY2018	FFY2019	FFY2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 7.2.3 - Number of press releases, social media posts and presentations about adolescent falls

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective				7	7
Annual Indicator	8	9	22	16	11
Numerator					
Denominator					
Data Source	TN Depart of Environmental and Conservation Report	TN Depart of Environmental and Conservation Report	TN Depart of Environmental and Conservation Report	TN Depart of Environmental and Conservation Report	TN Depart of Environmental and Conservation Report
Data Source Year	FFY2106	FFY2017	FFY2018	FFY2019	FFY2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 7.2.4 - Number of suicide-related articles, social media posts and trainings provided by TDH

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective				20	22
Annual Indicator	11	19	28	28	71
Numerator					
Denominator					
Data Source	TDH FHW Injury Prevention Section Program Data	TDH FHW Injury Prevention Section Program Data	TDH FHW Injury Prevention Section Program Data	TDH FHW Injury Prevention Section Program Data	TDH FHW Injury Prevention Section Program Data
Data Source Year	FFY2016	FFY2017	FFY2018	FFY2019	FFY2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 8.1.1 - Number of Gold Sneaker-recognized childcare facilities in Tennessee

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective				575	625
Annual Indicator	441	474	501	306	562
Numerator					
Denominator					
Data Source	TDH FHW Chronic Disease Program Data	TDH FHW Chronic Disease Program Data	TDH FHW Chronic Disease Program Data	TDH FHW Chronic Disease Program Data	TDH FHW Chronic Disease Program Data
Data Source Year	FFY2016	FFY2017	FFY2018	FFY2019	FFY2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 8.1.2 - Average number of monthly calls to the Tennessee Breastfeeding Hotline (TBH)

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**202**
Annual Objective				525	
Annual Indicator	485	523	520	475	
Numerator					
Denominator					
Data Source	TDH FHW SupplementalNutrition Section Program Data	TDH FHW SupplementalNutrition Section Program Data	TDH FHW SupplementalNutrition Section Program Data	TDH FHW SupplementalNutrition Section Program Data	TDH F Supplement Section F Dat
Data Source Year	FFY2016	FFY2017	FFY2018	FFY2019	FFY2
Provisional or Final ?	Final	Final	Final	Final	Fin

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 8.1.3 - Number of Baby Friendly-designated Tennessee birthing hospitals

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective				8	10
Annual Indicator	2	2	6	6	4
Numerator					
Denominator					
Data Source	Baby Friendly USA, Inc.	Baby Friendly USA, Inc.	Baby Friendly USA, Inc.	Baby Friendly USA, Inc.	Baby Friendly USA, Inc.
Data Source Year	FFY2106	FFY2017	FFY2018	FFY2019	FFY2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 8.2.1 - Number of Physical Activity Clubs in K-12 schools

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective				234	259
Annual Indicator	47	111	209	253	256
Numerator					
Denominator					
Data Source	TDH FHW Chronic Disease Program Data	TDH FHW Chronic Disease Program Data	TDH FHW Chronic Disease Program Data	TDH FHW Chronic Disease Program Data	TDH FHW Chronic Disease Program Data
Data Source Year	FFY2016	FFY2017	FFY2018	FFY2019	FFY2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 8.2.2 - Number of school gardens in Tennessee public schools

Measure Status:			Active	
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			451	476
Annual Indicator	337	426	348	348
Numerator				
Denominator				
Data Source	DOE - Farm to School Program	DOE - Farm to School Program	DOE - Farm to School Program	DOE - Farm to School Program
Data Source Year	FFY2017	FFY2018	FFY2019	FFY2020
Provisional or Final ?	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 8.2.3 - Number of Healthy Parks Healthy Person app users

Measure Status:			**Active**	
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			2,935	
Annual Indicator	1,661	2,853	4,928	8,787
Numerator				
Denominator				
Data Source	TDEC Healthy Parks Healthy Person App	TDEC Healthy Parks Healthy Person App	TDEC Healthy Parks Healthy Person App	TDEC Healthy Parks Healthy Person App
Data Source Year	FFY2017	FFY2018	FFY2019	FFY2020
Provisional or Final ?	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 11.1 - Number of providers trained and provided information on medical home implementation

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective				730	780
Annual Indicator	420	615	680	745	687
Numerator					
Denominator					
Data Source	TDH FHW Title V CYSHCN Program Data	TDH FHW Title V CYSHCN Program Data	TDH FHW Title V CYSHCN Program Data	TDH FHW Title V CYSHCN Program Data	TDH FHW Title V CYSHCN Program Data
Data Source Year	FFY2016	FFY2017	FFY2018	FFY2019	FFY2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 11.2 - Number of families that receive patient centered medical home training

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective				635	665
Annual Indicator	279	558	605	723	600
Numerator					
Denominator					
Data Source	TDH FHW Title V CYSHCN Program Data	TDH FHW Title V CYSHCN Program Data	TDH FHW Title V CYSHCN Program Data	TDH FHW Title V CYSHCN Program Data	TDH FHW Title V CYSHCN Program Data
Data Source Year	FFY2016	FFY2017	FFY2018	FFY2019	FFY2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 11.3 - Percentage of children served by the Children's Special Service (CSS) program receiving services in a medical home

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		80	85	90	95
Annual Indicator	74	72.7	73.5	70.5	75
Numerator					
Denominator					
Data Source	TDH FHW Title V CYSHCN Program Data	TDH FHW Title V CYSHCN Program Data	TDH FHW Title V CYSHCN Program Data	TDH FHW Title V CYSHCN Program Data	TDH FHW Title V CYSHCN Program Data
Data Source Year	FFY2016	FFY2017	FFY2018	FFY2019	FFY2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 11.4 - Number of children referred from the Tennessee Birth Defects Surveillance System (TNBDSS) program that were linked to appropriate supportive services

Measure Status:			**Active**
State Provided Data			
	2018	**2019**	**2020**
Annual Objective			100
Annual Indicator			41
Numerator			
Denominator			
Data Source			TDH FHW Title V CYSHCN Program Data
Data Source Year			2020
Provisional or Final ?			Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 12.1 - Number of adolescents on the Adolescent Advisory Council

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		5	7	9	11
Annual Indicator	7	7	7	14	23
Numerator					
Denominator					
Data Source	Title V CYSHCN Program Data	Title V CYSHCN Program Data	Title V CYSHCN Program Data	Title V CYSHCN Program Data	Title V CYSHCN Program Data
Data Source Year	FFY2016	FFY2017	FFY2018	FFY2019	FFY2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 12.2 - Number of providers who receive technical assistance and information on transition for youth and young adults with and without special health care needs

Measure Status:			Active	
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective		100	240	
Annual Indicator	0	215	450	380
Numerator				
Denominator				
Data Source	no data	TDH FHW Title V CYSHCN Program Data	TDH FHW Title V CYSHCN Program Data	TDH FHW Title V CYSHCN Program Data
Data Source Year	no data	FFY2018	FFY2019	FFY2020
Provisional or Final ?	Provisional	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 12.3 - Percentage of youth served by the Children's Special Services (CSS) program age 14 and older who have an annual transition plan

Measure Status:			Active	
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			80	85
Annual Indicator	65	60	54	45
Numerator				
Denominator				
Data Source	TDH FHW Title V CYSHCN Program Data	TDH FHW Title V CYSHCN Program Data	TDH FHW Title V CYSHCN Program Data	TDH FHW Title V CYSHCN Program Data
Data Source Year	FFY2017	FFY2018	FFY2019	FFY2020
Provisional or Final ?	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 12.4 - Number of youths and parents/legal guardians who have completed the Transition Readiness Assessment tool

Measure Status:			Active
State Provided Data			
	2018	**2019**	**2020**
Annual Objective			75
Annual Indicator			0
Numerator			
Denominator			
Data Source			TDH FHW Title V CYSHCN Program Data
Data Source Year			2020
Provisional or Final ?			Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 14.1.1 - Number of reproductive-aged female tobacco users (15-44 years) who received online or phone counseling services through the Tennessee Tobacco Quitline.

Measure Status:			**Active**	
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			800	880
Annual Indicator	624	599	567	372
Numerator				
Denominator				
Data Source	Tennessee Tobacco QuitLine Report	Tennessee Tobacco QuitLine Report	Tennessee Tobacco QuitLine Report	Tennessee Tobacco QuitLine Report
Data Source Year	FFY2017	FFY2018	FFY2019	FFY2020
Provisional or Final ?	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 14.2.1 - Number of child care facilities that voluntarily implement a tobacco-free campus policy

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective				570	615
Annual Indicator	441	474	501	306	549
Numerator					
Denominator					
Data Source	TDH FHW Chronic Disease Program Data	TDH FHW Chronic Disease Program Data	TDH FHW Chronic Disease Program Data	TDH FHW Chronic Disease Program Data	TDH FHW Chronic Disease Program Data
Data Source Year	FFY2016	FFY2017	FFY2018	FFY2019	FFY2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 14.2.2 - Percent of primary caregivers enrolled in home visiting who reported using any tobacco products at enrollments and were referred to tobacco cessation counseling or services within three months of enrollment

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		10	93	98.5	99
Annual Indicator	1.7	97.8	100	100	96.3
Numerator					
Denominator					
Data Source	TDH FHW Early Childhood Section Program Data	TDH FHW Early Childhood Section Program Data	TDH FHW Early Childhood Section Program Data	TDH FHW Early Childhood Section Program Data	TDH FHW Early Childhood Section Program Data
Data Source Year	FFY2016	FFY2017	FFY2018	FFY2019	FFY2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**

Field Note:
Data collection quality was poor in FY2016. Over the past year training was conducted for evidenced-based home visiting staff across the state to improve their understanding of what was considered a referral. Due to this training recent preliminary analysis shows that data collection quality has improved.

Form 10
State Performance Measure (SPM) Detail Sheets

State: Tennessee

SPM 1 - Percent of new mothers whose pregnancy was intended
Population Domain(s) – Women/Maternal Health

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To increase the percentage of new mothers whose pregnancy was intended</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of mothers reporting that their pregnancy was intended</td></tr>
<tr><td>Denominator:</td><td>Number of mothers that responded to the survey</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Pregnancy Risk Assessment Monitoring System (PRAMS)</td></tr>
<tr><td>Significance:</td><td>Unintended pregnancy is associated with increased risks for mothers and infants. If a woman is not planning to get pregnant, she may have unhealthy behaviors or delay getting health care during pregnancy, which can in turn affect her health and that of her infant. Most unintended pregnancies result from not using contraception or from not using it consistently or correctly. Family planning and contraceptive services provide social, economic, and health benefits and by allowing men and women to time and space the number of children they want, contraception prevents unintended, often high-risk pregnancies—too close together, too often, too early or too late in life—that can lead to maternal and child death and injury.</td></tr>
</table>

SPM 2 - Percent of facilities implementing patient safety recommendations
Population Domain(s) – Women/Maternal Health

Measure Status:	Active
Goal:	To reduce severe maternal morbidity and mortality through improved quality of care.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of birthing facilities implementing patient safety recommendations **Denominator:** Number of birthing facilities in Tennessee
Data Sources and Data Issues:	Maternal Mortality Review Information Application (MMRIA) and Vital Records Birth Statistical System
Significance:	Healthcare and other community-based agencies are strategically poised to identify at-risk populations for severe maternal morbidity and maternal mortality. Therefore, supporting these agencies is important in the secondary prevention of severe maternal morbidity and maternal deaths. This measure will be calculated as number of agencies funded with details on the populations they reach/serve.

SPM 3 - Number of community level recommendations implemented
Population Domain(s) – Women/Maternal Health

Measure Status:	Active
Goal:	To reduce severe maternal morbidity and mortality through community-level interventions.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of recommendations addressed at the community level **Denominator:** Number of recommendations addressed at the community level
Data Sources and Data Issues:	Maternal Mortality Review Information Application (MMRIA)
Significance:	Healthcare and other community-based agencies are strategically poised to identify at-risk populations for severe maternal morbidity and maternal mortality. Therefore, supporting these agencies is important in the secondary prevention of severe maternal morbidity and maternal deaths. This measure will be calculated as number of agencies funded with details on the populations they reach/serve.

SPM 4 - Percent of newborns who initiated breastfeeding
Population Domain(s) – Perinatal/Infant Health

Measure Status:	Active
Goal:	To increase the percent of Tennessee newborns who initiated breastfeeding
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of Tennessee newborns who initiated breastfeeding **Denominator:** Number of Tennessee newborns
Data Sources and Data Issues:	Tennessee Birth Statistical System
Significance:	Breastfeeding has a multitude of health benefits for both mother and infant. Initiation of breastfeeding has been associated with a reduction in infant mortality, so breastfeeding promotion and support warrants inclusion as a strategy of infant mortality reduction efforts.

SPM 5 - Percent of safe sleep diaper bag recipients who reported making a behavioral change in their infant sleep practices because of the items included in the bag
Population Domain(s) – Perinatal/Infant Health

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To increase the percentage of safe sleep diaper bag recipients who report making a behavioral change in their infant safe sleep practices because of the items included in the bag.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of safe sleep diaper bag recipients who report making a behavioral change in their infant safe sleep practices because of the items included in the bag</td></tr>
<tr><td>Denominator:</td><td>Number of evidence-based home visiting (EBHV) and Community Health Access and Navigation in Tennessee (CHANT) who reported receiving a safe sleep diaper bag from their home visitor</td></tr>
</table>
</td></tr>
<tr><td>Healthy People 2030 Objective:</td><td>Increase the proportion of infants who are put to sleep on their backs (MICH-14). Baseline: 78.7 percent of infants born in 2016 were put to sleep on their backs. Target: 88.9 percent. Data source: Pregnancy Risk Assessment Monitoring System (PRAMS), CDC/NCCDPHP.

Increase the proportion of infants who are put to sleep in a safe sleep environment (MICH-D03). No baseline data available.</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>REDCap CHANT and EBHV data collection tools</td></tr>
<tr><td>Significance:</td><td>The Safe Sleep Diaper Bag Project was created in 2018 to provide EBHV participants with 1) standardized safe sleep education from their home visitor and 2) a diaper bag containing materials with safe sleep messaging. In 2019, the project was expanded to also include participants of the CHANT program. Diaper bags include several useful materials to aid in safe sleep including a onesie, sleep sack, safe sleep door hanger, Sleep Baby Safe and Snug book, Calm Baby Gently book, and nightlight. As of July 2021, over 1600 safe sleep diaper bags have been distributed to EBHV and CHANT caregivers. When asked by their home visitor whether the items in the diaper bag had caused them to change how they put their infant to sleep, 35 percent of EBHV recipients and 53 percent of CHANT recipients reported making a change. Tennessee aims to continue increasing these percentages by using data collected so far to make adjustments shown to be associated with higher percentages of reported behavioral change, such as reaching parents in the prenatal period (rather than after the baby’s birth). Increasing the prevalence of the recommended safe sleep behaviors is critical to reducing the rate of sleep-related infant death in Tennessee, and partnering with EBHV and CHANT provides the opportunity to reach vulnerable, underserved parents.</td></tr>
</table>

SPM 6 - Percent of schools with at least 50% physical education class time spent in moderate to vigorous physical activity
Population Domain(s) – Child Health

Measure Status:	Active
Goal:	Increase the percentage of state public elementary and middle schools that provide or require moderate to vigorous physical education
Definition:	<table><tr><td>**Unit Type:**</td><td>Percentage</td></tr><tr><td>**Unit Number:**</td><td>100</td></tr><tr><td>**Numerator:**</td><td>Number of schools completing the survey and providing a positive response for the “50% moderate/vigorous physical education” question</td></tr><tr><td>**Denominator:**</td><td>Number of schools completing the survey and providing a valid response for the “50% moderate/vigorous physical education” question</td></tr></table>
Healthy People 2030 Objective:	Reduce the proportion of children and adolescents with obesity — NWS04 Increase the proportion of children who do enough aerobic physical activity — PA09
Data Sources and Data Issues:	The Coordinated School Health (CSH) annual Quality Physical Education Survey, which is completed by the lead physical education teacher at each LEA school. There is currently no baseline data for this state performance measure. A question is being added to the annual TDE Quality Physical Education Survey in the fall of 2021 that will provide those data. Target values for subsequent years will be set at that time.
Significance:	Given the huge proportion of the week that most children spend in school, regular physical education can go a long way toward satisfying the daily standard for physical activity within the elementary and middle school age groups. The values will include a simple count of all public elementary and middle schools statewide and a count of those schools indicating on the QPE Survey that they provide physical education for their students that includes moderate or vigorous physical activity at least half of the PE class period.

SPM 7 - Rate of Double Up Food Bucks purchases per SNAP recipient
Population Domain(s) – Child Health

Measure Status:	Active
Goal:	To increase the rate of Double Up Food Buck purchases transacted at eligible venues (e.g., farmers' markets and farmers' stores) in counties targeted by Nourish Knoxville per each SNAP recipient residing in those counties.
Definition:	**Unit Type:** Ratio **Unit Number:** 1 **Numerator:** Number of Double Up Food Bucks purchases transacted in the targeted counties **Denominator:** Total number of SNAP recipients in the targeted counties
Healthy People 2030 Objective:	NWS-04: Reduce the proportion of children and adolescents with obesity; NWS-06: Increase fruit consumption by people by aged 2 years and older; NWS-07: Increase vegetable consumption by people aged 2 years and older; NWS-08: Increase consumption of dark green vegetables, red and orange vegetables, and beans and peas by people aged 2 years and over; NWS-02: Eliminate very low food security in children
Data Sources and Data Issues:	Nourish Knoxville tracking database and program reports related to Double Up Food Bucks purchases and the Department of Human Services (DHS) database and website of aggregate SNAP recipients in the targeted counties (currently six); no known data issues.
Significance:	The consumption of healthier foods, especially fruits and vegetables, and healthier beverages is critical to maintaining or achieving healthy weight. Studies have shown that affordability of healthy food choices is often a barrier that influences access to foods that support healthy eating patterns. Concerted community planning and action among a diversified network of partners is critical to addressing low food security and increasing availability, access, affordability, and consumption related to healthier food and beverage options. Farmers' markets and farmers' stores, the TN Department of Health, the TN Department of Human Services (SNAP), and organizations such as Nourish Knoxville are key stakeholders in this effort. Partnerships can leverage shared resources in an effective and efficient manner. Values for this measure will be the number of Double Up Bucks purchases reimbursed by Nourish Nashville and well as the number of DHS SNAP recipients in the target geographic area.

SPM 8 - Percent of children with two or more ACEs
Population Domain(s) – Child Health

Measure Status:	Active
Goal:	To decrease the percent of children who experience 2 or more ACEs
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of children with 2 or more adverse childhood experiences **Denominator:** Number of children aged 0 -17 years
Data Sources and Data Issues:	NSCH- Limitation(s): 1) Data available upon release from the NSCH.
Significance:	Adverse childhood experiences (ACEs) are traumatic events occurring before age 18. ACEs include all types of abuse and neglect as well as parental mental illness, substance use, divorce, incarceration, and domestic violence. A landmark study in the 1990s found a significant relationship between the number of ACEs a person experienced and a variety of negative outcomes in adulthood, including poor physical and mental health, substance abuse, and risky behaviors. The more ACEs experienced, the greater the risk for these outcomes. The NSCH conducts a survey annually, which included tools to estimate the percent of children who experience one or more ACEs of the nine ACEs including child maltreatment, mental depression, IPV etc.

SPM 9 - Percent of substantiated child maltreatment cases among families served by home visiting programs
Population Domain(s) – Child Health

Measure Status:	Active
Goal:	To decrease percentage of children enrolled in home visiting that experience child maltreatment (i.e., substantiated claims to DCS)
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of children enrolled in a home visiting program who experience maltreatment (substantiated case) **Denominator:** Number of children enrolled in a home visiting program
Data Sources and Data Issues:	The number of substantiated child maltreatment cases among children enrolled in home visiting (i.e., the numerator) comes from a merged DCS file; EBHV REDCap Data Collection System. Data Issues: Because this measure is collaborative, it can only move forward as the merge is completed by DCS.
Significance:	The Injury and Violence Prevention goal of Healthy People 2020 is “prevent unintentional injuries and violence, and reduce their consequences.” Childhood abuse- physical, emotional, or sexual- is one of the ten categories of adverse childhood experiences. Prevention strategies of this ACE include increasing parenting skills and the promotion of strong, caring adult relationships by means of such programming as home visiting. We have chosen to focus on this measure as home visiting is potentially a prevention strategy of ACEs that will impact the aforementioned HP strategy. Centers for Disease Control and Prevention, Kaiser Permanente. The ACE Study Survey Data [Unpublished Data]. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention; 2016. Healthy People 2020 [Internet]. Washington, DC: U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion [cited 06/18/20].

SPM 10 - Percent of caregivers who experience intimate partner violence and do not receive professional support services among families served by home visiting
Population Domain(s) – Child Health

Measure Status:	Active
Goal:	To increase the percentage of enrolled home visiting caregivers who experience intimate partner violence and receive professional services.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of primary caregivers who screen positive for IPV but are not referred to professional support services **Denominator:** Number of primary caregivers who screen positive for IPV
Data Sources and Data Issues:	EBHV REDCAP Data Collection System, HITS Screen
Significance:	The Injury and Violence Prevention goal of Healthy People 2020 is “prevent unintentional injuries and violence, and reduce their consequences.” Injury and violence occurrences have been associated to premature death, an increase in years of potential life lost, depreciating mental health, and higher medical costs. This priority measure looks at how those that are and have previously experienced intimate partner violence are receiving professional services, which could possibly reduce the number of occurrences of the listed, negatively- associated health outcomes. The adverse child experience of witnessing domestic violence in the home could be mitigated by rehabilitative services received by a caregiver and thereby positively impact long-term health outcomes. Centers for Disease Control and Prevention, Kaiser Permanente. The ACE Study Survey Data [Unpublished Data]. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention; 2016. Child and Adolescent Health Measurement Initiative. 2017-2018 National Survey of Children’s Health (NSCH) data query. Data Resource Center for Child and Adolescent Health supported by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB).Retrieved [06/18/20] from [www.childhealthdata.org]. Healthy People 2020 [Internet]. Washington, DC: U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion [cited 06/18/20].

SPM 11 - Percent of high school students currently using cigarettes
Population Domain(s) – Adolescent Health

Measure Status:	Active
Goal:	To decrease the number of adolescents who smoke cigarettes
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number (weighted) of TN public high school students reporting current (past 30 day) use of cigarette(s) **Denominator:** Number (weighted) of TN public high school students responding to current cigarette use question
Healthy People 2030 Objective:	TU-04 Reduce current tobacco use in adolescents TU-10 Eliminate cigarette smoking initiation in adolescents and young adults
Data Sources and Data Issues:	Youth Risk Behavior Surveillance System (YRBS), biennial survey
Significance:	This metric is one of the most important intermediate goals for tobacco control, denoting the current burden of combustible cigarette use among TN public high school students. Changes in this trend and its demographic distributions inform the Tobacco Control Program's goals, activities, and resource allocation. Achieving low prevalence of combustible cigarette use among adolescents is paramount to reducing the overall health burden tobacco places on Tennessee's broader population in the future.

SPM 12 - Percent of high school students currently using e-cigarettes
Population Domain(s) – Adolescent Health

Measure Status:	Active
Goal:	To reduce the number of adolescents currently using e-cigarettes
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number (weighted) of public high school students reporting current (past 30 day) use of e-cigarette(s) **Denominator:** Number (weighted) of public high school students responding to current e-cigarette use question
Healthy People 2030 Objective:	TU-04 Reduce current tobacco use in adolescents TU-10 Eliminate cigarette smoking initiation in adolescents and young adults
Data Sources and Data Issues:	Youth Risk Behavior Surveillance System (YRBS), biennial survey
Significance:	Similar to combustible cigarette use, this metric is one of the most important intermediate goals for tobacco control, denoting the current burden of emerging tobacco product (including e-cigarette) use among TN public high school students. Changes in this trend and its demographic distributions inform the Tobacco Control Program's goals, activities, and resource allocation. Achieving low prevalence of e-cigarette use among adolescents is paramount to reducing the overall health burden tobacco use places on Tennessee's broader population in the future.

SPM 13 - Number of adolescents enrolled in cessation program
Population Domain(s) – Adolescent Health

Measure Status:	Active
Goal:	To increase the number of youth who enroll in tobacco cessation programs
Definition:	**Unit Type:** Count **Unit Number:** 150 **Numerator:** Number of adolescent-aged unique enrollees to cessation program **Denominator:**
Healthy People 2030 Objective:	TU-04 Reduce current tobacco use in adolescents
Data Sources and Data Issues:	Tennessee Tobacco Quitline & American Lung Association N-O-T: Not On Tobacco Program
Significance:	Adolescent utilization of cessation programs in Tennessee has historically been low, despite a growing proportion of youth using or experimenting with e-cigarettes and other emerging products. Additionally, standardized guidelines and recommendations for health care professionals to promote and support cessation attempts among adolescents is absent. Given the emerging public health issue of youth e-cigarette and emerging product use, TUPCP seeks to fill a key gap in assisting adolescents to quit using tobacco products and e-cigarettes in Tennessee.

SPM 14 - Number of CYSHCN receiving care in a medical home
Population Domain(s) – Children with Special Health Care Needs

Measure Status:	Active
Goal:	To increase the number of CYSHCN receiving care in medical home
Definition:	**Unit Type:** Count **Unit Number:** 1,050 **Numerator:** Number of CYSHCN receiving care in medical home **Denominator:**
Data Sources and Data Issues:	Data source: PTBMIS Limitation: The question asked is “have you had annual exam at your primary care provider’s office in the past 12 months”. Having annual exam at PCP is not equivalent to medical home.
Significance:	It is important to ensure the children with special healthcare needs served by the Tennessee Children’s Special Services program receive preventive services in medical home setting.

SPM 15 - Percent of providers with increased knowledge on medical home and care coordination
Population Domain(s) – Children with Special Health Care Needs

Measure Status:	Active
Goal:	To increase the percent of providerswith increased knowledge of medical home and care coordination
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of providers with increased knowledge of medical home and care coordination **Denominator:** Number of providers recieving education and resources
Healthy People 2030 Objective:	MICH-30.1 Increase the proportion of children who have access to a medical home – 63.3% MICH-30.2 Increase the proportion of children with special health care needs who have access to a medical home – 51.8% MICH-31.1 Increase the proportion of children aged 0 to 11 years with special health care needs who receive their care in family-centered, comprehensive, and coordinated systems – 22.4% MICH-31.2 Increase the proportion of children aged 12 to 17 years with special health care needs who receive their care in family-centered, comprehensive, coordinated systems – 15.1%
Data Sources and Data Issues:	Data source: The program plans to provide training, education and resources and conduct a survey among those providers receiving the information. Limitation: Not all providers surveyed will return the survey with complete answers.
Significance:	Increased knowledge among providers on medical home best practices is expected to result in increased adoption in their practices, resulting in increased access and utilization of the medical home.

SPM 16 - Percent of providers reporting improved system of care for CYSCHN
Population Domain(s) – Children with Special Health Care Needs

Measure Status:	Active
Goal:	To increase the percent of providers reporting an improved system of care for CYSHCN.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of providers surveyed who provided answers to the question reporting improved system of care in their practice **Denominator:** Number of providers provided information on systems of care
Healthy People 2030 Objective:	MICH-30.1 Increase the proportion of children who have access to a medical home – 63.3% MICH-30.2 Increase the proportion of children with special health care needs who have access to a medical home – 51.8% MICH-31.1 Increase the proportion of children aged 0 to 11 years with special health care needs who receive their care in family-centered, comprehensive, and coordinated systems – 22.4% MICH-31.2 Increase the proportion of children aged 12 to 17 years with special health care needs who receive their care in family-centered, comprehensive, coordinated systems – 15.1%
Data Sources and Data Issues:	Program plans to conduct a survey among providers. Limitation: Not all providers surveyed will respond.
Significance:	Providers with better knowledge of systems of care are more likely to practice medical home approach services to children under their care.

SPM 17 - Percent of families who complete an annual visit with their primary care provider
Population Domain(s) – Children with Special Health Care Needs

Measure Status:	Active
Goal:	To increase the percentage of children who complete an annual visit with their primary care provider.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of children who complete an annual primary care visit in the medical home **Denominator:** Number of children/youth referred for an annual primary care visit in the medical home
Healthy People 2030 Objective:	MICH-30.1 Increase the proportion of children who have access to a medical home – 63.3% MICH-30.2 Increase the proportion of children with special health care needs who have access to a medical home – 51.8% MICH-31.1 Increase the proportion of children aged 0 to 11 years with special health care needs who receive their care in family-centered, comprehensive, and coordinated systems – 22.4% MICH-31.2 Increase the proportion of children aged 12 to 17 years with special health care needs who receive their care in family-centered, comprehensive, coordinated systems – 15.1%
Data Sources and Data Issues:	Data source: CHANT REDCap data, Call Center data system Limitation: matching data from different data systems
Significance:	It is important to ensure that children and families receive annual medical exams and preventive care in an assigned medical home setting especially for continuity of care and detecting potential problems early.

SPM 18 - Percent of youth reporting with increased knowledge on transition resources and services
Population Domain(s) – Children with Special Health Care Needs

Measure Status:	Active
Goal:	To increase the percent of youth surveyed with increased knowledge on transition resources and services.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of youth reporting increased knowledge on transition resources and services **Denominator:** Number of youth provided education and resources on transition resources and services
Healthy People 2030 Objective:	MICH-30.1 Increase the proportion of children who have access to a medical home – 63.3% MICH-30.2 Increase the proportion of children with special health care needs who have access to a medical home – 51.8% MICH-31.1 Increase the proportion of children aged 0 to 11 years with special health care needs who receive their care in family-centered, comprehensive, and coordinated systems – 22.4% MICH-31.2 Increase the proportion of children aged 12 to 17 years with special health care needs who receive their care in family-centered, comprehensive, coordinated systems – 15.1%
Data Sources and Data Issues:	Data source: The program plans to provide training, education and resources and conduct a survey among youth that participate in the youth advisory conference. Limitation: Not all youth attending the conference will complete and return the survey with complete answers.
Significance:	Increased knowledge among youth on transition resources and services is expected to result in increased development and completion of an annual transition plan.

SPM 19 - Precent of YSHCN served by CHANT and YAC who complete an annual transition plan
Population Domain(s) – Children with Special Health Care Needs

Measure Status:	Active
Goal:	To increase each year by 3 persons the number of youth participating in advisory councils and state policy development.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of youth served by CHANT and YAC who complete an annual transition plan **Denominator:** Number of YSHCN who are served by CHANT and YAC
Healthy People 2030 Objective:	MICH-30.1 Increase the proportion of children who have access to a medical home – 63.3% MICH-30.2 Increase the proportion of children with special health care needs who have access to a medical home – 51.8% MICH-31.1 Increase the proportion of children aged 0 to 11 years with special health care needs who receive their care in family-centered, comprehensive, and coordinated systems – 22.4% MICH-31.2 Increase the proportion of children aged 12 to 17 years with special health care needs who receive their care in family-centered, comprehensive, coordinated systems – 15.1% DH-5 Increase the proportion of youth with special health care needs whose health care provider has discussed transition planning from pediatric to adult health care – 41.2%
Data Sources and Data Issues:	Data source: PTBMIS and REDCap. Limitation: Not all YSHCN will receive services through CHANT nor YAC
Significance:	The program is to encourage active participation and involvement of the youth in developing and completing an annual transition plan.

SPM 20 - Precent of youth leaders participating in advisory councils providing resources to other youth
Population Domain(s) – Children with Special Health Care Needs

Measure Status:	Active
Goal:	To increase each year by 3 persons the number of youth participating in advisory councils and state policy development.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of youth participating in advisory councils providing resources to other youth **Denominator:** Number of youth participating in advisory councils
Healthy People 2030 Objective:	MICH-30.1 Increase the proportion of children who have access to a medical home – 63.3% MICH-30.2 Increase the proportion of children with special health care needs who have access to a medical home – 51.8% MICH-31.1 Increase the proportion of children aged 0 to 11 years with special health care needs who receive their care in family-centered, comprehensive, and coordinated systems – 22.4% MICH-31.2 Increase the proportion of children aged 12 to 17 years with special health care needs who receive their care in family-centered, comprehensive, coordinated systems – 15.1% DH-5 Increase the proportion of youth with special health care needs whose health care provider has discussed transition planning from pediatric to adult health care – 41.2%
Data Sources and Data Issues:	Data source: Program records.
Significance:	The program is to encourage active participation and involvement of the youth and develop mentor-mentee relationships that will assist youth in completing a successful transition to adult care.

SPM 21 - Percent of women who reported 14+ days of poor mental health in the past month
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active
Goal:	To decrease the percent of women who reported 14+ days of poor mental health in the past month
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of women who reported 14+ days when mental health was not good **Denominator:** Total number of female respondents
Healthy People 2030 Objective:	Related to Mental Health and Mental Disorders (MHMD) Objective 01: Reduce the suicide rate. (Baseline: 14.2 suicides per 100,000 population occurred in 2018 (age adjusted to the year 2000 standard population), Target: 12.8 suicides per 100,000 population)
Data Sources and Data Issues:	Tennessee Behavioral Risk Factor Surveillance System (https://www.tn.gov/content/dam/tn/health/documents/brfss/TN19CALC.pdf)
Significance:	Mental health conditions are among the most common health conditions in the United States. According to the World Health Organization, more than 50% of people will be diagnosed with a mental illness or disorder at some point in their lifetime.1 Mental health is an important component of overall health and wellbeing and impacts chronic health conditions, such as heart disease. This measure will be obtained from the Tennessee Behavioral Risk Factor Surveillance System. 1 Kessler RC, Angermeyer M, Anthony JC, et al. Lifetime prevalence and age-of-onset distributions of mental disorders in the World Health Organization's World Mental Health Survey Initiative. World Psychiatry. 2007;6(3):168-176.

SPM 22 - Percent of children who had difficulties obtaining mental health care among those who received or needed care during the past 12 months, age 3-17 years
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active
Goal:	To decrease the percent of children who had difficulties obtaining mental health care among those who received or needed care during the past 12 months
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Received or needed mental health care but it was somewhat difficult to get it; Received or needed mental health care but it was very difficult to get it; It was not possible to obtain care **Denominator:** Children age 3-17 years who received or needed any mental health treatment or counseling
Healthy People 2030 Objective:	Related to Mental Health and Mental Disorders (MHMD) Objective 03: Increase the proportion of children with mental health problems who get treatment. (Baseline: 73.3% of children aged 4 to 17 years with mental health problems received treatment in 2018, Target: 82.4%)
Data Sources and Data Issues:	National Survey of Children's Health (NSCH) (https://www.childhealthdata.org/browse/survey)
Significance:	Mental/behavioral health conditions among US children and adolescents are increasing in prevalence1. However, gaps in access to treatment remain, and a significant number of children with mental health conditions experience difficulties obtaining mental health care. This measure will be obtained from the National Survey of Children's Health. 1Ghandour RM, Sherman LJ, Vladutiu CJ, et al. Prevalence and Treatment of Depression, Anxiety, and Conduct Problems in US Children. J Pediatr. 2019;206:256-267.e3. doi:10.1016/j.jpeds.2018.09.021

Form 10
State Outcome Measure (SOM) Detail Sheets

State: Tennessee

SOM 1 - Rate of pregnancy-associated mortality to live birth
Population Domain(s) – Women/Maternal Health

Measure Status:	Active
Goal:	To decrease the pregnancy-associated mortality
Definition:	**Unit Type:** Rate **Unit Number:** 100,000 **Numerator:** Number of pregnancy-associated deaths **Denominator:** Live births
Data Sources and Data Issues:	Maternal Mortality Review Information Application (MMRIA) and Vital Records Birth Statistical System
Significance:	Maternal mortality is a sentinel event and an indicator of a nation's health. Rate of pregnancy-associated mortality rate is calculated as a ratio of maternal deaths within 365 days after the end of a pregnancy per 100,000 live births. In calculating maternal mortality rate, we can identify populations that are disproportionately affected by maternal deaths and monitor Tennessee's progress in decreasing maternal mortality and severe maternal morbidity.

SOM 2 - Rate of pregnancy-related mortality to live births
Population Domain(s) – Women/Maternal Health

Measure Status:	Active
Goal:	To reduce the rate of pregnancy-related mortality
Definition:	**Unit Type:** Rate **Unit Number:** 100,000 **Numerator:** Pregnancy-related deaths **Denominator:** Live births
Data Sources and Data Issues:	Maternal Mortality Review Information Application (MMRIA) and Vital Records Birth Statistical System
Significance:	Maternal mortality is a sentinel event and an indicator of a nation's health. Maternal mortality rate is calculated as a ratio of maternal deaths within 365 days after the end of a pregnancy per 100,000 live births. In calculating maternal mortality rate, we can identify populations that are disproportionately affected by maternal deaths and monitor Tennessee's progress in decreasing maternal mortality and severe maternal morbidity.

SOM 3 - Percent of public school 6th graders who are overweight or obese
Population Domain(s) – Child Health

Measure Status:	Active
Goal:	Decrease the percentage of public school 6th graders who are overweight or obese
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of public school 6th graders who are overweight or obese **Denominator:** Number of TN public school 6th graders
Healthy People 2030 Objective:	Reduce the proportion of children and adolescents with obesity — NWS04
Data Sources and Data Issues:	Weight Status Database (TN Coordinated School Health). These annual data are based on direct height and weight measurements for participating students only in grades K, 2, 4, 6, 8, and any one year of high school who have permission from their parent to be measured. Therefore, there could be significant self-selection bias.
Significance:	This statistic is a direct, core measure of the child obesity priority for school-aged children. Sixth graders were selected as a cross-section of the target group, as these students represent both late elementary and early middle school populations. Both overweight and obesity are included in order to present a broader view of the health concern. Values for the measure will derive from the official CSH annual report entitled, “Tennessee Public Schools: A Summary of Weight Status Data.” The report includes statistics on students who have been identified with a BMI in the overweight or obese range.

SOM 4 - Percent of WIC recipients aged 2-4 years who are overweight or obese
Population Domain(s) – Child Health

Measure Status:	Active
Goal:	Decrease the percentage of WIC recipients aged 2-4 years who are overweight or obese
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of WIC recipients aged 2-4 years who are overweight or obese **Denominator:** Total number of WIC recipients aged 2-4 years
Healthy People 2030 Objective:	Reduce the proportion of children and adolescents with obesity — NWS04
Data Sources and Data Issues:	WIC program recipients database; no known data issues
Significance:	This statistic is a direct, core measure of the child obesity priority for pre-school aged children. The importance of starting children off right early in life when it comes to maintaining healthy weight through good nutrition and physical activity helps prevent further health problems related to obesity later in life. Values for the measure will derive from direct measurements taken by WIC clinical staff statewide.

SOM 5 - Percent of adults reporting Chronic obstructive pulmonary disease (COPD)
Population Domain(s) – Adolescent Health

Measure Status:	Active
Goal:	To decrease the rate of adults with COPD
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of hospital discharges with a principal diagnosis of COPD (ICD-9-CM codes 490-492, 496) among adults aged 45 years and over **Denominator:** Number of persons aged 45 years and over
Healthy People 2030 Objective:	RD-05 Reduce deaths from chronic obstructive pulmonary disease (COPD) in adults
Data Sources and Data Issues:	National Hospital Discharge Survey (NHDS), CDC/NCHS; Population Estimates, Census
Significance:	Asthma and chronic obstructive pulmonary disease (COPD) are significant public health burdens. Specific methods of detection, intervention, and treatment exist that may reduce this burden and promote health. Approximately 14.8 million adults have been diagnosed with COPD, and approximately 12 million people have not yet been diagnosed[1]. The burden of respiratory diseases affects individuals and their families, schools, workplaces, neighborhoods, cities, and states. [1] National Institutes of Health, National Heart, Lung, and Blood Institute (NHLBI). Morbidity and mortality: 2012 chart book on cardiovascular, lung and blood diseases. Bethesda, MD: NHLBI; 2012 Feb [cited 2016 Aug 15]. Available from: https://www.nhlbi.nih.gov/files/docs/research/2012_ChartBook_508.pdf

SOM 6 - Percent of adults reporting cardiovascular disease
Population Domain(s) – Adolescent Health

Measure Status:	Active
Goal:	To decrease the number of adult Tennesseans with cardiovascular disease
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number (weighted) of adults reporting they have ever been told they have angina or coronary heart disease **Denominator:** Number (weighted) of adults responding to coronary heart disease question
Healthy People 2030 Objective:	HDS-2 Reduce coronary heart disease deaths
Data Sources and Data Issues:	Behavioral Risk Factor Surveillance System (BRFSS), annual survey
Significance:	Cardiovascular disease continues to be a leading cause of death among adult Tennesseans. By addressing tobacco and e-cigarette use among adolescents, future prevalence of cardiovascular disease will be reduced, which in turn will reduce the mortality rate from cardiovascular disease in the state.

SOM 7 - Age-adjusted mortality rate from tobacco-attributable cancers among Tennesseans aged 35+
Population Domain(s) – Adolescent Health

Measure Status:	Active
Goal:	To decrease the number of deaths in Tennessee from tobacco-attributable cancers
Definition:	**Unit Type:** Rate **Unit Number:** 100,000 **Numerator:** Number of deaths from tobacco-attributable cancers **Denominator:** Number of deaths
Healthy People 2030 Objective:	C-01 Reduce the overall cancer death rate
Data Sources and Data Issues:	Tobacco-attributable cancer (or potentially all cancer) mortality rates will be derived from CDC Wonder
Significance:	Tobacco is the leading preventable cause of cancer death in Tennessee. By implementing the listed activities and effectively engaging partners, TUPCP aims to reduce Tennessee's mortality from tobacco-attributable cancers in the future.

SOM 8 - Percent of pregnancy-associated deaths in which mental health conditions was a contributing factor
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active
Goal:	To decrease the percent of pregnancy-associated deaths in which mental health conditions was a contributing factor
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of pregnancy-associated deaths in which a mental health condition was a contributing factor **Denominator:** Number of pregnancy-associated deaths
Healthy People 2030 Objective:	Related to Mental Health and Mental Disorders (MHMD) Objective 01: Reduce the suicide rate. (Baseline: 14.2 suicides per 100,000 population occurred in 2018 (age adjusted to the year 2000 standard population), Target: 12.8 suicides per 100,000 population)
Data Sources and Data Issues:	Tennessee Maternal Mortality Review Annual Report (https://www.tn.gov/content/dam/tn/health/program-areas/maternal-mortality/MMR_Annual_Report_2021.pdf)
Significance:	Mental health conditions contributed to substantial percentages of pregnancy-associated deaths in Tennessee from 2017 to 20191. The TN Maternal Mortality Review Committee determined that a mental health condition was a contributing factor in 21% of all pregnancy-associated deaths. This measure will be obtained from the TN Maternal Mortality Review Annual Report. 12021 Tennessee Maternal Mortality Annual Report. Available at https://www.tn.gov/content/dam/tn/health/program-areas/maternal-mortality/MMR_Annual_Report_2021.pdf

Form 10
Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets

State: Tennessee

ESM 1.1 - Create pre/posttests to assesses provider knowledge of and confidence using PATH (Parenthood/Pregnancy Attitude, Timing, and How important is pregnancy prevention).
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	Creation of pre/posttests to assesses provider knowledge of and confidence using PATH (Parenthood/Pregnancy Attitude, Timing, and How important is pregnancy prevention).
Definition:	**Unit Type:** Text **Unit Number:** Yes/No **Numerator:** Pre/post test **Denominator:**
Data Sources and Data Issues:	FP-01 (reduce the proportion of unintended pregnancies); FP-03 (reduce pregnancies in adolescents)
Evidence-based/informed strategy:	Increase knowledge, awareness, and usage of reproductive life plans through PATH across the state of Tennessee
Significance:	PATH is a patient-centered framework with a shared-decision making model that can be used with patients of any demographic without judgement to clarify the patient's reproductive goals and help them develop a reproductive life plan (RLP). Family planning providers play a key role in helping both women and men to reflect on their reproductive intentions, to complete a RLP and to access appropriate services to meet their RLP goals. PATH training is critical to ensuring a skilled family planning workforce that can provide client-centered, non-coercive, and culturally competent services.

ESM 1.2 - Percent of family planning encounters that occur via telehealth
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	To increase the percentage of family planning encounters that occur via telehealth.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of family planning encounters occurring via telehealth **Denominator:** Total number of family planning encounters
Data Sources and Data Issues:	Tennessee Department of Health's Patient Tracking Billing Management Information System (PTBMIS).
Evidence-based/informed strategy:	Increase rural access to family planning services through telehealth.
Significance:	There are many barriers to accessing health care services, especially among poor and rural populations. These include lack of transportation, long travel distances, lack of childcare, and lack of sick leave. Providing family planning services via telehealth is one way to address these barriers and help clients access needed services.

ESM 1.3 - Number of women receiving patient navigation for women's health services
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	To increase the number of women receiving patient navigation for women's health services
Definition:	**Unit Type:** Count **Unit Number:** 250 **Numerator:** Number of women receiving patient navigation services **Denominator:**
Data Sources and Data Issues:	To be determined (possibly electronic health record data or data collected via REDCap)
Evidence-based/informed strategy:	Increase access to women's health services by addressing and eliminating barriers to care through client navigation.
Significance:	Patient navigators are individuals whose primary responsibility is to provide personalized guidance to patients as they move through the health care system. Navigators can help remove barriers to care, foster patient autonomy and provide patients with information that enhances their ability to make appropriate health care choices and/or receive medical care with an enhanced sense of confidence about risks, benefits and responsibilities. Potential benefits of patient navigation include improved health outcomes, increased patient satisfaction, decreased no-show rates and reduced disparities in care.

ESM 1.4 - Percent of birthing hospitals receiving training by TIPQC or THA
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	To implement trainings at the facility level on patient safety recommendations to prevent maternal death.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of birthing hospitals in Tennessee training their providers on patient safety recommendations **Denominator:** Number of birthing hospitals in Tennessee
Data Sources and Data Issues:	MMR Program Notes
Evidence-based/informed strategy:	Hospital Education: Provide training to hospitals on top causes of maternal death as identified by MMRC
Significance:	Documents (including infographics) on disparities in maternal health shows the gap in interventions and areas of need. These documents will also inform the public and stakeholders in maternal health on populations and health conditions that need target interventions, thus fostering health equity.

ESM 1.5 - Percent of birthing hospital providers trained reporting a change in knowledge
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	To train healthcare providers on various recommendations to prevent maternal death.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of providers in Tennessee birthing hospitals reporting a change in knowledge of patient safety recommendations **Denominator:** Number of providers in Tennessee birthing hospitals trained on patient safety recommendations
Data Sources and Data Issues:	MMR Program Notes
Evidence-based/informed strategy:	Hospital Education: Provide training to hospitals on top causes of maternal death as identified by MMRC
Significance:	Documents (including infographics) on disparities in maternal health shows the gap in interventions and areas of need. These documents will also inform the public and stakeholders in maternal health on populations and health conditions that need target interventions, thus fostering health equity.

ESM 1.6 - Percent of non-clinical members participating in the action group
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	To engage members of Maternal Health Task Force in implementing recommendations from the Maternal Mortality Review Committee
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of non-clinical Maternal Health Task Force members **Denominator:** Number of Maternal Health Task Force members
Data Sources and Data Issues:	Maternal Health Task Force Program Files
Significance:	The goal of the MHTF is to implement recommendations from the Maternal Mortality Review Committee. The number of committee members and composition of the MHTF will inform the type implementations of MMRC recommendations.

ESM 1.7 - Percent of postpartum women with positive screenings for depression (using a validated screening tool) who will receive resources/education or referrals for professional services
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To identify women with signs and symptoms of postpartum depression and connect affected women to resources.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of postpartum women with positive screening for depression who receive resources/education or referrals for professional services</td></tr>
<tr><td>Denominator:</td><td>Number of postpartum women with positive screening for depression</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Community Health Access and Navigation in TN (CHANT) and Evidence Based Home Visiting (EBHV) REDCap projects</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>Screen and refer women to mental health treatment and resources</td></tr>
<tr><td>Significance:</td><td>The US Preventive Services Task Force (USPSTF), American College of Obstetricians and Gynecologists (ACOG), and other women’s health organizations recommend that pregnant and postpartum women be assessed for risk of depression so that they can receive intervention before symptoms arise.

This data will be obtained from REDCap. Postpartum women will be identified from the data field “Have you had a baby in the past two months?” Postpartum women who were screened for depression will be identified from the Edinburgh postnatal depression scale (EPDS) field. Women with positive screenings will be identified from the EPDS score data field.</td></tr>
</table>

ESM 1.8 - Percent of recommendations with who/what/when components
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	To provide recommendation for preventing maternal deaths
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Recommendations with who/what/when components **Denominator:** Number of recommendations
Data Sources and Data Issues:	Maternal Mortality Review Information Application (MMRIA)
Significance:	Recommendations from the MMRC provide actionable plans in preventing future maternal deaths. This measure is important to determine the domain of recommendation for prevention of maternal death.

ESM 3.1 - Percent of Tennessee birthing hospitals participating in perinatal quality collaborative projects
NPM 3 – Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

Measure Status:	Active
Goal:	To increase percent of Tennessee birthing hospitals participating in perinatal quality collaborative projects
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of Tennessee birthing hospitals participating in perinatal quality collaborative projects **Denominator:** Number of Tennessee birthing hospitals
Data Sources and Data Issues:	Family Health and Wellness tracking tool
Significance:	The Tennessee Initiative for Perinatal Quality Care seeks to improve health outcomes for mothers and infants by implementing data-driven provider- and community-based performance improvement initiatives. Current projects being implemented include initiatives targeted to neonatal abstinence syndrome, opioid use disorder, sleep-related infant death, and several maternal hypertension. More Tennessee birthing hospitals participating in these projects will ensure that the best evidence-based clinical practices are being allied to pressing public health facing mothers and infants. Ultimately, a higher percentage of birthing hospitals with these initiatives in place will lead to improved infant health outcomes and reduced disparities in access and treatment.

ESM 4.1 - Number of credentialed lactation professionals within WIC
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	To increase the number of credentialed lactation professionals within WIC (e.g., IBCLC, CLC, and CLS)
Definition:	**Unit Type:** Count **Unit Number:** 250 **Numerator:** Number of credentialed lactation professionals within WIC **Denominator:**
Data Sources and Data Issues:	WIC monitoring reports
Significance:	One barrier to breastfeeding is the lack of access to lactation professionals. Breastfeeding promotion and support is an integral part of the WIC Program. Increasing the number of trained lactation personnel will assist WIC mothers to make the best decision regarding infant feeding.

ESM 4.2 - Breastfeeding Welcomed Here (BFWH)-designated businesses with ideal workplace lactation policies NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	To increase the percent of BFWH-designated businesses with ideal workplace lactation policies
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of Breastfeeding Welcomed Here (BFWH)-designated businesses with ideal workplace lactation policies **Denominator:** Number of Breastfeeding Welcomed Here (BFWH)-designated businesses
Data Sources and Data Issues:	BFWH Tracking Spreadsheet
Evidence-based/informed strategy:	Re-enforce lactation policies that positively influence breastfeeding practices in the workplace.
Significance:	Lack of lactation support in the workplace continues to be a significant barrier for mothers returning to work. Breastfeeding initiation and duration rates tend be higher in in workplaces that have developed lactation policies, offer breastfeeding support programs, and designated spaces for mothers to breastfeed or express milk.

ESM 4.3 - Recognition process implemented for Breastfeeding Welcomed Here (BFWH)-designated businesses NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	To implement a recognition process for BFWH-designated businesses with lactation workplace policies for employees.
Definition:	**Unit Type:** Text **Unit Number:** Yes/No **Numerator:** Implement recognition process for Breastfeeding Welcomed Here (BFWH)-designated businesses with lactation workplace policies for employees **Denominator:**
Data Sources and Data Issues:	FHW Program data
Significance:	Lack of lactation support in the workplace continues to be a significant barrier for mothers returning to work. BFWH businesses that have ideal workplace lactation policies will be recognized to celebrate businesses with policies and practices that seek support working mothers.

ESM 5.6 - Percent of hospitals receiving national recognition or implementing approved safe sleep policy
NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Measure Status:	Active
Goal:	Increase the number of hospitals teaching parents to place infants in a safe sleep environment.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of birthing hospitals (1) recognized as a National Cribs for Kids certified hospital or with an approved safe sleep policy, and (2) submitting crib audit reports with ≤ 10% of infants being found in an unsafe sleep environment **Denominator:** Number of birthing hospitals in Tennessee
Data Sources and Data Issues:	Family Health and Wellness tracking tool
Significance:	The infant sleep behaviors modeled by hospital staff after birth have been shown to be important in determining the practices new parents adopt when returning home. Because of this highly influential role, it is key to ensure that all birthing hospitals in Tennessee are exemplifying proper safe sleep behaviors and demonstrating to parents that babies should sleep alone, on their back, and in a crib, bassinet, or pack n' play. By increasing the number of hospitals that meet this standard, we can increase the number of Tennessee parents who benefit from a positive example of safe sleep and, by extension, the number who continue to put their infant to sleep safely at home.

ESM 5.7 - Number of diaper bags with safe sleep educational materials distributed
NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Measure Status:	Active
Goal:	Increase the number of diaper bags with safe sleep educational materials that have been distributed
Definition:	**Unit Type:** Count **Unit Number:** 750 **Numerator:** Number of safe sleep diaper bags that have been distributed **Denominator:**
Data Sources and Data Issues:	REDCap CHANT and EBHV data collection tools
Significance:	The Safe Sleep Diaper Bag Project was created in 2018 to provide EBHV participants with 1) standardized safe sleep education from their home visitor and 2) a diaper bag containing materials with safe sleep messaging. In 2019, the project was expanded to also include participants of the CHANT program. Diaper bags include several useful materials to aid in safe sleep including a onesie, sleep sack, safe sleep door hanger, Sleep Baby Safe and Snug book, Calm Baby Gently book, and nightlight. As of July 2021, over 1600 safe sleep diaper bags have been distributed to EBHV and CHANT caregivers. When asked by their home visitor whether the items in the diaper bag had caused them to change how they put their infant to sleep, 35 percent of EBHV recipients and 53 percent of CHANT recipients reported making a change. Going forward, Tennessee aims to continue to increase the total number of EBHV and CHANT clients who receive the safe sleep diaper bag, particularly in areas with historically high rates of sleep-related infant death. Evaluation data collected so far demonstrate that substantial percentages of caregivers report that the bag was useful in causing them to adopt the recommended safe sleep practices for their infant, validating Tennessee's effort to increase the project's reach as much as possible throughout the state.

ESM 8.1.1 - Percent of physical education teachers receiving professional development related to 50% of PE class time spent in moderate to vigorous physical activity
NPM 8.1 – Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Measure Status:	Active
Goal:	Increase the percentage of PE teachers receiving professional development on physical education and physical activity related to 50% of PE class time spent in moderate to vigorous physical activity.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of PE teachers receiving PD related to 50% of PE class time spent in moderate to vigorous PA **Denominator:** Number of total PE teachers Statewide
Data Sources and Data Issues:	The Coordinated School Health (CSH) tracking survey. Quality Physical Education Survey question is being added for the Fall administration. No known data issues.
Significance:	Direct professional development and technical assistance among school and LEA staff is essential to producing opportunities to increase both physical education and physical activity within the school setting. Values will be simple counts of PE teachers receiving professional development divided by the total number of PE teachers statewide.

ESM 8.1.2 - Percentage of TN counties in which trainings related to mental health and physical health have occurred
NPM 8.1 – Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Measure Status:	Active
Goal:	Collaborate with DOE to increase the number of counties receiving professional learning opportunities that connect mental health and physical health for PHEs and Health Councils, and youth (i.e., trauma-informed care, Youth Mental Health 1st Aid trai
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of counties receiving training, resources, and tools to promote the connection between mental health and physical health **Denominator:** Total number of TN counties (n=95)
Data Sources and Data Issues:	Reduce the proportion of children and adolescents with obesity — NWS04 Increase interprofessional prevention education in health professions training programs — ECBPD08 Increase the proportion of children and adolescents who get preventive mental health care in school — EMCD06
Evidence-based/informed strategy:	Support school-based efforts to promote physical activity and good nutrition
Significance:	There is a synergistic relationship between good mental health and physical health. For example, physical activity promotes healthy weight as well as good mental health. Trusted county professionals and organizations, such as PHEs, health councils, local schools, and youth groups, are a key channel for raising awareness of the connection between mental health and physical health. TDH can support these professionals and groups with evidence-based training, technical assistance, and other resources. Values for this measure will be simple counts derived from program reports and tracking databases that are being developed.

ESM 8.1.3 - Number of Gold Sneaker certified childcare facilities
NPM 8.1 – Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Measure Status:	Active
Goal:	Increase the number of TN Gold Sneaker certified childcare facilities
Definition:	**Unit Type:** Count **Unit Number:** 1,200 **Numerator:** Number of TN Gold Sneaker certified childcare facilities **Denominator:**
Data Sources and Data Issues:	Gold Sneaker Initiative tracking system, which is continuous and up to date; no known issues
Significance:	The Gold Sneaker Initiative provides a framework, guidance, and policies pertaining to healthy nutrition, physical activity, tobacco prevention, and other health issues for childcare providers. In addition, Gold Sneaker is now a requirement for one component of the DHS 3-Star Quality rating, which gives childcare facilities an additional incentive to be certified and to follow policies. Values will be a simple count of the number of current, active Gold Sneaker certified childcare centers.

ESM 8.1.4 - Percent of LHD primary care clinics writing HPHP prescriptions annually
NPM 8.1 – Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Measure Status:	Active
Goal:	To increase the percentage of LHD primary care clinics writing HPHP prescriptions annually.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of LHD primary care clinics writing HPHP prescriptions **Denominator:** Total number of LHD primary care clinics
Data Sources and Data Issues:	NWS-04: Reduce the proportion of children and adolescents with obesity; PA-09: Increase the proportion of children who do enough aerobic physical activity
Evidence-based/informed strategy:	Community Health Services (CHS) - list or map of LHD primary care clinics; TDH electronic health records (Provider Rx); No known data issues
Significance:	Regular physical activity among children is a critical component to maintaining healthy weight or losing excess weight. The HPHP provides an easy and fun way for people to use state parks to remain active, and the program provides incentives for participation as well. Electronic health records show provider referrals from the West region are low as compared to other TDH regions. Increasing provider referrals from TDH clinics in the West region will promote physical activity and address health equity. Values will derive from the number of LHD primary clinics writing HPHP prescriptions.

ESM 8.1.5 - Number of Healthy Parks Healthy Person prescriptions written
NPM 8.1 – Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Measure Status:	Active
Goal:	Increase the number of TN Healthy Parks Health Person (HPHP) prescriptions written
Definition:	**Unit Type:** Count **Unit Number:** 700 **Numerator:** Number of TN Healthy Parks Health Person (HPHP) prescriptions written **Denominator:**
Data Sources and Data Issues:	TDH EHR tracking of HPHP prescription check off box. This check off box has not yet been incorporated into the TDH EHR template.
Significance:	Studies have shown that when a doctor or other health care provider writes a prescription or recommends a certain course of action or behavior to a patient, the patient's likelihood of adopting that behavior increases tremendously. In that regard, there has been good success thus far with the HPHP prescription program encouraging patients to download and use the HPHP app. Values will derive from the number of times the TDH EHR system shows that the HPHP prescription program was used with a patient, provided that a check off box is developed for the system.

ESM 8.1.6 - Percentage of TN counties with completed built environment projects
NPM 8.1 – Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Measure Status:	Active
Goal:	Increase the number of school and community based physical activity clubs or completed built environment projects
Definition:	**Unit Type:** Count **Unit Number:** 812 **Numerator:** Number of physical activity clubs or completed built environment projects **Denominator:**
Data Sources and Data Issues:	The CDHP/OPP tracking database of physical activity clubs and the OPP and Project Diabetes tracking databases of completed built environment projects. Historically, it has been difficult to determine what PA clubs are current and/or still active.
Significance:	Physical activity clubs and community built environment projects increase both access to and availability of physical activity opportunities in the community. Clubs have the additional benefit and reinforcement of being a fun, group activity. Values will be simple counts of the number of such clubs and projects as reported to TDH through LHDs and other sources.

ESM 8.1.7 - Percent of eligible venues offering the Double Up Food Bucks Program
NPM 8.1 – Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Measure Status:	Active
Goal:	To increase the percentage of eligible venues (e.g., farmers' markets and farmers' stores) in counties targeted by Nourish Knoxville that offer the Double Up Food Bucks Program.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of eligible venues in targeted counties that offer the Double Up Food Bucks Program **Denominator:** Total number of eligible venues in targeted counties
Data Sources and Data Issues:	Nourish Knoxville tracking database and program reports related to eligible venues and the reach of the Double Up Food Bucks Program in targeted counties (currently six); no known data issues
Significance:	The consumption of healthier foods, especially fruits and vegetables, and healthier beverages is critical to maintaining or achieving healthy weight. Studies have shown that accessibility of healthy food choices influences healthy eating patterns. Concerted community planning and action among a diversified network of partners is critical to addressing low food security and increasing availability, access, affordability, and consumption related to healthier food and beverage options. Farmers' markets and farmers' stores, the TN Department of Health, the TN Department of Human Services (SNAP), and organizations such as Nourish Knoxville are key stakeholders in this effort. Partnerships can leverage shared resources in an effective and efficient manner. Values for this measure will be a simple list and number of eligible venues and the number of those venues offering the Double Up Food Bucks Program.

ESM 8.1.8 - Percent of staff with an increase in ACEs and TIC knowledge as evidenced by post training evaluation
NPM 8.1 – Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Measure Status:	Active
Goal:	To increase provider ACE and TIC knowledge
Definition:	<table><tr><td>**Unit Type:**</td><td>Percentage</td></tr><tr><td>**Unit Number:**</td><td>100</td></tr><tr><td>**Numerator:**</td><td>Staff who increased knowledge as a result of training</td></tr><tr><td>**Denominator:**</td><td>Total number of staff who participated in staff training</td></tr></table>
Data Sources and Data Issues:	REDCap survey tool- Limitation(s): data collection tool is still under development
Evidence-based/informed strategy:	Increase knowledge and practice of ACE and Trauma Informed Care (TIC).
Significance:	Training on the science of ACEs is necessary to transform the organization and community partners into service delivery systems that are trauma informed and leaders who plan with prevention in mind. Over the course of the year, TDH will provide refresher training to its Child Fatality Review team members in the Building Strong Brains curriculum and will implement evidence based strategies for ACEs prevention and mitigation. This will increase awareness of ACEs.

ESM 8.1.9 - Percent of families with improved protective factors score
NPM 8.1 – Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Measure Status:	Active
Goal:	To increase the percentage of families who have an improved protective factors score
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of families enrolled in home visiting with an improved protective factors score at the time of reporting **Denominator:** Number of families enrolled in home visiting during the reporting year who have at least one protective factors score
Data Sources and Data Issues:	EBHV REDCAP Data Collection System, Annual Protective Factors Survey
Significance:	Protective factors are characteristics of strong parenting skills that reduce the effects of toxic stress and build resiliency in children. Protective factors have been shown to be essential in preventing ACES. Examples of protective factors include a parenting relationship that promotes literacy through healthy conversation and dedicated time to reading with an adult. A core activity of home visiting curriculum seeks to support parents in building resiliency for their families. This measure will demonstrate the capacity of home visiting to increase protective factors in families. Centers for Disease Control and Prevention, Kaiser Permanente. The ACE Study Survey Data [Unpublished Data]. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention; 2016. Healthy People 2020 [Internet]. Washington, DC: U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion [cited 06/18/20]. Kidcentral TN. “Adverse Childhood Experience: Protective Factors”. https://www.kidcentraltn.com/support/crisis-services-for-children/adverse-childhood-experience--protective-factors.html [accessed 06/19/20].

ESM 8.1.10 - Percent of families enrolled in CHANT care coordination who partially or fully complete pathways identified
NPM 8.1 – Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Measure Status:	Active
Goal:	To increase the number of families enrolled into CHANT care coordination who partially or fully complete pathways identified
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of enrolled families + families that exit and fully or partially complete pathways **Denominator:** Total number of referrals received
Data Sources and Data Issues:	CHANT REDCap Database Limitation(s): 1) includes only participants of CHANT in the state, 2) in any given reporting period, the numerator and denominator may not include the same sample since the receipt of services can take place in a different reporting period than the referral.
Significance:	Health status and related health behaviors are determined by influences at multiple levels: personal, organizational/institutional, environmental, and policy. Because significant and dynamic interrelationships exist among these different levels of health determinants, educational and community-based programs are most likely to succeed in improving health and wellness when they address influences at all levels and in a variety of environments/settings.

ESM 11.5 - Number of CYSHCN who receive CHANT/CSS care coordination
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
Goal:	To increase the number of children and youth with special health care needs receiving CHANT/CSS care coordination.
Definition:	**Unit Type:** Count **Unit Number:** 5,000 **Numerator:** Number of CYSHCN receiving CHANT/CSS care coordination **Denominator:**
Data Sources and Data Issues:	CYSHCN MCH/Title V Program data and CHANT Program data
Significance:	It is important to ensure the children with special healthcare needs served by the Tennessee Children's Special Services program receive care coordination services to assist in system navigation.

ESM 11.5 - Percent of providers adopting medical home approach
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
ESM Subgroup(s):	CSHCN
Goal:	To increase the percentage of providers adopting medical home approach in their practice
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of providers reporting adoption of the medical home approach **Denominator:** Number of providers participating in the medical home collaborative
Data Sources and Data Issues:	Program will host learning collaborative for providers, families and community members. Pre and Post assessments will be administered to determine providers who report adopting medical home approach.
Evidence-based/informed strategy:	Create a shared vision for integrating and improving CYSHCN system of care.
Significance:	By increasing the number of providers who adopt a medical home approach in their practices, this will also increase the number of children who receive care in a medical home.

ESM 11.6 - Number of families provided education and resources on importance of medical home access and utilization
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
Goal:	To increase the number of families who receive education and resources on the importance of coordinated and comprehensive care in the medical home.
Definition:	**Unit Type:** Count **Unit Number:** 1,100 **Numerator:** Number of families provided education and resources **Denominator:**
Data Sources and Data Issues:	Data Sources: CHANT program data and Call Center data; Limitations: Retrieving data from separate data systems
Significance:	It is important to ensure that children and families receive annual medical exams and preventive care in an assigned medical home setting. Providing education and knowledge on the importance of care in the medical home will be significant in increasing actual utilization of the medical home.

ESM 11.6 - Percent of providers reporting increased knowledge on systems of care
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
ESM Subgroup(s):	CSHCN
Goal:	To increase the percentage of providers reporting an increase in knowledge on systems of care.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of providers reporting increased knowledge on systems of care **Denominator:** Number of providers participating in the medical home collaborative
Data Sources and Data Issues:	Create a shared vision for integrating and improving CYSHCN system of care.
Evidence-based/informed strategy:	Program will host learning collaborative for providers, families and community members. Pre and Post assessments will be administered to determine providers who report increased knowledge.
Significance:	By increasing providers' knowledge on systems of care will increase the number of children who receive coordinated, comprehensive care in a medical home.

ESM 11.7 - Number of families receiving referrals to their child's primary care provider
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To increase the number of families referred to their child's primary care provider.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>500</td></tr>
<tr><td>Numerator:</td><td>Number of referrals to the primary care providers</td></tr>
<tr><td>Denominator:</td><td></td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>CHANT program data and Call Center data</td></tr>
<tr><td>Significance:</td><td>It is important to ensure that children and families receive annual medical exams and preventive care in an assigned medical home setting. Identifying and providing referrals to the primary care provider will be significant in increasing actual utilization of the medical home.</td></tr>
</table>

ESM 11.7 - Percent of providers who report an increase in their knowledge of available resources
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
ESM Subgroup(s):	CSHCN
Goal:	To increase the percentage of providers reporting increased resource referrals for CYSHCN.
Definition:	<table><tr><td>**Unit Type:**</td><td>Percentage</td></tr><tr><td>**Unit Number:**</td><td>100</td></tr><tr><td>**Numerator:**</td><td>Number of providers who report an increase in the number of referrals provided</td></tr><tr><td>**Denominator:**</td><td>Number of providers receiving educational material on available resources for children and youth with special health care needs</td></tr></table>
Data Sources and Data Issues:	Program will distribute resource information to providers. A pre-post questionnaire will be used to determine if increase in referrals occur based on resources provided.
Evidence-based/informed strategy:	Inform and educate families and providers to promote systems change.
Significance:	It is important that providers receive information on available resources and make referrals for CYSHCN by doing so, access and utilization of the medical home will increase and additional opportunities for systems change with the potential of increasing knowledge of providers and families of CYSHCN

ESM 11.8 - Percent of CHANT families who schedule an annual visit with their child's primary care provider
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To increase the percent families who schedule their child’s primary care appointment.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of CHANT families who schedule appointments</td></tr>
<tr><td>Denominator:</td><td>Number of CHANT families referred to primary care provider</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>CHANT program data and Call Center data</td></tr>
<tr><td>Significance:</td><td>It is important to ensure that children and families receive annual medical exams and preventive care in an assigned medical home setting. Assisting families to schedule appointments will be significant in increasing actual utilization of the medical home.</td></tr>
</table>

ESM 11.8 - Percent of families who report an increase in access and utilization of resources
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>ESM Subgroup(s):</td><td>CSHCN</td></tr>
<tr><td>Goal:</td><td>To increase the percentage of families who reporting increased access and utilization of CYSHCN.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of families who report an increase in access and utilization of resources</td></tr>
<tr><td>Denominator:</td><td>Number of families receiving list of available resources</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Program will distribute resource information to families. A pre-post questionnaire will be used to determine if increase in access and utilizations occur based on resources provided.</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>Inform and educate families and providers to promote systems change.v</td></tr>
<tr><td>Significance:</td><td>It is important that families receive information on available resources. Care for CYSHCN involves multiple stakeholders, including primary and specialty care providers as well as non-medical service providers. For CYSHCN to thrive, partnership between care providers and families is critical that resources are made available for as many needs as possible including health and community based. By doing so medical home access and utilization will increase.</td></tr>
</table>

ESM 11.9 - Percent of CYSHCN receiving CHANT care coordination who receive medical home education
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
ESM Subgroup(s):	CSHCN
Goal:	To increase the percent of children and youth with special health care needs receiving CHANT care coordination who receive medical home education.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of CYSHCN receiving CHANT care coordination who receive medical home education **Denominator:** Number of CYSHCN receiving CHANT care coordination
Data Sources and Data Issues:	Data source: PTBMIS and REDCap Limitations: Families may reject CSS services because they do not want to go through the CHANT screening and assessment
Evidence-based/informed strategy:	Increase the number of CYSHCN who have access to patient and family-centered care coordination.
Significance:	It is important to ensure the children with special healthcare needs served by the Tennessee Children's Special Services program receive medical home education to increase access and utilization and ensure positive health outcomes.

ESM 12.5 - Number of transition resource kits disseminated
NPM 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care

Measure Status:	Active
Goal:	To increase the number of youth with special health care needs that receive resources necessary for successful transition.
Definition:	**Unit Type:** Count **Unit Number:** 2,600 **Numerator:** Number of kits disseminated **Denominator:**
Data Sources and Data Issues:	CYSHCN MCH/Title V Program data
Significance:	Youth who receive education and knowledge on transition planning are expected to be successful transitioning to adult independence.

ESM 12.6 - Number of youth with special health care needs trained as mentors
NPM 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care

Measure Status:	Active
Goal:	To increase the number of youth with special health care needs that receive mentor other youth with special health care needs to serve as leaders on the Youth Advisory Council.
Definition:	**Unit Type:** Count **Unit Number:** 75 **Numerator:** Number of youth with special health care needs trained as mentors **Denominator:**
Data Sources and Data Issues:	CYSHCN MCH/Title V Program data
Significance:	The program is to encourage active participation and involvement of the youth and families in policy development.

ESM 12.7 - Number of parents and youth with special health care needs who receive leadership and self-advocacy training
NPM 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care

Measure Status:	Active
Goal:	To increase the number of parents and youth with special health care needs that receive leadership and self-advocacy training.
Definition:	**Unit Type:** Count **Unit Number:** 200 **Numerator:** Number of parents and youth with special health care needs who receive leadership and self-advocacy training **Denominator:**
Data Sources and Data Issues:	CYSHCN MCH/Title V Program data
Significance:	Youth and parents are provided leadership training and are able to provide mentoring and peer to peer support to other parents and youth with special health care needs. Trained parents and YSHCN are better equipped to become self-advocates and participate in the decision making process and policy development.

ESM 14.2.1 - Number of tobacco-free sports teams
NPM 14.2 – Percent of children, ages 0 through 17, who live in households where someone smokes

Measure Status:	Active
Goal:	To support smoke free environments as the social norm
Definition:	**Unit Type:** Count **Unit Number:** 100 **Numerator:** Sports teams making initial tobacco-free pledge **Denominator:**
Data Sources and Data Issues:	Tennessee Tobacco Control Program data
Significance:	The measure is significant in that it underlies the social norm change affected by youth leaders publicly pledging to their school, peers, and community to be tobacco free. The number of sports teams taking the tobacco-free pledge will consist of sports teams which are making their initial pledge (excluding re-pledges in subsequent years).

ESM 14.2.2 - Number of social media posts promoting text-based cessation services
NPM 14.2 – Percent of children, ages 0 through 17, who live in households where someone smokes

Measure Status:	Active
Goal:	To increase youth tobacco cessation.
Definition:	**Unit Type:** Count **Unit Number:** 24 **Numerator:** Number of social media posts promoting text-based cessation services **Denominator:**
Data Sources and Data Issues:	Tobacco Control Program data
Significance:	Cessation-supporting text services have been shown to be effective for youth and young adults who are experimenting with or currently using tobacco products. TDH and partner promotions of these services through social media aims to increase text service utilization.

ESM 14.2.3 - Number of anti-tobacco social media posts
NPM 14.2 – Percent of children, ages 0 through 17, who live in households where someone smokes

Measure Status:	Active
Goal:	To decrease youth tobacco use.
Definition:	**Unit Type:** Count **Unit Number:** 24 **Numerator:** Number of social media posts to TDH and TNSTRONG social media accounts **Denominator:**
Data Sources and Data Issues:	TDH Communications Office will track the number of anti-tobacco focused social media posts via Facebook, Twitter, and Instagram using designated hashtags.
Significance:	Anti-tobacco messaging is another cornerstone of tobacco control efforts and impacts the rate at which youth experiment with and initiate smoking and tobacco use. Social media's influence and pervasiveness among adolescents enables TUPCP and youth advocates to reach the target population more effectively.

ESM 14.2.4 - Number of youth who attend the state anti-tobacco conference trainings
NPM 14.2 – Percent of children, ages 0 through 17, who live in households where someone smokes

Measure Status:	Active
Goal:	Decrease tobacco use among youth through peer-to-peer intervention and youth advocates for anti-tobacco policy.
Definition:	**Unit Type:** Count **Unit Number:** 450 **Numerator:** Youth attendees at annual TNSTRONG conference/trainings **Denominator:**
Data Sources and Data Issues:	Tobacco Control Program - TNSTRONG Attendee Registration system
Significance:	TNSTRONG attendees, similar to ambassadors, are trained on peer-to-peer interventions and policy change, and are an essential component to reaching and influencing youth throughout Tennessee. TNSTRONG youth attendees are defined as school-aged individuals who attend the TNSTRONG event in their capacity as students (as opposed to presenters or chaperones).

ESM 14.2.5 - Number of ambassadors recruited
NPM 14.2 – Percent of children, ages 0 through 17, who live in households where someone smokes

Measure Status:	Active
Goal:	Decrease tobacco use among youth through peer-to-peer intervention and youth advocates for anti-tobacco policy.
Definition:	**Unit Type:** Count **Unit Number:** 26 **Numerator:** Number of ambassadors recruited **Denominator:**
Data Sources and Data Issues:	Tobacco Control Program data
Significance:	Youth who are recruited to serve as TNSTRONG ambassadors represent an important component of the TCP's efforts to reach and influence local youth. Ambassadors are often leaders within their schools and communities and are trained on peer-to-peer intervention and policy change. The number of ambassadors recruited will be tracked annually and will consist of the total number of ambassadors inclusive of those in their second year (of a two year cycle).

Form 10
Evidence-Based or -Informed Strategy Measure (ESM) (2016-2020 Needs Assessment Cycle)

2016-2020: ESM 1.1 - Number of press releases, PSAs and/or social media messages promoting preventive health care visits for women of reproductive age
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To increase the number of press releases, PSAs and/or social media messages promoting preventive health care visits for women of reproductive age</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>46</td></tr>
<tr><td>Numerator:</td><td>Number of press releases, PSAs and/or social media messages promoting preventive health care visits for women of reproductive age</td></tr>
<tr><td>Denominator:</td><td></td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>TDH Office of Communications; TDH Reproductive and Women’s Health Section program data</td></tr>
<tr><td>Significance:</td><td>The use of press releases and social media messages can help bring public awareness to the issue and general importance of preventive health care for women as well as to specific preventive care recommendations (e.g. Pap smears and mammograms). Social media and other emerging communication technologies have the potential to reach large and diverse populations and help reach individuals when, where and how they want to receive health messages. Social media is a way to expand reach, foster engagement and increase access to credible, science-based health messages in order to spread key messages and influence health decision making.</td></tr>
</table>

2016-2020: ESM 1.2 - Number of webinars for providers on increasing preventive care visits among women in their clinics
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	To Increase the number of webinars for providers on increasing preventive care visits among women in their clinics
Definition:	**Unit Type:** Count **Unit Number:** 33 **Numerator:** Number of webinars for providers on increasing preventive care visits among women in their clinics **Denominator:**
Data Sources and Data Issues:	TDH Reproductive and Women's Health Section program data
Significance:	Competing priorities and busy schedules can make it difficult for women to make time for their own health, especially for preventive health care, while changing recommendations can make it challenging for both patients and providers to navigate preventive care needs. Training primary care providers on how to leverage missed opportunities (such as acute care visits) for provision of preventive care and how to properly code such visits for reimbursement is one way to promote and increase preventive health care services among women of reproductive age.

2016-2020: ESM 1.3 - Number of site-level family planning utilization reports distributed to local health departments
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To distribute quarterly site-level family planning utilization reports to local health departments</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>4</td></tr>
<tr><td>Numerator:</td><td>Number of quarterly site-level family planning utilization reports distributed to local health departments</td></tr>
<tr><td>Denominator:</td><td></td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Tennessee Department of Health - Patient Tracking Billing Information Management System (PTBMIS)</td></tr>
<tr><td>Significance:</td><td>The number of Family Planning (FP) clients served by the department has been declining in recent years. Similar declines have been observed in FP programs nationwide, as well as in other health department programs such as WIC. Quarterly site-level family planning utilization reports are an effort to better understand the FP patient population at a very granular level (e.g. patient demographics, insurance status, and contraceptive methods at individual service sites). Better understanding of patient characteristics and trends among specific subgroups will help health department staff focus outreach efforts aimed at slowing and reversing declines in FP program utilization and providing these services to the greatest number of people possible. Family Planning visits offer an opportunity to not only help women avoid unintended pregnancies, but to also prepare for healthy pregnancies by addressing important preventive care issues among those of reproductive age.</td></tr>
</table>

2016-2020: ESM 1.4 - Number of region-level pregnancy-related service utilization reports distributed to regional health departments
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	To distribute quarterly region-level pregnancy-related service utilization reports to regional health departments
Definition:	**Unit Type:** Count **Unit Number:** 4 **Numerator:** Number of quarterly region-level pregnancy-related service utilization reports distributed to regional health departments **Denominator:**
Data Sources and Data Issues:	Tennessee Department of Health - Patient Tracking Billing Information Management System (PTBMIS)
Significance:	Most health department clients seeking a pregnancy test would benefit from the full array of Family Planning (FP) services which include discussions about a reproductive life plan and a medical history. The FP visit not only helps women to avoid unintended pregnancies, but also to prepare for healthy pregnancies by addressing important preventive care issues among those of reproductive age. Title X funding provides the opportunity for any health department pregnancy test and subsequent counseling to be coded to the FP program regardless of test result. Tests provided through FP are an indicator that appropriate FP counseling was made available. Quarterly region-level pregnancy-related service utilization reports provide information to regional staff on the percentage of pregnancy tests provided through FP versus other services, encourages them to treat all pregnancy test patients as FP clients, and allows them to track their progress in meeting department goals (currently set at 85% by the end of CY2016).

2016-2020: ESM 5.1 - Number of safe sleep educational material distributed
NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Measure Status:	Active
Goal:	To increase the number of safe sleep educational materials distributed
Definition:	**Unit Type:** Count **Unit Number:** 325,000 **Numerator:** Number of safe sleep educational materials distributed **Denominator:**
Data Sources and Data Issues:	TDH FHW child fatality review program data
Significance:	Safe sleep educational materials play an important role in educating new parents and caregivers about ways to keep babies safe while sleeping. In 2014, there were 99 infant deaths that resulted from an unsafe sleep environment, account for approximately 18% of all infant deaths. By focusing on distributing safe sleep educational materials can increase the awareness to put babies into safe sleep environment and decrease the sleep-related infant death and reduce the overall infant mortality rate.

2016-2020: ESM 5.2 - Percent of infant deaths to be reviewed by child fatality review teams
NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Measure Status:	Active
Goal:	To maintain the percent of infant deaths to be reviewed by child fatality review teams
Definition:	<table><tr><td>**Unit Type:**</td><td>Percentage</td></tr><tr><td>**Unit Number:**</td><td>100</td></tr><tr><td>**Numerator:**</td><td>Number of reviewed infant deaths</td></tr><tr><td>**Denominator:**</td><td>Number of infant deaths met the review criteria</td></tr></table>
Data Sources and Data Issues:	TDH FHW child death review database
Significance:	The overall 2014 infant mortality rate in Tennessee was 6.9 infant deaths per 1,000 live births, 15% higher than national rate. The deaths meeting the review criteria were all reviewed by CFR (Child Fatality Review) teams. Their careful review process results in a thorough description of the factors related to infant deaths. By reviewing these cases, it can provide a comprehensive depth of understanding of the deaths and reduce infant mortality.

2016-2020: ESM 5.3 - Percent of VLBW (Very Low Birth Weight) infants being delivered at Level III or IV birthing facilities

NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Measure Status:	Active
Goal:	Maintain that 80% of VLBW infants are being delivered at Level III or IV birthing facilities
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** VLBW infants are being delivered at Level III or IV birthing facilities **Denominator:** All VLBW infants
Data Sources and Data Issues:	Tennessee Department of Health, Births Statistical System
Significance:	Very low birth weight infants (<1,500 grams or 3.25 pounds) are at high risk of morbidity and mortality. VLBW infants are significantly more likely to survive when delivered at level III or IV birthing facilities.

2016-2020: ESM 5.4 - Percent of newborns with a positive metabolic screen who receive follow-up to definitive diagnosis and clinical management
NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Measure Status:	Active
Goal:	Maintain that at least 99% of newborns with a positive metabolic screen receive follow up to definitive diagnosis
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of infants who received follow-up to a definitive diagnosis **Denominator:** Number of infants with a positive metabolic screen
Data Sources and Data Issues:	Neometrics/Natus newborn screening database
Significance:	Metabolic newborn screening is mandatory for all babies born in Tennessee unless there is a refusal for religious reasons. The Tennessee system includes the State Laboratory, the follow-up staff, and the tertiary centers for referrals and follow-up. The system is designed to provide our families and providers the resources and services needed to assure that a timely diagnosis is made in each case. Early and appropriate intervention for each infant is critical for improving outcome.

2016-2020: ESM 5.5 - Number of individuals served by the Tennessee Adolescent Pregnancy Prevention Program (TAPPP)
NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To increase the number of individuals served by the Tennessee Adolescent Pregnancy Prevention Program (TAPPP)</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>56,000</td></tr>
<tr><td>Numerator:</td><td>Number of individuals served by the Tennessee Adolescent Pregnancy Prevention Program (TAPPP)</td></tr>
<tr><td>Denominator:</td><td></td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>TAPPP – Programmatic data collected from the 6 Regional and 2 Metro HD TAPPP Coordinators and County Health Educators using the state data reporting form.

Abstinence Education Grant Program – Programmatic data collected from the 13 abstinence education program coordinators using the required federal data collection sheet.</td></tr>
<tr><td>Significance:</td><td>Adolescent childbearing has been associated with increased risks for poor birth outcomes, including preterm delivery, low birthweight, and infant mortality. Causes for poorer birth outcomes in adolescents have been attributed to lower rates of adequate prenatal care, poor weight gain and nutrition, higher rates of tobacco use, high risk health behaviors and socioeconomic background characteristics. Therefore, increasing the number of individuals who participate in programs that address adolescent pregnancy prevention and abstinence education are critical in reducing teen pregnancies and infant mortality rates.</td></tr>
</table>

2016-2020: ESM 6.1 - Number of unique page views to the Developmental Milestones and Developmental Screenings kidcentraltn.com sites
2016-2020: NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Measure Status:	Active
Goal:	To increase general awareness of the need for developmental screening
Definition:	**Unit Type:** Count **Unit Number:** 4,000 **Numerator:** Number of site views from webpage and mobile app to the Developmental Milestones and Developmental Screenings site during the past 12 months **Denominator:**
Data Sources and Data Issues:	Kidcentraltn.com annual site traffic report from ioStudio
Significance:	The audience of this strategy is the general public. Kidcentraltn.com is the state platform used to reach the general public across the state via the website, Facebook, twitter, and mobile app. By creating additional content and intentionally promoting this content, we can drive site views to the Developmental Screenings and Milestones screens.

2016-2020: ESM 6.2 - Number of health department nurses trained in the START Autism and MCHAT-R/F program
2016-2020: NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Measure Status:	Active
Goal:	To increase number of health department nurses trained in the START Autism and MCHAT-R/F program
Definition:	**Unit Type:** Count **Unit Number:** 700 **Numerator:** Number of nurses trained in the START Autism and MCHAT-R/F program **Denominator:**
Data Sources and Data Issues:	TDH Community Health Services training data
Significance:	The audience of this strategy is health department nurses and the clients of health departments. The Tennessee Early Intervention System and the Tennessee Chapter of the American Academy of Pediatrics have partnered with the health department to train nurse supervisors in the administration of the M-CHAT R screening tool for autism. It is assumed that trained nurse will administer the screening to the patients they see in clinic. Thus, training the health department nurses will increase the number of Tennessee children who receive a validated developmental screen at a primary care visit.

2016-2020: ESM 6.3 - Percent of Developmental Screenings performed across the state for participants enrolled in an Evidence-Based Home Visiting Program
2016-2020: NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To increase the percent of Developmental Screenings performed across the state for participants enrolled in an Evidence-Based Home Visiting Program</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of ASQ-3 and ASQ:SE or ASQ:SE-2 screens documented at home visits during the past 12 months</td></tr>
<tr><td>Denominator:</td><td>Number of index children enrolled in an Evidence Based Home Visiting Program for at least 6 months</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>TDH FHW REDCap data base for MIECHV</td></tr>
<tr><td>Significance:</td><td>The audience of this strategy is non-medical providers that serve the child population. The Tennessee Young Child Wellness Council is partnering with agencies to create a catalog of developmental screening tools being used across the state, the settings in which these tools are being administered, and the degree of specificity. The Division of Family Health and Wellness continues to partner with state and federally funded evidence based home visiting programs. As an integral part of service delivery, and in compliance with national home visiting models, home visitors routinely administer developmental screenings.</td></tr>
</table>

2016-2020: ESM 7.1.1 - Number of parents and caregivers receiving car seat education
2016-2020: NPM 7.1 – Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9

Measure Status:	Active
Goal:	To increase the number of parents of caregivers receiving car seat education
Definition:	**Unit Type:** Count **Unit Number:** 3,000 **Numerator:** Number of parents and caregivers receiving car seat education **Denominator:**
Data Sources and Data Issues:	Tennessee Department of Health Child Injury Prevention Program Data
Significance:	Motor vehicle crash injuries are a leading cause of death among children in the United States. In 2014, over 1,000 children ages 12 and under were seen in Tennessee emergency departments because of motor vehicle crashes. CDC research suggests that black and Hispanic children ages 12 and under are less likely to buckle up than white children. The consistent and correct use of car seats and boosters can reduce the risk of serious injury and death for infants, toddlers, and children up to age 8. Tennessee utilizes a recommended practice to distribute car seats with education programs to increase restraint and decrease injuries and deaths to child passengers.

2016-2020: ESM 7.1.2 - Number of counties that adopt Count It! Drop It! Lock It! educational programs
2016-2020: NPM 7.1 – Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To increase the number of counties that adopt Count It! Drop It! Lock It! educational programs</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>95</td></tr>
<tr><td>Numerator:</td><td>Number of counties that adopt Count It! Drop It! Lock It! educational programs</td></tr>
<tr><td>Denominator:</td><td></td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Tennessee Department of Health Injury Prevention Program reports</td></tr>
<tr><td>Significance:</td><td>Unintentional poisoning killed 635 U.S. Children in 2014; almost 90% of them were teenagers, ages 10-19. In 2014 117,959 U.S. children visited emergency departments for unintentional poisoning-related injuries (WISQARS). Reducing the amount of prescription drugs in the home can reduce access to these drugs by children. Research indicates the high availability of prescription drugs in Tennessee is contributing to the addiction problem across the state. According to the 2010 National Survey on Drug Use and Health, 70% of people who abused or misused prescription drugs got them from a friend or relative, either for free, by purchasing them, or by stealing them. People who abuse prescription drugs also obtain them from other sources including “pill mills,” or illegitimate pain clinics; prescription fraud; pharmacy theft; illegal online pharmacies; and “doctor shopping”. Some individuals who use prescription drugs for non-medical reasons believe these substances are safer than illicit drugs because they are prescribed by a physician and dispensed by a pharmacist.

Communities that develop partnerships with schools, healthcare providers, pharmacists, law enforcement and other sectors to educate families about the importance of monitoring, securing, and properly disposing of prescription drugs can reduce access to unused prescription drugs and increase the perception of harm of the abuse of prescription drugs.</td></tr>
</table>

2016-2020: ESM 7.1.3 - Percent of families who receive injury prevention education through the AAP checklist among families participating in Evidence Based Home Visiting programs
2016-2020: NPM 7.1 – Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To increase the percent of families who receive injury prevention education through the AAP checklist among families participating in Evidence Based Home Visiting programs</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of children with at least one AAP screening completed</td></tr>
<tr><td>Denominator:</td><td>Number of children who reached first birthday during reporting period</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Tennessee Department of Health - Evidence Based Home Visiting Database</td></tr>
<tr><td>Significance:</td><td>Injury is a leading cause of child mortality and morbidity. In 2014, injuries resulted in more than 3,131 deaths and 2.3 million emergency department visits among 0-4 year olds in the US (CDC WISQARS). Home visitors can play an important role in increasing awareness about injury hazards, identifying risk and protective factors in the home setting, and teaching caregivers injury prevention methods.

Using a childhood injury risk assessment tool, home visitors can identify risks and provide education on a wide range of injury topics. Home visiting is one strategy that shows promise for reducing rates of self-reported and substantiated child maltreatment and use of emergency rooms to treat child injuries.</td></tr>
</table>

2016-2020: ESM 7.2.1 - Number of schools in the top ten crash rate counties (among ages 15-18) that conduct evidence-informed teen safe driving programming
2016-2020: NPM 7.2 – Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19

Measure Status:	Active
Goal:	To increase the number of schools in the top ten crash rate counties (among ages 15-18) that conduct evidence-informed teen safe driving programming
Definition:	**Unit Type:** Count **Unit Number:** 70 **Numerator:** Number of schools in the top ten crash rate counties that conduct evidence-informed teen safe driving programming **Denominator:**
Data Sources and Data Issues:	ReduceTNCrashes.org web based teen safe driving program reports
Significance:	Motor vehicle crash injuries are a leading cause of hospitalization among children in the United States. In 2014, over 840 adolescents ages 15-24 were hospitalized in Tennessee because of motor vehicle crashes. Research shows that in order for young drivers to remain collision-free, parents must model safe driving behaviors and invest in meaningful guided practice over a long period of time to turn these skills into good driving habits. It is our hope that new drivers will have a solid foundation to develop safe, collision-free driving habits that will last a lifetime through teen safe driving programming. The evidence-informed teen safe driving program can reduce risk and keep people safer on the road.

2016-2020: ESM 7.2.2 - Number of drug disposal bins installed statewide
2016-2020: NPM 7.2 – Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19

Measure Status:	Active
Goal:	To increase the total number of drug disposal bins installed statewide
Definition:	**Unit Type:** Count **Unit Number:** 401 **Numerator:** Number of drug disposal bins installed statewide **Denominator:**
Data Sources and Data Issues:	Tennessee Department of Environment and Conservation Reports
Significance:	The diversion and abuse of prescription drugs contributes to the leading cause of death in Tennessee. In 2014, over 2,500 children ages 19 and under were admitted to the emergency department for poisoning. Young children are particularly at risk for accidental overdose due to the ingestion of prescription drugs, and unwanted medicine disposed in the trash can be stolen and used, potentially resulting in illness, injury, or death. There are few safe and convenient ways for consumers to properly dispose of unused prescription drugs that do not harm the solid or liquid waste system. Drug disposal bins are cited as one way to reduce the diversion and ingestion of unused prescription drugs while reducing damage to the local environment.

2016-2020: ESM 7.2.3 - Number of press releases, social media posts and presentations about adolescent falls
2016-2020: NPM 7.2 – Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19

Measure Status:	Active
Goal:	To increase the number of press releases, social media posts and presentations about adolescent falls
Definition:	**Unit Type:** Count **Unit Number:** 22 **Numerator:** Number of press releases, social media posts and presentations about adolescent falls **Denominator:**
Data Sources and Data Issues:	Tennessee Department of Health Media Communications and Media Relations Department and Injury Prevention Program data
Significance:	Traumatic Brain Injury (TBI) is a leading cause of death and disability in the United States. Falls disproportionately impact children ages 0-5 and over 18,000 children age 0-5 were treated in emergency rooms in 2014 for unintentional fall injury. Young children living in families with low socioeconomic status in older communities have a high risk for fall injuries and targeted interventions to low socioeconomic status parents of young, male, children may be warranted. Media posts and presentations that focus on risk factors such as furniture (e.g. bunk beds or walkers) playground equipment will be developed and delivered.

2016-2020: ESM 7.2.4 - Number of suicide-related articles, social media posts and trainings provided by TDH
2016-2020: NPM 7.2 – Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19

Measure Status:	Active
Goal:	To increase number of suicide-related articles, social media posts and trainings provided by TDH
Definition:	**Unit Type:** Count **Unit Number:** 75 **Numerator:** Number of suicide-related articles, social media posts and trainings **Denominator:**
Data Sources and Data Issues:	Tennessee Department of Health injury prevention program data
Significance:	Suicides among young people continues to be a serious problem. Suicide is the third leading cause of death for Tennessee residents ages 15-24 according to the U.S. Center for Disease Control and Prevention. Suicide is a relatively rare event and it is difficult to accurately predict which persons with these risk factors will ultimately commit suicide. However, by providing articles, social media posts and training can increase awareness of the signs and risk factors of suicide attempts.

2016-2020: ESM 8.1.1 - Number of Gold Sneaker-recognized childcare facilities in Tennessee
NPM 8.1 – Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Measure Status:	Active
Goal:	Increase the number of Gold Sneaker-recognized childcare facilities in Tennessee
Definition:	<table><tr><td>**Unit Type:**</td><td>Count</td></tr><tr><td>**Unit Number:**</td><td>825</td></tr><tr><td>**Numerator:**</td><td>Number of Tennessee licensed childcare facilities recognized by TDH as meeting the requirements set by the Gold Sneaker Initiative</td></tr><tr><td>**Denominator:**</td><td></td></tr></table>
Data Sources and Data Issues:	The Gold Sneaker facility tracking database is housed within the Division of Family Health and Wellness, and will be used to provide facility counts. The Gold Sneaker tracking database is updated as facilities receive application approval. However, at this time, there is no process for ensuring previously recognized facilities are still “active” (licensed, open, etc.). An evaluation and recertification process is currently being developed.
Significance:	Through the Gold Sneaker recognition process, facilities are required to adopt nine policies related to physical activity (4), nutrition (4), and adoption of a smoke-free facility campus (1). The first Gold Sneaker policy directly relates to the National Performance Measure – requiring children to participate in at least 60 minutes of physical activity per day. Additional Gold Sneaker policies are in concert with recommendations made by the American Academy of Pediatrics, Tennessee Child Care Resource & Referral Network, and Tennessee Department of Health and Human Services.

2016-2020: ESM 8.1.2 - Average number of monthly calls to the Tennessee Breastfeeding Hotline (TBH)
NPM 8.1 – Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Measure Status:	Active
Goal:	To increase the average number of monthly calls to the Tennessee Breastfeeding Hotline
Definition:	<table><tr><td>**Unit Type:**</td><td>Count</td></tr><tr><td>**Unit Number:**</td><td>650</td></tr><tr><td>**Numerator:**</td><td>Count of individual calls (not unique callers) to the TBH during the reporting period</td></tr><tr><td>**Denominator:**</td><td></td></tr></table>
Data Sources and Data Issues:	The Tennessee Breastfeeding Hotline is operated by Le Bonhuer Children's Hospital in Memphis, Tennessee. TBH monitors call volume through electronic tracking (iCarol). Additional data elements for consideration include: referral sources, reason/concern, caller demographics, and follow-up call outcomes.
Significance:	The Tennessee Breastfeeding Hotline is available 24 hours a day, seven days a week. The Hotline is staffed by International Board Certified Lactation Consultants and Certified Lactation Counselors who can provide up-to-date information and support and to address common questions and concerns about breastfeeding. Through consultation provided by the TBH, TDH continues its efforts to reduce barriers associated with breastfeeding, correct common misconceptions, and further promote breastfeeding as the optimal approach to infant feeding.

2016-2020: ESM 8.1.3 - Number of Baby Friendly-designated Tennessee birthing hospitals
NPM 8.1 – Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Measure Status:	Active
Goal:	To increase the number of Baby Friendly-designated Tennessee birthing hospitals
Definition:	**Unit Type:** Count **Unit Number:** 18 **Numerator:** Number of Baby Friendly-designated Tennessee birthing hospitals **Denominator:**
Data Sources and Data Issues:	Baby Friendly Hospital Initiative tracks completion of its 10 guidelines and evaluation criteria. A list of Baby Friendly Tennessee birthing hospitals is provided at: https://www.babyfriendlyusa.org/find-facilities/designated-facilities--by-state
Significance:	Baby-Friendly USA, Inc. and its implementation of the Baby-Friendly Hospital Initiative (BFHI) in the United States is predicated on the fact that human milk fed through the mother's own breast is the normal way for human infants to be nourished. There is an abundance of scientific evidence that points to lower risks for certain diseases and improved health outcomes for both mothers and babies who breastfeed. Breastfeeding is the natural biological conclusion to pregnancy and an important mechanism for the continued normal development of the infant. With the correct information and the right supports in place, under normal circumstances, most women who choose to breastfeed are able to successfully achieve their goal.

2016-2020: ESM 8.2.1 - Number of Physical Activity Clubs in K-12 schools
2016-2020: NPM 8.2 – Percent of adolescents, ages 12 through 17 who are physically active at least 60 minutes per day

Measure Status:	Active
Goal:	To increase the number of Run Clubs for 5th through 8th graders
Definition:	**Unit Type:** Count **Unit Number:** 359 **Numerator:** Tennessee Run Clubs with participants in grades 5th through 8th grade (identified through TDH partnerships) **Denominator:**
Data Sources and Data Issues:	Physical Activity Clubs are tracked by the TDH Chronic Disease Section. New PA clubs are submitted by local health department staff (health educators, coordinators, etc.) and are subsequently added to a tracking tool.
Significance:	A Physical Activity Club is a community or school-based physical activity opportunity that allows a young person to see their progress over time through better run/walk times or longer distances. Activities may include walking, jogging or running around school grounds on a walking track, competition track, athletic field, green space, or may occur at other locations such as state parks, swimming pools or any organized sport program. Physical Activity Clubs provide opportunities for students to be physically active as part of a goal to reach at least 60-minutes a day of moderate to vigorous physical activity.

2016-2020: ESM 8.2.2 - Number of school gardens in Tennessee public schools
2016-2020: NPM 8.2 – Percent of adolescents, ages 12 through 17 who are physically active at least 60 minutes per day

Measure Status:	Active
Goal:	To increase the number of school gardens in Tennessee public schools
Definition:	**Unit Type:** Count **Unit Number:** 576 **Numerator:** number of school gardens in Tennessee public schools **Denominator:**
Data Sources and Data Issues:	The number of school gardens in TN public schools is tracked by the Farm to School Specialist in the Office of School Nutrition. The Department of Health, through contract, receives updated reports provided by the Office of School Nutrition.
Significance:	School gardens are a proven strategy for improving children's attitudes towards and consumption of produce, as well as incorporating experiential nutrition and agriculture education into school curriculum. TDH recognizes that children making healthy food choices while at school will significantly impact the statewide priority of reducing the prevalence of obesity.

2016-2020: ESM 8.2.3 - Number of Healthy Parks Healthy Person app users
2016-2020: NPM 8.2 – Percent of adolescents, ages 12 through 17 who are physically active at least 60 minutes per day

Measure Status:	Active
Goal:	To increase the number of Healthy Parks Healthy Person app users
Definition:	**Unit Type:** Count **Unit Number:** 9,000 **Numerator:** Number of Healthy Parks Healthy Person app users **Denominator:**
Data Sources and Data Issues:	The Healthy Parks Healthy Person app is managed by the Tennessee Department of Environment and Conservation. TDH must request access to the data on an ad hoc basis, and does not monitor or control data quality. The current app has limited tracking capabilities. During the upcoming year staff will be working to upgrade the app's functionality.
Significance:	Physical activity is an important part of good health for everyone, regardless of age or ability. Healthy Parks Healthy Person remove barriers to physical activity by promoting places to be active. Allowing access to physical activity spaces and facilities is a recommended strategy in the Healthy People 2020 goals for the nation's health. According to HP 2020, physical activity levels are positively affected by structural environments including trails and parks. Additionally, the National Physical Activity Plan Alliance recommends that communities develop new, and enhance existing, community recreation, fitness, and park programs that provide and promote healthy physical activity opportunities. Physical activity contributes to students' overall health and well-being. Furthermore, participating in physical activity in safe and clean public spaces helps everyone to feel more connected to their community.

2016-2020: ESM 11.1 - Number of providers trained and provided information on medical home implementation
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
Goal:	To increase the number of providers trained and provided information on medical home implementation
Definition:	**Unit Type:** Count **Unit Number:** 980 **Numerator:** Number of providers trained and provided information on medical home implementation **Denominator:**
Data Sources and Data Issues:	Title V Children and Youth with Special Healthcare Needs (CYSHCN) program training participation log
Significance:	The American Academy of Pediatrics (AAP) specifies seven qualities essential to medical home care: accessible, family-centered, continuous, comprehensive, coordinated, compassionate and culturally effective. Ideally, medical home care is delivered within the context of a trusting and collaborative relationship between the child's family and a competent health professional familiar with the child and family and the child's health history. Our program believes in the importance of training and plans to train more providers on medical home concept and provide information on medical home implementation.

2016-2020: ESM 11.2 - Number of families that receive patient centered medical home training
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
Goal:	Increase the number of families that receive patient centered medical home training
Definition:	**Unit Type:** Count **Unit Number:** 785 **Numerator:** Number of families that receive patient centered medical home training **Denominator:**
Data Sources and Data Issues:	Title V Children and Youth with Special Healthcare Needs (CYSHCN) program training participation log
Significance:	The American Academy of Pediatrics (AAP) specifies seven qualities essential to medical home care: accessible, family-centered, continuous, comprehensive, coordinated, compassionate and culturally effective. Ideally, medical home care is delivered within the context of a trusting and collaborative relationship between the child's family and a competent health professional familiar with the child and family and the child's health history. This measure gauges the number of families that receive patient centered medical home training.

2016-2020: ESM 11.3 - Percentage of children served by the Children's Special Service (CSS) program receiving services in a medical home
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
Goal:	To increase the percentage of children served by the CSS program receiving services in a medical home
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of children 0-20 years of age served by the CSS program receiving services in a medical home **Denominator:** Number of children 0-20 years of age served by the CSS program
Data Sources and Data Issues:	Tennessee Department of Health - Patient Tracking and Billing Management Information System (PTBMIS) - CSS Program data
Significance:	The American Academy of Pediatrics (AAP) specifies seven qualities essential to medical home care: accessible, family-centered, continuous, comprehensive, coordinated, compassionate and culturally effective. Ideally, medical home care is delivered within the context of a trusting and collaborative relationship between the child's family and a competent health professional familiar with the child and family and the child's health history. The measure is limited to the children served by the CSS program.

2016-2020: ESM 11.4 - Number of children referred from the Tennessee Birth Defects Surveillance System (TNBDSS) program that were linked to appropriate supportive services
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
Goal:	To increase the number of children referred from the TNBDSS program that were linked to appropriate supportive services
Definition:	<table><tr><td>**Unit Type:**</td><td>Count</td></tr><tr><td>**Unit Number:**</td><td>100</td></tr><tr><td>**Numerator:**</td><td>Number of children referred from the TNBDSS program that were linked to appropriate supportive services</td></tr><tr><td>**Denominator:**</td><td></td></tr></table>
Data Sources and Data Issues:	Tennessee Department of Health - CSS Program data captured in REDCap
Significance:	The American Academy of Pediatrics (AAP) specifies seven qualities essential to medical home care: accessible, family-centered, continuous, comprehensive, coordinated, compassionate and culturally effective. Ideally, medical home care is delivered within the context of a trusting and collaborative relationship between the child's family and a competent health professional familiar with the child and family and the child's health history. The measure is limited to the children identified with a birth defect and referred to the CSS program.

2016-2020: ESM 12.1 - Number of adolescents on the Adolescent Advisory Council
NPM 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care

Measure Status:	Active
Goal:	To expand the adolescent advisory council
Definition:	**Unit Type:** Count **Unit Number:** 25 **Numerator:** Number of adolescents on the advisory council **Denominator:**
Data Sources and Data Issues:	Children and Youth with Special Healthcare Needs (CYSHCN) program record
Significance:	The transition of youth to adulthood has become a priority issue nationwide as evidenced by the clinical report and algorithm developed jointly by the AAP, American Academy of Family Physicians and American College of Physicians to improve healthcare transitions for all youth and families. Over 90 percent of children with special health care needs now live to adulthood, but are less likely than their non-disabled peers to complete high school, attend college or to be employed. Health and health care are cited as two of the major barriers to making successful transitions. Our CSS program requires all children enrolled in the program have a transition plan in place by age of 14 years and updated every year afterward. The Youth Advisory Council will provide recommendations and advise the CSS program staff on transition concerns youth may face.

2016-2020: ESM 12.2 - Number of providers who receive technical assistance and information on transition for youth and young adults with and without special health care needs
NPM 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care

Measure Status:	Active
Goal:	To increase number of providers who receive technical assistance and information on transition for youth and young adults with and without special health care needs
Definition:	**Unit Type:** Count **Unit Number:** 450 **Numerator:** Number of providers who receive technical assistance and information on transition for youth and young adults with and without special health care needs **Denominator:**
Data Sources and Data Issues:	Children and Youth with Special Healthcare Needs (CYSHCN) program record
Significance:	The transition of youth to adulthood has become a priority issue nationwide as evidenced by the clinical report and algorithm developed jointly by the AAP, American Academy of Family Physicians and American College of Physicians to improve healthcare transitions for all youth and families. Over 90% of children with special health care needs now live to adulthood, but are less likely than their non-disabled peers to complete high school, attend college or to be employed. Health and health care are cited as two of the major barriers to making successful transitions. Our CSS program requires all children enrolled in the program have a transition plan in place by age 14 years and updated every year afterward. The Youth Advisory Council will provide recommendations and advise to CSS program staff on transition concerns youth may face.

2016-2020: ESM 12.3 - Percentage of youth served by the Children's Special Services (CSS) program age 14 and older who have an annual transition plan
NPM 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care

Measure Status:	Active
Goal:	To increase number of providers who receive technical assistance and information on transition for youth and young adults with and without special health care needs
Definition:	**Unit Type:** Count **Unit Number:** 100 **Numerator:** Number of providers who receive technical assistance and information on transition for youth and young adults with and without special health care needs **Denominator:**
Data Sources and Data Issues:	Children and Youth with Special Healthcare Needs (CYSHCN) program record
Significance:	The transition of youth to adulthood has become a priority issue nationwide as evidenced by the clinical report and algorithm developed jointly by the AAP, American Academy of Family Physicians and American College of Physicians to improve healthcare transitions for all youth and families. Over 90% of children with special health care needs now live to adulthood, but are less likely than their non-disabled peers to complete high school, attend college or to be employed. Health and health care are cited as two of the major barriers to making successful transitions. Our CSS program requires all children enrolled in the program have a transition plan in place by age 14 years and updated every year afterward. The Youth Advisory Council will provide recommendations and advise to CSS program staff on transition concerns youth may face.

2016-2020: ESM 12.4 - Number of youths and parents/legal guardians who have completed the Transition Readiness Assessment tool
NPM 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care

Measure Status:	Active
Goal:	Increase the number of youths and parents/legal guardians who have completed the Transition Readiness Assessment tool
Definition:	**Unit Type:** Count **Unit Number:** 100 **Numerator:** Number of youths and parents/legal guardians who have completed the Transition Readiness Assessment tool **Denominator:**
Data Sources and Data Issues:	Tennessee Department of Health - CSS Program data captured in REDCap
Significance:	The transition of youth to adulthood has become a priority issue nationwide as evidenced by the clinical report and algorithm developed jointly by the AAP, American Academy of Family Physicians and American College of Physicians to improve healthcare transitions for all youth and families. Over 90 percent of children with special health care needs now live to adulthood, but are less likely than their non-disabled peers to complete high school, attend college or to be employed. Health and health care are cited as two of the major barriers to making successful transitions. One of our CSS program's focuses is to endure children enrolled in the program have a transition plan in place by age of 14 years and updated every year afterward. The program is to develop a Transition Readiness Assessment tool and program staff will work with youth and parents/guardians to ensure the completion of the Transition Readiness Assessment tool before the children reach 12 years of age.

2016-2020: ESM 14.1.1 - Number of reproductive-aged female tobacco users (15-44 years) who received online or phone counseling services through the Tennessee Tobacco Quitline.
2016-2020: NPM 14.1 – Percent of women who smoke during pregnancy

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase the number of reproductive-aged female tobacco users (15-44 years) who received online or phone counseling services through the Tennessee Tobacco Quitline</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>1,275</td></tr>
<tr><td>Numerator:</td><td>Number of reproductive-aged female tobacco users (15-44 years) who received online or phone counseling services through the Tennessee Tobacco Quitline</td></tr>
<tr><td>Denominator:</td><td></td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Tennessee Tobacco Quitline Vendor Reports. Due to Tennessee’s external operation of the Quitline (current vendor is based out of state), data are not available in-house.</td></tr>
<tr><td>Significance:</td><td>Tobacco use is the number one cause of preventable death in the US and six of the top 10 leading causes of death of Tennessee residents were linked to smoking. In Tennessee, 21.9% of adult women smoke (BRFSS 2015). Tobacco cessation during preconception care can prevent adverse birth outcomes associated with prenatal smoking, such as low birth weight and preterm birth. Prenatal smoking rates have significantly declined in Tennessee, yet 14.3% of Tennessee women smoked during pregnancy in 2015. Smoking cessation also prevents nonsmoker exposure to secondhand and third hand smoke. Telephone-based cessation services like the Tennessee Tobacco Quitline adopt a public health-oriented approach by not only helping tobacco users who desire to quit, but also by actively promoting cessation among the general population.</td></tr>
</table>

2016-2020: ESM 14.2.1 - Number of child care facilities that voluntarily implement a tobacco-free campus policy
NPM 14.2 – Percent of children, ages 0 through 17, who live in households where someone smokes

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To increase the number of child care facilities that voluntarily implement a tobacco-free campus policy</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>795</td></tr>
<tr><td>Numerator:</td><td>Number of licensed childcare facilities in Tennessee who adopt Gold-Sneaker designated policies</td></tr>
<tr><td>Denominator:</td><td></td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>The Gold Sneaker facility tracking database is housed within the Division of Family Health and Wellness, and will be used to provide facility counts. The Gold Sneaker tracking database is updated as facilities receive application approval. However, at this time, there is no process for ensuring previously recognized facilities are still “active” (licensed, open, etc.). An evaluation and re-certification process is currently being developed.</td></tr>
<tr><td>Significance:</td><td>According to the Centers for Disease Control and Prevention (CDC), about 2 in 5 children (aged 3 to 11 years) are exposed to secondhand smoke (SHS). Secondhand smoke exposure increases the risk of infant death syndrome (SIDS), respiratory infections, ear infections, and asthma attacks in infants and children. Secondhand smoke exposure is still a serious problem within the home, the leading source of exposure among children. In Tennessee, roughly 30% of children live in a household where someone smokes. With initiatives such as Gold Sneaker, parents are educated about the dangers of secondhand smoke and the benefits of tobacco-free childcare centers and homes.</td></tr>
</table>

2016-2020: ESM 14.2.2 - Percent of primary caregivers enrolled in home visiting who reported using any tobacco products at enrollments and were referred to tobacco cessation counseling or services within three months of enrollment
NPM 14.2 – Percent of children, ages 0 through 17, who live in households where someone smokes

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To increase the percent of primary caregivers enrolled in home visiting who reported using any tobacco products at enrollments and were referred to tobacco cessation counseling or services within three months of enrollment</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of primary caregivers enrolled in home visiting who reported using any tobacco products at enrollment and were referred to tobacco cessation counseling or services within 3 months of enrollment</td></tr>
<tr><td>Denominator:</td><td>Number of primary caregivers enrolled in home visiting who reported using any tobacco products at enrollment and were enrolled for at least 3 months</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Evidence-Based Home Visiting (EBHV) Referral Tracker (RedCAP); Despite high prevalence of smoking throughout state, data regarding referrals to smoking cessation referrals for evidence-based home visiting participants are not consistently documented in RedCAP. Quality improvement efforts are in development, but the number of EBHV participants who are referred to smoking cessation services is likely underestimated.</td></tr>
<tr><td>Significance:</td><td>Currently operating in 31 of the state’s 95 counties, evidence-based home visiting programs are located in communities with higher rates of smoking, teen pregnancy, low birth weight, prematurity, and infant death. Smoking prevalence among mothers who reside in these select communities ranges from 6 percent to 31 percent. Home visitors assess a number of preventive health and prenatal practices, including prenatal tobacco use and use of tobacco in the home. Evidence-based home visiting services is one of the most effective and cost-effective interventions to help parents support their young children’s health and development and prevent adverse childhood experiences.</td></tr>
</table>

Form 11
Other State Data

State: Tennessee

The Form 11 data are available for review via the link below.

Form 11 Data

Form 12
MCH Data Access and Linkages

State: Tennessee

Annual Report Year 2020

	Access				Linkages	
Data Sources	(A) State Title V Program has Consistent Annual Access to Data Source	(B) State Title V Program has Access to an Electronic Data Source	(C) Describe Periodicity	(D) Indicate Lag Length for Most Timely Data Available in Number of Months	(E) Data Source is Linked to Vital Records Birth	(F) Data Source is Linked to Another Data Source
1) Vital Records Birth	Yes	Yes	More often than monthly	1		
2) Vital Records Death	Yes	Yes	More often than monthly	1	Yes	
3) Medicaid	No	No	Never	NA	No	
4) WIC	Yes	Yes	More often than monthly	0	No	
5) Newborn Bloodspot Screening	Yes	Yes	More often than monthly	0	Yes	
6) Newborn Hearing Screening	Yes	Yes	More often than monthly	0	Yes	
7) Hospital Discharge	Yes	Yes	Quarterly	18	No	
8) PRAMS or PRAMS-like	Yes	Yes	Annually	36	Yes	

Form Notes for Form 12:

None

Field Level Notes for Form 12:

None