Maternal and Child Health Services
Title V Block Grant

State Narrative for Tennessee

Application for 2012
Annual Report for 2010

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I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section. IA - Letter of Transmittal

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

Assurances and Certifications may be obtained from the Tennessee Department of Health, Maternal and Child Health Section, located at 425 5th Avenue, North, 5th Floor, Cordell Hull Building, Nashville, TN 37243.

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published March 2009; expires March 31, 2012.

E. Public Input

Three Public Hearings were conducted during the development of this application. The hearings were distributed throughout the state (East Tennessee--Knoxville, Middle Tennessee--Nashville, and West Tennessee--Jackson). Two hours were allotted for each hearing and representatives of MCH state leadership were present to lead the discussion and address questions and concerns. The purpose of these hearings was to invite the public to offer comments on the MCH Block Grant Application and programs and to participate in the development of the WIC State Plan of Operation and other relevant health programs.

Announcements were sent to state legislators, over 2000 individuals and grass root organizations, vendors, and health care organizations across the state. E-Mail was routed to supervisory health department employees as well as physicians from the Tennessee Hospital Association. The hearing information was posted on the official WIC and MCH Websites with relevant fact sheets and information about all of the WIC, CSFP, and MCH Programs. Hearing notices were posted in the aforementioned clinics and in some newspapers. Additionally, regional and metro MCH directors in each of the hearing locations were urged to invite consumers and staff to attend the hearings.

Nashville participants were generally pleased with MCH services. Those in attendance offered some suggestions for improving programs:
•Better coordination of postpartum family planning
•Referral to home visiting programs during prenatal care visits
•Lead screening during prenatal visits
•Combine home visiting programs instead of having several different programs
•Consider standard postpartum visit for everyone
•Explore additional family planning services for men
•Offer more education for providers on newborn screening

•Clarify Children's Special Services (CSS, state Title V CSHCN program) eligibility rules
•Include family planning in CSHCN transition planning
•Enhance communication between CSHCN program and hospitals

In Jackson, no participants were present, but staff from MCH and WIC programs were present. They were generally complimentary, noting that MCH staff in the Central Office are "very helpful." They also noted that based on feedback from the field, MCH Central Office staff have adapted some processes (e.g. home visiting documentation) to improve efficiency for staff in the field. The field staff reported that their WIC participants are "excited about the Farmer's Market opening" and were particularly pleased that Madison County was reported as having the highest redemption rate of WIC Farmers Market vouchers in the state. Staff are working with vendors to package food in ways that make it practical for participants to purchase fruits and vegetables in individual serving sizes. All offered some suggestions for improving MCH programs:
•Consider having an MCH nurse in the Central Office to field questions from field nurses
•Work with families to let them know the benefits of the CSS program. As CSS caseloads are declining because families have medical coverage from other sources, we need to promote the additional benefits offered by CSS.
•Streamline documentation across various programs (CSS, home visiting programs).
•Need more data to know about local needs, so that counties and regions can address local issues
•Need additional resources for children with identified developmental delays

Knoxville participants included representatives of the county health department, the East TN Regional Health Department and Child and Family Services, a community agency providing temporary housing and shelter for women and children. A portion of the public discussion focused on general administrative issues related to the Department of Health as a whole. Local staff suggested that the Central Office work to streamline the contract and amendment process. Staff also suggested that Program Managers from the Central Office spend time with program field staff to understand the breadth of work being done at the local level. Comments also focused on the need to enhance technology and consider innovative strategies for using technology to communicate with consumers and patients. Other comments included:
•Additional funding is needed for the Breast and Cervical Screening Program to meet the demand of older women and to address the diagnosis and treatment of HPV infections in younger women.
•The Breast and Cervical Cancer Screening Program should mount a strong statewide campaign promoting the HPV vaccine for young women.
•Infrastructure must be developed to improve the Department's information system.
•Consideration should be given to coordinating (or if possible combining) elements of the Child Fatality Review and Fetal Infant Mortality Review (FIMR).
•Co-sleeping is a growing issue in infant deaths but the issue is complex--to adequately address, we need to consider socioeconomic issues as well as cultural and historic norms. Perhaps consider providing cribs that meet current safety standards for safe sleep as we have done for infant car seats.
•Continue to focus on reproductive health services and education to inform and serve the women of Tennessee.

In addition to the Public Hearings described above, a presentation was made at the June 2010 meeting of the Early Childhood Comprehensive Systems (ECCS) Advisory Committee. Approximately 20 committee members were in attendance, representing the following constituencies: Departments of Children's Services, Education, Health, Mental Health and Developmental Disabilities; Family Voices; Prevent Child Abuse Tennessee; Tennessee Commission on Children and Youth; Cumberland Pediatric IPA; Monroe Carell Jr. Children's Hospital at Vanderbilt; Shelby County Early Success Coalition; Le Bonheur Children's Hospital. The MCH Director presented the state priority measures as well as an overview of the national and state performance and outcome data contained in the application.

Recognizing that some consumers may not be able to attend the scheduled public hearings, we

sought additional input through site visits at county health departments throughout the state. Dr. Michael Warren (Title V/MCH Director) visited the Maury County Health Department in Columbia, TN; Jacqueline Johnson (CSS Director) visited the Shelby County Health Department in Memphis, TN; and Mary Jane Dewey (MCH Program Director) visited the Greene County Health Department in Greeneville, TN. At each visit, MCH staff met informally with families who were in the health department to access one or more MCH-related services.

In Maury County, consumers were generally very complimentary of the services obtained through the health department. Families reported that: the services were convenient to access; staff meet their needs; the facility is spacious and clean; and the services are organized efficiently. Each consumer was asked for specific ways that MCH services might be improved. Only one consumer offered a suggestion for improvement--to coordinate WIC enrollment with local hospitals so that enrollment could happen sooner in the post-partum period.

State MCH staff also visited the Children's Special Services (CSS, Tennessee's Title V CSHCN program) clinic in Memphis. The Program Director and Nurse Consultant met with nine families and conducted informal, voluntary interviews about MCH services. Families were overall quite pleased with services at the health department and with the CSS program. They reported coming to the health department for: physical therapy, follow-up checks, immunizations, well-child checkups, and care coordination. Families shared positive comments about clinic wait times, ability to access services, and kind and knowledgeable staff. Several families identified opportunities for improvement: more general parking and better handicap access to the facility overall (including parking).

In Greene County, MCH staff met with eight adults (including two fathers and one residential agency worker) who were visiting the county health department. Most were there with children for WIC services. They reported that they also used the health department for immunizations, pregnancy tests, family planning services, and dental services through age 21. One woman reported that she was enrolled in the home visiting program for the past four years and had referred her two sisters for home visiting services. She also said of her home visitor, "I couldn't have made it through the first few months as a momma without her." Another family included a father recently discharged from the military. The family uses the health department for WIC and immunizations. When queried specifically about needs of military families, both parents stated that spouses need support groups during deployment. The mother noted that a support group would have been especially helpful for her as a new mother when her husband was overseas.

In addition to the public input described above, CSS staff asked the state Family Voices chapter to score Form 13 (detailing family involvement in MCH activities) in an effort to truly capture family perception of MCH activities. The ratings included in Form 13 represent the ones provided by Family Voices staff.

A draft of the application was distributed via email to stakeholders who interact throughout the year in some capacity with MCH staff and programs. A link to an electronic survey accompanied the application and reviewers were asked to submit comments about the draft (along with any other thoughts or comments about MCH programs) via the survey. An aggregate listing of the comments received via this mechanism will be included as an attached file once comments have been received on the draft.

After transmittal of the application, the entire document will be made available on the MCH website. The website will also contain contact information for the MCH Director so that anyone who would like to comment on the application may do so.

An attachment is included in this section. IE - Public Input

II. Needs Assessment

In application year 2012, Section IIC will be used to provide updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

The Needs Assessment for this Block Grant cycle was completed in 2010. The assessment process was founded on the principles of the Life Course Perspective, which emphasizes that the health of mothers and children must be considered within a holistic biopsychosocial and developmental context over the entire life trajectory. The Needs Assessment was intended to be used as a roadmap to guide and assess MCH activities and outcomes for the next 5 years.

Quantitative and qualitative assessment revealed consistent findings regarding major health issues surrounding MCH populations: 1) Tennessee's child and infant mortality rates are worse than those of the U.S., higher than the Healthy People 2010 targets for the U.S., and show wide racial disparities; 2) Injuries are the leading cause of death for Tennessee children and young people ages 1-24, with motor vehicle injury as the number one cause for injury fatality; 3) Childhood obesity is an epidemic engendered by genetic, sociocultural, and environmental factors and has life-long consequences; 4) Asthma impacts health, school attendance and performance, and quality of life; 5)Tobacco use is the chief preventable cause of death; 6) A growing population of children and youth with special health care needs (CSHCN) are surviving into adulthood with a need to transition to adult health care, independent living, and work; 7) Workforce training and development is intricately connected to each and every MCH health issue, in that we will not be able to effectively address these issues without a competent workforce. Objectives for healthy mothers and children go beyond the narrow view of categorical issues to a much broader landscape of integrated MCH services. There is clearly much work to be done in many areas, but these findings offer the rationale for the designation of these state performance/priority measures for the next five years:

1. Reduce the infant mortality rate.
2. Reduce the percentage of obesity and overweight (BMI for age/gender > 85%) among Tennessee K-12 students.
3. Reduce smoking in Tennesseans age 13 years and older.
4. Decrease asthma hospitalizations for children 0-5 years.
5. Improve MCH workforce capacity and competency by designing and implementing a workforce development program.
6. Increase the percentage of CSHCN age 14 and older who have formal plans for transition to adulthood.
7. Reduce unintentional injury deaths in children and young people ages 0-24 years.

The performance measures were chosen based on need; capacity to define, measure and track; connection with other priorities, lending to integrated approaches to the overall health of MCH populations; current political environment; promising or evidence-based practices reported in the literature; MCH workforce capacity and infrastructure; and existing collaborations and partnerships.

/2012/ INTERIM YEAR UPDATE

There have been no major changes in the population strengths and needs in the State priorities since the 2010 Block Grant application. There still remain great health and social challenges among Tennessee's families.

Several major changes have occurred with regards to State MCH Program staffing since the last application. In December 2010, Dr. Michael Warren joined the Department of

Health as Title V/Maternal and Child Health Director. Dr. Warren is a general pediatrician and previously worked in the Governor's Office of Children's Care Coordination. We have also filled several vacant staff positions: Director of Injury Prevention and Detection and Director of Adolescent Pregnancy Prevention. Additionally, the state's CDC-funded Core Violence and Injury Prevention Program was moved to the MCH section, providing many new opportunities to address injury-related morbidity and mortality among the MCH population.

MCH staff regularly review the latest data related to maternal and child health indicators. Through participation in field site visits, educational conferences, and inter-agency committees and projects, staff are able to stay abreast of the most current needs of Tennessee's MCH population.

Our MCH program is working diligently to operationalize the state priority measures identified in 2010. Each program within MCH has identified links between their program activities and the priority measures, and program directors are revising program goals and objectives to more fully incorporate the priority measures into ongoing work. Efforts are also being made to engage regional health department staff in understanding and addressing these priority measures. //2012//

III. State Overview

A. Overview

STATE BACKGROUND

Tennessee is unique in that state statute mandates that all counties have a county health department to provide for basic health needs of its citizens. Title V programs are offered through the county health departments including women's health and family planning, services for children with special health needs, home visiting programs, EPSDT, WIC and dental services for the women and children of Tennessee. The public health role has expanded in recent years to include county health councils for addressing specific county health problems based on data, communicable and environmental disease surveillance and intervention and emergency preparedness. MCH continues to work on developing the levels of the pyramid model concentrating especially on population based and infrastructure services through the health department structure.

The state health department is organized into Central Office divisions and Regional Health Offices to implement, coordinate, and monitor the changing environment of public health. The Central Office is responsible for grant writing, fiscal management, policy development and legislative monitoring and response. The Regional Offices implement Central Office policies and programs through the county health departments assigned to their area. The public health system is linked through an integrated data reporting system to collect demographic data, program services and billing information. As with any large state, the health needs of our citizens vary depending on social, economic and geographic factors that impact health and health services. The following is a summary of those factors of greatest significance to Tennesseans.

The state is geographically, politically, and constitutionally divided into three Grand Divisions: East, Middle and West Tennessee. East Tennessee is the label given to the eastern 35 county area characterized by high mountains and rugged terrain. The region's two urban areas, Knoxville and Chattanooga, are the 3rd and 4th largest cities in the state. Other important cities include the "Tri-Cities" of Bristol, Johnson City, and Kingsport located in the extreme northeastern most part of the state. Middle Tennessee is the 39 county area west of the dividing line between the Eastern and Central time zones and east of the Tennessee River. Middle Tennessee is known for its rolling hills and fertile stream valleys, as well as for its major city, Nashville, which is the state capital and second largest city. Other sizeable cities in Middle Tennessee include Clarksville and Murfreesboro. West Tennessee is the most sharply defined geographically. Its 21 counties are contained by the Mississippi River on the west and the Tennessee River on the east. The largest city in West Tennessee, by far, and the most populous in the state, is Memphis. Outside the greater Memphis area, the region is mostly agricultural. West Tennessee is distinct from Middle and East Tennessee in that African-Americans make up a large percent of the population.

Over 68 percent of Tennessee's population resides in the state's seven Metropolitan Statistical Areas, five of which are in the eastern two-thirds of the state. The most sparsely populated counties are primarily in rural Middle and West Tennessee. The major population centers are linked by the interstate highway system, running north and south and east and west. Transportation within and between the rural counties, roads across the mountains in the east, and links to the interstate system, especially in the west, are limited. Even though there is a health department in each of Tennessee's 95 counties, service delivery is hampered by this mix of topography, population and resource clusters, distances, and transportation difficulties.

According to 2008 Census data, Tennessee is the sixteenth largest state with a population of 6,214,888 people. Twenty-four percent (1,491,573) are under 18 years, and 13 percent (807,935) are 65 years and older. On average 86,000 babies are born each year in Tennessee and about 49% of those births are covered by TennCare the state Medicaid program. The state's population is 80% White and 17% Black. Hispanics are the largest ethnic minority representing three percent (or 186,447 people). ***/2012/The 2010 Census showed that the population of***

Tennessee has increased to 6,346,105; 77% are White, 17% are Black, and 4.6% are of Hispanic origin.//2012//

In 2007, 15.9 percent of Tennesseans lived below the poverty level compared to 13% of the nation. Twenty-three percent of children age 18 and under live in poverty, compared to 17.6 percent for the United States. Twelve percent of all families and 34% of female head of household families have incomes below the poverty level. Many more Blacks (29.9%) and Hispanics (28%) are living below the poverty level as compared to Whites (12.8%). ***/2012/By 2009, the poverty rate had increased to 16.1 percent. Among children under age 18, 22.6% live in poverty. The percentage of families in poverty has remained relatively static (12.2% in 2009). Poverty rates are higher for families with female heads of household (36.6%), and among Blacks 28.5%) and Hispanics (29.7%) compared to Whites (13.3%).//2012//***

Tennessee ranks 43rd in the nation for income. The per capita personal income is 86.2 percent of the national average. The median household income is $42,367 compared to $50,740 (United States median).

According to the 2010 publication, "An Economic Report to the Governor," unemployment in Tennessee has been between 10 and 11 percent since the first quarter of 2009. More than 150,000 jobs have been lost since the beginning of the recession. The number of unemployed has almost doubled since 2007. It is estimated that it will be at least 2 years for state economics to return to pre-recession levels. Sales tax revenues which fund state government are significantly impacted by unemployment, limited tourism and decreased discretionary spending due to the recession. ***/2012/Some improvement has been noted over the past year, with April 2011 employment rates being reported at 9.6%.//2012//***

While there is some variation among reports, it is generally accepted that roughly 70% of Tennessee's high school students graduate with a regular diploma in 4 years. Critical gaps are noted for graduation rates among minority students (e.g., 40-60% for Hispanic and Black students) (Kids Count, 2009).

The health and well-being of many Tennesseans was dramatically impacted by the May 2010 flood which impacted 48 of the state's 95 counties. The Tennessee Department of Health along with 24 other state agencies assisted the Tennessee Emergency Management Agency in responding to the emergency. The Department designated staff to work in the state emergency operations center and the joint field office. The Department also readied EPI (epidemiology) Strike teams in the event they were requested by TEMA (Tennessee Emergency Management Agency) or regional health departments and coordinated care for patients injured during the flood whose homes were destroyed. The Department's Emergency Medical Services Division provided for special needs and medical transportation assistance at temporary shelters in the affected counties.

The Department of Health secured and allocated to several county health departments quantities of tetanus vaccine to ensure flood survivors were protected as they worked to repair and rebuild their homes. As the flooding continued the Department released a series of news releases aimed at protecting the health of citizens affected by the floods. Some of the topics included in the news releases were food safety, vector control, dangers of high water, tetanus, water conservation and water safety.

Following the floods, the Department concentrated efforts on mosquito monitoring, testing and abatement. The Department communicated the need to control the mosquito populations. The Department worked to secure federal funding and/or reimbursement for these activities. Presently, the Department continues to closely examine opportunities to communicate public health messages and provide assistance in the aftermath of the flood.

STATE HEALTH OVERVIEW

Evidence points to there being a strong need to improve Tennesseans' health. While Tennessee has shown improvement in certain health outcome measurements, nationally, Tennessee is ranked 47th out of 51 jurisdictions (including all states and the District of Columbia) in terms of the overall health of its citizens. In 1990, it was ranked 37th and in 2007 it was ranked 46th. In other words, in comparison to these other jurisdictions, Tennessee is not keeping up. The comparatively poor health of Tennesseans negatively impacts not only the quality of life of our citizens, but a wide variety of other issues, including the economy of the state. In the United States and in Tennessee, chronic health conditions such as diabetes, heart disease, and cancer are the leading cause of death and disability. ***/2012/Tennessee's ranking improved to 42nd in 2010.//2012//***

Approximately 86,000 babies are born in Tennessee each year. According to the 2008 PRAMS report, 49% of the births in Tennessee are unplanned or mistimed. Two-thirds of mothers reported that their prenatal care began in the first trimester; it is notable that 4,073 mothers (4.7%) received no prenatal care and 19,499 mothers age 10-17 (22.5%) received little or no prenatal care. The percent of black mothers with no care was 8.8 in 2007--more than twice that of whites.

Adolescent pregnancy rate increased from 13.2 in 2004 to 13.9 in 2007. Black adolescent pregnancy rates are twice that of whites--18.4 vs. 9.2. In 2007, 9.4 percent of babies were born at low birth weight (under 2500 grams). Among Black babies, 14.9 percent were born at low birth weight babies, compared to 8.0 percent for white babies.

Tennessee's infant death rate is almost twice that for the nation at 8.3 per 1,000. Black infant mortality was twice that of whites at 16.4/1,000. There has been little change in the last 25 years. ***/2012/The 2009 infant mortality rate continued to decline, with an overall rate of 8.0 per 1,000 live births. Infant mortality rates remain higher for Black infants (16.0) compared to White infants (6.0). //2012//***

According to the 2008 KidsCount report, 39.1 percent (669,959) of children in Tennessee are enrolled in TennCare (Medicaid) for health care coverage. In 2008, there were 291,866 children under the age of 6 enrolled in TennCare. For these TennCare enrolled children, 98% had completed EPSDT exams; 55,322 of these children received preventive dental care and 19,732 received dental treatment. Lead screening was completed on 62,347 children. ***/2012/ In February 2011, TennCare reported 694,107 enrollees age 0-18. //2012//***

Nearly 28 percent of Tennessee children live in households receiving food stamps, and 38.8 percent of school age children receive free or reduced school lunch. Among students in the ninth grade cohort, 9.6 percent (7,950) drop out before finishing high school.

In 2007 (Current Population Survey), 15.6 percent of Tennessee women 18-64 years of age were uninsured, compared to the national average of 17.6 percent. 95,000 women age 40 to 64 are estimated to be uninsured and at or below 250% FPL (US Census). Health insurance status directly impacts the health of the MCH population. According to ACOG, uninsured 18-64 year old women are three times less likely to have a Pap test in the past 3 years and uninsured women with breast cancer have a 30-50 percent higher risk of dying than insured women (ACOG). An estimated 775,000 people are uninsured in Tennessee.

Smoking is a major risk factor for heart disease, stroke, and lung cancer, and is the single most preventable cause of disease and death in the United States. Tennessee has one of the highest rates of smoking in the United States and also some of the highest rates of heart disease, stroke, and lung cancer. Additionally, smoking during pregnancy can lead to pregnancy complications and serious health problems in newborns. A parent who smokes is also a known risk factor for children developing asthma and other respiratory problems. Approximately 27 percent of Tennessee mothers report tobacco use during pregnancy.

MCH PRIORITY POPULATIONS

The MCH priority populations for county health services are low income, medically underserved women, children and adolescents emphasizing outreach and service to African American and Hispanics who have no other financial resources or access to the health care system. While most special needs children have access to health care through private coverage or enrollment in the state Medicaid program called TennCare, more than 6,500 are enrolled in the state Children's Special Services program for assistance with other uncovered needs such as special formulas, adaptive equipment and co-pays and deductibles. These children remain a priority for MCH as well.

STATE HEALTH INITIATIVES

There are several state government initiatives to address chronic disease, including smoking cessation, a new State Healthcare Report Card on Diabetes and Hypertension, and Coordinated School Health programs.

Smoking Cessation

The State's Smoking Cessation initiative is a combination of two programs overseen by the Tennessee Department of Health (TDOH) and an increase in the tobacco sales tax. The Tennessee Non-Smokers Protection Act passed in 2007. Beginning October 1, 2007, Tennesseans were able to breathe smoke free at numerous restaurants, hotels, and many other establishments as a result of the Tennessee Non-Smokers Protection Act. This law, enforced by the TDOH, makes it illegal to smoke in most places where people work (http://health.state.tn.us/smokefreetennessee/). An additional resource is the Tennessee Tobacco QuitLine. The QuitLine is a toll-free telephone service (1-800-QUIT NOW) that provides personalized support for Tennesseans who want to quit smoking or chewing tobacco. Participants are assigned "quit coaches" who assist them in developing individualized quitting plans and work with them for an entire year. Additional information is available at: http://health.state.tn.us/tobaccoquitline.htm.

Accompanying the Non-Smoker Protection Act in 2007 was an increase in the tobacco sales tax. Effective July 1, 2007, the state tax on cigarettes increased from $0.20 to $0.62 per pack. Additional annual revenues from the increase are earmarked for education (estimate: $195 million), agricultural enhancements (estimate: $21 million) and trauma centers statewide (estimate: $12 million). More information is available at: http://tennessee.gov/revenue/misc/cigtaxincrease.htm.

School Health

Healthy habits begin in childhood, so the time that children spend in school is an opportunity to create healthy behaviors that will last into adulthood. In 2006, the General Assembly passed and Governor Phil Bredesen signed into law funding for Coordinated School Health for every Local Education Agency (LEA) in every school district in Tennessee. The statewide Coordinated School Health program is the first of its kind in the nation, and builds upon a five-year pilot project at ten sites in Tennessee.

The Office of Coordinated School Health works with local education departments on the following eight components of school health: nutrition; physical education, activity, and wellness; healthy school environment; mental health and school counseling; school staff wellness; student, family, and community partners; health services; and health education. Coordinated School Health programs create partnerships at the state and local level with county health departments, universities, businesses, hospitals, and non-profit organizations. The project has brought in four million dollars in grants and in-kind contributions at the local level as a result of its partnerships.

Tennessee law requires all public schools to include 90 minutes of physical education per week

during school hours from kindergarten through 12th grade. All local education agencies (LEAs) are also required to screen students in grades K, 2, 4, 6, and 8 for vision, hearing, body mass index (BMI), and blood pressure. In the first year of implementation, the 2007-08 academic year, 80.6 percent of schools were compliant. Some LEAs also conducted dental screenings (39 percent), BMI and blood pressure screenings in high school, and/or scoliosis screenings in 6th grade (41 percent). As a result of the required and optional screenings, 104,532 students were referred to doctors, with most referrals for BMI (45 percent), vision (27 percent), and dental (14 percent). Without these screenings these children might not have received care for their conditions.

In 2005, vending machine legislation was passed which addressed competitive foods sold within K-8 schools. Standards were developed and enacted which controlled portion sizes on these foods as well as nutrient content. Policy was also mandated statewide to enact 90 minutes of physical activity weekly for all public school students in Tennessee. Schools were compliant by the 2007-2008 school year. In August 2010, Executive Order #69 was published which promotes the sale of healthy food and beverage options in vending facilities on state property for use by vendors servicing these vending facilities.

Mental Health

The Department of Education's Office of Schools and Mental Health has a $301,010 eighteen-month grant from the United States Department of Education Office of Safe and Drug Free Schools for Coordinated School Health coordinators to integrate schools' health and mental health systems. School staff, including teachers, administrators, and bus drivers, will be trained to recognize signs of mental health problems and how to make referrals to the appropriate person. In addition, in Project BASIC (Better Attitudes and Skills in Children) the Tennessee Department of Mental Health and Developmental Disabilities (TDMHDD) places child development consultants in elementary schools to identify and refer children with severe emotional disturbances. TDMHDD also oversees and supports school based mental health services by providing liaisons who train teachers to provide positive behavioral supports and behavior plans. Liaisons also see youth for brief interventions and guide groups of children in anger management and communication skills enhancement.

The TDMHDD provides essential mental health services to 19,716 impoverished and uninsured severely and/or persistently mentally ill people through the Behavioral Health Safety Net. The program was created to help mentally ill people who were disenrolled from TennCare, Tennessee's Medicaid program, during the reforms of 2005. The Behavioral Health Safety Net is a partnership between the TDMHDD and 19 local mental health agencies. The Behavioral Health Safety Net provides assessment, evaluation, diagnostic, and therapeutic sessions; case management; psychiatric medication management; lab work related to medication management; and pharmacy assistance and coordination. The Behavioral Health Safety Net partners with the Cover Tennessee Cover Rx program for pharmacy services including discounts on generic and brand name drugs plus one atypical antipsychotic drug per month with a $5.00 co-pay. In 2007 the program was expanded so that lithium and Depakote could be available with a $5.00 co-pay. An additional 12,000 very low income Tennesseans diagnosed with severe and persistent mental illness were transferred from TennCare to the Behavioral Health Safety Net in January 2009.

Medicaid and Other Health Insurance Services

Operating under a Section 1115 waiver from the Centers for Medicaid and Medicare, TennCare serves Medicaid eligible persons and a small number of other uninsured Tennesseans. Data for December 2008 show there were 1,205,214 enrollees, and that 97.3 percent were on Medicaid. Approximately 24 percent (288,629 in 2007) of enrollees are females ages 14-44. Of the total births in Tennessee for 2007, 49 percent were covered by TennCare. All health care services are provided through a managed care approach with three managed care organizations (MCOs) providing medical and behavioral health services, a dental benefit manager (DBM) providing covered dental services for children, and a pharmacy benefit manager providing pharmacy services.

TennCare outreach in the local health department clinics assists clients with access and referral to his/her TennCare primary care provider, assists with navigating the system, and provides for close collaboration of health department staff with community providers. The TennCare September 2008 HEDIS report provides three years of comparative analysis of results from the MCOs on specified benchmarks. Two of these are applicable to the reproductive age population: cervical cancer screening and Chlamydia screening. Overall, statewide screening results for both indicators are lower than the Medicaid national average. Progress has been made from 2005 to 2008 for cervical cancer screening (54.1% to 59.2%), but Chlamydia screening has remained fairly constant (2006 -- 50.6%; 2008 -- 51.7%).

Through the Cover Tennessee Act of 2006, Governor Bredesen and the General Assembly authorized the Department of Finance and Administration to establish the Cover Tennessee program to provide health insurance options to certain uninsured individuals in Tennessee. More information can be found at http://www.covertn.gov or by calling 1-866-COVERTN. Cover Tennessee is an umbrella initiative designed for affordability and portability that includes four health insurance products and pharmacy assistance. These programs are:

CoverTN is a limited (non-catastrophic event), portable health insurance plan for employees of small businesses and self-employed individuals. It emphasizes low front-end costs to encourage preventive care, including free checkups, free mammograms, and low co-pays. Premiums are split 1/3 each by the individual, the employer, and the state.

CoverKids is Tennessee's program under the federal State Children's Health Insurance Program for families with incomes that are too high to qualify for TennCare coverage. The program provides coverage for children 18 and under and maternity coverage for pregnant women. It features no monthly premiums, but each participant pays reduced co-payments for services. The coverage includes an emphasis on preventive health services and coverage for physician services, hospitals, vaccinations, well-child visits, healthy babies program, developmental screenings, mental health vision care, and dental services. Qualifying for enrollment for CoverKids is based on a household income of up to 250% of the federal poverty level (FPL), the number of persons in the household and also on the age of the child you wish to enroll. Household income includes income earned and income received. Children in families with a household income greater than 250% FPL may buy into the CoverKids plan.

AccessTN provides comprehensive health insurance options for uninsurable Tennesseans--those with sufficient incomes but who can't purchase health insurance due to certain pre-existing conditions. There is no income test for this program, which is one of 34 State high-risk pools in the country that perform this function. Funding comes from several sources, including individual premiums, some state assistance, and assessments on the insurance industry.

Tennesseans Between Jobs, a CoverTN category, is open to those who have worked at least one 20-hour week in the last six months and earned an annual income of $43,000 or less, or who have had their work hours reduced to below 20 hours. The state will pay one-third of eligible workers' insurance premiums.

CoverRx is designed to help those who have no pharmacy coverage, but have a critical need for medication. It pays for up to five prescriptions per month. Insulin and diabetic supplies are excluded from the prescription limit. Because CoverRx is not insurance, there are no monthly premiums and no cost to join. Members are responsible for affordable, income-based co-pays when they fill prescriptions. Participants will pay a discounted price for any drugs that are not covered.

TENNderCare
The TENNderCare program is a robust outreach program established in 2004 to increase EPSDT rates across the state. Nurses and lay workers (122 Full Time Equivalents [FTE]) conduct home

visits, community outreach (health fairs, school health programs, etc.), and telephone outreach for TennCare enrollees to provide information and facilitate transportation, appointments, explanation of benefits, etc. Also in 2004, a centralized telephone call center was established, with an additional staff of 14 lay workers, aiming to encourage appropriate service use (early prenatal care, EPSDT, etc.) and to provide information about TennCare.

In 2006, the program was expanded to include targeted outreach to pregnant and post-partum women covered by TennCare to facilitate early and appropriate prenatal and infant care and to specifically work to resolve problems associated with presumptive eligibility. An additional 13 lay worker FTE's were added to the call center in order to reach more working patients and families and those not at home during daytime hours. A nurse call center was established (3 FTE's) to field more complex questions and to directly target increasing the proportion of pregnant women entering early prenatal care.

In 2010, 2 teen pregnancy care coordination pilots and an outreach initiative to increase EPSDT rates among adolescents have been initiated in middle and high schools with large numbers of students receiving free or reduced lunch. There are expansion plans for 2010-11 including additional targeted outreach to adolescents and pregnant teens; establishment of a TennCare/TENNderCare/MCO collaborative to specifically focus on process and performance improvements; and new case finding and management enhancements with CSS participants and families.

Department of Health
In keeping with the plan developed by the State Health Plan Advisory Committee, the Department of Health endorses the following principles which mirror many of the ten essential public health services and reinforces the mission of the Department which is to promote, protect and improve the health and wellbeing of Tennesseans.

1. The purpose of the State Health Plan is to improve the health of Tennesseans.
2. Every citizen should have reasonable access to health care.
3. The state's health care resources should be developed to address the needs of Tennesseans while encouraging competitive markets, economic efficiencies and the continued development of the state's health care system.
4. Every citizen should have confidence that the quality of health care is continually monitored and standards are adhered to by health care providers.
5. The state should support the development, recruitment, and retention of a sufficient and quality health care workforce.

The following are examples of how the Department actualizes the mission:

The Department promotes health by emphasizing the importance of healthy lifestyle behaviors through the Get Fit! Campaign for all Tennesseans (http://www.getfittn.com/). The Department has also implemented an evidence based smoking cessation initiative through county health departments by assessing willingness to quit and offering the tools to assist citizens in their effort to quit smoking. Fewer adults smoking has a positive effect on the immediate health of infants and children and will perhaps reduce teen smoking in future years. MCH promotes health by providing EPSDT screening, immunizations, and dental screening and care for children at the local level.

The Department protects health through MCH by providing home visiting services to at risk families emphasizing infant stimulation, child development, and appropriate parenting. Home visiting services also include referral to community resources for needed services to improve pregnancy outcome and prevent child abuse. SIDS and child fatality are addressed by thorough case review and public education campaigns to teach safe sleep practices, for example. The state advisory committee for Child Fatality Review recommends action that sometimes requires legislation such as the graduated driving license to reduce teen motor vehicle crashes as a

means of protecting the health of Tennesseans.

Finally, the Department and MCH are working to improve the health of Tennesseans using collaborative partnerships to develop infrastructure and population based services for children and families. The Genetics and Newborn Screening Program, which includes hearing screening, provides services to all children born in Tennessee resulting in early identification and intervention for improved health during infancy. The Early Childhood Coordinated Systems (ECCS/CISS) partnership is coordinating services and programs that address needs of young children and their families emphasizing early child care and social emotional health issues for children under age 6.

The Maternal and Child Health Section plays an important role in actualizing the mission of the Department. MCH continues to emphasize the importance of health behaviors that contribute to healthy births, appropriate growth and development, prevention and early intervention services that improve the quality of life for women and children in Tennessee. The needs assessment process resulted in identifying priority areas for state performance objectives to augment the required performance measures for all states.

OTHER STATE INITIATIVES

Diabetes and Hypertension Report Card

The Health Quality Initiative, a study group of state government health, health care, and health planning experts and private sector volunteers convened by M. D. Goetz, Jr., then Commissioner of Finance and Administration for the state, produced the State Healthcare Report Card Version 1.1 -- Diabetes and Hypertension in March 2009 available at the Division of Health Planning's website. (www.state.tn.us/finance/HealthPlan/dhpshtml) This report, for the first time, provides information on these two conditions at county and regional levels within Tennessee.

Resource Map of Children's Services

In 2009, Tennessee's Commission on Children and Youth (TCCY) conducted a statutorily mandated assessment of children's services in Tennessee. TCCY was charged with development of a resource map in order to develop a "clearer understanding of services and programs for children across the state to better inform the Governor and members of the General Assembly in developing policy, setting goals and making decisions regarding allocation of funds." The full report, published in April, 2010, is available at Resource Map of Expenditures for Tennessee Children, Tennessee Commission on Children and Youth, 2010 Annual Report. http://www.tn.gov/tccy/MAP-rpt10.pdf

Notable findings from the resource mapping project include:

-Twenty-five state agencies provided almost 20 million child/family services with expenditures totaling $4,475,705,465 for FY 2007-08.

-Many children receive multiple services, yet "current data systems are inadequate to precisely track the approximately 1.47 million children in Tennessee across multiple services within and across departments/agencies. They also do not tell us whether the children receiving services had one or multiple contacts with each program reporting them."

-Federal funding accounted for just over 2/3 of every dollar spent for children's and family services in Tennessee, and state funding accounted for 30% of expenditures in 2008. "State departments/agencies have been very diligent in identifying budget reduction strategies that do not result in the accompanying loss of substantial amounts of federal funds matched by state dollars. This is becoming increasingly difficult. Additional sizeable decreases in state dollars are more likely to further erode the foundation of essential services and supports as they precipitate the loss of federal funds due to the inability of departments/agencies to provide

required matching or maintenance of effort (MOE) dollars."

According to the 2010 Resource Map Report, "the largest source of expenditures for children is the BEP [Basic Education Program], then TennCare, followed by the departments of Human Services, Education and Children's Services. Department of Mental Health funding for services for children are substantially below the other primary departments, but TennCare funding for mental/behavioral health services totaled $118,415,200 in FY 2007 and $112,193,000 in FY 2008."***/2012/The 2011 Resource Map Report is available at: http://www.tn.gov/tccy/MAP-rpt11.pdf. According to the report, 25 state agencies served over 14,303,187 children in FY09-10, with expenditures of $9,434,304,196. Additionally, "excluding the BEP, around three of every four dollars spent on services for children and families in Tennessee were from federal funding sources (73 percent in FY 2009 and 78 percent in FY2010). State funding accounted for 26 percent of all expenditures in FY 2009 and 21 percent in FY 2010".//2012//***

PRIORITIZATION OF MCH ACTIVITIES

The process for establishing MCH priorities in Tennessee included several iterative steps, described in the following narrative.

MCH Stakeholder Survey

A Professional Stakeholder Survey was developed for the Needs Assessment. This survey was reviewed, updated, and sent out January 7, 2010. A copy of the Professional Stakeholder Survey and Final Report is contained in the Needs Assessment Appendix A. MCH related information was used to design the 39 item questionnaire. Items on the survey were directly tied to the National Maternal and Child Health Performance Measures, and to a somewhat lesser extent, Healthy People 2010 MCH-related outcomes. The survey design process was also influenced by information obtained in meetings with TDH-MCH staff members.

County Health Council Priorities

Tennessee implemented regional and county health councils in 1996 to increase local involvement in public health priorities. Each county has a health council made up of county professionals and citizens concerned about the health problems of its residents. Regional and county health priorities have been used to coordinate county and regional activities with partners, to mobilize communities to address priorities and to seek grant funding for special initiatives.

2009 county health priority lists were received from 61 of 89 counties (68.5%) and all 6 Metro Councils. All the lists were reviewed and MCH-relevant health issues were derived. A table was created for each of the 7 rural regions, containing the counties and the priorities per county. The top 3 MCH priorities per region were determined by counting how many times a priority was listed. The Metros were counted separately from the regions (rural counties). Combined regional and Metro priorities were counted to arrive at the top County Health Council health priorities.

Children's Special Service Advisory Council

The Children's Special Service Advisory Council (see CSS Advisory Council list in Needs Assessment Appendix B) met April 23, 2010 and established health priorities for children and youth with special health care needs. Jacqueline Johnson (CSS Program Director) presented an update on CSS data and outreach efforts, and results from the National Survey of Children with Special Health Care Needs and the Family Voices State survey. She also presented the current MCH National and State Performance Measures, along with a discussion on the MCH Pyramid and Life Course Perspective. Ms. Johnson reminded participants of the shift in CSS from direct services toward enabling services. Attendees discussed their experiences with gaps and strengths of CSHCN services and needs. The group considered survey results, trends, and their own experience to arrive at their top priorities. Nominal group process was used to determine and rank the priorities. The group decided that medical home and transition to adulthood were the key issues for CSHCN in Tennessee.

Key Informant Interviews
Key informant interviews also informed prioritization of health issues. Key informants included providers and administrators in county and regional Health Departments, MCH program directors, and State and local health agency leaders and members.

Review and Analysis of MCH Health Indicators
State, local, and national health indicators are reviewed and monitored regularly to identify trends and changes. Priorities are also considered based on acuity of need in each of the MCH populations.

Review of MCH Literature and Research
Current MCH literature and research from a variety of disciplines also informed decisions about health priorities. For example, several models and frameworks have been developed and adapted over the last 2 decades that illustrate and frame the social-ecological nature of health. The 2003 Institute of Medicine (IOM) report, The Future of the Public's Health in the 21st Century describes physical and social determinants of population health and the inextricable link among biological, environmental and social experiences. The Life-Course Perspective integrates this population-focused ecological approach with both an individual-focused "early program," and "cumulative" pathway approach. This integration offers a different framework for considering cumulative risk and protective factors, relative to time and critical periods of development (Halfon & Hochstein, 2002). With this in mind, the MCH team considered Tennessee health priorities and capacity from a more holistic instead of specific programmatic context.

Linking priority with capacity
The MCH team assessed the strengths and weakness in the capacity of the system across levels of the pyramid to meet the identified priority health needs. We compiled information gathered through the needs and capacity assessments and spent individual time and group "brainstorming" time to link needs with system capacity: including workforce training and development across programs and division, economic feasibility, ability to fully define and measure the problem, and current political environment.

2010 Tennessee MCH Priorities/Performance Measures
/2012/Utilizing the aforementioned prioritization process, the following state priority measures were identified://2012//

1. Reduce the infant mortality rate.
2. Reduce the percentage of obesity and overweight (BMI for age/gender > 85%) among Tennessee K-12 students.
3. Reduce smoking in Tennesseans age 13 years and older.
4. Decrease asthma hospitalizations for children 0-5 years.
5. Improve MCH workforce capacity and competency by designing and implementing a workforce development program.
6. Increase the percentage of CSHCN age 14 and older who have formal plans for transition to adulthood.
7. Reduce unintentional injury deaths in children and young people ages 0-24 years.

***NOTE: Portions of this overview are excerpted from the Tennessee State Health Plan 2009, available online at:
http://www.tn.gov/finance/healthplanning/Documents/2009TennesseeStateHealthPlan.pdf

B. Agency Capacity

/2012/The Tennessee Department of Health is well-equipped to promote and protect the health of all mothers and children, including CSHCN. //2012//Despite some significant public health and MCH resource challenges, Tennessee has a number of available resources and opportunities. An overview and some examples are described.

AGENCY BACKGROUND

/2012/The Tennessee Department of Health's mission is to promote, protect, and improve the lives of those who live in, work in, or visit Tennessee. The agency accomplishes this through provision of core public health services.//2012// 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 95 counties of the state 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.

The most recent local public health workforce survey was published by the National Association of County and City Health Officials (NACCHO) in 2008. At that time, TDOH reported employing 4216 employees (2149 rural and 2067 metro) equating to 3811 FTE's. Findings suggest a gap in advanced educational preparation for local public health executives with only 30% reporting preparation beyond the bachelor's degree level. Note this survey did not include central office personnel nor did it include that staffing levels have been reduced since 2008.

Few of Tennessee's local health department leaders have advanced degrees. Of 130 executive leaders, only 25 have master's degrees, 2 have MDs, 1 has a JD, and there are none with other doctorates. The rest have bachelor's or associate degrees.

In 2009, public health efforts were disproportionately funded with state vs. federal dollars when compared with most other states (Trust for America's Health, 2009). Funding examples include:

-Federal funding from CDC to Tennessee is $16.42 per capita compared to $19.23 per capita U.S. average (rank 42).

-Federal funding from HRSA to the state is $22.53 per capita compared to $24.71 per capita U.S. average (rank 30).

-State funding for public health $45.74 per capita compared to $28.92 per capita U.S. average (rank 18).

STATEWIDE SYSTEM OF SERVICES

/2012/The Department of Health has taken a number of steps to create a statewide system of services, either through direct administration of programs or through collaboration with other state agencies or private-sector stakeholders.//2012//

Home Visiting Services

/2012/The Department offers home visiting services in all 95 counties across the state.//2012//Home visiting programs operated by MCH include HUGS, (Help Us Grow Successfully) CHAD, (Child Health and Development program), Healthy Start, and Nurse Family Partnership. Key outcomes for MCH home visiting programs include improved birth spacing, child immunization and EPSDT rates, and decreased maltreatment or neglect reports. Good outcomes of these programs are contingent upon continued funding, well-staffed programs, a competent

workforce, robust data collection systems, and continued training and educational programs.

Plans for improving competency and capacity in MCH home visiting programs:

-Improve ability to use PTBMIS to collect and extract data from HUGs visits. Lessons learned from the methodology, data analysis, and application of this will inform plans and implementation for the other home visiting programs.

-Home visitors and nurses are included in the workforce development plan that incorporates Public Health Core Competency training and tracking.

Other MCH Initiatives
Funds supporting maternal and child health activity include several special funding sources in addition to the MCH Block Grant. These grants are administered by MCH staff.

Breast and Cervical Cancer Screening Program
A recent addition to the public health system is the availability of breast and cervical cancer screening, diagnosis, and treatment through the state's CDC recognized program. Over 14,000 of the estimated 95,000 eligible women are screened annually for breast and cervical cancer. County health departments and some primary care centers serve as points of entry. Breast centers and specialty providers participate by providing screening and diagnostic tests to confirm or rule out cancer. Those diagnosed are enrolled in TennCare for treatment. This program could be used as a model for other preventive screening initiatives and for reinforcing the importance of practicing healthy behaviors throughout the life cycle.

State Systems Development Initiative
The state's award for State Systems Development Initiative (SSDI) has been used to develop and update the computer network and data management infrastructure. This funding stream has benefited not only MCH but also the other sections of the Bureau of Health Services since SSDI funds were used for the integrated database on clients and services for program management called PTBMIS, which is used by all health service programs. SSDI funds have also been used in the past to upgrade the hardware and software used in the Genetic and Newborn Screening Program and to provide critical information from linked data sets.

Early Childhood Comprehensive Systems
MCH has received funding since 2003 for the state's Early Childhood Comprehensive System (ECCS) program. The purpose of ECCS/CISS is to support the Maternal and Child Health programs and the Title V partner organizations in collaborative efforts to strengthen the early childhood system of services for young children and their families. The ECCS/CISS system is designed to efficiently empower families and communities in their development of children ages 0-5 years old that are healthy and ready to learn at school entry. The funding is used for the quarterly advisory committee meetings, travel, and staff support.

Newborn Hearing
Newborn Hearing Screening funding is received from the federal government to provide follow-up on infants who failed to pass the initial hearing screen at birth; funding is being used for audiologist consultation, parent support staff, a deaf educator, and outreach to the Hispanic population and to rural populations.

Family Planning/Title X
Family planning funding is received through the Title X federal grant; the funding supports approximately 37 percent of the program expenditures; comprehensive family planning services are available in all 95 counties in 128 clinic sites. Title X funds have been provided to the Department of Health since 1972.

AGENCY CAPACITY FOR PREVENTIVE AND PRIMARY CARE SERVICES
TDOH is the state's largest, direct service health care provider, logging 2.4 million visits and serving just over 1 million unduplicated Tennesseans annually. Children, infants and child-bearing age women represent two-thirds of this number. Each of Tennessee's 95 counties has one or more local health department clinics where traditional public health services are delivered via sliding-fee schedule. These services include surveillance and investigation of communicable disease and other outbreaks, well-child checkups, EPSDT screenings, immunizations, women's health/reproductive health services, and WIC/nutrition services. Sliding-scale fee-based, primary care services are provided for uninsured adults (age 19-64 years) in 56 local health department sites. Thirteen of the 56 local health department clinic sites are designated as federally-funded, 330 health centers.

Clinical services delivered at TDOH clinics are rigorously monitored at state, regional, and local levels. Quality Improvement nurses and internal auditors routinely abstract data from patient records, conduct patient satisfaction surveys, and monitor adherence to policies and treatment guidelines via established criteria. In FY 2008-09, adherence to all criteria was generally >95%, but ranged from 90-100%. The complete report is available upon request (Quality Improvement Statewide Survey, Fiscal Year 2008-2009). Performance measures are currently under review, and new outcome measures are under development. A new Quality Management plan is anticipated to guide assessment activities in 2011.

A new, state-level Quality Improvement and Accreditation Division was established in 2008. The Division Director, Dr. Bridget McCabe, is a pediatrician with post-doctoral, Institute for Healthcare Improvement fellowship training in clinical improvement and health outcomes measurement. Dr. McCabe is charged with oversight and refurbishment of statewide quality assessment initiatives.

Direct Health Care Services: Paradigm Shift
In 2009, MCH consultant, Dr. Donna Petersen, noted an imbalance in service delivery levels in Tennessee's health departments. Using MCHB Pyramid criteria, the majority of services were notably "direct care" with far fewer services available to Tennesseans in the remaining categories. She subsequently recommended exploration of ways to reduce direct services and increase enabling, population-based, and infrastructure building activities in local health departments. Notwithstanding continuing efforts, the following has been accomplished to date:

-Two primary care clinics have been closed due to increased access provided by local FQHC expansions.

-Prenatal care services provided in 3 local health department clinics have been discontinued and patients transitioned to private medical homes in collaboration with TennCare/Cover Kids for coverage expansions. One clinic remains, due to FQHC status, to serve uninsured women.

-Children's Special Services specialty clinics (orthopedic, otolaryngology, speech, etc.) maintained by 4 regional health departments have been discontinued, alternate sources of care have been determined for patients in collaboration with TennCare/Cover Kids, and staff has been re-directed to patient navigation and case management activities.

-CSS, HUGS, and CHAD services have been integrated. In the past, each of these programs had separate staff. Budget constraints led to service integration where staff may be responsible for providing services within all three programs.

-CSS, HUGS, and CHAD program directors held state-wide leadership and staff meeting in 2010 to discuss service integration. Formal and informal brainstorming sessions led to a strategic plan addressing training needs. The overarching need was to develop standardized ongoing training that includes: programmatic training, Public Health/MCH Core Competencies, MCH Health Service Pyramid, Life Course Perspective, Florida Curriculum "Partners for Healthy Babies," and mentoring.

/2012/In addition to the previously described primary care and preventive services, the Department collaborates with other provider organizations to enhance the state's capacity to provide such services across the state.//2012//

Twenty-three federally qualified health centers (not affiliated with the health department) provided primary and prenatal care for more than 326,508 unduplicated patients in 132 sites across the state in 2009 (Tennessee Primary Care Association, 2009).

TDOH administers supplemental Safety Net funding to faith-based, federally qualified, and other community clinics for primary and preventive care services, as well as emergency dental services, for uninsured adults. In 2009-10, $10.2 million was appropriated by the Tennessee General Assembly for this purpose. ***/2012/In 2010-11, $10.2 million was again appropriated by the General Assembly for Safety Net funding; this includes $5.1 million for the FQHCs and $5.1 million for the Community & Faith Based providers.//2012//***

Virtually 100% of the Tennessee residents live within 30 miles of a primary care source yet despite availability of these direct care services at either a local health department or a federally qualified health center, 94 of Tennessee's 95 counties were designated as medically underserved (partial or whole) in 2005 (Tennessee Health Access Plan, 2005).

Other key measures of access to care include:
-31 counties were designated as Health Resource Shortage Areas
-30 counties were designated as obstetric shortage areas
-30 counties were declared pediatric primary care shortage areas
-30 counties have a shortage of providers accepting TennCare
-3 counties have no dentist (Pickett, Lake, and Van Buren counties)
-7 counties have ratios of >10,000 residents/dentist
-75 counties lack adequate mental health professionals (as measured by federal health professional shortage designation of >20,000 residents per mental health provider)

The Bureau of Health Services Administration, Community Health Systems division, regularly monitors direct primary care service delivery capacity. Available data sets (e.g., licensure registries) and statewide telephone and electronic surveys (physicians, mid-level providers, and dentists) are used to assess needs and to identify service gaps. Working directly with various stakeholders such as universities, the Tennessee Hospital Association, Tennessee Primary Care Association, and the Rural Health Partnership, Community Health Systems staff administer various programs designed to recruit primary care providers to practice in underserved Tennessee localities. Examples of such programs follow.

National Health Service Corps Program (NHSC) -- In 2010, ninety-eight (98) health care professionals received NHSC support: 20 Physicians, 12 Dentists, 36 advanced practice nurses, 4 Physician Assistants, 2 Nurse Mid-Wives, and 18 mental health providers. Forty-two of the 98 are practicing at Federally Qualified Health Centers. Fifty-three of the 98 are located in rural areas. ***/2012/There were approximately 206 NHSC loan repayment recipients practicing in Tennessee as of 12/31/2010 (State Office of Primary Care, March 2011).//2012//***

Graduate Medical Education (GME) - Residency Stipend Program - Medical residents enrolled in a Tennessee primary care residency program (ETSU, Meharry, University of Tennessee, or Vanderbilt) are eligible for a $25,000 annual GME Stipend. Funds are made available through TennCare (Medicaid).

J-1 Visa Waiver Programs - Foreign medical graduates receive a 2-year home residence waiver in exchange for a 3-year underserved area service obligation.

The Health Access Practice Incentive Grant Program (PIG) - Legislatively mandated and funded by unclaimed property, grants up to $50,000 can be awarded to physicians, dentists, or mid-level practitioners who agree to practice in a health resource shortage area for 3 years. These grants (entirely funded with state dollars) have been frozen since 2008 due to budget reductions.

State Loan Repayment Program (SLRP) - This program is funded by a 1:1 federal:state match for educational loan repayment to primary care practitioners in exchange for a 2-year service commitment in a Health Professional Shortage Area (HPSA).

/2012/The Department is also engaged in a number of other partnerships to improve the quality of care delivered to Tennesseans and to improve the workforce capacity of public health workers across the state.//2012//

We have increased our active participation with MCH/HRSA grantees, e.g., participation and work with Vanderbilt investigators to inform LEND topics based on field staff training needs for the coming year; work with grantees at the Boling Center to include topics such as community-based obesity prevention strategies and to budget training slots for up to 50 local and distance TDOH participants. We have provided a letter of support, citing TDOH training needs, for an ETSU training grant proposal, as their recent accreditation enables Tennessee's first opportunity to apply for such funding. Additional training opportunities and funding will be sought as guidance from the training needs assessment emerges.

AGENCY CAPACITY FOR CSHCN SERVICES

Children's Special Services (CSS) is the state's Title V CSHCN program. Children's Special Services addresses the special health care needs of children from birth to the age of 21 years who meet both medical and financial eligibility criteria. State statue defines children with special health care needs as: "A child under the age of 21 who is deemed chronically handicapped by any reason of physical infirmity, whether congenital or acquired, as a result of accident or disease, which requires medical, surgical, or dental treatment and rehabilitation, and is or may be totally or partially incapacitated for the receipt of a normal education or for self-support. This definition shall not include those children whose sole diagnosis is blindness or deafness; nor shall this definition include children who are diagnosed as psychotic." ***/2012/ The Legislature changed the definition of children with special health care needs. The statute now reads "A child under the age of 21 who is deemed to have a physical disability by any reason whether congenital or acquired, as a result of accident, or disease, which requires medical, surgical, or dental treatment and rehabilitation, and who is or may be totally or partially incapacitated for the receipt of a normal education or for self-support.//2012//***

Children's Special Services has an established financial criterion of income not greater than 200% of the federal poverty level. The program financial guidelines are updated by April 1 of each year. To assist families in qualifying financially, the CSS program will use spend-downs including; premiums paid for other health insurances, payments for child support, and any paid medical bills incurred over the past year for the entire family.

CSS provides reimbursement for medical care, supplies, pharmaceuticals, and therapies directly related to the child's diagnosis. Medical services are provided through a network of private and public, i.e., TennCare/Medicaid approved providers.

CSS refers participants to various multidisciplinary medical clinics in hospitals and other private provider offices. Comprehensive pediatric assessment clinics are not held in the regional and metro health departments due to primary care services being conducted through TennCare and its physician provider network. Since most children have some form of health insurance, including TennCare, the program makes every effort to obtain reimbursement for medical services.

All families with children who are newly eligible for Supplemental Security Income (SSI) are

contacted by CSS and provided information on CSS, mental health, developmental and intellectual disability, early intervention (TEIS), genetic services and other health department services that may be available. Approximately forty-one percent (2675) of the 6525 CSS enrollees have SSI.

CSS requires that all children applying for the CSS program apply for TennCare and CHIP; assists families in locating a medical home, specialists and related service providers within the MCOs' 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 CSS staff and parent interaction to ensure parent understanding of the changes and improve transition of services. CSS also helps families file appeals for denied medically necessary services.

CSS provides care coordination services to all participants in all 95 counties. Care coordination services are provided by social workers and public health nurses and include assessments of both medical and non-medical needs. Care Coordinators serve as liaisons between the medical provider, insurance company, transportation services, and the family. CSS care coordinators may attend medical appointments, and multidisciplinary meetings in the educational setting with participants and families.

Children's Special Services recognizes the need for parental involvement in all aspects of the program. Parents are involved as full participants in their child's care and as advisors to the program. One parent is a member of the CSS Advisory Committee. We are working with Family Voices and Vanderbilt School of Nursing on a plan to improve family participation: The goal is to better understand parent/family needs and how CSS can improve services to families of children with special health care needs. Researchers and partners are working on focus group planning and surveys. CSS also recognizes the needs of parents of a recently diagnosed child to talk and meet with other parents of a similar or like diagnosed child, so those parents can impart their knowledge, understanding and experience. If a family cannot be referred to another parent of a similar or like diagnosis then the family is referred to the national Mothers Understanding Mothers (MUMS) organization. At present, CSS does not reimburse the $5.00 fee for using the MUMS service.

CULTURALLY COMPETENT APPROACHES TO SERVICE DELIVERY

/2012/In order to improve the health of Tennessee's population, the Department of Health must meet the unique needs of a diverse population. One major barrier to meeting those needs in Tennessee is a low literacy level among our population.//2012// Health and education/literacy are inextricably linked. Literacy and health literacy are significant issues in Tennessee where 1 in 8 adults cannot read (Tennessee Literacy Coalition, 2010). Health literacy is the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions. Poor health literacy is associated with difficulty adhering to medication and treatment regimens, and is a strong predictor of poor health outcomes (Selden, et. al., 1999). ***/2012/Recognizing the impact of literacy on health, the Department understands the need to improve health literacy and numeracy in order to accomplish its mission of health promotion.//2012//***

A new partnership between the Department of Health and Vanderbilt Diabetes Research and Training Center has received R-18 translational National Institutes of Health (NIH) funding to assess efficacy of a low-literacy/numeracy-oriented intervention to improve diabetes care to uninsured adults in 10 middle Tennessee counties. We expect the clear communications training intervention will result in improved A1C, blood pressure, lipids, weight, self-efficacy, self-management behaviors, and use of clinical services at 12 and 24 months follow-up. Robust cost-evaluation and incremental cost- effectiveness ratios will be estimated and long-term sustainability and dissemination plans are intended. Workforce training and orientation plans

underway now will include specific health literacy/clear communication components. Technical assistance will be requested for similar applications in MCH.

/2012/Numerous other initiatives are underway to improve education in Tennessee.//2012//
Tennessee was recently awarded $50,000 by the National Governors Association Center for Best Practices to fund development of a drop out prevention and recovery work plan and state policies and practices designed to increase graduation rates.

Tennessee and Delaware were the first states to win the federal "Race to the Top" competition for education innovation. Tennessee will receive $502 million to develop a best-practice education success model. Half of the funding will be distributed to local school districts via existing Title I formula. The remaining $250 million will fund a "State Innovation Fund" to target improvements in about 200 failing or troubled schools; support professional development for teachers with emphasis on STEM (science, technology, engineering, and math); and improve teacher and student access to and use of technology and data. A noted strength of Tennessee's proposal was greater than 90% support from organized teacher groups across the state (Tennessee Department of Education [TDOE], 2010).

NOTED CHALLENGES

As with other states, Tennessee has experienced extreme budgetary challenges associated with the recession. Tennessee's budget is notably sensitive to consumer spending and sales tax collections, as there is no state income tax, and a balanced budget is statutorily mandated. According to the Tennessee Department of Finance and Administration, the state experienced negative growth in sales tax collections for 22 of the 27 months between January, 2008, and March, 2010. Budget reduction strategies were initiated in 2008 which included a hiring freeze, travel restrictions, and a voluntary buy out which rapidly reduced the TDOH workforce by 5% (with only 10 days for transition and succession planning) in addition to the average existing TDOH vacancy rate of about 16%. The hiring freeze has presented particular challenges for Central Office and other administrative staff, because some hiring of "direct care" providers (e.g., physicians, nurses, etc.) has been allowed, while hiring of program managers and support staff has been minimal, and a number of non-direct care positions such as health and nutrition educator positions have been permanently eliminated.

Since January, 2008, 272 of 2231 (12%) state-funded TDOH positions have been permanently eliminated, and an average vacancy rate of 16% has been maintained as a cost-control measure. MCH staffing has been reduced by about 30% compared to 2008 levels. These figures do not include elimination or reduction in state or local contract employees (thus excludes most of the 6 metro regions). In addition to challenges associated with increased vacancy rates, newly hired employees are generally less experienced, creating supervisory challenges for fewer seasoned staff who have assumed additional roles and responsibilities (staff training and orientation challenges will be addressed in a subsequent section).

TDOH salaries are not competitive (e.g., annual TDOH salary for an experienced physician is $40-60,000 less than a physician similarly qualified and with similar duties in a federally qualified health center). There have been no pay raises for state employees in 3 years, and no raises are expected in the near-term. Existing programs serving MCH groups will be continued for the next fiscal year with funding from a combination of state reserve funds and federal/ARRA funds. Future funding and viability of these programs is uncertain and cause for growing concern with regard to meeting maintenance of effort or match requirements to maintain federally funded programs. ***/2012/The FY2011-12 budget passed by the legislature in May 2011 included a 1.6% raise for state employees.//2012//***

The current nursing shortage has significantly affected public health nursing. Contributing factors include, an aging population of nurses, a poorly funded public health system resulting in inadequate/noncompetitive salaries, reduced and/or eliminated public health nursing positions,

bureaucratic hiring practices, limited public health advocacy, invisibility of public health nursing in media and marketing campaigns, and a growing shortage of nursing faculty adequately prepared to teach public health nursing (Quad Council, 2006).

TDOH does not have an electronic health record. The Patient Tracking Billing Management Information System (PTBMIS) is a mature but robust administrative data management system with some capacity to track limited clinical data and pharmaceutical inventories. A notable PTBMIS advantage is that all 95 county health departments are connected to PTBMIS enabling virtually real time collection of statewide data. A notable PTBMIS disadvantage is that it is a proprietary system, making data retrieval cumbersome and program revisions and upgrades expensive and time consuming. Also, it has reached maximum expansion capacity, and estimates for meaningful upgrades range from $10 million for minimal improvements to $50-60 million for significant improvements including addition of an electronic health record. Thus, upgrades are not feasible at this time due to budget constraints.

/2012/Despite the funding challenges associated with technology, there are some recent opportunities that may support further development in this area.//2012// Tennessee's Office of e-Health Initiatives has been awarded up to $24 million (ARRA funds) to support implementation of a new (2009) strategic plan to grow health information exchange (HIE) in the state through health information technology (HIT). The goal is to drive improvements in health care outcomes through coordinated statewide HIT that will enable vital, secure, decision-ready information to be available to clinicians at the point-of-care and benefit public health in general.

One early example of the state's commitment to HIE is the updated Tennessee Web Immunization System (TWIS). TWIS allows authorized users to obtain comprehensive immunization information on patients, update or initiate new patient records, links to other web sites to get comprehensive information on vaccines, vaccination strategies or current information from the Tennessee Immunization Program. TWIS is credited with helping to increase Tennessee's child immunization rates (4th best among the states) and won the 2009 Bull's Eye Award for Innovation and Excellence in Immunization from the Association of Immunization Managers for creation of a novel pre-registration strategy for clinicians to address the H1N1 pandemic flu threat. The award recognizes an outstanding immunization initiative and strategy that hits the mark of increasing immunization awareness and encouraging replication in other programs. ***/2012/In 2010, Tennessee was recognized by America's Health Rankings as leading the nation in immunization rates of 19-35 month olds (up from 23rd in 2005). TWIS has also established electronic data exchange using health language seven (HL7) standard messaging with a major pediatric provider and a regional health information exchange organization. A growing number of practices are preparing to implement data exchange in the coming year.//2012//***

An attachment is included in this section. IIIB - Agency Capacity

C. Organizational Structure

/2012/Tennessee's MCH and CSHCN programs are housed in the Tennessee Department of Health.//2012// The Department, part of the Executive branch of state government, is led by a Commissioner who is appointed by the Governor. The administration will change in January 2011 with the completion of Governor Phil N. Bredesen's second term as Tennessee's 48th Governor. Susan R. Cooper, MSN, RN., serves as the Commissioner of Health. Veronica Gunn, MD, MPH, FAAP, serves as the Chief Medical Officer for the Department of Health. ***/2012/Governor Bill Haslam was inaugurated in January 2011 as the 49th Governor of Tennessee. Commissioner Susan R. Cooper, MSN, RN, currently serves as Interim Commissioner for the Department of Health. Dr. Gunn left the Department of Health in December 2010, and Dr. Tim Jones is currently serving as the Chief Medical Officer for the Department. Dr. Cathy Taylor, DrPH, MSN, RN, serves as Assistant Commissioner for Health Services and oversees the Bureau which includes the Maternal and Child Health Section. //2012//***

The Department of Health has a range of responsibilities, including administering a variety of community-health programs, licensing health care professionals and maintaining health records and statistics. The Department works closely with local governments and nonprofit agencies to monitor and improve community health. The Department is organized into three bureaus, two divisions, and eight offices. The Bureaus are Health Licensure and Regulation, Health Services Administration (HSA), and Administrative Services. The divisions are Laboratory Services and Minority Health and Disparities Elimination. The offices include Policy, Planning, and Assessment, Human Resources, Information Technology Services, General Counsel, Internal Audit, Communications, Patient Care Advocacy, and Legislative Services. The Maternal and Child Health Section is in the Bureau of Health Services Administration along with several other sections providing services across the state (Communicable and Environmental Disease Services, Nutrition and Wellness, Community Services, General Environmental Health, HIV/AIDS/STD, Medical and Dental Services, Regional and Local Health).

The 95 counties in the state are divided into 13 health department regions; seven of the regions are comprised of rural counties, and six are comprised of metropolitan counties under the jurisdiction of metropolitan city councils/government. The counties in the seven rural regions are a part of the state's administrative system, whereas the six metropolitan counties are a part of the county administrative systems. Each county has a local health department with at least one clinic site. The Central Office of the Department, including the Maternal and Child Health Section, functions as the support, policy-making, and assurance office for the public health system. Central Office program staff works closely with staff in both rural and metropolitan regions on all program activities. The primary difference between the two types of regions is the method used to provide funding. Rural regions are part of the state government system, and metropolitan counties are separate city/county government systems. Both operate Maternal and Child Health programs using the same standards and guidelines. The Central Office provides support and technical assistance to both rural and metro regions.

The Department of Health was one of the first departments established by state mandate. Services for women and children have always been a major part of local health department activity. Title V has played an increasingly important, although often changing, role in providing services and funding for the county health department system, including services for children with special health care needs (CSHCN). Tennessee's local health departments in all 95 counties carry out health related programs for women, infants and children.

Formerly, Maternal and Child Health Services was housed within two sections of the Bureau of Health Services Administration. Maternal and Child Health was comprised of Child and Adolescent Health Services and Children's Special Services. Women's Health/Genetics consisted of Genetics and Newborn Screening Services and Women's Health. As of 2010, all programs were combined into the Maternal and Child Health Section, including Child and Adolescent Health, Children's Special Services, Women's Health, Genetics, and Newborn Screening Services.

/2012/ The Department of Health is responsible for the administration of programs carried out with allotments under Title V. The Maternal and Child Health Section is the nucleus for the Department's Title V efforts and is responsible for all programmatic, policy, and funding efforts related to Title V projects. Organizational charts for the Department of Health, Bureau of Health Services Administration, and Maternal and Child Health Section are uploaded as attachments to this section of the narrative.//2012//

An attachment is included in this section. IIIC - Organizational Structure

D. Other MCH Capacity

SECTION MANAGEMENT

/2012/In December 2010, Dr. Michael Warren joined the Department of Health as Director of Title V/Maternal and Child Health. Dr. Warren is a general pediatrician by training, having completed medical school at East Carolina University, residency and a chief resident year at Vanderbilt, and an academic general pediatrics fellowship and MPH at Vanderbilt. He served on the faculty at the Vanderbilt University School of Medicine, where he designed the Community-Oriented Resident Education (CORE) program, a community pediatrics and advocacy training curriculum developed with funding from the American Academy of Pediatrics. Prior to joining the Department of Health, Dr. Warren served as Medical Director in the Governor's Office of Children's Care Coordination, where he worked with a number of state child- and family-serving agencies on issues including strengthening of medical home services, implementation of quality improvement activities focused on improving adolescent health, coordination of EPSDT services, and infant mortality reduction initiatives. As Director of Title V/MCH, Dr. Warren oversees MCH programs in the Central Office and provides leadership and direction for MCH initiatives in all 95 counties.

Additional leadership for the section is provided by Margaret Major (Women's Health and Genetics), Mary Jane Dewey (Child Health/Breast and Cervical Cancer Screening), Jacqueline Johnson (CSHCN), and Rachel Heitmann (Injury Prevention and Detection).

Margaret Major has worked with the Department of Health since 1972 in a variety of roles, including Nutrition Consultant, Assistant MCH Director, Acting MCH Director, and Director of Family Planning. Ms. Major is currently the Director of Women's Health/Genetics, providing oversight for Women's Health, Family Planning/Title X, and Newborn Genetic and Hearing Screening. She also provides oversight for the Injury Prevention and Detection section. Ms. Major holds a Bachelor's degree in Food Science/Nutrition and a Master's in Public Administration/Health Services.

Mary Jane Dewey has more than 25 years of clinical and management experience in the state government and non-profit sector. She is the Program Director for the TN Breast and Cervical Screening Program and supervises staff responsible for the state's teen pregnancy prevention programs including abstinence education, home visiting services and the Early Childhood Comprehensive Systems grant from HRSA.

Jacqueline Johnson has served as the State's CSHCN Director since 2007. She has a master's degree in Public Administration, as well as a significant number of master's level hours in special education. Her career in public health has been solely with the Division of Maternal and Child Health. In 2005, Ms. Johnson began working as a public health program director for the Childhood Lead Poisoning Prevention Program, the SIDS Program, and the Child Fatality Review Program.

Rachel Heitmann oversees the section's initiatives related to Injury Prevention and Detection (Core Violence and Injury Prevention Program, Lead Poisoning Prevention, Fetal Infant Mortality Review, Child Fatality Review, and Sudden Infant Death Syndrome Prevention). Ms. Heitmann joined the MCH Section in 2010, having previously worked in the Department with the Traumatic Brain Injury program for five years. Prior to joining the department, she worked in a residential setting for clients with mental illness, substance abuse, and traumatic brain injury. She has a Master's Degree in Mental Health Counseling.

The Maternal and Child Health section sits within the Bureau of Health Services Administration, led by Dr. Cathy Taylor. Dr. Taylor has a Doctorate in Public Health and serves as an Assistant Commissioner for the Department of Health. She has both a Bachelor's and Master's degree in Nursing. Prior to joining the Department, she was on the faculty of the Vanderbilt University School of Nursing and has held a variety of nursing positions. She has served as a consultant at the national and international level for MCH

and public health initiatives. Dr. Taylor has served on numerous public health and MCH committees at the local, state, and national level. Prior to Dr. Warren's arrival in December 2010, Dr. Taylor served as Acting Director for the Maternal and Child Health Section.

PLANNING, EVALUATION, AND DATA ANALYSIS

Ongoing program planning is provided by individual program directors, in consultation with the section's Director and senior leadership. In 2011, the Director initiated a monthly Program Management meeting, during which all MCH Program Directors meet to 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. In 2011, the group is working through the Johns Hopkins MCH Public Health Leadership modules.

The section also utilizes outside consultants to provide assistance in long-term planning. In June 2011, Dr. Donna Petersen facilitated a strategic team-building and planning retreat for all members of the Maternal and Child Health section.

Data analysis support is provided through a number of collaborative relationships. The SSDI grant (managed by MCH) provides salary support for a doctoral-level epidemiologist as well as a statistical analyst, both housed in the Department's Office of Policy, Planning, and Assessment. The section also receives a great deal of data support through the Department's Division of Quality Improvement; this Division has provided invaluable assistance in implementing data collection tools for home visiting programs administered by MCH.

To build long-term epidemiology capacity for the section, several initiatives are currently underway. We plan to apply for a CDC Maternal and Child Health Epidemiology Assignee during the upcoming year. Additionally, we have received approval to hire two epidemiologists and a statistical analyst as part of the federal Maternal, Infant, and Early Childhood Home Visiting Program. Salaries for these positions will be paid for using MCH Block Grant funds, recognizing that these staff will provide epidemiological support for programs across the section. //2012//

/2012/ PARENT INVOLVEMENT

The MCH Section absolutely recognizes the vital nature of parental involvement throughout our section in program development, implementation, and evaluation. The Section has a longstanding collaborative relationship with the TN Family Voices chapter. In 2011, MCH staff began an enhanced effort to integrate parent input in all aspects of MCH services. Currently, MCH and Family Voices leadership are outlining additional opportunities for deliberate family engagement; such plans include nominating a Family Voices parent representative for the AMCHP Family Scholars program; creating standing times for MCH/Family Voices meetings and integrating family input into MCH team meetings; and exploring the feasibility of more formal input from families of CSHCN (i.e. staff or contractual arrangements).

OTHER MCH WORKFORCE INFORMATION

All state agencies have been under a hiring freeze since 2008, impacting the Department of Health's ability to fill vacant positions, including those in MCH. Restrictions eased somewhat in 2010, and within the past year, several MCH positions have been filled, including: Director of Injury Prevention and Detection; Program Director for Adolescent Pregnancy Prevention; and an Administrative Assistant for the Newborn Hearing Follow-Up Program. The Department has also received approval to fill six positions for the federal Maternal, Infant, and Early Childhood Home Visiting Program funded through the

Affordable Care Act. These positions include a Program Administrator, Program Director, Administrative Assistant, two Epidemiologists, and a Statistical Analyst. MCH plans to fund the positions with MCH Block Grant funds, recognizing that these positions can serve critical cross-section functions, in addition to their work related to home visiting. In this way, we hope to strengthen our own efforts to create a comprehensive system of early childhood services for children and families in Tennessee.//2012//

Workforce development funds previously available via federal preparedness grants have not been available since 2008, and no formal Department of Health training plans have been in place since the early 1990's. All division chiefs have been asked to survey training and succession needs in order to begin a formal planning process to produce near-term and long-term training plans. With respect to MCH, the acting MCH Director (Dr. Cathy Taylor) is currently a member of the University of Alabama at Birmingham's MCH Policy and Training Advisory Committee and a member of the MCH Training and Professional Development workgroup sponsored by MCHB. We expect this work to guide development of the MCH training plan for Tennessee in concert with training needs assessment findings. ***/2012/Dr. Taylor continues to work with national-level efforts related to MCH training and professional development.//2012//***

We have requested technical assistance for some residual staff re-training needs. In a 2009 consultation, Dr. Donna Petersen noted particular gaps in our core epidemiology, data management, and statistical support availability. Prior to being able to hire additional personnel due to the hiring freeze, we have increased our capacity by:

-increasing our collaboration with the division of Policy, Planning and Assessment (PPA), securing part-time assistance of two PhD-level statisticians

-increasing collaboration with the division of Nutrition and Wellness

-securing additional consultation from a MPH-level chronic disease epidemiologist (She recently attended the Training Course in Maternal and Child Health Epidemiology, May 10-14, 2010).

-creating multiple training and mentoring opportunities for the MCH epidemiologist to increase basic skills and to work with senior epidemiologists and CDC fellows in the Division of Communicable and Environmental Disease.

Five universities offer the MPH or MSPH in Tennessee: University of Memphis, Meharry Medical College and Vanderbilt University in Nashville, University of Tennessee at Knoxville, and East Tennessee State University (ETSU) in Johnson City. In addition to bachelor's and master's degrees in public health, ETSU confers DrPH and PhD degrees in public health and related sciences, and in 2009, became Tennessee's first Council on Education for Public Health (CEPH) accredited school, the only one in central Appalachia to earn that designation. ETSU was nationally recognized in 2005 for public health curriculum innovation by Delta Omega, Honor Society of Public Health and by the National Rural Health Association as Outstanding Rural Health Program of the Year in 2007.

In 2009, a University of Tennessee Health Sciences Center, College of Nursing (UTHSC CON) DNP (doctorate in nursing practice) student in public health nursing (Patti Scott) completed a public health workforce development project for the Tennessee Department of Health. The project included a needs assessment (including interviews with regional nursing directors), proposed plan for competency development and tracking, and development of a logic model for program planning and evaluation.

Dr. Pat Speck, UTHSC CON DNP Public Health Nursing Option Director was awarded a HRSA grant in 2009 to increase workforce diversity and education in public health nursing. This project will dovetail into Dr. Scott's project through leadership training sessions for TDOH regional nursing directors, beginning July, 2010. This project will also bring together community health

nursing faculty from across the state and TDOH regional nursing directors to discuss and plan improvements for community health nursing education.

Dr. Scott joined the MCH leadership team as a consultant in January, 2010. She comes as an experienced advanced practice nurse and educator, having worked most recently as a faculty member at Vanderbilt University School of Nursing, and continuing to maintain a part-time practice in Pediatric Pulmonology and Allergy at Vanderbilt. She has extensive expertise in school-based health care, injury prevention, asthma, and children with special health care needs. Dr. Scott has assumed a primary role in completion of the 5-year needs assessment and preparation of the Block Grant application. In the future, she will assist with the workforce development plan and implementation; and work to more formally integrate the Life Course Perspective and MCH priorities within established TDOH programs (e.g., WIC, family planning, chronic disease prevention, etc.). ***/2012/Dr. Scott moved to Arkansas in early 2011 to become the Child and Adolescent Health Program Nurse Manager for the Arkansas Department of Health. Prior to her departure, she met numerous times with the new MCH Director, Dr. Warren, to transition projects on which she was currently working.//2012//***

In 2010, Local Health Department Directors (n = 64, representing 80% of the total group) were surveyed regarding professional development needs. In response to the query, "What presentation topics would you recommend?" These were their responses ranked by importance:
1) Personnel issues (dealing with problem employees, team/morale building; personnel management issues in general; and communication with employees.
2) Best practices for local health department issues/protocols etc.
3) Communication with co-workers, with the public, and with elected officials
4) Financial Management basic skills/tools
5) Public health and legal issues
6) General administrative management tools.
These responses mirrored responses in Dr. Scott's interviews with TDOH regional nursing directors.

/2012/An additional opportunity for MCH workforce development is now available via the Department's collaboration with East Tennessee State University (ETSU). The ETSU College of Public Health has established the LIFEPATH program (Long-Distance Internet Facilitated Educational Program for Applied Training in Health). ETSU will make academic and non-academic courses available to state employees. Examples of the academic opportunities include graduate certificates, master's degrees in public health or epidemiology, and a doctorate in public health. State employees will be able to use the state waiver program which provides tuition coverage for one course per semester. Information about this opportunity has been made available to the entire MCH team, several of which have already expressed interest in the program.//2012//

E. State Agency Coordination

Maternal and Child Health and Women's Health staff at the central office, regional offices, and local health department levels are involved in numerous collaborative efforts within the Department with various programs, with other governmental departments and agencies, and with 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. 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 Assistant Commissioner, Bureau of Health Services Administration.

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 MCOs' 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 CSS staff and parent interaction to ensure parent 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. 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): This agency is responsible for the children in state custody. The Department of Health is providing the EPSDT screenings for all these children. Other collaborations with DCS include funding for both the Healthy Start and Child Health and Development home visiting programs. MCH gets referrals from DCS and makes home visits to the family. Also, 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.

Several 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, a multidisciplinary group of professionals and advocates focused on the welfare of children reported to have been abused or neglected, is charged with identifying existing problems and recommending solutions to DCS regarding the investigation and prosecution of child abuse and neglect. The Child Sex Abuse Task Force, a multidisciplinary group of professionals and advocates, is responsible for developing a plan of action for better coordination and integration of the goals, activities and funding of the Department of Children's Services pertaining to the detection, intervention, prevention and treatment of child sexual abuse. ***/2012/ MCH has a staff member who is an associate member of the TN Child Abuse Prevention Advisory Committee as well as several staff members who regularly attend the meetings. The committee focuses on statewide efforts to prevent child abuse. //2012//***

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 currently 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. In addition, MCH through its Early Childhood Comprehensive Systems Program and its Child Care Resource Centers assist DHS in providing technical assistance for state regulated day care centers. In 2007-2008, MCH enhanced its services to DHS by providing collaborative support to prevent childhood obesity and promote good social emotional development in child care populations.

Department of Education (DOE): The director of adolescent health serves on the advisory committee of the Office of Coordinated School Health (CSH). ***/2012/ While the adolescent health director no longer serves on the advisory committee, collaborations with the CSH staff continues via the asthma management initiative. //2012/***

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 years old identified with or having a potential for a developmental delay. TEIS has been an active participant in collaboration 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 representing all MCH programs. 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. The TEIS data collection system documents hearing follow-up. An MCH staff 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. CSS staff keeps DOE staff, including school health nurses, informed of TennCare changes to insure continuity of care.

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 meet regularly for discussion, information sharing and program policy coordination. The Director, along with Head Start health specialists and regional directors have been invited to attend the MCH video-conferences to learn more about MCH programs and current diagnosis and treatment of conditions affecting children. /2012/ The Newborn Hearing Screening Program, in collaboration with the National Center on Hearing Assessment and Management (NCHAM), will work with three 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 in each agency. //2012//

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 social-emotional development are one of the five critical areas being addressed in the Early Childhood Comprehensive Systems, and TDMHDD staff participate on the Advisory Committee. MCH's Adolescent Health Program Director is assisting in implementing a suicide prevention training grant recently received by TMHDD.

The adolescent health director serves as a member of the Tennessee Suicide Prevention Network and works with a state intradepartmental committee and the state advisory committee composed of members from the private and public sector to prevent suicide. The director co-chaired a subcommittee to address youth suicide prevention. The committee 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). ***/2012/ The state programs list has been expanded to include CSS, HUGS, Traumatic Brain Injury, Hematology/Sickle Cell Centers, Department of Mental Health and Developmental Disabilities, Department of Intellectual Disabilities, TEIC, Special Education, and the regional genetics centers. //2012//***

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.

Vocational Rehabilitation: See Department of Human Services.

Child Fatality Review: The Child Fatality Review process is a statewide network of multidisciplinary, multi-agency teams in the 31 judicial districts in Tennessee to review all deaths of children 17 years of age or younger. Members of the local teams 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.

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: ***/2012/ 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 (TSPN); the local and state Disproportionate Minority Contact and Confinement (DMCC) committees; the Tennessee Commission for Children and Youth (TCCY), Mid-Cumberland region committee; the Tennessee Alliance for Drug Endangered Children (TADEC); and the Tennessee Obesity Task Force (TOT) and the Workforce Wellness subcommittee. //2012//***

/2012/ The program director previously served on the Governor's Office of Children's Care Coordination (GOCCC), Teen Health subcommittee. The GOCCC was eliminated in the 2011 budget; however, the major collaborative project with the GOCCC will continue via the Adolescent Health Initiative. The program director will continue to coordinate activities of Maternal and Child Health programs with the Division of Mental Health and Developmental Disabilities, Wellness and Nutrition, the TENNderCare program, and community partners related to the annual Child Health Week campaign. Although there is no dedicated budget for the campaign, efforts center on working with the agencies to highlight current activities for child health and well-being. //2012//

Asthma Management: The overarching goal of the State of Tennessee Asthma Plan is to reduce the burden of asthma in Tennessee. 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 pre-school children, school-aged children, and adults 30 and older. ***/2012/ Activities in 2010 included collaboration with Vanderbilt Children's Hospital to provide in- service training for 150 professionals on childhood asthma, presentations across the state to medical providers, educators, parents, and youth as requested, providing print materials for home visitors and child care facilities to use to reduce smoking and indoor air pollution and training of EPA Indoor Air Quality Tools for Schools curriculum. MCH is also sponsoring 16 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. //2012//***

Federally Qualified Health Centers: Community Health Centers are located in medically underserved areas of the state. There are 24 Federally Qualified Health Centers (FQHC) that operate 142 clinic sites in Tennessee. These community health centers, which provide 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. ***/2012/ The 24 centers operate 153 clinic sites serving over 258,000 patients. //2012//***

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. A Bureau of Health Services representative meets monthly with two groups in TennCare: (1) the EPSDT Workgroup comprised of representatives from all the managed care organizations; and (2) the Tennessee Chapter of the American Academy of Pediatrics (TNAAP) representatives. ***/2012/ The Newborn Hearing Screening Program provided information on newborn hearing screening and follow-up at several Screening Tools and Referral Training (START) presentations sponsored by TNAAP. //2012//***

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 Tennessee on the need for folic acid. Central office staff developed and implemented many of the statewide activities. The Women's Health director serves on the state council. ***/2012/ The family planning program provides vitamins with folic acid to patients of reproductive age who receive program services. //2012//***

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 Women's Health and HIV/AIDS/STD programs. The Infertility Prevention Program (screening for Chlamydia, treatment, and data analysis) is a joint project of Family Planning, STD, and the State Laboratory.

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.

Office of Nursing: MCH and Women's Health central office nursing staff routinely provide program updates at their 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.

Nutrition and Wellness/WIC: Collaborative efforts among MCH and Women's Health staff, Health Promotion, and Nutrition/WIC, as well as partnerships with March of Dimes and other outside agencies on activities addressing prevention of smoking in pregnant women include advertising the availability of the state's QUITLINE and other educational activities. 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 PKU children.

Office of Policy, Planning and Assessment: Central office staff collaborate with the Health Statistics section on dissemination of annual releases of health data and special reports, collection of data through the joint Annual Report of Hospitals, collection of data for the Region IV Women and Infant Health Data Indicators Project, and in other MCH data projects. Women's Health staff coordinate with this office on data matching and reports for the newborn hearing screening program. MCH and this Office collaborate on the SSDI 2006-2011 grant.

Tennessee Adolescent Pregnancy Prevention Program: ***/2012/ Tennessee's adolescent pregnancy prevention efforts encompass two different strategies--the Tennessee Adolescent Pregnancy Prevention Program (TAPPP) and the Abstinence Education Program. //2012//*** TAPPP councils operate in four of the six metropolitan areas and in multi-county groupings in 6 of the 7 rural regions. The 10 Coordinators serve as the community contacts/resource persons for adolescent pregnancy issues in their respective areas. 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. ***/2012/ 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. //2012//***

/2012/ The Abstinence Education Program was reestablished with a federal allocation after a 3-year break in funding. The program requires funded sites to teach abstinence only as a means of reducing teen pregnancy. The state is currently in the process of awarding grants to community-based agencies through the state-required competitive process. An anticipated 13 projects will be funded beginning July 2011 in counties targeted because of high teen pregnancy rates, high school dropout rates, and other risk factors. All sites will

be required to implement service learning projects as a means of building self esteem and reinforcing individual goals for the future. //2012//

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.

/2012/ 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. //2012//

Other federal grant programs under the administration of the Department which serve maternal and child health populations include WIC, family planning, newborn hearing screening and follow-up, Early Comprehensive Childhood Systems (ECCS), sexually transmitted diseases programs including HIV/AIDS, immunizations, and PRAMS. ***/2012/ New grant funding has been received for home visiting services and abstinence education. //2012//***

F. Health Systems Capacity Indicators

Introduction

Following each indicator is a brief narrative including descriptions of programs and efforts that have impacted the HSCI as well as interpretations of data trends where appropriate. Data and data sources are noted on the forms.

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Indicator	28.9	29.6	26.6	22.7	
Numerator	1366	1188	1074	921	
Denominator	473085	400744	403306	405883	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

Notes - 2010

Provisional 2010 hospital discharge data are not available, therefore only 2009 hospital data are provided.

Notes - 2009

Data Source: Tennessee Department of Health, Division of Health Statistics, Population Projections and Hospital Discharge Data System

Notes - 2008

Data Source: Tennessee Department of Health, Division of Health Statistics, Population Projections and Hospital Discharge Data System

Narrative:
Fewer children less than five years of age were hospitalized for asthma in 2009 compared to previous years. As part of ongoing efforts to address this HSCI, MCH supports a statewide Asthma Initiative, which partners with community stakeholders to provide education about asthma and strategies for mitigating the impact of asthma on individuals and the community. In recent years, the Asthma Initiative has partnered with the Monroe Carell Jr. Children's Hospital at Vanderbilt to host a statewide asthma education conference attended by clinicians, social workers, and community partners. Additionally, collaboration with the state's Child Care Resource and Referral Centers resulted in the development of an asthma toolkit consisting of basic information about asthma pathophysiology and free resources for use with parents and child care providers.

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Indicator	62.9	83.6	71.8	80.6	82.3
Numerator	53033	48559	75323	85301	86017
Denominator	84277	58058	104882	105887	104457
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2010
Data Source: Tennessee Medicaid (TennCare) Program

Notes - 2009
Data Source: Tennessee Medicaid (TennCare) Program

Notes - 2008
Data Source: Tennessee Medicaid (TennCare) Program

Narrative:
The percentage of infants enrolled in Medicaid who received at least one initial periodic screen has steadily improved over the past five years. Several MCH programs work collaboratively with the state's Medicaid program (TennCare) and the TENNderCare Outreach Program to inform parents about the need for EPSDT screenings. The Help Us Grow Successfully (HUGS) Home Visiting program intake assessment addresses EPSDT status and home visitors regularly assess access to a medical home and immunization status. Home visitors also provide families with TENNderCare brochures, which outline the EPSDT program and discuss the importance of regular screening. The Children's Special Services (CSS, Title V CSHCN Program) also assesses EPSDT status and care coordinators encourage families to obtain screenings per the periodicity schedule. Additionally, EPSDT screens are provided in local health departments across the state.

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Indicator	0.0	0.0	100.0	100.0	61.6
Numerator	0	0	34704	30753	1564
Denominator	1	1	34704	30753	2541
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2010
Data Source: TennCare (Medicaid) Program and CoverKids (CHIP)

The state Medicaid program (TennCare) has an eligibility category known as TennCare Standard Uninsured; this category is only available to children under age 19 whose TennCare Medicaid eligibility is ending, who do not have access to insurance through a job or a family member's job, and whose family incomes are below 200% poverty. These children are considered "CHIP children" in the TennCare II extension. The amount reported for this indicator represents the summation of figures provided by Tennessee's SCHIP program (CoverKids) as well as by the state Medicaid program (TennCare).

Notes - 2008
Data Source: State of Tennessee Medicaid (TennCare) Program.
Tennessee's SCHIP program is CoverKids and these data reflect the children less than one year of age in CoverKids who have received at least one periodic screen.

Narrative:
In 2010, 61.6% of SCHIP enrollees under the age of one received at least one periodic screen. Screenings are available in local health departments across the state, as well as in community-based private clinics and federally qualified health centers. The importance of regular well-baby checkups is promoted through MCH home visiting programs.

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Indicator	76.8	83.8	93.2	88.5	87.1
Numerator	64738	72498	73270	66927	62585
Denominator	84277	86558	78578	75614	71895
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year					

moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2010
Data Source: Tennessee Department of Health, Divsion of Health Statistics, Birth Statistical System

Notes - 2009
Data Source: Tennessee Department of Health, Divsion of Health Statistics, Birth Statistical System

Note: Data for Health Systems Capacity Indicator #04 varies slightly from that reported in Health Systems Capacity Indicator #05D (Form 18). The data on this form are from the Department of Health, while the data on Form 18 are reported by the Bureau of TennCare (Medicaid).

Notes - 2008
Data Source: Tennessee Department of Health, Divsion of Health Statistics, Birth Statistical System

2008 methodolgy per Guidance:
Numerator
Number of women (15-44) during the reporting years whose observed to expected prenatal visits are greater than or equal to 80% on the Kotelchuck index
Denominator
All women (15-44) with a live birth during the reporting year

Narrative:
In 2010, 87.1% of pregnant women met this indicator. Prenatal services, including pregnancy testing, determination of and enrollment in prenatal presumptive eligibility for Medicaid, and referral for services, are available in local health departments across the state. Additionally, women enrolled in prenatal home visiting services are encouraged by their home visitor to seek regular prenatal care. The Department of Health also administers the TENNderCare Outreach Program. Outreach workers make calls to TennCare enrollees who are pregnant to provide prenatal education and assistance with making appointments for prenatal care. The Governor's Office of Children's Care Coordination has funded Centering Pregnancy, a group prenatal care model, in several locations across the state. Management of these programs will transfer to MCH in FY2011-12.

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Indicator	100.0	45.9	92.8	82.7	83.8
Numerator	743387	375016	759672	654277	682343
Denominator	743387	816486	818194	791343	814718
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2010
Data Source: Tennessee Medicaid (TennCare) Program

Numerator: 2010 TennCare program children 0-20 with a paid medical service.
Denominator: Eligible population = all TennCare members under 21 with Medicaid eligibility.

Notes - 2009
Data Source: Tennessee Medicaid (TennCare) Program
Numerator: 2009 TennCare program children 0-20 with a paid medical service.
Denominator: Eligible population: all TennCare members under 21 with Medicaid eligibility.

Notes - 2008
Data Source: Tennessee Medicaid (TennCare) Program
Numerator - 2008 TennCare program medical claims for children 0-20.
Denominator - Eligible population: all TennCare members under 21.
There is a large difference between 2007 and 2008 due to a large increase in enrollment for children/increased claims.

Narrative:
In 2010, 83.8% of Medicaid eligible children received a service paid by the Medicaid program. The Children's Special Services (CSS, Title V CSHCN) program supports this indicator. Care coordinators work with families to ensure that each child has a primary care provider and helps the family access services through that provider. MCH Home Visiting programs also support this indicator; home visitors routinely assess whether children have a medical home and promote regular screenings per the periodicity schedule. Home visitors also provide families with TENNderCare brochures, which outline the EPSDT program and discuss the importance of regular screening.

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Indicator	37.0	50.6	52.6	54.0	54.8
Numerator	56418	77255	77122	100908	106287
Denominator	152680	152575	146517	186817	193974
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2010
Data Source: Tennessee Medicaid (TennCare) EPSDT and claim system

Notes - 2009
Data Source: Tennessee Medicaid (TennCare) EPSDT and claim system

Notes - 2008
Data Source: Tennessee Medicaid (TennCare) EPSDT and claim system

Narrative:
The percent of EPSDT eligible children age 6-9 who have received dental services during the year has steadily increased over the past five years. The Department of Health administers the TENNderCare Outreach Program, which provides education about the importance of regular dental screenings per the EPSDT periodicity schedule. The Department also operates the School-Based Dental Prevention Program, a statewide, comprehensive dental prevention program for children in grades K-8. In FY2009, over 130,000 children had dental screenings in 306 schools across the state. Dental outreach activities include provision of informational material for TennCare (Medicaid) enrollment purposes and follow-up contacts for all recipients identified as having an urgent unmet dental need. The Department also operates 54 fixed dental clinics in 53 rural counties and three mobile clinics that provide comprehensive dental services to underserved children at school sites.

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Indicator	100.0	9.0	14.0	17.3	12.4
Numerator	22392	1962	2838	3676	2675
Denominator	22392	21881	20343	21286	21623
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2010
Data Sources:
Numerator--CSS (State Title V CSHSN Program) Data
Denominator--Provided by HRSA MCHB Federal Project Officer through the Data Resource Center for Child and Adolescent Health, Child and Adolescent Health Measurement Initiative.

Notes - 2008
For both 2007 and 2008, the methodology and data sources were changed in response to directives received at the block grant review.

Data sources are CSS program database and federal database of SSI recipients.

Narrative:
In 2010, 12.4% of State SSI beneficiaries less than 16 received services from the Children's Special Services (CSS) program. The Disability Determination Services Section of the Department of Human Services provides monthly printouts of individuals of all children and youth under 16 years of age who have been determined eligible to receive SSI. There were 3326 names provided for 2010. SSA Data for 2010 indicate 21,623 SSI recipients under age 16 live in Tennessee. CSS program staff continues to contact all families with newly diagnosed children and provide information on services available. All families with children who are newly eligible for Supplemental Security Income (SSI) are contacted by CSS and provided information on CSS, mental health, developmental and intellectual disabilities, early intervention (TEIS), genetic

services and other health department services that may be available to them. Approximately forty-one percent of the 6,525 CSS enrollees have SSI (FY 2010). CSS staff contacted 3326 during this time period and provided information regarding CSS program requirements and other services and resources for which the family may be eligible.

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of low birth weight (< 2,500 grams)	2009	matching data files	10.9	7.3	9.2

Notes - 2012
Data Source: Tennessee Department of Health, Division of Health Statistics, Birth Statistical System; TennCare (Medicaid) Files.

Narrative:
The percentage of Tennessee babies born at low birth weight has declined over the past five years. A number of programs and initiatives support this HSCI. MCH home visitors serving prenatal women encourage regular prenatal care and positive health habits for pregnant women. The TENNderCare Outreach Program provides education to pregnant Medicaid enrollees and assists with referral for prenatal services. Additionally, local health departments provide pregnancy testing, determination of and enrollment in prenatal presumptive eligibility for Medicaid, and referral to prenatal care. The WIC program provides supplemental food to pregnant women, improving their health status. The state's Tobacco Control Program provides information on the dangers of smoking (a risk factor associated with low birth weight) and resources for smoking cessation. The Governor's Office of Children's Care Coordination has funded the Centering Pregnancy program (a group prenatal care model) in several sites across the state, as well as the Tennessee Intervention for Pregnant Smokers (TIPS), through which pregnant women are assessed for smoking and provided with cessation resources

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Infant deaths per 1,000 live births	2009	matching data files	9.8	5.9	8

Notes - 2012
Data Source: Tennessee Department of Health, Division of Health Statistics, Birth Statistical System; TennCare (Medicaid) Files.

Narrative:

The infant mortality rate has declined in Tennessee over the past five years. Numerous programs support this indicator. Preconception health is promoted through a variety of efforts administered by the Department of Health, including WIC, the Tennessee Tobacco Quitline, Project Diabetes, and Get Fit Tennessee. The Department supports prenatal health by offering pregnancy tests and counseling in local health departments, in addition to determination of and enrollment in prenatal presumptive eligibility for Medicaid and referral for prenatal care. The TENNderCare Outreach Program also calls pregnant women enrolled in Medicaid, providing education and assistance with making prenatal care appointments. The state supports a regionalized perinatal network, allowing for specialized obstetrical and neonatal care for women and infants. The regionalized perinatal program also offers education to outlying providers to equip them with the skills necessary for stabilizing infants prior to transfer to a regional center.

Neonatal and infant health is also promoted through a variety of programs. The Tennessee Initiative for Perinatal Quality Care (TIPQC) has been funded by the Governor's Office of Children's Care Coordination and consists of a statewide collaborative of neonatal and obstetric providers and facilities working on quality improvement initiatives that include promotion of breastfeeding, stabilization of newborn temperature, and reduction of non-indicated elective inductions and deliveries. MCH Home Visiting programs provide families with valuable information about child health, development, safety tips, and appropriate parenting strategies. The State Immunization Program provides vaccines that protect against life-threatening diseases, including numerous vaccines for infants.

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2009	other	59	72	65

Notes - 2012

Data Source: Tennessee Department of Health, Division of Health Statistics, Birth Statistical System; TennCare (Medicaid) Files.

Note: Data on start of prenatal care is self reported on the birth certificate. A significant portion of women gained Medicaid eligibility after their first trimester. Data for Health Systems Capacity Indicator #05C varies slightly from that reported in National Performance Measure 18 (Form 11). The data on this form are from the Bureau of TennCare (Medicaid), while the data on Form 11 are reported by the Department of Health.

Narrative:

The Department of Health offers pregnancy testing and counseling in local health departments, in addition to prenatal presumptive eligibility determination and enrollment for Medicaid and referral to prenatal services. Prenatal care is covered for eligible women through Medicaid (TennCare) and SCHIP (CoverKids). The TENNderCare Outreach Program makes calls to pregnant Medicaid enrollees to provide prenatal education and assists with making appointments for prenatal care.

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2009	other	69.2	70.6	69.9

Notes - 2012
Data Source: Tennessee Department of Health, Division of Health Statistics, Birth Statistical System; TennCare (Medicaid) Files.

Note: Percent of pregnant women with adequate prenatal care was determined based on self-reported number of prenatal care visits and the date of first prenatal care (using birth records and TennCare files). Data for Health Systems Capacity Indicator #05D varies slightly from that reported in Health Systems Capacity Indicator #04 (Form 17). The data on this form are from the Bureau of TennCare (Medicaid), while the data on Form 17 are reported by the Department of Health.

Narrative:
Prenatal services, including pregnancy testing, determination of and enrollment in prenatal presumptive eligibility for Medicaid, and referral for services, are available in local health departments across the state. Additionally, women enrolled in prenatal home visiting services are encouraged by their home visitor to seek regular prenatal care. The Department of Health also administers the TENNderCare Outreach Program. Outreach workers make calls to TennCare enrollees who are pregnant to provide prenatal education and assistance with making appointments for prenatal care. The Governor's Office of Children's Care Coordination has funded Centering Pregnancy, a group prenatal care model, in several locations across the state. Management of these programs will transfer to MCH in FY2011-12.

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2010	185
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2010	250

Notes - 2012
Data Source: Tennessee Medicaid (TennCare) website, http://www.tn.gov/tenncare/mem-categories.html. Accessed on 6/4/2011.

Notes - 2012
Data Source: Tennessee SCHIP (CoverKids) Program
Age 0-1, eligibility for CHIP is 186-250% FPL.
Age 1-6, eligibility for CHIP is 134-250% FPL.
Age 6-18, eligibility for CHIP is 101-250% FPL.

Narrative:
Eligibility information for Medicaid and SCHIP is determined by the TennCare (Medicaid) and CoverKids (SCHIP) programs.

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Medicaid Children (Age range 1 to 6) (Age range 6 to 19) (Age range to)	2010	 133 100
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children (Age range 1 to 6) (Age range 6 to 18) (Age range to)	2010	 250 250

Notes - 2012
Data Source: Tennessee Medicaid (TennCare) website, http://www.tn.gov/tenncare/mem-categories.html. Accessed on 6/4/2011.

Notes - 2012
Data Source: Tennessee SCHIP (CoverKids) Program
Age 0-1, eligibility for CHIP is 186-250% FPL.
Age 1-6, eligibility for CHIP is 134-250% FPL.
Age 6-18, eligibility for CHIP is 101-250% FPL.

Narrative:
Eligibility information for Medicaid and SCHIP is determined by the TennCare (Medicaid) and CoverKids (SCHIP) programs.

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**

pregnant women.		
Pregnant Women	2010	185
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women	2010	250

Notes - 2012
Data Source: Tennessee Medicaid (TennCare) website, http://www.tn.gov/tenncare/mem-categories.html. Accessed on 6/4/2011.

Notes - 2012
Data Source: Tennessee SCHIP (CoverKids) Program
Age 0-1, eligibility for CHIP is 186-250% FPL.
Age 1-6, eligibility for CHIP is 134-250% FPL.
Age 6-18, eligibility for CHIP is 101-250% FPL.

Narrative:
Eligibility information for Medicaid and SCHIP is determined by the TennCare (Medicaid) and CoverKids (SCHIP) programs.

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	**Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)**	**Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)**
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	3	Yes
Annual linkage of birth certificates and WIC eligibility files	2	Yes
Annual linkage of birth certificates and newborn screening files	3	Yes
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	3	Yes
Annual birth defects surveillance system	3	Yes

Survey of recent mothers at least every two years (like PRAMS)	3	Yes

Notes - 2012

Narrative:
The MCH program has "direct access" to the electronic databases listed under Health Systems Capacity Indicator #09A through our collaboration with the Department of Health's Office of Policy, Planning, and Assessment (PPA). Using SSDI funds, we provide salary support for a PPA epidemiologist who provides data support for MCH; this epidemiologist has direct access to these databases.

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	No

Notes - 2012

Narrative:
The Tennessee Department of Education conducts the Youth Risk Behavior Survey. Students in grades 9-12 are surveyed in the spring of odd numbered years. The survey is voluntary and completely anonymous. When participation rates are high among selected schools, the results of the YRBS may be generalized to all students in the state in grades 9-12. The Office of Coordinated School Health administers the 87 question survey to approximately 1500 students. Additional information is available at: http://www.tn.gov/education/yrbs/.

IV. Priorities, Performance and Program Activities

A. Background and Overview

System accountability relies on documentation of outcomes related to program activities. The Tennessee Department of Health's Maternal and Child Health Section provides accountability for federal Title V Block Grant funds by: measuring the progress of each performance measure, budgeting and expending funds across the four areas of the MCHB pyramid, and determining the impact on outcome measures.

The Tennessee MCH performance measurement system is founded on principles of public health and includes: assessing needs and capacity, setting priorities, developing programs, allocating resources, establishing performance measures, and measuring outcomes.

Assessment of Needs and Capacity

The last Needs Assessment for Tennessee's Title V/Maternal and Child Health program was conducted in 2010. Quantitative and qualitative assessment revealed consistent findings regarding major health issues surrounding the three MCH populations. Potential priorities were derived from the MCH Stakeholder Survey, county health council priority lists, the National MCH agenda, specific conditions for which State and National data sources revealed high morbidity and mortality, key informant interviews, and Tennessee MCH leadership formal and informal brainstorming sessions.

Priority Setting

Once these broad priorities were determined, the MCH leadership team met several times to deliberate the topics and to formulate State Priority Measures. We all felt strongly that these were essential MCH health priorities, yet were fully cognizant of strengths and limitations of the state MCH capacity. We also felt strongly that we needed to consider risk, health promotion, protective factors, program development, intervention, and evaluation in a much more integrated rather than categorical context. Central to the team discussion were these considerations for each broad priority:

-Data trends
-Current MCH literature, research, and best practices
-The Life-Course Perspective
-MCH capacity (workforce abilities, training needs, funding)
-Partners and collaborators across departments, disciplines and regions
-Political environment
-Economic feasibility
-Ability to fully define and measure indicators
-Programs and policies that are working and not working

Through critical and deliberate consensus building, the team derived seven Tennessee MCH priorities and wrote the following corresponding State Priority Measures:

1. Reduce the infant mortality rate.
2. Reduce the percentage of obesity and overweight (BMI for age/gender > 85%) among Tennessee K-12 students.
3. Reduce smoking in Tennesseans age 13 years and older.
4. Decrease asthma hospitalizations for children 0-5 years.
5. Improve MCH workforce capacity and competency by designing and implementing a workforce development program.
6. Increase the percentage of CSHCN age 14 and older who have formal plans for transition to adulthood.
7. Reduce unintentional injury deaths in children and young people ages 0-24 years.

Program Development and Resource Allocation
A key element involved in the setting of priorities is an analysis of current capacity and identification of any programmatic or resource needs related to implementing the state priorities. For several of the aforementioned priority measures, related programs already exist within MCH. For example, the MCH Asthma Initiative provides leadership for state-level collaborations around improving outcomes for children with asthma; staff from this initiative will play an integral role in addressing the priority measure related to asthma hospitalization. Similarly, the Children's Special Services (CSS) program, Tennessee's Title V CSHCN program, already includes a transition component in its care coordination activities. CSS staff will work closely with health department staff across the state over the next five years to enhance transition planning and increase the percentage of CSHCN who have formal plans for transition to adulthood.

In other cases, primary program responsibility for some of these topic areas lies outside the Maternal and Child Health Section. In such instances, MCH staff work collaboratively with program staff within the Department of Health or from other agencies to address state priorities. For example, many smoking cessation activities within the Department of Health are based in the Nutrition and Wellness Section. However, MCH staff work closely with staff from Nutrition and Wellness to address smoking in the MCH population. As an example, a recent public awareness campaign organized by the MCH Early Childhood Comprehensive Systems (ECCS) program and Asthma Initiative included information about the state's Tobacco QuitLine and MCH staff discussed messaging strategies with Nutrition and Wellness staff. Collectively, efforts from both sections will aid Tennessee in addressing this priority measure.

MCH staff work with fiscal staff from the Bureau of Health Services Administration to ensure that allocation of MCH funds match the state priorities. Funds are spread across four areas: Direct Health Care Services, Enabling Services, Population-Based Services, and Infrastructure Services. Distribution of funding across these areas is monitored and reported annually during the MCH Block Grant application.

Performance and Outcome Measurement
Ongoing measurement of performance serves as a proxy for projecting outcomes. By incorporating evidence-based or theory-based measures into MCH work, we can estimate the impact on outcomes when such measures are implemented with fidelity. These performance measures are "process" type measures that can be examined on a regular basis (at least annually) in order to determine the likelihood of whether MCH efforts will have the desired impact on outcomes.

The gold standard for determining the impact of MCH programming efforts is to determine the impact on outcomes. However, determination of these outcomes may lag behind the actual performance efforts by months or years. Consider as an example the determination of infant mortality. By definition, the infant mortality rate cannot be determined until 364 days after the last infant in the cohort was born. For example, a baby born on December 31, 2009 is considered an infant until December 31, 2010. Thus, the infant mortality rate for 2009 cannot be finalized until at least January 1, 2011. Waiting until 2011 to decide whether infant mortality reduction programs are successful does not allow for ongoing program modification; hence, more readily attainable performance measures related to infant mortality (percent of infants receiving newborn screens, percentage of mothers receiving early prenatal care, etc) provide early proxy measures to help determine whether the desired outcome of reducing infant mortality will be achieved.

B. State Priorities

The following seven state priorities were established in the 2010 MCH Needs Assessment:

1. Reduce the infant mortality rate.
2. Reduce the percentage of obesity and overweight (BMI for age/gender > 85%) among

Tennessee K-12 students.
3. Reduce smoking in Tennesseans age 13 years and older.
4. Decrease asthma hospitalizations for children 0-5 years.
5. Improve MCH workforce capacity and competency by designing and implementing a workforce development program.
6. Increase the percentage of CSHCN age 14 and older who have formal plans for transition to adulthood.
7. Reduce unintentional injury deaths in children and young people ages 0-24 years.

In this section, each state priority/performance measure (SPM) will be discussed, with respect to its relationship to national performance measures and to capacity and resource capability of Tennessee's Title V program.

SPM #1: REDUCE THE INFANT MORTALITY RATE

Designation of infant mortality reduction as a priority in Tennessee is critical, given the high infant mortality rate (8.0 per 1,000 live births) compared to other states. Additionally, the disparity in infant mortality rates between Black and White infants (greater than a two-fold difference) calls for a focus on increasing survival of infants during the first year of life.

This SPM is related to several national performance measures, including:
-NPM #1: percent of screen-positive newborns who receive timely follow up to diagnosis and clinical management
-NPM #8: rate of birth to teenagers age 15-17
-NPM #11: percent of mothers who breastfeed their infants at 6 months of age
-NPM #15: percentage of women who smoke in the last three months of pregnancy
-NPM #17: percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates
-NPM #18: percent of infants born to pregnant women receiving prenatal care beginning in the first trimester

Existing MCH/Title V capacity supports this priority measure. The Newborn Screening Program provides follow-up for all infants with presumptive positive newborn screens. The Adolescent Pregnancy Prevention Program provides support for communities implementing teen pregnancy prevention initiatives. Home visiting programs encourage breastfeeding, smoking cessation, and early prenatal care. Additionally, MCH has access to linked birth and death certificate data, allowing for determination of infant mortality rate at the state level, by race, and by county. The state's Fetal Infant Mortality Review (FIMR) program, housed within MCH, also provides rich community-level data that can inform infant mortality reduction initiatives.

Resources external to MCH further support this priority area. The Department of Health has local health departments in all 95 counties across the state; staff in each local department provide pregnancy testing, necessary referrals for other services, WIC services for pregnant women, mothers, and infants, and EPSDT screenings. Collaborations with partner agencies (Medicaid, CHIP, local infant mortality reduction initiatives, March of Dimes, etc) further support the work related to this priority area.

SPM #2: REDUCE THE PERCENTAGE OF OVERWEIGHT AND OBSEITY AMONG TENNESSEE K-12 STUDENTS

Addressing childhood overweight and obesity is an obvious priority, given the high rates of both among Tennessee's children. In 2008, 39% of Tennessee school children were overweight or obese (BMI > 85% for age and gender on CDC growth charts). Based on the 2007 National Survey of Children's Health, Tennessee children ages 10-17 ranked 4th in the Nation for

childhood obesity and overweight, putting children at risk for associated adverse health and social consequences. These statistics demonstrate the need for ongoing efforts to prevent or reduce childhood overweight and obesity.

This SPM is related to several national performance measures, including:
-NPM #11: percent of mothers who breastfeed their infants at 6 months of age
-NPM #14: percentage of children, ages 2 to 5 years, receiving WIC services that have a BMI at or above the 85th percentile

Existing collaborations between MCH and other partners support this priority measure. The Department of Health's obesity prevention and reduction initiatives are housed in the Nutrition and Wellness Section. MCH staff have a strong working relationship with staff from Nutrition and Wellness. Additionally, partnership with the Office of Coordinated School Health allows for collection of annual data for this measure; CSH staff across the state collect body mass index (BMI) measurements on public school students statewide.

SPM #3: REDUCE SMOKING IN TENNESSEANS AGE 13 YEARS AND OLDER

Smoking was included as a state priority given the high rate of tobacco use among Tennessee's adolescent and adult populations. Every year, 14,600 Tennessee youth under 18 years of age become daily smokers. At this rate, 28,300 Tennessee youth alive today will die an early, preventable death because of a decision made as a youngster. More than 20% of all deaths in the United States are attributable to tobacco, making tobacco use the chief preventable cause of death.

This SPM is related to several national performance measures, including:
-NPM #15: percentage of women who smoke in the last three months of pregnancy
-NPM #18: percent of infants born to pregnant women receiving prenatal care beginning in the first trimester

Additionally, this SPM is related to SPM #1 (reduce infant mortality rate) and SPM #4 (reduce asthma hospitalizations). Smoking during pregnancy is associated with premature delivery and delivery of low birth weight babies; given that a large portion of Tennessee's infant mortality is attributable to low birth weight and prematurity, reducing smoking among women who are pregnant should also impact infant mortality. Smoking is also a known trigger for asthma exacerbations. Reducing smoking will, in turn, reduce smoke exposure among asthmatic children and should therefore reduce asthma hospitalizations.

Existing MCH/Title V capacity supports this measure. MCH home visitors provide health messages (including avoidance of tobacco and the importance of smoking cessation) to parents across the state. Through the Asthma Initiative, staff increase public awareness about the dangers of secondhand smoke and the relationship with asthma exacerbations. MCH also has access to aggregate data on smoking from the Youth Risk Behavior Survey (YRBS) conducted biannually by the Department of Education and the Behavioral Risk Factor Surveillance System (BRFSS) conducted annually by the Centers for Disease Control and Prevention.

Resources external to MCH further support this area. MCH frequently partners with the Department of Health's Nutrition and Wellness Section, which coordinates the state's tobacco cessation activities, including the Tennessee Tobacco QuitLine.

SPM #4: DECREASE ASTHMA HOSPITALIZATIONS FOR CHILDREN 0-5 YEARS

Designation of asthma hospitalizations as a priority measure was based on the prevalence of asthma among Tennessee's children and the burden of asthma hospitalizations on the state.

Approximately 10% of children in Tennessee suffered from asthma in 2007. Although inpatient hospitalizations have decreased since 1997, emergency department (ED) visits and charges for both inpatient and outpatient hospitalizations have increased. Younger children with asthma have more hospitalizations than older children. In addition, there are significant gender, racial, socioeconomic and geographic disparities in childhood asthma. More school days are lost due to asthma than any other chronic condition, and in Tennessee 98% of emergency treatments in schools are for asthma.

This SPM is related to several national performance measures, including:
-NPM #3: percent of CSHCN age 0-18 who receive coordinated, ongoing, comprehensive care within a medical home
-NPM #4: percent of CSHCN age 0-18 whose families have adequate private and/or public insurance to pay for the services they need
-NPM #5: percent of CSHCN age 0-17 whose families report the community-based service systems are organized so they can use them easily
-NPM #13: percent of children without health insurance
-NPM #15: percentage of women who smoke in the last three months of pregnancy

Additionally, this SPM is related to SPM #3 (reducing smoking). Smoking is a known trigger for asthma exacerbations. Reduction in asthma hospitalizations would be expected when exposure to secondhand smoke is reduced.

Existing MCH/Title V capacity supports this measure. The Asthma Initiative works to increase public awareness about asthma pathophysiology, treatment, and resources and works with the medical provider community to support evidence-based treatment for patients with asthma. The Children's Special Services (CSS) program, Tennessee's Title V CSHCN program, provides direct medical and care coordination services for children with special health needs, including asthma. MCH also has access to the state's hospital discharge database, which provides information on diagnosis-specific hospital discharges.

Resources external to MCH further support this area. MCH works collaboratively with the Monroe Carell Jr. Children's Hospital at Vanderbilt to provide asthma education opportunities for staff from medical clinics, health departments, and community agencies. MCH also partners with the state's network of Child Care Resource and Referral (CCR&R) centers to provide asthma information to child care providers and parents.

SPM #5: IMPROVE MCH WORKFORCE CAPACITY AND COMPETENCY BY DESIGNING AND IMPLEMENTING A WORKFORCE DEVELOPMENT PROGRAM

A competent workforce is vital to the success of a state's Title V program; therefore workforce capacity and competency was designated as a state priority. Our workforce has been focused and trained on direct clinical services for many years. Department of Health nursing leadership has requested help in developing competencies in public health basics and leadership. MCH program directors and home visiting staff have also expressed a need for additional training and mentoring in order to increase competencies in enabling services, population-based services, and infrastructure building.

This SPM is related to several national performance measures, including:
-NPM #1: percent of screen-positive newborns who receive timely follow up to diagnosis and clinical management
-NPM #6: percentage of CSHCN who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence
-NPM #7: percent of 19-35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B

-NPM #9: percent of third grade children who have received protective sealants on at least one permanent molar tooth
-NPM #12: percentage of newborns who have been screened for hearing before hospital discharge
-NPM #17: percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates

Existing MCH/Title V capacity supports this priority measure. Dr. Cathy Taylor, Assistant Commissioner for Health Services within the Department of Health, was the interim MCH Director until December 2010. She has vast experience in MCH workforce development at the national level.

Resources external to MCH further support this priority measure. East Tennessee State University (ETSU) recently developed LIFEPATH (Long-Distance Internet Facilitated Education Program for Applied Training and Health) and has the capacity to provide both academic and non-academic training to MCH staff across the state. Tennessee also has two HRSA Leadership Education in Neurodevelopmental and Related Disabilities (LEND) sites: Vanderbilt University and the University of Tennessee Health Science Center.

SPM #6: INCREASE PERCENTAGE OF CSHCN AGE 14 AND OLDER WHO HAVE FORMAL PLANS FOR TRANSITION TO ADULTHOOD

Transition planning for CSHCN was deemed a priority given the growing population of CSHCN experiencing a transition to adult health care, independent living, and work. Nearly 90% of CSHCN now survive to adulthood. Many respondents to the Family Voices Survey reported they are not having discussions with health care providers or educational staff regarding transition. Forty-eight percent (48%) reported that providers talked with them about planning for changing health care needs as the child ages, and forty-four percent (44%) reported their child's teacher discussed issues related to their child's transition to adulthood.

This SPM is related to several national performance measures, including:
-NPM #2: percent of CSHCN age 0-18 whose families partner in decision-making at all levels and are satisfied with the services they receive
-NPM #3: percent of CSHCN age 0-18 who receive coordinated, ongoing, comprehensive care within a medical home
-NPM #5: percent of CSHCN age 0-17 whose families report the community-based service systems are organized so they can use them easily
-NPM #6: percentage of CSHCN who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence

Existing MCH/Title V capacity supports this priority measure. The Children's Special Services (CSS) program, Tennessee's Title V CSHCN program, provides care coordination services (including transition planning) for enrollees. The program also partners with providers and family organizations to support the implementation of a medical home approach to care for all CSHCN. The Department of Health's Patient Tracking Billing Management Information System (PTBMIS) provides a mechanism for tracking documentation of transition planning for CSS enrollees.

Resources external to MCH further support this priority measure. MCH has a strong partnership with the state's Family Voices chapter, allowing for the inclusion of family input into efforts to improve transition planning. Additionally, MCH collaborates with the state chapter of the American Academy of Pediatrics on a number of health-related issues; this relationship will enhance efforts to increase transition planning for CSHCN.

SPM #7: REDUCE UNINTENTIONAL INJURY DEATHS IN CHILDREN AND YOUNG PEOPLE

AGES 0-24 YEARS

Reduction of unintentional injury was designated as a state priority measure after consideration of the injury burden in Tennessee. Injuries are the leading cause of death for U.S. and Tennessee children and young people ages 1-24, with motor vehicle injury as the number one cause for injury fatality. The rate of injury deaths in children has declined in the last 2 decades, yet rates of childhood injury deaths are greater in the US than in other developed countries. Nonfatal injuries contribute substantially to childhood morbidity, disability, and reduced quality of life; and lifetime costs are estimated to be over 50 billion dollars.

This SPM is related to several national performance measures, including:
-NPM #10: rate of deaths to children age 14 years and younger caused by motor vehicle crashes

Existing MCH/Title V capacity supports this priority measure. The state's CDC-funded Core Violence and Injury Prevention Program was recently moved to the Maternal and Child Health section. This move will allow for greater focus on prevention of childhood injury. Additionally, injury prevention messages are provided through MCH home visiting programs across the state and during EPSDT screenings provided at all county health departments.

Resources external to MCH further support this priority measure. MCH partially funds the state's network of Child Care Resource and Referral (CCR&R) centers, which provide technical support to child care providers and parents. Each center has a child health consultant, and messages about child health (including injury prevention) are made available to parents nad child care providers.

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	180	164	204	161	169
Denominator	180	164	204	161	169
Data Source			Department of Health	Department of Health	Department of Health
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2011	**2012**	**2013**	**2014**	**2015**
Annual Performance Objective	100	100	100	100	100

Notes - 2010
Data Source: Tennessee Department of Health, Newborn Screening Program

Notes - 2009
Data Source: Tennessee Department of Health, Newborn Screening Program

Notes - 2008
Data Source: Tennessee Department of Health, Newborn Screening Program

a. Last Year's Accomplishments
Tennessee's Genetics and Newborn Screening (NBS) Program was established in 1968 with mandated PKU screening of all babies. The NBS Program continues to utilize an established network of tertiary level providers for referral, case management and treatment of infants and children with genetic and metabolic diseases. Close linkages exist among NBS Follow-up staff, the tertiary centers and the Children's Special Services (Title V CSHCN) staff for referrals. An advisory committee guides program activities. Follow-up staff, located at the State Laboratory, is responsible for interfacing with the State Lab to identify, locate and follow up on unsatisfactory or abnormal results from the mandated screening. Referrals are made to the genetics and sickle cell centers as well as pediatric endocrinologists. Access to genetic screening, diagnostic testing and counseling services is available at three regional comprehensive genetic centers, two satellite genetic centers, four pediatric endocrinology clinics, two comprehensive sickle cell centers and two satellite sickle cell centers for individuals and families. If needed, local health department nurses assist in locating an infant needing follow-up.

This performance measure continues to be successfully met due to the state law requiring testing of all infants born in the state and the quality and efficiency of the State Laboratory and the NBS follow-up program. A newborn screening online course and DVD continue to be available to health care providers in order to educate them about newborn screening testing, proper specimen collection and follow up protocols for abnormal and unsatisfactory results and referrals. Periodic newsletters are electronically sent (and posted on the web site) to providers and birthing facilities statewide with the latest information on screening and follow-up.

The State Laboratory has continually monitored testing cut-off values to determine if changes need to be made based on the population of Tennesseans. The data collected are reviewed by the Genetics Advisory Committee (GAC) which includes the Genetic Centers Directors, Pediatric Endocrinologists, Neonatologists, and others.

Effective January 1, 2009, the NBS program began utilizing case management software to notify regional tertiary Centers and Primary Care Providers by fax of presumed positive results. Abnormal results with instructions and fact sheets can be faxed from the case file at the computer. This has greatly reduced the amount of paper record storage. Documents are now scanned into case files for retention.

Information on newborn screening for parents and for health care providers is located on the Department's web site.

During CY 2010, follow up staff called 2,033 presumed positive results to primary care providers or neonatal intensive care units and to the tertiary centers. In addition, follow-up was done on 1,753 unsatisfactory samples, 1,147 samples which were collected before the infant was 24 hours of age, and 121 infants that needed follow up due to transfusions. Reports for infants on parenteral nutrition support were created and sent to tertiary centers on a regular basis. Provisional 2010 data indicate that 89,285 tests were performed on infants born in Tennessee during the calendar year (both resident and non-resident). A total of 2,308 cases were opened and followed by the staff in 2010.

Since the State Laboratory began charging hospitals for repeat specimens in January 2009, there

has been a significant decrease in the number of unsatisfactory samples collected. Follow up staff continue to monitor the unsatisfactory collection rate by hospital. For 2010, the State's unsatisfactory rate was 1.9 percent. Unsatisfactory rates per hospital are posted on the Newborn Screening Follow Up web site.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Screen all infants born in Tennessee for those diseases/metabolites determined by the Genetics Advisory Committee and the Department and State law.			X	
2. Follow up on all infants needing a repeat test or further diagnostic workup.	X	X		
3. Work closely with the Genetics and Sickle Cell centers on follow-up and treatment.	X	X		
4. Work closely with birthing facilities on improving the unsatisfactory rates by distributing the revised training CD and performing site visits.	X			X
5. Support the Genetics Advisory Committee.			X	X
6. Work closely with all birthing facilities and health care providers on newborn screening testing and results.	X			X
7. Provide educational materials for parents and providers on newborn screening tests.	X		X	
8. Assist with re-evaluation of cut-off values for testing.			X	
9.				
10.				

b. Current Activities

The Genetics Advisory Committee (GAC) (members from the genetic centers, pediatric endocrinologists, hematologist, pediatrician/lawyer, neonatologist, pediatric pulmonologist) met twice to guide the program and recommend changes in tests and procedures.

Guidelines for screening for congenital hypothyroidism on babies less than 1500 grams birth weight were developed and shared with the GAC for review and input. Investigation and evaluation procedures for adding SCID (Severe Combined Immunodeficiency Syndrome) to the screening panel were begun; a work group to assist the Department was developed and one meeting has been held. Preliminary discussions were held on screening infants at birth for critical congenital cyanotic heart disease; a work group will be formed to explore and discuss further.

The program continues to provide both parent and provider information on all the different metabolites and disorders. The department website continues to be updated and has extensive information available to both health professionals and parents. NBS follow-up staff members are available to both providers and families to provide information.

The Genetics Program rules have been revised to include mandated hearing screening and guidelines for testing NICU infants; these are in the review and approval process.

c. Plan for the Coming Year

The plan for the next year will be to continue to provide follow up as efficiently as possible. The NBS program will continue to perform and document all follow up for presumed positives, unsatisfactory results, and transfused infants. Follow-up staff will plan to present information and

data on the State's Newborn Screening Program at statewide meetings of health professionals organizations.

The policy for screening very low birth weight infants for congenital hypothyroidism will be finalized and implemented.

The Genetics Advisory Committee has formed a group to look at testing for SCID (severe combined immunodeficiency syndrome); their work will continue. The group consists of geneticists, laboratory staff, and nurses; others will be added as needed.

The Genetics Advisory Committee's work group on screening for critical congenital cyanotic heart disease will meet and make recommendations to the Committee for possible implementation in Tennessee.

The Genetics Advisory Committee plans two face to face meetings in November and in May.

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

Total Births by Occurrence:	**87141**					
Reporting Year:	**2009**					
Type of Screening Tests:	**(A) Receiving at least one Screen (1)**		**(B) No. of Presumptive Positive Screens**	**(C) No. Confirmed Cases (2)**	**(D) Needing Treatment that Received Treatment (3)**	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)		0.0				
Congenital Hypothyroidism (Classical)	87141	100.0	316	53	53	100.0
Galactosemia (Classical)	87141	100.0	106	8	8	100.0
Sickle Cell Disease		0.0				
Biotinidase Deficiency	87141	100.0	15	1	1	100.0
Congenital Adrenal Hyperplasia	87141	100.0	902	4	4	100.0
Cystic Fibrosis	87141	100.0	1098	17	17	100.0
Amino Acids	87141	100.0	202	8	8	100.0
Acylcarnitines	87141	100.0	190	11	11	100.0
Hemoglobinopathy	87141	100.0	74	59	59	100.0

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	62	62	62	62	62
Annual Indicator	60.0	60.7	60.7	60.7	60.7
Numerator	3807	3381	136524	136524	136524
Denominator	6349	5570	224895	224895	224895
Data Source			CSHCN Survey	CSHCN Survey	CSHCN Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2011	**2012**	**2013**	**2014**	**2015**
Annual Performance Objective	62	62	62	62	62

Notes - 2010
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Numerator and denominator reported here are those reported as the weighted estimates for the national survey. Data source: http://cshcndata.org

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Numerator and denominator reported here are those reported as the weighted estimates for the national survey. Data source: http://cshcndata.org

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Numerator and denominator reported here are those reported as the weighted estimates for the national survey. Data source: http://cshcndata.org

a. Last Year's Accomplishments
Staff from Children's Special Services (CSS, Tennessee's Title V CSHCN Program) continued to work to ensure that children and parents become active participants in all levels of decision making. CSS participants and their families continued to participate in the development of a Family Service Plan (FSP). This plan is an assessment tool from which a problem/needs list is identified and goals and objectives are developed to address those problems/needs. The FSP includes medical and non-medical assessments including an individual plan of care and the identification of community resources. CSS Care Coordinators continued to offer education and assistance to families and participants on interaction with health care providers and integrated system navigation.

The CSS program director and staff served on advisory committees and collaborated with the Tennessee Council of Developmental Disabilities, the Tennessee Technical Assistance and Resources for Enhancing Deaf Blind Supports (TREDS), Family Voices, Tennessee Early Intervention Services, the Governor's Office of Children's Care Coordination, Genetics Advisory Committee, Newborn Hearing and Screening Advisory Committee, and Early Childhood Comprehensive Systems. Through these collaborations, they actively participated in policy and

program development for children and youth with special health care needs.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Partner with groups who advocate and serve children and youth with special health care needs.		X	X	X
2. Have parents help develop the child's family services plan for each child enrolled in CSS.		X		
3. Include parents on the CSS Advisory Board.		X	X	X
4. Conduct parent satisfaction survey.			X	X
5. Include parents and CSHCN as participants and presenters at conferences and training events.		X	X	X
6. Develop parent advisory committee.		X	X	X
7. Family Service Plans are developed with participants and families to address medical and non-medical needs annually.	X	X		
8. Develop training and competencies for Care Coordinators.		X	X	X
9. Provide additional educational resources and training for participants and families on interaction with health care providers and decision-making strategies.		X	X	X
10.				

b. Current Activities

Care coordination best practices and standards are being developed and all care coordinators will be trained so that all regions of the state are operating under the same guidelines. Competencies are being developed that all coordinators will have to meet as part of their job duties. Program directors and care coordinators are meeting with medical providers in their regions/counties to develop referral systems for children with special health care needs. Family Service Plans continue to address any specific needs the family or CSHCN may have regarding decision making and satisfaction with the medical provider. Care coordinators continue to provide resources and education to families on interaction with medical providers and how to be an integral part of the medical decisions for the participant. Families and CSS participants will be recruited to develop a parent advisory committee and to serve as facilitators and presenters at local and statewide training for CSS staff and CSS Advisory Committee meetings. CSS staff continue to encourage parents to serve and participate on the CSS Advisory Committee in advisory/advocacy roles. CSS is engaged with the State Family Voices staff and are currently discussing issues surrounding family involvement and developing mechanism to include more family involvement in the upcoming year.

c. Plan for the Coming Year

Best practice and standards will continue to be developed and care coordinators will continue to be trained on these standards. Evaluation of care coordination best practices and standards will be conducted to determine if these methods are making a difference in the satisfaction level of families of children and youth with special health care needs. A satisfaction survey will be developed and families will be requested to complete the survey at their annual recertification period. The survey will capture families satisfaction with their health care providers, their insurance providers, the CSS program and transition planning activities. Parents will continue to be invited to attend and to participate in the CSS Advisory Committee meetings. CSS staff is actively seeking parent participation for AMCHP's Family Scholar program.

Family service plans will continue to be developed with families and participants to address

medical and non-medical needs.

Collaborations with state agencies and advisory committees will continue as our efforts to improve service delivery and programmatic policy for children and youth with special health care needs increase.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	63	64	65	65	65
Annual Indicator	60.7	52.7	52.7	52.7	52.7
Numerator	3857	2935	115761	115761	115761
Denominator	6349	5570	219634	219634	219634
Data Source			CSHCN Survey	CSHCN Survey	CSHCN Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2011	**2012**	**2013**	**2014**	**2015**
Annual Performance Objective	55	55	60	60	60

Notes - 2010
Indicator data come from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Numerator and denominator reported here are those reported as the weighted estimates for the national survey. Data source: http://cshcndata.org

Notes - 2009
Indicator data come from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Numerator and denominator reported here are those reported as the weighted estimates for the national survey. Data source: http://cshcndata.org

Notes - 2008
Indicator data come from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Numerator and denominator reported here are those reported as the weighted estimates for the national survey. Data source: http://cshcndata.org

a. Last Year's Accomplishments
CSS staff reviewed the Medical Home Provider Survey data and collaborated with staff from the Early Childhood Comprehensive Systems (ECCS) program and the Governor's Office of Children's Care Coordination to develop activities based on the survey results. CSS staff collaborated with state and local agencies to ensure that all children have a medical home in the county of residence, and with the Medicaid managed care organizations to ensure that participants were assigned and received services from a primary care provider and were referred to specialty providers as needed.

The CSS Family Service Plan (FSP) included a comprehensive transition plan for all participants

age 14-21 years old. The plan helps families identify and develop a medical home transition process from pediatric to adolescent and adult providers. Based on results of on-site monitoring during the previous year, policies and procedures were updated and developed to ensure the medical home is identified for all participants not just those of transitional age. CSS Care Coordinators continued assisting families in coordinating services between the primary, sub-specialty, and specialty providers in the development of a medical home for all participants.

CSS received referrals from the Newborn Hearing, Screening and the Genetics Screening Programs. These families are contacted and assisted in applying for CSS or other eligible services. Emphasis is being placed on those families considered lost to follow-up. Care coordinators conduct home visits to determine if the families have unmet needs and assist them in applying for services.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide standardized care coordinaton services to each enrolled child and his/her family.	X	X		
2. Assist families to obtain medical home.		X		
3. Use the Family Service Plan to help identify each participant's medical home, or the need for one.		X		X
4. Continue to educate local primary care providers on the medical home concept.			X	X
5. Use survey data results to address gaps and barriers that limit primary care providers role as a medical home.		X		
6. Collaborate with Newborn Hearing and Screening and Genetics on referrals and follow-up of newly-identified CSHCN.	X	X	X	X
7. Collaborate with TennCare (Medicaid), CoverKids (CHIP), and managed care organizations to identify medical homes for CSHCN.		X		
8. Promote communication by facilitating exchange of medical records, reports, summaries and recommendations between hospitals, specialty providers, and primary care providers.		X		
9.				
10.				

b. Current Activities

CSS staff participated in a medical home summit sponsored by the AAP Community Pediatrics Training Initiative at Vanderbilt. The summit included Grand Rounds with visiting professor Dr. Carl Cooley ("Implementing the Family-Centered Medical Home: It's Not Maybe Anymore") and a Roundtable Discussion ("Engaging Community Partners in the Medical Home"). Action plans from the summit are discussed below.

CSS continues to participate in the development of a State Medical Home Plan and is partnering with an ECCS workgroup to plan and host a medical home summit where state and provider agencies who are working on medical home provisions are brought together to share initiatives, recommendations and solutions. CSS continues to collaborate with other agencies to develop medical homes for all CSHCN, and program staff continues to assist families in identifying and accessing medical homes, and while assisting with the coordination of services between providers.

CSS continues outreach efforts with insurance and primary care providers to establish medical homes and payment sources for CSHCN, and continues facilitating information exchanges

between health care providers and families. Care coordinators continue working with and enrolling families identified by newborn hearing and screening programs.

CSS staff continues to provide participants with a portable medical history summary form for participants to provide their health care providers the most recent and pertinent medical history.

c. Plan for the Coming Year

CSS personnel are members of the ECCS Workgroup and are involved in planning the Medical Homes Summit. It is anticipated that information gathered from this summit will assist the State of Tennessee to develop an operational definition of what a medical home is and offer insight into any opportunities that may exist for providers as they develop the medical home concept in their practices. Data from the GOCCC/ECCS survey on barriers and gaps will be used to inform project efforts.

CSS staff will continue care coordination for children and youth with special health care needs and provide educational information to provider. The electronic medical home tool kit will be updated as needed and used as a referral source for providers and families.

As a follow-up to the Vanderbilt University Medical Center Medical Homes Summit, CSS staff will collaborating with the medical providers as well as the community providers in developing a Medical Home 101 presentation to educate providers, partners and other consumers about the medical home concept. Workgroups were also formed to develop a care coordination tool kit to improve care coordination between inpatient/outpatient/subspecialist and create a "how-to" for care coordination. CSS staff will also work with the group to create a standard portable health history record or care notebook that can be utilized statewide.

The Governor's Office of Children's Care Coordination developed a Medical Homes Tool Kit for families and providers. The CSS program staff provides this information to families and providers in an effort to create awareness of the medical home concept. The toolkit is available at: http://www.tn.gov/goccc/initiatives/medicalhome/index.html. It is anticipated that this web site will move to the MCH Section of the Department of Health and CSS staff will update the toolkit as needed.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Performance Objective	64	64	69	69	69
Annual Indicator	61.4	67.7	67.7	67.7	67.7
Numerator	3897	3771	152224	152224	152224
Denominator	6349	5570	224965	224965	224965
Data Source			CSHCN Survey	CSHCN Survey	CSHCN Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					

Is the Data Provisional or Final?				Final	Final
	2011	**2012**	**2013**	**2014**	**2015**
Annual Performance Objective	70	70	70	70	70

Notes - 2010
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Numerator and denominator reported here are those reported as the weighted estimates for the national survey. Data source: http://cshcndata.org

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Numerator and denominator reported here are those reported as the weighted estimates for the national survey. Data source: http://cshcndata.org

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Numerator and denominator reported here are those reported as the weighted estimates for the national survey. Data source: http://cshcndata.org

a. Last Year's Accomplishments
The Child Health Insurance Program (CHIP) was temporarily closed for enrollment during the past year, and budgetary constraints prevented TennCare from expanding their medically needy enrollees. Based on those changes in the State health insurance plans, CSS saw a slight increase in enrollment. CSS collaborated with CHIP and the MCOs to develop mechanisms that provided families information and assistance needed to understand program requirements and application for benefits. CSS staff was trained on all the CHIP products, and continued providing this information to participants and families. CSS continued to provide medical services as well as care coordination and provided education and resources to families regarding available public and private insurance options.

CSS continued to assess insurance status of all participants during six-month and annual eligibility reviews and provided necessary assistance in applying for coverage and appealing denied services.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Assure that all children applying for CSS services also apply for TennCare (Medicaid) or CoverKids (CHIP) services.		X		
2. Provide care coordination services to all CSS families statewide assisting families with access to medical care, utilization of services, transportation, etc.	X	X		
3. Work with TennCare (Medicaid), managed care organizations, and providers to ensure service needs of this special population are met.	X	X		
4. Assist families with any needed appeals to public and private insurance providers for denied services.		X	X	X
5. Monitor Federal and State public insurance programs for changes.		X	X	X
6. Recruit providers for CSS approved vendor list.		X		X
7.				
8.				
9.				

10.				

b. Current Activities
CSS is partnering with the TennCare managed care organizations (MCOs) to ensure insurance is available to all eligible constituents by establishing a referral system that will allow participants with special health care needs to be referred to the MCOs by CSS, or vice versa.

CSS continues social marketing and outreach activities that include contacting all child-serving agencies, local health care providers, and community resource agencies to request that they provide information regarding CSS Services, TennCare and CHIP in their informational brochures provided to families receiving services from those agencies.

CSS continues to display program information electronically in the local human services offices, which include program eligibility requirements, and information regarding other government sponsored insurance programs. CSS provides narrative and electronic information for inclusion in the MCO newsletters and other printed resource material.

CSS continues providing medical services to those individuals who meet program eligibility requirements and determining insurance status of eligible participants at six months and one year intervals. CSS continues to assist families and participants in applying for all insurance programs and third party resources for which they may be eligible.

c. Plan for the Coming Year
CSS program staff will continue current activities during upcoming fiscal year.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	82	82	93	93	93
Annual Indicator	80.8	91.8	91.8	91.8	91.8
Numerator	5128	5113	208995	208995	208995
Denominator	6349	5570	227739	227739	227739
Data Source			CSHCN Survey	CSHCN Survey	CSHCN Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2011	**2012**	**2013**	**2014**	**2015**
Annual Performance Objective	93	93	93	93	93

Notes - 2010
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Numerator and denominator reported here are those reported as the weighted estimates for the national survey. Data source: http://cshcndata.org

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Numerator and denominator reported here are those reported as the weighted estimates for the national survey. Data source: http://cshcndata.org

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Numerator and denominator reported here are those reported as the weighted estimates for the national survey. Data source: http://cshcndata.org

a. Last Year's Accomplishments
CSS continued to identify needed services available within the community that are easily accessible. Staff worked closely with MCOs, insurance companies, and other providers for improving access to local services. Patient satisfaction surveys were conducted during regular clinic visits. In addition, CSS continued to collaborate with agencies to facilitate referral and access to CSS and partner agencies' services. CSS developed, updated and disseminated a statewide resource directory with available resources in all 95 counties that was utilized to identify community resources and make referrals to families.

CSS continued to intensify efforts with the Tennessee Council on Developmental Disability, Tennessee Disability Pathfinder, Tennessee Technical Assistance & Resources for Enhancing Deafblind Supports (TREDS), Tennessee Early Intervention Systems (TEIS), Tennessee Housing and Development Agency (THDA), United Cerebral Palsy (UCP), Tennessee Department of Labor and the Governor's Office of Children's Care Coordination in an effort to provide CSS participants with information regarding all eligible community services and resources.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Coordinate CSS services with other health department services.		X		X
2. Provide care coordination services, including referrals and linkages with community agencies, to all families participating in the program.	X	X	X	X
3. Work with regional and local health councils to identify needs and gaps in servcices in specific communities.		X	X	X
4. Work with state agencies such as the Departments of Mental Health and Developmental Disabilities and Education, local mental health centers, and school systems to develop a culturally competent approach to services for the population.	X	X	X	X
5. Conduct parent satisfaction surveys.		X		X
6. CSHCN ages 0-3 will be referred to TEIS Part C Early Intervention services in the local communities.		X	X	X
7. CSHCN ages 3-21 will be referred to local school districts for Part B services in the local community.		X	X	X
8.				
9.				
10.				

b. Current Activities
CSS continues to update and disseminate the statewide resource directory annually. This resource directory allows care coordinators and families to access community based resources at

the local county level. CSS attempts to include all known local/community based resources that are available.

CSS marketing and outreach campaign will further identify available resources and CSS eligible families will be notified of new resources during their FSP review.

CSS continues working with partner agencies and families of children and youth with special health care needs to develop a system of service that is organized for easy access and use. CSS continues working with public and private providers to ensure access to appropriate medical and non- medical services for CSHCN. CSS continues to collaborate with other agencies and advisory committees related to community resources and services. CSS continues to notify all families of recently SSA eligible participants of available services and resources.

c. Plan for the Coming Year

CSS staff will participate in statewide health fairs, community resource fairs, attend parent teacher meetings at schools, visit doctor's offices and other community agencies in an effort to increase awareness of services for children and families.

CSS will continue to identify challenges and barriers to providing services in certain areas of the state, and continue contractual agreements with the Tennessee Lions Charities for vision screening, referral and follow-up in the local head start and child care centers for children between 12 and 72 months of age. CSS will continue contractual agreements with the University of Tennessee at Martin for a speech and language therapy program for children in underserved counties of Northwest Tennessee.

CSS will continue working with other agencies and families to develop a system of services organized for easy access and use.

CSS will continue current activities as budgetary constraints allow.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	39.6	39.6	39.6
Numerator	1561	1534	34477	34477	34477
Denominator	1561	1534	87141	87141	87141
Data Source			CSHCN Survey	CSHCN Survey	CSHCN Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2011	**2012**	**2013**	**2014**	**2015**

Annual Performance Objective	40	45	50	55	60

Notes - 2010
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Numerator and denominator reported here are those reported as the weighted estimates for the national survey. Data source: http://cshcndata.org

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Numerator and denominator reported here are those reported as the weighted estimates for the national survey. Data source: http://cshcndata.org

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Numerator and denominator reported here are those reported as the weighted estimates for the national survey. Data source: http://cshcndata.org

a. Last Year's Accomplishments
In the past, CSS received technical assistance from Healthy Ready to Work which allowed CSS program staff to develop the resources necessary to create a statewide transitional plan that was used as a model for all individual transition plans.

CSS collaborated with the Department of Children's Services, the Department of Education, the Department of Mental Health and Developmental Disabilities, the Tennessee Council on Developmental Disabilities and Family Voices to develop a statewide transition task force. This task force was established to formulate programmatic policies and procedures for transition plans for all children and child serving state agencies.

CSS worked to identify each and every need a participant and their family could have concerning transition from adolescence to adulthood. CSS staff worked on the development of a statewide and regional transitional team and continued to identify transitional resources within the community.

A CSS workgroup was developed to formulate transition standards for CSHCN. Some of the aspects included in the plan include post secondary and vocational education, medical home options, employment opportunities, social and recreational opportunities, legal and financial needs and housing.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Include transition services in the individual care plans for those participants age 14 and older.	X	X		
2. Maintain listing of community referral resources.			X	X
3. Assist with all appropriate referrals for CSHCN.		X		
4. Provide training and development opportunities for CSS staff on transition issues.		X	X	X
5. Provide updated resource materials for CSS staff and CSHCN.			X	X
6. Encourage youth to present at transition meetings and training events.			X	
7. Collaborate with state agencies, work groups and advisory committees for transition policy development.		X	X	X

8. Develop additional transition materials and resources, transition brochures, and guides.			X	
9.				
10.				

b. Current Activities
CSS continues to collaborate with the Departments of Children's Services, Education, Mental Health and Developmental Disabilities, Intellectual Disabilities, Juvenile Justice, Labor and Workforce Development, and representatives from other child serving agencies on the Youth Transition Task Force that addresses transition from youth to adulthood. CSS continues working with the Department of Education to include a medical home transition component in the Department's transition guidelines and to provide input on the IEP and education transition for CSHCN. CSS collaborated with the Governor's Office of Children's Care Coordination, Family Voices, TennCare, Vocational Rehabilitation and the Department of Higher Education to develop model transition plans.

CSS continues to develop transition plans that can be utilized statewide. Care Coordination standards are being established to standardize and enhance transition services for CSS participants. Age appropriate transition plans will continue to be developed for all participants age 14 and older and will include components relative to medical home, independent living, higher education, employment and recreation. A Medical History Summary Form is provided to all CSS participants as a concise medical history that can be provided to medical providers as the participants transition from pediatric to adult providers. The form will also be made available to any CSS participant leaving the program.

c. Plan for the Coming Year
CSS will continue to collaborate with other child serving agencies to develop a transition toolkit. CSS will continue to monitor national development regarding transition standards and best practices and will incorporate those initiatives into our program where feasible.

Care coordination training will continue to be developed and implemented for transition planning for CSHCN.

CSHCN participants and families will be asked to participate in CSS Advisory Committee meeting regarding transitional needs.

A satisfaction survey will be developed for CSS participants to determine success of individualized transition plan and determine any gaps and barriers that may exist.

CSS will collaborate with the American Academy of Pediatrics to develop emergency preparedness guidelines for children and youth with special health care needs that will become part of the individualized transition plan.

CSS staff will continue to partner with pediatric providers to locate adult providers for CSHCN who are aging off the program.

CSS staff will continue to collaborate with state agencies, advisory groups and work groups regarding youth transition issues and program and policy development.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	81	83	88	88	88
Annual Indicator	86.7	86.7	83.0	83.0	77.0
Numerator	1300	1300	278	278	261
Denominator	1500	1500	335	335	339
Data Source			2008 NIS Survey	2008 NIS Survey	2009 NIS Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2011	**2012**	**2013**	**2014**	**2015**
Annual Performance Objective	80	80	80	80	80

Notes - 2010
Data source is the final 2009 National Immunization Survey (NIS). The result for this aggregate measure (abbreviated "4:3:1:3:3" in the NIS) is significantly lower for this report because of a national shortage of Hib vaccine from December 2007 through mid-2009, which substantially reduced the number of children in this birth cohort who received 3 doses of the Hib vaccine.

Notes - 2009
Data source is the final 2008 NIS publication.

Notes - 2008
Data source is the 2008 NIS. Sample size (completing household interviews and with adequate provider data = 335) for Tennessee is small, confidence intervals are wide.

a. Last Year's Accomplishments
Tennessee measures immunization at age 24 months through its annual immunization survey. The survey is a sample of the immunization status of two-year-old children that is statistically valid for each of the state's administrative regions. The 2010 survey comprised 1,480 children. The completion rate for the new standard 4:3:1:3:3:1:4 series, as defined by the Centers for Disease Control and Prevention's (CDC) National Center for Immunization and Respiratory Diseases (NCIRD), was 72.3%. The state immunization program tracks how many of the vaccines included in this series reach 90% or higher coverage levels. In 2010, 5 of the 7 vaccines achieved this goal: only falling short with the 4th dose of DTaP and pneumococcal vaccines; however, completion rates for 3 doses of these two vaccines is approximately 95%, so last year's educational goals focused on targeting children ages 20-24 months missing their fourth DTaP dose. Local health department staff have been trained to review the immunization status of any person presenting for any type of service at the clinics and provide needed immunizations, or assist with referrals to the primary care provider. There is no racial disparity between black and white children, as assessed in this survey, for the vaccines in the 4:3:1:3:3:1:4 series; however, a pronounced racial disparity continues for influenza vaccine, specifically. While use of influenza vaccine increased from 2009 to 2010, there were wide regional variations in coverage (from 16% in one region to 80% in another). The Medical Director of the Immunization Program shares its findings with TennCare and with the state chapters of the American Academy of Pediatrics and the Academy of Family Physicians. The Immunization Program has published the results of its surveys of 24-month-old children on its web page (https://twis.tn.gov).

The Department's contractual arrangement with TennCare to provide EPSDT exams has

provided additional opportunities to provide immunizations and to check current status. In 2010, new immunization requirements went into effect for pre-school and school-aged children. These new requirements include pneumococcal vaccine and hepatitis A and B vaccines for children in child care, as well as a resumption of the Hib vaccine requirement that had been suspended as a result of the national Hib vaccine shortage.

Influenza vaccination was first assessed in the state's 2007 annual survey of immunization coverage among 24 month-old children. The Medical Director of the Immunization Program continued to highlight this finding at state and national meetings, with public health field staff and through meetings with representatives of vaccine manufacturers who visit provider offices regularly. The Immunization Program also receives grant funds from CDC to promote influenza immunization; it uses this funding to support site visits to healthcare providers by public health field staff who highlight these findings and educate providers about the CDC recommendation to provide influenza vaccine to all children under age 19 years.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide immunizations in local health department clinics.	X			
2. Check immunization status of persons requesting any type of services at local health department clinics.	X			
3. Maintain and continue to improve the Immunization Registry software and capacity for electronic access for submission and retrieval of data.			X	X
4. Use intranet connection to increase data input by private physicians to Immunization Registry.			X	X
5. Assess immunization coverage levels in the population.			X	X
6. Immunization staff continues to work with providers within their geographic areas providing technical assistance.			X	X
7.				
8.				
9.				
10.				

b. Current Activities

Current activities include: (1) identifying high-risk children and assuring completion of their immunizations, targeting 20-24 month olds immunized in local health departments who lack evidence of receiving the 4th dose of DTaP; (2) performing site visits to all VFC providers at least every other year to ensure efficient vaccine delivery; (3) continuing to capitalize on provider interest in linking electronic health record systems with the state immunization registry and expanding registry access in physician offices; (4) conducting assessments in population sub groups such as day care enrollees, identifying those at high risk of not completing immunizations and devising strategies to reach them; and (5) conducting follow-up on children born to hepatitis B infected women to ensure receipt of recommended vaccine/immunoglobulin.

ARRA funds ($4.4M) were used to provide additional vaccines through health departments for children and adults. There was a time limited adult vaccination campaign primarily promoting tetanus-diphtheria-pertussis (Tdap), with over 30,000 adults immunized in 2010, as well as pneumococcal vaccine for high risk adults under 65. For children, ARRA funds helped fund the surge of children and teens ineligible for the VFC Program who received public health administered vaccines to meet the state's new school immunization requirements for the 2010-11 school year. Such children typically have high insurance deductibles or co-pays for vaccination services

c. Plan for the Coming Year
The strategy will be much the same as this year. The major emphasis will be on the VFC/AFIX visits to the providers' offices to assure appropriate adequate use of vaccines and compliance with federal VFC Program requirements. There will also be an emphasis on increasing the number of private provider practices electronically exchanging data with the immunization registry. Interest in this work is being generated by the availability of Medicaid "Meaningful Use" grants to private providers to support the accelerated implementation of electronic health records capable of communicating with other health information systems, such as state immunization registries. Immunization level assessment activities will continue as well as the development of approaches to reach those less likely to complete immunizations on time. Follow-up of children born to hepatitis B infected women will also continue.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	27	26.5	26.5	26	24
Annual Indicator	28.6	27.8	27.3	24.0	20.3
Numerator	3392	3361	3328	2955	2531
Denominator	118599	120852	122020	123216	124467
Data Source			Department of Health	Department of Health	Department of Health
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2011	**2012**	**2013**	**2014**	**2015**
Annual Performance Objective	20	19.5	19	18.5	18

Notes - 2010
Data Source: Tennessee Department of Health, Division of Health Statistics, Population Projections and Birth Statistical System

Notes - 2009
Data Source: Tennessee Department of Health, Division of Health Statistics, Population Projections and Birth Statistical System

Notes - 2008
Data Source: Tennessee Department of Health, Division of Health Statistics, Population Projections and Birth Statistical System

a. Last Year's Accomplishments

The Family Planning Program provided contraceptive education and clinical services in 125 sites statewide as one strategy for reducing teen pregnancy; teens are a priority population, especially for outreach. CY 2010 data from the Family Planning Annual Report show that the program served 13,464 clients ages 17 and under - a decrease of 1,621 from CY 2009. Discussions are taking place to try to determine the reason for this continued decline of services in this age range.

The state continued to provide EPSDT visits for children and adolescents in the local health departments, under contract with TennCare/Medicaid. During FY 2009, the health department clinics performed 64,461 EPSDT screenings, of which 9,285 were to adolescents ages 12-20. These exams include assessment regarding sexual activity and referral for family planning services as appropriate.

Tennessee Adolescent Pregnancy Prevention Program (TAPPP) councils operated in three of the six metropolitan areas and in multi-county groupings in six of the seven rural regions. One rural region and one metro region dropped out of the program due to financial constraints. Nine TAPPP Coordinators served as the community contacts/resource persons for adolescent pregnancy issues in their respective areas. All council memberships were broadly representative of the surrounding community. Each council participated in a wide range of activities, depending on local priorities and resources. Networking to provide community education and awareness activities for students, parents, and providers through classes in schools, in community agencies, health fairs, and media presentations is a TAPPP priority. Data for FY 09-10 show that statewide staff provided family life education programs to over 55,500 students; provided education and training to over 7,700 adults; and worked with 4,200 parents and 6,100 professionals.

The Adolescent Health Advisory Committee, which covers a broad focus of teen issues, is a collaborative of representatives from Maternal and Child Health, TENNderCare, the Division of Minority Health and Disparity Elimination, the Division of Alcohol and Drug Abuse Services, the Governor's Office of Children's Care Coordination, the Division of Special Populations, the Division of Clinical Leadership, and regional health department staff. Members are selected based on their expertise in one or more areas of youth health care, well-being and development. During FY 09-10, the Committee met quarterly and discussed best practice strategies to meet Healthy People 2010 health objectives for adolescents. Educational activities and advocacy for obesity prevention, nutrition and exercise counseling, and asset development were among the pertinent health issues addressed. The online "Adolescent and Young Adult Health in Tennessee Report" is updated bi-annually as the data become available.

Additional data information on adolescent pregnancies is included in the section on plans for the coming year due to space limitations.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide family planning services in all 95 counties.	X			
2. Provide education in community settings related to adolescent health and prevention of risk-taking behaviors.	X		X	X
3. Provide EPSDT screeing for teens with referrals to family planning as appropriate.	X			
4. Continue TAPPP coordinators' activities and coalitions.				X
5. Emphasize services for adolescents, including direct services, care coordination, and referral.			X	
6. Continue meetings of the Adolescent Health Advisory				X

Committee.				
7. Apply for TItle V Abstinence Education funding, if eligible.		X		
8.				
9.				
10.				

b. Current Activities

During the first half of FY11, 13,464 adolescents ages 17 and under were provided services through the statewide Family Planning Program, with services at 125 sites in all 95 counties. The Tennessee Adolescent Pregnancy Prevention Program (TAPPP) utilizes county and regional level health educators to provide community education. The number of educational contacts with adults, professionals, and parents remains consistent with last year's numbers. Presentations and consultations cover a variety of issues and topics such as community awareness of teen pregnancy, health department services, sexuality education curricula review and revision, teacher training on health issues and curricula, abstinence education, parenting concerns, teen parenting events and adolescent/child growth and development. The National Day to Prevent Teen Pregnancy has been a popular focal point for prevention messages. The primary event is teens gathering to take an online quiz about sexual risk taking and consequences; for 2010 additional online activities for teens were added.

The Adolescent Health Advisory Committee continues to meet quarterly and includes speakers on disparities in health care through improving cultural proficiency, mental health, and youth development.

c. Plan for the Coming Year

MCH programs will continue to offer clinical and educational services to the adolescent population, in addition to offering support, technical assistance, and training to community agencies and other groups working towards lowering the teen pregnancy and birth rates. All current year activities will continue.

Tennessee was allocated $1,141,533.00 in federal funds to implement Abstinence Education Programs (Section 510 of the Social Security Act). The State intends to enter into 13 grants for a period of 36 months with an expected effective period from July 1, 2011 to June 30, 2014 and a maximum grant amount of $150,000 per fiscal year to each agency. The State Plan for Abstinence Education identified 20 counties in highest need of abstinence education services based on teen pregnancy and birth rates, rate of mothers in poverty and school dropout rates. The focus of the Abstinence Education Program is to provide comprehensive, evidence-based, and medically accurate programs to middle school children and expand up to age 17 after year one. The program intervention site can be a middle school with required approval of the school system, or a community center of a community based program for youth in this age group.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Performance Objective	23	23	24	40	40
Annual Indicator	22.3	21.8	37.2	37.2	37.2
Numerator	75789	3769	366	366	366
Denominator	339485	17256	983	983	983

Data Source			Tennessee Oral Health Survey	Tennessee Oral Health Survey	Tennessee Oral Health Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2011	**2012**	**2013**	**2014**	**2015**
Annual Performance Objective	40	40	40	40	40

Notes - 2010
Data Source: 2008 Tennessee Oral Health Survey of children ages 5 - 11 years.

Notes - 2009
Data Source: 2008 Tennessee Oral Health Survey of children ages 5 - 11 years.

Notes - 2008
Data Source: 2008 Tennessee Oral Health Survey of children ages 5 - 11 years.

a. Last Year's Accomplishments
The School Based Dental Prevention Program (SBDPP) is a statewide, comprehensive dental prevention program for children in grades K-8 in schools with 50% or more free and reduced lunch. It consists of three parts: dental screening and referral, dental health education, and application of sealants. During FY 10 (July 1, 2009-June 30, 2010), school based dental prevention services were being delivered in all 13 health department regions. Data for FY 09 show that 130,947 children had dental screenings in 306 schools. Of these, 27,077 children were referred for unmet dental needs. Full dental exams were conducted on 63,271 children. A total number of 270,924 teeth were sealed on 48,445 children. 173,171 children received oral health education programs at their schools by a public health dental hygienist. Dental outreach activities include provision of informational material for TennCare (Medicaid) enrollment purposes and follow-up contacts for all recipients identified as having an urgent unmet dental need.

Fixed and Mobile Dental Program: The Tennessee Department of Health (TD)H) has 54 fixed dental clinics located in 53 rural counties. The scope of services includes comprehensive dental care to children and emergency dental care for adults. During FY10, more than 22,200 children and more than 7000 adults were treated in TDOH dental clinics. TDOH also operates three mobile dental clinics providing comprehensive dental services to underserved children at school sites. During FY10, 77 children received more than $34,500 worth of dental services in TDOH mobile dental clinics.

Cavity Free In Tennessee - Early Childhood Caries (ECC) Prevention Program targets regular Early and Periodic, Screening, Diagnosis and Treatment (EPSDT) visits with children at risk for ECC. In the first year of life, a child may visit a health care professional as many as six times as a part of EPSDT. Nurses and nurse practitioners can deliver preventive oral health services to children during these visits, as well as educate their parents or caregivers about keeping children's teeth healthy. These visits provide an opportunity for children to receive dental screenings, the application of fluoride varnish, and early dental referrals. Because many children

do not access dental care until there is a need or until school-age, this program now allows many children to receive a preventive service they might not have otherwise received.

Children will continue to be referred to their dental provider for regularly scheduled visits for dental services or at any sign of need such as decay, eruption abnormalities, prolonged nonnutritive sucking, and other oral health concerns. While children, birth to 5 years old, are the target population for Cavity Free In Tennessee (CFIT), this program is available for children and teens in all seven rural regions of Tennessee. Currently all the rural regions are providing these expanded dental preventive services. From July 1, 2009 -June 30, 2010 more than 15,800 at risk children have been screened, referred, and had fluoride varnish applied in TDOH medical clinics by nursing staff.

Statewide Oral Health Survey: In the fall of 2008, the TDH, Oral Health Services Section conducted a statewide oral health survey of a sample of children ages 5-11 years, representing approximately 551,000 Tennessee children in this age group. The survey goals were to establish age-specific data for the prevalence of dental caries, sealants, dental injuries, estimates of treatment needs and to describe variations according to age, sex, race, and socioeconomic status. Oral Health Services plans to conduct this type of survey every 5 years.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide clinical dental services to TennCare (Medicaid) children.	X			
2. Provide preventive dental services including sealants and oral health education to children in schools.	X	X	X	
3. Provide dental outreach activities.		X	X	
4. Provide dental services using the three mobile units in Northeast, Mid-Cumberland, and West Tennessee regions.	X	X		X
5. Continue the fluoride varnish program.	X			
6.				
7.				
8.				
9.				
10.				

b. Current Activities
All services described in the previous section continue in the current year with the exception of the Oral Health Survey which will occur every five years.

c. Plan for the Coming Year
Data from the statewide survey of elementary aged school children will continue to be used to facilitate planning and program development during the upcoming year. All direct services and education services described in the above sections will continue.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Performance Objective	3	2.5	2.5	2	2
Annual Indicator	5.4	3.9	3.4	2.7	1.8
Numerator	65	47	41	33	22
Denominator	1210629	1194718	1201009	1207621	1214522
Data Source			Department of Health	Department of Health	Department of Health
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2011	**2012**	**2013**	**2014**	**2015**
Annual Performance Objective	1.7	1.7	1.7	1.7	1.7

Notes - 2010
Data Source: Tennessee Department of Health, Divsion of Health Statistics, Population Projections and Death Statistical System

Notes - 2009
Data Source: Tennessee Department of Health, Divsion of Health Statistics, Population Projections and Death Statistical System

Notes - 2008
Data Source: Tennessee Department of Health, Divsion of Health Statistics, Population Projections and Death Statistical System

a. Last Year's Accomplishments
The rate (per 100,000) of motor vehicle crash deaths to children 14 and younger decreased from 2.7 in 2009 to 1.8 in 2010. Tennessee's child passenger safety law of 2004 specified and strengthened requirements for child restraint devices. Maternal and Child Health programs continued to collaborate with other Tennessee Department of Health divisions and state agencies including the following: local law enforcement agencies, Safe Kids Coalitions, Head Start Centers, school systems, and the Governor's Highway Safety Office to educate families about the law. Additional education was provided on resources for purchasing and fitting child restraint devices. Each of the home visiting programs (HUGS, CHAD, and Healthy Start) provided education to families. Health department clinic clients were also educated about child restraint device use as part of guidance during the EPSDT exam.

There are 90 fitting stations across the state, staffed by certified technicians that help families install their child safety device correctly. Three Child Passenger Safety Centers in the state serve as resources to the 90 fitting stations. The centers are located at East Tennessee State University in Johnson City, Meharry Medical College in Nashville and The Mayor's Office of Early Childhood and Youth in Memphis. The centers can refer to the children's hospitals' rehabilitation

centers in their areas for fitting a child with special health care needs, if needed.

The Nutrition and Wellness Division of the Tennessee Department of Health oversees the Child Safety Fund Program. Funding for the program is provided by the fines collected from motorists who were ticketed for being in violation of the Tennessee child passenger restraint law. Government or nonprofit organizations are eligible to obtain child safety funds to provide services to children, 0-8 years old, in low income families that meet federal poverty guidelines. From October 1, 2009 to September 30, 2010, the Child Safety Seat Fund has received $193,902.71 in funds, expended $172,544.53, and purchased 3,779 child safety seats. Of the seats purchased, 3,709 have been distributed.

The Tennessee Road Builder's Association sponsors the Ollie the Otter Program. This program provides booster seat and seat belt education including the importance of using booster seats and seat belts and using them correctly. The program has reached 32,000 children and teens.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Educate health department staff and the general public about child restraint laws.		X	X	
2. Collaborate with Children's Hospitals, Child Passenger Safety Centers and fitting stations to educate communities about their services and CRD use.			X	X
3. Partner with local law enforcement agencies, Safe Kids Coalition, Head Start Centers, school systems, and Governor's Highway Safety Office.				X
4. Include injury prevention in the MCH workforce development plan.				X
5. Provide identification for car seats through the WHALE program.		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Last year's activities continue as noted. The Child Safety Fund Program has continued to purchase and distribute child restraint devices. From October 2010 to December 2010, 1,925 seats have been distributed (1,847 purchased during this time period). In 2010, Monroe Carell Jr. Children's Hospital at Vanderbilt opened a safety seat clinic for children with special health care needs. The clinic is staffed by physical and occupational therapists who are certified child restraint device technicians. The clinic visit for the fitting and the restraint device is covered by private insurance and TennCare (Medicaid). The Children's Hospital is collaborating with the Middle Tennessee Child Passenger Safety Center at Meharry to provide education and outreach.

The Ollie the Otter Program has continued to visit elementary and middle schools to provide education on booster seat and seat belt use.

The Governor's Highway Safety Office is hosting the Tennessee Lifesavers Conference. The conference is designed for law enforcement, prosecutors, judicial personnel, educators, highway safety advocates and any member of the general public interested in learning more about highway safety issues. The conference goal is to develop strategies, build alliances, and

communicate agendas towards reducing the number of fatalities and injuries on Tennessee's roadways.

c. Plan for the Coming Year
The Nutrition and Wellness Division of the Tennessee Department of Health will continue to purchase and distribute child restraint devices through the child safety fund.

The Ollie the Otter Program will continue to educate children and teens on the importance of using booster seats and seat belts correctly.

The Governor's Highway Safety Office will continue to host the Tennessee Lifesavers Conference.

The Tennessee Injury and Violence Prevention Program (TIVPP), located in Maternal and Child Health, will implement the WHALE (We Have a Little Emergency) program. The program provides identification cards for car seats, enabling first responders to have pertinent information about a child that has been in a motor vehicle collision. The program will be implemented through the Healthy Start and HUGS home visiting programs and is expected to reach 800 children. Home visiting staff will be trained on the importance of the identification cards and having them on the child restraint device.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	32	34	36	30	40
Annual Indicator	28.0	31.4	37.9	37.9	35.6
Numerator	420	14705	31952	31952	29230
Denominator	1500	46777	84308	84308	82109
Data Source			CDC/National Immunization Survey	CDC/National Immunization Survey	CDC/National Immunization Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2011	**2012**	**2013**	**2014**	**2015**
Annual Performance	37.5	40	45	50	55

Objective					

Notes - 2009
Data Source: National Immunization Survey. Per the CDC NIS, the data from the NIS are provisional for the 2007 birth cohort used in this survey until final estimates are available in August 2011. We have marked "final" for the purpose of this report.

Notes - 2008
Data Source: National Immunization Survey.

a. Last Year's Accomplishments
Breastfeeding is widely promoted through the WIC program, and local health departments must establish and maintain an environment which supports and encourages women in the initiation and continuation of breastfeeding. Print and audio-visual materials in the clinic must be free of infant formula product names and formula must be stored out of the view of clients. Educational materials are to portray breastfeeding in a way that is culturally and aesthetically appropriate for the population served. Health departments must have a designated area for mothers who prefer to breastfeed in a private place. In addition, each of the thirteen established nutrition centers has a room exclusively for breastfeeding mothers to use.

Breastfeeding counseling is a required nutrition education component of the WIC Program and all pregnant women are encouraged to breastfeed, unless contraindicated for health reasons. Breastfeeding education is offered individually and in group settings. Last year, WIC served about 20,562 pregnant women and enrolled half of newborns in the state. Thirty percent of WIC-delivered mothers were breastfeeding at time of postpartum certification. There were 7,258 breastfeeding mothers on the WIC program. WIC provides on-going breastfeeding information and counseling in the clinic, hospital, and home setting. Manual and electric pumps are issued to eligible mothers. Mothers who deliver prematurely or have a baby in the Neonatal Intensive Care Unit were given priority for hospital grade electric pumps.

Home visitors in the HUGS (Help Us Grow Successfully) program promote breastfeeding with all their pregnant clients and provide support to new mothers, in coordination with the WIC and Nutrition staff. Combining breastfeeding education and support and HUGS home visits significantly facilitated the promotion of breastfeeding in the populations served.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Breastfeeding coordinators and advocates in every region work with health care providers, health department staff and postpartum women to assist and promote breastfeeding.	X	X		
2. Breastfeeding data are routinely collected on WIC clients.				X
3. USDA grant continues to be used to maintain an effective breastfeeding peer counselor program in selected counties.	X			X
4. Establish breastfeeding objectives in the Tennessee Obesity Prevention Plan.				X
5. Continue to partner with the Tennessee Initiative for Perinatal Quality Care (TIPQC) on their statewide breastfeeding initiative.				X
6. Promote breastfeeding with the clients served in the home visiting programs.	X			
7.				
8.				
9.				

10.				

b. Current Activities

Tennessee has maintained funding the past 6 years for the WIC breastfeeding peer counselor program. A peer counselor is a paraprofessional, ideally a current or previous WIC client, who has successfully breastfed and has a desire to help other mothers succeed with breastfeeding. By combining peer support with the on-going breastfeeding promotion efforts in the WIC program, peer counselors have the potential to impact breastfeeding rates among participants, and, most significantly, increase the harder-to-achieve breastfeeding duration rates. The long-range vision is to institutionalize peer counseling as a core service in WIC. Breastfeeding rates have increased in areas receiving grant funds to hire peer counselors and expand their efforts.

The Tennessee Initiative for Perinatal Quality Care (TIPQC), funded by the Governor's Office of Children's Care Coordination, was officially launched in fall 2008 with a goal of engaging providers across the perinatal spectrum in statewide, evidence-based and data driven quality improvement projects. The obstetrical community joined together for the first time in a statewide collaborative at the March 2009 TIPQC meeting, and further developments occurred at the 2010 meeting. The OB section of TIPQC has continues to organize under a committee of leaders throughout the state. At the 2010 meeting, the OB members voted on their first state project, which will focus on a breastfeeding awareness campaign targeted at all pregnant women

c. Plan for the Coming Year

Plans for the coming year include continuing and expanding the WIC breastfeeding peer counselor program, continuing to work with HUGS to strengthen breastfeeding support for mothers and their families, inclusion of a breastfeeding focus in the Tennessee Obesity Prevention Plan, and networking with Tennessee Initiative for Perinatal Quality Care (TIPQC) on their breastfeeding initiative. Tennessee received WIC expansion funds to provide services to families of service members, and this will be promoted and evaluated.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	98	98	98	98	98
Annual Indicator	88.9	91.1	94.2	97.6	97.1
Numerator	80173	83570	85613	85080	82058
Denominator	90155	91754	90885	87141	84535
Data Source			Department of Health	Department of Health	Department of Health
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2011	**2012**	**2013**	**2014**	**2015**

Annual Performance Objective	98	99	99	99	99

Notes - 2010
Data Source: Tennessee Department of Health, Newborn Hearing Screening Program

Notes - 2009
Data Source: Tennessee Department of Health, Newborn Hearing Screening Program

Notes - 2008
Data Source: Tennessee Department of Health, Newborn Hearing Screening Program

a. Last Year's Accomplishments
The Newborn Hearing Screening Program reported 2009 data to the Centers for Disease Control and Prevention in February 2011. The program follows the recommendations set by the Joint Committee on Infant Hearing (JCIH) 2007 position statement. There were 87,141 occurrent (resident and non-resident) births reported by vital records. 85,080 (97.6%) infants received a hearing screen in 2009; of those infants, 98% were screened prior to discharge or one month of age. In 2009, 72 infants were diagnosed with permanent hearing loss. The expected incidence of hearing loss for Tennessee is 89-127 infants (National incidence 1:1000 to 3:1000). Tennessee's incidence was 0.83:1000 in 2009. The number of follow-up hearing tests reported by individual providers and audiologists continued to improve. In 2009, 67 audiology groups/individuals performed 1,683 first retests on infants and 1,415 additional follow-up tests. Of the 67 reporting groups, 7 groups saw more than 100 infants each and 6 saw 50-99 infants each.

The Newborn Hearing Screening Program has been successful in meeting the majority of the National Early Hearing Detection and Intervention (EHDI) and Healthy People 2010 "1-3-6 Goals":

Goal 1: HP2010 90% - EHDI 95%- should complete hearing screen by 1 month of age. In 2009, Tennessee screened 98%.

Goal 2: HP2010 70% - EHDI 90% should complete a diagnostic audiological evaluation by 3 months of age. Tennessee completed retesting on 61% by 3 months of age. A total of 77% received a rescreen by 3-6 months, an increase from 69.8% in 2008. 21% infants were considered lost to follow-up (number excludes infants that died (8), refused testing (33), or moved (23)).

Goal 3: HP2010 85% - EHDI 90% should begin early intervention and habilitation services by 6 months of age. Tennessee was only able to document that 28 infants (39%) were enrolled in the Department of Education Early Intervention Systems (TEIS) Part C program in 2009. The program will continue to address challenges associated with reporting due to restrictions on release of information between agencies. In July 2010, the NHS program contracted with an early intervention deaf education coordinator to contact families of children with hearing loss to assess services provided and make appropriate referrals for parent support by the Family Voices parent consultants.

The Tennessee Early Intervention System (TEIS) consultant (contracted by TEIS through the University of Tennessee Center on Deafness) contacted 2425 families in need of hearing retests to track follow-up status and make referrals if needed for audiological assessment. 48% of the infants had passed a rescreen, 2% were not interested in a retest, and they were unable to locate 15% of the families, a decrease from 27% in 2009. Two part time nurses hired with the CDC Tracking and Surveillance EHDI grant tracked 240 families of infants that had pending hearing results after an audiological assessment and were able to identify 14 infants with hearing loss. Only 19 infants were listed as "lost to follow-up", a decrease from 57 infants in 2009. Follow-up activities continue to decrease the lost to follow-up rate of the hearing screening program.

In July 2008, Tennessee implemented a legislative mandate, known as "Claire's Law" that required all hospitals to conduct hearing screening prior to discharge or before one month of age and required insurance to reimburse for the screening. In addition, the mandate required the Tennessee Department of Education's Early Intervention System (TEIS), Part C of the Individuals with Disabilities Act (IDEA), to assist in follow-up of infants not passing the screen and those at risk for hearing loss. Hospitals are required to complete a report prepared by the Hearing Program on all infants with no hearing results reported from the hospital. In addition, parents receive a letter advising them of the need for screening if the program has not received hearing results. These two activities have improved the reported number of hearing screening conducted and reported.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Promote newborn hearing screening in all birthing facilities.			X	
2. Promote the use of the data collection system by all birthing facilities.			X	
3. Provide technical assistance and education to providers.				X
4. Revise, as needed, the directory of hearing providers.				X
5. Coordinate referrals and follow-up on infants with abnormal results.		X	X	
6. Coordinate the activities of the Newborn Hearing Screening Task Force.				X
7. Distribute educational materials for parents, providers, facilities, and intervention programs.			X	X
8. Utilize survey and assessment materials to monitor effectiveness of program components.				X
9. Conduct site visits to hospitals to monitor screening effectivness, access to evaluation, and parent/provider satisfaction.				X
10. Integrate and/or coordinate data systems related to newborns and hearing.			X	X

b. Current Activities

The family outreach coordinator tracks children identified with hearing loss to document early intervention and family support services. A search continues for a bilingual (Spanish) family member of a child with hearing loss to serve with Family Voices.

We continue to distribute the parent education video on hearing follow-up to hospitals, physician offices, and prenatal classes. It is available on the National Centers for Hearing Assessment and Management (NCHAM) website http://www.infanthearing.org. The Family Voices Family Hearing Notebook is now available in Spanish at http://www.tndisability.org/familyvoices. Medical provider education continues on the need for timely follow-up.

In collaboration with NCHAM, the program will implement the Early Childhood Hearing Outreach Initiative to train Early Head Start staff to conduct hearing screening. Teleaudiology will be implemented in collaboration with Vanderbilt University as a pilot project in targeted West TN counties to reduce loss to follow-up.

Activities continue to promote the formation of a Hands and Voices Chapter for parent support of children with hearing loss.

Access to current family addresses, phone, and medical home provider through data systems

links to vital records, the immunization registry, and the department Patient Tracking, Billing, Management System (PTBMIS) will decrease the lost to follow-up rate.

c. Plan for the Coming Year

During FY 12, the program will continue to expand and refine program operations by implementing activities that focus on reducing loss to follow-up and in communicating with non-English speaking families, especially Hispanic families. Planned activities include: 1) Family surveys will be distributed to assess family experience with the newborn hearing screening system and identify areas in need of improvement; 2) Conduct site visits to hospitals and hearing providers, including otolaryngologists; 3) Participate with a number of other state Early Hearing Detection and Intervention (EHDI) programs in the Learning Collaborative for the National Initiative on Child Health Quality (NICHQ) to conduct program assessment, develop and implement new strategies to improve implementation of services to meet JCIH standards for EHDI; 4) Develop and provide training activities and materials to a variety of health professionals and consumners to promote the goals of newborn hearing screening; and 5) Implement and expand the pilot project to conduct tele-audiology services in targeted counties to reduce hearing loss to follow-up.

Coordination of the CDC EHDI grant and HRSA grant activities and staff will continue for the purpose of meeting Healthy People objectives and JCIH goals related to early hearing screening by one month of age, diagnosis by three months of age and implementation of early intervention services by 6 months of age and reducing infants lost to follow-up during the process.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	6	6	6	6	3
Annual Indicator	6.4	6.4	4.9	3.7	3.9
Numerator	97933	88283	72258	54759	57912
Denominator	1530196	1386911	1474653	1479972	1484923
Data Source			UT CBER	UT CBER	UT CBER
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2011	**2012**	**2013**	**2014**	**2015**
Annual Performance Objective	3.7	3.5	3.3	3	3

Notes - 2010

Data Source: University of Tennessee Center for Business and Economic Research (UT CBER) "The Impact of Tenn Care: A Survey of Recipients 2010. Available at: http://cber.bus.utk.edu/tncare/tncare10.pdf

Notes - 2009

Data Source: University of Tennessee Center for Business and Economic Research (UT CBER) "The Impact of Tenn Care: A Survey of Recipients 2009. August, 2009

Notes - 2008
Data source is the University of Tennessee Center for Business and Economic Research (UT CBER) "The Impact of TennCare: A Survey of Recipients August, 2009

a. Last Year's Accomplishments
Data on the percent of children in Tennessee without health insurance can be found in several national sources, but for varying age groups and income levels. U.S. Census Bureau (2009 Annual Social and Economic Supplement Current Population Survey) data show that nationally 83.3% of all persons and 90% of children under age 18 were covered by some type of health insurance. U.S. Census data for a three-year average for 2007-2009 show that 5.0% of children under age 19 and at or below 200% of poverty were without health insurance in Tennessee. A 2010 survey from University of Tennessee Center for Business and Economic Research showed 3.7% of Tennessee children under age 18 in 2009 and 3.9% in 2010 were without insurance.

The state's managed care program for Medicaid recipients remains the major source of health insurance coverage for children. As of September 15, 2010, 747,093 children ages 0 to 21 years were enrolled in TennCare statewide.

The Department of Health has entered into participating provider agreements with all of the TennCare Managed Care Organizations (MCOs) to provide services to TennCare members. The Bureau also had agreements with selected MCOs to provide gatekeeping primary care services in two rural regions. Since July 2001, TennCare has requested that the local health departments assist with providing Early Periodic Screening, Diagnosis and Treatment (EPSDT) screenings to TennCare enrollees. During federal FY 2009-10, health department clinics provided 67,041 EPSDT screenings to TennCare enrollees.

All local health departments offer pregnancy testing. If the patient is pregnant, the health department screens for income and determines if the woman qualifies for prenatal presumptive eligibility, a TennCare Medicaid category of coverage for pregnant women. Four criteria must be met for the woman to qualify for presumptive eligibility: Tennessee residence, valid social security number, household income at or below 185% federal poverty level and verification of pregnancy. The information is entered into the TennCare eligibility system directly by health department staff so that the women are immediately on TennCare and eligible for coverage of needed services for at least 45 days. TennCare coverage will end after the 45 days of presumptive eligibility unless a TennCare application is made with the Department of Human Services and the woman is approved for continued coverage in TennCare.

All children enrolled in Children's Special Services (Tennessee's Title V CSHCN program) are required to apply for enrollment in TennCare. Ninety percent of children in the program receiving medical services are on TennCare. Each child is assigned to a program care coordinator who assists the family in accessing needed medical services, including preventive, routine medical care, and specialty care. The care coordinator also assists the family with the TennCare appeals process, as needed.

All local health department clinics provide advocacy and outreach for TennCare, and through contact with low income persons and families receiving a wide variety of services (home visiting, family planning, immunizations, etc.) make referrals to the Department of Human Services (DHS) for potential enrollment into TennCare.

Tennessee's CoverKIDS Children's Health Insurance Program is available for uninsured children age 18 and younger whose families earn within 250% of the federal poverty level but are not eligible for TennCare. Maternity coverage is also available for pregnant women through

CoverKIDS. Children in families with a household income greater than 250% of the federal poverty level may buy into the CoverKIDS plan with premiums. Benefits are similar to those offered to dependents of state employees. Enrollment in CoverKIDS was suspended for new applicants December 1, 2009, when membership reached the maximum that could be supported by the current state budget. Enrollment was resumed on March 1, 2010.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide outreach and advocacy services in all health care department clinics for TennCare (Medicaid) enrollees.		X		
2. Provide EPSDT screening for TennCare enrollees.	X			
3. Provide EPSDT screenings for children in state custody.	X			
4. Continue the EPSDT community outreach project.		X		
5. Provide presumptive eligibility for pregnant women in all health department clinics.		X		
6. Assist all children applying for CSS services with enrollment in TennCare.		X		
7. Assist TennCare enrollees with the TennCare appeals process.		X		
8.				
9.				
10.				

b. Current Activities

TennCare enrollment data for February 2011 show a total of 746,364 participants under age 21.

All local activities described in the section with last year's accomplishments continue. Referrals are made to the Department of Human Services (DHS) for TennCare enrollment of any families with children who may qualify. All local health department clinics provide presumptive eligibility for pregnant women to enroll in TennCare and referral to DHS for enrollment. All health department clinics provide EPSDT screening exams for children.

Currently, county health departments in two rural regions are primary care provider (gatekeeper) sites and have been assigned TennCare clients by the managed care organizations. These enrollees include persons of all ages. The Department continues its TENNderCare outreach initiative to encourage parents of children and youth to take advantage of free TENNderCare screenings for their children.

c. Plan for the Coming Year

Departmental activities related to children and insurance coverage described previously will continue: enrollment of pregnant women in TennCare under presumptive eligibility; enrollment of CSS children in TennCare and assistance with access to care by the care coordinators; provision of EPSDT screenings for TennCare children; outreach and advocacy activities for TennCare enrollees; EPSDT community outreach initiative; EPSDT Call Center; provision of primary care services in selected counties; and referral of children/families to DHS for TennCare enrollment.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	9	9	30	14	25
Annual Indicator	24.2	34.0	14.9	15.2	15.4
Numerator	22265	53971	9407	10490	11075
Denominator	92164	158733	63134	69015	71914
Data Source			Department of Health	Department of Health	Department of Health
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2011	**2012**	**2013**	**2014**	**2015**
Annual Performance Objective	15	15	15	15	15

Notes - 2010
Data Source: Tennessee Department of Health, PedNSS/TN WIC Database.

Notes - 2009
Data Source: Tennessee Department of Health, PedNSS/TN WIC Database.

Note: (2012 application)--The 2009 numbers reported in the 2011 application were only for a 6 month period due to CDC having problems with changes in their analytical program. The correct values were recently made available and are reported here as final.

Notes - 2008
Data Source: Tennessee Department of Health, PedNSS/TN WIC Database. Data is from calendar year. Variation is due to calendar year data, decrease in the total number of children within the age group of 2-5 years receiving WIC. Data categories may include children under the age of 2 years to 5 years.

a. Last Year's Accomplishments
All WIC children are measured for height and weight; BMI is calculated for each child. If the BMI is above the 85th percentile, the family/parent/caregiver is provided individualized nutrition counseling sessions, and tracked until age 5. To address the child's health problems, the nutrition counselor assists the family in setting goals for the child.

Utilizing the state PTBMIS computer system, specific surveillance data was obtained and examined using the Centers for Disease Control and Prevention (CDC), Pediatric Nutrition Surveillance System [Ped NSS (pre2004 version)] to calculate provisional analysis. Final results were prepared by CDC. Preliminary information was supplied to 14 regional nutrition directors for the development of FY 09-10 nutrition services plans. Two different reports were initiated or made available at this regional level. The High/Low listing was supplied on a bi-monthly basis which showed only participants whose certification values were outside the range for age and gender.

These listings also provided the BMI for all participants that appear on this report. A second set of reports was developed listing individuals with assessment values judged to potentially impact the development and wellness of the participants. In FY 10-11 each region developed an activity addressing overweight in their state plan.

In order to detect changes in the percentage of overweight and/or risk of overweight almost all of the clinic locations providing WIC services were equipped with electronic digital scales. Calibration procedures were in place to promote correct weight determinations in the clinics. Techniques used to assure accurate weight were periodically reviewed and/or technical assistance provided.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide data and provisional analysis to regional and local nutrition directors for program development.				X
2. Assist with training when policy/procedural changes are instituted.				X
3. Provide nutrition counseling to WIC participants with BMI at or above the 85th percentile.	X			
4. Provide up-to-date information of overweight and anemia to local health department programs.				X
5. Monitor compliance with policy and completeness of data at regional and local WIC program levels.				X
6. Provide technical assistance on as-needed basis to regional nutrition, nursing, and clerical directors.				X
7. Continue to utilize the state PTBMIS computer system for surveillance.			X	X
8. Continue to examine (CDC) Pediatric Nutrition Surveillance System to calculate provisional analysis for program planning and development purposes.			X	X
9.				
10.				

b. Current Activities

All regions are kept up to date on the incidence of overweight in the pediatric WIC participants. The reports provide indicators of correctness, compliance with policy, and completeness of data on both initial and recertification of WIC participants.

Discovery of marked changes in percentages of participants classified as overweight is followed up with regional staff. If discussions with regional nutrition, nursing and clerical directors lead to requests for technical assistance, it is provided to the specific discipline(s) involved.

c. Plan for the Coming Year

The reports will continue to be provided to local WIC agencies. The current PedNSS reporting format will continue to be used and shared quarterly with the Local WIC Agencies. Appropriate techniques used in
assessment and data input will be followed. The incidence of BMI at the 85th percentile will be tracked and reports will be shared.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	9.7	9	7.5	13	13
Annual Indicator	15.8	19.4	15.4	15.0	14.2
Numerator	13288	16774	13138	12257	11252
Denominator	84277	86558	85480	81888	79094
Data Source			Department of Health	Department of Health	Department of Health
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2011	**2012**	**2013**	**2014**	**2015**
Annual Performance Objective	13.5	13	12.5	12	12

Notes - 2010
Data Source: Tennessee Department of Health, Division of Health Statistics, Birth Statistical System

Notes - 2009
Data Source: Tennessee Department of Health, Division of Health Statistics, Birth Statistical System

Notes - 2008
Data Source: Tennessee Department of Health, Division of Health Statistics, Birth Statistical System

Note:
The 2007 data was never corrected as final.
The recorded 2007 data on the form is actually provisional. (unable to correct on the form now).
The actual 2007 final is 14059/86661 = 16.2

a. Last Year's Accomplishments
Assisting pregnant women who smoke with cessation has long been a priority of staff within the Department of Health. Local health department nurses and nutritionists counseled pregnant women and provided education, information, and referral to community smoking cessation classes and to QuitLine resources. All 128 WIC clinics assessed pregnant women for smoking status.

According to birth certificate data, 15.4% of births in 2008 were to women who smoked. This is a decrease from 16.2% for 2007. However, there is great variation across the state with higher smoking rates in the eastern counties. There also is wide disparity based on race. For the ten-year period 1999-2008, birth certificate data showed the percent for white females being over twice the percent for black females.

In September 2007, the Department of Health began a new tobacco initiative (Smoke-Free Tennessee) which targeted reproductive age women and teens: It included: 1) evaluating all health department clients, 13 years or older, on smoking status and implementing the evidence based 5As or 5Rs approach; and 2) if client expressed the desire to stop tobacco use, he/she was offered smoking cessation counseling through the Tennessee QuitLine, and/or pharmacologic treatment (for non-pregnant clients). This effort has significantly increased the number of QuitLine users and persons agreeing to take smoking cessation medications. In the same year, the cigarette tax was increased from 20 cents to 62 cents, and the Non-Smokers Protection Act prohibiting smoking in most restaurants and work places went into effect.

Opportunities in local health department clinics for educating and counseling pregnant women regarding smoking include: pregnancy testing (77,173 in CY10), enrollment in TennCare/Medicaid through presumptive eligibility (17,564 in CY10), WIC, and the HUGS home visiting program. The prenatal care guidelines and protocols for nurses and the home visiting protocols provide guidance to staff on assisting pregnant women. The Department operates a centralized EPSDT/TennCare call center to contact TennCare pregnant women and mothers of infants
regarding access to care, appointments, referrals, and education on healthy behaviors.

The Governor's Office of Children's Care Coordination (in March 2007) awarded a $1.44 million 4-year grant to East Tennessee State University to implement an evidence-based smoking cessation program for 4,200 women in Northeast Tennessee, where rates of smoking during pregnancy are near 40%. The project is providing case management to 2,100 women to support smoking cessation efforts, to increase prenatal care use, and to assist with reducing life stressors. It is estimated that these interventions have saved the State nearly $3 million in health care costs.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide WIC/Nutrition services, including smoking cessation, in all local health department clinics (all counties).	X	X		
2. Provide pregnancy testing, counseileng, referrals, and presumptive eligibility for TennCare enrollment in all health department clinics.	X	X		
3. Provide home visiting services for pregnant women.		X		
4. Offer comprehensive prenatal care services, including counseling and education, in two counties.	X			
5. Support the activities of the TennCare/EPSDT Call Center staff related to calls to pregnant women and new mothers.		X		
6. Support the State's activities of Smoke-Free Tennessee.	X	X		X
7. Work with the Governor's Office of Children's Care Coordination on initiatives to improve birth outcomes.	X			X
8.				
9.				
10.				

b. Current Activities

The State is continuing to provide all the services described above with the exception of the provision of cessation medications. Funding for purchasing medications is no longer available. All health department clinics offer pregnancy testing. Currently, one county offers prenatal care services in an FQHC status health department clinic, predominately to non-TennCare eligible uninsured women, who are then delivered by private physicians. All clients qualifying for

TennCare presumptive eligibility are provided with assistance in locating a local physician for prenatal care and delivery. They are enrolled in the state's two food supplement programs (WIC or CSFP). There are 127 WIC clinics statewide. Pregnant women are assessed for eligibility in one of the home visiting programs; all 95 counties have home visiting services for pregnant women. All these visits provide opportunity for counseling on the effects of smoking on the pregnant woman and her baby and offering assistance in stopping, including referral to the QuitLine. Additional information is in State Performance Measure 3.

c. Plan for the Coming Year
The Department will continue to provide the services described above (pregnancy testing, counseling, referrals, WIC and nutrition services, home visiting services, prenatal care in selected counties, enrollment in TennCare under presumptive eligibility, TennCare outreach and advocacy, and its tobacco cessation program).

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	6	6	5.2	5	5
Annual Indicator	8.7	6.9	5.6	9.1	5.3
Numerator	36	29	24	39	23
Denominator	414947	422058	426040	430127	434389
Data Source			Department of Health	Department of Health	Department of Health
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2011	**2012**	**2013**	**2014**	**2015**
Annual Performance Objective	5	5	5	5	5

Notes - 2010
Data Source: Tennessee Department of Health, Division of Health Statistics, Population Projections and Death Statistical System

Notes - 2009
Data Source: Tennessee Department of Health, Division of Health Statistics, Population Projections and Death Statistical System

Notes - 2008

Data Source: Tennessee Department of Health, Division of Health Statistics, Population Projections and Death Statistical System

a. Last Year's Accomplishments

The Director of Adolescent Health, located in the Maternal and Child Health section, participated as an active member of the Tennessee Suicide Prevention Network to address suicide prevention issues. She attended the network's bi-monthly meetings as well as advisory council meetings. The director also attended the annual retreat, where the suicide prevention program manager from the Fort Campbell army installation discussed the high number of suicides by military servicemen and their family members. The Tennessee Suicide Prevention Network Task Force collaborated with him to develop strategies to reduce the number of suicides and the negative impact to families and community members.

The Tennessee Department of Mental Health and Developmental Disabilities received the Tennessee Lives Count Juvenile Justice grant for the second year. The grant provides funding to educate employees working in the juvenile justice system on the tools and resources needed to identify youth at risk of suicide. All adults in the youth development centers and group homes received advanced suicide prevention training. Youth in all group homes and residential facilities received peer youth suicide awareness training.

In 2007, legislation was passed that required all teachers to have two hours of suicide prevention education annually. Thousands of teachers in Tennessee received training last year through a collaborative effort of the Tennessee Department of Education and the Tennessee Department of Mental Health and Developmental Disabilities. The training gives teachers the tools and resources needed to identify and assist at-risk youth.

Information on suicide prevention was distributed by the adolescent health director to several agencies including the local health departments. She also updated educational fact sheets on suicide prevention and posted them on the Department of Health website. A resource list with links to information on suicide prevention was also created and posted on the website.

The Tennessee Suicide Prevention network held their annual symposium which is attended by employees of the health department, mental health agencies, and other community partners.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Partner with the Tennessee Suicide Prevention Network (TSPN).				X
2. Assist with carrying out the State Youth Suicide Prevention Plan.			X	X
3. Distribute fact sheets statewide on adolescent suicide prevention.			X	
4. Provide suicide prevention training for teachers.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Director of Adolescent Health continues to partner with the Tennessee Department of Mental Health and Developmental Disabilities and the Tennessee Suicide Prevention Network. She has provided training at her quarterly adolescent health meetings on suicide prevention.

The Director of Adolescent Health has continued to distribute fact sheets on suicide prevention to several agencies including the local health departments throughout Tennessee. Information is distributed to the adolescent health coordinators from the TeenScreen program located at Tennessee Voices for Children. The TeenScreen program creates partnerships with communities across the nation to implement local suicide screening programs for youth.

The adolescent health director was part of the committee for a conference focused on Suicide Prevention and the African American Faith Communities. One of the goals of the conference was to develop a mission statement and action plan for suicide prevention in faith-based communities.

The Tennessee Suicide Prevention Network held their annual symposium in April. The symposium is attended by representatives from several different agencies to gain valuable information on preventing suicide.

c. Plan for the Coming Year

Education to schools, teacher, parents and youth organizations will continue through the collaboration with the Tennessee Suicide Prevention Network and the Tennessee Department of Mental Health and Developmental Disabilities.

Information on suicide prevention will continue to be distributed to local health departments and other agencies by the Adolescent Health director. She will also network through committees, conferences and meetings to create linkages between state and national organizations working with youth wellness and suicide prevention. She will continue to serve on the conference committee for the Suicide Prevention and the African American Faith Communities Conference to be held in Nashville.

The Adolescent Health director will continue to participate in the Tennessee Suicide Prevention Network's advisory committee meetings and annual retreat. She will also continue to serve as the TDOH representative on the intra-state committee for suicide prevention.

The Tennessee Suicide Prevention Network will continue to hold an annual symposium that health department employees and other community agencies will be invited to attend.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	80	80	80	70	80
Annual Indicator	69.3	68.5	80.7	79.1	82.6
Numerator	1045	1036	1112	1085	1026
Denominator	1508	1513	1378	1371	1242
Data Source			Department of Health	Department of Health	Department of Health
Check this box if you cannot report the numerator because					

1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2011	**2012**	**2013**	**2014**	**2015**
Annual Performance Objective	83	83.5	84	84.5	85

Notes - 2010
Data Source: Tennessee Department of Health, Division of Health Statistics, Birth Statistical System

Notes - 2009
Data Source: Tennessee Department of Health, Division of Health Statistics, Birth Statistical System

Notes - 2008
Data Source: Tennessee Department of Health, Division of Health Statistics, Birth Statistical System

This data reflects hospitals self designated (self/voluntary designation in TN) as birthing hospitals with level 3 nurseries. Because of improved collaboration and communication via TIPQC (Tennessee Initiative for Perinatal Quality Care), this more accurately reflects births at these centers. Previously, the facility list originated from the Joint Annual Report of Hospitals which did not keep a list of level 3 nurseries.

a. Last Year's Accomplishments
Data for the determination of the percentage of very low birth weight infants born in tertiary level facilities are compiled by Health Statistics. Information on facilities by level of care is collected on the Joint Annual Report of Hospitals and is used for statistical analysis. For 2009 and 2010, the Regional Perinatal Centers were asked to list those hospitals in their geographic areas providing high risk (or Level III) care. Data from 2007-2009 show a range of 68.5% to 80.7% of VLBW babies delivered in tertiary level hospitals. Provisional data for 2010 (82.6%) for this indicator show improvement from 2009 final (79.1%). Provisional data for 2010 for total very low weight births, as compared to 2009, show a decrease of 129 infants; the rate changed from 1.7 to 1.6 with total births estimated to decrease in number by 2,821.

2009 data for live births 500-1499 grams in hospitals show that 68.1% were born in tertiary level hospitals (827 out of a total of 1,214). This percent has been consistent over the past few years.

The state has five regional perinatal centers providing specialty care for high risk pregnant women and infants, as well as consultation to all health care providers within the respective geographic area. This system has been in place in the state since the 1970s and is well established and recognized. Medical staffs in all five centers are available for 24 hour consultation for both high risk obstetrical and neonatal care. Education and training for providers within the geographic areas are provided by all the centers. An advisory committee, established by legislation and coordinated by Maternal and Child Health staff, advises the Department on issues and concerns related to perinatal care. The state is responsible for the development, revision, and dissemination of guidelines for regionalization of perinatal care, guidelines for perinatal transportation, and educational objectives for nurses and social workers working in perinatal care. Contracts between TennCare and the managed care organizations require that the MCOs work with the perinatal center(s) operating in their geographic area.

The information to calculate the percentage of very low birth weight infants born in tertiary

facilities continues to be difficult to collect by the level of care by facility. The system for determining level of care in the state is self-designation, not regulatory.

All services within the regional perinatal centers continued during the past year. Women's Health personnel worked with the Perinatal Advisory Committee to complete the process of finalizing the regionalization guidelines and the educational guidelines for nurses in perinatal medicine.

During state FY 2010, the five obstetrical perinatal centers had 13,236 deliveries for Tennessee residents (compared to 82,080 resident births for CY 2009), documented 872 telephone consultations and 27,031 onsite patient consultations, and provided 1,660 hours of education. Data from the five neonatal perinatal centers for the same time period show 3,137 in-born admissions to Tennessee residents, of which 483 were VLBW (2009 VLBW resident births were 1,371); 1,520 transports; 2,934 on-site consultations; and 3,318 hours of education provided.

The Tennessee Initiative for Perinatal Quality Care (TIPQC) began in 2007 to develop a statewide quality collaborative to improve birth outcomes in the state. The voluntary organization has grown to over 900 members, including perinatologists, neonatologists, hospitals at all levels of perinatal care, administrators, third party payors, state officials, and community constituents. Over 170 physicians, nurses, advocates, payors, hospital administrators, government leaders, and families met in March 2010 to collaborate on ways to reduce infant mortality and morbidity. The first statewide project was on NICU admission temperature, followed by central line associated bloodstream infections, human milk for the NICU infant, and reduction of elective deliveries before 39 weeks.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue the perinatal regionalization system.	X			X
2. Coordinate the activities of the perinatal advisory committee.				X
3. Update and revise perinatal program manuals as needed.				X
4. Contract and partner with the Tennessee Initiative on Perinatal Quality Care (TIPQC).				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The structure of the five regional perinatal centers continues to be in place. The state (TennCare) contracts with each of the centers to support the infrastructure of the centers (consultation, professional education, maternal-fetal and neonatal transport, post-neonatal follow-up, data collection, and site visits to hospitals upon request). Staffs at all centers are available to health care providers in the appropriate geographic area to provide consultation, assistance and referral for any high risk pregnant woman or infant.

The revision to the guidelines for transportation will begin this year; a work group will be formed as a part of the Perinatal Advisory Committee.

TIPQC continued with the annual meeting, continuation of the quality projects, the addition of new projects, and plans for the future. Teams from across the perinatal spectrum are engaging in statewide, evidence-based and data-driven quality improvement projects. Projects under development or being piloted include breastfeeding promotion and the NICU golden hour

(designed to improve the first hour of life by involving families and other key stakeholders). Currently funded by the Governor's Office of Children's Care Coordination, the TIPQC contract will transition to the Department of Health on July 1, 2011.

c. Plan for the Coming Year
The state will continue to contract with the five regional perinatal centers as in the past. The Perinatal Advisory Committee will continue to advise the Department on perinatal care issues and revise manuals as needed. The work group will finalize the revision of the "Transportation Guidelines" manual.

The Department will work closely with TIPQC on the planned quality improvement projects. Projects being developed for 2012 include maternal mortality review, neonatal follow up work, undetected critical congenital heart disease registry, and neonatal abstinence syndrome.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	90	90	90	70	70
Annual Indicator	62.5	63.7	67.7	69.0	70.4
Numerator	52684	55134	54765	53529	52271
Denominator	84277	86558	80887	77565	74220
Data Source			Department of Health	Department of Health	Department of Health
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2011	**2012**	**2013**	**2014**	**2015**
Annual Performance Objective	75	80	85	90	90

Notes - 2010
Data Source: Tennessee Department of Health, Division of Health Statistics, Birth Statistical System

Notes - 2009
Data Source: Tennessee Department of Health, Division of Health Statistics, Birth Statistical System

Note: Data for National Performance Measure 18 varies slightly from that reported in Health Systems Capacity Indicator #05C (Form 18). The data on this form are from the Department of Health, while the data on Form 18 are reported by the Bureau of TennCare (Medicaid).

Notes - 2008
Data Source: Tennessee Department of Health, Division of Health Statistics, Birth Statistical System

a. Last Year's Accomplishments
Provisional 2010 birth certificate data show that 70.4% of pregnant women entered prenatal care in the first trimester (for those certificates with the data completed). 2009 birth certificate data show that 69.1% of pregnant women started prenatal care in the first trimester. However, these data are often not completed on the form, and continue to reflect problems in using the revised birth certificate format and an incompleteness of the data. Prior to implementation of the current format, over 80% of women were starting prenatal care in the first trimester.

Of the total births in Tennessee in 2009, 52.8% were on TennCare/Medicaid; this is an increase over 49% for 2008. Comparing the provisional 2010 data for entry into prenatal care for Medicaid and non-Medicaid births, the data show that 61.8% of infants on Medicaid were born to pregnant women receiving prenatal care beginning in the first trimester, 80.5% for the non-Medicaid, and 70.4% overall. Using the same data set, 83.4% of pregnant women on Medicaid received adequate prenatal care (Kotelchuck index); 91.1% for non-Medicaid women; and 87.1% for all pregnant women.

The Department of Health has historically considered the reduction of infant mortality and improving birth outcomes as priorities. The role of the Department is to remain abreast of evidence-based best practices and to implement public health initiatives and programming consistent with those practices. All local health department clinics offer basic prenatal services, which includes pregnancy testing (77,173 tests in CY 2010), presumptive eligibility determination for TennCare (17,564 enrolled in CY 2010), WIC/nutrition services, counseling, information, and referrals to health care providers for medical care. The availability of these services in all counties increases the likelihood that pregnant women will enter into care early. Women are also referred for home visiting services as appropriate (HUGS, Healthy Start, or CHAD). For the last fiscal year, 2,202 pregnant women were provided HUGS home visiting services, and 129 served in the Healthy Start home visiting projects.

Under the managed care system in place under TennCare, almost all prenatal care is provided by private sector providers. Only one local health department clinic provided comprehensive prenatal care in 2010. Delivery services are by a private physician in the community. Data for this clinic for CY 2010 show services to 79 pregnant women, and of these, 81% were self pay (not on TennCare) and 62% were Hispanic.

Using funding from the State, the Governor's Office of Children's Care Coordination has worked to develop an initiative to improve birth outcomes in Tennessee. After first assessing need related to obstetrical care and infant mortality and partnering with numerous agencies and providers, programs and projects, using evidence-based models, have been implemented in Memphis, Chattanooga, Nashville, and Northeast Tennessee. Activities funded last year included intervention for pregnant smokers, Centering Pregnancy clinical services, Tennessee Initiative for Perinatal Quality Care (TIPQC) to improve health outcomes for mothers and infants through quality improvement methodologies, and pilot projects for fetal-infant mortality review teams (FIMR).

The Campaign for Healthier Babies, operating in Memphis since 1993, is a media/educational effort to improve rates of first trimester prenatal care entry and birth outcomes. The Campaign centers around a toll-free number promoted through television, newspaper, and print materials. Callers receive a free Happy Birthday Baby Book of information and merchandise coupons to be validated at prenatal visits. In CY 2010, 2,977 phone calls were received at the Shelby County Health Department, and 4,014 coupon books, along with folic acid, WIC, and other prenatal/infant educational information (9,475 brochures), were mailed.

The 2008 PRAMS report was finalized and released (on the Department's web site). Data from the survey report have been widely used by programs and projects across the state.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide pregnancy testing, counseling, and referral and presumptive eligibility determination in all local health departments.	X	X		
2. Provide home visiting services for pregnant women.	X	X		
3. Provide comprehensive prenatal care in one county.	X			
4. Provide WIC/nutrition services in all local health department clinics.	X	X		
5. Work with the Campaign for Healthier Babies in Shelby County.			X	X
6. Continue operating the toll-free Baby Line.	X	X		
7. Support the projects previously administered by the Governor's Office of Children's Care Coordination (Centering Pregnancy, smoking cessation, FIMR, TN Initiative for Perinatal Quality Care).	X			X
8.				
9.				
10.				

b. Current Activities

All previously described activities continue. Emphasis is placed on providing pregnancy testing, assisting with prenatal care or arranging referrals to community private health care providers and offering home visiting services. One health department clinic offers full prenatal care; in all other counties pregnant women are seen by private sector providers. All clients qualifying for TennCare presumptive eligibility are provided with assistance in locating a physician and are enrolled in WIC or CSFP, if eligible. April 2011 WIC data show that 19,985 pregnant women were participating in WIC in 127 clinics.

Effective July 1, 2011, the Governor's Office of Children's Care Coordination has been eliminated and the programs/projects will be dispersed to various state departments. Those projects transitioning to Health include the Centering Pregnancy programs (Chattanooga, Memphis, and Nashville), TIPQC, FIMR, smoking cessation and substance abuse case management (two rural East TN counties), and Tennessee Intervention for Pregnant Smokers (Northeast Tennessee).

The central office continues to operate the toll free Baby Line. Staff in the Department's EPSDT/TennCare call center contact all TennCare pregnant women and mothers of infants.

Third year PRAMS data (2009) are being analyzed. A draft report will be available for review by the Steering Committee by July. The report will be widely distributed, and plans for action considered.

c. Plan for the Coming Year

All previously discussed activities will continue into the coming year. Local and regional health departments will continue to assess the need for providing prenatal care within their clinics depending upon the availability of services within the private health care systems.

D. State Performance Measures

State Performance Measure 1: *Reduce the infant mortality rate*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective					
Annual Indicator				8.0	7.9
Numerator				655	628
Denominator				82108	79307
Data Source				Department of Health	Department of Health
Is the Data Provisional or Final?				Final	Provisional
	2011	**2012**	**2013**	**2014**	**2015**
Annual Performance Objective	7	7	7	7	7

Notes - 2010
Data Source: Tennessee Department of Health, Division of Health Statistics, Birth and Death Statistical Systems

Notes - 2009
Data Source: Tennessee Department of Health, Division of Health Statistics, Birth and Death Statistical Systems

a. Last Year's Accomplishments
Several programs in Tennessee are providing services to reduce the rate of infant mortality. All local health department clinics offered basic prenatal services, which includes pregnancy testing, presumptive eligibility determination for TennCare/Medicaid, WIC/nutrition services, counseling, and referrals to health care providers for medical care. The availability of these services in all counties increases the possibility that pregnant women will enter into care early. Pregnant women in all local health departments are referred for home visiting services as appropriate to programs such as HUGS, Healthy Start, or CHAD. Currently, all 95 counties provide home visiting services.

The Tennessee Initiative for Perinatal Quality Care (TIPQC) is a statewide collaborative working with hospitals and providers across the state to optimize birth outcomes and implement improvement initiatives. The efforts of this collaboration have been recognized nationally as model practice for improving birth outcomes. TIPQC worked on the elective delivery reduction project. This project discourages doctors from delivering before 39 weeks unless medically necessary. TIPQC also worked on reducing central line associated blood stream infections. These infections are a recognized source of excess morbidity, mortality, costs, and length of stay in hospitals.

The state has five regional perinatal centers providing specialty care for high risk pregnant women and infants. These centers provide 24-hour consultation, transportation, professional education for providers and technical assistance to facilities and providers. This system has been in place in the state since the 1970s and is well established and recognized. A Perinatal Advisory Committee (PAC) advises the Department on perinatal care. The state is responsible for the development, revision, and dissemination of guidelines for regionalization of perinatal care, perinatal transportation, and educational objectives for perinatal nurses and social workers.

Another important service which can impact the health of women and play a role in lowering the overall infant mortality rate is family planning. All local health department clinics offer family

planning services, including education, counseling, and birth control methods.

The four pilot Fetal and Infant Mortality Review (FIMR) programs assisted in developing new initiatives to address the problem of infant mortality in Tennessee. The projects, located in Nashville, Memphis, Chattanooga and Knoxville increased public awareness of infant mortality by attending health fairs in the community and presenting at local schools and community organizations. They have also provided educational information to the community on issues found to be associated with infant mortality such as preconception health, signs of preterm labor, managing stress and genetic counseling.

The Nashville Metro Public Health Department, along with community partners, provides two events annually that are focused on decreasing the infant mortality rate. The "Incredible Baby Shower" is an event that provides new parents or soon to be parents with important information for having a healthy pregnancy and raising a healthy child. Many Tennessee Department of Health programs have an exhibit at the event to distribute information. The Metro Health Department also organized "Project Blossom" which is an annual conference focusing on infant mortality awareness. National and local speakers were invited to speak at the conference.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide pregnancy testing, counseling, referral, and presumptive eligibility determination in all local health department clinics.	X	X		
2. Provide home visiting services for pregnant women.	X	X		
3. Participate in the Tennessee Initiative for Perinatal Quality Care (TIPQC) initiative.	X			X
4. Provide WIC/nutrition services in all local health department clinics.	X	X		
5. Continue to provide education through the Project Blossom conference and the baby shower event.				X
6. Continue the FIMR projects and other infant mortality reduction activities.				X
7.				
8.				
9.				
10.				

b. Current Activities

All programs and services described in the previous section continue to be available. All clients qualifying for TennCare presumptive eligibility are provided with assistance in locating a physician for prenatal care and delivery. They are also enrolled in WIC, the state's supplemental food and nutrition program. In addition, they continue to be referred to home visiting programs as appropriate.

TIPQC has continued their effort with the elective delivery reduction project. This project discourages doctors from delivering before 39 weeks unless medically necessary. TIPQC has also continued work with their efforts to reduce central line association blood stream infections.

The Nashville Metro Health Department organized the Project Blossom conference again this year in October. They also hosted, along with other community partners, the Incredible Baby Shower event in April. Both events focused on reducing the infant mortality rate by educating parents and professionals on topics such as prenatal care, stress management, and SIDS

prevention.

All of the FIMR projects have continued to provide education to the public on topics that lead to infant mortality. The Hamilton County FIMR project created a flu vaccine awareness campaign in which information was distributed on the importance of flu vaccine for pregnant women. The Davidson County FIMR project has been networking to create linkages between clinics and community partners to prevent gaps in services for pregnant women.

c. Plan for the Coming Year

The Nashville Metro Health Department will continue to organize the Project Blossom conference to create awareness and provide education on the topic of infant mortality. They will also continue to host the Incredible Baby Shower event to provide education on topics such as prenatal care, safe sleep, SIDS prevention, etc. to new and expecting parents to keep them and their babies healthy.

The Department of Health will continue to provide services such as pregnancy testing, counseling and referrals, WIC and nutrition services, home visiting services, enrollment in TennCare under presumptive eligibility, TennCare outreach and advocacy, smoking cessation counseling, and family planning.

The Tennessee Initiative for Perinatal Quality Care (TIPQC) will continue to work with hospitals and providers across the state to optimize birth outcomes and implement improvement initiatives. TIPQC will continue their effort with the elective delivery reduction project. This project discourages doctors from delivering before 39 weeks unless medically necessary. TIPQC will also continue to work on reducing central line associated blood stream infections in the NICU.

The four FIMR projects will continue to provide education to the public on topics such as prenatal care, SIDS prevention and safe sleep for babies. The projects will continue to develop initiatives to prevent infant mortality. Hamilton County FIMR project will continue to offer one on one education/case management for the pregnant women identified in their clinics as high risk, those residing in high risk zip code areas, those with food/housing/financial issues, and those with lack of social support. Davidson County FIMR project will continue to create linkages in services between clinics and other community partners to prevent gaps in services of patients.

The Tennessee Department of Health Injury Prevention and Detection section, located in Maternal and Child Health, will research evidence based strategies for promoting safe sleep messages. Sleep related and SIDS deaths in Tennessee accounted for 20.5% of infant deaths in 2008.

State Performance Measure 2: *Reduce the percentage of obesity and overweight among Tennessee K-12 students*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective					
Annual Indicator			40.9	39.0	
Numerator			194814	191090	
Denominator			476318	489975	
Data Source			Department of	Department of	Department of

			Education	Education	Education
Is the Data Provisional or Final?				Final	
	2011	**2012**	**2013**	**2014**	**2015**
Annual Performance Objective	25	25	25	25	25

Notes - 2010
Data Source: Tennessee Department of Education, Office of Coordinated School Health.

BMI measurements of K-12 students during the 2009-2010 and 2010-11 school year have been collected but have not yet been released; those data will be uploaded once made available from the Department of Education.

Notes - 2009
Data Source: Tennessee Department of Education, Office of Coordinated School Health. Data represent BMI measurements of K-12 students during the 2008-2009 school year. Available at: http://www.tn.gov/education/schoolhealth/data_reports/doc/Executive_Summary_2008-09.pdf, page 26.

Notes - 2008
Data Source: Tennessee Department of Education, Office of Coordinated School Health. Data represent BMI measurements of K-12 students during the 2007-2008 school year.

a. Last Year's Accomplishments
Save the Children selected Tennessee as one of their target states and awarded a grant to the Tennessee Chapter of the American Heart Association and the YMCA as part of the Tennessee Obesity Task Force (TOT) to support advocacy efforts targeted at childhood obesity. The two main focus areas of their efforts were Coordinated School Health and Menu Labeling. Coordinated School Health has a mission to improve students' health and their capacity to learn through the support of families, communities and schools and is state funded in every local education agency in Tennessee. The goal of advocacy efforts is to maintain state funding for this program, which was achieved during the legislative session.

Coordinated School Health continues to implement wellness policies (including 90 minutes of physical activity per week and nutritional guidelines); comprehensive health education; school-specific wellness plans; and school health advisory councils.

To address the lack of supermarket access, the Food Trust of Philadelphia targeted Tennessee to address urban food deserts and developed a taskforce to address food desert and food scarcity issues. The Food Trust combines rigorous research and policy advocacy to forge innovative public/private partnerships that bring supermarkets and other fresh food retail markets to areas of need.

Through the Nutrition, Physical Activity and Obesity (NPAO) program, TOT developed a state plan, "Eat Well, Play More Tennessee: A comprehensive plan to reduce obesity and chronic disease" and ensured each of the national focus areas are addressed within the state plan: increase physical activity; increase the consumption of fruits and vegetables; decrease the consumption of sugar sweetened beverages; increase breastfeeding initiation, duration and exclusivity; reduce the consumption of high energy dense foods; and decrease television viewing. The taskforce created groups to specify goals and objectives that would address each of the focus areas of the plan. Over 100 goals and objectives have been developed around the following strategic areas: Where we Live, Where we Play, Where we Learn, Where we Heal, Where we Work, and Vulnerable Populations; the strategic areas were further organized by objective and strategies specifically addressing advocacy, breastfeeding, built environment/transportation, early child care, food systems, health systems, parks and recreation, schools, vulnerable populations

and worksite wellness. The plan was disseminated at the annual meeting of the Tennessee Public Health Association and rolled out by the Governor and Commissioner of Health. The plan has been widely distributed through the taskforce partnering organizations which consist of over 100 organizations throughout the state, other chronic disease programs within the Department of Health, and through online distribution at www.eatwellplaymoretn.org. Statewide, over 3 million media impressions were tracked when the plan was released.

The state plan is being implemented at both the state and the local level through existing Department of Health infrastructure, program partners, and contractual agreements. A mini grant process was outlined, and criteria for awarding the mini grants will be created by the Department of Health in conjunction with the TOT; 28 applicants sought funding, with 8 being approved for a mini grant.

Statewide, the early childhood portion of Eat Well, Play More plan was implemented through the Gold Sneaker program. The initiative continued to enhance policy related to physical activity and nutrition within licensed child care facilities across Tennessee. Gold Sneaker is a collaboration among the Department of Health and the Department of Human Services. Facilities are encouraged to enact policies that include minimum requirements on physical activity, sedentary activities, breastfeeding, meal time, behaviors and portion sizes. Child care facilities that implement the proposed enhanced physical activity and nutrition policies will earn a "Gold Sneaker" award which designates them as a "Gold Sneaker" child care facility. Such designation can be used for marketing purposes for the child care facilities, and local organizations will encourage parents to select such facilities. Facilities receive recognition through a certificate, decals, stickers and website recognition. Gold Sneaker training sessions are available to providers online as well as in person

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collaborate with Office of Coordinated School Health on obesity prevention, including assistance with evidence-based health education programs and school health policy.			X	X
2. Provide technical assistance to Coordinated School Health for BMI measurements and surveillance.			X	X
3. Encourage child care facilities to enhance nutrition and physical activity policies through the Gold Sneaker initiative.			X	X
4. Develop statewide obesity prevention infrastructure through the CDC planning grant: Nutrition, Physical Activity, and Obesity (NPAO) program.				X
5. Partner with local and metropolitan health departments on obesity prevention initiatives (such as CPPW in Nashville).				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Promotion and implementation of the state plan has continued. Widespread distribution of the plan has continued, and the taskforce developed a website (www.eatwellplaymoretn.org). The plan has been adopted by numerous community organizations and county health councils. The TOT has grown to include 136 organizations and 258 individuals.

Eight grantees received funding to implement portions of the state plan. Grants ranging from

$10,000 to $20,000 have been awarded to organizations throughout the state. Training on basic implementation techniques and evaluation procedures will be available to all grantees. The attached table lists the grantees and includes a brief description of their scope of work.

TOT has developed ten "action teams" around each of the state plan strategies. Each action team developed an implementation plan focusing on 2-5 goals and objectives of the state plan and will implement a minimum of one goal in 2011.

The Gold Sneaker initiative continues statewide. As part of Nashville's "Communities Putting Prevention to Work" (CPPW) grant, TDOH staff are working with the Nashville Metro Health Department to assist in the implementation of the Gold Sneaker initiative within Nashville child care facilities.

The evaluation plan for the program continues through the Tennessee Obesity Action Support Team (TOAST). This external evaluation includes a web-based system available to all partners for documenting progress, resources, and success stories.
An attachment is included in this section. IVD_SPM2_Current Activities

c. Plan for the Coming Year
The majority of the work in 2011-2012 will involve the implementation of strategies presented in the statewide plan by partners and the state Nutrition, Physical Activity and Obesity program. This will be completed by awarding grants to organizations implementing at least one of the strategic goals in the state plan; also, the Tennessee Obesity Taskforce will continue with the development of action teams that will work to implement at least one of the strategic goals, as is being done in the current year. Ten action teams have been developed from the Tennessee Obesity Taskforce, each focusing on one of the strategic areas of the state plan, 1) Advocacy, 2) Breastfeeding, 3) Built Environment/Transportation, 4) Early Childcare, 5) Food Systems, 6) Health Systems, 7) Parks and Recreation, 8) Schools, 9) Vulnerable Populations, and 10) Worksite Wellness. Statewide, portions of the early childhood plan will continue to be implemented through the Gold Sneaker program and an integration of state resources. Many professionals in the state of Tennessee still chose to focus on "programs" and it is a goal of the Nutrition, Physical Activity and Obesity program to use the implementation process to clarify the goal of focusing on policy and environmental changes in order to sustain obesity reduction.

The evaluation plan for the program will continue to be maintained through the Tennessee Obesity Action Support Team (TOAST), a subgroup of the Tennessee Obesity Taskforce. This is an external evaluation conducted by a contractor as a multiyear contract. The web based system will continue to be available to all partners for documenting progress, resources and success stories. The current evaluation plan can be viewed on the evaluation website (http://healthpsych.psy.vanderbilt.edu/TOT/index.asp). Each goal and objective outlined in the state plan has an evaluation process connected with it and will be monitored and evaluated over time.

Through this implementation, a sustainability plan will be developed over the next two years. This plan will describe actions to secure and sustain implementation and partnership activities within the state plan by leveraging partnership resources and expertise. Adoption of the state plan by additional partners will be a primary focus of the sustainability plan.

State Performance Measure 3: *Reduce smoking in Tennesseans age 13 years and older*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and	**2006**	**2007**	**2008**	**2009**	**2010**

Performance Data					
Annual Performance Objective					
Annual Indicator			29.6	29.6	20.3
Numerator			121909	121909	18289
Denominator			411751	411751	89969
Data Source			Department of Health	Department of Health	Department of Health
Is the Data Provisional or Final?				Final	Final
	2011	**2012**	**2013**	**2014**	**2015**
Annual Performance Objective	20	19	19	18	18

Notes - 2010
Data Source: Department of Health, Patient Tracking Billing Management Information System

Data represent encounters from February 2010 to January 2011.

Notes - 2009
Data Source: Department of Health, Patient Tracking Billing Management Information System

Data listed for 2008 and 2009 were collected from 2007 through February 2010. Unable to classify further by year at this time.

Notes - 2008
Data Source: Department of Health, Patient Tracking Billing Management Information System

Data listed for 2008 and 2009 were collected from 2007 through February 2010. Unable to classify further by year at this time.

a. Last Year's Accomplishments
The Department of Health continued its tobacco initiative (Smoke-Free Tennessee) which targeted reproductive age women and teens. The initiative included: 1) evaluating all health department clients, 13 years or older, on smoking status and implementing the evidence-based 3As or 3Rs approach and 2) if a client expressed the desire to stop tobacco use, he/she was offered smoking cessation counseling through the Tennessee QuitLine. The Non-Smokers Protection Act that took place in Tennessee in October 2007, continues to alleviate secondhand smoke in most restaurants and workplaces. Along with the increase in the cigarette tax from 20 cents to 62 cents in 2007, tobacco use control and prevention continue to be a priority with public health.

The Tobacco Use Prevention and Cessation Initiative (TUPCP) continued the QuitLine web page which is accessible from the Tennessee Department of Health's website http://health.tn.gov/tobaccoquitline.htm. The site allows regional staff and partners to freely print information on the services provided by the QuitLine and to access promotional print materials and best practice strategies for tobacco use and dependency.

As a part of the tobacco cessation counseling in the clinics, referrals are made to the QuitLine. The increased volume resulted in an expansion to the Quitline contract. Oversight and administration of the QuitLine contract are imperative to the referral mechanism, and data were collected reflecting all Quitline referrals, counseling, quit attempts, and volume of calls.

From August 2006 to March 31, 2011, the QuitLine has received a total of 42,904 calls. Thirteen thousand six hundred thirty two callers (32%) completed the intake process and were assigned to

a Quit Coach. Of the callers assigned to a Quit Coach, 9,591 callers (70%) have enrolled into the "iCanQuit" tobacco cessation program, and 416 self-help information packets have been distributed.

TUPCP secured earned media promoting the QuitLine from more than 25 sources including television news stations, public radio, radio stations, talk radio shows, medical center journals, health system web reports, press releases, national, state and local newspapers and health professional publications.

The Federal Synar legislation requires compliance checks for retailers selling tobacco products and reporting of violation rates. This is coordinated through the Tennessee Department of Mental Health and Developmental Disabilities Division of Alcohol and Drug Abuse and the Department of Agriculture. The departments implement both the Synar survey and tobacco enforcement programs. Tobacco compliance checks are completed statewide in establishments that sell tobacco products accessible by minors to ensure that tobacco products are not being sold to minors. Synar was implemented statewide and targeted all youth under the age of 18. There were 3,296 compliance checks completed.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Screen local health department clients for tobacco use and offer assistance.	X			
2. Continue the Tennessee Tobacco QuitLine.	X	X		
3. Provide education and awareness through the state web site.			X	
4. Collaborate with partner agencies.				X
5. Conduct tobacco compliance checks through Synar.	X			
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Tobacco cessation services continue at all health department clinics and the Tennessee QuitLine remains active. Funding to purchase cessation medications is no longer available.

Through Synar, there will be approximately 3,000 tobacco compliance checks.

Collaboration on policy efforts continue to grow with the state advocacy coalition.

TUPCP partnered with TennCare to provide a more accessible email referral system for the pregnant women in the MCO's. Case managers now have the ability to email referrals. The patient must be in the stage of wanting to quit, and allows the case manger to email their information to the quitline provider for a more expeditious follow-up of the pregnant mother. The provision of tobacco cessation services to pregnant women was a required activity of the Affordable Care Act of 2010.

TUPCP continues to contract with the Tobacco Technical Assistance Consortium to facilitate the Strategic Plan. More than 40 partners created a 2009-2014 state strategic plan for tobacco use prevention, control and cessation. The plan will address goals related to: leadership and coordination of statewide efforts; surveillance and evaluation; reduction of tobacco use; reduction

of tobacco-associated morbidity, mortality, and disability; increased access to cessation services; and identification and elimination of tobacco-related disparities.

c. Plan for the Coming Year

As a result of the implementation process by the Tobacco program, a Tobacco Work Group Committee was formed from representatives of the Strategic Planning workgroup. The Tobacco program will host educational training meetings for the Tennessee Tobacco Work Group Committee, providing training and technical assistance on tobacco related topics. The Tobacco Work Group Committee will assist in prioritizing the implementation steps for the State's Tobacco Control Strategic Plan. The Tobacco program will promote and provide information on new proactive counseling and media placement through the Tobacco Quitline as well as the state's Gold Sneaker initiative which includes a smoke and tobacco free policy for designated child care facilities. The Tobacco program will also provide capacity-building webinars to the Tobacco Work Group Committee as well as various agencies focusing on populations who tend to experience disparities in access to and use of preventative and tobacco cessation services.

The Tobacco Program will continue to collaborate with a grassroots tobacco advocacy coalition to educate the public and motivate Tennesseans to advocate for moving policy change at the state level. The Tobacco Program through its youth empowerment focus will partner with the Tennessee Tobacco Advocacy Initiative and other agencies to hold Youth Tobacco Summits in West, Middle and East Tennessee. The Youth Tobacco Summits will empower youth to present tobacco prevention issues to their local legislatures and civic groups and to present their communities' views on tobacco policy issues.

Synar compliance checks will continue.

The Department of Health will continue to raise awareness of the dangers of tobacco use; mobilize the general public and priority populations; build capacity of state and local coalitions to affect tobacco-related social norms; promote environmental change; and support grass roots advocacy for non-tobacco policy. The program plans to strengthen its relationships with internal and external partners by convening quarterly meetings of the multiple strategic planning workgroups and maintaining monthly technical assistance and training teleconferences with regional staff and community program staff.

State Performance Measure 4: *Decrease asthma hospitalizations for children 0-5 years*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Performance Objective					
Annual Indicator				22.0	
Numerator				1070	
Denominator				485318	
Data Source				Department of Health	
Is the Data Provisional or Final?				Final	
	2011	**2012**	**2013**	**2014**	**2015**
Annual Performance Objective	20	20	20	20	18

Notes - 2010

Provisional 2010 hospital discharge data are not available, therefore only 2009 hospital data are provided.

Notes - 2009

Data Source: Tennessee Department of Health, Division of Health Statistics, Population Projections and Hospital Discharge Data System

a. Last Year's Accomplishments

The Tennessee Department of Health (TDOH) was required by Public Chapter 1154 to develop a comprehensive state plan to address the burden of asthma in the state's school children and to report to standing House and Senate committees annually. The first progress report was submitted in September 2010. This report was developed in conjunction with the Department of Education's Office of Coordinated School Health.

TDOH's Office of Policy, Planning and Assessment released "Burden of Asthma in Tennessee in 2008" and "Childhood Asthma in Tennessee 1997-2007" in 2009. Both documents provide insight into the impact of asthma in Tennessee and especially on children ages 0-17 and were used as the basis for the "STAT Plan to Reduce the Burden of Asthma in Tennessee, 2009."

The director of the Asthma Initiative provided educational content at 20 conferences and health fairs serving approximately 13,705 people. Additionally, six asthma presentations were provided across the state with approximately 340 people in attendance. Staff for the asthma initiative were instrumental in developing material for World Asthma Day including two asthma fact sheets for wide distribution. MCH staff provided assistance to the Monroe Carell Jr. Children's Hospital for the first-ever World Asthma Day conference. The conference, attended by 124 participants, included: an overview of the state asthma burden by the Asthma Initiative director; medical education on the pathophysiology of asthma, pharmacotherapeutic management of asthma, and related testing (allergy testing and spirometry); and a discussion on social issues and school and community health issues related to asthma.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide in-service training and education to professionals.				X
2. Advocate for the adoption and use of the EPA's Indoor Air Quality tool.				X
3. Provide training and resources to asthma initiative coordinators across the state.				X
4. Update online and print educational resources for use by collaborators, parents, and youth.			X	
5. Continue community outreach via health fairs.		X	X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The MCH section partnered with Vanderbilt to co-sponsor the second-annual World Asthma Day Conference. The conference included continuing medical education, a discussion of the state asthma burden, and a roundtable discussion to identify next steps in improving asthma outcomes.

The Asthma Initiative has also partnered with Vanderbilt to provide presentations across the state to medical providers, educators, parents, and youth as requested; to develop print materials for home visitors and child care facilities to use to reduce smoking and indoor air pollution; and to provide training on EPA's Indoor Air Quality Tools for Schools.

In collaboration with ECCS, the Asthma Initiative developed a public awareness campaign, featuring table tents, car visor stickers, and door hangers with a "No Smoking" message.

In partnership with Children's Special Services (Title V CSHCN program), the Asthma Initiative is sponsoring 8 children to attend a summer asthma camp. The camp is designed to promote "typical" camp activities along with important asthma education and self-management skills.

The 10 Child Care Resource and Referral (CCR&R) centers were provided with asthma toolkits. The centers provide free training and technical assistance to child care providers to improve the quality of child care for all children. The toolkits contain basic information about asthma pathophysiology and free resources for use with parents and child care providers.

c. Plan for the Coming Year

During the coming year, the Asthma Initiative will review the State of Tennessee Asthma Task Force (STAT) work plans which will enable STAT and the executive committee to revise identified objectives as needed, ensuring that the overall goal of reducing the burden of asthma in Tennessee is met.

Staff will continue to collaborate with other STAT members and community partners to advocate for utilization of evidence-based asthma management guidelines by medical providers via venues such as conferences or Pediatric Grand Rounds.

Awareness and education will continue to be addressed through school and community training and development and provision of educational tools and materials.

In collaboration with the Tennessee Department of Environment and Conservation (TDEC), MCH staff will continue to train school staff with the Indoor Air Quality Tools for Schools curriculum as well as conducting radon testing.

The Office of Policy, Planning and Assessment (PPA) is scheduled to review and update the "Burden of Asthma" documents in 2012. Once those updates are complete, MCH staff will work with PPA epidemiologists to update the MCH asthma fact sheets and Fast Stats documents.

A Boston University Doctorate in Public Health (DrPH) student will be fulfilling her practicum requirements by working with the MCH section in 2011-2012. She will focus her work on understanding the practical issues associated with implementing asthma management and improvement strategies in schools. We anticipate she will work closely with MCH Asthma Initiative and Coordinated School Health staff to review existing resources available for schools, identify barriers to optimal implementation of asthma management and improvement strategies, and identify any additional resources needed to optimize the management of asthma in schools.

State Performance Measure 5: *Improve MCH workforce capacity and competency by designing and implementing a workforce development program*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Performance Objective					
Annual Indicator					
Numerator					
Denominator					
Data Source					
Is the Data Provisional or Final?					
	2011	2012	2013	2014	2015

Annual Performance Objective	0	0	0	0	0

Notes - 2010
Data is non-numeric in nature; therefore, no numerator/denominator data is reported for this performance measure.

Notes - 2009
Data is non-numeric in nature; therefore, no numerator/denominator data is reported for this performance measure.

a. Last Year's Accomplishments
The Tennessee Department of Health (TDOH) collaborated with East Tennessee State University (ETSU) to explore public health workforce needs in Tennessee. ETSU is the state's only CePH-accredited College of Public Health. In 2010, ETSU finalized plans for LIFEPATH, (Long-Distance Internet Facilitated Educational Program for Applied Training in Health). LIFEPATH is a workforce development partnership aimed at providing both academic and non-academic training to public health employees in the state of Tennessee. The program is housed at ETSU's College of Public Health and includes academic partnerships with the Meharry College of Medicine, the University of Memphis, and the University of Tennessee, and non-academic partnerships with the Tennessee Department of Health and Tennessee Public Health Association (TPHA).

Dr. Cathy Taylor, TDOH Assistant Commissioner for Health Services and interim MCH Director during 2009-10, was an active participant in national-level MCH workforce development activities. She participated in the HRSA/MCHB Professional Development & Learning System Work Group. She also served as a peer evaluator for the Council on Education in Public Health.

The TDOH Maternal and Child Health section continued a longstanding partnership with Vanderbilt's HRSA funded Leadership Education in Neurodevelopmental and Related Disabilities (LEND) training program, known as Mid-Tennessee Interdisciplinary Instruction in Neurodevelopmental Disabilities (MIND). Monthly MIND videoconferences included a variety of workforce development topics, were hosted by TDOH, and were broadcast to public health staff across the state.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. A catalog of public health core competency course offerings will be made available to all MCH section staff.				X
2. Each MCH section staff member will complete an individual development plan, outlining strategies for professional development related to the public health core competencies.				X
3. Each MCH section staff member will review progress on the individual development plan at least three times annually, at the interim and annual evaluations.				X
4. MCH program management staff will complete the Johns Hopkins Maternal and Child Health Leadership Skills Development Series.				X
5. MCH leadership will explore opportunities for scaling workforce development opportunities to regional and local MCH staff.				X
6.				
7.				

8.				
9.				
10.				

b. Current Activities
A workforce development initiative has been incorporated into monthly MCH program management meetings. Staff are working through the Johns Hopkins Bloomberg School of Public Health Maternal and Child Health Leadership Skills Development Series.

All MCH staff have been made aware of the LIFEPATH course offerings and encouraged to participate in the academic and non-academic opportunities. State employees can utilize an employee tuition benefit to take one academic course per semester with tuition charges waived. One member of the MCH senior leadership team (the Title V CSHCN Director) has already expressed interest in pursuing a LIFEPATH graduate certificate in Epidemiology.

Dr. Cathy Taylor continues to be involved in MCH workforce development at the national level. She remains an active participant in the HRSA/MCHB Professional Development & Learning System Work Group and has also become a member of the National Strategic Plan for Training Workgroup.

Dr. Michael Warren, the new MCH Director, was selected to participate in the Association of Maternal and Child Health (AMCHP) New Director Mentor Program. Toni Wall, Title V CSHCN Director in Maine, was assigned as Dr. Warren's mentor.

MCH has continued the MIND videoconference series in partnership with the Vanderbilt LEND program.

Dr. Warren met with representatives from both of Tennessee's HRSA-funded LEND sites to explore opportunities for additional collaboration related to workforce development.

c. Plan for the Coming Year
Course offerings related to training in the core public health competencies will be catalogued and made available to all MCH session staff. Each staff member will complete an individual development plan, outlining individual training needs, identifying resources to meet those needs, and documenting completion of training programs. Each staff member's plan will be reviewed by their supervisor at the interim and annual evaluations.

The MCH section will continue to explore opportunities for collaboration with the ETSU LIFEPATH program. Staff will continue to be encouraged to pursue academic training opportunities through LIFEPATH.

Dr. Taylor will continue to participate in national-level MCH workforce development activities.

Dr. Warren will complete the AMCHP New Director Mentor Program.

MCH will continue to host the MIND videoconferences. These monthly videoconferences will be made available to local and regional health department staff and will address numerous topics applicable to workforce development.

MCH will continue dialogue with Vanderbilt University and the University of Tennessee Health Sciences Center, Tennessee's two HRSA-funded LEND sites, to explore additional opportunities for collaboration related to workforce development.

State Performance Measure 6: *Increase the percentage of children and youth with special health care needs age 14 years and older who have formal plans for transtion to adulthood.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective					
Annual Indicator			39.6	39.6	39.6
Numerator			34477	34477	34477
Denominator			87141	87141	87141
Data Source			CSHCN Survey	CSHCN Survey	CSHCN Survey
Is the Data Provisional or Final?				Final	Final
	2011	**2012**	**2013**	**2014**	**2015**
Annual Performance Objective	45	45	45	55	55

Notes - 2010
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Numerator and denominator reported here are those reported as the weighted estimates for the national survey. Data source: http://cshcndata.org

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Numerator and denominator reported here are those reported as the weighted estimates for the national survey. Data source: http://cshcndata.org

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Numerator and denominator reported here are those reported as the weighted estimates for the national survey. Data source: http://cshcndata.org

a. Last Year's Accomplishments
In the past, Children's Special Services (CSS, the state's Title V CSHCN program) received technical assistance from Healthy Ready to Work which allowed CSS program staff to develop the resources necessary to create a statewide transitional plan that was used as a model for all individual transition plans.

CSS collaborated with the Department of Children's Services, the Department of Education, the Department of Mental Health and Developmental Disabilities, the Tennessee Council on Developmental Disabilities and Family Voices to develop a statewide transition task force. This task force was established to formulate program policies and procedures for transition plans for all children and child serving state agencies.

CSS worked to identify all the needs a participant and their family could have concerning transition from adolescence to adulthood. CSS staff worked on the development of a statewide and regional transitional team and continued to identify transitional resources within the community.

A CSS workgroup was developed to formulate transition standards for CSHCN. Some of the areas included in the plan include post secondary and vocational education, medical home options, employment opportunities, social and recreational opportunities, legal and financial needs and housing.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Include transition services in the individual care plans for those participants age 14 and older.	X	X		
2. Maintain listing of community referral resources.			X	X
3. Assist with all appropriate referrals for CSHCN.		X		
4. Provide training and development opportunities for CSS staff on transition issues.		X	X	X
5. Provide updated resource material for CSS staff and CSHCN.			X	X
6. Encourage youth to present at transition meetings and training events.			X	
7. Collaborate with state agencies, work groups, and advisory committees for transition policy development.		X	X	X
8. Develop additional transition materials and resources, transition brochures and guides.			X	
9.				
10.				

b. Current Activities

CSS continues to collaborate with Tennessee Departments of Children's Services, Education, Mental Health and Developmental Disabilities, Intellectual Disabilities, Juvenile Justice, Labor and Workforce Development, and other child-serving agencies on the Youth Transition Task Force that addresses all transition services necessary for transition to adulthood. CSS continues working with the Department of Education (DOE) to include a medical home transition component in the DOE transition guidelines and to provide input on the IEP and educational plans for CSHCN. CSS collaborated with the Governor's Office of Children's Care Coordination, Family Voices, TennCare, Vocational Rehabilitation and the Department of Higher Education to develop model transition plans.

CSS continues to develop transition plans for its participants. Care Coordination standards are being established to standardize and enhance transitional services. Comprehensive, age-appropriate transitional plans will continue to be developed for all participants age 14 and older. A Medical History Summary Form is provided to all CSS participants as a concise medical history that can be used as the participants transition to adult medical providers. The form will also be made available to any CSS participant that reaches maximum treatment or who leaves the program.

c. Plan for the Coming Year

CSS will continue to collaborate with other child serving agencies to develop a transition tool kit. CSS will continue to monitor national development regarding transition standards and best practices and will incorporate those initiatives into our program where feasible.

Care coordination training will continue to be developed and implemented for transitioning planning for CSHCN.

CSS participants and families will be asked to participate in a CSS Advisory Committee meeting regarding transitional needs.

A satisfaction survey will be developed for CSS participants to determine the success of individualized transition plans and determine any gaps and barriers that may exist.

CSS will collaborate with the Tennessee Chapter of the American Academy of Pediatrics to develop emergency preparedness guidelines for children and youth with special health care

needs that will become part of the individualized transition plan.

CSS staff will continue to partner with pediatric providers to locate adult providers for CSHCN who are aging off the program.

CSS staff will continue to collaborate with state agencies, advisory groups and work groups regarding youth transition issues and program and policy development.

State Performance Measure 7: *Reduce unintentional injury death in children and young people ages 0-24*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective					
Annual Indicator				19.0	14.4
Numerator				376	286
Denominator				1974006	1988211
Data Source				Department of Health	Department of Health
Is the Data Provisional or Final?				Final	Provisional
	2011	**2012**	**2013**	**2014**	**2015**
Annual Performance Objective	14	14	13.5	13.5	13

Notes - 2010
Data Source: Tennessee Department of Health, Division of Health Statistics, Population Projections and Death Statistical System

Notes - 2009
Data Source: Tennessee Department of Health, Division of Health Statistics, Population Projections and Death Statistical System

a. Last Year's Accomplishments
The Tennessee Core Violence and Injury Prevention Program (TVIPP) held an annual symposium in June of 2010. The symposium provided education on several injury prevention topics including fire safety, disaster preparedness, motor vehicle safety, poisoning prevention and fall prevention.

The Department of Commerce and Insurance developed "Safe At Home," a fire safety curriculum for all ages, and continued to use that to provide education. The Safe at Home program helps people go through their home to find fire hazards and make an escape plan. The Department also bought and installed over 8,000 smoke detectors. In addition, the department conducted an annual fire safety poster contest. The contest was open to students in all 95 counties in Tennessee.

The Tennessee Department of Health's Traumatic Brain Injury Program held a bike safety poster contest for students in grades K-8 in Tennessee. The purpose of the contest was to promote the use of bike helmets to reduce brain injuries among children. One winner from each grade was chosen and awarded a $50 savings bond by the Department of Health. The winners were chosen by a committee at the Department of Health. The Brain Injury Program also provided educational presentations to hundreds of children in Tennessee on the importance of wearing bike helmets to reduce injuries.

The Tennessee Poison Center provided statewide education to the public through health fairs and conference exhibits on poisoning prevention. Thousands of brochures and posters on poisoning prevention were also distributed. The center helps an average of 127,000 people per year.

The Community Anti-Drug Coalition Across Tennessee (CADCAT) has provided education to prevent drug abuse among Tennesseans. The mission of the group is to bring together community coalitions, implement proven strategies and policies, and promote a drug-free Tennessee.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Plan and host the annual Injury Prevention Symposium.				X
2. Plan and host the annual Injury Prevention 101 training.			X	X
3. Collaborate with the Department of Commerce and Insurance to reduce fire-related injuries.			X	X
4. Collaborate with the Poison Control Center to distribute poisoning prevention materials.		X	X	X
5. Promote annual bike safety poster contest.			X	
6. Collaborate with CADCAT to promote a drug-free Tennessee.			X	
7. Promote safe sleep education.		X	X	
8.				
9.				
10.				

b. Current Activities

This year, the Tennessee Core Violence and Injury Prevention Program (TVIPP) will continue to hold an annual symposium. The symposium, planned for July 2011, will focus on protecting the lives of children and teens. Sessions will include preventing concussions, safe sleep for infants, teen violence prevention, and other injury prevention topics. The TIVPP also held an Injury Prevention 101 training in February 2011 to provide education to professionals about the core competencies of injury prevention including: data collection and analysis, program development, implementation and evaluation, policies that influence injury prevention, and education and training.

The Department of Commerce and Insurance continued to use Safe At Home, a fire safety curriculum for all ages. The Department also continued to install smoke detectors in homes and held the fire safety poster contest.

The Traumatic Brain Injury Program is holding the statewide bike safety poster contest again for children in grades K-8.

The Poison Center has continued to distribute information on poisoning prevention through health fairs and conference exhibits.

CADCAT has continued to provide education and information to the community to promote a drug free Tennessee.

The TVIPP partnered with the TN Public Health Association to promote National Public Health Week, which was focused on injury prevention. County-level injury data were provided to inform programming efforts.

c. Plan for the Coming Year
Tennessee has been awarded CDC funding for the Base Integration Component of the Core Violence and Injury Prevention Program (Tennesse Core Violence and Injury Prevention Program, or TVIPP), beginning August 1, 2011 and continuing through 2015.

The TVIPP will have another injury prevention symposium in the upcoming year. Among the offerings at the symposium will be topics related to prevention of injuries in children. The TIVPP will also hold the Injury Prevention 101 training. TVIPP will help coordinate "Battle of the Belt," a program to encourage competition among high schools for improvements in seatbelt usage among students. TVIPP will also partner with home visiting programs administered by the Department of Health to provide safety messaging and injury prevention materials to home visitors.

The Traumatic Brain Injury Program will continue to organize the statewide bike safety poster contest for children in grades K-8.

The Poison Center will continue to distribute information on poisoning prevention through health fairs and conference exhibits.

The Tennessee Department of Health SIDS Program will distribute information on safe sleep to prevent injuries to infants (specifically, sleep-related deaths).

The Department of Commerce and Insurance will continue to use Safe At Home, a fire safety curriculum for all ages. The Department will also continue to install smoke detectors in homes and hold the fire safety poster contest.

CADCAT will continue providing education to further their mission of promoting a drug-free Tennessee.

E. Health Status Indicators

Introduction
Tennessee's Title V program reports annually on the health status indicators outlined in the Title V Block Grant Guidance. The health status indicators fulfill the following functions: provide information on the State's residents; assist in directing public health efforts; serve as a surveillance or monitoring tool; and function as an evaluative measure.

The health status indicators provide information on the health status of Tennesseans. The indicators include birth outcomes, injury rates, rates of sexually transmitted infections (STI), vital statistics data, and socioeconomic data.

Availability of these data allows for appropriate distribution of public health resources. These data also support the increasing focus on data-driven decision making by policymakers.

The health status indicators also support surveillance and monitoring (such as STI and injury rates). Program staff utilize these data in preparing annual reports that monitor program outcomes. These data also assist in evaluative efforts for MCH programs; indicators #01A-#05B yield important information about the efficacy of MCH programs aimed at improving maternal, infant, and child health.

Brief summaries follow each indicator, including where to locate full descriptions of the health

issue in the needs assessment and block grant documents.

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Indicator	9.6	9.4	9.2	9.2	9.0
Numerator	8100	8162	7834	7535	7158
Denominator	84277	86558	85454	82080	79259
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2010
Data Source: Tennessee Department of Health, Division of Health Statistics, Birth Statistical System

Notes - 2009
Data Source: Tennessee Department of Health, Division of Health Statistics, Birth Statistical System

Notes - 2008
Data Source: Tennessee Department of Health, Division of Health Statistics, Birth Statistical System

Narrative:
The percentage of live births weighing less than 2,500 grams has declined over the past five years. A number of programs and initiatives support this HSI. MCH home visitors serving prenatal women encourage regular prenatal care and positive health habits for pregnant women. The TENNderCare Outreach Program provides education to pregnant Medicaid enrollees and assists with referral for prenatal services. Additionally, local health departments provide pregnancy testing, determination of and enrollment in prenatal presumptive eligibility for Medicaid, and referral to prenatal care. The WIC program provides supplemental food to pregnant women, improving their health status. The state's Tobacco Control Program provides information on the dangers of smoking (a risk factor associated with low birth weight) and resources for smoking cessation. The Governor's Office of Children's Care Coordination has funded the Centering Pregnancy program (a group prenatal care model) in several sites across the state, as well as the Tennessee Intervention for Pregnant Smokers (TIPS), through which pregnant women are assessed for smoking and provided with cessation resources. Tennessee also has a regionalized perinatal system (funded by Medicaid) which supports consultation for obstetrical and neonatal providers across the state by experts at regional perinatal centers.

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2006	2007	2008	2009	2010

Annual Indicator	7.6	7.5	7.4	7.5	7.4
Numerator	6446	6452	6085	5961	5679
Denominator	84277	86558	82708	79491	76763
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2010
Data Source: Tennessee Department of Health, Division of Health Statistics, Birth Statistical System

Notes - 2009
Data Source: Tennessee Department of Health, Division of Health Statistics, Birth Statistical System

Notes - 2008
Data Source: Tennessee Department of Health, Division of Health Statistics, Birth Statistical System

Narrative:
The percentage of live singleton births weighing less than 2,500 grams has declined slightly since 2006. See narrative for HSI 01A for an explanation of this indicator.

Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Indicator	1.8	1.7	1.6	1.7	1.6
Numerator	1508	1513	1378	1371	1242
Denominator	84277	86558	85454	82080	79259
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2010
Data Source: Tennessee Department of Health, Division of Health Statistics, Birth Statistical System

Notes - 2009
Data Source: Tennessee Department of Health, Division of Health Statistics, Birth Statistical System

Notes - 2008
Data Source: Tennessee Department of Health, Division of Health Statistics, Birth Statistical System

Narrative:
The percentage of live births weighing less than 1,500 grams has declined slightly since 2006. See narrative for HSI 01A for an explanation of this indicator.

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Indicator	1.4	1.3	1.3	1.3	1.2
Numerator	1166	1159	1043	1068	947
Denominator	84277	86558	82708	79491	76763
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2010
Data Source: Tennessee Department of Health, Division of Health Statistics, Birth Statistical System

Notes - 2009
Data Source: Tennessee Department of Health, Division of Health Statistics, Birth Statistical System

Notes - 2008
Data Source: Tennessee Department of Health, Division of Health Statistics, Birth Statistical System

Narrative:
The percentage of live singleton births weighing less than 1,500 grams has declined slightly since 2006. See narrative for HSI 01A for an explanation of this indicator.

Health Status Indicators 03A: *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Indicator	7.0	8.0	10.2	7.9	5.9
Numerator	85	96	122	95	72
Denominator	1210629	1194718	1201099	1207621	1214522
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over					

the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2010
Data Source: Tennessee Department of Health, Divsion of Health Statistics, Population Projections and Death Statistical System

Notes - 2009
Data Source: Tennessee Department of Health, Divsion of Health Statistics, Population Projections and Death Statistical System

Notes - 2008
Data Source: Tennessee Department of Health, Divsion of Health Statistics, Population Projections and Death Statistical System

Narrative:
The rate of injury fatalities among children 14 years and younger has declined since 2006. The Department of Health's Core Violence and Injury Prevention Program (VIPP) has been funded by the CDC during this time. VIPP efforts include an annual injury symposium (featuring education on injury prevention topics), development of partnerships and collaborations with community agencies for implementation of local injury prevention efforts, and production of injury data (at county and state level) to inform injury programming efforts and to monitor results. MCH Home Visitors discuss safety techniques with families of young children during home visits. Injury prevention efforts are also conducted by other Department programs and other state agencies, including: the Department of Commerce and Insurance (Safe At Home fire safety curriculum and free smoke detector program); the Department of Health's Traumatic Brain Injury Program (annual bike safety poster contest and distribution of information about helmets); the Tennessee Poison Center (statewide educational efforts and operation of toll-free call center).

Health Status Indicators 03B: *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Indicator	2.7	3.3	3.4	2.7	1.8
Numerator	33	39	41	33	22
Denominator	1210629	1194718	1201099	1207621	1214522
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2010
Data Source: Tennessee Department of Health, Divsion of Health Statistics, Population Projections and Death Statistical System

Notes - 2009

Data Source: Tennessee Department of Health, Divsion of Health Statistics, Population Projections and Death Statistical System

Notes - 2008
Data Source: Tennessee Department of Health, Divsion of Health Statistics, Population Projections and Death Statistical System

Narrative:
The rate of motor vehicle fatalities for children 14 and younger has declined since 2006. Tennessee's child passenger safety law of 2004 specified and strengthened requirements for child restraint devices. Maternal and Child Health programs collaborate with other Tennessee Department of Health divisions and state agencies including the following: local law enforcement agencies, Safe Kids Coalitions, Head Start Centers, school systems, and the Governor's Highway Safety Office to educate families about the law. Additional education was provided on resources for purchasing and fitting child restraint devices. Each of the home visiting programs (HUGS, CHAD, and Healthy Start) also provides education to families. Health department clinic clients also receive information about child restraint device use as part of anticipatory guidance during the EPSDT exam.

Ninety fitting stations across the state, staffed by certified technicians, help families install their child safety device correctly. Three Child Passenger Safety Centers in the state serve as resources to the fitting stations. The centers are located at East Tennessee State University in Johnson City, Meharry Medical College in Nashville and The Mayor's Office of Early Childhood and Youth in Memphis. The centers can refer to the children's hospitals' rehabilitation centers in their areas for fitting a child with special health care needs, if needed.

The Nutrition and Wellness Division of the Tennessee Department of Health oversees the Child Safety Fund Program. Funding for the program is provided by the fines collected from motorists who were ticketed for being in violation of the Tennessee child passenger restraint law. Government or nonprofit organizations are eligible to obtain child safety funds to provide services to children, 0-8 years old, in low income families that meet federal poverty guidelines.

The Tennessee Road Builders' Association sponsors the Ollie the Otter Program. This program provides booster seat and seat belt education including the importance of using booster seats and seat belts and using them correctly.

Health Status Indicators 03C: *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Indicator	20.9	30.8	29.8	24.6	18.6
Numerator	172	257	250	208	159
Denominator	821651	833229	839914	846897	854231
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2010
Data Source: Tennessee Department of Health, Divsion of Health Statistics, Population Projections and Death Statistical System

Notes - 2009
Data Source: Tennessee Department of Health, Divsion of Health Statistics, Population Projections and Death Statistical System

Notes - 2008
Data Source: Tennessee Department of Health, Divsion of Health Statistics, Population Projections and Death Statistical System

Narrative:
The rate of motor vehicle fatalities for youth aged 15 through 24 has declined since 2006. Tennessee's Graduated Driver License (GDL) Program was implemented in 2001. It is a multi-tiered program designed to ease young novice drivers into full driving privileges as they become more mature and develop their driving skills. By requiring more supervised practice, the State of Tennessee hopes to save lives and prevent tragic injuries. The GDL program places certain restrictions on teens under the age of 18 who have learner permits and driver licenses. The program requires parent/legal guardian involvement, and emphasizes the importance of a good driving record.

The GDL law provides for three phases of licensing for teens under 18 years of age: learner permit, intermediate restricted license, and intermediate unrestricted license.

Health Status Indicators 04A: *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Indicator	13,135.9	13,239.4	12,313.1	12,487.9	
Numerator	158253	158173	147882	150807	
Denominator	1204737	1194718	1201009	1207621	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

Notes - 2010
Provisional 2010 hospital discharge data are not available, therefore only 2009 hospital data are provided.

Notes - 2009
Data Source: Tennessee Department of Health, Division of Health Statistics, Population Projections and Hospital Discharge Data System

Notes - 2008
Data Source: Tennessee Department of Health, Division of Health Statistics, Population Projections and Hospital Discharge Data System

Large adjustment to final is due to methodolgical differences in calculation from provisional.
Actual final calculated per Guidance:
Numerator: Number of children age 14 years and younger who have a hospital discharge for non-fatal injuries
Denominator: Number of children age 14 years and younger in the state for the reporting period

Narrative:
The rate of nonfatal injuries among children younger than 14 has declined since 2006. See narrative for HSI 03A for an explanation of this indicator.

Health Status Indicators 04B: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Indicator	797.2	819.3	722.3	718.6	
Numerator	9604	9788	8675	8678	
Denominator	1204737	1194718	1201009	1207621	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

Notes - 2010
Provisional 2010 hospital discharge data are not available, therefore only 2009 hospital data are provided.

Notes - 2009
Data Source: Tennessee Department of Health, Division of Health Statistics, Population Projections and Hospital Discharge Data System

Notes - 2008
Data Source: Tennessee Department of Health, Division of Health Statistics, Population Projections and Hospital Discharge Data System

Narrative:
The rate of nonfatal injuries due to motor vehicle crashes among children under age 14 has declined since 2006. See narrative for HSI 03B for an explanation of this indicator.

Health Status Indicators 04C: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Indicator	3,461.5	3,472.0	3,064.8	3,028.5	
Numerator	28239	28930	25742	25648	
Denominator	815796	833229	839914	846897	

Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

Notes - 2010
Provisional 2010 hospital discharge data are not available, therefore only 2009 hospital data are provided.

Notes - 2009
Data Source: Tennessee Department of Health, Division of Health Statistics, Population Projections and Hospital Discharge Data System

Notes - 2008
Data Source: Tennessee Department of Health, Division of Health Statistics, Population Projections and Hospital Discharge Data System

Narrative:
The rate of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 has declined since 2006. See narrative for HSI 03C for an explanation of this indicator.

Health Status Indicators 05A: *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Indicator	36.5	40.0	42.1	42.1	38.8
Numerator	7373	8153	8815	8815	8210
Denominator	201861	203767	209417	209417	211540
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2010
Data Source: Tennessee STD Program Surveillance Morbidity Database which is the Communicable Disease Surveillance System

Notes - 2009
Data Source: Tennessee STD Program Surveillance Morbidity Database which is the Communicable Disease Surveillance System

Notes - 2008
Data Source: Tennessee STD Program Surveillance Morbidity Database which is the Communicable Disease Surveillance System

Narrative:
Infections due to chlamydia are among the most prevalent of all STDs. There is strong collaboration between the staff of the MCH and HIV/AIDS/STD sections. Family planning staff in local health departments educate clients regarding all STDs. The Infertility Prevention Program (screening for chlamydia, treatment, and data analysis) is a joint project of Family Planning, STD, and the State Laboratory. The introduction of federal Infertility Prevention Project funding in 1998 has led to modest increases in testing in subsequent years.

Health Status Indicators 05B: *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Indicator	10.1	10.4	11.8	11.8	11.4
Numerator	10539	10859	12300	12300	11862
Denominator	1043888	1041926	1045578	1044578	1044145
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2010
Data Source: Tennessee STD Program Surveillance Morbidity Database which is the Communicable Disease Surveillance System

Notes - 2009
Data Source: Tennessee STD Program Surveillance Morbidity Database which is the Communicable Disease Surveillance System

Notes - 2008
Data Source: Tennessee STD Program Surveillance Morbidity Database which is the Communicable Disease Surveillance System

Narrative:
See narrative for HSI 05A for an explanation of this indicator.

Health Status Indicators 06A: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	80542	60639	17955	0	0	0	0	1948
Children 1 through 4	327971	247757	71961	0	0	0	0	8253

Children 5 through 9	403411	305529	87923	0	0	0	0	9959
Children 10 through 14	402598	307650	86021	0	0	0	0	8927
Children 15 through 19	434389	335964	90611	0	0	0	0	7814
Children 20 through 24	419842	329123	81963	0	0	0	0	8756
Children 0 through 24	2068753	1586662	436434	0	0	0	0	45657

Notes - 2012
Data Source for all fields in HSI #06A: Tennessee Department of Health, Division of Health Statistics, Population Projections

Narrative:
Demographic information is addressed in the Needs Assessment document (sections 3, 4, and 5) and in the State Overview section of the Block Grant Narrative.

Health Status Indicators 06B: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	76356	4186	0
Children 1 through 4	309551	18420	0
Children 5 through 9	380541	22870	0
Children 10 through 14	382086	20512	0
Children 15 through 19	417852	16537	0
Children 20 through 24	402287	17555	0
Children 0 through 24	1968673	100080	0

Notes - 2012
Data Source for all fields in HSI #06B: Tennessee Department of Health, Division of Health Statistics, Population Projections

Narrative:
Demographic information is addressed in the Needs Assessment document (sections 3, 4, and 5) and in the State Overview section of the Block Grant Narrative.

Health Status Indicators 07A: *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

HSI #07A - Demographics (Total live births)

CATEGORY Total live births	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific**	**More than one race reported**	**Other and Unknown**

						Islander		
Women < 15	116	51	63	0	0	0	0	2
Women 15 through 17	2531	1642	860	6	6	0	0	17
Women 18 through 19	6706	4592	2021	18	21	9	0	45
Women 20 through 34	61551	47263	12310	125	1186	111	0	556
Women 35 or older	8376	6639	1343	12	298	14	0	70
Women of all ages	79280	60187	16597	161	1511	134	0	690

Notes - 2012
Data Source for all fields in HSI #07A: Tennessee Department of Health, Division of Health Statistics, Birth Statistical System

Narrative:
Demographic information is addressed in the Needs Assessment document (sections 3, 4, and 5) and in the State Overview section of the Block Grant Narrative.

Health Status Indicators 07B: *Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)*

HSI #07B - Demographics (Total live births)

CATEGORY Total live births	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Women < 15	106	10	0
Women 15 through 17	2270	260	1
Women 18 through 19	6181	521	4
Women 20 through 34	55982	5539	30
Women 35 or older	7574	788	14
Women of all ages	72113	7118	49

Notes - 2012
Data Source for all fields in HSI #07B: Tennessee Department of Health, Division of Health Statistics, Birth Statistical System

Narrative:
Demographic information is addressed in the Needs Assessment document (sections 3, 4, and 5) and in the State Overview section of the Block Grant Narrative.

Health Status Indicators 08A: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

CATEGORY Total deaths	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	628	381	232	0	0	5	0	10
Children 1 through 4	104	68	30	1	1	1	0	3
Children 5 through 9	54	41	13	0	0	0	0	0
Children 10 through 14	76	48	25	0	0	3	0	0
Children 15 through 19	246	177	63	1	0	5	0	0
Children 20 through 24	474	365	101	1	1	3	0	3
Children 0 through 24	1582	1080	464	3	2	17	0	16

Notes - 2012
Data Source for all fields in HSI #08A: Tennessee Department of Health, Division of Health Statistics, Death Statistical System

Narrative:
Deaths of all children age 17 and under in Tennessee are reviewed as part of the State's Child Fatality Review process, which is mandated in statute. Local child fatality review teams in 31 judicial districts review deaths and make recommendations to the State Team, which compiles aggregate data and makes recommendations to the Governor and General Assembly. Tennessee also has a Fetal Infant Mortality Review (FIMR) initiative in three metropolitan counties (Davidson, Hamilton, and Shelby) as well as a 10-county region in East Tennessee. Fetal and infant deaths are reviewed by a community team; the review process includes a maternal interview. Based on findings from the review team, a community action team then determines appropriate community-based interventions to reduce infant mortality.

Health Status Indicators 08B: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)*

HSI #08B - Demographics (Total deaths)

CATEGORY Total deaths	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	589	38	1
Children 1 through 4	97	7	0
Children 5 through 9	51	3	0
Children 10 through 14	75	1	0
Children 15 through 19	237	9	0
Children 20 through 24	457	17	0
Children 0 through 24	1506	75	1

Notes - 2012
Data Source for all fields in HSI #08B: Tennessee Department of Health, Division of Health Statistics, Death Statistical System

Narrative:
See narrative for HSI 08A for an explanation of this indicator.

Health Status Indicators 09A: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

CATEGORY Misc Data BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**	**Specific Reporting Year**
All children 0 through 19	1648911	1257539	354471	0	0	0	0	36901	2010
Percent in household headed by single parent	27.5	23.3	47.4	0.0	0.0	0.0	0.0	3.1	2010
Percent in TANF (Grant) families	7.0	3.8	19.0	0.0	0.0	0.0	0.0	2.4	2010
Number enrolled in Medicaid	689051	377328	223287	1008	8	8089	0	79331	2010
Number enrolled in SCHIP	87644	54513	13731	113	976	688	0	17623	2010
Number living in foster home care	4070	2713	996	9	10	5	157	180	2010
Number enrolled in food stamp program	534351	337063	190108	909	4275	590	1406	0	2010
Number enrolled in WIC	207903	151555	54985	40	1323	0	0	0	2010
Rate (per 100,000) of juvenile crime arrests	2159.0	1366.0	5071.0	0.0	0.0	0.0	0.0	1027.0	2009
Percentage of high school drop-outs (grade 9 through 12)	3.3	2.4	5.4	2.8	1.3	1.5	0.0	12.4	2009

Notes - 2012
Data Source: Tennessee Department of Health, Division of Health Statistics, Population Projections

Data Source: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement (table creator accessed at http://www.census.gov/hhes/www/cpstc/cps_table_creator.html)

Data Source: Tennessee Department of Human Services

Data Source: Tennessee Medicaid (TennCare) data effective as of September 2010.

Data Source: Tennessee SCHIP (CoverKids) Program and Tennessee Medicaid (TennCare)

Note: The state Medicaid program (TennCare) has an eligibility category known as TennCare Standard Uninsured; this category is only available to children under age 19 whose TennCare Medicaid eligibility is ending, who do not have access to insurance through a job or a family member's job, and whose family incomes are below 200% poverty. These children are considered "CHIP children" in the TennCare II extension. The amount reported for this indicator represents the summation of figures provided by Tennessee's SCHIP program (CoverKids) as well as by the state Medicaid program (TennCare).

In this case, 59,372 children were enrolled in CoverKids and 28,272 children were enrolled in TennCare Standard Uninsured, for a total of 87,644.

Data Source: Tennessee Department of Human Services

Data Source: TN Department of Health, Nutrition and Wellness Section, WIC Program.

Data Source: TBI Tennessee Crime Statistics Online (accessed 4/21/2011 at http://www.tbi.state.tn.us/tn_crime_stats/crime_stats_online.shtml) and Tennessee Department of Health, Division of Health Statistics, Population Projections

The 2009 data presented here are different than the 2009 data from last year's grant submission. The data provided last year came from a Tennessee Bureau of Investigation (TBI) report entitled 'Crime in Tennessee 2009' that was published in May of 2010. TBI has not yet published a similar report for 2010. However, they do have an online database that can be used to generate crime statistics. This database is continually updated, even after a report such as the one cited above is published. As a result, even though 2010 data has not yet been added to the database, the 2009 data that is available is more up-to-date than that published in the report and used in last year's grant submission. The updated 2009 data is provided here. It should also be noted that by using the online database we were able to restrict the data to TN residents (the published report made no such distinctions) and analyze the data by ethnicity (the published report did not include data by ethnicity).

Data Source: Tennessee Department of Education

Data Source: Tennessee Department of Children's Services. Includes number of children living in foster home care and medically fragile foster home care.

Narrative:
Tennessee infants and children receive services from a wide variety of state agencies. Data for this indicator are obtained from state agencies including the Departments of Health, Human Services, TennCare (Medicaid), CoverKids (SCHIP), Children's Services, and Education. According to the 2011 Resource Mapping Report produced by the Tennessee Commission on Children and Youth, in FY09-10 state agencies provided services to 14,303,187 children, with total expenditures of $9,434,304,196.

Health Status Indicators 09B: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity. (Demographics)*

HSI #09B - Demographics (Miscellaneous Data)

CATEGORY Miscellaneous Data BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**	**Specific Reporting Year**
All children 0 through 19	1566386	82525	0	2010
Percent in household headed by single parent	26.8	36.2	0.0	2010
Percent in TANF (Grant) families	7.2	5.0	0.0	2010
Number enrolled in Medicaid	632895	56153	3	2010
Number enrolled in SCHIP	26050	5206	56388	2010
Number living in foster home care	3563	224	283	2010
Number enrolled in food stamp program	497928	36421	0	2010
Number enrolled in WIC	177774	30129	0	2010
Rate (per 100,000) of juvenile crime arrests	2163.0	1251.0	0.0	2009
Percentage of high school drop-outs (grade 9 through 12)	2.4	2.8	0.0	2009

Notes - 2012

Data Source: Tennessee Department of Health, Division of Health Statistics, Population Projections

Data Source: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement (table creator accessed at http://www.census.gov/hhes/www/cpstc/cps_table_creator.html)

Data Source: Tennessee Department of Human Services

Data Source: Tennessee Medicaid (TennCare) data effective as of September 2010.

Data Source: Tennessee SCHIP (CoverKids) Program and Tennessee Medicaid (TennCare)

Note: The state Medicaid program (TennCare) has an eligibility category known as TennCare Standard Uninsured; this category is only available to children under age 19 whose TennCare Medicaid eligibility is ending, who do not have access to insurance through a job or a family member's job, and whose family incomes are below 200% poverty. These children are considered "CHIP children" in the TennCare II extension. The amount reported for this indicator represents the summation of figures provided by Tennessee's SCHIP program (CoverKids) as well as by the state Medicaid program (TennCare).

In this case, 59,372 children were enrolled in CoverKids and 28,272 children were enrolled in TennCare Standard Uninsured, for a total of 87,644.

Data Source: Tennessee Department of Human Services

Data Source: TN Department of Health, Nutrition and Wellness Section, WIC Program.

Data Source: TBI Tennessee Crime Statistics Online (accessed 4/21/2011 at http://www.tbi.state.tn.us/tn_crime_stats/crime_stats_online.shtml) and Tennessee Department of Health, Division of Health Statistics, Population Projections

Numerator: Number of juvenile arrests for group A (violent) and group B (nonviolent) offenses in 2009; restricted to residents. Data source: TBI Tennessee Crime Statistics Online. Other/unknown race = Asian, Native American and unknown race. Juvenile is defined as <18 years old (TBI does not provide crime data on 0-19 years age group).

Denominator: Population of persons <18 years old in 2009. Data source: Health Statistics population projections. Other/unknown race = non-white/black. Population projections for other/unknown ethnicity unavailable; therefore, could not calculate arrest rate for this group.

The 2009 data presented here are different than the 2009 data from last year's grant submission. The data provided last year came from a Tennessee Bureau of Investigation (TBI) report entitled 'Crime in Tennessee 2009' that was published in May of 2010. TBI has not yet published a similar report for 2010. However, they do have an online database that can be used to generate crime statistics. This database is continually updated, even after a report such as the one cited above is published. As a result, even though 2010 data has not yet been added to the database, the 2009 data that is available is more up-to-date than that published in the report and used in last year's grant submission. The updated 2009 data is provided here. It should also be noted that by using the online database we were able to restrict the data to TN residents (the published report made no such distinctions) and analyze the data by ethnicity (the published report did not include data by ethnicity).

Data Source: Tennessee Department of Education

Data Source: Tennessee Department of Children's Services. Includes number of children living in foster home care and medically fragile foster home care.

Narrative:
See narrative for HSI 09A for an explanation of this indicator.

Health Status Indicators 10: *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	Total
Living in metropolitan areas	1137749
Living in urban areas	1053654
Living in rural areas	595257
Living in frontier areas	0
Total - all children 0 through 19	1648911

Notes - 2012
Data Sources: Tennessee Department of Health, Division of Health Statistics, Population Projections and 2000 U.S. Census. Note: urban and metropolitan areas overlap; total children 0-19 equals the sum of children living in urban and rural areas. Counts were determined by multiplying 2010 population projections by the percentage of TN children in metro/urban/rural areas from the 2000 U.S. Census

Narrative:
Approximately one-third of Tennessee's children live in rural areas; the remainder live in metropolitan (mostly urban) areas. A description of Tennessee's geography is found in the State Overview of the Block Grant Narrative.

Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

Poverty Levels	Total
Total Population	6239752.0
Percent Below: 50% of poverty	5.2
100% of poverty	16.5
200% of poverty	38.6

Notes - 2012
Data Source: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement (table creator accessed at http://www.census.gov/hhes/www/cpstc/cps_table_creator.html)

Narrative:
Over one-third of Tennessee's population lives below 200% of the federal poverty level. Over 16% of the population lives below 100% of the federal poverty level. Additional demographic information for the State can be found in the State Overview of the Block Grant Narrative.

Health Status Indicators 12: *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

Poverty Levels	Total
Children 0 through 19 years old	1615968.0
Percent Below: 50% of poverty	7.1
100% of poverty	23.5
200% of poverty	45.8

Notes - 2012
Data Source: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement (table creator accessed at http://www.census.gov/hhes/www/cpstc/cps_table_creator.html)

Narrative:
Compared to the overall Tennessee population, a disproportionate share of Tennessee children live in poverty--45.8% live below 200% of the federal poverty level, and nearly a quarter live below 100% of the federal poverty level. Additional demographic information for the State can be found in the State Overview of the Block Grant Narrative.

F. Other Program Activities

The MCH Section of the Tennessee Department of Health uses Title V Block Grant dollars to fund a variety of services offered to women and children. Many of the programs have been discussed in the National and State Performance Measures sections. Additional programs and

efforts not substantially described elsewhere are outlined below.

Prenatal Services
All local health department clinics offer pregnancy testing, presumptive eligibility determination for TennCare/Medicaid, WIC, counseling, information, and referral.

Childhood Lead Poisoning Prevention Program
Tennessee's Childhood Lead Poisoning Prevention Program monitors elevated blood lead levels reported for children under the age of six; promotes screening of children at high risk for lead exposure; assures proper follow-up for children with elevated blood lead levels; and provides professional and public awareness concerning lead poisoning.

Child Care Resource Centers
Tennessee's Child Care Resource Centers assist child care providers to improve the quality of child care. These Centers are the result of a collaborative involving the Tennessee Departments of Human Services and Health and the Tennessee Developmental Disabilities Council. There are ten child care resource centers serving providers in all 95 counties. Areas emphasized by the centers are: developmentally appropriate practice, health and safety, and the inclusion of children with special needs. Services include: training, technical assistance and consultation, and a lending resource library.

Child Fatality Review
Tennessee's review system is designed to identify why children are dying and what preventive measures can be taken. Multi-disciplinary, multi-agency child fatality review teams in the 31 judicial districts review all deaths of children 17 years of age or younger. The state child fatality prevention team reviews the reports and recommendations from the local teams, analyzes statistics of the incidence and causes of child deaths, and makes recommendations to the Governor and General Assembly to promote the safety and well being of children.

Fetal Infant Mortality Review (FIMR)
Tennessee has one of the highest infant mortality rates in the nation. FIMR pilot projects began in 2009 in 4 sites (Davidson, Hamilton, and Shelby Counties and East Tennessee Region Counties) to help state policy makers better understand the causes of fetal and infant deaths. Using the guidelines from the National Fetal and Infant Mortality Review Program, a collaborative program between the American College of Obstetricians and Gynecologists and the Federal Maternal and Child Health Bureau, this program gathers data from multiple sources including maternal interviews and works to identify and implement community strategies for improving birth outcomes.

Home Visiting Programs
Tennessee has several home visiting programs that emphasize child health and development, child abuse and neglect prevention, education and parental support. Healthy Start services are available in 30 counties and target first time parents. The program provides intensive home visiting services prenatally through the child's fifth birthday with goals of preventing child abuse and neglect and promoting family health. CHAD (Child Health and Development) is a home-based prevention and intervention service in 22 Tennessee counties. The services are provided to children ages birth to 6 years who are at risk of abuse or neglect, are at risk of developmental delay and/or have an identified delay. Pregnant women under age 18 may be enrolled during pregnancy to prevent or reduce the risk of abuse or developmental delay to the unborn child. The Help Us Grow Successfully (HUGS) programs are available in all of Tennessee's 95 counties. HUGS serves pregnant and postpartum women and children under six.

Family Planning Program
Comprehensive family planning services, including medical examinations, laboratory tests, education and counseling, and contraceptive supplies are provided in all 95 counties through state and metropolitan health departments. These services include Pap smears, screening and

treatment for sexually transmitted diseases, breast exams, and screening for anemia.

Breast and Cervical Cancer Screening Program
The Tennessee Breast and Cervical Screening Program provides clinical breast exams, mammograms and Pap tests for eligible Tennessee women free of charge. Eligibility is based on age, income, and insurance coverage status. Participating statewide providers, including local health departments and primary care clinics, provide screening services and referrals if additional tests are needed. About 14,000 Tennessee women were screened in 2010.

Partnerships with TennCare (Medicaid)
The local health departments statewide provide outreach and assistance to TennCare enrollees. Local health departments provide direct on-line application for pregnant women who are presumed eligible for TennCare, assist enrollees with formal appeals to TennCare, assist in scheduling medical appointments and transportation, and provide EPSDT exams for TennCare children. Staff enrolls eligible clients from the Tennessee Breast and Cervical Cancer Early Detection Program in TennCare for coverage of treatment services.

Hotlines
The MCH section operates two hotlines. Both are staffed by the MCH and Women's Health sections. The Baby Line, a toll-free telephone line, answers questions, refers callers for pregnancy testing, TennCare and prenatal care within the area where they live, and responds to requests for printed material. The goal is to get women into care during the first trimester of pregnancy. The Clearinghouse for Information on Adolescent Pregnancy Issues is a separate, central, toll-free telephone for professionals and parents seeking information on local resources, teen pregnancy statistics, resource materials, information on adolescent issues, and services.

Advisory Committees
MCH has four mandated advisory committees: Perinatal Advisory Committee for the Perinatal Regionalization Program; Genetics Advisory Committee for the Newborn Metabolic Screening and the Newborn Hearing Screening Programs; the Children's Special Services Advisory Committee; and the Women's Health Advisory Committee. Other task forces and advisory groups for MCH programs (not mandated by law) include: Tennessee Childhood Lead Poisoning Prevention Advisory Committee, Adolescent Health Advisory Committee, Asthma Task Force, and Early Childhood Comprehensive Systems Work Group.

Quality Improvement
Local quality units are empowered to resolve problems whenever possible in addition to streamlining existing services. The State Quality Council meets yearly to review reports on quality activities, including aggregated trends and recommendations from quality units and quality teams. The MCH Director serves on the State Quality Council. The statewide Quality Management Plan developed by the Bureau of Health Services is updated yearly. Quality management, including record review and follow up, is conducted statewide to assure an optimum level of services for all clients. Clinic-specific patient satisfaction surveys, in English and Spanish, are conducted for one week each year in all rural clinics.

G. Technical Assistance

We are requesting Technical Assistance in four areas as listed on Form 15:

(1) Assistance is needed in determining the best methods to report expenditures by the four levels of the MCHB Pyramid. A variety of methods are used by the Region IV states to provide information. Comparability is not possible across states. Assistance is requested to develop instructions for the states on compiling this information.

(2) Children's Special Services (CSS, Title V CSHCN Program) is redesigning the care coordination provided to participants. Assistance is needed in identifying best practices and

training resources. Care coordinators need to have the skills to address social/physical environments, disparities, cultural needs, self-management support, and health literacy.

(3) We need assistance in developing a workforce training plan (built on core competencies) for current MCH staff at both central office and local levels. Our workforce has expressed the need to improve skills in communication, cultural competency, and community dimensions of practice. There are gaps in other domains as well.

(4) We need guidance on how to incorporate Life Course Perspective into practice and programs using current (limited) funding. We need assistance on best methodologies to shift the current paradigm from direct service and categorical programs.

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

	FY 2010		FY 2011		FY 2012	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
1. Federal Allocation *(Line1, Form 2)*	11645007	8558526	11645007		11539865	
2. Unobligated Balance *(Line2, Form 2)*	3500000	0	3000000		3100000	
3. State Funds *(Line3, Form 2)*	13250000	13325000	13250000		13250000	
4. Local MCH Funds *(Line4, Form 2)*	0	0	0		0	
5. Other Funds *(Line5, Form 2)*	0	0	0		0	
6. Program Income *(Line6, Form 2)*	5800900	5539280	5900000		5550000	
7. Subtotal	34195907	27422806	33795007		33439865	
8. Other Federal Funds *(Line10, Form 2)*	7872484	7603405	7145900		11831199	
9. Total *(Line11, Form 2)*	42068391	35026211	40940907		45271064	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2010		FY 2011		FY 2012	
I. Federal-State MCH Block Grant Partnership	**Budgeted**	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
a. Pregnant Women	1025877	330719	668803		403285	
b. Infants < 1 year old	4069313	2926288	3881695		3568368	
c. Children 1 to 22 years old	13813306	11945862	13848481		14324393	
d. Children with	3761550	3147418	3493503		3461960	

Special Healthcare Needs						
e. Others	10361360	8633522	10738025		10527873	
f. Administration	1164501	438997	1164500		1153986	
g. SUBTOTAL	34195907	27422806	33795007		33439865	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	0		0		0	
b. SSDI	93763		92872		93763	
c. CISS	100000		105000		132000	
d. Abstinence Education	993844		0		1141533	
e. Healthy Start	0		0		0	
f. EMSC	0		0		0	
g. WIC	0		0		0	
h. AIDS	0		0		0	
i. CDC	0		0		0	
j. Education	0		0		0	
k. Other						
Family Planning	6534877		6648028		6897373	
Injury Prevention	0		0		125185	
MIECHV Home Visiting	0		0		3141345	
Newborn Hearing	150000		300000		300000	

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2010		**FY 2011**		**FY 2012**	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
I. Direct Health Care Services	25988889	17024078	20979940		20759467	
II. Enabling Services	4322363	6367576	7847201		7764737	
III. Population-Based Services	1586690	2728569	3362603		3327267	
IV. Infrastructure Building Services	2297965	1302583	1605263		1588394	
V. Federal-State Title V Block Grant Partnership Total	34195907	27422806	33795007		33439865	

A. Expenditures

The Bureau of Administrative Services (BAS) within the Department of Health is responsible for all fiscal management. BAS uses Project 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 and 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 the

Department of Health's Internal Audit staff.

Maternal and Child Health Programs are organizationally aligned to the Bureau of Health Services, Tennessee Department of Health. The Bureau of Health Services has developed detailed policies and procedures for use by local health departments, metropolitan health departments, regional public health offices and central office staff involved with budgeting of funds, collection of revenues, depositing revenues, accounts receivable, aging of accounts, charging patients and third parties, petty cash, posting receipts and contracting for services. Bureau of Health Services policies and procedures are available to all sites and are posted on the Department's Intra-Net for easy references. All policies and procedures have been developed in accordance with applicable state law and rules of the Department of Finance and Administration.

B. 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 Bureau of Health Services Fiscal Services Section, 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.

The Department of Health 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 Bureau of Health Services 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 rural 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 the Tennessee Department of Health. RBRVS is fully automated with computer linkage 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 CPT procedure 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 for the Maternal and Child Health Block Grant was established in 1989 in accordance with requirements of the block grant. The maintenance of effort, $13,125,024.28, was established through an analysis of 15 months of expenditures for Maternal and Child Health Programs, adjusted for differences between the state and federal fiscal years, as well as adjustments for accrued liabilities. The Tennessee Department of Health, Bureau of Health Services fully supports using state funds to meet the maintenance of effort and match requirements in support of Maternal and Child Health Program activities.

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 block grant regulations. Any carry forward noted in the annual report will be used to support or expand Maternal and Child Health activities. Carry forward funding has been used to develop

new services or to expand current programs. During recent years carry forward funding has been used to improve dental and other health care screening services, provide preventive fluoride varnish for children seen in health department clinics, fund increased program activity relative to infant mortality, teen pregnancy prevention and enhancement of breast and cervical screening for reproductive age women. Funding was also used to increase home visiting services for pregnant women and families with high risk infants and young children as well as care coordination services for families with children with special health care needs.

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.

Title V Block Grant Application
Forms (2-21)
State: TN
Application Year: 2012

FORM 2

MCH BUDGET DETAILS FOR FY 2012

[Secs. 504 (d) and 505(a)(3)(4)]

STATE: TN

1. FEDERAL ALLOCATION $ 11,539,865

(Item 15a of the Application Face Sheet [SF 424])
Of the Federal Allocation (1 above), the amount earmarked for:

A.Preventive and primary care for children:

$ 3,461,960 (30 %)

B.Children with special health care needs:

$ 3,461,960 (30 %)

(If either A or B is less than 30%, a waiver request must accompany the application)[Sec. 505(a)(3)]

C.Title V admininstrative costs:

$ 1,153,986 (10 %)

(The above figure cannot be more than 10%)[Sec. 504(d)]

2. UNOBLIGATED BALANCE (Item 15b of SF 424) $ 3,100,000

3. STATE MCH FUNDS (Item 15c of the SF 424) $ 13,250,000

4. LOCAL MCH FUNDS (Item 15d of SF 424) $ 0

5. OTHER FUNDS (Item 15e of SF 424) $ 0

6. PROGRAM INCOME (Item 15f of SF 424) $ 5,550,000

7. TOTAL STATE MATCH (Lines 3 through 6) $ 18,800,000

(Below is your State's FY 1989 Maintainence of Effort Amount)
$ 13,125,024

8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP (SUBTOTAL) $ 33,439,865

(Total lines 1 through 6. Same as line 15g of SF 424)

9. OTHER FEDERAL FUNDS

(Funds under the control of the person responsible for the administration of the Title V program)

a. SPRANS:	$ 0
b. SSDI:	$ 93,763
c. CISS:	$ 132,000
d. Abstinence Education:	$ 1,141,533
e. Healthy Start:	$ 0
f. EMSC:	$ 0
g. WIC:	$ 0
h. AIDS:	$ 0
i. CDC:	$ 0
j. Education:	$ 0
k. Other:	
Family Planning	$ 6,897,373
Injury Prevention	$ 125,185
MIECHV Home Visiting	$ 3,141,345
Newborn Hearing	$ 300,000

10. OTHER FEDERAL FUNDS (SUBTOTAL of all Funds under item 9) $ 11,831,199

11. STATE MCH BUDGET TOTAL $ 45,271,064

(Partnership subtotal + Other Federal MCH Funds subtotal)

FORM NOTES FOR FORM 2

None

FIELD LEVEL NOTES

None

FORM 3

STATE MCH FUNDING PROFILE

[Secs. 505(a) and 506((a)(I-3)]

STATE: TN

	FY 2007		FY 2008		FY 2009	
	BUDGETED	EXPENDED	BUDGETED	EXPENDED	BUDGETED	EXPENDED
1. Federal Allocation *(Line1, Form 2)*	$ 11,855,000	$ 14,682,820	$ 11,855,578	$ 9,502,319	$ 11,658,473	$ 8,967,477
2. Unobligated Balance *(Line2, Form 2)*	$ 7,500,000	$ 0	$ 7,500,000	$ 0	$ 5,000,000	$ 0
3. State Funds *(Line3, Form 2)*	$ 13,250,000	$ 13,325,000	$ 13,300,000	$ 13,250,000	$ 13,325,000	$ 13,300,000
4. Local MCH Funds *(Line4, Form 2)*	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0
5. Other Funds *(Line5, Form 2)*	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0
6. Program Income *(Line6, Form 2)*	$ 6,682,000	$ 5,371,883	$ 5,128,300	$ 5,800,931	$ 5,371,900	$ 5,884,387
7. Subtotal	$ 39,287,000	$ 33,379,703	$ 37,783,878	$ 28,553,250	$ 35,355,373	$ 28,151,864
	(THE FEDERAL-STATE TITLE BLOCK GRANT PARTNERSHIP)					
8. Other Federal Funds *(Line10, Form 2)*	$ 8,250,000	$ 7,742,714	$ 8,177,027	$ 7,122,906	$ 6,557,014	$ 7,024,247
9. Total *(Line11, Form 2)*	$ 47,537,000	$ 41,122,417	$ 45,960,905	$ 35,676,156	$ 41,912,387	$ 35,176,111
	(STATE MCH BUDGET TOTAL)					

FORM 3

STATE MCH FUNDING PROFILE

[Secs. 505(a) and 506((a)(I-3)]

STATE: TN

	FY 2010		FY 2011		FY 2012	
	BUDGETED	**EXPENDED**	**BUDGETED**	**EXPENDED**	**BUDGETED**	**EXPENDED**
1. Federal Allocation *(Line1, Form 2)*	$ 11,645,007	$ 8,558,526	$ 11,645,007	$	$ 11,539,865	$
2. Unobligated Balance *(Line2, Form 2)*	$ 3,500,000	$ 0	$ 3,000,000	$	$ 3,100,000	$
3. State Funds *(Line3, Form 2)*	$ 13,250,000	$ 13,325,000	$ 13,250,000	$	$ 13,250,000	$
4. Local MCH Funds *(Line4, Form 2)*	$ 0	$ 0	$ 0	$	$ 0	$
5. Other Funds *(Line5, Form 2)*	$ 0	$ 0	$ 0	$	$ 0	$
6. Program Income *(Line6, Form 2)*	$ 5,800,900	$ 5,539,280	$ 5,900,000	$	$ 5,550,000	$
7. Subtotal	$ 34,195,907	$ 27,422,806	$ 33,795,007	$ 0	$ 33,439,865	$ 0
	(THE FEDERAL-STATE TITLE BLOCK GRANT PARTNERSHIP)					
8. Other Federal Funds *(Line10, Form 2)*	$ 7,872,484	$ 7,603,405	$ 7,145,900	$	$ 11,831,199	$
9. Total *(Line11, Form 2)*	$ 42,068,391	$ 35,026,211	$ 40,940,907	$ 0	$ 45,271,064	$ 0
	(STATE MCH BUDGET TOTAL)					

FORM NOTES FOR FORM 3

None

FIELD LEVEL NOTES

1. **Section Number:** Form3_Main
   Field Name: FedAllocExpended
   Row Name: Federal Allocation
   Column Name: Expended
   Year: 2010
   Field Note:
   The expended is based on true expenditures.

2. **Section Number:** Form3_Main
   Field Name: FedAllocExpended
   Row Name: Federal Allocation
   Column Name: Expended
   Year: 2009
   Field Note:
   The expended is based on true expenditures.

3. **Section Number:** Form3_Main
   Field Name: UnobligatedBalanceExpended
   Row Name: Unobligated Balance
   Column Name: Expended
   Year: 2010
   Field Note:
   This difference in expended amount will be used prior to the grant deadline.

4. **Section Number:** Form3_Main
   Field Name: UnobligatedBalanceExpended
   Row Name: Unobligated Balance
   Column Name: Expended
   Year: 2009
   Field Note:
   The difference in expended amount will be used prior to the grant deadline.

FORM 4

BUDGET DETAILS BY TYPES OF INDIVIDUALS SERVED (I) AND SOURCES OF OTHER FEDERAL FUNDS (II)

[Secs 506(2)(2)(iv)]

STATE: TN

	FY 2007		FY 2008		FY 2009	
I. Federal-State MCH Block Grant Partnership	**BUDGETED**	**EXPENDED**	**BUDGETED**	**EXPENDED**	**BUDGETED**	**EXPENDED**
a. Pregnant Women	$ 864,314	$ 1,134,910	$ 1,209,084	$ 856,598	$ 1,202,083	$ 557,125
b. Infants < 1 year old	$ 4,360,857	$ 3,805,286	$ 4,194,011	$ 3,397,837	$ 4,030,513	$ 3,233,523
c. Children 1 to 22 years old	$ 18,582,751	$ 12,327,096	$ 11,320,907	$ 11,784,055	$ 13,047,012	$ 11,964,732
d. Children with Special Healthcare Needs	$ 6,560,929	$ 4,729,932	$ 8,236,885	$ 3,144,199	$ 5,020,463	$ 3,048,058
e. Others	$ 7,503,817	$ 10,280,949	$ 11,637,434	$ 8,651,635	$ 10,889,455	$ 8,944,973
f. Administration	$ 1,414,332	$ 1,101,530	$ 1,185,557	$ 718,926	$ 1,165,847	$ 403,453
g. SUBTOTAL	$ 39,287,000	$ 33,379,703	$ 37,783,878	$ 28,553,250	$ 35,355,373	$ 28,151,864
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	$ 0		$ 0		$ 0	
b. SSDI	$ 100,000		$ 94,644		$ 93,763	
c. CISS	$ 100,000		$ 100,000		$ 100,000	
d. Abstinence Education	$ 993,000		$ 993,368		$ 0	
e. Healthy Start	$ 0		$ 0		$ 0	
f. EMSC	$ 0		$ 0		$ 0	
g. WIC	$ 0		$ 0		$ 0	
h. AIDS	$ 0		$ 0		$ 0	
i. CDC	$ 0		$ 0		$ 0	
j. Education	$ 0		$ 0		$ 0	
k.Other						
Family Planning	$ 0		$ 6,121,679		$ 6,213,251	
Newborn Hearing	$ 0		$ 150,000		$ 150,000	
CHAD	$ 717,000		$ 717,336		$ 0	
New Born Hearing	$ 150,000		$ 0		$ 0	
Title X F. P.	$ 6,190,000		$ 0		$ 0	
III. SUBTOTAL	$ 8,250,000		$ 8,177,027		$ 6,557,014	

FORM 4

BUDGET DETAILS BY TYPES OF INDIVIDUALS SERVED (I) AND SOURCES OF OTHER FEDERAL FUNDS (II)

[Secs 506(2)(2)(iv)]

STATE: TN

	FY 2010		FY 2011		FY 2012	
I. Federal-State MCH Block Grant Partnership	**BUDGETED**	**EXPENDED**	**BUDGETED**	**EXPENDED**	**BUDGETED**	**EXPENDED**
a. Pregnant Women	$ 1,025,877	$ 330,719	$ 668,803	$	$ 403,285	$
b. Infants < 1 year old	$ 4,069,313	$ 2,926,288	$ 3,881,695	$	$ 3,568,368	$
c. Children 1 to 22 years old	$ 13,813,306	$ 11,945,862	$ 13,848,481	$	$ 14,324,393	$
d. Children with Special Healthcare Needs	$ 3,761,550	$ 3,147,418	$ 3,493,503	$	$ 3,461,960	$
e. Others	$ 10,361,360	$ 8,633,522	$ 10,738,025	$	$ 10,527,873	$
f. Administration	$ 1,164,501	$ 438,997	$ 1,164,500	$	$ 1,153,986	$
g. SUBTOTAL	$ 34,195,907	$ 27,422,806	$ 33,795,007	$ 0	$ 33,439,865	$ 0
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	$ 0		$ 0		$ 0	
b. SSDI	$ 93,763		$ 92,872		$ 93,763	
c. CISS	$ 100,000		$ 105,000		$ 132,000	
d. Abstinence Education	$ 993,844		$ 0		$ 1,141,533	
e. Healthy Start	$ 0		$ 0		$ 0	
f. EMSC	$ 0		$ 0		$ 0	
g. WIC	$ 0		$ 0		$ 0	
h. AIDS	$ 0		$ 0		$ 0	
i. CDC	$ 0		$ 0		$ 0	
j. Education	$ 0		$ 0		$ 0	
k.Other						
Family Planning	$ 6,534,877		$ 6,648,028		$ 6,897,373	
Injury Prevention	$ 0		$ 0		$ 125,185	
MIECHV Home Visiting	$ 0		$ 0		$ 3,141,345	
Newborn Hearing	$ 150,000		$ 300,000		$ 300,000	
III. SUBTOTAL	$ 7,872,484		$ 7,145,900		$ 11,831,199	

FORM NOTES FOR FORM 4

None

FIELD LEVEL NOTES

1. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
   Field Name: PregWomenBudgeted
   Row Name: Pregnant Women
   Column Name: Budgeted
   Year: 2010
   Field Note:
   Budget amount is estimated.

2. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
   Field Name: PregWomenBudgeted
   Row Name: Pregnant Women
   Column Name: Budgeted
   Year: 2009
   Field Note:
   Amount is estimated.

3. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
   Field Name: PregWomenExpended
   Row Name: Pregnant Women
   Column Name: Expended
   Year: 2010
   Field Note:
   The expended is based on true expenditures.

4. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
   Field Name: PregWomenExpended
   Row Name: Pregnant Women
   Column Name: Expended
   Year: 2009
   Field Note:
   Expended amount is true expenditures.

5. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
   Field Name: Children_0_1Budgeted
   Row Name: Infants <1 year old
   Column Name: Budgeted
   Year: 2010
   Field Note:
   Budget amount is estimated.

6. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
   Field Name: Children_0_1Budgeted
   Row Name: Infants <1 year old
   Column Name: Budgeted
   Year: 2009
   Field Note:
   Amount is estimated.

7. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
   Field Name: Children_0_1Expended
   Row Name: Infants <1 year old
   Column Name: Expended
   Year: 2010
   Field Note:
   The expended is based on true expenditures.

8. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
   Field Name: Children_0_1Expended
   Row Name: Infants <1 year old
   Column Name: Expended
   Year: 2009
   Field Note:
   Expended amount is true expenditures

9. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
   Field Name: Children_1_22Budgeted
   Row Name: Children 1 to 22 years old
   Column Name: Budgeted
   Year: 2010
   Field Note:
   Budget amount is estimated.

10. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
    Field Name: Children_1_22Budgeted
    Row Name: Children 1 to 22 years old
    Column Name: Budgeted
    Year: 2009
    Field Note:
    Amount is estimated.

11. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
    Field Name: Children_1_22Expended
    Row Name: Children 1 to 22 years old
    Column Name: Expended
    Year: 2010
    Field Note:
    The expended is based on true expenditures.

12. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
    Field Name: CSHCNBudgeted
    Row Name: CSHCN

Column Name: Budgeted
Year: 2010
Field Note:
Budget amount is estimated.

13. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
Field Name: CSHCNBudgeted
Row Name: CSHCN
Column Name: Budgeted
Year: 2009
Field Note:
Amount is estimated.

14. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
Field Name: CSHCNExpended
Row Name: CSHCN
Column Name: Expended
Year: 2010
Field Note:
The expended is based on true expenditures.

15. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
Field Name: CSHCNExpended
Row Name: CSHCN
Column Name: Expended
Year: 2009
Field Note:
Expended amount is true expenditures.

16. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
Field Name: AllOthersBudgeted
Row Name: All Others
Column Name: Budgeted
Year: 2010
Field Note:
Budget amount is estimated.

17. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
Field Name: AllOthersBudgeted
Row Name: All Others
Column Name: Budgeted
Year: 2009
Field Note:
Amount is estimated.

18. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
Field Name: AllOthersExpended
Row Name: All Others
Column Name: Expended
Year: 2010
Field Note:
The expended is based on true expenditures.

19. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
Field Name: AllOthersExpended
Row Name: All Others
Column Name: Expended
Year: 2009
Field Note:
Expended amount is true expenditures.

20. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
Field Name: AdminBudgeted
Row Name: Administration
Column Name: Budgeted
Year: 2010
Field Note:
Budget amount is estimated.

21. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
Field Name: AdminBudgeted
Row Name: Administration
Column Name: Budgeted
Year: 2009
Field Note:
Amount is estimated.

22. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
Field Name: AdminExpended
Row Name: Administration
Column Name: Expended
Year: 2010
Field Note:
The expended is based on true expenditures.

23. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
Field Name: AdminExpended
Row Name: Administration
Column Name: Expended
Year: 2009
Field Note:
Expended amount is true expenditures

FORM 5

STATE TITLE V PROGRAM BUDGET AND EXPENDITURES BY TYPES OF SERVICES

[Secs. 505(a)(2)(A-B) and 506(a)(1)(A-D)]

STATE: TN

TYPE OF SERVICE	FY 2007		FY 2008		FY 2009	
	BUDGETED	EXPENDED	BUDGETED	EXPENDED	BUDGETED	EXPENDED
I. Direct Health Care Services (Basic Health Services and Health Services for CSHCN.)	$ 28,443,788	$ 24,166,905	$ 27,355,528	$ 21,700,470	$ 25,597,290	$ 17,476,677
II. Enabling Services (Transportation, Translation, Outreach, Respite Care, Health Education, Family Support Services, Purchase of Health Insurance, Case Management, and Coordination with Medicaid, WIC, and Education.)	$ 4,557,292	$ 3,872,046	$ 4,382,930	$ 3,609,131	$ 4,101,224	$ 6,536,863
III. Population-Based Services (Newborn Screening, Lead Screening, Immunization, Sudden Infant Death Syndrome Counseling, Oral Health, Injury Prevention, Nutrition, and Outreach/Public Education.)	$ 3,300,108	$ 2,803,895	$ 3,173,846	$ 1,324,871	$ 2,969,851	$ 2,801,110
IV. Infrastructure Building Services (Needs Assessment, Evaluation, Planning, Policy Development, Coordination, Quality Assurance, Standards Development, Monitoring, Training, Applied Research, Systems of Care, and Information Systems.)	$ 2,985,812	$ 2,536,857	$ 2,871,574	$ 1,918,778	$ 2,687,008	$ 1,337,214
V. Federal-State Title V Block Grant Partnership Total (Federal-State Partnership only. Item 15g of SF 42r. For the "Budget" columns this is the same figure that appears in Line 8, Form 2, and in the "Budgeted" columns of Line 7 Form 3. For the "Expended" columns this is the same figure that appears in the "Expended" columns of Line 7, Form 3.)	$ 39,287,000	$ 33,379,703	$ 37,783,878	$ 28,553,250	$ 35,355,373	$ 28,151,864

FORM 5

STATE TITLE V PROGRAM BUDGET AND EXPENDITURES BY TYPES OF SERVICES

[Secs. 505(a)(2)(A-B) and 506(a)(1)(A-D)]

STATE: TN

TYPE OF SERVICE	FY 2010		FY 2011		FY 2012	
	BUDGETED	EXPENDED	BUDGETED	EXPENDED	BUDGETED	EXPENDED
I. Direct Health Care Services (Basic Health Services and Health Services for CSHCN.)	$ 25,988,889	$ 17,024,078	$ 20,979,940	$	$ 20,759,467	$
II. Enabling Services (Transportation, Translation, Outreach, Respite Care, Health Education, Family Support Services, Purchase of Health Insurance, Case Management, and Coordination with Medicaid, WIC, and Education.)	$ 4,322,363	$ 6,367,576	$ 7,847,201	$	$ 7,764,737	$
III. Population-Based Services (Newborn Screening, Lead Screening, Immunization, Sudden Infant Death Syndrome Counseling, Oral Health, Injury Prevention, Nutrition, and Outreach/Public Education.)	$ 1,586,690	$ 2,728,569	$ 3,362,603	$	$ 3,327,267	$
IV. Infrastructure Building Services (Needs Assessment, Evaluation, Planning, Policy Development, Coordination, Quality Assurance, Standards Development, Monitoring, Training, Applied Research, Systems of Care, and Information Systems.)	$ 2,297,965	$ 1,302,583	$ 1,605,263	$	$ 1,588,394	$
V. Federal-State Title V Block Grant Partnership Total (Federal-State Partnership only. Item 15g of SF 42r. For the "Budget" columns this is the same figure that appears in Line 8, Form 2, and in the "Budgeted" columns of Line 7 Form 3. For the "Expended" columns this is the same figure that appears in the "Expended" columns of Line 7, Form 3.)	$ 34,195,907	$ 27,422,806	$ 33,795,007	$ 0	$ 33,439,865	$ 0

FORM NOTES FOR FORM 5

None

FIELD LEVEL NOTES

1. **Section Number:** Form5_Main
   Field Name: DirectHCBudgeted
   Row Name: Direct Health Care Services
   Column Name: Budgeted
   Year: 2010
   Field Note:
   Budget amount is estimated.

2. **Section Number:** Form5_Main
   Field Name: DirectHCBudgeted
   Row Name: Direct Health Care Services
   Column Name: Budgeted
   Year: 2009
   Field Note:
   Budgeted amount is estimated.

3. **Section Number:** Form5_Main
   Field Name: DirectHCExpended
   Row Name: Direct Health Care Services
   Column Name: Expended
   Year: 2010
   Field Note:
   The expended is based on true expenditures.

4. **Section Number:** Form5_Main
   Field Name: DirectHCExpended
   Row Name: Direct Health Care Services
   Column Name: Expended
   Year: 2009
   Field Note:
   Expended amount is true expenditures.

5. **Section Number:** Form5_Main
   Field Name: EnablingBudgeted
   Row Name: Enabling Services
   Column Name: Budgeted
   Year: 2010
   Field Note:
   Budget amount is estimated.

6. **Section Number:** Form5_Main
   Field Name: EnablingBudgeted
   Row Name: Enabling Services
   Column Name: Budgeted
   Year: 2009
   Field Note:
   Budgeted amount is estimated.

7. **Section Number:** Form5_Main
   Field Name: EnablingExpended
   Row Name: Enabling Services
   Column Name: Expended
   Year: 2010
   Field Note:
   The expended is based on true expenditures.

8. **Section Number:** Form5_Main
   Field Name: EnablingExpended
   Row Name: Enabling Services
   Column Name: Expended
   Year: 2009
   Field Note:
   Expended amount is true expenditures.

9. **Section Number:** Form5_Main
   Field Name: PopBasedBudgeted
   Row Name: Population-Based Services
   Column Name: Budgeted
   Year: 2010
   Field Note:
   Budget amount is estimated.

10. **Section Number:** Form5_Main
    Field Name: PopBasedBudgeted
    Row Name: Population-Based Services
    Column Name: Budgeted
    Year: 2009
    Field Note:
    Budgeted amount is estimated.

11. **Section Number:** Form5_Main
    Field Name: PopBasedExpended
    Row Name: Population-Based Services
    Column Name: Expended
    Year: 2010
    Field Note:
    The expended is based on true expenditures.

12. **Section Number:** Form5_Main
    Field Name: InfrastrBuildBudgeted
    Row Name: Infrastructure Building Services

Column Name: Budgeted
Year: 2010
Field Note:
Budget amount is estimated.

13. **Section Number:** Form5_Main
Field Name: InfrastrBuildBudgeted
Row Name: Infrastructure Building Services
Column Name: Budgeted
Year: 2009
Field Note:
Budgeted amount is estimated.

14. **Section Number:** Form5_Main
Field Name: InfrastrBuildExpended
Row Name: Infrastructure Building Services
Column Name: Expended
Year: 2010
Field Note:
The expended is based on true expenditures.

15. **Section Number:** Form5_Main
Field Name: InfrastrBuildExpended
Row Name: Infrastructure Building Services
Column Name: Expended
Year: 2009
Field Note:
Expended amount is true expenditures.

FORM 6

NUMBER AND PERCENTAGE OF NEWBORNS AND OTHERS SCREENED, CASES CONFIRMED, AND TREATED

Sect. 506(a)(2)(B)(iii)

STATE: TN

Total Births by Occurrence: 87,141 | **Reporting Year: 2009**

Type of Screening Tests	(A) Receiving at least one Screen (1)		(B) No. of Presumptive Positive Screens	(C) No. Confirmed Cases (2)	(D) Needing Treatment that Received Treatment (3)	
	No.	%			No.	%
Phenylketonuria						
Congenital Hypothyroidism	87,141	100	316	53	53	100
Galactosemia	87,141	100	106	8	8	100
Sickle Cell Disease						
Other Screening (Specify)						
Biotinidase Deficiency	87,141	100	15	1	1	100
Congenital Adrenal Hyperplasia	87,141	100	902	4	4	100
Cystic Fibrosis	87,141	100	1,098	17	17	100
Amino Acids	87,141	100	202	8	8	100
Acylcarnitines	87,141	100	190	11	11	100
Hemoglobinopathy	87,141	100	74	59	59	100
Screening Programs for Older Children & Women (Specify Tests by name)						

(1) Use occurrent births as denominator.
(2) Report only those from resident births.
(3) Use number of confirmed cases as denominator.

FORM NOTES FOR FORM 6

For "Total Births by Occurrence":
Data Source: Tennessee Department of Health, Division of Health Statistics, Birth Statistical System

For all Newborn Screening Data:
Data Source: Tennessee Department of Health, Newborn Screening Program

Note: The state's Newborn Screening Program actually documented 87,469 unique screens in 2009. This is slightly more than the 87,141 occurrent births reported for 2009. There are two main explanations for this small discrepancy: 1) some babies are born in another state but transferred to a NICU in Tennessee where a screen might been collected; and 2) screens may be sent to the TN lab for home births that occur just across the TN state line. Both scenarios would result in additional screens that would make the number of unique screens greater than the number of occurrent births in Tennessee.

FIELD LEVEL NOTES

None

FORM 7

NUMBER OF INDIVIDUALS SERVED (UNDUPLICATED) UNDER TITLE V (BY CLASS OF INDIVIDUALS AND PERCENT OF HEALTH COVERAGE)

[Sec. 506(a)(2)(A)(i-ii)]

STATE: TN

Number of Individuals Served - Historical Data by Annual Report Year

Types of Individuals Served	2005	2006	2007	2008	2009
Pregnant Women	15,212	15,350	16,315	14,673	9,808
Infants < 1 year old	78,503	53,033	54,388	86,661	82,078
Children 1 to 22 years old	334,260	252,764	251,971	259,614	264,056
Children with Special Healthcare Needs	10,982	8,804	8,583	8,224	7,275
Others	134,328	146,704	147,430	147,911	157,433
Total	573,285	476,655	478,687	517,083	520,650

Reporting Year: 2010

	TITLE V	PRIMARY SOURCES OF COVERAGE				
Types of Individuals Served	(A) Total Served	(B) Title XIX %	(C) Title XXI %	(D) Private/Other %	(E) None %	(F) Unknown %
Pregnant Women	6,240	39.8	0.0	1.3	58.9	0.1
Infants < 1 year old	87,469	38.2	0.0	0.1	61.6	0.0
Children 1 to 22 years old	286,647	38.8	0.0	0.6	60.5	0.0
Children with Special Healthcare Needs	6,525	14.6	0.0	0.9	84.6	0.0
Others	162,963	15.8	0.4	1.0	82.8	0.4
TOTAL	549,844					

FORM NOTES FOR FORM 7

None

FIELD LEVEL NOTES

1. **Section Number:** Form7_Main
   Field Name: PregWomen_XXI
   Row Name: Pregnant Women
   Column Name: Title XXI %
   Year: 2012
   Field Note:
   Actual value reported is 0.03% (N=2) but EHB system rounds to 0.

2. **Section Number:** Form7_Main
   Field Name: Children_0_1_TS
   Row Name: Infants <1 year of age
   Column Name: Title V Total Served
   Year: 2012
   Field Note:
   The total number of infants served under Title V is at least 87,469. Newborn Screening is provided through Title V, and thefore, at least the number of infants receiving screens (87,469) receive Title V services.

   The Department of Health Patient Tracking Billing Management Information System tracks encounters for Title V services provided through local health departments. The number of infants who received these services is 55,232 (Data Source: TDOH PTBMIS). It is estimated that most of these infants would be included in the total listed above (87,469); however, some infants who receive Title V services through the health departments may have moved to Tennessee after birth and therefore would not have received a newborn screen in Tennessee. Therefore, the explanation above is that "at least" 87,469 infants were served through Title V, because the number may actually be greater.

   Note: For the row labeled "Infants <1 year old," the values listed under "primary sources of coverage" apply to the 55,232 infants who received services through the health departments; the source of coverage for the infants in the newborn screening program is not known.

3. **Section Number:** Form7_Main
   Field Name: Children_0_1_Unknown
   Row Name: Infants <1 year of age
   Column Name: Unknown %
   Year: 2012
   Field Note:
   Actual value reported is 0.02% (N=10) but EHB system rounds to 0.

4. **Section Number:** Form7_Main
   Field Name: Children_1_22_Unknown
   Row Name: Children 1 to 22 years of age
   Column Name: Unknown %
   Year: 2012
   Field Note:
   Actual value reported is 0.02% (N=70) but EHB system rounds to 0.

5. **Section Number:** Form7_Main
   Field Name: CSHCN_XXI
   Row Name: Children with Special Health Care Needs
   Column Name: Title XXI %
   Year: 2012
   Field Note:
   Actual value reported is 0.02% (N=1) but EHB system rounds to 0.

FORM 8
DELIVERIES AND INFANTS SERVED BY TITLE V AND ENTITLED TO BENEFITS UNDER TITLE XIX
(BY RACE AND ETHNICITY)
[SEC. 506(A)(2)(C-D)]
STATE: TN

Reporting Year: 2010

I. UNDUPLICATED COUNT BY RACE

	(A) Total All Races	(B) White	(C) Black or African American	(D) American Indian or Native Alaskan	(E) Asian	(F) Native Hawaiian or Other Pacific Islander	(G) More than one race reported	(H) Other and Unknown
DELIVERIES								
Total Deliveries in State	79,307	60,187	16,597	161	1,511	134		717
Title V Served	79,307	60,187	16,597	161	1,511	134		717
Eligible for Title XIX	40,683	27,706	12,282	97	381	58		159
INFANTS								
Total Infants in State	80,542	60,639	17,955					1,948
Title V Served	55,232	42,316	11,334	146	371	22	0	1,043
Eligible for Title XIX	28,849	20,072	6,405		2,372			

II. UNDUPLICATED COUNT BY ETHNICITY

				HISPANIC OR LATINO (Sub-categories by country or area of origin)				
	(A) Total NOT Hispanic or Latino	(B) Total Hispanic or Latino	(C) Ethnicity Not Reported	(B.1) Mexican	(B.2) Cuban	(B.3) Puerto Rican	(B.4) Central and South American	(B.5) Other and Unknown
DELIVERIES								
Total Deliveries in State	72,135	7,118	54	4,517	112	309		2,180
Title V Served	72,135	7,118	54	4,517	112	309		2,180
Eligible for Title XIX	36,797	3,887	16	2,465	56	163		1,203
INFANTS								
Total Infants in State	76,356	4,186						
Title V Served	49,569	5,663						
Eligible for Title XIX	28,850	0						

FORM NOTES FOR FORM 8

None

FIELD LEVEL NOTES

1. **Section Number:** Form8_I. Unduplicated Count By Race
   Field Name: DeliveriesTotal_All
   Row Name: Total Deliveries in State
   Column Name: Total All Races
   Year: 2012
   Field Note:
   Data Source: Tennessee Department of Health, Division of Health Statistics, Birth Statistical System (2010 provisional)

2. **Section Number:** Form8_I. Unduplicated Count By Race
   Field Name: DeliveriesTitleV_All
   Row Name: Title V Served
   Column Name: Total All Races
   Year: 2012
   Field Note:
   Data Source: Tennessee Department of Health, Division of Health Statistics, Birth Statistical System (2010 provisional)

   Note: The same number was used for this row as in the row above, since Title V services in Tennessee include Newborn Screening, and every baby receives a newborn screen at birth.

3. **Section Number:** Form8_I. Unduplicated Count By Race
   Field Name: DeliveriesTitleXIX_All
   Row Name: Eligible for Title XIX
   Column Name: Total All Races
   Year: 2012
   Field Note:
   Data Source: Tennessee Department of Health, Division of Health Statistics, Birth Statistical System (2010 provisional); based on mother's delivery payment source=TennCare (Medicaid).

4. **Section Number:** Form8_I. Unduplicated Count By Race
   Field Name: InfantsTotal_All
   Row Name: Total Infants in State
   Column Name: Total All Races
   Year: 2012
   Field Note:
   Tennessee Department of Health, Division of Health Statistics, Population Projections (2010)

5. **Section Number:** Form8_I. Unduplicated Count By Race
   Field Name: InfantsTitleV_All
   Row Name: Title V Served
   Column Name: Total All Races
   Year: 2012
   Field Note:
   Data Source: Tennessee Department of Health, Patient Tracking Billing Management Information System

   Note: These numbers represent infants who received a service through the Department of Health.

6. **Section Number:** Form8_I. Unduplicated Count By Race
   Field Name: InfantsTitleXIX_All
   Row Name: Eligible for Title XIX
   Column Name: Total All Races
   Year: 2012
   Field Note:
   Data source: The Current Population Survey (CPS) Annual Social and Economic Supplement Table Creator; includes infants with income-to-poverty ratio < %175; data is from the 2010 survey but survey questions regarding income ask about the previous year's income (i.e. 2009)

   Note: The actual Medicaid eligibility for infants is <185% of the federal poverty level but the value of 175% is the closest cutoff level available in the CPS report cited above. This would likely give a slight underestimate of the infants eligible for Title XIX.

7. **Section Number:** Form8_II. Unduplicated Count by Ethnicity
   Field Name: DeliveriesTotal_TotalNotHispanic
   Row Name: Total Deliveries in State
   Column Name: Total Not Hispanic or Latino
   Year: 2012
   Field Note:
   Data Source: Tennessee Department of Health, Division of Health Statistics, Birth Statistical System (2010 provisional)

8. **Section Number:** Form8_II. Unduplicated Count by Ethnicity
   Field Name: DeliveriesTitleV_TotalNotHispanic
   Row Name: Title V Served
   Column Name: Total Not Hispanic or Latino
   Year: 2012
   Field Note:
   Data Source: Tennessee Department of Health, Division of Health Statistics, Birth Statistical System (2010 provisional)

   Note: The same number was used for this row as in the row above, since Title V services in Tennessee include Newborn Screening, and every baby receives a newborn screen at birth.

9. **Section Number:** Form8_II. Unduplicated Count by Ethnicity
   Field Name: DeliveriesTitleXIX_TotalNotHispanic
   Row Name: Eligible for Title XIX
   Column Name: Total Not Hispanic or Latino
   Year: 2012
   Field Note:
   Data Source: Tennessee Department of Health, Division of Health Statistics, Birth Statistical System (2010 provisional); based on mother's delivery payment source=TennCare (Medicaid).

10. **Section Number:** Form8_II. Unduplicated Count by Ethnicity
    Field Name: InfantsTotal_TotalNotHispanic
    Row Name: Total Infants in State
    Column Name: Total Not Hispanic or Latino

Year: 2012
Field Note:
Tennessee Department of Health, Division of Health Statistics, Population Projections (2010)

Note: The state does not have population projections for subcategories of Hispanic ethnicity; therfore columns B1-B5 are blank.

11. **Section Number:** Form8_II. Unduplicated Count by Ethnicity
Field Name: InfantsTotal_TotalHispanic
Row Name: Total Infants in State
Column Name: Total Hispanic or Latino
Year: 2012
Field Note:
The state does not have population projections for subcategories of Hispanic ethnicity; therefore columns B1-B5 are blank.

12. **Section Number:** Form8_II. Unduplicated Count by Ethnicity
Field Name: InfantsTotal_Mexican
Row Name: Total Infants in State
Column Name: Mexican
Year: 2012
Field Note:
The state does not have population projections for subcategories of Hispanic ethnicity; therefore columns B1-B5 are blank.

13. **Section Number:** Form8_II. Unduplicated Count by Ethnicity
Field Name: InfantsTitleV_TotalNotHispanic
Row Name: Title V Served
Column Name: Total Not Hispanic or Latino
Year: 2012
Field Note:
Data Source: Tennessee Department of Health, Patient Tracking Billing Management Information System

Note: These numbers represent infants who received a service through the Department of Health. The system does not report subcategories of Hispanic ethnicity; therefore columns B1-B5 are blank.

14. **Section Number:** Form8_II. Unduplicated Count by Ethnicity
Field Name: InfantsTitleV_TotalHispanic
Row Name: Title V Served
Column Name: Total Hispanic or Latino
Year: 2012
Field Note:
Data Source: Tennessee Department of Health, Patient Tracking Billing Management Information System

Note: These numbers represent infants who received a service through the Department of Health. The system does not report subcategories of Hispanic ethnicity; therefore columns B1-B5 are blank.

15. **Section Number:** Form8_II. Unduplicated Count by Ethnicity
Field Name: InfantsTitleV_Mexican
Row Name: Title V Served
Column Name: Mexican
Year: 2012
Field Note:
Data Source: Tennessee Department of Health, Patient Tracking Billing Management Information System

Note: These numbers represent infants who received a service through the Department of Health. The system does not report subcategories of Hispanic ethnicity; therefore columns B1-B5 are blank.

16. **Section Number:** Form8_II. Unduplicated Count by Ethnicity
Field Name: InfantsTitleXIX_TotalNotHispanic
Row Name: Eligible for Title XIX
Column Name: Total Not Hispanic or Latino
Year: 2012
Field Note:
Data source: The Current Population Survey (CPS) Annual Social and Economic Supplement Table Creator; includes infants with income-to-poverty ratio < %175; data is from the 2010 survey but survey questions regarding income ask about the previous year's income (i.e. 2009)

Note: The actual Medicaid eligibility for infants is <185% of the federal poverty level but the value of 175% is the closest cutoff level available in the CPS report cited above. This would likely give a slight underestimate of the infants eligible for Title XIX.

Note: The CPS reported cited above is based on survey data. No infants were reported as being of Hispanic/Latino ethnicity when this report was generated at the poverty level of <175%. It is possible that the unweighted sample size of infants broken down by ethnicity and poverty level was too small to allow for an estimation for infants of Hispanic/Latino ethnicity.

FORM 9
STATE MCH TOLL-FREE TELEPHONE LINE DATA FORM (OPTIONAL)
[SECS. 505(A)(E) AND 509(A)(8)]
STATE: TN

	FY 2012	FY 2011	FY 2010	FY 2009	FY 2008
1. State MCH Toll-Free "Hotline" Telephone Number					
2. State MCH Toll-Free "Hotline" Name					
3. Name of Contact Person for State MCH "Hotline"					
4. Contact Person's Telephone Number					
5. Contact Person's Email					
6. Number of calls received on the State MCH "Hotline" this reporting period	0	0	0	0	0

FORM 9
STATE MCH TOLL-FREE TELEPHONE LINE DATA FORM
[SECS. 505(A)(E) AND 509(A)(8)]
STATE: TN

	FY 2012	FY 2011	FY 2010	FY 2009	FY 2008
1. State MCH Toll-Free "Hotline" Telephone Number	(800) 428-2229	(800) 428-2229	(800) 428-2229	(800) 428-2229	(800) 428-2229
2. State MCH Toll-Free "Hotline" Name	TN Baby Line	TN Baby Line	TN Baby Line	TN Baby Line	TN Baby Line
3. Name of Contact Person for State MCH "Hotline"	Deana Vaughn	Deana Vaughn	Deana Vaughn	Deana vaughn	Deana Vaughn
4. Contact Person's Telephone Number	(615) 741-0370	(615) 741-0307	(615) 741-0370	(615) 741-0370	(615) 741-0370
5. Contact Person's Email	Deana.vaughn@tn.gov	Deana.Vaughn@tn.org	Deana.Vaughn@tn.gov		
6. Number of calls received on the State MCH "Hotline" this reporting period	0	0	63	34	22

FORM NOTES FOR FORM 9

None

FIELD LEVEL NOTES

1. **Section Number:** Form9_Main
   Field Name: calls_2
   Row Name: Number of calls received On the State MCH Hotline This reporting period
   Column Name: FY
   Year: 2010
   Field Note:
   Calls received during state FY 2010 (July 1, 2009-June 30, 2010)

FORM 10
TITLE V MATERNAL & CHILD HEALTH SERVICES BLOCK GRANT
STATE PROFILE FOR FY 2012
[SEC. 506(A)(1)]
STATE: TN

1. State MCH Administration:
(max 2500 characters)

The Maternal and Child Health Section is housed within the Bureau of Health Services in the Tennessee Department of Health. The section includes the following programs: Adolescent Health, Asthma, Breast and Cervical Cancer Screening, Child Fatality Review, Children's Special Services (Title V CSHCN Program), Early Childhood Comprehensive Systems, Family Planning (Title X), Fetal-Infant Mortality Review, Home Visiting (including the federal Maternal, Infant, and Early Childhood Home Visiting Program), Injury Prevention, Lead Poisoning Prevention, Newborn Metabolic and Hearing Screening (including a network of genetics and sickle cell centers), Perinatal Regionalization, Teen Pregnancy Prevention, and Women's Health.

Block Grant Funds	
2. Federal Allocation (Line 1, Form 2)	$ 11,539,865
3. Unobligated balance (Line 2, Form 2)	$ 3,100,000
4. State Funds (Line 3, Form 2)	$ 13,250,000
5. Local MCH Funds (Line 4, Form 2)	$ 0
6. Other Funds (Line 5, Form 2)	$ 0
7. Program Income (Line 6, Form 2)	$ 5,550,000
8. Total Federal-State Partnership (Line 8, Form 2)	$ 33,439,865

9. Most significant providers receiving MCH funds:

Rural and Metro Health Departments
Genetics and Sickle Cell Centers
Community-Based Agencies
Teaching Hospitals

10. Individuals served by the Title V Program (Col. A, Form 7)

a. Pregnant Women	6,240
b. Infants < 1 year old	87,469
c. Children 1 to 22 years old	286,647
d. CSHCN	6,525
e. Others	162,963

11. Statewide Initiatives and Partnerships:

a. Direct Medical Care and Enabling Services:
(max 2500 characters)

Direct Medical Care: Direct services, provided statewide through health department clinics and nonprofit agencies, include pregnancy testing, family planning, nutrition services, immunizations and well child visits, EPSDT screening, follow-up and referral, and breast and cervical cancer screening. All EPSDT screenings for children in state custody are done in health department clinics. Enabling Services: These efforts include care coordination, case management, home visiting services, newborn screening follow-up, and coordination between various child- and family-serving programs. The care coordination component of Children's Special Services (Title V CSHCN Program) provides family-centered support to enable families to better meet their child's health needs. MCH nurses in the Breast and Cervical Cancer Screening Program assist patients in accessing diagnostic services and additional coverage for related treatments. Statewide home visiting services provide intensive services for pregnant women and families of infants and toddlers that emphasize education, parent support, infant stimulation, assessment and referral to assure that children are healthy, free from child abuse and ready for school. As part of the newborn metabolic and hearing screening programs, MCH nurses provide follow-up and case management for infants with presumptive positive screens.

b. Population-Based Services:
(max 2500 characters)

Child Fatality Review: Teams in 31 judicial districts review all deaths of children under age 18 and make recommendations for prevention efforts. The state child fatality review team reviews reports from the local teams, analyzes statistics of the incidence and causes of child deaths, and makes recommendations to the Governor and General Assembly to promote the safety and well being of children. Childhood Lead Poisoning Prevention Program: Staff work to identify and provide follow-up services to children with elevated blood lead levels and to educate citizens and health care providers, with the goal of preventing childhood lead poisoning. Newborn Metabolic and Hearing Screening: Every infant born in Tennessee is screened for congenital hearing loss as well as a panel of genetic and metabolic illnesses. MCH nurses provide follow-up for infants with positive screens and collaborate with a strong network of tertiary providers to ensure appropriate diagnostic and therapeutic follow-up. Both screenings are mandated by state law. Pregnancy Risk Assessment Monitoring System (PRAMS): This population-based surveillance tool provides state-specific information about maternal attitudes and preconception, prenatal, and perinatal behaviors that influence the health and well-being of mothers and children. PRAMS has been implemented in Tennessee and the 2008 report is available at http://health.state.tn.us/statistics/PdfFiles/2008%20TN%20PRAMS%20Report.pdf. Fetal-Infant Mortality Review (FIMR): FIMR was established in Tennessee in 2008. This community-based process yields valuable information about local determinants that influence maternal and infant health. As of 2011, teams are operational in three metropolitan counties and one rural region.

c. Infrastructure Building Services:
(max 2500 characters)

Regional and County Health Councils: These entities operate in all 95 counties to assess needs and gaps, develop plans, identify available resources, and implement strategies for action. Many of the targeted activities are for the MCH populations. Child Care Resource and Referral Centers: This statewide network of centers, partially funded by MCH, provides technical assistance, training, consultation, and resources to child care providers to improve the health and safety of children in child care. Each center's staff includes a child health consultant. Medical Home Work Group: This group, a subcommittee of the Early Childhood Comprehensive Systems (ECCS) program, consists of parents, health care providers, and payer representatives. The group is working to establish a common operational definition of "medical home" and to identify initiatives to support medical homes for all children in Tennessee. Standards Development: MCH staff are actively involved in development and updating of maternal and child health protocols in use by all 95 county health departments. The state MCH Director is also working with Regional MCH Directors to update the Department's Child Health Manual, which contains background information and guidelines for the care of children.

12. The primary Title V Program contact person:

Name	Michael D. Warren, MD MPH
Title	Director, Title V/Maternal and Child Health
Address	4th Floor Cordell Hull, 425 Fifth Avenue North
City	Nashville
State	TN
Zip	37243
Phone	615-741-0305
Fax	615-741-1063
Email	michael.d.warren@tn.gov
Web	

13. The children with special health care needs (CSHCN) contact person:

Name	Jacqueline Johnson, MPA
Title	Director, Children's Special Services
Address	4th Floor Cordell Hull, 425 Fifth Avenue North
City	Nashville
State	TN
Zip	37243
Phone	615-741-0361
Fax	615-741-1063
Email	jacqueline.johnson@tn.gov
Web	

FORM NOTES FOR FORM 10

None

FIELD LEVEL NOTES

None

FORM 11
TRACKING PERFORMANCE MEASURES
[SECS 485 (2)(2)(B)(III) AND 486 (A)(2)(A)(III)]
STATE: TN

Form Level Notes for Form 11

None

PERFORMANCE MEASURE # 01

The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.

Annual Objective and Performance Data

	2006	2007	2008	2009	2010
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	180	164	204	161	169
Denominator	180	164	204	161	169
Data Source			Department of Health	Department of Health	Department of Health
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2011	2012	2013	2014	2015
Annual Performance Objective	100	100	100	100	100
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #1
   Field Name: PM01
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   Data Source: Tennessee Department of Health, Newborn Screening Program

2. **Section Number:** Form11_Performance Measure #1
   Field Name: PM01
   Row Name:
   Column Name:
   Year: 2009
   Field Note:
   Data Source: Tennessee Department of Health, Newborn Screening Program

3. **Section Number:** Form11_Performance Measure #1
   Field Name: PM01
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   Data Source: Tennessee Department of Health, Newborn Screening Program

PERFORMANCE MEASURE # 02

The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)

Annual Objective and Performance Data

	2006	2007	2008	2009	2010
Annual Performance Objective	62	62	62	62	62
Annual Indicator	60.0	60.7	60.7	60.7	60.7
Numerator	3,807	3,381	136,524	136,524	136,524
Denominator	6,349	5,570	224,895	224,895	224,895
Data Source			CSHCN Survey	CSHCN Survey	CSHCN Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Final

Annual Objective and Performance Data

	2011	2012	2013	2014	2015
Annual Performance Objective	62	62	62	62	62
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #2
   Field Name: PM02
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Numerator and denominator reported here are those reported as the weighted estimates for the national survey. Data source: http://cshcndata.org

2. **Section Number:** Form11_Performance Measure #2
   Field Name: PM02
   Row Name:
   Column Name:
   Year: 2009
   Field Note:
   Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Numerator and denominator reported here are those reported as the weighted estimates for the national survey. Data source: http://cshcndata.org

3. **Section Number:** Form11_Performance Measure #2
   Field Name: PM02
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Numerator and denominator reported here are those reported as the weighted estimates for the national survey. Data source: http://cshcndata.org

PERFORMANCE MEASURE # 03

The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)

Annual Objective and Performance Data

	2006	2007	2008	2009	2010
Annual Performance Objective	63	64	65	65	65
Annual Indicator	60.7	52.7	52.7	52.7	52.7
Numerator	3,857	2,935	115,761	115,761	115,761
Denominator	6,349	5,570	219,634	219,634	219,634
Data Source			CSHCN Survey	CSHCN Survey	CSHCN Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Final

Annual Objective and Performance Data

	2011	2012	2013	2014	2015
Annual Performance Objective	55	55	60	60	60
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #3
   Field Name: PM03
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   Indicator data come from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Numerator and denominator reported here are those reported as the weighted estimates for the national survey. Data source: http://cshcndata.org

2. **Section Number:** Form11_Performance Measure #3
   Field Name: PM03
   Row Name:
   Column Name:
   Year: 2009
   Field Note:
   Indicator data come from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Numerator and denominator reported here are those reported as the weighted estimates for the national survey. Data source: http://cshcndata.org

3. **Section Number:** Form11_Performance Measure #3
   Field Name: PM03
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   Indicator data come from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Numerator and denominator reported here are those reported as the weighted estimates for the national survey. Data source: http://cshcndata.org

PERFORMANCE MEASURE # 04

The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)

Annual Objective and Performance Data

	2006	2007	2008	2009	2010
Annual Performance Objective	64	64	69	69	69
Annual Indicator	61.4	67.7	67.7	67.7	67.7
Numerator	3,897	3,771	152,224	152,224	152,224
Denominator	6,349	5,570	224,965	224,965	224,965
Data Source			CSHCN Survey	CSHCN Survey	CSHCN Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Final

Annual Objective and Performance Data

	2011	2012	2013	2014	2015
Annual Performance Objective	70	70	70	70	70
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #4
   Field Name: PM04
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Numerator and denominator reported here are those reported as the weighted estimates for the national survey. Data source: http://cshcndata.org

2. **Section Number:** Form11_Performance Measure #4
   Field Name: PM04
   Row Name:
   Column Name:
   Year: 2009
   Field Note:
   Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Numerator and denominator reported here are those reported as the weighted estimates for the national survey. Data source: http://cshcndata.org

3. **Section Number:** Form11_Performance Measure #4
   Field Name: PM04
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Numerator and denominator reported here are those reported as the weighted estimates for the national survey. Data source: http://cshcndata.org

PERFORMANCE MEASURE # 05

Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)

Annual Objective and Performance Data

	2006	2007	2008	2009	2010
Annual Performance Objective	82	82	93	93	93
Annual Indicator	80.8	91.8	91.8	91.8	91.8
Numerator	5,128	5,113	208,995	208,995	208,995
Denominator	6,349	5,570	227,739	227,739	227,739
Data Source			CSHCN Survey	CSHCN Survey	CSHCN Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Final

Annual Objective and Performance Data

	2011	2012	2013	2014	2015
Annual Performance Objective	93	93	93	93	93
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #5
   Field Name: PM05
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Numerator and denominator reported here are those reported as the weighted estimates for the national survey. Data source: http://cshcndata.org

2. **Section Number:** Form11_Performance Measure #5
   Field Name: PM05
   Row Name:
   Column Name:
   Year: 2009
   Field Note:
   Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Numerator and denominator reported here are those reported as the weighted estimates for the national survey. Data source: http://cshcndata.org

3. **Section Number:** Form11_Performance Measure #5
   Field Name: PM05
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Numerator and denominator reported here are those reported as the weighted estimates for the national survey. Data source: http://cshcndata.org

PERFORMANCE MEASURE # 06

The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.

Annual Objective and Performance Data

	2006	2007	2008	2009	2010
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	39.6	39.6	39.6
Numerator	1,561	1,534	34,477	34,477	34,477
Denominator	1,561	1,534	87,141	87,141	87,141
Data Source			CSHCN Survey	CSHCN Survey	CSHCN Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Final

Annual Objective and Performance Data

	2011	2012	2013	2014	2015
Annual Performance Objective	40	45	50	55	60
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #6
   Field Name: PM06
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Numerator and denominator reported here are those reported as the weighted estimates for the national survey. Data source: http://cshcndata.org

2. **Section Number:** Form11_Performance Measure #6
   Field Name: PM06
   Row Name:
   Column Name:
   Year: 2009
   Field Note:
   Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Numerator and denominator reported here are those reported as the weighted estimates for the national survey. Data source: http://cshcndata.org

3. **Section Number:** Form11_Performance Measure #6
   Field Name: PM06
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Numerator and denominator reported here are those reported as the weighted estimates for the national survey. Data source: http://cshcndata.org

PERFORMANCE MEASURE # 07

Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.

Annual Objective and Performance Data

	2006	2007	2008	2009	2010
Annual Performance Objective	81	83	88	88	88
Annual Indicator	86.7	86.7	83.0	83.0	77.0
Numerator	1,300	1,300	278	278	261
Denominator	1,500	1,500	335	335	339
Data Source			2008 NIS Survey	2008 NIS Survey	2009 NIS Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Final

Annual Objective and Performance Data

	2011	2012	2013	2014	2015
Annual Performance Objective	80	80	80	80	80
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #7
   Field Name: PM07
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   Data source is the final 2009 National Immunization Survey (NIS). The result for this aggregate measure (abbreviated "4:3:1:3:3" in the NIS) is significantly lower for this report because of a national shortage of Hib vaccine from December 2007 through mid-2009, which substantially reduced the number of children in this birth cohort who received 3 doses of the Hib vaccine.

2. **Section Number:** Form11_Performance Measure #7
   Field Name: PM07
   Row Name:
   Column Name:
   Year: 2009
   Field Note:
   Data source is the final 2008 NIS publication.

3. **Section Number:** Form11_Performance Measure #7
   Field Name: PM07
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   Data source is the 2008 NIS. Sample size (completing household interviews and with adequate provider data = 335) for Tennessee is small, confidence intervals are wide.

PERFORMANCE MEASURE # 08

The rate of birth (per 1,000) for teenagers aged 15 through 17 years.

Annual Objective and Performance Data

	2006	2007	2008	2009	2010
Annual Performance Objective	27	26.5	26.5	26	24
Annual Indicator	28.6	27.8	27.3	24.0	20.3
Numerator	3,392	3,361	3,328	2,955	2,531
Denominator	118,599	120,852	122,020	123,216	124,467
Data Source			Department of Health	Department of Health	Department of Health
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2011	2012	2013	2014	2015
Annual Performance Objective	20	19.5	19	18.5	18
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #8
   Field Name: PM08
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   Data Source: Tennessee Department of Health, Division of Health Statistics, Population Projections and Birth Statistical System

2. **Section Number:** Form11_Performance Measure #8
   Field Name: PM08
   Row Name:
   Column Name:
   Year: 2009
   Field Note:
   Data Source: Tennessee Department of Health, Division of Health Statistics, Population Projections and Birth Statistical System

3. **Section Number:** Form11_Performance Measure #8
   Field Name: PM08
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   Data Source: Tennessee Department of Health, Division of Health Statistics, Population Projections and Birth Statistical System

PERFORMANCE MEASURE # 09

Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

Annual Objective and Performance Data

	2006	2007	2008	2009	2010
Annual Performance Objective	23	23	24	40	40
Annual Indicator	22.3	21.8	37.2	37.2	37.2
Numerator	75,789	3,769	366	366	366
Denominator	339,485	17,256	983	983	983
Data Source			Tennessee Oral Health Survey	Tennessee Oral Health Survey	Tennessee Oral Health Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. ***(Explain data in a year note. See Guidance, Appendix IX.)***					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2011	2012	2013	2014	2015
Annual Performance Objective	40	40	40	40	40
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #9
   Field Name: PM09
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   Data Source: 2008 Tennessee Oral Health Survey of children ages 5 - 11 years.

2. **Section Number:** Form11_Performance Measure #9
   Field Name: PM09
   Row Name:
   Column Name:
   Year: 2009
   Field Note:
   Data Source: 2008 Tennessee Oral Health Survey of children ages 5 - 11 years.

3. **Section Number:** Form11_Performance Measure #9
   Field Name: PM09
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   Data Source: 2008 Tennessee Oral Health Survey of children ages 5 - 11 years.

PERFORMANCE MEASURE # 10

The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.

Annual Objective and Performance Data

	2006	2007	2008	2009	2010
Annual Performance Objective	3	2.5	2.5	2	2
Annual Indicator	5.4	3.9	3.4	2.7	1.8
Numerator	65	47	41	33	22
Denominator	1,210,629	1,194,718	1,201,009	1,207,621	1,214,522
Data Source			Department of Health	Department of Health	Department of Health
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2011	2012	2013	2014	2015
Annual Performance Objective	1.7	1.7	1.7	1.7	1.7
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #10
   Field Name: PM10
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   Data Source: Tennessee Department of Health, Divsion of Health Statistics, Population Projections and Death Statistical System

2. **Section Number:** Form11_Performance Measure #10
   Field Name: PM10
   Row Name:
   Column Name:
   Year: 2009
   Field Note:
   Data Source: Tennessee Department of Health, Divsion of Health Statistics, Population Projections and Death Statistical System

3. **Section Number:** Form11_Performance Measure #10
   Field Name: PM10
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   Data Source: Tennessee Department of Health, Divsion of Health Statistics, Population Projections and Death Statistical System

PERFORMANCE MEASURE # 11

The percent of mothers who breastfeed their infants at 6 months of age.

Annual Objective and Performance Data

	2006	2007	2008	2009	2010
Annual Performance Objective	32	34	36	30	40
Annual Indicator	28.0	31.4	37.9	37.9	35.6
Numerator	420	14,705	31,952	31,952	29,230
Denominator	1,500	46,777	84,308	84,308	82,109
Data Source			CDC/National Immunization Survey	CDC/National Immunization Survey	CDC/National Immunization Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. ***(Explain data in a year note. See Guidance, Appendix IX.)***					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2011	2012	2013	2014	2015
Annual Performance Objective	37.5	40	45	50	55
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #11
   Field Name: PM11
   Row Name:
   Column Name:
   Year: 2009
   Field Note:
   Data Source: National Immunization Survey. Per the CDC NIS, the data from the NIS are provisional for the 2007 birth cohort used in this survey until final estimates are available in August 2011. We have marked "final" for the purpose of this report.

2. **Section Number:** Form11_Performance Measure #11
   Field Name: PM11
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   Data Source: National Immunization Survey.

PERFORMANCE MEASURE # 12

Percentage of newborns who have been screened for hearing before hospital discharge.

Annual Objective and Performance Data

	2006	2007	2008	2009	2010
Annual Performance Objective	98	98	98	98	98
Annual Indicator	88.9	91.1	94.2	97.6	97.1
Numerator	80,173	83,570	85,613	85,080	82,058
Denominator	90,155	91,754	90,885	87,141	84,535
Data Source			Department of Health	Department of Health	Department of Health
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2011	2012	2013	2014	2015
Annual Performance Objective	98	99	99	99	99
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #12
   Field Name: PM12
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   Data Source: Tennessee Department of Health, Newborn Hearing Screening Program

2. **Section Number:** Form11_Performance Measure #12
   Field Name: PM12
   Row Name:
   Column Name:
   Year: 2009
   Field Note:
   Data Source: Tennessee Department of Health, Newborn Hearing Screening Program

3. **Section Number:** Form11_Performance Measure #12
   Field Name: PM12
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   Data Source: Tennessee Department of Health, Newborn Hearing Screening Program

PERFORMANCE MEASURE # 13

Percent of children without health insurance.

Annual Objective and Performance Data

	2006	2007	2008	2009	2010
Annual Performance Objective	6	6	6	6	3
Annual Indicator	6.4	6.4	4.9	3.7	3.9
Numerator	97,933	88,283	72,258	54,759	57,912
Denominator	1,530,196	1,386,911	1,474,653	1,479,972	1,484,923
Data Source			UT CBER	UT CBER	UT CBER
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2011	2012	2013	2014	2015
Annual Performance Objective	3.7	3.5	3.3	3	3
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #13
   Field Name: PM13
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   Data Source: University of Tennessee Center for Business and Economic Research (UT CBER) "The Impact of Tenn Care: A Survey of Recipients 2010. Available at: http://cber.bus.utk.edu/tncare/tncare10.pdf

2. **Section Number:** Form11_Performance Measure #13
   Field Name: PM13
   Row Name:
   Column Name:
   Year: 2009
   Field Note:
   Data Source: University of Tennessee Center for Business and Economic Research (UT CBER) "The Impact of Tenn Care: A Survey of Recipients 2009. August, 2009

3. **Section Number:** Form11_Performance Measure #13
   Field Name: PM13
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   Data source is the University of Tennessee Center for Business and Economic Research (UT CBER) "The Impact of TennCare: A Survey of Recipients August, 2009

PERFORMANCE MEASURE # 14

Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.

Annual Objective and Performance Data

	2006	2007	2008	2009	2010
Annual Performance Objective	9	9	30	14	25
Annual Indicator	24.2	34.0	14.9	15.2	15.4
Numerator	22,265	53,971	9,407	10,490	11,075
Denominator	92,164	158,733	63,134	69,015	71,914
Data Source			Department of Health	Department of Health	Department of Health
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2011	2012	2013	2014	2015
Annual Performance Objective	15	15	15	15	15
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #14
   Field Name: PM14
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   Data Source: Tennessee Department of Health, PedNSS/TN WIC Database.

2. **Section Number:** Form11_Performance Measure #14
   Field Name: PM14
   Row Name:
   Column Name:
   Year: 2009
   Field Note:
   Data Source: Tennessee Department of Health, PedNSS/TN WIC Database.

   Note: (2012 application)--The 2009 numbers reported in the 2011 application were only for a 6 month period due to CDC having problems with changes in their analytical program. The correct values were recently made available and are reported here as final.

3. **Section Number:** Form11_Performance Measure #14
   Field Name: PM14
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   Data Source: Tennessee Department of Health, PedNSS/TN WIC Database. Data is from calendar year. Variation is due to calendar year data, decrease in the total number of children within the age group of 2-5 years receiving WIC. Data categories may include children under the age of 2 years to 5 years.

PERFORMANCE MEASURE # 15

Percentage of women who smoke in the last three months of pregnancy.

Annual Objective and Performance Data

	2006	2007	2008	2009	2010
Annual Performance Objective	9.7	9	7.5	13	13
Annual Indicator	15.8	19.4	15.4	15.0	14.2
Numerator	13,288	16,774	13,138	12,257	11,252
Denominator	84,277	86,558	85,480	81,888	79,094
Data Source			Department of Health	Department of Health	Department of Health
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2011	2012	2013	2014	2015
Annual Performance Objective	13.5	13	12.5	12	12
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #15
   Field Name: PM15
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   Data Source: Tennessee Department of Health, Division of Health Statistics, Birth Statistical System

2. **Section Number:** Form11_Performance Measure #15
   Field Name: PM15
   Row Name:
   Column Name:
   Year: 2009
   Field Note:
   Data Source: Tennessee Department of Health, Division of Health Statistics, Birth Statistical System

3. **Section Number:** Form11_Performance Measure #15
   Field Name: PM15
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   Data Source: Tennessee Department of Health, Division of Health Statistics, Birth Statistical System

   Note:
   The 2007 data was never corrected as final.
   The recorded 2007 data on the form is actually provisional. (unable to correct on the form now).
   The actual 2007 final is 14059/86661 = 16.2

PERFORMANCE MEASURE # 16

The rate (per 100,000) of suicide deaths among youths aged 15 through 19.

Annual Objective and Performance Data

	2006	2007	2008	2009	2010
Annual Performance Objective	6	6	5.2	5	5
Annual Indicator	8.7	6.9	5.6	9.1	5.3
Numerator	36	29	24	39	23
Denominator	414,947	422,058	426,040	430,127	434,389
Data Source			Department of Health	Department of Health	Department of Health
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. ***(Explain data in a year note. See Guidance, Appendix IX.)***					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2011	2012	2013	2014	2015
Annual Performance Objective	5	5	5	5	5
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #16
   Field Name: PM16
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   Data Source: Tennessee Department of Health, Division of Health Statistics, Population Projections and Death Statistical System

2. **Section Number:** Form11_Performance Measure #16
   Field Name: PM16
   Row Name:
   Column Name:
   Year: 2009
   Field Note:
   Data Source: Tennessee Department of Health, Division of Health Statistics, Population Projections and Death Statistical System

3. **Section Number:** Form11_Performance Measure #16
   Field Name: PM16
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   Data Source: Tennessee Department of Health, Division of Health Statistics, Population Projections and Death Statistical System

PERFORMANCE MEASURE # 17

Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

Annual Objective and Performance Data

	2006	2007	2008	2009	2010
Annual Performance Objective	80	80	80	70	80
Annual Indicator	69.3	68.5	80.7	79.1	82.6
Numerator	1,045	1,036	1,112	1,085	1,026
Denominator	1,508	1,513	1,378	1,371	1,242
Data Source			Department of Health	Department of Health	Department of Health
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2011	2012	2013	2014	2015
Annual Performance Objective	83	83.5	84	84.5	85
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #17
   Field Name: PM17
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   Data Source: Tennessee Department of Health, Division of Health Statistics, Birth Statistical System

2. **Section Number:** Form11_Performance Measure #17
   Field Name: PM17
   Row Name:
   Column Name:
   Year: 2009
   Field Note:
   Data Source: Tennessee Department of Health, Division of Health Statistics, Birth Statistical System

3. **Section Number:** Form11_Performance Measure #17
   Field Name: PM17
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   Data Source: Tennessee Department of Health, Division of Health Statistics, Birth Statistical System

   This data reflects hospitals self designated (self/voluntary designation in TN) as birthing hospitals with level 3 nurseries. Because of improved collaboration and communication via TIPQC (Tennessee Initiative for Perinatal Quality Care), this more accurately reflects births at these centers. Previously, the facility list originated from the Joint Annual Report of Hospitals which did not keep a list of level 3 nurseries.

PERFORMANCE MEASURE # 18

Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

Annual Objective and Performance Data

	2006	2007	2008	2009	2010
Annual Performance Objective	90	90	90	70	70
Annual Indicator	62.5	63.7	67.7	69.0	70.4
Numerator	52,684	55,134	54,765	53,529	52,271
Denominator	84,277	86,558	80,887	77,565	74,220
Data Source			Department of Health	Department of Health	Department of Health
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. ***(Explain data in a year note. See Guidance, Appendix IX.)***					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2011	2012	2013	2014	2015
Annual Performance Objective	75	80	85	90	90
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #18
   Field Name: PM18
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   Data Source: Tennessee Department of Health, Division of Health Statistics, Birth Statistical System

2. **Section Number:** Form11_Performance Measure #18
   Field Name: PM18
   Row Name:
   Column Name:
   Year: 2009
   Field Note:
   Data Source: Tennessee Department of Health, Division of Health Statistics, Birth Statistical System

   Note: Data for National Performance Measure 18 varies slightly from that reported in Health Systems Capacity Indicator #05C (Form 18). The data on this form are from the Department of Health, while the data on Form 18 are reported by the Bureau of TennCare (Medicaid).

3. **Section Number:** Form11_Performance Measure #18
   Field Name: PM18
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   Data Source: Tennessee Department of Health, Division of Health Statistics, Birth Statistical System

FORM 11
TRACKING PERFORMANCE MEASURES
[SECS 485 (2)(2)(B)(III) AND 486 (A)(2)(A)(III)]
STATE: TN

Form Level Notes for Form 11

None

STATE PERFORMANCE MEASURE # 1 - REPORTING YEAR

Reduce the infant mortality rate

Annual Objective and Performance Data

	2006	2007	2008	2009	2010
Annual Performance Objective					
Annual Indicator				8.0	7.9
Numerator				655	628
Denominator				82,108	79,307
Data Source				Department of Health	Department of Health
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2011	2012	2013	2014	2015
Annual Performance Objective	7	7	7	7	7
Annual Indicator	Future year objectives for state performance measures from needs assessment period 2006-2010 are view-only. If you are continuing any of these measures in the new needs assessment period, you may establish objectives for those measures on Form 11 for the new needs assessment period.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_State Performance Measure #1
   Field Name: SM1
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   Data Source: Tennessee Department of Health, Division of Health Statistics, Birth and Death Statistical Systems

2. **Section Number:** Form11_State Performance Measure #1
   Field Name: SM1
   Row Name:
   Column Name:
   Year: 2009
   Field Note:
   Data Source: Tennessee Department of Health, Division of Health Statistics, Birth and Death Statistical Systems

STATE PERFORMANCE MEASURE # 2 - REPORTING YEAR

Reduce the percentage of obesity and overweight among Tennessee K-12 students

Annual Objective and Performance Data

	2006	2007	2008	2009	2010
Annual Performance Objective					
Annual Indicator			40.9	39.0	
Numerator			194,814	191,090	
Denominator			476,318	489,975	
Data Source			Department of Education	Department of Education	Department of Education
Is the Data Provisional or Final?				Final	

Annual Objective and Performance Data

	2011	2012	2013	2014	2015
Annual Performance Objective	25	25	25	25	25
Annual Indicator	Future year objectives for state performance measures from needs assessment period 2006-2010 are view-only. If you are continuing any of these measures in the new needs assessment period, you may establish objectives for those measures on Form 11 for the new needs assessment period.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_State Performance Measure #2
   Field Name: SM2
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   Data Source: Tennessee Department of Education, Office of Coordinated School Health.

   BMI measurements of K-12 students during the 2009-2010 and 2010-11 school year have been collected but have not yet been released; those data will be uploaded once made available from the Department of Education.

2. **Section Number:** Form11_State Performance Measure #2
   Field Name: SM2
   Row Name:
   Column Name:
   Year: 2009
   Field Note:
   Data Source: Tennessee Department of Education, Office of Coordinated School Health. Data represent BMI measurements of K-12 students during the 2008-2009 school year. Available at: http://www.tn.gov/education/schoolhealth/data_reports/doc/Executive_Summary_2008-09.pdf, page 26.

3. **Section Number:** Form11_State Performance Measure #2
   Field Name: SM2
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   Data Source: Tennessee Department of Education, Office of Coordinated School Health. Data represent BMI measurements of K-12 students during the 2007-2008 school year.

STATE PERFORMANCE MEASURE # 3 - REPORTING YEAR

Reduce smoking in Tennesseans age 13 years and older

Annual Objective and Performance Data

	2006	2007	2008	2009	2010
Annual Performance Objective					
Annual Indicator			29.6	29.6	20.3
Numerator			121,909	121,909	18,289
Denominator			411,751	411,751	89,969
Data Source			Department of Health	Department of Health	Department of Health
Is the Data Provisional or Final?				Final	Final

Annual Objective and Performance Data

	2011	2012	2013	2014	2015
Annual Performance Objective	20	19	19	18	18
Annual Indicator	Future year objectives for state performance measures from needs assessment period 2006-2010 are view-only. If you are continuing any of these measures in the new needs assessment period, you may establish objectives for those measures on Form 11 for the new needs assessment period.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_State Performance Measure #3
   Field Name: SM3
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   Data Source: Department of Health, Patient Tracking Billing Management Information System

   Data represent encounters from February 2010 to January 2011.

2. **Section Number:** Form11_State Performance Measure #3
   Field Name: SM3
   Row Name:
   Column Name:
   Year: 2009
   Field Note:
   Data Source: Department of Health, Patient Tracking Billing Management Information System

   Data listed for 2008 and 2009 were collected from 2007 through February 2010. Unable to classify further by year at this time.

3. **Section Number:** Form11_State Performance Measure #3
   Field Name: SM3
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   Data Source: Department of Health, Patient Tracking Billing Management Information System

   Data listed for 2008 and 2009 were collected from 2007 through February 2010. Unable to classify further by year at this time.

STATE PERFORMANCE MEASURE # 4 - REPORTING YEAR

Decrease asthma hospitalizations for children 0-5 years

Annual Objective and Performance Data

	2006	2007	2008	2009	2010
Annual Performance Objective					
Annual Indicator				22.0	
Numerator				1,070	
Denominator				485,318	
Data Source				Department of Health	
Is the Data Provisional or Final?				Final	

Annual Objective and Performance Data

	2011	2012	2013	2014	2015
Annual Performance Objective	20	20	20	20	18
Annual Indicator	Future year objectives for state performance measures from needs assessment period 2006-2010 are view-only. If you are continuing any of these measures in the new needs assessment period, you may establish objectives for those measures on Form 11 for the new needs assessment period.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_State Performance Measure #4
   Field Name: SM4
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   Provisional 2010 hospital discharge data are not available, therefore only 2009 hospital data are provided.

2. **Section Number:** Form11_State Performance Measure #4
   Field Name: SM4
   Row Name:
   Column Name:
   Year: 2009
   Field Note:
   Data Source: Tennessee Department of Health, Division of Health Statistics, Population Projections and Hospital Discharge Data System

STATE PERFORMANCE MEASURE # 5 - REPORTING YEAR

Improve MCH workforce capacity and competency by designing and implementing a workforce development program

Annual Objective and Performance Data

	2006	2007	2008	2009	2010
Annual Performance Objective					
Annual Indicator					
Numerator					
Denominator					
Data Source					
Is the Data Provisional or Final?					

Annual Objective and Performance Data

	2011	2012	2013	2014	2015
Annual Performance Objective	0	0	0	0	0
Annual Indicator					
Numerator					
Denominator					

Future year objectives for state performance measures from needs assessment period 2006-2010 are view-only. If you are continuing any of these measures in the new needs assessment period, you may establish objectives for those measures on Form 11 for the new needs assessment period.

Field Level Notes

1. **Section Number:** Form11_State Performance Measure #5
   Field Name: SM5
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   Data is non-numeric in nature; therefore, no numerator/denominator data is reported for this performance measure.

2. **Section Number:** Form11_State Performance Measure #5
   Field Name: SM5
   Row Name:
   Column Name:
   Year: 2009
   Field Note:
   Data is non-numeric in nature; therefore, no numerator/denominator data is reported for this performance measure.

STATE PERFORMANCE MEASURE # 6 - REPORTING YEAR

Increase the percentage of children and youth with special health care needs age 14 years and older who have formal plans for transtion to adulthood.

Annual Objective and Performance Data

	2006	2007	2008	2009	2010
Annual Performance Objective					
Annual Indicator			39.6	39.6	39.6
Numerator			34,477	34,477	34,477
Denominator			87,141	87,141	87,141
Data Source			CSHCN Survey	CSHCN Survey	CSHCN Survey
Is the Data Provisional or Final?				Final	Final

Annual Objective and Performance Data

	2011	2012	2013	2014	2015
Annual Performance Objective	45	45	45	55	55
Annual Indicator	Future year objectives for state performance measures from needs assessment period 2006-2010 are view-only. If you are continuing any of these measures in the new needs assessment period, you may establish objectives for those measures on Form 11 for the new needs assessment period.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_State Performance Measure #6
   Field Name: SM6
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Numerator and denominator reported here are those reported as the weighted estimates for the national survey. Data source: http://cshcndata.org

2. **Section Number:** Form11_State Performance Measure #6
   Field Name: SM6
   Row Name:
   Column Name:
   Year: 2009
   Field Note:
   Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Numerator and denominator reported here are those reported as the weighted estimates for the national survey. Data source: http://cshcndata.org

3. **Section Number:** Form11_State Performance Measure #6
   Field Name: SM6
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Numerator and denominator reported here are those reported as the weighted estimates for the national survey. Data source: http://cshcndata.org

STATE PERFORMANCE MEASURE # 7 - REPORTING YEAR

Reduce unintentional injury death in children and young people ages 0-24

Annual Objective and Performance Data

	2006	2007	2008	2009	2010
Annual Performance Objective					
Annual Indicator				19.0	14.4
Numerator				376	286
Denominator				1,974,006	1,988,211
Data Source				Department of Health	Department of Health
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2011	2012	2013	2014	2015
Annual Performance Objective	14	14	13.5	13.5	13
Annual Indicator	Future year objectives for state performance measures from needs assessment period 2006-2010 are view-only. If you are continuing any of these measures in the new needs assessment period, you may establish objectives for those measures on Form 11 for the new needs assessment period.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_State Performance Measure #7
   Field Name: SM7
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   Data Source: Tennessee Department of Health, Division of Health Statistics, Population Projections and Death Statistical System

2. **Section Number:** Form11_State Performance Measure #7
   Field Name: SM7
   Row Name:
   Column Name:
   Year: 2009
   Field Note:
   Data Source: Tennessee Department of Health, Division of Health Statistics, Population Projections and Death Statistical System

FORM 12
TRACKING HEALTH OUTCOME MEASURES
[SECS 505 (A)(2)(B)(III) AND 506 (A)(2)(A)(III)]
STATE: TN

Form Level Notes for Form 12

None

OUTCOME MEASURE # 01

The infant mortality rate per 1,000 live births.

Annual Objective and Performance Data

	2006	2007	2008	2009	2010
Annual Performance Objective	7.5	7.5	7.5	7.5	7.5
Annual Indicator	8.7	8.2	8.0	8.0	7.9
Numerator	729	709	686	655	628
Denominator	84,277	86,558	85,480	82,108	79,307
Data Source			Department of Health	Department of Health	Department of Health
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2011	2012	2013	2014	2015
Annual Performance Objective	7	7	7	7	7
Annual Indicator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form12_Outcome Measure 1
   Field Name: OM01
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   Data Source: Tennessee Department of Health, Division of Health Statistics, Birth and Death Statistical System

2. **Section Number:** Form12_Outcome Measure 1
   Field Name: OM01
   Row Name:
   Column Name:
   Year: 2009
   Field Note:
   Data Source: Tennessee Department of Health, Division of Health Statistics, Birth and Death Statistical System

3. **Section Number:** Form12_Outcome Measure 1
   Field Name: OM01
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   Data Source: Tennessee Department of Health, Division of Health Statistics, Birth and Death Statistical System

OUTCOME MEASURE # 02

The ratio of the black infant mortality rate to the white infant mortality rate.

Annual Objective and Performance Data

	2006	2007	2008	2009	2010
Annual Performance Objective	2.1	2.1	2.1	2.1	2.1
Annual Indicator	2.3	2.4	2.5	2.7	2.2
Numerator	16.7	16.4	15	16	14
Denominator	7.4	6.9	6.1	6	6.3
Data Source			Department of Health	Department of Health	Department of Health
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2011	2012	2013	2014	2015
Annual Performance Objective	2.1	2.1	2.1	2.1	2.1
Annual Indicator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form12_Outcome Measure 2
   Field Name: OM02
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   Data Source: Tennessee Department of Health, Division of Health Statistics, Birth and Death Statistical System

2. **Section Number:** Form12_Outcome Measure 2
   Field Name: OM02
   Row Name:
   Column Name:
   Year: 2009
   Field Note:
   Data Source: Tennessee Department of Health, Division of Health Statistics, Birth and Death Statistical System

3. **Section Number:** Form12_Outcome Measure 2
   Field Name: OM02
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   Data Source: Tennessee Department of Health, Division of Health Statistics, Birth and Death Statistical System

OUTCOME MEASURE # 03

The neonatal mortality rate per 1,000 live births.

Annual Objective and Performance Data

	2006	2007	2008	2009	2010
Annual Performance Objective	4.3	4.3	4.3	4.3	4.3
Annual Indicator	5.8	5.1	4.9	4.7	4.6
Numerator	487	440	420	390	362
Denominator	84,277	86,558	85,480	82,108	79,307
Data Source			Department of Health	Department of Health	Department of Health
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2011	2012	2013	2014	2015
Annual Performance Objective	4.3	4.3	4.3	4.3	4.3
Annual Indicator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form12_Outcome Measure 3
   Field Name: OM03
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   Data Source: Tennessee Department of Health, Division of Health Statistics, Birth and Death Statistical Systems

2. **Section Number:** Form12_Outcome Measure 3
   Field Name: OM03
   Row Name:
   Column Name:
   Year: 2009
   Field Note:
   Data Source: Tennessee Department of Health, Division of Health Statistics, Birth and Death Statistical Systems

3. **Section Number:** Form12_Outcome Measure 3
   Field Name: OM03
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   Data Source: Tennessee Department of Health, Division of Health Statistics, Birth and Death Statistical Systems

OUTCOME MEASURE # 04

The postneonatal mortality rate per 1,000 live births.

Annual Objective and Performance Data

	2006	2007	2008	2009	2010
Annual Performance Objective	2.6	2.6	2.6	2.6	2.6
Annual Indicator	2.9	3.1	3.1	3.2	3.4
Numerator	242	269	266	265	266
Denominator	84,277	86,558	85,480	82,108	79,307
Data Source			Department of Health	Department of Health	Department of Health
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2011	2012	2013	2014	2015
Annual Performance Objective	2.6	2.6	2.6	2.6	2.6
Annual Indicator					
Numerator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Denominator					

Field Level Notes

1. **Section Number:** Form12_Outcome Measure 4
   Field Name: OM04
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   Data Source: Tennessee Department of Health, Division of Health Statistics, Birth and Death Statistical Systems

2. **Section Number:** Form12_Outcome Measure 4
   Field Name: OM04
   Row Name:
   Column Name:
   Year: 2009
   Field Note:
   Data Source: Tennessee Department of Health, Division of Health Statistics, Birth and Death Statistical Systems

3. **Section Number:** Form12_Outcome Measure 4
   Field Name: OM04
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   Data Source: Tennessee Department of Health, Division of Health Statistics, Birth and Death Statistical Systems

OUTCOME MEASURE # 05

The perinatal mortality rate per 1,000 live births plus fetal deaths.

Annual Objective and Performance Data

	2006	2007	2008	2009	2010
Annual Performance Objective	8	8	8	8	8
Annual Indicator	8.7	9.9	6.9	6.8	6.5
Numerator	729	861	594	557	516
Denominator	84,277	87,076	85,759	82,364	79,552
Data Source			Department of Health	Department of Health	Department of Health
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2011	2012	2013	2014	2015
Annual Performance Objective	8	7.5	7.5	7	7
Annual Indicator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form12_Outcome Measure 5
   Field Name: OM05
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   Data Source: Tennessee Department of Health, Division of Health Statistics, Birth, Death, and Fetal Death Statistical Systems

2. **Section Number:** Form12_Outcome Measure 5
   Field Name: OM05
   Row Name:
   Column Name:
   Year: 2009
   Field Note:
   Data Source: Tennessee Department of Health, Division of Health Statistics, Birth, Death, and Fetal Death Statistical Systems

3. **Section Number:** Form12_Outcome Measure 5
   Field Name: OM05
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   Data Source: Tennessee Department of Health, Division of Health Statistics, Birth, Death, and Fetal Death Statistical Systems
   Updated methodology per Guidance:
   Numerator
   Number of fetal deaths 28 weeks or more gestation plus early neonatal deaths occurring under 7 days
   Denominator
   Live births plus fetal deaths

OUTCOME MEASURE # 06

The child death rate per 100,000 children aged 1 through 14.

Annual Objective and Performance Data

	2006	2007	2008	2009	2010
Annual Performance Objective	20	15	15	15	15
Annual Indicator	21.7	20.1	21.6	18.0	20.6
Numerator	245	224	242	203	234
Denominator	1,130,488	1,114,294	1,120,539	1,127,109	1,133,980
Data Source			Department of Health	Department of Health	Department of Health
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2011	2012	2013	2014	2015
Annual Performance Objective	15	15	15	15	15
Annual Indicator					
Numerator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Denominator					

Field Level Notes

1. **Section Number:** Form12_Outcome Measure 6
   Field Name: OM06
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   Data Source: Tennessee Department of Health, Division of Health Statistics, Population Projections and Death Statistical System

2. **Section Number:** Form12_Outcome Measure 6
   Field Name: OM06
   Row Name:
   Column Name:
   Year: 2009
   Field Note:
   Data Source: Tennessee Department of Health, Division of Health Statistics, Population Projections and Death Statistical System

3. **Section Number:** Form12_Outcome Measure 6
   Field Name: OM06
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   Data Source: Tennessee Department of Health, Division of Health Statistics, Population Projections and Death Statistical System

FORM 12
TRACKING HEALTH OUTCOME MEASURES
[SECS 505 (A)(2)(B)(III) AND 506 (A)(2)(A)(III)]
STATE: TN

Form Level Notes for Form 12

None

FORM 13
CHARACTERISTICS DOCUMENTING FAMILY PARTICIPATION IN CSHCN PROGRAMS
STATE: TN

1. Family members participate on advisory committee or task forces and are offering training, mentoring, and reimbursement, when appropriate.

3

2. Financial support (financial grants, technical assistance, travel, and child care) is offered for parent activities or parent groups.

3

3. Family members are involved in the Children with Special Health Care Needs elements of the MCH Block Grant Application process.

3

4. Family members are involved in service training of CSHCN staff and providers.

3

5. Family members hired as paid staff or consultants to the State CSHCN program (a family member is hired for his or her expertise as a family member).

0

6. Family members of diverse cultures are involved in all of the above activities.

2

Total Score: 14

Rating Key
0 = Not Met
1 = Partially Met
2 = Mostly Met
3 = Completely Met

FORM NOTES FOR FORM 13

None

FIELD LEVEL NOTES

1. **Section Number:** Form13_Main
   Field Name: Question1
   Row Name: #1. Family members participate on advisory committee or task forces...
   Column Name:
   Year: 2012
   Field Note:
   Family members serve on the CSS Advisory Committee (as outlined in Tennessee statute). Family Voices also provides family liasions for the CSS Advisory Committee and provides training through the MIND videoconference series (a partnership with Vanderbilt's LEND program). Families are also referred to Family Voices for peer to peer counseling.

2. **Section Number:** Form13_Main
   Field Name: Question2
   Row Name: #2. Financial support (...) is offered for parent activities or parent groups.
   Column Name:
   Year: 2012
   Field Note:
   Travel is reimbursed for family members when they are requested to attend meetings. For example, parents have been requested to attend meetings and present to the Advisory Committee regarding services they have received or services they may need. Family Voices parent professionals are also invited to attend and participate in the Advisory Committee meetings; meals and travel reimbursements are provided.

3. **Section Number:** Form13_Main
   Field Name: Question3
   Row Name: #3. Family members are involved in the Children with Special Health Care Needs...
   Column Name:
   Year: 2012
   Field Note:
   Family members attend the public input meetings and offer input into the Block Grant Application. This year the Block Grant was sent to Family Voices for parent and family stakeholders to review and provide comment.

4. **Section Number:** Form13_Main
   Field Name: Question4
   Row Name: #4. Family members are involved in service training of CSHCN staff and providers.
   Column Name:
   Year: 2012
   Field Note:
   Parents of children with special health care needs, including parent professionals from Family Voices have provided training for CSHCN staff through their participation and presentation at MIND videoconferences (part of Vanderbilt's LEND program). CSHCN staff have also attended conferences sponsored by Family Voices where parents and family members were presenters and panel members.

5. **Section Number:** Form13_Main
   Field Name: Question5
   Row Name: #5. Family members hired as paid staff or consultants to the State CSHCN program...
   Column Name:
   Year: 2012
   Field Note:
   Currently State budgetary constraints prevent MCH from hiring program staff or paid consultants.

6. **Section Number:** Form13_Main
   Field Name: Question6
   Row Name: #6. Family members of diverse cultures are involved in all of the above activities
   Column Name:
   Year: 2012
   Field Note:
   Family members from all cultures are invited to participate in in all of the above activities.

FORM 14
LIST OF MCH PRIORITY NEEDS

[Sec. 505(a)(5)]

STATE: TN FY: 2012

Your State's 5-year Needs Assessment should identify the need for preventive and primary care services for pregnant women, mothers, and infants; preventive and primary care services for children and services for Children with Special Health Care Needs. With each year's Block Grant application, provide a list (whether or not the priority needs change) of the top maternal and child health needs in your state. Using simple sentence or phrase ,list below your State's needs. Examples of such statements are: "To reduce the barriers to the delivery of care for pregnant women, " and "The infant mortality rate for minorities should be reduced."

MCHB will capture annually every State's top 7 to 10 priority needs in an information system for comparison, tracking, and reporting purposes; you must list at least 7 and no more than 10. Note that the numbers listed below are for computer tracking only and are not meant to indicate priority order. If your State wishes to report more than 10 priority needs, list additional priority needs in a note at the form level.

1. Reduce the infant mortality rate
2. Reduce the percentage of obesity and overweight (BMI for age/gender greater than or equal to the 85th percentile) among Tennessee K-12 students
3. Reduce smoking in Tennesseans age 13 years and older
4. Decrease asthma hospitalizations for children 0-5 years
5. Improve MCH workforce capacity and competency by designing and implementing a workforce development program
6. Increase the percentage of youth with special health care needs age 14 and older who have formal plans for transition to adulthood
7. Reduce unintentional injury deaths in children and young people ages 0-24
8.
9.
10.

FORM NOTES FOR FORM 14

None

FIELD LEVEL NOTES

None

FORM 15
TECHNICAL ASSISTANCE(TA) REQUEST

STATE: TN **APPLICATION YEAR: 2012**

No.	Category of Technical Assistance Requested	Description of Technical Assistance Requested *(max 250 characters)*	Reason(s) Why Assistance Is Needed *(max 250 characters)*	What State, Organization or Individual Would You suggest Provide the TA (if known) *(max 250 characters)*
1.	**General Systems Capacity Issues** If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here: N/A	Assistance is needed in determining the best methods to report expenditures by the four levels of the Pyramid.	A variety of methods are used by the Region IV states to provide this information. Comparability is not possible across states. Assistance requested to develop instructions for the states on compiling this information.	MCHB
2.	**State Performance Measure Issues** If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here: 6	CSS is redesigning the care coordination provided to participants. Assistance is needed in identifying best practices and training resources.	Care Coordinators need to have skills to address social/physical environments, disparities, cultural needs, self-management support, and health literacy.	MCHB (Kathy Watters); Maine (Toni Wall)
3.	**State Performance Measure Issues** If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here: 5	We need assistance in developing a workforce training plan (built on core competencies) for current MCH staff at both central office and local levels.	Our workforce has expressed the need to improve skills in communication, cultural competency, and community dimensions of practice. There are gaps in other domains as well.	East Tennessee State University LIFEPATH Program; MCHB
4.	**State Performance Measure Issues** If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here: 5	We need guidance on how to incorporate Life Course Perspective into practice and programs using current (limited) funding.	We need assistance on best methodologies to shift the current paradigm from direct service and categorical programs.	MCHB
5.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here:			
6.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here:			
7.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here:			
8.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here:			
9.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here:			
10.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the			

	measure number here: _____			
11.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here: _____			
12.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here: _____			

FORM NOTES FOR FORM 15

None

FIELD LEVEL NOTES

None

FORM 16
STATE PERFORMANCE AND OUTCOME MEASURE DETAIL SHEET
STATE: TN

SP() # 1

PERFORMANCE MEASURE:	Reduce the infant mortality rate
STATUS:	Active
GOAL	To reduce the number of infant deaths
DEFINITION	The infant mortality rate is the number of infant deaths (from birth through 364 days of age) per 1,000 live births. **Numerator:** Number of deaths to infants from birth to 364 days of age **Denominator:** Number of live births **Units:** 1000 **Text:** Rate
HEALTHY PEOPLE 2010 OBJECTIVE	16-1c The Healthy People 2010 target for infant mortality was 4.5 per 1,000 live births. Note: The Healthy People 2020 target for infant mortality (MICH-1.3) has been revised to 6.0 per 1,000 live births.
DATA SOURCES AND DATA ISSUES	Tennessee Department of Health, Division of Health Statistics, Birth and Death Statistical Systems
SIGNIFICANCE	The need is critical. Tennessee consistently ranks among the states with the highest rates of infant mortality. Of particular concern is the disparity between the black and white populations. In 2009, the infant mortality rate for births to black women was 2.67 times that of the rate for births to white women. This disparity has remained for the last two decades, even as the overall rate has declined.

SP() # 2

PERFORMANCE MEASURE:	Reduce the percentage of obesity and overweight among Tennessee K-12 students
STATUS:	Active
GOAL	Reduce childhood obesity and overweight
DEFINITION	Combined overweight and obesity is defined as BMI that is greater than or equal to the 85th percentile on CDC BMI charts for age and gender. **Numerator:** K-12 children measured with BMIs greater than or equal to the 85th percentile for age/gender **Denominator:** K-12 children measured **Units:** 100 **Text:** Percent
HEALTHY PEOPLE 2010 OBJECTIVE	HP 2010 19-3c The Healthy People 2010 target for reducing the proportion of children and adolescents who are overweight or obese was 5%. The Healthy People 2020 targets for reducing the proportion of 6-11 year olds who are obese (NWS-10.2) and the proportion of 12-19 year olds who are obese (NWS-10.3) are 15.7 and 16.1 percent, respectively.
DATA SOURCES AND DATA ISSUES	Tennessee Department of Education, Office of Coordinated School Health, Annual BMI Surveillance in Tennessee Public Schools
SIGNIFICANCE	The need is critical. In 2008, 39% of Tennessee school children were overweight or obese (BMI > 85% for age and gender on CDC growth charts). Based on the 2007 National Survey of Children's Health, Tennessee children ages 10-17 ranked 4th in the Nation for childhood obesity and overweight, putting children at risk for associated adverse health and social consequences.

SP() # 3

PERFORMANCE MEASURE:	Reduce smoking in Tennesseans age 13 years and older
STATUS:	Active
GOAL	Reduce smoking among Tennessee adolescents and adults
DEFINITION	Current cigarette use **Numerator:** Health Department patients who report not smoking in the last 30 days **Denominator:** Health Department patients who are screened for cigarette use **Units:** 100 **Text:** Percent
HEALTHY PEOPLE 2010 OBJECTIVE	27-01a The Healthy People 2010 target for cigarette use by adults was 21%. The Healthy People 2020 target for cigarette use by adults (TU-1.1) has been revised to 12%. 27-02b The Healthy People 2010 target for adolescent cigarette use (grades 9-12) was 16%. The Healthy People 2020 target for cigarette use by adolescents (TU-2.2) remains at 16%.
DATA SOURCES AND DATA ISSUES	The Department of Health maintains the PTBMIS (Patient Tracking and Billing Management System). Recorded in the system are the number of patients screened for smoking status as well as the screening response.
SIGNIFICANCE	The need is critical. Every year, 14,600 Tennessee youth under 18 years of age become daily smokers. At this rate, 28,300 Tennessee youth alive today will die an early, preventable death because of a decision made as a youngster. More than 20% of all deaths in the United States are attributable to tobacco, making tobacco use the chief preventable cause of death. We opted to include the entire 13 and over population in this measure since tobacco smoke affects health and well-being throughout the entire lifespan.

SP() # 4

PERFORMANCE MEASURE:	Decrease asthma hospitalizations for children 0-5 years
STATUS:	Active
GOAL	Decrease asthma hospitalizations for children 0-5 years.
DEFINITION	Hospitalizations are in-patient hospital stays, not including extended ED visits. **Numerator:** Number of resident asthma (ICD-9 codes 493.0 - 493.9) hospital discharges for children less than five years old. **Denominator:** Estimate of all children less than five years old in the state **Units:** 10000 **Text:** Rate
HEALTHY PEOPLE 2010 OBJECTIVE	24-2a The Healthy People 2010 target for reducing asthma hospitalizations in children 0-5 was 25 per 10,000. Note: The Healthy People 2020 target for reducing asthma hospitalizations in children 0-5 (RD-2.1) has been revised to 18.1 per 10,000.
DATA SOURCES AND DATA ISSUES	Tennessee Department of Health, Division of Health Statistics, Population Projections and Hospital Discharge Data System
SIGNIFICANCE	The need is critical. Approximately 10% of children in Tennessee suffered from asthma in 2007. Although inpatient hospitalizations have decreased since 1997, emergency department (ED) visits and charges for both inpatient and outpatient hospitalizations have increased. Younger children with asthma have more hospitalizations than older children. In addition, there are significant gender, racial, socioeconomic and geographic disparities in childhood asthma. More school days are lost due to asthma than any other chronic condition, and in Tennessee 98% of emergency treatments in schools are for asthma.

SP() # 5

PERFORMANCE MEASURE:	Improve MCH workforce capacity and competency by designing and implementing a workforce development program
STATUS:	Active
GOAL	Improve MCH workforce capacity and competency
DEFINITION	A workforce development program is defined as having regular optional and mandated courses founded on COL Public Health Core Competencies; workforce and academic linkages and input; a course/training tracking and documentation system; and a Public Health Core Competency tool for tracking and evaluation. The value of the measure for each of these is "yes/no." **Numerator:** not applicable **Denominator:** not applicable **Units:** No **Text:** Text
HEALTHY PEOPLE 2010 OBJECTIVE	23-10 (Developmental) Increase the proportion of Federal, Tribal, State, and local public health agencies that provide continuing education to develop competency in essential public health services for their employees. Healthy People 2020 Objectives PHI-1 and PHI-2 Related Healthy People 2020 objectives include: (PHI-1), Increase the proportion of Federal, Tribal, State, and local public health agencies that incorporate Core Competencies for Public Health Professionals into job descriptions and performance evaluations; and (PHI-2), Increase the proportion of Tribal, State, and local public health personnel who receive continuing education consistent with the Core Competencies for Public Health Professionals.
DATA SOURCES AND DATA ISSUES	not applicable
SIGNIFICANCE	The need is critical. Our workforce has been focused and trained on direct clinical services for many years. TDH nursing leadership has requested help in developing competencies in public health basics and leadership. MCH program directors and home visiting staff have also expressed need for additional training and mentoring in order to increase competencies in enabling services, population-based services, and infrastructure building. The Public Health Accreditation Board includes workforce competency, training and development (Domain 8) in the proposed standards. The program will be founded on the 8 COL Public Health Core Competencies.

SP() # 6

PERFORMANCE MEASURE:	Increase the percentage of children and youth with special health care needs age 14 years and older who have formal plans for transtion to adulthood.
STATUS:	Active
GOAL	Increase the percentage of CSHCN age 14 years and older who have formal plans for transtion to adulthood.
DEFINITION	Youth with special health care needs who receive the services necessary to make appropriate transitions to adult health care, work and independence. (From National Survey of Children with Special Health Care Needs, derived, ages 12-17 only) **Numerator:** Outcome successfully achieved **Denominator:** Outcome not achieved **Units:** 100 **Text:** Percent
HEALTHY PEOPLE 2010 OBJECTIVE	
DATA SOURCES AND DATA ISSUES	National Survey of Children with Special Health Care Needs, conducted by the Centers for Disease Control and Prevention's National Center for Health Statistics. Survey is not updated annually.
SIGNIFICANCE	The need is critical to provide a growing population of CSHCN with the means to transition to adult health care, independent living and work. Nearly 90% of CSHCN now survive to adulthood. Many respondents to the Family Voices Survey reported they are not having discussions with health care providers or educational staff regarding transition. Forty-eight percent (48%) reported that providers talked with them about planning for changing health care needs as the child ages, and forty-four percent (44%) reported their child's teacher discussed issues related to their child's transition to adulthood.

SP() # 7

PERFORMANCE MEASURE:	Reduce unintentional injury death in children and young people ages 0-24
STATUS:	Active
GOAL	Reduce unintentional injury death in children and young people ages 0-24
DEFINITION	Death due to any type of unintentional injury **Numerator:** Number of deaths from all unintentional injuries for children and young people ages 0-24 **Denominator:** Number of children and youth ages 0-24 in the State for the reporting period. **Units:** 100000 **Text:** Rate
HEALTHY PEOPLE 2010 OBJECTIVE	15-13 The Healthy People 2010 target for unintentional injury deaths was 17.1 per 100,000. The Healthy People 2020 target for unintentional injury deaths (IVP-11) has been revised to 36.0 per 100,000.
DATA SOURCES AND DATA ISSUES	Tennessee Department of Health, Division of Health Statistics, Population Projections and Death Statistical System.
SIGNIFICANCE	The need is critical. Injuries are the leading cause of death for U.S. and Tennessee children and young people ages 1-24, with motor vehicle injury as the number one cause for injury fatality. The rate of injury deaths in children has declined in the last 2 decades, yet rates of childhood injury deaths are greater in the US than in other developed countries. Nonfatal injuries contribute substantially to childhood morbidity, disability, and reduced quality of life; and lifetime costs are estimated to be over 50 billion dollars.

FORM NOTES FOR FORM 16

None

FIELD LEVEL NOTES

None

FORM 17
HEALTH SYSTEMS CAPACITY INDICATORS
FORMS FOR HSCI 01 THROUGH 04, 07 & 08 - MULTI-YEAR DATA
STATE: TN

Form Level Notes for Form 17

None

HEALTH SYSTEMS CAPACITY #01

The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.

	Annual Indicator Data				
	2006	**2007**	**2008**	**2009**	**2010**
Annual Indicator	28.9	29.6	26.6	22.7	
Numerator	1,366	1,188	1,074	921	
Denominator	473,085	400,744	403,306	405,883	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	

Field Level Notes

1. **Section Number:** Form17_Health Systems Capacity Indicator #01
   Field Name: HSC01
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   Provisional 2010 hospital discharge data are not available, therefore only 2009 hospital data are provided.

2. **Section Number:** Form17_Health Systems Capacity Indicator #01
   Field Name: HSC01
   Row Name:
   Column Name:
   Year: 2009
   Field Note:
   Data Source: Tennessee Department of Health, Division of Health Statistics, Population Projections and Hospital Discharge Data System

3. **Section Number:** Form17_Health Systems Capacity Indicator #01
   Field Name: HSC01
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   Data Source: Tennessee Department of Health, Division of Health Statistics, Population Projections and Hospital Discharge Data System

HEALTH SYSTEMS CAPACITY #02

The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.

	Annual Indicator Data				
	2006	**2007**	**2008**	**2009**	**2010**
Annual Indicator	62.9	83.6	71.8	80.6	82.3
Numerator	53,033	48,559	75,323	85,301	86,017
Denominator	84,277	58,058	104,882	105,887	104,457
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form17_Health Systems Capacity Indicator #02
   Field Name: HSC02
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   Data Source: Tennessee Medicaid (TennCare) Program

2. **Section Number:** Form17_Health Systems Capacity Indicator #02
   Field Name: HSC02
   Row Name:
   Column Name:
   Year: 2009
   Field Note:
   Data Source: Tennessee Medicaid (TennCare) Program

3. **Section Number:** Form17_Health Systems Capacity Indicator #02
   Field Name: HSC02
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   Data Source: Tennessee Medicaid (TennCare) Program

HEALTH SYSTEMS CAPACITY #03

The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.

	Annual Indicator Data				
	2006	**2007**	**2008**	**2009**	**2010**
Annual Indicator	0.0	0.0	100.0	100.0	61.6
Numerator	0	0	34,704	30,753	1,564
Denominator	1	1	34,704	30,753	2,541
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Final

Field Level Notes

1. **Section Number:** Form17_Health Systems Capacity Indicator #03
   Field Name: HSC03
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   Data Source: TennCare (Medicaid) Program and CoverKids (CHIP)

   The state Medicaid program (TennCare) has an eligibility category known as TennCare Standard Uninsured; this category is only available to children under age 19 whose TennCare Medicaid eligibility is ending, who do not have access to insurance through a job or a family member's job, and whose family incomes are below 200% poverty. These children are considered "CHIP children" in the TennCare II extension. The amount reported for this indicator represents the summation of figures provided by Tennessee's SCHIP program (CoverKids) as well as by the state Medicaid program (TennCare).

2. **Section Number:** Form17_Health Systems Capacity Indicator #03
   Field Name: HSC03
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   Data Source: State of Tennessee Medicaid (TennCare) Program.
   Tennessee's SCHIP program is CoverKids and these data reflect the children less than one year of age in CoverKids who have received at least one periodic screen.

HEALTH SYSTEMS CAPACITY #04

The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.

	Annual Indicator Data				
	2006	**2007**	**2008**	**2009**	**2010**
Annual Indicator	76.8	83.8	93.2	88.5	87.1
Numerator	64,738	72,498	73,270	66,927	62,585
Denominator	84,277	86,558	78,578	75,614	71,895
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form17_Health Systems Capacity Indicator #04
   Field Name: HSC04
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   Data Source: Tennessee Department of Health, Divsion of Health Statistics, Birth Statistical System

2. **Section Number:** Form17_Health Systems Capacity Indicator #04
   Field Name: HSC04
   Row Name:
   Column Name:
   Year: 2009
   Field Note:
   Data Source: Tennessee Department of Health, Divsion of Health Statistics, Birth Statistical System

   Note: Data for Health Systems Capacity Indicator #04 varies slightly from that reported in Health Systems Capacity Indicator #05D (Form 18). The data on this form are from the Department of Health, while the data on Form 18 are reported by the Bureau of TennCare (Medicaid).

3. **Section Number:** Form17_Health Systems Capacity Indicator #04
   Field Name: HSC04
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   Data Source: Tennessee Department of Health, Divsion of Health Statistics, Birth Statistical System

   2008 methodolgy per Guidance:
   Numerator
   Number of women (15-44) during the reporting years whose observed to expected prenatal visits are greater than or equal to 80% on the Kotelchuck index
   Denominator
   All women (15-44) with a live birth during the reporting year

HEALTH SYSTEMS CAPACITY #07A

Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.

	Annual Indicator Data				
	2006	**2007**	**2008**	**2009**	**2010**
Annual Indicator	100.0	45.9	92.8	82.7	83.8
Numerator	743,387	375,016	759,672	654,277	682,343
Denominator	743,387	816,486	818,194	791,343	814,718
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form17_Health Systems Capacity Indicator #07A
   Field Name: HSC07A
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   Data Source: Tennessee Medicaid (TennCare) Program

   Numerator: 2010 TennCare program children 0-20 with a paid medical service.
   Denominator: Eligible population = all TennCare members under 21 with Medicaid eligibility.

2. **Section Number:** Form17_Health Systems Capacity Indicator #07A
   Field Name: HSC07A
   Row Name:
   Column Name:
   Year: 2009
   Field Note:
   Data Source: Tennessee Medicaid (TennCare) Program
   Numerator: 2009 TennCare program children 0-20 with a paid medical service.
   Denominator: Eligible population: all TennCare members under 21 with Medicaid eligibility.

3. **Section Number:** Form17_Health Systems Capacity Indicator #07A
   Field Name: HSC07A
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   Data Source: Tennessee Medicaid (TennCare) Program
   Numerator - 2008 TennCare program medical claims for children 0-20.
   Denominator - Eligible population: all TennCare members under 21.
   There is a large difference between 2007 and 2008 due to a large increase in enrollment for children/increased claims.

HEALTH SYSTEMS CAPACITY #07B

The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.

	Annual Indicator Data				
	2006	**2007**	**2008**	**2009**	**2010**
Annual Indicator	37.0	50.6	52.6	54.0	54.8
Numerator	56,418	77,255	77,122	100,908	106,287
Denominator	152,680	152,575	146,517	186,817	193,974
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form17_Health Systems Capacity Indicator #07B
   Field Name: HSC07B
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   Data Source: Tennessee Medicaid (TennCare) EPSDT and claim system

2. **Section Number:** Form17_Health Systems Capacity Indicator #07B
   Field Name: HSC07B
   Row Name:
   Column Name:
   Year: 2009
   Field Note:
   Data Source: Tennessee Medicaid (TennCare) EPSDT and claim system

3. **Section Number:** Form17_Health Systems Capacity Indicator #07B
   Field Name: HSC07B
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   Data Source: Tennessee Medicaid (TennCare) EPSDT and claim system

HEALTH SYSTEMS CAPACITY #08

The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.

	Annual Indicator Data				
	2006	**2007**	**2008**	**2009**	**2010**
Annual Indicator	100.0	9.0	14.0	17.3	12.4
Numerator	22,392	1,962	2,838	3,676	2,675
Denominator	22,392	21,881	20,343	21,286	21,623
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Provisional	Provisional

Field Level Notes

1. **Section Number:** Form17_Health Systems Capacity Indicator #08
   Field Name: HSC08
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   Data Sources:
   Numerator--CSS (State Title V CSHSN Program) Data
   Denominator--Provided by HRSA MCHB Federal Project Officer through the Data Resource Center for Child and Adolescent Health, Child and Adolescent Health Measurement Initiative.

2. **Section Number:** Form17_Health Systems Capacity Indicator #08
   Field Name: HSC08
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   For both 2007 and 2008, the methodology and data sources were changed in response to directives received at the block grant review.

   Data sources are CSS program database and federal database of SSI recipients.

FORM 18
HEALTH SYSTEMS CAPACITY INDICATOR #05
(MEDICAID AND NON-MEDICAID COMPARISON)
STATE: TN

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
a) *Percent of low birth weight (< 2,500 grams)*	2009	Matching data files	10.9	7.3	9.2
b) *Infant deaths per 1,000 live births*	2009	Matching data files	9.8	5.9	8
c) *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*	2009	Other	59	72	65
d) *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*	2009	Other	69.2	70.6	69.9

FORM 18
HEALTH SYSTEMS CAPACITY INDICATOR #06(MEDICAID ELIGIBILITY LEVEL)
STATE: TN

INDICATOR #06 ***The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.***	**YEAR**	**PERCENT OF POVERTY LEVEL MEDICAID (Valid range: 100-300 percent)**
a) *Infants (0 to 1)*	2010	185
b) *Medicaid Children* (Age range 1 to 6) (Age range 6 to 19) (Age range _____ to _____)	2010	133 100 _____
c) *Pregnant Women*	2010	185

FORM 18
HEALTH SYSTEMS CAPACITY INDICATOR #06(SCHIP ELIGIBILITY LEVEL)
STATE: TN

INDICATOR #06 ***The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, SCHIP and pregnant women.***	**YEAR**	**PERCENT OF POVERTY LEVEL** **SCHIP**
a) *Infants (0 to 1)*	2010	250
b) *Medicaid Children* (Age range 1 to 6) (Age range 6 to 18) (Age range _____ to _____)	2010	250 250 _____
c) *Pregnant Women*	2010	250

FORM NOTES FOR FORM 18

None

FIELD LEVEL NOTES

1. **Section Number:** Form18_Indicator 06 - Medicaid
   Field Name: Med_Infant
   Row Name: Infants
   Column Name:
   Year: 2012
   Field Note:
   Data Source: Tennessee Medicaid (TennCare) website, http://www.tn.gov/tenncare/mem-categories.html. Accessed on 6/4/2011.

2. **Section Number:** Form18_Indicator 06 - Medicaid
   Field Name: Med_Children
   Row Name: Medicaid Children
   Column Name:
   Year: 2012
   Field Note:
   Data Source: Tennessee Medicaid (TennCare) website, http://www.tn.gov/tenncare/mem-categories.html. Accessed on 6/4/2011.

3. **Section Number:** Form18_Indicator 06 - Medicaid
   Field Name: Med_Women
   Row Name: Pregnant Women
   Column Name:
   Year: 2012
   Field Note:
   Data Source: Tennessee Medicaid (TennCare) website, http://www.tn.gov/tenncare/mem-categories.html. Accessed on 6/4/2011.

4. **Section Number:** Form18_Indicator 06 - SCHIP
   Field Name: SCHIP_Infant
   Row Name: Infants
   Column Name:
   Year: 2012
   Field Note:
   Data Source: Tennessee SCHIP (CoverKids) Program
   Age 0-1, eligibility for CHIP is 186-250% FPL.
   Age 1-6, eligibility for CHIP is 134-250% FPL.
   Age 6-18, eligibility for CHIP is 101-250% FPL.

5. **Section Number:** Form18_Indicator 06 - SCHIP
   Field Name: SCHIP_Children
   Row Name: SCHIP Children
   Column Name:
   Year: 2012
   Field Note:
   Data Source: Tennessee SCHIP (CoverKids) Program
   Age 0-1, eligibility for CHIP is 186-250% FPL.
   Age 1-6, eligibility for CHIP is 134-250% FPL.
   Age 6-18, eligibility for CHIP is 101-250% FPL.

6. **Section Number:** Form18_Indicator 06 - SCHIP
   Field Name: SCHIP_Women
   Row Name: Pregnant Women
   Column Name:
   Year: 2012
   Field Note:
   Data Source: Tennessee SCHIP (CoverKids) Program
   Age 0-1, eligibility for CHIP is 186-250% FPL.
   Age 1-6, eligibility for CHIP is 134-250% FPL.
   Age 6-18, eligibility for CHIP is 101-250% FPL.

7. **Section Number:** Form18_Indicator 05
   Field Name: LowBirthWeight
   Row Name: Percent of ow birth weight (<2,500 grams)
   Column Name:
   Year: 2012
   Field Note:
   Data Source: Tennessee Department of Health, Division of Health Statistics, Birth Statistical System; TennCare (Medicaid) Files.

8. **Section Number:** Form18_Indicator 05
   Field Name: InfantDeath
   Row Name: Infant deaths per 1,000 live births
   Column Name:
   Year: 2012
   Field Note:
   Data Source: Tennessee Department of Health, Division of Health Statistics, Birth Statistical System; TennCare (Medicaid) Files.

9. **Section Number:** Form18_Indicator 05
   Field Name: CareFirstTrimester
   Row Name: Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester
   Column Name:
   Year: 2012
   Field Note:
   Data Source: Tennessee Department of Health, Division of Health Statistics, Birth Statistical System; TennCare (Medicaid) Files.

   Note: Data on start of prenatal care is self reported on the birth certificate. A significant portion of women gained Medicaid eligibility after their first trimester. Data for Health Systems Capacity Indicator #05C varies slightly from that reported in National Performance Measure 18 (Form 11). The data on this form are from the Bureau of TennCare (Medicaid), while the data on Form 11 are reported by the Department of Health.

10. **Section Number:** Form18_Indicator 05
    Field Name: AdequateCare
    Row Name: Percent of pregnant women with adequate prenatal care
    Column Name:
    Year: 2012

Field Note:
Data Source: Tennessee Department of Health, Division of Health Statistics, Birth Statistical System; TennCare (Medicaid) Files.

Note: Percent of pregnant women with adequate prenatal care was determined based on self-reported number of prenatal care visits and the date of first prenatal care (using birth records and TennCare files). Data for Health Systems Capacity Indicator #05D varies slightly from that reported in Health Systems Capacity Indicator #04 (Form 17). The data on this form are from the Bureau of TennCare (Medicaid), while the data on Form 17 are reported by the Department of Health.

FORM 19
HEALTH SYSTEMS CAPACITY INDICATOR - REPORTING AND TRACKING FORM
STATE: TN

HEALTH SYSTEMS CAPACITY INDICATOR #09A (General MCH Data Capacity)
(The Ability of the State to Assure MCH Program Access to Policy and Program Relevant Informatioin)

DATABASES OR SURVEYS	Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3) *	Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)
ANNUAL DATA LINKAGES		
Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	3	Yes
Annual linkage of birth certificates and WIC eligibility files	2	Yes
Annual linkage of birth certificates and newborn screening files	3	Yes
REGISTRIES AND SURVEYS		
Hospital discharge survey for at least 90% of in-State discharges	3	Yes
Annual birth defects surveillance system	3	Yes
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

*Where:
1 = No, the MCH agency does not have this ability.
2 = Yes, the MCH agency sometimes has this ability, but not on a consistent basis.
3 = Yes, the MCH agency always has this ability.

FORM 19
HEALTH SYSTEMS CAPACITY INDICATOR - REPORTING AND TRACKING FORM
STATE: TN

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)*	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	No
Other: _____		
_____		
_____		

*Where:
1 = No
2 = Yes, the State participates but the sample size is not large enough for valid statewide estimates for this age group.
3 = Yes, the State participates and the sample size is large enough for valid statewide estimates for this age group.

Notes:

1. HEALTH SYSTEMS CAPACITY INDICATOR #09B was formerly reported as Developmental Health Status Indicator #05.

FORM NOTES FOR FORM 19

MCH has direct access to the electronic databases listed in HSCI #09A through an epidemiologist supported with SSDI funding. The epidemiologist is housed within the Department of Health's Office of Policy, Planning, and Assessment but has 50% salary support from MCH.

FIELD LEVEL NOTES

None

FORM 20
HEALTH STATUS INDICATORS #01-#05
MULTI-YEAR DATA
STATE: TN

Form Level Notes for Form 20

None

HEALTH STATUS INDICATOR #01A

The percent of live births weighing less than 2,500 grams.

Annual Indicator Data

	2006	2007	2008	2009	2010
Annual Indicator	9.6	9.4	9.2	9.2	9.0
Numerator	8,100	8,162	7,834	7,535	7,158
Denominator	84,277	86,558	85,454	82,080	79,259
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form20_Health Status Indicator #01A
   Field Name: HSI01A
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   Data Source: Tennessee Department of Health, Division of Health Statistics, Birth Statistical System

2. **Section Number:** Form20_Health Status Indicator #01A
   Field Name: HSI01A
   Row Name:
   Column Name:
   Year: 2009
   Field Note:
   Data Source: Tennessee Department of Health, Division of Health Statistics, Birth Statistical System

3. **Section Number:** Form20_Health Status Indicator #01A
   Field Name: HSI01A
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   Data Source: Tennessee Department of Health, Division of Health Statistics, Birth Statistical System

HEALTH STATUS INDICATOR #01B

The percent of live singleton births weighing less than 2,500 grams.

	Annual Indicator Data				
	2006	**2007**	**2008**	**2009**	**2010**
Annual Indicator	7.6	7.5	7.4	7.5	7.4
Numerator	6,446	6,452	6,085	5,961	5,679
Denominator	84,277	86,558	82,708	79,491	76,763
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form20_Health Status Indicator #01B
   Field Name: HSI01B
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   Data Source: Tennessee Department of Health, Division of Health Statistics, Birth Statistical System

2. **Section Number:** Form20_Health Status Indicator #01B
   Field Name: HSI01B
   Row Name:
   Column Name:
   Year: 2009
   Field Note:
   Data Source: Tennessee Department of Health, Division of Health Statistics, Birth Statistical System

3. **Section Number:** Form20_Health Status Indicator #01B
   Field Name: HSI01B
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   Data Source: Tennessee Department of Health, Division of Health Statistics, Birth Statistical System

HEALTH STATUS INDICATOR #02A

The percent of live births weighing less than 1,500 grams.

	Annual Indicator Data				
	2006	**2007**	**2008**	**2009**	**2010**
Annual Indicator	1.8	1.7	1.6	1.7	1.6
Numerator	1,508	1,513	1,378	1,371	1,242
Denominator	84,277	86,558	85,454	82,080	79,259
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form20_Health Status Indicator #02A
   Field Name: HSI02A
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   Data Source: Tennessee Department of Health, Division of Health Statistics, Birth Statistical System

2. **Section Number:** Form20_Health Status Indicator #02A
   Field Name: HSI02A
   Row Name:
   Column Name:
   Year: 2009
   Field Note:
   Data Source: Tennessee Department of Health, Division of Health Statistics, Birth Statistical System

3. **Section Number:** Form20_Health Status Indicator #02A
   Field Name: HSI02A
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   Data Source: Tennessee Department of Health, Division of Health Statistics, Birth Statistical System

HEALTH STATUS INDICATOR #02B

The percent of live singleton births weighing less than 1,500 grams.

	Annual Indicator Data				
	2006	**2007**	**2008**	**2009**	**2010**
Annual Indicator	1.4	1.3	1.3	1.3	1.2
Numerator	1,166	1,159	1,043	1,068	947
Denominator	84,277	86,558	82,708	79,491	76,763
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form20_Health Status Indicator #02B
   Field Name: HSI02B
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   Data Source: Tennessee Department of Health, Division of Health Statistics, Birth Statistical System

2. **Section Number:** Form20_Health Status Indicator #02B
   Field Name: HSI02B
   Row Name:
   Column Name:
   Year: 2009
   Field Note:
   Data Source: Tennessee Department of Health, Division of Health Statistics, Birth Statistical System

3. **Section Number:** Form20_Health Status Indicator #02B
   Field Name: HSI02B
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   Data Source: Tennessee Department of Health, Division of Health Statistics, Birth Statistical System

HEALTH STATUS INDICATOR #03A

The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.

	Annual Indicator Data				
	2006	**2007**	**2008**	**2009**	**2010**
Annual Indicator	7.0	8.0	10.2	7.9	5.9
Numerator	85	96	122	95	72
Denominator	1,210,629	1,194,718	1,201,099	1,207,621	1,214,522
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form20_Health Status Indicator #03A
   Field Name: HSI03A
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   Data Source: Tennessee Department of Health, Divsion of Health Statistics, Population Projections and Death Statistical System

2. **Section Number:** Form20_Health Status Indicator #03A
   Field Name: HSI03A
   Row Name:
   Column Name:
   Year: 2009
   Field Note:
   Data Source: Tennessee Department of Health, Divsion of Health Statistics, Population Projections and Death Statistical System

3. **Section Number:** Form20_Health Status Indicator #03A
   Field Name: HSI03A
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   Data Source: Tennessee Department of Health, Divsion of Health Statistics, Population Projections and Death Statistical System

HEALTH STATUS INDICATOR #03B

The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.

	Annual Indicator Data				
	2006	**2007**	**2008**	**2009**	**2010**
Annual Indicator	2.7	3.3	3.4	2.7	1.8
Numerator	33	39	41	33	22
Denominator	1,210,629	1,194,718	1,201,099	1,207,621	1,214,522
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form20_Health Status Indicator #03B
   Field Name: HSI03B
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   Data Source: Tennessee Department of Health, Divsion of Health Statistics, Population Projections and Death Statistical System

2. **Section Number:** Form20_Health Status Indicator #03B
   Field Name: HSI03B
   Row Name:
   Column Name:
   Year: 2009
   Field Note:
   Data Source: Tennessee Department of Health, Divsion of Health Statistics, Population Projections and Death Statistical System

3. **Section Number:** Form20_Health Status Indicator #03B
   Field Name: HSI03B
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   Data Source: Tennessee Department of Health, Divsion of Health Statistics, Population Projections and Death Statistical System

HEALTH STATUS INDICATOR #03C

The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.

	Annual Indicator Data				
	2006	**2007**	**2008**	**2009**	**2010**
Annual Indicator	20.9	30.8	29.8	24.6	18.6
Numerator	172	257	250	208	159
Denominator	821,651	833,229	839,914	846,897	854,231
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form20_Health Status Indicator #03C
   Field Name: HSI03C
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   Data Source: Tennessee Department of Health, Divsion of Health Statistics, Population Projections and Death Statistical System

2. **Section Number:** Form20_Health Status Indicator #03C
   Field Name: HSI03C
   Row Name:
   Column Name:
   Year: 2009
   Field Note:
   Data Source: Tennessee Department of Health, Divsion of Health Statistics, Population Projections and Death Statistical System

3. **Section Number:** Form20_Health Status Indicator #03C
   Field Name: HSI03C
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   Data Source: Tennessee Department of Health, Divsion of Health Statistics, Population Projections and Death Statistical System

HEALTH STATUS INDICATOR #04A

The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.

	Annual Indicator Data				
	2006	**2007**	**2008**	**2009**	**2010**
Annual Indicator	13,135.9	13,239.4	12,313.1	12,487.9	
Numerator	158,253	158,173	147,882	150,807	
Denominator	1,204,737	1,194,718	1,201,009	1,207,621	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	

Field Level Notes

1. **Section Number:** Form20_Health Status Indicator #04A
   Field Name: HSI04A
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   Provisional 2010 hospital discharge data are not available, therefore only 2009 hospital data are provided.

2. **Section Number:** Form20_Health Status Indicator #04A
   Field Name: HSI04A
   Row Name:
   Column Name:
   Year: 2009
   Field Note:
   Data Source: Tennessee Department of Health, Division of Health Statistics, Population Projections and Hospital Discharge Data System

3. **Section Number:** Form20_Health Status Indicator #04A
   Field Name: HSI04A
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   Data Source: Tennessee Department of Health, Division of Health Statistics, Population Projections and Hospital Discharge Data System

   Large adjustment to final is due to methodolgical differences in calculation from provisional.
   Actual final calculated per Guidance:
   Numerator: Number of children age 14 years and younger who have a hospital discharge for non-fatal injuries
   Denominator: Number of children age 14 years and younger in the state for the reporting period

HEALTH STATUS INDICATOR #04B

The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.

	Annual Indicator Data				
	2006	**2007**	**2008**	**2009**	**2010**
Annual Indicator	797.2	819.3	722.3	718.6	
Numerator	9,604	9,788	8,675	8,678	
Denominator	1,204,737	1,194,718	1,201,009	1,207,621	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	

Field Level Notes

1. **Section Number:** Form20_Health Status Indicator #04B
   Field Name: HSI04B
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   Provisional 2010 hospital discharge data are not available, therefore only 2009 hospital data are provided.

2. **Section Number:** Form20_Health Status Indicator #04B
   Field Name: HSI04B
   Row Name:
   Column Name:
   Year: 2009
   Field Note:
   Data Source: Tennessee Department of Health, Division of Health Statistics, Population Projections and Hospital Discharge Data System

3. **Section Number:** Form20_Health Status Indicator #04B
   Field Name: HSI04B
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   Data Source: Tennessee Department of Health, Division of Health Statistics, Population Projections and Hospital Discharge Data System

HEALTH STATUS INDICATOR #04C

The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.

	Annual Indicator Data				
	2006	**2007**	**2008**	**2009**	**2010**
Annual Indicator	3,461.5	3,472.0	3,064.8	3,028.5	
Numerator	28,239	28,930	25,742	25,648	
Denominator	815,796	833,229	839,914	846,897	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	

Field Level Notes

1. **Section Number:** Form20_Health Status Indicator #04C
   Field Name: HSI04C
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   Provisional 2010 hospital discharge data are not available, therefore only 2009 hospital data are provided.

2. **Section Number:** Form20_Health Status Indicator #04C
   Field Name: HSI04C
   Row Name:
   Column Name:
   Year: 2009
   Field Note:
   Data Source: Tennessee Department of Health, Division of Health Statistics, Population Projections and Hospital Discharge Data System

3. **Section Number:** Form20_Health Status Indicator #04C
   Field Name: HSI04C
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   Data Source: Tennessee Department of Health, Division of Health Statistics, Population Projections and Hospital Discharge Data System

HEALTH STATUS INDICATOR #05A

The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.

	Annual Indicator Data				
	2006	**2007**	**2008**	**2009**	**2010**
Annual Indicator	36.5	40.0	42.1	42.1	38.8
Numerator	7,373	8,153	8,815	8,815	8,210
Denominator	201,861	203,767	209,417	209,417	211,540
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Final

Field Level Notes

1. **Section Number:** Form20_Health Status Indicator #05A
   Field Name: HSI05A
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   Data Source: Tennessee STD Program Surveillance Morbidity Database which is the Communicable Disease Surveillance System

2. **Section Number:** Form20_Health Status Indicator #05A
   Field Name: HSI05A
   Row Name:
   Column Name:
   Year: 2009
   Field Note:
   Data Source: Tennessee STD Program Surveillance Morbidity Database which is the Communicable Disease Surveillance System

3. **Section Number:** Form20_Health Status Indicator #05A
   Field Name: HSI05A
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   Data Source: Tennessee STD Program Surveillance Morbidity Database which is the Communicable Disease Surveillance System

HEALTH STATUS INDICATOR #05B

The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.

	Annual Indicator Data				
	2006	**2007**	**2008**	**2009**	**2010**
Annual Indicator	10.1	10.4	11.8	11.8	11.4
Numerator	10,539	10,859	12,300	12,300	11,862
Denominator	1,043,888	1,041,926	1,045,578	1,044,578	1,044,145
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Final

Field Level Notes

1. **Section Number:** Form20_Health Status Indicator #05B
   Field Name: HSI05B
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   Data Source: Tennessee STD Program Surveillance Morbidity Database which is the Communicable Disease Surveillance System

2. **Section Number:** Form20_Health Status Indicator #05B
   Field Name: HSI05B
   Row Name:
   Column Name:
   Year: 2009
   Field Note:
   Data Source: Tennessee STD Program Surveillance Morbidity Database which is the Communicable Disease Surveillance System

3. **Section Number:** Form20_Health Status Indicator #05B
   Field Name: HSI05B
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   Data Source: Tennessee STD Program Surveillance Morbidity Database which is the Communicable Disease Surveillance System

FORM 21
HEALTH STATUS INDICATORS
DEMOGRAPHIC DATA
STATE: TN

HSI #06A - Demographics (Total Population) *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

For both parts A and B: Reporting Year: 2010 Is this data from a State Projection? Yes Is this data final or provisional? Final

CATEGORY TOTAL POPULATION BY RACE	Total All Races	White	Black or African American	American Indian or Native Alaskan	Asian	Native Hawaiian or Other Pacific Islander	More than one race reported	Other and Unknown
Infants 0 to 1	80,542	60,639	17,955	0	0	0	0	1,948
Children 1 through 4	327,971	247,757	71,961	0	0	0	0	8,253
Children 5 through 9	403,411	305,529	87,923	0	0	0	0	9,959
Children 10 through 14	402,598	307,650	86,021	0	0	0	0	8,927
Children 15 through 19	434,389	335,964	90,611	0	0	0	0	7,814
Children 20 through 24	419,842	329,123	81,963	0	0	0	0	8,756
Children 0 through 24	2,068,753	1,586,662	436,434	0	0	0	0	45,657

HSI #06B - Demographics (Total Population) *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and ethnicity. (Demographics)*

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	Total NOT Hispanic or Latino	Total Hispanic or Latino	Ethnicity Not Reported
Infants 0 to 1	76,356	4,186	0
Children 1 through 4	309,551	18,420	0
Children 5 through 9	380,541	22,870	0
Children 10 through 14	382,086	20,512	0
Children 15 through 19	417,852	16,537	0
Children 20 through 24	402,287	17,555	0
Children 0 through 24	1,968,673	100,080	0

FORM 21
HEALTH STATUS INDICATORS
DEMOGRAPHIC DATA
STATE: TN

HSI #07A - Demographics (Total live births) *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

For both parts A and B: Reporting Year: 2010 Is this data from a State Projection? No Is this data final or provisional? Provisional

CATEGORY TOTAL LIVE BIRTHS BY RACE	Total All Races	White	Black or African American	American Indian or Native Alaskan	Asian	Native Hawaiian or Other Pacific Islander	More than one race reported	Other and Unknown
Women < 15	116	51	63	0	0	0	0	2
Women 15 through 17	2,531	1,642	860	6	6	0	0	17
Women 18 through 19	6,706	4,592	2,021	18	21	9	0	45
Women 20 through 34	61,551	47,263	12,310	125	1,186	111	0	556
Women 35 or older	8,376	6,639	1,343	12	298	14	0	70
Women of all ages	79,280	60,187	16,597	161	1,511	134	0	690

HSI #07B - Demographics (Total live births) *Live births to women (of all ages) enumerated by maternal age and ethnicity. (Demographics)*

CATEGORY TOTAL LIVE BIRTHS BY HISPANIC ETHNICITY	Total NOT Hispanic or Latino	Total Hispanic or Latino	Ethnicity Not Reported
Women < 15	106	10	0
Women 15 through 17	2,270	260	1
Women 18 through 19	6,181	521	4
Women 20 through 34	55,982	5,539	30
Women 35 or older	7,574	788	14
Women of all ages	72,113	7,118	49

FORM 21
HEALTH STATUS INDICATORS
DEMOGRAPHIC DATA
STATE: TN

HSI #08A - Demographics (Total deaths) *Deaths of Infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

For both parts A and B: Reporting Year: 2010 Is this data from a State Projection? No Is this data final or provisional? Provisional

CATEGORY TOTAL DEATHS BY RACE	Total All Races	White	Black or African American	American Indian or Native Alaskan	Asian	Native Hawaiian or Other Pacific Islander	More than one race reported	Other and Unknown
Infants 0 to 1	628	381	232	0	0	5	0	10
Children 1 through 4	104	68	30	1	1	1	0	3
Children 5 through 9	54	41	13	0	0	0	0	0
Children 10 through 14	76	48	25	0	0	3	0	0
Children 15 through 19	246	177	63	1	0	5	0	0
Children 20 through 24	474	365	101	1	1	3	0	3
Children 0 through 24	1,582	1,080	464	3	2	17	0	16

HSI #08B - Demographics (Total deaths) *Deaths of Infants and children aged 0 through 24 years enumerated by age subgroup and ethnicity. (Demographics)*

CATEGORY TOTAL DEATHS BY HISPANIC ETHNICITY	Total NOT Hispanic or Latino	Total Hispanic or Latino	Ethnicity Not Reported
Infants 0 to 1	589	38	1
Children 1 through 4	97	7	0
Children 5 through 9	51	3	0
Children 10 through 14	75	1	0
Children 15 through 19	237	9	0
Children 20 through 24	457	17	0
Children 0 through 24	1,506	75	1

FORM 21
HEALTH STATUS INDICATORS
DEMOGRAPHIC DATA
STATE: TN

HSI #09A - Demographics (Miscellaneous Data) *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

Is this data final or provisional? Provisional

CATEGORY Miscellaneous Data BY RACE	Total All Races	White	Black or African American	American Indian or Native Alaskan	Asian	Native Hawaiian or Other Pacific Islander	More than one race reported	Other and Unknown	Specific Reporting Year
All children 0 through 19	1,648,911	1,257,539	354,471	0	0	0	0	36,901	2010
Percent in household headed by single parent	27.5	23.3	47.4	0.0	0.0	0.0	0.0	3.1	2010
Percent in TANF (Grant) families	7.0	3.8	19.0	0.0	0.0	0.0	0.0	2.4	2010
Number enrolled in Medicaid	689,051	377,328	223,287	1,008	8	8,089	0	79,331	2010
Number enrolled in SCHIP	87,644	54,513	13,731	113	976	688	0	17,623	2010
Number living in foster home care	4,070	2,713	996	9	10	5	157	180	2010
Number enrolled in food stamp program	534,351	337,063	190,108	909	4,275	590	1,406	0	2010
Number enrolled in WIC	207,903	151,555	54,985	40	1,323	0	0	0	2010
Rate (per 100,000) of juvenile crime arrests	2,159.0	1,366.0	5,071.0	0.0	0.0	0.0	0.0	1,027.0	2009
Percentage of high school drop-outs (grade 9 through 12)	3.3	2.4	5.4	2.8	1.3	1.5	0.0	12.4	2009

HSI #09B - Demographics (Miscellaneous Data) *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by ethnicity.(Demographics)*

CATEGORY Miscellaneous Data BY HISPANIC ETHNICITY	Total NOT Hispanic or Latino	Total Hispanic or Latino	Ethnicity Not Reported	Specific Reporting Year
All children 0 through 19	1,566,386	82,525	0	2010
Percent in household headed by single parent	26.8	36.2	0.0	2010
Percent in TANF (Grant) families	7.2	5.0	0.0	2010
Number enrolled in Medicaid	632,895	56,153	3	2010
Number enrolled in SCHIP	26,050	5,206	56,388	2010
Number living in foster home care	3,563	224	283	2010
Number enrolled in food stamp program	497,928	36,421	0	2010
Number enrolled in WIC	177,774	30,129	0	2010
Rate (per 100,000) of juvenile crime arrests	2,163.0	1,251.0	0.0	2009
Percentage of high school drop-outs (grade 9 through 12)	2.4	2.8	0.0	2009

FORM 21
HEALTH STATUS INDICATORS
DEMOGRAPHIC DATA
STATE: TN

HSI #10 - Demographics (Geographic Living Area) *Geographic living area for all resident children aged 0 through 19 years old. (Demographics)*

Reporting Year: 2010 Is this data from a State Projection? Yes Is this data final or provisional? Final

GEOGRAPHIC LIVING AREAS	TOTAL
Living in metropolitan areas	1,137,749
Living in urban areas	1,053,654
Living in rural areas	595,257
Living in frontier areas	0
Total - all children 0 through 19	1,648,911

Note:
The Total will be determined by adding reported numbers for urban, rural and frontier areas.

FORM 21
HEALTH STATUS INDICATORS
DEMOGRAPHIC DATA
STATE: TN

HSI #11 - Demographics (Poverty Levels) *Percent of the State population at various levels of the federal poverty level. (Demographics)*

Reporting Year: 2010 Is this data from a State Projection? No Is this data final or provisional? Final

POVERTY LEVELS	TOTAL
Total Population	6,239,752.0
Percent Below: 50% of poverty	5.2
100% of poverty	16.5
200% of poverty	38.6

FORM 21
HEALTH STATUS INDICATORS
DEMOGRAPHIC DATA
STATE: TN

HSI #12 - Demographics (Poverty Levels) *Percent of the State population aged 0 through 19 at various levels of the federal poverty level. (Demographics)*

Reporting Year: 2010 Is this data from a State Projection? No Is this data final or provisional? Final

POVERTY LEVELS	TOTAL
Children 0 through 19 years old	1,615,968.0
Percent Below: 50% of poverty	7.1
100% of poverty	23.5
200% of poverty	45.8

FORM NOTES FOR FORM 21

None

FIELD LEVEL NOTES

1. **Section Number:** Form21_Indicator 06A
   Field Name: S06_Race_Infants
   Row Name: Infants 0 to 1
   Column Name:
   Year: 2012
   Field Note:
   Data Source for all fields in HSI #06A: Tennessee Department of Health, Division of Health Statistics, Population Projections

2. **Section Number:** Form21_Indicator 06B
   Field Name: S06_Ethnicity_Infants
   Row Name: Infants 0 to 1
   Column Name:
   Year: 2012
   Field Note:
   Data Source for all fields in HSI #06B: Tennessee Department of Health, Division of Health Statistics, Population Projections

3. **Section Number:** Form21_Indicator 07A
   Field Name: Race_Women15
   Row Name: Women < 15
   Column Name:
   Year: 2012
   Field Note:
   Data Source for all fields in HSI #07A: Tennessee Department of Health, Division of Health Statistics, Birth Statistical System

4. **Section Number:** Form21_Indicator 07B
   Field Name: Ethnicity_Women15
   Row Name: Women < 15
   Column Name:
   Year: 2012
   Field Note:
   Data Source for all fields in HSI #07B: Tennessee Department of Health, Division of Health Statistics, Birth Statistical System

5. **Section Number:** Form21_Indicator 08A
   Field Name: S08_Race_Infants
   Row Name: Infants 0 to 1
   Column Name:
   Year: 2012
   Field Note:
   Data Source for all fields in HSI #08A: Tennessee Department of Health, Division of Health Statistics, Death Statistical System

6. **Section Number:** Form21_Indicator 08B
   Field Name: S08_Ethnicity_Infants
   Row Name: Infants 0 to 1
   Column Name:
   Year: 2012
   Field Note:
   Data Source for all fields in HSI #08B: Tennessee Department of Health, Division of Health Statistics, Death Statistical System

7. **Section Number:** Form21_Indicator 09A
   Field Name: HSIRace_Children
   Row Name: All children 0 through 19
   Column Name:
   Year: 2012
   Field Note:
   Data Source: Tennessee Department of Health, Division of Health Statistics, Population Projections

8. **Section Number:** Form21_Indicator 09A
   Field Name: HSIRace_SingleParentPercent
   Row Name: Percent in household headed by single parent
   Column Name:
   Year: 2012
   Field Note:
   Data Source: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement (table creator accessed at http://www.census.gov/hhes/www/cpstc/cps_table_creator.html)

9. **Section Number:** Form21_Indicator 09A
   Field Name: HSIRace_TANFPercent
   Row Name: Percent in TANF (Grant) families
   Column Name:
   Year: 2012
   Field Note:
   Data Source: Tennessee Department of Human Services

10. **Section Number:** Form21_Indicator 09A
    Field Name: HSIRace_MedicaidNo
    Row Name: Number enrolled in Medicaid
    Column Name:
    Year: 2012
    Field Note:
    Data Source: Tennessee Medicaid (TennCare) data effective as of September 2010.

11. **Section Number:** Form21_Indicator 09A
    Field Name: HSIRace_SCHIPNo
    Row Name: Number enrolled in SCHIP
    Column Name:
    Year: 2012
    Field Note:
    Data Source: Tennessee SCHIP (CoverKids) Program and Tennessee Medicaid (TennCare)

    Note: The state Medicaid program (TennCare) has an eligibility category known as TennCare Standard Uninsured; this category is only available to children under age 19

whose TennCare Medicaid eligibility is ending, who do not have access to insurance through a job or a family member's job, and whose family incomes are below 200% poverty. These children are considered "CHIP children" in the TennCare II extension. The amount reported for this indicator represents the summation of figures provided by Tennessee's SCHIP program (CoverKids) as well as by the state Medicaid program (TennCare).

In this case, 59,372 children were enrolled in CoverKids and 28,272 children were enrolled in TennCare Standard Uninsured, for a total of 87,644.

12. **Section Number:** Form21_Indicator 09A
Field Name: HSIRace_FoodStampNo
Row Name: Number enrolled in food stamp program
Column Name:
Year: 2012
Field Note:
Data Source: Tennessee Department of Human Services

13. **Section Number:** Form21_Indicator 09A
Field Name: HSIRace_WICNo
Row Name: Number enrolled in WIC
Column Name:
Year: 2012
Field Note:
Data Source: TN Department of Health, Nutrition and Wellness Section, WIC Program.

14. **Section Number:** Form21_Indicator 09A
Field Name: HSIRace_JuvenileCrimeRate
Row Name: Rate (per 100,000) of juvenile crime arrests
Column Name:
Year: 2012
Field Note:
Data Source: TBI Tennessee Crime Statistics Online (accessed 4/21/2011 at http://www.tbi.state.tn.us/tn_crime_stats/crime_stats_online.shtml) and Tennessee Department of Health, Division of Health Statistics, Population Projections
The 2009 data presented here are different than the 2009 data from last year's grant submission. The data provided last year came from a Tennessee Bureau of Investigation (TBI) report entitled 'Crime in Tennessee 2009' that was published in May of 2010. TBI has not yet published a similar report for 2010. However, they do have an online database that can be used to generate crime statistics. This database is continually updated, even after a report such as the one cited above is published. As a result, even though 2010 data has not yet been added to the database, the 2009 data that is available is more up-to-date than that published in the report and used in last year's grant submission. The updated 2009 data is provided here. It should also be noted that by using the online database we were able to restrict the data to TN residents (the published report made no such distinctions) and analyze the data by ethnicity (the published report did not include data by ethnicity).

15. **Section Number:** Form21_Indicator 09A
Field Name: HSIRace_DropOutPercent
Row Name: Percentage of high school drop-outs (grade 9 through 12)
Column Name:
Year: 2012
Field Note:
Data Source: Tennessee Department of Education

16. **Section Number:** Form21_Indicator 09B
Field Name: HSIEthnicity_Children
Row Name: All children 0 through 19
Column Name:
Year: 2012
Field Note:
Data Source: Tennessee Department of Health, Division of Health Statistics, Population Projections

17. **Section Number:** Form21_Indicator 09B
Field Name: HSIEthnicity_SingleParentPercent
Row Name: Percent in household headed by single parent
Column Name:
Year: 2012
Field Note:
Data Source: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement (table creator accessed at http://www.census.gov/hhes/www/cpstc/cps_table_creator.html)

18. **Section Number:** Form21_Indicator 09B
Field Name: HSIEthnicity_TANFPercent
Row Name: Percent in TANF (Grant) families
Column Name:
Year: 2012
Field Note:
Data Source: Tennessee Department of Human Services

19. **Section Number:** Form21_Indicator 09B
Field Name: HSIEthnicity_MedicaidNo
Row Name: Number enrolled in Medicaid
Column Name:
Year: 2012
Field Note:
Data Source: Tennessee Medicaid (TennCare) data effective as of September 2010.

20. **Section Number:** Form21_Indicator 09B
Field Name: HSIEthnicity_SCHIPNo
Row Name: Number enrolled in SCHIP
Column Name:
Year: 2012
Field Note:
Data Source: Tennessee SCHIP (CoverKids) Program and Tennessee Medicaid (TennCare)

Note: The state Medicaid program (TennCare) has an eligibility category known as TennCare Standard Uninsured; this category is only available to children under age 19 whose TennCare Medicaid eligibility is ending, who do not have access to insurance through a job or a family member's job, and whose family incomes are below 200% poverty. These children are considered "CHIP children" in the TennCare II extension. The amount reported for this indicator represents the summation of figures provided by Tennessee's SCHIP program (CoverKids) as well as by the state Medicaid program (TennCare).

In this case, 59,372 children were enrolled in CoverKids and 28,272 children were enrolled in TennCare Standard Uninsured, for a total of 87,644.

21. **Section Number:** Form21_Indicator 09B
Field Name: HSIEthnicity_FoodStampNo

Row Name: Number enrolled in food stamp program
Column Name:
Year: 2012
Field Note:
Data Source: Tennessee Department of Human Services

22. **Section Number:** Form21_Indicator 09B
Field Name: HSIEthnicity_WICNo
Row Name: Number enrolled in WIC
Column Name:
Year: 2012
Field Note:
Data Source: TN Department of Health, Nutrition and Wellness Section, WIC Program.

23. **Section Number:** Form21_Indicator 09B
Field Name: HSIEthnicity_JuvenileCrimeRate
Row Name: Rate (per 100,000) of juvenile crime arrests
Column Name:
Year: 2012
Field Note:
Data Source: TBI Tennessee Crime Statistics Online (accessed 4/21/2011 at http://www.tbi.state.tn.us/tn_crime_stats/crime_stats_online.shtml) and Tennessee Department of Health, Division of Health Statistics, Population Projections

Numerator: Number of juvenile arrests for group A (violent) and group B (nonviolent) offenses in 2009; restricted to residents. Data source: TBI Tennessee Crime Statistics Online. Other/unknown race = Asian, Native American and unknown race. Juvenile is defined as <18 years old (TBI does not provide crime data on 0-19 years age group).

Denominator: Population of persons <18 years old in 2009. Data source: Health Statistics population projections. Other/unknown race = non-white/black. Population projections for other/unknown ethnicity unavailable; therefore, could not calculate arrest rate for this group.

The 2009 data presented here are different than the 2009 data from last year's grant submission. The data provided last year came from a Tennessee Bureau of Investigation (TBI) report entitled 'Crime in Tennessee 2009' that was published in May of 2010. TBI has not yet published a similar report for 2010. However, they do have an online database that can be used to generate crime statistics. This database is continually updated, even after a report such as the one cited above is published. As a result, even though 2010 data has not yet been added to the database, the 2009 data that is available is more up-to-date than that published in the report and used in last year's grant submission. The updated 2009 data is provided here. It should also be noted that by using the online database we were able to restrict the data to TN residents (the published report made no such distinctions) and analyze the data by ethnicity (the published report did not include data by ethnicity).

24. **Section Number:** Form21_Indicator 09B
Field Name: HSIEthnicity_DropOutPercent
Row Name: Percentage of high school drop-outs (grade 9 through 12)
Column Name:
Year: 2012
Field Note:
Data Source: Tennessee Department of Education

25. **Section Number:** Form21_Indicator 10
Field Name: Metropolitan
Row Name: Living in metropolitan areas
Column Name:
Year: 2012
Field Note:
Data Sources: Tennessee Department of Health, Division of Health Statistics, Population Projections and 2000 U.S. Census. Note: urban and metropolitan areas overlap; total children 0-19 equals the sum of children living in urban and rural areas. Counts were determined by multiplying 2010 population projections by the percentage of TN children in metro/urban/rural areas from the 2000 U.S. Census

26. **Section Number:** Form21_Indicator 11
Field Name: S11_total
Row Name: Total Population
Column Name:
Year: 2012
Field Note:
Data Source: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement (table creator accessed at http://www.census.gov/hhes/www/cpstc/cps_table_creator.html)

27. **Section Number:** Form21_Indicator 12
Field Name: S12_Children
Row Name: Children 0 through 19 years old
Column Name:
Year: 2012
Field Note:
Data Source: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement (table creator accessed at http://www.census.gov/hhes/www/cpstc/cps_table_creator.html)

28. **Section Number:** Form21_Indicator 09A
Field Name: HSIRace_FosterCare
Row Name: Number living in foster home care
Column Name:
Year: 2012
Field Note:
Data Source: Tennessee Department of Children's Services. Includes number of children living in foster home care and medically fragile foster home care.

29. **Section Number:** Form21_Indicator 09B
Field Name: HSIEthnicity_FosterCare
Row Name: Number living in foster home care
Column Name:
Year: 2012
Field Note:
Data Source: Tennessee Department of Children's Services. Includes number of children living in foster home care and medically fragile foster home care.