Maternal and Child Health Services Title V Block Grant

State Narrative for Tennessee

Application for 2013
Annual Report for 2011

Document Generation Date: Wednesday, September 05, 2012

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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, 4th 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 January 2012; expires January 31, 2015.

E. Public Input

PUBLIC INPUT ON 2013 APPLICATION AND MCH PROGRAMS
Historically, public hearings have been conducted as part of the MCH Block Grant public input process. Prior to 2011, the public hearings had been combined with public hearings for the WIC State Plan. Attendance was generally very low and typically consisted of mostly health department staff. Even in 2012, when special effort was made to increase promotion of the MCH Block Grant hearings, attendance remained low. In contrast, visits by MCH staff to local and regional health departments in 2012 proved to be incredibly informative. For public input prior to the 2013 application, MCH leadership decided to repeat these visits in addition to soliciting input through a web-based survey. Details of both follow.

Jacqueline Johnson (CSS Director) visited Jefferson and Knox counties (a rural and Metro county in East Tennessee, respectively); Mary Jane Dewey (MCH Program Director) visited the Putnam County Health Department in Cookeville, TN (a rural county); and Dr. Michael Warren (Title V/MCH Director) visited the West TN Regional Health Office in Jackson, TN (meeting a mix of metro and rural staff). At each visit, MCH staff met informally with regional or local staff and/or families who were in the health department to access one or more MCH-related services.

Ms. Johnson made home visits in Jefferson and Knox Counties with a local CSS Care Coordinator. During the visits, she conducted informal, voluntary interviews about MCH services. Families were extremely pleased with services they were receiving through the CSS program. They reported that CSS staff provided flexibility in scheduling appointments, assisted with coverage of necessary expenses, and advocated for the child and family with insurance companies. One caregiver even reported that her care coordinator brought the family a bucket of cleaning supplies at the last visit. Families reported challenges with obtaining and maintaining insurance coverage, being able to pay high deductibles, and obtaining appropriate dental care. Families identified several opportunities for improvement, including increasing the eligibility

thresholds for CSS and working to maintain consistent staffing for local programs.

Ms. Johnson noted that the families with which she visited seemed to be thriving despite challenging social circumstances. One of the children in the program was being featured in a local art exhibit. Families were extremely grateful for the services received through CSS and several remarked that if it were not for this program and TennCare her child would not get the services they need; one mother remarked that her child would "probably be dead" without the services she gets from CSS and TennCare. Families were also concerned about what might happen if they lost CSS program benefits.

In Putnam County, Mrs. Dewey visited with patients and families in the health department waiting room. Most were there for periodic WIC visits to supplement their household food resources. As one mother stated, "with milk at almost $4.00 a gallon, every little bit helps." Another mother, there for WIC services had recently delivered her third child and was breastfeeding. The range of reasons for other appointments included vasectomy scheduling to collection of county death certificates for Overton County residents who died in Putnam County. Putnam County continues to serve a large immigrant population from Spanish speaking countries and Africa due to the industry in the region and Tennessee Tech where degrees in engineering, agri-science and computer science are strong degree programs. Additional observations included: while most children had health insurance through Medicaid, none of the adults interviewed had health insurance; families with jobs may not be able to afford employer-sponsored insurance because of cost; families are generally very satisfied with the services they receive through the health department; and some people are still unaware of the breadth of services offered at the health department.

During her visit in Putnam County, Mrs. Dewey noticed a distribution table to give food for the weekend to eligible children on the school system's backpack program. This program represents a dynamic community intervention project whereby school counselors refer food insecure children to the Second Harvest Food Bank. An interdenominational group of churches contribute food products and financial resources to provide non-perishable food items for six weekend meals. During the school year, these backpacks are distributed at school. For the summer months, church members volunteer to distribute food from the county health department and other community sites for enrolled children making this a year round community support service.

In Jackson, Dr. Warren met with staff from the West TN Regional Office as well as those who work in rural West TN counties. Staff reported a number of initiatives that were going well: meetings between regional health department staff and coordinated school health staff; flexibility in protocols (standing orders for injectable contraception, deferred pelvic exam for family planning startup, etc); and patients are generally satisfied with the service they receive. They cited unmet needs as including: availability of physicians or advanced practice nurses in all locations to do family planning procedures; some difficulty in getting referrals from schools (for family planning or services for CSHCN); availability of sufficient breast and cervical cancer screening services in counties with rates of both diseases; and transportation for patients. Staff noted several trends that are important to monitor: increasing incidence of use of "bath salts" and other synthetic drugs; need for staff training for how to deal with children with difficult behaviors; rise in bullying and link to suicides; and need for training and awareness on providing care for LGBTQ populations.

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 representative of Family Voices also provided content edits to the narrative for the CSHCN performance measures.

The draft application was posted on the Department of Health website for one month prior to submission (see Attachment). Last year, stakeholders who reviewed the application noted that it

would be helpful for them to have a guide to direct to sections in which they might have particular interest (rather than having to read the whole application). In response to this need, MCH staff developed a "Quick Reference Guide" which accompanied the draft (see Attachment). The Guide served as a cross-reference for various topics and allowed for rapid location of sections of interest to particular stakeholders.

A draft of the application was also distributed via email to stakeholders who interact throughout the year in some capacity with MCH staff and programs. Stakeholders included: local, regional, and state health department staff; university partners; community partners; families and family advocacy organizations; other child- and family-serving state agencies; and health care providers.

A link to an electronic survey was posted on the website and was included in the email to stakeholders; reviewers were asked to submit comments about the draft (along with any other thoughts or comments about MCH programs) via the survey. A summary of the comments received via this mechanism is included as an attachment to this section.

MECHANISM FOR ONGOING FEEDBACK
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. The electronic survey will continue to be available throughout the year and reviewed on at least a quarterly basis by MCH leadership.

Central Office MCH staff seek input throughout the year from representatives of local and regional health departments, and by extension, their clients and communities. Regional MCH Directors are convened via conference call monthly. On each call, a specific program is highlighted and regional staff have the opportunity to provide candid feedback on program operations and opportunities for improvement. Each region also has the opportunity to give an update on region-specific issues and share strategies they are using to address local needs and priorities. Additionally, Central Office program staff have been asked to visit each of the Department's 13 regions at least once every two years to visit directly with front-line program staff. The visits are separate from required monitoring visits, and are aimed to provide opportunities for Central Office staff to see firsthand the unique needs of Tennessee communities and to understand how state-level staff can best support front-line staff.

Feedback on specific MCH program areas is also obtained throughout the year via advisory committee meetings. These include the Genetics Advisory Committee (focused on newborn screening), Perinatal Advisory Committee (focused on perinatal health and the regionalization system), and the Children's Special Services Advisory Committee (focused on the Title V CSHCN program). Committee members are appointed by the Department of Health Commissioner and provide topic-specific expertise to the respective committees. In addition, these meetings are subject to the State's Open Meetings Law and are open for attendance by members of the general public.

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

II. Needs Assessment

In application year 2013, Section IIC will be used to provide updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

NEEDS ASSESSMENT SUMMARY

STATE PRIORITIES

The Needs Assessment for this Block Grant cycle was completed in 2010. 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 priorities 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 among Tennesseans.
4. Decrease unnecessary health care utilization associated with asthma.
5. Improve MCH workforce capacity and competency.
6. Increase transition services available to children with special health care needs.
7. Reduce unintentional injury deaths in children and young people ages 0-24 years.

CHANGES IN POPULATION STRENGTHS/NEEDS SINCE LAST APPLICATION

Tennessee has experienced some economic improvement since the submission of the 2010 Needs Assessment. State revenue collections increased 9.8% from 2010 to 2011, and thus far in 2012 collections are 3.4% greater than those in 2011. Unemployment rates have also improved. The most recently published rate of 7.7% in April 2012 (down from a recent high of 10.5% in 2009). State employees have received salary increases in the last two years; a 1.6% increase in 2011 and a 2.5% increase in 2012.

A major recent trend in Tennessee's MCH population relates to sleep-related infant deaths. While the number of Sudden Infant Death Syndrome (SIDS) cases have steadily declined over the last decade, other sleep-related infant deaths (suffocation, entrapment, strangulation), have concomitantly increased. This trend was identified through Tennessee's robust Child Fatality Review process, which reviews over 99% of all deaths of children under 18.

In 2010, 131 infants succumbed to non-SIDS sleep-related deaths, accounting for 20% of all

infant deaths during the same year. The contribution of sleep-related deaths to the state's high infant mortality rate is notable; elimination of these 131 deaths would lower Tennessee's infant mortality rate (43rd in the nation) to the national average. Over the past year, Central Office staff, with input from local and regional staff as well as various community partners and members of the general public, have developed a statewide campaign to promote safe sleep practices. The campaign includes print materials, media placements, and tools for integrating safe sleep promotion into MCH programs.

Since the last Needs Assessment, and particularly since the last application, Tennessee has seen an influx in federal funding for MCH programs. A combination of formula and competitive funding has resulted in over $9 million annually being available between 2012 and 2015 to support expansion of evidence-based home visiting services and infrastructure. This investment represents a unique opportunity to align early childhood services and expand home visiting services as a strategy to improve the health and well-being of MCH populations. Tennessee has also been awarded a State Implementation Grant for Systems of Services for CSHCN; this funding will support the core performance measures related to CSHCN as well as the state performance measure related to transition.

CHANGES IN STATE MCH PROGRAM/SYSTEM CAPACITY SINCE LAST APPLICATION

Several staff were hired during the implementation of the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program in Tennessee in 2011. The Administrator of Early Childhood Initiatives oversees the implementation of the MIECHV project, in the context of other early childhood initiatives. The Administrator also coordinates the Early Childhood Comprehensive Systems (ECCS) initiative. A Program Director coordinates the six community-based home visiting projects, providing operational support and technical assistance to community grantees. An MCH Epidemiologist has overseen the design of the data collection system to capture various benchmark constructs and is coordinating data entry, analysis, and reporting.

A Nurse Consultant was recruited in 2011 to oversee special initiatives in the MCH section. She provides leadership for special projects and technical assistance to various program initiatives. Currently she is coordinating implantation of critical congenital heart disease (CCHD) screening and is overseeing the transition to a web-based newborn screening case management system.

With the start of State Fiscal Year 2011-12, the MCH section absorbed the infant mortality and women's health functions of the former Governor's Office of Children's Care Coordination (GOCCC). The GOCCC previously administered legislatively-appropriated funds aimed at improving women's health and reducing infant mortality. Funded projects include the Tennessee Initiative for Perinatal Quality Care (TIPQC), a statewide perinatal quality collaborative; the Tennessee Intervention for Pregnant Smokers (TIPS), aimed at reducing smoking among pregnant women in East Tennessee; Fetal Infant Mortality Review (FIMR) in four areas with high infant mortality rates; and Centering Pregnancy (group prenatal care) demonstration projects in several areas.

A major change since the last application has been reorganization within the Department of Health that resulted in the merging of the Maternal and Child Health section with the Nutrition and Wellness section. Nutrition and Wellness housed a variety of programs, including: WIC, Commodities Supplemental Food Program, and CDC-funded chronic disease initiatives including: Arthritis, Diabetes, Heart Disease/Stroke, Obesity, Rape and Violence Prevention, and Tobacco. The merge of the two sections resulted in a new Division, the Division of Family Health and Wellness. The merge has resulted in expanded opportunities for collaboration on important MCH topics (such as breastfeeding) as well as integration of programs across the life course perspective (particularly with the addition of the chronic disease initiatives).

ACTIVITIES TO OPERATIONALIZE NEEDS ASSESSMENT

In an ongoing effort to break down silos and integrate strategies to address priorities across programs, MCH program managers have mapped key program activities to various state priorities. Through this exercise, programs have identified strategies for integrating one or more of the seven state priorities into their program activities. As an example, Children's Special Services (CSS) staff are developing strategies to implement obesity reduction strategies among participants in the state's Title V CSHCN program.

In the newly-organized Division of Family Health and Wellness, monthly topic-based meetings have been instituted in place of the typical "business-oriented" monthly staff meetings. Each month, staff present on a theme related to various MCH priority or life course topics. A brief overview presentation is followed by sharing of related activities by various programs (both internal and external to the Department). Staff then break into small groups to answer focused questions about the topic before reconvening as a large group to identify common themes and next steps for action. The topic schedule, meeting format, and a sample presentation are attached to this section.

ONGOING ACTIVITIES TO GATHER INFORMATION

As part of the public input process for this application, a survey was developed to identify strengths/opportunities related to MCH populations. Respondents were asked about specific needs across populations and opportunities for improving existing services. The survey will be maintained on the MCH website and reviewed on an ongoing basis by MCH leadership. A summary of survey results to date is attached to Section I-E (Public Input).

State MCH staff seek feedback on a regular basis from regional and county-level MCH staff. Through monthly conference calls with Regional MCH Directors, Central Office leadership learn about regional trends and learn about programming issues that inform state-level policy development. Central Office staff also regularly visit the 13 regional offices, along with local health departments, to learn about local issues, provide technical assistance, and elicit feedback on program operations.

MCH staff in the Central Office have worked with Department leadership on the development of county health assessment modules. Central Office staff work with local health department staff to complete modules on areas of local interest; the modules guide local partners in obtaining and understanding relevant data and developing strategies to address data findings. To date, these modules have been completed in 93 of 95 counties. Two modules (infant mortality rate and child death rate) relate to the MCH population.

An attachment is included in this section. IIC - Needs Assessment Summary

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. ***/2013/ Organizationally, Title V services in Tennessee are coordinated centrally by the Department of Health's Division of Family Health and Wellness. The Central Office provides programmatic guidance and technical assistance. Direct services are generally carried out at the local level (in health departments in all 95 counties). //2013//***

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 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 impacted 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). 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.

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%). 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%).

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. Some improvement has been noted over the past year, with April 2011 employment rates being reported at 9.6%. ***/2013/In May 2012, the Tennessee unemployment rate was reported at 7.9%.//2013//***

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. Tennessee's ranking improved to 42nd in 2010. ***/2013/Tennessee achieved its highest ranking in recent years (39th) in 2011.//2013//***

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. ***/2013/The adolescent pregnancy rate has decreased by 35% from 2001 (15.3) to 2010 (10.0). The adolescent pregnancy rate among Black adolescents (17.9) remains more than twice as high as that of White adolescents (8.3). In 2010, 10.3 percent of babies were born at low birth weight. This percentage is higher for Black babies (12.9%) compared to White babies (8.8%).//2013//***

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. 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). ***/2013/Tennessee's infant mortality rate has continued to decline over the past few years. In 2010, the infant mortality rate was 7.9 per 1,000 live births. Disparities between Black and White populations remain, with Black infants dying at a rate more than double that of White infants (13.8 vs. 6.3, respectively).//2013//***

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. In February 2011, TennCare reported 694,107 enrollees age 0-18. ***/2013/As of March 2012, 688,734 children age 0-18 were enrolled in TennCare.//2013//***

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. ***/2013/According to the 2008 PRAMS survey, 19.7% of Tennessee mothers report smoking during pregnancy.//2013//***

MCH PRIORITY POPULATIONS

The MCH priority populations for county health services are low income, medically underserved women, children and adolescents. 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 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 Act. This law, enforced by the TDH, makes it illegal to smoke in most places where people work (http://health.tn.gov/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.tn.gov/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).

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 (CSH) 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. ***/2013/From the 2007-2008 through 2010-2011 school years, CSH Coordinators have secured over 50 million in grants and in-kind services to expand capacity for schools to address school health concerns.//2013//***

Tennessee law requires all public schools to include 90 minutes of physical education per week during school hours from kindergarten through 12th grade. According to the Tennessee School Health Screening Guidelines, students in grades PreK, K, 2, 4, 6 and 8 are screened annually for vision and hearing. Students in grades K, 2, 4, 6 and 8 and one year of high school (usually Lifetime Wellness class) are screened annually for blood pressure and Body Mass Index (BMI) in addition to vision and hearing. School staffs are encouraged to screen students for oral health problems and screen 6th grade students for scoliosis. 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.

/2013/ During the 2010-2011 school year, 1,520,245 health screenings occurred in Tennessee schools. Approximately 48% of all LEAs provided scoliosis screening and 47% of all LEAs provided some type of dental screening. Of all Tennessee students who were required to receive a hearing and vision screening, 97% received one in 2010-2011. Also, 76% of all students who were required to receive a BMI screen received one and 71% received a blood pressure screen. In addition, 92% of all students who were required to receive a school health screening received one during the 2010-2011 school year. The percentage of all school health screenings increased by 7% from 2008-2009 to 2010-2011. The most significant increases occurred with hearing screenings (16%), BMI screenings (16%) and blood pressure screenings (11%). Decreases occurred in the percentage of students screened for scoliosis (-25%) and vision (-6%).

During the 2010-2011 school year, 225,914 student referrals were made to a Health Care Provider after a school health screening. Most referrals were a result of BMI screenings (36%), dental screenings (34%) and vision screenings (17.5%). The total number of students referred to healthcare providers increased 325% between 2006-2007 and 2010-2011. The most significant increase in referrals from 2006-2007 to 2010-2011 were for BMI (1,035%), blood pressure (679%) and dental (384%).//2013//

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. ***/2013/Project BASIC is now in 38 primarily rural sites across the state.//2013//***

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. ***/2013/ The Division of Family Health and Wellness is involved with several infant and child behavioral health projects funded by TDMHDD including: the Team TN-CSEFEL project; the Early Connections Network targeting a five county area for improved services for families with young children using a public health model; and the Infant Mental Health Initiative, a volunteer group focused on developing a system of care for very young children to address issues before school entry.//2013//***

/2013/The Office of Coordinated School Health secured and implemented the Schools and Mental Health Systems Integration grant from the U.S. Department of Education At the conclusion of the implementation period of the grant, Mental Health Team Leaders from each school district were given an on-line survey to share progress on specific goals and overall outcomes (N=112). Ninety-three percent (93%) of all school systems reported their school district either had a policy/guideline approved by their local education agency (LEA) or in the process of approval. This represents 77% of all school districts in Tennessee (N=134). Also, 91% re-ported their school district either had linkages with child serving agencies in the community either approved or in the approval process. This represents 74% of all school districts in Tennessee (N=134). Finally, 94% of those responding school systems reported they have either trained or are in the process of training their school staff to make appropriate referrals to mental health services. This represents 77% of all school districts in Tennessee (N=134).

While developing infrastructure was a stated goal of this program, other benefits have been realized. Eighty-six percent (86%) of school systems responding to the survey report that communication improved between school staff and in-school mental health providers. Likewise, 85% of school systems affirm that communication in-creased between school staff and community mental health providers. Seventy-one percent (71%) of school systems believe that communication improved between school staff and DCS staff and 62% stated communication had improved between school staff and local Juvenile Justice staff. Also, 92% of school systems report their mental health team plans to continue to meet after the grant period concludes.//2013//

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. ***/2013/As of March 2012, there were 1,206,538 enrollees in TennCare.//2013//***

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%). ***/2013//The 2011 HEDIS report showed that cervical cancer screening has improved to 67.3%, and Chlamydia screening has improved to 57.2%. Both screening percentages are higher than the national Medicaid average.//2013//***

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. 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 $55,000 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. CoverTN suspended enrollment December 1, 2009.

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. 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. HealthyTNBabies provides pre-natal visits, delivery and 60-days post partum care. 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 cannot 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.

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 screening rates across the state. Full time coordinators and part time lay workers in the Community Outreach section conduct home visits and participate in community based activities such as health fairs and school health programs for TennCare enrollees to provide information about the importance of EPSDT benefits. In 2005 a centralized telephone call center was established in TENNderCare with 14 additional full time staff responsible for delivering an educational message about the importance of EPSDT/well child benefits to parents and guardians of TennCare enrollees. The Call Center also makes EPSDT appointments for TennCare enrollees with a primary care provider or a health department and arranges transportation for the member. In 2006 the program was expanded to add a second shift and 13 full time positions to the Call Center. A Nursing Call Center was added at that time with three full time positions to make phone calls to pregnant women enrolled in TennCare. An educational message is provided to the pregnant women to promote the importance of prenatal care and share information about resources available to them.

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 protect, promote and improve the health and prosperity of people in Tennessee.

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 high-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 also protects health 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. 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. (http://tn.gov/finance/healthplanning/Documents/HealthcareReportCard.pdf) This report, for the first time, provides information on these two conditions at county and regional levels within Tennessee.

/2013/ Diabetes Prevention and Control Program
According to the Centers for Disease Control and Prevention (CDC), the current rate for diabetes in Tennessee is 11.3%. The Diabetes Prevention and Control Program (DPCP) and its partners are in the early phases of implementing core interventions and strategies currently recommended by the CDC, Division of Diabetes Translation (DDT). This includes (1) promoting health communication campaigns that contribute to improving the quality of care of persons with and at risk for diabetes (National Diabetes Education Program's "Know your diabetes ABC's" campaign targeting diabetes patients receiving health care services); (2) promoting coalition initiatives that contribute to improving the quality of clinical care of persons with and at risk for diabetes (development of diabetes coalition in the Northeast Region of Tennessee in collaboration with Wellmont Health Systems); and (3) expanding access to Stanford University's Chronic Disease Self-Management Program/Diabetes Self-Management Program for persons with diabetes. The implementation of these evidence-based strategies and interventions has the potential to greatly reduce the economic burden of diabetes in the State of Tennessee.

Health Educators employed by the State of Tennessee are being trained as Leaders in Stanford University's Chronic Disease Self-Management (CDSM) and Diabetes Self-Management (DSM) programs. The CDSM and DSM programs are evidence-based and are being offered to primary care patients at the local health department who are identified as having one or more chronic illnesses. To measure effectiveness, pre and post surveys are being conducted; these include qualitative data from participants as well as clinical data such as A1C, blood pressure, cholesterol, and body mass index (BMI).

Project Diabetes is a statewide initiative focusing on innovative education and prevention for diabetes and obesity. Through this initiative, the Department of Health awards multiple contracts with fundamental goals to:

-Decrease the prevalence of overweight/obesity across the State and, in turn, prevent or delay the onset of Type 2 diabetes and/or the consequences of this devastating disease.
-Educate the public about current and emerging health issues linked to diabetes and obesity.
-Promote community public-private partnerships to identify and solve regional health problems related to obesity and diabetes.
-Advise and recommend policies and programs that support individual and community health improvement efforts.
-Evaluate effectiveness of improvement efforts/programs that address overweight, obesity, pre-diabetes, and diabetes.
-Disseminate best practices for diabetes prevention and health improvement.

Other chronic disease management efforts include health educators partnering with community health clinics and primary care sites to increase opportunities for blood pressure screenings through clinic services and community health fairs. The heart disease and stroke prevention program is focused on hypertension awareness and increasing or improving screening techniques and educational awareness.//2013//

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 ***/2013/ The Resource Map of Expenditures for Tennessee Children, Tennessee Commission on Children and Youth, 2011 Annual Report is available at http://www.tn.gov/tccy/MAP-rpt11.pdf.//2013//***

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." 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".

/2013/ The 2012 Resource Map Report is available at: http://www.tn.gov/tccy/MAP-rpt12.pdf. According to the report, 25 state agencies served over 16,341,899 children in FY10-11, with expenditures of $8,953,178,695. Additionally, "excluding the BEP, three of every four dollars spent on services for children and families in Tennessee in FY 2011 were from federal funding sources. State funding accounted for 23 percent of all non-BEP expenditures in FY 2011. Almost nine of every 10 dollars in the state budget for children, 89 percent in FY 2011, were either federal or required as match/maintenance of effort for federal funding."//2013//

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
Utilizing the aforementioned prioritization process, the following state priorities were identified:

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 among Tennesseans.
4. Decrease unnecessary health care utilization associated with asthma.
5. Improve MCH workforce capacity and competency.
6. Increase transition services available to children with special health care needs.
7. Reduce unintentional injury deaths in children and young people ages 0-24 years.

B. Agency Capacity

The Tennessee Department of Health (TDH) is well-equipped to promote and protect the health of all mothers and children, including CSHCN. 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
The Tennessee Department of Health's mission is to promote, protect, and improve the health and prosperity of people in Tennessee. The agency accomplishes this through provision of core public health services. Public health services are evolving into gap filling functions providing direct services to those who do not have public or private insurance and into population based,

infrastructure and enabling services that support an integrated health care system to meet citizen needs. Services are provided in all 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, TDH 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.

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).

/2013/As of Spring 2012, the Department of Health reported 3037 employees working in both rural and metropolitan settings across the state.//2013//

STATEWIDE SYSTEM OF SERVICES
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.

Home Visiting Services
The Department offers home visiting services in all 95 counties across the state. Home-based services offered by MCH include HUGS, (Help Us Grow Successfully) CHAD, (Child Health and Development program), Healthy Start, and Nurse Family Partnership. ***/2013/HUGS is funded by Medicaid as a targeted case management program. State funds support the Nurse Family Partnership, and interdepartmental funds (from the Department of Children's Services) support the Healthy Start and CHAD programs. In summer 2012, six community sites began offering new evidence-based home visiting services with funding from the Affordable Care Act's Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program. Programs serve five of the counties identified as most at risk in the 2010 MIECHV statewide needs assessment. An additional program serves military families in Montgomery County, home of the Fort Campbell Army installation.//2013//*** 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.

/2013/-Organization of home visiting services into a continuum of services offered across the state, organized by level of intensity and reach.//2013//

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

TDH 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 54 local health department sites. Fifteen of the 54 local health department clinic sites are designated as federally-funded, 330 health centers.

Clinical services delivered at TDH 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 a 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.

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.

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). ***/2013/In 2011, twenty-three FQHCs, including health department FHQC sites, provided primary and prenatal care for more than 328,000 unduplicated patients in 114 sites across the state (UDS Report, Department of US Health and Human Services.)//2013//***

TDH 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. 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. ***/2013/In 2011-12, $10.2 million was again appropriated for Safety Net funding.//2013//***

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)

/2013/As of May 2012:
-5 counties have no dentist (Grundy, Moore, Pickett, Lake, and Van Buren counties)
-5 counties have ratios of >10,000 residents/dentist (Bledsoe, Marshall, Macon, Meigs, McNairy)
//2013//

The Bureau of Health Services Administration, Community Health Systems division, regularly monitors direct primary care service delivery capacity. ***/2013/In January 2012, the division was reorganized and is now known as the Community Health Systems Section of the Division of Health Disparities.//2013//*** 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. There were approximately 206 NHSC loan repayment recipients practicing in Tennessee as of 12/31/2010 (State Office of Primary Care, March 2011). ***/2013/ In 2011, one hundred and one (101) health care professionals received NHSC support, including 20 Physicians, 12 Dentists, 36 advanced practice nurses, and 18 mental health providers, among other licensed health professionals. There were approximately 209 NHSC scholar and loan repayment recipients practicing at designated NHSC sites in Tennessee as of 6/30/2011.//2013//***

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).

/2013/ Tennessee Rural Health Loan Forgiveness Program - provides student enrolled in postsecondary institution with School of Medicine, Dentistry, Osteopathy, physician assistant, or nurse practitioner programs a $12,000 stipend per academic year in exchange for a payback obligation in an area designated as health resource shortage area by the Tennessee Department of Health.//2013//

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. ***/2013/There were approximately 57 physicians practicing under the J-1 Visa Waiver program as of June 30, 2011.//2013//***

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) - ***/2013/Implemented in late 2009,//2013//*** 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). ***/2013/ There were approximately ten (10) physicians, dentists and mid-level providers practicing in Tennessee under this program, with applications for another 17 eligible practitioners pending final approval as of 5/1/12.//2013//***

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.

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 TDH participants. We have provided a letter of support, citing TDH 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." The Legislature has subsequently 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.

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. ***/2013/ Twenty-two percent (1359) of the 6059 CSS enrollees have SSI.//2013//***

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 managed care organizations' (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

/2013/Numerous health disparities are present among Tennessee's population. To address MCH-related health disparities, Tennessee's Title V program has partnered with the University of Tennessee at Knoxville (UTK), a HRSA-MCHB grant recipient, to provide cultural competency training. Over an 18-month span beginning in March 2012, selected Department of Health staff in all 13 regions will participate in the half-day training provided by UTK. The workshop takes an in-depth look at individual cultural competence. It is specifically designed to increase awareness, knowledge, and skills in dealing with clients, patients, and co-workers whose world view is different from one's self. The emphasis is on the health-related professions.//2013//

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. 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). 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.

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.

Numerous other initiatives are underway to improve education in Tennessee. 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 TDH workforce by 5% (with only 10 days for transition and succession planning) in addition to the average existing TDH 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 TDH 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).

TDH salaries are not competitive (e.g., annual TDH 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. The FY2011-12 budget passed by the legislature in May 2011 included a 1.6% raise for state employees. ***/2013/The FY2012-13 budget passed by the legislature in May 2012 included a 2.5% raise for state employees.//2013//***

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).

TDH does not have an electronic health record (EHR). 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.

/2013/Since the arrival of the Department's new Commissioner and Chief Medical Officer, there has been renewed interest in implementation of a Department-wide electronic health

record. Current efforts include a review of possible EHR systems and strategies for integrating various siloed and proprietary data systems into an integrated system that can be used across the Department.//2013//

Despite the funding challenges associated with technology, there are some recent opportunities that may support further development in this area. 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, link to other web sites to get comprehensive information on vaccines, and learn about vaccination strategies or obtain 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. 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.

C. Organizational Structure

Tennessee's MCH and CSHCN programs are housed in the Tennessee Department of Health. The Department, part of the Executive branch of state government, is led by a Commissioner who is appointed by the Governor. Governor Bill Haslam was inaugurated in January 2011 as the 49th Governor of Tennessee. ***/2013/In September 2011, Governor Haslam appointed Dr. John Dreyzehner as Commissioner of the Department of Health. Dr. Dreyzehner previously served as director of the Cumberland Plateau Health District in Southwest Virginia. During his nine years in that role, he also spent two years serving as acting director of the Lenowisco Health District. Dr. Dreyzehner began his medical career as a United States Air Force flight surgeon, and prior to returning to public service with the Virginia Department of Health, he practiced occupational medicine as director of the Blue Ridge Occupational Health Clinic in Lebanon, Va.***

Dr. Dreyzehner subsequently appointed Dr. David Reagan as Chief Medical Officer for the Department in January 2012. Dr. Reagan previously served as chief of staff for the Veterans Affairs Medical Center in Mountain Home, Tennessee and associate dean for veterans affairs and clinical professor of medicine in the Department of Internal Medicine at James H. Quillen College of Medicine at East Tennessee State University. He completed an internal medicine residency at Vanderbilt and a fellowship in clinical epidemiology and infectious diseases at the University of Iowa Hospitals and Clinics in Iowa City.//2013//

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. ***/2013/The Department is organized into nine divisions and eight offices. The Divisions are: Policy, Planning and Assessment; Health***

Disparities; Community Health Services; Family Health and Wellness; Communicable Environmental Disease and Emergency Preparedness; Health Licensure and Regulation; Laboratory Services; Administrative Services; and Information Technology Services. The offices include: Communications and Media Services; Compliance; General Counsel; Health Policy Advisor; Legislative Services; Patient Care Advocacy; Quality Improvement; and Human Resources. The Title V/Maternal and Child Health functions are housed within the Division of Family Health and Wellness along with the Women, Infants and Children (WIC) Program and CDC-funded chronic disease programs (Obesity, Diabetes, Tobacco, Heart Disease and Stroke, Arthritis, and Rape and Violence Prevention).//2013//

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 Division of Family Health and Wellness which houses MCH program areas, 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.

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. ***/2013/In January 2012, the Commissioner reorganized several sections and divisions within the Department. The Maternal and Child Health Section was merged with the Nutrition and Wellness Section. (Nutrition and Wellness previously included WIC and the CDC-funded chronic disease initiatives). The two sections were merged into the Division of Family Health and Wellness. Organizational charts for the Department of Health and the Division of Family Health and Wellness are uploaded as attachments to this section of the narrative.//2013//***

/2013/Several MCH programs have statutorily mandated advisory groups. The Children's Special Services Advisory Committee is comprised of members appointed by the Commissioner. Committee members advise the MCH and CSHCN Directors on priority areas and recommend programmatic and policy changes as needed. Representatives include primary care and subspecialty providers as well as a parent representative. The Genetics Advisory Committee is comprised of representatives from various tertiary genetic, endocrine, pulmonary, cardiology, and hematology centers across the state. Committee members advise the Commissioner on program and policy changes related to newborn screening. The Perinatal Advisory Committee provides consultation to the Department on obstetrical and neonatal issues. The Committee is comprised of representatives from the regional perinatal centers as well as representatives from medical schools, health and environmental agencies, hospitals, medical specialties, and the public.//2013//

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

D. Other MCH Capacity

SECTION MANAGEMENT

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 Melissa Blair (Deputy Director), Mary Jane Dewey (Child Health/Breast and Cervical Cancer Screening), Rachel Heitmann (Injury Prevention and Detection), Jacqueline Johnson (CSHCN), Peggy Lewis (WIC), and Margaret Major (Women's Health and Genetics).

/2013/ With the merging of the MCH and Nutrition and Wellness sections Melissa Blair was named Deputy Director of this newly created Division. Ms. Blair has over 20 years of state government experience having most recently served as the Director of Nutrition and Wellness Section in the Department of Health and provides oversight for WIC, and Chronic Disease Programs within the division. Ms. Blair has a Bachelor's degree in merchandising and home economics and a Master's in Human Ecology with a minor in Business.//2013//

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.

Rachel Heitmann oversees the Division'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.

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.

/2013/Peggy Lewis serves as the State WIC Director, a position she has held since 2002. She is a licensed dietitian/nutritionist with a Master's Degree in Foods and Nutrition. Prior to her current role, she has served as a regional WIC Director in Tennessee and as a

clinical dietitian and WIC Program Manager at an Ohio hospital. She has also taught Nutrition and Food Service courses at the undergraduate level and has served as President of the National WIC Association.//2013//

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.

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. ***/2013/Dr. Taylor was appointed Dean for the College of Health Sciences and Nursing at Belmont University on December 12, 2011 and concluded her tenure with the Department of Health in January 2012.//2013//***

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. ***/2013/An epidemiologist was hired for the MIECHV program in late summer 2011.//2013//***

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.

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.
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.). 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.

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.

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./***2013/Currently, Jacqueline Johnson, is enrolled in the Epidemiology Certification Program.//2013//***

/2013/To address MCH-related health disparities, Tennessee's Title V program has partnered with the University of Tennessee at Knoxville (UTK), a HRSA-MCHB grant recipient, to provide cultural competency training. Over an 18-month span beginning in March 2012, selected Department of Health staff in all 13 regions will participate in the half-day training provided by UTK. The workshop takes an in-depth look at individual cultural

competence. It is specifically designed to increase awareness, knowledge, and skills in dealing with clients, patients, and co-workers whose world view is different from one's self. The emphasis is on the health-related professions.//2013//

E. State Agency Coordination

Maternal and Child Health and Women's Health (***/2013/ part of the Division of Family Health and Wellness//2013//***) staff at the central office, regional offices, and local health department levels are involved in numerous collaborative efforts within the Department with various programs, other governmental departments and agencies, and organizations and agencies outside government (universities, school systems, city/county government, hospitals, and nonprofit agencies such as March of Dimes, American Cancer Society, American Heart Association, Arthritis Foundation, Tennessee Suicide Prevention Network, State Minority Health Task Force, Family Voices, The Tennessee Disability Coalition, and the Council for Developmental Disabilities).

MCH has always had a strong collaborative relationship with metropolitan health departments in the state. Since these entities have separate boards of health, the state's role is to provide needed service, focused funding, training and continuing education and participation as a partner in all planning and system change initiated to improve the public's health. The six designated metro health departments receive funds through the state's contractual system. Staff in Metro Health Departments who provide MCH services are regularly included in conference calls, quarterly meetings, in-service training and planning meetings about MCH programs and services. ***/2013/ The MCH Director holds monthly conference calls with all regional MCH Coordinators; the agenda includes updates from the central office, regional updates, topical presentations on MCH programs, and information on specific MCH performance and priority measures. //2013//*** Metro Regional Directors participate as active partners with rural Regional Directors in public health planning and new initiatives. The primary difference between these two entities is that metros report to boards of health and the mayor, while rural regional directors report to the Department.

Examples of collaborative efforts:

TennCare/Medicaid: The Childhood Lead Poisoning Prevention Program has a cost-sharing protocol with TennCare for cases when an environmental investigation is conducted for a lead poisoned child on Medicaid. CSS requires that all children applying for the CSS program apply for TennCare; assists families in locating a medical home, specialists and related service providers within the managed care organizations' (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 for home visits. DCS staff are involved on teams reviewing cases for the Child Fatality Review program. MCH staff is invited to attend the multidisciplinary teams to case manage clients. CSS regional coordinators work with the DCS Regional Health Unit nurses to coordinate health services for CSHCN in state custody. ***/2013/New collaborations are occurring between the Child Fatality Review Program***

(housed in MCH) and DCS. The MCH Director meets regularly with senior leadership from DCS to discuss opportunities for primary prevention of child maltreatment. Local DCS staff have for many years participated on the local child fatality review teams, and state DCS leadership has participated on the state team.//2013//

MCH staff are members of the Children's Justice Task Force and the Child Sex Abuse Task Force, whose members are from many state government departments and community organizations. The Children's Justice Task Force focuses on the welfare of children reported to have been abused or neglected and is charged with identifying existing problems and recommending solutions. The Child Sex Abuse Task Force is responsible for assisting DCS in developing a plan for better coordination and integration of the goals, activities and funding for detection, intervention, prevention and treatment of child sexual abuse. MCH has a staff member who is an associate member of the TN Child Abuse Prevention Advisory Committee. The committee focuses on statewide efforts to prevent child abuse.

Department of Human Services (DHS): DHS houses the Division of Vocational Rehabilitation, TN Services for the Blind and Visually Impaired and the TN Technology Access Project. These programs work in collaboration with the CSS program. The Deaf/Blind Coordinator has participated on the Newborn Hearing Screening (NHS) Task Force since 1997. DHS offices serve as the place of application for Medicaid and TennCare. DHS provides CSS proof that CSS applicants have applied to TennCare. MCH has collaborated with DHS since 1996 to build a statewide network of child care resource centers which include a child care health consultant. Services provided include: technical assistance and consultation, training, and lending resource library materials and are available to all child care providers in the State. MCH through its Early Childhood Comprehensive Systems Program and its Child Care Resource Centers assist DHS in providing technical assistance for state regulated day care centers.

Department of Education (DOE): The director of adolescent health collaborates with the Coordinated School Health (CSH) program staff on the asthma management initiative. ***/2013/There is increasing collaboration between regional TDH staff and regional CSH staff. In early 2012, TDH Regional MCH Directors provided an overview of MCH-related services at regional CSH meetings. Feedback from both MCH and CSH staff indicated that the meetings were useful for sharing program information and building local connections.//2013//***

The Department of Education, Division of Special Education, is the lead agency for the IDEA Part C, TN Early Intervention System (TEIS) for infants and toddlers birth to 3 identified with or having a potential for a developmental delay. TEIS has been an active collaborator with the CSS program since 1990 and with Newborn Hearing Screening (NHS) since 1996. The programs coordinate referral and care coordination activities on infants and children requiring services from both agencies. An MCH staff person serves on the State IDEA Interagency Coordinating Council. TEIS staff serve on the NHS Task Force. TEIS works closely with the NHS program to provide tracking, follow-up and intervention services for infants referred for or identified with a hearing loss after hospital hearing screening. An MCH staff member serves on the Part C (Early Intervention) Monitoring Review Committee. CSS central office and regional office staff participate in Early Intervention Administrators' Forums which include various agencies and promote interagency linkages at the program administrators' level. Local CSS staff participate in meetings for individual CSHCN with DOE Part C and Part B personnel in developing coordinated care plans to insure the coordination of services.

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

Assessment and Management (NCHAM), works with 3 Early Head Start agencies across the state to implement the Early Childhood Hearing Outreach (ECHO) initiative to provide training on hearing screening, follow-up and reporting. ***/2013/The MCH Director also liaisons with the Director of the State Head Start Collaboration on an as-needed basis. For example, the two collaborated to clarify policies related to EPSDT screening and worked with Head Start staff and community health care providers to promote better understanding and compliance with policies.//2013//***

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. The MCH adolescent health director serves as a member of the Tennessee Suicide Prevention Network and works with a state intradepartmental committee and the state suicide prevention advisory committee. The committee has developed a state plan to address youth suicide prevention.

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

Tennessee Bureau of Investigation (TBI): TBI staff are active members of the Child Fatality Review program at both local and state levels. CSS staff work with Corrections staff to get wheelchair ramps and custom made furniture for CSHCN constructed at no cost to families. Child Fatality Review: The Child Fatality Review process is a statewide network of multidisciplinary, multi-agency teams in the 31 judicial districts to review all deaths of children 18 and younger. Members of each local team include: Department of Health regional health officer; Department of Human Services social services supervisor; Medical Examiner; prosecuting attorney appointed by the District Attorney General; local law enforcement officer; mental health professional; pediatrician or family practice physician; emergency medical services provider or firefighter; juvenile court representative; and representatives of other community agencies serving children. Members of the State Child Fatality team include: Department of Health commissioner; Attorney General; Department of Human Services commissioner; Tennessee Bureau of Investigation director; physician (nominated by Tennessee Medical Association); physician credentialed in forensic pathology; Department of Mental Health and Developmental Disabilities commissioner; Department of Education commissioner; judiciary member nominated by the Supreme Court Chief Justice; Tennessee Commission on Children and Youth chairperson; two members of the Senate; and two members of the House of Representatives.

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

Adolescent and Young Adult Health: The adolescent health director provides educational presentations and resources to adolescent health coordinators and the advisory committee

through quarterly teleconferences. The director serves on several committees designed to improve the quality of life for youth and provide educational opportunities for youth and adults including the intra-departmental committee of the Tennessee Suicide Prevention Network; the local and state Disproportionate Minority Contact and Confinement (DMCC) committees; the Tennessee Commission for Children and Youth (TCCY)/Mid-Cumberland committee; and the Tennessee Alliance for Drug Endangered Children (TADEC).

/2013/The Adolescent & Young Adult Health director also collaborates with the Tennessee Obesity Task Force (TOT), and the Disparate Populations subcommittee. TOT is a broad-based statewide coalition charged with implementing Eat Well Play More, Tennessee's statewide nutrition and physical activity plan to reduce obesity and chronic disease in Tennessee by 2015. The subcommittee's goal is to educate public health professionals regarding cultural competency to eliminate communication and insensitivity barriers; motivate vulnerable populations to action and sustained change of unhealthy behaviors; and motivate families to choose healthier lifestyle resources within their means. The director is on the planning committee for the annual Cultivating Healthy Communities of Faith conference designed to enhance the relationship between faith-based organizations and the health community in order to address issues such as improved food access, nutrition and obesity, cultural competency, and caring for the caregiver.

The Adolescent & Young Adult Health director also assists in coordinating activities of the Department's annual Child Health Week with Mental Health and Developmental Disabilities, the TENNderCare program, and community partners. Additional collaborations for the Adolescent & Young Adult Health director include coordinating a committee from throughout the Family Health and Wellness Division (FHW) that developed a DVD addressing numerous chronic diseases and health issues for Women's Health Week 2011 and Men's Health Week 2011. The DVD was distributed to 127 local health departments with television viewing areas.//2013//

Asthma Management: State of Tennessee Asthma Task Force (STAT) members, in conjunction with Early Childhood Comprehensive Systems, the TennCare Bureau and the Department of Education, developed and are implementing a comprehensive state plan to reduce the burden of asthma among Tennesseans. The goal of the Tennessee Asthma Plan is to reduce the burden of asthma in Tennessee. 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. 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.***/2013/ A nurse consultant was funded to provide training and technical assistance to the staff at CCR&Rs on health related issues of young children in group care including asthma management. Print material on prevention of tobacco/smoking exposure was developed and circulated to child health related programs across the state.//2013//***

Federally Qualified Health Centers: Community Health Centers are located in medically underserved areas of the state. There are 24 FQHCs 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. The 24 centers operate 153 clinic sites serving over 258,000 patients. ***/2013/ Community Health Centers in TN are***

community-based public and private nonprofit corporations that provide comprehensive primary health care services to all people regardless of the patient's ability to pay for those services. There is a network of 31 nonprofit centers operating 204 sites across the state. There are 25 federally qualified health centers with 197 sites and six other types of community-based centers operating 7 sites. They are located in medically underserved areas of the state, both rural and urban. These 31 sites provide primary health care, mental health care and dental services to over 361,000 people per year. //2013//

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. 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.

Folic Acid Education Campaign: Women's Health and Nutrition staff (central and regional offices) are partnering with the March of Dimes, Girl Scouts, and members of the state folic acid council to educate the citizens of TN on the need for folic acid. Staff developed and implemented many of the statewide activities. The Women's Health director serves on the state council. The family planning program provides vitamins with folic acid to patients of reproductive age who receive program services. ***/2013/ MCH staff are currently partnering with the March of Dimes and a health education consultant on a grant to use text messaging and web technology to educate college women on important lifestyle issues.//2013//***

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

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. ***/2013/ The program accepts any referrals of eligible symptomatic women.//2013//***

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

Nutrition and Wellness/WIC: 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. ***/2013/ Effective January 2012, MCH and Nutrition and Wellness were merged into the Division of Family Health and Wellness.//2013//***

Office of Policy, Planning and Assessment: Staff collaborate with Health Statistics on dissemination of data releases and special reports, data collection for the joint Annual Report of Hospitals, data collection for the Region IV Women and Infant Health Data Indicators Project, and other MCH data projects. Staff coordinate on data matching and reports for the newborn hearing

screening program, and on the SSDI grant. ***/2013/ The SSDI competitive grant was approved for TN but the time period was shortened to three years. SSDI funds will be used to maintain the Health Information Tennessee site which provides the most current state information through a web based application that can be customized by the user. Grant funds will also be used to develop system wide understanding and application of the life course theory as required by the funding source.//2013//***

Tennessee Adolescent Pregnancy Prevention Program: Tennessee's adolescent pregnancy prevention efforts encompass two different strategies--the Tennessee Adolescent Pregnancy Prevention Program (TAPPP) and the Abstinence Education Program. TAPPP councils operate in four of the six metropolitan areas and in 6 of the 7 rural regions. The 10 Coordinators serve as the community contacts/resource persons for adolescent pregnancy issues. ***/2013/TAPPP councils operate in three of the six metropolitan areas and in the multi-county groupings in six of the seven regions. Nine Coordinators serve as the community contacts/resource persons for adolescent pregnancy.//2013//*** All council memberships are broadly representative of the surrounding community, and include Girl Scouts, March of Dimes, Department of Human Services, Department of Children's Services, community-based youth serving organizations, hospitals, local businesses, schools, universities, adoption service agencies, faith-based organizations, juvenile justice agencies, media representatives, and regional and local health councils. Each council participates in a wide range of activities, depending on local priorities and resources, including conferences, parenting and adolescent health fairs, workshops, legislative briefings, and training for professionals. TAPPP councils operate in three of the six metro areas. Each Metro and Regional Health Department utilizes health educators to implement a wide range of activities, depending on local priorities and resources, including educational classes, teen pregnancy and parenting events, conferences, adolescent health fairs, workshops, legislative briefings, and training for professionals. ***/2013/The TN State Department of Health Program Director for Adolescent Pregnancy Prevention and Abstinence Programs and TAPPP Coordinators participate in quarterly conference calls to discuss regional program updates, upcoming events and effective collaborations for future community activities.//2013//***

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. ***/2013/ The Department of Health received $1,141,533.00 to implement evidence-based medically accurate abstinence programs in both school and community-based settings. The program serves middle school aged children, 10-14 year olds and expanding up to age 17 after year one. Targeted counties are those identified as having high teen pregnancy and birth rates, high rates of mothers in poverty and high school dropout rates. Thirteen community-based agencies were awarded funds to provide abstinence education, as defined by federal law. All sites incorporate service learning projects as a tool to build self esteem, promote community involvement and emphasize the importance of future life goals.***

The Department of Health/MCH is the current recipient of the Pregnancy Assistance Fund (PAF) grant. This grant was originally awarded in 2010 to the Governor's Office of Children's Care Coordination (GOCCC) with intent to fund project activities in Shelby County. Approval from the Legislature to spend the funds was not received until March 2011. Prior to that time, no work (including subcontracts with Shelby County) was allowed to proceed. Shortly after the GOCCC was given approval, the GOCCC office was eliminated and all projects/grants were transitioned to other state agencies. The PAF grant was transferred to the Department of Health on July 1, 2011. MCH staff began working with

Shelby County partners to begin preparing for the subcontracts needed to implement this project. As of March 2012, thirteen subcontracts have been approved by the Department of Health and the Shelby County Commission to provide services to pregnant and parenting teens in Memphis. Services consist of access to prenatal care, well child clinical services, a standardized tracking system for program participants, a Baby Store incentive program to purchase needed child care items, and educational information and resources.//2013//

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. ***/2013/ The state's Breast and Cervical Screening Program is partnering with TPCA and member organizations to explore the options for developing a training mechanism for community health workers and patient navigators across systems. //2013//***

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. ***/2013/In Spring 2012, Tennessee signed on to the March of Dimes/Association of State and Territorial Health Officials (ASTHO) pledge to reduce prematurity by 8% by 2014.//2013//***

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 1: The rate of children hospitalized for asthma (ICD-9 Codes: 493.0-493.9) per 10,000 children less than five years of age.

Asthma hospitalizations declined between 2007-2010. 2011 data are not available at the time of this submission because population estimates for 2011 are not available.

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.

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 Children's Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.

In 2011, 51.1% 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 and through MCH collaboration with the TENNderCare Outreach Program.

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.

In 2011, 86.6% of pregnant women met this indicator. Prenatal services, including pregnancy testing, determination of 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 all TennCare enrollees who are pregnant to provide prenatal education and assistance with making appointments for prenatal care. Legislatively-appropriated funds have supported Centering Pregnancy, a group prenatal care model, in several locations across the state.

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

In 2010, 82.7% 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.

The percent of EPSDT eligible children age 6-9 who have received dental services during the year has 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 FY2011, over 131,000 children had dental screenings in 324 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 55 fixed dental clinics in 54 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.

In 2011, 13.9% 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 all children and youth under 16 years of age who have been determined eligible to receive SSI. There were 3062 names provided for 2011. SSA Data for 2011 indicate 22,001 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 twenty-two percent of the 6,059 CSS enrollees have SSI (FY 2011). CSS staff contacted 3062 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)

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 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.

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 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) 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.

The Department of Health offers pregnancy testing and counseling in local health departments, in addition to presumptive eligibility determination 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 assist 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% on the Kotelchuck Index).

Prenatal services, including pregnancy testing, determination of 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 all TennCare enrollees who are pregnant to provide prenatal education and assistance with making appointments for prenatal care. Legislatively-appropriated funds have supported Centering Pregnancy, a group prenatal care model, in several locations across the state.

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

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--Children (1 to 6 and 6 to 19).

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.

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.

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.

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
-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 among Tennesseans.
4. Decrease unnecessary health care utilization associated with asthma.
5. Improve MCH workforce capacity and competency.
6. Increase transition services available to children with special health care needs.
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 discussed messaging strategies with Nutrition and Wellness staff. Collectively, efforts from both sections will aid Tennessee in addressing this priority measure.

/2013/In January 2012, the Maternal and Child Health Section merged with the Nutrition and Wellness Section to form the Division of Family Health and Wellness. This has more closely aligned programs serving the MCH population under one Division, which now includes the Women, Infants and Children (WIC) program and CDC-funded chronic disease initiatives. This new alignment supports efforts to incorporate the life course perspective into MCH programming in an attempt to improve health and well-being across the life span and across generations.//2013//

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 among Tennesseans.
4. Decrease unnecessary health care utilization associated with asthma.
5. Improve MCH workforce capacity and competency.
6. Increase transition services available to children with special health care needs.
7. Reduce unintentional injury deaths in children and young people ages 0-24 years.

/2013/Seven corresponding state performance measures were established corresponding to each of the priorities.//2013// In this section, each state priority will be discussed, with respect to its relationship of priority with state/national performance measures and with capacity and resource capability of Tennessee's Title V program.

STATE PRIORITY #1: REDUCE 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 priority is related to several 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
-SPM #1: number of infant sleep-related deaths

Existing MCH/Title V capacity supports this priority. 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. Through home visiting programs, breastfeeding, smoking cessation, and early prenatal care are encouraged. ***/2013/The CDC-funded Core Violence and Injury Prevention Program, housed in MCH, has listed sleep-related infant deaths as a priority.//2013//*** 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. 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.

/2013/SPM #1 was modified in 2012 (had previously been infant mortality rate). The infant mortality rate is already reported as a national outcome measure. Review of recent trends from the statewide Child Fatality Review process have indicated a rising number of non-SIDS sleep-related deaths in Tennessee over the past few years. In 2010, there were 131 such sleep-related deaths. These deaths account for approximately 20% of all infant deaths, thus significantly contributing to the state's infant mortality rate. An MCH stakeholder group revised this performance measure to monitor the number of non-SIDS sleep-related deaths per year in Tennessee.//2013//

STATE PRIORITY #2: REDUCE OVERWEIGHT AND OBESITY

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 priority is related to several 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
-SPM #2: percentage of obesity and overweight (BMI for age/gender >85th percentile) among Tennessee K-12 students

Existing collaborations between MCH and other partners support this priority. 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 SPM #2; CSH staff across the state collect body mass index (BMI) measurements on public school students statewide.

STATE PRIORITY #3: REDUCE SMOKING

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 priority is related to several 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
-SPM #3: percentage of women age 18-44 who smoke
-SPM #4: rate of emergency department visits due to asthma for children age 1-4

Additionally, this priority is related to state priority #1 (reduce infant mortality rate) and state priority #4 (decrease unnecessary healthcare utilization due to asthma). 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 priority. 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 priority. 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.

/2013/SPM #3 was modified in 2012. The smoking rate among Tennesseans age 13 and older (the original performance measure) proved difficult to measure. Other analyses (such as the Behavioral Risk Factor Surveillance System, BRFSS) allow for population level estimation of smoking. Recognizing the impact of smoking on maternal and infant health, an MCH stakeholder group revised this performance measure to monitor the percentage of women of childbearing age (18-44) who report smoking. This redefined performance measure will assist the Tennessee Title V program in addressing tobacco use among women who may become pregnant, impacting their health across the lifespan and the future health of their infant (given the relationship between smoking and adverse birth outcomes such as low birth weight and prematurity).//2013//

STATE PRIORITY #4: DECREASE ASTHMA-RELATED HEALTHCARE UTILIZATION

Designation of asthma hospitalizations as a priority 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 priority is related to several 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
-SPM #3: percentage of women age 18-44 who smoke
-SPM #4: rate of emergency department visits due to asthma for children age 1-4

Additionally, this priority is related to state priority #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 priority. 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 priority. 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.

/2013/SPM #4 was modified in 2012. The previous measure (asthma hospitalization rate for young children) is already reported as a health systems capacity indicator. Review of statewide asthma burden data indicates a high number of emergency department visits for children with asthma, particularly among those enrolled in Medicaid. An MCH stakeholder group revised this performance measure to monitor the rate of asthma-related emergency department visits for children age 1-4 per year in Tennessee.//2013//

STATE PRIORITY #5: IMPROVE MCH WORKFORCE CAPACITY AND COMPETENCY

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 need for additional training and mentoring in order to increase competencies in enabling services, population-based services, and infrastructure building.

This priority is related to several 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
-SPM #5: percentage of Central Office and Regional MCH staff who have completed a self-assessment and based on the assessment have identified and completed a module in the MCH Navigator system

//2013//Existing MCH/Title V capacity supports this priority. Dr. Michael Warren, Title V/MCH Director, participates on a national AMCHP committee related to workforce development. He has presented at the state and national levels on this topic and worked with HRSA/MCHB staff to develop a section of the MCH Navigator related to workforce assessment.//2013//

Resources external to MCH further support this priority. 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.

/2013/SPM #5 was modified in 2012. The previous measure had been to develop and implement a workforce development program. A core MCH planning group (including regional MCH staff) felt that the measure needed to allow for more concrete measurement of progress related to this priority. Existing tools allow staff to self-assess strengths and opportunities in MCH and public health core competencies. The MCH Navigator system allows staff to complete workforce development activities based on identified needs. //2013//

STATE PRIORITY #6: INCREASE CSHCN TRANSITION PLANNING

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 priority is related to several 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
-SPM #6: percentage of youth (14 and older) enrolled in the state CSHCN program who have formal plans for transition to adulthood

Existing MCH/Title V capacity supports this priority. 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. 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.

/2013/SPM #6 was modified in 2012. The previously designated measure (percentage of CSHCN receiving transition services) is already reported as a national performance measure, based on the National Survey of Children with Special Health Care Needs. The measure has been modified to specifically focus on CSHCN enrolled in the state CSS program. We plan to measure the percentage of CSS enrollees 14 and older who have a documented formal transition plan to adulthood. //2013//

STATE PRIORITY #7: REDUCE UNINTENTIONAL INJURY

Reduction of unintentional injury was designated as a state priority 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 priority 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
-SPM #7: rate of unintentional injury death in children and young adults (ages 1-24)

Existing MCH/Title V capacity supports this priority. The state's CDC-funded Core Violence and Injury Prevention Program moved in 2011 to the Maternal and Child Health section, allowing 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. 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 and 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	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	99.4	100.0
Numerator	164	204	161	161	170
Denominator	164	204	161	162	170
Data Source		Department of Health	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

	2012	2013	2014	2015	2016
Annual Performance Objective	100	100	100	100	100

Notes - 2011
Data Source: Tennessee Department of Health, Newborn Screening Program

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

Notes - 2009
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. Since that time, screening has expanded to cover 29 of the 31 core conditions and 24 of the 26 secondary conditions recommended for screening by the Secretary's Committee on Heritable Disorders in Newborns and Children (U. S. Department of Health and Human Services). 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 Centers and the Children's Special Services staff for referrals. The Genetics Advisory Committee (GAC) guides program activities.

Follow-up staff is responsible for interfacing with the State Laboratory to identify, locate and follow up on unsatisfactory or abnormal results from the mandated screening panel. If needed, local health department nurses assist in locating an infant needing follow-up. Referrals for screening, diagnositc testing and counseling services are made for individuals and families at tertiary centers across the state which include 3 regional comprehensive genetic centers, 2 satellite genetic centers, 4 pediatric endocrinologists, 5 pulmonology centers, 2 comprehensive sickle cell centers and 2 satellite sickle cell centers.

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. An online course and DVD continue to be available to health care providers in to educate them about newborn screening tests, proper specimen collection and follow up protocols for abnormal and unsatisfactory results and referrals. For 2011, the State's unsatisfactory rate was 2.5 percent. Hospitals were notified quarterly of their unsatisfactory rates and reports were posted on the NBS web site. Periodic newsletters are electronically sent (and posted on the web site) to healthcare providers statewide with the latest information on screening and follow-up. Information about screening for parents and healthcare providers is located on the Department's web site.

In April, 2011, the Severe Combined Immunodeficiency Disease (SCID) work group met to discuss screening. The group will continue to monitor and review the development of new testing methodology. During the May, 2011 GAC meeting the recommended guidelines for very low birth weight (less than 1500 grams) infants to identify congenital hypothyroidism were revised and approved by the committee.

In June, 2011 the Critical Congenital Heart Disease (CCHD) subcommittee met to have preliminary discussions about implementation in anticipation of legislation. During this time the senate bill was introduced but awaiting action in the house.

During the CY 2011, the case managers followed-up on 2,190 presumed positive results for disease. In addition, follow-up was done on 2,387 unsatisfactory samples, 958 samples collected before the infant was 24 hours of age, 323 infants due to transfusions, 1,941 infants with possible

hemoglobin traits and 356 infants with abnormal results on parenteral nutritional support. Provisional 2011 data indicate that 88,963 tests were performed on infants born in Tennessee during the calendar year (both resident and non-resident). Follow-up staff continue to monitor the unsatisfactory collection rate by hospital.

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.

The program continues to provide updated information through pamphlets and the department website for both parent and provider information about the newborn screening program. NBS follow-up staff are also available to provide education and information.

The GAC recommended guidelines for very low birth weight (less than 1500 grams) infants to identify congenital hypothyroidism have been forwarded to the Commissioner of Health for approval.

In January, 2012 the NBS program applied for a federal Critical Congenital Heart Disease (CCHD) funding opportunity to support the development of a screening infrastructure. In March, 2012 the Tennessee State Legislature passed a bill directing the GAC to develop a screening program using pulse oximetry to identify CCHD by January, 2013. The CCHD subcommittee met in May, 2012 to discuss implementation of a screening program in Tennessee.

In March, 2012 the Commissioner of Health approved the additon of a pediatric cardiologist to the GAC.

The Genetics Program rules and regulations have been revised to include CCHD screening; these are in the review and approval process.

c. Plan for the Coming Year
The plan for the next year will be to continue providing efficient follow up on all abnormal and unsatisfactory specimens. 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 guidelines for screening very low birth weight (less than 1500 grams) infants to identify congenital hypothyroidism will be approved by the Commissioner of Health and implemented.

The Severe Combined Immunodeficiency Disease (SCID) work group will continue to monitor and review the development of new testing methodology for screening.

The Critical Congenital Heart Disease (CCHD) subcommittee will meet to determine current statewide practices and develop educational materials and resources to implement screening in Tennessee.

The program's revised rules and regulations to include CCHD screening will be approved and implemented.

The program plans to implement software to allow web access to the newborn screening case management system. The web access will allow the staff to have reliable and consistent remote access to the server. It also allows disease specialists to have remote diagnostic entry in turn providing quicker comprehensive follow-up and data. This is consistent with current standards of high-quality patient care as well as with national performance measures.

The Genetics Advisory Committee plans two face to face meetings.

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:	**84533**					
Reporting Year:	**2010**					
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)	84016	99.4	290	52	52	100.0
Galactosemia (Classical)	84016	99.4	230	0	0	
Sickle Cell Disease		0.0				
Biotinidase	84016	99.4	43	2	2	100.0

Deficiency						
Congenital Adrenal Hyperplasia	84016	99.4	315	3	3	100.0
Cystic Fibrosis	84016	99.4	622	17	17	100.0
Hemoglobinopathy	84016	99.4	75	64	64	100.0
Amino Acidemia	84016	99.4	220	11	10	90.9
Fatty or Organic Acidemia	84016	99.4	241	13	13	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	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	62	62	62	62	62
Annual Indicator	60.7	60.7	60.7	60.7	72.3
Numerator	3381	136524	136524	136524	183180
Denominator	5570	224895	224895	224895	253333
Data Source		CSHCN Survey	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
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	75	75	75	75	75

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

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

a. Last Year's Accomplishments

CSS staff 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, the CSS Director actively participates in policy and program development for children and youth with special health care needs.

The CSS program staff collaborated with the home visitation staff to develop a core curriculum, training and competencies for home visitors and care coordinators. Staff continued to work towards developing best practices and standards for care coordinators. Care Coordinators and program staff continued to meet with medical providers in their regions and counties to develop referral systems 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 Service Plan for each child enrolled in CSS.		X		
3. Include parents on the CSS Advisory Board.		X		X
4. Conduct parent satisfaction survey.			X	X
5. Include parents and CSHCN as participants and presenters at conferences and training events.				X
6. Develop parent advisory committee.		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
9. Provide additional educational resources and training for participants and families on interaction with health care providers and decision-making strategies.		X		
10.				

b. Current Activities

Program staff will continue the collaborative efforts to develop a core curriculum, training best practices and standards for all care coordinators. The competencies developed will be included in the job plan and evaluations of care coordinators.

Program directors and care coordinators will continue meeting with medical providers in their regions/counties to develop referral systems for children with special health care needs.

Family Service Plans will continue to address specific needs the family or CYSHCN may have regarding decision making and satisfaction with the medical provider. Care coordinators will 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 members, facilitators and presenters at local and statewide training for CSS staff, CSS Advisory Committee meetings, and other Family Health and Wellness committees and meetings. CSS staff will 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 AMCHP's Family Youth Leadership Committee and will continue discussing issues surrounding family involvement and the development of mechanisms to include more family leadership and involvement in the upcoming year.

c. Plan for the Coming Year

Development of a core curriculum, training, standards and competencies for care coordinators will continue. 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 with children and youth with special health care needs.

The staff will continue in the development of a satisfaction survey to be administered to families during the upcoming year. 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. The CSS program director will work with the Advisory Commmittee to plan the biannual meetings in a manner that program participants and their families will be invited to present on selected topics of interest. CSS staff is actively seeking parent participation to attend the AMCHP conference and become active with the Family Youth Leadership Committee.

Family Service Plans will continue to be developed with families and participants to address participation in decision making strategies and interaction with health care providers.

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	2007	2008	2009	2010	2011

Annual Performance Objective	64	65	65	65	55
Annual Indicator	52.7	52.7	52.7	52.7	45.9
Numerator	2935	115761	115761	115761	113064
Denominator	5570	219634	219634	219634	246352
Data Source		CSHCN Survey	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
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	50	55	60	60	60

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

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

a. Last Year's Accomplishments
CSS program director partnered with the ECCS Medical Home Sub-Committee and staff to plan and develop a pediatric medical home summit. The summit activities were designed to develop a shared understanding of the Patient Centered Medical Home (PCMH) concept, understand the opportunities and challenges for implementation of PCMH, learn about practitioners and payers current initiatives towards implementation of the PCMH, and to identify strategies to support PCMH implementation focused on family-centered care. Parents fully participated in the Summit; in addition to attending the Summit, family members participated in planning and served as presenters.

The CSS program director served on the Vanderbilt University Medical Center work groups to develop a Medical Home 101 presentation to educate providers, partners, and consumers about the medical home concept. The CSS program director also continued involvement with the

Health History and Care Coordination work groups to develop a standardized care plan notebook and a standardized portable medical information form for children and youth with special health care needs.

The CSS care coordinations collaborated with state and local agencies to ensure that all participants have a medical home in the county of residence, and with MCO's 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 transitional process from pediatric to adolescent and adult providers. 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 coordination 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
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 Screening 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 the Pediatric Medical Home Summit where state and provider agencies who are working on medical home provisions were brought together to share initiatives, recommendations and solutions. A summary of the summit findings is attached to this section. One of the next steps identified at this summit was to provide the Medical Homes Index for Families to Parents and encourage them to complete it. Staff currently are referring parents and families to the on-line Medical Homes Tool Kit and are providing a portable health history summary form with recent and pertinent medical history to youth age 14 years old and older.

CSS staff is collaborating with other agencies to establish medical homes for all CSHCN, and program staff continue to assist families to identify and access medical homes. Staff also assist in the coordination of services between providers.

CSS staff is conducting outreach with insurance and primary care providers to establish medical homes and payment sources for CSHCN, and continues to facilitate information exchanges between the health care providers and families. Care coordinators continue to enroll infants identified by Newborn Hearing and Screening Programs.

The transition section of the Family Service Plan is currently being updated to include a section on the Medical Homes Index and families are encouraged and assisted with the completion of the Index.
An attachment is included in this section. IVC_NPM03_Current Activities

c. Plan for the Coming Year
CSS staff involved in planning the Medical Homes Summit will continue to serve on the ECCS Medical Home Sub-Committee, and will work towards the development of an operational definition of what a patient medical home is and offer insight into any opportunities that may exist for providers as they develop the medical home concept in their practices. CSS staff will continue to serve on the Vanderbilt University Medical Center Medical Home, Health History, and Care Coordination work groups. The Health History work group is exploring the idea of electronic health records that may be accessed statewide and not just by local hospital or network providers.

CSS staff will continue care coordination for children and youth with special health care needs and provide educational information to providers. CSS staff will continue to work towards the development of a care coordination tool kit to improve care coordination between inpatient/outpatient/subspecialist and create a "how-to" for care coordination. CSS staff will continue to work towards a statewide standard care plan notebook for all CYSHCN.

The electronic Medical Home Tool Kit will be updated as needed and continue to be used as a referral source for providers and families. 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 accessible at: http://health.tn.gov/MCH/MedicalHome/index.shtml.

CSS staff will promote the Medical Homes 101: Building Medical Homes that Work - presentation developed by Family Voices of Tennessee as a resource for families and CYSHCN. Families will also be able to access the materials online through Family Voices.

CSS staff will continue to collaborate with insurance and health care providers to establish medical homes and payment sources for CYSHCN.

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	2007	2008	2009	2010	2011
Annual Performance Objective	64	69	69	69	70
Annual Indicator	67.7	67.7	67.7	67.7	70.4
Numerator	3771	152224	152224	152224	174402
Denominator	5570	224965	224965	224965	247879

Data Source		CSHCN Survey	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
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	75	75	75	75	75

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

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

a. Last Year's Accomplishments
During TennCare open enrollment (February 2011), the CSS program staff notified all program participants that had previously been denied coverage and assisted with application for services. CSS collaborated with CHIP and the MCOs to develop mechanisms that provided families with information and assistance needed to understand program requirements and application for benefits. CSS staff received an update on the CHIP services, 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.

CSS partnered with the MCO's to ensure insurance is available to all eligible constituents and established a referral system that allowed participants with special health care needs to receive referrals to the MCOs by CSS and also allows for the MCOs to refer to CSS.

CSS partnered with other child serving agencies, local health care providers and community resource agencies to provide information regarding the CSS program, TennCare and CHIP services.

CSS program eligibility requirements and information regarding other programs was displayed electronically in the local human services offices. CSS provided narrative and electronic information for inclusion in the MCO newsletters and other printed resource material.

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		
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 will continue to partner with TennCare managed care organizations (MCOs) to ensure insurance is available to all eligible constituents. CSS will continue the collaboration that allows participants with special health care needs to be referred to local MCO providers by CSS, or MCOs to refer participants to CSS for eligible medical services.

CSS continues social marketing and outreach activities that include contacting child-serving agencies, local health care providers, and community resource agencies to 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, including 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. CSS will continue notification of participants regarding the law that requires private providers to cover hearing aids for children.

c. Plan for the Coming Year

CSS program staff will continue to provide notification to families and CYSHCN regarding open enrollment of TennCare. Program staff will continue to assist families to apply for emergency

coverage when admitted to the hospital.

CSS staff will continue to assist families with identifying and applying for public and or private insurance resources.

CSS will continue outreach and marketing activities notifying other child serving agencies of services available for families and CYSHCN.

CSS will continue providing medical services to those individuals wo meet program eligibility requirements.

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	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	82	93	93	93	93
Annual Indicator	91.8	91.8	91.8	91.8	71.5
Numerator	5113	208995	208995	208995	179700
Denominator	5570	227739	227739	227739	251473
Data Source		CSHCN Survey	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
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	75	80	85	90	90

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

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

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 staff participated in statewide and local health fairs, community resource fairs, attended parent teacher meetings at schools, contacted local health care providers and other community agencies in an effort to increase awareness of community based services for children and families.

Local CSS staff conducted marketing and outreach campaigns to assist in the identification of available community based resources. Families and CYSHCN (as well as their providers) were notified of these resources.

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 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
3. Work with regional and local health councils to identify gaps in services in specific communities.		X	X	X
4. Work with state agencies such as the Departments of Mental Health, Intellectual 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	
7. CSHCN ages 3-21 will be referred to local school districts for Part B services in the local community.		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 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 to work with the Early Childhood Comprehensive Systems Progam and the Early Childhood Program in the Familiy Health and Wellness Section and other internal and external partners to develop a community based system of services that is accessible and organized for ease of use.

CSS staff will assist health care providers to identify community based resources by allowing access to the CSS Resource Directory electronically.

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	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	100	100	100	100	40
Annual Indicator	100.0	39.6	39.6	39.6	41.8

Numerator	1534	34477	34477	34477	40413
Denominator	1534	87141	87141	87141	96752
Data Source		CSHCN Survey	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
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	45	50	55	60	60

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

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

a. Last Year's Accomplishments
The CSS program director collaborated with the Department of Children's Services, the Department of Education, the Department of Mental Health and Developmental Disabilities, Intellectual Disabilities, the Tennessee Council on Developmental Disabilities and Family Voices and continued to serve on a statewide transition task force. This task force was established to formulate programmatic policies and procedures for transition plans for all children receiving services through state agencies.

CSS staff worked to identify the needs of participants and their families concerning transition from adolescence to adulthood and continued to identify transitional resources within the community.

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

As a participant in the AAP Community Pediatrics Training Initative at Vanderbilt, the CSS program director met with Dr. Carl Cooley, visiting professor and received feedback on the program's transition planning tools and on the program's portable health history summary form that is provided for those program participants that are aged 14 and older.

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
5. Provide updated resource materials for CSS staff and CSHCN.		X		X
6. Encourage youth to present at transition meetings and training events.			X	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 staff continues to develop Care Coordination standards that will 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, post secondary education, vocational programming, employment and recreation. A Medical History Summary Form is provided to all CSS articipants as a concise medical history that can be provided to medical providers as the participants transition from pediatric to adult providers.

CSS will continue to work with other agencies to ensure that all CYSHCN receive transition planning.

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.

CSS will continue the development of a satisfaction survey for CSS participants to determine success of individualized transition plan and determine any gaps and barriers that may exist.

CSS will continue to utilize the American Academy of Pediatrics 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	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	83	88	88	88	80
Annual Indicator	86.7	83.0	83.0	77.0	83.6
Numerator	1300	278	278	261	310
Denominator	1500	335	335	339	371
Data Source		2008 NIS Survey	2008 NIS Survey	2009 NIS Survey	2010 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	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	85	85	85	85	85

Notes - 2011
Data Source: 2010 National Immunization Survey (NIS). We are using the earlier definition of the NIS reported estimate that takes into account only whether the child has had 3 doses of vaccine, irrespective of the brand.

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.

a. Last Year's Accomplishments
Although nationally published measurements and ratings use the National Immunization Survey (NIS); Tennessee measures immunization at age 24 months through its detailed annual immunization survey of nearly 1,500 children distributed across the state by public health region. The survey is statistically valid for each of the state's administrative regions. The 2011 survey evaluated 1,465 children. The completion rate for the 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 74.9%. As we aim to achieve Healthy People 2020 objectives, the state immunization program (TIP) tracks how many of the vaccines included in this series reach 90% or higher coverage levels. In 2011, 5 of the 7 vaccines achieved this goal: only falling short with the 4th doses of DTaP and pneumococcal vaccines; however, completion rates for 3 doses of these two vaccines is approximately 95%. In the previous year, TIP targeted children ages 20-24 months seen at public health clinics and missing their fourth DTaP dose for active follow up. 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. Although the 2010 survey showed no racial disparity between black and white children for the vaccines in the 4:3:1:3:3:1:4 series, the 2011 survey showed a small disparity in receipt of the 4th doses of DTaP and pneumococcal conjugate vaccine; however, it is not known if this represents a trend or a single year aberration. A pronounced racial disparity continues for influenza vaccine, specifically. While use of influenza vaccine increased from 2010 to 2011, wide regional variations in coverage exist, although narrower than in 2010. The Medical Director of the Immunization Program shares these 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.The 2010 immunization requirements for pre-school and school-aged children have had a measurable impact on hepatitis A vaccine coverage and have provided additional opportunities to administer all recommended vaccines to students. Educational outreach to school nurses has also improved their capacity to educate students and healthcare providers who do not understand state requirements or appropriate immunization intervals.

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 and adults.

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 communication 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 Vaccines for Children Program (VFC) providers at least every other year to educate them and evaluate vaccine delivery; (3) working with healthcare providers and vendors to link electronic health record systems with the state immunization registry and expanding registry access in physician offices; (4) conducting immunization assessments in population sub groups such as day care enrollees, (5) identifying those at high risk of not completing immunizations and devising strategies to reach them; and (6) conducting follow-up on children born to hepatitis B infected women to ensure appropriate post-exposure prophylaxis.

A significant drop in federal 317 funds used to immunize fully insured children (i.e., those ineligible for VFC vaccine) and adults through health departments has altered health department vaccination practices. For the current year, health departments remain able to provide 317-funded vaccines to fully insured children 0-6 years seen at the health department and to provide those required for school entry to those 7-18 years. The health department has been educating families with insurance coverage for vaccines of the value of being vaccinated by a provider who can bill commercial insurance.

c. Plan for the Coming Year

The strategy will be much the same as this year. The major emphasis will be on site visits to at least half of all Vaccines for Children (VFC) Program participating providers in order to provide education and assess compliance with program requirements; when feasible an assessment of the quality of services will be done. Records of school children and daycare attendees will be reviewed for compliance with state immunization requirements. We will continue to emphasize increasing the number of private provider practices electronically exchanging data with the immunization registry. Private sector interest in this work is being generated by the availability of Medicaid "Meaningful Use" grants to support the accelerated implementation of electronic health records capable of communicating with other health information systems, such as state immunization registries. The Immunization Registry Unit of the TIP is exploring outsourcing registry managment to an experienced vendor in 2013 in order to meet the 12 federal functional registry standards and to improve the capacity to test and implement electronic data exchange with the growing number of interested providers. Immunization rate assessment activities will continue. TIP will continue to foster and promote 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	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	26.5	26.5	26	24	20
Annual Indicator	27.8	27.3	24.0	20.2	
Numerator	3361	3328	2955	2532	
Denominator	120852	122020	123216	125133	
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
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	19.5	19	18.5	18	17.5

Notes - 2011
Because 2011 population estimates are not available at this time, we are currently unable to report this indicator. Updated data for this reporting year will be made available to HRSA/MCHB as soon as updated population estimates are available.

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

Notes - 2009
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 123 sites statewide as one strategy for reducing teen pregnancy; teens are a priority population, especially for outreach. CY 2011 data from the Family Planning Annual Report show that the program served 12,380 clients ages 17 and under - a decrease of 1,084 from CY 2010. 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 2011, the health department clinics performed 64,830 EPSDT screenings, of which 9,291 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. 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 10-11 show that statewide staff provided family life education programs to over 60,100 students; provided education and training to over 4,800 adults; and worked with 2,100 parents and 6,400 professionals.

The TN State Department of Health received $1,141,533.00 in federal funds to implement evidence-based medically accurate abstinence programs in both school and community-based settings. The program serves middle school aged children, 10-14 years olds and expanding up to age 17 after year one. Targeted counties include those identified as having high teen pregnancy and birth rates, high rates of mothers in poverty and high school drop out rates. Thirteen community-based agencies were awarded funds to provide abstinence education, as defined by Section 510 of the Social Security Act (Section 510 (b)(2) A-H elements). All sites incorporate service learning projects as a tool to build self esteem, promote community involvement and emphasize the importnace of future life goals.

The TN State Department of Health, Maternal and Child Health (MCH) section was the recipient of the Pregnancy Assistance Fund (PAF) grant. The grant was originally awarded to the Govenor's Office of Children's Care Coordination (GOCCC) with the intent to fund project activities in Shelby County, Tennessee. The TN legislature approved the grant funds in March 2011. Shortly after the approval of the funds, the GOCCC office was discontinued and the PAF grant was transferred to the TN State Department of Health, MCH section on July 1, 2011. MCH staff began working with Shelby County partners to begin preparing for the subcontracts needed to implement the project.

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 10-11, 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, depression and suicide ideation and asset development were among the pertinent health issues addressed.

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

b. Current Activities
In calendar year 2011, 12,380 adolescents ages 17 and under were provided services through the statewide Family Planning Program, with services at 123 sites in all 95 counties.

The Tennessee Adolescent Pregnancy Prevention Program (TAPPP) continued to utilize county and regional level health educators to provide community education. Program activities cover topics such as community awareness of teen pregnancy, comprehensive sexuality education, professional training, abstinence education, and adolescent growth and development.

Thirteen community-based agencies began implementation of federally funded abstinence education programs in both school and community-based settings. As part of the programs, all sites incorporated service learning projects to promote community involvement and self esteem. During the first half of FY12, 10,200 adolescents received school based programs, 1160 received after school programs and over 400 hours of community service was completed.

The Pregnancy Assistance Fund (PAF) grant received approval for thirteen subcontracts to provide services to approximately 340 pregnant and parenting teens in Memphis, TN. Services include: prenatal care, clinical services, educational information and referrals to community resources.

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

The Abstinence Education Program will continue to provide comprehensive, evidence-based, and medically accurate educational programs to middle school aged children (10-14 years old) expanding to high school students in the upcoming year. The programs will cover topics, such as: abstinence as a lifestyle choice, life vision and life skills, healthy lifestyle choices, positive support systems and leadership for service. Service learning projects will emphasize community involvement, supporting local volunteer organizations and promoting school and community service learning initiatives.

The Pregnancy Assistance Fund (PAF) grant program will partner with Memphis County School social workers and community liaisons to recruit teen participants, provide linkages to required resources, support educational attainment and track participant progess through a specialized tracking system. The participants will utilize Teen Centering Pregnancy (TCP) clinical services located at two high schools, as well as community health clinics, for prenatal care that provides an individual assessment, referral for community resources, parenting education, and support of pregnant teens. Through coordinated services, participants will have the opportunity to purchase

needed baby items through the Baby Store incentive program. A specialized tracking system will monitor, in real time, the services the pregnant or pareting teen use. The system will eliminate duplication of services, document number of prenatal and well child clinic visits and track purchases made at the Baby Stores.

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	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	23	24	40	40	40
Annual Indicator	21.8	37.2	37.2	37.2	37.2
Numerator	3769	366	366	366	366
Denominator	17256	983	983	983	983
Data Source		Tennessee Oral Health Survey	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	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	40	40	40	40	40

Notes - 2011
Data Source: 2008 Tennessee Oral Health Survey of children ages 5-11 years. This survey is conducted every FIVE years.

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.

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 11 (July 1, 2010-June 30, 2011), school based dental prevention services were being delivered in all 13 health department regions. Data for FY 11 show that 131,030 children had dental screenings in 324 schools. Of these, 26,991 children were

referred for unmet dental needs. Full dental exams were conducted on 58,750 children. A total number of 243,371 teeth were sealed on 44,488 children. 193,295 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 (TDH) has 55 fixed dental clinics located in 54 rural counties. The scope of services includes comprehensive dental care to children and emergency dental care for adults. During FY11, more than 17,595 children and more than 5,600 adults were treated in TDH dental clinics. TDH also operates three mobile dental clinics providing comprehensive dental services to underserved children at school sites. During FY11, 108 children received 1675 dental services in TDH 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 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 are 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, 2010 -June 30, 2011 more than 18,500 at risk children have been screened, referred, and had fluoride varnish applied in TDH 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	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	2.5	2.5	2	2	1.7
Annual Indicator	3.9	3.4	2.7	2.5	
Numerator	47	41	33	31	
Denominator	1194718	1201009	1207621	1238935	
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
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	2.4	2.3	2.3	2.3	2.3

Notes - 2011
Because 2011 population estimates are not available at this time, we are currently unable to report this indicator. Updated data for this reporting year will be made available to HRSA/MCHB as soon as updated population estimates are available.

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

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 2.5 in 2010. Tennessee's child passenger safety law of 2004 specified and strengthened requirements for child restraint devices. Maternal and Child Health programs collaborated 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, 2010 to September 30, 2011, the Child Safety Seat Fund received $42,099.35 in funds, expended $18,264.90, and purchased 299 child safety seats. During the same time period, 435 seats were distributed (includes some seats left over from previous year).

The Tennessee Road Builder's Association sponsors the Ollie the Otter Program. This program provided booster seat and seat belt education including the importance of using booster seats and seat belts and using them correctly.

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 child safety restraint 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
The Child Safety Fund Program has continued to purchase and distribute child restraint devices. From October 2010 to December 2011, 435 seats have been distributed (464 purchased during this time period). The Monroe Carell Jr. Children's Hospital at Vanderbilt continues to operate 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 collaborates with the Middle Tennessee Child Passenger Safety Center at Meharry to provide education and outreach.

The Ollie the Otter Program continues 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 in August 2012. The conference is designed for law enforcement, prosecutors, judicial personnel, educators, highway safety advocates and any member of the general public. The conference goal is to develop strategies, build alliances, and communicate agendas towards reducing the number of fatalities and injuries on Tennessee's roadways.

The Tennessee Violence and Injury Prevention Program (TVIPP), started training the home visiting staff on the WHALE (We Have a Little Emergency) program. The program provides identification cards for car seats.

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 continue to 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 programs and is expected to reach 800 children. Home visiting staff will make identification cards for all children participating in the HUGS and Healthy Start programs.

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	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	34	36	30	40	37.5
Annual Indicator	31.4	37.9	37.9	35.6	35.5
Numerator	14705	31952	31952	29230	29178

Denominator	46777	84308	84308	82109	82089
Data Source		CDC/National Immunization Survey	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
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	36	37	38	39	40

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.

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 an average of 20,150 pregnant women per month and enrolled about 52% of newborns in the state. Thirty percent of WIC delivered mothers were breastfeeding at time of postpartum certification. There were 8885 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.

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.

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. Staff training for all service levels on breastfeeding and the role of each staff level in its promotion.	X	X		
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.

TIPQC activities have continued, with current projects focused on breastfeeding promotion in both obstetrical and pediatric settings. The TIPQC initiative is now overseen by the Division of Family Health and Wellness (following the closure of the Governor's Office of Children's Care Coordination).

The Department of Health, jointly with the Tennessee Hospital Association (THA), sent a letter to every hospital in the state encouraging breastfeeding promotion and support. The letter included information about the benefits of breastfeeding and the strategies that could be used by hospitals to increase breastfeeding rates. The letter is included as an attachment to this section.
An attachment is included in this section. IVC_NPM11_Current Activities

c. Plan for the Coming Year

Plans for the coming year include continuing and expanding the WIC breastfeeding peer counselor program to the entire state, continuing to work with HUGS to strengthen breastfeeding support for mothers and their families, continuing a breastfeeding focus in the Tennessee Obesity Prevention Plan, and continuing the networking with Tennessee Initiative for Perinatal Quality Care (TIPQC) on their breastfeeding initiative. World Breastfeeding Week activities will focus on evidence-based information for the general public. A breastfeeding hotline is also being explored.

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	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	98	98	98	98	98
Annual Indicator	91.1	94.2	97.6	97.1	97.5
Numerator	83570	85613	85080	82058	82313
Denominator	91754	90885	87141	84535	84393
Data Source		Department of Health	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
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	99	99	99	99	99

Notes - 2011
Data Source: Tennessee Department of Health, Newborn Hearing Screening Program

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

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

a. Last Year's Accomplishments
The Early Hearing Detection and Intervention (EHDI) Newborn Hearing program documented 82,313 hearing screens of 84,393 occurrent births (97.5%) from January 2011-December 2011. This was just under the 98% goal for NPM #12. The program was able to meet the following Healthy People 2020 goals for hearing screening:

Goal 1: HP2020 90.2% should complete hearing screen by 1 month of age. In 2010, Tennessee screened 97.5%.

Goal 2: HP2020 72.6% should complete a diagnostic audiological evaluation by 3 months of age. Tennessee completed retesting on 70% by 3 months of age.

Goal 3: HP2020 55% should begin early intervention and habilitation services by 6 months of age. Tennessee documented start of early intervention services in 55% of infants by 6 months of age.

Of the 3,191 infants referred for further hearing screening, 63% completed diagnostic follow-up, 7% had pending results from an audiologist, and 30% were lost to follow-up after multiple attempts to contact the family. Sixty-three (63) infants were diagnosed with permanent hearing loss (incidence 0.66:1000), and 83% of those were documented with enrollment in the Tennessee Early Intervention System. The program continues to work on strategies and initiatives to meet the national EHDI goals of 1-3-6 and to reduce the number of infants lost to follow-up between the initial screen and diagnosis and between diagnosis of hearing loss and enrollment into early intervention services.

HRSA newborn hearing grant funds are utilized to contract for part-time services by an audiology consultant, deaf-educator/family outreach consultant and four parent consultants. The program partners with the University of Tennessee-Knoxville Center of Deafness and the Tennessee Disability Coalition - Family Voices organization for the consultant positions. The Centers for Disease Control and Prevention (CDC) Early Hearing Detection and Intervention (EHDI) grant provide an epidemiologist to conduct data evaluation and data links to other related programs such as vital records and the Department patient data system (PTBMIS). The newborn metabolic and hearing screening programs experienced several staffing challenges from October 2011 through March 2012. Four staff positions were vacant and one staff member was on extended illness. Nurses from other programs were trained to conduct follow-up. Vacancies were filled in December 2011 and June 2011. Due to CDC funding cuts, two fulltime nurse consultants that provided follow-up tracking funded by the EHDI grant were discontinued in September 2011.

Educational and quality improvement activities for hospitals included the distribution of new tools on hearing risk indicators, scripts on how to report hearing results to families to optimize follow-up, monthly reports on infants that had no hearing reported, and quarterly reports on hearing screens by method, number screened, diagnosed, and enrolled in early intervention. Consultation and site visits were provided to individual hospitals. The audiology consultant participated in pediatric grand rounds training for several hospital and physicians' groups. Hearing screening equipment and training were provided to two midwifery groups in West Tennessee. Midwives will share equipment. The program provided support to assist families of children with hearing loss create the Tennessee Chapter of Hands and Voices, in September 2011. This family support organization will expand and compliment the parent support activities provided by the Family Voices parent consultants.

The hearing program purchased hearing screening equipment for the East Tennessee Children's Special Services program and for the West Tennessee School for the Deaf. The equipment enabled the programs to add automated auditory brainstem response (AABR) testing. The program partnered with the Vanderbilt University School of Medicine, Department of Hearing and Speech Sciences to initiate a pilot project to conduct audiological diagnostic teleaudiology services in the West Tennessee Region, an area with less access to hearing professionals and a higher rate of loss to follow-up after a referred hearing screen.

Program evaluation is conducted through data system links to metabolic screening, hearing screening, vital records and the Department's Patient Tracking, Billing, and Management System. The links enable the program to accurately assess the percentage of births.

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 effectiveness, 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

Program staffing and reorganization occurred from January to March 2012. The program provided funding from October -- December 2011 for the two nursing positions previously funded by the CDC EHDI grant; the positions were then discontinued due to CDC funding cuts. Hearing follow-up activities performed by these staff members had to be absorbed by existing staff. In January 2011, newborn screening staff relocated from the state laboratory to the downtown MCH office. In March 2012, the program was restructured to fully integrate the metabolic and hearing newborn screening programs. Training is currently being conducted for staff to better serve in their expanded roles. In January 2012, a Spanish speaking parent consultant was added to the Family Voices contract. The bilingual consultant provides direct contact to Spanish speaking families of infants with a hearing loss or in need of hearing follow-up.

Statewide training has been conducted for Early Head Start and Tennessee Early Intervention staff on otoacoustic emission screening for the birth to three years of age population to implement the Early Childhood Hearing Outreach (ECHO) project. Training activities continue to be conducted for families, hospitals, audiologists and other health professionals. Program activities focus on screening all infants for hearing loss and reducing the percentage of loss to follow-up for infants in need of diagnostic evaluation, early intervention services and family support services.

c. Plan for the Coming Year

The Newborn Hearing Program will continue to conduct activities to meet the goals and objectives outlined in the HRSA Newborn Hearing Grant and the CDC EDHI grant in regard to meeting the National 1-3-6 goals for Newborn Screening.

Goal 1: By January 2014, decrease from 2.2% to 1% the number of infants that do not receive a hearing screen prior to one month of age. Activities to achieve this goal include monthly monitoring of hospital hearing screening rates to identify missed infants, and providing primary care providers, obstetric and prenatal care providers and with educational information in hard copy and electronic formats.

Goal 2: By January 2014, increase from 69.8% to 80% the number of infants that received follow-up after an initial failed screen prior to 3 months of age. Activities to achieve this goal include

providing electronic and hardcopy lists of audiological providers to families, medical providers and others; implementing teleaudiology services to areas with a lack of hearing providers; and training of audiologists to increase reporting of hearing follow-up testing to the program. Due to recent HRSA funding cuts, planned hearing equipment purchasing for midwives will be discontinued.

Goal 3: By January 2014, increase the percentage of hearing screens and decrease the percentage of lost to follow-up in special populations including African American, Hispanic, and home births. The program will collaborate with home visiting programs to implement procedures to improve child assessment criteria to identify children in need of hearing follow-up due to a failed screen or in need of hearing follow-up. Expanded information systems links (vital records, health department programs like WIC, and home visiting programs) will be utilized to identify new addresses, phone numbers and name changes. The Early Head Start Childhood Hearing Outreach (ECHO) hearing screening program will have results linked to Newborn Hearing to identify children not previously reported as having received follow-up. The bilingual parent consultant will improve outreach to individual Hispanic families with infants in need of follow-up or identified with hearing loss.

Goal 4: By 2013, assess the effectiveness of the Newborn Hearing Program by participating in the Learning Collaborative for the National Initiative on Child Health Quality (NICHQ) as required by the HRSA grant. In April 2013, the newborn hearing program will participate with several other states in a quality improvement process through the National Initiative on Child Health Quality (NICHQ) to develop strategies to improve progress toward program goals to identify infants with hearing loss and assure quality timely intervention services. A committee of hearing professionals, early interventionists, parents, educators and medical professionals have been identified to participate in this task.

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	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	6	6	6	3	3.7
Annual Indicator	6.4	4.9	3.7	3.9	2.4
Numerator	88283	72258	54759	57912	35743
Denominator	1386911	1474653	1479972	1484923	1489292
Data Source		UT CBER	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
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	2.3	2.3	2.2	2.2	2.1

Notes - 2011
Data Source: "The Impact of TennCare, A Survey of Recipients, 2011."
Available at http://cber.bus.utk.edu/tncare/tncare11.pdf (Table 1a, page 3)

There has also been a decrease in the number and percentage of uninsured Tennesseans versus previous reporting periods. Per the report explanation (also on page 3): "The slight decrease in the total uninsured rate is attributable to the not-so-slight decrease in the uninsured rate of children, a result possibly driven by increased TennCare and CoverKids enrollments as well as sampling changes."

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

a. Last Year's Accomplishments
TennCare, the state's managed care program for Medicaid recipients, continued as the major source of health insurance coverage for children. TennCare enrollment data for February 2011 show a total of 746,364 participants under age 21.

U.S. Census Bureau 2010 Annual Social and Economic Supplement Current Population Survey data show that nationally 83.7% of all persons and 90.2% of children under age 18 were covered by some type of health insurance. U.S. Census data for a three-year average for 2008-2010 showed that 5.5.% of children under age 19 and at or below 200% of poverty were without health insurance in Tennessee. A 2011 survey from University of Tennessee Center for Business and Economic Research showed 3.9% of Tennessee children under age 18 in 2010 and 2.4% in 2011 were without insurance.

County health departments assisted persons with completion of the Department of Human Services (DHS)/TennCare application and made referrals to DHS for TennCare enrollment of any families with children who may qualify. All local health department clinics provided pregnancy testing and prenatal presumptive eligibility determination and enrollment for women who meet criteria for this Medicaid eligibility category. Eligibility begins immediately (day of application) for 45 days when the woman meets prenatal presumptive eligibility criteria. The presumptive eligible woman is urged by Department of Health staff to go to DHS as soon as possible to complete her application for full TennCare benefits that will go beyond the 45 days to cover her throughout her pregnancy and after the birth of the baby.

County health departments in two Department of Health regions are primary care provider (gatekeeper) sites for TennCare Managed Care Organizations and were assigned TennCare members. The assigned members are persons of all ages. During federal fiscal year 2010-2011, county health departments provided 64,830 EPSDT (well child) screens to TennCare eligibles under the age of 21.

The Department of Health TENNderCare Program conducted outreach initiatives for TennCare to encourage parents/guardians of members under the age of 21 to take advantage of free well child (TENNderCare) screenings.

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 heatlh 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
Departmental activities related to children and insurance coverage continue with health department sites performing prenatal presumptive eligibility determination and enrollment, enrollment of CSS children in TennCare and assistance with access to care by the coordinators. Health departments across the state perform EPSDT screenings for TennCare children and some health departments participate in TennCare as primary care physician (gatekeeper) provider sites. Outreach initiatives to educate and inform TennCare members and their parents about free EPSDT screens are conducted through the TENNderCare Call Center and Community Outreach. Outreach is performed by the Nursing Call Center to contact pregnant women enrolled in TennCare and provide a message about the importance of prenatal care. Assistance with completing the DHS application for TennCare is provided in health departments.

TennCare enrollment data for November 2011 shows 742,855 participants under the age of 21.

c. Plan for the Coming Year
Department of Health activities for children and insurance coverage will continue and will include enrollment in TennCare prenatal presumptive eligibility, assistance with completion of DHS (Medicaid) applications to persons interested in TennCare eligibility, provision of EPSDT (well child) screens at all county health departments, TENNderCare outreach efforts through the EPSDT Call Center, Nursing Call Center, Community Based outreach, and gatekeeper/primary care physician designation by TennCare managed care organizations of some health departments in the middle region of the state. Home visitation to TennCare members not up to date on the EPSDT screen will continue as a project of the TENNderCare Community Based outreach program.

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	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	9	30	14	25	15
Annual Indicator	34.0	14.9	15.2	15.4	10.7
Numerator	53971	9407	10490	11075	19967
Denominator	158733	63134	69015	71914	186444
Data Source		Department of Health	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
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	10	10	10	10	10

Notes - 2011
Data Source: Tennessee Department of Health, PedNSS/TN WIC Database.

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.

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 10-11 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 nutritional counseling to WIC participants with BMI at or above the 85th percentile.	X			
4. Provide up-to-date information on overweight and anemia to local health department programs.	X			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 exammine (CDC) Pediatric Nutrition Surveillance System to calculate provisional analysis for program planning and development purposes.*PedNSS will end with data for 2011. Final 2011 data is expected in Late summer/early fall.			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. Reports have been color-coded for easier reviewing by nursing, nutrition and clerical staff.

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.

Important note: The final PedNSS data will be provided for 2011 in late summer/early fall 2012. After the 2011 data is compiled, there will no longer be PedNSS data collection by CDC.

c. Plan for the Coming Year

The regional specific reports will continue to be provided to local WIC agencies. The current PedNSS reporting format will be discontinued by CDC; however, the data will be extracted from PTBMIS so that quarterly sharing of this information can continue 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	2007	2008	2009	2010	2011
Annual Performance Objective	9	7.5	13	13	13.5

Annual Indicator	19.4	15.4	15.0	14.2	13.6
Numerator	16774	13138	12257	11260	10769
Denominator	86558	85480	81888	79130	79028
Data Source		Department of Health	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
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	13	12.5	12	12	12

Notes - 2011
Data Source: Tennessee Department of Health, Division of Health Statistics, Birth Statistical System

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

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 WIC 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, postpartum and breastfeeding women for smoking status.

According to birth certificate data, 14.2% of births in 2010 were to women who smoked during the last 3 months of pregnancy. This is a decrease from 15.0% in 2009. However, there is great variation across the state, with higher maternal smoking rates in the eastern counties. There is also a wide disparity based on race. In 2010, birth certificate data showed that the percent of white women who smoked during pregnancy was over twice that of black women (16.5% vs. 7.2%, respectively).

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	X	
2. Provide pregnancy testing, counseling, referrals, and presumptive eligibility for TennCare enrollment in all health department clinics.	X	X	X	
3. Provide home visiting services for pregnant women.		X		
4. Offer comprehensive prenatal care services, including counseling education, in selected 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	X
7.				
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 supplemental nutrition 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	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	6	5.2	5	5	5
Annual Indicator	6.9	5.6	9.1	7.1	
Numerator	29	24	39	31	
Denominator	422058	426040	430127	437186	
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
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	7	7	6.8	6.8	6.6

Notes - 2011
Because 2011 population estimates are not available at this time, we are currently unable to report this indicator. Updated data for this reporting year will be made available to HRSA/MCHB as soon as updated population estimates are available.

Notes - 2010
Data Source: Tennessee Department of Health, Division of Health Statistics, Death Statistical System and 2010 US Census.

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

a. Last Year's Accomplishments
Data from the 2011 Tennessee Youth Risk Behavior Survey (YRBS) indicated that in the past 12 months, 26% of students surveyed felt sad or hopeless for two weeks of more; 15% seriously considered attempting suicide; 11% made a suicide plan; 6% attempted suicide; and 2% attempted suicide resulting in injury, poisoning or overdose requiring medical treatment. The Director of Adolescent Health 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. One of the goals the Adolescent Health Initiative addresses is to ensure access to mental health services and to ensure availability of mental health services for early identification and intervention with at-risk adolescents.

The Tennessee Department of Mental Health and Developmental Disabilities (TMHDD) 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. TMHDD works closely with the Tennessee Suicide Prevention Network (TSPN). TSPN is the statewide public-private organization responsible for implementing the Tennessee Strategy for Suicide Prevention as defined by the 2001 National Strategy for Suicide Prevention.

TSPN 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 educational materials statewide on adolescent suicide prevention.			X	
4. Provide suicide prevention training for teachers.				X
5. Initiate QPR (Question, Persuade, Refer) training for TDH central office staff.				X
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 adolescent health director was part of the planning 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.

The Adolescent Health Director initiated Question, Persuade and Refer (QPR) training for MCH and other Tennessee Department of Health staff at the Central Office.

c. Plan for the Coming Year
TSPN will conduct a series of three advocacy and training sessions in 2012. QPR training will enable staff to recognize signs of suicide ideation, initiate conversation about the situation and make appropriate referrals.

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 committee for the Suicide Prevention and the African American Faith Communities which will work more closely with faith-based organizations on a local level to develop suicide prevention awareness and management policies.

The adolescent health director will continue to participate in the Tennessee Suicide Prevention Network's advisory committee meetings and annual advisory board meeting. She will also continue to serve as the TDH 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	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	80	80	70	80	83
Annual Indicator	68.5	80.7	79.1	82.9	84.0
Numerator	1036	1112	1085	1032	997
Denominator	1513	1378	1371	1245	1187
Data Source		Department of Health	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
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance	84.5	85	85.5	86	86.5

Objective					

Notes - 2011
Data Source: Tennessee Department of Health, Division of Health Statistics, Birth Statistical System

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

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. Annually, the Regional Perinatal Centers have been asked to list those hospitals in their geographic areas providing high risk (Level III) care. Data from 2007-2010 show a range of 68.5% to 82.6% of VLBW babies delivered in tertiary level hospitals. Provisional data for 2011 (82.9%) for this indicator show that this statistic is improving. Final data for 2010 for total very low weight births, as compared to 2009, show a decrease of 129 infants; the percentage changed from 1.7% to 1.6% with total births estimated to decrease in number by 2,764.

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. Work during 2011 focused on a legislative directive to study (and develop recommendations for) hospital discharge for premature infants and collaboration with the Genetics Advisory Committee on Critical Congenital Heart Disease (CCHD) implementation.

During state FY 2011, the five obstetrical perinatal centers had 13,285 deliveries for Tennessee residents (compared to 79,345 resident births statewide for CY 2010), documented 742 telephone consultations and 35,097 onsite patient consultations, and provided 1,720 hours of education. Data from the five neonatal perinatal centers for the same time period show 3,264 in-born admissions to Tennessee residents, of which 454 were VLBW (2010 VLBW resident births statewide were 1,245); 1,274 transports; 3,148 on-site consultations; and 3,729 hours of education taught.

The Tennessee Initiative for Perinatal Quality Care (TIPQC) began in 2008 to develop a

statewide quality collaborative to improve birth outcomes in the state. The voluntary organization has grown to over 1,400 members, including perinatologists, neonatologists, hospitals at all levels of perinatal care, administrators, third party payors, state officials, and community constituents. In March 2011, over 300 physicians, nurses, advocates, payors, hospital administrators, government leaders, and families met to collaborate on ways to reduce infant mortality and morbidity through sharing of their quality improvement projects and focusing specifically on obstetrical management. The first statewide project was on NICU admission temperature, followed by central line associated bloodstream infections, human milk for the NICU infant, breastfeeding promotion, registry for undetected CCHD, 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	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 (pending release of new national guidelines); a work group has been 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 in delivery centers and the NICU golden hour (designed to improve the first hour of life by involving families and other key stakeholders). Numerous national bodies, including CMS (Medicare and Medicaid) and the March of Dimes, are focusing on early elective deliveries; TIPQC will be holding webinars on the topic and recruiting facilities to join the project to reduce early elective deliveries before 39 weeks in Tennessee.

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. Work groups will finalize the revision of the "Transportation Guidelines" manual and work on revisions to the regionalization guidelines if new national

guidelines are released.

The Department will work closely with TIPQC on the planned quality improvement projects. New projects include maternal mortality and specifically post-partum hemorrhage, neonatal follow up, 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	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	90	90	70	70	75
Annual Indicator	63.7	67.7	69.0	70.5	69.9
Numerator	55134	54765	53529	52372	50351
Denominator	86558	80887	77565	74301	72014
Data Source		Department of Health	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
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	70	71	72	73	74

Notes - 2011
Data Source: Tennessee Department of Health, Division of Health Statistics, Birth Statistical System

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).

a. Last Year's Accomplishments

Final 2010 birth certificate data show that 70.5% of pregnant women entered prenatal care in the first trimester. 2009 birth certificate data show that 69.1% of pregnant women started prenatal care in the first trimester.

Of the total births in Tennessee in 2010, 52.2% were on TennCare/Medicaid; this is similar to data for 2009.

Comparing the 2010 data for entry into prenatal care for Medicaid and non-Medicaid births, the data show that 61.7% of infants on Medicaid were born to pregnant women receiving prenatal care beginning in the first trimester, 81.0% for the non-Medicaid, and 70.5% overall. Using the same data set, 83.4% of pregnant women on Medicaid received adequate prenatal care (Kotelchuck index); 91.2% for non-Medicaid women; and 87.0% 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 (75,991 tests in CY 2011), presumptive eligibility determination for TennCare (15,765 enrolled in CY 2011), 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 FY 2011, 1,202 pregnant women were provided HUGS home visiting services, and 311 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 2011; delivery services are by a private physician in the community. Data for this clinic for CY 2011 show services to 446 pregnant women, and of these, 93.7% were self pay (not on TennCare) and 34.8% were Hispanic.

Effective July 1, 2011, the Governor's Office of Children's Care Coordination was eliminated and the programs/projects transferred to various state departments. Those projects transitioning to TDH included the Centering Pregnancy programs (Chattanooga, Memphis, and Nashville), TIPQC, Fetal Infant Mortality Review (FIMR), smoking cessation and substance abuse case management (two rural East TN counties), and the Tennessee Intervention for Pregnant Smokers (Northeast Tennessee).

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 2011, 2,467 phone calls were received at the Shelby County Health Department, and 3,351 coupon books, along with folic acid, WIC, and other prenatal/infant educational information (approximately 3,000 brochures), were mailed.

The 2009 PRAMS report was finalized and is being shared throughout the State. The response rate was insufficient to allow for comparison with other states; however, the data are very useful for the Departmental programs and for partner agencies.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide pregnancy testing, counseling, and referral, and	X	X	X	

presumptive eligibility in all local health department clinics.				
2. Provide home visiting services for pregnant women.	X	X		
3. Provide comprehensive prenatal care in 1 county.	X			
4. Provide WIC/nutrition services in all local health department clinics.	X	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	X	X
7. Support the infant mortality/women's health projects funded through TennCare agreement with the Department.	X	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. March 2012 WIC data show that 20,652 pregnant women were participating in WIC in 134 clinics.

Funding continued for infant mortality/women's health projects related to Centering Pregnancy, smoking cessation, substance abuse counseling and prevention, the 4 FIMR pilot projects, infant mortality prevention in Chattanooga and Memphis, and TIPQC.

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.

The statewide PRAMS system continues with data/information collection and data analysis.

c. Plan for the Coming Year

All previously discussed activities will continue into the coming year with the exception of those infant mortality projects whose funding ended during FY 2012. 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: *Rate of sleep-related infant deaths (per 1,000 live births).*

Tracking Performance Measures

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

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective					7
Annual Indicator			1.6	1.7	
Numerator			129	131	
Denominator			82109	79345	
Data Source			Department of	Department of	

			Health	Health	
Is the Data Provisional or Final?				Final	
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	1	1	1	1	1

Notes - 2011
Data not available for 2011. The Child Fatality data for 2011 (source for the numerator) is expected to be available in late 2012.

Notes - 2010
Data Source: Number of sleep related deaths (numerator) comes from the Child Fatality Review. The number of births (denominator) comes from the Tennessee Department of Health, Division of Health Statistics, Birth and Death Statistical Systems.

Notes - 2009
Data Source: Number of sleep related deaths (numerator) comes from the Child Fatality Review. The number of births (denominator) comes from the Tennessee Department of Health, Division of Health Statistics, Birth and Death Statistical Systems.

a. Last Year's Accomplishments
Middle Tennessee State University, through a contract with the Tennessee Department of Health, provided two death scene investigation trainings for unexpected child deaths. The trainings were for first responders, including firefighters, law enforcement and emergency medical techniicans. The trainings include information for first responders on what to look for at the death scene to determine if a death was sleep-related.

Child Fatality Review teams reviewed all sleep-related infant deaths to better understand the circumstances involved and target prevention efforts.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Distribute safe sleep educational materials.			X	
2. Broadcast safe sleep public service announcement.			X	
3. Advertise safe sleep messages on city buses.			X	
4. Distribute promotionals items with a safe sleep message.			X	
5. Continue Death Scene Investigation training.			X	X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Middle Tennessee State University provided two death scene investigation trainings for unexpected child death again this year; one in February and one in May. This training continued to provide education to first responders on sleep-related infant deaths.

TheTennessee Department of Health developed new posters, flyers, and door hangers to be distributed promoting safe sleep for infants. All families with infants participating in the home visiting program will receive information on safe sleep. The Department of Health also purchased onesies, dry erase memo boards, and pens with a safe sleep message. The Department of Health will be promoting safe sleep from June through September by running ads on the outside of city buses in Memphis and Nashville. In addition, the Department of Health will air public

service announcements statewide on the radio during the same time period. Samples of campaign materials are included as an attachment to this section.

The Fetal and Infant Mortality Review (FIMR) program in East Tennessee created bookmarks with a safe sleep message that they are distributing to community members. The program has also collaborated with Food City grocery store to implement the "Floor Talkers" project This project will put safe sleep messages on the floors of the baby aisles.

The FIMR program in Chattanooga will be running ads on the outside of city buses in the Chattanooga area.

The Child Fatality Review teams continued to review all sleep-related deat
An attachment is included in this section. IVD_SPM1_Current Activities

c. Plan for the Coming Year
Middle Tennessee State University will continue to provide two death scene investigation trainings for first responders.

The Child Fatality Review teams will continue to review all sleep-related deaths.

The Tennessee Department of Health will continue to distribute posters, flyers and door hangers promoting infant safe sleep. The Department will also continue to send the public service announcement to television news networks for broadcasting.

The East Tennessee FIMR program will continue to implement the Floor Talkers project. This project will continue to put safe sleep messages on the floors of the baby aisles in Food City grocery stores. The FIMR program will also continue to distribute the bookmarks with the safe sleep message.

State Performance Measure 2: *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	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective					25
Annual Indicator		40.9	39.0		
Numerator		194814	191090		
Denominator		476318	489975		
Data Source		Department of Education	Department of Education	Department of Education	Department of Education
Is the Data Provisional or Final?					
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	25	25	25	25	25

Notes - 2011
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 - 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.

a. Last Year's Accomplishments
Widespread promotion and implementation of the state plan for Nutrition, Phsyical Activity and Obesity (NPAO) has continued and the plan has been adopted by over 600 organizations and individuals, all coming together with a consistent message and plan of action.

The state plan has been implemented at both the state and the local level through existing Department of Health infrastructure, partners and contractual agreements. Eight grantees received funding to implement portions of the plan focused on reducing obesity. On the local level projects included expanding access to local parks and recreation facilities, providing healthier concession options at such facilities, refurbishing playground equipment, installing walking tracks while ensuring joint use agreements are in place for community use. Training for health professionals and phsycians took place, and policy recommendations were created for people with special needs. A one stop recreation online resource guide was developed for statewide use.

Save the Children selected Tennessee as one of their target states to support advocacy efforts targeted at childhood obesity. The main focus area of their efforts this year was the Coordinated School Health Program which 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; however, the funding continues to be in jeopardy until it is placed into a "recurring" status in the state budget.

Breastfeeding legislation passed authorizing mothers to publicly breastfeed their babies beyond the previously-established 12 month age limit. The "Breastfeeding Welcomed Here" campaign began in Davidson County, encouraging businesses to sign a pledge and advertise their committment to breastfeeding mothers and babies and to the Tennessee breastfeeding laws. The percentage of women initiating breastfeeding in Tennessee increased for the fourth year in a row to 65.6% in 2011 according to the CDC's breastfeeding report card.

The Gold Sneaker initiative continued statewide enhancing 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.

The Food Trust provided technical assistance to the state to find a solution to urban food deserts. The "Food Desert Relief Act" was presented to the legislature, to consider incentives to grocers willing to locate in such areas. This bill did not pass, but brought much attention to the topic, and the creation of a statewide Food Access Committee.

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 measurement 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 grant for the Nutrition, Physical Activity, and Obesity (NPAO) Program.				X
5. Partner with local and metropolitan health departments on obesity prevention initiatives.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Widespread promotion and implementation of the state plan for Nutrition, Physical Activity and Obesity (NPAO) has continued and the plan has been adopted by numerous community organizations and county health councils. The Tennessee Obesity Taskforce has grown to include over 600 individual representatives.

Save the Children selected Tennessee to support advocacy efforts targeted at childhood obesity with a specific focus of securing funding for the Coordinated School Health Program which was achieved and the funding is now in a "recurring" status. The program implements wellness policies (physical activity and nutrition guidelines); comprehensive health education; school specific wellness plans and school health advisory councils.

Eight grantees throughout the state received funding to implement portions of the NPAO state plan. Grants focused on reducing childhood obesity by expanding access to local parks and recreation facilities, healthier concession options, refurbishing playground equipment and installing walking tracks combined with joint use agreements to make such areas open for the public outside of school hours. On a statewide level, nutrition and physical activity policy was developed for persons with special needs.

Gold Sneaker continues, changing policy in child care facilities. At this time, 247 facilities have earned the staus, reaching over 13,000 children, 729 providers and 51,000 family members.

c. Plan for the Coming Year
The majority of the work in 2012-2013 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 in addition to implementation work from TDH. Statewide, the Gold Sneaker program will continue to be promoted, training will continue and technical assistance will continue. The ABC 123 Curricula from the Cancer Control Program will be offered to all Gold Sneaker facilities. This curricula is general health education aimed at preventing chronic disease, in general, based on diet and activity.

Six grantees throughout the state have received funding to implement portions of the NPAO state plan. Grants focused on reducing obesity on the local level includes increasing the value of EBT/Food Stamp cards when purchasing fresh fruits and vegetables at local farmers markets; increasing access to fruits and vegetables for the senior population; cooking and exercise programs for seniors; professional development and support, including resources, for early child care providers; a conference for both early child care providers and families of children in care; a nutrition value scoring system in a middle school to assist students in making healtheir food choices; and construction of a walking track in a rural area, with a joint use agreement in place to ensure community access. On a statewide level, a "one stop" website for public parks and recreation areas in the state will be created so that residents will be aware of all oppportunities to be phsyically active rather than relying on various individual organization websites.

The Davidson County "Breastfeeding Welcomed Here" campaign was degined for businesses to pledge to support breatfeeding in their places of business and increasing awareness of the legal rights of breastfeeding mothers and children; this will be implemented statewide through the Tennessee Breastfeeding Coalition. State office buildings, local health departments, child care facilities and local businesses will be targeted for participation.

Work with Parks and Recreation will continue, enphasizing joint use agreements with schools and community facilities, ensuring citizens have access to safe opportunities to be physically active.

The sustainability plan that was developed by the Nutrition, Physical Activity and Obesity program will be put into action. This plan describes actions to secure and sustain implementation and partnership activities within the state plan by leveraging partnership resources and expertise.

State Performance Measure 3: *Percentage of smoking among women of age 18-44.*

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

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective					20
Annual Indicator		29.6	15.0	14.2	
Numerator		121909	12257	11252	
Denominator		411751	81888	79094	
Data Source		Department of Health	Department of Health	Department of Health	
Is the Data Provisional or Final?				Final	
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance	20	20	19	19	18

Objective					

Notes - 2011
Data for 2011 not yet available. This state performance measure has changed from previous years. The data source will be the Behavioral Risk Factor Surveillance System (BRFSS).

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.

a. Last Year's Accomplishments
Prenatal Patients on TennCare were offered tobacco cessation services through their MCOs, including medications. This was a requirement of the Affordable Care Act.

With ARRA funds, a media campaign began in 2010 with first radio spots promoting the quitline. Target populations were all smokers in TN, including pregnant women. In July 2010, the quitline vendor was awarded, and enhanced quitline services through web based counseling were introduced, as well as a media campaign targeting disparate population smokers, including pregnant women. The "Jenny Smokes" campaign depicted a mother holding her newborn baby, stating that "Jenny smokes two packs a day, and so does her mom." The campaign stressed the harms of second hand smoke that occurs to a newborn.

TN WIC services included smoking cessation information and the effects of secondhand smoke on children. Written materials were provided along with limited counseling, quitline number, and education.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. A Media Campaign targets pregnant women and women with children, and parents who smoke, emphasizing the harms of second hand smoke, and importance of utilizing the Quitline services.			X	
2. Anti-Tobacco Advocacy Initiative educates and informs all citizens about issues related to tobacco prevention, and availability for quitline services.			X	
3. Tobacco Technical Assistance Consortium provides technical training to the statewide tobacco workgroup related to the four national goals as defined by the Centers for Disease Control.				X
4. Tennessee Quitline provides tobacco quitline cessation counseling services and referral to all callers within the State of Tennessee.		X	X	
5. TennCare provides assistance in the promotion of the quitline through their managed care organizations, especially to those patients who identify as being pregnant, and provides tobacco cessation treatment.			X	
6. Collaborate with the Tennessee Office of Coordinated School			X	X

Health to help with the promotion of tobacco prevention education and referral to the Tennessee Tobacco Quitline.				
7. WIC services provide smoking cessation, education, and limited counseling for participants and their families.	X			
8.				
9.				
10.				

b. Current Activities
The "Jenny Smokes" Campaign has continued across the state. This campaign was developed to stimulate and drive smokers to the Quitline Services. Special emphasis is placed on pregnant women to utilize the Quitline services.

The Anti-Tobacco Advocacy Initiative educates and informs all citizens about issues related to tobacco prevention, and availability for quitline service.

The Tennessee Quitline provides tobacco quitline cessation counseling services and referral to all callers within the State of Tennessee.

TennCare provides assistance in the promotion of the quitline through their managed care organizations, especially to those patients who identify as being pregnant, and provides tobacco cessation treatment. All TennCare patients are now offered tobacco cessation services.

The Department of Health also collaborates with the Tennessee Office of Coordinated School Health to help with the promotion of tobacco prevention education and referral.

The Tobacco Technical Assistance Consortium provides technical training to the statewide tobacco workgroup related to the four national goals as defined by the Centers for Disease Control.

As a part of the TN WIC Program education and counseling, all prenatal, postpartum and breastfeeding women receive smoking cessation information, quitline number, and support. Additionally, all families with infants and children receive education and information about the effects of secondhand smoke.

c. Plan for the Coming Year
The Anti-Tobacco Advocacy Initiative will educate and inform all citizens about issues related to tobacco prevention and availability of quitline services.

The Tobacco Technical Assistance Consortium will continue to provide technical training to the statewide tobacco workgroup related to the four national goals as defined by the Centers for Disease Control.

The Tennessee Quitline will continue to provide tobacco quitline cessation counseling services and referral to all callers within the State of Tennessee.

TennCare will continue to provide assistance in the promotion of the quitline through their managed care organizations, especially to those patients who identify as being pregnant, and will continue to provide tobacco cessation treatment.

The Department of Health will continue to collaborate with the Tennessee Office of Coordinated School Health to help with the promotion of tobacco prevention education and referral to the Tennessee Tobacco Quitline.

WIC will continue to provide smoking cessation, education, and support for its participants as well as written educational materials and promotion of the quitline.

State Performance Measure 4: *Rate of emergency department visits due to asthma for children 1-4 years of age (per 100,000).*

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

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					20
Annual Indicator			220.5	1,827.0	
Numerator			1070	6007	
Denominator			485318	328797	
Data Source			Department of Health	Department of Health	
Is the Data Provisional or Final?				Final	
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	1700	1650	1600	1550	1500

Notes - 2011
Because 2011 population estimates are not available at this time, we are currently unable to report this indicator. Also, provisional 2011 hospital discharge data system (HDDS) numerator data was not available at time of the report. Updated data for this reporting year will be made available to HRSA/MCHB as soon as updated population estimates and HDDS data are available.

Notes - 2010
Data Source: Tennessee Department of Health, Office of Health Statistics, Hospital Discharge Data System and 2010 US Census.

NOTE: This performance measure was changed in 2011, such that the 2010 data reported here is not comparable with previous years.

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

Note for 2013 application: This state performance measure has been changed. Therefore, comparison between the 2009 and 2010 indicators is not appropriate.

a. Last Year's Accomplishments
During FY 2010-2011 activities were conducted based on the goals and objectives established in the STAT Plan to Reduce the Burden of Asthma, 2009. Many of the activities address reducing emergency department (ED) visits for children 1-4 years.

The Asthma Management Intiative director developed and provided training on the potential uses for asthma kits for Child Care Resource and Referral (CCR&R) coordinators. Follow-up communication indicated that the coordinators utilized the kit to train community child-care providers.

The Asthma Management Initiative online asthma kit was updated with current resources and tools for parents, clinicians, childcare providers, local and state governments.

An educational print campaign on the potential health consequences of secondhand smoke on

young children was conducted. Door knob hangers, car visor plaques and table tents were distributed to local health departments, Children Special Services coordinators, home visiting coordinators, managed care organizations, adolescent health coordinators and State of Tennessee Asthma Task Force (STAT) members. The materials were distributed statewide and promoted the TN Quitline, a free service assisting Tennesseans to quit tobacco use.

The Asthma Management Initiative director co-presented with STAT nurses at several at conferences targeting child care educators, including the Nashville Area Association for the Education of Young Children.

Quarterly STAT teleconferences were convened to share updates on current state and community level activities.

The Initiative collaborated with Monroe Carrell Jr. Children's Hospital at Vanderbilt by sponsoring regional health representatives to attend their annual Pediatric Asthma Education Conference sponsored attendees are then required to work with STAT in facilitating established goals and objectives.

Another activity included supporting community efforts, i.e. Not One More Life (NOML) asthma education programs in Memphis and Chattnooga by encouraging agencies to host educational events at their sites.

CSS sponsored eight participants with an asthma diagnosis to attend a week-long asthma camp coordinated by the YMCA and Vanderbilt. The camp provides regular learning and development activities and provides additional asthma management education for children with asthma.

Asthma awareness and management messages were distributed via the Department's Twitter and Facebook accounts during the annual Child Health Week celebration.
An attachment is included in this section. IVD_SPM4_Last Year's Accomplishments

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Update the asthma kits for CCR&R Coordinators and CSS participants.		X		
2. Update the Asthma Management Initiative website.			X	
3. Conduct educational speaking engagements.		X		
4. Facilitate quarterly STAT teleconferences.				X
5. Sponsor regional health office representatives to attend the Vanderbilt pediatric asthma conference.		X		
6. Submit asthma management and asthma action plan messages during Child Health Week to Twitter and Facebook.			X	
7.				
8.				
9.				
10.				

b. Current Activities
Collaboration continues between the Asthma Initiative and the CCR&Rs. Activities include: updates to the toolkits, identification of resources for more advanced training for CCR&R Coordinators, and development of a survey to assess toolkit use.

The director continues to conduct public presentations and recently presented for the University of Tennessee at Knoxville, Parent Education Summit and the 2012 NAAEYC Conference.

Presentations are also scheduled for the Early Childhood Summit and the East Tennessee Nurses Conference.

Quarterly STAT teleconferences are convened providing updates on current activities.

The Initiative sponsored eight regional health office representatives to attend the pediatric asthma conference. Those who attended are expected to participate in quarterly STAT calls, provide at least one in-service training for regional and local staff on basic asthma mangement and use of asthma action plans, and disseminate secondhand smoke and indoor air quality information through their communities.

The director continues to encourage agencies to host NOML events and will add asthma massages to the state's Twitter and Facebook account.

c. Plan for the Coming Year

The Asthma Initiative director will continue to collaborate with the CCR&R Network Coordinator and obtain feedback on the coordinator's asthma activities. This should provide a greater level of accountability for asthma education and promotion of asthma action plans and provide data on the extent of asthma training and education among child care providers.

The director will continue to pursue opportunities for speaking engagements targeting child care providers, educators and health care providers increasing awareness of basic asthma management, importance of asthma action plans and the role of environmental asthma triggers.

Quarterly STAT calls will be convened encouraging members to utilize oportunities to further the goals and objectives of the STAT Plan to Reduce the Burden of Asthma.

The director will continue to encourage agencies to host NOML asthma education events in their respective sites.

Asthma management and asthma action plans messages will be added to the state's Twitter and Facebook accounts during Child Health Week.

State Performance Measure 5: *Number of MCH staff who have completed a self-assessment and based on the assessment have identified and completed a module in the MCH Navigator system.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					0
Annual Indicator					
Numerator					
Denominator					
Data Source					
Is the Data Provisional or Final?					
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	0	0	0	0	0

Notes - 2011

This SPM has been changed. Therefore data is not reported for 2011 but will be reported in future years.

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
N/A--This is a new State Performance Measure.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. N/A--this is a new State Performance Measure.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
N/A--This is a new State Performance Measure.

c. Plan for the Coming Year
In the coming year, the state MCH Director will work with all Central Office MCH staff to complete a self-assessment (either the Council on Linkages Public Health Leadership Self-Assessment or the MCH Core Competencies Self-Assessment). Based on the results of the self-assessment, each staff member will work with his/her supervisor to identify at least one activity for completion in the MCH Navigator system.

In the coming year, the state MCH Director will also work with all thirteen regional MCH Directors to introduce them to the MCH Navigator system. A webinar will be held in which the Navigator will be introduced. Specific applications related to workforce development will be discussed.

All regional MCH Directors will be asked to complete one of the self-assessment tools (either the Council on Linkages Public Health Leadership Self-Assessment or the MCH Core Competencies Self-Assessment). Based on the results of the self-assessment, each regional MCH Director will identify at least one activity for completion in the MCH Navigator system.

The State MCH Director and Central Office staff will work with regional MCH staff to encourage dissemination of information on the Life Course perspective. All regional MCH Directors will be encouraged to facilitate the "Life Course Game" with their regional and local MCH staff as a method of reinforcing knowledge about the Life Course perspective.

Later in the year, each Regional MCH Director will be asked to share the MCH Navigator system with their staff.

The State MCH Director will work with the State Director of Nursing (who oversees all public health nurses in the State) to explore opportunities for adding modules from the MCH Navigator system to the state Public Health Nurse standardized orientation.

State Performance Measure 6: *Percentage of youth (14 and older) enrolled in the state CSHCN program 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	2007	2008	2009	2010	2011
Annual Performance Objective					45
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	
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	45	45	55	55	60

Notes - 2011
This SPM has been changed. Therefore data is not reported for 2011 but will be reported in future years.

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

a. Last Year's Accomplishments
N/A. This is a new state performance measure.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. N/A--this is a new State Performance Measure.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

N/A. This is a new state performance measure.

c. Plan for the Coming Year
CSS staff will target all participants 14 years of age and older and will conduct individualized transition planning that includes the following domains of transition: Medical, Independent Living, Financial, Legal, Education/Vocational, Employment, Social/Recreation, Family Resources and any Additional Resources requested by the family or CYSHCN.

CSS staff will provide a portable medical history summary form to all participants age 14 and older that will include pertinent health care information and can be utilized when participants transition to adult health care providers.

CSS staff will continue to work with health care providers to ensure that transitioning participants have a medical home.

CSS will continue to collaborate with other child serving agencies to develop a transition tool kit that may be used within all agencies that provide services to youth of transition age, and will be inclusive of health goals and objectives. Staff will continue collaboration with these agencies to develop a state wide policy regarding transition where feasible.

CSS will include the American Chapter of Pediatrics Emergency Preparedness Guidelines into the transition plan for CSHCN.

CSS will continue to monitor national developments regarding transition standards and best practices, and will incorporate those initiatives into our program where feasible.

CSS will continue to provide professional development and training to staff surrounding transition issues.

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State Performance Measure 7: *Rate of unintentional injury death in children and young people ages 0-24 (per 100,000).*

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

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective					14
Annual Indicator			19.0	19.7	
Numerator			376	398	
Denominator			1974006	2023349	
Data Source			Department of Health	Department of Health	
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	18.5	18	17.5	17	16.5

Notes - 2011

Because 2011 population estimates are not available at this time, we are currently unable to report this indicator. Also, provisional 2011 hospital discharge data system (HDDS) numerator data was not available at time of the report. Updated data for this reporting year will be made available to HRSA/MCHB as soon as updated population estimates and HDDS data are available.

Notes - 2010
Data Source: Tennessee Department of Health, Division of Health Statistics, Death Statistical System and 2010 US Census.

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

a. Last Year's Accomplishments
Last year, the Tennessee Core Violence and Injury Prevention Program (TVIPP) held an annual symposium. The symposium, held in July, focused on protecting the lives of children and teens. Sessions included preventing concussions, safe sleep for infants, teen violence prevention, and other injury prevention topics. The TVIPP 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 used Safe At Home, a fire safety curriculum for all ages, to provide education on fire safety. The Department also installed smoke detectors in homes and held the fire safety poster contest.

The Traumatic Brain Injury Program held the statewide bike safety poster contest again for children in grades K-8.

The Poison Center continued to distribute information on poisoning prevention through health fairs and conference exhibits.

Community Anti-Drug Coalitions Across Tennessee (CADCAT) 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.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Plan and host annual Injury Prevention Symposium.				X
2. Plan and host 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. Implement the WHALE program.		X	X	

9.				
10.				

b. Current Activities
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 July 2012 related to prevention of prescription drug overdose. The TVIPP will also hold the Injury Prevention 101 training in July 2012. TVIPP will help coordinate "Battle of the Belt," a program to encourage competition among high schools for improvements in seatbelt usage among students. TVIPP has also partnered 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 has continued to distribute information on poisoning prevention through health fairs and conference exhibits.

The Tennessee Department of Health is distributing information on safe sleep to prevent injuries to infants (specifically, sleep-related deaths). The Department is also implemening a media campaign on prevention of sleep-related deaths.

The Department of Commerce and Insurance has continued to use Safe At Home, a fire safety curriculum for all ages. The Department has also continued to install smoke detectors in homes and hold the fire safety poster contest.

c. Plan for the Coming Year
The TVIPP will have another injury prevention symposium in the upcoming year. The TVIPP will also hold the Injury Prevention 101 training. TVIPP will continue to assist with coordinating "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. This will be accomplished through the We Have A Little Emergency (WHALE) program; the program involves identification cards with the child's name, emergency contacts, and medical history being put on child safety seats. In addition, the parents are given safety information when they get the identification cards.

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 will continue to distribute information, including posters, flyers and door hangers 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. The TVIPP will collaborate with the Department of Commerce and Insurance to purchase smoke detectors and have them installed in the homes of

the families participating in the home visiting programs.

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 Indicator 01A: The percent of live births weighing less than 2,500 grams

The percentage of live births weighing less than 2,500 grams has trended down 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 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. Legislatively-appropriated funds for infant mortality reduction and women's health improvement have 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.

In 2012, the Tennessee Department of Health signed on to the March of Dimes/Association of State and Territorial Health Officials (ASTHO) pledge to reduce prematurity by 8% by 2014. Planning is currently underway to explore strategies for reaching this goal. Current efforts include a major effort by the statewide perinatal quality collaborative (TIPQC) to reduce the number of elective c-sections or inductions prior to 39 weeks gestation.

While some improvement has been seen in this indicator (and in HSI 01B, 02A, and 02A), the

improvements are generally small and indicate the need for ongoing efforts to reduce low birth weight (frequently associated with prematurity). While multiple gestation births do contribute to the frequency of low birth weight and very low birth weight births, these births are not the main drivers of Tennessee's births weighing less than 2,500 or 1,500 grams.

Health Status Indicator 01B: The percent of live singleton births weighing less than 2,500 grams

The percentage of live singleton births weighing less than 2,500 grams has declined slightly since 2007. See narrative for HSI 01A for an explanation of this indicator.

Health Status Indicator 02A: The percent of live births weighing less than 1,500 grams

The percentage of live births weighing less than 1,500 grams has declined slightly since 2007. See narrative for HSI 01A for an explanation of this indicator.

Health Status Indicator 02B: The percent of live singleton births weighing less than 1,500 grams

The percentage of live singleton births weighing less than 1,500 grams has declined slightly since 2007. See narrative for HSI 01A for an explanation of this indicator.

Health Status Indicator 03A: The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.

The rate of injury fatalities among children 14 years and younger has fluctuated since 2007; 2011 data are not available at the time of this submission because population estimates for 2011 are not available.

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).

A new addition to the Department's injury prevention initiatives is the Safe Sleep Campaign. Child Fatality Review data indicate that 20% of infant deaths in Tennessee are attributable to unsafe sleep environments. In 2012, the Department launched the "ABC's of Safe Sleep" campaign, encouraging that babies should sleep Alone, on their Back, and in a Crib.

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.

The rate of motor vehicle fatalities for children 14 and younger declined from 2007-2010. 2011 data are not available at the time of this submission because population estimates for 2011 are not available.

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 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.

Health Status Indicator 03C: The death rate per 100,000 for unintentional injuries among youth aged 15 through 24 due to motor vehicle crashes.

The rate of motor vehicle fatalities for youth aged 15 through 24 declined from 2007-2010. 2011 data are not available at the time of this submission because population estimates for 2011 are not available.

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 Indicator 04A: The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.

The rate of nonfatal injuries among children younger than 14 declined from 2007-2010. 2011 data are not available at the time of this submission because population estimates for 2011 are not available. See narrative for HSI 03A for an explanation of this indicator.

Health Status Indicator 04B: The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.

The rate of nonfatal injuries due to motor vehicle crashes among children under age 14 declined from 2007-2010. 2011 data are not available at the time of this submission because population estimates for 2011 are not available. See narrative for HSI 03B for an explanation of this indicator.

Health Status Indicator 04C: The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.

The rate of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 declined from 2007-2010. 2011 data are not available at the time of this submission because population estimates for 2011 are not available. See narrative for HSI 03C for an explanation of this indicator.

Health Status Indicator 05A: The rate per 1,000 women aged 15 through 19 years with a reported case of Chlamydia.

Infections due to Chlamydia are among the most prevalent of all STDs. There is strong collaboration between the staff of the MCH and HIV /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 and state appropriations in 1998 led to increases in testing in subsequent years. In testing sites in Tennessee reporting cases to the Department of Health, rates of infection among 15-19 year old remained relatively stable from 2007-2011. There has been continued emphasis on screening adolescents both within the health department clinics and within the private sector over this time period. Data specifically from the health department clinics for all ages for 2008-2011 show an increase in the number of positive Chlamydia cases 11,194 to 13,208) as well as an increase in positivity (8.7% to 10.5%). Health department protocols require routine screening of adolescents less than age 24 in all family planning clinics statewide. Also contributing to the increase was the addition in 2011 of screening in a juvenile detention center and 4 school-based clinics in Memphis.

Health Status Indicator 05B: The rate per 1,000 women aged 20 through 44 years with a reported case of Chlamydia.

See narrative for HSI 05A for an explanation of this indicator.

Health Status Indicator 06A: Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race.

Demographic information is addressed in the Needs Assessment document and in the State Overview section of the Block Grant Narrative.

Health Status Indicator 06B: Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity.

Demographic information is addressed in the Needs Assessment document and in the State Overview section of the Block Grant Narrative.

Health Status Indicator 07A: Live births to all women (of all ages) enumerated by maternal age and race.

Demographic information is addressed in the Needs Assessment document and in the State Overview section of the Block Grant Narrative.

Health Status Indicator 07B: Live births to all women (of all ages) enumerated by maternal age and Hispanic ethnicity.

Demographic information is addressed in the Needs Assessment document and in the State Overview section of the Block Grant Narrative.

Health Status Indicator 08A: Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race.

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. Annually, over 99% of all deaths of children age 17 and under are reviewed.

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 Indicator 08B: Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity.

See narrative for HSI 08A for an explanation of this indicator.

Health Status Indicator 09A: Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race.

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 2012 Resource Mapping Report produced by the Tennessee Commission on Children and Youth, 25 state agencies served 16,341,899 children in FY10-11, with expenditures of $8,953,178,695.

Health Status Indicator 09B: Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity.

See narrative for HSI 09A for an explanation of this indicator.

Health Status Indicator 10: Geographic living area for all children aged 0 through 19 years.

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 Indicator 11: Percent of the State Population at various levels of the federal poverty level.

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 Indicator 12: Percent of the State Population aged 0 through 19 at various levels of the federal poverty level.

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 TN Department of Health/MCH uses Title V dollars to fund a variety of services offered to women and children. Many are discussed in the Performance Measures sections; other programs and efforts not described are outlined below.

Childhood Lead Poisoning Prevention Program
Tennessee's Childhood Lead Poisoning Prevention Program monitors elevated blood lead levels reported for children under the age of 6; promotes screening of children at high risk for lead exposure; assures proper follow-up for children with elevated levels; and provides professional and public awareness.

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. Over 99% of all deaths are reviewed annually.

Fetal Infant Mortality Review (FIMR)
FIMR pilot projects began in 2009 in 4 sites (Davidson, Hamilton, and Shelby Counties and East Tennessee Region) to help state policymakers better understand the causes of fetal and infant deaths. Using the national FIMR guidelines, a collaborative program between the American College of Obstetricians and Gynecologists and the Federal MCH Bureau, this program gathers data from multiple sources including maternal interviews and works to identify and implement community strategies for improving birth outcomes.

/2013/ Injury Prevention Program
The injury prevention program provides education and program implementation to prevent injuries in children and adults. The program holds quarterly meetings with an injury community planning group to implement projects on four chosen priority areas: motor vehicle crashes, falls, poisoning, and sleep-related infant deaths. The program provides an annual conference for the community on injury prevention and annual Injury Prevention 101 training for the community.//2013//

Home Visiting Programs
Tennessee's home visiting programs 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) program (targeted case management) is available in all 95 counties, serving pregnant and postpartum women and children under six. ***/2013/The Healthier Beginnings program, funded with federal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) dollars, began during the last fiscal year. Six community based agencies implementing three different evidenced based models are funded; one project is exclusively focused on serving military families in the Fort Campbell Army base area. An anticipated 460 children will be served in Year One.//2013//***

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. 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.***/2013/ The program continues to target 14,000 each year due to funding limitations.//2013//***

Partnerships with TennCare (Medicaid)
Local health departments provide outreach and assistance to TennCare enrollees; staff 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 2 hotlines. The Baby Line, a toll-free telephone line, answers questions, refers callers for pregnancy testing, TennCare and prenatal care, and responds to requests for information. The Clearinghouse for Information on Adolescent Pregnancy Issues is a separate, central, toll-free telephone for professionals seeking information on local resources, teen pregnancy statistics, resource materials, information on adolescent issues, and services.

Advisory Committees
MCH has 4 mandated advisory committees: Perinatal Advisory Committee; Genetics Advisory Committee for newborn screening; 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) include: Childhood Lead Poisoning Prevention Advisory Committee, Adolescent Health Advisory Committee, Asthma Task Force, and Early Childhood Comprehensive Systems Work Group.

Quality Improvement
The State Quality Council meets yearly to review reports on local/regional quality activities, including aggregated trends and recommendations. The MCH Director serves on the State Quality Council. The statewide Quality Management Plan is updated yearly. Quality management, including record review and follow up, is conducted statewide to assure an optimum level of services for clients. Patient satisfaction surveys (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.

/2013/

2013 Application Request

We are requesting Technical Assistance in three areas as listed on Form 15:

(1) Children's Special Services (CSS, Title V CSHCN Program) is redesigning the care coordination provided to participants. Assistance continues to be 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. Care coordination has been and continues to be an integral component of service for CSHCN. The Patient Centered Medical Home Concept places a huge emphasis on the provision of care coordination services where the family, the physician, and other service providers work to implement a specific care plan as an organized team. While there is wide agreement among professional and family leadership organizations about the desirability of achieving care coordination within a medical home

for all CSHCN, there is inconsistent progress toward this goal. In an effort to overcome this barrier, the Title V CSHCN program's investment in best practices and standardized training will provide continuous, comprehensive care for CSHCN, thereby enhancing the well-being of the child and family. With the technical assistance, the program intends to develop standard qualifications and responsibilities necessary to provide a comprehensive system of care, and ensure that CSHCN receive services in a medical home, and ultimately provide certification for the care coordinators working within the program.

(2) The Maternal and Child Health Section has recently combined with the Nutrition and Wellness Section which has resulted in a new Division of Family Health and Wellness. We need guidance on how to shift the current paradigm from direct service and categorical programs to a more integrated approach to promoting healthy people across the lifespan.

(3) An ongoing challenge is how to incorporate Life Course Perspective into a variety of programs using current (limited) funding and determining metrics for measuring progress within a Life Course framework.
//2013//

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 2011		FY 2012		FY 2013	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
1. Federal Allocation *(Line1, Form 2)*	11645007	9415863	11539865		11539865	
2. Unobligated Balance *(Line2, Form 2)*	3000000	3000000	3100000		5500000	
3. State Funds *(Line3, Form 2)*	13250000	13550000	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)*	5900000	5813868	5550000		5650000	
7. Subtotal	33795007	31779731	33439865		35939865	
8. Other Federal Funds *(Line10, Form 2)*	7145900	8508413	11831199		160809386	
9. Total *(Line11, Form 2)*	40940907	40288144	45271064		196749251	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2011		FY 2012		FY 2013	
I. Federal-State MCH Block Grant Partnership	**Budgeted**	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
a. Pregnant Women	668803	679133	403285		768035	
b. Infants < 1 year old	3881695	3397571	3568368		3842331	
c. Children 1 to 22 years old	13848481	13378245	14324393		15538410	

d. Children with Special Healthcare Needs	3493503	3975431	3461960		3461960	
e. Others	10738025	9881590	10527873		11175142	
f. Administration	1164500	467761	1153986		1153987	
g. SUBTOTAL	33795007	31779731	33439865		35939865	
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	92872		93763		65357	
c. CISS	105000		132000		255000	
d. Abstinence Education	0		1141533		1154546	
e. Healthy Start	0		0		0	
f. EMSC	0		0		0	
g. WIC	0		0		135977824	
h. AIDS	0		0		0	
i. CDC	0		0		7301220	
j. Education	0		0		0	
k. Home Visiting	0		0		6953766	
k. Other						
Family Planning	6648028		6897373		6535476	
Preg Assistance Fund	0		0		2566197	
Injury Prevention	0		125185		0	
MIECHV Home Visiting	0		3141345		0	
Newborn Hearing	300000		300000		0	

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2011		FY 2012		FY 2013	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
I. Direct Health Care Services	20979940	19728857	20759467		22311467	
II. Enabling Services	7847201	7379254	7764737		8345237	
III. Population-Based Services	3362603	3162083	3327267		3576017	
IV. Infrastructure Building Services	1605263	1509537	1588394		1707144	
V. Federal-State Title V Block Grant Partnership Total	33795007	31779731	33439865		35939865	

A. Expenditures

The Division of Administrative Services within the Department of Health is responsible for all fiscal management. Division staff use 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.

The Department 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. Departmental 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 Department's 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 Department's central and regional offices and for selected contract expenditures. The RBRVS cost allocation method is used to allocate costs which cannot be directly allocated to one or more programs. These costs arise from the delivery of direct health or patient care services in 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 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: 2013

FORM 2

MCH BUDGET DETAILS FOR FY 2013

[Secs. 504 (d) and 505(a)(3)(4)]

STATE: TN

1. FEDERAL ALLOCATION
(Item 15a of the Application Face Sheet [SF 424]) $ 11,539,865
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) $ 5,500,000

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) $ 5,650,000

7. TOTAL STATE MATCH (Lines 3 through 6) $ 18,900,000
(Below is your State's FY 1989 Maintainence of Effort Amount)
$ 13,125,024

8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP (SUBTOTAL) $ 35,939,865
(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:	$ 65,357
c. CISS:	$ 255,000
d. Abstinence Education:	$ 1,154,546
e. Healthy Start:	$ 0
f. EMSC:	$ 0
g. WIC:	$ 135,977,824
h. AIDS:	$ 0
i. CDC:	$ 7,301,220
j. Education:	$ 0
k. Home Visiting:	$ 6,953,766
l. Other:	
Family Planning	$ 6,535,476
Preg Assistance Fund	$ 2,566,197

10. OTHER FEDERAL FUNDS (SUBTOTAL of all Funds under item 9) $ 160,809,386

11. STATE MCH BUDGET TOTAL $ 196,749,251
(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 2008		FY 2009		FY 2010	
	BUDGETED	EXPENDED	BUDGETED	EXPENDED	BUDGETED	EXPENDED
1. Federal Allocation *(Line1, Form2)*	$ 11,855,578	$ 9,502,319	$ 11,658,473	$ 8,967,477	$ 11,645,007	$ 8,558,526
2. Unobligated Balance *(Line2, Form2)*	$ 7,500,000	$ 0	$ 5,000,000	$ 0	$ 3,500,000	$ 0
3. State Funds *(Line3, Form2)*	$ 13,300,000	$ 13,250,000	$ 13,325,000	$ 13,300,000	$ 13,250,000	$ 13,325,000
4. Local MCH Funds *(Line4, Form2)*	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0
5. Other Funds *(Line5, Form2)*	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0
6. Program Income *(Line6, Form2)*	$ 5,128,300	$ 5,800,931	$ 5,371,900	$ 5,884,387	$ 5,800,900	$ 5,539,280
7. Subtotal	$ 37,783,878	$ 28,553,250	$ 35,355,373	$ 28,151,864	$ 34,195,907	$ 27,422,806
	(THE FEDERAL-STATE TITLE BLOCK GRANT PARTNERSHIP)					
8. Other Federal Funds *(Line10, Form2)*	$ 8,177,027	$ 7,122,906	$ 6,557,014	$ 7,024,247	$ 7,872,484	$ 7,603,405
9. Total *(Line11, Form2)*	$ 45,960,905	$ 35,676,156	$ 41,912,387	$ 35,176,111	$ 42,068,391	$ 35,026,211
	(STATE MCH BUDGET TOTAL)					

FORM 3

STATE MCH FUNDING PROFILE

[Secs. 505(a) and 506((a)(I-3)]

STATE: TN

	FY 2011		FY 2012		FY 2013	
	BUDGETED	EXPENDED	BUDGETED	EXPENDED	BUDGETED	EXPENDED
1. Federal Allocation *(Line1, Form2)*	$ 11,645,007	$ 9,415,863	$ 11,539,865	$	$ 11,539,865	$
2. Unobligated Balance *(Line2, Form2)*	$ 3,000,000	$ 3,000,000	$ 3,100,000	$	$ 5,500,000	$
3. State Funds *(Line3, Form2)*	$ 13,250,000	$ 13,550,000	$ 13,250,000	$	$ 13,250,000	$
4. Local MCH Funds *(Line4, Form2)*	$ 0	$ 0	$ 0	$	$ 0	$
5. Other Funds *(Line5, Form2)*	$ 0	$ 0	$ 0	$	$ 0	$
6. Program Income *(Line6, Form2)*	$ 5,900,000	$ 5,813,868	$ 5,550,000	$	$ 5,650,000	$
7. Subtotal	$ 33,795,007	$ 31,779,731	$ 33,439,865	$ 0	$ 35,939,865	$ 0
	(THE FEDERAL-STATE TITLE BLOCK GRANT PARTNERSHIP)					
8. Other Federal Funds *(Line10, Form2)*	$ 7,145,900	$ 8,508,413	$ 11,831,199	$	$ 160,809,386	$
9. Total *(Line11, Form2)*	$ 40,940,907	$ 40,288,144	$ 45,271,064	$ 0	$ 196,749,251	$ 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: 2011
   Field Note:
   Remaining funds were carried over as unobligated funds in FY2012.

2. **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.

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: OtherFedFundsExpended
   Row Name: Other Federal Funds
   Column Name: Expended
   Year: 2011
   Field Note:
   The FY2011 expenditure amount included the MIECHV funding. This grant was not included in the budgeted amount listed for FY2011 since the State had not yet received the award at the time the application was done.

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 2008		FY 2009		FY 2010	
I. Federal-State MCH Block Grant Partnership	**BUDGETED**	**EXPENDED**	**BUDGETED**	**EXPENDED**	**BUDGETED**	**EXPENDED**
a. Pregnant Women	$ 1,209,084	$ 856,598	$ 1,202,083	$ 557,125	$ 1,025,877	$ 330,719
b. Infants < 1 year old	$ 4,194,011	$ 3,397,837	$ 4,030,513	$ 3,233,523	$ 4,069,313	$ 2,926,288
c. Children 1 to 22 years old	$ 11,320,907	$ 11,784,055	$ 13,047,012	$ 11,964,732	$ 13,813,306	$ 11,945,862
d. Children with Special Healthcare Needs	$ 8,236,885	$ 3,144,199	$ 5,020,463	$ 3,048,058	$ 3,761,550	$ 3,147,418
e. Others	$ 11,637,434	$ 8,651,635	$ 10,889,455	$ 8,944,973	$ 10,361,360	$ 8,633,522
f. Administration	$ 1,185,557	$ 718,926	$ 1,165,847	$ 403,453	$ 1,164,501	$ 438,997
g. SUBTOTAL	$ 37,783,878	$ 28,553,250	$ 35,355,373	$ 28,151,864	$ 34,195,907	$ 27,422,806
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	$ 94,644		$ 93,763		$ 93,763	
c. CISS	$ 100,000		$ 100,000		$ 100,000	
d. Abstinence Education	$ 993,368		$ 0		$ 993,844	
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. Home Visiting	$ 0		$ 0		$ 0	
l. Other						
Family Planning	$ 6,121,679		$ 6,213,251		$ 6,534,877	
Newborn Hearing	$ 150,000		$ 150,000		$ 150,000	
CHAD	$ 717,336		$ 0		$ 0	
III. SUBTOTAL	$ 8,177,027		$ 6,557,014		$ 7,872,484	

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 2011		FY 2012		FY 2013	
I. Federal-State MCH Block Grant Partnership	**BUDGETED**	**EXPENDED**	**BUDGETED**	**EXPENDED**	**BUDGETED**	**EXPENDED**
a. Pregnant Women	$ 668,803	$ 679,133	$ 403,285	$	$ 768,035	$
b. Infants < 1 year old	$ 3,881,695	$ 3,397,571	$ 3,568,368	$	$ 3,842,331	$
c. Children 1 to 22 years old	$ 13,848,481	$ 13,378,245	$ 14,324,393	$	$ 15,538,410	$
d. Children with Special Healthcare Needs	$ 3,493,503	$ 3,975,431	$ 3,461,960	$	$ 3,461,960	$
e. Others	$ 10,738,025	$ 9,881,590	$ 10,527,873	$	$ 11,175,142	$
f. Administration	$ 1,164,500	$ 467,761	$ 1,153,986	$	$ 1,153,987	$
g. SUBTOTAL	$ 33,795,007	$ 31,779,731	$ 33,439,865	$ 0	$ 35,939,865	$ 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	$ 92,872		$ 93,763		$ 65,357	
c. CISS	$ 105,000		$ 132,000		$ 255,000	
d. Abstinence Education	$ 0		$ 1,141,533		$ 1,154,546	
e. Healthy Start	$ 0		$ 0		$ 0	
f. EMSC	$ 0		$ 0		$ 0	
g. WIC	$ 0		$ 0		$ 135,977,824	
h. AIDS	$ 0		$ 0		$ 0	
i. CDC	$ 0		$ 0		$ 7,301,220	
j. Education	$ 0		$ 0		$ 0	
k. Home Visiting	$ 0		$ 0		$ 6,953,766	
l. Other						
Family Planning	$ 6,648,028		$ 6,897,373		$ 6,535,476	
Preg Assistance Fund	$ 0		$ 0		$ 2,566,197	
Injury Prevention	$ 0		$ 125,185		$ 0	
MIECHV Home Visiting	$ 0		$ 3,141,345		$ 0	
Newborn Hearing	$ 300,000		$ 300,000		$ 0	
III. SUBTOTAL	$ 7,145,900		$ 11,831,199		$ 160,809,386	

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: PregWomenExpended
   Row Name: Pregnant Women
   Column Name: Expended
   Year: 2010
   Field Note:
   The expended is based on true expenditures.
3. **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.
4. **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: 2011
   Field Note:
   The expended is based on true expenditures.
5. **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.
6. **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.
7. **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.
8. **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.
9. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
   Field Name: CSHCNExpended
   Row Name: CSHCN
   Column Name: Expended
   Year: 2011
   Field Note:
   The expended is based on true expenditures.
10. **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.
11. **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.

12. **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.

13. **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.

14. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
Field Name: AdminExpended
Row Name: Administration
Column Name: Expended
Year: 2011
Field Note:
The expended is based on true expenditures.

15. **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.

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 2008		FY 2009		FY 2010	
	BUDGETED	EXPENDED	BUDGETED	EXPENDED	BUDGETED	EXPENDED
I. Direct Health Care Services (Basic Health Services and Health Services for CSHCN.)	$ 27,355,528	$ 21,700,470	$ 25,597,290	$ 17,476,677	$ 25,988,889	$ 17,024,078
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.)	$ 4,382,930	$ 3,609,131	$ 4,101,224	$ 6,536,863	$ 4,322,363	$ 6,367,576
III. Population-Based Services (Newborn Screening, Lead Screening, Immunization, Sudden Infant Death Syndrome Counseling, Oral Health, Injury Prevention, Nutrition, and Outreach/Public Education.)	$ 3,173,846	$ 1,324,871	$ 2,969,851	$ 2,801,110	$ 1,586,690	$ 2,728,569
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.)	$ 2,871,574	$ 1,918,778	$ 2,687,008	$ 1,337,214	$ 2,297,965	$ 1,302,583
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.)	$ 37,783,878	$ 28,553,250	$ 35,355,373	$ 28,151,864	$ 34,195,907	$ 27,422,806

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 2011		FY 2012		FY 2013	
	BUDGETED	EXPENDED	BUDGETED	EXPENDED	BUDGETED	EXPENDED
I. Direct Health Care Services (Basic Health Services and Health Services for CSHCN.)	$ 20,979,940	$ 19,728,857	$ 20,759,467	$	$ 22,311,467	$
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.)	$ 7,847,201	$ 7,379,254	$ 7,764,737	$	$ 8,345,237	$
III. Population-Based Services (Newborn Screening, Lead Screening, Immunization, Sudden Infant Death Syndrome Counseling, Oral Health, Injury Prevention, Nutrition, and Outreach/Public Education.)	$ 3,362,603	$ 3,162,083	$ 3,327,267	$	$ 3,576,017	$
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.)	$ 1,605,263	$ 1,509,537	$ 1,588,394	$	$ 1,707,144	$
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.)	$ 33,795,007	$ 31,779,731	$ 33,439,865	$ 0	$ 35,939,865	$ 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: DirectHCExpended
   Row Name: Direct Health Care Services
   Column Name: Expended
   Year: 2010
   Field Note:
   The expended is based on true expenditures.

3. **Section Number:** Form5_Main
   Field Name: EnablingBudgeted
   Row Name: Enabling Services
   Column Name: Budgeted
   Year: 2010
   Field Note:
   Budget amount is estimated.

4. **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.

5. **Section Number:** Form5_Main
   Field Name: PopBasedBudgeted
   Row Name: Population-Based Services
   Column Name: Budgeted
   Year: 2010
   Field Note:
   Budget amount is estimated.

6. **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.

7. **Section Number:** Form5_Main
   Field Name: InfrastrBuildBudgeted
   Row Name: Infrastructure Building Services
   Column Name: Budgeted
   Year: 2010
   Field Note:
   Budget amount is estimated.

8. **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.

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: 84,533 | **Reporting Year: 2010**

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	84,016	99.4	290	52	52	100
Galactosemia	84,016	99.4	230	0	0	
Sickle Cell Disease						
Other Screening (Specify)						
Biotinidase Deficiency	84,016	99.4	43	2	2	100
Congenital Adrenal Hyperplasia	84,016	99.4	315	3	3	100
Cystic Fibrosis	84,016	99.4	622	17	17	100
Hemoglobinopathy	84,016	99.4	75	64	64	100
Amino Acidemia	84,016	99.4	220	11	10	90.9
Fatty or Organic Acidemia	84,016	99.4	241	13	13	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

None

FIELD LEVEL NOTES

1. **Section Number:** Form6_Main
   Field Name: BirthOccurence
   Row Name: Total Births By Occurence
   Column Name: Total Births By Occurence
   Year: 2013
   Field Note:
   Data Source: Tennessee Department of Health, Division of Health Statistics, Birth Statistical System.

2. **Section Number:** Form6_Main
   Field Name: Congenital_OneScreenNo
   Row Name: Congenital
   Column Name: Receiving at least one screen
   Year: 2013
   Field Note:
   Of the 84,533 occurent births, 517 were without a metabolic screen. For 228 babies, screens were not performed because the infants died on the day of birth (N=198) or on day of life #1 (N=30). Of the remaining 289 infants who have a documented birth certificate but no newborn screen recorded, 157 were born at home.

3. **Section Number:** Form6_Other Screening Types
   Field Name: Other
   Row Name: All Rows
   Column Name: All Columns
   Year: 2013
   Field Note:
   All but one infant with confirmed disease received follow-up; the exception is one case of amino acidemia. The explanation is that the infant had already expired when the newborn screening result was called. Autopsy confirmed the diagnosis of Amino Acidemia.

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	2006	2007	2008	2009	2010
Pregnant Women	15,350	16,315	14,673	9,808	6,240
Infants < 1 year old	53,033	54,388	86,661	82,078	87,469
Children 1 to 22 years old	252,764	251,971	259,614	264,056	286,647
Children with Special Healthcare Needs	8,804	8,583	8,224	7,275	6,525
Others	146,704	147,430	147,911	157,433	162,963
Total	476,655	478,687	517,083	520,650	549,844

Reporting Year: 2011

	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	10,416	46.4	0.0	1.8	51.9	0.0
Infants < 1 year old	84,533	39.4	0.0	0.2	60.4	0.0
Children 1 to 22 years old	267,264	41.2	0.0	1.0	57.9	0.0
Children with Special Healthcare Needs	6,059	12.9	0.0	0.8	86.3	0.0
Others	151,550	33.6	0.1	1.0	65.2	0.1
TOTAL	519,822					

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: 2013
   Field Note:
   Actual value reported is 0.04% (N=4) 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: 2013
   Field Note:
   The total number of infants served under Title V is at least 84,533. Newborn Screening is provided through Title V, and thefore, at least the number of infants receiving screens (84,533) 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 52,106 (Data Source: TDOH PTBMIS). It is estimated that most of these infants would be included in the total listed above (84,533); 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" 84,533 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 52,106 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_XXI
   Row Name: Infants <1 year of age
   Column Name: Title XXI %
   Year: 2013
   Field Note:
   Actual value reported is 0.002% (N=1) but EHB system rounds to 0.

4. **Section Number:** Form7_Main
   Field Name: Children_0_1_Unknown
   Row Name: Infants <1 year of age
   Column Name: Unknown %
   Year: 2013
   Field Note:
   Actual value reported is 0.004% (N=2) but EHB system rounds to 0.

5. **Section Number:** Form7_Main
   Field Name: Children_1_22_XXI
   Row Name: Children 1 to 22 years of age
   Column Name: Title XXI %
   Year: 2013
   Field Note:
   Actual value reported is 0.01% (N=23) but EHB system rounds to 0.

6. **Section Number:** Form7_Main
   Field Name: Children_1_22_Private
   Row Name: Children 1 to 22 years of age
   Column Name: Private/Other %
   Year: 2013
   Field Note:
   Actual value reported is 0.95% (N=2,552) but EHB system rounds to 1.

7. **Section Number:** Form7_Main
   Field Name: Children_1_22_Unknown
   Row Name: Children 1 to 22 years of age
   Column Name: Unknown %
   Year: 2013
   Field Note:
   Actual value reported is 0.01% (N=32) 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	79,345	60,190	16,599	161	1,512	134	0	749
Title V Served	79,345	60,190	16,599	161	1,512	134	0	749
Eligible for Title XIX	40,703	27,709	12,283	97	381	58	0	175
INFANTS								
Total Infants in State	79,016	53,423	15,959					9,634
Title V Served	52,106	39,910	10,658	70	299	18	0	1,151
Eligible for Title XIX	33,259	29,965	3,294	0	0	0	0	0

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	72,169	7,121	55	4,517	112	310	0	2,182
Title V Served	72,169	7,121	55	4,517	112	310	0	2,182
Eligible for Title XIX	36,800	3,887	16	2,465	56	163	0	1,203
INFANTS								
Total Infants in State	71,208	7,808	0	0	0	0	0	0
Title V Served	47,105	5,001	0	0	0	0	0	0
Eligible for Title XIX	26,961	6,297	0	0	0	0	0	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: 2013
Field Note:
Data Source: Tennessee Department of Health, Division of Health Statistics, Birth Statistical System (2010).

2. **Section Number:** Form8_I. Unduplicated Count By Race
Field Name: DeliveriesTitleV_All
Row Name: Title V Served
Column Name: Total All Races
Year: 2013
Field Note:
Data Source: Tennessee Department of Health, Division of Health Statistics, Birth Statistical System (2010).

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: 2013
Field Note:
Data Source: Tennessee Department of Health, Division of Health Statistics, Birth Statistical System; 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: 2013
Field Note:
Data Source: 2010 US Census

5. **Section Number:** Form8_I. Unduplicated Count By Race
Field Name: InfantsTitleXIX_All
Row Name: Eligible for Title XIX
Column Name: Total All Races
Year: 2013
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 2011 survey but survey questions regarding income ask about the previous year's income (i.e. 2010)

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.

6. **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: 2013
Field Note:
Data Source: Tennessee Department of Health, Division of Health Statistics, Birth Statistical System.

7. **Section Number:** Form8_II. Unduplicated Count by Ethnicity
Field Name: DeliveriesTotal_TotalHispanic
Row Name: Total Deliveries in State
Column Name: Total Hispanic or Latino
Year: 2013
Field Note:
Note: The state does not have population projections for subcategories of Hispanic ethnicity; therefore columns B1-B5 are blank.

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: 2013
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: 2013
Field Note:
Data Source: Tennessee Department of Health, Division of Health Statistics, Birth Statistical System; 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: 2013
Field Note:

Data Source: 2010 US Census

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: 2013
Field Note:
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_EthnicityOther
Row Name: Total Infants in State
Column Name: Other and Unknown
Year: 2013
Field Note:
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_TotalHispanic
Row Name: Title V Served
Column Name: Total Hispanic or Latino
Year: 2013
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: InfantsTitleXIX_TotalNotHispanic
Row Name: Eligible for Title XIX
Column Name: Total Not Hispanic or Latino
Year: 2013
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 2011 survey but survey questions regarding income ask about the previous year's income (i.e. 2010)

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.

15. **Section Number:** Form8_II. Unduplicated Count by Ethnicity
Field Name: InfantsTitleXIX_TotalHispanic
Row Name: Eligible for Title XIX
Column Name: Total Hispanic or Latino
Year: 2013
Field Note:
Note: The state does not have information on subcategories of Hispanic ethnicity; therefore columns B1-B5 are blank.

16. **Section Number:** Form8_II. Unduplicated Count by Ethnicity
Field Name: InfantsTitleXIX_EthnicityOther
Row Name: Eligible for Title XIX
Column Name: Other and Unknown
Year: 2013
Field Note:
Note: The state does not have information on subcategories of Hispanic ethnicity; therefore columns B1-B5 are blank.

FORM 9
STATE MCH TOLL-FREE TELEPHONE LINE DATA FORM (OPTIONAL)
[SECS. 505(A)(E) AND 509(A)(8)]
STATE: TN

	FY 2013	FY 2012	FY 2011	FY 2010	FY 2009
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 2013	FY 2012	FY 2011	FY 2010	FY 2009
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"	Sara Guerra	Deana Vaughn	Deana Vaughn	Deana Vaughn	Deana vaughn
4. Contact Person's Telephone Number	615-741-7353	(615) 741-0370	(615) 741-0307	(615) 741-0370	(615) 741-0370
5. Contact Person's Email	sara.guerra@tn.gov	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	29	63	34

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: 2011
   Field Note:
   Calls received are for Calendar Year 2011. We have noticed a decline in calls to this line over the past few years. We are actively exploring reasons for this decline and contemplating ways to increase usage of the line. A possible explanation is the availability of numerous other toll-free lines, including the TENNderCare call center, a large operation serving Medicaid-eligible families.

FORM 10
TITLE V MATERNAL & CHILD HEALTH SERVICES BLOCK GRANT
STATE PROFILE FOR FY 2013
[SEC. 506(A)(1)]
STATE: TN

1. State MCH Administration:
(max 2500 characters)

The Maternal and Child Health Section is housed within the Division of Family Health and Wellness 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)	$ 5,500,000
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)	$ 5,650,000
8. Total Federal-State Partnership (Line 8, Form 2)	$ 35,939,865

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	10,416
b. Infants < 1 year old	84,533
c. Children 1 to 22 years old	267,264
d. CSHCN	6,059
e. Others	151,550

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 reports of 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 of factors 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 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 regularly involved in development and updating of maternal and child health protocols in use by all 95 county health departments.

12. The primary Title V Program contact person:

Name	Michael D. Warren, MD MPH FAAP
Title	Director, Division of Family Health and Wellness
Address	4th Floor CHB, 425 Fifth Ave North

13. The children with special health care needs (CSHCN) contact person:

Name	Jacqueline Johnson, MPA
Title	Director, Children's Special Services
Address	4th Floor CHB, 425 Fifth Ave North

City	Nashville	City	Nashville
State	TN	State	TN
Zip	37243	Zip	37243
Phone	615-741-7353	Phone	615-741-7353
Fax	615-741-1063	Fax	615-741-1063
Email	michael.d.warren@tn.gov	Email	jacqueline.johnson@tn.gov
Web	http://health.tn.gov/mch	Web	http://health.tn.gov/mch

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)(II)]
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

	2007	2008	2009	2010	2011
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	99.4	100.0
Numerator	164	204	161	161	170
Denominator	164	204	161	162	170
Data Source		Department of Health	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

	2012	2013	2014	2015	2016
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: 2011
   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: 2010
   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: 2009
   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

	2007	2008	2009	2010	2011
Annual Performance Objective	62	62	62	62	62
Annual Indicator	60.7	60.7	60.7	60.7	72.3
Numerator	3,381	136,524	136,524	136,524	183,180
Denominator	5,570	224,895	224,895	224,895	253,333
Data Source		CSHCN Survey	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

	2012	2013	2014	2015	2016
Annual Performance Objective	75	75	75	75	75
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #2
   Field Name: PM02
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

   All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2. **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

3. **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

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

	2007	2008	2009	2010	2011
Annual Performance Objective	64	65	65	65	55
Annual Indicator	52.7	52.7	52.7	52.7	45.9
Numerator	2,935	115,761	115,761	115,761	113,064
Denominator	5,570	219,634	219,634	219,634	246,352
Data Source		CSHCN Survey	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

	2012	2013	2014	2015	2016
Annual Performance Objective	50	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: 2011
   Field Note:
   For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

   All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2. **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

3. **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

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

	2007	2008	2009	2010	2011
Annual Performance Objective	64	69	69	69	70
Annual Indicator	67.7	67.7	67.7	67.7	70.4
Numerator	3,771	152,224	152,224	152,224	174,402
Denominator	5,570	224,965	224,965	224,965	247,879
Data Source		CSHCN Survey	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

	2012	2013	2014	2015	2016
Annual Performance Objective	75	75	75	75	75
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #4
   Field Name: PM04
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

   All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2. **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

3. **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

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

	2007	2008	2009	2010	2011
Annual Performance Objective	82	93	93	93	93
Annual Indicator	91.8	91.8	91.8	91.8	71.5
Numerator	5,113	208,995	208,995	208,995	179,700
Denominator	5,570	227,739	227,739	227,739	251,473
Data Source		CSHCN Survey	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

	2012	2013	2014	2015	2016
Annual Performance Objective	75	80	85	90	90
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #5
   Field Name: PM05
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

   All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2. **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

3. **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

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

	2007	2008	2009	2010	2011
Annual Performance Objective	100	100	100	100	40
Annual Indicator	100.0	39.6	39.6	39.6	41.8
Numerator	1,534	34,477	34,477	34,477	40,413
Denominator	1,534	87,141	87,141	87,141	96,752
Data Source		CSHCN Survey	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

	2012	2013	2014	2015	2016
Annual Performance Objective	45	50	55	60	60
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #6
   Field Name: PM06
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

   All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2. **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

3. **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

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

	2007	2008	2009	2010	2011
Annual Performance Objective	83	88	88	88	80
Annual Indicator	86.7	83.0	83.0	77.0	83.6
Numerator	1,300	278	278	261	310
Denominator	1,500	335	335	339	371
Data Source		2008 NIS Survey	2008 NIS Survey	2009 NIS Survey	2010 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	Provisional

Annual Objective and Performance Data

	2012	2013	2014	2015	2016
Annual Performance Objective	85	85	85	85	85
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #7
   Field Name: PM07
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Data Source: 2010 National Immunization Survey (NIS). We are using the earlier definition of the NIS reported estimate that takes into account only whether the child has had 3 doses of vaccine, irrespective of the brand.

2. **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.

3. **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.

PERFORMANCE MEASURE # 08

The rate of birth (per 1,000) for teenagers aged 15 through 17 years.

Annual Objective and Performance Data

	2007	2008	2009	2010	2011
Annual Performance Objective	26.5	26.5	26	24	20
Annual Indicator	27.8	27.3	24.0	20.2	
Numerator	3,361	3,328	2,955	2,532	
Denominator	120,852	122,020	123,216	125,133	
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

	2012	2013	2014	2015	2016
Annual Performance Objective	19.5	19	18.5	18	17.5
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #8
   Field Name: PM08
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Because 2011 population estimates are not available at this time, we are currently unable to report this indicator. Updated data for this reporting year will be made available to HRSA/MCHB as soon as updated population estimates are available.

2. **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, Birth Statistical System and 2010 US Census.

3. **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

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

	2007	2008	2009	2010	2011
Annual Performance Objective	23	24	40	40	40
Annual Indicator	21.8	37.2	37.2	37.2	37.2
Numerator	3,769	366	366	366	366
Denominator	17,256	983	983	983	983
Data Source		Tennessee Oral Health Survey	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	Final

Annual Objective and Performance Data

	2012	2013	2014	2015	2016
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: 2011
   Field Note:
   Data Source: 2008 Tennessee Oral Health Survey of children ages 5-11 years. This survey is conducted every FIVE years.

2. **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.

3. **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.

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

	2007	2008	2009	2010	2011
Annual Performance Objective	2.5	2.5	2	2	1.7
Annual Indicator	3.9	3.4	2.7	2.5	
Numerator	47	41	33	31	
Denominator	1,194,718	1,201,009	1,207,621	1,238,935	
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

	2012	2013	2014	2015	2016
Annual Performance Objective	2.4	2.3	2.3	2.3	2.3
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #10
   Field Name: PM10
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Because 2011 population estimates are not available at this time, we are currently unable to report this indicator. Updated data for this reporting year will be made available to HRSA/MCHB as soon as updated population estimates are available.

2. **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

3. **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

PERFORMANCE MEASURE # 11

The percent of mothers who breastfeed their infants at 6 months of age.

Annual Objective and Performance Data

	2007	2008	2009	2010	2011
Annual Performance Objective	34	36	30	40	37.5
Annual Indicator	31.4	37.9	37.9	35.6	35.5
Numerator	14,705	31,952	31,952	29,230	29,178
Denominator	46,777	84,308	84,308	82,109	82,089
Data Source		CDC/National Immunization Survey	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

	2012	2013	2014	2015	2016
Annual Performance Objective	36	37	38	39	40
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.

PERFORMANCE MEASURE # 12

Percentage of newborns who have been screened for hearing before hospital discharge.

Annual Objective and Performance Data

	2007	2008	2009	2010	2011
Annual Performance Objective	98	98	98	98	98
Annual Indicator	91.1	94.2	97.6	97.1	97.5
Numerator	83,570	85,613	85,080	82,058	82,313
Denominator	91,754	90,885	87,141	84,535	84,393
Data Source		Department of Health	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

	2012	2013	2014	2015	2016
Annual Performance Objective	99	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: 2011
   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: 2010
   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: 2009
   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

	2007	2008	2009	2010	2011
Annual Performance Objective	6	6	6	3	3.7
Annual Indicator	6.4	4.9	3.7	3.9	2.4
Numerator	88,283	72,258	54,759	57,912	35,743
Denominator	1,386,911	1,474,653	1,479,972	1,484,923	1,489,292
Data Source		UT CBER	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

	2012	2013	2014	2015	2016
Annual Performance Objective	2.3	2.3	2.2	2.2	2.1
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #13
   Field Name: PM13
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Data Source: "The Impact of TennCare, A Survey of Recipients, 2011."
   Available at http://cber.bus.utk.edu/tncare/tncare11.pdf (Table 1a, page 3)

   There has also been a decrease in the number and percentage of uninsured Tennesseans versus previous reporting periods. Per the report explanation (also on page 3): "The slight decrease in the total uninsured rate is attributable to the not-so-slight decrease in the uninsured rate of children, a result possibly driven by increased TennCare and CoverKids enrollments as well as sampling changes."

2. **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

3. **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

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

	2007	2008	2009	2010	2011
Annual Performance Objective	9	30	14	25	15
Annual Indicator	34.0	14.9	15.2	15.4	10.7
Numerator	53,971	9,407	10,490	11,075	19,967
Denominator	158,733	63,134	69,015	71,914	186,444
Data Source		Department of Health	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

	2012	2013	2014	2015	2016
Annual Performance Objective	10	10	10	10	10
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #14
   Field Name: PM14
   Row Name:
   Column Name:
   Year: 2011
   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: 2010
   Field Note:
   Data Source: Tennessee Department of Health, PedNSS/TN WIC Database.

3. **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.

PERFORMANCE MEASURE # 15

Percentage of women who smoke in the last three months of pregnancy.

Annual Objective and Performance Data

	2007	2008	2009	2010	2011
Annual Performance Objective	9	7.5	13	13	13.5
Annual Indicator	19.4	15.4	15.0	14.2	13.6
Numerator	16,774	13,138	12,257	11,260	10,769
Denominator	86,558	85,480	81,888	79,130	79,028
Data Source		Department of Health	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

	2012	2013	2014	2015	2016
Annual Performance Objective	13	12.5	12	12	12
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #15
   Field Name: PM15
   Row Name:
   Column Name:
   Year: 2011
   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: 2010
   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: 2009
   Field Note:
   Data Source: Tennessee Department of Health, Division of Health Statistics, Birth Statistical System

PERFORMANCE MEASURE # 16

The rate (per 100,000) of suicide deaths among youths aged 15 through 19.

Annual Objective and Performance Data

	2007	2008	2009	2010	2011
Annual Performance Objective	6	5.2	5	5	5
Annual Indicator	6.9	5.6	9.1	7.1	
Numerator	29	24	39	31	
Denominator	422,058	426,040	430,127	437,186	
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

	2012	2013	2014	2015	2016
Annual Performance Objective	7	7	6.8	6.8	6.6
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #16
   Field Name: PM16
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Because 2011 population estimates are not available at this time, we are currently unable to report this indicator. Updated data for this reporting year will be made available to HRSA/MCHB as soon as updated population estimates are available.

2. **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, Death Statistical System and 2010 US Census.

3. **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

PERFORMANCE MEASURE # 17

Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

Annual Objective and Performance Data

	2007	2008	2009	2010	2011
Annual Performance Objective	80	80	70	80	83
Annual Indicator	68.5	80.7	79.1	82.9	84.0
Numerator	1,036	1,112	1,085	1,032	997
Denominator	1,513	1,378	1,371	1,245	1,187
Data Source		Department of Health	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

	2012	2013	2014	2015	2016
Annual Performance Objective	84.5	85	85.5	86	86.5
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #17
   Field Name: PM17
   Row Name:
   Column Name:
   Year: 2011
   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: 2010
   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: 2009
   Field Note:
   Data Source: Tennessee Department of Health, Division of Health Statistics, Birth Statistical System

PERFORMANCE MEASURE # 18

Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

Annual Objective and Performance Data

	2007	2008	2009	2010	2011
Annual Performance Objective	90	90	70	70	75
Annual Indicator	63.7	67.7	69.0	70.5	69.9
Numerator	55,134	54,765	53,529	52,372	50,351
Denominator	86,558	80,887	77,565	74,301	72,014
Data Source		Department of Health	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

	2012	2013	2014	2015	2016
Annual Performance Objective	70	71	72	73	74
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #18
   Field Name: PM18
   Row Name:
   Column Name:
   Year: 2011
   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: 2010
   Field Note:
   Data Source: Tennessee Department of Health, Division of Health Statistics, Birth Statistical System

3. **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).

FORM 11
TRACKING PERFORMANCE MEASURES
[SECS 485 (2)(2)(B)(III) AND 486 (A)(2)(A)(II)]
STATE: TN

Form Level Notes for Form 11

None

STATE PERFORMANCE MEASURE # 1 - REPORTING YEAR

Rate of sleep-related infant deaths (per 1,000 live births).

Annual Objective and Performance Data

	2007	2008	2009	2010	2011
Annual Performance Objective					7
Annual Indicator			1.6	1.7	
Numerator			129	131	
Denominator			82,109	79,345	
Data Source			Department of Health	Department of Health	
Is the Data Provisional or Final?				Final	

Annual Objective and Performance Data

	2012	2013	2014	2015	2016
Annual Performance Objective	1	1	1	1	1
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: 2011
   Field Note:
   Data not available for 2011. The Child Fatality data for 2011 (source for the numerator) is expected to be available in late 2012.

2. **Section Number:** Form11_State Performance Measure #1
   Field Name: SM1
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   Data Source: Number of sleep related deaths (numerator) comes from the Child Fatality Review. The number of births (denominator) comes from the Tennessee Department of Health, Division of Health Statistics, Birth and Death Statistical Systems.

3. **Section Number:** Form11_State Performance Measure #1
   Field Name: SM1
   Row Name:
   Column Name:
   Year: 2009
   Field Note:
   Data Source: Number of sleep related deaths (numerator) comes from the Child Fatality Review. The number of births (denominator) comes from the Tennessee Department of Health, Division of Health Statistics, Birth and Death Statistical Systems.

STATE PERFORMANCE MEASURE # 2 - REPORTING YEAR

Percentage of obesity and overweight among Tennessee K-12 students

Annual Objective and Performance Data

	2007	2008	2009	2010	2011
Annual Performance Objective					25
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	Department of Education
Is the Data Provisional or Final?					

Annual Objective and Performance Data

	2012	2013	2014	2015	2016
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: 2011
   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: 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.

3. **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.

STATE PERFORMANCE MEASURE # 3 - REPORTING YEAR

Percentage of smoking among women of age 18-44.

Annual Objective and Performance Data

	2007	2008	2009	2010	2011
Annual Performance Objective					20
Annual Indicator		29.6	15.0	14.2	
Numerator		121,909	12,257	11,252	
Denominator		411,751	81,888	79,094	
Data Source		Department of Health	Department of Health	Department of Health	
Is the Data Provisional or Final?				Final	

Annual Objective and Performance Data

	2012	2013	2014	2015	2016
Annual Performance Objective	20	20	19	19	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: 2011
   Field Note:
   Data for 2011 not yet available. This state performance measure has changed from previous years. The data source will be the Behavioral Risk Factor Surveillance System (BRFSS).

2. **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.

3. **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.

STATE PERFORMANCE MEASURE # 4 - REPORTING YEAR

Rate of emergency department visits due to asthma for children 1-4 years of age (per 100,000).

Annual Objective and Performance Data

	2007	2008	2009	2010	2011
Annual Performance Objective					20
Annual Indicator			220.5	1,827.0	
Numerator			1,070	6,007	
Denominator			485,318	328,797	
Data Source			Department of Health	Department of Health	
Is the Data Provisional or Final?				Final	

Annual Objective and Performance Data

	2012	2013	2014	2015	2016
Annual Performance Objective	1,700	1,650	1,600	1,550	1,500
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: 2011
   Field Note:
   Because 2011 population estimates are not available at this time, we are currently unable to report this indicator. Also, provisional 2011 hospital discharge data system (HDDS) numerator data was not available at time of the report. Updated data for this reporting year will be made available to HRSA/MCHB as soon as updated population estimates and HDDS data are available.

2. **Section Number:** Form11_State Performance Measure #4
   Field Name: SM4
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   Data Source: Tennessee Department of Health, Office of Health Statistics, Hospital Discharge Data System and 2010 US Census.

   NOTE: This performance measure was changed in 2011, such that the 2010 data reported here is not comparable with previous years.

3. **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

   Note for 2013 application: This state performance measure has been changed. Therefore, comparison between the 2009 and 2010 indicators is not appropriate.

STATE PERFORMANCE MEASURE # 5 - REPORTING YEAR

Number of MCH staff who have completed a self-assessment and based on the assessment have identified and completed a module in the MCH Navigator system.

Annual Objective and Performance Data

	2007	2008	2009	2010	2011
Annual Performance Objective					0
Annual Indicator					
Numerator					
Denominator					
Data Source					
~~Is the Data Provisional or Final?~~					

Annual Objective and Performance Data

	2012	2013	2014	2015	2016
Annual Performance Objective	0	0	0	0	0
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 #5
   Field Name: SM5
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   This SPM has been changed. Therefore data is not reported for 2011 but will be reported in future years.

2. **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.

3. **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

Percentage of youth (14 and older) enrolled in the state CSHCN program who have formal plans for transtion to adulthood.

Annual Objective and Performance Data

	2007	2008	2009	2010	2011
Annual Performance Objective					45
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	

Annual Objective and Performance Data

	2012	2013	2014	2015	2016
Annual Performance Objective	45	45	55	55	60
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: 2011
   Field Note:
   This SPM has been changed. Therefore data is not reported for 2011 but will be reported in future years.

2. **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

3. **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

STATE PERFORMANCE MEASURE # 7 - REPORTING YEAR

Rate of unintentional injury death in children and young people ages 0-24 (per 100,000).

Annual Objective and Performance Data

	2007	2008	2009	2010	2011
Annual Performance Objective					14
Annual Indicator			19.0	19.7	
Numerator			376	398	
Denominator			1,974,006	2,023,349	
Data Source			Department of Health	Department of Health	
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2012	2013	2014	2015	2016
Annual Performance Objective	18.5	18	17.5	17	16.5
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: 2011
   Field Note:
   Because 2011 population estimates are not available at this time, we are currently unable to report this indicator. Also, provisional 2011 hospital discharge data system (HDDS) numerator data was not available at time of the report. Updated data for this reporting year will be made available to HRSA/MCHB as soon as updated population estimates and HDDS data are available.

2. **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, Death Statistical System and 2010 US Census.

3. **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

	2007	2008	2009	2010	2011
Annual Performance Objective	7.5	7.5	7.5	7.5	7
Annual Indicator	8.2	8.0	8.0	7.9	7.4
Numerator	709	686	655	628	587
Denominator	86,558	85,480	82,108	79,345	79,255
Data Source		Department of Health	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

	2012	2013	2014	2015	2016
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: 2011
   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: 2010
   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: 2009
   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

	2007	2008	2009	2010	2011
Annual Performance Objective	2.1	2.1	2.1	2.1	2.1
Annual Indicator	2.4	2.5	2.7	2.2	2.1
Numerator	16.4	15	16	13.8	12.8
Denominator	6.9	6.1	6	6.3	6
Data Source		Department of Health	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

	2012	2013	2014	2015	2016
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: 2011
   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: 2010
   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: 2009
   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

	2007	2008	2009	2010	2011
Annual Performance Objective	4.3	4.3	4.3	4.3	4.3
Annual Indicator	5.1	4.9	4.7	4.6	4.6
Numerator	440	420	390	364	365
Denominator	86,558	85,480	82,108	79,345	79,255
Data Source		Department of Health	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

	2012	2013	2014	2015	2016
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: 2011
   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: 2010
   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: 2009
   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

	2007	2008	2009	2010	2011
Annual Performance Objective	2.6	2.6	2.6	2.6	2.6
Annual Indicator	3.1	3.1	3.2	3.3	2.8
Numerator	269	266	265	262	222
Denominator	86,558	85,480	82,108	79,345	79,255
Data Source		Department of Health	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

	2012	2013	2014	2015	2016
Annual Performance Objective	2.6	2.6	2.6	2.6	2.6
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 4
   Field Name: OM04
   Row Name:
   Column Name:
   Year: 2011
   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: 2010
   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: 2009
   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

	2007	2008	2009	2010	2011
Annual Performance Objective	8	8	8	8	8
Annual Indicator	9.9	6.9	6.8	6.5	7.3
Numerator	861	594	557	516	580
Denominator	87,076	85,759	82,364	79,589	79,563
Data Source		Department of Health	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

	2012	2013	2014	2015	2016
Annual Performance Objective	7.5	7.5	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 5
   Field Name: OM05
   Row Name:
   Column Name:
   Year: 2011
   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: 2010
   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: 2009
   Field Note:
   Data Source: Tennessee Department of Health, Division of Health Statistics, Birth, Death, and Fetal Death Statistical Systems

OUTCOME MEASURE # 06

The child death rate per 100,000 children aged 1 through 14.

Annual Objective and Performance Data

	2007	2008	2009	2010	2011
Annual Performance Objective	15	15	15	15	15
Annual Indicator	20.1	21.6	18.0	20.3	
Numerator	224	242	203	236	
Denominator	1,114,294	1,120,539	1,127,109	1,159,919	
Data Source		Department of Health	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

	2012	2013	2014	2015	2016
Annual Performance Objective	15	15	15	15	15
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 6
   Field Name: OM06
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Because 2011 population estimates are not available at this time, we are currently unable to report this indicator. Updated data for this reporting year will be made available to HRSA/MCHB as soon as updated population estimates are available.

2. **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

3. **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

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: 2013
   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: 2013
   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: 2013
   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: 2013
   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: 2013
   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: 2013
   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: 2013

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 among Tennesseans.
4. Decrease unnecessary health care utilization associated with asthma.
5. Improve MCH workforce capacity and competency.
6. Increase transition services available to children with special health care needs.
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: 2013**

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 continues to be 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.	The Title V CSHCN program is redesigning the care coordination services provided to program participants. Investing in best practices and standardized training will provide continuous, comprehensive care for CSHCN, and enhance the well-being of the child and family.	If possible, a state that has successfully instituted care coordination standards, training and certification for CSHCN.
2.	**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:	We need guidance on how to shift the current paradigm from direct service and categorical programs to a more integrated approach to promoting healthy people across the lifespan.	The Maternal and Child Health Section has recently combined with the Nutrition and Wellness Section which has resulted in a new Division of Family Health and Wellness.	If possible, a state which has successfully undergone re-organization to include both MCH and Chronic Disease.
3.	**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	We need guidance on incorporation of Life Course Perspective (theory and metrics) into existing programs.	An ongoing challenge is how to incorporate Life Course Perspective into a variety of programs using current (limited) funding and determining metrics for measuring progress within a Life Course framework.	Unknown
4.	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.	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			

	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:	Rate of sleep-related infant deaths (per 1,000 live births).
STATUS:	Active
GOAL	To reduce the number of sleep-related infant deaths.
DEFINITION	The rate of sleep-related infant deaths per 1,000 live births. Sleep-related deaths are deaths that occur in the sleep environment due to suffocation or strangulation. This does not include deaths reported as SIDS (Sudden Infant Death Syndrome). **Numerator:** Number of deaths due to infants (less than or equal to 364 days of age) attribute to sleep-related causes (suffocation, strangulation, etc). **Denominator:** Number of live births **Units:** 1000 **Text:** Rate
HEALTHY PEOPLE 2020 OBJECTIVE	MICH-1.9 Infant deaths from sudden unexpected infant deaths (includes SIDS, Unknown Cause, Accidental Suffocation, and Strangulation in Bed). Target: 0.84 infant deaths per 1,000 live births. Baseline: 0.93 infant deaths per 1,000 live births were attributed to sudden unexpected/unexplained causes in 2006.
DATA SOURCES AND DATA ISSUES	Numerator: Tennessee Child Fatality Review. Data will typically lag 12-18 months behind the calendar year reported. Denominator: 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. In 2010, non-SIDS sleep-related infant deaths accounted for approximately 20% of all infant deaths.

SP() # 2

Performance Measure:	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 2020 Objective	NWS–10.4 Reduce the proportion of children and adolescents who are considered obese (ages 2-19 years). Target: 14.6 percent. Baseline: 16.2 percent of children and adolescents aged 2 to 19 years were considered obese in 2005–08.
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:	Percentage of smoking among women of age 18-44.
Status:	Active
Goal	Reduce smoking among Tennessee adolescents and adults
Definition	Adults who report that they currently smoke (in response to BRFSS survey question). **Numerator:** Adults who report that they currently smoke. **Denominator:** Total number of adults surveyed. **Units:** 100 **Text:** Percent
Healthy People 2020 Objective	TU-1 Reduce tobacco use by adults. Baseline: 20.6 percent of adults aged 18 years and older were current cigarette smokers in 2008 (age adjusted to the year 2000 standard population). Target: 12.0 percent.
Data Sources and Data Issues	Behavioral Risk Factor Surveillance System.
Significance	The need is critical. Smoking is clearly related to adverse health outcomes including heart disease, lung disease, and certain cancers. Additionally, smoking among pregnant women is harmful to offspring, potentially resulting in premature delivery or low birth weight, among other problems.

SP() # 4

Performance Measure:	Rate of emergency department visits due to asthma for children 1-4 years of age (per 100,000).
Status:	Active
Goal	Decrease emergency department utilization among children with asthma (age 1-4).
Definition	Rate (per 100,000 population) of emergency department visits with asthma documented as cause for visit. **Numerator:** Number of resident asthma (ICD-9 codes 493.0 - 493.9) emergency department visits for children aged 1-4. **Denominator:** Estimate of all children age 1-4 years old in the state **Units:** 100000 **Text:** Rate
Healthy People 2020 Objective	RD-3 Reduce hospital emergency department visits for asthma (Children under age 5 years). Target: 95.5 emergency department visits per 10,000. Baseline: 132.7 emergency department visits for asthma per 10,000 children under age 5 years occurred in 2005–07.
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:	Number of MCH staff who have completed a self-assessment and based on the assessment have identified and completed a module in the MCH Navigator system.
Status:	Active
Goal	Improve MCH workforce capacity and competency
Definition	A "self-assessment" is defined as the "MCH Leadership Skills Self-Assessment" or the "Council on Linkages Public Health Core Competencies for Public Health Professionals Self Assessment." The MCH Navigator is a web-based catalogue of self-directed training modules for MCH professionals. **Numerator:** Number of MCH staff in Central Office, Regional Offices, and local health departments who have completed a self-assessment (either the MCH Leadership Self-Assessment or the Council on Linkages Self-Assessment) and based on the results of the assessment have identified and completed at least one module in the MCH Navigator system. **Denominator:** Number of MCH staff in Central Office, Regional Offices, and local health departments **Units:** 100 **Text:** Percent
Healthy People 2020 Objective	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; 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	Data will come from reports by Central Office, Regional Office, and local health department staff.
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.

SP() # 6

Performance Measure:	Percentage of youth (14 and older) enrolled in the state CSHCN program who have formal plans for transtion to adulthood.
Status:	Active
Goal	Increase the percentage of CSHCN (age 14 years and older) enrolled in the state CSHCN program (Children's Special Services, CSS) who have formal plans for transtion to adulthood.
Definition	A formal plan for transition to adulthood is defined as a transition planning document completed (or updated) within the past 12 months and documented in the patient's CSS chart. **Numerator:** Number of CSS enrollees age 14 and older who have a formal plan for transition to adulthood documented in their chart. **Denominator:** Total number of CSS enrollees age 14 and older. **Units:** 100 **Text:** Percent
Healthy People 2020 Objective	DH-5 Increase the proportion of youth with special health care needs whose health care provider has discussed transition planning from pediatric to adult health care. Target: 45.3 percent. Baseline: 41.2 percent of youth with special health care needs had health care providers who discussed transition planning from pediatric to adult health care in 2005–06.
Data Sources and Data Issues	Data will be extracted from patient records for children enrolled in the Tennessee Children's Special Services (CSS) program.
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:	Rate of unintentional injury death in children and young people ages 0-24 (per 100,000).
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 2020 Objective	IVP-11 Reduce unintentional injury deaths. Target: 36.0 deaths per 100,000 population. Baseline: 40.0 deaths per 100,000 population were caused by unintentional injuries in 2007 (age adjusted to the year 2000 standard population).
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				
	2007	**2008**	**2009**	**2010**	**2011**
Annual Indicator	29.6	26.6	22.7	19.4	
Numerator	1,188	1,074	921	792	
Denominator	400,744	403,306	405,883	407,813	
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 #01
   Field Name: HSC01
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   .Because 2011 population estimates are not available at this time, we are currently unable to report this indicator. Also, provisional 2011 hospital discharge data system (HDDS) numerator data was not available at time of the report. Updated data for this reporting year will be made available to HRSA/MCHB as soon as updated population estimates and HDDS data are available.

2. **Section Number:** Form17_Health Systems Capacity Indicator #01
   Field Name: HSC01
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   Data sources: Tennessee Department of Health, Division of Health Statistics, Hospial Discharge Data System and 2010 US Census.

3. **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

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				
	2007	**2008**	**2009**	**2010**	**2011**
Annual Indicator	83.6	71.8	80.6	82.6	85.4
Numerator	48,559	75,323	85,301	89,536	87,004
Denominator	58,058	104,882	105,887	108,351	101,903
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: 2011
   Field Note:
   Data Source: Bureau of TennCare (Medicaid)
   Numerator–TennCare eligible children that received an EPSDT screening during the respective FFY and were included in the denominator
   Denominator–Eligible population: all TennCare members age 0 during the respective FFY

2. **Section Number:** Form17_Health Systems Capacity Indicator #02
   Field Name: HSC02
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   Data Source: Bureau of TennCare (Medicaid)
   Denominator–Eligible population: all TennCare members age 0 during the respective FFY
   Numerator–TennCare eligible children that received an EPSDT screening during the respective FFY and were included in the denominator

3. **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

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				
	2007	**2008**	**2009**	**2010**	**2011**
Annual Indicator	0.0	100.0	100.0	61.6	51.1
Numerator	0	34,704	30,753	1,564	1,049
Denominator	1	34,704	30,753	2,541	2,051
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 #03
   Field Name: HSC03
   Row Name:
   Column Name:
   Year: 2011
   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: 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).

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				
	2007	**2008**	**2009**	**2010**	**2011**
Annual Indicator	83.8	93.2	88.5	87.0	86.6
Numerator	72,498	73,270	66,927	62,619	60,140
Denominator	86,558	78,578	75,614	71,946	69,432
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: 2011
   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: 2010
   Field Note:
   Data Source: Tennessee Department of Health, Divsion of Health Statistics, Birth Statistical System

3. **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).

HEALTH SYSTEMS CAPACITY #07A

Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.

	Annual Indicator Data				
	2007	**2008**	**2009**	**2010**	**2011**
Annual Indicator	45.9	92.8	82.7	82.3	82.7
Numerator	375,016	759,672	654,277	674,964	687,199
Denominator	816,486	818,194	791,343	819,953	830,577
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: 2011
   Field Note:
   Data Source: Bureau of TennCare (Medicaid)
   Numerator: TennCare program children 1-20 with a paid medical service.
   Denominator: Eligible population = all TennCare members age 1-20 with Medicaid eligibility.

2. **Section Number:** Form17_Health Systems Capacity Indicator #07A
   Field Name: HSC07A
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   Data Source: Bureau of TennCare (Medicaid)
   Numerator: TennCare program children 1-20 with a paid medical service.
   Denominator: Eligible population = all TennCare members age 1-20 with Medicaid eligibility.

3. **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.

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				
	2007	**2008**	**2009**	**2010**	**2011**
Annual Indicator	50.6	52.6	54.0	59.2	58.0
Numerator	77,255	77,122	100,908	114,851	115,134
Denominator	152,575	146,517	186,817	194,038	198,543
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: 2011
   Field Note:
   Data Source: Bureau of TennCare (Medicaid)
   Numerator–TennCare program children 6-9 with a claim for a dental service in the year
   Denominator–Eligible population: all TennCare members ages 6-9 at some point during the year with Medicaid eligibility

2. **Section Number:** Form17_Health Systems Capacity Indicator #07B
   Field Name: HSC07B
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   Data Source: Bureau of TennCare (Medicaid)
   Numerator–TennCare program children 6-9 with a claim for a dental service in the year
   Denominator–Eligible population: all TennCare members ages 6-9 at some point during the year with Medicaid eligibility

3. **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

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				
	2007	**2008**	**2009**	**2010**	**2011**
Annual Indicator	9.0	14.0	17.3	12.4	13.9
Numerator	1,962	2,838	3,676	2,675	3,062
Denominator	21,881	20,343	21,286	21,623	22,001
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 #08
   Field Name: HSC08
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Data Sources:
   Numerator–CSS (State Title V CSHSN Program) Data
   Denominator–Provided by HRSA MCHB 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: 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.

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)*	2010	Matching data files	10.8	7.1	9
b) *Infant deaths per 1,000 live births*	2010	Matching data files	9.8	5.9	8
c) *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*	2010	Matching data files	60.8	71.7	66
d) *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*	2010	Matching data files	64.4	67.7	66

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)*	2011	185
b) *Medicaid Children* (Age range 1 to 6) (Age range 6 to 19) (Age range to)	2011	133 100
c) *Pregnant Women*	2011	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)*	2011	250
b) *Medicaid Children* (Age range 1 to 5) (Age range 6 to 18) (Age range to)	2011	250 250
c) *Pregnant Women*	2011	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: 2013
   Field Note:
   Data Source: Tennessee Medicaid (TennCare) website, http://www.tn.gov/tenncare/mem-categories.html. Accessed on 05/19/2012.
2. **Section Number:** Form18_Indicator 06 - Medicaid
   Field Name: Med_Children
   Row Name: Medicaid Children
   Column Name:
   Year: 2013
   Field Note:
   Data Source: Tennessee Medicaid (TennCare) website, http://www.tn.gov/tenncare/mem-categories.html. Accessed on 05/19/2012.
3. **Section Number:** Form18_Indicator 06 - Medicaid
   Field Name: Med_Women
   Row Name: Pregnant Women
   Column Name:
   Year: 2013
   Field Note:
   Data Source: Tennessee Medicaid (TennCare) website, http://www.tn.gov/tenncare/mem-categories.html. Accessed on 05/19/2012.
4. **Section Number:** Form18_Indicator 06 - SCHIP
   Field Name: SCHIP_Infant
   Row Name: Infants
   Column Name:
   Year: 2013
   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.

   Pregnant women with incomes below 250% FPL are eligible for CHIP.
5. **Section Number:** Form18_Indicator 06 - SCHIP
   Field Name: SCHIP_Children
   Row Name: SCHIP Children
   Column Name:
   Year: 2013
   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.

   Pregnant women with incomes below 250% FPL are eligible for CHIP.
6. **Section Number:** Form18_Indicator 06 - SCHIP
   Field Name: SCHIP_Women
   Row Name: Pregnant Women
   Column Name:
   Year: 2013
   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.

   Pregnant women with incomes below 250% FPL are eligible for CHIP.
7. **Section Number:** Form18_Indicator 05
   Field Name: LowBirthWeight
   Row Name: Percent of ow birth weight (<2,500 grams)
   Column Name:
   Year: 2013
   Field Note:
   Data Source: Bureau of TennCare (Medicaid); Tennessee Department of Health Birth and Death Records matched with TennCare records
8. **Section Number:** Form18_Indicator 05
   Field Name: InfantDeath
   Row Name: Infant deaths per 1,000 live births
   Column Name:
   Year: 2013
   Field Note:
   Data Source: Bureau of TennCare (Medicaid); Tennessee Department of Health Birth and Death Records matched with TennCare records

   The infant mortality rates presented here were calculated using the 2010 linked birth-death file (the most recently available linked file). This file is restricted to births and deaths that occurred among infants born to TN resident mothers in 2010. Using the linked birth-death file allows for analysis of infant mortality by characteristics recorded on the birth certificate (e.g. payment source). The overall infant mortality rate presented here will be slightly different than that presented elsewhere, such as on Forms 16 and 20. The infant mortality rate on those other forms was calculated using the number of TN resident infant deaths from the Death Statistical System for a given year and the number of births to TN resident mothers from the Birth

Statistical System for the same year.

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: 2013
Field Note:
Data Source: Bureau of TennCare (Medicaid). Data includes self-reported data (Tennessee Department of Health–birth certificates) and TennCare data. A significant portion of women gained Medicaid eligibility after the 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, 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: 2013
Field Note:
Data Source: Bureau of TennCare (Medicaid); Indicator determined based on self-reported number of prenatal care visits and the date of first prenatal care (Tennessee Department of Health–birth certificates) and TennCare data. A significant portion of women gained Medicaid eligibility after their first trimester which impacts the adequacy of care possible. 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, 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

1. **Section Number:** Form19_Indicator 09B
   Field Name: YRBSS_09B
   Row Name: Youth Risk Behavior Survey (YRBS)
   Column Name:
   Year: 2013
   Field Note:
   In Tennessee, the YRBS is conducted by the Department of Education. The Department of Health has access to the published results via the internet: http://www.tn.gov/education/yrbs/

   Tennessee began participating in the YRBS survey in 1991. The state receives both technical assistance and financial support from the CDC to conduct the YRBS. 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.

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				
	2007	**2008**	**2009**	**2010**	**2011**
Annual Indicator	9.4	9.2	9.2	9.0	9.0
Numerator	8,162	7,834	7,535	7,166	7,157
Denominator	86,558	85,454	82,080	79,305	79,215
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: 2011
   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: 2010
   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: 2009
   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				
	2007	**2008**	**2009**	**2010**	**2011**
Annual Indicator	7.5	7.4	7.5	7.4	7.4
Numerator	6,452	6,085	5,961	5,688	5,647
Denominator	86,558	82,708	79,491	76,812	76,695
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: 2011
   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: 2010
   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: 2009
   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				
	2007	**2008**	**2009**	**2010**	**2011**
Annual Indicator	1.7	1.6	1.7	1.6	1.5
Numerator	1,513	1,378	1,371	1,245	1,187
Denominator	86,558	85,454	82,080	79,305	79,215
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: 2011
   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: 2010
   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: 2009
   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				
	2007	**2008**	**2009**	**2010**	**2011**
Annual Indicator	1.3	1.3	1.3	1.2	1.2
Numerator	1,159	1,043	1,068	950	955
Denominator	86,558	82,708	79,491	76,812	76,695
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: 2011
   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: 2010
   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: 2009
   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				
	2007	**2008**	**2009**	**2010**	**2011**
Annual Indicator	8.0	10.2	7.9	10.3	
Numerator	96	122	95	127	
Denominator	1,194,718	1,201,099	1,207,621	1,238,935	
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 #03A
   Field Name: HSI03A
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Because 2011 population estimates are not available at this time, we are currently unable to report this indicator. Updated data for this reporting year will be made available to HRSA/MCHB as soon as updated population estimates are available.

2. **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, Death Statistical System and 2010 US Census.

3. **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

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				
	2007	**2008**	**2009**	**2010**	**2011**
Annual Indicator	3.3	3.4	2.7	2.5	
Numerator	39	41	33	31	
Denominator	1,194,718	1,201,099	1,207,621	1,238,935	
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	

Field Level Notes

1. **Section Number:** Form20_Health Status Indicator #03B
   Field Name: HSI03B
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Because 2011 population estimates are not available at this time, we are currently unable to report this indicator. Updated data for this reporting year will be made available to HRSA/MCHB as soon as updated population estimates are available.

2. **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, Death Statistical System and 2010 US Census.

3. **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

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				
	2007	**2008**	**2009**	**2010**	**2011**
Annual Indicator	30.8	29.8	24.6	23.4	
Numerator	257	250	208	202	
Denominator	833,229	839,914	846,897	863,430	
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 #03C
   Field Name: HSI03C
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Because 2011 population estimates are not available at this time, we are currently unable to report this indicator. Updated data for this reporting year will be made available to HRSA/MCHB as soon as updated population estimates are available.

2. **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, Death Statistical System and 2010 US Census.

3. **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

HEALTH STATUS INDICATOR #04A

The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.

	Annual Indicator Data				
	2007	**2008**	**2009**	**2010**	**2011**
Annual Indicator	13,239.4	12,313.1	12,487.9	11,867.8	
Numerator	158,173	147,882	150,807	147,034	
Denominator	1,194,718	1,201,009	1,207,621	1,238,935	
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: 2011
   Field Note:
   Because 2011 population estimates are not available at this time, we are currently unable to report this indicator. Updated data for this reporting year will be made available to HRSA/MCHB as soon as updated population estimates are available.

2. **Section Number:** Form20_Health Status Indicator #04A
   Field Name: HSI04A
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   Data Source: Tennessee Department of Health, Division of Health Statistics, Hospital Discharge Data System and 2010 US Census.

3. **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

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				
	2007	**2008**	**2009**	**2010**	**2011**
Annual Indicator	819.3	722.3	718.6	674.1	
Numerator	9,788	8,675	8,678	8,352	
Denominator	1,194,718	1,201,009	1,207,621	1,238,935	
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: 2011
   Field Note:
   Because 2011 population estimates are not available at this time, we are currently unable to report this indicator. Updated data for this reporting year will be made available to HRSA/MCHB as soon as updated population estimates are available.

2. **Section Number:** Form20_Health Status Indicator #04B
   Field Name: HSI04B
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   Data Source: Tennessee Department of Health, Division of Health Statistics, Hospital Discharge Data System and 2010 US Census.

3. **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

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				
	2007	**2008**	**2009**	**2010**	**2011**
Annual Indicator	3,472.0	3,064.8	3,028.5	2,886.5	
Numerator	28,930	25,742	25,648	24,923	
Denominator	833,229	839,914	846,897	863,430	
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: 2011
   Field Note:
   Because 2011 population estimates are not available at this time, we are currently unable to report this indicator. Updated data for this reporting year will be made available to HRSA/MCHB as soon as updated population estimates are available.

2. **Section Number:** Form20_Health Status Indicator #04C
   Field Name: HSI04C
   Row Name:
   Column Name:
   Year: 2010
   Field Note:
   Data Source: Tennessee Department of Health, Division of Health Statistics, Hospital Discharge Data System and 2010 US Census.

3. **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

HEALTH STATUS INDICATOR #05A

The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.

	Annual Indicator Data				
	2007	**2008**	**2009**	**2010**	**2011**
Annual Indicator	40.0	42.1	42.1	38.8	40.2
Numerator	8,153	8,815	8,815	8,210	8,511
Denominator	203,767	209,417	209,417	211,540	211,482
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 #05A
   Field Name: HSI05A
   Row Name:
   Column Name:
   Year: 2011
   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: 2010
   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: 2009
   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				
	2007	**2008**	**2009**	**2010**	**2011**
Annual Indicator	10.4	11.8	11.8	11.4	12.6
Numerator	10,859	12,300	12,300	11,862	13,174
Denominator	1,041,926	1,045,578	1,044,578	1,044,145	1,047,577
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 #05B
   Field Name: HSI05B
   Row Name:
   Column Name:
   Year: 2011
   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: 2010
   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: 2009
   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? No 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	79,016	53,423	15,959	0	0	0	0	9,634
Children 1 through 4	328,797	225,619	65,221	0	0	0	0	37,957
Children 5 through 9	412,181	292,461	79,609	0	0	0	0	40,111
Children 10 through 14	418,941	301,353	85,405	0	0	0	0	32,183
Children 15 through 19	437,186	313,046	95,258	0	0	0	0	28,882
Children 20 through 24	426,244	308,445	86,331	0	0	0	0	31,468
Children 0 through 24	2,102,365	1,494,347	427,783	0	0	0	0	180,235

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	71,208	7,808	0
Children 1 through 4	297,258	31,539	0
Children 5 through 9	380,580	31,601	0
Children 10 through 14	394,744	24,197	0
Children 15 through 19	414,616	22,570	0
Children 20 through 24	397,265	28,979	0
Children 0 through 24	1,955,671	146,694	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? Final

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	2,532	1,642	860	6	7	0	0	17
Women 18 through 19	6,708	4,593	2,022	18	21	9	0	45
Women 20 through 34	61,578	47,265	12,311	125	1,186	111	0	580
Women 35 or older	8,384	6,639	1,343	12	298	14	0	78
Women of all ages	79,318	60,190	16,599	161	1,512	134	0	722

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	2,271	260	1
Women 18 through 19	6,183	521	4
Women 20 through 34	56,006	5,541	31
Women 35 or older	7,581	789	14
Women of all ages	72,147	7,121	50

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? Final

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	626	382	229	0	0	5	0	10
Children 1 through 4	106	69	31	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	247	178	63	1	0	5	0	0
Children 20 through 24	477	367	101	1	1	3	0	4
Children 0 through 24	1,586	1,085	462	3	2	17	0	17

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	585	40	1
Children 1 through 4	99	7	0
Children 5 through 9	51	3	0
Children 10 through 14	75	1	0
Children 15 through 19	238	9	0
Children 20 through 24	460	17	0
Children 0 through 24	1,508	77	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	1,676,121	1,185,902	341,452	0	0	0	0	148,767	2010
Percent in household headed by single parent	32.1	23.7	59.8	41.6	48.5	0.0	67.2	0.0	2011
Percent in TANF (Grant) families	6.8	4.1	18.8	0.0	0.0	0.0	0.0	0.6	2011
Number enrolled in Medicaid	694,217	377,559	223,788	969	5	8,273	0	83,623	2011
Number enrolled in SCHIP	58,757	37,955	10,571	74	1,196	37	0	8,924	2011
Number living in foster home care	5,978	3,785	1,294	25	5	9	0	860	2011
Number enrolled in food stamp program	540,596	341,644	191,421	898	4,360	704	1,569	0	2011
Number enrolled in WIC	216,886	144,114	71,074	55	1,643	0	0	0	2011
Rate (per 100,000) of juvenile crime arrests	1,834.0	1,203.0	4,762.0	0.0	0.0	0.0	0.0	190.0	2010
Percentage of high school drop-outs (grade 9 through 12)	1.8	1.4	3.0	2.6	0.8	1.4	0.0	0.4	2010

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	1,558,406	117,715	0	2010
Percent in household headed by single parent	31.7	37.7	0.0	2011
Percent in TANF (Grant) families	7.0	3.8	0.0	2011
Number enrolled in Medicaid	634,982	59,234	1	2011
Number enrolled in SCHIP	0	3,485	55,272	2011
Number living in foster home care	5,200	343	435	2011
Number enrolled in food stamp program	501,913	38,683	0	2011
Number enrolled in WIC	184,531	32,355	0	2011
Rate (per 100,000) of juvenile crime arrests	1,851.0	754.0	0.0	2010
Percentage of high school drop-outs (grade 9 through 12)	1.8	2.3	0.0	2010

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? No Is this data final or provisional? Final

GEOGRAPHIC LIVING AREAS	TOTAL
Living in metropolitan areas	1,156,523
Living in urban areas	1,071,041
Living in rural areas	605,080
Living in frontier areas	0
Total - all children 0 through 19	1,676,121

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: 2011 Is this data from a State Projection? No Is this data final or provisional? Final

POVERTY LEVELS	TOTAL
Total Population	6,302,173
Percent Below: 50% of poverty	6.8
100% of poverty	16.6
200% of poverty	38.9

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: 2011 Is this data from a State Projection? No Is this data final or provisional? Final

POVERTY LEVELS	TOTAL
Children 0 through 19 years old	1,649,270
Percent Below: 50% of poverty	9.2
100% of poverty	24.3
200% of poverty	48.6

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: 2013
   Field Note:
   Data Source: 2010 US Census
2. **Section Number:** Form21_Indicator 06A
   Field Name: S06_Race_Children1to4
   Row Name: children 1 through 4
   Column Name:
   Year: 2013
   Field Note:
   Data Source: 2010 US Census
3. **Section Number:** Form21_Indicator 06A
   Field Name: S06_Race_Children5to9
   Row Name: children 5 through 9
   Column Name:
   Year: 2013
   Field Note:
   Data Source: 2010 US Census
4. **Section Number:** Form21_Indicator 06A
   Field Name: S06_Race_Children10to14
   Row Name: children 10 through 14
   Column Name:
   Year: 2013
   Field Note:
   Data Source: 2010 US Census
5. **Section Number:** Form21_Indicator 06A
   Field Name: S06_Race_Children15to19
   Row Name: children 15 through 19
   Column Name:
   Year: 2013
   Field Note:
   Data Source: 2010 US Census
6. **Section Number:** Form21_Indicator 06A
   Field Name: S06_Race_Children20to24
   Row Name: children 20 through 24
   Column Name:
   Year: 2013
   Field Note:
   Data Source: 2010 US Census
7. **Section Number:** Form21_Indicator 06B
   Field Name: S06_Ethnicity_Infants
   Row Name: Infants 0 to 1
   Column Name:
   Year: 2013
   Field Note:
   Data Source: 2010 US Census
8. **Section Number:** Form21_Indicator 06B
   Field Name: S06_Ethnicity_Children1to4
   Row Name: children 1 through 4
   Column Name:
   Year: 2013
   Field Note:
   Data Source: 2010 US Census
9. **Section Number:** Form21_Indicator 06B
   Field Name: S06_Ethnicity_Children5to9
   Row Name: children 5 through 9
   Column Name:
   Year: 2013
   Field Note:
   Data Source: 2010 US Census
10. **Section Number:** Form21_Indicator 06B
    Field Name: S06_Ethnicity_Children10to14
    Row Name: children 10 through 14
    Column Name:
    Year: 2013
    Field Note:
    Data Source: 2010 US Census
11. **Section Number:** Form21_Indicator 06B
    Field Name: S06_Ethnicity_Children15to19
    Row Name: children 15 through 19
    Column Name:
    Year: 2013
    Field Note:
    Data Source: 2010 US Census

12. **Section Number:** Form21_Indicator 06B
Field Name: S06_Ethnicity_Children20to24
Row Name: children 20 through 24
Column Name:
Year: 2013
Field Note:
Data Source: 2010 US Census

13. **Section Number:** Form21_Indicator 07A
Field Name: Race_Women15
Row Name: Women < 15
Column Name:
Year: 2013
Field Note:
Data Source: Tennessee Department of Health, Division of Health Statistics, Birth Statistical System. NOTE: Does not include 27 women who were missing data on maternal age and could not be categorized into age sub-groups.

14. **Section Number:** Form21_Indicator 07A
Field Name: Race_Women15to17
Row Name: Women 15 through 17
Column Name:
Year: 2013
Field Note:
Data Source: Tennessee Department of Health, Division of Health Statistics, Birth Statistical System. NOTE: Does not include 27 women who were missing data on maternal age and could not be categorized into age sub-groups.

15. **Section Number:** Form21_Indicator 07A
Field Name: Race_Women18to19
Row Name: Women 18 through 19
Column Name:
Year: 2013
Field Note:
Data Source: Tennessee Department of Health, Division of Health Statistics, Birth Statistical System. NOTE: Does not include 27 women who were missing data on maternal age and could not be categorized into age sub-groups.

16. **Section Number:** Form21_Indicator 07A
Field Name: Race_Women20to34
Row Name: Women 20 through 34
Column Name:
Year: 2013
Field Note:
Data Source: Tennessee Department of Health, Division of Health Statistics, Birth Statistical System. NOTE: Does not include 27 women who were missing data on maternal age and could not be categorized into age sub-groups.

17. **Section Number:** Form21_Indicator 07A
Field Name: Race_Women35
Row Name: Women 35 or older
Column Name:
Year: 2013
Field Note:
Data Source: Tennessee Department of Health, Division of Health Statistics, Birth Statistical System. NOTE: Does not include 27 women who were missing data on maternal age and could not be categorized into age sub-groups.

18. **Section Number:** Form21_Indicator 07B
Field Name: Ethnicity_Women15
Row Name: Women < 15
Column Name:
Year: 2013
Field Note:
Data Source: Tennessee Department of Health, Division of Health Statistics, Birth Statistical System. NOTE: Does not include 27 women who were missing data on maternal age and could not be categorized into age sub-groups.

19. **Section Number:** Form21_Indicator 07B
Field Name: Ethnicity_Women15to17
Row Name: Women 15 through 17
Column Name:
Year: 2013
Field Note:
Data Source: Tennessee Department of Health, Division of Health Statistics, Birth Statistical System. NOTE: Does not include 27 women who were missing data on maternal age and could not be categorized into age sub-groups.

20. **Section Number:** Form21_Indicator 07B
Field Name: Ethnicity_Women18to19
Row Name: Women 18 through 19
Column Name:
Year: 2013
Field Note:
Data Source: Tennessee Department of Health, Division of Health Statistics, Birth Statistical System. NOTE: Does not include 27 women who were missing data on maternal age and could not be categorized into age sub-groups.

21. **Section Number:** Form21_Indicator 07B
Field Name: Ethnicity_Women20to34
Row Name: Women 20 through 34
Column Name:
Year: 2013
Field Note:
Data Source: Tennessee Department of Health, Division of Health Statistics, Birth Statistical System. NOTE: Does not include 27 women who were missing data on maternal age and could not be categorized into age sub-groups.

22. **Section Number:** Form21_Indicator 07B
Field Name: Ethnicity_Women35
Row Name: Women 35 or older
Column Name:

Year: 2013
Field Note:
Data Source: Tennessee Department of Health, Division of Health Statistics, Birth Statistical System. NOTE: Does not include 27 women who were missing data on maternal age and could not be categorized into age sub-groups.

23. **Section Number:** Form21_Indicator 08A
Field Name: S08_Race_Infants
Row Name: Infants 0 to 1
Column Name:
Year: 2013
Field Note:
Data Source: Tennessee Department of Health, Division of Health Statistics, Death Statistical System.

24. **Section Number:** Form21_Indicator 08A
Field Name: S08_Race_Children1to4
Row Name: children 1 through 4
Column Name:
Year: 2013
Field Note:
Data Source: Tennessee Department of Health, Division of Health Statistics, Death Statistical System.

25. **Section Number:** Form21_Indicator 08A
Field Name: S08_Race_Children5to9
Row Name: children 5 through 9
Column Name:
Year: 2013
Field Note:
Data Source: Tennessee Department of Health, Division of Health Statistics, Death Statistical System.

26. **Section Number:** Form21_Indicator 08A
Field Name: S08_Race_Children10to14
Row Name: children 10 through 14
Column Name:
Year: 2013
Field Note:
Data Source: Tennessee Department of Health, Division of Health Statistics, Death Statistical System.

27. **Section Number:** Form21_Indicator 08A
Field Name: S08_Race_Children15to19
Row Name: children 15 through 19
Column Name:
Year: 2013
Field Note:
Data Source: Tennessee Department of Health, Division of Health Statistics, Death Statistical System.

28. **Section Number:** Form21_Indicator 08A
Field Name: S08_Race_Children20to24
Row Name: children 20 through 24
Column Name:
Year: 2013
Field Note:
Data Source: Tennessee Department of Health, Division of Health Statistics, Death Statistical System.

29. **Section Number:** Form21_Indicator 08B
Field Name: S08_Ethnicity_Infants
Row Name: Infants 0 to 1
Column Name:
Year: 2013
Field Note:
Data Source: Tennessee Department of Health, Division of Health Statistics, Death Statistical System.

30. **Section Number:** Form21_Indicator 08B
Field Name: S08_Ethnicity_Children1to4
Row Name: children 1 through 4
Column Name:
Year: 2013
Field Note:
Data Source: Tennessee Department of Health, Division of Health Statistics, Death Statistical System.

31. **Section Number:** Form21_Indicator 08B
Field Name: S08_Ethnicity_Children5to9
Row Name: children 5 through 9
Column Name:
Year: 2013
Field Note:
Data Source: Tennessee Department of Health, Division of Health Statistics, Death Statistical System.

32. **Section Number:** Form21_Indicator 08B
Field Name: S08_Ethnicity_Children10to14
Row Name: children 10 through 14
Column Name:
Year: 2013
Field Note:
Data Source: Tennessee Department of Health, Division of Health Statistics, Death Statistical System.

33. **Section Number:** Form21_Indicator 08B
Field Name: S08_Ethnicity_Children15to19
Row Name: children 15 through 19
Column Name:
Year: 2013
Field Note:
Data Source: Tennessee Department of Health, Division of Health Statistics, Death Statistical System.

34. **Section Number:** Form21_Indicator 08B

Field Name: S08_Ethnicity_Children20to24
Row Name: children 20 through 24
Column Name:
Year: 2013
Field Note:
Data Source: Tennessee Department of Health, Division of Health Statistics, Death Statistical System.

35. **Section Number:** Form21_Indicator 09A
Field Name: HSIRace_Children
Row Name: All children 0 through 19
Column Name:
Year: 2013
Field Note:
Data Source: 2010 US Census

36. **Section Number:** Form21_Indicator 09A
Field Name: HSIRace_SingleParentPercent
Row Name: Percent in household headed by single parent
Column Name:
Year: 2013
Field Note:
Data source: US 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)

37. **Section Number:** Form21_Indicator 09A
Field Name: HSIRace_TANFPercent
Row Name: Percent in TANF (Grant) families
Column Name:
Year: 2013
Field Note:
Data Source: Department of Human Services

NOTE: The denominator for this calculation is from the 2010 census (provdied above in the enumeration of all children 0-19). Thus, these percentages may vary from those calculated using 2011 population estimates (which are not currently available to us).

38. **Section Number:** Form21_Indicator 09A
Field Name: HSIRace_MedicaidNo
Row Name: Number enrolled in Medicaid
Column Name:
Year: 2013
Field Note:
Data Source: Bureau of TennCare (Medicaid); TennCare office data effective as of September 2011.

39. **Section Number:** Form21_Indicator 09A
Field Name: HSIRace_SCHIPNo
Row Name: Number enrolled in SCHIP
Column Name:
Year: 2013
Field Note:
Data Source: Tennessee SCHIP (CoverKids) Program

40. **Section Number:** Form21_Indicator 09A
Field Name: HSIRace_FoodStampNo
Row Name: Number enrolled in food stamp program
Column Name:
Year: 2013
Field Note:
Data Source: Department of Human Services

41. **Section Number:** Form21_Indicator 09A
Field Name: HSIRace_WICNo
Row Name: Number enrolled in WIC
Column Name:
Year: 2013
Field Note:
Dat Source: Tennessee Department of Health, Division of Family Health and Wellness, WIC Program.

42. **Section Number:** Form21_Indicator 09A
Field Name: HSIRace_JuvenileCrimeRate
Row Name: Rate (per 100,000) of juvenile crime arrests
Column Name:
Year: 2013
Field Note:
Data sources: TBI Tennessee Crime Statistics Online (accessed 4/10/2012 at http://www.tbi.state.tn.us/tn_crime_stats/crime_stats_online.shtml) and 2010 US Census.

43. **Section Number:** Form21_Indicator 09A
Field Name: HSIRace_DropOutPercent
Row Name: Percentage of high school drop-outs (grade 9 through 12)
Column Name:
Year: 2013
Field Note:
Data Source: Tennessee Department of Education (2010-11 School Year)

44. **Section Number:** Form21_Indicator 09B
Field Name: HSIEthnicity_Children
Row Name: All children 0 through 19
Column Name:
Year: 2013
Field Note:
Data Source: 2010 US Census

45. **Section Number:** Form21_Indicator 09B
Field Name: HSIEthnicity_SingleParentPercent

Row Name: Percent in household headed by single parent
Column Name:
Year: 2013
Field Note:
Data source: US 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)

46. **Section Number:** Form21_Indicator 09B
Field Name: HSIEthnicity_TANFPercent
Row Name: Percent in TANF (Grant) families
Column Name:
Year: 2013
Field Note:
Data Source: Department of Human Services

NOTE: The denominator for this calculation is from the 2010 census (provdied above in the enumeration of all children 0-19). Thus, these percentages may vary from those calculated using 2011 population estimates (which are not currently available to us).

47. **Section Number:** Form21_Indicator 09B
Field Name: HSIEthnicity_MedicaidNo
Row Name: Number enrolled in Medicaid
Column Name:
Year: 2013
Field Note:
Data Source: Bureau of TennCare (Medicaid); TennCare office data effective as of September 2011.

48. **Section Number:** Form21_Indicator 09B
Field Name: HSIEthnicity_SCHIPNo
Row Name: Number enrolled in SCHIP
Column Name:
Year: 2013
Field Note:
Data Source: Tennessee SCHIP (CoverKids) Program

49. **Section Number:** Form21_Indicator 09B
Field Name: HSIEthnicity_FoodStampNo
Row Name: Number enrolled in food stamp program
Column Name:
Year: 2013
Field Note:
Data Source: Department of Human Services

50. **Section Number:** Form21_Indicator 09B
Field Name: HSIEthnicity_WICNo
Row Name: Number enrolled in WIC
Column Name:
Year: 2013
Field Note:
Dat Source: Tennessee Department of Health, Division of Family Health and Wellness, WIC Program.

51. **Section Number:** Form21_Indicator 09B
Field Name: HSIEthnicity_JuvenileCrimeRate
Row Name: Rate (per 100,000) of juvenile crime arrests
Column Name:
Year: 2013
Field Note:
Data sources: TBI Tennessee Crime Statistics Online (accessed 4/10/2012 at http://www.tbi.state.tn.us/tn_crime_stats/crime_stats_online.shtml) and 2010 US Census.

52. **Section Number:** Form21_Indicator 09B
Field Name: HSIEthnicity_DropOutPercent
Row Name: Percentage of high school drop-outs (grade 9 through 12)
Column Name:
Year: 2013
Field Note:
Data Source: Tennessee Department of Education (2010-11 School Year)

53. **Section Number:** Form21_Indicator 10
Field Name: Metropolitan
Row Name: Living in metropolitan areas
Column Name:
Year: 2013
Field Note:
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 US Census counts for 0-19 year olds by the percentage of TN children 0-18 in metro/urban/rural areas from the 2000 US Census, which is still the most recent year for which these percentages are avaiable.

54. **Section Number:** Form21_Indicator 10
Field Name: Urban
Row Name: Living in urban areas
Column Name:
Year: 2013
Field Note:
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 US Census counts for 0-19 year olds by the percentage of TN children 0-18 in metro/urban/rural areas from the 2000 US Census, which is still the most recent year for which these percentages are avaiable.

55. **Section Number:** Form21_Indicator 10
Field Name: Frontier
Row Name: Living in frontier areas
Column Name:
Year: 2013
Field Note:
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 US Census

counts for 0-19 year olds by the percentage of TN children 0-18 in metro/urban/rural areas from the 2000 US Census, which is still the most recent year for which these percentages are avaiable.

56. **Section Number:** Form21_Indicator 11
Field Name: S11_total
Row Name: Total Population
Column Name:
Year: 2013
Field Note:
Data source: US 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 is from the 2011 survey but survey questions regarding income ask about the previous year's income (i.e. 2010)

57. **Section Number:** Form21_Indicator 11
Field Name: S11_50percent
Row Name: Percent Below: 50% of poverty
Column Name:
Year: 2013
Field Note:
Data source: US 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 is from the 2011 survey but survey questions regarding income ask about the previous year's income (i.e. 2010)

58. **Section Number:** Form21_Indicator 11
Field Name: S11_100percent
Row Name: 100% of poverty
Column Name:
Year: 2013
Field Note:
Data source: US 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 is from the 2011 survey but survey questions regarding income ask about the previous year's income (i.e. 2010)

59. **Section Number:** Form21_Indicator 11
Field Name: S11_200percent
Row Name: 200% of poverty
Column Name:
Year: 2013
Field Note:
Data source: US 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 is from the 2011 survey but survey questions regarding income ask about the previous year's income (i.e. 2010)

60. **Section Number:** Form21_Indicator 12
Field Name: S12_Children
Row Name: Children 0 through 19 years old
Column Name:
Year: 2013
Field Note:
Data source: US 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 is from the 2011 survey but survey questions regarding income ask about the previous year's income (i.e. 2010)

61. **Section Number:** Form21_Indicator 12
Field Name: S12_50percent
Row Name: Percent Below: 50% of poverty
Column Name:
Year: 2013
Field Note:
Data source: US 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 is from the 2011 survey but survey questions regarding income ask about the previous year's income (i.e. 2010)

62. **Section Number:** Form21_Indicator 12
Field Name: S12_100percent
Row Name: 100% of poverty
Column Name:
Year: 2013
Field Note:
Data source: US 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 is from the 2011 survey but survey questions regarding income ask about the previous year's income (i.e. 2010)

63. **Section Number:** Form21_Indicator 12
Field Name: S12_200percent
Row Name: 200% of poverty
Column Name:
Year: 2013
Field Note:
Data source: US 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 is from the 2011 survey but survey questions regarding income ask about the previous year's income (i.e. 2010)

64. **Section Number:** Form21_Indicator 09A
Field Name: HSIRace_FosterCare
Row Name: Number living in foster home care
Column Name:
Year: 2013
Field Note:
Source: Tennessee Department of Children's Services. Includes number of children living in foster home care and medically fragile foster home care. This number also includes children who were in pre-adoptive homes as this is technically foster care (adoption not yet finalized).

65. **Section Number:** Form21_Indicator 09B
Field Name: HSIEthnicity_FosterCare
Row Name: Number living in foster home care
Column Name:
Year: 2013
Field Note:
Source: Tennessee Department of Children's Services. Includes number of children living in foster home care and medically fragile foster home care. This number also includes children who were in pre-adoptive homes as this is technically foster care (adoption not yet finalized).