Maternal and Child Health Services Title V Block Grant

State Narrative for Tennessee

Application for 2015
Annual Report for 2013

Document Generation Date: Monday, July 07, 2014

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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

Required Assurances and Certifications are attached to this section. Copies are also available from the Tennessee Department of Health, Division of Family Health and Wellness, located at 710 James Robertson Parkway, 8th Floor, Andrew Johnson Tower, Nashville, TN 37243 or by email at michael.d.warren@tn.gov.

An attachment is included in this section. IC - Assurances and Certifications

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 COMMENT PROCESS
In keeping with the Tennessee Department of Health's commitment to offering ample time for public comment on the annual Maternal and Child Health (MCH) Block Grant, a near-final draft of the 2015 Application/2013 Report was made available online for four weeks (from June 9, 2014 to July 7, 2014).

Announcement of the posting was made available on the Tennessee Department of Health Website as well as through announcements by email. The announcement was sent to the organizations listed below and recipients were asked to forward broadly to anyone who might be interested. A reminder email was sent out when one week remained for public comment.

Departments/Offices within Tennessee Department of Health (TDH):
Commissioner's Executive Leadership Team
Central Office MCH Staff
Regional Health Officers
Regional MCH Directors
Regional Nursing Supervisors
State Immunization Program
State Dental Program
Communicable and Environmental Diseases and Emergency Preparedness
Policy, Planning and Assessment

Departments/Organizations External to TDH:
Perinatal Advisory Committee

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Genetics Advisory Committee
Children's Special Services Advisory Committee
Department of Education
Office of Coordinated School Health
Department of Children's Services
Department of Human Services
Department of Mental Health and Substance Abuse Services
CoverKids
Medicaid (TennCare)
Family Voices
TN Initiative for Perinatal Quality Care (TIPQC)
Regional Perinatal Centers
University of Tennessee--Knoxville
Belmont University
Vanderbilt TRIAD
Vanderbilt LEND
University of TN at Memphis Boling Center
Head Start
TN Chapter, American Academy of Pediatrics
Cumberland Pediatric Foundation
Volunteer State Health Plan (Blue Cross)
United Healthcare
Governor's Children's Cabinet
Office of the First Lady
Children's Hospital Alliance of Tennessee (CHAT)
Shelby County Breastfeeding Coalition
Julie's Village
East TN Breastfeeding Coalition
TN Commission on Children and Youth
Prevent Child Abuse Tennessee
TN Developmental Disabilities Council
TN Autism Team
Young Child Wellness Council
Newborn Hearing Task Force
Various pediatric healthcare providers
Various TDH grantees

CHARACTERISTIC OF RESPONDENTS
177 individuals responded to an online survey to offer public comment. Participants were asked to best describe their role (selecting multiple categories, if appropriate). The attached summary shows the categories of respondents.

GEOGRAPHIC DISTRIBUTION OF RESPONDENTS
In order to better understand whether the public comments were representative of the population, respondents were asked to indicate the area of the state in which they work or live. The distribution of respondents is consistent with the distribution of Tennessee's population.

MCH BLOCK GRANT REVIEW STATUS
Respondents were asked whether they had read a draft of the MCH Block Grant before (in prior years). Nearly forty percent of respondents indicated that they had read a draft of the grant before (up from approximately one quarter of respondents last year).

SUMMARY OF PUBLIC COMMENTS
The document attached to this section contains a summary of the responses obtained during the public comment period for the 2015 Application/2013 Report.

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RESPONSE TO PUBLIC COMMENT
177 individuals responded via the online survey tool. A number of other individuals responded via email to share narrative updates, edits, or suggested re-wording.

Fifty-four individuals supplied an email address and requested that they receive a final copy of the Application/Report when approved by HRSA. MCH staff will share the final approved version with those individuals once notification is received from HRSA that the Application/Report has been approved.

The public comments will be reviewed in their entirety by the Senior Leadership for the Division of Family Health and Wellness (which houses MCH) and a copy will also be shared with senior Departmental leadership as well as the Regional Directors, Health Officers, MCH Directors, and Nursing Supervisors.

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 Children with Special Health Care Needs, 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

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II. Needs Assessment

In application year 2015, 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 (CYSHCN) 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 year on year (March to March) by 12.3% from 2011 to 2012, then by 2.2% from 2012-13 and 2.1% from 2013-14. Unemployment rates have also improved. The most recently published rate of 7.0% in March 2014 (down from a recent high of 10.5% in 2009). State employees have received salary increases in three of the last four years; a 1.6% increase in 2011, 2.5% in 2012, and 1.5% in 2013.

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, at the onset of the safe sleep campaign, 131 infants succumbed to non-SIDS sleep-

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related deaths, accounting for 20% of all infant deaths during the same year; the number decreased to 121 in 2012. Over the past two years, 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. In January 2014, a hospital campaign was launched, with 100% of TN birthing hospitals pledging to develop and implement a safe sleep policy and to educate all families about infant safe sleep.

Another recent development has been the marked increase in cases of Neonatal Abstinence Syndrome (NAS), a condition in which infants experience withdrawal symptoms after exposure to a substance in utero. In Tennessee, the rise in NAS cases is closely linked to the use and misuse of prescription painkillers as well as overdoses related to prescription drugs. The Tennessee Department of Health added NAS to the list of reportable diseases and events as of January 1, 2013. A subcabinet working group, consisting primarily of Cabinet-level officials from Public Health, Child Welfare, Mental Health, Human Services, and Medicaid are working on policy and programming strategies to reduce the burden of NAS through primary prevention. In 2013, 921 cases of NAS were reported to TDH. Weekly surveillance summaries are posted online at http://health.tn.gov/mch/nas/. The annual surveillance report for 2013 is attached to this section.

CHANGES IN STATE MCH PROGRAM/SYSTEM CAPACITY SINCE LAST APPLICATION

As recent hiring freezes have been lifted, the Division of Family Health and Wellness (FHW) has worked to quickly fill vacant positions. Two doctoral-trained epidemiologists were hired in June 2013; one works on the Core Violence and Injury Prevention grant and the other primarily focuses on the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program. Both also assist with broader MCH-related epidemiology needs. A nurse was hired in May 2013 to oversee the Newborn Screening Follow-Up and Childhood Lead Poisoning Prevention Programs. Staff vacancies have also been filled in Newborn Screening; Childhood Lead Poisoning; Children's Special Services; Infant Mortality; Women, Infants, and Children (WIC); and Chronic Disease. Plans for 2014 include recruitment of a Deputy Medical Director (physician) and a part-time Women's Health nurse practitioner.

FHW is currently hosting a Council on State and Territorial Epidemiologists (CSTE) Fellow. The Fellow, a recent MPH graduate from Georgia Southern University, is working with MCH-related programs for a two-year period and is overseeing the completion of the five-year Title V MCH Needs Assessment. We are also hosting a CDC-funded Public Health Associate Program (PHAP) assignee. This assignee is focusing on injury prevention programs within FHW.

Over the past year, an additional Program Director position was established to support the daily operation of the Children's Special Services (CSS) program, the state Title V program for CYSHCN. The CYSHCN section also arranged to have a family member (contracted from Family Voices) spend some time working in our Central Office to provide family input on FHW programming.

At the Department level, the Commissioner of Health has instituted a Primary Prevention Initiative for all Department employees. All field staff are asked to spend up to 5% of their time in the community working on primary prevention strategies to improve population health. Of the five focus areas, all have a link to state MCH priorities or performance measures (tobacco, immunizations, teen pregnancy, infant mortality, and obesity).

ACTIVITIES TO OPERATIONALIZE NEEDS ASSESSMENT

In an ongoing effort to break down silos and integrate strategies to address priorities across programs, FHW 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, WIC staff collaborated with injury prevention staff to add a safe sleep message to WIC paper food instruments (vouchers) that are distributed to approximately 38,000 participants per month.

In the Division of Family Health and Wellness, topic-based meetings continue in place of the typical "business-oriented" monthly staff meetings. Every other month, staff from each section within the Division present current activities, allowing for shared knowledge among Division staff.

A core planning group is meeting regularly to complete the five year Title V MCH Needs Assessment due in July 2015. The group is planning for the first meeting of the Stakeholder Advisory Committee in June 2014.

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.

Since the last Needs Assessment, 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. Program staff have also worked with Departmental leadership to develop logic models on program areas across the Department, including many related to MCH.

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; Early Periodic Screening, Diagnosis and Treatment (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 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. 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).

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. There has been a 1.7% increase in population from 2010 to 2012 with almost 6.5 million people residing in the state. ***/2015/In 2013, the US Census Bureau estimated the population of Tennessee to be 6,495,978; 79.3% are White, 17.0% are Black, and 4.8% are of Hispanic origin. There has been a 2.4% incrase in population from 2010 to 2013.//2015//***

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%). The state poverty level was 18.4% (26.5% for children) in 2011. ***/2015/In 2012, 13.3% of Tennessee families lived in poverty , compared to the national rate of 11.8%. Children in Tennessee (under age 18) were more likely to be in poverty (24.9%) than children in the rest of the country (21.8%). Poverty rates were also higher for families with female heads of household in Tennessee (53.3%) compared to the rest of the nation (42.5%).//2015//***

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). The US Census Bureau reports that median household income in Tennessee from 2007-2011 was $43,989, lower than the national median of $52,762. ***/2015/Tennessee's median household income ($44,140) continued to lag the national median ($53,046) in 2008-2012.//2015//***

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%. In May 2012, the Tennessee unemployment rate was reported at 7.9%. As of March 2013, the statewide unemployment rate was 7.9% with Knox County having the lowest unemployment rate at 6.2%. ***/2015/The statewide unemployment rate in March 2014 had declined to 7.0%, with Williamson County having the lowest unemployment rate in the state (4.6%).//2015//***

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 (TDH) 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

and 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 (America's Health Rankings, United Health Foundation). 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. Tennessee achieved its highest ranking in recent years (41st) in 2011. In 2012, Tennessee scored 39th in the national health rankings which is the highest overall rating since 1990. ***/2015/Tennessee ranked 42nd in the national health rankings in 2013.//2015//***

Approximately 80,000 babies are born in Tennessee each year. According to the 2008 Pregnancy Risk Assessment Monitoring System (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.

The adolescent pregnancy rate (ages 10-17) 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. 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). The adolescent pregnancy rate declined to 8.9 in 2011; significant racial disparities still exist, with white and black rates of 7.3 and 15.5, respectively. ***/2015/In 2012, the adolescent pregnancy rate decreased to 8.3 overall; a disparity still exists between white (7.0) and black (14.2) adolescents.//2015//***

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. 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%). In 2011, 9.0 percent of babies were born at low birth weight; significant racial disparities still exist, with white and black percentages of 7.7 and 13.9, respectively. ***/2015/In 2012, the overall percentage of low birth weight babies was 9.2%, with white and black percentages of 7.9% and 14.0% respectively.//2015//***

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). 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). In 2011, the infant mortality rate was 7.4, with a white rate of 6.0 and a black rate of 12.8. ***/2015/The infant mortality rate continued to decline in 2012, with a statewide rate of 7.2. Disparities persist, with a rate of 5.9 among white infants and 12.1 among black infants.//2015//***

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. As of March 2012, 688,734 children age 0-18 were enrolled in TennCare. As of January 2013, 688,170 children age 0-18 were enrolled in TennCare. ***/2015/As of January 2014, 684,367 children age 0-18 were enrolled in TennCare.//2015//***

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% Federal Poverty Level (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. According to the 2008 PRAMS survey, 19.7% of Tennessee mothers report smoking during pregnancy. ***/2015/In 2012, 16.3% of pregnant women in Tennessee reported smoking during pregnancy, with the highest percentages during the first trimester. Smoking rates varied from 4.2% to 41.1% across the state.//2015//***

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).

/2015/In 2013, the General Assembly appropriated $15 million ($5 million per year for three years) from the Tobacco Master Settlement fund to support local initiatives to reduce tobacco-related disease. TDH worked to distribute funding to all 95 counties with a focus on three primary areas: reduction of pregnancy smoking, prevention of smoking among youth, and reduction of secondhand smoke exposure to children.//2015//

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 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. 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. From 2007-2008 to the 2011-2012 school year, CSH Coordinators secured an additional $73 million in health grants and in-kind resources/gifts for Tennessee schools which was used to expand local capacity to address school health priorities. ***/2015/From the 2007-08 to 2012-13 school years, CSH Coordinators secured an additional $103 million in health grants and in-kind resources/gifts for Tennessee schools which was used to expand local capacity to address school health priorities.//2015//***

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 staff 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.

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%).

During the 2011-2012 school year, 1,316,649 student health screenings occurred in Tennessee schools. The most common type of screenings were vision (27%), hearing (23%) and body mass index (BMI) (22%). Also, 164,571 student referrals were made to a health care provider as a result of a school health screening. Most referrals were associated with BMI screenings (49%), vision screenings (27%) and dental screenings (9%).

/2015/In 2012-13 over 1.4 million student health screenings occurred in Tennessee public schools. Of those screened, 144,468 students were referred to a health care provider for additional medical attention through parental notification. This represents a 172 percent increase over the number of referrals in 2006-07. Of the total number of school health screenings; 24 percent were vision, another 24 percent were hearing, and 23 percent were BMI making up the common types of sub-screens conducted.//2015//

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

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. 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.

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% reported 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 increased 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.

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. As of March 2012, there were 1,206,538 enrollees in TennCare. TennCare enrollment

remains relatively stable at 1,205,480 enrollees through Dec. 2012. ***/2015/In January 2014, 1,190,766 Tennesseans were enrolled in TennCare.//2015//***

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%). 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. TennCare has added two HEDIS measures, beginning with 2012 as the baseline year, that will track pap tests for women and HPV vaccine completion. ***/2015/The 2013 HEDIS report showed that cervical cancer screening has improved slightly to 69.8% and Chlamydia screening has improved to 57.4%; the national averages are 66.7% and 58%, respectively. Among TennCare enrollees, 16.8% of adolescent females received the Human Papillomavirus (HPV) vaccine, compared to 17.7% nationally.//2015//***

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. ***/2015/Effective October 31, 2013, all new enrollment in CoverTN was suspended. Coverage for all CoverTN members ended December 31, 2013.//2015//***

CoverKids is Tennessee's program under the federal State Children's Health Insurance Program for families with incomes that are too high to qualify for TennCare coverage. The program provides coverage for children 18 and younger. 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 prenatal 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. ***/2015/For families with a household income greater than 250 percent of the federal poverty level (which participated in the CoverKids buy-in program) coverage ended December 31, 2013.//2015//***

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. ***/2015/Effective October 31, 2013, no new applications were accepted for AccessTN. For current members who are above the federal poverty level and/or are not currently receiving premium assistance, coverage ended April 30, 2014.//2015//***

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 pay a discounted price for any drugs that are not covered. ***/2015/For members with incomes at or above 100 percent of the federal poverty level, coverage ended December 31, 2013.//2015//***

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. Collaboration between TENNderCare and Family Health and Wellness (FHW) programs including home-based targeted case management services, adolescent health checks and parent outreach is strengthening the integration of services for families with dependent children.

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 reinforce 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 Child Fatality Review Team 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 the Division of Family Health and Wellness (FHW) 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) 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.

FHW plays an important role in actualizing the mission of the Department. FHW 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.

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. As of July 1, 2013, TDH was

awarded a 5 year combined Diabetes, Heart Disease, Obesity and School Health grant with a competitive Enhanced Component for a total of $1,854,220 annually. This funding supports statewide implementation of cross-cutting approaches to promote health, prevent and control chronic diseases along with their risk factors.

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.

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 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.

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".

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."

The 2013 Resource Map Report is available at: http://www.tn.gov/tccy/MAP-rpt13.pdf. According to the report, 23 state agencies served over 17,096,177 children in FY11-12, with expenditures of $9,107,212,958. Additionally, "excluding the BEP, almost three of every four dollars spent on services for children and families in Tennessee in FY 2012 were from federal funding sources. State funding accounted for 26.5 percent of all non-BEP expenditures in FY 2012. Excluding the BEP, over nine of every 10 dollars in the state budget for children, 91.5 percent in FY 2012, were either federal or required as match/maintenance of effort for federal funding."

/2015/The 2014 Resource Map Report is available at: http://www.tn.gov/tccy/MAP-rpt14.pdf. According to the report, 23 state agencies served 18,153,769 children in FY12-13, with expenditures of $9,346,346,355. Additionally, "excluding the BEP, around three of every four dollars spent on services for children and families in Tennessee in FY 2013 were from federal funding sources (73 percent in FY2013). State funding accounted for 26 percent of all non-BEP expenditures in FY 2013."//2015//

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. ***/2015/In 2013, NACCHO published a report regarding local health departments job losses and program cuts; 12% of Tennessee local health departments reported staff cuts and 55% reported cuts to at least one program.//2015//***

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). In 2013, the trend of disproportionate funding continued (Trust for America's Health 2013). 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 CDC to Tennessee is $17.12 per capita compared to $19.54 per capita U.S. Average (rank 42). ***/2015/According to a 2014 report from Trust for America's Health, the federal CDC funding for Tennessee is $$16.71 per capita (national rank of 41) compared to the national average of $18.92.//2015//***

-Federal funding from HRSA to the state is $22.53 per capita compared to $24.71 per capita U.S. average (rank 30). Federal funding from HRSA to the state increased in 2012 and is $22.54 per capita compared to $23.18 per capita U.S. average, the state's rank improved from 30 to 23. ***/2015/Trust for America's Health indicated in 2014 that the HRSA per capita funding to Tennessee was $21.76 (national rank of 27), compared to the national average of $21.40.//2015//***

-State funding for public health $45.74 per capita compared to $28.92 per capita U.S. average (rank 18). State funding for public health decreased during FY 2011-2012 to $43.76 per capita compared to $27.40 per capita U.S. average. Tennessee's rank went from 18 to 16. ***/2015/In FY 2012-13, state funding for public health in Tennessee was $43.01 (ranked 16th nationally) compared to the national median of $27.49.//2015//***

As of Spring 2012, the Department of Health reported 3037 employees working in both rural and metropolitan settings across the state. As of Spring 2013, the Department of Health reported 4,176 employees working in both rural and metropolitan settings across the state. ***/2015/As of Spring 2014, the Department of Health reported 4,116 employees working in both rural and metropolitan settings across the state.//2015//***

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. HUGS is funded by Medicaid as a targeted case management program. State funds support the Nurse Family Partnership, 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. 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. In 2013, Tennessee was awarded competitive MIECHV funds, allowing for the expansion of evidence-based home visiting to the 30 most at-risk counties as identified in the 2010 Needs Assessment. ***/2015/In 2014, the state funding available for Healthy Start was decreased to approximately $1.9 million. Funding was made available through a competitive bid process and 22 counties were funded. Between the MIECHV funding and the Healthy Start funding, evidence-based home visiting will be available in 50 of the 59 most at-risk counties across the state.//2015//***

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

-Improve ability to use the Department's Patient Tracking Billing Management Information System (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.

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

/2015/ TDH identified key core competencies through a collaborative process which included research on competencies being used in existing home visiting programs in Tennessee, a review of competencies utilized by other states, a survey of home visiting professionals in Tennessee and discussions with direct service staff, supervisors, and managers in a variety of home visiting programs around the state. Within each of the competency areas, specific knowledge, skills and attitudes have been identified to provide further descriptions of what is encompassed within that competency. Additionally, each home visitor will need to be competent in implementing the particular research-informed or evidence-based model and therefore a foundational competency area has been included.

Using the Core Competencies for the Field of Home Visiting in Tennessee, an online, 10-week Home Visitor Preparation class which provides fundamental knowledge and an orientation to all of the Core Competencies for the Field of Home Visiting in Tennessee has been developed and the first session was offered beginning in January 2013. An additional nine orientations were offered throughout 2013 with over 100 home visitors and care coordinators successfully completing the course. Two sessions have been offered in 2014 (including one currently in process) which will add an additional 45 participants to those who have successfully completed the course.

The Child Development Associate credential (CDA) is the only national credential for home visiting professionals and is awarded by the Council for Professional Recognition to individuals who have successfully completed the CDA assessment process. Earning the CDA credential has many advantages for home visiting staff, including motivating practitioners toward continuing education and providing a platform for professional and career opportunities in Early Childhood Development.

Adopting this credential, promoting its availability and supporting home visitors to participate will allow Tennessee to offer a Home Visiting credential that is aligned with current research-based best practices and is credit-bearing, based within a system of higher education. TDH worked with the Tennessee State University and the Council for Professional Recognition to develop a cadre of field staff who can serve as CDA advisors for home visitors interested in pursuing the CDA and four home visitors have successfully been awarded the CDA credential.

Utilizing the information from the Home Visiting Workforce Development Survey, a Maternal, Infant and Early Childhood Home Visiting Institute is being planned for August 2014 for any professionals working with expecting families or families with young children in home visiting programs, care coordination programs, early intervention programs and other home-based early childhood programs.

This Institute will provide an opportunity to not tout the strength of one program over another, but rather ensure a spectrum of high quality home visiting services are available to all families who need and want them and assure home visiting programs are able to effectively assist families on their terms and according to their needs. The Institute will also provide an opportunity for a wide variety of stakeholders to continue the conversation of how to expand and provide home visiting for all communities.//2015//

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. ***/2015/SSDI funding has been leveraged to provide additional MCH epidemiology capacity by supporting up to half-time salary for an epidemiologist in the TDH Division of Policy, Planning, and Assessment. The epidemiologist provides invaluable support for MCH-related data requests throughout the year and also for preparation of the annual MCH Block Grant Application and Report. In 2013, SSDI funds were used to support Collaborative Improvement and Innovation Network (CoIIN) activities in Tennessee related to smoking cessation, perinatal regionalization, safe sleep, and reduction of early elective deliveries.//2015//***

Early Childhood Comprehensive Systems
MCH has received funding since 2003 for the state's Early Childhood Comprehensive System (ECCS) program. The purpose of ECCS 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 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. ***/2015/The ECCS Advisory Council has been transitioned into the Tennessee Young Child Wellness Council, a statewide early childhood entity focused specifically on infants and young children in order to assure a common understanding that promoting young child health and wellness is an important issue. The TNYCWC is a mechanism to assure to assure a common understanding of the social ecological model of wellness, Life Course theory, research on Protective Factors, and role of primary prevention exists across all early childhood professionals, family providers, and topic specific interventionists such as substance abuse and mental health providers. This statewide entity is tasked with assuring recognition and understanding that child development and wellness needs to be influenced in a positive way by focusing on prevention rather than remediation; starting prevention efforts early; and supporting nurturing relationships through comprehensive multi-level approaches. Over 80 statewide partners, agencies and organizations have committed their involvement and are enthusiastically participating in the TNYCWC. Members of the TNYCWC will strengthen knowledge of one another's work; embrace a shared goal and agenda; and work to implement collectively identified strategies. Because the TNYCWC will serve as a vehicle for proposing infrastructure reforms, policy recommendations and improved workforce***

coordination to the Governor's Children's Cabinet and other decision making bodies, it will be in an excellent position to successfully promote home visiting as a key strategy in reaching the identified outcomes.//2015//

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. In 2013, federal Title X funds provided approximately 39% of total program funding. There are 126 clinic sites.

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 56 local health department sites. Fifteen of the 56 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). 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.)

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

The HealthCare Safety Net Primary Care for Uninsured Adults 19-64 Years of Age provided 528,386 medical encounters to uninsured adults in FY 11--12. Dental providers for the Safety Net Emergency Dental Program for Uninsured Adults19-64 Years of Age performed 22,464 extractions in FY 11- 12. In FY 12-13 the General Assembly appropriated $12 million for the Adult Health Safety Net funding; this includes $6 million for FQHCs and $6 million for Community Faith Based providers.

/2015/ The HealthCare Safety Net Primary Care for Uninsured Adults 19-64 Years of Age provided 648,422 medical encounters to uninsured adults in FY 12--13. Dental providers for the Safety Net Emergency Dental Program for Uninsured Adults19-64 Years of Age performed 20,569 extractions in FY 12- 13. In FY 13-14 the General Assembly appropriated $12 million for the Adult Health Safety Net funding; this includes $6 million for FQHCs and $6 million for Community Faith Based providers.//2015//

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 Update, 2005).

Other key measures of access to care in 2005 included:
-30 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 had a shortage of providers accepting TennCare
-3 counties had no dentist (Pickett, Lake, and Van Buren counties)
-7 counties had ratios of >10,000 residents/dentist
-75 counties lacked adequate mental health professionals (as measured by federal health professional shortage designation of >20,000 residents per mental health provider)

As of May 2012:
-5 counties had no dentist (Bledsoe, Moore, Pickett, Lake, and Trousdale counties)
-10 counties have ratios of greater than 10,000 residents/dentist (Grundy, Grainger, Van Buren, Macon, Johnson, Wayne, Marion, Hickman, Meigs and Lauderdale)

/2015/ As of April 2014:
-2 counties have no dentist (Grundy and Lake)
-12 counties have ratios of greater than 10,000 residents/dentist (Van Buren, Pickett, Grainger, Fayette, Wayne, Meigs, Morgan, Perry, Hickman, Lauderdale, Fentress, and Johnson)//2015//

The Community Health Systems Section State Office of Rural Health and Health Access, regularly monitors direct primary care service delivery capacity. In January 2012, the Bureau was reorganized and the State Office of Rural Health and Health Access is now aligned under the Division of Health Disparities. Available data sets (e.g., licensure registries) and statewide telephone and primary care provider census surveys (physicians, mid-level providers, and dentists) are used to assess primary care provider workforce shortage areas. Working collaboratively with key stakeholders such as medical school university resident programs, the Tennessee Hospital Association, Tennessee Primary Care Association, and The Rural Partnership, the Office of Health Access staff administers various recruitment incentive programs designed to recruit and retain primary care providers in exchange for a service obligation in underserved communities in Tennessee. 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). 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.

During 2012 one hundred sixty-seven health care professionals practicing in Tennessee received NHSC support. They are comprised of: 32 Physicians, 19 Dentists, 3 Registered Dental Hygienists, 72 advanced practice nurses, 11 Physician Assistants, 3 Nurse Midwives, and 27 mental health providers. Sixty-six of the 167 are practicing at Federally Qualified Health Centers. Nine-two of the 167 are located in rural areas. There were approximately 204 NHSC practice site locations in Tennessee as of 12/31/2012 (State Office of Primary Care, May 2013).

/2015/ National Health Service Corps Program (NHSC) -- During the calendar year from January 1, 2013 through December 31, 2013 one hundred twenty-two (122) health care professionals practicing at one hundred one (101) separate sites in Tennessee received NHSC support. They are comprised of: 25 Physicians, 9 Dentists, 3 Registered Dental

Hygienists, 28 advanced practice nurses, 25 Physician Assistants, 1 Nurse Mid-Wife, and 31 mental health providers. Forty-eight (48) of the 122 are practicing at Federally Qualified Health Centers. Sixty-seven (67) of the 122 are located in rural areas. There were approximately 235 currently certified NHSC practice site locations in Tennessee as of December 31, 2013. (State Office of Primary Care, May 2014).//2015//

The Tennessee Rural Partnership Stipend Program, formerly known as the Graduate Medical Education Residency Stipend Program, encourages clinicians to practice in rural and underserved areas of Tennessee by providing a financial incentive in exchange for a practice commitment in an identified area of need. Eligible practitioners include: physicians in primary care residency programs in Tennessee; physicians with Tennessee affiliations who are in out-of-state primary care residency programs but who are interested in primary care practice in rural/underserved communities of Tennessee; and nurse practitioners and physician assistants studying in Tennessee programs interested in primary care practice in rural/underserved communities of Tennessee. For physicians, the awards range up to $35,000 per year for 3-4 years, depending upon the length of the residency program [maximum $140,000]. For Physician Assistants & Primary Care Nurse Practitioners, the maximum award is $15,000 per year for 2 years. Fifteen (15) Tennessee Rural Partnership Stipends were awarded in 2012.
/2015/Seventeen physician residents received a Tennessee Rural Partnership (TRP) Stipend award in 2013.//2015//

The Tennessee Rural Health Loan Forgiveness Program, a five year pilot program that ended in May 2013, has provided students enrolled in postsecondary institutions with Schools of Medicine, Dentistry, Osteopathy, physician assistant, or nurse practitioner programs a $12,000 stipend per academic year in exchange for a service obligation in an area designated as health resource shortage area by the Tennessee Department of Health. Since its inception, in May 2008 this program has provided stipends to a total of 97 recipients comprised of 74 nurse practitioners, 8 physician assistants, 14 doctors of osteopathy and 1 dentist.

Conrad 30 J-1 Visa Waiver Program: In 2012 Eight (8) Foreign medical graduates received a 2-year home residence waiver in exchange for a 3-year service obligation in an underserved community.

/2015/ The Conrad 30 J-1 Visa Waiver Program: In 2013 eleven (11) Foreign medical graduates received a 2-year home residence waiver in exchange for a 3-year service obligation to provide needed medical service in an underserved community.//2015//

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. This program is no longer active.

Tennessee State Loan Repayment Program (TSLRP): Implemented in late 2009, 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). 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. Eligible primary care practitioners are physicians, nurse practitioners, physician assistants and dentists, who can receive up to $60,000 in educational loan repayment in exchange for an initial two year service commitment at a public, nonprofit or private not-for-profit primary care ambulatory entity located in a federally designated Health Professional Shortage Area (HPSA). As of May 2013 there are a total of 20 TSLRP recipients currently practicing under a service obligation in a shortage area; comprised of 1 physician, 14 nurse practitioners, 3 dentists and 2 physician assistants.

/2015/As of May 2014 there are a total of 29 TSLRP recipients currently practicing under a service obligation in a Health Professional Shortage Area; comprised of 2 physicians, 17 advanced nurse practitioners, 3 dentists, and 7 physician assistants. Eligible primary care practitioners are physicians, nurse practitioners, physician assistants and dentists, who can receive up to $50,000 in educational loan repayment in exchange for an initial two year service commitment at a public, nonprofit or private not-for-profit primary care ambulatory entity located in a federally designated Health Professional Shortage Area (HPSA).//2015//

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. ***/2015/The Department actively collaborates with the state's first public health training center, LIFEPATH at East Tennessee State University, for academic and non-academic offerings for public health staff.//2015//***

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. In 2011, approximately forty-one percent (2675) of the 6525 CSS enrollees had SSI. In 2012, twenty-two percent (1359) of the 6059 CSS enrollees had SSI. In 2013, approximately twenty-four percent (1278) of the 5266 CSS enrollees had SSI. ***/2015/ In 2014, approximately nineteen percent (1059) of the 5573 CSS enrollees have SSI.//2015//***

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. The Department (CSS) program applied for and received the D70 State Implementation of Services for CYSHCN Grant. The funds from this grant will allow the program to enhance participation and decision making capabilities of parents and families of CYSHCN. A parent consultant position has been established at Family Voices of Tennessee and that individual will be housed part-time in the CSS program office. Families will be connected to leadership opportunities and to parent-to-parent networks and training will be provided to help parents navigate health care and community systems. The CSS program has hired a full time director for this grant initiative and recruited a parent volunteer who is assisting with program development for parents and families.

CULTURALLY COMPETENT APPROACHES TO SERVICE DELIVERY

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 participated 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. ***/2015/The evaluation from the first round of training is attached to this section . Once the first round***

of training was completed, a second round of training commenced, focused on front-line service delivery staff. UTK staff will once again provide the training to all regions of the state.//2015//

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.

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. The FY2012-13 budget passed by the legislature in May 2012 included a 2.5% raise for state employees. The FY 2013-14 budget passed by the legislature in April 2013 included a 1.5% raise for state employees. ***/2015/There were no raises for state employees in the FY 2014-15 budget passed in April 2014.//2015//***

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.

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. ***/2015/Plans for implementation of the Department's EHR have continued to progress, with a pilot test planned for Fall 2014 in Northeast Tennessee. MCH staff have been involved in the planning for clinical templates and workflows. Once in place, the system will allow for enhanced data collection from MCH programs, including Family Planning, Children's Special Services, and Breast and Cervical Screening//2015//***

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).

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

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. 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.

The Department of Health has a range of responsibilities, including administering a variety of community-health programs, licensing health care professionals and maintaining health records and statistics. The Department works closely with local governments and nonprofit agencies to monitor and improve community health. The Department is organized into 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, and Rape and Violence Prevention).

/2015/The mission of the Tennessee Department of Health is to protect, promote, and improve the health and prosperity of people in Tennessee. The Department's vision is to be a recognized and trusted leader, partnering and engaging to make Tennessee one of the Nation's 10 healthiest states.//2015//

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. 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. Current organizational charts for the Department of Health and the Division of Family Health and Wellness are uploaded as attachments to this section.

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. In 2013, a pediatric cardiologist was added to the Genetics Advisory Committee to assist the Department in implementing screening for critical congenital heart disease. 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.

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

D. Other MCH Capacity

SECTION MANAGEMENT

/2015/Tennessee's MCH-related programs are organized in the Division of Family Health and Wellness within the Tennessee Department of Health.//2015// 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.

/2015/Additional MCH leadership for the section is provided by Melissa Blair (Deputy Director), Kelly Luskin (Reproductive and Women's Health), Rachel Heitmann (Injury Prevention and Detection), Jacqueline Johnson (CSHCN), Peggy Lewis (WIC), Margaret Major (Perinatal, Infant, and Pediatric Care) and Loraine Lucinski (Early Childhood).//2015//

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.

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.

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.

/2015/Kelly Luskin serves as the Director of Reproductive and Women's Health. Kelly is a women's health nurse practitioner and worked in a clinical setting providing direct care prior to joining the Department in 2012. Mrs. Luskin oversees Family Planning, Adolescent Pregnancy Prevention, and the Breast and Cervical Cancer Screening Program. She holds an MSN degree and is a board-certified Women's Health Nurse Practitioner.//2015//

/2015/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 Perinatal, Infant, and Pediatric Care, providing oversight for Perinatal Regionalization, Newborn Screening, and Childhood Lead Poisoning Prevention. Ms. Major holds a Bachelor's degree in Food Science/Nutrition and a Master's in Public Administration/Health Services.//2015//

Loraine Lucinski joined the Department in September 2011 and began leading the Early Childhood Systems Initiatives Team in January 2013. The Early Childhood Systems Team oversees a number of early childhood programs including the Early Childhood Comprehensive Systems Initiative, the Maternal, Infant and Early Childhood Home Visiting (MIECHV) Program, state funded home visiting programs, the Medicaid Targeted Case Management Program for high risk infants and mothers and the new Universal Parent Outreach Initiative, Welcome Baby. Ms. Lucinski holds a Bachelor Degree in Developmental Psychology, a Master's Degree in Public Health and a Graduate Certificate in Maternal and Child Health Epidemiology.

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 worked 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.

/2015/A program evaluation training was held in Summer 2014 for FHW program leadership. Faculty from four Tennessee public health programs (East Tennessee State University, University of Tennessee-Knoxville, Tennessee State University, and the University of Memphis) presented examples of program evaluation strategies and then worked in small group sessions with program management staff to help identify plans for evaluating FHW programs.//2015//

To build long-term epidemiology capacity for the section, several initiatives are currently underway. ***/2015/Two PhD-level epidemiologists were hired in 2013; Dr. Angela Miller works primarily with the early childhood section and Dr. Ester Nilles with the injury prevention section. Both also provide support for broader MCH data needs. Dr. Miller has a PhD in Epidemiology from Emory University. At Emory, her research was focused on father involvement and preterm birth; she has also studied childhood nutrition, postpartum depression, and pregnancy outcomes. Dr. Nilles has a PhD in Biostatistics from Florida State University. In Florida, Dr. Nilles worked for the Agency for Health Care Administration to develop statistical analysis plans, develop data mining algorithms, and lead a team of researchers to produce data reports. Plans are underway to reclassify three positions to epidemiologist positions that will support Newborn Screening/CYSHCN, Reproductive & Women's Health, and WIC/Chronic Disease.***

FHW also currently is hosting a CDC/CSTE (Council on State and Territorial Epidemiologists) Epidemiology Fellow, Julie Traylor. Ms. Traylor is a recent MPH graduate from Georgia Southern University and is working on a variety of MCH initiatives, including development of a "real-time" infant mortality dashboard and oversight of the 2015 Five-Year Title V MCH Needs Assessment.//2015//

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).

Advances have been made over the past year to further involvement of parents in planning, programming and implementing Title V Programs. ***/2015/In 2013, Tennessee had both an***

AMCHP Family Scholar and an AMCHP Family Delegate attend the annual conference. Two family representatives attended in 2014. One of our key family partners (and our 2013 Family Scholar), Belinda Hotchkiss, was named in 2014 to be part of the AMCHP Next Generation Advisory Workgroup. Through the D70 Systems Integration Grant, TDH has worked with Family Voices to establish a parent to parent network and to build skill and capacity for parents to be active, engaged partners in their child's health.//2015// The CSHCN Program has also been implementing a number of activities in partnership with Family Voices to further expand parent involvement including development of training and leadership opportunities.

OTHER MCH WORKFORCE INFORMATION
An 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. Currently Jacqueline Johnson, State CSHCN Director, is enrolled in the Epidemiology Certificate Program. ***/2015/Staff from LIFEPATH also facilitate other workforce development activities on an ad-hoc basis. In 2013, they hosted a workshop for FHW program managers on grant writing and covered basic skills related to reading a funding announcement and developing a grant application.//2015//***

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. Since March 2012, selected Department of Health staff in all 13 regions are participating 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. ***/2015/UTK completed the first round of training (regional and Central Office Leadership) in 2013 and is now holding additional sessions across the state to provide the training to front-line service delivery staff.//2015//***

As part of ongoing efforts to systemically address workforce development, all MCH-related Central Office and Field Staff are completing the MCH Leadership Competencies Self-Assessment and utilizing the findings to complete at least one module in the MCH Navigator. More information about this can be found within SPM 5.

An additional collaborative workforce development effort has been directed at the home visiting workforce. In partnership with MIECHV and Tennessee State University, Core Competencies for Home Visitors, a self-assessment tool and an on-line home visiting orientation based on the competencies has been developed and will have been completed by fifty home visitors and supervisors by June 2013. Continued offering of the orientation will result in over 300 home visitors participating. An infrastructure for awarding the National Child Development Associate Credential to home visitors in Tennessee has been created and will be available for staff beginning summer 2013. A partnership with Nashville State Community College has resulted in the offering of a Child Development course designed for home visitors.

/2015/FHW staff are always encouraged to take advantage of external workforce development activities. In the past several years, four FHW staff (including three members of our senior leadership team) have completed LEAD Tennessee, a statewide, 12-month development initiative which includes six one-day summits of intense, personally tailored, high impact learning focused on twelve core leadership competencies. The goal of LEAD

Tennessee is to increase the state's leadership bench strength by providing agencies with a continuous pipeline of motivated and prepared leaders that share a common language and mindset about great leadership. The Division's Deputy Director, Melissa Blair, participated in the MCH Public Health Leadership Institute at the University of North Carolina-Chapel Hill. PHLI is an executive-education program designed to significantly expand self-awareness and quickly build practical skills for effectively leading, managing people, and building partnerships, to advocate for and create the MCH systems of tomorrow. Additionally, Jacqueline Johnson, state CYSHCN Director, is currently participating in the AMCHP Leadership Institute for CYSHCN Directors. This program promotes valuable components for both new and experienced directors. The Division Director, Dr. Michael Warren, currently serves on the AMCHP Workforce Development Committee, on the Advisory Committee for the National MCH Workforce Development Center and also as a mentor in the AMCHP New Director Mentor Program.//2015//

E. State Agency Coordination

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

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

Examples of collaborative efforts:

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

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

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

Department of Education (DOE): Central Office MCH staff collaborate routinely with the Office of Coordinated School Health (OCSH), which is housed within the Department of Education. There is also increasing collaboration between regional TDH staff and regional CSH staff. In early 2012, TDH Regional MCH Directors provided an overview of MCH-related services at regional CSH meetings. Feedback from both MCH and CSH staff indicated that the meetings were useful for sharing program information and building local connections. MCH staff in collaboration with CSH recently organized an Adolescent Institute for Adolescent Health and Adolescent Pregnancy Prevention Coordinators, CSH Professionals, Health Educators, and Abstinence Education Grant Program Staff. Institute workshops addressed: childhood obesity, asthma, the importance of breakfast, physical activity, vision, aggression and violence, ADHD and teen pregnancy and parenting.

The Department of Education, Division of Special Education, is the lead agency for the IDEA Part C TN Early Intervention System (TEIS) for infants and toddlers birth to 3 identified with or having a potential for a developmental delay. TEIS has been an active collaborator with the CSS program since 1990 and with Newborn Hearing Screening (NHS) since 1996. The programs coordinate referral and care coordination activities on infants and children requiring services from

both agencies. An MCH staff person serves on the State IDEA Interagency Coordinating Council. TEIS staff serve on the NHS Task Force. TEIS works closely with the NHS program to provide tracking, follow-up and intervention services for infants referred for or identified with a hearing loss after hospital hearing screening. An MCH staff member serves on the Part C (Early Intervention) Monitoring Review Committee. CSS central office and regional office staff participate in Early Intervention Administrators' Forums which include various agencies and promote interagency linkages at the program administrators' level. Local CSS staff participate in meetings for individual CSHCN with DOE Part C and Part B personnel in developing coordinated care plans to insure the coordination of services.

Head Start: A staff person representing Head Start and Early Head Start is an active member of the TEIS State Interagency Coordinating Council; MCH works through this committee with Head Start. The DOE Head Start Collaboration Officer is a member of the Childhood Lead Poisoning Prevention Program and the Early Childhood Comprehensive Systems Advisory Committees. These committees include state agency staff and advocates for children and who meet regularly. The Newborn Hearing Screening Program, in collaboration with the National Center on Hearing Assessment and Management (NCHAM), works with 3 Early Head Start agencies across the state to implement the Early Childhood Hearing Outreach (ECHO) initiative to provide training on hearing screening, follow-up and reporting. The MCH Director also liaisons with the Director of the State Head Start Collaboration on an as-needed basis. For example, the two collaborated to clarify policies related to EPSDT screening and worked with Head Start staff and community health care providers to promote better understanding and compliance with policies.

Mental Health/Developmental Disabilities: Staff are active members of the Child Fatality Review program at both local and state levels. MCH staff work collaboratively with the Department of Mental Health/Developmental Disabilities (TDMHDD) to assure that appropriate mental health services are accessed for children with special health care needs. CSS includes an assessment of a child's psychosocial development and refers CSHCN and family members to local mental health centers or other local mental health providers if appropriate. Mental health and 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. ***/2015/The TDH Injury Prevention and Detection Director serves as a member of the Tennessee Suicide Prevention Network and works with a state intradepartmental committee and the state suicide prevention advisory committee.//2015//*** The committee has developed a state plan to address youth suicide prevention.

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

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

Child Fatality Review: The Child Fatality Review process is a statewide network of multidisciplinary, multi-agency teams in the 31 judicial districts to review all deaths of children 18 and younger. Members of each local team include: Department of Health regional health officer; Department of Human Services social services supervisor; Medical Examiner; prosecuting attorney appointed by the District Attorney General; local law enforcement officer; mental health professional; pediatrician or family practice physician; emergency medical services provider or firefighter; juvenile court representative; and representatives of other community agencies serving children. Members of the State Child Fatality team include: Department of Health commissioner;

Attorney General; Department of Human Services commissioner; Tennessee Bureau of Investigation director; physician (nominated by Tennessee Medical Association); physician credentialed in forensic pathology; Department of Mental Health and Developmental Disabilities commissioner; Department of Education commissioner; judiciary member nominated by the Supreme Court Chief Justice; Tennessee Commission on Children and Youth chairperson; two members of the Senate; and two members of the House of Representatives. The state child fatality team is collaborating with several agencies to implement prevention initiatives. The Injury Prevention Program is collaborating with the Tennessee Department of Education and the trauma centers to implement the Battle of the Belt Program, an educational intervention to increase seatbelt usage among high school students. The Department of Health is collaborating with the Department of Children's Services, the Tennessee Commission on Children and Youth, the Department of Human Services, UT Extension, the Department of Education and Prevent Child Abuse Tennessee to distribute safe sleep materials.

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

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

The Adolescent & Young Adult Health director 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.

Asthma Management: State of Tennessee Asthma Task Force (STAT) members, in conjunction with Early Childhood Comprehensive Systems, the TennCare Bureau and the Department of Education, developed and are implementing a comprehensive state plan to reduce the burden of asthma among Tennesseans. The plan includes surveillance and epidemiology; public awareness and education; medical management; and environmental management components.

The program director currently collaborates with STAT nurses to make educational presentations across the state to medical providers, educators, parents, and youth. STAT plans to target 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 also sponsors 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. A nurse consultant was funded to provide training and technical assistance to the staff at CCR&Rs on health related issues of young children in group care including asthma management. Print material on prevention of tobacco/smoking exposure was developed and circulated to child health related programs across the state.

Federally Qualified Health Centers: Community Health Centers are located in medically underserved areas of the state. In 2010, there were 24 FQHCs that operated 142 clinic sites in Tennessee. These community health centers provided primary health care, dental and mental health services to more than 280,400 patients. Referral systems exist between those community health centers and health departments located within the same county. In 2011, the 24 centers operated 153 clinic sites serving over 258,000 patients. 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. In 2012, there was a network of 31 nonprofit centers operating 204 sites across the state. There were 25 federally qualified health centers with 197 sites and six other types of community-based centers operating 7 sites. They were located in medically underserved areas of the state, both rural and urban. These 31 sites provided primary health care, mental health care and dental services to over 361,000 people per year. As of June 2013, there are 27 FQHCs and one FQHC Look-A-Like with 140 primary care clinical sites, serving over 306,000 people. ***/2015/As of June 2014, the number of FQHCs and primary care clinical sites is unchanged.//2015//***

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

Autism Spectrum Disorders and Other Neurodevelopmental Disorders: TDH actively participates on the TN Autism Summit Team (led by the Tennessee Disability Coalition) and has been actively involved in the development of the Autism State Plan. TDH has also partnered with staff from the TN Chapter of the AAP and the CDC Act Early Champion to develop a pilot protocol for autism spectrum disorder (ASD) screening in local health departments.

The Early Childhood Initiatives section of MCH successfully applied for funding from AMCHP to co-brand CDC materials on ASDs and developmental screening. These materials will be distributed through a number of venues including early childhood home visits.

Developmental screening (using the PEDS and Ages and Stages tools) is conducted in all local health departments as part of EPSDT screenings. Staff in all thirteen regions were trained over the past two years on the appropriate administration and scoring of these tools; staff also received guidance on making appropriate referrals and talking for families about suspected delays.

Folic Acid Education Campaign: Women's Health and Nutrition staff (central and regional offices) are partnering with the March of Dimes, Girl Scouts, and members of the state folic acid council to educate the citizens of TN on the need for folic acid. Staff developed and implemented many of

the statewide activities. The Women's Health director serves on the state council. The family planning program provides vitamins with folic acid to patients of reproductive age who receive program services. MCH staff are currently partnering with the March of Dimes and a health education consultant on a grant to use text messaging and web technology to educate college women on important lifestyle issues.

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

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

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

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 children with PKU. Effective January 2012, MCH and Nutrition and Wellness were merged into the Division of Family Health and Wellness.

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

Tennessee Adolescent Pregnancy Prevention Program: Tennessee's adolescent pregnancy prevention efforts encompass two different strategies--the Tennessee Adolescent Pregnancy Prevention Program (TAPPP) and the Abstinence Education Program. TAPPP councils operate in four of the six metropolitan areas and in 6 of the 7 rural regions. The 10 Coordinators serve as the community contacts/resource persons for adolescent pregnancy issues. All council memberships are broadly representative of the surrounding community, and include Girl Scouts, March of Dimes, Department of Human Services, Department of Children's Services, community-based youth serving organizations, hospitals, local businesses, schools, universities, adoption service agencies, faith-based organizations, juvenile justice agencies, media representatives, and regional and local health councils. Each council participates in a wide range of activities, depending on local priorities and resources, including conferences, parenting and adolescent health fairs, workshops, legislative briefings, and training for professionals. TAPPP councils operate in three of the six metro areas. Each Metro and Regional Health Department utilizes

health educators to implement a wide range of activities, depending on local priorities and resources, including educational classes, teen pregnancy and parenting events, conferences, adolescent health fairs, workshops, legislative briefings, and training for professionals. The TN State Department of Health Program Director for Adolescent Pregnancy Prevention and Abstinence Programs and TAPPP Coordinators participate in quarterly conference calls to discuss regional program updates, upcoming events and effective collaborations for future community activities. In 2012-13, Tennessee Adolescent Pregnancy Prevention Program (TAPPP) councils operated in two of the six metropolitan areas and in multi-county groupings in six of the seven rural regions. Eight TAPPP Coordinators served as the community contacts/resource persons for adolescent pregnancy issues in their respective areas.

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. 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. In 2012-13, the PAF project continued with outreach to pregnant and parenting teens and operation of the Baby Stores.

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

March of Dimes: MCH staff began partnering with March of Dimes many years ago and support the organization's work on decreasing and preventing prematurity, decreasing infant mortality and enhancing the newborn screening program. Staff also support the March of Dimes programs by serving on various local and state committees. 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. The Department is partnering with the March of Dimes, TN Hospital Association, and TIPQC on an initiative to reduce early elective deliveries. Products of the

collaborative have included a new website, a letter issuing a challenge to hospitals (attached to this section), social media, presentations, and articles.

/2015/Tennessee Chapter, American Academy of Pediatrics (TNAAP): TDH staff participate in quarterly meetings with representatives from TennCare and the Tennessee Chapter of the American Academy of Pediatrics (TNAAP). TNAAP staff also partnered with FHW on the implementation of the D70 Integrated Systems grant. MCH Block Grant funds have been used to sponsor TNAAP educational events and the Division Director routinely attends TNAAP board meetings and functions to provide updates on state-level MCH activities.

Universities: FHW collaborates regularly with university partners across the state on project implementation, evaluation, and consultation. Examples of such collaboration include: program evaluation training for FHW staff by faculty from four Tennessee universities (UT Knoxville, University of Memphis, Tennessee State University, and East TN State University) in 2013; partnership with Tennessee Tech University to provide web hosting for a youth motor vehicle safety intervention (Battle of the Belt); and collaboration with Middle Tennessee State University to provide training on death scene investigation for first responders.//2015//

F. Health Systems Capacity Indicators

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

Health Systems Capacity Indicators Forms for HSCI 01 - Multi-Year Data

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Indicator	22.7	19.4	21.6	20.1	
Numerator	921	792	873	814	
Denominator	405883	407813	405046	403971	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

Notes - 2013
Because 2013 population estimates are not available at this time, we are currently unable to report this indicator. Also, provisional 2013 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 - 2012
Data sources: TDH Office of Health Statistics Hospital Discharge Data Sysytem and 2012 US Census

Notes - 2011
Data sources: TDH Office of Health Statistics Hospital Discharge Data Sysytem and 2011 US Census

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Narrative:
Asthma hospitalizations declined from 2009 to 2012. 2013 data are not available at the time of this submission because population estimates for 2013 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.*

Health Systems Capacity Indicators Forms for HSCI 02 - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Indicator	80.6	82.6	86.1	87.6	88.0
Numerator	85301	89536	88584	90355	90904
Denominator	105887	108351	102930	103147	103303
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2013
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.

Notes - 2012
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

Notes - 2011
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

Narrative:
The percentage of infants enrolled in Medicaid who received at least one initial periodic screen has improved since 2009 (from 80.6% to 88% in 2013). Several MCH programs work collaboratively with the state's Medicaid program (TennCare) and the TENNderCare Outreach Program to inform parents about the need for EPSDT screenings. The Help Us Grow

Successfully (HUGS) Home Visiting program intake assessment addresses EPSDT status and home visitors regularly assess access to a medical home and immunization status. Home visitors also provide families with TENNderCare brochures, which outline the EPSDT program and discuss the importance of regular screening. The Children's Special Services (CSS, Title V CSHCN Program) also assesses EPSDT status and care coordinators encourage families to obtain screenings per the periodicity schedule. Additionally, EPSDT screens are provided in local health departments across the state.

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

Health Systems Capacity Indicators Forms for HSCI 03 - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Indicator	100.0	61.6	51.1	34.3	35.3
Numerator	30753	1564	1049	2577	2730
Denominator	30753	2541	2051	7524	7724
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2013
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 212% poverty. These children are considered "CHIP children" in the TennCare II extension. The amount reported for this indicator represents the summation of figures provided by Tennessee's SCHIP program (CoverKids) as well as by the state Medicaid program (TennCare).

Notes - 2012
Data Source: TennCare (Medicaid) Program and CoverKids (CHIP)

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

Notes - 2011
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

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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).

Narrative:
In 2013, 35.3% 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.*

Health Systems Capacity Indicators Forms for HSCI 04 - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Indicator	88.5	87.0	86.3	86.9	86.3
Numerator	66927	62619	61170	63882	63192
Denominator	75614	71946	70859	73470	73223
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2013
Data source: TDH Office of Health Statistics Birth Statistical System

Notes - 2012
Data source: TDH Office of Health Statistics Birth Statistical System

Notes - 2011
Data source: TDH Office of Health Statistics Birth Statistical System

Narrative:
In 2013, 86.3% 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.*

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Health Systems Capacity Indicators Forms for HSCI 07A - Multi-Year Data

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Indicator	82.7	82.3	86.0	87.9	87.7
Numerator	654277	674964	716232	725947	721657
Denominator	791343	819953	832746	826000	822443
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2013
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.

Notes - 2012
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.

Notes - 2011
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.

Narrative:
In 2013, 87.7% 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.*

Health Systems Capacity Indicators Forms for HSCI 07B - Multi-Year Data

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Indicator	54.0	59.2	59.4	60.5	60.3
Numerator	100908	114851	117980	121938	124586
Denominator	186817	194038	198785	201691	206545
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.					

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Is the Data Provisional or Final?				Final	Provisional

Notes - 2013
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.

Notes - 2012
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

Notes - 2011
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

Narrative:
The percent of EPSDT eligible children age 6-9 who have received dental services during the year increased from 2009 to 2013. 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 FY2013, over 123,000 children had dental screenings in 311 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 51 fixed dental clinics in 49 rural counties.

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

Health Systems Capacity Indicators Forms for HSCI 08 - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Indicator	17.3	12.4	13.9	16.8	17.5
Numerator	3676	2675	3062	3752	3862
Denominator	21286	21623	22001	22321	22056
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2013
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.

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Notes - 2012
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.

Notes - 2011
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.

Narrative:
In 2013, 17.5% 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 3862 names provided for 2013. SSA Data for 2013 indicate 22,056 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 nineteen percent of the 5,573 CSS enrollees have SSI (FY 2013). CSS staff contacted 3862 during this time period and provided information regarding CSS program requirements and other services and resources for which the family may be eligible.

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

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of low birth weight (< 2,500 grams)	2012	matching data files	10.9	7.1	9.2

Notes - 2015
Data Source: Tennessee Department of Health Birth and Death Records and TennCare (Medicaid) Records. Restricted to only mothers with residency in TN.

Narrative:
The percentage of Tennessee babies born at low birth weight has remained relatively stable over the past five years. A number of programs and initiatives support efforts to improve 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*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Infant deaths per 1,000 live births	2012	matching data files	9.6	4.1	7.1

Notes - 2015
Data Source: Tennessee Department of Health Birth and Death Records and TennCare (Medicaid) Records. Restricted to only mothers with residency in TN.

Narrative:
The infant mortality rate has steadily 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*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the***	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL

State					
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2012	matching data files	60.7	72.4	65.9

Notes - 2015
The breakdown of infants born to pregnant women receiving prenatal care beginning in the first trimester. Data is from self reported from Tennessee Department of Health birth records and TennCare (Medicaid) data. A significant portion of women gained Medicaid eligibility after their first trimester. Restricted to only mothers with residency in TN.

Narrative:
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% [Kotelchuck Index])*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2012	matching data files	68.9	74.7	71.5

Notes - 2015
Percent of pregnant women with adequate prenatal care was determined based on self reported number of prenatal care visits and the date of first prenatal care using the Tennessee Department of Health birth records and TennCare (Medicaid) data. Only records where prenatal care was reported were used in this calculation. A significant portion of women gained Medicaid eligibility after their first trimester which impacts the adequacy of care possible. Restricted to only mothers with residency in TN.

Narrative:
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.

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

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2013	195
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2013	250

Notes - 2015
Tennessee Medicaid (TennCare) website, http://www.tn.gov/tenncare/mem-categories.shtml. Accessed on 05/06/2014.

Notes - 2015
Data Source: Tennessee SCHIP (CoverKids) Program.
Age 0-1: eligibility for CHIP is 196-250% FPL.
Age 1-6: eligibility for CHIP is 143-250% FPL.
Age 6-18: eligibility for CHIP is 134-250% FPL.
Pregnant women with incomes below 250% FPL are eligible for CHIP coverage (for the unborn child).

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

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

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Medicaid Children (Age range 1 to 6) (Age range 6 to 19) (Age range to)	2013	 142 133
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children (Age range 1 to 5) (Age range 6 to 18) (Age range to)	2013	 250 250

Notes - 2015
Tennessee Medicaid (TennCare) website, http://www.tn.gov/tenncare/mem-categories.shtml. Accessed on 05/06/2014.

Notes - 2015

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Data Source: Tennessee SCHIP (CoverKids) Program.
Age 0-1: eligibility for CHIP is 196-250% FPL.
Age 1-6: eligibility for CHIP is 143-250% FPL.
Age 6-18: eligibility for CHIP is 134-250% FPL.
Pregnant women with incomes below 250% FPL are eligible for CHIP coverage (for the unborn child).

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

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

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Pregnant Women	2013	195
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women	2013	250

Notes - 2015
Tennessee Medicaid (TennCare) website, http://www.tn.gov/tenncare/mem-categories.shtml. Accessed on 05/06/2014.

Notes - 2015
Data Source: Tennessee SCHIP (CoverKids) Program.
Age 0-1: eligibility for CHIP is 196-250% FPL.
Age 1-6: eligibility for CHIP is 143-250% FPL.
Age 6-18: eligibility for CHIP is 134-250% FPL.
Pregnant women with incomes below 250% FPL are eligible for CHIP coverage (for the unborn child).

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

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

DATABASES OR SURVEYS	**Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)**	**Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)**
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	Yes
	3	Yes

Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files		
Annual linkage of birth certificates and WIC eligibility files	2	Yes
Annual linkage of birth certificates and newborn screening files	3	Yes
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	3	Yes
Annual birth defects surveillance system	3	Yes
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

Notes - 2015

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

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

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

Notes - 2015

Narrative:
The Tennessee Department of Education conducts the Youth Risk Behavior Survey. 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. Both High School and Middle School students are now surveyed in the spring of odd numbered calendar years. The survey is voluntary and completely anonymous. The Office of Coordinated School Health administers the 99-question High School survey to approximately 1500 students statewide. 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. Additional information is available at: http://www.tn.gov/education/yrbs/.

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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 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:

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

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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 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, the Department of Education's Office of Coordinated School Health (OCSH) oversees measurement of body mass index (BMI) among school-age students; this data is then analyzed by the Department of Health's Office of Policy, Planning, and Assessment (PPA). FHW staff then work with OCSH and PPA to understand the data and develop appropriate programming and policy responses based on the data (as part of our state priority related to obesity among K-12 student). FHW is the recipient of a competitive CDC grant focused on chronic disease and school health, and the BMI data is being used to target efforts to increase physical activity/physical education and increase consumption of health foods in school settings. FHW staff are working closely with OCSH staff on these efforts. Collectively, efforts from both departments will aid Tennessee in addressing this priority measure.

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.

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.

Seven corresponding state performance measures were established corresponding to each of the priorities. 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. The CDC-funded Core Violence and Injury Prevention Program, housed in MCH, has listed sleep-related infant deaths as a priority. 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,

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CHIP, local infant mortality reduction initiatives, March of Dimes, etc) further support the work related to this priority.

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.

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 Division of Family Health and Wellness (FHW). FHW 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. The Department's chronic disease initiatives, including those related to tobacco, are housed in the Division of Family Health and Wellness. FHW staff coordinate the state's tobacco cessation activities, including the Tennessee Tobacco QuitLine.

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).

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 regional health departments.

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.

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

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.

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.

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.

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.

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.

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	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	99.4	100.0	99.5	100.0
Numerator	161	161	170	182	154
Denominator	161	162	170	183	154
Data Source	Department of Health	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					

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cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	100	100	100	100	100

Notes - 2013
Data Source: Tennessee Department of Health, Newborn Screening Program.

Notes - 2012
Data Source: Tennessee Department of Health, Newborn Screening Program. Note: Identified one infant with Nonketotic Hyperglycinemia (NKH) in 2012 who did not receive treatment. There is limited treatment available with poor outcomes. Family chose to remove infant from life support, discontinue medications and provide palliative care through hospice.

Notes - 2011
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 phenylketonuria (PKU) screening of all babies. Since that time, screening has expanded to cover 30 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). Tennessee's Genetics Advisory Committee (GAC) (members from the genetic centers, pediatric endocrinologists, hematologist, pediatrician/lawyer, neonatologist, and pediatric pulmonologist) met twice (October 2012 and May 2013) to guide the program and recommend changes in tests and procedures.

Follow-up staff is responsible for interfacing with the State Laboratory to identify, locate and follow-up on unsatisfactory or abnormal results from the screening panel. If needed, local health department nurses assist in locating an infant needing follow-up. Referrals for confirmatory / diagnostic testing and counseling services are made for individuals and families to tertiary centers across the state which include 3 regional comprehensive genetic centers, 2 satellite genetic centers, 4 pediatric endocrinology centers, 5 pulmonology centers, 2 comprehensive sickle cell centers and 2 satellite sickle cell centers. Close linkages exist among NBS follow-up staff, the Centers and the Children's Special Services (TN's Title V CSHCN program) staff for referrals.

This performance measure continues to be successfully met due to the state law requiring testing of all infants born in the state and the quality and efficiency of the State Laboratory and the NBS follow-up program. A DVD continues to be available to health care providers to educate them about newborn screening tests, proper specimen collection and follow up protocols for abnormal and unsatisfactory results. For 2013, the State's unsatisfactory rate for dried blood spots was 4.51 percent. Hospitals were notified monthly of their unsatisfactory rates, and reports were posted quarterly on the NBS web site (http://health.tn.gov/MCH/NBS.shtml#5). Information for parents and healthcare providers about screening is located on the Department's web site.

Outreach education on screening for Critical Congenital Heart Disease (CCHD) began in September 2012; staff from the five Regional Perinatal Centers provided training and education in all birthing facilities and midwives across the State. In January 2013 implementation of CCHD screening began. In 2013 five infants received a postnatal diagnosis solely due to a failed screen. A pediatric cardiologist continues to serve on the GAC.

In September 2012, the program began creating a product requirement document with Natus Medical Inc. to design a web-based NBS case management system. The web access will allow the staff to have reliable and consistent remote access to the server. This is consistent with

current standards of high-quality patient care as well as with national performance measures. This project also supports the newborn screening program's emergency preparedness goals by ensuring access to the system from any site with interenet access.

The State Laboratory has investigated the requirements for implementation of Severe Combined Immunodeficiency Disease (SCID) screening.

During CY 2013, the program followed-up on 2,256 presumed positive results for disease. In addition, follow-up was done on 3,974 unsatisfactory samples, 875 samples collected before the infant was 24 hours of age, 304 infants due to transfusions, 2,055 infants with possible hemoglobin traits, and 546 infants with abnormal results on parenteral nutritional support. Provisional 2013 data indicate that 89,270 tests were performed on infants born in Tennessee.

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 conditions determined by the Genetics Advisory Committee, 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		X
4. Work closely with birthing facilities on improving the unsatisfactory rates by distributing the revised training DVD and performing site visits.				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		
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 GAC met in October 2013 and May 2014.

The program continues to include 30 of the 31 core conditions recommended for screening by the Secretary's Committee on Heritable Disorders in Newborns and Children.

Planning continues for implementation of SCID screening. The GAC will assist in the development of follow up protocols and identifying services for confirmatory testing and treatment.

In January 2013 the program began sending the Unsatisfactory Rates Report to Hospitals monthly instead of quarterly allowing the opportunity to identify hospitals with high rates and intervene in a more timely manner. A report showing infants with blood spots without a CCHD screen is also included. Each birthing facility will receive onsite assistance, with priority given to birthing facilities that have greater than 1% unsatisfactory rate. This began in April of 2014 and will continue through December 2014.

The Newborn Screening Program has developed and implemented an Emergency Response Recovery plan. This plan was activated during a winter weather event in March 2014; staff

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worked from several alternative locations in the state.

The design team at Natus Medical Inc. is in the process of building the web-based follow-up system. The first module, Secure Remote Viewer, is a system that allows healthcare providers to view and print screening results via the web. This module was rolled out in September/October 2013. Over 900 providers have signed up for access to the system.

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 and reduce the percental of unsatisfactory specimens collected. Follow-up staff will plan to present information and data to all birthing facilities.

It is anticipated that by January 2015, screening for Severe Combined Immunodeficiency Disease (SCID) will be implemented.

The Critical Congenital Heart Disease (CCHD) subcommittee will meet to evaluate data collected during the second year of screening.

The Lysosomal Storage Disease (LSD) screening workgroup will continue to monitor national developments and recommendations.

The remaining phases of the web-based newborn screening case management system, which include allowing hospitals to upload the hearing results directly from the device files to the system and a remote diagnostic entry module allowing disease specialists to have remote entry via the web (in turn providing quicker comprehensive follow-up and data), will be finalized. This is consistent with current standards of high-quality patient care as well as with national performance measures.

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

The Genetics Advisory Committee plans two face to face meetings (October 2014 and May 2015).

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:	**84974**					
Reporting Year:	**2013**					
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		0.0				

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(Classical)						
Congenital Hypothyroidism (Classical)	84404	99.3	387	52	52	100.0
Galactosemia (Classical)	84404	99.3	29	0	0	
Sickle Cell Disease		0.0				
Biotinidase Deficiency	84404	99.3	25	2	2	100.0
Congenital Adrenal Hyperplasia	84404	99.3	422	7	7	100.0
Cystic Fibrosis	84404	99.3	716	13	13	100.0
Fatty or Organic Acidemia	84404	99.3	317	16	16	100.0
Amino Acidemia (includes Phenylketonuria)	84404	99.3	305	14	14	100.0
Hemoglobinopathies (includes Sickle Cell Disease)	84404	99.3	55	50	50	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	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	62	62	62	75	75
Annual Indicator	60.7	60.7	72.3	72.3	72.3
Numerator	136524	136524	183180	183180	183180
Denominator	224895	224895	253333	253333	253333
Data Source	CSHCN Survey	CSHCN Survey	2009/10 CSHCN Survey	2009/10 CSHCN Survey	2009/10 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
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	72.3	72.3	75	75	75

Notes - 2013
See Notes - 2011

Notes - 2012
See Notes - 2011

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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.

a. Last Year's Accomplishments
The collaborative efforts that were initiated between Family Voices and the CYSHCN program through the State Implementation Grant for Children with Special Health Care Needs (D70 Grant) provided an opportunity for patients and families to learn more about partnering in the decision making process. A Family and Patient Centered Workshop was conducted with parents and families to provide training on standards for parents partnering in the decision making process. The workshops also provided a forum to educate families on how to "tell their story". Parents were provided training and checklist tools so they would be better able to advocate for their child's care needs and reinforce expectations with their health care provider for comprehensive and coordinated care. Parents were also provided training and tools to assess components of the practice to determine if the components of the Medical Home concept were being met.

CYSHCN and Family Voices worked together to develop a parent and youth advisory group and joined forces with the Monroe Carrell, Jr. Children's Hospital at Vanderbilt Family Advisory Group to solicit members and provide training to family members who wish to serve as facilitators and presenters. The CYSHCN program had access to a youth volunteer who helped coordinate and plan a YSHCN forum.

CYSHCN staff continued working 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 CYSHCN director 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, Genetics Advisory Committee, and the Newborn Hearing Screening Task Force. Through these collaborations, the CYSHCN director actively participated in policy and program development for children and youth with special health care needs.

The CYSHCN director in collaboration with the Vanderbilt Children's Hospital Care Coordination work group began to look at developing care coordination standards, competencies, and training. These standards will be based on the six core outcomes for CYSHCN and when completed, will be available to public and private health care providers.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service

	DHC	ES	PBS	IB
1. Partner with groups who advocate for and serve children and youth with special health care needs.		X	X	X
2. Develop Family Service Plans with participants and families to address medical and non-medical needs annually.	X	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/youth advisory committee.		X		X
7. Develop training and competencies for Care Coordinators.		X		X
8. Provide additional educational resources and training for participants and families on interaction with health care providers and decision-making strategies.		X		X
9.				
10.				

b. Current Activities

A youth with special health care needs was hired to assist with the coordination of family and youth activities and the development of the parent/youth advisory committee. The youth coordinator has participated in the patient and family-centered workshops and will continue to lead the youth advisory group in becoming self-advocates and learning how to partner in the decision making process.

A Parent to Parent Network has been formed and parent mentors have been identified. Trainings have taken place in Nashville, Memphis, and are scheduled for Knoxville and Chattanooga. Parent matching will be provided through the Network.

CYSHCN continues to coordinate with Tennessee Family Voices staff and AMCHP's Family Youth Leadership Committee and are discussing issues surrounding family/youth involvement and the development of mechanisms to include more family leadership and involvement in the upcoming year.

The CSS program care coordinators participated in a Care Coordination Summit (hosted by the state AAP chapter) and were paired with the health care providers from their cities or counties. This allowed both the health departments and local provider offices to engage in an exchange of ideas and resources that will benefit CYSHCN and their families in the decision making process. Care coordinators provide resources and education to families regarding interaction with medical providers and how to be an integral part of the medical decisions for the participant.

c. Plan for the Coming Year

A Parent Summit is being planned and families will have the opportunity to receive additional training, coaching and mentoring on partnering in the decision making process. Parents will also have the opportunity to network with health care providers and will be encouraged to utilize skills learned at the summit at their future provider appointments.

Parents will continue to be invited to attend and to participate in the CSS Advisory Committee meetings. The CYSHCN director will work with the Advisory Committee to plan the biannual meetings in such a manner that program participants and their families will be invited to present on selected topics of interest. CYSHCN staff will continue requesting parent/family participation and attendance at AMCHP and other leadership development training opportunities.

Web-based care coordination training and educational resources will be developed and promoted

to pediatricians, family practitioners, local health departments and federally qualified health centers.

The satisfaction survey will be administered to families and analyzed 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.

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

The D70 Grant will provide for three contracted parent/youth consultant positions. The addition of these positions will enhance participation in and decision-making capability of parents of CYSHCN and YSHCN. The consultants will serve as a resource for other parents. They will help parents to navigate the health care system and provide on-going recommendations to incorporate parental input into program operations.

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	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	65	65	55	50	50
Annual Indicator	52.7	52.7	45.9	45.9	45.9
Numerator	115761	115761	113064	113064	113064
Denominator	219634	219634	246352	246352	246352
Data Source	CSHCN Survey	CSHCN Survey	2009/10 CSHCN Survey	2009/10 CSHCN Survey	2009/10 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
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	45.9	45.9	50	50	50

Notes - 2013
See Notes - 2011

Notes - 2012
See Notes - 2011

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.

a. Last Year's Accomplishments
The CYSHCN director collaborated with the Tennessee Pediatric Society Foundation (TPSF) to develop plans for three medical home summits over the next two years. The medical home summits will improve health care service delivery for CYSHCN by increasing the number of primary care providers implementing medical home concepts in their practices across Tennessee.

Comprehensive medical home educational resources and tools were developed for all Tennessee pediatricians and family physicians who choose to implement medical home concepts in their practice.

The Tennessee Medical Homes Website was developed and launched and can be accessed at www.tennesseemedicalhome.com. This website is currently housed by the Tennessee Chapter of the American Academy of Pediatrics but will become a part of the State's website at the end of the D70 Grant.

CSS program staff referred parents and families to the on-line Medical Homes Tool Kit and provided a portable health history summary form with recent and pertinent medical history to youth ages 14 years and older. The Medical Homes Tool Kit may be accessed at http://health.state.tn.us/MCH/MedicalHome/index.shtml

CSS program staff collaborated with other agencies to assist families with identifying and accessing medical homes. CSS program staff also assisted with coordination of services between providers.

CSS program staff conducted outreach with insurance and primary care providers to establish medical homes and payment sources for CYSHCN, and facilitated information exchanges between the health care providers and families. Care coordinators provided follow-up for infants that were identified by the Newborn Screening Program and enrolled the infants into the CSS program.

Transition plans were developed for all participants aged 14 and older and under the Medical domain, establishing a medical home was one of the major objectives as participants move from the pediatric to adolescent or adult health care provider.

The parent and youth consultant worked on developing a Summit for teens and youth that will incorporate medical home transition called GAIN (Gaining Knowledge, Relationships, Independence and Happiness) as teens and youth move into the young adult role.

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		
4. Continue to educate primary care providers on the medical home concept.				X
5. Use survey data results to address gaps and barriers that limit primary care providers' ability to provide medical home services.				X
6. Collaborate with Newborn Screening on referrals and follow-up of newly-identified CYSHCN.	X	X	X	X
7. Collaborate with TennCare (Medicaid), CoverKids (CHIP), and managed care organizations to identify medical homes for CYSHCN.		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
The CYSHCN director collaborated with TPSF to plan the Medical Home Summit and examine opportunities that exist for providers as they develop the medical home concept in their practices. The first Summit (agenda attached) focused on care coordination and through collaborative efforts CSS staff and local health care providers were brought together and resources provided to increase the knowledge of medical home concepts. Provider practices that participated in this Summit were provided an opportunity to work towards certification as a medical home and all attendees received training on Care Coordination in the Medical Home, Best Practices in Disease Management, Screening for CYSHCN, Family Impact and Developing a Provider Culture of Dynamic Quality Improvement. Twenty-two practices participated in the summit and a joint QI collaborative; at the end of the collaborative, the practices will have the opportunity to become NCQA certified medical homes.

The CYSHCN director served on the Vanderbilt Children's Hospital Medical Home, Health History, and Care Coordination work groups. The Health History work group continues to explore the idea of electronic health history summaries that may be accessed statewide and not just by local hospital or network providers. The work group is also analyzing data from a pilot project in Macon County and working with the State EMS to develop a plan for emergency personnel to utilize the health history summary form in other areas of the Stat
An attachment is included in this section. IVC_NPM03_Current Activities

c. Plan for the Coming Year
CSS program staff will continue care coordination for children and youth with special health care needs and provide educational information to providers. CYSHCN program 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.

CYSHCN staff will continue coordinated efforts with other agencies and health care providers to develop a statewide standard care plan notebook for all CYSHCN.

The electronic Medical Home Tool Kit will be updated as needed and will 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 program staff will continue to promote the Medical Homes 101: Building Medical Homes That Work - presentation developed by Family Voices of Tennessee as a resource for families and CYSHCN.

CSS program staff will continue to collaborate with insurance and health care providers to establish medical homes and payment sources for CYSHCN, and continue to assist families to identify and access medical homes.

The second Medical Home Summit focusing on Culturally Effective Care looking at the culture of family/provider partnerships and family engagement will be held. Health care providers and CYSHCN staff will participate in the conference. Both the parent and youth consultant will present at the Summit.

CYSHCN staff in conjunction with the TPSF will continue to work on identifying and implementing effective strategies for collaboration with medical training programs, identifying effective methods of pre-service training reviews, and identifying components of existing care coordination curriculum to be included in the web based care coordination model.

Through the Integrated Systems Grant, TPSF staff will become trained and certified as NCQA Content Experts and will assist other health care providers in the state to become certified medical homes.

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	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	69	69	70	75	75
Annual Indicator	67.7	67.7	70.4	70.4	70.4
Numerator	152224	152224	174402	174402	174402
Denominator	224965	224965	247879	247879	247879
Data Source	CSHCN Survey	CSHCN Survey	2009/10 CSHCN Survey	2009/10 CSHCN Survey	2009/10 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
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	70.4	70.4	75	75	75

Notes - 2013
See Notes - 2011

Notes - 2012
See Notes - 2011

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.

a. Last Year's Accomplishments
CSS program staff collaborated with CHIP and the Medicaid managed care organizations (MCOs) to develop mechanisms that provided families with information and assistance needed to understand program requirements and application for benefits. The CSS program continued to provide reimbursement for medical services as well as care coordination and provided education and resources to families regarding available public and private insurance options.

CSS program staff 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.

The CYSHCN director and CSS program staff partnered with the MCOs to ensure insurance is available to all eligible participants 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 program staff 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.

The CYSHCN director and CSS program staff conducted social marketing and outreach activities that included 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.

Family Voices provided information to families on insurance both public and private and payor sources during the patient and family centered care workshops.

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		
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		

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5. Monitor Federal and State public insurance programs for changes.				X
6. Recruit providers for CSS approved vendor list.	X	X		X
7.				
8.				
9.				
10.				

b. Current Activities
The CYSHCN director partnered with other departmental staff and TennCare agency staff to ensure that families are able to apply for insurance coverage through the Federal Health Insurance Market Place. CSS program staff provide assistance to families on accessing coverage through the marketplace and referring participants with special health care needs to local MCOs. The CSS program continues to receive referrals from the MCOs for eligible medical services.

The CYSHCN director 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.

The CYSHCN director continues to provide information to the local human services offices, including CSS program eligibility requirements, information about other government sponsored insurance programs, and narrative and electronic information for inclusion in the MCO newsletters and other printed resource material.

The CSS program continues providing reimbursement for medical services to eligible individuals and determining insurance status of eligible participants at six months and one year intervals. CSS program staff assists families and participants in applying for all insurance programs and third party resources for which they may be eligible.

c. Plan for the Coming Year
CSS program staff will provide notification to families and CYSHCN when open enrollment for the Health Insurance Market Place begins. Program staff will continue to assist families to apply for emergency Medicaid coverage when admitted to the hospital.

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

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

CSS program will continue providing reimbursement for medical services to those individuals who meet program eligibility requirements.

Parent consultants will assist families and CYSHCN to become self-advocates for insurance benefits and coverage.

In conjunction with activities of the Integrated Systems Grant, a family summit is being planned. There will be several breakout sessions on insurance and health care coverage for families of CYSHCN.

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	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	93	93	93	75	71.5
Annual Indicator	91.8	91.8	71.5	71.5	71.5
Numerator	208995	208995	179700	179700	179700
Denominator	227739	227739	251473	251473	251473
Data Source	CSHCN Survey	CSHCN Survey	2009/10 CSHCN Survey	2009/10 CSHCN Survey	2009/10 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
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	71.5	71.5	75	75	75

Notes - 2013
See Notes - 2011

Notes - 2012
See Notes - 2011

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.

a. Last Year's Accomplishments
CYSHCN staff, Family Voices and TPSF staff met quarterly to discuss the advances made towards developing a system of services for CYSHCN. The team participated in a QI initiative with John Snow staff that provided guidance on measuring and evaluating the Integrated Systems grant activities. The team also participated in monthly webinars with other states to discuss and learn about what other states were initiating for their D 70 grant.

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CYSHCN and Family Voices staff attended the National Parent to Parent USA conference and started the process of developing a parent to parent network in Tennessee. Parent mentor training was developed and parents were identified to serve as mentors.

CSS program staff 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. In addition, CSS program staff continued to collaborate with agencies to facilitate referral and access to the CSS program and partner agencies' services.

CSS program staff participated in statewide and local health fairs and community resource fairs; attended parent teacher meetings at schools; and 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 program 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.

The CYSHCN director continued to work with the Tennessee Council on Developmental Disability, Tennessee Disability Pathfinder, Tennessee Technical Assistance & Resources for Enhancing Deafblind Supports (TREDS), Tennessee Early Intervention System (TEIS), Tennessee Housing and Development Agency (THDA), United Cerebral Palsy (UCP), Tennessee Department of Labor and the Multi-Cultural Disability Alliance to provide CSS participants with information regarding all eligible community services and resources.
Referrals were made to the Tennessee Family Support (TFS) Program and the Tennessee Respite Coalition.

CSS staff continued to work with partner agencies and families of CYSHCN to develop a system of service that is organized for easy access and use. This includes working with public and private providers to ensure access to appropriate medical and non-medical services for CYSHCN. Staff collaborated with other agencies and advisory committees related to community resources and services to ensure that families experienced ease of access to needed services. Notification of available services and resources to all families of recently SSA eligible participants continued.

The State of Tennessee Children's Cabinet developed and launched an electronic resource center, kidcentraltn, Tennessee's one stop shop for families to access information on state resources. CSS staff routinely referred families to kidcentraltn either while the family was receiving services in the health department or through the families' personal internet access. The site may be accessed at kidcentraltn.com

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		
3. Work with regional and local health councils to identify gaps in services in specific communities.				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	X	X		X

develop a culturally competent approach to services for the population.				
5. Conduct parent satisfaction surveys.		X		X
6. Refer CSHCN ages 0-3 to TEIS Part C Early Intervention Services in the local communities.		X		
7. Refer CSHCN ages 3-21 to local school districts for Part B services in the local community.		X		
8.				
9.				
10.				

b. Current Activities

An electronic resource directory was developed and is housed on the CYSHCN web site. The directory contains resources for all 95 counties in the State and can be accessed by families, providers or others searching for community based resources. The directory may be accessed at http://health.state.tn.us/MCH/CSS.shtml CYSHCN staff continues to provide updates to the electronic resource directory. The directory allows care coordinators and families to access community based resources at the local/county level, and also contain many state and federal resources. The CSS program attempts to include all known local/community based resources that are available.

The patient and family centered care workshop provided a forum for parents and families to receive training on navigating health care and community support systems. CYSHCN staff is also identifying fact sheets and other resources for CYSHCN that will provide diagnosis-specific information and also basic information for families that have just been notified of their child's diagnosis. The parent to parent network will also provide resources and referrals at parents' request.

In conjunction with the Medical Home Summit, a community resource directory was developed for all counties and cities that were participants in the summit. Local health department staff and local health care providers also met and exchanged resource and referral information at the summit.

c. Plan for the Coming Year

Training and workshops for families of CYSHCN will be conducted to develop and increase parent's knowledge of navigating health care and community support systems. One-on-one coaching will be provided to assist families in accessing needed services and follow-up sessions will be conducted to determine if services were easily accessible or useful.

Questions regarding community based services will be included on the survey that Family Voices has been contracted to conduct. Analysis and survey results will be provided to TDH for use in program planning and development to ensure that community based services are organized in ways that families can easily use them.

The parent/youth advisory committee will provide recommendations to CYSHCN staff regarding service needs. The CYSHCN director will continue working with other agencies and families to develop a system of services organized for easy access and use.

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

CSS program staff will continue to work with the Early Childhood Program in the Family Health and Wellness Section and other internal and external partners including the Tennessee Autism Planning Team, Tennessee Disability Pathfinders staff and the Department of Intellectual and

Developmental Disabilities, to develop a community based system of services that is accessible and organized for ease of use.

The CYSHCN director will continue to identify challenges and barriers to providing services in certain areas of the state.

Access to the electronic resource directory will be provided to families, health care providers and community agencies.

CYSHCN staff, TPSF, and Family Voices will continue strategic planning meetings and further concentrate on cultural diversity outreach efforts for community based systems.
Care Coordination standards, training and best practices will be developed and provided to public and private providers to help families navigate community based services.

The Tennessee Parent to Parent Network program will be launched statewide and will provide parent matching, mentoring and training in self-advocacy for parents and CYSHCN.

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	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	100	100	40	45	45
Annual Indicator	39.6	39.6	41.8	41.8	41.8
Numerator	34477	34477	40413	40413	40413
Denominator	87141	87141	96752	96752	96752
Data Source	CSHCN Survey	CSHCN Survey	2009/10 CSHCN Survey	2009/10 CSHCN Survey	2009/10 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
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	41.8	41.8	45	45	45

Notes - 2013
See Notes - 2011

Notes - 2012
See Notes - 2011

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

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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.

a. Last Year's Accomplishments

The CYSHCN director collaborated with the Departments of Children's Services, Education, Mental Health, Developmental and Intellectual Disabilities, the Tennessee Council on Developmental Disabilities, and the Tennessee Disability Coalition - Family Voices to formulate programmatic policies and procedures for transition plans for all children receiving services through state agencies.

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

CSS program participants age 14 and older received formal transition discussion and planning. The portable Health History Summary Form was included as part of the transition planning.

The CYSHCN director continued to collaborate with the Departments of Children's Services, Education, Mental Health and Developmental and 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.

CYSHCN staff worked 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 CYSHCN.

The CYSHCN director collaborated with Family Voices, TennCare, Vocational Rehabilitation and the Department of Higher Education to develop model transition plans.

CYSHCN, Family Voices and TPSF staff attended the Baylor College of Medicine 14th Annual Chronic Illness and Disability Conference -- Transition from Pediatric to Adult-based Care. Information gathered from the conference assisted the team with addressing goals of the Integrated Systems grant related to providing public and private health care professionals with necessary supports to assist youth with special health care needs to successfully transition to adult health care services.

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 CYSHCN.		X		
4. Provide training and development opportunities for CSS staff on transition issues.				X

5. Provide updated resource materials for CSS staff and CYSHCN.		X		X
6. Encourage youth to present at transition meetings and training events.				X
7. Collaborate with state agencies, work groups and advisory committees for transition policy development.		X	X	X
8. Develop additional transition materials and resources, transition brochures, and guides.			X	X
9.				
10.				

b. Current Activities
Training continues to be provided on transition planning for CYSHCN. CSS program staff continues to utilize the American Academy of Pediatrics emergency preparedness guidelines for CYSHCN as part of the individualized transition plan and continues to partner with pediatric providers to locate adult providers for CYSHCN who are aging off the program.

CSS program staff continues to collaborate with state agencies, advisory groups and work groups regarding youth transition issues and program and policy development and will continue to work with those groups to ensure that all CYSHCN receive transition planning.

CYSHCN staff will develop a mechanism to determine participant's satisfaction and the success of individualized transition plan and determine any gaps/barriers and challenges that may exist.

Training continues throughout the state on the standards and requirements for conducting transition planning with CSS program participants.

Family Voices staff and youth consultant continues to develop the GAIN workshop and will provide discussion and training on transition issues for teens and youth.

Discussions around developing a pilot transition plan for one of the local FQHCs are being held.

c. Plan for the Coming Year
CYSHCN staff will continue 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. A portable Health History Summary Form will continue to be provided to all transitioning participants as a concise medical history that can be provided to medical providers as the participants transition from pediatric to adult providers.

CYSHCN staff in conjunction with TPSF and Family Voices will develop a transition toolkit. The transition toolkit will be marketed to providers, families and community partners. An evaluation will be developed for feed-back and ongoing improvement of the toolkit. The toolkit will be housed on the TDH website. The medical home website will be updated to house information on transition.

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

TPSF will develop and conduct a Transition Summit. Families will be invited to participate as speakers and provide information on their personal transition experience. The conference will focus on medical transition from pediatric to adult providers and the provider community will also provide breakout sessions on elements of successful transition.

CSS program staff will continue to develop transition plans for all participants age 14 and older

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and will work to transition children and families to local adult health care providers.

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	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	88	88	80	85	80
Annual Indicator	83.0	77.0	82.2	73.4	73.3
Numerator	278	261	305	262	222
Denominator	335	339	371	357	303
Data Source	2008 NIS Survey	2009 NIS Survey	2010 NIS Survey	2011 NIS Survey	2012 NIS Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	80	80	80	80	80

Notes - 2013
CDC reported the denominator of 303 on a different data table (no denominator was provided on the general data table). Their calculated estimate was 73.1 +/- 6.8

Notes - 2012
Data Source: 2011 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.

NOTE: Annual performance objective for 2012 should be 80, consistent with Healthy People 2020 benchmarks.

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.

a. Last Year's Accomplishments
Although nationally published measurements and ratings use the National Immunization Survey (NIS), the Tennessee Immunization Program (TIP) 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 2013 survey evaluated 1,489 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 75.4%. As we aim to achieve Healthy

People 2020 objectives, TIP tracks how many of the vaccines included in this series reach 90% or higher coverage levels. In 2013, 5 of the 7 vaccines achieved this goal: falling short with the 4th doses of DTaP and pneumococcal vaccines; however, completion rates for 3 doses of each of these two vaccines is approximately 95%. Through the year, TIP targeted children ages 20-24 months seen at public health clinics and missing their fourth DTaP dose for active follow up; however, impact is limited to the 19% of children who receive one or more immunizations in a public health department. 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. As in 2012, the 2013 survey showed no statistically significant racial disparity between black and white children for the vaccines in the 4:3:1:3:3:1:4 series. The pronounced racial disparity in influenza vaccine diminished slightly but continues. Wide regional variations in influenza coverage exist. The Director of TIP shares these findings with the state Medicaid agency (TennCare) and with the state chapters of the American Academy of Pediatrics and the Academy of Family Physicians. In 2013, TIP initiated plans with the Office of Minority Health to conduct focus groups in 2014 among young minority mothers to better understand their concerns and possible reasons for the disparity. TIP has published the results of its 2013 survey of 24-month-old children on its web page under the heading Immunization Statistics (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 state immunization requirements updated in 2010 for pre-school and school-aged children have had a measurable impact on hepatitis A vaccine and Tdap vaccine coverage and have provided additional opportunities to administer all recommended vaccines to students. The Tdap requirement for all students entering 7th grade has provided an essential opportunity to address all preteen immunizations with each student. Educational outreach and collaboration with school nurses has improved their capacity to educate students and work more effectively with healthcare providers.

Influenza vaccination was first assessed in the state's 2007 annual survey of immunization coverage among 24 month-old children. The Director of TIP highlights influenza at state and national meetings, with public health field staff and through meetings with representatives of vaccine manufacturers who visit provider offices regularly. TIP 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 influenza findings and educate providers about influenza vaccination of all children and adults, including pregnant women.

TIP introduced a popular new tool in its immunization information system (IIS) in April 2013: the Immunization Certificate Validation Tool. This feature enables any IIS user to evaluate and print a valid state immunization certificate for any preschool or school-aged child whose records are in the IIS. If the child's record is not up to state requirements, the tool produces a failed validation report highlighting to the user precisely what the missing or invalid dose is so he or she may address the need and complete the record. This tool was used for over 14,000 children in its pilot school season and was awarded an Association of Immunization Managers (AIM) Bull's Eye award as a quality innovation useful to other states in improving immunization services.

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

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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 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 information system (IIS) and promoting the school immunization certificate validation tool; (4) implementing the new vendor-managed IIS in 2014 in order to meet all national IIS functional standards, including vaccine forecasting and reminder-recall functions for providers; (5) conducting immunization assessments in population sub groups, such as day care enrollees; and, (6) following up on children born to hepatitis B infected women to ensure appropriate prophylaxis.

A 46% drop in federal 317 funds in federal FY2014 has continued to impact public health vaccination practices. With the exception of outbreaks or post-exposure prophylaxis, fully insured children are no longer immunized using federal vaccine. State purchased vaccines are available but are not free. The health department is actively pursuing contracts with commercial plans to be an in-network provider. Families whose plans cannot yet be billed may purchase state vaccine or are directed to an in-network provider.

c. Plan for the Coming Year

The primary change in strategy in the coming year is the full implementation and provider education on the new Immunization Information System (IIS) managed by STC Corporation. The new IIS will provide powerful new tools to immunization providers, helping them identify and track children in need of immunization and improve their performance. As more providers connect to the IIS as part of the meaningful use of their electronic health record system, more children will benefit from the IIS. In the Vaccines for Children (VFC) Program, participating providers will be required to complete an annual VFC education activity and will receive site visits from VFC representatives at least every other year; assessments of the quality of services will be done for providers who document all patient immunizations in the IIS. TIP will continue to promote the use of its Immunization Certificate Validation Tool (ICVT) in the IIS for the efficient production of accurate school immunization records by any IIS user. Failed validation reports of incomplete records can provide patient-specific guidance on missing immunizations. The ICVT will continue to be promoted to incentivize private provider practices to electronically exchange data with the IIS. IIS staff will continue to work with IT vendors and practices on electronic data exchange being driven by the availability of Medicaid "Meaningful Use" grants to support the accelerated implementation of electronic health records.

Immunization rate assessment activities will continue among 2 year old children. TIP will continue to foster and promote approaches to reach those less likely to complete immunizations on time. TIP will follow up on findings of the planned influenza vaccine focus group discussions among African American mothers to be conducted by the state Office of Minority Health. Case management of children born to hepatitis B infected women will also continue. The TIP Director will focus educational outreach efforts to healthcare providers on these target issues:

immunizations during pregnancy; HPV vaccine; and, on time 4th doses of DTaP and pneumococcal conjugate vaccines among toddlers.

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	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	26	24	20	19.5	18
Annual Indicator	24.0	20.2	18.5	17.4	
Numerator	2955	2532	2287	2117	
Denominator	123216	125133	123785	121665	
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	
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	17.4	17.4	17	17	16.5

Notes - 2013
Because 2013 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 - 2012
Data sources: TDH Office of Health Statistics Birth Statistical System and 2012 US Census

Notes - 2011
Data sources: TDH Office of Health Statistics Birth Statistical System and 2011 US Census

a. Last Year's Accomplishments
The Family Planning Program continued to provide contraceptive education and clinical services in 126 sites statewide. Teens were a priority population, especially for outreach. CY 2012 data from the Family Planning Annual Report show that the program served 12,662 clients ages 17 and under in CY 2012.

The state continued to provide EPSDT visits for children and adolescents in the local health departments, under contract with TennCare/Medicaid. During FY 2013, the health department clinics performed 67,158 EPSDT screenings, of which 16,325 were to adolescents ages 10-20. These exams include assessment regarding sexual activity and referral for family planning

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services as appropriate.

Tennessee Adolescent Pregnancy Prevention Program (TAPPP) councils operated in two of the six metropolitan areas and in multi-county groupings in six of the seven rural regions. Eight 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 12-13 show that statewide staff provided family life education programs to over 24,235 students; provided education and training to over 7901 adults; and worked with 3159 teen and adult parents and 2627 professionals. Participation in TAPPP activities decreased October 2012 through September 2013 due to the impact of the Family Life Education Act, Senate Bill 3310; health department employees had limited participation in family life education within the school system until clarification on civil liability issues was obtained.

The TN State Department of Health received $1,137,264.00 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 importance of future life goals.

The TN State Department of Health is responsible for the implementation of the Pregnancy Assistance Fund (PAF) federal grant which provides funds, through a state contract, with Shelby County for implementation of the Teen Pregnancy and Parenting Success (TPPS) program. During FY 12-13, the TTPS program enrolled over 400 pregnant and/or parenting teens, provided educational services to increase high school graduation, GED attainment and college enrollment and referred teens to available community resources and services. TPPS implemented an incentive point system for teens to access and purchase needed baby supplies through one of four contracted "Baby Stores." Teens were awarded points for attending scheduled prenatal care visits, being enrolled in a home visitation program and attending educational classes.

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	
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. Implement Title V Abstinence Education Grant Program (AEGP) activities.			X	
7. Implement Pregnancy Assistance Fund (PAF) Teen		X	X	

Pregnancy and Parenting Success Initiatives.				
8.				
9.				
10.				

b. Current Activities
In CY 2013, 9,809 adolescents ages 17 and under were provided services through the statewide Family Planning Program, with services at 126 sites in all 95 counties.

TAPPP continues to utilize county and regional level health educators to provide school and community education. Program activities cover topics such as awareness of teen pregnancy, comprehensive sexuality education, professional training and abstinence education. Health department employees partner with local schools as requested to provide health information and education.

Thirteen community-based agencies continue to implement 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 improve self-esteem. During FY13, approximately 9,200 adolescents received school based programs, 900 participated in after school programs, 975 received mentoring services and over 2000 hours of community service were completed.

The Pregnancy Assistance Fund (PAF) addresses the needs of teen pregnancy and parenting in the Shelby County area. The Early Success Coalition (ESC), an extensive community collaborative that supports the PAF project, provides resources and services for health care, parenting education, infant care and educational attainment. The PAF grant ends on August 31, 2014.

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 Tennessee Adolescent Pregnancy Prevention Program (TAPPP) will continue to utilize county and regional level health educators to provide school and community education. The program activities will cover topic such as community awareness of teen pregnancy, family life education, comprehensive sexuality education, professional training, abstinence education, healthy relationships, asset building in youth and adolescent growth and development.

The Abstinence Education Grant 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. On February 4, 2014, the Abstinence Education Grant Program received $1,037,995 from the Department of Health and Human Services to implement abstinence education through September 30, 2015.

The Family Planning Program will continue to provide contraceptive education and clinical services in 126 sites statewide. Services provided include: medical examinations, laboratory

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tests, counseling, contraception, Pap smears, sexually transmitted infection screening and treatment, and cancer screening. Teens are a priority population, especially for outreach.

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	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	40	40	40	40	40
Annual Indicator	37.2	37.2	37.2	37.2	37.2
Numerator	366	366	366	366	366
Denominator	983	983	983	983	983
Data Source	Tennessee Oral Health Survey	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
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	28.1	28.1	28.1	28.1	28.1

Notes - 2013
Data Source: 2008 Tennessee Oral Health Survey of children ages 5-11 years. This survey is conducted every FIVE years as Central Office staffing permits.

Source for objective for future years: HP 2020, OH-12.2: increase the proportion of children aged 6-9 years who have received dental sealnts on one or more of their permanent first molar teeth

Notes - 2012
Data Source: 2008 Tennessee Oral Health Survey of children ages 5-11 years. This survey is conducted every FIVE years as Central Office staffing permits.

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

a. Last Year's Accomplishments

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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 13 (July 1, 2012-June 30, 2013), school based dental prevention services were being delivered in all 13 health department regions. Data for FY 13 show that 123,691children had dental screenings in 311 schools. Of these, 22,202 children were referred for unmet dental needs. Full dental exams were conducted on 51,583 children. A total number of 209,900 teeth were sealed on 38,696 children. 162,011 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. During FY 13, the Dental Practice Act was amended to allow sealant and fluoride varnish application by public health hygienists without requiring an evaluation by a dentist. The sucess of this legislative action was aided by the support of state oral heath partners, the Tennessee Dental Association and the Tennessee Dental Hygiene Association. As intended, implementation of this change has impacted service delivery in a positive way. Reassigning existing dental staff from the sealant program to the clinical setting has resulted in 650 additional clinic days per year.

Fixed and Mobile Dental Program: The Tennessee Department of Health (TDH) has 51 fixed dental clinics located in 49 rural counties and one regional offce. The scope of services includes comprehensive dental care to children and emergency dental care for adults. During FY13, more than 16,040 children and more than 5,015 adults were treated in TDH dental clinics. The TDH also has three clinical dental settings providing comprehensive care to targeted adult populations to include prenatals and diabetics. These clinics have fourth year dental students from UT Dental School and Meharry Dental School providing care during clinical rotations. No care was provided in the TDH three mobile dental clinics during FY 13, due to lack of staffing.

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, 2012 -June 30, 2013 more than 17,682 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 as staffing permits.

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	
3. Provide dental outreach activities.		X	X	
4. Provide dental services using the three mobile units in Northeast, Mid-Cumberland, and West Tennessee regions as staffing permits.	X	X		X
5. Continue the fluoride varnish program.	X			
6. Provide clinical rotation sites for fourth year dental students and general practice residents.	X			X
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 should occur every five years as Central Office staffing permits.

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	2009	2010	2011	2012	2013
Annual Performance Objective	2	2	1.7	2.4	3.5
Annual Indicator	2.7	2.5	3.7	1.7	
Numerator	33	31	46	21	
Denominator	1207621	1238935	1237679	1241590	
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	

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Final?					
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	1.7	1.7	1.6	1.6	1.5

Notes - 2013
Because 2013 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 - 2012
Data sources: TDH Office of Health Statistics Death Statistical System and 2012 US Census

Notes - 2011
Data sources: TDH Office of Health Statistics Death Statistical System and 2011 US Census

a. Last Year's Accomplishments
The Child Safety Fund Program has continued to purchase and distribute child restraint devices. From October 2012 to September 2013, $192,862 was distributed to 32 community agencies to purchase and distribute infant restraint systems, convertible car seats and booster seats. Many of the agencies that receive funds also hosted car seat safety checks to assist parents with ensuring their seat was installed correctly.

The Monroe Carell Jr. Children's Hospital at Vanderbilt operated 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 has taught seat belt and booster seat safety in elementary schools across Tennessee and involved hundreds of middle and high school service learning volunteers to implement the program.

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. Distribute funds to community agencies to purchase and distribute child restraint devices.				X
5.				
6.				
7.				
8.				
9.				
10.				

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b. Current Activities
The Child Safety Fund has continued to provide funds to agencies to purchase and distribute child restraint devices. From October 2013 to March 2014 $99,091 was was distributed to 28 agencies to purchase child restraint devices. Many of these agencies have continued to host car seat safety checks to ensure their seats are installed correctly.

The Monroe Carell Jr. Children's Hospital at Vanderbilt operates 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.

This year, the Ollie the Otter Program taught seat belt and booster seat safety over 350 times in elementary schools across Tennessee and involves hundreds of middle and high school service learning volunteers to implement the program.

Motor vehicle death data for children was presented to several groups including the Committee on Pediatric Emergency Care (CoPEC), the child fatality state team and first responders.

c. Plan for the Coming Year
The Tennessee Department of Health Division of Family Health and Wellness will continue to disburse funds for child restraint devices through the child safety fund. Several agencies that receive funds will continue to provide car seat safety checks for families to ensure the seats are installed correctly.

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

The Monroe Carell Jr. Children's Hospital at Vanderbilt will continue to operate a safety seat clinic for children with special health care needs.

The Statewide Injury Prevention Coalition will continue to engage law enforcement, Safe Kids Coalition Members, the Governor's Highway Safety Office, Department of Education, and other stakeholders in active promotion of child restraint policy development, enforcement, and evaluation.

The TDH Injury Prevention Program will continue to present data on motor vehicle crashes among children at relevant conferences and meetings.

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	2009	2010	2011	2012	2013

Performance Data					
Annual Performance Objective	30	40	37.5	36	40
Annual Indicator	37.9	29.8	35.5	30.8	29.9
Numerator	31952				
Denominator	84308				
Data Source	CDC/National Immunization Survey	CDC/National Immunization Survey-2007 Birth Cohort	CDC/National Immunization Survey-2008 Birth Cohort	CDC/National Immunization Survey-2009 Birth Cohort	CDC/National Immunization Survey-2010 Birth Cohort
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
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	30	30.5	31	31.5	32

Notes - 2013
http://www.cdc.gov/breastfeeding/pdf/2013breastfeedingreportcard.pdf

Notes - 2012
http://www.cdc.gov/breastfeeding/pdf/2012BreastfeedingReportCard.pdf

Notes - 2011
http://www.cdc.gov/breastfeeding/pdf/2011BreastfeedingReportCard.pdf

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 20,158 pregnant women per month and enrolled about 52% of newborns in the state. Thirty-six percent of WIC delivered mothers were breastfeeding at time of postpartum certification. There were 7257 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.

Case management staff 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 visits significantly facilitated the promotion of breastfeeding in the populations served.

The Tennessee Initiative for Perinatal Quality Care (TIPQC) continued with implementation of breastfeeding projects in 2013. A meeting of the Tennessee Breastfeeding Coalition was held in conjunction with the annual TIPQC meeting. Strong collaboration between WIC and MCH continued with support from the State Health Commissioner.

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	X	
2. Breastfeeding data are routinely collected on WIC clients.			X	X
3. USDA grant continues to be used to maintain an effective breastfeeding peer counselor program in selected counties.	X	X	X	X
4. Establish a statewide breastfeeding hotline for breastfeeding moms and their families and for healthcare providers.		X	X	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		X
7. Train staff at all service levels on breastfeeding and the role of each staff level in its promotion.	X	X	X	X
8.				
9.				
10.				

b. Current Activities

TN has maintained funding for the WIC breastfeeding peer counselor program. Peer counselors have the potential to impact breastfeeding rates among participants, and, most significantly, increase the harder-to-achieve breastfeeding duration rates. Breastfeeding rates have increased in areas receiving grant funds to hire peer counselors and expand their efforts.

A statewide breastfeeding summit was held in November 2013 in Johnson City, TN and was

broadcast live to audiences in Nashville, Chattanooga, and Memphis. Attendees included local primary care providers and staff, health department staff, and hospital perinatal and lactation staff. The agenda and handouts from the summit can be accessed at: http://www.etsu.edu/com/cme/InfantCareSummit.aspx

MCH funds are being used to fund 10% of an FTE to support the state breastfeeding coalition.

TIPQC activities have continued, with current projects focused on breastfeeding promotion in both obstetrical and pediatric settings. The TN Breastfeeding Coalition met during the annual TIPQC meeting and discussed greater collaboration efforts. The State WIC Breastfeeding Coordinator and Peer Counselor Coordinator were in attendance and highlighted a few efforts that were in process. The TN Breastfeeding Hotline (24/7) was implemented in November. In the first six months of operation of the Hotline, there have been 826 calls to i

c. Plan for the Coming Year
Plans for the coming year include continuing and expanding the WIC breastfeeding peer counselor program, continuing to work with HUGS to strengthen breastfeeding support for mothers and their families, and continuing the networking with Tennessee Initiative for Perinatal Quality Care (TIPQC) on their breastfeeding initiative.

Using a CDC-funded chronic disease prevention and school health promotion grant, FHW staff will partner with the TN Hospital Association to engage hospitals and increase the number of hospitals implementing practices and policies to promote and support breastfeeding.

The TN Breastfeeding Hotline (24/7) will continue to provide resources for prenatals, breastfeeding moms and their families, and healthcare providers. A promotional campaign will include birthing hospitals, physician offices, and appropriate professional organizations.
It is staffed by IBCLCs and CLCs.

World Breastfeeding Week statewide activities will focus on evidence-based information for the general public and promotion of the Hotline.

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	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	98	98	98	99	99
Annual Indicator	97.6	97.1	97.5	96.2	97.2
Numerator	85080	82058	82313	82809	83457
Denominator	87141	84535	84393	86068	85838
Data Source	Department of Health	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					

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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
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	99	99	99	99	99

Notes - 2013
Data Source: Tennessee Department of Health, Newborn Screening Program

Notes - 2012
Data Source: Tennessee Department of Health, Newborn Screening Program

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

a. Last Year's Accomplishments
The Early Hearing Detection and Intervention (EHDI) program (Newborn Hearing) utilized HRSA grant funds to contract for an audiologist, a deaf educator and five parents of children with hearing loss to conduct outreach, provide training to targeted audiences, and provide family support. The overall percent of infants that received a hearing screen prior to one month of age was 98.2%. Of the 2,381 infants not screened: 9.7% declined the screen; 12.3% were still in the hospital; 7.5% discharged or transferred; 4.8% expired; and 9.8% were not screened/unable to test. To increase the number of home births screened, seven midwifery groups were provided training and five sets of Otoacoustic Emissions (OAE) equipment to share. The number of days for these infants to receive a hearing screen decreased from an average of 23 days to 5 days. Hospitals were sent monthly reports of infants with unreported/inaccurately reported hearing results to complete and return. Hospitals with a high percentage of missed babies received consultation on how to improve reporting.

The percentage of hearing follow-up reported prior to 3 months increased to 84.3% for calendar year 2013. The number percentage of infants lost to follow-up/lost to documentation (LTF/LTD) decreased to 35% for calendar year 2013. Sixty-eight infants were diagnosed with hearing loss during this period. The type of hearing loss included 40 sensorineural; 5 mixed; 4 conductive; 2 auditory neuropathy; 12 unspecified. Children with hearing loss were referred to Tennessee Early Intervention System (TEIS) and to the Children with Special Health Care Needs (CSHCN) program. Sixty-nine percent of infants with hearing loss were enrolled in TEIS by six months of age. The incidence of hearing loss was 0.79:1000.

To decrease the number of infants LTF/LTD, a diagnostic equipment loan program provided automated brain stem equipment to three audiology providers to share. Services covered twelve rural counties. Contract audiologists conducted Otoacustic Emissions (OAE) training for all Early Head Start agencies and nine Tennessee Early Intervention System (TEIS) Part C districts. Early Head Start programs conduct follow-up screens as needed in areas with lack of access to an audiologist. TEIS tracked over 2,000 infants and documented results directly into the State's Neometrics data system.

Tennessee participated in the National Initiative for Children's Health Care Quality (NICHQ) to improve EHDI systems and reduce the number of infants LTF/LTD from October 2012 -- August 2013. The six partners included Jacque Cundall, RN, BSN, EHDI director; Yinmei Li, Ph.D., CDC EHDI epidemiologist; Julie Beeler, EHDI Audiology Consultant; Tamala Bradham, Ph.D.,

Audiology Professor, Vanderbilt Bill Wilkerson Center; Tonya Bowman, Family Voices/Hands and Voices Parent Consultant, and Claudia Weber, ME, SW, Part C/TEIS Hearing Follow-up Coordinator. The Quality Improvement model to introduce the concept of using "small steps of change" was in the "Plan-Do-Study Act" (PDSA) format. PDSA small steps of change were conducted with three audiology centers and the TEIS office. One aim was to improve the quality, timeliness, and documentation/reporting of diagnostic evaluation and permanent hearing loss to the EHDI program. The initiatives included use of a "Findings and Audiology Next Steps" (FANS) checklist to provide families with audiological results and recommendations. Another plan revised reporting protocols for the birth to three years old to better define the need to report normal as well as abnormal results, report risk follow-up results, report follow-up on pending retests, and to report within 7 days of the test. The majority of centers now report results by fax on the day of test. Data on the number of days between the day of test and date received are currently being collected. Successful strategies will be included into the Audiology Protocols for EHDI. Another initiative tracked infants needing follow-up in one Women, Infants and Children (WIC) clinic. Results indicated that one-third of the infants passed a rescreen but did not have results reported to the program. Additional expanded PDSAs have been planned for other WIC clinic sites. The PDSA Quality Improvement method was continued into the next year to reduce lost to follow-up after a referred hearing screen and to improve program systems.

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		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	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		X
10. Integrate and/or coordinate data systems related to newborns and hearing.			X	X

b. Current Activities

In January 2014, the EHDI program began new initiatives that included: a pilot teleaudiology site in a rural West Tennessee county with no access to an audiologist; home visits by Family Voices parent support staff to families of children diagnosed with hearing loss; and implementation of six regional EHDI meetings to train and utilize stakeholders in the PDSA method of quality improvement to reduce the number of infants lost to follow-up by 5 % in each region by March 2015.

To increase support to families, the EHDI program began making direct referrals to the Family Voices parents to enable them to make direct contact by phone and home visits to families shortly after a diagnosis of hearing loss. To further improve parent support, the contract for parent support will transition to the National Hands and Voices "Guide By Your Side" model. This is a fee

for service model to reimburse trained parent guides to provide calls, home visits and community outreach.

In November 2013, audiologists were provided access to the Neometrics web-based system Secure Remote Viewer (SRV) module to view initial hospital hearing results to enable them to determine the type of follow-up needed.

c. Plan for the Coming Year

In the coming year, the electronic Neometric data system will expand to add a Remote Diagnostic Entry module that allows access by audiologists, TEIS central office staff, genetic centers, and parent support staff to document hearing follow-up and services. The Device Case Management module will provide an electronic upload of hospital hearing results directly from the hearing equipment.

The HRSA Universal Newborn Hearing Screening grant focus is to reduce the number of infants lost to follow-up after a referred hearing screen by 5% for each of three years, ending March 2017. To achieve this goal, conference calls, trainings and webinars will be continued with each of the six Regional Tennessee EHDI groups. Additional partners will be invited to participate and the Plan-Do-Study-Act Quality Improvement method will be used to identify new strategies, expand and improve current strategies, document and measure success, and institutionalize proven strategies. An AIM Statement was developed for six areas. 1) Hospitals - By March 31, 2015, Tennessee hospitals, in partnership with the NHS program, will develop, test, and implement change strategies that address LTF/LTD for babies who refer on their newborn hearing screen to decrease LFU/LTD rate by 5%. 2) Audiologists - By March 31, 2015, Tennessee audiologists, in partnership with NHS Program, will develop, test, and implement change strategies using quality improvement methodologies for infants who refer on their newborn hearing screen to decrease LFU/LTD rate by 5%. 3) WIC - By March 31, 2015, WIC staff, in partnership with the NHS Program, will develop, test, and implement change strategies using quality improvement methodologies that address Lost to Follow-up and Lost to Documentation (LTF/LTD) for babies who refer on their newborn hearing screen. 4) Community Providers - By March 31, 2015, community providers, in partnership with NHS Program, will develop, test, and implement change strategies using quality improvement methodologies for infants who refer on their newborn hearing screen to decrease LFU/LTD rate by 5%. 5) Family Support - By March 31, 2015, Family Voices (FV), in partnership with the NHS program, will develop, test, and implement change strategies using quality improvement methodologies that address the provision of family-centered support to parents with a child who is deaf or hard-of-hearing by providing a home visit to at least 20 families. 6) TEIS Part C Early Intervention - By March 31,2015, Part C, in partnership with the NHS program, will develop, test, and implement change strategies using quality improvement methodologies for infants who refer on their newborn hearing screen to decrease the LFU/LTD rate by 5%.

Data for all projects will be reported to and measured by the NHS Neometrics system.

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	2009	2010	2011	2012	2013
Annual Performance Objective	6	3	3.7	2.3	2.5
Annual Indicator	3.7	3.9	2.4	2.7	3.7
Numerator	54759	57912	35743	40700	55319

Denominator	1479972	1484923	1489292	1507407	1495108
Data Source	UT CBER	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	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	3.5	3.4	3.3	3.2	3.1

Notes - 2013
Data Source: "The Impact of TennCare, A Survey of Recipients, 2013."
http://cber.bus.utk.edu/tncare/tncare13.pdf (Table 2a, page 3)

Notes - 2012
Data Source: "The Impact of TennCare, A Survey of Recipients, 2012."
Available at http://cber.bus.utk.edu/tncare/tncare12.pdf (Table 2a, page 3)

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."

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 2013 show a total of 733,568 participants under age 21.

U.S. Census Bureau 2012 Annual Social and Economic Supplement Current Population Survey data show that nationally 84.6% of all persons and 91.1% of children under age 18 were covered by some type of health insurance. U.S. Census data for a three-year average for 2010-2012 showed that 5.6% of children under age 19 and at or below 200% of poverty were without health insurance in Tennessee. A 2013 survey from University of Tennessee Center for Business and Economic Research showed 2.7% of Tennessee children under age 18 in 2012 and 3.7% in 2013 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 met 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 was 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 FY 2013, the health department clinics performed 67,158 EPSDT screenings to TennCare eligibles under the age of 21.

The Department of Health Primary Prevention Impact Services Program (formerly theTENNderCare 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 health department clinics.		X		
6. Assist all children applying for CSS services with enrollment in TennCare.		X		
7. Assist TennCare enrollees with the TennCare appeals process.		X		
8.				
9.				
10.				

b. Current Activities

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 perform EPSDT screenings for TennCare children; some health departments participate in TennCare as primary care physician provider sites. Outreach initiatives to educate and inform TennCare members and their parents about free EPSDT screens are conducted through the Primary Prevention Impact Services 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. Effective 1/1/14, TennCare changed the Medicaid application process and began using exclusively the Federal Facilitated Marketplace as the application portal. Health departments provided information to individuals about the healthcare.gov web site as well as contact information for ACA Navigator agencies in the state. Effective 1/1/14, all county health departments under the Department of Health became participating providers with Blue Cross Blue Shield of Tennessee for their private insurance plans, their ACA Marketplace plans and the state Cover Kids program.

TennCare enrollment data for December 2013 shows 726,962 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; sharing information about enrolling in

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Medicaid via healthcare.gov; provision of EPSDT (well child) screens at all county health departments; Primary Prevention Impact Services outreach efforts through the EPSDT Call Center, Nursing Call Center, and 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 Primary Prevention Impact Services Community Based outreach program. The Department of Health will continue in 2014 to seek participating provider agreements with other high volume private insurance plans and ACA Marketplace plans in the state which will expand the Department's ability to accept children with these insurances and provide vaccines.

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	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	14	25	15	10	10.2
Annual Indicator	15.2	15.4	10.7	10.4	10.5
Numerator	10490	11075	19967	18890	19128
Denominator	69015	71914	186444	182282	182297
Data Source	Department of Health	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	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	10.4	10.3	10.2	10.1	10

Notes - 2013
Data Source: Tennessee Department of Health, PedNSS/TN WIC Database.

Notes - 2012
Data Source: Tennessee Department of Health, PedNSS/TN WIC Database.

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

a. Last Year's Accomplishments

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All regions were 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 were color-coded for easier reviewing by the healthcare providers in all of the regions and clinics. Central Office staff work with regional staff when data show marked changes in the percentages of participants classified as overweight. Central Office staff provided technical assistance to regional and local WIC and nursing staff as needed.

Important note: The final PedNSS data was provided for 2011 in fall 2012. Since CDC will no longer analyze WIC data through PedNSS, this report is the last that will use PedNSS data.

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	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
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.				
9.				
10.				

b. Current Activities

Although the submission of WIC pediatric data ceased, the TN WIC Program has continued to extract data using the program provided by CDC. Regional and clinic health department staff review quarterly reports for identification of trends as well as individual clinic reports to spot potential problems.

All prenatals are encouraged to breastfeed their infants. Peer counselors are working with new moms to help increase the duration of breastfeeding to assist in the prevention of childhood obesity.

Through nutrition education WIC families are receiving information on healthy meals, snacks, and healthy choices when eating away from home. Cooking demonstrations are being provided in many clinic locations to provide experience and tasting of new food items.

c. Plan for the Coming Year

Central Office WIC staff will continue to provide region-specific reports on overweight and obesity to local WIC agencies/clinics on a quarterly basis. Central Office staff will also work with regional and local staff to assure that appropriate techniques are used in assessment of BMI status and data input. TN WIC will continue to collect BMI data so that even in the absence of PedNSS data, we will be able to track the incidence of overweight and obesity among the TN WIC population.

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WIC will continue to provide core nutrition messages on WIC food instruments (vouchers) to encourage more vegetables and fruits, use of low fat and nonfat milk, and incorporation of more whole grain products. The "MyPlate" materials will continue to be used to assist all WIC nutrition education activities. Staff will encourage physical activity as a part of all nutrition education activities for 2 to 5 year olds. Nutrition education is provided face to face and in groups for high risk participants and online for low risk WIC participants. More online nutrition education modules will be produced to expand the topic areas.

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	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	13	13	13.5	13	12.5
Annual Indicator	15.0	14.2	13.6	13.1	12.9
Numerator	12257	11260	10782	10433	10178
Denominator	81888	79130	79234	79928	79001
Data Source	Department of Health	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
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	12.8	12.8	12.7	12.7	12.6

Notes - 2013
Data source: TDH Office of Health Statistics Birth Statistical System

Notes - 2012
Data source: TDH Office of Health Statistics Birth Statistical System

Notes - 2011
Data source: TDH Office of Health Statistics Birth Statistical System

a. Last Year's Accomplishments
Providing pregnant women with cessation resources, medication and support has long been a priority of staff within the Tennessee Department of Health. Local health department nurses and

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WIC nutritionists have continued to counsel pregnant women and provide 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, 13.0% of births in 2012 were to women who smoked during the last 3 months of pregnancy. This is a decrease from 13.6% in 2011. 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 2012, birth certificate data showed that the percent of white women who smoked during pregnancy was over twice that of black women (18.8% vs. 9.1%, respectively).

Since 2011, the Bureau of TennCare has covered medically necessary smoking cessation products for all enrollees in the program. The change in pharmacy benefits covers both prescription and over-the-counter products for all enrollees. Adults are limited to a total of 24 weeks of smoking cessation medication each year. Previously this benefit was only available to pregnant women and enrollees under the age of 21. This policy change has significantly increased the number of QuitLine users and persons agreeing to take smoking cessation medications.

Opportunities in local health department clinics for educating and counseling pregnant women regarding smoking include: pregnancy testing, enrollment in TennCare/Medicaid through presumptive eligibility, 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 enrolled pregnant women and mothers of infants regarding access to care, appointments, referrals, and education on healthy behaviors.

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, including educational material about the effects of secondhand smoke and cessation services.		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. Tennessee Tobacco Quitline provides pregnant women with tobacco quitline cessation counseling.		X	X	
7. Utilize tobacco settlement funds to provide programs for pregnant women who smoke.	X		X	
8.				
9.				
10.				

b. Current Activities

The State is continuing to provide all the services described above with the exception of the provision of cessation medications. Funding for purchasing medications is no longer available. All

health department clinics offer pregnancy testing. Currently, one county offers prenatal care services in an FQHC status health department clinic, predominantly 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 128 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.

The Tennessee Department of Health is using tobacco master settlement funds to support projects across the state aimed at reducing pregnancy smoking; these include Baby and Me Tobacco Free, Tennessee Intervention for Pregnant Smokers (TIPS), and Smart Moms.

TDH home visiting and tobacco prevention and control staff are participating in the federal COIIN aimed at reducing pregnancy smoking.

c. Plan for the Coming Year
All previously described activities in local health departments will continue.

The Tennessee Department of Health will continue to use tobacco master settlement funds to support projects across the state aimed at reducing pregnancy smoking; these include Baby and Me Tobacco Free, Tennessee Intervention for Pregnant Smokers (TIPS), and Smart Moms.

Though the COIIN activities for Region IV will end in August 2014, TDH home visiting and tobacco prevention and control staff will continue to partner with local-level home visiting agencies to screen pregnant women for smoking status and make appropriate referrals to the Tobacco QuitLine.

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	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	5	5	5	7	7
Annual Indicator	9.1	7.1	7.3	9.0	
Numerator	39	31	31	38	
Denominator	430127	437186	426828	421428	
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	
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	8.9	8.9	8.8	8.8	8.7

Notes - 2013
Because 2013 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 - 2012
Data sources: TDH Office of Health Statistics Death Statistical System and 2012 US Census

Notes - 2011
Data sources: TDH Office of Health Statistics Death Statistical System and 2011 US Census

a. Last Year's Accomplishments
Data from the 2011 Tennessee Youth Risk Behavior Survey (YRBS) indicated that in the previous 12 months, 26% of students surveyed felt sad or hopeless for two weeks or 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.

In 2012, The Injury Prevention Director invited the Tennessee Suicide Prevention Network (TSPN) to speak at one of the quarterly injury prevention meetings to provide education to the 35 members of the Tennessee injury community planning group. In addition, a TSPN representative attended all of the quarterly injury prevention meetings to give updates on suicide prevention activities.

TSPN held their annual symposium which is attended by employees of the health department, mental health agencies, and other community partners. The Injury Prevention Director and the Adolescent Health Director were also both members of the newly created Intra-State Departmental Advisory Council for Suicide Prevention. This group consists of representatives in each state department that collaborate to prevent suicide.

TDH has a representative on the Suicide Prevention in the African American Faith Community Coalition. The Coalition won the NashVitality Innovator Award in 2014. The coalition brings together families, the faith and medical communities to increase awareness of suicide prevention and develop strategies to improve outreach to communities.

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) by participating in the Intra-State Departmental Meetings.				X
2. Assist TSPN in sharing information to local groups such as the Trauma Care Advisory Council and Committee on Pediatric Emergency Care.				X
3. Implement evaluation to study the effectiveness of the Tennessee State Suicide Prevention Plan.				X

4. Increase Suicide Prevention Efforts by health educators through Primary Prevention Initiative Programs.			X	X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
TDH Injury Prevention staff regularly attended the Suicide Prevention Intra-State Departmental Meetings. These meetings foster collaboration among different state agencies to promote suicide prevention awareness.

TDH Injury Prevention staff and TSPN collaborated on a proposal to participate in a week long training in May on evaluating suicide prevention efforts in Tennessee. The goal of this effort will be to evaluate the state suicide prevention strategic plan to identify strengths and weaknesses.

The TSPN Executive Director served as an ex-officio member of the State Child Fatality Review (CFR)Team. Because of an increase in suicides, a recommendation to expand mental health services was included in the Annual Child Fatality Review Report. TSPN is working with other state agencies to identify existing resources and communicate with key school personnel.

TDH has compiled a statewide injury prevention resource directory and included suicide prevention contact information as part of that resource. The directory focuses on injury prevention efforts aimed at children.

TDH Injury Prevention staff created a powerpoint for health educators on suicide prevention primary prevention activities (see attached). Health educators have implemented some of those activities in the community incuding a gun safety campaign in Blount County directed to retailers and firing ranges. This campaign educates retailers how to recognize and respond to signs of suicidal ideation by gun buyers.
An attachment is included in this section. IVC_NPM16_Current Activities

c. Plan for the Coming Year
Education to schools, teachers, parents and youth organizations will continue through the collaboration with the Tennessee Suicide Prevention Network, the Department of Mental Health and Substance Abuse and other state agencies,

TDH will continue to include suicide prevention as one of the topics health educators can choose for Primary Prevention Initiative projects.

TDH staff will continue to serve as representatives on the intra-state departmental committee for suicide prevention. This committee will continue to explore strategies for suicide prevention awareness within their individual state departments.

The TSPN Executive Director will continue to serve as an ex-officio member of the State Child Fatality Review Team.

The Injury Prevention Manager will continue to work with TSPN to implement the evaluation of Tennessee's Suicide Prevention State Plan.

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.
TSPN staff will continue to be invited to the Injury Prevention quarterly meetings to provide an

update on suicide prevention activities throughout the state.

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	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	70	80	83	84.5	72
Annual Indicator	79.1	82.9	70.9	80.9	83.0
Numerator	1085	1032	843	1014	1084
Denominator	1371	1245	1189	1254	1306
Data Source	Department of Health	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
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	83.5	83.5	84	84	85

Notes - 2013
Data source: TDH Office of Health Statistics Birth Statistical System

Notes - 2012
Data source: TDH Office of Health Statistics Birth Statistical System

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

a. Last Year's Accomplishments
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. The state (TennCare) contracts with the centers to support the infrastructure. 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.

All services within the regional perinatal centers continued during the past year. Work during 2012 focused on quality improvement activities with TIPQC (Tennessee Initiative for Perinatal Quality Care) and collaboration with the Department and the Genetics Advisory Committee on implementation of screening for critical congenital heart disease (CCHD).

During state FY 2012, the five obstetrical perinatal centers had 15,476 deliveries for Tennessee residents (compared to 80,202 resident births statewide for CY 2012), documented 878 telephone consultations and 39,388 onsite patient consultations, and provided 1,594 hours of education. Data from the five neonatal perinatal centers for the same time period show 3,581 in-born admissions to Tennessee residents, of which 505 were VLBW (2012 VLBW resident births statewide were 1,254); 1,203 transports; 2,898 on-site consultations; and 3,965 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 1,800 members, including perinatologists, neonatologists, hospitals at all levels of perinatal care, administrators, third party payors, state officials, and community constituents. In February 2013, 385 physicians, nurses, advocates, payors, hospital administrators, government leaders, and families met to collaborate on ways to improve birth outcomes through sharing of their quality improvement projects. The first statewide projects were on NICU admission temperature, reduction of central line associated bloodstream infections, human milk for the NICU infant, breastfeeding promotion, and a registry for undetected CCHD; these are in sustainment.

A new partnership (March of Dimes, Tennessee Hospital Association, Tennessee Center for Patient Safety, TIPQC, and the Department of Health) was formed to increase awareness and to educate providers and parents about the benefits of waiting until at least 39 weeks for delivery. Activities included a new website with educational information, TV ads, print, online print, transit ads in Memphis, and a joint letter to hospitals requesting their participation.

Staff participated in the federal COIIN activities aimed at increasing the number of VLBW infants born at an appropriate (level III or level IV) facililty. Initial efforts focused on revising the perinatal regionalization guidelines and identifying baseline data on delivery at appropriate facilities.

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. Participate in national and statewide initiatives to reduce infant mortality.				X
6. Partner with stakeholders at the national and state levels to improve perinatal outcomes in Tennessee.				X
7.				

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8.				
9.				
10.				

b. Current Activities
The structure of the five regional perinatal centers continues.

The revisions to the regionalization guidelines and transportation guidelines were approved by the Perinatal Advisory Committee in January. Work on revising the educational objectives for nurses and for perinatal social workers is in process.

Staff continued to participate in the perinatal regionalization COIIN. Epidemiology staff created data reports on the percent of VLBW infants delivered at the appropriate level of care (stratified by region and hospital).

TIPQC continues to thrive. Teams from across the perinatal spectrum are engaging in statewide, evidence-based and data-driven quality improvement projects. Current projects include reducing early elective deliveries, neonatal abstinence management, family involvement, and breastfeeding promotion. Projects under development or being piloted include hospital acquired infection reduction, maximizing antenatal steriod therapy initiative, and breastfeeding promotion (second wave).

The focus continued to reduce early elective deliveries. All 66 delivery hospitals signed a "hard stop" policy. The state's efforts were nationally recognized with the second highest reduction rate, at 83%, for all CMS Hospital Engagement Networks (Nov 2013 - 2.6%). SSDI funds were used to purchase recognition banners for hospitals that achieved their goals.

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. Representatives from the Perinatal Advisory Committee and from the Department are continuing work on the federal COIIN initiative to reduce infant mortality in our southern states.

The Department will work closely with TIPQC on the sustained and planned quality improvement projects.

The Tennessee Healthy Babies Are Worth the Wait partnership will continue to work on joint activities for statewide improvement in perinatal outcomes and sustainment of the reduction of early elective deliveries.

The Department will be compiling data on deliveries by level of perinatal care and providing feedback to the birthing facilities.

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	2009	2010	2011	2012	2013

Annual Performance Objective	70	70	75	70	71
Annual Indicator	69.0	70.5	69.6	70.1	71.2
Numerator	53529	52372	51094	52878	53618
Denominator	77565	74301	73445	75458	75339
Data Source	Department of Health	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
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	72	72	73	73	74

Notes - 2013
Data source: TDH Office of Health Statistics Birth Statistical System

Notes - 2012
Data source: TDH Office of Health Statistics Birth Statistical System

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

a. Last Year's Accomplishments
Final 2012 vital statistics data show that 70.1% of pregnant women entered prenatal care in the first trimester. Preliminary 2013 data show 71.3%, a slight increase.

Of the total births in Tennessee in 2012, 52% were on TennCare/Medicaid; this is slightly higher than the percentage for 2011 (50.7%).

Comparing the 2012 Medicaid data for entry into prenatal care for Medicaid and non-Medicaid births, the data show that 60.7% of infants on Medicaid were born to pregnant women receiving prenatal care beginning in the first trimester, 72.4% for the non-Medicaid, and 65.9% overall. Using the same data set, 68.9% of pregnant women on Medicaid received adequate prenatal care (Kotelchuck index); 74.7% for non-Medicaid women; and 71.5% for all pregnant women.

The Department of Health has historically considered the reduction of infant mortality and improving birth outcomes as priorities. The role of the Department is to remain abreast of evidence-based best practices and to implement public health initiatives and programming consistent with those practices. All local health department clinics offer basic prenatal services, which includes pregnancy testing (77,006 tests in FY 2013), presumptive eligibility determination for TennCare (17,155 enrolled in FY 2013), WIC/nutrition services, counseling, information, and

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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 or case management services as appropriate (HUGS, Healthy Start, or CHAD). For FY 2013, 1,945 pregnant women were provided HUGS case management services. The Healthy Start home visiting projects served 129 pregnant women in FY 2013.

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 2013 (to 34 pregnant women, with delivery services provided by a private physician in the community).

Funding continued for infant mortality/women's health projects related to Centering Pregnancy, the four Fetal Infant Mortality projects (three metro regions and one rural region), infant mortality prevention in Chattanooga and Memphis, and TIPQC (Tennessee Initiative for Perinatal Quality Care). MCH led statewide efforts to develop a state infant mortality reduction strategic plan; numerous stakeholders participated in the process and are continuing with local and regional activities. The plan is included as an attachment to this section.

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 newspaper, print materials, and provider education. Callers receive a free Happy Birthday Baby Book of information and merchandise coupons to be validated at prenatal visits. In CY 2013, 535 phone calls were received at the Shelby County Health Department, and 2,820 coupon books, along with prenatal/infant educational information (approximately 1600 brochures), were distributed.

Tennessee representatives continued to participate on the CoIIN work groups (early elective delivery, smoking cessation for pregnant women, SIDS/SUID, and perinatal regionalization).

Work began on utlization and distribution statewide of $15 million received through the Tobacco Settlement Fund. All counties will receive funds for specified evidence-based projects (smoking cessation for pregnant women, reducing infant exposure to second-hand smoke, and preventing children from beginning to smoke).

An attachment is included in this section. IVC_NPM18_Last Year's Accomplishments

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide pregnancy testing, counseling, and referral and presumptive eligibility determination in all local health departments.	X	X	X	
2. Provide home visiting and case management services for pregnant women.	X	X		
3. Provide comprehensive prenatal care in one county.	X			
4. Provide WIC/nutrition services in all local health department clinics.	X	X	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. Implement the prevention of smoking in pregnancy projects in selected counties across the state.	X	X		

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 or case management 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. February 2014 WIC data show that 18,051 pregnant women were participating in WIC in 129 clinics.

Five Metro Health Departments are developing new infant mortality reduction plans to align with the state strategic plan; one option for selection of activities is to increase early entry into prenatal care in their geographic area.

Funding continued for infant mortality/women's health projects related to Centering Pregnancy, the four FIMR 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.

Sixty-three counties (78 programs) are implementing projects on the prevention of smoking in pregnancy. The "Baby and Me Tobacco Free" Program offers counseling for pregnant women.

Tennessee is participating in four COIIN workgroups.

c. Plan for the Coming Year
All previously discussed current year activities will continue into the coming year with the exception of those infant mortality projects whose funding ended during FY 2014. 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.

Tennessee representatives will continue to participate in four COIIN workgroups: early elective delivery, SIDS/SUID, smoking cessation for pregnant women, and perinatal regionalization.

The smoking and pregnancy projects funded with the Tobacco Settlement Fund will continue for a total of three years with the goal of reducing smoking in pregnancy and the number low birth weight babies.

The approved infant mortality reduction plans will be implemented in the five metro counties. The Knox County Health Department will begin operating a new FIMR project in their county.

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	2009	2010	2011	2012	2013

Annual Performance Objective			7	1	1
Annual Indicator	1.6	1.7	1.4	1.5	
Numerator	129	131	109	121	
Denominator	82109	79345	79462	80202	
Data Source	Department of Health	Department of Health	Department of Health	Department of Health	
Is the Data Provisional or Final?				Final	
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	1	1	1	1	1

Notes - 2013
Data not yet available for 2013. The Child Fatality data for 2013 (source for the numerator) is expected to be available in late 2014.

Notes - 2012
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 - 2011
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
MTSU provided two death scene investigation trainings for unexpected child death again this year. This training continued to provide education to first responders on sleep-related infant deaths.

Tennessee Department of Health (TDH) continued to promote the safe sleep message this year by distributing educational materials and promotional items to families through the home visiting programs, the health departments, clinics, hospitals, day cares, Department of Children's Services and other community agencies. TDH purchased cribs and destributed them through the local health departments to families that could not afford to buy one.

The WIC program put a safe sleep message on all of their infant WIC vouchers. This message reaches approximately 38,000 families a year.

TDH held a safe sleep conference in November 2012 with approximately 125 attendees. TDH staff presented information on safe sleep as requested at meetings and conferences including in November 2012 with 125 participants, in December 2012 with 150 participants, and in March 2013 with about 75 participants.

Since May 2013, all new mothers receive the safe sleep message through the Welcome Baby Project. This project identifies at-risk infants and initiated a home visit for the mothers of those infants. The mothers are then given information on safe sleep and other relevant topics and programs available to them.

Tennessee had 46 participants in the NICHD Safe Sleep Champion Program.

The Child Fatality Review teams reviewed all sleep-related deaths to obtain a better

understanding of the circumstances surrounding the deaths.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Distribute safe sleep educational materials and promotional items.			X	
2. Print safe sleep message on infant WIC vouchers.			X	
3. Distribute cribs to families that do not have access to one.			X	
4. Partner with stores to display the safe sleep floor talkers.			X	
5. Continute to support hospitals to implement a safe sleep policy.			X	X
6. Develop two online training modules; one for daycare providers and one for WIC recipients.			X	X
7. Offer additional trainings for the DOSE program and continue to provide support to first responder agencies that participated in the first training.			X	X
8.				
9.				
10.				

b. Current Activities

TDH has continued to promote the safe sleep message by distributing educational materials to families through many state and community agencies. An infant mortality action team event was held in December 2013 and included many teams working on safe sleep.

TDH partnered with 71 hospitals (including 100% of birthing hospitals) to develop and implement a safe sleep policy; all facilities have agreed to teach safe sleep to their staff and patients and also model safe sleep behavior. Each participating hospital will receive an educational flipchart, enough copies of the "Sleep Baby Safe and Snug" board books for all of their births for a year, educational materials and a certificate signed by the Commissioner of Health.

TDH developed a safe sleep floor talker; these are large stickers to be placed on the floor of the baby aisles in stores.

TDH implemented the Direct On Scene Education (DOSE) program. The DOSE program utilizes first responders to educate families about safe sleep for all infants. First responders provide families with infants safe sleep information and ensure they have a safe sleep environment for their baby.

Radio and television stations statewide will air a safe sleep public service announcement from April - June. The PSA is available at: http://safesleep.tn.gov/media.shtml

Cribs are being provided to the local health departments to distribute to families that cannot afford one.

c. Plan for the Coming Year

TDH will continue to distribute posters, flyers and door hangers promoting infant safe sleep. In addition, the department will continue to distribute other promotional items with a safe sleep message such as onesies and dry erase boards. These materials will continue to be distributed to families through home visiting programs, health departments, clinics, hospitals, day cares, the

Department of Children's Services and other community agencies. TDH will continue to distribute cribs to families that cannot afford one.

TDH will continue to work with retail stores to provide the safe sleep floor talkers. The large stickers have a safe sleep message and will be placed in the baby aisles of stores.

TDH will continue to work with partner hospitals on the implementation of safe sleep policies. All facilities will continue to teach safe sleep and model safe sleep behavior. TDH will continue to provide hospitals that implement a safe sleep policy with educational materials and the "Sleep Baby Safe and Snug" board book.

WIC will continue to distribute the infant vouchers with a safe sleep message on them.

TDH will continue to implement the Welcome Baby project, providing safe sleep information to all new mothers.

TDH will collaborate with Nashville Metro Health Department to host a Direct On Scene Education (DOSE) training for first responders in Nashville, TN. The DOSE program utilizes first responders to educate families about safe sleep for all infants. TDH will continue to provide support (distribute training materials, cribs, etc.) to first responder agencies that participate in this program.

TDH will develop two online training modules; one for daycare providers and one for WIC recipients.

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	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective			25	25	38
Annual Indicator	39.0			38.6	38.5
Numerator	191090			106880	126208
Denominator	489975			276877	327487
Data Source	Department of Education	Department of Education	Department of Education	Office of Coordinated School Health	Department of Health
Is the Data Provisional or Final?				Final	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	38.4	38.2	38	37.8	37.6

Notes - 2013
Data are for 2012-13 school year.

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Data Source: "BMI School Summary Data State and County 2012-13" Available online at: http://www.tn.gov/education/schoolhealth/data_reports/doc/BMI_School_Summary_2012-13.pdf

Notes - 2012
Data are for 2011-12 school year.

Data Source: "A Summary of Weight Status Data
Tennessee Public Schools, 2011-2012 School Year." Available online at:
http://www.tn.gov/education/schoolhealth/data_reports/doc/BMI_Sum_Data_State_Co_2013.pdf

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.

a. Last Year's Accomplishments
Widespread promotion and implementation of the state plan for Nutrition, Physical Activity and Obesity continued and the plan was adopted by numerous community organizations and county health councils. The Tennessee Obesity Taskforce grew to include over 800 individual representatives. Through Eat Well, Play More grants several objectives from the state plan were implemented. Statewide, one new project included creation of a statewide food policy council to implement the objectives of the Eat Well Play More state plan. Local activities included: development of a family meal time media campaign; construction of a downtown fitness trail; training of physicians on evidence-based resources for obesity; special focus in Knox County addressing walking routes to school, food deserts and farm-to-fork initiatives; improvement of concessions and vending in Nashville-Metro parks and recreation facilities; and breastfeeding promotion and referral for physicians.

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 voluntary 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. Facilities receive recognition through a certificate, decals, stickers and website recognition. Gold Sneaker training sessions were available to providers online as well as in person. 275 facilities have earned the Gold Sneaker certification.

The "Breastfeeding Welcomed Here" campaign began statewide, encouraging businesses to sign a pledge and advertise their commitment to breastfeeding mothers and babies. It is the law in Tennessee to permit a mother to breastfeed her child in any location, public or private. However, there are some businesses and employees that may be unaware of this current law. This can cause an awkward and embarrassing situation for the mother that is simply feeding her child. This campaign's aim is for businesses to demonstrate their support for breastfeeding by making a commitment through a pledge, and then displaying a clearly visible window decal.

Two "tool kits" were developed for use at the local level -- a walking trail/track guide and a community garden guide. These guides have been helpful in assuring that such projects focusing on environmental modifications are built for sustainability. Several more tracks, trails and community gardens were proposed through various application processes; these tool kits provide guidance to grantees.

Through partnerships with Parks and Recreation, joint use agreements with schools and

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community facilities were promoted, ensuring citizens have access to safe opportunities to be physically active. A "Joint Use" locator was developed as an online tool so that people have easy access to locating these spaces. Additionally, the locator should bring awareness to the joint use concept, thus hopefully increasing the number of such agreements that are in place.

Project Diabetes, funded at $3 million annually, was focused on the prevention of obesity. Distributed through a competitive grant application, the state awarded 71 contracts for projects aimed at decreasing and preventing obesity. A majority of these projects were at the local level, promoting environmental and systems changes such as increasing access to physical activity and nutritious food, as well as programs aimed at promoting healthy lifestyles. Efforts with State Parks included promotion of the Junior Ranger program, which was available at every state park within the state last year. Junior Ranger is a week long program which emphasizes physical activity and the nutrition needed for a healthy lifestyle, in the outdoors. Run Clubs, established with local middle schools to promote running for all children, were expanded to encompass additional schools and parks for running locations. The Run Club events included Family Fun Runs, to involve the whole family and community in events to promote getting active.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collaborate with the Office of Coordinated School Health on obesity prevention, including assistance with evidence-based health education programs and school health policy.			X	X
2. Collaborate with Department of Education Food Service Program to promote fruit, vegetable, and water consumption.			X	X
3. Encourage child care facilities to enhance nutrition and physical activity policies through the Gold Sneaker initiative.			X	X
4. Partner with local and metropolitan health departments on obesity prevention initiatives.			X	X
5. Increase breastfeeding friendly environments within the health care system.			X	X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Gold Sneaker continues, changing policy around nutrition, physical activity and tobacco in licensed child care facilities. Over 300 facilities have earned the status, reaching over 14,000 children, and an estimated 800 providers and 55,000 family members.

Promotion of the Breastfeeding Welcomed Here campaign continues; currently 192 businesses across the state have taken the pledge, with a goal of 50 new businesses to take the pledge annually. Breastfeeding efforts include provision of training for health care providers in an attempt to increase familiarity and comfort levels to in turn increase the number of mothers initiating and continuing breastfeeding.

Using funding from the CDC chronic disease prevention and school health promotion grant, TDH is partnering with the TN hospital association to assist hospitals in implement practices to promote and support breastfeeding.

Partnerships with Parks and Recreation continue, emphasizing joint use agreements in communities. Over 400 joint use agreements are mapped across the state.

State funded Project Diabetes funding ($2.8 million annually) has been refocused to encompass the Institute of Medicine's Recommendations for Obesity. The state awarded approximately 47 contracts for projects which span a 2-3 year contract period. A majority of these projects are at the local level, and examples include: walking tracks, park programs, school projects, community gardens and breastfeeding initiatives.

c. Plan for the Coming Year

Promotion of the Breastfeeding Welcomed Here campaign will continue, with a goal of a minimum of 50 new businesses which sign up to take the pledge annually. Breastfeeding efforts will include provision of training for physicians and health care providers in an attempt to increase familiarity and comfort levels to in turn increase the number of mothers initiating and continuing breastfeeding. Through a partnership with the Tennessee Hospital Association, we will increase the number of breast feeding friendly facilities through the implementation of at least 5 of the 10 steps to successful breast feeding within birthing facilities across the state.

Gold Sneaker will continue to be promoted, and the state plans to increase the number of Gold Sneaker facilities by at least 50 facilities annually. The Gold Sneaker program will continue to be updated, based on feedback from child care providers.

Partnerships with Parks and Recreation will continue, emphasizing joint use agreements with schools and community facilities and ensuring citizens have access to safe opportunities to be physically active. Joint use agreements will be promoted through local county health councils and school boards. To increase the percent of youth and adults walking, policies, practices and strategies will be developed that communities can adopt, including education for community leaders, to increase the proportion of people who are physically active.

Efforts with State Parks will include promotion of the Junior Ranger program, encouraging children to get outside and play. Run Clubs, established with local middle schools to promote running for all children, will be expanded to encompass additional schools and parks for running locations. State Park restaurants will undergo an assessment of current practices to identify ways to implement healthier food service guidelines and therefore menu offerings.

State funded Project Diabetes grants will continue.

A partnership with the Department of Education will result in promotion of food service guidelines within the schools, as well as quality physical activity throughout the school day. Professional development on marketing and resources for these promotions will be provided. Focus will be on accessible water for all students throughout the day, and increasing fruit and vegetable consumption.

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	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective			20	20	20
Annual Indicator	15.0	21.7	23.6	25.2	
Numerator	12257	245470	269595	278516	
Denominator	81888	1130950	1141863	1105002	

Data Source	Department of Health	Department of Health	Department of Health	Department of Health	
Is the Data Provisional or Final?				Final	
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	19	19	18	18	18

Notes - 2013
Data from 2013 not yet available.

Notes - 2012
Data source: Tennessee Department of Health; Division of Policy, Planning and Assessment; Office of Health Statistics; Behavioral Risk Factor Surveillance System (BRFSS). Analysis limited to women aged 18-44 years. Smoking is defined as smoking within the past 30 days (i.e. current smoking).

Due to changes in BRFSS methodology implemented in 2011, estimates for 2011 and after cannot be compared to those from earlier years. Any shifts in estimates from previous years to 2011 may be the result of the new methodology and not a true change in the population.

Notes - 2011
Data Source: Behavioral Risk Factor Surveillance System (BRFSS).

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.

A media campaign promoted the Tennessee Tobacco Quitline. Target populations were all smokers in TN, including women of childbearing age. Enhanced quitline services through web based counseling were offered. 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. Continue the media campaign targeting 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. Support the Anti-Tobacco Advocacy Initiative to educate and inform all citizens about issues related to tobacco prevention, and availability of QuitLine services.			X	
3. Provide the Tobacco QuitLine to offer cessation counseling services to all callers within the State of Tennessee.		X	X	
4. 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.			X	X
5. Provide education on the dangers of smoking and referrals to	X	X		

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the Tobacco QuitLine through WIC.				
6. Utilize tobacco settlement funding to support community-based activities that will reduce smoking among women of childbearing age.	X		X	
7.				
8.				
9.				
10.				

b. Current Activities

The "Jenny Smokes" Campaign has continued across the state. The Bingham Group Inc., provided advertising space on one billboard in 8 counties for 4 consecutive months utilizing the the Jenny Smokes campaign.

Tobacco Settlement funding being spent in 50+ counties on the Baby and Me Tobacco Free project. This project provides prenatal counseling for smoking cessation and the mother can receive vouchers for diapers if she remains smoke-free after the baby is born.

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

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

TennCare provides tobacco cessation treatment to all its enrollees. The MCOs promote the QuitLine, especially to those patients who identify as being pregnant.

The WIC Program educates all prenatal, postpartum and breastfeeding women on smoking cessation information and provides the Tobacco QuitLine number.

Home Visiting programs provide education and information about the effects of secondhand smoke to parents and family members and promote the Tobacco QuitLine.

c. Plan for the Coming Year

The Tennessee Anti-Tobacco Advocacy Initiative will host and maintain an interactive website for local, state and national news and data related to tobacco control, position statements and/or talking points on state or national tobacco related policy issues, tobacco related poll results, and links to national tobacco control organizations including, the Campaign for Tobacco-Free Kids and Americans for Non-Smokers' Rights.

By October of each year The Anti-Tobacco Advocacy Initiative will present tobacco control advocacy spokesperson trainings in each of the three (3) grand divisions of the State. Trainings will provide information on effective advocacy methods and will build a network of community advocates who will campaign for tobacco control policy at the local, regional and state levels. Following each grand division trainings, advocacy spokespersons will implement at least two (2) advocacy activities.

The Tennessee Anti-Tobacco Advocay Initiative continues public relations campaign involving routine and strategic activities designed to educate the public about the dangers of secondhand smoke exposure, promote the elimination of secondhand smoke exposure, promote support of tobacco control policies and sustainability of tobacco use prevention and cessation funding among the general public and decision makers, and educate the public about the continued need for policy such as the Non-Smokers Protection Act.

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Tobacco Settlement Funding will continue to be used to provide sevices to women who smoke.

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. All TennCare patients are now offered covered tobacco cessation services.

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.

The Home Visiting Program will continue to receive educational material about the effects of secondhand smoke as it relates to infants, children, parents and family members.

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	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective			20	1700	1750
Annual Indicator	220.5	1,827.0	1,828.1	1,894.0	
Numerator	1070	6007	5928	6141	
Denominator	485318	328797	324270	324238	
Data Source	Department of Health	Department of Health	Department of Health	Department of Health	
Is the Data Provisional or Final?				Final	
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	1850	1825	1800	1775	1750

Notes - 2013
Because 2013 population estimates are not available at this time, we are currently unable to report this indicator. Also, provisional 2013 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 - 2012
Data sources: TDH Office of Health Statistics Hospital Discharge Data System and 2012 US Census

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Notes - 2011
Data sources: TDH Office of Health Statistics Hospital Discharge Data System and 2012 US Census

a. Last Year's Accomplishments
TDH staff provided asthma management presentations at several conferences targeting early child care educators and staff across Tennessee.

MCH sponsored regional health representatives to attend Vanderbilt's 4th annual Pediatric Asthma Education Conference. Sponsored attendees were then required to work with regional Children's Special Services (CSS) coordinators to increase enrollment of children ages 1-4 with an asthma diagnosis. Young children in this age group have the highest prevalence of (ED) visits in Tennessee. The goal was to increase the population of young children with asthma who are being served by the CSS program and ultimately to impact the ED visit rate in the same population. Monthly webinars were facilitated and were designed to be both educational and to provide time and a platform to provide technical assistance for regional staff.

At professional Grand Round presentations for physicians and other clinical staff, participants were encouraged to partner with community agencies such as Not One More Life (NOML) asthma screening and education programs in Memphis, Chattnooga and Knoxville.

TDH distributed asthma awareness and management messages via the Department's Twitter and Facebook accounts during the annual Child Health Week celebration.

TDH maintained an asthma page on the Department's web site.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Support local and regional health department staff in their work with community partners to reduce the burden of asthma.			X	X
2. Provide asthma training and technical assistance as requested.			X	X
3. Promote the Tennessee Tobacco QuitLine, as cigarette smoke is a well-established asthma trigger.			X	
4. Promote smoke-free childcare campuses through the Gold Sneaker program.			X	X
5. Include asthma awareness and education messages in TDH's annual Child Health Week event.			X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities
MCH again sponsored the Vanderbilt Pediatric Asthma Education Conference by supporting the attendance of regional health department MCH staff. The MCH Director provided introductory remarks at the conference.

The asthma initiative director is providing technical assistance and training related to asthma, secondhand smoke and third-hand smoke to childcare providers, home visitors and tobacco settlement projects as appropriate.

The asthma initiative director provided a report TDH asthma-related activities with recommendations for activities and future goals.

The MCH director is beginning conversations with provider organizations and payers about population-level initiatives that might be implemented in order to reduce the burden of asthma among Tennessee children.

TDH continues to promote use of the Tobacco QuitLine, as cigarette smoke is a known trigger for asthma exacerbations. Staff also promote smoke-free childcare campuses through the Gold Sneaker recognition for licensed child care centers.

c. Plan for the Coming Year

TDH staff will continue to provide asthma education and technical assistance to home visitors, tobacco settlement teams, county level wellness committees, program staff, professional groups and others as needed in the form of presentations, consults, print materials, teleconferences, webinars or by other appropriate means as identified.

MCH will continue to sponsor attendance of health department employees at Vanderbilt's annual Pediatric Asthma Education Conference.

Staff will continue to promote use of the Tobacco QuitLine, as cigarette smoke is a known trigger for asthma exacerbations.

Staff will work with licensed child care facilities to obtain Gold Sneaker recognition. One of the criteria for this recognition is that the child care center agrees to maintain a smoke-free campus 24 hours a day, 7 days a week. Elimination of secondhand smoke in these environments should help reduce asthma exacerbations among young children.

TDH will include asthma awareness and education messages in the Department's annual celebration of 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	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective			0	0	140
Annual Indicator					
Numerator				134	173
Denominator					
Data Source				Department of Health	Department of Health
Is the Data Provisional or Final?				Final	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	180	190	200	200	200

Notes - 2013

Data Source: The State MCH Director maintains a log of which staff in the Central Office and in the regions have completed a self-assessment and a module in the Navigator.

Notes - 2012
Data Source: The State MCH Director maintains a log of which staff in the Central Office and in the regions have completed a self-assessment and a module in the Navigator.

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

a. Last Year's Accomplishments
The state MCH Director worked with 70 Central Office staff to complete a self-assessment (either the Council on Linkages Public Health Leadership Self-Assessment or the MCH Leadership Competencies Self-Assessment). Based on the results of the self-assessment, each staff member then worked with his/her supervisor to identify at least one activity for completion in the MCH Navigator system.

All thirteen regional MCH Directors were introduced to the MCH Navigator system on a conference call. Specific applications related to workforce development were discussed. All regional MCH Directors were asked to complete one of the self-assessment tools and then, based on the results of the self-assessment, identified at least one activity for completion in the MCH Navigator system. Regional MCH Directors also worked with regional MCH program leadership to help them complete a self-assessment and Navigator module. A total of fifty-nine regional staff completed the assessment and a module.

The State MCH Director worked with Laura Kavanagh and Holly Grason to present a workshop at AMCHP on integrating core competency self-assessments and MCH Navigator modules into MCH professional development. The Director also recorded two instructional videos that are housed on the MCH Navigator site.

MCH partnered with the University of Tennessee-Knoxville, a HRSA training grant recipient, to provide cultural competency training to regional MCH leadership across the state.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. All new MCH staff will complete the MCH Core Competency Self-Assessment and based on the results of the self-assessment complete at least one module in the MCH Navigator.				X
2. The State MCH Director will convene regular conference calls with the Regional MCH Directors, with each call focusing on one of the state MCH priorities.				X
3. Promote the East Tennessee State University LIFEPATH (Long Distance Internet Facilitated Educational Program for Applied Training in Health), Tennessee's public health training center.				X
4. Offer practicum opportunities to MPH and other public health students.				X
5. Participate in the AMCHP Workforce Development Committee.				X
6.				
7.				
8.				
9.				
10.				

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b. Current Activities
All new Family Health and Wellness (FHW) staff in the Central Office complete the self-assessment and a relevant Navigator module. Regional MCH/FHW leadership and program staff are also encouraged to use the self-assessment and Navigator modules with new field staff.

Navigator modules have been built into the standard orientation for all new Central Office MCH staff.

The State MCH Director has convened regular (usually monthly) conference calls with the Regional MCH Directors. The calls provide a venue for sharing updates and information between regions; each call also offers an opportunity to present information on one of the seven state MCH priorities.

FHW continues to promote participation in LIFEPATH, East Tennessee State University's Long-Distance Internet Facilitated Educational Program for Applied Training in Health (Tennessee's first and only public health training centers). Staff can take advantage of certificate and degree programs as well as non-academic learning opportunities.

FHW continues to offer practicum experiences for students in MPH or related public health programs.

The State MCH Director participates on the AMCHP Workforce Development Committee and has co-authored a paper (with Title V directors from OK and MD) on use of the Navigator in state MCH programs (to appear in an upcoming edition of the MCH Journal).

FHW is hosting a CDC/CSTE Epidemiology fellow (focusing on the Title V Needs Assessment) and a CDC PHAP (focusing on injury prevention).

c. Plan for the Coming Year
All new Family Health and Wellness (FHW) staff in the Central Office will continue to complete the MCH Core Competency Self Assessment, and based on the results of the self-assessment will complete at least one relevant module in the MCH Navigator. Regional MCH/FHW leadership and program staff will also be encouraged to use the self-assessment and Navigator modules with new field staff.

MCH Orientation modules (on the Navigator) will continue to be used as part of the standard orientation for all new Central Office MCH staff.

The State MCH Director will continue to convene regular (usually monthly) conference calls with the Regional MCH Directors. The calls provide a venue for sharing updates and information between regions; each call also offers an opportunity to present information on one of the seven state MCH priorities.

The Division of Family Health and Wellness will continue to promote participation in LIFEPATH, East Tennessee State University's Long-Distance Internet Facilitated Educational Program for Applied Training in Health (Tennessee's first and only public health training centers). Staff can take advantage of certificate and degree programs as well as non-academic learning opportunities.

The Division of Family Health and Wellness will continue to offer practicum experiences for students in MPH or related public health programs.

The State MCH Director will continue to participate in the AMCHP Workforce Development Committee.

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The Division of Family Health and Wellness will continue to pursue opportunities to host fellows (such as CDC/CSTE Epidemiology Fellows and CDC PHAP associates).

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	2009	2010	2011	2012	2013
Annual Performance Objective			45	45	45
Annual Indicator	39.6	39.6		15.3	19.7
Numerator	34477	34477		125	481
Denominator	87141	87141		817	2441
Data Source	CSHCN Survey	CSHCN Survey		TDH PTBMIS	TDH PTBMIS
Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	55	55	60	60	60

Notes - 2013
The data for this form was taken from the TDH Patient Tracking Billing Management Information System (PTBMIS). The denominator is the total number of individuals on the Children's Special Servives (CSS) program age 14 and older. The numerator is the number of transition plans that have been conducted.

Notes - 2012
The data for this form was taken from the TDH Patient Tracking Billing Management Information System (PTBMIS). The denominator is the total number of individuals on the Children's Special Servives (CSS) program age 14 and older. The numerator is the number of initial transition plans that have been conducted since the policy and form was approved February 13, 2013.

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

a. Last Year's Accomplishments
The transition standards and policy was approved and local CSS program staff conducted transition planning at the initial application and annual re-certification for all participants age 14 and older.

CSS program participants age 14 and older received formal transition discussion and planning. The portable Health History Summary Form was included as part of the transition planning.

Transition training was conducted with all regional and local CSS program staff.

A Transition work group was formed worked to develop a transition guideline work book to assist parents and youth in the development of the transition plan.

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

CSS program participants age 14 and older received formal transition discussion and planning.

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The portable Health History Summary Form was included as part of the transition planning.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Complete Portable Health History Form for all participants 14 years of age and older.	X	X		
2. Complete Transition Plan for all participants 14 years of age and older.	X	X		
3. Provide training for CSS Care Coordinators on conducting transition planning meeting with families and CYSHCN.		X	X	X
4. Collaborate with state agencies, work groups, and advisory committees for transition policy development that is inclusive of health planning.		X	X	X
5. Provide additional training and development opportunities for CSS staff around transition issues for CYSHCN.		X	X	X
6. Develop additional transition resources and materials including a Guide to Transition and brochures.			X	
7. Continue to provide community resource guide to CSS staff and make available to other partners and agencies.			X	X
8. Assist with all appropriate referrals for CYSHCN.			X	X
9. Work with families and local providers to ensure transitional aged CYSHCN have a medical home.		X	X	X
10.				

b. Current Activities

Care coordination training continues to be provided on transition planning for CYSHCN. CSS program staff continues to utilize the American Academy of Pediatrics emergency preparedness guidelines for children and youth with special health care needs as part of the individualized transition plan and continues to partner with pediatric providers to locate adult providers for CYSHCN who are aging off the program.

CSS program staff target all participants 14 years of age and older and 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 program staff provide a portable health history summary form to all participants age 14 and older that includes pertinent health care information and can be utilized when participants transition to adult health care providers.

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

CYSHCN staff continue collaborating with the local FQHCs to develop a pilot transition from pediatric to adult health care project.

Training continues throughout the state on the standards and requirements for conducting transition planning with CSS program participants.

c. Plan for the Coming Year

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The CYSHCN director will continue to collaborate with Family Voices, TPSF and 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. Collaboration with these agencies to develop a statewide policy regarding transition will continue where feasible.

The American Academy of Pediatrics Emergency Preparedness Guidelines will be used as a resource for the transition plan for CYSHCN.

National developments regarding transition standards and best practices will continue to be monitored, and those initiatives will be incorporated into the CSS program where feasible.

Professional development and training of staff on transition issues will continue.

An evaluation will be developed to determine the impact of transition planning, to ascertain the participants' satisfaction and the success of individualized transition planning and to determine any gaps/barriers and challenges that may exist.

The CYSHCN director is collaborating with the Tennessee Pediatric Society Foundation (TPSF) to develop a transition toolkit that will provide resources and supports to youth with special health care needs and their families as they transition to adult health care services.

TPSF will develop and conduct a Transition Summit. Families will be invited to participate as speakers and provide information on their personal transition experience. The conference will focus on medical transition from pediatric to adult providers and the provider community will also provide breakout sessions on the elements of successful transition.

CSS program staff will continue to develop transition plans for all participants age 14 and older and will work with the local health care providers to ensure that participants transition to an adult medical provider.

CYSHCN staff will continue to explore the possibility of a pilot transition model that can be developed as a standard for transition CYSHCN from pediatric to adult health care providers.

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	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective			14	18.5	16
Annual Indicator	19.0	19.7	16.9	17.7	
Numerator	376	398	342	360	
Denominator	1974006	2023349	2025215	2038481	
Data Source	Department of Health	Department of Health	Department of Health	Department of Health	
Is the Data Provisional or Final?				Final	
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	17.5	17.5	17	17	16.5

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Notes - 2013
Because 2013 population estimates are not available at this time, we are currently unable to report this indicator. Also, provisional 2013 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 - 2012
Data sources: TDH Office of Health Statistics Death Statistical System and 2012 US Census

Notes - 2011
Data sources: TDH Office of Health Statistics Death Statistical System and 2011 US Census

a. Last Year's Accomplishments
The Tennessee Injury and Violence Prevention Program (TIVPP) held the Injury Prevention 101 and 102 training in July 2013 where 35 professionals received training on policy and core competencies for prevention. TVIPP coordinated "Battle of the Belt," a program to encourage competition among 9 high schools for improvements in seatbelt usage among students. TVIPP also partnered with home visiting programs administered by the Department of Health to provide safety messaging and injury prevention materials to home visitors. Childproofing kits were provided to 3200 families participating in the home visiting program.

The Poison Center distributed 504,569 pieces of information on poisoning prevention through health fairs and conference exhibits. They conducted 151 direct presentations impacting 8,193 individuals. In addition, the Tennessee Department of Environment and Conservation (TDEC) and the Department of Health collaborated to place 50 new secure drug drop off bins throughout the state. These bins will allow families easier access to disposing of drugs and therefore, make drugs less accessible to children.

The Tennessee Department of Health distributed information on safe sleep to prevent injuries to infants (specifically, sleep-related deaths). The Department provided 254 cribs to the local health departments to distribute to families that cannot afford one.

The Department has also provided 600 smoke detectors for home visiting families that did not have a working smoke detectors and 350 Home Safety Kits to prevent child home injury.

The Tennessee Department of Health provided funding to 32 community agencies to purchase and distribute child safety seats. Many agencies and health departments conducted child safety seat check events; these events allowed parents to have their child safety seat checked for correct installation.

In April 2013, Tennessee passed a sports concussion law designed to reduce youth sports concussions and increase awareness of traumatic brain injury. TDH injury prevention staff collaborated with other departments to review and choose appropriate educational materials for coaches to utilize.

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 TDEC to install and promote the locations of secure medication drop off bins.			X	

4. Collaborate with the Poison Control Center to distribute poisoning prevention materials.		X	X	X
5. Collaborate with the Department of Education and the Trauma Centers to get more high schools involved with the Battle of the Belt Program and do more motor vehicle safety presentations in schools.			X	
6. Promote safe sleep education.		X	X	
7. Create awareness through the Count it, Lock it, Drop it awareness campaign.				X
8.				
9.				
10.				

b. Current Activities
The TVIPP held the Injury Prevention 101 and 102 training in July 2013. TVIPP coordinated the "Battle of the Belt," competition among 28 high schools to improve seatbelt usage. TVIPP also partnered with the Governor's Highway Safety Office to promote the reducetncrashes.org website that highlights activities motor vehicle prevention efforts in schools.

The Poison Center distributed 100,311 educational materials on poisoning prevention through events and conference exhibits. The TN Department of Environment and Conservation (TDEC) has placed drug drop off bins in the state. Health Department staff have partnered to promote box locations and free incineration.

TDH provided 600 locked medicine boxes to reduce child poisoning in the home.

TDH distributed information on safe sleep to reduce sleep-related deaths. Fire and EMS departments in nine counties were trained to identify unsafe sleep enviorments. TDH also provided intentives to hospitals to create safe sleep policies and 100% of birthing hospitals agreed to develop and implement a policy. Cribs were distributed to local health departments to distribute to families that cannot afford one.

TVIPP also partnered with TDH home visiting programs to provide safety messaging and injury prevention materials to home visitors.

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. TDH will also continue to fund community agencies to purchase and distribute child safety seats. TVIPP will also partner with TDH home visiting programs to provide safety messaging and injury prevention materials to home visitors.

The Poison Center will continue to distribute information on poisoning prevention through health fairs and conference exhibits. TDH will be creating awareness of prescription drug abuse prevention through the "count it, lock it, drop it" campaign. This campaign teaches the community to count their pills to prevent theft, lock them up when in the home and dispose of them when no longer needed to reduce access to children and others.

A Prescription Drug Abuse Prevention Conference is scheduled for October 2014 with a goal of reducing overdose fatalities.

TDH will continue to distribute information, including posters, flyers and door hangers on safe

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sleep to prevent injuries to infants (specifically, sleep-related deaths). TDH will continue to partner with the birthing hospitals to implement safe sleep policies in the hospitals. TDH will expand first responder agencies participating in the Direct On Scene Education (DOSE) program to educate families about safe sleep.

E. Health Status Indicators

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01A - Multi-Year Data

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Indicator	9.2	9.0	9.0	9.2	9.1
Numerator	7535	7166	7169	7359	7233
Denominator	82080	79305	79426	80151	79227
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2013
Data source: TDH Office of Health Statistics Birth Statistical System

Notes - 2012
Data source: TDH Office of Health Statistics Birth Statistical System

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

Narrative:
The percentage of live births weighing less than 2,500 grams has remained relatively stable over the past five years. A number of programs and initiatives support efforts to improve 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.

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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. 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.

In 2013, TDH partnered with the Tennessee Hospital Association, the March of Dimes, and the Tennessee Initiative for Perinatal Quality Care to promote the "Tennessee Healthy Babies Are Worth the Wait" campaign. All birthing hospitals have signed a "hard-stop" pledge related to reducing early elective deliveries. Among participating hospitals, the early elective delivery rate dropped from 15% at baseline to consistently below 3% as of November 2013. TDH vital statistics data have been used to validate the hospital data; birth certificate data show that over the past few years there has been a decline in deliveries at 37-38 weeks, a rise in deliveries at 39+ weeks, and no real change in deliveries <37 weeks.

While much effort has been put into improving this indicator (and in HSI 01B, 02A, and 02A), the data trends illustrate 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 Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01B - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Indicator	7.5	7.4	7.4	7.5	7.5
Numerator	5961	5688	5656	5784	5749
Denominator	79491	76812	76897	77563	76787
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2013
Data source: TDH Office of Health Statistics Birth Statistical System

Notes - 2012
Data source: TDH Office of Health Statistics Birth Statistical System

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

Narrative:
The percentage of live singleton births weighing less than 2,500 grams has remained relatively stable since 2009. See narrative for HSI 01A for an explanation of this indicator.

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

Health Status Indicators Forms for HSI 02A - Multi-Year Data

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Indicator	1.7	1.6	1.5	1.6	1.6
Numerator	1371	1245	1189	1254	1306
Denominator	82080	79305	79426	80151	79227
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2013
Data source: TDH Office of Health Statistics Birth Statistical System

Notes - 2012
Data source: TDH Office of Health Statistics Birth Statistical System

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

Narrative:
The percentage of live births weighing less than 1,500 grams has remained relatively stable since 2009. See narrative for HSI 01A for an explanation of this indicator.

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

Health Status Indicators Forms for HSI 02B - Multi-Year Data

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Indicator	1.3	1.2	1.2	1.2	1.3
Numerator	1068	950	957	960	984
Denominator	79491	76812	76897	77563	76787
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2013
Data source: TDH Office of Health Statistics Birth Statistical System

Notes - 2012
Data source: TDH Office of Health Statistics Birth Statistical System

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

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Narrative:
The percentage of live singleton births weighing less than 1,500 grams has remained relatively stable since 2009. See narrative for HSI 01A for an explanation of this indicator.

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

Health Status Indicators Forms for HSI 03A - Multi-Year Data

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Indicator	7.9	10.3	9.6	7.9	
Numerator	95	127	119	98	
Denominator	1207621	1238935	1237679	1241590	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

Notes - 2013
Because 2013 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 - 2012
Data sources: TDH Office of Health Statistics Death Statistical System and 2012 US Census

Notes - 2011
Data sources: TDH Office of Health Statistics Death Statistical System and 2011 US Census

Narrative:
The rate of injury fatalities among children 14 years and younger has fluctuated since 2009; 2013 data are not available at the time of this submission because population estimates for 2013 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); and the Tennessee Poison Center (statewide educational efforts and operation of toll-free call center).

TDH continues to support 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

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Alone, on their Back, and in a Crib. The campaign has recently been expanded to include a hospital project to promote safe sleep education and the modeling of correct safe sleep practices by health care providers.

Health Status Indicators 03B: *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 03B - Multi-Year Data

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Indicator	2.7	2.5	3.7	1.7	
Numerator	33	31	46	21	
Denominator	1207621	1238935	1237679	1241590	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

Notes - 2013
Because 2013 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 - 2012
Data sources: TDH Office of Health Statistics Death Statistical System and 2012 US Census

Notes - 2011
Data sources: TDH Office of Health Statistics Death Statistical System and 2011 US Census

Narrative:
The rate of motor vehicle fatalities for children 14 and younger flucutated from 2009-2012. 2013 data are not available at the time of this submission because population estimates for 2013 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.

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The Division of Family Health and Wellness 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 Indicators 03C: *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 03C - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Indicator	24.6	23.4	20.8	22.8	
Numerator	208	202	181	200	
Denominator	846897	863430	868312	876624	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

Notes - 2013
Because 2013 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 - 2012
Data sources: TDH Office of Health Statistics Death Statistical System and 2012 US Census

Notes - 2011
Data sources: TDH Office of Health Statistics Death Statistical System and 2011 US Census

Narrative:
The rate of motor vehicle fatalities for youth aged 15 through 24 declined from 2009 to 2012. 2013 data are not available at the time of this submission because population estimates for 2013 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.

In 2013, the State Child Fatality Review Team made reduction of teen motor vehicle fatalities one of its recommendations to the Governor and General Assembly. TDH staff are working with partners from the Office of Coordinated School Health to implement school-based educational programs to reduce these fatalities.

TDH staff have partnered with the Office of Coordinated School Health and the regional trauma centers to implement the "Battle of the Belt" program. Participating schools conduct a pre-intervention audit to see how many students are wearing their seatbelts when they drive to school. Then, a student-led group develops an educational campaign and conducts various educational activities throughout the year. A post-intervention audit is performed at the end of the year and schools are awarded prizes for the most creative educational campaign and the greatest improvement in seatbelt usage.

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

Health Status Indicators Forms for HSI 04A - Multi-Year Data

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Indicator	12,487.9	11,867.8	12,007.7	12,066.2	
Numerator	150807	147034	148617	149813	
Denominator	1207621	1238935	1237679	1241590	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

Notes - 2013
Because 2013 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 - 2012
Data sources: TDH Office of Health Statistics Hospital Discharge Data Sysytem and 2012 US Census

Notes - 2011
Data sources: TDH Office of Health Statistics Hospital Discharge Data Sysytem and 2011 US Census

Narrative:
The rate of nonfatal injuries among children younger than 14 fluctuated from 2009-2012. 2013 data are not available at the time of this submission because population estimates for 2013 are not available. See narrative for HSI 03A for an explanation of this indicator.

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

Health Status Indicators Forms for HSI 04B - Multi-Year Data

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Indicator	718.6	674.1	662.4	679.2	
Numerator	8678	8352	8198	8433	
Denominator	1207621	1238935	1237679	1241590	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

Notes - 2013
Because 2013 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 - 2012
Data sources: TDH Office of Health Statistics Hospital Discharge Data Sysytem and 2012 US Census

Notes - 2011
Data sources: TDH Office of Health Statistics Hospital Discharge Data Sysytem and 2011 US Census

Narrative:
The rate of nonfatal injuries due to motor vehicle crashes among children under age 14 fluctuated from 2009 to 2012. 2013 data are not available at the time of this submission because population estimates for 2013 are not available. See narrative for HSI 03B for an explanation of this indicator.

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

Health Status Indicators Forms for HSI 04C - Multi-Year Data

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Indicator	3,028.5	2,886.5	2,814.8	2,803.9	
Numerator	25648	24923	24441	24580	
Denominator	846897	863430	868312	876624	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

Notes - 2013
Because 2013 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.

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Notes - 2012
Data sources: TDH Office of Health Statistics Hospital Discharge Data Sysytem and 2012 US Census

Notes - 2011
Data sources: TDH Office of Health Statistics Hospital Discharge Data Sysytem and 2011 US Census

Narrative:
The rate of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 declined from 2009-2012. 2013 data are not available at the time of this submission because population estimates for 2013 are not available. See narrative for HSI 03C for an explanation of this indicator.

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

Health Status Indicators Forms for HSI 05A - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Indicator	42.1	38.8	40.2	39.4	34.1
Numerator	8815	8210	8511	8334	7221
Denominator	209417	211540	211482	211484	211563
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2013
Data Source: Tennessee STD Program Surveillance Morbidity Database which is the Communicable Disease Surveillance System

Notes - 2012
Data Source: Tennessee STD Program Surveillance Morbidity Database which is the Communicable Disease Surveillance System

Notes - 2011
Data Source: Tennessee STD Program Surveillance Morbidity Database which is the Communicable Disease Surveillance System

Narrative:
Chlamydia rates among 15-19 year olds declined from 2009 to 2013. 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.

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

Health Status Indicators Forms for HSI 05B - Multi-Year Data

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Indicator	11.8	11.4	12.6	13.2	12.8
Numerator	12300	11862	13174	13885	13502
Denominator	1044578	1044145	1047577	1051386	1055630
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2013
Data Source: Tennessee STD Program Surveillance Morbidity Database which is the Communicable Disease Surveillance System

Notes - 2012
Data Source: Tennessee STD Program Surveillance Morbidity Database which is the Communicable Disease Surveillance System

Notes - 2011
Data Source: Tennessee STD Program Surveillance Morbidity Database which is the Communicable Disease Surveillance System

Narrative:
Chlamydia rates among 20-44 year olds fluctuated between 2009 and 2013. See narrative for HSI 05A for an explanation of this indicator.

Health Status Indicators 06A: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY RACE	Total All Races	White	Black or African American	American Indian or Native Alaskan	Asian	Native Hawaiian or Other Pacific Islander	More than one race reported	Other and Unknown
Infants 0 to 1	79733	56612	17540	0	0	0	0	5581
Children 1 through 4	324238	235157	66627	0	0	0	0	22454
Children 5 through 9	414823	307343	81163	0	0	0	0	26317
Children 10 through 14	422796	315216	85521	0	0	0	0	22059
Children 15 through 19	421428	310840	91946	0	0	0	0	18642
Children 20	455196	340029	96562	0	0	0	0	18605

through 24								
Children 0 through 24	2118214	1565197	439359	0	0	0	0	113658

Notes - 2015
Data Source: 2012 US Census

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

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

HSI #06B - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	71489	8244	0
Children 1 through 4	291908	32330	0
Children 5 through 9	378766	36057	0
Children 10 through 14	395008	27788	0
Children 15 through 19	396827	24601	0
Children 20 through 24	427640	27556	0
Children 0 through 24	1961638	156576	0

Notes - 2015
Data Source: 2012 US Census

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

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

HSI #07A - Demographics (Total live births)

CATEGORY Total live births	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Women < 15	89	52	35	0	1	1	0	0
Women 15 through 17	2117	1403	687	5	5	5	0	12
Women 18 through 19	5772	3995	1697	14	23	7	0	36
Women 20 through 34	63665	48621	12833	96	1320	144	0	651
Women 35	8539	6720	1306	16	384	23	0	90

or older								
Women of all ages	80182	60791	16558	131	1733	180	0	789

Notes - 2015
Data Source: TDH Office of Health Statistics Birth Statistical System.
*Note: Does not include 20 women who were missing data on maternal age and could not be categorized into age sub-groups.

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

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

HSI #07B - Demographics (Total live births)

CATEGORY Total live births	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Women < 15	76	13	0
Women 15 through 17	1920	197	0
Women 18 through 19	5294	478	0
Women 20 through 34	58250	5383	32
Women 35 or older	7628	906	5
Women of all ages	73168	6977	37

Notes - 2015
Data Source: TDH Office of Health Statistics Birth Statistical System.
*Note: Does not include 20 women who were missing data on maternal age and could not be categorized into age sub-groups.

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

Health Status Indicators 08A: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

CATEGORY Total deaths	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	576	357	200	1	4	0	0	14
Children 1 through 4	110	79	27	1	1	0	0	2

Children 5 through 9	48	36	12	0	0	0	0	0
Children 10 through 14	51	35	14	0	1	0	0	1
Children 15 through 19	285	204	78	0	1	0	0	2
Children 20 through 24	424	298	122	0	2	0	0	2
Children 0 through 24	1494	1009	453	2	9	0	0	21

Notes - 2015
Data Source: TDH Office of Health Statistics Death Statistical System

Narrative:
Deaths of all children age 17 and under in Tennessee are reviewed as part of the State's Child Fatality Review process, which is mandated in statute. Local child fatality review teams in 31 judicial districts review deaths and make recommendations to the State Team, which compiles aggregate data and makes recommendations to the Governor and General Assembly. 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. In FY14-15, FIMR will expand to include one additional metro region (Knox County).

Health Status Indicators 08B: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)*

HSI #08B - Demographics (Total deaths)

CATEGORY Total deaths	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	543	26	7
Children 1 through 4	103	7	0
Children 5 through 9	46	2	0
Children 10 through 14	47	4	0
Children 15 through 19	275	9	1
Children 20 through 24	413	10	1
Children 0 through 24	1427	58	9

Notes - 2015
Data Source: TDH Office of Health Statistics Death Statistical System

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

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

HSI #09A - Demographics (Miscellaneous Data)

CATEGORY Misc Data BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**	**Specific Reporting Year**
All children 0 through 19	1663018	1225168	342797	0	0	0	0	95053	2012
Percent in household headed by single parent	31.1	23.0	61.8	100.0	0.0	0.0	21.6	0.0	2013
Percent in TANF (Grant) families	5.4	3.5	13.4	0.0	0.0	0.0	0.0	0.8	2013
Number enrolled in Medicaid	702794	372619	219400	859	8462	0	0	101454	2013
Number enrolled in SCHIP	19309	13455	2276	33	434	0	0	3111	2013
Number living in foster home care	6215	4448	1566	23	10	7	0	161	2013
Number enrolled in food stamp program	552051	351189	192849	874	4734	906	1499	0	2013
Number enrolled in WIC	207933	145757	57199	426	1739	146	0	2666	2013
Rate (per 100,000) of juvenile crime arrests	1711.0	1121.0	4208.0	0.0	0.0	0.0	0.0	358.0	2012
Percentage of high school drop-outs (grade 9 through 12)	5.0	3.5	9.4	7.0	2.6	2.4	5.7	0.0	2013

Notes - 2015
Data Source (All children 0 through 19): 2012 US Census

Data Source (Percent in household headed by single parent): The Current Population Survey (CPS) Annual Social and Economic Supplement Table Creator (http://www.census.gov/cps/data/cpstablecreator.html)

Numerator: Number of children aged 0-19 living in single male/female-headed primary families, no spouse present.

Denominator: Total number of children aged 0-19 living in primary families (inc. single male/female-headed and married couple families).

Data Source (Percent in TANF (Grant) Families): Tennessee Department of Human Services. Number of enrollees provided by Department of Human Services and then divided by total number of children 0-19 (from first line of this form, obtained from US Census). Census data not available for racial categories other than "White" or "Black or African American," so the other categories are grouped together under "Other and unknown."

Data Source (Number enrolled in Medicaid): Bureau of TennCare (Medicaid); TennCare office data effective as of September 2013.

Data Source (Number enrolled in SCHIP): Tennessee SCHIP (CoverKids) Program

Data Source (Number enrolled in food stamp program): Tennessee Department of Human Services

Data Source (Number enrolled in WIC): Tennessee Department of Health, Division of Family Health and Wellness, WIC Program. Note: Of the 207,933 children reported, 5,291 reported more than once race; however, these are included in the other categories.

Data Sources (Rate per 100,000 of juvenile crime arrests): TBI Tennessee Crime Statistics Online (accessed 4/29/2014 at http://www.tbi.state.tn.us/tn_crime_stats/crime_stats_online.shtml) and 2012 US Census.

Numerator: Number of juvenile arrests for group A (violent) and group B (nonviolent) offenses in 2012; restricted to residents. Data source: TBI Tennessee Crime Statistics Online. Other/unknown race = Asian, Native American/Alaskan Native and unknown race. Juvenile is defined as <18 years old (TBI does not provide crime data on 0-19 years age group).

Denominator: Population of persons <18 years old in 2012. Data source: 2012 US Census. Other/unknown race = non-white/black. Population projections for other/unknown ethnicity unavailable --> could not calculate arrest rate for this group

Data Source (Percentage of high school drop-outs grade 9 through 12): Tennessee Department of Education (2012-13 School Year)

Data Source (Number living in foster home care): Tennessee Department of Children's Services. This count includes children in any type of family care, including pre-adoptive and trial home visits. It excludes children in group care, institutions, youth development centers, and runaways. The source is the TFACTS Custodial Mega Report dated 3/31/2014.

Narrative:
Tennessee infants and children receive services from a wide variety of state agencies. Data for this indicator are obtained from state agencies including the Departments of Health, Human Services, TennCare (Medicaid), CoverKids (SCHIP), Children's Services, and Education. According to the 2014 Resource Mapping Report produced by the Tennessee Commission on Children and Youth, 23 state agencies served 18,153,769 children in FY12-13, with expenditures of $9,346,346,355.

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

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HSI #09B - Demographics (Miscellaneous Data)

CATEGORY Miscellaneous Data BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**	**Specific Reporting Year**
All children 0 through 19	1533998	129020	0	2012
Percent in household headed by single parent	31.2	29.7	0.0	2013
Percent in TANF (Grant) families	5.6	2.8	0.0	2013
Number enrolled in Medicaid	638285	64509	0	2013
Number enrolled in SCHIP	16931	2378	0	2013
Number living in foster home care	5413	378	424	2013
Number enrolled in food stamp program	507594	44457	0	2013
Number enrolled in WIC	179323	28610	0	2013
Rate (per 100,000) of juvenile crime arrests	1755.0	906.0	0.0	2012
Percentage of high school drop-outs (grade 9 through 12)	5.0	5.2	0.0	2013

Notes - 2015
Data Source (All children 0 through 19): 2012 US Census

Data Source (Percent in household headed by single parent): The Current Population Survey (CPS) Annual Social and Economic Supplement Table Creator (http://www.census.gov/cps/data/cpstablecreator.html)

Numerator: Number of children aged 0-19 living in single male/female-headed primary families, no spouse present.

Denominator: Total number of children aged 0-19 living in primary families (inc. single male/female-headed and married couple families).

Data Source (Percent in TANF (Grant) families): Tennessee Department of Human Services. Number of enrollees provided by Department of Human Services and then divided by total number of children 0-19 (from first line of this form, obtained from US Census). Census data not available for racial categories other than "White" or "Black or African American," so the other categories are grouped together under "Other and unknown."

Data Source (Number enrolled in Medicaid): Bureau of TennCare (Medicaid); TennCare office data effective as of September 2013.

Data Source (Number enrolled in SCHIP): Tennessee SCHIP (CoverKids) Program

Data Source (Number enrolled in food stamp program): Tennessee Department of Human Services

Data Source (Number enrolled in WIC): Tennessee Department of Health, Division of Family Health and Wellness, WIC Program.

Data Sources (Rate per 100,000 of juvenile crime arrests): TBI Tennessee Crime Statistics Online (accessed 4/29/2014 at http://www.tbi.state.tn.us/tn_crime_stats/crime_stats_online.shtml) and 2012 US Census.

Numerator: Number of juvenile arrests for group A (violent) and group B (nonviolent) offenses in 2012; restricted to residents. Data source: TBI Tennessee Crime Statistics Online. Other/unknown race = Asian, Native American/Alaskan Native and unknown race. Juvenile is

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defined as <18 years old (TBI does not provide crime data on 0-19 years age group).

Denominator: Population of persons <18 years old in 2012. Data source: 2012 US Census. Other/unknown race = non-white/black. Population projections for other/unknown ethnicity unavailable --> could not calculate arrest rate for this group

Data Source (Percentage of high school drop-outs grade 9 through 12): Tennessee Department of Education (2012-13 School Year)

Data Source (Number living in foster home care): Tennessee Department of Children's Services. This count includes children in any type of family care, including pre-adoptive and trial home visits. It excludes children in group care, institutions, youth development centers, and runaways. The source is the TFACTS Custodial Mega Report dated 3/31/2014.

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

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

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	Total
Living in metropolitan areas	1114593
Living in urban areas	1014585
Living in rural areas	481416
Living in frontier areas	0
Total - all children 0 through 19	1496001

Notes - 2015
Data Sources: US Census Bureau, 2010 Census. 2010 Census Summary File 1, Table PCT12.

Notes: Data are for 2010. Urban and metropolitan areas overlap; 'total - all children 0 through 19' equals the sum of children living in urban and rural areas. Data are for children 0-18 years only--data for 0-19 year olds are not available from the US Census. Number of children living in metropolitan areas is the number in 'metropolitan statistical areas.'

Narrative:
Approximately 32% of Tennessee's children live in rural areas; the remainder live in metropolitan (mostly urban) areas. A description of Tennessee's geography is found in the State Overview of the Block Grant Narrative.

Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

Poverty Levels	Total
Total Population	6422468
Percent Below: 50% of poverty	9
100% of poverty	18.6
200% of poverty	39.2

Notes - 2015
Data Source: The Current Population Survey (CPS) Annual Social and Economic Supplement Table Creator (http://www.census.gov/cps/data/cpstablecreator.html); data are from the 2013 survey but survey questions regarding income ask about the previous year's income (i.e. 2012)

Narrative:
Over one-third of Tennessee's population lives below 200% of the federal poverty level. Over 18% of the population lives below 100% of the federal poverty level. Additional demographic information for the State can be found in the State Overview of the Block Grant Narrative.

Health Status Indicators 12: *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

Poverty Levels	Total
Children 0 through 19 years old	1639106
Percent Below: 50% of poverty	15.1
100% of poverty	27.8
200% of poverty	49.1

Notes - 2015
Data Source: The Current Population Survey (CPS) Annual Social and Economic Supplement Table Creator (http://www.census.gov/cps/data/cpstablecreator.html); data are from the 2013 survey but survey questions regarding income ask about the previous year's income (i.e. 2012)

Narrative:
Compared to the overall Tennessee population, a disproportionate share of Tennessee children live in poverty--49.1% live below 200% of the federal poverty level, and more than 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 and Referral 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. ***/2015/ The annual Child Fatality Review state reports can be found online at: http://health.tn.gov/mch/childfatality.shtml.//2015//***

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.

"Tennesseans Teaming Up for Change" Statewide Infant Mortality Summit
The Department of Health sponsored a statewide infant mortality summit in the fall of 2012. Over 200 attendees representing 42 local community teams participated. Keynote speakers included Dr. Michael Lu and Dr. Michael Fraser. Attendees also heard about successful infant mortality reduction initiatives from Wisconsin and Kentucky. Eight breakout sessions focused on specific topics or skills relevant to reducing infant mortality. At the conclusion of the summit, 31 teams developed a community action plan. Two follow-up webinars have been held to share successes and to learn about resources to support the ongoing work of the teams. A follow-up summit is being planned for Fall 2013. Archived conference and follow-up webinar materials can be found at http://health.tn.gov/MCH/IMsummitMaterials.shtml and the archived keynote and breakout presentations can be viewed at http://health.tn.gov/MCH/IMsummitPresentations.shtml.

/2015/A follow-up summit was held in December 2013 and was attended by 15 community teams. TDH staff provided training for the teams on the development of logic models to guide program implementation and evaluation.//2015//

Injury Prevention Program
The CDC-funded 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.

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. 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.

TDH received an MIECHV Expansion grant in March, 2012 which expanded evidence-based home visiting programs to 30 of the most at-risk counties with an additional 1200 children to be served. Additionally, these funds are supporting Welcome Baby, a universal outreach initiative to newborns based on risk factors identified from the birth file. The purpose of Welcome Baby is to connect parents of newborns to home visiting and other community resources. Annually, close to 20,000 newborns are expected to receive an outreach contact in the 30 counties where evidence-based home visiting programs have been established.

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. The program continues to target 14,000 women each year due to funding limitations.

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 directly 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. ***/2015/A third hotline, the Tennessee Breastfeeding Hotline, is contracted out to one of the state's children's hospitals. The hotline provides 24/7 toll-free access to certified lactation counselors.//2015//***

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: Public Health Advisory Committee on Infant Mortality, Childhood Lead Poisoning Prevention Advisory Committee, and Young Child Wellness Council.

/2015/Efforts Related to Autism Spectrum Disorders

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TDH staff participate in the TN State Autism Team efforts to understand the resources available for children and youth with autism spectrum disorders and their families and to identify opportunities for improvements in the system of care for this population. Staff from the FHW Early Childhood Initiatives group have also been involved in the preparation and distribution of "Act Early" materials (with funding provided from an AMCHP grant) and the Division Director has worked with the state AAP chapter and local ASD experts to develop a protocol for ASD screening in local health departments; as of May 2014, ASD screening is being piloted in two local health departments.//2015//

G. Technical Assistance

2012 Application Request

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 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.

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(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.

2014 Application Request

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

(1) Tennessee has historically focused on direct care delivery in many public health program areas. With the changing health and health care environment, it is necessary to redirect professional efforts toward population based approaches and systems orientation. Tennessee MCH staff need assistance at all levels in operationalizing the transition from direct care services to a broader population-based approach.

(2) Newborn Screening follow-up is one of the most time-sensitive daily tasks performed by MCH in Tennessee. It is imperative to have an emergency preparedness plan in the event of some disruption in normal operations. The Newborn Screening Follow-Up Program needs assistance in developing an emergency preparedness plan.

/2015/2015 Application Request

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

(1) One of our seven state priority areas is workforce development for MCH staff. With growing reliance on federal funding, there is a great need for program staff to be able to write strong grant applications for federally funded programs. We need assistance in identifying training resources for staff who have less experience with grant writing.

(2) We are fortunate in TN to have numerous agencies and programs that serve families and children. A pitfall, however, is that most agencies and programs have their own unique protocols for care coordination and developing family service plans. We request assistance in identifying model efforts to align and streamline such protocols among various child- and family-serving agencies.//2015//

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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 2013		FY 2014		FY 2015	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
1. Federal Allocation *(Line1, Form 2)*	11539865	11231410	11539865		11562887	
2. Unobligated Balance *(Line2, Form 2)*	5500000	0	7500000		5500000	
3. State Funds *(Line3, Form 2)*	13250000	16560796	13250000		14200000	
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)*	5650000	3331071	3250000		3350000	
7. Subtotal	35939865	31123277	35539865		34612887	
8. Other Federal Funds *(Line10, Form 2)*	160809386	143519514	161158344		147748378	
9. Total *(Line11, Form 2)*	196749251	174642791	196698209		182361265	

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

	FY 2013		FY 2014		FY 2015	
I. Federal-State MCH Block Grant Partnership	**Budgeted**	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
a. Pregnant Women	768035	1850341	759487		2057805	
b. Infants < 1 year old	3842331	3446996	3799567		3833481	

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c. Children 1 to 22 years old	15538410	11049782	15314098		13520375	
d. Children with Special Healthcare Needs	3461960	4792414	3461960		3468866	
e. Others	11175142	9509811	11050766		10576071	
f. Administration	1153987	473933	1153987		1156289	
g. SUBTOTAL	35939865	31123277	35539865		34612887	
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	65357		66392		90462	
c. CISS	255000		405000		140000	
d. Abstinence Education	1154546		1154546		1037995	
e. Healthy Start	0		0		0	
f. EMSC	0		0		0	
g. WIC	135977824		131165255		122176510	
h. AIDS	0		0		0	
i. CDC	7301220		5101537		7511392	
j. Education	0		0		0	
k. Home Visiting	6953766		14196195		9122591	
k. Other						
Family Planning	6535476		6272934		6062336	
Int Comm Systems D70					551710	
Preg Assistance Fund	2566197				0	
Project LAUNCH					800000	
Univ Newborn Hearing			270000		255382	
Int Comm Systems			288000			
Preg Assist Fund			2238485			

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

	FY 2013		FY 2014		FY 2015	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
I. Direct Health Care Services	22311467	19321330	22063147		21487681	
II. Enabling Services	8345237	7226825	8252357		8037112	
III. Population-Based Services	3576017	3096766	3536217		3443982	
IV. Infrastructure	1707144	1478356	1688144		1644112	

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Building Services						
V. Federal-State Title V Block Grant Partnership Total	35939865	31123277	35539865		34612887	

A. Expenditures

The Division of Administrative Services within the Department of Health is responsible for all fiscal management. Division staff use 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,change funds, 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 Financial Management 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 linked at the service delivery level to AS 400 computers at the regional and central offices.

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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.

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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.

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Title V Block Grant Application
Forms (2-21)
State: TN
Application Year: 2015

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FORM 2
MCH BUDGET DETAILS FOR FY 2015
[Secs. 504 (d) and 505(a)(3)(4)]
STATE: TN

1. FEDERAL ALLOCATION $ 11,562,887
(Item 15a of the Application Face Sheet [SF 424])
Of the Federal Allocation (1 above), the amount earmarked for:

A.Preventive and primary care for children:

$ 3,468,866 (30 %)

B.Children with special health care needs:

$ 3,468,866 (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:

$ 1,156,288 (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) $ 14,200,000

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) $ 3,350,000

7. TOTAL STATE MATCH (Lines 3 through 6) $ 17,550,000
(Below is your State's FY 1989 Maintainence of Effort Amount)
$ 13,125,024

8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP (SUBTOTAL) $ 34,612,887
(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:	$ 90,462
c. CISS:	$ 140,000
d. Abstinence Education:	$ 1,037,995
e. Healthy Start:	$ 0
f. EMSC:	$ 0
g. WIC:	$ 122,176,510
h. AIDS:	$ 0
i. CDC:	$ 7,511,392
j. Education:	$ 0
k. Home Visiting:	$ 9,122,591
l. Other:	
Family Planning	$ 6,062,336
Int Comm Systems D70	$ 551,710
Preg Assistance Fund	$ 0
Project LAUNCH	$ 800,000
Univ Newborn Hearing	$ 255,382

10. OTHER FEDERAL FUNDS (SUBTOTAL of all Funds under item 9) $ 147,748,378

11. STATE MCH BUDGET TOTAL $ 182,361,265
(Partnership subtotal + Other Federal MCH Funds subtotal)

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Form Notes for Form 2

None

Field Level Notes

None

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Form 3
State MCH Funding Profile
[Secs. 505(a) and 506((a)(I-3)]
State: TN

	FY 2010		FY 2011		FY 2012	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
1. Federal Allocation *(Line1, Form 2)*	$ 11,645,007	$ 8,558,526	$ 11,645,007	$ 9,415,863	$ 11,539,865	$ 4,655,248
2. Unobligated Balance *(Line2, Form 2)*	$ 3,500,000	$ 0	$ 3,000,000	$ 3,000,000	$ 3,100,000	$ 0
3. State Funds *(Line3, Form 2)*	$ 13,250,000	$ 13,325,000	$ 13,250,000	$ 13,550,000	$ 13,250,000	$ 21,966,127
4. Local MCH Funds *(Line4, Form 2)*	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0
5. Other Funds *(Line5, Form 2)*	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0
6. Program Income *(Line6, Form 2)*	$ 5,800,900	$ 5,539,280	$ 5,900,000	$ 5,813,868	$ 5,550,000	$ 3,236,496
7. Subtotal	$ 34,195,907	$ 27,422,806	$ 33,795,007	$ 31,779,731	$ 33,439,865	$ 29,857,871
	(THE FEDERAL-STATE TITLE BLOCK GRANT PARTNERSHIP)					
8. Other Federal Funds *(Line10, Form 2)*	$ 7,872,484	$ 7,603,405	$ 7,145,900	$ 8,508,413	$ 11,831,199	$ 10,697,095
9. Total *(Line11, Form 2)*	$ 42,068,391	$ 35,026,211	$ 40,940,907	$ 40,288,144	$ 45,271,064	$ 40,554,966
	(STATE MCH BUDGET TOTAL)					

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Form 3
State MCH Funding Profile
[Secs. 505(a) and 506((a)(l-3)]
State: TN

	FY 2013		FY 2014		FY 2015	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
1. Federal Allocation *(Line1, Form 2)*	$ 11,539,865	$ 11,231,410	$ 11,539,865	$	$ 11,562,887	$
2. Unobligated Balance *(Line2, Form 2)*	$ 5,500,000	$ 0	$ 7,500,000	$	$ 5,500,000	$
3. State Funds *(Line3, Form 2)*	$ 13,250,000	$ 16,560,796	$ 13,250,000	$	$ 14,200,000	$
4. Local MCH Funds *(Line4, Form 2)*	$ 0	$ 0	$ 0	$	$ 0	$
5. Other Funds *(Line5, Form 2)*	$ 0	$ 0	$ 0	$	$ 0	$
6. Program Income *(Line6, Form 2)*	$ 5,650,000	$ 3,331,071	$ 3,250,000	$	$ 3,350,000	$
7. Subtotal	$ 35,939,865	$ 31,123,277	$ 35,539,865	$ 0	$ 34,612,887	$ 0
	(THE FEDERAL-STATE TITLE BLOCK GRANT PARTNERSHIP)					
8. Other Federal Funds *(Line10, Form 2)*	$ 160,809,386	$ 143,519,514	$ 161,158,344	$	$ 147,748,378	$
9. Total *(Line11, Form 2)*	$ 196,749,251	$ 174,642,791	$ 196,698,209	$ 0	$ 182,361,265	$ 0
	(STATE MCH BUDGET TOTAL)					

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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: 2012
   Field Note:
   Actual federally-funded expenditures.
2. **Section Number:** Form3_Main
   Field Name: UnobligatedBalanceExpended
   Row Name: Unobligated Balance
   Column Name: Expended
   Year: 2013
   Field Note:
   This difference in expended amount will be used prior to the grant deadline.
3. **Section Number:** Form3_Main
   Field Name: UnobligatedBalanceExpended
   Row Name: Unobligated Balance
   Column Name: Expended
   Year: 2012
   Field Note:
   This difference in expended amount will be used prior to the grant deadline.
4. **Section Number:** Form3_Main
   Field Name: StateMCHFundsExpended
   Row Name: State Funds
   Column Name: Expended
   Year: 2013
   Field Note:
   This figure represents actual state expenditures.
5. **Section Number:** Form3_Main
   Field Name: StateMCHFundsExpended
   Row Name: State Funds
   Column Name: Expended
   Year: 2012
   Field Note:
   This resulted from a one-time increase in state appropriations used by the Tennessee Department of Health to fund services for women and children.
6. **Section Number:** Form3_Main
   Field Name: ProgramIncomeExpended
   Row Name: Program Income
   Column Name: Expended
   Year: 2013
   Field Note:
   This figure represents actual program income.
7. **Section Number:** Form3_Main
   Field Name: ProgramIncomeExpended
   Row Name: Program Income
   Column Name: Expended
   Year: 2012
   Field Note:
   Tennessee Department of Health experienced a significant decrease in revenue collections in several programs during this period.
8. **Section Number:** Form3_Main
   Field Name: OtherFedFundsExpended
   Row Name: Other Federal Funds
   Column Name: Expended
   Year: 2013
   Field Note:
   This figure represents actual other federal funds expended.

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FORM 4

BUDGET DETAILS BY TYPES OF INDIVIDUALS SERVED (I) AND SOURCES OF OTHER FEDERAL FUNDS (II)

[Secs 506(2)(2)(iv)]

STATE: TN

	FY 2010		FY 2011		FY 2012	
I. Federal-State MCH Block Grant Partnership	BUDGETED	EXPENDED	BUDGETED	EXPENDED	BUDGETED	EXPENDED
a. Pregnant Women	$ 1,025,877	$ 330,719	$ 668,803	$ 679,133	$ 403,285	$ 638,063
b. Infants < 1 year old	$ 4,069,313	$ 2,926,288	$ 3,881,695	$ 3,397,571	$ 3,568,368	$ 3,192,105
c. Children 1 to 22 years old	$ 13,813,306	$ 11,945,862	$ 13,848,481	$ 13,378,245	$ 14,324,393	$ 12,498,562
d. Children with Special Healthcare Needs	$ 3,761,550	$ 3,147,418	$ 3,493,503	$ 3,975,431	$ 3,461,960	$ 3,779,891
e. Others	$ 10,361,360	$ 8,633,522	$ 10,738,025	$ 9,881,590	$ 10,527,873	$ 9,284,006
f. Administration	$ 1,164,501	$ 438,997	$ 1,164,500	$ 467,761	$ 1,153,986	$ 465,244
g. SUBTOTAL	$ 34,195,907	$ 27,422,806	$ 33,795,007	$ 31,779,731	$ 33,439,865	$ 29,857,871
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	$ 0		$ 0		$ 0	
b. SSDI	$ 93,763		$ 92,872		$ 93,763	
c. CISS	$ 100,000		$ 105,000		$ 132,000	
d. Abstinence Education	$ 993,844		$ 0		$ 1,141,533	
e. Healthy Start	$ 0		$ 0		$ 0	
f. EMSC	$ 0		$ 0		$ 0	
g. WIC	$ 0		$ 0		$ 0	
h. AIDS	$ 0		$ 0		$ 0	
i. CDC	$ 0		$ 0		$ 0	
j. Education	$ 0		$ 0		$ 0	
k. Home Visiting	$ 0		$ 0		$ 0	
l. Other						
Family Planning	$ 6,534,877		$ 6,648,028		$ 6,897,373	
Injury Prevention	$		$		$ 125,185	
MIECHV Home Visiting	$		$		$ 3,141,345	
Newborn Hearing	$ 150,000		$ 300,000		$ 300,000	
III. TOTAL	$ 7,872,484		$ 7,145,900		$ 11,831,199	

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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 2013		FY 2014		FY 2015	
I. Federal-State MCH Block Grant Partnership	BUDGETED	EXPENDED	BUDGETED	EXPENDED	BUDGETED	EXPENDED
a. Pregnant Women	$ 768,035	$ 1,850,341	$ 759,487	$	$ 2,057,805	$
b. Infants < 1 year old	$ 3,842,331	$ 3,446,996	$ 3,799,567	$	$ 3,833,481	$
c. Children 1 to 22 years old	$ 15,538,410	$ 11,049,782	$ 15,314,098	$	$ 13,520,375	$
d. Children with Special Healthcare Needs	$ 3,461,960	$ 4,792,414	$ 3,461,960	$	$ 3,468,866	$
e. Others	$ 11,175,142	$ 9,509,811	$ 11,050,766	$	$ 10,576,071	$
f. Administration	$ 1,153,987	$ 473,933	$ 1,153,987	$	$ 1,156,289	$
g. SUBTOTAL	$ 35,939,865	$ 31,123,277	$ 35,539,865	$ 0	$ 34,612,887	$ 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	$ 65,357		$ 66,392		$ 90,462	
c. CISS	$ 255,000		$ 405,000		$ 140,000	
d. Abstinence Education	$ 1,154,546		$ 1,154,546		$ 1,037,995	
e. Healthy Start	$ 0		$ 0		$ 0	
f. EMSC	$ 0		$ 0		$ 0	
g. WIC	$ 135,977,824		$ 131,165,255		$ 122,176,510	
h. AIDS	$ 0		$ 0		$ 0	
i. CDC	$ 7,301,220		$ 5,101,537		$ 7,511,392	
j. Education	$ 0		$ 0		$ 0	
k. Home Visiting	$ 6,953,766		$ 14,196,195		$ 9,122,591	
l. Other						
Family Planning	$ 6,535,476		$ 6,272,934		$ 6,062,336	
Int Comm Systems D70	$		$		$ 551,710	
Preg Assistance Fund	$ 2,566,197		$		$ 0	
Project LAUNCH	$		$		$ 800,000	
Univ Newborn Hearing	$		$ 270,000		$ 255,382	
Int Comm Systems	$		$ 288,000		$	
Preg Assist Fund	$		$ 2,238,485		$	
III. TOTAL	$ 160,809,386		$ 161,158,344		$ 147,748,378	

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Form Notes for Form 4

None

Field Level Notes

1. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
   Field Name: PregWomenExpended
   Row Name: Pregnant Women
   Column Name: Expended
   Year: 2013
   Field Note:
   An error was made during the preparation of the FY13 budget amounts for the Types of Individuals Served that caused the budgeted amounts reported to be incorrect with the exception of CSHCN and administration. The amounts reported as expended for each type represents the actual expenditures for FY13.
2. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
   Field Name: PregWomenExpended
   Row Name: Pregnant Women
   Column Name: Expended
   Year: 2012
   Field Note:
   Actual expenditures
3. **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: 2013
   Field Note:
   An error was made during the preparation of the FY13 budget amounts for the Types of Individuals Served that caused the budgeted amounts reported to be incorrect with the exception of CSHCN and administration. The amounts reported as expended for each type represents the actual expenditures for FY13.
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: 2012
   Field Note:
   Actual expenditures
5. **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: 2013
   Field Note:
   An error was made during the preparation of the FY13 budget amounts for the Types of Individuals Served that caused the budgeted amounts reported to be incorrect with the exception of CSHCN and administration. The amounts reported as expended for each type represents the actual expenditures for FY13.
6. **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: 2012
   Field Note:
   Actual expenditures
7. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
   Field Name: CSHCNExpended
   Row Name: CSHCN
   Column Name: Expended
   Year: 2013
   Field Note:
   Figure represents actual expenditures.
8. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
   Field Name: AllOthersExpended
   Row Name: All Others
   Column Name: Expended
   Year: 2013
   Field Note:
   An error was made during the preparation of the FY13 budget amounts for the Types of Individuals Served that caused the budgeted amounts reported to be incorrect with the exception of CSHCN and administration. The amounts reported as expended for each type represents the actual expenditures for FY13.
9. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
   Field Name: AllOthersExpended
   Row Name: All Others
   Column Name: Expended
   Year: 2012
   Field Note:

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Actual expenditures

10. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
Field Name: AdminExpended
Row Name: Administration
Column Name: Expended
Year: 2013
Field Note:
Figure represents actual expenditures.

11. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
Field Name: AdminExpended
Row Name: Administration
Column Name: Expended
Year: 2012
Field Note:
Actual expenditures

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Form 5

State Title V Program Budget and Expenditures by Types of Services

[Secs. 505(a)(2)(A-B) and 506(a)(1)(A-D)]

State: TN

Type of Service	FY 2010		FY 2011		FY 2012	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
I. Direct Health Care Services (Basic Health Services and Health Services for CSHCN.)	$ 25,988,889	$ 17,024,078	$ 20,979,940	$ 19,728,857	$ 20,759,467	$ 18,535,766
II. Enabling Services (Transportation, Translation, Outreach, Respite Care, Health Education, Family Support Services, Purchase of Health Insurance, Case Management, and Coordination with Medicaid, WIC, and Education.)	$ 4,322,363	$ 6,367,576	$ 7,847,201	$ 7,379,254	$ 7,764,737	$ 6,932,998
III. Population-Based Services (Newborn Screening, Lead Screening, Immunization, Sudden Infant Death Syndrome Counseling, Oral Health, Injury Prevention, Nutrition, and Outreach/Public Education.)	$ 1,586,690	$ 2,728,569	$ 3,362,603	$ 3,162,083	$ 3,327,267	$ 2,970,858
IV. Infrastructure Building Services (Needs Assessment, Evaluation, Planning, Policy Development, Coordination, Quality Assurance, Standards Development, Monitoring, Training, Applied Research, Systems of Care, and Information Systems.)	$ 2,297,965	$ 1,302,583	$ 1,605,263	$ 1,509,537	$ 1,588,394	$ 1,418,249
V. Federal-State Title V Block Grant Partnership Total (Federal-State Partnership only. Item 15g of SF 42r. For the "Budget" columns this is the same figure that appears in Line 8, Form 2, and in the "Budgeted" columns of Line 7 Form 3. For the "Expended" columns this is the same figure that appears in the "Expended" columns of Line 7, Form 3.)	$ 34,195,907	$ 27,422,806	$ 33,795,007	$ 31,779,731	$ 33,439,865	$ 29,857,871

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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 2013		FY 2014		FY 2015	
	BUDGETED	EXPENDED	BUDGETED	EXPENDED	BUDGETED	EXPENDED
I. Direct Health Care Services (Basic Health Services and Health Services for CSHCN.)	$ 22,311,467	$ 19,321,330	$ 22,063,147	$	$ 21,487,681	$
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.)	$ 8,345,237	$ 7,226,825	$ 8,252,357	$	$ 8,037,112	$
III. Population-Based Services (Newborn Screening, Lead Screening, Immunization, Sudden Infant Death Syndrome Counseling, Oral Health, Injury Prevention, Nutrition, and Outreach/Public Education.)	$ 3,576,017	$ 3,096,766	$ 3,536,217	$	$ 3,443,982	$
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.)	$ 1,707,144	$ 1,478,356	$ 1,688,144	$	$ 1,644,112	$
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.)	$ 35,939,865	$ 31,123,277	$ 35,539,865	$ 0	$ 34,612,887	$ 0

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Form Notes for Form 5

None

Field Level Notes

1. **Section Number:** Form5_Main
   Field Name: DirectHCExpended
   Row Name: Direct Health Care Services
   Column Name: Expended
   Year: 2013
   Field Note:
   Figure represents actual expenditures.
2. **Section Number:** Form5_Main
   Field Name: DirectHCExpended
   Row Name: Direct Health Care Services
   Column Name: Expended
   Year: 2012
   Field Note:
   Actual expenditures
3. **Section Number:** Form5_Main
   Field Name: EnablingExpended
   Row Name: Enabling Services
   Column Name: Expended
   Year: 2013
   Field Note:
   Figure represents actual expenditures.
4. **Section Number:** Form5_Main
   Field Name: EnablingExpended
   Row Name: Enabling Services
   Column Name: Expended
   Year: 2012
   Field Note:
   Actual expenditures
5. **Section Number:** Form5_Main
   Field Name: PopBasedExpended
   Row Name: Population-Based Services
   Column Name: Expended
   Year: 2013
   Field Note:
   Figure represents actual expenditures.
6. **Section Number:** Form5_Main
   Field Name: PopBasedExpended
   Row Name: Population-Based Services
   Column Name: Expended
   Year: 2012
   Field Note:
   Actual expenditures
7. **Section Number:** Form5_Main
   Field Name: InfrastrBuildExpended
   Row Name: Infrastructure Building Services
   Column Name: Expended
   Year: 2013
   Field Note:
   Figure represents actual expenditures.
8. **Section Number:** Form5_Main
   Field Name: InfrastrBuildExpended
   Row Name: Infrastructure Building Services
   Column Name: Expended
   Year: 2012
   Field Note:
   Actual expenditures

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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: 84,974 | Reporting Year: 2013

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	84,404	99.3	387	52	52	100
Galactosemia	84,404	99.3	29	0	0	
Sickle Cell Disease						
Other Screening (Specify)						
Biotinidase Deficiency	84,404	99.3	25	2	2	100
Congenital Adrenal Hyperplasia	84,404	99.3	422	7	7	100
Cystic Fibrosis	84,404	99.3	716	13	13	100
Fatty or Organic Acidemia	84,404	99.3	317	16	16	100
Amino Acidemia (includes Phenylketonuria)	84,404	99.3	305	14	14	100
Hemoglobinopathies (includes Sickle Cell Disease)	84,404	99.3	55	50	50	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.

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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: 2015
   Field Note:
   Of the 84,970 occurent births, 570 were without a metabolic screen. For 234 babies, screens were not performed because the infants died on the day of birth (N=193) or on day of life #1 (N=41); an additional 12 died within 2-7 days of life and 6 died at >7 days. Of the remaining 318 infants who have a documented birth certificate but no newborn screen recorded, 197 were born at home; only 121 had no record of death and were not categorized as home births.
2. **Section Number:** Form6_Main
   Field Name: PhenylketonuriaOneScreenNo
   Row Name: Phenylketonuria
   Column Name: Receiving at least one screen
   Year: 2015
   Field Note:
   Screening, presumptive positive, and confirmed cases for phenylketonuria are reported with "Other: Amino Acidemias" below.
3. **Section Number:** Form6_Main
   Field Name: SickleCellDiseaseOneScreenNo
   Row Name: SickleCellDisease
   Column Name: Receiving at least one screen
   Year: 2015
   Field Note:
   Screening, presumptive positive, and confirmed cases for sickle cell disease are reported with "Other: Hemoglobinopathies" below.
4. **Section Number:** Form6_Main
   Field Name: PhenylketonuriaPresumptive
   Row Name: Phenylketonuria
   Column Name: Presumptive positive screens
   Year: 2015
   Field Note:
   Screening, presumptive positive, and confirmed cases for phenylketonuria are reported with "Other: Amino Acidemias" below.
5. **Section Number:** Form6_Main
   Field Name: SickleCellDiseasePresumptive
   Row Name: SickleCellDisease
   Column Name: Presumptive positive screens
   Year: 2015
   Field Note:
   Screening, presumptive positive, and confirmed cases for sickle cell disease are reported with "Other: Hemoglobinopathies" below.
6. **Section Number:** Form6_Main
   Field Name: PhenylketonuriaConfirmed
   Row Name: Phenylketonuria
   Column Name: Confirmed Cases
   Year: 2015
   Field Note:
   Screening, presumptive positive, and confirmed cases for phenylketonuria are reported with "Other: Amino Acidemias" below.
7. **Section Number:** Form6_Main
   Field Name: SickleCellDiseaseConfirmed
   Row Name: SickleCellDisease
   Column Name: Confirmed Cases
   Year: 2015
   Field Note:
   Screening, presumptive positive, and confirmed cases for sickle cell disease are reported with "Other: Hemoglobinopathies" below.
8. **Section Number:** Form6_Main
   Field Name: PhenylketonuriaTreatmentNo
   Row Name: Phenylketonuria
   Column Name: Needing treatment that received treatment
   Year: 2015
   Field Note:
   Screening, presumptive positive, and confirmed cases for phenylketonuria are reported with "Other: Amino Acidemias" below.
9. **Section Number:** Form6_Main
   Field Name: SickleCellDiseaseTreatmentNo
   Row Name: SickleCellDisease
   Column Name: Needing treatment that received treatment
   Year: 2015
   Field Note:
   Screening, presumptive positive, and confirmed cases for sickle cell disease are reported with "Other: Hemoglobinopathies" below.

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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	2008	2009	2010	2011	2012
Pregnant Women	14,673	9,808	6,240	10,416	25,421
Infants < 1 year old	86,661	82,078	87,469	84,533	84,412
Children 1 to 22 years old	259,614	264,056	286,647	267,264	238,569
Children with Special Healthcare Needs	8,224	7,275	6,525	6,059	5,266
Others	147,911	157,433	162,963	151,550	137,058
Total	517,083	520,650	549,844	519,822	490,726

Reporting Year: 2013

	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	26,360	57.9	0.1	3.3	38.7	0.0
Infants < 1 year old	80,202	30.7	0.0	0.5	68.8	0.0
Children 1 to 22 years old	226,867	31.7	0.0	2.0	66.5	0.0
Children with Special Healthcare Needs	5,573	6.8	0.0	1.6	91.6	0.0
Others	135,477	13.7	0.4	2.3	83.7	0.0
TOTAL	474,479					

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Form Notes for Form 7

1) An additional code (V72.42) was added to the definition for Pregnant Women in Reporting Year 2012. This code indicates "Pregnancy examination or test, positive result". There was no corresponding code prior to this. This results in an increase of the number of pregnant women from the previous years.

2) Prior to Reporting Year 2012, previous year reporting has been unduplicated at the site level. The data analysis this year is unduplicated at the regional level. When counting at the site level, one will count the same person multiple times if they were seen at multiple sites. Hence, data from Reporting Year 2012 and beyond will indicate a decrease in total people served, but is more accurate.

Field Level Notes

1. **Section Number:** Form7_Main
   Field Name: PregWomen_TS
   Row Name: Pregnant Women
   Column Name: Title V Total Served
   Year: 2015
   Field Note:
   Data Source: Tennessee Department of Health, Patient Tracking Billing Management Information System (PTBMIS)

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: 2015
   Field Note:
   The total number of infants served under Title V is at least 80,202. Newborn Screening is provided through Title V, and thefore, at least the number of infants receiving screens (80,202) 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 49,106 (Data Source: TDH PTBMIS). It is estimated that most of these infants would be included in the total listed above (80,202); 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" 80,202 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 49,106 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_1_22_TS
   Row Name: Children 1 to 22 years of age
   Column Name: Title V Total Served
   Year: 2015
   Field Note:
   Data Source: Tennessee Department of Health, Patient Tracking Billing Management Information System (PTBMIS)

4. **Section Number:** Form7_Main
   Field Name: CSHCN_TS
   Row Name: Children with Special Health Care Needs
   Column Name: Title V Total Served
   Year: 2015
   Field Note:
   Data Source: Tennessee Department of Health, Patient Tracking Billing Management Information System (PTBMIS)

5. **Section Number:** Form7_Main
   Field Name: AllOthers_TS
   Row Name: Others
   Column Name: Title V Total Served
   Year: 2015
   Field Note:
   Data Source: Tennessee Department of Health, Patient Tracking Billing Management Information System (PTBMIS)

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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: 2012

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	80,202	60,792	16,560	131	1,733	180	0	806
Title V Served	80,202	60,792	16,560	131	1,733	180	0	806
Eligible for Title XIX	41,672	28,421	12,424	76	487	65	0	199
INFANTS								
Total Infants in State	79,733	56,612	17,540	0	0	0	0	5,581
Title V Served	49,106	31,479	8,490	47	253	21	0	8,816
Eligible for Title XIX	50,095	32,885	6,890	3,762	0	0	6,558	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	73,182	6,977	43	4,500	92	303	0	2,082
Title V Served	73,182	6,977	43	4,500	92	303	0	2,082
Eligible for Title XIX	36,769	4,891	12	3,232	48	163	0	1,448
INFANTS								
Total Infants in State	71,489	8,244	0	0	0	0	0	0
Title V Served	39,727	4,198	5,163	0	0	0	0	18
Eligible for Title XIX	44,202	5,893	0	0	0	0	0	0

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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: 2015
   Field Note:
   Data Source: TDH Office of Health Statistics Birth Statistical System (2012)
2. **Section Number:** Form8_I. Unduplicated Count By Race
   Field Name: DeliveriesTitleV_All
   Row Name: Title V Served
   Column Name: Total All Races
   Year: 2015
   Field 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: 2015
   Field Note:
   Data Source: TDH Office of Health Statistics Birth Statistical System (2012; based on mother's delivery payment source=TennCare)
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: 2015
   Field Note:
   Data Source: 2012 US Census
5. **Section Number:** Form8_I. Unduplicated Count By Race
   Field Name: InfantsTitleV_All
   Row Name: Title V Served
   Column Name: Total All Races
   Year: 2015
   Field Note:
   Data Source: Tennessee Department of Health, Patient Tracking Billing Management Information System
6. **Section Number:** Form8_I. Unduplicated Count By Race
   Field Name: InfantsTitleXIX_All
   Row Name: Eligible for Title XIX
   Column Name: Total All Races
   Year: 2015
   Field Note:
   Data Source: The Current Population Survey (CPS) Annual Social and Economic Supplement Table Creator (http://www.census.gov/cps/data/cpstablecreator.html); includes infants with income-to-poverty ratio <175%; data is from the 2013 survey but survey questions regarding income ask about the previous year's income (i.e. 2012)
7. **Section Number:** Form8_II. Unduplicated Count by Ethnicity
   Field Name: DeliveriesTotal_TotalNotHispanic
   Row Name: Total Deliveries in State
   Column Name: Total Not Hispanic or Latino
   Year: 2015
   Field Note:
   Data Source: TDH Office of Health Statistics Birth Statistical System (2012)
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: 2015
   Field 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: 2015
   Field Note:

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Data Source: TDH Office of Health Statistics Birth Statistical System (2012; based on mother's delivery payment source=TennCare)

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: 2015
Field Note:
Data Source: 2012 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: 2015
Field Note:
Data Source: 2012. US Census. Data not available on the subcategories B1-B5.

12. **Section Number:** Form8_II. Unduplicated Count by Ethnicity
Field Name: InfantsTitleV_TotalNotHispanic
Row Name: Title V Served
Column Name: Total Not Hispanic or Latino
Year: 2015
Field Note:
Data Source: Tennessee Department of Health, Patient Tracking Billing Management Information System

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: 2015
Field Note:
Data Source: Tennessee Department of Health, Patient Tracking Billing Management Information System. Data not available on the subcategories B1-B5.

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: 2015
Field Note:
Data Source: The Current Population Survey (CPS) Annual Social and Economic Supplement Table Creator (http://www.census.gov/cps/data/cpstablecreator.html); includes infants with income-to-poverty ratio <175%; data is from the 2013 survey but survey questions regarding income ask about the previous year's income (i.e. 2012)

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: 2015
Field Note:
Data Source: The Current Population Survey (CPS) Annual Social and Economic Supplement Table Creator (http://www.census.gov/cps/data/cpstablecreator.html); includes infants with income-to-poverty ratio <175%; data is from the 2013 survey but survey questions regarding income ask about the previous year's income (i.e. 2012). Data not available on the subcategories B1-B5.

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Form 9

State MCH Toll-Free Telephone Line Data Form (Optional)

[Secs. 505(a)(E) and 509(a)(8)]

State: TN

	FY 2015	FY 2014	FY 2013	FY 2012	FY 2011
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

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Form 9

State MCH Toll-Free Telephone Line Data Form

[Secs. 505(a)(E) and 509(a)(8)]

State: TN

	FY 2015	FY 2014	FY 2013	FY 2012	FY 2011
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"	Kelly Luskin	Kelly Luskin	Sara Guerra	Deana Vaughn	Deana Vaughn
4. Contact Person's Telephone Number	615-741-0370	615-741-0370	615-741-7353	(615) 741-0370	(615) 741-0307
5. Contact Person's Email	kelly.luskin@tn.gov	kelly.luskin@tn.gov	sara.guerra@tn.gov	Deana.vaughn@tn.gov	Deana.Vaughn@tn.org
6. Number of calls received on the State MCH "Hotline" this reporting period	0	0	66	37	29

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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: 2013
   Field Note:
   Number of calls represents calls for State FY2013 (July 1, 2012-June 30, 2013)

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FORM 10
TITLE V MATERNAL & CHILD HEALTH SERVICES BLOCK GRANT
STATE PROFILE FOR FY 2015
[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: Breast and Cervical Cancer Screening; Child Fatality Review; Children's Special Services (Title V CSHCN Program); Integrated Systems for CYSHCN (D70); Early Childhood Comprehensive Systems; Family Planning (Title X); Fetal-Infant Mortality Review; Welcome Baby; Home Visiting (including the federal Maternal, Infant, and Early Childhood Home Visiting Program); Injury Prevention; Lead Poisoning Prevention; Newborn Metabolic, Hearing, and CCHD Screening (including a network of genetics and sickle cell centers); Perinatal Regionalization; Adolescent Pregnancy Prevention; and Reproductive and Women's Health.

Block Grant Funds	
2. Federal Allocation (Line 1, Form 2)	$ 11,562,887
3. Unobligated balance (Line 2, Form 2)	$ 5,500,000
4. State Funds (Line 3, Form 2)	$ 14,200,000
5. Local MCH Funds (Line 4, Form 2)	$ 0
6. Other Funds (Line 5, Form 2)	$ 0
7. Program Income (Line 6, Form 2)	$ 3,350,000
8. Total Federal-State Partnership (Line 8, Form 2)	$ 34,612,887

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	26,360
b. Infants < 1 year old	80,202
c. Children 1 to 22 years old	226,867
d. CSHCN	5,573
e. Others	135,477

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, nonprofit agencies, primary care centers, and tertiary centers, include pregnancy testing, family planning, nutrition services, immunizations and well child visits, EPSDT screening, follow-up and referral, newborn screening disgnosis and follow-up, 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 by connecting children and their families to medical care, monitoring needs, and referring to community resources. 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, hearing, and CCHD screening programs, MCH nurses provide follow-up and case management for infants with presumptive positive screens. Through the Welcome Baby initiative, every family of a newborn in TN receives a "welcome" letter via postal mail with information on resources for families with young children. Families deemed as being at medium- or high-risk for experiencing an infant death receive a voluntary phone call (for medium-risk families) or a voluntary outreach visit (for high-risk families) to identify needed resources and connect them to available community services.

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, Hearing, and CCHD Screening: Every infant born in Tennessee is screened for congenital hearing loss as well as a panel of

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genetic and metabolic illnesses and critical congenital heart disease. 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. All three 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 data and findings have been a valuable resource for planning and monitoring. 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 2014, 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. Recently, regional and local health councils have planned for use of funding received from the Tobacco Settlement Fund to implement evidence-based projects in one or more three areas (preventing children from beginning to smoke; helping pregnant women who smoke to stop; and reducing infant exposure to second-hand smoke). 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. For example, staff from the early childhood and nutrition sections have worked with staff from the Department of Human Services to update child care licensing standards. Additonally, in consultation with a member of the Perinatal Advisory Committee and the Genetics Advisory Committee, MCH staff developed and implemented an innovative algorithm and protocol for screening all newborns for critical congenital heart disease. Tennessee has a strong perinatal regionalization system which has been in place since the 1970s. Consultation on high risk perinatal care is available 24/7 for all health care providers statewide. Outreach educators from each of the 5 Centers provide professional education to staff in their area hospitals on high risk perinatal care – both obstetrics and neonatal.

12. The primary Title V Program contact person:

Name	Michael Warren, MD MPH FAAP
Title	Director, Division of Family Health and Wellness
Address	8th Floor Andrew Johnson Tower, 710 James Robertson
City	Nashville
State	TN
Zip	37243
Phone	615-741-7353
Fax	615-741-1063
Email	michael.d.warren@tn.gov
Web	http://health.tn.gov/mch

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

Name	Jacqueline Johnson, MPA
Title	Director, Division of Family Health and Wellness
Address	8th Floor Andrew Johnson Tower, 710 James Robertson
City	Nashville
State	TN
Zip	37243
Phone	615-741-7353
Fax	615-741-1063
Email	jacqueline.johnson@tn.gov
Web	http://health.tn.gov/mch

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Form Notes for Form 10

None

Field Level Notes

None

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Form 11
Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]
State: TN

Form Level Notes for Form 11

None

Performance Measure # 01

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

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	99.4	100.0	99.5	100.0
Numerator	161	161	170	182	154
Denominator	161	162	170	183	154
Data Source	Department of Health	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	Final

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
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: 2013
   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: 2012
   Field Note:
   Data Source: Tennessee Department of Health, Newborn Screening Program. Note: Identified one infant with Nonketotic Hyperglycinemia (NKH) in 2012 who did not receive treatment. There is limited treatment available with poor outcomes. Family chose to remove infant from life support, discontinue medications and provide palliative care through hospice.

3. **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

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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

	2009	2010	2011	2012	2013
Annual Performance Objective	62	62	62	75	75
Annual Indicator	60.7	60.7	72.3	72.3	72.3
Numerator	136,524	136,524	183,180	183,180	183,180
Denominator	224,895	224,895	253,333	253,333	253,333
Data Source	CSHCN Survey	CSHCN Survey	2009/10 CSHCN Survey	2009/10 CSHCN Survey	2009/10 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

	2014	2015	2016	2017	2018
Annual Performance Objective	72.3	72.3	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: 2013
   Field Note:
   See Notes - 2011

2. **Section Number:** Form11_Performance Measure #2
   Field Name: PM02
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   See Notes - 2011

3. **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.

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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

	2009	2010	2011	2012	2013
Annual Performance Objective	65	65	55	50	50
Annual Indicator	52.7	52.7	45.9	45.9	45.9
Numerator	115,761	115,761	113,064	113,064	113,064
Denominator	219,634	219,634	246,352	246,352	246,352
Data Source	CSHCN Survey	CSHCN Survey	2009/10 CSHCN Survey	2009/10 CSHCN Survey	2009/10 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

	2014	2015	2016	2017	2018
Annual Performance Objective	45.9	45.9	50	50	50
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #3
   Field Name: PM03
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   See Notes - 2011

2. **Section Number:** Form11_Performance Measure #3
   Field Name: PM03
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   See Notes - 2011

3. **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 NPM3. However, the same questions were used to generate the NPM3 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.

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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

	2009	2010	2011	2012	2013
Annual Performance Objective	69	69	70	75	75
Annual Indicator	67.7	67.7	70.4	70.4	70.4
Numerator	152,224	152,224	174,402	174,402	174,402
Denominator	224,965	224,965	247,879	247,879	247,879
Data Source	CSHCN Survey	CSHCN Survey	2009/10 CSHCN Survey	2009/10 CSHCN Survey	2009/10 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

	2014	2015	2016	2017	2018
Annual Performance Objective	70.4	70.4	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: 2013
   Field Note:
   See Notes - 2011

2. **Section Number:** Form11_Performance Measure #4
   Field Name: PM04
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   See Notes - 2011

3. **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 NPM4 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.

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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

	2009	2010	2011	2012	2013
Annual Performance Objective	93	93	93	75	71.5
Annual Indicator	91.8	91.8	71.5	71.5	71.5
Numerator	208,995	208,995	179,700	179,700	179,700
Denominator	227,739	227,739	251,473	251,473	251,473
Data Source	CSHCN Survey	CSHCN Survey	2009/10 CSHCN Survey	2009/10 CSHCN Survey	2009/10 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

	2014	2015	2016	2017	2018
Annual Performance Objective	71.5	71.5	75	75	75
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #5
   Field Name: PM05
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   See Notes - 2011

2. **Section Number:** Form11_Performance Measure #5
   Field Name: PM05
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   See Notes - 2011

3. **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.

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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

	2009	2010	2011	2012	2013
Annual Performance Objective	100	100	40	45	45
Annual Indicator	39.6	39.6	41.8	41.8	41.8
Numerator	34,477	34,477	40,413	40,413	40,413
Denominator	87,141	87,141	96,752	96,752	96,752
Data Source	CSHCN Survey	CSHCN Survey	2009/10 CSHCN Survey	2009/10 CSHCN Survey	2009/10 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

	2014	2015	2016	2017	2018
Annual Performance Objective	41.8	41.8	45	45	45
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #6
   Field Name: PM06
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   See Notes - 2011

2. **Section Number:** Form11_Performance Measure #6
   Field Name: PM06
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   See Notes - 2011

3. **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 NPM6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM6 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.

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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

	2009	2010	2011	2012	2013
Annual Performance Objective	88	88	80	85	80
Annual Indicator	83.0	77.0	82.2	73.4	73.3
Numerator	278	261	305	262	222
Denominator	335	339	371	357	303
Data Source	2008 NIS Survey	2009 NIS Survey	2010 NIS Survey	2011 NIS Survey	2012 NIS Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Final

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	80	80	80	80	80
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #7
   Field Name: PM07
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   CDC reported the denominator of 303 on a different data table (no denominator was provided on the general data table). Their calculated estimate was 73.1 +/- 6.8

2. **Section Number:** Form11_Performance Measure #7
   Field Name: PM07
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Data Source: 2011 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.

   NOTE: Annual performance objective for 2012 should be 80, consistent with Healthy People 2020 benchmarks.

3. **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.

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PERFORMANCE MEASURE # 08

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

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	26	24	20	19.5	18
Annual Indicator	24.0	20.2	18.5	17.4	
Numerator	2,955	2,532	2,287	2,117	
Denominator	123,216	125,133	123,785	121,665	
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	

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	17.4	17.4	17	17	16.5
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #8
   Field Name: PM08
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   Because 2013 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: 2012
   Field Note:
   Data sources: TDH Office of Health Statistics Birth Statistical System and 2012 US Census

3. **Section Number:** Form11_Performance Measure #8
   Field Name: PM08
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Data sources: TDH Office of Health Statistics Birth Statistical System and 2011 US Census

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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

	2009	2010	2011	2012	2013
Annual Performance Objective	40	40	40	40	40
Annual Indicator	37.2	37.2	37.2	37.2	37.2
Numerator	366	366	366	366	366
Denominator	983	983	983	983	983
Data Source	Tennessee Oral Health Survey	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

	2014	2015	2016	2017	2018
Annual Performance Objective	28.1	28.1	28.1	28.1	28.1
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #9
   Field Name: PM09
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   Data Source: 2008 Tennessee Oral Health Survey of children ages 5-11 years. This survey is conducted every FIVE years as Central Office staffing permits.

   Source for objective for future years: HP 2020, OH-12.2: increase the proportion of children aged 6-9 years who have received dental sealnts on one or more of their permanent first molar teeth

2. **Section Number:** Form11_Performance Measure #9
   Field Name: PM09
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Data Source: 2008 Tennessee Oral Health Survey of children ages 5-11 years. This survey is conducted every FIVE years as Central Office staffing permits.

3. **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.

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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

	2009	2010	2011	2012	2013
Annual Performance Objective	2	2	1.7	2.4	3.5
Annual Indicator	2.7	2.5	3.7	1.7	
Numerator	33	31	46	21	
Denominator	1,207,621	1,238,935	1,237,679	1,241,590	
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	

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	1.7	1.7	1.6	1.6	1.5
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #10
   Field Name: PM10
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   Because 2013 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: 2012
   Field Note:
   Data sources: TDH Office of Health Statistics Death Statistical System and 2012 US Census

3. **Section Number:** Form11_Performance Measure #10
   Field Name: PM10
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Data sources: TDH Office of Health Statistics Death Statistical System and 2011 US Census

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PERFORMANCE MEASURE # 11

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

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	30	40	37.5	36	40
Annual Indicator	37.9	29.8	35.5	30.8	29.9
Numerator	31,952				
Denominator	84,308				
Data Source	CDC/National Immunization Survey	CDC/National Immunization Survey-2007 Birth Cohort	CDC/National Immunization Survey-2008 Birth Cohort	CDC/National Immunization Survey-2009 Birth Cohort	CDC/National Immunization Survey-2010 Birth Cohort
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

	2014	2015	2016	2017	2018
Annual Performance Objective	30	30.5	31	31.5	32
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #11
   Field Name: PM11
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   http://www.cdc.gov/breastfeeding/pdf/2013breastfeedingreportcard.pdf

2. **Section Number:** Form11_Performance Measure #11
   Field Name: PM11
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   http://www.cdc.gov/breastfeeding/pdf/2012BreastfeedingReportCard.pdf

3. **Section Number:** Form11_Performance Measure #11
   Field Name: PM11
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   http://www.cdc.gov/breastfeeding/pdf/2011BreastfeedingReportCard.pdf

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PERFORMANCE MEASURE # 12

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

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	98	98	98	99	99
Annual Indicator	97.6	97.1	97.5	96.2	97.2
Numerator	85,080	82,058	82,313	82,809	83,457
Denominator	87,141	84,535	84,393	86,068	85,838
Data Source	Department of Health	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	Final

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
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: 2013
   Field Note:
   Data Source: Tennessee Department of Health, Newborn Screening Program

2. **Section Number:** Form11_Performance Measure #12
   Field Name: PM12
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Data Source: Tennessee Department of Health, Newborn Screening Program

3. **Section Number:** Form11_Performance Measure #12
   Field Name: PM12
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Data Source: Tennessee Department of Health, Newborn Screening Program

AS SUBMITTED TO HRSA ON 07.09.2014 201

PERFORMANCE MEASURE # 13

Percent of children without health insurance.

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	6	3	3.7	2.3	2.5
Annual Indicator	3.7	3.9	2.4	2.7	3.7
Numerator	54,759	57,912	35,743	40,700	55,319
Denominator	1,479,972	1,484,923	1,489,292	1,507,407	1,495,108
Data Source	UT CBER	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	Final

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	3.5	3.4	3.3	3.2	3.1
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #13
   Field Name: PM13
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   Data Source: "The Impact of TennCare, A Survey of Recipients, 2013." http://cber.bus.utk.edu/tncare/tncare13.pdf (Table 2a, page 3)

2. **Section Number:** Form11_Performance Measure #13
   Field Name: PM13
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Data Source: "The Impact of TennCare, A Survey of Recipients, 2012."
   Available at http://cber.bus.utk.edu/tncare/tncare12.pdf (Table 2a, page 3)

3. **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."

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

	2009	2010	2011	2012	2013
Annual Performance Objective	14	25	15	10	10.2
Annual Indicator	15.2	15.4	10.7	10.4	10.5
Numerator	10,490	11,075	19,967	18,890	19,128
Denominator	69,015	71,914	186,444	182,282	182,297
Data Source	Department of Health	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	Final

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	10.4	10.3	10.2	10.1	10
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #14
   Field Name: PM14
   Row Name:
   Column Name:
   Year: 2013
   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: 2012
   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: 2011
   Field Note:
   Data Source: Tennessee Department of Health, PedNSS/TN WIC Database.

AS SUBMITTED TO HRSA ON 07.09.2014 203

Performance Measure # 15

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

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	13	13	13.5	13	12.5
Annual Indicator	15.0	14.2	13.6	13.1	12.9
Numerator	12,257	11,260	10,782	10,433	10,178
Denominator	81,888	79,130	79,234	79,928	79,001
Data Source	Department of Health	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

	2014	2015	2016	2017	2018
Annual Performance Objective	12.8	12.8	12.7	12.7	12.6
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #15
   Field Name: PM15
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   Data source: TDH Office of Health Statistics Birth Statistical System

2. **Section Number:** Form11_Performance Measure #15
   Field Name: PM15
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Data source: TDH Office of Health Statistics Birth Statistical System

3. **Section Number:** Form11_Performance Measure #15
   Field Name: PM15
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Data source: TDH Office of Health Statistics Birth Statistical System

AS SUBMITTED TO HRSA ON 07.09.2014 204

PERFORMANCE MEASURE # 16

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

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	5	5	5	7	7
Annual Indicator	9.1	7.1	7.3	9.0	
Numerator	39	31	31	38	
Denominator	430,127	437,186	426,828	421,428	
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	

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	8.9	8.9	8.8	8.8	8.7
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #16
   Field Name: PM16
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   Because 2013 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: 2012
   Field Note:
   Data sources: TDH Office of Health Statistics Death Statistical System and 2012 US Census

3. **Section Number:** Form11_Performance Measure #16
   Field Name: PM16
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Data sources: TDH Office of Health Statistics Death Statistical System and 2011 US Census

AS SUBMITTED TO HRSA ON 07.09.2014 205

PERFORMANCE MEASURE # 17

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

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	70	80	83	84.5	72
Annual Indicator	79.1	82.9	70.9	80.9	83.0
Numerator	1,085	1,032	843	1,014	1,084
Denominator	1,371	1,245	1,189	1,254	1,306
Data Source	Department of Health	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

	2014	2015	2016	2017	2018
Annual Performance Objective	83.5	83.5	84	84	85
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #17
   Field Name: PM17
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   Data source: TDH Office of Health Statistics Birth Statistical System

2. **Section Number:** Form11_Performance Measure #17
   Field Name: PM17
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Data source: TDH Office of Health Statistics Birth Statistical System

3. **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

AS SUBMITTED TO HRSA ON 07.09.2014 206

PERFORMANCE MEASURE # 18

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

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	70	70	75	70	71
Annual Indicator	69.0	70.5	69.6	70.1	71.2
Numerator	53,529	52,372	51,094	52,878	53,618
Denominator	77,565	74,301	73,445	75,458	75,339
Data Source	Department of Health	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

	2014	2015	2016	2017	2018
Annual Performance Objective	72	72	73	73	74
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #18
   Field Name: PM18
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   Data source: TDH Office of Health Statistics Birth Statistical System

2. **Section Number:** Form11_Performance Measure #18
   Field Name: PM18
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Data source: TDH Office of Health Statistics Birth Statistical System

3. **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

AS SUBMITTED TO HRSA ON 07.09.2014 207

Form 11
Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]
State: TN

Form Level Notes for Form 11

None

State Performance Measure # 1 - Reporting Year

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

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective			7	1	1
Annual Indicator	1.6	1.7	1.4	1.5	
Numerator	129	131	109	121	
Denominator	82,109	79,345	79,462	80,202	
Data Source	Department of Health	Department of Health	Department of Health	Department of Health	
Is the Data Provisional or Final?				Final	

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
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: 2013
   Field Note:
   Data not yet available for 2013. The Child Fatality data for 2013 (source for the numerator) is expected to be available in late 2014.

2. **Section Number:** Form11_State Performance Measure #1
   Field Name: SM1
   Row Name:
   Column Name:
   Year: 2012
   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: 2011
   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.

AS SUBMITTED TO HRSA ON 07.09.2014 208

STATE PERFORMANCE MEASURE # 2 - REPORTING YEAR

Percentage of obesity and overweight among Tennessee K-12 students

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective			25	25	38
Annual Indicator	39.0			38.6	38.5
Numerator	191,090			106,880	126,208
Denominator	489,975			276,877	327,487
Data Source	Department of Education	Department of Education	Department of Education	Office of Coordinated School Health	Department of Health
Is the Data Provisional or Final?				Final	Final

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	38.4	38.2	38	37.8	37.6
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: 2013
   Field Note:
   Data are for 2012-13 school year.

   Data Source: "BMI School Summary Data State and County 2012-13" Available online at:
   http://www.tn.gov/education/schoolhealth/data_reports/doc/BMI_School_Summary_2012-13.pdf

2. **Section Number:** Form11_State Performance Measure #2
   Field Name: SM2
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Data are for 2011-12 school year.

   Data Source: "A Summary of Weight Status Data
   Tennessee Public Schools, 2011-2012 School Year." Available online at:
   http://www.tn.gov/education/schoolhealth/data_reports/doc/BMI_Sum_Data_State_Co_2013.pdf

3. **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.

AS SUBMITTED TO HRSA ON 07.09.2014 209

State Performance Measure # 3 - Reporting Year

Percentage of smoking among women of age 18-44.

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective			20	20	20
Annual Indicator	15.0	21.7	23.6	25.2	
Numerator	12,257	245,470	269,595	278,516	
Denominator	81,888	1,130,950	1,141,863	1,105,002	
Data Source	Department of Health	Department of Health	Department of Health	Department of Health	
Is the Data Provisional or Final?				Final	

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	19	19	18	18	18
Annual Indicator	Future year objectives for state performance measures from needs assessment period 2006-2010 are view-only. If you are continuing any of these measures in the new needs assessment period, you may establish objectives for those measures on Form 11 for the new needs assessment period.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_State Performance Measure #3
   Field Name: SM3
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   Data from 2013 not yet available.

2. **Section Number:** Form11_State Performance Measure #3
   Field Name: SM3
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Data source: Tennessee Department of Health; Division of Policy, Planning and Assessment; Office of Health Statistics; Behavioral Risk Factor Surveillance System (BRFSS). Analysis limited to women aged 18-44 years. Smoking is defined as smoking within the past 30 days (i.e. current smoking).

   Due to changes in BRFSS methodology implemented in 2011, estimates for 2011 and after cannot be compared to those from earlier years. Any shifts in estimates from previous years to 2011 may be the result of the new methodology and not a true change in the population.

3. **Section Number:** Form11_State Performance Measure #3
   Field Name: SM3
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Data Source: Behavioral Risk Factor Surveillance System (BRFSS).

AS SUBMITTED TO HRSA ON 07.09.2014 210

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

	2009	2010	2011	2012	2013
Annual Performance Objective			20	1,700	1,750
Annual Indicator	220.5	1,827.0	1,828.1	1,894.0	
Numerator	1,070	6,007	5,928	6,141	
Denominator	485,318	328,797	324,270	324,238	
Data Source	Department of Health	Department of Health	Department of Health	Department of Health	
Is the Data Provisional or Final?				Final	

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	1,850	1,825	1,800	1,775	1,750
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: 2013
   Field Note:
   Because 2013 population estimates are not available at this time, we are currently unable to report this indicator. Also, provisional 2013 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: 2012
   Field Note:
   Data sources: TDH Office of Health Statistics Hospital Discharge Data System and 2012 US Census

3. **Section Number:** Form11_State Performance Measure #4
   Field Name: SM4
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Data sources: TDH Office of Health Statistics Hospital Discharge Data System and 2012 US Census

AS SUBMITTED TO HRSA ON 07.09.2014 211

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

	2009	2010	2011	2012	2013
Annual Performance Objective			0	0	140
Annual Indicator					
Numerator				134	173
Denominator					
Data Source				Department of Health	Department of Health
Is the Data Provisional or Final?				Final	Final

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	180	190	200	200	200
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: 2013
   Field Note:
   Data Source: The State MCH Director maintains a log of which staff in the Central Office and in the regions have completed a self-assessment and a module in the Navigator.

2. **Section Number:** Form11_State Performance Measure #5
   Field Name: SM5
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Data Source: The State MCH Director maintains a log of which staff in the Central Office and in the regions have completed a self-assessment and a module in the Navigator.

3. **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.

AS SUBMITTED TO HRSA ON 07.09.2014 212

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	2009	2010	2011	2012	2013
Annual Performance Objective			45	45	45
Annual Indicator	39.6	39.6		15.3	19.7
Numerator	34,477	34,477		125	481
Denominator	87,141	87,141		817	2,441
Data Source	CSHCN Survey	CSHCN Survey		TDH PTBMIS	TDH PTBMIS
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data	2014	2015	2016	2017	2018
Annual Performance Objective	55	55	60	60	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: 2013
   Field Note:
   The data for this form was taken from the TDH Patient Tracking Billing Management Information System (PTBMIS). The denominator is the total number of individuals on the Children's Special Servives (CSS) program age 14 and older. The numerator is the number of transition plans that have been conducted.

2. **Section Number:** Form11_State Performance Measure #6
   Field Name: SM6
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   The data for this form was taken from the TDH Patient Tracking Billing Management Information System (PTBMIS). The denominator is the total number of individuals on the Children's Special Servives (CSS) program age 14 and older. The numerator is the number of initial transition plans that have been conducted since the policy and form was approved February 13, 2013.

3. **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.

AS SUBMITTED TO HRSA ON 07.09.2014 213

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

	2009	2010	2011	2012	2013
Annual Performance Objective			14	18.5	16
Annual Indicator	19.0	19.7	16.9	17.7	
Numerator	376	398	342	360	
Denominator	1,974,006	2,023,349	2,025,215	2,038,481	
Data Source	Department of Health	Department of Health	Department of Health	Department of Health	
Is the Data Provisional or Final?				Final	

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	17.5	17.5	17	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: 2013
   Field Note:
   Because 2013 population estimates are not available at this time, we are currently unable to report this indicator. Also, provisional 2013 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: 2012
   Field Note:
   Data sources: TDH Office of Health Statistics Death Statistical System and 2012 US Census

3. **Section Number:** Form11_State Performance Measure #7
   Field Name: SM7
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Data sources: TDH Office of Health Statistics Death Statistical System and 2011 US Census

AS SUBMITTED TO HRSA ON 07.09.2014 214

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

	2009	2010	2011	2012	2013
Annual Performance Objective	7.5	7.5	7	7	7
Annual Indicator	8.0	7.9	7.4	7.2	6.7
Numerator	655	628	587	576	532
Denominator	82,108	79,345	79,462	80,202	79,254
Data Source	Department of Health	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

	2014	2015	2016	2017	2018
Annual Performance Objective	6.6	6.6	6.5	6.5	6.4
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: 2013
   Field Note:
   Data Source: Tennessee Department of Health, Office of Health Statistics, Birth and Death Statistical System

2. **Section Number:** Form12_Outcome Measure 1
   Field Name: OM01
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Data Source: Tennessee Department of Health, Office of Health Statistics, Birth and Death Statistical System

3. **Section Number:** Form12_Outcome Measure 1
   Field Name: OM01
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Data Source: Tennessee Department of Health, Office of Health Statistics, Birth and Death Statistical System

AS SUBMITTED TO HRSA ON 07.09.2014 215

Outcome Measure # 02

The ratio of the black infant mortality rate to the white infant mortality rate.

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	2.1	2.1	2.1	2.1	2.1
Annual Indicator	2.7	2.2	2.1	2.1	2.2
Numerator	16	13.8	12.8	12.1	11.6
Denominator	6	6.3	6	5.9	5.3
Data Source	Department of Health	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

	2014	2015	2016	2017	2018
Annual Performance Objective	2.1	2.1	2	2	1.9
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: 2013
   Field Note:
   Data Source: Tennessee Department of Health, Office of Health Statistics, Birth and Death Statistical System

2. **Section Number:** Form12_Outcome Measure 2
   Field Name: OM02
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Data Source: Tennessee Department of Health, Office of Health Statistics, Birth and Death Statistical System

3. **Section Number:** Form12_Outcome Measure 2
   Field Name: OM02
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Data Source: Tennessee Department of Health, Office of Health Statistics, Birth and Death Statistical System

AS SUBMITTED TO HRSA ON 07.09.2014 216

Outcome Measure # 03

The neonatal mortality rate per 1,000 live births.

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Performance Objective	4.3	4.3	4.3	4.3	4.2
Annual Indicator	4.7	4.6	4.6	4.3	4.1
Numerator	390	364	365	345	326
Denominator	82,108	79,345	79,462	80,202	79,254
Data Source	Department of Health	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	2014	2015	2016	2017	2018
Annual Performance Objective	4	4	3.9	3.9	3.8
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: 2013
   Field Note:
   Data Source: Tennessee Department of Health, Office of Health Statistics, Birth and Death Statistical Systems

2. **Section Number:** Form12_Outcome Measure 3
   Field Name: OM03
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Data Source: Tennessee Department of Health, Office of Health Statistics, Birth and Death Statistical Systems

3. **Section Number:** Form12_Outcome Measure 3
   Field Name: OM03
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Data Source: Tennessee Department of Health, Office of Health Statistics, Birth and Death Statistical Systems

AS SUBMITTED TO HRSA ON 07.09.2014 217

Outcome Measure # 04

The postneonatal mortality rate per 1,000 live births.

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	2.6	2.6	2.6	2.6	2.8
Annual Indicator	3.2	3.3	2.8	2.9	2.6
Numerator	265	262	222	231	206
Denominator	82,108	79,345	79,462	80,202	79,254
Data Source	Department of Health	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

	2014	2015	2016	2017	2018
Annual Performance Objective	2.5	2.5	2.4	2.4	2.3
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 4
   Field Name: OM04
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   Data Source: Tennessee Department of Health, Office of Health Statistics, Birth and Death Statistical Systems

2. **Section Number:** Form12_Outcome Measure 4
   Field Name: OM04
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Data Source: Tennessee Department of Health, Office of Health Statistics, Birth and Death Statistical Systems

3. **Section Number:** Form12_Outcome Measure 4
   Field Name: OM04
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Data Source: Tennessee Department of Health, Office of Health Statistics, Birth and Death Statistical Systems

AS SUBMITTED TO HRSA ON 07.09.2014 218

Outcome Measure # 05

The perinatal mortality rate per 1,000 live births plus fetal deaths.

	Annual Objective and Performance Data				
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	8	8	8	7.5	6.7
Annual Indicator	6.8	6.5	7.3	7.0	6.6
Numerator	557	516	581	560	523
Denominator	82,364	79,589	79,770	80,485	79,515
Data Source	Department of Health	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				
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	6.5	6.5	6.4	6.4	6.3
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 5
   Field Name: OM05
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   Data Source: Tennessee Department of Health, Office 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: 2012
   Field Note:
   Data Source: Tennessee Department of Health, Office 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: 2011
   Field Note:
   Data Source: Tennessee Department of Health, Office of Health Statistics, Birth, Death, and Fetal Death Statistical Systems

AS SUBMITTED TO HRSA ON 07.09.2014 219

Outcome Measure # 06

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

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Performance Objective	15	15	15	15	18
Annual Indicator	18.0	20.3	18.5	18.0	
Numerator	203	236	214	209	
Denominator	1,127,109	1,159,919	1,156,903	1,161,857	
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	

Annual Objective and Performance Data	2014	2015	2016	2017	2018
Annual Performance Objective	17.5	17.5	17	17	16.5
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: 2013
   Field Note:
   Because 2013 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: 2012
   Field Note:
   Data sources: TDH Office of Health Statistics Death Statistical System and 2012 US Census

3. **Section Number:** Form12_Outcome Measure 6
   Field Name: OM06
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Data sources: TDH Office of Health Statistics Death Statistical System and 2011 US Census

AS SUBMITTED TO HRSA ON 07.09.2014 220

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

AS SUBMITTED TO HRSA ON 07.09.2014 221

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).

3

6. Family members of diverse cultures are involved in all of the above activities.

3

Total Score: 18

Rating Key
0 = Not Met
1 = Partially Met
2 = Mostly Met
3 = Completely Met

AS SUBMITTED TO HRSA ON 07.09.2014 222

Form Notes for Form 13

We provided a copy of this form to our state chapter of Family Voices to obtain an external assessment of our family participation. They independently scored the form and concur with the results we are reporting on this form.

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: 2015
   Field Note:
   Family members serve on the CSS Advisory Committee (as outlined in Tennessee statute). Family Voices also provides family liaisons 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: 2015
   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. The Tennessee Department of Health also provided travel reimbursement for a family consultant to attend the 2013 AMCHP meeting.

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: 2015
   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: 2015
   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: 2015
   Field Note:
   The Tennessee Department of Health was awarded a D-70 Systems Integration Grant in 2012; with a portion of that funding, we are providing salary support for a Family Consultant that will work with Family Voices and the state Title V program. Family Voices has also hired a youth consultant to assist in establishing a family youth advisory council.

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: 2015
   Field Note:
   Family members from all cultures are invited to participate in in all of the above activities.

AS SUBMITTED TO HRSA ON 07.09.2014 223

Form 14
List of MCH Priority Needs

[Sec. 505(a)(5)]

State: TN FY: 2015

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

AS SUBMITTED TO HRSA ON 07.09.2014 225

FORM 15
TECHNICAL ASSISTANCE (TA) REQUEST

STATE: TN APPLICATION YEAR: 2015

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	We request assistance in identifying model efforts to align and streamline such protocols among various child- and family-serving agencies.	We are fortunate in TN to have numerous agencies and programs that serve families and children. A pitfall, however, is that most agencies and programs have their own unique protocols for care coordination and developing family service plans.	Unknown
2.	**State Performance Measure Issues** If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here: 5	We need assistance in identifying training resources for staff who have less experience with grant writing.	One of our seven state priority areas is workforce development for MCH staff. With growing reliance on federal funding, there is a great need for program staff to be able to write strong grant applications for federally funded programs.	Unknown
3.	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:			
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.				

AS SUBMITTED TO HRSA ON 07.09.2014 226

	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here:			
10.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here:			
11.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here:			
12.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here:			

AS SUBMITTED TO HRSA ON 07.09.2014 227

Form Notes for Form 15

None

Field Level Notes

None

AS SUBMITTED TO HRSA ON 07.09.2014 228

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.

AS SUBMITTED TO HRSA ON 07.09.2014 229

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.

AS SUBMITTED TO HRSA ON 07.09.2014 231

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.

AS SUBMITTED TO HRSA ON 07.09.2014 232

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:** (Not applicable--the measure will be a count). **Units:** Yes **Text:** Text
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.

AS SUBMITTED TO HRSA ON 07.09.2014 233

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.

AS SUBMITTED TO HRSA ON 07.09.2014 234

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.

AS SUBMITTED TO HRSA ON 07.09.2014 235

Form Notes for Form 16

None

Field Level Notes

None

AS SUBMITTED TO HRSA ON 07.09.2014 236

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				
	2009	**2010**	**2011**	**2012**	**2013**
Annual Indicator	22.7	19.4	21.6	20.1	
Numerator	921	792	873	814	
Denominator	405,883	407,813	405,046	403,971	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	

Field Level Notes

1. **Section Number:** Form17_Health Systems Capacity Indicator #01
   Field Name: HSC01
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   Because 2013 population estimates are not available at this time, we are currently unable to report this indicator. Also, provisional 2013 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: 2012
   Field Note:
   Data sources: TDH Office of Health Statistics Hospital Discharge Data Sysytem and 2012 US Census

3. **Section Number:** Form17_Health Systems Capacity Indicator #01
   Field Name: HSC01
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Data sources: TDH Office of Health Statistics Hospital Discharge Data Sysytem and 2011 US Census

AS SUBMITTED TO HRSA ON 07.09.2014 237

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				
	2009	2010	2011	2012	2013
Annual Indicator	80.6	82.6	86.1	87.6	88.0
Numerator	85,301	89,536	88,584	90,355	90,904
Denominator	105,887	108,351	102,930	103,147	103,303
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: 2013
   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: 2012
   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

3. **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

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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				
	2009	2010	2011	2012	2013
Annual Indicator	100.0	61.6	51.1	34.3	35.3
Numerator	30,753	1,564	1,049	2,577	2,730
Denominator	30,753	2,541	2,051	7,524	7,724
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: 2013
   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 212% 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: 2012
   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).

3. **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).

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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				
	2009	2010	2011	2012	2013
Annual Indicator	88.5	87.0	86.3	86.9	86.3
Numerator	66,927	62,619	61,170	63,882	63,192
Denominator	75,614	71,946	70,859	73,470	73,223
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: 2013
   Field Note:
   Data source: TDH Office of Health Statistics Birth Statistical System

2. **Section Number:** Form17_Health Systems Capacity Indicator #04
   Field Name: HSC04
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Data source: TDH Office of Health Statistics Birth Statistical System

3. **Section Number:** Form17_Health Systems Capacity Indicator #04
   Field Name: HSC04
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Data source: TDH Office of Health Statistics Birth Statistical System

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Health Systems Capacity #07A

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

	Annual Indicator Data				
	2009	2010	2011	2012	2013
Annual Indicator	82.7	82.3	86.0	87.9	87.7
Numerator	654,277	674,964	716,232	725,947	721,657
Denominator	791,343	819,953	832,746	826,000	822,443
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: 2013
   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: 2012
   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: 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.

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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				
	2009	2010	2011	2012	2013
Annual Indicator	54.0	59.2	59.4	60.5	60.3
Numerator	100,908	114,851	117,980	121,938	124,586
Denominator	186,817	194,038	198,785	201,691	206,545
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: 2013
   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: 2012
   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: 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

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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				
	2009	2010	2011	2012	2013
Annual Indicator	17.3	12.4	13.9	16.8	17.5
Numerator	3,676	2,675	3,062	3,752	3,862
Denominator	21,286	21,623	22,001	22,321	22,056
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: 2013
   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: 2012
   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.

3. **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.

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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)*	2012	Matching data files	10.9	7.1	9.2
b) *Infant deaths per 1,000 live births*	2012	Matching data files	9.6	4.1	7.1
c) *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*	2012	Matching data files	60.7	72.4	65.9
d) *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*	2012	Matching data files	68.9	74.7	71.5

AS SUBMITTED TO HRSA ON 07.09.2014 244

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)*	2013	195
b) *Medicaid Children* (Age range 1 to 6) (Age range 6 to 19) (Age range to)	2013	142 133
c) *Pregnant Women*	2013	195

AS SUBMITTED TO HRSA ON 07.09.2014 245

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)*	2013	250
b) *Medicaid Children* (Age range 1 to 5) (Age range 6 to 18) (Age range to)	2013	250 250
c) *Pregnant Women*	2013	250

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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: 2015
   Field Note:
   Tennessee Medicaid (TennCare) website, http://www.tn.gov/tenncare/mem-categories.shtml. Accessed on 05/06/2014.
2. **Section Number:** Form18_Indicator 06 - Medicaid
   Field Name: Med_Children
   Row Name: Medicaid Children
   Column Name:
   Year: 2015
   Field Note:
   Tennessee Medicaid (TennCare) website, http://www.tn.gov/tenncare/mem-categories.shtml. Accessed on 05/06/2014.
3. **Section Number:** Form18_Indicator 06 - Medicaid
   Field Name: Med_Women
   Row Name: Pregnant Women
   Column Name:
   Year: 2015
   Field Note:
   Tennessee Medicaid (TennCare) website, http://www.tn.gov/tenncare/mem-categories.shtml. Accessed on 05/06/2014.
4. **Section Number:** Form18_Indicator 06 - SCHIP
   Field Name: SCHIP_Infant
   Row Name: Infants
   Column Name:
   Year: 2015
   Field Note:
   Data Source: Tennessee SCHIP (CoverKids) Program.
   Age 0-1: eligibility for CHIP is 196-250% FPL.
   Age 1-6: eligibility for CHIP is 143-250% FPL.
   Age 6-18: eligibility for CHIP is 134-250% FPL.
   Pregnant women with incomes below 250% FPL are eligible for CHIP coverage (for the unborn child).
5. **Section Number:** Form18_Indicator 06 - SCHIP
   Field Name: SCHIP_Children
   Row Name: SCHIP Children
   Column Name:
   Year: 2015
   Field Note:
   Data Source: Tennessee SCHIP (CoverKids) Program.
   Age 0-1: eligibility for CHIP is 196-250% FPL.
   Age 1-6: eligibility for CHIP is 143-250% FPL.
   Age 6-18: eligibility for CHIP is 134-250% FPL.
   Pregnant women with incomes below 250% FPL are eligible for CHIP coverage (for the unborn child).
6. **Section Number:** Form18_Indicator 06 - SCHIP
   Field Name: SCHIP_Women
   Row Name: Pregnant Women
   Column Name:
   Year: 2015
   Field Note:
   Data Source: Tennessee SCHIP (CoverKids) Program.
   Age 0-1: eligibility for CHIP is 196-250% FPL.
   Age 1-6: eligibility for CHIP is 143-250% FPL.
   Age 6-18: eligibility for CHIP is 134-250% FPL.
   Pregnant women with incomes below 250% FPL are eligible for CHIP coverage (for the unborn child).
7. **Section Number:** Form18_Indicator 05
   Field Name: LowBirthWeight
   Row Name: Percent of ow birth weight (<2,500 grams)
   Column Name:
   Year: 2015
   Field Note:
   Data Source: Tennessee Department of Health Birth and Death Records and TennCare (Medicaid) Records. Restricted to only mothers with residency in TN.
8. **Section Number:** Form18_Indicator 05
   Field Name: InfantDeath
   Row Name: Infant deaths per 1,000 live births
   Column Name:
   Year: 2015

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Field Note:
Data Source: Tennessee Department of Health Birth and Death Records and TennCare (Medicaid) Records. Restricted to only mothers with residency in TN.

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: 2015
Field Note:
The breakdown of infants born to pregnant women receiving prenatal care beginning in the first trimester. Data is from self reported from Tennessee Department of Health birth records and TennCare (Medicaid) data. A significant portion of women gained Medicaid eligibility after their first trimester. Restricted to only mothers with residency in TN.

10. **Section Number:** Form18_Indicator 05
Field Name: AdequateCare
Row Name: Percent of pregnant women with adequate prenatal care
Column Name:
Year: 2015
Field Note:
Percent of pregnant women with adequate prenatal care was determined based on self reported number of prenatal care visits and the date of first prenatal care using the Tennessee Department of Health birth records and TennCare (Medicaid) data. Only records where prenatal care was reported were used in this calculation. A significant portion of women gained Medicaid eligibility after their first trimester which impacts the adequacy of care possible. Restricted to only mothers with residency in TN.

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

*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.

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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.

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Form Notes for Form 19

None

Field Level Notes

None

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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				
	2009	2010	2011	2012	2013
Annual Indicator	9.2	9.0	9.0	9.2	9.1
Numerator	7,535	7,166	7,169	7,359	7,233
Denominator	82,080	79,305	79,426	80,151	79,227
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: 2013
   Field Note:
   Data source: TDH Office of Health Statistics Birth Statistical System

2. **Section Number:** Form20_Health Status Indicator #01A
   Field Name: HSI01A
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Data source: TDH Office of Health Statistics Birth Statistical System

3. **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

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HEALTH STATUS INDICATOR #01B

The percent of live singleton births weighing less than 2,500 grams.

	Annual Indicator Data				
	2009	2010	2011	2012	2013
Annual Indicator	7.5	7.4	7.4	7.5	7.5
Numerator	5,961	5,688	5,656	5,784	5,749
Denominator	79,491	76,812	76,897	77,563	76,787
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: 2013
   Field Note:
   Data source: TDH Office of Health Statistics Birth Statistical System

2. **Section Number:** Form20_Health Status Indicator #01B
   Field Name: HSI01B
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Data source: TDH Office of Health Statistics Birth Statistical System

3. **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

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HEALTH STATUS INDICATOR #02A

The percent of live births weighing less than 1,500 grams.

	Annual Indicator Data				
	2009	2010	2011	2012	2013
Annual Indicator	1.7	1.6	1.5	1.6	1.6
Numerator	1,371	1,245	1,189	1,254	1,306
Denominator	82,080	79,305	79,426	80,151	79,227
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: 2013
   Field Note:
   Data source: TDH Office of Health Statistics Birth Statistical System

2. **Section Number:** Form20_Health Status Indicator #02A
   Field Name: HSI02A
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Data source: TDH Office of Health Statistics Birth Statistical System

3. **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

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HEALTH STATUS INDICATOR #02B

The percent of live singleton births weighing less than 1,500 grams.

	Annual Indicator Data				
	2009	2010	2011	2012	2013
Annual Indicator	1.3	1.2	1.2	1.2	1.3
Numerator	1,068	950	957	960	984
Denominator	79,491	76,812	76,897	77,563	76,787
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: 2013
   Field Note:
   Data source: TDH Office of Health Statistics Birth Statistical System

2. **Section Number:** Form20_Health Status Indicator #02B
   Field Name: HSI02B
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Data source: TDH Office of Health Statistics Birth Statistical System

3. **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

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HEALTH STATUS INDICATOR #03A

The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.

	Annual Indicator Data				
	2009	2010	2011	2012	2013
Annual Indicator	7.9	10.3	9.6	7.9	
Numerator	95	127	119	98	
Denominator	1,207,621	1,238,935	1,237,679	1,241,590	
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: 2013
   Field Note:
   Because 2013 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: 2012
   Field Note:
   Data sources: TDH Office of Health Statistics Death Statistical System and 2012 US Census

3. **Section Number:** Form20_Health Status Indicator #03A
   Field Name: HSI03A
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Data sources: TDH Office of Health Statistics Death Statistical System and 2011 US Census

AS SUBMITTED TO HRSA ON 07.09.2014 256

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				
	2009	2010	2011	2012	2013
Annual Indicator	2.7	2.5	3.7	1.7	
Numerator	33	31	46	21	
Denominator	1,207,621	1,238,935	1,237,679	1,241,590	

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 #03B
   Field Name: HSI03B
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   Because 2013 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: 2012
   Field Note:
   Data sources: TDH Office of Health Statistics Death Statistical System and 2012 US Census

3. **Section Number:** Form20_Health Status Indicator #03B
   Field Name: HSI03B
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Data sources: TDH Office of Health Statistics Death Statistical System and 2011 US Census

AS SUBMITTED TO HRSA ON 07.09.2014 257

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				
	2009	2010	2011	2012	2013
Annual Indicator	24.6	23.4	20.8	22.8	
Numerator	208	202	181	200	
Denominator	846,897	863,430	868,312	876,624	

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: 2013
   Field Note:
   Because 2013 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: 2012
   Field Note:
   Data sources: TDH Office of Health Statistics Death Statistical System and 2012 US Census

3. **Section Number:** Form20_Health Status Indicator #03C
   Field Name: HSI03C
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Data sources: TDH Office of Health Statistics Death Statistical System and 2011 US Census

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HEALTH STATUS INDICATOR #04A

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

	Annual Indicator Data				
	2009	2010	2011	2012	2013
Annual Indicator	12,487.9	11,867.8	12,007.7	12,066.2	
Numerator	150,807	147,034	148,617	149,813	
Denominator	1,207,621	1,238,935	1,237,679	1,241,590	
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: 2013
   Field Note:
   Because 2013 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: 2012
   Field Note:
   Data sources: TDH Office of Health Statistics Hospital Discharge Data Sysytem and 2012 US Census

3. **Section Number:** Form20_Health Status Indicator #04A
   Field Name: HSI04A
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Data sources: TDH Office of Health Statistics Hospital Discharge Data Sysytem and 2011 US Census

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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				
	2009	2010	2011	2012	2013
Annual Indicator	718.6	674.1	662.4	679.2	
Numerator	8,678	8,352	8,198	8,433	
Denominator	1,207,621	1,238,935	1,237,679	1,241,590	

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: 2013
   Field Note:
   Because 2013 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: 2012
   Field Note:
   Data sources: TDH Office of Health Statistics Hospital Discharge Data Sysytem and 2012 US Census

3. **Section Number:** Form20_Health Status Indicator #04B
   Field Name: HSI04B
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Data sources: TDH Office of Health Statistics Hospital Discharge Data Sysytem and 2011 US Census

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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				
	2009	2010	2011	2012	2013
Annual Indicator	3,028.5	2,886.5	2,814.8	2,803.9	
Numerator	25,648	24,923	24,441	24,580	
Denominator	846,897	863,430	868,312	876,624	

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: 2013
   Field Note:
   Because 2013 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: 2012
   Field Note:
   Data sources: TDH Office of Health Statistics Hospital Discharge Data Sysytem and 2012 US Census

3. **Section Number:** Form20_Health Status Indicator #04C
   Field Name: HSI04C
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Data sources: TDH Office of Health Statistics Hospital Discharge Data Sysytem and 2011 US Census

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HEALTH STATUS INDICATOR #05A

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

	Annual Indicator Data				
	2009	2010	2011	2012	2013
Annual Indicator	42.1	38.8	40.2	39.4	34.1
Numerator	8,815	8,210	8,511	8,334	7,221
Denominator	209,417	211,540	211,482	211,484	211,563
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Final

Field Level Notes

1. **Section Number:** Form20_Health Status Indicator #05A
   Field Name: HSI05A
   Row Name:
   Column Name:
   Year: 2013
   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: 2012
   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: 2011
   Field Note:
   Data Source: Tennessee STD Program Surveillance Morbidity Database which is the Communicable Disease Surveillance System

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HEALTH STATUS INDICATOR #05B

The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.

	Annual Indicator Data				
	2009	2010	2011	2012	2013
Annual Indicator	11.8	11.4	12.6	13.2	12.8
Numerator	12,300	11,862	13,174	13,885	13,502
Denominator	1,044,578	1,044,145	1,047,577	1,051,386	1,055,630
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Final

Field Level Notes

1. **Section Number:** Form20_Health Status Indicator #05B
   Field Name: HSI05B
   Row Name:
   Column Name:
   Year: 2013
   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: 2012
   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: 2011
   Field Note:
   Data Source: Tennessee STD Program Surveillance Morbidity Database which is the Communicable Disease Surveillance System

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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: 2012 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	79,733	56,612	17,540	0	0	0	0	5,581
Children 1 through 4	324,238	235,157	66,627	0	0	0	0	22,454
Children 5 through 9	414,823	307,343	81,163	0	0	0	0	26,317
Children 10 through 14	422,796	315,216	85,521	0	0	0	0	22,059
Children 15 through 19	421,428	310,840	91,946	0	0	0	0	18,642
Children 20 through 24	455,196	340,029	96,562	0	0	0	0	18,605
Children 0 through 24	2,118,214	1,565,197	439,359	0	0	0	0	113,658

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	71,489	8,244	0
Children 1 through 4	291,908	32,330	0
Children 5 through 9	378,766	36,057	0
Children 10 through 14	395,008	27,788	0
Children 15 through 19	396,827	24,601	0
Children 20 through 24	427,640	27,556	0
Children 0 through 24	1,961,638	156,576	0

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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: 2012 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	89	52	35	0	1	1	0	0
Women 15 through 17	2,117	1,403	687	5	5	5	0	12
Women 18 through 19	5,772	3,995	1,697	14	23	7	0	36
Women 20 through 34	63,665	48,621	12,833	96	1,320	144	0	651
Women 35 or older	8,539	6,720	1,306	16	384	23	0	90
Women of all ages	80,182	60,791	16,558	131	1,733	180	0	789

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	76	13	0
Women 15 through 17	1,920	197	0
Women 18 through 19	5,294	478	0
Women 20 through 34	58,250	5,383	32
Women 35 or older	7,628	906	5
Women of all ages	73,168	6,977	37

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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: 2012 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	576	357	200	1	4	0	0	14
Children 1 through 4	110	79	27	1	1	0	0	2
Children 5 through 9	48	36	12	0	0	0	0	0
Children 10 through 14	51	35	14	0	1	0	0	1
Children 15 through 19	285	204	78	0	1	0	0	2
Children 20 through 24	424	298	122	0	2	0	0	2
Children 0 through 24	1,494	1,009	453	2	9	0	0	21

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	543	26	7
Children 1 through 4	103	7	0
Children 5 through 9	46	2	0
Children 10 through 14	47	4	0
Children 15 through 19	275	9	1
Children 20 through 24	413	10	1
Children 0 through 24	1,427	58	9

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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? Final

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	1,663,018	1,225,168	342,797	0	0	0	0	95,053	2012
Percent in household headed by single parent	31.1	23.0	61.8	100.0	0.0	0.0	21.6	0.0	2013
Percent in TANF (Grant) families	5.4	3.5	13.4	0.0	0.0	0.0	0.0	0.8	2013
Number enrolled in Medicaid	702,794	372,619	219,400	859	8,462	0	0	101,454	2013
Number enrolled in SCHIP	19,309	13,455	2,276	33	434	0	0	3,111	2013
Number living in foster home care	6,215	4,448	1,566	23	10	7	0	161	2013
Number enrolled in food stamp program	552,051	351,189	192,849	874	4,734	906	1,499	0	2013
Number enrolled in WIC	207,933	145,757	57,199	426	1,739	146	0	2,666	2013
Rate (per 100,000) of juvenile crime arrests	1,711.0	1,121.0	4,208.0	0.0	0.0	0.0	0.0	358.0	2012
Percentage of high school drop-outs (grade 9 through 12)	5.0	3.5	9.4	7.0	2.6	2.4	5.7	0.0	2013

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	1,533,998	129,020	0	2012
Percent in household headed by single parent	31.2	29.7	0.0	2013
Percent in TANF (Grant) families	5.6	2.8	0.0	2013
Number enrolled in Medicaid	638,285	64,509	0	2013
Number enrolled in SCHIP	16,931	2,378	0	2013
Number living in foster home care	5,413	378	424	2013
Number enrolled in food stamp program	507,594	44,457	0	2013
Number enrolled in WIC	179,323	28,610	0	2013
Rate (per 100,000) of juvenile crime arrests	1,755.0	906.0	0.0	2012

Percentage of high school drop-outs (grade 9 through 12)	5.0	5.2	0.0	2013

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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	1,114,593
Living in urban areas	1,014,585
Living in rural areas	481,416
Living in frontier areas	0
Total - all children 0 through 19	1,496,001

Note:
The Total will be determined by adding reported numbers for urban, rural and frontier areas.

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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: 2013 Is this data from a State Projection? No Is this data final or provisional? Final

POVERTY LEVELS	TOTAL
Total Population	6,422,468
Percent Below: 50% of poverty	9
100% of poverty	18.6
200% of poverty	39.2

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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: 2013 Is this data from a State Projection? No Is this data final or provisional? Final

POVERTY LEVELS	TOTAL
Children 0 through 19 years old	1,639,106
Percent Below: 50% of poverty	15.1
100% of poverty	27.8
200% of poverty	49.1

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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: 2015
   Field Note:
   Data Source: 2012 US Census
2. **Section Number:** Form21_Indicator 06B
   Field Name: S06_Ethnicity_Infants
   Row Name: Infants 0 to 1
   Column Name:
   Year: 2015
   Field Note:
   Data Source: 2012 US Census
3. **Section Number:** Form21_Indicator 07A
   Field Name: Race_Women15
   Row Name: Women < 15
   Column Name:
   Year: 2015
   Field Note:
   Data Source: TDH Office of Health Statistics Birth Statistical System.
   *Note: Does not include 20 women who were missing data on maternal age and could not be categorized into age sub-groups.
4. **Section Number:** Form21_Indicator 07B
   Field Name: Ethnicity_Women15
   Row Name: Women < 15
   Column Name:
   Year: 2015
   Field Note:
   Data Source: TDH Office of Health Statistics Birth Statistical System.
   *Note: Does not include 20 women who were missing data on maternal age and could not be categorized into age sub-groups.
5. **Section Number:** Form21_Indicator 08A
   Field Name: S08_Race_Infants
   Row Name: Infants 0 to 1
   Column Name:
   Year: 2015
   Field Note:
   Data Source: TDH Office of Health Statistics Death Statistical System
6. **Section Number:** Form21_Indicator 08B
   Field Name: S08_Ethnicity_Infants
   Row Name: Infants 0 to 1
   Column Name:
   Year: 2015
   Field Note:
   Data Source: TDH Office of Health Statistics Death Statistical System
7. **Section Number:** Form21_Indicator 09A
   Field Name: HSIRace_Children
   Row Name: All children 0 through 19
   Column Name:
   Year: 2015
   Field Note:
   Data Source (All children 0 through 19): 2012 US Census
8. **Section Number:** Form21_Indicator 09A
   Field Name: HSIRace_SingleParentPercent
   Row Name: Percent in household headed by single parent
   Column Name:
   Year: 2015
   Field Note:
   Data Source (Percent in household headed by single parent): The Current Population Survey (CPS) Annual Social and Economic Supplement Table Creator (http://www.census.gov/cps/data/cpstablecreator.html)

   Numerator: Number of children aged 0-19 living in single male/female-headed primary families, no spouse present.

   Denominator: Total number of children aged 0-19 living in primary families (inc. single male/female-headed and married couple families).
9. **Section Number:** Form21_Indicator 09A
   Field Name: HSIRace_TANFPercent
   Row Name: Percent in TANF (Grant) families

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Column Name:
Year: 2015
Field Note:
Data Source (Percent in TANF (Grant) Families): Tennessee Department of Human Services. Number of enrollees provided by Department of Human Services and then divided by total number of children 0-19 (from first line of this form, obtained from US Census). Census data not available for racial categories other than "White" or "Black or African American," so the other categories are grouped together under "Other and unknown."

10. **Section Number:** Form21_Indicator 09A
Field Name: HSIRace_MedicaidNo
Row Name: Number enrolled in Medicaid
Column Name:
Year: 2015
Field Note:
Data Source (Number enrolled in Medicaid): Bureau of TennCare (Medicaid); TennCare office data effective as of September 2013.

11. **Section Number:** Form21_Indicator 09A
Field Name: HSIRace_SCHIPNo
Row Name: Number enrolled in SCHIP
Column Name:
Year: 2015
Field Note:
Data Source (Number enrolled in SCHIP): Tennessee SCHIP (CoverKids) Program

12. **Section Number:** Form21_Indicator 09A
Field Name: HSIRace_FoodStampNo
Row Name: Number enrolled in food stamp program
Column Name:
Year: 2015
Field Note:
Data Source (Number enrolled in food stamp program): Tennessee Department of Human Services

13. **Section Number:** Form21_Indicator 09A
Field Name: HSIRace_WICNo
Row Name: Number enrolled in WIC
Column Name:
Year: 2015
Field Note:
Data Source (Number enrolled in WIC): Tennessee Department of Health, Division of Family Health and Wellness, WIC Program. Note: Of the 207,933 children reported, 5,291 reported more than once race; however, these are included in the other categories.

14. **Section Number:** Form21_Indicator 09A
Field Name: HSIRace_JuvenileCrimeRate
Row Name: Rate (per 100,000) of juvenile crime arrests
Column Name:
Year: 2015
Field Note:
Data Sources (Rate per 100,000 of juvenile crime arrests): TBI Tennessee Crime Statistics Online (accessed 4/29/2014 at http://www.tbi.state.tn.us/tn_crime_stats/crime_stats_online.shtml) and 2012 US Census.

Numerator: Number of juvenile arrests for group A (violent) and group B (nonviolent) offenses in 2012; restricted to residents. Data source: TBI Tennessee Crime Statistics Online. Other/unknown race = Asian, Native American/Alaskan Native and unknown race. Juvenile is defined as <18 years old (TBI does not provide crime data on 0-19 years age group).

Denominator: Population of persons <18 years old in 2012. Data source: 2012 US Census. Other/unknown race = non-white/black. Population projections for other/unknown ethnicity unavailable --> could not calculate arrest rate for this group

15. **Section Number:** Form21_Indicator 09A
Field Name: HSIRace_DropOutPercent
Row Name: Percentage of high school drop-outs (grade 9 through 12)
Column Name:
Year: 2015
Field Note:
Data Source (Percentage of high school drop-outs grade 9 through 12): Tennessee Department of Education (2012-13 School Year)

16. **Section Number:** Form21_Indicator 09B
Field Name: HSIEthnicity_Children
Row Name: All children 0 through 19
Column Name:
Year: 2015
Field Note:
Data Source (All children 0 through 19): 2012 US Census

17. **Section Number:** Form21_Indicator 09B
Field Name: HSIEthnicity_SingleParentPercent
Row Name: Percent in household headed by single parent
Column Name:
Year: 2015
Field Note:
Data Source (Percent in household headed by single parent): The Current Population Survey (CPS) Annual Social and Economic Supplement Table Creator

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(http://www.census.gov/cps/data/cpstablecreator.html)

Numerator: Number of children aged 0-19 living in single male/female-headed primary families, no spouse present.

Denominator: Total number of children aged 0-19 living in primary families (inc. single male/female-headed and married couple families).

18. **Section Number:** Form21_Indicator 09B
Field Name: HSIEthnicity_TANFPercent
Row Name: Percent in TANF (Grant) families
Column Name:
Year: 2015
Field Note:
Data Source (Percent in TANF (Grant) families): Tennessee Department of Human Services. Number of enrollees provided by Department of Human Services and then divided by total number of children 0-19 (from first line of this form, obtained from US Census). Census data not available for racial categories other than "White" or "Black or African American," so the other categories are grouped together under "Other and unknown."

19. **Section Number:** Form21_Indicator 09B
Field Name: HSIEthnicity_MedicaidNo
Row Name: Number enrolled in Medicaid
Column Name:
Year: 2015
Field Note:
Data Source (Number enrolled in Medicaid): Bureau of TennCare (Medicaid); TennCare office data effective as of September 2013.

20. **Section Number:** Form21_Indicator 09B
Field Name: HSIEthnicity_SCHIPNo
Row Name: Number enrolled in SCHIP
Column Name:
Year: 2015
Field Note:
Data Source (Number enrolled in SCHIP): Tennessee SCHIP (CoverKids) Program

21. **Section Number:** Form21_Indicator 09B
Field Name: HSIEthnicity_FoodStampNo
Row Name: Number enrolled in food stamp program
Column Name:
Year: 2015
Field Note:
Data Source (Number enrolled in food stamp program): Tennessee Department of Human Services

22. **Section Number:** Form21_Indicator 09B
Field Name: HSIEthnicity_WICNo
Row Name: Number enrolled in WIC
Column Name:
Year: 2015
Field Note:
Data Source (Number enrolled in WIC): Tennessee Department of Health, Division of Family Health and Wellness, WIC Program.

23. **Section Number:** Form21_Indicator 09B
Field Name: HSIEthnicity_JuvenileCrimeRate
Row Name: Rate (per 100,000) of juvenile crime arrests
Column Name:
Year: 2015
Field Note:
Data Sources (Rate per 100,000 of juvenile crime arrests): TBI Tennessee Crime Statistics Online (accessed 4/29/2014 at http://www.tbi.state.tn.us/tn_crime_stats/crime_stats_online.shtml) and 2012 US Census.

Numerator: Number of juvenile arrests for group A (violent) and group B (nonviolent) offenses in 2012; restricted to residents. Data source: TBI Tennessee Crime Statistics Online. Other/unknown race = Asian, Native American/Alaskan Native and unknown race. Juvenile is defined as <18 years old (TBI does not provide crime data on 0-19 years age group).

Denominator: Population of persons <18 years old in 2012. Data source: 2012 US Census. Other/unknown race = non-white/black. Population projections for other/unknown ethnicity unavailable --> could not calculate arrest rate for this group

24. **Section Number:** Form21_Indicator 09B
Field Name: HSIEthnicity_DropOutPercent
Row Name: Percentage of high school drop-outs (grade 9 through 12)
Column Name:
Year: 2015
Field Note:
Data Source (Percentage of high school drop-outs grade 9 through 12): Tennessee Department of Education (2012-13 School Year)

25. **Section Number:** Form21_Indicator 10
Field Name: Metropolitan
Row Name: Living in metropolitan areas
Column Name:
Year: 2015
Field Note:
Data Sources: US Census Bureau, 2010 Census. 2010 Census Summary File 1, Table PCT12.

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Notes: Data are for 2010. Urban and metropolitan areas overlap; 'total - all children 0 through 19' equals the sum of children living in urban and rural areas. Data are for children 0-18 years only--data for 0-19 year olds are not available from the US Census. Number of children living in metropolitan areas is the number in 'metropolitan statistical areas.'

26. **Section Number:** Form21_Indicator 11
Field Name: S11_total
Row Name: Total Population
Column Name:
Year: 2015
Field Note:
Data Source: The Current Population Survey (CPS) Annual Social and Economic Supplement Table Creator (http://www.census.gov/cps/data/cpstablecreator.html); data are from the 2013 survey but survey questions regarding income ask about the previous year's income (i.e. 2012)

27. **Section Number:** Form21_Indicator 12
Field Name: S12_Children
Row Name: Children 0 through 19 years old
Column Name:
Year: 2015
Field Note:
Data Source: The Current Population Survey (CPS) Annual Social and Economic Supplement Table Creator (http://www.census.gov/cps/data/cpstablecreator.html); data are from the 2013 survey but survey questions regarding income ask about the previous year's income (i.e. 2012)

28. **Section Number:** Form21_Indicator 09A
Field Name: HSIRace_FosterCare
Row Name: Number living in foster home care
Column Name:
Year: 2015
Field Note:
Data Source (Number living in foster home care): Tennessee Department of Children's Services. This count includes children in any type of family care, including pre-adoptive and trial home visits. It excludes children in group care, institutions, youth development centers, and runaways. The source is the TFACTS Custodial Mega Report dated 3/31/2014.

29. **Section Number:** Form21_Indicator 09B
Field Name: HSIEthnicity_FosterCare
Row Name: Number living in foster home care
Column Name:
Year: 2015
Field Note:
Data Source (Number living in foster home care): Tennessee Department of Children's Services. This count includes children in any type of family care, including pre-adoptive and trial home visits. It excludes children in group care, institutions, youth development centers, and runaways. The source is the TFACTS Custodial Mega Report dated 3/31/2014.

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