Maternal and Child Health Services Title V Block Grant

Tennessee

FY 2021 Application/ FY 2019 Annual Report

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I. General Requirements

I.A. Letter of Transmittal

July 1, 2020

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

Dear Grants Management Officer,

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

'Please contact me directly if further information is needed.

Sincerely,

Morgan F. McDonald, MD FAAP FACP
Deputy Commissioner
Title V Director
Tennessee Department of Health

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710 James Robertson Parkway • Nashville, TN 37228
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I.B. Face Sheet

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

I.C. Assurances and Certifications

The State certifies assurances and certifications, as specified in Appendix F of the 2018 Title V Application/Annual Report Guidance, are maintained on file in the States' MCH program central office, and will be able to provide them at HRSA's request.

I.D. Table of Contents

This report follows the outline of the Table of Contents provided in the *"Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms,"* OMB NO: 0915-0172; Expires: December 31, 2020.

II. Logic Model

Please refer to figure 4 in the "Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms," OMB No: 0915-0172; Expires: December 31, 2020.

III. Components of the Application/Annual Report

III.A. Executive Summary

III.A.1. Program Overview

Needs Assessment

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

The Tennessee Department of Health (TDH) conducted the comprehensive needs assessment for the 2021-2025 cycle during 2019 and 2020 in conjunction with over 100 stakeholders. Key components included:

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

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

Needs and Priorities

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

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

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

- Increase family planning
- Decrease pregnancy-associated mortality
- Increase breastfeeding
- Decrease infant mortality
- Increase prevention and mitigation of Adverse Childhood Experiences (ACEs)
- Decrease overweight and obesity
- Decrease tobacco and e-cigarette use

- Increase medical home
- Improve transition from pediatric to adult care

Program Planning

The MCH/Title V Program is managed within the Tennessee Department of Health's Division of Family Health and Wellness. This division includes sections for:

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

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

Performance Reporting

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

Assuring Comprehensive, Coordinated, Family-Centered Services

The MCH/Title V Program assures comprehensive and coordinated services in a number of ways. Core services such as WIC, family planning, breast and cervical cancer screening, preventive care for children (EPSDT and immunizations), health promotion, community outreach and the care coordination services of Help Us Grow Successfully (HUGS) and Children's Special Services (CSS) are offered in all county health departments. Rural health departments report to regional office and to the Community Health Services (CHS) division of the state health department. Metro health departments are independent and accountable to local governments but operate closely via contract with TDH. This organizational structure assures that MCH/Title V and other state and federal funds are administered comprehensively to all 95 counties and that program fidelity is maintained via direct management or contract. Regular communication occurs with the Regional Leadership Team (metro and regional directors and CHS leadership), the Medical Leadership Team (metro and regional health officers), Nursing Leadership Team (metro and regional nursing leads), and the MCH regional directors to assure multi-directional transmission of key information and provide opportunities for sharing of ideas. Other core MCH/Title V services such as newborn screening provide services to the entire state but are centrally located at the state lab to assure excellent communication between the lab and the FHW clinical follow up team for lead, genetic disorders, hearing loss, and congenital heart disease.

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

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

Partnerships

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

For example, a multitude of local, state, and national partnerships have emerged statewide regarding the opioid crisis and prevention of neonatal abstinence syndrome. In 2019, this resulted in the second consecutive year to year decline (26% from 2017) in cases reported to the NAS surveillance system since 2013. The NAS subcabinet met regularly from 2013-19 with representatives from TDH, Department of Mental Health and Substance Abuse (TDMHSA), Department of Education (DOE), Department of Children's Services (DCS), TennCare, Department of Human Services (DHS) and several others to review NAS surveillance data and research and to plan interventions together. TDH has partnered with the PAC, regional perinatal centers, rural hospitals, Tennessee Hospital Association and the Tennessee Initiative for Perinatal Quality Care (TIPQC) to share best practice and information regarding treatment of drug exposed mothers and infants. TDH is partnering closely with TennCare, TIPQC, and TDMHSAS in the multi-state Opioid Use Disorder, Maternal Outcomes, and Neonatal Abstinence Syndrome Initiative (OMNI) Learning Community. Much of this work has centered on supporting TIPQC in the roll out of maternal and neonatal quality bundles in the care of substance exposed mothers and infants. In addition, TDH has partnered with local drug coalitions, law enforcement, multiple state agencies and insurance companies to fund and promote medication take back sites in all 95 counties. The response to the opioid epidemic has been complex and growing, involving legislative action, law enforcement, regulation education, prevention messaging, and treatment.

Infant mortality reduction efforts have likewise relied extensively on partnerships. For example, DOE, DCS, EMS entities, the medical community, and the judicial system have been critical to maintaining the Child Fatality Review. Local review teams in all judicial districts serve on a volunteer basis and are essential to determining cause of death

for infants and children. This data guides the priorities for the upcoming years, and the local review teams serve as bodies to dissemination information to local communities as well. Given the lack of improvement in the infant mortality rate in the state, the infant mortality strategic plan was revised during 2019 with the assistance of numerous partners including Tennessee Chapter of the American Academy of Pediatrics (TNAAP), TIPQC, the PAC, academic partners such as Vanderbilt University and Children's Hospital, the Children's Hospital Alliance of Tennessee, the Tennessee Breastfeeding Coalition, federally qualified health centers, MCH directors statewide, and community advocacy groups.

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

Leveraging of Federal and Non-Federal Funds

Aligning Title V funds within the Division of Family Health and Wellness allows for planning across programs to address population health priorities by leveraging both federal and state funds. This occurs for all priority areas. For example, reducing and mitigating the effect of ACEs is a priority area for Tennessee Title V since the most recent needs assessment, and activity around this topic has escalated dramatically over the last 5 years in all areas of the state. Title V state and federal funds have been used to support data collection and dissemination, workforce training of thousands of health department staff, and facilitation of multiple partnership meetings across the state. Assuring supportive infrastructure for families is essential to preventing ACEs, and FHW has an active role in this via WIC food security (federal), family planning (federal Title X, reimbursement, and state and federal MCH), investment in the built environment (state Project Diabetes and additional dedicated built environment funds). Positive youth development is promoted via federal rape prevention education funding, state and federal adolescent pregnancy prevention funding, and state funding for youth tobacco prevention councils in 64 counties. Specific programs in FHW also address social determinants of health, enhance parenting skills, and improve community linkages. These include state Healthy Start and federal MIECHV evidence based home visiting programs and the care coordination programs of HUGS and CSS. TDH also participates in several inter-agency and community partnerships targeting ACEs including the Children's Cabinet's "no wrong door" Single Team Single Plan approach to service coordination, the Three Branches Institute, the Young Child Wellness Council, and the Early Success Coalition via federally funded Project LAUNCH.

III.A.2. How Federal Title V Funds Support State MCH Efforts

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

III.A.3. MCH Success Story

The federal-state MCH/Title V partnership has enabled surveillance of SARS-CoV-2 (the virus that causes COVID-19 disease) among pregnant women in Tennessee. With the MCH population in mind an MCH/Title V supported epidemiologist analyzed data from the SARS-CoV-2 Case Report Form. Through this analysis stark ethnic disparities where identified among pregnant women.

Typically 11% of births in Tennessee are to Hispanic/Latina women. However when reviewing SARS-CoV-2 confirmed cases in pregnant women almost half were among Hispanic/Latina women. This is a difference in magnitude of 4.2, showing that these women were being infected at a much higher rate than expected.

These findings were communicated to the Tennessee Department of Health's Division of Health Disparities, as well as the emergency response leadership. MCH/Title V staff reached out to multiple stakeholder groups, including the Health Disparities Task Force and Statewide Regional Call for Health Officers, both of which confirmed these findings were consistent with what was happening on the ground. Staff then worked with the Office of Communications to produce a COVID-19 and pregnancy PSA specifically featuring a Hispanic/Latina pregnant woman and included messaging around the importance of receiving prenatal care. This PSA was distributed to partner organizations around the state and is featured on the Spanish website for COVID-19: https://www.tn.gov/health/cedep/ncov/covid-19-resources-information-in-spanish.html

III.B. Overview of the State

Demographics, Geography, Economy, and Urbanization

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

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

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

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

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

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

Health Status of Tennessee's MCH Population

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

- Low birthweight (41st)
- Children in poverty (42nd)
- Infant mortality (43rd)

However, the state also ranks well on a few MCH indicators including:

- Excessive drinking (8th)
- High school graduation (3rd)
- Pertussis case rate (13th)

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

State Health Agency Roles, Responsibilities, and Priorities

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

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

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

the MCH population across the life course.

The Department is also broadly focusing on primary prevention—preventing disease before it ever occurs. Introduced in 2017, all 95 counties have developed, implemented, and evaluated primary prevention plans. The Primary Prevention Plans are a component of the County Performance Plan. The TDH Primary Prevention Plans are developed by all staff and partners to focus on community based prevention activities. The goal is to implement local policy, systems and environmental changes that positively influence population health. The Primary Prevention Planning Process allows for a consistent and measurable format, and also allows for innovation from the local health department to address community needs. The majority of the plans focus on obesity, tobacco-free environments, physical activity, substance misuse, and immunizations. Over the past year, county prevention plans are now being informed by the county health assessment process which is being rolled out across the state.

In addition to programmatic and policy efforts on these other public health topics, the Department has undertaken a major commitment to performance excellence using the Baldrige framework. The department supported Baldrige Examiner training for 132 LHD employees in the course of six years through TNCPE. The examiners then formed an internal Baldrige Advisory Group to promote enterprise-wide efforts to diffuse quality improvements into LHDs and other TDH services and programs. This quality atmosphere supported program implementation and, in turn, examples of processes and outcomes supported individuals' involvement in the departmental improvement drive. As a result, there was substantial growth in county and program-level applications for TNCPE awards. To date, the total number of TNCPE awards recognizing the work of departments, offices or programs include:

- 82 Interest Recognition Awards
- 40 Commitment Awards
- 6 Achievement Awards

TNCPE named 17 organizations as 2018 Award winners representing outstanding achievement in the following industry sectors: health care, manufacturing, service, education, government and nonprofit.
Of those recognized, the Tennessee Department of Health, eight county health departments and five offices received an award at the 26th Annual Excellence in Tennessee Awards Banquet. TDH was recognized by TNCPE for the second time with a Level 3: Achievement Award – our first was in 2016. In addition, 7 individual counties, a regional office, and five divisions/offices were recognized with awards.

State Systems of Care for Underserved and Vulnerable Populations

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

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

clinics) which has facilitated grants and population health planning among the entities.

The distribution of primary care providers varies across the state. A map with health resource shortage areas for obstetrics and pediatrics can be found in the Supporting Documents section. This section also includes the annual Safety Net report as well as the assessment of rural health for the state as required by the Governor's Executive order #1, both of which highlight MCH needs and state support for these efforts. As of July 2020, the following counts of full-time or part-time, actively licensed providers were available through the TDH Division of Health Licensure and Regulation[4]:

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

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

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

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

State Statutes and Other Regulations Impacting MCH/Title V

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

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

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

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

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

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

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[1] Data Profiles. Tennessee 2018. https://data.census.gov/cedsci/profile?g=0400000US47&hidePreview=true&tid=ACSDP1Y2018.DP02&vintage=2018
[2] America' Health Rankings. 2019. https://www.americashealthrankings.org/explore/annual/state/ALL
[3] America's Health Rankings. 2019 Health of Women and Children Report. https://www.americashealthrankings.org/learn/reports/2019-health-of-women-and-children-report/findings-state-rankings
[4] Tennessee Department of Health. Division of Health Disparities. Healthcare Provider Census.
[5] Tennessee Department of Health, Division of Policy, Planning, and Assessment, Office of Health Statistics. Birth Statistical System, 2013-2017 Nashville, TN

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

III.C.2.a. Process Description

Purpose and Requirements

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

Population Domains:

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

Framework

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

Public Health Planning Cycle:

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

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

Stages in Needs Assessment Process

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

6. Resource Allocation Stage

Planning and Implementation

Start-up Planning Stage

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

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

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

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

Operational Planning Stage

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

In January of 2019 epidemiologists from each domain team met to discuss how to analyze and present the quantitative data in a consistent way across all domains. It was decided that there were three perspectives to cover for each topic. The first was comparing state level data to national data. The second was showing the geographic distribution across the state

through a map rendering. The third was to compare race and ethnic groups to check for any disparities. Then the overall findings from these perspectives would be summarized in a data interpretation section. A template was created and utilized to gather each of these elements. However, for some topics the data was not collected in a way that allowed it to be broken down into each of these perspectives. When this happened, the epidemiologists made substitutions based on what was available.

Data Stage

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

Women's and Maternal Health Topics

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

Perinatal and Infant Health Topics

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

Child Health Topics

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

Adolescent Health Topics

- Physical Activity

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

CYSHCN Topics

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

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

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

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

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

the partner organizations and participants by qualitative method and topic covered.

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

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

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

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

Needs Analysis Stage

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

The matrix was administered at the fall stakeholder meeting. During this meeting each domain team presented the quantitative, qualitative, and capacity assessment data compiled for that domain. The teams then facilitated a discussion

on the data. Feedback on each potential priority was then collected by asking everyone (including TDH staff) to fill out the matrix. The matrix and scores are available in the Supporting Documents section of this grant.

In November of 2019 the MCH Block Grant Coordinator analyzed the data collected through the prioritization matrix and shared the results with each team. Each team then met to discuss the results and identify which potential priority should be recommended as the priority for the new grant cycle. In January of 2020 all domain teams met as one group to finalize the priorities. Each domain team recommended a priority and provided an explanation of why it should be chosen based on data gathered and stakeholder feedback. The MCH Block Grant Coordinator also recommended priorities for the Cross-Cutting domain based on topics that were identified as issues in all the domains. All recommendations were discussed, and the priorities were finalized at this meeting.

Program and Policy Development Stage

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

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

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

Action Plan Structure:

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

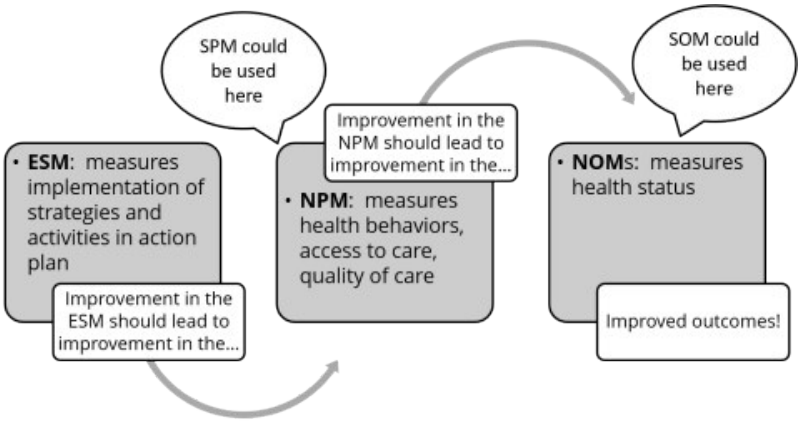
Another requirement is that measurements be developed to assess the impact of the action plan. Therefore, teams developed measures following the 3-tiered measurement framework in the grant guidance. There are three types of measurements that relate to one another.

Types of Measures:

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

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

Relationship Between Measures:



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

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

Resource Allocation Stage

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

III.C.2.b. Findings

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

MCH Population Health Status

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

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

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

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

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

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

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

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

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

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

participated in ACEs training and health disparities training which include implicit bias training and cultural competencies. ACEs training has been provided statewide to both regional and local staff. A Health Equity Toolkit has been developed that includes resources and education around health disparities, cultural biases in order to provide awareness and education to all FHW staff with plans to distribute the toolkit department wide.

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

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

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

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

all health department services are ACEs informed. The Department of Health continues to expand understanding of ACEs and further explore how we can ensure that ACEs are considered as we make program, policy, and procedure decisions.

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

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

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

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

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

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

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

All local health departments are providing outreach, advocacy, and EPSDT screenings for TennCare enrollees and referring patients to their medical home as applicable. The clinics refer patients who may be eligible to TennCare. The family planning program informs patients who test positive for pregnancy about TennCare's presumptive eligibility benefit and refers eligible patients to the agency for application. Department of Children's Services (DCS) is responsible for the children in state custody. The Department of Health is providing the EPSDT screenings for all these children. MCH gets referrals from DCS for home visits. DCS staff are involved on teams reviewing cases for the Child Fatality Review program. MCH staff is invited to attend the multidisciplinary teams to case manage clients. CSS regional coordinators work with the DCS Regional Health Unit nurses to coordinate health services for CSHCN in state custody.

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

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

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

Mental Health/Developmental Disabilities: Staff are active members of the Child Fatality Review program at both local and state levels. MCH staff work collaboratively with the Department of Mental Health/Developmental Disabilities (TDMHDD) to assure that appropriate mental health services are accessed for children with special health care needs. CSS includes an assessment of a child's psychosocial development and refers CSHCN and family members to local mental health centers or other local mental health providers if appropriate. Mental health and socialemotional development are one of the five critical areas being addressed in the Early Childhood

Comprehensive Systems, and TDMHDD staff participate on the Advisory Committee. The TDH Injury Prevention and Detection Director serves as a member of the Tennessee Suicide Prevention Network and works with a state intradepartmental committee and the state suicide prevention advisory committee. The committee has developed a state plan to address youth suicide prevention.

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

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

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

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

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

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

Tennessee Commission for Children and Youth (TCCY)/Mid-Cumberland committee; and the Tennessee Alliance for Drug Endangered Children (TADEC). The Adolescent & Young Adult Health director assists in coordinating activities of the Department's annual Child Health Week with Mental Health and Developmental Disabilities, the TENNderCare program, and community partners. Additional collaborations for the Adolescent & Young Adult Health director include coordinating a committee from throughout the Family Health and Wellness Division (FHW).

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

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

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

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

Folic Acid Education Campaign: Women's Health and Nutrition staff (central and regional offices) are partnering with the March of Dimes, Girl Scouts, and members of the state folic acid council to educate the citizens of TN on the need for folic acid. Staff developed and implemented many of the statewide activities. The Women's Health director serves on the state council. The family planning program provides vitamins with folic acid to patients of reproductive

age who receive program services. MCH staff are currently partnering with the March of Dimes and a health education consultant on a grant to use text messaging and web technology to educate college women on important lifestyle issues.

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

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

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

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

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

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

Prevention and Abstinence Programs and TAPPP Coordinators participate in quarterly conference calls to discuss regional program updates, upcoming events and effective collaborations for future community activities. The Department of Health/MCH is the current recipient of the Pregnancy Assistance Fund (PAF) grant. The PAF grant was transferred to the Department of Health on July 1, 2011. Services consist of access to prenatal care, well child clinical services, a standardized tracking system for program participants, a Baby Store incentive program to purchase needed child care items, and educational information and resources.

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

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

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

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

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

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

Maternal and Women's Health

Family Planning

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

Pregnancy-Associated Mortality

Maternal mortality was ranked 3rd on the prioritization matrix for this domain. Although it was not at the very

top, once again it was felt that work around this priority would impact most of the other potential priorities. The priority was renamed to pregnancy-associated mortality to be more specific.

Perinatal and Infant Health

Breastfeeding

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

Infant Mortality

Infant mortality came in 2nd on the prioritization matrix, just behind breastfeeding. While the state has seen an improvement in this area, the state rate remains well above the national average. Infant mortality is a measure of population health and the quality of health care. Therefore, the team felt that it should continue to be a priority for this domain.

Child Health

Overweight/Obesity

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

Adverse Childhood Experiences (ACEs)

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

Adolescent Health

Tobacco and E-cigarette Use

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

Children with Special Health Care Needs

Medical Home

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

Transition from Pediatric to Adult Care

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

III.D. Financial Narrative

	2017		2018	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$11,749,682	$11,714,889	$12,749,682	$11,817,625
State Funds	$30,000,000	$32,875,484	$30,000,000	$14,525,370
Local Funds	$0	$0	$0	$0
Other Funds	$0	$0	$0	$14,278,869
Program Funds	$4,400,000	$2,647,702	$4,400,000	$2,180,291
SubTotal	$46,149,682	$47,238,075	$47,149,682	$42,802,155
Other Federal Funds	$163,167,051	$143,415,868	$158,886,385	$134,695,633
Total	$209,316,733	$190,653,943	$206,036,067	$177,497,788

	2019		2020	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$12,750,000	$11,449,081	$12,750,000	
State Funds	$32,000,000	$14,002,061	$14,000,000	
Local Funds	$0	$0	$0	
Other Funds	$0	$0	$0	
Program Funds	$2,881,646	$1,853,003	$2,100,000	
SubTotal	$47,631,646	$27,304,145	$28,850,000	
Other Federal Funds	$174,823,962	$119,705,038	$159,282,034	
Total	$222,455,608	$147,009,183	$188,132,034	

	2021	
	Budgeted	Expended
Federal Allocation	$11,800,000	
State Funds	$14,000,000	
Local Funds	$0	
Other Funds	$0	
Program Funds	$1,900,000	
SubTotal	$27,700,000	
Other Federal Funds	$139,734,625	
Total	$167,434,625	

III.D.1. Expenditures

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

The Tennessee Department of Health adheres to the policies and procedures developed by the Department of Finance and Administration. These policies can be found on the Department of Finance and Administration website and pertain to the multiple financial functions of the State.

The Tennessee MCH/Title V Program met all legislative requirements in regards to the spending of grant funds. This includes a maintenance of effort in the amount of $13,125,024 set by the state in 1989. This figure is based on the amount the state was spending on maternal and child health programs in 1989. The state is required to continue to contribute at least that amount to the program in order to receive this federal grant. The state met that amount in FY2019. The state is also required to match the federal dollars 3 to 4. For every 4 federal dollars the state receives they must contribute 3 dollars. For FY2019 Tennessee received $11,797,538 federal dollars, therefore the required state match amount was $8,848,153.50. The state exceeded that match amount in FY2019. The last requirement is that of the federal allocation states spend at least 30% of federal grant funds on preventive and primary care for children, 30% on children with special health care needs, and no more than 10% on administrative cost. Tennessee met all of these thresholds during FY2019. It also should be noted that none of the services paid by the grant were reimbursable by other agencies (namely Medicaid) or providers. This is assured through eligibility determination processes for programs such as CSS as well as regular communication with TennCare regarding the reimbursement services of the MCOs.

During FY2019 federal and state match MCH/Title V Program dollars supported programs across the health domains as illustrated below. Some of the programs span multiple domains, and therefore are repeated among the domains.

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

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

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

III.D.2. Budget

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

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.

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

The maintenance of effort requirement for the Maternal and Child Health Block Grant was established in 1989. This requirement specifies that the state must, at minimum, continue to fund Tennessee MCH/Title V Program efforts through state funds at the level it was in 1989. At that time Tennessee calculated its maintenance of effort to be $13,125,024.28. This calculation was based on an analysis of 15 months of expenditures for the program, adjusted for differences between the state and federal fiscal years, as well as adjustments for accrued liabilities. TDH fully supports using state funds to meet the maintenance of effort and match requirements in support of Maternal and Child Health Program activities. TDH monitors its maintenance of effort annually and has exceeded requirements in all reporting years.

Tennessee fully utilizes Maternal and Child Health Block Grant funding within the 24 month allowable timeframe and meets all targeted maintenance and match requirements set forth in the grant regulations. Any unobligated balance noted in the report will be used to support or expand program activities. This funding has typically been used to develop new services or to expand current programs. During recent years funding has been used in teen pregnancy prevention and for breast and cervical screening for reproductive age women. Funding has also supported 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.

The Tennessee MCH/Title V Program is not proposing major changes to the reported budget for this year. The budget will mirror that of the FY2019 expenditures. This budget aligns with Tennessee's priorities for the grant. Federal dollars are used to extend the reach of state dollars. The federal allocation allows Tennessee to serve more

of the maternal and child population.

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

Other Federal Programs

- Abstinence Education Grant
- Breast and Cervical Cancer Screening Grant
- Childhood Lead Poisoning Prevention
- Commodity Supplemental Food Program (CSFP)
- Family Planning (Title X)
- Injury Surveillance and Prevention
- The Loving Support Peer Counseling Program
- Maternal, Infant, Early Childhood Home Visiting Program
- Preventive Health Services Block Grant
- Rape Prevention and Education
- State Systems Development Initiative
- Sudden Death in the Young Registry
- Tobacco Quitline
- Tobacco Use Prevention and Control
- Traumatic Brain Injury
- Universal Newborn Hearing
- Women, Infants, and Children

The required state match and maintenance of effort is monitored throughout the year by the Division of Administrative Services. All programs of the TDH must be free from discrimination. The Department's non-discrimination policy is below.

TDH Non-Discrimination Statement:

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

III.E. Five-Year State Action Plan

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

State: Tennessee

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

State Action Plan Table - Entry View

State Action Plan Table - Legal Size Paper View

III.E.2. State Action Plan Narrative Overview

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

Partnership and Leadership Roles in Accomplishing Goals and Mission

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

Framework and Approach to Addressing the MCH Priorities

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

Population Health Domains:

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

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

III.E.2.b. Supportive Administrative Systems and Processes

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

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

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

In 2018-2019, all central office FHW staff participated in trainings designed to educate and provide awareness related to health equity. These trainings included ACEs, health disparities, and implicit bias education and awareness. In 2019, a Health Equity Steering Committee, led by Jacqueline Johnson, state CYSHCN Director, has been developed that includes representatives from all FHW programs. The Steering Committee has developed a FHW Health Equity Three-Year Plan year that includes the development of a Health Equity 101 tool kit for all FHW employees. The goal is for all new employees to participate in the training provided in the tool within the first 6 months of employment and existing employees will incorporate the training into their annual Health Equity goal that each FHW staff member has in their individual performance plans.

To enhance our ability to provide culturally competent services, Tennessee's MCH/Title V Program has partnered with the University of Tennessee at Knoxville (UTK), a HRSA-MCHB grant recipient, to provide cultural competency training to health department staff. Since March 2012, selected Department of Health staff in all 13 regions participate in a half-day training provided by UTK annually. The workshop takes an in-depth look at individual cultural competence. It is specifically designed to increase awareness, knowledge, and skills in dealing with clients, patients, and co-workers whose world view is different from one's self. The emphasis is on the health-related professions. The first round of training focused on regional and Central Office Leadership and subsequent sessions (ongoing) are providing the training to front-line service delivery staff. During 2018-2019, several professional development efforts have been held for the evidence based home visiting and care coordination workforce. Training topics included reproductive life plan, implicit bias, maternal depression and integrating Georgia Department of Health's Talk with Me Baby language nutrition program into TDH interactions with families.

The Department of Health has taken a leadership role in the Building Strong Brains: Tennessee's ACEs Initiative and has set a goal of increasing the workforce's knowledge of ACEs. Staff members in each region have been trained in the standardized ACEs curriculum that shares key information about the brain science behind ACEs, the importance of safe and nurturing relationships during early childhood, and strategies for reducing the impact of ACEs. The majority of TDH staff have been trained in the ACEs standardized curriculum. Knowledge dissemination is the first step in ensuring that all health department services are ACEs informed. Over the next few years, the Department of Health will continue to expand our understanding of ACEs and further explore how we can ensure that ACEs are considered as we make program, policy, and procedure decisions.

FHW staff are also encouraged to take advantage of external workforce development activities. Tennessee is one of the states participating in the MCH Workforce Development Center Cohorts, with a focus on CHANT training for statewide programmatic roll out. Academic partnerships with ETSU and CDC/Harvard School of Public Health have

facilitated two evaluation skill building workshops. Some staff participate in LEAD Tennessee, a statewide, 12-month development initiative which includes six one-day summits of intense, personally tailored, high impact learning focused on twelve core leadership competencies. The goal of LEAD Tennessee is to increase the state's leadership bench strength by providing agencies with a continuous pipeline of motivated and prepared leaders that share a common language and mindset about great leadership. Jacqueline Johnson, state CYSHCN Director, participated in the AMCHP Leadership Institute for CYSHCN Directors. This program promotes valuable components for both new and experienced directors. Ms. Johnson also participated in the health equity institute offered by the University of Washington.

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

Over the past five years, TDH has recruited fourteen epidemiologists to FHW (including five doctoral-level epidemiologists). The epidemiologists provide broad support for data analysis and program evaluation across the Division and specialized support in program areas such as home visiting, chronic disease prevention and health promotion, injury prevention and detection, reproductive and women's health, newborn screening, childhood lead poisoning prevention, and children and youth with special healthcare needs. Ms. Traylor, Epidemiologist, MCH Block Grant and SSDI Grant Coordinator, has helped to build surge capacity for MCH epidemiology-related issues. She has considerably expanded the Division and the Department's capacity. She spearheads data quality initiatives with vital records, provides mentoring structure for division epidemiologists, expands capacity for analytics in maternal mortality, among many other initiatives. She has also instituted a well-attended journal club as well as publications work group with participants from across the Division.

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

FHW routinely hosts student interns from a variety of training levels (undergraduate, graduate, and post-graduate). Products of recent or current trainees include:

- Investigation of pediatric opioid overdose with publication of relevant infographics for key stakeholders.
- Development of an online overview of health equity approaches in all fifty states.
- Literature synthesis for statewide provider, payer, and advocate groups which have developed to address the recurrent prematurity prevention initiatives of17-OHP utilization and access to immediate post-partum long-acting contraception
- Educational materials on preventing unintended pregnancy for adolescents and adolescent health care providers

- Development of "one key question" outreach to providers encouraging them to act to reduce unintended pregnancy
- Mapping of tobacco retailers in relation to school and engaging youth in tobacco prevention activities
- Focus groups to gain understanding of decision making of minority fathers regarding breastfeeding initiation

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

III.E.2.b.iii. States Systems Development Initiative and Other MCH Data Capacity Efforts

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

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

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

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

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

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

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

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

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

The SSDI grant also supports key MCH data priority needs. For example, the SSDI coordinator has been supporting the building of the birth defects surveillance system for the state. This includes how birth defect data is collected, transferred and stored within systems. The coordinator is available for data enhancement activities throughout the division as they arise and time permits.

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

Health Care Delivery System

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

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

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

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

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

The scope of MCH/Title V partnership with TennCare extends far beyond reimbursement for MCH services in local health departments. The agencies partner together in multiple population health priorities. For example, TennCare partially funds infant mortality reduction initiatives through MCH/Title V programs such as group prenatal care pilots, FIMR teams, safe sleep promotion, and training in long acting reversible contraception insertion. TennCare representatives routinely participate in the Perinatal Advisory Committee to discuss issues such as delivery at appropriate levels of care, implementation of the LOCATe tool, NAS management, and back transport policies. TennCare, TDH, and the MCOs also meet at least quarterly with the Tennessee Chapter of the American Academy of

Pediatrics to coordinate efforts around EPSDT, immunizations, PCMH, and emerging population health priorities. In addition, the MCH/Title V director meets regularly with TennCare in context such as the NAS subcabinet, TIPQC, and on an ad hoc basis. TennCare has intentionally included input from TDH and the MCH/Title V Program regarding the implementation of its episodes of care model for payment reform. TennCare funding also supports TDH outreach efforts and partially supports the HUGS care coordination services, and TDH has worked extensively with TennCare and the MCOs to align service delivery via CHANT. The agencies collaborate on multiple other MCH related efforts such as lead screening and EPSDT outreach. There has been ongoing joint action to minimize barriers to contraception and particularly voluntary long acting reversible contraception in the immediate post-partum period, co-authorship of the legislatively mandated diabetes report, co-authorship of a 2017 legislatively mandated report on neonatal abstinence syndrome, joint work around maternal mortality reduction initiatives, and support for the perinatal quality collaborative roll out of its quality bundles for substance exposed mothers and neonates.

TDH Efforts for Outreach and Enrollment

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

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

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

In 2018 (CY), TDH assisted 17,980 pregnant women with presumptive eligibility assistance and 14,313 pregnant women with Medicaid and CoverKids enrollment assistance. TDH conducts routine training with local staff on changes in the Medicaid enrollment process to ensure that eligible persons can be served.

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

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

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

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

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

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

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

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

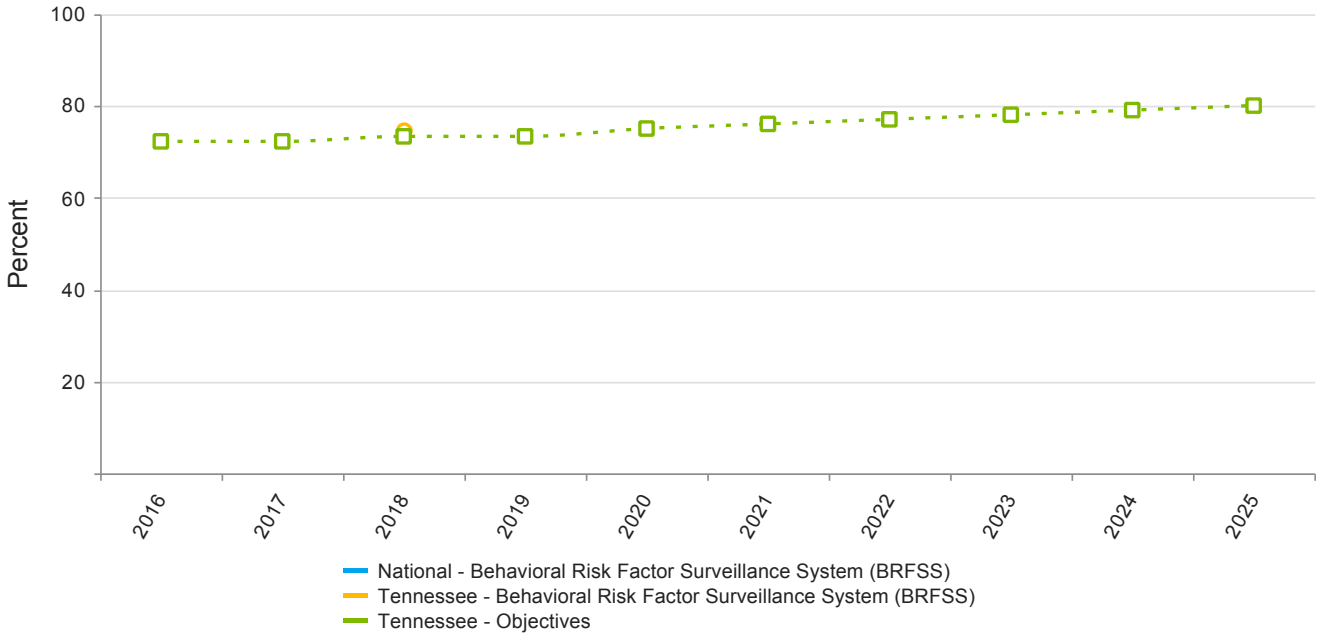
Women/Maternal Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations	SID-2017	75.0	NPM 1 NPM 14.1
NOM 3 - Maternal mortality rate per 100,000 live births	NVSS-2014_2018	24.9	NPM 1 NPM 14.1
NOM 4 - Percent of low birth weight deliveries (<2,500 grams)	NVSS-2018	9.3 %	NPM 1 NPM 14.1
NOM 5 - Percent of preterm births (<37 weeks)	NVSS-2018	11.1 %	NPM 1 NPM 14.1
NOM 6 - Percent of early term births (37, 38 weeks)	NVSS-2018	27.9 %	NPM 1 NPM 14.1
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2017	6.8	NPM 1 NPM 14.1
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2017	7.3	NPM 1 NPM 14.1
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2017	4.6	NPM 1 NPM 14.1
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2017	2.7	NPM 1 NPM 14.1
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2017	201.2	NPM 1 NPM 14.1
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2017	149.4	NPM 14.1
NOM 10 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy	PRAMS-2015	5.5 %	NPM 1
NOM 11 - The rate of infants born with neonatal abstinence syndrome per 1,000 hospital births	SID-2017	16.2	NPM 1
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2017_2018	88.7 %	NPM 14.1
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2018	25.3	NPM 1
NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth	PRAMS-2015	15.4 %	NPM 1

National Performance Measures

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



Federally Available Data				
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)				
	2016	**2017**	**2018**	**2019**
Annual Objective	72.2	72.2	73.3	73.3
Annual Indicator	69.6	66.0	68.3	74.6
Numerator	794,110	760,359	781,733	875,792
Denominator	1,140,291	1,152,528	1,144,543	1,174,631
Data Source	BRFSS	BRFSS	BRFSS	BRFSS
Data Source Year	2015	2016	2017	2018

Annual Objectives						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	75.0	76.0	77.0	78.0	79.0	80.0

Evidence-Based or –Informed Strategy Measures

ESM 1.1 - Toolkit developed and distributed to help family planning clinics reduce barriers to care among males, teens and LGBTQ+ persons

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	Yes	No	No	No	No

ESM 1.2 - Percent of family planning providers trained to use reproductive life plan assessments

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	0.0	80.0	80.0	80.0	80.0

ESM 1.3 - Percent of family planning visits that occur via telehealth at pilot sites

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	10.0	15.0	20.0	25.0	30.0

ESM 1.4 - Person-Centered Contraceptive Counseling Measure survey piloted at one Title X site

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	Yes	No	No	No	No

ESM 1.5 - Family planning information packet created for distribution at TennCare (medicaid) presumptive eligibility visits

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	Yes	No	No	No	No

ESM 1.6 - Number of presentations provided to Sexual Risk Avoidance Education and Rape Prevention Education sub-grantees on TDH-funded family planning services

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	22.0	22.0	22.0	22.0	22.0

ESM 1.7 - Percent of Tennessee Breast and Cervical Screening Program vendors educated on TDH-funded family planning services

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	20.0	40.0	60.0	80.0	100.0

ESM 1.8 - Percent of family planning providers trained on trauma-informed care

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	80.0	80.0	80.0	80.0	80.0

ESM 1.9 - Number of workgroup meetings held by the TDH Family Planning Program and the Tennessee Department of Mental Health and Substance Abuse (TDMHSA)

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	1.0	2.0	2.0	2.0	2.0

ESM 1.10 - Number of recommendations provided as real-time alerts

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	4.0	4.0	4.0	4.0	4.0

ESM 1.11 - Number of simulation trainings

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	1.0	2.0	3.0	3.0	4.0

ESM 1.12 - Number of presentations completed by the speaker's bureau

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	15.0	20.0	25.0	30.0	35.0

ESM 1.13 - Number of high-risk obstetric consultations

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	8,400.0	8,820.0	9,261.0	9,724.0	10,210.0

ESM 1.14 - Number of Maternal Health Task Force members

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	80.0	85.0	90.0	95.0	100.0

ESM 1.15 - Number of community agencies funded to implement Maternal Mortality Review Committee (MMRC) recommendations

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	5.0	5.0	5.0	5.0	5.0

ESM 1.16 - Percent of CHANT and EBHV participants screened for depression

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	94.0	95.0	97.0	98.0	100.0

ESM 1.17 - Number of CHANT and EBHV staff trained on Question, Persuade, Refer suicide prevention

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	225.0	250.0	250.0	275.0	275.0

ESM 1.18 - Number of women applying for presumptive eligibility

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	12,700.0	12,700.0	12,700.0	12,700.0	12,700.0

ESM 1.19 - Percent of identified maternal deaths reviewed

Measure Status:	Active

Baseline data was not available/provided.

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

ESM 1.20 - Number of recommendations implemented for preventing maternal deaths

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	7.0	9.0	11.0	13.0	13.0

ESM 1.21 - Number of documents disseminated with health disparity data

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	2.0	3.0	3.0	4.0	4.0

State Performance Measures

SPM 1 - Percent of new mothers whose pregnancy was intended

Measure Status:	Active

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

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	62.0	62.0	63.0	63.0	64.0	64.0

SPM 2 - Percent of facilities implementing patient safety recommendations

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	24.2	23.5	22.0	21.8	20.5

SPM 3 - Number of non-clinical Maternal Morality Review Committee (MMRC) recommendations implemented

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	5.0	6.0	7.0	7.0	8.0

SPM 4 - Percent of staff reporting high or very high understanding of suicide warning signs post training

Measure Status:	Active

Baseline data was not available/provided.

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

SPM 5 - Percent of community level recommendations implemented

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	12.5	12.5	20.0	20.0	25.0

State Outcome Measures

SOM 1 - Rate of pregnancy-related mortality to live births

Measure Status:	Active

Baseline data was not available/provided.

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

SOM 2 - Number of pregnancy-associated, but not related, deaths

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	49.0	48.0	48.0	45.0	42.0

SOM 3 - Rate of pregnancy-associated mortality

Measure Status:	Active

Baseline data was not available/provided.

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

State Action Plan Table

State Action Plan Table (Tennessee) - Women/Maternal Health - Entry 1

Priority Need

Decrease pregnancy-associated mortality

NPM

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

Objectives

Decrease pregnancy-associated mortality

Strategies

Improve preconception and prenatal health through increased enrollment in both family planning and presumptive eligibility

ESMs	Status
ESM 1.1 - Toolkit developed and distributed to help family planning clinics reduce barriers to care among males, teens and LGBTQ+ persons	Active
ESM 1.2 - Percent of family planning providers trained to use reproductive life plan assessments	Active
ESM 1.3 - Percent of family planning visits that occur via telehealth at pilot sites	Active
ESM 1.4 - Person-Centered Contraceptive Counseling Measure survey piloted at one Title X site	Active
ESM 1.5 - Family planning information packet created for distribution at TennCare (medicaid) presumptive eligibility visits	Active
ESM 1.6 - Number of presentations provided to Sexual Risk Avoidance Education and Rape Prevention Education sub-grantees on TDH-funded family planning services	Active
ESM 1.7 - Percent of Tennessee Breast and Cervical Screening Program vendors educated on TDH-funded family planning services	Active
ESM 1.8 - Percent of family planning providers trained on trauma-informed care	Active

ESM 1.9 - Number of workgroup meetings held by the TDH Family Planning Program and the Tennessee Department of Mental Health and Substance Abuse (TDMHSA)	Active
ESM 1.10 - Number of recommendations provided as real-time alerts	Active
ESM 1.11 - Number of simulation trainings	Active
ESM 1.12 - Number of presentations completed by the speaker’s bureau	Active
ESM 1.13 - Number of high-risk obstetric consultations	Active
ESM 1.14 - Number of Maternal Health Task Force members	Active
ESM 1.15 - Number of community agencies funded to implement Maternal Mortality Review Committee (MMRC) recommendations	Active
ESM 1.16 - Percent of CHANT and EBHV participants screened for depression	Active
ESM 1.17 - Number of CHANT and EBHV staff trained on Question, Persuade, Refer suicide prevention	Active
ESM 1.18 - Number of women applying for presumptive eligibility	Active
ESM 1.19 - Percent of identified maternal deaths reviewed	Active
ESM 1.20 - Number of recommendations implemented for preventing maternal deaths	Active
ESM 1.21 - Number of documents disseminated with health disparity data	Active

NOMs

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

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

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

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

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

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

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

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

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

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

NOM 10 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy

NOM 11 - The rate of infants born with neonatal abstinence syndrome per 1,000 hospital births

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

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

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

Priority Need

Increase family planning

SPM

SPM 1 - Percent of new mothers whose pregnancy was intended

Objectives

Increase access to family planning services.

Strategies

Remove barriers to care at Title X clinics across the state and provide high-quality, non-coercive, culturally competent family planning services to all clients

Increase awareness of the availability of Title X family planning services in Tennessee and of how to access these services through community education and outreach

Promote mental health and increase client confidence in care through provision of client centered, trauma-informed care

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

Priority Need

Decrease pregnancy-associated mortality

SPM

SPM 2 - Percent of facilities implementing patient safety recommendations

Objectives

Decrease pregnancy-associated mortality

Strategies

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

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

Priority Need

Decrease pregnancy-associated mortality

SPM

SPM 3 - Number of non-clinical Maternal Morality Review Committee (MMRC) recommendations implemented

Objectives

Decrease pregnancy-associated mortality

Strategies

Increase community involvement to improve maternal health outcomes

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

Priority Need

Decrease pregnancy-associated mortality

SPM

SPM 4 - Percent of staff reporting high or very high understanding of suicide warning signs post training

Objectives

Decrease pregnancy-associated mortality

Strategies

Improve mental health among women of childbearing age

State Action Plan Table (Tennessee) - Women/Maternal Health - Entry 6

Priority Need

Decrease pregnancy-associated mortality

SPM

SPM 5 - Percent of community level recommendations implemented

Objectives

Decrease pregnancy-associated mortality

Strategies

Increase surveillance of maternal deaths

State Action Plan Table (Tennessee) - Women/Maternal Health - Entry 7

Priority Need

Decrease pregnancy-associated mortality

SOM

SOM 1 - Rate of pregnancy-related mortality to live births

Objectives

Decrease pregnancy-associated mortality

Strategies

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

State Action Plan Table (Tennessee) - Women/Maternal Health - Entry 8

Priority Need

Decrease pregnancy-associated mortality

SOM

SOM 2 - Number of pregnancy-associated, but not related, deaths

Objectives

Decrease pregnancy-associated mortality

Strategies

Improve mental health among women of childbearing age

State Action Plan Table (Tennessee) - Women/Maternal Health - Entry 9

Priority Need

Decrease pregnancy-associated mortality

SOM

SOM 3 - Rate of pregnancy-associated mortality

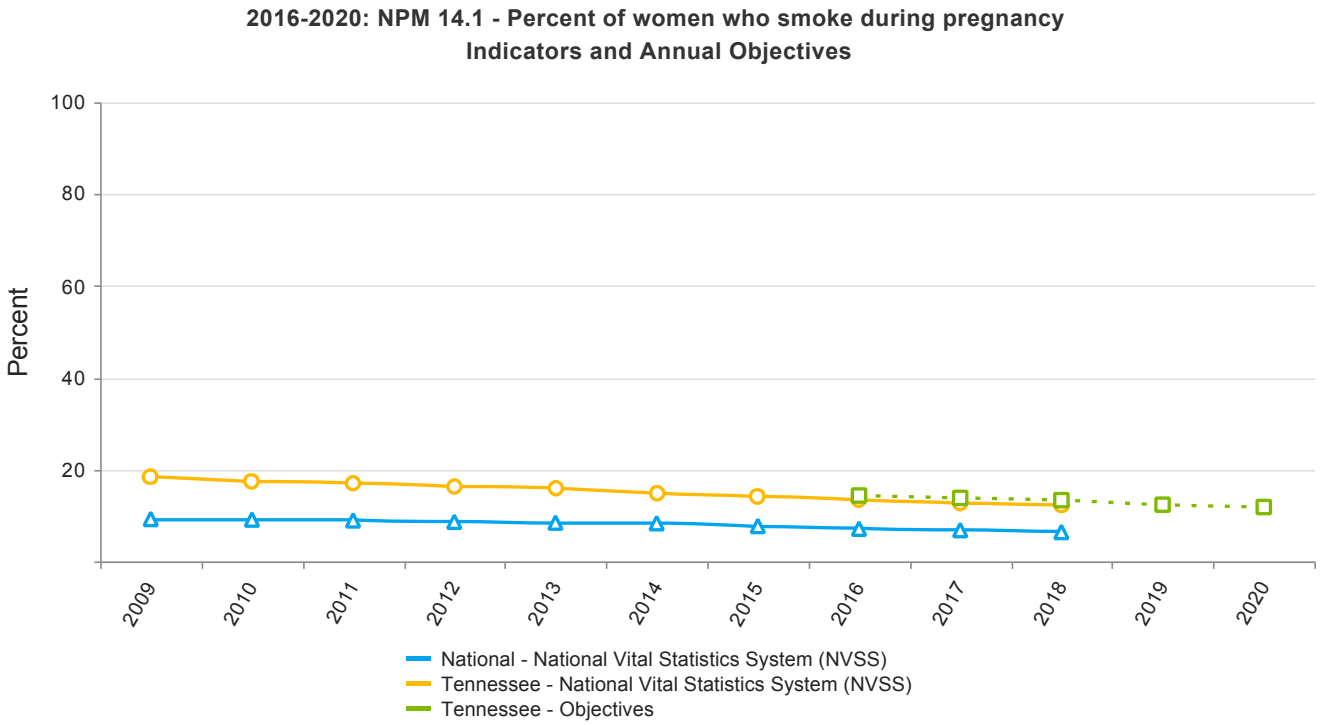
Objectives

Decrease pregnancy-associated mortality

Strategies

Increase surveillance of maternal deaths

2016-2020: National Performance Measures



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

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

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

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

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

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

NPM 1: In calendar year 2018, the percent of women with a past year preventive medical visit was 74.6% compared to 69.6% in calendar year 2015. However, based on overlapping confidence intervals this difference was not statistically significant. This measure has remained steady since the beginning of the grant period.

SPM 3: In calendar year 2017, the percent of women with an unintended pregnancy was 51.5% compared to 51.6% in calendar year 2013. There has not been a statistically significant change in this measure since the beginning of the grant period.

ESM 1.1: In state fiscal year 2019, there were 21press releases, PSAs and/or social media messages promoting preventive health care visits for women of reproductive age. This was 1 more than the goal of 20.

ESM 1.2: In state fiscal year 2019, there were 33 webinars for providers on increasing preventive care visits among women in their clinics conducted and/or promoted. This was 31 more than the goal of 2.

ESM 1.3: In state fiscal year 2019, there were 2 site-level family planning utilization reports distributed, which met the goal for this measure.

ESM 1.4: In state fiscal year 2019, there were 2 region-level pregnancy-related service utilization reports distributed, which met the goal for this measure.

Accomplishments and Challenges (based on FY2019 Action Plan)

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

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

Report 1a: Distributed over forty thousand of "Healthy Women Tennessee" flyers to local health departments, faith-based institutions and community organizations promoting preventive health annual visits and recommended screenings. Developed and disseminated press releases for Breast Cancer Awareness, Sexual Assault Awareness, Teen Pregnancy Prevention Month. Promoted "Let's Talk Month" to support healthy communication between mother's and daughters about personal health.

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

Report 1b: The Reproductive and Women's Health Educator promotes the need for preventative health visits at every opportunity. She has provided education on over 40 occasions to multiple different audiences and has worked with Family Planning, Breast and Cervical, Rape Prevention and Education, Health Promotion, Immunization, Sexually Transmitted Disease, Teenage Pregnancy Prevention, Sexual Risk Avoidance among others.

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

Report 1c: During state fiscal year 2019, there were 791 education and outreach activities promoting preventive health care visits for girls/women reported in the RWH REDCap system.

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

Report 1d: **"**Healthy Women Tennessee" flyers were distributed to faith-based organizations and disseminated in church bulletins during Women's Health Week.

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

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

Report 2a: Multiple trainings have been conducted across the state by the Women's Health Clinical Trainer. Fifteen face to face presentations discussing the importance of preventative care and ways to decrease patient barriers have been completed in both private and public settings.

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

Report 2b: The promotion of the importance of a reproductive life plan is ongoing. However, the Family Planning program is transitioning from the use of One Key Questions to utilizing PATH, a more informative, gender neutral discussion. PATH is being

incorporated into the local health department's electronic health record system along with One Key Question. The Family Planning Program is continuing to ensure the discussion of a reproductive life plan using one of these methods through site visits. Partnerships with other public health programs promoting assessment and counseling on the importance of having a reproductive life plan are ongoing.

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

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

Report 3a: All local health departments continue to provide quality family planning services across the state. Every family planning client is offered preventative health exams and referrals were made as needed based on examination findings. More than 11,000 women needing breast or cervical cancer screenings received these services or a referral for these services though a local health department.

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

Report 3b: Currently, TDH has 19 memoranda of understandings with FQHC's with 83 clinical sites to facilitate referrals for primary care services not available at local health departments. In addition to the MOU's, 51 counties have local health departments that provide primary care services directly on site.

Activity 3c: Create quarterly site-level reports for Family Planning clinics assessing client demographic trends for use in targeting outreach activities and promoting Family Planning clinic utilization and preventive reproductive health services.

Report 3c: Bi-annual site-level reports were distributed to Family Planning Administrators (FPAs). Reports provided clinic and client demographic data and trends used for targeting outreach efforts and promoting Family Planning clinic utilization and preventive reproductive health services.

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

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

Report 4a: All local health departments continue to offer basic prenatal services including pregnancy testing, presumptive eligibility determination for Medicaid, WIC, counseling, information and referral for medical care. Local health departments

are also assisting pregnant women with full enrollment of Medicaid services to ensure the continuation of care.

Activity 4b: Provide a hotline for women to obtain information about healthcare providers and health care services through TDH's Primary Prevention Impact Services call center.

Report 4b: The toll-free Title V hotline for women was maintained.

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

Report 4c: The local health departments distributed 10,400 bottles vitamins with folic acid in 2018,and provided folic acid education to both nonpregnant and pregnant women.

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

Report 4d: A report conducted in May 2019 found that approximately 9,200 women were presumptively enrolled into TennCare in calendar year 2018 and that over one half of these women (58.7%) had not had a pregnancy test.

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

Report 4e: During state fiscal year 2019, there were 19 TTOPS, life maze and baby shower activities reported by TAPPP staff. In addition, there were 5 life mazes conducted by Abstinence Education staff.

Priority: Reduce exposure to tobacco among the MCH population (pregnancy smoking exposure).

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

NPM 14.1: Prenatal smoking rates have continued to decline by approximately 0.5 percentage points year over year. This continued decline is likely due to continuing social norm changes across the state and is further supported by prenatal smoking cessation programs such as Baby & Me Tobacco Free which target rural and low-income populations of women most likely to smoke during pregnancy.

ESM 14.1.1: The number of reproductive-aged female tobacco users who receive online or phone counseling services through the Tennessee Tobacco QuitLine has been in decline by approximately 4% each year since FY17. This is in line with national downward trends in QuitLine usage and enrollment, especially among individuals under 45 years of age. A unifying reason for this decline has yet to be identified either in Tennessee or nationally.

Accomplishments and Challenges (based on FY2019 Action Plan)

Strategy 1: Collaborate with Tobacco Prevention and Control staff to promote the Tennessee Tobacco QuitLine.

Activity 2a: Promote the QuitLine as a resource through CDC media outreach, publications, and presentations targeted to women of reproductive age.

Report 2a: Tobacco Coordinators and Health Educators partner with OB/GYN and Primary Care offices to host classes to educate their female patients of childbearing age about the dangers of smoking. Pregnant women who smoke are also referred to the Baby & Me Tobacco Free Program (BMTF). BMTF is offered through the health departments in all 95 counties.

Activity 2b: Continue the partnership with Vanderbilt University Medical Center to expand pilot of QuitLine referrals directly from the electronic health record.

Report 2b: The partnership between the Tennessee Tobacco QuitLine vendor and Vanderbilt University Medical Center has continued the bi-directional e-referral system, and expanded to allow all providers in the Vanderbilt system access to refer directly to the QuitLine.

Activity 2c: Continue collaboration with women's health providers to distribute information about the dangers of prenatal smoking, including ENDS use, and the availability of the TN Quitline, Baby and Me Tobacco Free, Power to Quit, etc. as smoking cessation resources to women seeking preconception/interconception care. Include new resources as they are available (Ex. QR-coded resources).

Report 2c: Tobacco Coordinators and Health Educators disseminate educational brochures and materials to promote smoking cessation. These materials include QuitLine palm cards and BABY & ME Tobacco Free brochures, to health offices that offer care for women that are pregnant and those of childbearing age. Presentations to healthcare providers including OB/GYNs were also provided to promote BABY & ME Tobacco Free.

Priority: Increase access to family planning services

The following strategies and activities are planned for FY21:

Strategy 1: Remove barriers to care at Title X clinics across the state and provide high-quality, non-coercive, culturally competent family planning services to all clients.

Activity 1a: Utilize the results of teen/male/LGBTQ+ friendly surveys that were conducted in all Title X clinics in FY20 to guide implementation of strategies to reduce barriers to care among these vulnerable populations.

Activity 1b: Promote use of reproductive life plan assessments at Title X clinics by training Tennessee Department of Health family planning providers.

Activity 1c: Deliver family planning services through telehealth as a means to reach underserved populations.

Activity 1d: Pilot the Person-Centered Contraceptive Counseling Measure survey at one Title X site. In order to ensure a racially/ethnically diverse sample, the pilot sight will be chosen based on the demographic distribution of family planning patients.

Strategy 2: Increase awareness of the availability of Title X family planning services in Tennessee and of how to access these services through community education and outreach.

Activity 2a: Create an information packet with resources and information on birth spacing and on how to access postpartum family planning services for distribution during TennCare presumptive eligibility visits.

Activity 2b: The Adolescent Pregnancy Prevention and Rape Prevention Education Program Directors will educate sub-grantees about family planning services available through Tennessee Department of Health.

Activity 2c: The Tennessee Breast and Cervical Screening Program will educate contracting providers outside of local health departments about the availability of family planning services through the Tennessee Department of Health.

Strategy 3: Promote mental health and increase client confidence in care through provision of client centered, trauma-informed care.

Activity 3a: Require completion of a webinar on providing trauma-informed care for Tennessee Department of Health family planning providers as part of the Title X annual training.

Activity 3b: Form a collaborative working group between the Tennessee Department of Health's Family Planning Program and the Tennessee Department of Mental Health and Substance Abuse.

Priority: Pregnancy-Associated Mortality

The following strategies and activities are planned for FY21:

Strategy 1: Increase evidence-based practice implementation at hospitals on topics identified by the Maternal Mortality Review Committee (MMRC)

Activity 1a: Contract with Tennessee Hospital Association to provide simulation training to birthing hospitals on top topics leading to maternal death as identified by the MMRC. Birthing hospitals in the grand region of the state with highest disparities will be given top priority for simulation training.

Activity 1b: Contract with Tennessee Initiative for Perinatal Quality Care (TIPQC) to develop a speaker's bureau to train birthing hospital staff on topics identified by the MMRC. Birthing hospitals in the grand region of the state with the highest disparities will give given top priority for training.

Activity 1c: Provide real-time alerts quarterly to hospitals and other healthcare providers on emerging issues as identified by the MMRC with a minimum of 1 recommendation in each alert focused on disparities.

Activity 1d: Provide consultation and education on high risk OB care to health care providers through the regional perinatal centers with the highest number of educational consults being in the grand region with the most disparities.

Strategy 2: Increase community involvement to improve maternal health outcomes

Activity 2a: Convene a maternal health task force, with a minimum of 25 members, quarterly to highlight innovative and best practices for preventing maternal death. The task force will include membership from the Office of Minority Health and Disparities Elimination to represent disparate populations.

Activity 2b: Fund up to 5 community agencies to implement MMR recommendations related to top topics identified by the MMRC including substance abuse, domestic violence and mental health issues. Proposals will be evaluated on how well they are addressing disparate populations.

Strategy 3: Improve mental health among women of childbearing age

Activity 3a: Screen women enrolled in CHANT and evidence-based home visiting (EBHV) for depression with a specific emphasis on Middle Tennessee participants.

Activity 3b: Provide Question, Persuade, and Refer (QPR) training to CHANT and evidence-based home visiting staff with a particular emphasis on Middle Tennessee participants.

Strategy 4: Improve preconception and prenatal health through increased enrollment in both family planning and presumptive eligibility

Activity 4a: Increase the number of women of childbearing age participating in family planning by expanding and promoting telehealth to better reach those people living in rural areas.

Activity 4b: Increase the number of women applying for presumptive eligibility by developing an outreach plan and collaborating with a minimum of 1 partner to reach disparate populations.

Strategy 5: Increase surveillance of maternal deaths

Activity 5a: Identify pregnancy-associated deaths and facilitate state Maternal Mortality review Committee meetings. The Committee will identify age, race and place for each death reviewed to identify disparities.

Activity 5b: Through the Maternal Mortality Review Committee, determine proportion of deaths that are pregnancy-related along with contributing factors. For each pregnancy-related death determine age, race and place of death to identify disparities.

Activity 5c: Develop recommendations based upon MMRC findings for inclusion in the Maternal Mortality annual report and dissemination to relevant stakeholders. These recommendations will include reference to specific disparities identified in the reviews.

Perinatal/Infant Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2017	6.8	NPM 3
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2017	7.3	NPM 3 NPM 4 NPM 5
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2017	4.6	NPM 3
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2017	2.7	NPM 4 NPM 5
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2017	201.2	NPM 3
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2017	149.4	NPM 4 NPM 5

National Performance Measures

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

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

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

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

Evidence-Based or –Informed Strategy Measures

ESM 3.1 - Number of hospitals participating in the Opioid Exposed Newborns and/or Opioid Use Disorder projects

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	18.0	18.0	0.0	0.0	0.0

ESM 3.3 - Perinatal regionalization guidelines revised

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	No	No	No	No	Yes

ESM 3.4 - Number of regional perinatal center neonatal instructor hours delivered

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	5,000.0	5,000.0	5,000.0	5,000.0	5,000.0

ESM 3.5 - Percent of newborns with a positive dried blood spot (DBS) screen who receive follow-up to definitive diagnosis and clinical case management

Measure Status:	Active

Baseline data was not available/provided.

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

ESM 3.6 - Percent of facilities (with unsatisfactory dried blood spot rate >10 percent) who received education and consultative outreach

Measure Status:	Active

Baseline data was not available/provided.

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

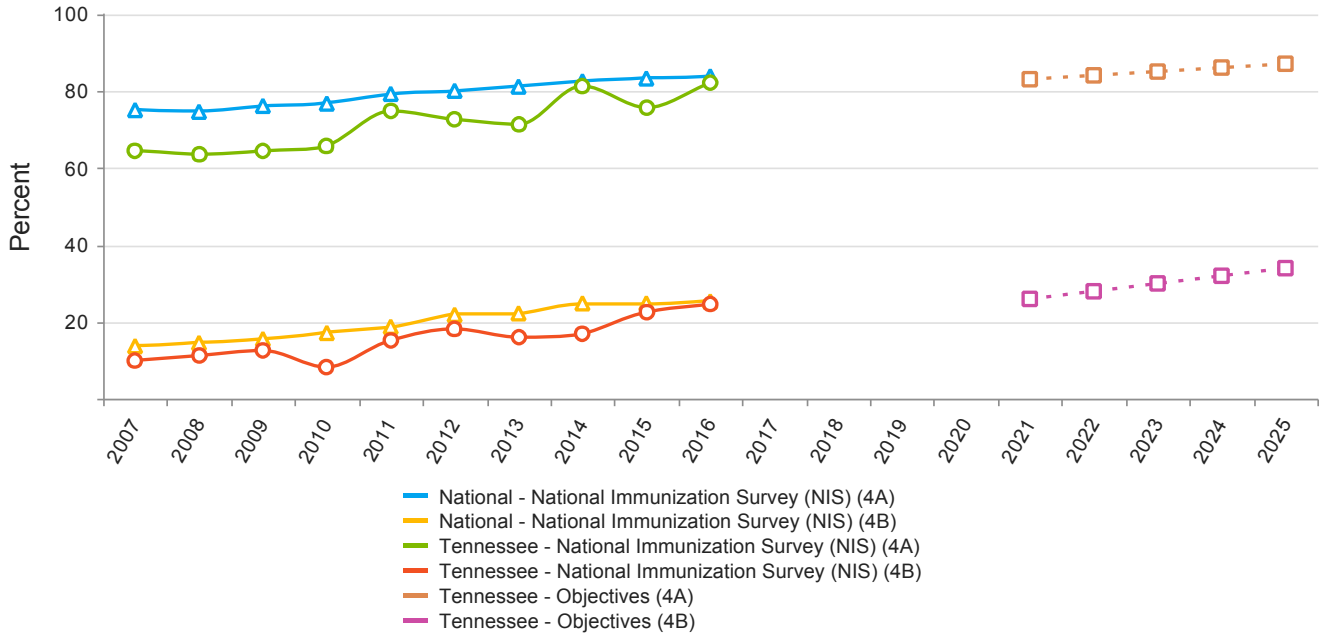
ESM 3.7 - Average number of hours transit time (from collection site to state laboratory) for NBS dried blood spot specimen

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	38.5	38.0	37.5	37.0	36.5

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



NPM 4A - Percent of infants who are ever breastfed

Federally Available Data	
Data Source: National Immunization Survey (NIS)	
	2019
Annual Objective	
Annual Indicator	82.2
Numerator	63,360
Denominator	77,089
Data Source	NIS
Data Source Year	2016

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

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

Federally Available Data	
Data Source: National Immunization Survey (NIS)	
	2019
Annual Objective	
Annual Indicator	24.5
Numerator	18,257
Denominator	74,506
Data Source	NIS
Data Source Year	2016

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

Evidence-Based or –Informed Strategy Measures

ESM 4.1 - Number of average monthly calls to Tennessee Breastfeeding Hotline (TBH)

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	450.0	475.0	500.0	525.0	550.0

ESM 4.2 - Number of birthing hospitals with a Memorandum of Understanding (MOU) for onsite breastfeeding peer counselor support

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	4.0	6.0	8.0	10.0	12.0

ESM 4.3 - Percent of NICU-admitted infants breastfed at hospital discharge

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	75.1	75.3	75.5	75.7	75.9

ESM 4.4 - Number of Tennessee birthing hospitals that have implemented > 5 Steps to Breastfeeding Success

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	38.0	39.0	40.0	41.0	42.0

ESM 4.5 - Percent of health care providers who complete 20-hour lactation education training

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	74.3	76.2	78.1	80.0	82.0

ESM 4.6 - Number of credentialed lactation professionals within WIC

Measure Status:	Active

Baseline data was not available/provided.

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

ESM 4.7 - Lactation education developed for health care curriculum

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	Yes	No	No	No	No

ESM 4.8 - WIC Breastfeeding Buddy Program piloted in three counties

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	Yes	No	No	No	No

ESM 4.9 - Unique Designated Breastfeeding Expert for each county

Measure Status:	Active

Baseline data was not available/provided.

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

ESM 4.10 - Number of minority-owned or rural businesses with Breastfeeding Welcomed Here (BFWH) designation

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	853.0	878.0	903.0	928.0	953.0

ESM 4.11 - WIC telehealth services implemented in rural areas

Measure Status:	Active

Baseline data was not available/provided.

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

ESM 4.12 - Mental Health resource referral list provided to Tennessee Breastfeeding Hotline (TBH)

Measure Status:	Active

Baseline data was not available/provided.

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

ESM 4.13 - Breastfeeding Welcomed Here (BFWH)-designated businesses surveyed to assess workplace lactation policies

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	Yes	No	No	No	No

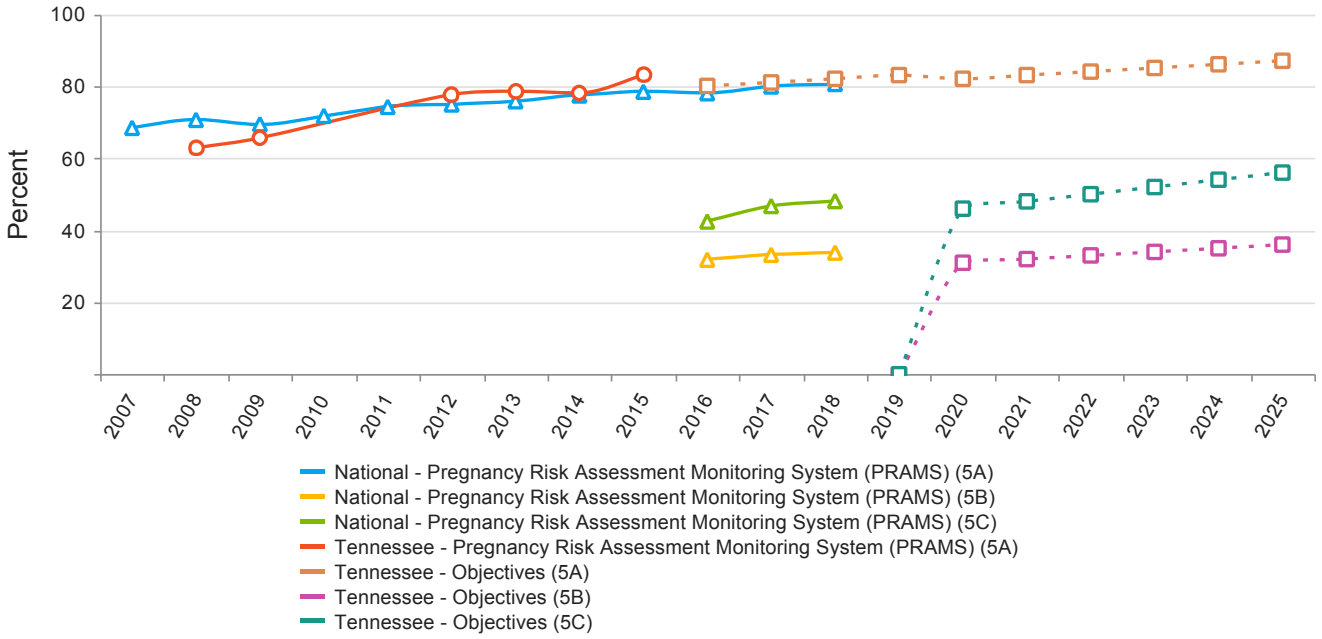
ESM 4.14 - Recognition process implemented for Breastfeeding Welcomed Here (BFWH)-designated businesses

Measure Status:	Active

Baseline data was not available/provided.

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

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



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

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

Annual Objectives						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	82.0	83.0	84.0	85.0	86.0	87.0

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

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

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

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	31.0	32.0	33.0	34.0	35.0	36.0

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

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

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

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	46.0	48.0	50.0	52.0	54.0	56.0

Evidence-Based or –Informed Strategy Measures

ESM 5.1 - Percent of hospitals receiving national recognition or implementing approved safe sleep policy

Measure Status:	Active

Baseline data was not available/provided.

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

ESM 5.2 - Number of educational materials distributed

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	240,000.0	240,000.0	240,000.0	240,000.0	240,000.0

ESM 5.3 - Number of elderly caregivers trained

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	25.0	25.0	25.0	25.0	25.0

ESM 5.4 - Number of local housing authorities trained on Direct On Scene Education (DOSE)

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	7.0	7.0	7.0	7.0	7.0

ESM 5.5 - Number of first responders trained on Direct On Scene Education (DOSE)

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	7.0	7.0	7.0	7.0	7.0

ESM 5.6 - Number of hospitals participating in the Safe to Sleep module

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	13.0	15.0	15.0	0.0	0.0

ESM 5.7 - Maintain affiliate state licensure with the Alliance for the Advancement of Infant Mental Health

Measure Status:	Active

Baseline data was not available/provided.

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

ESM 5.8 - Number of reflective supervision cohort groups held

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	72.0	72.0	72.0	72.0	72.0

State Performance Measures

SPM 6 - Percent of newborns who initiated breastfeeding

Measure Status:	Active

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

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	80.7	81.2	81.7	82.2	82.7	83.2

SPM 7 - Percent of WIC infants breastfeeding at six months

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	26.6	27.1	27.6	28.1	28.6

SPM 8 - Composite score of maternity care practices and policies

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	72.0	74.0	74.0	76.0	76.0

SPM 9 - Percent of time-critical presumed positive dried blood spot specimen results reported out by day of life 5

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	85.5	86.5	87.5	88.5	89.5

SPM 10 - Percent of dried blood spot specimen results reported out by day of life 7

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	92.0	93.0	94.0	95.0	96.0

SPM 11 - Number of evidence-based home visiting workforce receiving IMH Endorsement ®

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	25.0	25.0	25.0	25.0	25.0

State Action Plan Table

State Action Plan Table (Tennessee) - Perinatal/Infant Health - Entry 1

Priority Need

Increase breastfeeding

NPM

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

Objectives

Increase breastfeeding

Strategies

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

ESMs	Status
ESM 4.1 - Number of average monthly calls to Tennessee Breastfeeding Hotline (TBH)	Active
ESM 4.2 - Number of birthing hospitals with a Memorandum of Understanding (MOU) for onsite breastfeeding peer counselor support	Active
ESM 4.3 - Percent of NICU-admitted infants breastfed at hospital discharge	Active
ESM 4.4 - Number of Tennessee birthing hospitals that have implemented > 5 Steps to Breastfeeding Success	Active
ESM 4.5 - Percent of health care providers who complete 20-hour lactation education training	Active
ESM 4.6 - Number of credentialed lactation professionals within WIC	Active
ESM 4.7 - Lactation education developed for health care curriculum	Active
ESM 4.8 - WIC Breastfeeding Buddy Program piloted in three counties	Active
ESM 4.9 - Unique Designated Breastfeeding Expert for each county	Active
ESM 4.10 - Number of minority-owned or rural businesses with Breastfeeding Welcomed Here (BFWH) designation	Active
ESM 4.11 - WIC telehealth services implemented in rural areas	Active
ESM 4.12 - Mental Health resource referral list provided to Tennessee Breastfeeding Hotline (TBH)	Active
ESM 4.13 - Breastfeeding Welcomed Here (BFWH)-designated businesses surveyed to assess workplace lactation policies	Active
ESM 4.14 - Recognition process implemented for Breastfeeding Welcomed Here (BFWH)-designated businesses	Active

NOMs
NOM 9.1 - Infant mortality rate per 1,000 live births
NOM 9.3 - Post neonatal mortality rate per 1,000 live births
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

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

Priority Need

Decrease infant mortality

NPM

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

Objectives

Decrease infant mortality

Strategies

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

ESMs	Status
ESM 5.1 - Percent of hospitals receiving national recognition or implementing approved safe sleep policy	Active
ESM 5.2 - Number of educational materials distributed	Active
ESM 5.3 - Number of elderly caregivers trained	Active
ESM 5.4 - Number of local housing authorities trained on Direct On Scene Education (DOSE)	Active
ESM 5.5 - Number of first responders trained on Direct On Scene Education (DOSE)	Active
ESM 5.6 - Number of hospitals participating in the Safe to Sleep module	Active
ESM 5.7 - Maintain affiliate state licensure with the Alliance for the Advancement of Infant Mental Health	Active
ESM 5.8 - Number of reflective supervision cohort groups held	Active

NOMs

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

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

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

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

Priority Need

Decrease infant mortality

NPM

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

Objectives

Decrease infant mortality

Strategies

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

ESMs	Status
ESM 3.1 - Number of hospitals participating in the Opioid Exposed Newborns and/or Opioid Use Disorder projects	Active
ESM 3.2 - Number of TIPQC learning sessions held	Active
ESM 3.3 - Perinatal regionalization guidelines revised	Active
ESM 3.4 - Number of regional perinatal center neonatal instructor hours delivered	Active
ESM 3.5 - Percent of newborns with a positive dried blood spot (DBS) screen who receive follow-up to definitive diagnosis and clinical case management	Active
ESM 3.6 - Percent of facilities (with unsatisfactory dried blood spot rate >10 percent) who received education and consultative outreach	Active
ESM 3.7 - Average number of hours transit time (from collection site to state laboratory) for NBS dried blood spot specimen	Active

NOMs

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

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

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

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

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

Priority Need

Increase breastfeeding

SPM

SPM 6 - Percent of newborns who initiated breastfeeding

Objectives

Increase breastfeeding

Strategies

Influence community-based breastfeeding and mental health support through program enhancements and partnerships

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

Priority Need

Increase breastfeeding

SPM

SPM 7 - Percent of WIC infants breastfeeding at six months

Objectives

Increase breastfeeding

Strategies

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

State Action Plan Table (Tennessee) - Perinatal/Infant Health - Entry 6

Priority Need

Increase breastfeeding

SPM

SPM 8 - Composite score of maternity care practices and policies

Objectives

Increase breastfeeding

Strategies

Partner with Tennessee birthing hospitals to increase lactation sup-port and provision of breast milk, particularly communities with low breastfeeding rates

State Action Plan Table (Tennessee) - Perinatal/Infant Health - Entry 7

Priority Need

Decrease infant mortality

SPM

SPM 9 - Percent of time-critical presumed positive dried blood spot specimen results reported out by day of life 5

Objectives

Decrease infant mortality

Strategies

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

State Action Plan Table (Tennessee) - Perinatal/Infant Health - Entry 8

Priority Need

Decrease infant mortality

SPM

SPM 10 - Percent of dried blood spot specimen results reported out by day of life 7

Objectives

Decrease infant mortality

Strategies

Influence community-based breastfeeding and mental health support through program enhancements and partnerships

State Action Plan Table (Tennessee) - Perinatal/Infant Health - Entry 9

Priority Need

Decrease infant mortality

SPM

SPM 11 - Number of evidence-based home visiting workforce receiving IMH Endorsement ®

Objectives

Decrease infant mortality

Strategies

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

Priority: Reduce infant mortality.

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

NPM 5a: Based on 2016 PRAMS data, 79.3 percent of Tennessee mothers surveyed reported placing their infant to sleep on their back. This number represents a slight decrease from our year 3 performance (83.0 percent) and is consistent with the performance for years 2 and 3 (78.0 percent). The year 4 performance fell slightly below the objective of 83 percent, but it did exceed the national percentage for the same year which was 78.0 percent.

NPM 5b: Based on 2016 PRAMS data, 32.0 percent of Tennessee mothers surveyed reported that their baby always or often sleeps alone, usually in a crib, bassinet, or pack and play, and not usually in a standard bed, couch, sofa, armchair, car seat, or swing. Because 2016 was the first year for which the PRAMS data included these questions, it is currently not possible to evaluate Tennessee's trend over time. Tennessee's performance was consistent with the 2016 national percentage for this measure (31.8 percent).

NPM 5c: Based on 2016 PRAMS data, 33.0 percent of Tennessee mothers surveyed reported that their baby does not usually sleep with blankets, toys, cushions, pillows, or crib bumper pads. Because 2016 was the first year for which the PRAMS data included these questions, it is currently not possible to evaluate Tennessee's trend over time. Tennessee's performance was lower than the 2016 national percentage for this measure (42.4 percent).

ESM 5.1: During year 4, Tennessee Department of Health distributed 311,629 safe sleep educational materials. This number is consistent with the performance for year 3 (317,334) and represents a substantial increase from the performance for years 1 and 2 (226,881 and 257,694, respectively). This significant increase reflects the strategy to connect with new parents and caregivers at multiple touchpoints, including in the Welcome Baby booklet mailed to all parents of newborns.

ESM 5.2: During year 4, 100 percent of eligible infant deaths were reviewed by the child fatality review teams. This percent has been stable for many years, as we have consistently met our objective of reviewing all infant deaths.

ESM 5.3: Based on birth data for state fiscal year 2019 (7/1/2018-6/30/2019), 84 percent of VLBW infants were delivered in Level III or IV birthing facilities. This percentage has remained highly consistent over the most recent four years. The year 4 performance was very slightly below the objective for this year (85 percent).

ESM 5.4: During year 4, 100 percent of newborns with a positive metabolic screen received follow-up to definitive diagnosis and clinical management. This number has remained steady over the past several years, as we have consistently met our objective to follow up with all newborns who have positive metabolic screens.

ESM 5.5: During year 4, 47,597 individuals were served by the TAPPP program, exceeding the objective of serving 46,500 individuals. Performance for this measure increased from year 1 to year 3,

reaching a peak of 55,583 individuals in year 3.

Accomplishments and Challenges (based on FY2019 Action Plan)

Strategy 1: Educate parents and caregivers on safe sleep.

Activity 1a: Disseminate safe sleep flyers, door hangers, posters, educational flipcharts and Sleep Baby Safe and Snug board books to hospitals, daycares, Department of Children's Services, Girl Scouts, Red Cross, generational caregivers and other agencies serving infants.

Report 1a: From October 1, 2018 through September 30, 2019, 311,629 safe sleep educational items were distributed to community partners and infant caregivers. This includes "Sleep Baby Safe and Snug" books to all births in the state, the Welcome Baby book that includes a page on infant safe sleep and all requested materials from community partners such as door hangers and flyers.

Activity 1b: Increase the number of educational materials distributed through the Direct On Scene Education (DOSE) program from 1600 to 1900 by September 30, 2019. Through this activity, first responder agencies and local housing authorities will be provided with packets of safe sleep information and access to portable cribs for families that do not have a safe sleep environment for their infant child.

Report 1b: A total of 2,010 DOSE kits have been distributed by first responder agencies and housing authorities since the inception of the program. Each of the participating agencies also received portable cribs and distributed 159 of them to families who were in need of a safe sleep environment for their infant.

Activity 1c. Increase the number of safe sleep floor talkers placed in stores, clinics, health departments, daycares and other agencies from 800 to 1000 by September 30th, 2019.

Report 1c: A total of 1,419 floor talkers have been placed at health departments, hospitals, child care centers, community centers, grocery stores, housing authorities, and universities.

Activity 1d: Increase the number of WIC parents completing the new safe sleep educational module from 500 to 800 by September 30, 2019.

Report 1d: From October 1, 2018 through September 30. 2019 717 WIC participants completed the online training module, "Help Your Baby Sleep Safe and Sound". A total of 1,995 participants have completed the module since it was released. There have been 3 additional lessons that also include the infant safe sleep message, Feeding Your Newborn, Getting the Support You Need in baby's First Weeks and Understanding Your Newborn: Sleep, Crying, and Cues.

Activity 1e: Increase the number of non-birthing hospitals providing safe sleep education from 3 to 10 by September 30th, 2019.

Report 1e: Currently there are 6 non-birthing hospitals disseminating materials.

Activity 1f: Disseminate Spanish and English safe sleep crib card to a minimum of 40 birthing hospitals by September 30th, 2019.

Report 1f: The crib card was offered to all 59 birthing facilities and 35,400 crib cards were distributed to 30 facilities in this FY. A total of 30 facilities are using the crib cards. To increase the number of hospitals using the card, it was modified to meet the needs of Baby Friendly hospitals.

Activity 1g: Engage at least 3 additional local fraternity and sorority chapters to participate in safe sleep education initiatives by September 30th, 2019.

Report 1g: A conference call was held with the founder of the Kappa Alpha Psi fraternity safe sleep initiative. The founder helped with facilitating a relationship with the health and wellness coordinator for the Tennessee state Kappa Alpha Psi. Fraternities and Sororities have been engaged at local universities in Shelby County and Knox County through their local FIMR Community Action Teams.

Activity 1h: Translate a minimum of two safe sleep materials into additional languages and make available on the safe sleep website by September 30th, 2019.

Report 1h: Safe sleep materials have been translated into Spanish, Arabic, Kurdish, Swahili, Somolia, Nepali, and Burmese. These are available at the following website: https://www.tn.gov/health/health-program-areas/fhw/vipp/safe-sleep/safe-sleep-campaign-materials.html

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

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

Report 2a: The 34 CFR teams are provided with a monthly file of child deaths, and are able to request birth transcripts, death certificates, and autopsy reports to be able to complete reviews. The 4 FIMR teams are provided fetal death certificates to review deaths.

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

Report 2b: New Member orientation webinars are held quarterly October 2018, January 22, 2019, May 15 2019, and July 7, 2019. An in person meeting was held in April 2019 where teams developed prevention plans.

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

collected.

Report 2c: Data quality reports were sent to teams a minimum of monthly starting in March 2019.

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

Report 2d: Two trainings were held this year, one in Cookeville, TN and in Memphis, TN. The trainings had approximately 80 participants including law enforcement, fire fighters, EMS, and DCS. Dolls to assist with reenactment were provided to those who needed them.

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

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

Report 3a: The Department of Health continued to contract with Vanderbilt to coordinate the work of the Tennessee Initiative for Perinatal Quality Care (TIPQC). Under the direction of the Oversight Committee, hospital teams have created and implemented new quality improvement projects, continued with existing projects, collected data to track progress and outcomes, attended learning sessions, and participated in the annual educational conference. This year, TIPQC partnered with hospitals to implement its first ever dual-arm quality improvement project, addressing opioid use disorder in pregnancy and exposure in newborns.

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

Report 3b: During the fiscal year, MCH staff have continued to work closely with the five Regional Perinatal Centers and the Perinatal Advisory Committee. In state fiscal year 2019, the five Centers provided direct care for 4,847 high-risk neonates and 15,606 high-risk maternal patients, and 4,847 hours of education and training were provided to staff at community hospitals to help them prepare for recognizing and treating complex medical conditions. Updates were made to the perinatal social workers educational objectives, regionalization and transportation guidelines, and a new document was created to prepare EMS and non-delivering

hospital staff for providing care to high-risk pregnant women and newborns in emergent situations.

Activity 3c: Coordinate the Perinatal Advisory Committee meetings.

Report 3c: The Perinatal Advisory Committee met three times during the federal fiscal year (October 9, 2018, April 11, 2019, and July 11, 2019). Highlights for the year included: analysis of LOCATe survey responses and discussion of results, maternal mortality, pilot testing process to streamline requests to MCOs for back transport, update on implementation of the AIM OUD/OEN bundle, and newborn screening.

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

Activity 4a: FHW staff will provide follow-up on all abnormal newborn screening results and unsatisfactory tests. Referrals are made to the genetics and sickle cell centers across the state. Access to genetic screening, diagnostic testing and counseling services is available at three comprehensive and two satellite Genetic Centers and two comprehensive and two satellite Sickle Cell Centers for individuals and families who have or who are at risk for genetic disorders.

Report 4a: All babies born in Tennessee are required to be screened for metabolic conditions, hearing, and CCHD by the birthing facility. All newborn screening test results which are abnormal or unsatisfactory are sent to the follow-up staff for action. Providers are contacted and referrals made to the tertiary centers across the state for confirmation testing, counseling, and long term follow-up. During this past year, the State approved adding Spinal Muscular Atrophy (SMA) to the newborn screening panel and monitored screening for X-ALD added the prior year. During the federal fiscal year, the education nurse held 2 BLS/Heart Saver classes, conducted 17 hospital site visits, 11 primary care physician trainings, 2 OB/GYN trainings, 4 local health department trainings, and 2 spinal muscular atrophy (SMA) hospital educational sessions.

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

Report 4b: Weekly, the program epidemiologist receives a raw birth file received from the Office of Vital Records (OVR) and matches the records to those in the Newborn Screening Database to identify any babies born in the state who did not have a dried blood spot screening test and generate lists of the babies by birthing hospitals. The quality improvement (QI) nurse sends these facilities a report on those babies and informs them of the need for a dried blood spot screening for those babies. Another monthly process is conducted by the program epidemiologist to link the provisional birth file cleaned up by the OVR, which is more complete but less timely in capturing birth events in Tennessee, with the newborn screening records and to identify infants who did not receive one or

more of the three types of newborn screening – i.e., dried blood spot, hearing loss and critical congenital heart disease. The QI nurse sends a list of babies without a screening to the birthing facilities and asks for information on screening to be reported back to the state, and if not screened why, and these records are tracked to assure a response is received. In addition to the weekly and monthly lists of babies who missed screening, a summative report is sent to the birthing or collection hospitals on the indicators related to the completeness and timeliness of newborn screening for their facilities. Site visits were made to hospitals which requested training and/or assistance and to those with metrics not reaching the standard criteria for age at collection, unsatisfactory rate, or transit time to the Lab. TDH received a grant that will also facilitate the implementation of the OZ system to track in real time collection, transport, and reporting of results for TDH and birth hospitals.

Activity 4c: FHW staff will plan and facilitate three face-to-face meetings of the Genetics Advisory Committee.

Report 4c: The Genetics Advisory Committee met three times during this past federal fiscal year (November 28, 2019, April 25, 2019, and August 15, 2019). Much of the work centered on laboratory and follow-up procedures for adding SMA to the newborn screening panel, including creating procedures, validating tests, determining appropriate follow-up to prepare for implementation in January 2020.

Strategy 5: Reduce unintended pregnancies.

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

Report 5a: The TFPP provides comprehensive services in 124 clinics across the state of TN. In CY2018 the program served 74,027 unduplicated clients (69,009 females and 1,683 males). The program provides clinical services in all 95 Tennessee counties, with emphasis on the adolescent, low income, medically underserved, and black populations. Services are targeted to those reproductive age persons who lack access to traditional medical care and for those who have no other financial resources for family planning and contraceptive supplies, which puts them at high risk of an unintended/unplanned pregnancy.

Activity 5b: Prevent adolescent pregnancies through a comprehensive, community-wide, collaborative effort that promotes abstinence, self-respect, constructive life options, and responsible decision-making about sexuality, healthy relationships and the future. These efforts are accomplished by: providing networking opportunities such as workshops and conferences for adults, professionals and parents; conducting community education and awareness activities for students, parents, and providers through classes in schools and community agencies; and disseminating pregnancy prevention material at clinics, malls, libraries, health fairs and community events.

Report 5b: The TN Adolescent Pregnancy Prevention Program (TAPPP) provided risk reduction and pregnancy prevention education to students, ages 10-19, in both during and after school settings. From July to September 2019, 322 TAPPP activities were done. 117 students attended sessions on abstinence, 58 attended self-respect, 81 positive youth development, 117 healthy relationships, , and 114 risky behaviors. 496 parents/guardians and 453 community professionals attended education and training sessions. There was 35,067 residents that attended community events, health fairs, and awareness education sessions.

Activity 5c: The abstinence education program will continue to encourage youth to participate in community service learning projects. The service learning experience improves the adolescent's knowledge of global and local societal needs, encourages unity among participants, incorporates community activities that enhance personal growth and accomplishments and fosters asset building, positive self-worth and healthy decision making.

Report 5c: TAPPP encourages students to get involved in community initiatives as well as create innovative ways to bring impact. TAPPP provides funding to twelve community serving agencies that focus on sexual risk avoidance education (SRAE) via CDC funding. Each agency plans at least ten hours of service learning projects. The agencies reported 105 students active involvement in 356 hours of service. A few of the projects included: Reading Buddies, community clean-up, Meals on Wheels, holiday cards and care packages to nursing homes and first responders, National Day to Prevent Teen Pregnancy events, creation of posters for Sexual Assault Awareness month and suicide prevention, and participation in the statewide Red Sand Project highlighting human trafficking as a public health concern.

Activity 5d: 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 topics 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.

Report 5d: TAPPP health educators are present in all 95 counties of the state. The educators planned and facilitated 58 community events and held 52 health council meetings and planning sessions. The educators were also responsible for providing 172 community/school education sessions, with 14 geared specifically to parents and 24 geared to professionals. These events all focused on a component of TAPPP and was designed to equip attendees with the tools necessary to make the most informed decision when placed in a situation that would place their loved one, child, student, or themselves at risk.

Priority: Breastfeeding

The following strategies and activities are planned for FY21:

Strategy 1: Partner with Tennessee birthing hospitals to increase lactation support and provision of breast milk, particularly communities with low breastfeeding rates

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

Activity 1b: Partner with hospitals to develop a Memorandum of Understanding (MOU) Agreement to provide on-site breastfeeding peer counselor support

Activity 1c: Promote the use of breast and donor milk in neonatal intensive care unit (NICU) settings and at discharge facilitating culturally appropriate staff interventions

Activity 1d: Monitor and assess maternity and infant care practices that create a supportive environment for breastfeeding

Strategy 2: Cultivate a diverse community of professional lactation support through education and training opportunities across health care disciplines

Activity 2a: Advertise the 20-hour lactation curriculum to health care providers that serve in communities with low breastfeeding engagement

Activity 2b: Provide advanced lactation training to WIC public health nutritionists and nursing staff within local health departments, focusing on areas with limited community breastfeeding support professionals.

Activity 2c: Partner with Historically Black Colleges and Universities (HBCUs) to develop lactation education within health care curriculums for students of color

Strategy 3: Influence community-based breastfeeding and mental health support through program enhancements and partnerships

Activity 3a: Pilot WIC Breastfeeding Buddy Program within three counties with limited access to community breastfeeding resources

Activity 3b: Establish a unique Designated Breastfeeding Experts (DBEs) for each county

Activity 3c: Promote Breastfeeding Welcomed Here (BFWH) designation in rural areas and among minority-owned businesses

Activity 3d: Provide telehealth services among WIC participants receiving nutrition and breastfeeding education in rural areas with access limitations based on internet and transportation issues

Activity 3e: Partner with Department of Mental Health and Substance Abuse to obtain and provide mental health resources to Tennessee Breastfeeding Hotline's referral list

Strategy 4: Re-enforce lactation policies that positively influence breastfeeding practices in the workplace

Activity 4a: Assess workplace lactation policies for businesses with BFWH designation

Activity 4b: Acknowledge BFWH-designated businesses that have established lactation workplace policies for employees

Priority: Infant Mortality

The following strategies and activities are planned for FY21:

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

Activity 1a: Increase the number of birthing hospitals (1) recognized as a National Cribs for Kids certified hospital or with an approved safe sleep policy, and (2) submitting crib audit reports with ≤ 10% of infants being found in an unsafe sleep environment

Activity 1b: Distribute educational materials

Activity 1c: Increase distribution of safe sleep materials with particular focus on areas with the highest disparities

Activity 1d: Partner with Tennessee Commission on Aging to expand availability of safe sleep training for elderly caregivers

Activity 1e: Increase the number of local housing authority agencies and first responders that have received Direct On-Scene Education training in targeted regions with highest disparities

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

Activity 2a: Contract with the state's perinatal collaborative, TIPQC, to maintain professional oversight committee, implement statewide quality improvement projects, and host professional training and educational opportunities for health care providers

Activity 2b: Review state's current maternal care guidelines for levels 1-4 and make revisions and additions as per latest guidance issued by SMFM/ACOG

Activity 2c: Provide transport and consultative services to all hospitals, promote utilization of the regionalization guidelines, and offer professional education to hospital staff and healthcare providers through the state's five regional perinatal centers.

Strategy 3: Support the newborn screening follow-up program, particularly amongst low-performing hospitals, through quality improvement efforts

Activity 3a: Provide case management follow-up for tested newborns with abnormal screening results and unsatisfactory tests

Activity 3b: Provide education and consultative outreach to low performing hospitals with a monthly unsatisfactory dried blood spot submission rate above 10%

Activity 3c: Improve newborn screening transit time of the dried blood spot from collection to arrival at the state lab through implementation of the OZ tracking system, conducting site visits and providing education to the top 20 facilities with the highest transit times

Strategy 4: Support the healthy social and emotional development of infants

Activity 4a: Contract with the Association of Infant Mental Health in Tennessee (AIMHiTN) to maintain the IMH Endorsement® system in Tennessee

Activity 4b: Contract with AIMHiTN to build Infant and Early Childhood Mental Health (IECMH) best practices, core competencies, professional standards, and reflective practice among the Evidence-Based Home Visiting (EBHV) workforce

Child Health

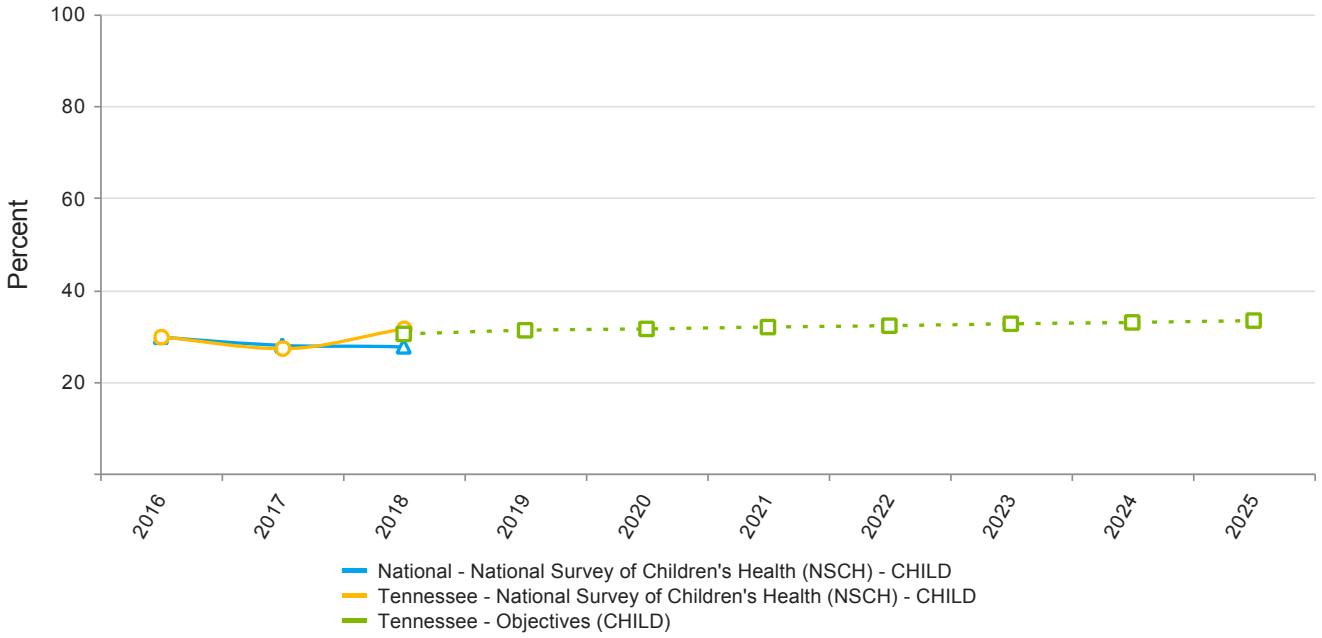
Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations	SID-2017	75.0	NPM 14.2
NOM 3 - Maternal mortality rate per 100,000 live births	NVSS-2014_2018	24.9	NPM 14.2
NOM 4 - Percent of low birth weight deliveries (<2,500 grams)	NVSS-2018	9.3 %	NPM 14.2
NOM 5 - Percent of preterm births (<37 weeks)	NVSS-2018	11.1 %	NPM 14.2
NOM 6 - Percent of early term births (37, 38 weeks)	NVSS-2018	27.9 %	NPM 14.2
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2017	6.8	NPM 14.2
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2017	7.3	NPM 14.2
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2017	4.6	NPM 14.2
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2017	2.7	NPM 14.2
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2017	201.2	NPM 14.2
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2017	149.4	NPM 14.2
NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)	NSCH	Data Not Available or Not Reportable	NPM 6
NOM 15 - Child Mortality rate, ages 1 through 9, per 100,000	NVSS-2018	22.3	NPM 7.1
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000	NVSS-2018	44.9	NPM 7.1
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000	NVSS-2016_2018	15.3	NPM 7.1
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000	NVSS-2016_2018	13.2	NPM 7.1

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2017_2018	88.7 %	NPM 6 NPM 8.1 NPM 14.2
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	NSCH-2017_2018	16.7 %	NPM 8.1
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	WIC-2016	14.6 %	NPM 8.1
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	YRBSS-2017	20.5 %	NPM 8.1

National Performance Measures

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



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

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

Annual Objectives						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	31.5	31.9	32.2	32.6	32.9	33.3

Evidence-Based or –Informed Strategy Measures

ESM 8.1.1 - Number of physical activity clubs or completed built environment projects

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	575.0	632.0	692.0	752.0	812.0

ESM 8.1.2 - Number of LEAs receiving professional development on physical education and physical activity

Measure Status:	Active

Baseline data was not available/provided.

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

ESM 8.1.3 - Number of Public Health Educators and LEA staff receiving professional education in healthy lifestyle choices before, during, and after school hours

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	50.0	100.0	150.0	200.0	250.0

ESM 8.1.4 - Number of Gold Sneaker certified childcare facilities

Measure Status:	Active

Baseline data was not available/provided.

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

ESM 8.1.5 - Number of Healthy Parks Healthy Person prescriptions written

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	50.0	110.0	180.0	260.0	350.0

ESM 8.1.6 - Number of Healthy Parks Healthy Person app users

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	1,800.0	1,870.0	1,950.0	2,040.0	2,140.0

ESM 8.1.7 - Number of primary prevention plans with a goal related to reducing sugary drink consumption

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	12.0	14.0	16.0	18.0	20.0

ESM 8.1.8 - Number of partners to develop and implement strategies that increase access to healthier community food and beverage options

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	235.0	255.0	275.0	295.0	315.0

ESM 8.1.9 - Number of LEAs that have a policy/protocal for joint use agreements of facilities

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	126.0	128.0	130.0	132.0	134.0

ESM 8.1.10 - Number of LHDs receiving training, resources, and tools to promote the mental health benefits of physical activity

Measure Status:	Active

Baseline data was not available/provided.

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

ESM 8.1.11 - Number of LEAs receiving professional development on mental health benefits of physical activity

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	8.0	16.0	24.0	32.0	40.0

ESM 8.1.12 - ACEs online curriculum developed and implemented

Measure Status:	Active

Baseline data was not available/provided.

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

ESM 8.1.13 - Trauma informed care online curriculum developed and implemented

Measure Status:	Active

Baseline data was not available/provided.

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

ESM 8.1.14 - Percent of child fatality teams provided ACEs refresher training

Measure Status:	Active

Baseline data was not available/provided.

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

ESM 8.1.15 - Number of families enrolled in a home visiting program

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	2,000.0	2,300.0	2,400.0	2,500.0	2,700.0

ESM 8.1.16 - Number of families enrolled in a home visiting program for at least 14 months

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	450.0	550.0	650.0	750.0	850.0

ESM 8.1.17 - Percent of families with improved protective factors score

Measure Status:	Active

Baseline data was not available/provided.

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

ESM 8.1.18 - Percent of families enrolled in CHANT care coordination

Measure Status:	Active

Baseline data was not available/provided.

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

ESM 8.1.19 - Percent of uninsured people who enroll into a health insurance plan

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	18.0	19.0	20.0	21.0	22.0

ESM 8.1.20 - Percent of people with an employment need referred to employment services

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	17.0	18.0	19.0	20.0	21.0

ESM 8.1.21 - Percent of people with a housing need referred to a housing agency

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	3.0	4.0	5.0	6.0	7.0

ESM 8.1.22 - Percent of caregivers screened for depression

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	80.0	81.0	81.5	85.5	86.0

ESM 8.1.23 - Percent of caregivers who screen positive for depression and receive a referral to mental health services

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	96.5	96.8	97.0	98.0	98.5

State Performance Measures

SPM 12 - Percent of state LEA elementary and middle schools that provide or require daily physical education

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	7.5	8.8	10.0	11.3	12.5

SPM 13 - Percent of state LEA secondary schools that do not sell less healthy foods and beverages

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	54.7	55.1	55.5	55.9	56.3

SPM 14 - Percent of children with two or more ACEs

Measure Status:	Active

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

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	23.0	22.5	22.0	21.6	21.2	21.0

SPM 15 - Percent of substantiated child maltreatment cases among families served by home visiting programs

Measure Status:	Active

Baseline data was not available/provided.

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

SPM 16 - Percent of caregiver substance abuse among families served by home visiting programs

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	12.0	12.0	11.0	11.0	11.0

SPM 17 - Percent of caregivers who experience intimate partner violence and do not receive professional support services among families served by home visiting

Measure Status:	Active

Baseline data was not available/provided.

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

SPM 18 - Percent of caregivers with depression who receive referrals for services

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	90.0	91.0	92.0	93.0	95.0

State Outcome Measures

SOM 4 - Number of public school 6th graders who are overweight or obese

Measure Status:	Active

Baseline data was not available/provided.

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

SOM 5 - Percent of adults with Major Depressive Episode

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	7.1	7.0	6.9	6.8	6.7

SOM 6 - Percent of adults reporting Chronic obstructive pulmonary disease (COPD)

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	9.3	9.2	9.1	9.0	8.9

State Action Plan Table

State Action Plan Table (Tennessee) - Child Health - Entry 1

Priority Need
Decrease overweight and obesity among children

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

Objectives
Decrease overweight and obesity among children

Strategies
Partner with healthcare providers to promote physical activity counseling during well-child visits
Promote the mental health benefits of physical activity

ESMs	Status
ESM 8.1.1 - Number of physical activity clubs or completed built environment projects	Active
ESM 8.1.2 - Number of LEAs receiving professional development on physical education and physical activity	Active
ESM 8.1.3 - Number of Public Health Educators and LEA staff receiving professional education in healthy lifestyle choices before, during, and after school hours	Active
ESM 8.1.4 - Number of Gold Sneaker certified childcare facilities	Active
ESM 8.1.5 - Number of Healthy Parks Healthy Person prescriptions written	Active
ESM 8.1.6 - Number of Healthy Parks Healthy Person app users	Active
ESM 8.1.7 - Number of primary prevention plans with a goal related to reducing sugary drink consumption	Active
ESM 8.1.8 - Number of partners to develop and implement strategies that increase access to healthier community food and beverage options	Active

ESM 8.1.9 - Number of LEAs that have a policy/protocal for joint use agreements of facilities	Active
ESM 8.1.10 - Number of LHDs receiving training, resources, and tools to promote the mental health benefits of physical activity	Active
ESM 8.1.11 - Number of LEAs receiving professional development on mental health benefits of physical activity	Active
ESM 8.1.12 - ACEs online curriculum developed and implemented	Active
ESM 8.1.13 - Trauma informed care online curriculum developed and implemented	Active
ESM 8.1.14 - Percent of child fatality teams provided ACEs refresher training	Active
ESM 8.1.15 - Number of families enrolled in a home visiting program	Active
ESM 8.1.16 - Number of families enrolled in a home visiting program for at least 14 months	Active
ESM 8.1.17 - Percent of families with improved protective factors score	Active
ESM 8.1.18 - Percent of families enrolled in CHANT care coordination	Active
ESM 8.1.19 - Percent of uninsured people who enroll into a health insurance plan	Active
ESM 8.1.20 - Percent of people with an employment need referred to employment services	Active
ESM 8.1.21 - Percent of people with a housing need referred to a housing agency	Active
ESM 8.1.22 - Percent of caregivers screened for depression	Active
ESM 8.1.23 - Percent of caregivers who screen positive for depression and receive a referral to mental health services	Active

NOMs

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

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

Priority Need

Decrease overweight and obesity among children

SPM

SPM 12 - Percent of state LEA elementary and middle schools that provide or require daily physical education

Objectives

Decrease overweight and obesity among children

Strategies

Support school-based efforts to promote physical activity and good nutrition

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

Priority Need

Decrease overweight and obesity among children

SPM

SPM 13 - Percent of state LEA secondary schools that do not sell less healthy foods and beverages

Objectives

Decrease overweight and obesity among children

Strategies

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

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

Priority Need

Increase prevention and mitigation of Adverse Childhood Experiences (ACEs)

SPM

SPM 14 - Percent of children with two or more ACEs

Objectives

Increase prevention and mitigation of Adverse Childhood Experiences (ACEs)

Strategies

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

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

Priority Need

Increase prevention and mitigation of Adverse Childhood Experiences (ACEs)

SPM

SPM 15 - Percent of substantiated child maltreatment cases among families served by home visiting programs

Objectives

Increase prevention and mitigation of Adverse Childhood Experiences (ACEs)

Strategies

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

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

Priority Need

Increase prevention and mitigation of Adverse Childhood Experiences (ACEs)

SPM

SPM 16 - Percent of caregiver substance abuse among families served by home visiting programs

Objectives

Increase prevention and mitigation of Adverse Childhood Experiences (ACEs)

Strategies

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

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

Priority Need

Increase prevention and mitigation of Adverse Childhood Experiences (ACEs)

SPM

SPM 17 - Percent of caregivers who experience intimate partner violence and do not receive professional support services among families served by home visiting

Objectives

Increase prevention and mitigation of Adverse Childhood Experiences (ACEs)

Strategies

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

State Action Plan Table (Tennessee) - Child Health - Entry 8

Priority Need

Increase prevention and mitigation of Adverse Childhood Experiences (ACEs)

SPM

SPM 18 - Percent of caregivers with depression who receive referrals for services

Objectives

Increase prevention and mitigation of Adverse Childhood Experiences (ACEs)

Strategies

CHANT and EBHV will screen and link families to mental health services

State Action Plan Table (Tennessee) - Child Health - Entry 9

Priority Need

Decrease overweight and obesity among children

SOM

SOM 4 - Number of public school 6th graders who are overweight or obese

Objectives

Decrease overweight and obesity among children

Strategies

Promote Gold Sneaker voluntary recognition program for licensed childcare centers

State Action Plan Table (Tennessee) - Child Health - Entry 10

Priority Need

Increase prevention and mitigation of Adverse Childhood Experiences (ACEs)

SOM

SOM 5 - Percent of adults with Major Depressive Episode

Objectives

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

Strategies

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

State Action Plan Table (Tennessee) - Child Health - Entry 11

Priority Need

Increase prevention and mitigation of Adverse Childhood Experiences (ACEs)

SOM

SOM 6 - Percent of adults reporting Chronic obstructive pulmonary disease (COPD)

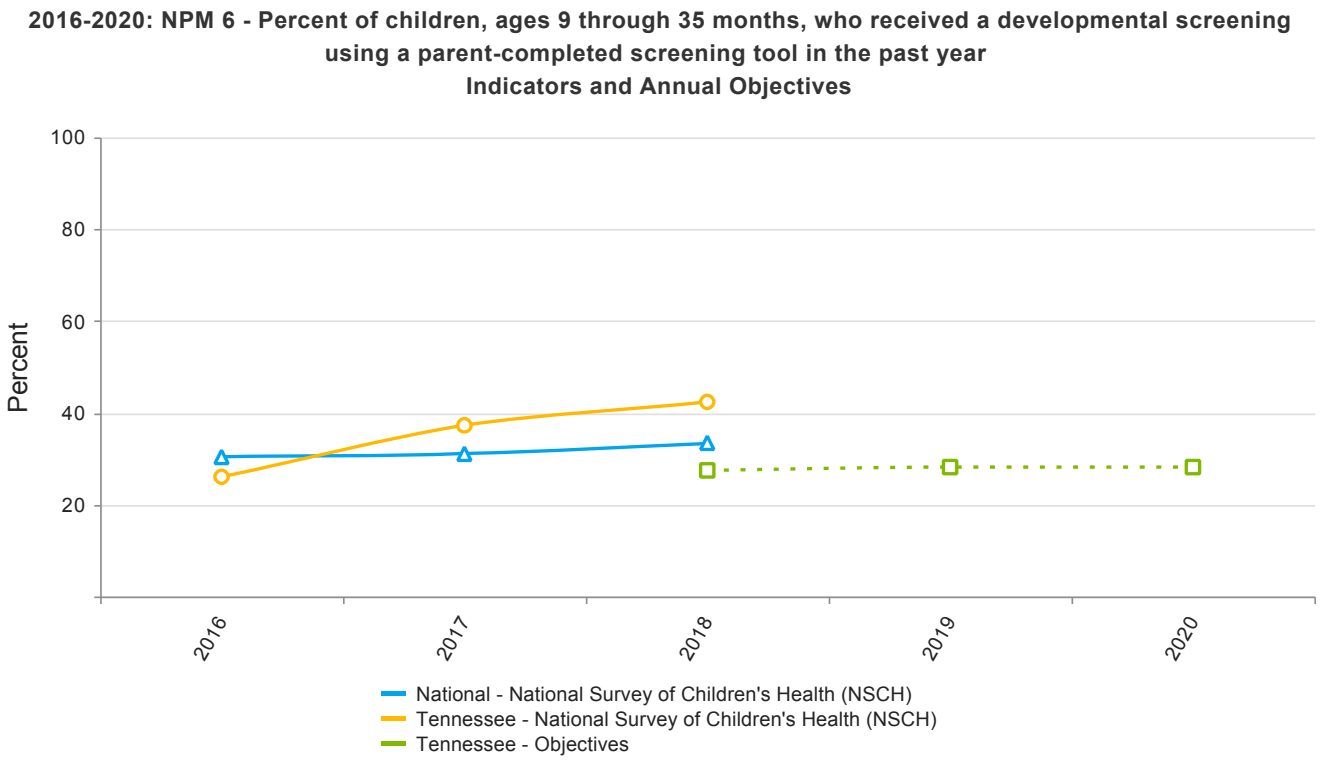
Objectives

Increase prevention and mitigation of Adverse Childhood Experiences (ACEs)

Strategies

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

2016-2020: National Performance Measures



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

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

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

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

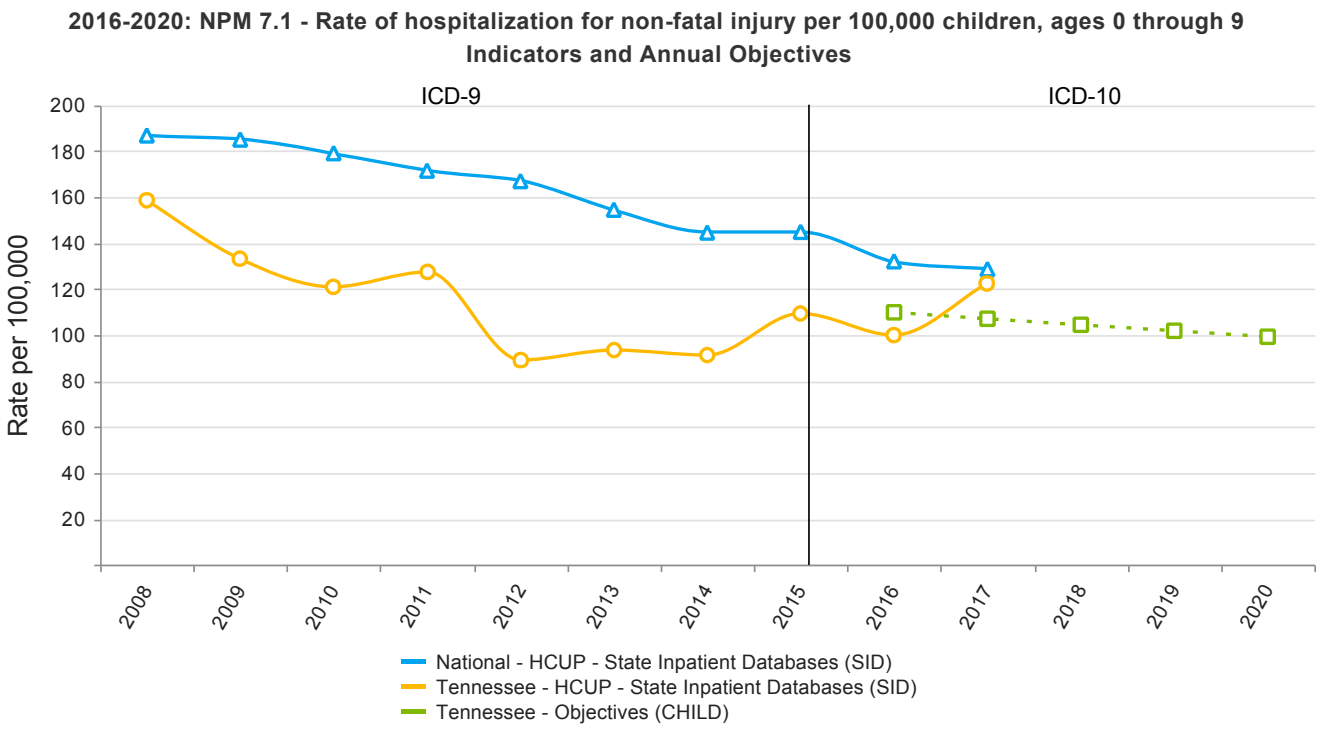
Measure Status:			**Active**	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective			800	1,200
Annual Indicator	979	953	1,167	510
Numerator				
Denominator				
Data Source	TDH FHW Early Childhood Section Program Data	TDH FHW Early Childhood Section Program Data	TDH FHW Early Childhood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

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

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

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

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



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

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

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

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

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

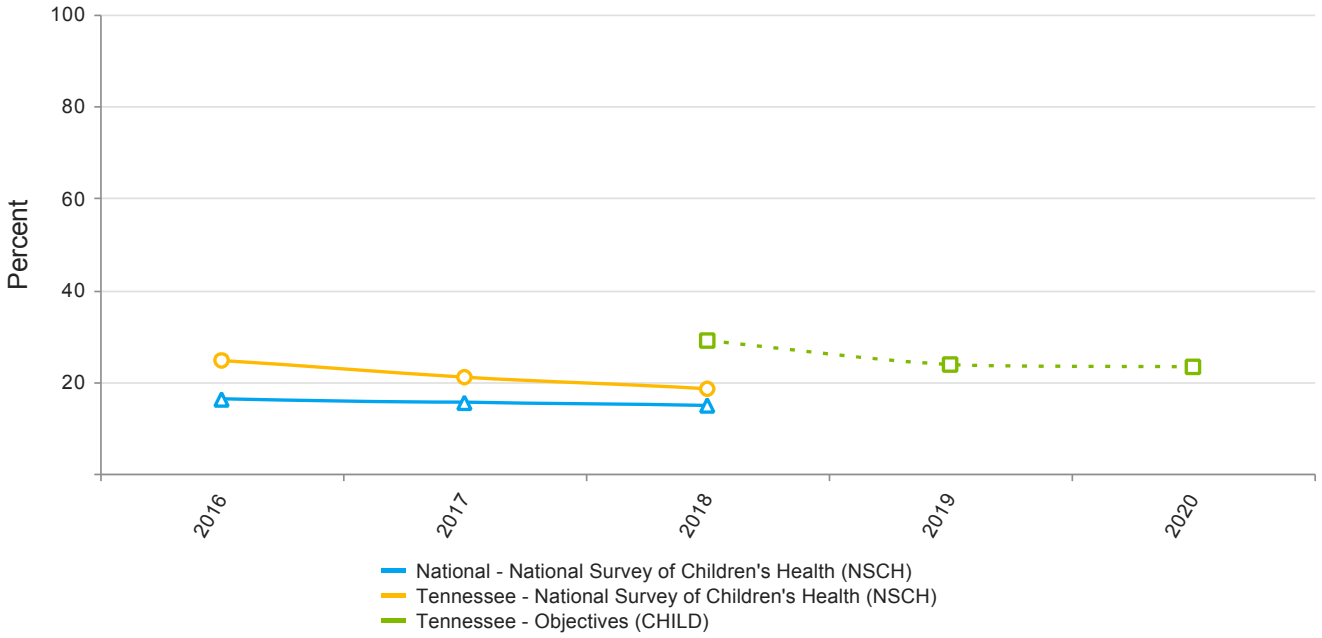
2016-2020: ESM 7.1.2 - Number of counties that adopt Count It! Drop It! Lock It! educational programs

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

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

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

2016-2020: NPM 14.2 - Percent of children, ages 0 through 17, who live in households where someone smokes Indicators and Annual Objectives



2016-2020: NPM 14.2 - Child Health

Federally Available Data				
Data Source: National Survey of Children's Health (NSCH)				
	2016	**2017**	**2018**	**2019**
Annual Objective			29	23.8
Annual Indicator		24.9	21.1	18.6
Numerator		362,200	311,958	276,334
Denominator		1,457,726	1,478,634	1,485,841
Data Source		NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018

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

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

2016-2020: ESM 14.2.1 - Number of child care facilities that voluntarily implement a tobacco-free campus policy

Measure Status:			**Active**	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective				570
Annual Indicator	441	474	501	306
Numerator				
Denominator				
Data Source	TDH FHW Chronic Disease Program Data	TDH FHW Chronic Disease Program Data	TDH FHW Chronic Disease Program Data	TDH FHW Chronic Disease Program Data
Data Source Year	FFY2016	FFY2017	FFY2018	FFY2019
Provisional or Final ?	Final	Final	Final	Final

2016-2020: ESM 14.2.2 - Percent of primary caregivers enrolled in home visiting who reported using any tobacco products at enrollments and were referred to tobacco cessation counseling or services within three months of enrollment

Measure Status:			**Active**	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective		10	93	98.5
Annual Indicator	1.7	97.8	100	100
Numerator				
Denominator				
Data Source	TDH FHW Early Childhood Section Program Data	TDH FHW Early Childhood Section Program Data	TDH FHW Early Childhood Section Program Data	TDH FHW Early Childhood Section Program Data
Data Source Year	FFY2016	FFY2017	FFY2018	FFY2019
Provisional or Final ?	Final	Final	Final	Final

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

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

NPM 6: For years 2017 and 2018, the National Survey of Children's Health (NSCH) reported that the percentage of Tennessee children who received a parent completed developmental screening improved to 42.4%, which surpassed the stated objective for Year 4.

ESM 6.1: An additional 51 Tennessee Department of Health nursing staff were trained in modules that assist in screening for Autism and Autism-Spectrum disorders.

ESM 6.2: The exposure of developmental information on web-based platform KidCentralTN saw a decline in Year 4, with 510 unique page views, 424 visits, and 401 unique visitors to developmental milestone and developmental screening web pages. The administration of KidCentraltn transitioned to Tennessee Commission on Children and Youth (TCCY) at end of FY18 and some web addresses for site material were affected, which invariably impacted accessibility of information.

ESM 6.3: The percentage of families enrolled in evidence-based home visiting in Tennessee did see a decrease to 71% in Year 4. While this number did not meet the goal of 91%, this number is only representative of families from a single funding stream, rather than all home-visiting programs that are supported by the Department of Health.

Accomplishments and Challenges (based on FY2019 Action Plan)

Strategy 1: Increase general awareness among parents and caregivers of the need for developmental screening.

Activity 1a: Develop information and tools to assist caregivers to understand the importance of screening and early intervention which will increase demand for use of screening and assessment tools in early childhood settings.

Report 1a: TNAAP has prepared several resources and tools for distribution. They can be found here https://brightfutures.aap.org/materials-and-tools/Pages/default.aspx

Activity 1b: Revise and renew contract with the Department of Human Services to promote trainings in child development and developmental screenings through the Child Care Resource and Referral (CCR&R) Network.

Report 1b: A new contract with CCRR was completed in July 2019 for them to provide training on ASQ's. They are working on a training video to be distributed to EBHV and CHANT staff.

Activity 1c: Incorporate developmental screening pathways into the enhanced model of care coordination in the Community Health Access and Navigation in Tennessee (CHANT) integrated model of services.

Report 1c: CHANT conducts ASQ's for all children ages 0-5 on a developmental pathway since roll out across the state in July 2019. So far, there have been 588 ASQ's completed. Most children have received at least 2 screenings based on the timeframe for when screenings should be completed.

Activity 1d: Implement the Talk with Me Baby initiative in WIC clinics across the state to promote language nutrition and awareness of infant development.

Report 1d: **T**here have been over 650 WIC clinic staff trained across the state. A training video was developed for all county offices to use during staff trainings. There have been 60,000 Talk with Me Baby books sent out to the counties and EBHV programs for distribution to families.

Strategy 2: Encourage and support providers to integrate developmental screening as a part of routine care.

Activity 2a: Promote the Medical Home model with an emphasis on incorporating developmental and behavioral screening, reimbursement methods, and referral pathways.

Report 2a: The medical home website was developed by TNAAP and running as of September 2019.

Activity 2b: Gather information on interagency processes between care coordination and evidence-based home visiting agencies and local primary care physicians to understand the referral process landscape across the state.

Report 2b: The call center has developed an internal referral process between welcome baby list referrals and prequalification criteria for CHANT (medium risk and EBHV high risk) External processes are handled at the local level within each county or regional health department with coordinating community stakeholders.

Activity 2c: Identify available technology tools that can help child-serving entities efficiently use and share screening data, while respecting the legal privacy rights of families.

Report 2c: There are ASQ's online that parents can perform and share information with their providers; thereby empowering parents and resolving the confidentiality issues. This needs to be promoted within the medical and home visiting community in order to be an effective method.

Activity 2d: Continue to partner with Tennessee Early Intervention System and the Tennessee Chapter of the American Academy of Pediatrics to provide training on the Modified-Checklist for Autism in Toddlers, Revised (M-CHAT R) and ASQ-3 screening tools to all local health department regions.

Report 2d: The CNE has expired for the online modules. It expired in July 2019 . The total trained in person and online is 582. They do however continue to use the online

links to CEUS for all new hires . CEUS have not expired. Their numbers are included in the 582. TNAAP in partnership with Vanderbilt and the START program have provided continuing education https://vimeo.com/228976910 and resources here https://brightfutures.aap.org/materials-and-tools/Pages/default.aspx

Activity 2e: Continue working with the Tennessee Chapter of the American Academy of Pediatrics and staff from Tennessee Early Intervention Services to discuss collaboration on training for pediatricians regarding developmental screenings and referrals for services.

Report 2e: TNAAP continues to provide 26 or more Screening Tools and Referral Training programs across the state each year to Pediatricians and Family physicians.

Activity 2f: Collaborate with TennCare/MCOs to incorporate a Primary Care Medical Home (PCMH) pathways into the enhanced model of care coordination in the Community Health Access and Navigation in Tennessee (CHANT) integrated model of services.

Report 2f: CHANT began reporting in July 2019 the number of children with TNCARE who need to be referred due to no medical home or well child visit. Also, referrals are made for those who have no insurance. For the fourth quarter, there were 18 referrals made due to no medical home or well child visit. There were 151 referrals made due to no insurance.

Strategy 3: Explore opportunities for incorporating developmental screening into settings outside of primary care.

Activity 3a: Continue to partner with state and federally funded evidence-based home visiting programs to promote administration of developmental screening.

Report 3a: EBHV programs which consist of 11 agencies across the state are completing developmental screenings on all eligible children according to the administration guidelines.

Activity 3b: Partner with the Tennessee Chapter of the American Academy of Pediatrics (TNAPP) to provide ASQ-3 and ASQ:SE-2 training to care coordination and evidence-based home visiting staff across the state.

Report 3b: Train the trainer modules are being developed by TNAAP for use within Community Health Access and Navigation in Tennessee and Evidence-Based Home Visiting programs.

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

Report 3c: START program is working on this as well as our evidenced based home visiting programs (EBHV) and CHANT programs.

Activity 3d: Explore inclusion of developmental screening administration and language nutrition/Talk with Me Baby into the Gold Sneaker Initiative and designation standards at Department of Health.

Report 3d: Golden Sneaker program targets physical activity, tobacco, nutrition and may not be a good fit for the developmental screening content. Childcare resource and referral network trains on ASQ's and talk with me baby video is available to the Child Care Resource and Referral network.

Priority: Reduce the burden of injuries among children.

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

NPM 7.1: The rate of hospitalizations for non-fatal injury per 100,000 children aged 0 to 9 in 2019 (119.1) remained similar to 2018's rate (119.4).

ESM 7.1.1: In FY 2019, 2,525 parents and caregivers received education on car seats. 389 more parents were educated than in 2018. Nonetheless, the actual performance for 2019 fell short of the year's objective of providing education on car seats to 2875 parents and caregivers.

ESM 7.1.2: The "Count it! Drop it! Lock it!" educational program expanded to all Tennessee counties (n=95). This presence of "Count it! Drop it! Lock it!" across Tennessee resulted in the state surpassing its 2019 objective of reaching 93 counties.

ESM 7.1.3: 54% of families participating in Evidence-Based Home Visiting programs received education on injury prevention. This proportion represents an 8% increase in the reported proportion for 2018. At 54%, the 2019 target of reaching 89% of families was not met.

Accomplishments and Challenges (based on FY2019 Action Plan)

Strategy 1: Promote the use of child safety seats.

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

Report 1a: From October 1, 2018 to September 30, 2018, TDH provided $153,533 to 23 agencies that purchased 2,525 child safety seats, infant-only seats, and booster seats for distribution. Agencies conduct education while ensuring that seats are properly installed. Each agency is required to have a certified child safety seat technician on staff.

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

Report 1b: An infographic titled "The Road to Crash Prevention"—which contained general

safe driving information along with child safety seat education—was disseminated. Over 1,000 infographics were sent to 23 child safety seat funded recipients for use in educational programs.

Activity 1c: Assess community agencies who distribute car seats to document how need is determined and how car seat availability is communicated to communities they serve.

Report 1c: An assessment was conducted among 20 funded agencies to ensure that recipients understood the scope and regulations of the program and to gather recommendations to improve the program. Fifteen agencies were contacted by phone and five were interviewed in person. The criteria to receive funding, reporting guidelines, and service recipients were also discussed with participants. Findings suggested that: i) currently funded agencies varied in their measurement of car seat safety; ii) agencies differed on the methods of distributing car seats; and iii) hospitals had a greater capacity to serve non-English speaking families. Also, very few entities reported that they had additional funding to purchase car seats. As a result of the assessment, changes were made to the application process to clearly identify private non profit agency status.

Strategy 2: Promote safe storage of medications.

Activity 2a: Promote safe storage and disposal of medications through the Count it, Lock it™, Drop it initiative. The goal of Count It, Lock It, Drop It™ is to increase the number of individuals tracking medication, securing medication in a locked medicine box, and utilizing medicine drop boxes. Staff will collaborate with partners to conduct four presentations to promote Count It, Lock It, Drop It™ to increase safe storage and disposal of medication.

Report 2a: As of September 30th, 2019 all 95 counties had implemented the Count It! Lock It! Drop It!™ program that includes education and securing medication in locked medicine boxes. In fact, a total of 106 (one hundred and six) groups in Tennessee are conducting the program with some multiple programs in some counties. This sustainability and increase in this program has been a success story for our local partners. This year, we ranked groups on their “level of effort” defined by criteria designed to measure the community engagement of the program from 0 (just starting) to 3 (full implementation with multiple community entities). Six counties were successful in increasing the level of activity including: Bedford County (02): Cannon County (02): Lake County (1 2): Loudon County (1 2): Monroe County (03) Wilson County (0 2). Next year, we plan to continue to encourage existing groups to increase levels of community engagement.

Activity 2b: Partner with a minimum of 25 hospitals by September 30, 2019 to promote safe storage of medications to patients.

Report 2b: TDH partnered with Count It! Lock It! Drop It! (CLD) staff to encourage hospitals and medical providers to provide information to patients to monitor, secure, and dispose of medication at twenty-five (25) medical facilities. Programs included:

patient information efforts, prescription safety training, drug take back events, medical forum on safe prescribing, and coalition training regarding drug take back events.

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

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

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

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

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

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

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

Activity 3c: Develop and distribute infographics on a minimum of 3 child injury topics.

Report 3c: Three thousand infographics on suicide, safe sleep and motor vehicle crashes were updated with 2017 child fatality data and distributed to childcare providers who serve families with at-risk children.

<u>Priority:</u> Reduce the number of children who are overweight/obese.

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

Overall, Tennessee (TN) continues to see modest improvements in child health and primary prevention

indicators that promote healthy weight among children as follows:

NPM 8.1: Combined 2017-2018 data from the National Survey of Children's Health show that nearly one-third of children ages 6-11 meet physical activity guidelines. This rate is in line with the Year 4 target objective and represents an increase over Years 2 and 3. The increase is likely due to more statewide programming leading to enhanced opportunities for physical activity.

SPM 2: Breastfeeding initiation among newborns remained relatively steady at 80.8% in 2018 compared to 2017. This rate was somewhat below expectations, although the rate has increased from 78.3% in 2016. Tennessee continues to engage with community-based partners, health care providers, and lactation care providers in WIC to promote breastfeeding efforts.

ESM 8.1.1: The number of Gold Sneaker-recognized childcare facilities decreased substantially from 501 in 2018 to 306 in 2019. However, the decline followed the redesign of the initiative's policies and certification process in partnership with the Tennessee Department of Human Services. This redesign resulted in all facilities having to reapply for certification. Since November 2018, certifications have increased at the fastest rate ever due to Gold sneaker being included as a requirement in DHS's coveted 3-star rating for child care centers.

ESM 8.1.2: The average number of monthly calls to the TN Breastfeeding Hotline declined moderately from 519 in 2018 to 475 in 2019. This decline is most likely due to an increased availability of other support (e.g., Designated Breastfeeding Experts in every local health department) for breastfeeding families. Also, TBH's call volume might have been impacted by Tennessee's transition to an out-of-state vendor and decreased promotion of the available service.

ESM 8.1.3: The number of TN Baby Friendly-designated birthing hospitals held steady at six in 2019. Though TN has remained stagnant in the number of Baby Friendly-designated hospitals (likely due to the rigor and extensive cost of attaining and maintaining the designation), TDH created BEST (Breastfeeding, Early Elective Delivery Reduction, and Safe Sleep for Tennessee Babies) to celebrate hospital efforts to reduce infant deaths. In addition to the six Baby-Friendly hospitals, fifteen hospitals had a breastfeeding initiation rate at or above 82.0%.

Accomplishments and Challenges (based on FY2019 Action Plan)

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

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

Report 1a: Local health educators across the state and central office staff continue to educate licensed child care facilities about the benefits of Gold Sneaker certification. The Gold Sneaker Director also promotes the initiative by engaging facilities directly through direct training. The Gold Sneaker web page also contains current information specific to certification training under the revised

policies. As of September, 2019, 254 daycares obtained Gold Sneaker certification under the revised policies.

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

Report 1b: Gold Sneaker policies were revised in November 2018, requiring all participating childcare facilities to complete a new certification training and application. As a result of the policy revision, technical assistance requests to childcare facilities have primarily focused on training and updates to the application requirements. Technical assistance is available upon request. Additionally, in-person educational workshops and webinar opportunities were designed to assist providers with maintaining compliance with Gold Sneaker policies.

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

Report 1c: TDH staff continues its collaboration with TDHS following the successful integration of GS policies with TDHS Star-Quality Rating System. Tennessee's 2018 licensing revisions catapulted the state from 39th in the nation for strength of ECE regulations supportive of Healthy Weight Practices. TDH and TDHS staff continue to participate in quarterly partner meetings.

Activity 1d: Continue evaluation processes that support existing Gold Sneaker facilities.

Report 1d: TDH and TDHS are in discussions specific to the annual evaluation of certified Gold Sneaker facilities by TDHS evaluators. An online GS certification application was implemented during the reporting period. A brief 5-question survey was developed to gauge a user's experience and satisfaction with the online submission of the GS certification application.

Activity 1e: Continue Gold Sneaker Advisory Group collaboration to assist in the ongoing certification and re-designation process for Gold Sneaker facilities.

Report 1e: The Gold Sneaker Advisory Group continues to meet annually to provide feedback on the certification process and annual childcare facility evaluation.

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

Report 1f: TDH staff provided a total of 6 training webinars for partners including TDH Health Educators, TDHS Evaluators, and Tennessee Child Care Resource and Referral Network staff. Webinars were recorded and made available to partners unable to attend the live training.

Strategy 2: Increase support for breastfeeding initiation and duration (recognizing the impact of

breastfeeding on long-term overweight/obesity risk for children).

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

Report 2a: Breastfeeding has been promoted through many avenues-Head Start, local community organizations, websites like KidCentral, TN WIC Program, physician offices, local county health departments, the breastfeeding initiatives of the TN Academy of Pediatrics, and many meetings where MCH partners were in attendance.

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

Report 2b: Breastfeeding Hotline materials have been distributed as requested throughout the performance period. The Welcome Baby booklets were recently updated and the breastfeeding information was reviewed and updated.

Activity 2c: Partner with the Tennessee Hospital Association (THA) to offer 20 continuing medical education credits (CMEs) to medical providers for breastfeeding education (as funding allows).

Report 2c: The promotion of the CMEs through THA continued for all professionals who work with pregnant and breastfeeding women. Unfortunately the funding source for this project has ended; however, THA is committed to providing information about these CMEs.

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

Report 2d: THA is an active supporter in improving breastfeeding practices and encourages hospitals to adopt breastfeeding practices to work toward a BEST hospital. BEST = Improvement in BF initiation rates by 5% from one year to the next or have a BF initiation rate of 82% or higher; decreasing early elective deliveries (5% or less aggregate rate for prior year, submit documentation of safe sleep practices in TN.

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

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

Report 3a: The State School Nurse Consultant is working to increase health education through school nurses regarding health and wellness, including physical activity and nutrition as it relates to establishing healthy lifestyles. The nurse consultant also provides support and guidance of health screenings as it provides additional avenues to educate students on healthy habits.

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

Report 3b: During the reporting period, TDH was informed of 273 physical activity clubs. TDH and CSH partnered to conduct physical activity clubs and activities, including but not limited to: walk/run clubs, Go Girl Go, jump rope contests, Walk to School Day and dance challenges. A link to a free, downloadable run club toolkit (designed to help those interested in starting a run club) was also provided to staff interested in establishing a run club.

Activity 3c: Provide resources (toolkits) to schools planning to implement a run club, physical activity club or other CSPAP activity. Promote resources through webinars, conference calls, group trainings, and other avenues, as they arise.

Report 3c: Physical education (PE) and physical activity (PA) trainings were facilitated by the Coordinated School Health State Physical Education Coordinator. Multiple trainings were conducted for districts on topics included but not limited to: PE best practices, TN state standards, standards-based instruction, classroom physical activity, recess policy guidance and best practices, and Comprehensive School Physical Activity Programs (CSPAP). The Coordinator also facilitated three (3) grand regional PE workshops providing two free days of breakout sessions for up to 12 hours of educator professional development (only 1 day in East TN). A new workshop was also hosted, serving over 160 attendees addressing the supervision and evaluation of physical education in a four-hour TASL event. This workshop was conducted a total of six times (twice in each grand region).

Activity 3d: Continue evaluating processes that support school-based physical activity/clubs strategies.

Report 3d: A tracking document is used to determine the number of physical activity clubs. During the reporting period, TDH was informed of 273 physical activity clubs. Staff conducting the clubs revised the tool used to capture information on physical activity clubs. Information requested included: (club name, location, name of organizer, school based/community-based, and date initiated). This information is helpful in reducing the possibility of reporting duplication. Additionally, the link to a free, downloadable run club toolkit (designed to help those interested in starting a run club) was provided to staff interested in establishing a run club.

Priority: Reduce the number of children exposed to adverse childhood experiences.

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

SPM 1: The number of children who reported two or more adverse child experiences (ACEs) saw a slight decline to 24.1% in Year 4 reporting period. Such initiatives as Building Strong Brains are seeing and impact on the number's continual decline since it's initial monitoring in FY 16.

ESM for SPM 1.1: *This ESM* was *retired in FY 16,Year 2.*

ESM for SPM 1.2: There were only four ACEs presentations across the state in Year 4, which is considerably less than Year 3 (59). Data collection for this measure has declined over time as regional offices have completed *training* for all staff members. Considerations to expand the training to more professional groups will be needed to see improvements for this measure.

ESM for SPM 1.3: Evidence-based home visiting caregiver enrollees were only screened for ACEs 69.9 % of the time during the reporting period, which is a decline over the previous year. No trend can be established yet from the years' data collected this far.

Accomplishments and Challenges (based on FY2019 Action Plan)

Strategy 1: Increase general awareness of adverse childhood experiences (ACEs) in the community.

Activity 1a: Under the leadership of the Title V Program staff, disseminate the Tennessee ACEs Briefs related to the "Big 4" (TDH priorities areas of obesity, physical activity, substance abuse, and tobacco use) and present information about the CDC ACEs Study to early childhood and health professionals in order to raise awareness of the implications of ACEs.

Report 1a: Tennessee's current Strategic Priorities are now guiding the development of ACEs briefs. These briefs are in development and will focus on the current priorities of 1) supporting local leadership; 2) Youth Obesity; 3) Tobacco Use; 4) Substance Misuse; 5) prevention and mitigation of ACEs. These will be distributed to stakeholders and young child wellness partners and be posted on kid central website. We will use any CDC publications already developed that may meet these priority areas.

Activity 1b: Review and update ACEs Handout, How to Protect Your Child from Toxic Stress in the Welcome Baby packets to increase parents' understanding of ACEs and strategies to protect their child, and promote the concept of resilience.

Report 1b: The Welcome Baby Booklet has been updated and the Booklet has been mailed to the families of 75,930 newborns between 10-1-2018 and 9-30-2019.

Activity 1c: Explore alternate ways to educate parents and other caregivers on ACEs, with a focus on non-English speakers. This will include translation of new Welcome Baby packet into Spanish

Report 1c: The Welcome Baby Book revision 3 is in the process of being finalized. This version has all the ACE edits from parent focus groups and field staff. A vendor has been located and version 3 of the Welcome Baby Book will be translated into Spanish, followed by the second most identified language, Arabic.

Activity 1d: Provide ongoing leadership to Building Strong Brains, Tennessee's ACEs Initiative formed in 2015.

Report 1d: TDH continues to meet weekly with the Steering Committee of the Building Strong Brains Initiative. Participation also includes working on the development of a statewide strategic plan. Added to the plan developed in May of 2019 is an action to train representatives from TDOH as a Building Strong Brains Trainer of Trainers. This will allow TDH to develop the capacity to provide enough trainers across the TDH Regions to meet the volume of trainings needed to maintain the trained workforce.

Activity 1e: Provide ACEs training to the 34 Child Fatality Review teams during their annual meeting.

Report 1e: In April of 2019, ACEs training was presented as a work session at the Annual Child Fatality Review Team Meeting in Franklin, Tennessee.

Strategy 2: Collect Tennessee-specific data on ACEs and utilize that data to inform program and policy decisions.

Activity 2a: Continue to collect and disseminate Tennessee specific data such as from Evidence-Based Home Visiting Programs, and compare to state and nationally representative data sources such as BRFSS and NSCH.

Report 2a: The TDH Office of Population Health Surveillance is preparing an updated ACE handout and has provided updated information to TCCY for use in the Building Strong Brains presentation. Building Strong Brains has presented to X persons between 10/1/2018 and 9/30/2019.

Activity 2b: Collect ACEs data in underserved and at risk populations such as home visiting and compare to state and national measures. Disseminate findings to appropriate stakeholders serving these populations.

Report 2b: EBHV programs complete the ACE questionnaire with families and enter that data through the RedCap database. This data was included in the 2019 Home Visiting Legislative Report, and provided to HRSA to be used in the Home Visiting Yearbook. CHANT addresses ACES in the Child Health and Development Pathway. 2496 families screened into that Pathway; 599 families completed the Pathway and 496 families are actively working on completing

the Pathway as of 09/30/2019.

Priority: Reduce exposure to tobacco among the MCH population (secondhand smoke exposure for children).

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

NPM 14.2: The percentage of Tennessee children who live in households where someone smokes has decreased by 12% since FY17. This is likely due to continuing social norm changes across the state as well as statewide programs providing cessation services (QuitLine & BMTF) and social support (EBHV & CHANT) to families in Tennessee.

ESM 14.2.1: The number of child care facilities that voluntarily implemented a tobacco free policy under the Gold Sneaker initiative saw a precipitous drop in FY19 following the revision of the program's policies and designation process in partnership with the Tennessee Department of Human Services at the start of the fiscal year. However, uptake of the new policies since the revision has drastically outpaced previous years and is continued to increase due to the policy's inclusion in DHS's 3-star requirements for child care centers.

ESM 14.2.2: The percentage of primary caregivers enrolled in home visiting who screened positive for tobacco use and were referred to the QuitLine has remained at 100%. This is due to the continued, systematic implementation of the screening and referral process EBHV has instituted.

Accomplishments and Challenges (based on FY2019 Action Plan)

Strategy 1: Continue the Gold Sneaker voluntary recognition program for licensed childcare centers (one of the policy areas is promotion of tobacco-free child care campuses).

Activity 1a: Recruit a minimum of 50 childcare facilities statewide by educating Facility Directors about the benefits of deciding to pursue Gold Sneaker certification or re-designation.

Report 1a: As part of the Tennessee Department of Human Services' standards for 3-star designation, the Gold Sneaker Initiative underwent changes to the application process. The new GS training was available January 2019. There are currently 432 certified Gold Sneaker facilities.

Activity 1b: Provide technical assistance to childcare centers to help in the development and implementation of policies related to tobacco exposure.

Report 1b: Health Educators and Tobacco Coordinators continue to schedule Gold Sneaker Trainings to recruit new daycare centers and childcare facilities to apply for the program. As part of the new application process, applicants are asked to complete a web-based survey that will help gauge potential for process revisions and the need for further technical assistance. A resource packet including information related to tobacco exposure is sent to certified Gold Sneaker

facilities.

Activity 1c: Provide information for center staff and parents to educate about harm resulting from the use of Electronic Nicotine Delivery Systems (ENDS), the dangers of secondhand and thirdhand smoke exposure, and the benefits of tobacco-free childcare centers and homes, and provide tobacco-free signage.

Report 1c: Tobacco Coordinators and Health Educators across the state provide health education materials to licensed child care facilities. TDH provides palm cards promoting the Tobacco Quitline as well as other health education pamphlets including information on 2nd and 3rd hand smoke and ENDS. Information and TA is provided when a request is made by the facility.

Strategy 2: Refer participants in federally-funded programs to smoking cessation services where appropriate.

Activity 3a: Continue to screen participants in home visiting to the Tobacco QuitLine and other community-based cessation services.

Report 3a: During Year 4, 100% of participants in home visiting were screened for tobacco use and referred to the Tennessee Tobacco QuitLine or to BABY & ME Tobacco Free.

Activity 3b: Refer 98.5% of smoking participants in home visiting to the Tobacco QuitLine and other community-based cessation services within three months of enrollment.

Report 3b: Home Visitors continue working to ensure that all primary caregivers enrolled in the Evidence-based Home Visiting program who report using any tobacco products at enrollment are referred to Tobacco Quitline within three months of enrollment.

Activity 3c: Support integration of smoking assessment, including ENDS use, and cessation resources into the TDH electronic health record (EPI) as it is scheduled to be deployed statewide during this reporting year.

Report 3c: The TDH electronic health record (EPI) system has integrated smoking assessment to include all tobacco products including use of ENDS. Providers are prompted to ask what products are used, age of initiation, product used, whether the patient would like to quit tobacco, and offers an option for preventative counseling.

Activity 3d: Provide quality improvement education and technical support to home visiting staff regarding available tobacco cessation services.

Report 3d: Central Office tobacco program staff continue to offer subject matter expertise and materials for use by home visiting when interacting with primary caregivers who report using any tobacco products throughout enrollment.

Priority: Obesity

The following strategies and activities are planned for FY21:

Strategy 1: Support school-based efforts to promote physical activity and good nutrition

Activity 1a: Collaborate with the Tennessee Department of Environment and Conservation (TDEC) and the Department of Education Coordinated School Health to increase the number of statewide physical activity clubs (walking, running, etc.) in both school-based, community-based sites from 275 to 285 clubs.

Activity 1b: Partner with the Department of Education Coordinated School Health staff to provide professional development on school physical education and physical activity to at least 10 local education agencies with an emphasis on areas with the highest youth obesity rates.

Activity 1c: Partner with the Department of Education Coordinated School Health (CSH) staff to provide professional development on promoting healthy lifestyle choices before, during, and after school to at least 50 PHEs and local education agency staff (Smart Snacks in Schools, Junior Chef, National After School Association's HEPA standards, etc.)

Strategy 2: Promote Gold Sneaker voluntary recognition program for licensed childcare centers

Activity 2a: Participate in 1-2 meetings with the TN Department of Human Services to promote the Gold Sneaker 3 Star requirement and explore opportunities to add Gold Sneaker requirements to licensed childcare standards.

Activity 2b: Provide a minimum of 1-2 trainings on the Gold Sneaker policies for public health educators, TN Department of Human Services staff, and Child Care Resource & Referral Center staff, and other partners statewide.

Activity 2c: Identify and disseminate educational resources to Gold Sneaker certified daycares that support implementation of Gold Sneaker policies related to physical activity, nutrition, and tobacco exposure.

Activity 2d: Increase number of daycares that complete the voluntary Gold Sneaker certification from 535 to 600.

Strategy 3: Partner with healthcare providers to promote physical activity counseling during well-child visits

Activity 3a: Identify a minimum of 5 health provider champions including pediatricians and family practitioners, to increase the awareness and use of the Healthy Parks Healthy Person park prescription program for patients and their families to increase physical activity.

Activity 3b: Promote the use of the Healthy Parks Healthy Person park prescription program and app by PHNs, WIC staff, and other health providers in 10 local health departments.

Strategy 4: Promote policy, systems, and environmental change (PSE) strategies to increase physical activity and promote access to healthy food and beverages

Activity 4a: Support local communities who set a goal with Primary Prevention Plans from community needs assessment of reducing consumption of sugary drinks with an emphasis on distressed and at risk counties.

Activity 4b: Identify a min of 5 partners to develop and implement strategies that increase access to healthier food and beverage options with an emphasis on distressed and at risk counties.

Activity 4c: Promote joint use agreements that encourage after-hours use of school and community facilities for reactional activity.

Strategy 5 Promote the mental health benefits of physical activity

Activity 5a: Provide training, resources, and tools for 10 health departments promoting the mental health benefits of being physically active in nature.

Activity 5b: Partner with the Department of Education Coordinated School Health staff to provide professional development on the mental health benefits of physical activity to at least 8 local education agencies with an emphasis on areas with the highest youth obesity rates.

Priority: Adverse Childhood Experiences (ACEs)

The following strategies and activities are planned for FY21:

Strategy 1: Increase knowledge and practice of ACE and Trauma Informed Care (TIC)

Activity 1a: Develop and implement online ACEs training for TDH staff, including those in the CHANT and EBHV programs. Increasing the awareness of the impact of ACEs on families will provide a better understanding of what has happened to families and how to offer services in a supportive manner.

Activity 1b: Develop and implement online TIC training for TDH staff, including those in the CHANT and EBHV programs.
Through this training TDH staff and CHANT and EBHV programs will be able to integrate trauma informed practices into their work with families, mitigating the impact of ACEs.

Activity 1c: Provide ACE and TIC refresher training for child fatality teams as part of their ongoing training. This training will provide information and insight to teams on the impact of ACEs and trauma and assist in understanding the impact on social determinants of health.

Strategy 2: Ensure a strong start for children by promoting a healthy parent-child attachment through implementation of home visiting programs throughout the 95 counties of Tennessee.

Activity 2a: Teach positive parenting skills through home visitation in partnership with local EBHV implementing agencies. This will include encouraging social-emotional learning and parent-child relationship whose instability has been exacerbated by the COVID-19 global pandemic.

Activity 2b: Provide health education through EBHV home visiting programs in counties throughout Tennessee. Communicating the importance of children having a medical home to parents promotes high quality and culturally effective integrated care

Activity 2c: Provide supportive care and additional services to families and children through EBHV home visitation. By connecting families with concrete services and knowledge of parenting and child development improve protective factors which mitigate or prevent ACEs.

Strategy 3: Intervene to lessen immediate and long-term harms by linking families to health and social services.

Activity 3a: Screen and assess families for enrollment in CHANT to identify health and social needs that have long term impact on families and children. By identifying the needs of families immediate, priority services can be provided to families.

Activity 3b: Provide referrals to families for identified health care and social service needs. Identifying which of the sixteen pathways of care families have identified as needs increase the protective factors within a family by providing concrete services at the time identified.

Activity 3c: Assist families in navigating the healthcare and social services system through the CHANT care-coordination model. Providing assistance in navigating any of the sixteen pathways, including obtaining and medical home or an EPSDT, is solution focused as barriers and other obstacles are addressed. Through this families resiliency is increased as a strategy to eliminate and mitigate ACEs the family might have experienced.

Strategy 4: CHANT and EBHV will screen and link families to mental health services

Activity 4a: Screen primary caregivers and families for depression using the Edinburg depression screening tool in EBHV home visiting programs and at CHANT screening and assessment. Depression can impact someone's ability to care for themselves or a child. Early identification can result in earlier access to treatment.

Activity 4b: Refer families and caregivers identified in EBHV home visiting programs and CHANT that have elevated depression screening scores to mental health providers. Risk for those experiencing depression include: withdrawal, disconnecting from your baby/child, difficulty completing everyday tasks and fear of hurting yourself or others. Depression treatment includes medication and/or talk therapy and has an impact on preventing and mitigating ACEs.

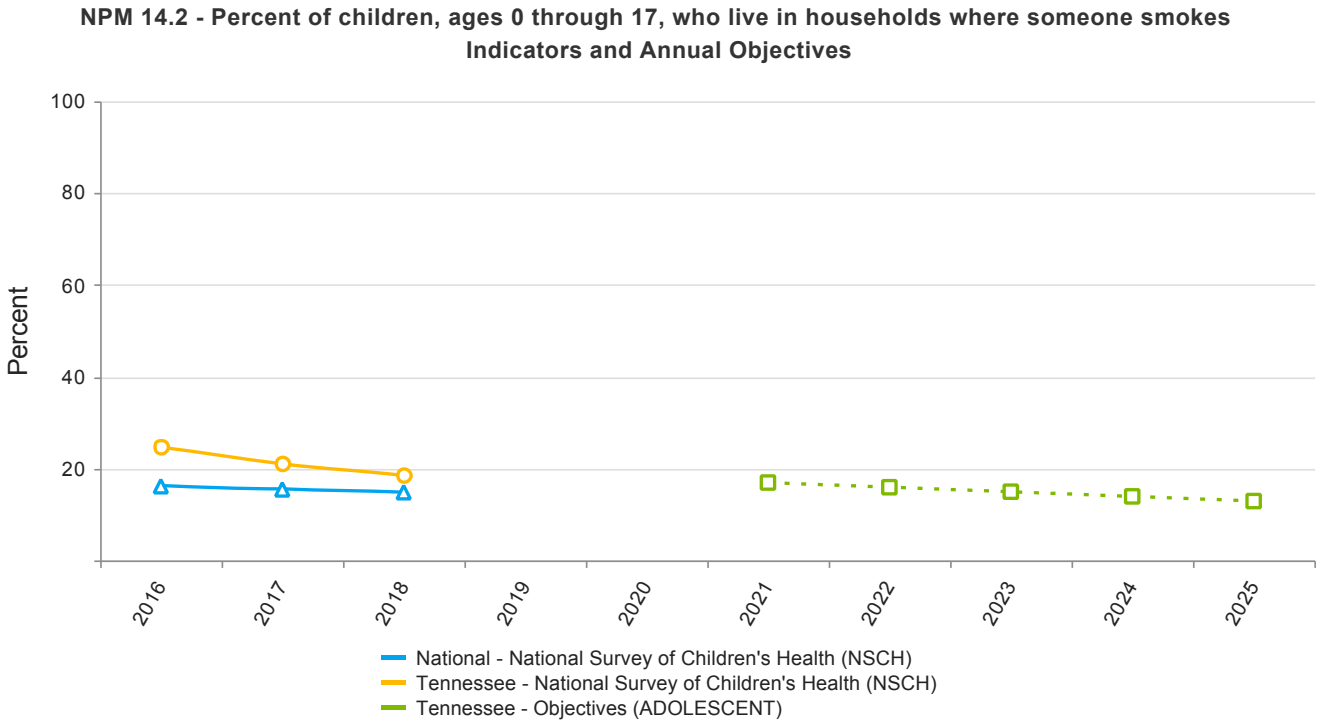
Adolescent Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations	SID-2017	75.0	NPM 14.2
NOM 3 - Maternal mortality rate per 100,000 live births	NVSS-2014_2018	24.9	NPM 14.2
NOM 4 - Percent of low birth weight deliveries (<2,500 grams)	NVSS-2018	9.3 %	NPM 14.2
NOM 5 - Percent of preterm births (<37 weeks)	NVSS-2018	11.1 %	NPM 14.2
NOM 6 - Percent of early term births (37, 38 weeks)	NVSS-2018	27.9 %	NPM 14.2
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2017	6.8	NPM 14.2
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2017	7.3	NPM 14.2
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2017	4.6	NPM 14.2
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2017	2.7	NPM 14.2
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2017	201.2	NPM 14.2
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2017	149.4	NPM 14.2
NOM 15 - Child Mortality rate, ages 1 through 9, per 100,000	NVSS-2018	22.3	NPM 7.2
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000	NVSS-2018	44.9	NPM 7.2
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000	NVSS-2016_2018	15.3	NPM 7.2
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000	NVSS-2016_2018	13.2	NPM 7.2
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2017_2018	88.7 %	NPM 8.2 NPM 14.2

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	NSCH-2017_2018	16.7 %	NPM 8.2
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	WIC-2016	14.6 %	NPM 8.2
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	YRBSS-2017	20.5 %	NPM 8.2

National Performance Measures



NPM 14.2 - Adolescent Health

Federally Available Data				
Data Source: National Survey of Children's Health (NSCH)				
	2016	**2017**	**2018**	**2019**
Annual Objective			29	
Annual Indicator		24.9	21.1	18.6
Numerator		362,200	311,958	276,334
Denominator		1,457,726	1,478,634	1,485,841
Data Source		NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018

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

Annual Objectives					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	17.0	16.0	15.0	14.0	13.0

Evidence-Based or –Informed Strategy Measures

ESM 14.2.1 - Number of tobacco-free sports teams

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	79.0	81.0	83.0	85.0	88.0

ESM 14.2.2 - Number of ambassadors recruited

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	26.0	26.0	26.0	26.0	26.0

ESM 14.2.3 - Number of youth councils

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	72.0	74.0	76.0	78.0	80.0

ESM 14.2.4 - Number of youth-created PSAs

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	2.0	5.0	5.0	10.0	10.0

ESM 14.2.5 - Number of youth who attend the state anti-tobacco conference

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	75.0	300.0	300.0	350.0	400.0

ESM 14.2.6 - Number of trainings educating youth on tobacco issues

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	5.0	10.0	10.0	10.0	10.0

ESM 14.2.7 - Number of anti-tobacco social media posts

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	6.0	21.0	12.0	24.0	24.0

ESM 14.2.8 - Number of meetings with partners to increase screening and referral of adolescents using tobacco to cessation resources

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	2.0	2.0	2.0	2.0	2.0

ESM 14.2.9 - Number of meetings with partners to expand data collection

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	2.0	2.0	2.0	2.0	2.0

ESM 14.2.10 - Number of social media posts promoting text-based cessation services

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	6.0	12.0	12.0	24.0	24.0

ESM 14.2.11 - Number of meetings with partner organizations to enhance tobacco activities in coalition action plans

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	2.0	2.0	2.0	2.0	2.0

ESM 14.2.12 - Number of new materials added to partner media library

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	2.0	4.0	6.0	8.0	10.0

ESM 14.2.13 - Number of meetings with potential new partner organizations

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	2.0	2.0	2.0	2.0	2.0

ESM 14.2.14 - Number of Question Persuade Refer (QPR) trainings

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	1.0	1.0	2.0	2.0	2.0

ESM 14.2.15 - Number of meetings with internal stakeholders on protocols for screening and referring adolescents for mental health disorders and services

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	1.0	1.0	1.0	1.0	1.0

State Performance Measures

SPM 19 - Percent of high school students currently using cigarettes

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	6.4	5.8	5.3	4.8	4.3

SPM 20 - Percent of high school students currently using e-cigarettes

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	18.0	17.9	17.8	17.8	17.7

SPM 21 - Number of adolescents enrolled in cessation program

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	0.0	20.0	50.0	100.0	125.0

State Outcome Measures

SOM 7 - Percent of adults reporting cardiovascular disease

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	5.3	5.3	5.3	5.2	5.2

SOM 8 - Age-adjusted mortality rate from tobacco-attributable cancers among Tennesseans aged 35+

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	176.4	171.4	166.4	161.3	156.3

State Action Plan Table

State Action Plan Table (Tennessee) - Adolescent Health - Entry 1

Priority Need

Decrease tobacco and e-cigarette use among adolescents

NPM

NPM 14.2 - Percent of children, ages 0 through 17, who live in households where someone smokes

Objectives

Decrease tobacco and e-cigarette use among adolescents

Strategies

Prevention and Engagement

ESMs	Status
ESM 14.2.1 - Number of tobacco-free sports teams	Active
ESM 14.2.2 - Number of ambassadors recruited	Active
ESM 14.2.3 - Number of youth councils	Active
ESM 14.2.4 - Number of youth-created PSAs	Active
ESM 14.2.5 - Number of youth who attend the state anti-tobacco conference	Active
ESM 14.2.6 - Number of trainings educating youth on tobacco issues	Active
ESM 14.2.7 - Number of anti-tobacco social media posts	Active
ESM 14.2.8 - Number of meetings with partners to increase screening and referral of adolescents using tobacco to cessation resources	Active
ESM 14.2.9 - Number of meetings with partners to expand data collection	Active
ESM 14.2.10 - Number of social media posts promoting text-based cessation services	Active
ESM 14.2.11 - Number of meetings with partner organizations to enhance tobacco activities in coalition action plans	Active
ESM 14.2.12 - Number of new materials added to partner media library	Active
ESM 14.2.13 - Number of meetings with potential new partner organizations	Active
ESM 14.2.14 - Number of Question Persuade Refer (QPR) trainings	Active
ESM 14.2.15 - Number of meetings with internal stakeholders on protocols for screening and referring adolescents for mental health disorders and services	Active

NOMs

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

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

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

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

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

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

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

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

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

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

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

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

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

Priority Need

Decrease tobacco and e-cigarette use among adolescents

SPM

SPM 19 - Percent of high school students currently using cigarettes

Objectives

Decrease tobacco and e-cigarette use among adolescents

Strategies

Mental Health

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

Priority Need

Decrease tobacco and e-cigarette use among adolescents

SPM

SPM 20 - Percent of high school students currently using e-cigarettes

Objectives

Decrease tobacco and e-cigarette use among adolescents

Strategies

Support Partners

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

Priority Need

Decrease tobacco and e-cigarette use among adolescents

SPM

SPM 21 - Number of adolescents enrolled in cessation program

Objectives

Decrease tobacco and e-cigarette use among adolescents

Strategies

Cessation

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

Priority Need

Decrease tobacco and e-cigarette use among adolescents

SOM

SOM 7 - Percent of adults reporting cardiovascular disease

Objectives

Decrease tobacco and e-cigarette use among adolescents

Strategies

Prevention and Engagement

Cessation

Support Partners

Mental Health

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

Priority Need

Decrease tobacco and e-cigarette use among adolescents

SOM

SOM 8 - Age-adjusted mortality rate from tobacco-attributable cancers among Tennesseans aged 35+

Objectives

Decrease tobacco and e-cigarette use among adolescents

Strategies

Prevention and Engagement

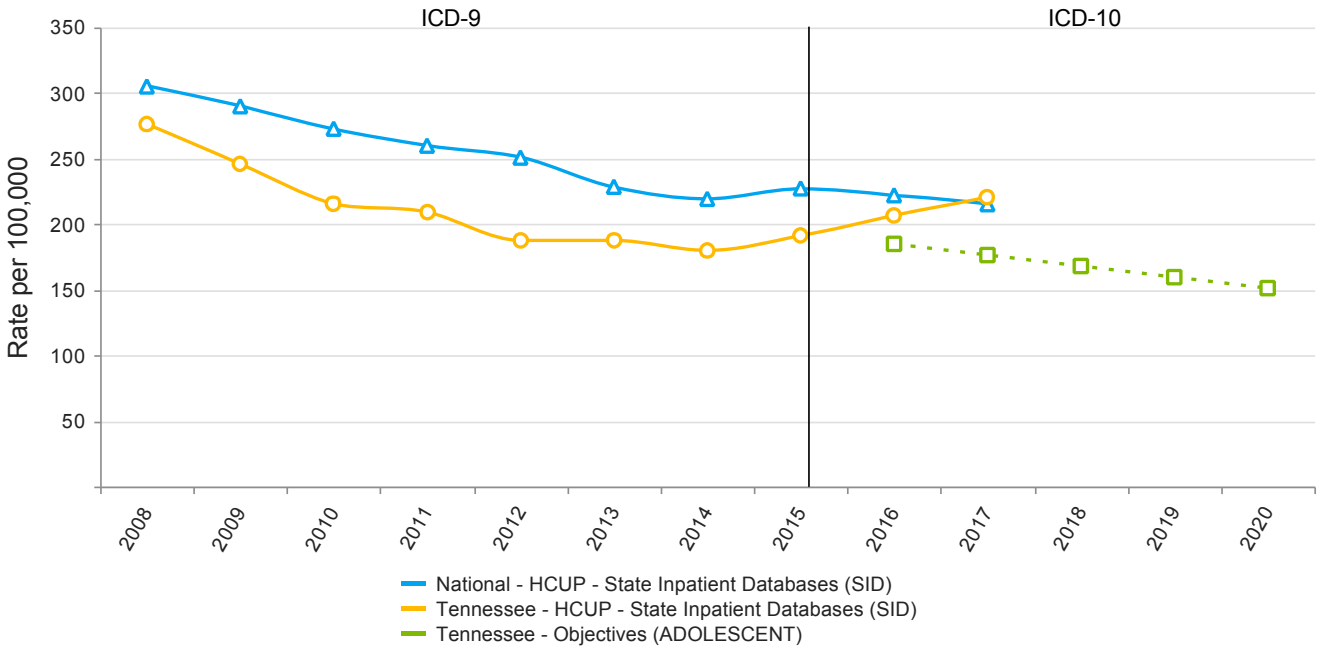
Cessation

Support Partners

Mental Health

2016-2020: National Performance Measures

2016-2020: NPM 7.2 - Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19
Indicators and Annual Objectives



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

Federally Available Data				
Data Source: HCUP - State Inpatient Databases (SID)				
	2016	**2017**	**2018**	**2019**
Annual Objective	184.8	176.4	168	159.6
Annual Indicator	207.7	191.6	206.3	220.7
Numerator	1,746	1,206	1,738	1,877
Denominator	840,564	629,323	842,341	850,432
Data Source	SID-ADOLESCENT	SID-ADOLESCENT	SID-ADOLESCENT	SID-ADOLESCENT
Data Source Year	2014	2015	2016	2017

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

2016-2020: ESM 7.2.1 - Number of schools in the top ten crash rate counties (among ages 15-18) that conduct evidence-informed teen safe driving programming

Measure Status:			**Active**	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective				59
Annual Indicator	46	43	48	53
Numerator				
Denominator				
Data Source	ReduceTNCrashes.org Safe Driving Report	ReduceTNCrashes.org Safe Driving Report	ReduceTNCrashes.org Safe Driving Report	ReduceTNCrashes.org Safe Driving Report
Data Source Year	FFY2016	FFY2017	FFY2018	FFY2019
Provisional or Final ?	Final	Final	Final	Final

2016-2020: ESM 7.2.2 - Number of drug disposal bins installed statewide

Measure Status:			**Active**	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective				326
Annual Indicator	206	236	311	350
Numerator				
Denominator				
Data Source	TN Depart of Environmental and Conservation Report	TN Depart of Environmental and Conservation Report	TN Depart of Environmental and Conservation Report	TN Depart of Environmental and Conservation Report
Data Source Year	FFY2106	FFY2017	FFY2018	FFY2019
Provisional or Final ?	Final	Final	Final	Final

2016-2020: ESM 7.2.3 - Number of press releases, social media posts and presentations about adolescent falls

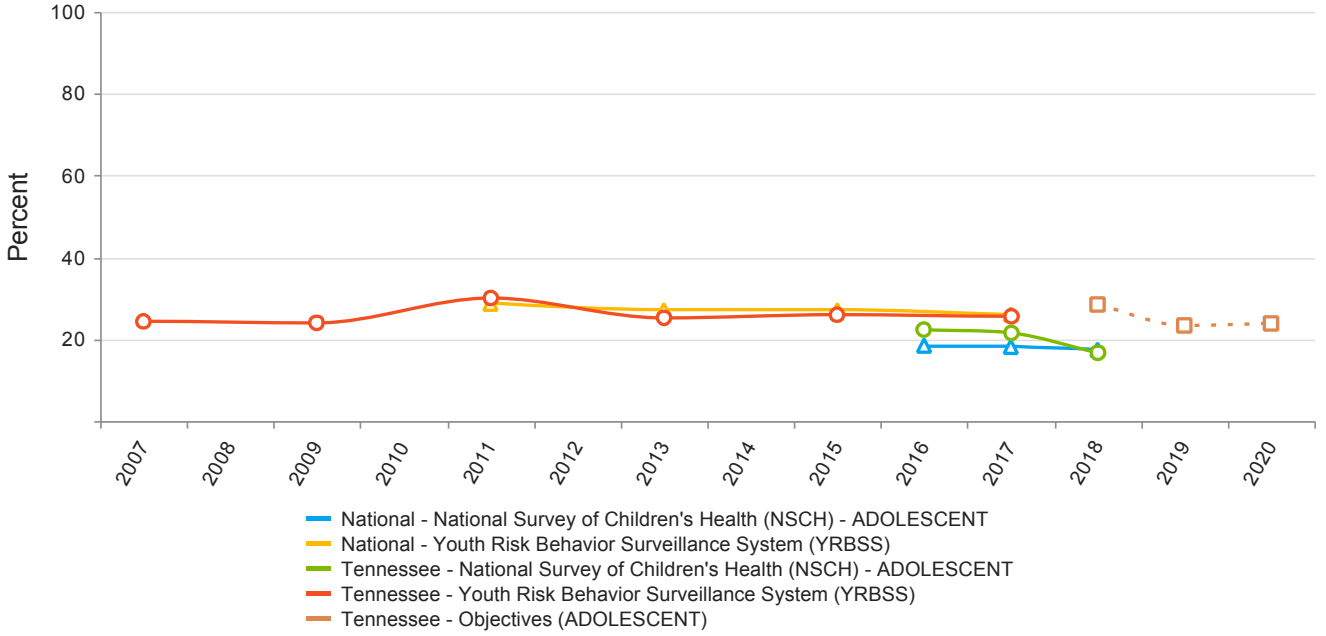
Measure Status:			Active	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective				7
Annual Indicator	8	9	22	16
Numerator				
Denominator				
Data Source	TN Depart of Environmental and Conservation Report	TN Depart of Environmental and Conservation Report	TN Depart of Environmental and Conservation Report	TN Depart of Environmental and Conservation Report
Data Source Year	FFY2106	FFY2017	FFY2018	FFY2019
Provisional or Final ?	Final	Final	Final	Final

2016-2020: ESM 7.2.4 - Number of suicide-related articles, social media posts and trainings provided by TDH

Measure Status:			Active	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective				20
Annual Indicator	11	19	28	28
Numerator				
Denominator				
Data Source	TDH FHW Injury Prevention Section Program Data	TDH FHW Injury Prevention Section Program Data	TDH FHW Injury Prevention Section Program Data	TDH FHW Injury Prevention Section Program Data
Data Source Year	FFY2016	FFY2017	FFY2018	FFY2019
Provisional or Final ?	Final	Final	Final	Final

2016-2020: NPM 8.2 - Percent of adolescents, ages 12 through 17 who are physically active at least 60 minutes per day

Indicators and Annual Objectives



Federally Available Data				
Data Source: Youth Risk Behavior Surveillance System (YRBSS)				
	2016	**2017**	**2018**	**2019**
Annual Objective	26.9	27.7	28.5	23.4
Annual Indicator	25.9	25.9	25.6	25.6
Numerator	70,480	70,480	73,476	73,476
Denominator	272,118	272,118	286,547	286,547
Data Source	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT
Data Source Year	2015	2015	2017	2017

Federally Available Data				
Data Source: National Survey of Children's Health (NSCH) - ADOLESCENT				
	2016	**2017**	**2018**	**2019**
Annual Objective			28.5	23.4
Annual Indicator		22.4	21.5	16.9
Numerator		107,989	105,885	85,908
Denominator		481,757	491,600	509,523
Data Source		NSCH-ADOLESCENT	NSCH-ADOLESCENT	NSCH-ADOLESCENT
Data Source Year		2016	2016_2017	2017_2018

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

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

2016-2020: ESM 8.2.1 - Number of Physical Activity Clubs in K-12 schools

Measure Status:			**Active**	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective				234
Annual Indicator	47	111	209	253
Numerator				
Denominator				
Data Source	TDH FHW Chronic Disease Program Data	TDH FHW Chronic Disease Program Data	TDH FHW Chronic Disease Program Data	TDH FHW Chronic Disease Program Data
Data Source Year	FFY2016	FFY2017	FFY2018	FFY2019
Provisional or Final ?	Final	Final	Final	Final

2016-2020: ESM 8.2.2 - Number of school gardens in Tennessee public schools

Measure Status:		**Active**	
State Provided Data			
	2017	**2018**	**2019**
Annual Objective			451
Annual Indicator	337	426	348
Numerator			
Denominator			
Data Source	DOE - Farm to School Program	DOE - Farm to School Program	DOE - Farm to School Program
Data Source Year	FFY2017	FFY2018	FFY2019
Provisional or Final ?	Final	Final	Final

2016-2020: ESM 8.2.3 - Number of Healthy Parks Healthy Person app users

Measure Status:		**Active**	
State Provided Data			
	2017	**2018**	**2019**
Annual Objective			2,935
Annual Indicator	1,661	2,853	4,928
Numerator			
Denominator			
Data Source	TDEC Healthy Parks Healthy Person App	TDEC Healthy Parks Healthy Person App	TDEC Healthy Parks Healthy Person App
Data Source Year	FFY2017	FFY2018	FFY2019
Provisional or Final ?	Final	Final	Final

Priority: Reduce the burden of injury among adolescents.

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

ESM 7.2.1: In FY2019, 53 high schools in the top-ten crash rate counties participated in the evidenced-based Checkpoints program, an educational program that promotes safe driving among teens. Compared to 2018, there was a 10% increase in the number of evidenced-based driving programs implemented across Tennessee schools in 2019. The state did not meet its objective of implementing an evidence-based safe driving program in 59 schools.

ESM 7.2.2: In FY2019, three hundred and fifty drug disposal bins were installed in Tennessee, marking an improvement on 2018's value (n=311) and exceeding the 2019 objective of 326 installed bins.

ESM 7.2.3: In FY2019, the state made 16 press releases, social media posts, and presentations on adolescent falls, therefore greatly exceeding its 2019 objective of seven posts, press release, or presentation.

ESM 7.2.4: In 2019, the injury prevention program had 28 articles, social media posts, and trainings on suicide prevention. This year, the state exceeded the measure's objective of 20 articles, social-media posts, or trainings on suicide prevention.

NPM 7.2: In FY2019, the rate of hospitalizations for non-fatal injury 10 through 20 was 227.5 per 100,000 adolescents. At this rate, the injury prevention program did not meet its 2019 objective of reducing the rate of hospitalizations to 159.6 hospitalizations per 100,000 adolescents. Nonetheless, the rate of hospitalization for non-fatal injury in 2019 was 16% lower than in 2018.

Accomplishments and Challenges (based on FY2019 Action Plan)

Strategy 1: Increase implementation of evidence based or evidence informed activities related to motor vehicle safety in schools.

Activity 1a: In the ten counties with the highest teen motor vehicle crash rates, increase the number of schools that utilize ReduceTNCrashes.Org to conduct a teen safe driving program from 14 to 30.

Report 1a: A total of 53 schools registered for ReduceTNCrashes.Org, with a majority of those residing in the counties with the highest teen motor vehicle crash rates, crash counts, emergency department visits or rates (i.e. high teen crash risk). Staff promoted Reduce TN Crashes at the Tennessee Health Occupation Student Organization Conference, FCCLA Conference. Staff also partnered with the Tennessee Department of Education to create a Teen Safe Driving Conference Track at the Tennessee Coordinated School Health Institute. During the year, schools documented 229 teen-crash prevention activities. Nine of the ten high crash rate counties did experience a decline in the number of emergency department visits from 2016 to 2018 and six of ten experienced a decline in the number of teen crashes during that same time period.

Activity 1b: Partner with 15 schools to conduct the Checkpoints™ program to increase the number of teen/parent driving agreements.

Report 1b: A total of 17 schools and organizations conducted the Checkpoints program. Ten of those schools were in Williamson County with other schools and organizations located throughout the state. The groups conducted the evidence-based Checkpoints™ program, completing over 1,900 parent-teen driving agreements to address teen driving risks. This year, we recruited one church youth group, a teen center, and expanded the program to serve home-schooled children as well. Since we had high school participation in Williamson County, we analyzed teen crash data from the Tennessee Department of Homeland Security for Williamson County. After the first year of Checkpoints in Williamson County, there was a 2.9% reduction in teen crashes (among 16- and 17-year-olds) from 2017-2018.

Activity 1c: Partner with schools to provide Graduated Driver's License education to 2000 teens and caregivers.

Report 1c: Fourteen thousand eight hundred (14,800) Graduated Driver's License educational wallet-brochures were distributed to 30 schools in counties that border Kentucky. Also, over 1,900 students and families received direct education regarding Graduated Driver's License through the Checkpoints Parent-Teen Driving Agreement education program.

Strategy 2: Increase awareness of proper storage and disposal of medications.

Activity 2a: Promote safe storage and disposal of medications through the Count it, Lock it, Drop™ it initiative. The goal of Count It, Lock It, Drop It™ is to increase the number of individuals tracking medication, securing medication in a locked medicine box, and utilizing medicine drop boxes. Staff will conduct presentations to promote Count It, Lock It, Drop It™ to increase safe storage and disposal of medication

Report 2a: TDH partnered with Count It! Lock It! Drop It! staff to encourage hospitals and medical providers to provide information to patients to monitor, secure, and dispose of medication. DH partnered with Count It! Lock It! Drop It! (CLD) staff to encourage hospitals and medical providers to provide information to patients to monitor, secure, and dispose of medication at twenty-five (25) medical facilities. Programs included: patient information efforts, prescription safety training, drug take back events, medical forum on safe prescribing, and coalition training regarding drug take back events.

Activity 2b: Partner with a minimum of 25 hospitals and/or other providers by September 30, 2019 to promote safe storage of medications to patients.

Report 2b: As of September 30th, 2019 all 95 counties have implemented the Count It! Lock It! Drop It!™ program that includes education and securing medication in locked medicine boxes. In fact, a total of 106 (one hundred and six) groups in Tennessee

are conducting the program with some multiple programs in some counties. This sustainability and increase in this program has been a success story for our local partners. Through a partnership with the Tennessee Department of Environment and Conservation, we placed a total of 350 drug disposal drop boxes throughout the state. These programs all partner together to promote drug take back days and other prescription drug abuse prevention programs.

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

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

Strategy 3: Increase general awareness of the causes of adolescent hospitalizations due to falls.

Activity 3a: Increase the number of youth sports leagues that apply for Safe Stars recognition from 5 to 25 by September 30, 2019.

Report 3a: A total of 40 organizations applied for Safe Stars recognition and a total of 33 organizations were recognized as Safe Stars Gold Star Status and one as Bronze status. Funding for automated external defibrillators (AEDs) was also utilized to provide AEDs for qualifying organizations. Policy templates were updated to assist organizations to develop safety policies that would qualify them for Safe Stars recognition.

Activity 3b: Collaborate with TDH Office of Communications to integrate routine social media postings (e.g. Facebook, Twitter) around activities that place adolescents at risk for falls (such as sports).

Report 3b: A total of nine social media fall prevention messages were posted on Tennessee Department of Health's Twitter and Facebook sites during the grant period. These messages include playground safety and the Safe Stars Initiative to Reduce Injury (concussion) in sports.

Activity 3c: Participate in the child safety CoIIN to decrease falls due to sports.

Report 3c: TDH staff worked on projects that focus on decreasing falls due to sports including Safe Stars and Return to Learn/Return to Play Guidelines education with schools. The Safe Stars Initiative is a youth sports league safety rating system. Leagues are designated as gold, silver or bronze based on specific safety criteria. Twenty-six schools and 4 youth sports organizations, and 4 recreation centers have qualified for Safe Stars Recognition. The Return-to Learn/Return-to-Play Guidelines were updated this year to better represent appropriate return to play practice. The department has also partnered with the Tennessee Chapter of the American Academy of Pediatrics to develop a plan to educate providers on the newly released CDC Mild Traumatic Brain Injury Guidelines and printed 1,200

guidelines.

Strategy 4: Increase awareness of the signs and risk factors of suicide attempts.

Activity 4a: Provide Question, Persuade and Refer (QPR) trainings to TDH staff by offering lunch and learn sessions.

Report 4a: TDH staff members throughout the state 67 were provided QPR suicide prevention training to better recognize suicidal symptoms and make appropriate referrals. This year, QPR training was provided to community partners such as Rape Prevention Educators that also included local health department staff. Finally, QPR training was offered through partners to youth impactors throughout the state.

Activity 4b: Disseminate a suicide prevention infographic to schools and community agencies.

Report 4b: A suicide prevention infographic (1,000) that included updated data and referral sources was provided to Tennessee Suicide Prevention Network partners to educate schools and other stakeholders. Staff also partnered with the Tennessee Suicide Prevention Network (TSPN) and the Department of Education to present information about TSPN, Question Persuade, Refer Training; and Mental Health First Aid to schools and other youth provider organizations throughout the state.

Activity 4c: Post social media messages on Facebook and Twitter during suicide prevention awareness month.

Report 4c: A total of twenty-two social media suicide prevention messages were posted on Tennessee Department of Health's Twitter and Facebook sites during the grant period. These messages include Suicide Prevention Lifeline, World Suicide Prevention Day, Suicide Warning Signs, Men's Health and Suicide Prevention, Suicide Prevention Crisis Text Line, and Suicide Awareness Day. Additional suicide prevention activities included implementation of the 2018 Suicide Prevention legislation, hiring a Suicide Prevention Program Director, establishing a Suicide Prevention Task Force (statewide), creating a real-time suicide ESSENCE system to train suicidal ideation among youth, and assisting Tennessee Suicide Prevention Network in a number of initiatives.

Priority: Reduce the number of adolescents who are overweight/obese.

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

Overall, Tennessee (TN) has experienced mixed progress in child health and primary prevention indicators that promote healthy weight among adolescents as follows:

NPM 8.2: Combined 2017-2018 data from the National Survey of Children's Health show that the proportion of adolescents (ages 12-17) in TN meeting physical activity guidelines has

decreased to 16.9% in 2018 from 22.4% in 2016. Although the year to year comparisons are not statistically significant, it still represents a steady decline over three survey years. Any real decline is most likely due to the trend toward a more sedentary lifestyle within this age group.

ESM 8.2.1: In contrast to NPM 8.2, the number of physical activity clubs for K-12 graders has grown to 253 compared to just 47 in FY2016. The increase is due in part to the inclusion of these clubs in many county Primary Prevention Plans in TN. Although there appears to be increased interest in these groups, little is known about the types and duration of physical activity that they promote.

ESM 8.2.2: There was a moderate decline in the number of school gardens in TN public schools from 426 in FY2018 to 348 in FY2019. This decline underscores the barriers related to sustaining these gardens in school settings, especially over summer vacation and considering the turnover in students as well as staff and faculty. Nonetheless, the current number of school gardens remains higher than the 337 that were reported in FY2017.

ESM 8.2.3: The number of Healthy Parks Healthy Person app users continues to experience exponential growth from 2853 in FY2018 to 4928 in FY2019. This represents nearly a three-fold increase in users since FY2017. The tremendous expansion highlights the popularity of this method to increase physical activity in parks as well as the extensive promotional efforts of the TN Department of Environment and Conservation.

Accomplishments and Challenges (based on FY2019 Action Plan)

Strategy 1: Support the Office of Coordinated School Health in school-based efforts to promote physical activity and good nutrition.

Activity 1a: Utilize Title V funding to support a State School Nurse Consultant to be housed in the Department of Education, Office of Coordinated School Health.

Report 1a: The School Nurse Consultant offers trainings statewide to school nurses. The State School Nurse Consultant is working to increase health education through school nurses regarding health and wellness, including physical activity and nutrition as it relates to establishing healthy lifestyles. The nurse consultant also provides support and guidance of health screenings as it provides additional avenues to educate students on healthy habits.

Activity 1b: Encourage collaboration between the Office of Coordinated School Health, state, regional and local health departments that are focusing on obesity-related primary prevention.

Report 1b: TDH staff worked closely with CSH to develop and implement programs and disseminate educational materials that support the Whole School, Whole Community, Whole Child approach, which includes promotion of the importance of healthy eating and physical activity. Activities included conducting classes on healthy lifestyle choices, nutrition and physical activity, and campaigns to reduce consumption of sugary drinks and increase the availability of health snacks.

Activity 1c: Develop and implement strategies that support increased physical activity before, during and after school.

Report 1c: The School Health and Wellness Director received training focused on promoting healthy lifestyle choices during out of school time. This training will be offered to health educators and school staff in LEAs statewide.

Activity 1d: Develop and implement strategies that increase access to healthier food and beverage options.

Report 1d: To increase access to healthier food and beverage options, TDH and CSH partnered with LEAs and schools to identify gaps in the school nutrition environment and provided professional development and training based on the school's need. Training topics included: Farm to School, Junior Chef, Water Wednesday's, Smart Snacks in Schools, summer meals and other healthy eating learning opportunities.

Adolescent Health - Application Year

Priority: Tobacco and E-cigarette Use

The following strategies and activities are planned for FY21:

Strategy 1: Prevention and Engagement

Activity 1a: Promote tobacco-free baseball and softball, and increase the number of teams taking the pledge to be tobacco-free athletes

Activity 1b: Increase promotion of TN Quit Week to bring awareness of vaping cessation services available for adolescents.

Activity 1c: Improve staff capacity through hosting trainings for field staff on engagement of students to build and maintaining youth councils.

Activity 1d: Support youth/TNSTRONG groups in creating and disseminating anti-tobacco/anti-vaping PSAs

Activity 1e: Host annual TNSTRONG Youth Summit to engage adolescent and adolescent leaders around tobacco prevention efforts across the state

Activity 1f: Provide education to adolescents on the dangers of using tobacco products, and offer trainings on policy and advocacy

Activity 1g: Promote anti-tobacco messaging via social media

Strategy 2: Cessation

Activity 2a: Engage Department of Human Services regarding at risk adolescents to screen for tobacco use and refer to federally funded services when available

Activity 2b: Promote local health department resources available for adolescents, including mental health and cessation resources

Activity 2c: Promote cessation text programs via social media

Activity 2d: Increase data collection, by working with Department of Mental Health and Substance Abuse services to add questions to TNTogether Survey

Strategy 3: Support Partners

Activity 3a: Increase partnerships with anti-drug and tobacco coalitions statewide

Activity 3b: Expand partner media library to provide ready-made/approved material for use.

Strategy 4: Mental Health

Activity 4a Promote local health department resources available for adolescents, including mental health and cessation resources

Activity 4b: Expand partnerships w/ Department of Education-Coordinated School Health, school-based liaisons, school resource officers, mental health counselors

Activity 4c: Host Question, Persuade and Refer (QPR) trainings with partners for suicide prevention

Activity 4d: Screen and refer adolescents for mental health services

Children with Special Health Care Needs

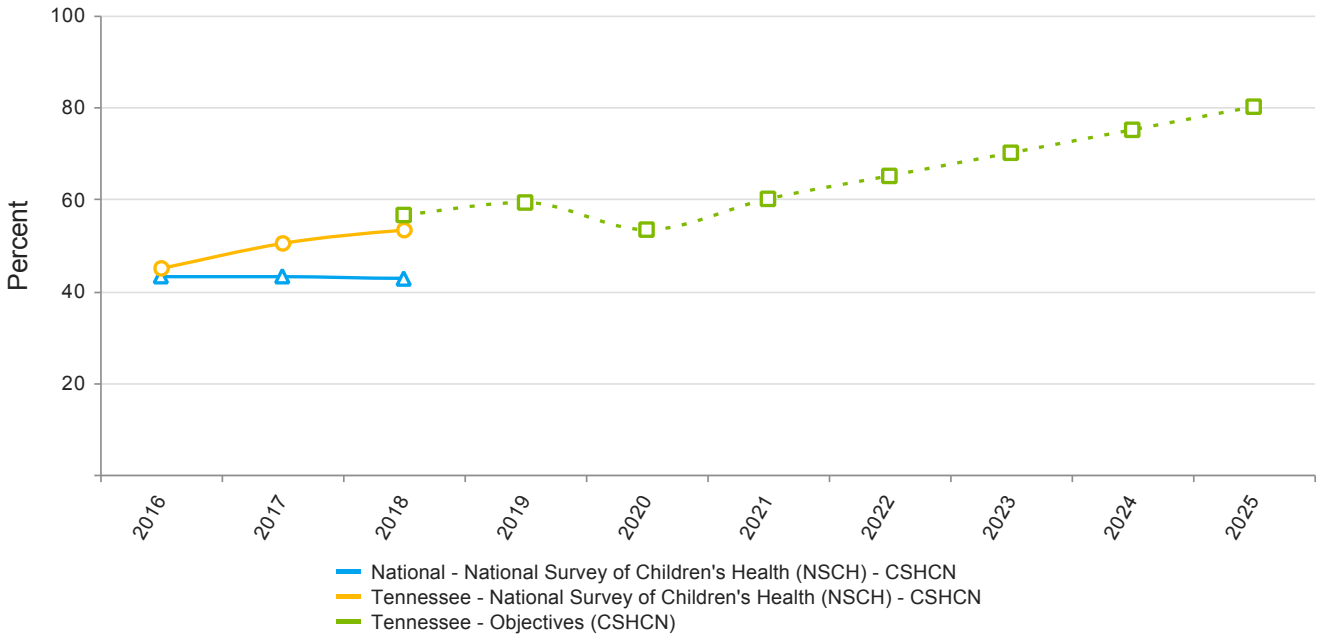
Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	NSCH-2017_2018	13.3 %	NPM 11 NPM 12
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH-2017_2018	40.6 %	NPM 11
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2017_2018	88.7 %	NPM 11
NOM 25 - Percent of children, ages 0 through 17, who were not able to obtain needed health care in the last year	NSCH-2017_2018	2.4 %	NPM 11

National Performance Measures

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Indicators and Annual Objectives



NPM 11 - Children with Special Health Care Needs

Federally Available Data				
Data Source: National Survey of Children's Health (NSCH) - CSHCN				
	2016	**2017**	**2018**	**2019**
Annual Objective			56.5	59.2
Annual Indicator		44.8	50.4	53.3
Numerator		125,986	143,840	164,583
Denominator		281,120	285,167	308,848
Data Source		NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017	2017_2018

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

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	53.3	60.0	65.0	70.0	75.0	80.0

Evidence-Based or –Informed Strategy Measures

ESM 11.1 - Number of people participating in the medical home learning collaborative

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	175.0	225.0	275.0	325.0	375.0

ESM 11.2 - Number of medical home conference attendees

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	100.0	125.0	159.0	175.0	200.0

ESM 11.3 - Number of non-Medicaid providers who receive technical assistance on medical home implementation

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	75.0	100.0	125.0	150.0	175.0

ESM 11.4 - Number of providers and families educated on the medical home approach

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	600.0	700.0	800.0	900.0	1,000.0

ESM 11.5 - Number of resources provided to families and providers

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	20.0	25.0	30.0	35.0	40.0

ESM 11.6 - Number of medical home tool-kits distributed

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	600.0	700.0	800.0	900.0	1,000.0

ESM 11.7 - Number of care coordination tool-kits distributed

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	175.0	200.0	225.0	250.0	275.0

ESM 11.8 - Number of CYSHCN who receive CHANT/CSS care coordination

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	2,500.0	3,000.0	3,500.0	4,000.0	4,500.0

ESM 11.9 - Number of CSS authorized vendors who receive medical home resources

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	650.0	700.0	750.0	800.0	850.0

ESM 11.10 - Number of families provided education and resources on importance of medical home access and utilization

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	600.0	700.0	800.0	900.0	1,000.0

ESM 11.11 - Number of families receiving referrals to their child's primary care provider

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	375.0	400.0	425.0	450.0	475.0

ESM 11.12 - Number of families who schedule an annual visit with their child's primary care provider

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	375.0	400.0	425.0	450.0	475.0

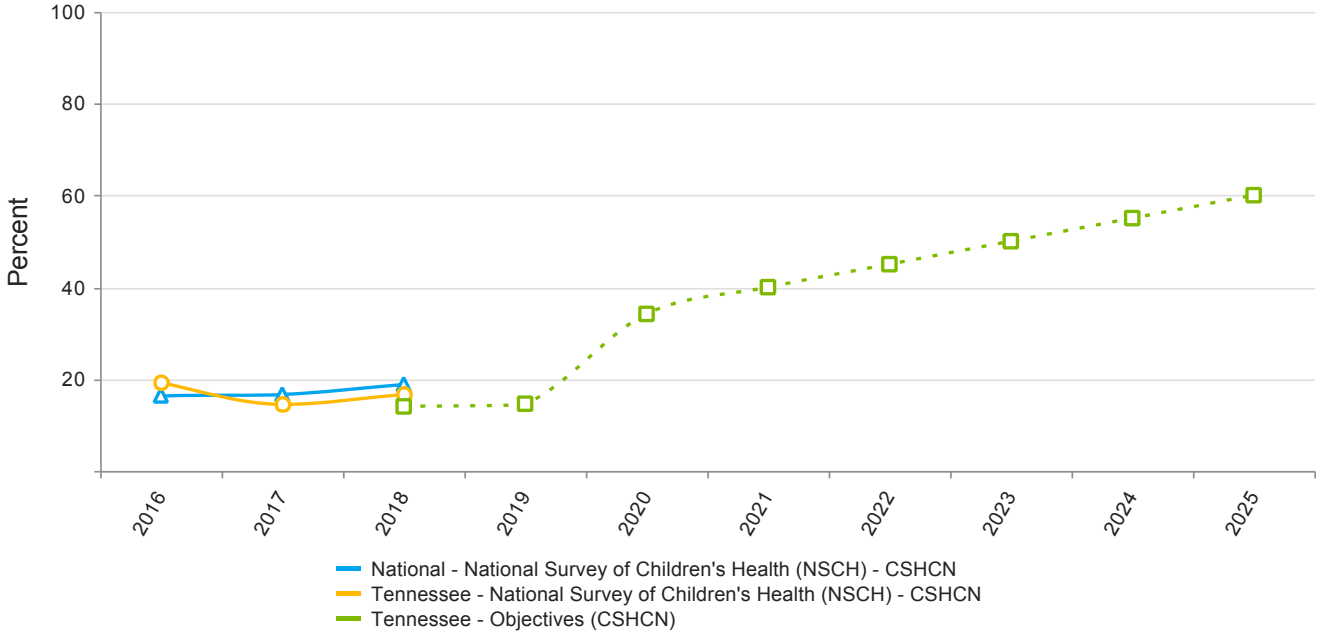
ESM 11.13 - Number of children who complete an annual visit with their primary care provider

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	375.0	400.0	425.0	450.0	475.0

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care
Indicators and Annual Objectives



NPM 12 - Children with Special Health Care Needs

Federally Available Data				
Data Source: National Survey of Children's Health (NSCH) - CSHCN				
	2016	**2017**	**2018**	**2019**
Annual Objective			14.1	14.7
Annual Indicator		19.2	14.4	16.6
Numerator		16,734	17,666	26,590
Denominator		87,214	122,975	159,749
Data Source		NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017	2017_2018

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

Annual Objectives						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	34.2	40.0	45.0	50.0	55.0	60.0

Evidence-Based or –Informed Strategy Measures

ESM 12.1 - Number of transition resources identified

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	25.0	35.0	45.0	55.0	65.0

ESM 12.2 - Number of transition resource kits disseminated

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	150.0	300.0	600.0	1,200.0	2,400.0

ESM 12.3 - Number of youth with special health care needs receiving transition training

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	75.0	100.0	125.0	150.0	175.0

ESM 12.4 - Number of Youth Advisory Council members with special healthcare needs

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	25.0	25.0	25.0	25.0	25.0

ESM 12.5 - Number of youth with special health care needs trained as mentors

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	25.0	35.0	45.0	55.0	65.0

ESM 12.6 - Number of parents and youth with special health care needs who receive leadership and self-advocacy training

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	50.0	75.0	100.0	125.0	150.0

State Performance Measures

SPM 22 - Number of providers adopting the medical home approach in their practice

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	650.0	800.0	950.0	1,100.0	1,250.0

SPM 23 - Number of CYSHCN receiving care in a medical home

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	800.0	850.0	900.0	950.0	1,000.0

SPM 24 - Number of families confident speaking to their provider

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	400.0	450.0	500.0	550.0	600.0

SPM 25 - Number of providers providing resources and behavioral and mental health referrals

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	600.0	700.0	800.0	900.0	1,000.0

SPM 26 - Number of care coordinators with increased knowledge

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	175.0	200.0	225.0	250.0	275.0

SPM 27 - Number of vendors with increased knowledge

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	650.0	700.0	750.0	800.0	850.0

SPM 28 - Number of children who complete an annual visit with their primary care provider

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	800.0	850.0	900.0	950.0	1,000.0

SPM 29 - Number of YSHCN receiving transition services

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	50.0	75.0	100.0	125.0	150.0

SPM 30 - Number of transition self-advocates

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	20.0	25.0	30.0	35.0	40.0

State Action Plan Table

State Action Plan Table (Tennessee) - Children with Special Health Care Needs - Entry 1

Priority Need

Increase medical homes among children with special healthcare needs

NPM

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Objectives

Increase medical homes among children with special healthcare needs

Strategies

Mobilize Community Partners (policy makers, health care providers, families, and the public) to create a shared vision for integrating and improving CYSHCN System of Care

Inform and educate families and providers about medical home components to promote systems change

Identify and disseminate resources on medical home best practices in Tennessee to inform and educate families and providers

Collaborate with local health departments, CHANT and the Call Center to increase medical home access and utilization for families through education, resources, referral, care coordination, navigation and follow-up

ESMs	Status
ESM 11.1 - Number of people participating in the medical home learning collaborative	Active
ESM 11.2 - Number of medical home conference attendees	Active
ESM 11.3 - Number of non-Medicaid providers who receive technical assistance on medical home implementation	Active
ESM 11.4 - Number of providers and families educated on the medical home approach	Active
ESM 11.5 - Number of resources provided to families and providers	Active
ESM 11.6 - Number of medical home tool-kits distributed	Active
ESM 11.7 - Number of care coordination tool-kits distributed	Active
ESM 11.8 - Number of CYSHCN who receive CHANT/CSS care coordination	Active
ESM 11.9 - Number of CSS authorized vendors who receive medical home resources	Active
ESM 11.10 - Number of families provided education and resources on importance of medical home access and utilization	Active
ESM 11.11 - Number of families receiving referrals to their child’s primary care provider	Active
ESM 11.12 - Number of families who schedule an annual visit with their child's primary care provider	Active
ESM 11.13 - Number of children who complete an annual visit with their primary care provider	Active

NOMs
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health
NOM 25 - Percent of children, ages 0 through 17, who were not able to obtain needed health care in the last year

State Action Plan Table (Tennessee) - Children with Special Health Care Needs - Entry 2

Priority Need

Improve transition from pediatric to adult care among children with special health care needs

NPM

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care

Objectives

Improve transition from pediatric to adult care among children with special healthcare needs

Strategies

Inform, educate and link YSHCN, families and providers to available transition resources and services, and how to access those services

Promote successful transition through educational opportunities and self-advocacy training

ESMs	Status
ESM 12.1 - Number of transition resources identified	Active
ESM 12.2 - Number of transition resource kits disseminated	Active
ESM 12.3 - Number of youth with special health care needs receiving transition training	Active
ESM 12.4 - Number of Youth Advisory Council members with special healthcare needs	Active
ESM 12.5 - Number of youth with special health care needs trained as mentors	Active
ESM 12.6 - Number of parents and youth with special health care needs who receive leadership and self-advocacy training	Active

NOMs

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

State Action Plan Table (Tennessee) - Children with Special Health Care Needs - Entry 3

Priority Need

Increase medical homes among children with special healthcare needs

SPM

SPM 22 - Number of providers adopting the medical home approach in their practice

Objectives

Increase medical homes among children with special healthcare needs

Strategies

Mobilize Community Partners (policy makers, health care providers, families, and the public) to create a shared vision for integrating and improving CYSHCN System of Care

State Action Plan Table (Tennessee) - Children with Special Health Care Needs - Entry 4

Priority Need

Increase medical homes among children with special healthcare needs

SPM

SPM 23 - Number of CYSHCN receiving care in a medical home

Objectives

Increase medical homes among children with special healthcare needs

Strategies

Inform and educate families and providers about medical home components to promote systems change

State Action Plan Table (Tennessee) - Children with Special Health Care Needs - Entry 5

Priority Need

Increase medical homes among children with special healthcare needs

SPM

SPM 24 - Number of families confident speaking to their provider

Objectives

Increase medical homes among children with special healthcare needs

Strategies

Inform and educate families and providers about medical home components to promote systems change

State Action Plan Table (Tennessee) - Children with Special Health Care Needs - Entry 6

Priority Need

Increase medical homes among children with special healthcare needs

SPM

SPM 25 - Number of providers providing resources and behavioral and mental health referrals

Objectives

Increase medical homes among children with special healthcare needs

Strategies

Inform and educate families and providers about medical home components to promote systems change

State Action Plan Table (Tennessee) - Children with Special Health Care Needs - Entry 7

Priority Need

Increase medical homes among children with special healthcare needs

SPM

SPM 26 - Number of care coordinators with increased knowledge

Objectives

Increase medical homes among children with special healthcare needs

Strategies

Identify and disseminate resources on medical home best practices in Tennessee to inform and educate families and providers

State Action Plan Table (Tennessee) - Children with Special Health Care Needs - Entry 8

Priority Need

Increase medical homes among children with special healthcare needs

SPM

SPM 27 - Number of vendors with increased knowledge

Objectives

Increase medical homes among children with special healthcare needs

Strategies

Identify and disseminate resources on medical home best practices in Tennessee to inform and educate families and providers

State Action Plan Table (Tennessee) - Children with Special Health Care Needs - Entry 9

Priority Need

Increase medical homes among children with special healthcare needs

SPM

SPM 28 - Number of children who complete an annual visit with their primary care provider

Objectives

Increase medical homes among children with special healthcare needs

Strategies

Collaborate with local health departments, CHANT and the Call Center to increase medical home access and utilization for families through education, resources, referral, care coordination, navigation and follow-up

State Action Plan Table (Tennessee) - Children with Special Health Care Needs - Entry 10

Priority Need

Improve transition from pediatric to adult care among children with special health care needs

SPM

SPM 29 - Number of YSHCN receiving transition services

Objectives

Improve transition from pediatric to adult care among children with special healthcare needs

Strategies

Inform, educate and link YSHCN, families and providers to available transition resources and services, and how to access those services

State Action Plan Table (Tennessee) - Children with Special Health Care Needs - Entry 11

Priority Need

Improve transition from pediatric to adult care among children with special health care needs

SPM

SPM 30 - Number of transition self-advocates

Objectives

Improve transition from pediatric to adult care among children with special healthcare needs

Strategies

Promote successful transition through educational opportunities and self-advocacy training

Priority: Increase the number of children (with and without special healthcare needs) who have a medical home.

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

NPM 11: The most recent data for 2017-2018 show 51.2% of Tennessee children with and without special healthcare needs had a medical home, which was a slight drop from 53.8% in 2016 but still higher than the national data of 48.2% for 2017-2018. It was short of the objective set for FY2019 of 59.2%.

ESM 11.1: 745 providers were trained and provided information on medical home implementation during FY2019, and the objective of 730 was met.

ESM 11.2: 723 families received patient centered medical home training and the objective of 635 was met.

ESM 11.3: 70.5% of children served by the Children's Special Service (CSS) program received services in a medical home for FY2019 and it was short of the goal of 90%. Despite the statewide efforts in training and educating providers and families on medical home, the effect has not been observed among the sub-population the CSS program serves. Medical home is one of the pathways of the Community Health Access and Navigation in Tennessee (CHANT) program, which CSS is part of. The clients coming into the CHANT needing a medical home are advised of and/or referred to appropriate care provider to serve as a medical home. We expect this measure to improve in near future as the CHANT program reaches more children in Tennessee.

ESM 11.4: This is a new objective added for FY2020, and there are no data to report at this time.

Accomplishments and Challenges (based on FY2019 Action Plan)

Strategy 1: Support primary care providers in implementing a medical home approach to care.

Activity 1a: The CYSHCN program will continue partnering with Tennessee Chapter of the American Academy of Pediatrics and the Tennessee Academy of Family Physicians to provide opportunities for training and National Committee for Quality Assurance (NCQA) certification as patient centered medical homes to eligible providers and facilities.

Report 1a: The CYSHCN section provided information on NCQA certification and medical home educational material to over 200 providers identified through the TN Birth Defects surveillance system and to an additional 85 certified TennCare Patient Centered Medical Home Providers. TNAAP has conducted training and CYSHCN continues to notify vendors and other providers when the training is taking place. One challenge is that many small providers do not have the capacity to meet all of the requirements for NCQA certification,. To offset this barrier, TNAAP continues to provide training and assistance to providers are encouraged to meet as many of the requirements as possible. While this may not provide actual certification, the practice may still be recognized as a medical home.

Activity 1b: CYSHCN staff will partner with Family Voices to support practices and provide opportunities to develop and implement family engagement policies.

Report 1b: The CYSHCN staff continue to partner with Family Voices and seek opportunities for development and implementation of family engagement policies. Family members are included in the YAC meetings; they were included in the Youth Engagement Summit and will have break-out sessions in the upcoming youth conference. CYSHCN staff are working with the youth coordinator and family consultant at Family Voices to develop additional opportunities for family members to participate in policy development around family engagement.

Activity 1c: CYSHCN staff will identify and provide educational resources to practices seeking medical home certification.

Report 1c: The CYSHCN staff have identified several educational resources and have mailed out over 600 packages of medical home educational material. The program is scheduled to mail out at least 2000 additional packages over the next quarter to all licensed pediatric providers in Tennessee. One challenge to this activity is identifying those that are seeking certification. Since the program does not have the ability to generate this information, some providers that are already certified have and will receive the resources also.

Strategy 2: Increase general awareness of the importance of a medical home approach to care.

Activity 2a: CYSHCN staff will maintain the electronic Medical Home Toolkit as a resource for providers and families.

Report 2a: The medical home tool kit is active and is located on the MCH website at: https://www.tn.gov/health/health-program-areas/mch/mch-mh.html. The program will continue to update and add resources as they are developed. The fact that the web site is not on the CYSHCN site was identified as a challenge to updating, however the program has requested that the site be moved to CYSHCN and will be updated continuously by CYSHCN staff. Between October 1, 2018 and September 2019, there were a total of 675 page views, with 410 visits of which 382 were unique.

Activity 2b: CYSHCN staff will continue to partner with Family Voices to coordinate and refer families to the Parent to Parent program and to provide families with information and support on accessing ongoing, comprehensive care in a medical home.

Report 2b: Referrals are provided to Family Voices through the TN Birth Defects Program and the Children's Special Services Program. During this past fiscal year, there were 231 referrals received and 69 family matches made. Over 600 Partnering with your Doctor Booklets were provided to families being served through the CHANT care coordination process. The CHANT medical home pathway provides resources and referrals to families. Family Voices has been able to secure

additional funding for the Parent to Parent Mentoring program which provides and opportunity for serving a greater number of families statewide.

Activity 2c: CYSHCN staff will continue to partner with Family Voices to provide workshops and resources for families that include health advocacy, resources, system navigation, and partnering in the decision making process.

Report 2c: CYSHCN continues to partner with Family Voices to conduct workshops and resources. During the last Youth Advisory Council meeting, families and youth received training on policy development, health advocacy and system navigation. The plenary session at the youth summit included presentations and resources on advocacy, system navigation and partnering with your doctor in making decisions regarding health and treatment options. The Youth Advisory Council meets quarterly and training for families and the youth participants take place at each of the quarterly meetings.

Activity 2d: CYSHCN staff will continue to partner with Tennessee Chapter of the American Academy of Pediatrics, Tennessee Academy of Family Physicians, Family Voices, Tennessee Voices for Children and the Department of Mental Health and Substance Services to provide educational opportunities on the availability of behavioral health resources.

Report 2d: CYSHCN staff collaborate with the organizations and agencies listed to provide educational resources and opportunities on behavioral health. The youth summit included two break outs and one plenary session on behavioral and mental health. There was also a panel presentation with staff from the Department of Mental Health who provided resources for families and youth attending the conference. Staff from the Department Health serve on the Youth Taskforce and are collaborating to bring additional resources to Tennessee Youth in areas where behavioral health resources are lacking. The lack of dedicated funding makes it challenging to provide additional behavioral and mental health resources to health care providers.

Strategy 3: Link families to medical homes through Children's Special Services, Tennessee's Title V CYSHCN program.

Activity 3a: Provide training and care coordination resources to assist families to identify and access medical homes.

Report 3a: CHANT care coordinators state-wide have received training and are assisting families to identify and access medical home resources. Since October 1, 2018 to September 30, 2019 there were 3,330 families who triggered the medical home pathway. There were 632 families who started the pathway and 235 completed the medical home pathway. Of those families, 397 were still navigating the pathway as of September 30, 2019. All Medicaid eligible families receive information and resources about medical homes. Any family that indicates they are unaware of their medical home or primary care provider are assisted with locating who the provider is, and making appointments. CHANT

and CSS families are provided copies of the Partnering with Your Doctor booklet and are given additional information on the importance of receiving care in the medical home.

Activity 3b: Utilize the results of the CSS program participant satisfaction survey to increase medical home utilization.

Report 3b: The CSS program participant satisfaction survey has not been conducted. Families are encouraged and receive assistance in making appointments with their medical home provider. Referrals are provided for any family that indicates they do not have a medical home. The challenge for this activity has been administering the medical home utilization survey to CSS family participants. The program is working with the CHANT team to develop a mechanism to distribute the survey electronically.

Activity 3c: CSS staff will work with Medicaid to identify patient-centered medical homes and provide referral and resources to connect families to primary and specialty care providers implementing the CHANT patient centered medical home pathway.

Report 3c: CSS staff partner with Medicaid (TennCare Bureau) and families to assist with identifying patient-centered medical home providers. Families receiving services through the CSS program or CHANT care coordination are referred to primary care and specialty providers. CHANT care coordination is now available statewide and all families who indicate they do not have a medical home or specialty provider are assisted in determining their primary care provider and referrals for specialty providers are made as needed.

Priority: Increase the number of children (with and without special healthcare needs) who receive services necessary to make transitions to adult health care.

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

NPM 12: The most recent data for 2017-2018 show 17.3% of Tennessee adolescents with and without special healthcare needs had a plan to transition to adult care, a 29% increase from 13.4% in 2016. This was also higher than the national data of 15.3% for 2017-2018. It also surpassed the objective of 14.7% set for FY2019. The heightened awareness of transition needs for CYHSCN and the emphasis of transition among the transition workgroups may have been contributing factors for such improvement.

ESM 12.1: The number of individuals with and without special health care needs on the CYSHCN Advisory Council increased to 14 in FY2019, doubled the number in FY2018 and also surpassed the goal of 9. The widened outreach from the CYSHCN staff and the Family Voices may have resulted in increased recruitment and retention of youth on the Advisory Council.

ESM 12.2: 450 providers received technical assistance and information on transition for youth and young adults with and without special health care needs during FY2019, exceeding the goal of 240.

ESM 12.3: The goal for FY2019 was set to be 80% of youth served by the Children's Special Services (CSS) program age 14 and older having an annual transition plan in place, but the actual rate was 54.4%. The changes in staff and new processes may have contributed to this decline.

ESM 12.4: This measure, number of youths and parents/legal guardians who have completed the Transition Readiness Assessment tool, is new for FY2020 and there are no data to report at this time.

Accomplishments and Challenges (based on FY2019 Action Plan)

Strategy 1: Identify adult medical home practices to provide care for youth and young adults with special health care needs.

Activity 1a: CYSHCN staff will collaborate with the National Center for Medical Home Implementation and utilize “Got Transition” to provide technical assistance to the CYSHCN program and providers on developing transition policies.

Report 1a: CYSHCN staff continue to collaborate and seek assistance from the National Center for Medical Home Implementation and Got Transition. The National Resource Center for Patient and Family-Centered Medical Home Implementation requested Tennessee CYSHCN participate in an Action Learning Collaborative to foster implementation of best practices around screening and referrals for social determinants of health, identification of protective factors and medical home access. The program was unable to participate in this initiative because of lack of participation from other required agencies. Tennessee has worked with Got Transition to ensure that TN data is included in the national transition data and updates this information as necessary.

Activity 1b: CYSHCN staff will partner with two local Federally Qualified Health Centers to increase transition from pediatric providers to adult providers.

Report 1b: CYSHCN staff have held a preliminary conversation with staff at Matthew Walker Comprehensive Health Center to develop a partnership and transition initiative. Staff will meet with the medical director to determine how best to implement a transition pilot project within the FQHC. Noted challenges to this activity include the fact that many of the children and youth are already seeing an adult provider and there is not an opportunity to receive a referral from a pediatric provider.

Strategy 2: Incorporate health care transition planning into written plans of care for children with special health care needs.

Activity 2a: CYSHCN staff will continue to work with the Tennessee Chapter of the American Academy of Pediatrics (TNAAP) to ensure policies and processes for transition planning and preparation are available to pediatric providers.

Report 2a: TNAAP continues to provide training and to pediatric providers around transition.

Videos and training material developed in conjunction with the CYSHCN program are available on TNAAP's website and providers continue to access the training material. Without dedicated funding, it is somewhat difficult to continue to update and provide current resources, material and training opportunities.

Activity 2b: CSS care coordinators will work with families to develop (and renew annually) a transition plan for all program participants starting at age 14.

Report 2b: CHANT care coordinators are responsible for conducting annual transition planning with all youth and young adults aged 14-21. The completion rate for the state fiscal year was 54.4% which was below the 80% projected state completion rate. It is believed that challenges to meeting this goal included rolling out CHANT, and new staff unfamiliar with required procedures for CSS transition. The CYSHCN staff have provided state-wide training for all CHANT care coordinators.

Activity 2c: CSS program staff will work with youth to complete the Transition Readiness Assessment tool.

Report 2c: The CYSHCN program initially planned to administer the Got Transition readiness assessment tool. After meeting with Got Transition, it was determined that the program needed to develop a state specific transition readiness assessment tool that will be administered to all CSS participants age 12-13 and their parent(s)/caregiver(s). Challenges to meeting this activity include epidemiologist previously assigned to project taking new job. CYSHCN staff are now working with CHANT Epi and others to develop electronic tool that can be administered between to youth and their parents/caregivers.

Strategy3: Support youth participation in the transition process.

Activity 3a: CYSHCN program staff will collaborate with Family Voices and LEND to recruit and retain members to serve on a youth advisory group.

Report 3a: CYSHCN staff continue to lead the youth advisory efforts with Family Voices and LEND. The Youth Advisory Council has increased from 9 members to 17. The Council is youth driven and led and holds quarterly meetings that include presentations on medical home, transition, advocacy, system navigation and policy development. The Council also hosts social activities at local gaming venues and restaurants in an effort to build connections and relationships.

Activity 3b: In conjunction with Family Voices, CYSHCN will provide training and conferences for youth and families with special health care needs regarding transition to adult health care providers.

Report 3b: CYSHCN convened and facilitates a state Youth Transition Workgroup with members from all state child-serving agencies. The workgroup planned the first state-wide youth conference. Funds were pooled from each of the participating

agencies to ensure that youth were able to participate. There were participants from each of the participating agencies and from local schools. The youth facilitated many of the breakout and plenary sessions. Session topics included medical home, transition, post secondary education, behavioral and mental health and advocacy. There were over 75 persons in attendance. The second state-wide Youth Summit is being planned for July 2020. This summit will include breakout sessions specific to parents and caregivers.

Activity 3c: CYSHCN staff will actively encourage youth participation in policy and advocacy opportunities.

Report 3c: The Youth Advisory Council has participated in several quarterly meetings that provided presentations and interactive sessions on self-advocacy. Each year prior to Disability Days on the Hill, the Youth Advisory Council participates in a role-play activity that includes mock interactions with elected officials. These youth are then provided opportunities to tell their story to their specific legislator or ones that are supporting legislation that is of interest to their or their family's circumstances.

Activity 3d: CYSHCN will collaborate with the LEND program at the Boling Center in West Tennessee to replicate the youth advisory council in other areas of the state.

Report 3d: The CYSHCN program is still working out logistics to host a youth advisory council at the Boling Center. Challenges to meeting this activity include being able to schedule meeting times that are conducive to youth and to staff and ensuring that means for conducting the meeting by web are available. Although the Boling Center has not been successful, the CYSHCN program has provided funding for a site in the Chattanooga Hamilton area and expanded Parent to Parent access and youth advisory capacity.

Priority: Increase CYSHCN Medical Home Access and Utilization

The following strategies and activities are planned for FY21:

Strategy 1: Mobilize Community Partners (policy makers, health care providers, families, and the public) to create a shared vision for integrating and improving CYSHCN System of Care.

Activity 1a: Sponsor learning collaborative to help improve service coordination and CYSHCN linkage for minority and other disparate populations to providers and community-based services.

Activity 1b: Promote access to equitable and more efficient health care for disparate populations by partnering with TennCare, TNAAP, TPCA, TAFP, Office of Minority Health and Disparity Elimination and Family Voices to host a Statewide Medical Home Conference.

Activity 1c: Identify and provide technical assistance including information on medical home disparities to non-Medicaid providers seeking to implement a medical home approach to care.

Strategy 2: Inform and educate families and providers about medical home components to promote systems change.

Activity 2a: Target minority and disparate families and providers by geographic location and promote medical home implementation through education, training and resources.

Activity 2b: Identify and provide resources and referrals to minority and disparate families and geographically targeted providers on dental home, behavioral/mental health care coordination, respite care and family engagement practices.

Strategy 3: Identify and disseminate resources on medical home best practices in Tennessee to inform and educate families and providers.

Activity 3a: Create and disseminate medical home tool-kit to families and providers including information on health equity and disparities.

Activity 3b: Create and disseminate care coordination tool-kit including information on diverse populations and geographic locations to health care providers and CHANT care coordinators.

Activity 3c: Promote health equity in the medical home and provide care coordination and medical home referrals to families receiving services through the Children's Special Services Program.

Activity 3d: Provide education and resources to Children's Special Services authorized vendors.

Strategy 4: Collaborate with local health departments, CHANT and the Call Center to increase medical home access and utilization for families through education, resources, referral, care coordination, navigation and follow-up.

Activity 4a: Increase the number of families who receive education and resources on the importance of

coordinated and comprehensive care in the medical home.

Activity 4b: Increase the number of families who receive referrals to their child's assigned primary care provider.

Activity 4c: Increase the number of families who schedule appointments with their child's assigned primary care provider.

Activity 4d: Increase the number of children who complete an annual visit with their assigned primary care provider.

Priority: Transition from Pediatric to Adult Care

The following strategies and activities are planned for FY21:

Strategy 1: Inform, educate and link YSHCN, families and providers to available transition resources and services, and how to access those services.

Activity 1a: Identify available resources by age and geographic location for YSHCN and families – inclusive, but not limited to, medical home, dental home, behavioral/mental health services and transition.

Activity 1b: Identify, develop and disseminate a state-wide resource kit (medical and dental home, etc.) including resources for disparate and minority populations.

Activity 1c: Provide training for families, youth, partners and providers on all aspects of transition.

Strategy 2: Promote successful transition through educational opportunities and self-advocacy training.

Activity 2a: Recruit and retain YAC council members ensuring diverse representation including race, ethnicity, age and gender.

Activity 2b: Identify and train YAC members from diverse populations to mentor other YSHCN in the community.

Activity 2c: Provide learning opportunities (leadership training – ex. Peer-to-Peer support program, talking to legislators, taking control of your healthcare) for youth.

Cross-Cutting/Systems Building

Cross-Cutting/Systems Builiding - Annual Report

No content was entered for the Cross-Cutting/Systems Building - Annual Report in the State Action Plan Narrative by Domain section.

Cross-Cutting/Systems Building - Application Year

No content was entered for the Cross-Cutting/Systems Building - Application in the State Action Plan Narrative by Domain section.

III.F. Public Input

Public Comment – During Report/Application Development

Tennessee's MCH/Title V Program offers four main mechanisms for the public to provide feedback on the annual application/report. The first is through participating in in-person stakeholder meetings that are held twice each year. These meetings are open to the public, with special effort being made to reach out to those serving the MCH population as well as parents (including parents of CYSHCN, foster parents, and grandparents). During the meetings, participants evaluate the progress made on action plan measures. At the fall meeting, that evaluation is utilized to identify partnership opportunities between the Tennessee MCH/Title V Program and the other stakeholders/organizations that will help to achieve measurable progress. At the spring meeting the information is used to develop the action plan for the coming year. Both meetings have an average of 100 stakeholders in attendance.

The second opportunity to provide feedback is through membership or public participation in advisory committees. The division convenes multiple advisory committees commissioned by Tennessee statute including: Genetics Advisory Committee (focused on newborn screening), Perinatal Advisory Committee (focused on perinatal health and the regionalization system), Children's Special Services Advisory Committee and Birth Defects Registry Advisory Committee (focused on the MCH/Title V CYSHCN program). Committee members are appointed by the Department of Health Commissioner or the Governor and provide topic-specific expertise to the respective committees. Furthermore, these meetings are subject to the State's Open Meetings Law and are open for attendance by members of the general public. The MCH/Title V director and program staff are in regular communication with committee members, members of the public, and members of the General Assembly on topic areas of interest to those committees. In addition to these long standing committees, the MCH/Title V CYSHCN program established a youth advisory committee in 2017, and sections of the Division operate advisory committees for grants such as the Preventive Health and Health Services Block Grant.

Another avenue used to gather ongoing feedback is through FHW program staff. Program staff seek input throughout the year from representatives of local and regional health departments, and by extension, their clients and communities. Regional MCH Directors are convened via conference call every other month. On each call, all central office program representatives and regional MCH Directors are offered the opportunity to present updates for their program/region. These highlights focus on information that increases understanding and collaborative efforts between programs, as well as updates that affect all MCH programs. Additionally, Central Office program staff regularly visit each of the Department's 13 regions to individually meet with front- line program staff. The visits are separate from required monitoring visits, and are aimed to provide opportunities for Central Office staff to see firsthand the unique needs of Tennessee communities and to understand how state-level staff can best support front-line staff.

Lastly, feedback is gathered through an annual survey that is posted online with the draft of the report/application each spring. Notice of the posting is communicated via email to stakeholders and they are asked to share the notice broadly with their contacts. The survey asks respondents to provide comments on each section of the draft. It also asks them to provide demographic information so that the diversity of respondents can be assessed. This demographic information includes: county of residence, gender, age, race, ethnicity, organization affiliation, and whether or not they are a parent. Below is a summary of the comments from this year's draft.

Feedback from Annual Survey of 2021 Application / 2019 Report Draft

The draft application/report was posted to the TDH website. Notice of the posting and link to the survey was emailed to MCH stakeholders (see list below). Stakeholders were encouraged to distribute the notice to others The survey was open for two weeks in September of 2020. A reminder email to complete the survey was sent out halfway thru the public comment period.

Commenter Demographics:

A total of 73 individuals provided comments on the draft report/application via the online posting and survey. Of those who provided their demographic information 91% were female, with an average age of 47 and a range of 28 to 70 years old. The racial breakdown was 70% white, 25% black, 2.5% Asian, and 2.5% American Indian or Alaska Native. There was one person that identified themselves as Hispanic. Overall, 79% noted they were parents, with 23% of those being parents of children with special health care needs. Of the respondents, 83% indicated they read the draft report/application for this year, and 61% noted that this was their first time ever reading the report/application. A list of organizations that the respondents represented is below.

Executive Summary:

Overall, the respondents agreed with the priorities identified in the executive summary and thought of them as well considered. Tennessee Primary Care Association (TPCA) appreciated the focus on women's health as members recognize and understand the opportunity to improve maternal and child health requires attention to women's health throughout the lifespan. The Tennessee Hospital Association (THA) commended the broad scope of assessment and work that TDH was undertaking to improve the short and long-term health of families, especially mothers, infants, and young children. Another comment stated that they were impressed by the breadth of the report and the multiple public health entities that were currently collaborating to improve the health of Tennesseans across the lifespan. Other comments recommended a broader view of maternal health with the adoption of a health disparities focus that recognizes the need for special attention to women of color.

Overview of the State:

The comments in this section expressed that they were surprised by some of the state's statistics compared to the rest of the United States, but while there were improvements in areas such as home owners and insurance, Tennesseans still have a long way to go. Specifically, one comment mentioned a lack of quality gyn providers was a real barrier that should be adequately addressed. Other comments mentioned a need for an emphasis placed on health disparities and our most vulnerable populations.

Needs Assessment Update:

The comments in this section affirmed the choice of priorities. One respondent mentioned an appreciation for the many opportunities for stakeholder engagement, including this comprehensive needs assessment. One comment mentioned that the assessment was right on target with communities in Tennessee considering racial disparities in varying communities and the increasing hostility against citizens of color, mental health and ACEs need to be a continued focus area. A suggestion was made to address laws that keep effective, evidence-based sex ed out of Tennessee public schools. Another suggestion stated that while prenatal care is targeted, postpartum care is not addressed as much even though it is just as critical for some of the presented objectives. Regarding contraception, one comment stated concerns of the many barriers to access all contraceptive methods.

Women's/Maternal Health:

For this section, respondents noted that there is still need for more care and education. One respondent stated that TDH has made significant inroads into identifying causes of maternal mortality to act upon to decrease the recurrence, whether due to physiological or human factors. The respondent then went on to say that there have been opportunities to increase breastfeeding rates which impact the overall health of the mother and the infant as well as work to improve the use of LARCs to prevent unplanned pregnancies. It was suggested to create awareness for better healthcare for single women by providing community resources such as improved information and transportation. Lastly, one comment mentioned that there should be more education regarding preconception as well as discussing options for women and girls to choose. There is also a need to focus on male/fatherhood engagement.

Perinatal/Infant Health:

A comment in this section described the positive impact of the work with hospitals to improve safe sleep, reduce early elective delivery, and newborn screenings in that they have reduced infant mortality while allowing early interventions as needed from screenings. Another comment noted that access and utilization of prenatal care as well as a lack of pregnancy education. Recommendations from respondents included increased awareness about developmentally appropriate handling, play and touch times for infants, increased awareness of resources available for children over the age of 2, and supporting mothers when going back to work after childbirth. A separate comment noted the need for trainings to address race inequity and its relation to overall infant health and mortality. One comment suggested the developing a group prenatal education program within the department of health using local providers and serving the clients who already come for other services (such as pregnancy tests) while linking them to resources through an app or web platform.

Child Health:

Comments in this section mainly focused on the effects that the COVID-19 pandemic has had and will continue to have on all of us for generations to come. One last comment suggested a need to expand and include more training with FIMR and CFR teams.

Adolescent Health:

Comments in this section affirmed the priorities that were chosen. One comment pointed out the increased influence of social media on young adults and adolescents regarding mental health.

Children and Youth with Special Health Care Needs:

One comment mentioned the strong relationships that TDH had with community partners that provide services to CYSHCN. Comments in this section affirmed the priorities that were chosen and described the need to address access to services. On that note, one comment stated that creating and promoting accessible resources for youth and families about their health care needs should be a priority broadly for all youth. They then went on to state that providing these resources can reduce healthcare costs and increase the health of the overall health of our state. Supporting strategies included: support for primary care providers in implementing a medical home approach to care and increase general awareness of the importance of a

medical home approach to care. Possible partnerships include Voc Rehab to get community resource providers (CRPs) they have on their list to pay to also spread information in schools. Lastly, the commentator believes that they see schools as the hub for meeting youths needs.

Response to Public Comments

The public comments are reviewed by the MCH/Title V Director, MCH/Title V CYSHCN Director, and MCH/Title V Coordinator. Based on this review adjustments are made the application/report as necessary.

Public Comment Process – After Report/Application Submission

After submission of the application/report, the draft on the website is replaced with the final document. Contact information for the MCH Director is also provided; so that comments can be made/contact with the director is available on an ongoing basis.

III.G. Technical Assistance

Tennessee's MCH/Title V Program is not requesting any technical assistance at this time.

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - Tennessee Title V-Medicaid IAA_MOU with Letter.pdf

V. Supporting Documents

The following supporting documents have been provided to supplement the narrative discussion.

Supporting Document #01 - III.B. - Legislative Mandates and Healthcare Provider Ratios.pdf

Supporting Document #02 - III.C.2.b.i. - Needs Assessment Quantitative Data.pdf

Supporting Document #03 - III.C.2.b.i. - Needs Assessment Qualitative Data.pdf

Supporting Document #04 - III.C.2.b.ii. - Capacity Assessment Program Inventories.pdf

Supporting Document #05 - III.C.2.c - Prioritization Matrix.pdf

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - Tennessee Organizational Charts.pdf

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Tennessee

	FY 21 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 11,800,000	
A. Preventive and Primary Care for Children	$ 4,200,000	(35.5%)
B. Children with Special Health Care Needs	$ 4,700,000	(39.8%)
C. Title V Administrative Costs	$ 826,000	(7%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 9,726,000	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 14,000,000	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 1,900,000	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 15,900,000	
A. Your State's FY 1989 Maintenance of Effort Amount $ 13,125,024		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 27,700,000	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS(Subtotal of all funds under item 9)	$ 139,734,625	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 167,434,625	

OTHER FEDERAL FUNDS	FY 21 Application Budgeted
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 100,000
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Abstinence Education Grant Program	$ 1,436,756
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 108,971,756
US Department of Agriculture (USDA) > Food and Nutrition Services > Commodity Supplemental Food Program (CSFP)	$ 913,231
US Department of Agriculture (USDA) > Food and Nutrition Services > The Loving Support Peer Counseling Program (Breastfeeding)	$ 1,200,818
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Injury Prevention and Control	$ 250,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Tobacco Control Programs	$ 1,163,365
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventive Health and Health Services Block Grant	$ 2,726,668
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Breast and Cervical Cancer Early Detection Program (NBCCEDP)	$ 2,125,887
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	$ 726,122
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	$ 9,855,815
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 8,125,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 250,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Zika Surveillance Systems Grant Program	$ 600,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Traumatic Brain Injury	$ 300,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State and Local Healthy Homes and Childhood Lead Poisoning Prevention Programs (CLPPPs)	$ 451,852

OTHER FEDERAL FUNDS	FY 21 Application Budgeted
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Comprehensive Cancer Control Program (NCCCP)	$ 325,655
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Sudden Death in the Young (SDY) Registry	$ 211,700

	FY 19 Annual Report Budgeted		FY 19 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 12,750,000		$ 11,449,081	
A. Preventive and Primary Care for Children	$ 3,853,809	(30.2%)	$ 4,288,369	(37.4%)
B. Children with Special Health Care Needs	$ 3,917,993	(30.7%)	$ 4,735,490	(41.3%)
C. Title V Administrative Costs	$ 788,680	(6.2%)	$ 693,209	(6.1%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 8,560,482		$ 9,717,068	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 32,000,000		$ 14,002,061	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0		$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0		$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 2,881,646		$ 1,853,003	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 34,881,646		$ 15,855,064	
A. Your State's FY 1989 Maintenance of Effort Amount $ 13,125,024				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 47,631,646		$ 27,304,145	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.				
10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9)	$ 174,823,962		$ 119,705,038	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 222,455,608		$ 147,009,183	

OTHER FEDERAL FUNDS	FY 19 Annual Report Budgeted	FY 19 Annual Report Expended
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 100,000	$ 131,255
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Abstinence Education Grant Program	$ 2,174,303	$ 1,450,821
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 131,729,969	$ 92,262,944
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Injury Prevention and Control	$ 250,000	$ 211,118
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State Public Health Actions-1305 Chronic Disease	$ 2,508,803	$ 0
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Tobacco Control Programs	$ 1,506,829	$ 1,165,593
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventive Health and Health Services Block Grant	$ 2,513,815	$ 2,519,909
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Breast and Cervical Cancer Early Detection Program (NBCCEDP)	$ 1,692,396	$ 2,300,548
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	$ 640,250	$ 772,300
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	$ 21,866,791	$ 9,300,324
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 6,710,000	$ 8,347,598
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 250,000	$ 265,830

OTHER FEDERAL FUNDS	FY 19 Annual Report Budgeted	FY 19 Annual Report Expended
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Sudden Death in the Young (SDY) Registry	$ 262,744	$ 149,192
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State and Local Healthy Homes and Childhood Lead Poisoning Prevention Programs (CLPPPs)	$ 475,362	$ 335,722
Department of Health and Human Services (DHHS) > Substance Abuse and Mental Health Services Administration > Project LAUNCH	$ 1,292,700	$ 0
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Traumatic Brain Injury	$ 250,000	$ 312,117
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Zika Surveillance Systems Grant Program	$ 600,000	$ 179,767

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**1.FEDERAL ALLOCATION**
	Fiscal Year:	**2019**
	Column Name:	**Annual Report Expended**
	Field Note: The federal allocation has not been fully expended but will be by the end of the grant period.	
2.	**Field Name:**	**Federal Allocation, A. Preventive and Primary Care for Children:**
	Fiscal Year:	**2019**
	Column Name:	**Annual Report Expended**
	Field Note: The federal allocation is unknown when the budget is originally submitted with the application. Therefore, the budget is created based on an estimate. In FY2019 the estimate was higher than the actual allocation. Due to this many budget categories had to be adjusted, including this line item.	
3.	**Field Name:**	**Federal Allocation, B. Children with Special Health Care Needs:**
	Fiscal Year:	**2019**
	Column Name:	**Annual Report Expended**
	Field Note: The federal allocation is unknown when the budget is originally submitted with the application. Therefore, the budget is created based on an estimate. In FY2019 the estimate was higher than the actual allocation. Due to this many budget categories had to be adjusted, including this line item.	
4.	**Field Name:**	**Federal Allocation, C. Title V Administrative Costs:**
	Fiscal Year:	**2019**
	Column Name:	**Annual Report Expended**
	Field Note: The federal allocation is unknown when the budget is originally submitted with the application. Therefore, the budget is created based on an estimate. In FY2019 the estimate was higher than the actual allocation. Due to this many budget categories had to be adjusted, including this line item.	
5.	**Field Name:**	**3. STATE MCH FUNDS**
	Fiscal Year:	**2019**

	Column Name:	**Annual Report Expended**
	Field Note: The federal allocation is unknown when the budget is originally submitted with the annual application/report. Therefore, the budget is created based on an estimate. In FY2019 the estimate was higher than the actual allocation. The federal allocation also affects the state match amount. Due to this many budget categories had to be adjusted, including this line item.	
6.	**Field Name:**	**6. PROGRAM INCOME**
	Fiscal Year:	**2019**
	Column Name:	**Annual Report Expended**
	Field Note: In FY2019 the estimate was higher than the actual income.	

Data Alerts: None

Form 3a
Budget and Expenditure Details by Types of Individuals Served

State: Tennessee

I. TYPES OF INDIVIDUALS SERVED

IA. Federal MCH Block Grant	FY 21 Application Budgeted	FY 19 Annual Report Expended
1. Pregnant Women	$ 1,143	$ 1,109
2. Infants < 1 year	$ 935,722	$ 907,895
3. Children 1 through 21 Years	$ 3,839,974	$ 3,725,777
4. CSHCN	$ 3,549,305	$ 3,443,752
5. All Others	$ 2,647,856	$ 2,677,339
Federal Total of Individuals Served	$ 10,974,000	$ 10,755,872

IB. Non-Federal MCH Block Grant	FY 21 Application Budgeted	FY 19 Annual Report Expended
1. Pregnant Women	$ 163,800	$ 204,145
2. Infants < 1 year	$ 883,400	$ 1,002,553
3. Children 1 through 21 Years	$ 3,759,000	$ 3,301,372
4. CSHCN	$ 1,885,800	$ 2,435,101
5. All Others	$ 7,308,000	$ 7,058,891
Non-Federal Total of Individuals Served	$ 14,000,000	$ 14,002,062
Federal State MCH Block Grant Partnership Total	$ 24,974,000	$ 24,757,934

Form Notes for Form 3a:

None

Field Level Notes for Form 3a:

1.	**Field Name:**	**IA. Federal MCH Block Grant, 3. Children 1 through 21 years**
	Fiscal Year:	**2021**
	Column Name:	**Application Budgeted**
	Field Note: The discrepancy between the amount budgeted for Children 1-21 Years on Form 3a and the amount budgeted for Preventive and Primary care for Children (Form 2, Line 1A) is due to classification of particular programs that span multiple populations. For example, family planning funds are used, in part, to serve children age 1-22 but also serve other populations (and therefore are not counted in the "Preventive and Primary Care for Children" category on Form 2).	
2.	**Field Name:**	**IA. Federal MCH Block Grant, 4. CSHCN**
	Fiscal Year:	**2021**
	Column Name:	**Application Budgeted**
	Field Note: The discrepancy between the amount budgeted for CSHCN on Form 3a and the amount budgeted for for CSHCN (Form 2, Line 1A) is due to classification of particular programs that span multiple populations. For example, child health funds are used, in part, to serve CSHCN but also serve infant and child populations (and therefore are not counted in the "CSHCN" category on Form 2).	
3.	**Field Name:**	**IA. Federal MCH Block Grant, 3. Children 1 through 21 years**
	Fiscal Year:	**2019**
	Column Name:	**Annual Report Expended**
	Field Note: The discrepancy between the amount expended for Children 1-21 Years on Form 3a and the amount expended for for Preventive and Primary care for Children (Form 2, Line 1A) is due to classification of particular programs that span multiple populations. For example, family planning funds are used, in part, to serve children age 1-22 but also serve other populations (and therefore are not counted in the "Preventive and Primary Care for Children" category on Form 2).	
4.	**Field Name:**	**IA. Federal MCH Block Grant, 4. CSHCN**
	Fiscal Year:	**2019**
	Column Name:	**Annual Report Expended**
	Field Note: The discrepancy between the amount expended for CSHCN on Form 3a and the amount expended for for CSHCN (Form 2, Line 1A) is due to classification of particular programs that span multiple populations. For example, child health funds are used, in part, to serve CSHCN but also serve infant and child populations (and therefore are not counted in the "CSHCN" category on Form 2).	

Data Alerts:

- Children 1 through 21 Years, Application Budgeted does not equal Form 2, Line 1A, Preventive and Primary Care for Children Application Budgeted. A field-level note indicating the reason for the discrepancy was provided.
- CSHCN, Application Budgeted does not equal Form 2, Line 1B, Children with Special Health Care Needs, Application Budgeted. A field-level note indicating the reason for the discrepancy was provided.
- Children 1 through 21 Years, Annual Report Expended does not equal Form 2, Line 1A, Preventive and Primary Care for Children, Annual Report Expended. A field - level note indicating the reason for the discrepancy was provided.
- CSHCN, Annual Report Expended does not equal Form 2, Line 1B, Children with Special Health Care Needs, Annual Report Expended. A field-level note indicating the reason for the discrepancy was provided.

Form 3b
Budget and Expenditure Details by Types of Services

State: Tennessee

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY 21 Application Budgeted	FY 19 Annual Report Expended
1. Direct Services	$ 765,597	$ 738,880
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 42,882	$ 38,866
B. Preventive and Primary Care Services for Children	$ 21,428	$ 20,791
C. Services for CSHCN	$ 701,287	$ 679,223
2. Enabling Services	$ 7,488,371	$ 7,265,675
3. Public Health Services and Systems	$ 3,546,032	$ 3,444,526
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 129,511
Physician/Office Services		$ 55,830
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 262,097
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 52,794
Laboratory Services		$ 50,398
Other		
Orthodontic; Interpreter		$ 188,250
Direct Services Line 4 Expended Total		$ 738,880
Federal Total	$ 11,800,000	$ 11,449,081

IIB. Non-Federal MCH Block Grant	FY 21 Application Budgeted	FY 19 Annual Report Expended
1. Direct Services	$ 839,132	$ 1,172,056
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 143,240	$ 166,814
B. Preventive and Primary Care Services for Children	$ 9,230	$ 11,280
C. Services for CSHCN	$ 686,662	$ 993,962
2. Enabling Services	$ 9,941,960	$ 10,646,523
3. Public Health Services and Systems	$ 3,218,908	$ 2,183,482
4. Select the types of Non-Federally-supported "Direct Services", as reported in II.B.1. Provide the total amount of Non-Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 228,991
Physician/Office Services		$ 63,653
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 342,348
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 102,243
Laboratory Services		$ 180,399
Other		
Orthodontic; Interpreter		$ 254,422
Direct Services Line 4 Expended Total		$ 1,172,056
Non-Federal Total	$ 14,000,000	$ 14,002,061

Form Notes for Form 3b:

None

Field Level Notes for Form 3b:

None

Form 4
Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated

State: Tennessee

Total Births by Occurrence: 89,670 **Data Source Year: 2019**

1. Core RUSP Conditions

Program Name	(A) Aggregate Total Number Receiving at Least One Screen	(B) Aggregate Total Number Presumptive Positive Screens	(C) Aggregate Total Number Confirmed Cases	(D) Aggregate Total Number Referred for Treatment
Core RUSP Conditions	89,383 (99.7%)	1,664	166	166 (100.0%)

Program Name(s)				
3-Hydroxy-3-Methyglutaric Aciduria	3-Methylcrotonyl-Coa Carboxylase Deficiency	Argininosuccinic Aciduria	Biotinidase Deficiency	Carnitine Uptake Defect/Carnitine Transport Defect
Citrullinemia, Type I	Classic Galactosemia	Classic Phenylketonuria	Congenital Adrenal Hyperplasia	Critical Congenital Heart Disease
Cystic Fibrosis	Glutaric Acidemia Type I	Glycogen Storage Disease Type II (Pompe)	Hearing Loss	Holocarboxylase Synthase Deficiency
Homocystinuria	Isovaleric Acidemia	Long-Chain L-3 Hydroxyacyl-Coa Dehydrogenase Deficiency	Maple Syrup Urine Disease	Medium-Chain Acyl-Coa Dehydrogenase Deficiency
Methylmalonic Acidemia (Cobalamin Disorders)	Methylmalonic Acidemia (Methylmalonyl-Coa Mutase)	Mucopolysaccharidosis Type 1	Primary Congenital Hypothyroidism	Propionic Acidemia
S, ßeta-Thalassemia	S,C Disease	S,S Disease (Sickle Cell Anemia)	Severe Combined Immunodeficiences	ß-Ketothiolase Deficiency
Trifunctional Protein Deficiency	Tyrosinemia, Type I	Very Long-Chain Acyl-Coa Dehydrogenase Deficiency	X-Linked Adrenoleukodystrophy	

2. Other Newborn Screening Tests

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
2-Methyl-3-hydroxybutyric aciduria	89,383 (99.7%)	49	0	0 (0%)
2-Methylbutyrylglycinuria	89,383 (99.7%)	5	0	0 (0%)
3-Methylglutaconic aciduria	89,383 (99.7%)	49	0	0 (0%)
Argininemia	89,383 (99.7%)	3	0	0 (0%)
Biopterin defect in cofactor biosynthesis	89,383 (99.7%)	25	4	4 (100.0%)
Biopterin defect in cofactor regeneration	89,383 (99.7%)	25	4	4 (100.0%)
Carnitine acylcarnitine translocase deficiency	89,383 (99.7%)	16	0	0 (0%)
Methylmalonic acidemia with homocystinuria	89,383 (99.7%)	78	0	0 (0%)
Citrullinemia, type II	89,383 (99.7%)	13	0	0 (0%)
Carnitine palmitoyltransferase type I deficiency	89,383 (99.7%)	1	0	0 (0%)
Carnitine palmitoyltransferase type II deficiency	89,383 (99.7%)	16	1	1 (100.0%)
2,4 Dienoyl-CoA reductase deficiency	89,383 (99.7%)	2	0	0 (0%)
Glutaric acidemia type II	89,383 (99.7%)	25	0	0 (0%)
Galactoepimerase deficiency	89,383 (99.7%)	116	0	0 (0%)
Galactokinase deficiency	89,383 (99.7%)	116	0	0 (0%)
Benign hyperphenylalaninemia	89,383 (99.7%)	25	4	4 (100.0%)

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Isobutyrylglycinuria	89,383 (99.7%)	25	0	0 (0%)
Malonic acidemia	89,383 (99.7%)	25	0	0 (0%)
Medium-chain ketoacyl-CoA thiolase deficiency	89,383 (99.7%)	25	0	0 (0%)
Hypermethioninemia	89,383 (99.7%)	10	0	0 (0%)
Short-chain acyl-CoA dehydrogenase deficiency	89,383 (99.7%)	25	1	1 (100.0%)
Tyrosinemia, type II	89,383 (99.7%)	69	0	0 (0%)
Tyrosinemia, type III	89,383 (99.7%)	69	0	0 (0%)
Various other hemoglobinopathies	89,383 (99.7%)	11	8	8 (100.0%)
T-Cell related lymphocyte deficiencies	89,383 (99.7%)	88	4	4 (100.0%)
Hyperornithinemiahyperammonemia-homocitrullinemia	89,383 (99.7%)	4	0	0 (0%)
Non-ketotic hyperglycinemia	89,383 (99.7%)	26	0	0 (0%)
Carbamoyl phosphate synthetase I deficiency	89,383 (99.7%)	1	0	0 (0%)
Ornithine transcarbamylase deficiency	89,383 (99.7%)	0	0	0 (0%)

3. Screening Programs for Older Children & Women

None

4. Long-Term Follow-Up

Tennessee's Newborn Screening Follow-Up has a case management section which provides short-term follow up to monitor all cases with abnormal tests through to confirmatory testing and treatment initiation. The State contracts with tertiary specialty centers to assure follow-up and confirmatory testing for all infants with abnormal screens. The centers are required, by contract, to report the results (whether disease was confirmed) back to the State, and for cases in which disease was confirmed, the center reports the date on which treatment was started. Currently, the State does not monitor confirmed diagnosed infants beyond notification of diagnosis and treatment initiation by the contracted tertiary specialty center. However, the State provides infrastructure funding at each center to support longterm treatment, genetic testing for vulnerable individuals, and education/outreach

Form Notes for Form 4:

None

Field Level Notes for Form 4:

None

Data Alerts: None

Form 5
Count of Individuals Served by Title V & Total Percentage of Populations Served by Title V

State: Tennessee

Annual Report Year 2019

Form 5a – Count of Individuals Served by Title V
(Direct & Enabling Services Only)

		Primary Source of Coverage				
Types Of Individuals Served	(A) Title V Total Served	(B) Title XIX %	(C) Title XXI %	(D) Private / Other %	(E) None %	(F) Unknown %
1. Pregnant Women	15,781	57.0	0.0	13.0	30.0	0.0
2. Infants < 1 Year of Age	39,540	36.0	0.0	1.0	63.0	0.0
3. Children 1 through 21 Years of Age	204,765	33.0	0.0	12.0	55.0	0.0
3a. Children with Special Health Care Needs	5,530	0.0	1.0	0.0	99.0	0.0
4. Others	143,679	11.0	1.0	8.0	80.0	0.0
Total	403,765					

Form 5b – Total Percentage of Populations Served by Title V
(Direct, Enabling, and Public Health Services and Systems)

Populations Served by Title V	Reference Data	Used Reference Data?	Denominator	Total % Served	Form 5b Count (Calculated)	Form 5a Count
1. Pregnant Women	80,751	Yes	80,751	100	80,751	15,781
2. Infants < 1 Year of Age	86,484	Yes	86,484	100	86,484	39,540
3. Children 1 through 21 Years of Age	1,765,856	Yes	1,765,856	61	1,077,172	204,765
3a. Children with Special Health Care Needs	387,252	Yes	387,252	3	11,618	5,530
4. Others	4,925,180	Yes	4,925,180	12	591,022	143,679

Form Notes for Form 5:

None

Field Level Notes for Form 5a:

1.	**Field Name:**	**Pregnant Women Total Served**
	Fiscal Year:	**2019**
	Field Note: The majority of this count comes from women's health services in local health departments, including family planning.	
2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2019**
	Field Note: The majority of this count comes from TennCare (Medicaid) outreach efforts, well child visits in local health departments (mostly for TennCare enrollees), and general child health services in local health departments.	
3.	**Field Name:**	**Children 1 through 21 Years of Age**
	Fiscal Year:	**2019**
	Field Note: The majority of this count comes from TennCare (Medicaid) outreach efforts, as well as general child health services and reproductive health services in the local health departments.	
4.	**Field Name:**	**Children with Special Health Care Needs**
	Fiscal Year:	**2019**
	Field Note: This count comes fro Children's Special Services, Tennessee's MCH/Title V Children with Special Health Care Needs program, in local health departments.	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2019**
	Field Note: The majority of this count comes from women's health services in the local health department.	

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women**
	Fiscal Year:	**2019**

Field Note:
This percentage is based on how many pregnant women were served through multiple programs during the reporting year. At this time de-duplication between programs is not possible therefore the percentage may be an overestimation.

Programs that serve this population include: Healthy Start (not the federal program), Home Visiting, Child Health and Development, Help Us Grow Successfully, Diabetes Prevention, Tobacco QuitLine, Local Health Department Services, Perinatal Centers, WIC, and Maternal Mortality Review.

2.	**Field Name:**	**InfantsLess Than One Year**
	Fiscal Year:	**2019**

Field Note:
This percentage is based on how many infants were served through multiple programs during the reporting year. At this time de-duplication between programs is not possible therefore the percentage may be an overestimation.

Programs that serve this population include: Healthy Start (not the federal program), Home Visiting, Child Health and Development, Help Us Grow Successfully, Poison Control, Birth Defect Follow-Up, Local Health Department Services, Perinatal Centers, Newborn Metabolic Screening, Newborn Hearing Screening, WIC, SIDS, Sudden Death in the Young, Child Fatality Review and Prevention, Fetal Infant Mortality Review, Infant Mortality Reduction Initiative, and Child Safety Fund.

3.	**Field Name:**	**Children 1 Through 21 Years of Age**
	Fiscal Year:	**2019**

Field Note:
This percentage is based on how many children age 1-21 were served through multiple programs during the reporting year. At this time de-duplication between programs is not possible therefore the percentage may be an overestimation.

Programs that serve this population include: Healthy Start (not the federal program), Home Visiting, Child Health and Development, Help Us Grow Successfully, Diabetes Prevention, Poison Control, Chronic Disease, Tobacco QuitLine, Birth Defect Follow-Up, Local Health Department Services, Abstinence Education, Family Planning, Adolescent Pregnancy Prevention, Rape Prevention, Breast and Cervical Cancer Detection, Lead Poisoning Prevention, WIC, Unexplained Child Death, Sudden Death in the Young, Child Fatality Review and Prevention, Injury Surveillance and Prevention, Child Safety Fund and Traumatic Brain Injury.

4.	**Field Name:**	**Children With Special Health Care Needs**
	Fiscal Year:	**2019**

Field Note:
This percentage is based on how many children with special health care needs were served through multiple programs during the reporting year. At this time de-duplication between programs is not possible therefore the percentage may be an overestimation.

Programs that serve this population include: Children Special Services, Birth Defect Follow-Up, Lead Poison Prevention, Genetics, Newborn Screening Follow-Up, and Newborn Hearing Follow-Up.

5.	**Field Name:**	**Others**

Fiscal Year: **2019**

Field Note:
This percentage is based on how many other individuals were served through multiple programs during the reporting year. At this time de-duplication between programs is not possible therefore the percentage may be an overestimation.

Programs that serve this population include: Healthy Start (not the federal program), Home Visiting, Child Health and Development, Help Us Grow Successfully, Diabetes Prevention, Health Promotion, Poison Control, Chronic Disease, Tobacco QuitLine, Local Health Department Services, Abstinence Education, Family Planning, Adolescent Pregnancy Prevention, Rape Prevention, Breast and Cervical Cancer Detection, Genetics, WIC, Epilepsy, and Traumatic Brain Injury.

Data Alerts: None

Form 6
Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: Tennessee

Annual Report Year 2019

I. Unduplicated Count by Race/Ethnicity

	(A) Total	(B) Non-Hispanic White	(C) Non-Hispanic Black or African American	(D) Hispanic	(E) Non-Hispanic American Indian or Native Alaskan	(F) Non-Hispanic Asian	(G) Non-Hispanic Native Hawaiian or Other Pacific Islander	(H) Non-Hispanic Multiple Race	(I) Other & Unknown
1. Total Deliveries in State	88,027	60,217	16,684	8,366	162	1,861	243	0	494
Title V Served	88,027	60,217	16,684	8,366	162	1,861	243	0	494
Eligible for Title XIX	44,464	26,326	11,578	5,590	94	536	113	0	227
2. Total Infants in State	90,523	59,283	16,231	8,894	0	0	0	0	6,115
Title V Served	42,392	31,196	6,795	3,899	42	210	36	0	214
Eligible for Title XIX	52,973	26,644	16,426	7,655	0	0	0	2,248	0

Form Notes for Form 6:

None

Field Level Notes for Form 6:

None

Form 7
State MCH Toll-Free Telephone Line and Other Appropriate Methods Data

State: Tennessee

A. State MCH Toll-Free Telephone Lines	2021 Application Year	2019 Annual Report Year
1. State MCH Toll-Free "Hotline" Telephone Number	(615) 741-7353	(877) 548-3861
2. State MCH Toll-Free "Hotline" Name	Family Health and Wellness	Primary Prevention Impact Services Call Center
3. Name of Contact Person for State MCH "Hotline"	Morgan McDonald	Morgan McDonald
4. Contact Person's Telephone Number	(615) 532-8672	(615) 532-8672
5. Number of Calls Received on the State MCH "Hotline"		0

B. Other Appropriate Methods	2021 Application Year	2019 Annual Report Year
1. Other Toll-Free "Hotline" Names	Tennessee Breastfeeding Hotline	Tennessee Breastfeeding Hotline
2. Number of Calls on Other Toll-Free "Hotlines"		5,700
3. State Title V Program Website Address	www.kidcentraltn.com	www.kidcentraltn.com
4. Number of Hits to the State Title V Program Website		91,724
5. State Title V Social Media Websites	www.facebook.com/TN DeptofHealth	www.facebook.com/TN DeptofHealth
6. Number of Hits to the State Title V Program Social Media Websites		667,817

Form Notes for Form 7:

None

Form 8
State MCH and CSHCN Directors Contact Information

State: Tennessee

1. Title V Maternal and Child Health (MCH) Director	
Name	Morgan McDonald, MD FAAP FACP
Title	Assistant Commissioner, Division of Family Health and Wellness
Address 1	710 James Robertson Parkway
Address 2	5th Floor
City/State/Zip	Nashville / TN / 37243
Telephone	(615) 532-8672
Extension	
Email	morgan.mcdonald@tn.gov

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Jacqueline Johnson, MPA
Title	Director, Children's Special Services
Address 1	710 James Robertson Parkway
Address 2	7th Floor
City/State/Zip	Nashville / TN / 37243
Telephone	(615) 741-0361
Extension	
Email	jacqueline.johnson@tn.gov

3. State Family or Youth Leader (Optional)	
Name	Tori Goddard
Title	AMCHP Family Delegate
Address 1	5004 Indiana Avenue
Address 2	
City/State/Zip	Nashville / TN / 37209
Telephone	(615) 335-7800
Extension	
Email	torigoddard@yahoo.com

Form Notes for Form 8:

None

Form 9
State Priorities – Needs Assessment Year

State: Tennessee

Application Year 2021

No.	Priority Need	Priority Need Type (New, Revised or Continued Priority Need for this five-year reporting period)
1.	Increase family planning	New
2.	Decrease pregnancy-associated mortality	New
3.	Increase breastfeeding	New
4.	Decrease infant mortality	Continued
5.	Decrease overweight and obesity among children	Continued
6.	Increase prevention and mitigation of Adverse Childhood Experiences (ACEs)	Continued
7.	Decrease tobacco and e-cigarette use among adolescents	Revised
8.	Increase medical homes among children with special healthcare needs	Revised
9.	Improve transition from pediatric to adult care among children with special health care needs	Continued

Form Notes for Form 9:

None

Field Level Notes for Form 9:

None

Form 10
National Outcome Measures (NOMs)

State: Tennessee

Form Notes for Form 10 NPMs, NOMs, SPMs, SOMs, and ESMs.

None

NOM 1 - Percent of pregnant women who receive prenatal care beginning in the first trimester

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	75.6 %	0.2 %	56,759	75,035
2017	74.8 %	0.2 %	56,693	75,746
2016	74.2 %	0.2 %	51,493	69,385
2015	74.2 %	0.2 %	55,756	75,125
2014	74.2 %	0.2 %	56,654	76,364
2013	71.6 %	0.2 %	54,489	76,103
2012	70.4 %	0.2 %	53,419	75,885
2011	69.9 %	0.2 %	51,605	73,832
2010	70.6 %	0.2 %	52,663	74,579
2009	69.5 %	0.2 %	54,058	77,795

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 1 - Notes:

None

Data Alerts: None

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

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	75.0	3.3	525	70,011
2016	70.8	3.3	460	65,002
2015	90.8	4.4	439	48,340
2014	91.2	3.8	589	64,567
2013	105.7	4.0	706	66,790
2012	96.2	3.8	636	66,091
2011	89.2	3.6	625	70,038
2010	82.0	3.5	570	69,538
2009	76.9	3.3	557	72,462
2008	76.1	3.2	569	74,738

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 2 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014_2018	24.9	2.5	101	405,861

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 3 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	9.3 %	0.1 %	7,471	80,473
2017	9.2 %	0.1 %	7,409	80,813
2016	9.3 %	0.1 %	7,431	80,084
2015	9.2 %	0.1 %	7,460	81,384
2014	9.0 %	0.1 %	7,297	81,441
2013	9.1 %	0.1 %	7,307	79,962
2012	9.2 %	0.1 %	7,377	80,318
2011	9.0 %	0.1 %	7,176	79,554
2010	9.0 %	0.1 %	7,179	79,451
2009	9.2 %	0.1 %	7,539	82,172

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 4 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	11.1 %	0.1 %	8,911	80,541
2017	11.1 %	0.1 %	8,962	80,847
2016	11.3 %	0.1 %	9,085	80,340
2015	11.0 %	0.1 %	8,959	81,538
2014	10.8 %	0.1 %	8,780	81,497
2013	11.1 %	0.1 %	8,826	79,691
2012	11.2 %	0.1 %	8,961	79,807
2011	11.1 %	0.1 %	8,729	78,903
2010	11.4 %	0.1 %	8,988	78,936
2009	11.3 %	0.1 %	9,231	81,518

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 5 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	27.9 %	0.2 %	22,468	80,541
2017	27.6 %	0.2 %	22,338	80,847
2016	27.2 %	0.2 %	21,868	80,340
2015	26.6 %	0.2 %	21,662	81,538
2014	26.1 %	0.2 %	21,293	81,497
2013	26.2 %	0.2 %	20,856	79,691
2012	27.8 %	0.2 %	22,149	79,807
2011	28.9 %	0.2 %	22,784	78,903
2010	30.1 %	0.2 %	23,721	78,936
2009	31.5 %	0.2 %	25,645	81,518

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 6 - Notes:

None

Data Alerts: None

NOM 7 - Percent of non-medically indicated early elective deliveries

Data Source: CMS Hospital Compare

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018/Q2-2019/Q1	2.0 %			
2018/Q1-2018/Q4	2.0 %			
2017/Q4-2018/Q3	2.0 %			
2017/Q3-2018/Q2	2.0 %			
2017/Q2-2018/Q1	2.0 %			
2017/Q1-2017/Q4	2.0 %			
2016/Q4-2017/Q3	2.0 %			
2016/Q3-2017/Q2	2.0 %			
2016/Q2-2017/Q1	2.0 %			
2016/Q1-2016/Q4	2.0 %			
2015/Q4-2016/Q3	2.0 %			
2015/Q3-2016/Q2	1.0 %			
2015/Q2-2016/Q1	2.0 %			
2015/Q1-2015/Q4	2.0 %			
2014/Q4-2015/Q3	2.0 %			
2014/Q3-2015/Q2	2.0 %			
2014/Q2-2015/Q1	2.0 %			
2014/Q1-2014/Q4	3.0 %			
2013/Q4-2014/Q3	3.0 %			
2013/Q3-2014/Q2	3.0 %			
2013/Q2-2014/Q1	4.0 %			

Legends:

NOM 7 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	6.8	0.3	549	81,276
2016	6.8	0.3	555	81,107
2015	6.4	0.3	521	81,958
2014	6.8	0.3	554	81,875
2013	7.0	0.3	558	80,281
2012	7.2	0.3	582	80,674
2011	7.4	0.3	595	79,909
2010	6.6	0.3	524	79,743
2009	6.8	0.3	561	82,469

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 8 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	7.3	0.3	591	81,016
2016	7.4	0.3	594	80,807
2015	7.0	0.3	568	81,685
2014	6.9	0.3	561	81,602
2013	6.8	0.3	544	79,992
2012	7.2	0.3	582	80,371
2011	7.4	0.3	592	79,588
2010	7.9	0.3	626	79,495
2009	8.0	0.3	657	82,211

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.1 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	4.6	0.2	372	81,016
2016	4.2	0.2	343	80,807
2015	4.1	0.2	335	81,685
2014	4.3	0.2	349	81,602
2013	4.2	0.2	333	79,992
2012	4.3	0.2	349	80,371
2011	4.6	0.2	365	79,588
2010	4.6	0.2	368	79,495
2009	4.8	0.2	396	82,211

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.2 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	2.7	0.2	219	81,016
2016	3.1	0.2	251	80,807
2015	2.9	0.2	233	81,685
2014	2.6	0.2	212	81,602
2013	2.6	0.2	211	79,992
2012	2.9	0.2	233	80,371
2011	2.9	0.2	227	79,588
2010	3.2	0.2	258	79,495
2009	3.2	0.2	261	82,211

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.3 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	201.2	15.8	163	81,016
2016	211.6	16.2	171	80,807
2015	189.8	15.3	155	81,685
2014	230.4	16.8	188	81,602
2013	193.8	15.6	155	79,992
2012	209.0	16.1	168	80,371
2011	214.9	16.5	171	79,588
2010	245.3	17.6	195	79,495
2009	255.4	17.7	210	82,211

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.4 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	149.4	13.6	121	81,016
2016	153.5	13.8	124	80,807
2015	153.0	13.7	125	81,685
2014	111.5	11.7	91	81,602
2013	123.8	12.5	99	79,992
2012	164.2	14.3	132	80,371
2011	154.5	14.0	123	79,588
2010	171.1	14.7	136	79,495
2009	153.3	13.7	126	82,211

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.5 - Notes:

None

Data Alerts: None

NOM 10 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	5.5 %	1.0 %	4,299	78,404
2014	5.8 %	1.1 %	4,524	77,863
2013	4.8 %	1.0 %	3,677	77,144
2012	6.7 %	1.1 %	5,139	77,036
2009	5.6 %	1.1 %	4,474	79,825
2008	3.4 %	0.8 %	2,774	81,407

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

NOM 10 - Notes:

None

Data Alerts: None

NOM 11 - The rate of infants born with neonatal abstinence syndrome per 1,000 hospital births

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	16.2	0.5	1,099	67,827
2016	18.0	0.5	1,134	63,143
2015	16.9	0.6	793	46,904
2014	15.3	0.5	959	62,637
2013	12.5	0.4	815	65,309
2012	8.9	0.4	584	65,480
2011	6.0	0.3	414	69,570
2010	5.4	0.3	375	69,409
2009	4.3	0.2	311	72,741
2008	3.0	0.2	225	75,307

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 11 - Notes:

None

Data Alerts: None

NOM 12 - Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner. (DEVELOPMENTAL)

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

NOM 12 - Notes:

None

Data Alerts: None

NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

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

NOM 13 - Notes:

None

Data Alerts: None

NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017_2018	13.7 %	1.6 %	189,299	1,379,241
2016_2017	10.7 %	1.5 %	149,356	1,391,773
2016	8.9 %	1.6 %	124,646	1,402,272

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 14 - Notes:

None

Data Alerts: None

NOM 15 - Child Mortality rate, ages 1 through 9, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	22.3	1.7	165	739,940
2017	23.3	1.8	173	741,775
2016	23.2	1.8	172	741,404
2015	18.3	1.6	135	739,432
2014	20.6	1.7	152	738,611
2013	21.1	1.7	156	738,334
2012	22.4	1.7	166	739,838
2011	20.0	1.7	147	736,697
2010	22.0	1.7	163	740,978
2009	20.0	1.7	148	738,731

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 15 - Notes:

None

Data Alerts: None

NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	44.9	2.3	384	855,439
2017	43.5	2.3	370	850,432
2016	39.9	2.2	336	842,341
2015	39.8	2.2	335	840,920
2014	36.7	2.1	309	841,738
2013	35.5	2.1	299	841,885
2012	40.3	2.2	340	844,247
2011	37.1	2.1	315	848,300
2010	38.2	2.1	327	856,127
2009	42.4	2.2	363	855,924

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.1 - Notes:

None

Data Alerts: None

NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016_2018	15.3	1.1	195	1,272,255
2015_2017	15.5	1.1	197	1,267,849
2014_2016	15.1	1.1	191	1,262,485
2013_2015	14.1	1.1	177	1,259,614
2012_2014	15.5	1.1	195	1,260,128
2011_2013	16.9	1.2	214	1,267,375
2010_2012	18.9	1.2	243	1,285,474
2009_2011	19.2	1.2	250	1,302,264
2008_2010	21.7	1.3	285	1,312,853
2007_2009	28.1	1.5	368	1,307,973

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.2 - Notes:

None

Data Alerts: None

NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016_2018	13.2	1.0	168	1,272,255
2015_2017	12.4	1.0	157	1,267,849
2014_2016	11.2	0.9	142	1,262,485
2013_2015	10.1	0.9	127	1,259,614
2012_2014	9.8	0.9	123	1,260,128
2011_2013	8.7	0.8	110	1,267,375
2010_2012	7.8	0.8	100	1,285,474
2009_2011	7.8	0.8	102	1,302,264
2008_2010	7.2	0.7	94	1,312,853
2007_2009	7.1	0.7	93	1,307,973

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.3 - Notes:

None

Data Alerts: None

NOM 17.1 - Percent of children with special health care needs (CSHCN), ages 0 through 17

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017_2018	20.6 %	1.6 %	308,848	1,502,862
2016_2017	19.1 %	1.5 %	285,900	1,494,648
2016	19.0 %	1.9 %	282,585	1,488,549

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.1 - Notes:

None

Data Alerts: None

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017_2018	13.3 %	2.5 %	41,061	308,848
2016_2017	17.2 %	3.0 %	49,083	285,167
2016	20.7 %	4.5 %	58,242	281,120

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.2 - Notes:

None

Data Alerts: None

NOM 17.3 - Percent of children, ages 3 through 17, diagnosed with an autism spectrum disorder

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017_2018	3.0 %	0.6 %	37,557	1,253,631
2016_2017	2.0 %	0.6 %	24,820	1,232,350
2016	1.8 %	0.8 %	21,252	1,212,557

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.3 - Notes:

None

Data Alerts: None

NOM 17.4 - Percent of children, ages 3 through 17, diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017_2018	10.6 %	1.3 %	131,344	1,234,743
2016_2017	10.2 %	1.3 %	124,036	1,217,529
2016	10.1 %	1.6 %	121,186	1,201,276

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.4 - Notes:

None

Data Alerts: None

NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017_2018	40.6 %	5.6 %	84,514	207,992
2016_2017	41.7 %	6.2 %	69,811	167,435
2016	48.7 %	7.9 %	71,834	147,604

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 18 - Notes:

None

Data Alerts: None

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

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017_2018	88.7 %	1.4 %	1,326,928	1,495,696
2016_2017	89.7 %	1.3 %	1,336,207	1,488,972
2016	89.2 %	1.6 %	1,326,511	1,486,938

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 19 - Notes:

None

Data Alerts: None

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

Data Source: WIC

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	14.6 %	0.2 %	7,457	51,157
2014	14.9 %	0.2 %	8,083	54,429
2012	15.3 %	0.2 %	8,130	53,033
2010	16.0 %	0.2 %	9,126	57,153
2008	14.7 %	0.2 %	7,596	51,616

Legends:

Indicator has a denominator <50 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	20.5 %	1.2 %	56,429	275,401
2015	18.7 %	1.0 %	49,352	263,605
2013	16.9 %	0.9 %	41,966	248,272
2011	15.3 %	0.8 %	40,590	265,373
2009	15.8 %	1.0 %	42,140	267,393
2007	16.9 %	0.9 %	45,472	269,340
2005	14.4 %	1.3 %	36,927	257,157

Legends:

Indicator has an unweighted denominator <100 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017_2018	16.7 %	2.5 %	111,281	666,245
2016_2017	15.6 %	2.3 %	98,467	631,225
2016	19.2 %	2.8 %	111,864	583,745

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 20 - Notes:

None

Data Alerts: None

NOM 21 - Percent of children, ages 0 through 17, without health insurance

Data Source: American Community Survey (ACS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	4.7 %	0.3 %	70,287	1,509,769
2017	4.2 %	0.3 %	62,707	1,505,959
2016	3.5 %	0.3 %	52,909	1,502,677
2015	4.3 %	0.3 %	63,432	1,493,057
2014	5.2 %	0.3 %	77,115	1,493,436
2013	5.7 %	0.4 %	84,902	1,492,149
2012	5.6 %	0.4 %	83,030	1,492,012
2011	5.8 %	0.4 %	86,513	1,489,552
2010	5.3 %	0.3 %	79,838	1,499,117
2009	5.8 %	0.3 %	85,685	1,489,741

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 21 - Notes:

None

Data Alerts: None

NOM 22.1 - Percent of children, ages 19 through 35 months, who completed the combined 7-vaccine series (4:3:1:3*:3:1:4)

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	70.8 %	3.9 %	84,752	119,715
2017	79.3 %	3.0 %	95,758	120,738
2016	67.4 %	3.8 %	80,590	119,570
2015	70.1 %	3.8 %	82,260	117,280
2014	71.9 %	3.9 %	84,560	117,608
2013	68.5 %	3.5 %	79,216	115,715
2012	73.1 %	3.5 %	86,800	118,788
2011	70.4 %	3.4 %	85,567	121,578
2010	61.8 %	3.4 %	78,476	127,008
2009	44.8 %	3.4 %	55,979	124,975

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate >1.2

Estimates with 95% confidence interval widths >20 or that are inestimable might not be reliable

NOM 22.1 - Notes:

None

Data Alerts: None

NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza

Data Source: National Immunization Survey (NIS) - Flu

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	62.1 %	1.8 %	883,469	1,423,801
2017_2018	61.5 %	2.1 %	867,500	1,411,591
2016_2017	57.4 %	2.0 %	799,927	1,393,844
2015_2016	61.8 %	1.9 %	865,797	1,400,513
2014_2015	61.8 %	2.0 %	871,825	1,409,807
2013_2014	60.2 %	2.0 %	836,358	1,390,019
2012_2013	56.4 %	2.3 %	789,668	1,400,851
2011_2012	50.4 %	2.7 %	695,541	1,379,253
2010_2011	56.6 %	3.8 %	777,299	1,373,320
2009_2010	48.9 %	3.9 %	617,746	1,263,285

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or because the relative standard error is >0.3.

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.2 - Notes:

None

Data Alerts: None

NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	62.3 %	3.5 %	265,046	425,286
2017	56.1 %	3.4 %	238,814	425,789
2016	55.3 %	3.4 %	235,979	426,750
2015	48.7 %	3.3 %	207,308	425,570

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate > 1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.3 - Notes:

None

Data Alerts: None

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	90.7 %	1.9 %	385,687	425,286
2017	89.4 %	2.0 %	380,743	425,789
2016	89.3 %	2.2 %	381,010	426,750
2015	79.7 %	2.7 %	339,136	425,570
2014	86.0 %	2.3 %	363,547	422,685
2013	80.0 %	2.7 %	338,276	422,624
2012	77.4 %	3.2 %	325,269	420,423
2011	67.6 %	3.2 %	283,974	420,127
2010	58.7 %	3.2 %	243,261	414,201
2009	48.0 %	3.1 %	199,390	415,570

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate > 1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.4 - Notes:

None

Data Alerts: None

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	85.2 %	2.5 %	362,229	425,286
2017	75.0 %	3.1 %	319,476	425,789
2016	76.3 %	3.0 %	325,708	426,750
2015	76.7 %	2.9 %	326,284	425,570
2014	74.0 %	3.0 %	312,756	422,685
2013	67.8 %	3.1 %	286,448	422,624
2012	69.4 %	3.4 %	291,733	420,423
2011	63.3 %	3.3 %	265,999	420,127
2010	50.6 %	3.2 %	209,556	414,201
2009	52.1 %	3.1 %	216,515	415,570

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate >1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.5 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	25.3	0.4	5,258	207,756
2017	26.6	0.4	5,516	207,240
2016	28.0	0.4	5,766	206,065
2015	30.6	0.4	6,267	204,782
2014	33.2	0.4	6,756	203,551
2013	34.8	0.4	7,105	204,285
2012	38.4	0.4	7,910	205,905
2011	40.8	0.4	8,497	208,285
2010	43.5	0.5	9,254	212,929
2009	48.4	0.5	10,378	214,436

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 23 - Notes:

None

Data Alerts: None

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

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	15.4 %	1.6 %	12,063	78,110
2014	13.6 %	1.6 %	10,620	78,096
2013	18.1 %	1.8 %	13,695	75,835
2012	17.2 %	1.6 %	13,157	76,677

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

NOM 24 - Notes:

None

Data Alerts: None

NOM 25 - Percent of children, ages 0 through 17, who were not able to obtain needed health care in the last year

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017_2018	2.4 %	0.7 %	35,789	1,499,644
2016_2017	1.8 %	0.5 %	26,301	1,484,581
2016	2.1 %	0.8 %	30,908	1,471,004

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 25 - Notes:

None

Data Alerts: None

Form 10
National Performance Measures (NPMs)

State: Tennessee

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

Federally Available Data				
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)				
	2016	**2017**	**2018**	**2019**
Annual Objective	72.2	72.2	73.3	73.3
Annual Indicator	69.6	66.0	68.3	74.6
Numerator	794,110	760,359	781,733	875,792
Denominator	1,140,291	1,152,528	1,144,543	1,174,631
Data Source	BRFSS	BRFSS	BRFSS	BRFSS
Data Source Year	2015	2016	2017	2018

Annual Objectives						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	75.0	76.0	77.0	78.0	79.0	80.0

Field Level Notes for Form 10 NPMs:

None

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

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

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

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

Field Level Notes for Form 10 NPMs:

None

NPM 4A - Percent of infants who are ever breastfed

Federally Available Data	
Data Source: National Immunization Survey (NIS)	
	2019
Annual Objective	
Annual Indicator	82.2
Numerator	63,360
Denominator	77,089
Data Source	NIS
Data Source Year	2016

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

Field Level Notes for Form 10 NPMs:

None

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

Federally Available Data	
Data Source: National Immunization Survey (NIS)	
	2019
Annual Objective	
Annual Indicator	24.5
Numerator	18,257
Denominator	74,506
Data Source	NIS
Data Source Year	2016

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

Field Level Notes for Form 10 NPMs:

None

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

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

Annual Objectives						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	82.0	83.0	84.0	85.0	86.0	87.0

Field Level Notes for Form 10 NPMs:

None

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

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

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

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	31.0	32.0	33.0	34.0	35.0	36.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
Data will be available from PRAMS next year.

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

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

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

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	46.0	48.0	50.0	52.0	54.0	56.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
Data will be available from PRAMS next year.

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

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

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

Annual Objectives						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	31.5	31.9	32.2	32.6	32.9	33.3

Field Level Notes for Form 10 NPMs:

None

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - Children with Special Health Care Needs

Federally Available Data				
Data Source: National Survey of Children's Health (NSCH) - CSHCN				
	2016	**2017**	**2018**	**2019**
Annual Objective			56.5	59.2
Annual Indicator		44.8	50.4	53.3
Numerator		125,986	143,840	164,583
Denominator		281,120	285,167	308,848
Data Source		NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017	2017_2018

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

Annual Objectives						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	53.3	60.0	65.0	70.0	75.0	80.0

Field Level Notes for Form 10 NPMs:

None

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care - Children with Special Health Care Needs

Federally Available Data				
Data Source: National Survey of Children's Health (NSCH) - CSHCN				
	2016	**2017**	**2018**	**2019**
Annual Objective			14.1	14.7
Annual Indicator		19.2	14.4	16.6
Numerator		16,734	17,666	26,590
Denominator		87,214	122,975	159,749
Data Source		NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017	2017_2018

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

Annual Objectives						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	34.2	40.0	45.0	50.0	55.0	60.0

Field Level Notes for Form 10 NPMs:

None

NPM 14.2 - Percent of children, ages 0 through 17, who live in households where someone smokes - Adolescent Health

Federally Available Data				
Data Source: National Survey of Children's Health (NSCH)				
	2016	**2017**	**2018**	**2019**
Annual Objective			29	
Annual Indicator		24.9	21.1	18.6
Numerator		362,200	311,958	276,334
Denominator		1,457,726	1,478,634	1,485,841
Data Source		NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018

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

Annual Objectives					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	17.0	16.0	15.0	14.0	13.0

Field Level Notes for Form 10 NPMs:

None

Form 10
National Performance Measures (NPMs) (2016-2020 Needs Assessment Cycle)

State: Tennessee

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

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

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

Field Level Notes for Form 10 NPMs:

None

2016-2020: NPM 7.1 - Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9

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

Field Level Notes for Form 10 NPMs:

None

2016-2020: NPM 7.2 - Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19

Federally Available Data				
Data Source: HCUP - State Inpatient Databases (SID)				
	2016	**2017**	**2018**	**2019**
Annual Objective	184.8	176.4	168	159.6
Annual Indicator	207.7	191.6	206.3	220.7
Numerator	1,746	1,206	1,738	1,877
Denominator	840,564	629,323	842,341	850,432
Data Source	SID-ADOLESCENT	SID-ADOLESCENT	SID-ADOLESCENT	SID-ADOLESCENT
Data Source Year	2014	2015	2016	2017

Field Level Notes for Form 10 NPMs:

None

2016-2020: NPM 8.2 - Percent of adolescents, ages 12 through 17 who are physically active at least 60 minutes per day

Federally Available Data				
Data Source: Youth Risk Behavior Surveillance System (YRBSS)				
	2016	**2017**	**2018**	**2019**
Annual Objective	26.9	27.7	28.5	23.4
Annual Indicator	25.9	25.9	25.6	25.6
Numerator	70,480	70,480	73,476	73,476
Denominator	272,118	272,118	286,547	286,547
Data Source	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT
Data Source Year	2015	2015	2017	2017

Federally Available Data				
Data Source: National Survey of Children's Health (NSCH) - ADOLESCENT				
	2016	**2017**	**2018**	**2019**
Annual Objective			28.5	23.4
Annual Indicator		22.4	21.5	16.9
Numerator		107,989	105,885	85,908
Denominator		481,757	491,600	509,523
Data Source		NSCH-ADOLESCENT	NSCH-ADOLESCENT	NSCH-ADOLESCENT
Data Source Year		2016	2016_2017	2017_2018

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

Field Level Notes for Form 10 NPMs:

None

2016-2020: NPM 14.1 - Percent of women who smoke during pregnancy

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

Field Level Notes for Form 10 NPMs:

None

2016-2020: NPM 14.2 - Percent of children, ages 0 through 17, who live in households where someone smokes - Child Health

Federally Available Data				
Data Source: National Survey of Children's Health (NSCH)				
	2016	**2017**	**2018**	**2019**
Annual Objective			29	23.8
Annual Indicator		24.9	21.1	18.6
Numerator		362,200	311,958	276,334
Denominator		1,457,726	1,478,634	1,485,841
Data Source		NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018

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

Field Level Notes for Form 10 NPMs:

None

Form 10
State Performance Measures (SPMs)

State: Tennessee

SPM 1 - Percent of new mothers whose pregnancy was intended

Measure Status:	Active			
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective		51.6	49.9	49.9
Annual Indicator	51.6	54.1	50.6	51.5
Numerator				
Denominator				
Data Source	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2013	2014	2015	2017
Provisional or Final ?	Final	Final	Provisional	Final

Annual Objectives						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	62.0	62.0	63.0	63.0	64.0	64.0

Field Level Notes for Form 10 SPMs:

None

SPM 2 - Percent of facilities implementing patient safety recommendations

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	24.2	23.5	22.0	21.8	20.5

Field Level Notes for Form 10 SPMs:

None

SPM 3 - Number of non-clinical Maternal Morality Review Committee (MMRC) recommendations implemented

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	5.0	6.0	7.0	7.0	8.0

Field Level Notes for Form 10 SPMs:

None

SPM 4 - Percent of staff reporting high or very high understanding of suicide warning signs post training

Measure Status:	Active

Baseline data was not available/provided.

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

Field Level Notes for Form 10 SPMs:

None

SPM 5 - Percent of community level recommendations implemented

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	12.5	12.5	20.0	20.0	25.0

Field Level Notes for Form 10 SPMs:

None

SPM 6 - Percent of newborns who initiated breastfeeding

Measure Status:	Active

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

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	80.7	81.2	81.7	82.2	82.7	83.2

Field Level Notes for Form 10 SPMs:

None

SPM 7 - Percent of WIC infants breastfeeding at six months

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	26.6	27.1	27.6	28.1	28.6

Field Level Notes for Form 10 SPMs:

None

SPM 8 - Composite score of maternity care practices and policies

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	72.0	74.0	74.0	76.0	76.0

Field Level Notes for Form 10 SPMs:

None

SPM 9 - Percent of time-critical presumed positive dried blood spot specimen results reported out by day of life 5

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	85.5	86.5	87.5	88.5	89.5

Field Level Notes for Form 10 SPMs:

None

SPM 10 - Percent of dried blood spot specimen results reported out by day of life 7

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	92.0	93.0	94.0	95.0	96.0

Field Level Notes for Form 10 SPMs:

None

SPM 11 - Number of evidence-based home visiting workforce receiving IMH Endorsement ®

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	25.0	25.0	25.0	25.0	25.0

Field Level Notes for Form 10 SPMs:

None

SPM 12 - Percent of state LEA elementary and middle schools that provide or require daily physical education

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	7.5	8.8	10.0	11.3	12.5

Field Level Notes for Form 10 SPMs:

None

SPM 13 - Percent of state LEA secondary schools that do not sell less healthy foods and beverages

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	54.7	55.1	55.5	55.9	56.3

Field Level Notes for Form 10 SPMs:

None

SPM 14 - Percent of children with two or more ACEs

Measure Status:	Active

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

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	23.0	22.5	22.0	21.6	21.2	21.0

Field Level Notes for Form 10 SPMs:

None

SPM 15 - Percent of substantiated child maltreatment cases among families served by home visiting programs

Measure Status:	Active

Baseline data was not available/provided.

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

Field Level Notes for Form 10 SPMs:

None

SPM 16 - Percent of caregiver substance abuse among families served by home visiting programs

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	12.0	12.0	11.0	11.0	11.0

Field Level Notes for Form 10 SPMs:

None

SPM 17 - Percent of caregivers who experience intimate partner violence and do not receive professional support services among families served by home visiting

Measure Status:	Active

Baseline data was not available/provided.

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

Field Level Notes for Form 10 SPMs:

None

SPM 18 - Percent of caregivers with depression who receive referrals for services

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	90.0	91.0	92.0	93.0	95.0

Field Level Notes for Form 10 SPMs:

None

SPM 19 - Percent of high school students currently using cigarettes

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	6.4	5.8	5.3	4.8	4.3

Field Level Notes for Form 10 SPMs:

None

SPM 20 - Percent of high school students currently using e-cigarettes

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	18.0	17.9	17.8	17.8	17.7

Field Level Notes for Form 10 SPMs:

None

SPM 21 - Number of adolescents enrolled in cessation program

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	0.0	20.0	50.0	100.0	125.0

Field Level Notes for Form 10 SPMs:

None

SPM 22 - Number of providers adopting the medical home approach in their practice

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	650.0	800.0	950.0	1,100.0	1,250.0

Field Level Notes for Form 10 SPMs:

None

SPM 23 - Number of CYSHCN receiving care in a medical home

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	800.0	850.0	900.0	950.0	1,000.0

Field Level Notes for Form 10 SPMs:

None

SPM 24 - Number of families confident speaking to their provider

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	400.0	450.0	500.0	550.0	600.0

Field Level Notes for Form 10 SPMs:

None

SPM 25 - Number of providers providing resources and behavioral and mental health referrals

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	600.0	700.0	800.0	900.0	1,000.0

Field Level Notes for Form 10 SPMs:

None

SPM 26 - Number of care coordinators with increased knowledge

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	175.0	200.0	225.0	250.0	275.0

Field Level Notes for Form 10 SPMs:

None

SPM 27 - Number of vendors with increased knowledge

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	650.0	700.0	750.0	800.0	850.0

Field Level Notes for Form 10 SPMs:

None

SPM 28 - Number of children who complete an annual visit with their primary care provider

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	800.0	850.0	900.0	950.0	1,000.0

Field Level Notes for Form 10 SPMs:

None

SPM 29 - Number of YSHCN receiving transition services

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	50.0	75.0	100.0	125.0	150.0

Field Level Notes for Form 10 SPMs:

None

SPM 30 - Number of transition self-advocates

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	20.0	25.0	30.0	35.0	40.0

Field Level Notes for Form 10 SPMs:

None

Form 10
State Outcome Measures (SOMs)

State: Tennessee

SOM 1 - Rate of pregnancy-related mortality to live births

Measure Status:	Active

Baseline data was not available/provided.

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

Field Level Notes for Form 10 SOMs:

None

SOM 2 - Number of pregnancy-associated, but not related, deaths

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	49.0	48.0	48.0	45.0	42.0

Field Level Notes for Form 10 SOMs:

None

SOM 3 - Rate of pregnancy-associated mortality

Measure Status:	Active

Baseline data was not available/provided.

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

Field Level Notes for Form 10 SOMs:

None

SOM 4 - Number of public school 6th graders who are overweight or obese

Measure Status:	Active

Baseline data was not available/provided.

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

Field Level Notes for Form 10 SOMs:

None

SOM 5 - Percent of adults with Major Depressive Episode

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	7.1	7.0	6.9	6.8	6.7

Field Level Notes for Form 10 SOMs:

None

SOM 6 - Percent of adults reporting Chronic obstructive pulmonary disease (COPD)

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	9.3	9.2	9.1	9.0	8.9

Field Level Notes for Form 10 SOMs:

None

SOM 7 - Percent of adults reporting cardiovascular disease

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	5.3	5.3	5.3	5.2	5.2

Field Level Notes for Form 10 SOMs:

None

SOM 8 - Age-adjusted mortality rate from tobacco-attributable cancers among Tennesseans aged 35+

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	176.4	171.4	166.4	161.3	156.3

Field Level Notes for Form 10 SOMs:

None

Form 10
Evidence-Based or –Informed Strategy Measure (ESM)

State: Tennessee

ESM 1.1 - Toolkit developed and distributed to help family planning clinics reduce barriers to care among males, teens and LGBTQ+ persons

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	Yes	No	No	No	No

Field Level Notes for Form 10 ESMs:

None

ESM 1.2 - Percent of family planning providers trained to use reproductive life plan assessments

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	0.0	80.0	80.0	80.0	80.0

Field Level Notes for Form 10 ESMs:

None

ESM 1.3 - Percent of family planning visits that occur via telehealth at pilot sites

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	10.0	15.0	20.0	25.0	30.0

Field Level Notes for Form 10 ESMs:

None

ESM 1.4 - Person-Centered Contraceptive Counseling Measure survey piloted at one Title X site

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	Yes	No	No	No	No

Field Level Notes for Form 10 ESMs:

None

ESM 1.5 - Family planning information packet created for distribution at TennCare (medicaid) presumptive eligibility visits

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	Yes	No	No	No	No

Field Level Notes for Form 10 ESMs:

None

ESM 1.6 - Number of presentations provided to Sexual Risk Avoidance Education and Rape Prevention Education sub-grantees on TDH-funded family planning services

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	22.0	22.0	22.0	22.0	22.0

Field Level Notes for Form 10 ESMs:

None

ESM 1.7 - Percent of Tennessee Breast and Cervical Screening Program vendors educated on TDH-funded family planning services

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	20.0	40.0	60.0	80.0	100.0

Field Level Notes for Form 10 ESMs:

None

ESM 1.8 - Percent of family planning providers trained on trauma-informed care

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	80.0	80.0	80.0	80.0	80.0

Field Level Notes for Form 10 ESMs:

None

ESM 1.9 - Number of workgroup meetings held by the TDH Family Planning Program and the Tennessee Department of Mental Health and Substance Abuse (TDMHSA)

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	1.0	2.0	2.0	2.0	2.0

Field Level Notes for Form 10 ESMs:

None

ESM 1.10 - Number of recommendations provided as real-time alerts

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	4.0	4.0	4.0	4.0	4.0

Field Level Notes for Form 10 ESMs:

None

ESM 1.11 - Number of simulation trainings

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	1.0	2.0	3.0	3.0	4.0

Field Level Notes for Form 10 ESMs:

None

ESM 1.12 - Number of presentations completed by the speaker’s bureau

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	15.0	20.0	25.0	30.0	35.0

Field Level Notes for Form 10 ESMs:

None

ESM 1.13 - Number of high-risk obstetric consultations

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	8,400.0	8,820.0	9,261.0	9,724.0	10,210.0

Field Level Notes for Form 10 ESMs:

None

ESM 1.14 - Number of Maternal Health Task Force members

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	80.0	85.0	90.0	95.0	100.0

Field Level Notes for Form 10 ESMs:

None

ESM 1.15 - Number of community agencies funded to implement Maternal Mortality Review Committee (MMRC) recommendations

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	5.0	5.0	5.0	5.0	5.0

Field Level Notes for Form 10 ESMs:

None

ESM 1.16 - Percent of CHANT and EBHV participants screened for depression

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	94.0	95.0	97.0	98.0	100.0

Field Level Notes for Form 10 ESMs:

None

ESM 1.17 - Number of CHANT and EBHV staff trained on Question, Persuade, Refer suicide prevention

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	225.0	250.0	250.0	275.0	275.0

Field Level Notes for Form 10 ESMs:

None

ESM 1.18 - Number of women applying for presumptive eligibility

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	12,700.0	12,700.0	12,700.0	12,700.0	12,700.0

Field Level Notes for Form 10 ESMs:

None

ESM 1.19 - Percent of identified maternal deaths reviewed

Measure Status:	Active

Baseline data was not available/provided.

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

Field Level Notes for Form 10 ESMs:

None

ESM 1.20 - Number of recommendations implemented for preventing maternal deaths

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	7.0	9.0	11.0	13.0	13.0

Field Level Notes for Form 10 ESMs:

None

ESM 1.21 - Number of documents disseminated with health disparity data

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	2.0	3.0	3.0	4.0	4.0

Field Level Notes for Form 10 ESMs:

None

ESM 3.1 - Number of hospitals participating in the Opioid Exposed Newborns and/or Opioid Use Disorder projects

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	18.0	18.0	0.0	0.0	0.0

Field Level Notes for Form 10 ESMs:

None

ESM 3.3 - Perinatal regionalization guidelines revised

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	No	No	No	No	Yes

Field Level Notes for Form 10 ESMs:

None

ESM 3.4 - Number of regional perinatal center neonatal instructor hours delivered

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	5,000.0	5,000.0	5,000.0	5,000.0	5,000.0

Field Level Notes for Form 10 ESMs:

None

ESM 3.5 - Percent of newborns with a positive dried blood spot (DBS) screen who receive follow-up to definitive diagnosis and clinical case management

Measure Status:	Active

Baseline data was not available/provided.

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

Field Level Notes for Form 10 ESMs:

None

ESM 3.6 - Percent of facilities (with unsatisfactory dried blood spot rate >10 percent) who received education and consultative outreach

Measure Status:	Active

Baseline data was not available/provided.

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

Field Level Notes for Form 10 ESMs:

None

ESM 3.7 - Average number of hours transit time (from collection site to state laboratory) for NBS dried blood spot specimen

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	38.5	38.0	37.5	37.0	36.5

Field Level Notes for Form 10 ESMs:

None

ESM 4.1 - Number of average monthly calls to Tennessee Breastfeeding Hotline (TBH)

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	450.0	475.0	500.0	525.0	550.0

Field Level Notes for Form 10 ESMs:

None

ESM 4.2 - Number of birthing hospitals with a Memorandum of Understanding (MOU) for onsite breastfeeding peer counselor support

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	4.0	6.0	8.0	10.0	12.0

Field Level Notes for Form 10 ESMs:

None

ESM 4.3 - Percent of NICU-admitted infants breastfed at hospital discharge

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	75.1	75.3	75.5	75.7	75.9

Field Level Notes for Form 10 ESMs:

None

ESM 4.4 - Number of Tennessee birthing hospitals that have implemented > 5 Steps to Breastfeeding Success

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	38.0	39.0	40.0	41.0	42.0

Field Level Notes for Form 10 ESMs:

None

ESM 4.5 - Percent of health care providers who complete 20-hour lactation education training

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	74.3	76.2	78.1	80.0	82.0

Field Level Notes for Form 10 ESMs:

None

ESM 4.6 - Number of credentialed lactation professionals within WIC

Measure Status:	Active

Baseline data was not available/provided.

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

Field Level Notes for Form 10 ESMs:

None

ESM 4.7 - Lactation education developed for health care curriculum

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	Yes	No	No	No	No

Field Level Notes for Form 10 ESMs:

None

ESM 4.8 - WIC Breastfeeding Buddy Program piloted in three counties

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	Yes	No	No	No	No

Field Level Notes for Form 10 ESMs:

None

ESM 4.9 - Unique Designated Breastfeeding Expert for each county

Measure Status:	Active

Baseline data was not available/provided.

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

Field Level Notes for Form 10 ESMs:

None

ESM 4.10 - Number of minority-owned or rural businesses with Breastfeeding Welcomed Here (BFWH) designation

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	853.0	878.0	903.0	928.0	953.0

Field Level Notes for Form 10 ESMs:

None

ESM 4.11 - WIC telehealth services implemented in rural areas

Measure Status:	Active

Baseline data was not available/provided.

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

Field Level Notes for Form 10 ESMs:

None

ESM 4.12 - Mental Health resource referral list provided to Tennessee Breastfeeding Hotline (TBH)

Measure Status:	Active

Baseline data was not available/provided.

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

Field Level Notes for Form 10 ESMs:

None

ESM 4.13 - Breastfeeding Welcomed Here (BFWH)-designated businesses surveyed to assess workplace lactation policies

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	Yes	No	No	No	No

Field Level Notes for Form 10 ESMs:

None

ESM 4.14 - Recognition process implemented for Breastfeeding Welcomed Here (BFWH)-designated businesses

Measure Status:	Active

Baseline data was not available/provided.

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

Field Level Notes for Form 10 ESMs:

None

ESM 5.1 - Percent of hospitals receiving national recognition or implementing approved safe sleep policy

Measure Status:	Active

Baseline data was not available/provided.

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

Field Level Notes for Form 10 ESMs:

None

ESM 5.2 - Number of educational materials distributed

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	240,000.0	240,000.0	240,000.0	240,000.0	240,000.0

Field Level Notes for Form 10 ESMs:

None

ESM 5.3 - Number of elderly caregivers trained

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	25.0	25.0	25.0	25.0	25.0

Field Level Notes for Form 10 ESMs:

None

ESM 5.4 - Number of local housing authorities trained on Direct On Scene Education (DOSE)

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	7.0	7.0	7.0	7.0	7.0

Field Level Notes for Form 10 ESMs:

None

ESM 5.5 - Number of first responders trained on Direct On Scene Education (DOSE)

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	7.0	7.0	7.0	7.0	7.0

Field Level Notes for Form 10 ESMs:

None

ESM 5.6 - Number of hospitals participating in the Safe to Sleep module

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	13.0	15.0	15.0	0.0	0.0

Field Level Notes for Form 10 ESMs:

None

ESM 5.7 - Maintain affiliate state licensure with the Alliance for the Advancement of Infant Mental Health

Measure Status:	Active

Baseline data was not available/provided.

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

Field Level Notes for Form 10 ESMs:

None

ESM 5.8 - Number of reflective supervision cohort groups held

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	72.0	72.0	72.0	72.0	72.0

Field Level Notes for Form 10 ESMs:

None

ESM 8.1.1 - Number of physical activity clubs or completed built environment projects

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	575.0	632.0	692.0	752.0	812.0

Field Level Notes for Form 10 ESMs:

None

ESM 8.1.2 - Number of LEAs receiving professional development on physical education and physical activity

Measure Status:	Active

Baseline data was not available/provided.

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

Field Level Notes for Form 10 ESMs:

None

ESM 8.1.3 - Number of Public Health Educators and LEA staff receiving professional education in healthy lifestyle choices before, during, and after school hours

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	50.0	100.0	150.0	200.0	250.0

Field Level Notes for Form 10 ESMs:

None

ESM 8.1.4 - Number of Gold Sneaker certified childcare facilities

Measure Status:	Active

Baseline data was not available/provided.

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

Field Level Notes for Form 10 ESMs:

None

ESM 8.1.5 - Number of Healthy Parks Healthy Person prescriptions written

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	50.0	110.0	180.0	260.0	350.0

Field Level Notes for Form 10 ESMs:

None

ESM 8.1.6 - Number of Healthy Parks Healthy Person app users

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	1,800.0	1,870.0	1,950.0	2,040.0	2,140.0

Field Level Notes for Form 10 ESMs:

None

ESM 8.1.7 - Number of primary prevention plans with a goal related to reducing sugary drink consumption

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	12.0	14.0	16.0	18.0	20.0

Field Level Notes for Form 10 ESMs:

None

ESM 8.1.8 - Number of partners to develop and implement strategies that increase access to healthier community food and beverage options

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	235.0	255.0	275.0	295.0	315.0

Field Level Notes for Form 10 ESMs:

None

ESM 8.1.9 - Number of LEAs that have a policy/protocal for joint use agreements of facilities

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	126.0	128.0	130.0	132.0	134.0

Field Level Notes for Form 10 ESMs:

None

ESM 8.1.10 - Number of LHDs receiving training, resources, and tools to promote the mental health benefits of physical activity

Measure Status:	Active

Baseline data was not available/provided.

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

Field Level Notes for Form 10 ESMs:

None

ESM 8.1.11 - Number of LEAs receiving professional development on mental health benefits of physical activity

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	8.0	16.0	24.0	32.0	40.0

Field Level Notes for Form 10 ESMs:

None

ESM 8.1.12 - ACEs online curriculum developed and implemented

Measure Status:	Active

Baseline data was not available/provided.

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

Field Level Notes for Form 10 ESMs:

None

ESM 8.1.13 - Trauma informed care online curriculum developed and implemented

Measure Status:	Active

Baseline data was not available/provided.

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

Field Level Notes for Form 10 ESMs:

None

ESM 8.1.14 - Percent of child fatality teams provided ACEs refresher training

Measure Status:	Active

Baseline data was not available/provided.

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

Field Level Notes for Form 10 ESMs:

None

ESM 8.1.15 - Number of families enrolled in a home visiting program

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	2,000.0	2,300.0	2,400.0	2,500.0	2,700.0

Field Level Notes for Form 10 ESMs:

None

ESM 8.1.16 - Number of families enrolled in a home visiting program for at least 14 months

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	450.0	550.0	650.0	750.0	850.0

Field Level Notes for Form 10 ESMs:

None

ESM 8.1.17 - Percent of families with improved protective factors score

Measure Status:	Active

Baseline data was not available/provided.

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

Field Level Notes for Form 10 ESMs:

None

ESM 8.1.18 - Percent of families enrolled in CHANT care coordination

Measure Status:	Active

Baseline data was not available/provided.

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

Field Level Notes for Form 10 ESMs:

None

ESM 8.1.19 - Percent of uninsured people who enroll into a health insurance plan

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	18.0	19.0	20.0	21.0	22.0

Field Level Notes for Form 10 ESMs:

None

ESM 8.1.20 - Percent of people with an employment need referred to employment services

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	17.0	18.0	19.0	20.0	21.0

Field Level Notes for Form 10 ESMs:

None

ESM 8.1.21 - Percent of people with a housing need referred to a housing agency

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	3.0	4.0	5.0	6.0	7.0

Field Level Notes for Form 10 ESMs:

None

ESM 8.1.22 - Percent of caregivers screened for depression

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	80.0	81.0	81.5	85.5	86.0

Field Level Notes for Form 10 ESMs:

None

ESM 8.1.23 - Percent of caregivers who screen positive for depression and receive a referral to mental health services

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	96.5	96.8	97.0	98.0	98.5

Field Level Notes for Form 10 ESMs:

None

ESM 11.1 - Number of people participating in the medical home learning collaborative

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	175.0	225.0	275.0	325.0	375.0

Field Level Notes for Form 10 ESMs:

None

ESM 11.2 - Number of medical home conference attendees

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	100.0	125.0	159.0	175.0	200.0

Field Level Notes for Form 10 ESMs:

None

ESM 11.3 - Number of non-Medicaid providers who receive technical assistance on medical home implementation

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	75.0	100.0	125.0	150.0	175.0

Field Level Notes for Form 10 ESMs:

None

ESM 11.4 - Number of providers and families educated on the medical home approach

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	600.0	700.0	800.0	900.0	1,000.0

Field Level Notes for Form 10 ESMs:

None

ESM 11.5 - Number of resources provided to families and providers

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	20.0	25.0	30.0	35.0	40.0

Field Level Notes for Form 10 ESMs:

None

ESM 11.6 - Number of medical home tool-kits distributed

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	600.0	700.0	800.0	900.0	1,000.0

Field Level Notes for Form 10 ESMs:

None

ESM 11.7 - Number of care coordination tool-kits distributed

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	175.0	200.0	225.0	250.0	275.0

Field Level Notes for Form 10 ESMs:

None

ESM 11.8 - Number of CYSHCN who receive CHANT/CSS care coordination

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	2,500.0	3,000.0	3,500.0	4,000.0	4,500.0

Field Level Notes for Form 10 ESMs:

None

ESM 11.9 - Number of CSS authorized vendors who receive medical home resources

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	650.0	700.0	750.0	800.0	850.0

Field Level Notes for Form 10 ESMs:

None

ESM 11.10 - Number of families provided education and resources on importance of medical home access and utilization

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	600.0	700.0	800.0	900.0	1,000.0

Field Level Notes for Form 10 ESMs:

None

ESM 11.11 - Number of families receiving referrals to their child's primary care provider

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	375.0	400.0	425.0	450.0	475.0

Field Level Notes for Form 10 ESMs:

None

ESM 11.12 - Number of families who schedule an annual visit with their child's primary care provider

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	375.0	400.0	425.0	450.0	475.0

Field Level Notes for Form 10 ESMs:

None

ESM 11.13 - Number of children who complete an annual visit with their primary care provider

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	375.0	400.0	425.0	450.0	475.0

Field Level Notes for Form 10 ESMs:

None

ESM 12.1 - Number of transition resources identified

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	25.0	35.0	45.0	55.0	65.0

Field Level Notes for Form 10 ESMs:

None

ESM 12.2 - Number of transition resource kits disseminated

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	150.0	300.0	600.0	1,200.0	2,400.0

Field Level Notes for Form 10 ESMs:

None

ESM 12.3 - Number of youth with special health care needs receiving transition training

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	75.0	100.0	125.0	150.0	175.0

Field Level Notes for Form 10 ESMs:

None

ESM 12.4 - Number of Youth Advisory Council members with special healthcare needs

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	25.0	25.0	25.0	25.0	25.0

Field Level Notes for Form 10 ESMs:

None

ESM 12.5 - Number of youth with special health care needs trained as mentors

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	25.0	35.0	45.0	55.0	65.0

Field Level Notes for Form 10 ESMs:

None

ESM 12.6 - Number of parents and youth with special health care needs who receive leadership and self-advocacy training

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	50.0	75.0	100.0	125.0	150.0

Field Level Notes for Form 10 ESMs:

None

ESM 14.2.1 - Number of tobacco-free sports teams

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	79.0	81.0	83.0	85.0	88.0

Field Level Notes for Form 10 ESMs:

None

ESM 14.2.2 - Number of ambassadors recruited

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	26.0	26.0	26.0	26.0	26.0

Field Level Notes for Form 10 ESMs:

None

ESM 14.2.3 - Number of youth councils

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	72.0	74.0	76.0	78.0	80.0

Field Level Notes for Form 10 ESMs:

None

ESM 14.2.4 - Number of youth-created PSAs

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	2.0	5.0	5.0	10.0	10.0

Field Level Notes for Form 10 ESMs:

None

ESM 14.2.5 - Number of youth who attend the state anti-tobacco conference

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	75.0	300.0	300.0	350.0	400.0

Field Level Notes for Form 10 ESMs:

None

ESM 14.2.6 - Number of trainings educating youth on tobacco issues

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	5.0	10.0	10.0	10.0	10.0

Field Level Notes for Form 10 ESMs:

None

ESM 14.2.7 - Number of anti-tobacco social media posts

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	6.0	21.0	12.0	24.0	24.0

Field Level Notes for Form 10 ESMs:

None

ESM 14.2.8 - Number of meetings with partners to increase screening and referral of adolescents using tobacco to cessation resources

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	2.0	2.0	2.0	2.0	2.0

Field Level Notes for Form 10 ESMs:

None

ESM 14.2.9 - Number of meetings with partners to expand data collection

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	2.0	2.0	2.0	2.0	2.0

Field Level Notes for Form 10 ESMs:

None

ESM 14.2.10 - Number of social media posts promoting text-based cessation services

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	6.0	12.0	12.0	24.0	24.0

Field Level Notes for Form 10 ESMs:

None

ESM 14.2.11 - Number of meetings with partner organizations to enhance tobacco activities in coalition action plans

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	2.0	2.0	2.0	2.0	2.0

Field Level Notes for Form 10 ESMs:

None

ESM 14.2.12 - Number of new materials added to partner media library

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	2.0	4.0	6.0	8.0	10.0

Field Level Notes for Form 10 ESMs:

None

ESM 14.2.13 - Number of meetings with potential new partner organizations

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	2.0	2.0	2.0	2.0	2.0

Field Level Notes for Form 10 ESMs:

None

ESM 14.2.14 - Number of Question Persuade Refer (QPR) trainings

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	1.0	1.0	2.0	2.0	2.0

Field Level Notes for Form 10 ESMs:

None

ESM 14.2.15 - Number of meetings with internal stakeholders on protocols for screening and referring adolescents for mental health disorders and services

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	1.0	1.0	1.0	1.0	1.0

Field Level Notes for Form 10 ESMs:

None

Form 10
Evidence-Based or -Informed Strategy Measures (ESMs) (2016-2020 Needs Assessment Cycle)

2016-2020: ESM 1.1 - Number of press releases, PSAs and/or social media messages promoting preventive health care visits for women of reproductive age

Measure Status:			**Active**	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective			9	20
Annual Indicator	6	46	21	21
Numerator				
Denominator				
Data Source	TDH FHW Womens Health Section Program Data	TDH FHW Womens Health Section Program Data	TDH FHW Womens Health Section Program Data	TDH FHW Womens Health Section Program Data
Data Source Year	FFY2016	FFY2017	2017	2018
Provisional or Final ?	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

Field Note:
FY2018 performance based on data from 7/1 through 12/31 2017

2016-2020: ESM 1.2 - Number of webinars for providers on increasing preventive care visits among women in their clinics

Measure Status:			**Active**	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective				2
Annual Indicator	0	7	22	33
Numerator				
Denominator				
Data Source	TDH FHW Womens Health Section Program Data	TDH FHW Womens Health Section Program Data	TDH FHW Womens Health Section Program Data	TDH FHW Womens Health Section Program Data
Data Source Year	FFY2016	FFY2017	2017	2018
Provisional or Final ?	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

Field Note:
FY2018 performance based on data from 7/1 through 12/31 2017

2016-2020: ESM 1.3 - Number of site-level family planning utilization reports distributed to local health departments

Measure Status:			**Active**	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective		4	4	2
Annual Indicator	0	2	2	2
Numerator				
Denominator				
Data Source	TDH FHW Womens Health Section Program Data	TDH FHW Womens Health Section Program Data	TDH FHW Womens Health Section Program Data	TDH FHW Womens Health Section Program Data
Data Source Year	FFY2016	FFY2017	2017	2018
Provisional or Final ?	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

Field Note:
FY2018 performance based on data from 7/1 through 12/31 2017

2016-2020: ESM 1.4 - Number of region-level pregnancy-related service utilization reports distributed to regional health departments

Measure Status:			Active	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective		4	4	2
Annual Indicator	4	4	2	2
Numerator				
Denominator				
Data Source	TDH FHW Womens Health Section Program Data	TDH FHW Womens Health Section Program Data	TDH FHW Womens Health Section Program Data	TDH FHW Womens Health Section Program Data
Data Source Year	FFY2016	FFY2017	2017	2018
Provisional or Final ?	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

Field Note:
FY2018 performance based on data from 7/1 through 12/31 2017

2016-2020: ESM 5.1 - Number of safe sleep educational material distributed

Measure Status:			Active	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective				80,000
Annual Indicator	226,881	257,694	317,334	311,629
Numerator				
Denominator				
Data Source	TDH FHW Injury Prevention Section Program Data	TDH FHW Injury Prevention Section Program Data	TDH FHW Injury Prevention Section Program Data	TDH FHW Injury Prevention Section Program Data
Data Source Year	FFY2016	FFY2017	FFY2018	FFY2019
Provisional or Final ?	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 5.2 - Percent of infant deaths to be reviewed by child fatality review teams

Measure Status:			**Active**	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective		100	100	100
Annual Indicator	100	100	100	100
Numerator				
Denominator				
Data Source	TDH FHW Injury Section Program Data - CFR Report	TDH FHW Injury Prevention Section Program Data	TDH FHW Injury Prevention Section Program Data	TDH FHW Injury Prevention Section Program Data
Data Source Year	CY2016	CY2017	CY2018	CY2019
Provisional or Final ?	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 5.3 - Percent of VLBW (Very Low Birth Weight) infants being delivered at Level III or IV birthing facilities

Measure Status:			Active	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective		80	80	85
Annual Indicator	84	85	85	84
Numerator				
Denominator				
Data Source	TDH PPA - Birth Statistical System	TDH PPA - Birth Statistical System	TDH PHA - Birth Statistical System	TDH PHA - Birth Statistical System
Data Source Year	FFY2016	FFY2017	FFY2018	FFY2019
Provisional or Final ?	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 5.4 - Percent of newborns with a positive metabolic screen who receive follow-up to definitive diagnosis and clinical management

Measure Status:			**Active**	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective		100	100	100
Annual Indicator	100	100	100	100
Numerator				
Denominator				
Data Source	TDH FHW Perinatal Health Section Program Data	TDH FHW Perinatal Health Section Program Data	TDH FHW Perinatal Health Section Program Data	TDH FHW Perinatal Health Section Program Data
Data Source Year	CY2016	CY2017	CY2018	CY2019
Provisional or Final ?	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 5.5 - Number of individuals served by the Tennessee Adolescent Pregnancy Prevention Program (TAPPP)

Measure Status:			**Active**	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective				46,500
Annual Indicator	45,881	47,159	55,583	47,597
Numerator				
Denominator				
Data Source	TDH FHW Womens Health Section Program Data	TDH FHW Womens Health Section Program Data	TDH FHW Womens Health Section Program Data	TDH FHW Womens Health Section Program Data
Data Source Year	FFY2015	FFY2016	FFY2017	FFY2018
Provisional or Final ?	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

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

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

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
The data collection system changed in 2019, numbers may not be comparable to previous years.

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

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

Field Level Notes for Form 10 ESMs:

None

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

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

Field Level Notes for Form 10 ESMs:

None

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

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

Field Level Notes for Form 10 ESMs:

None

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

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

Field Level Notes for Form 10 ESMs:

None

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

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

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 7.2.1 - Number of schools in the top ten crash rate counties (among ages 15-18) that conduct evidence-informed teen safe driving programming

Measure Status:			**Active**	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective				59
Annual Indicator	46	43	48	53
Numerator				
Denominator				
Data Source	ReduceTNCrashes.org Safe Driving Report	ReduceTNCrashes.org Safe Driving Report	ReduceTNCrashes.org Safe Driving Report	ReduceTNCrashes.org Safe Driving Report
Data Source Year	FFY2016	FFY2017	FFY2018	FFY2019
Provisional or Final ?	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 7.2.2 - Number of drug disposal bins installed statewide

Measure Status:			Active	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective				326
Annual Indicator	206	236	311	350
Numerator				
Denominator				
Data Source	TN Depart of Environmental and Conservation Report	TN Depart of Environmental and Conservation Report	TN Depart of Environmental and Conservation Report	TN Depart of Environmental and Conservation Report
Data Source Year	FFY2106	FFY2017	FFY2018	FFY2019
Provisional or Final ?	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 7.2.3 - Number of press releases, social media posts and presentations about adolescent falls

Measure Status:			**Active**	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective				7
Annual Indicator	8	9	22	16
Numerator				
Denominator				
Data Source	TN Depart of Environmental and Conservation Report	TN Depart of Environmental and Conservation Report	TN Depart of Environmental and Conservation Report	TN Depart of Environmental and Conservation Report
Data Source Year	FFY2106	FFY2017	FFY2018	FFY2019
Provisional or Final ?	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 7.2.4 - Number of suicide-related articles, social media posts and trainings provided by TDH

Measure Status:			Active	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective				20
Annual Indicator	11	19	28	28
Numerator				
Denominator				
Data Source	TDH FHW Injury Prevention Section Program Data	TDH FHW Injury Prevention Section Program Data	TDH FHW Injury Prevention Section Program Data	TDH FHW Injury Prevention Section Program Data
Data Source Year	FFY2016	FFY2017	FFY2018	FFY2019
Provisional or Final ?	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 8.1.1 - Number of Gold Sneaker-recognized childcare facilities in Tennessee

Measure Status:			**Active**	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective				575
Annual Indicator	441	474	501	306
Numerator				
Denominator				
Data Source	TDH FHW Chronic Disease Program Data	TDH FHW Chronic Disease Program Data	TDH FHW Chronic Disease Program Data	TDH FHW Chronic Disease Program Data
Data Source Year	FFY2016	FFY2017	FFY2018	FFY2019
Provisional or Final ?	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 8.1.2 - Average number of monthly calls to the Tennessee Breastfeeding Hotline (TBH)

Measure Status:			**Active**	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective				525
Annual Indicator	485	523	520	475
Numerator				
Denominator				
Data Source	TDH FHW SupplementalNutrition Section Program Data	TDH FHW SupplementalNutrition Section Program Data	TDH FHW SupplementalNutrition Section Program Data	TDH FHW SupplementalNutrition Section Program Data
Data Source Year	FFY2016	FFY2017	FFY2018	FFY2019
Provisional or Final ?	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 8.1.3 - Number of Baby Friendly-designated Tennessee birthing hospitals

Measure Status:			Active	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective				8
Annual Indicator	2	2	6	6
Numerator				
Denominator				
Data Source	Baby Friendly USA, Inc.	Baby Friendly USA, Inc.	Baby Friendly USA, Inc.	Baby Friendly USA, Inc.
Data Source Year	FFY2106	FFY2017	FFY2018	FFY2019
Provisional or Final ?	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 8.2.1 - Number of Physical Activity Clubs in K-12 schools

Measure Status:			**Active**	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective				234
Annual Indicator	47	111	209	253
Numerator				
Denominator				
Data Source	TDH FHW Chronic Disease Program Data	TDH FHW Chronic Disease Program Data	TDH FHW Chronic Disease Program Data	TDH FHW Chronic Disease Program Data
Data Source Year	FFY2016	FFY2017	FFY2018	FFY2019
Provisional or Final ?	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 8.2.2 - Number of school gardens in Tennessee public schools

Measure Status:			**Active**
State Provided Data			
	2017	**2018**	**2019**
Annual Objective			451
Annual Indicator	337	426	348
Numerator			
Denominator			
Data Source	DOE - Farm to School Program	DOE - Farm to School Program	DOE - Farm to School Program
Data Source Year	FFY2017	FFY2018	FFY2019
Provisional or Final ?	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 8.2.3 - Number of Healthy Parks Healthy Person app users

Measure Status:		Active	
State Provided Data			
	2017	**2018**	**2019**
Annual Objective			2,935
Annual Indicator	1,661	2,853	4,928
Numerator			
Denominator			
Data Source	TDEC Healthy Parks Healthy Person App	TDEC Healthy Parks Healthy Person App	TDEC Healthy Parks Healthy Person App
Data Source Year	FFY2017	FFY2018	FFY2019
Provisional or Final ?	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 11.1 - Number of providers trained and provided information on medical home implementation

Measure Status:			**Active**	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective				730
Annual Indicator	420	615	680	745
Numerator				
Denominator				
Data Source	TDH FHW Title V CYSHCN Program Data	TDH FHW Title V CYSHCN Program Data	TDH FHW Title V CYSHCN Program Data	TDH FHW Title V CYSHCN Program Data
Data Source Year	FFY2016	FFY2017	FFY2018	FFY2019
Provisional or Final ?	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 11.2 - Number of families that receive patient centered medical home training

Measure Status:			**Active**	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective				635
Annual Indicator	279	558	605	723
Numerator				
Denominator				
Data Source	TDH FHW Title V CYSHCN Program Data	TDH FHW Title V CYSHCN Program Data	TDH FHW Title V CYSHCN Program Data	TDH FHW Title V CYSHCN Program Data
Data Source Year	FFY2016	FFY2017	FFY2018	FFY2019
Provisional or Final ?	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 11.3 - Percentage of children served by the Children's Special Service (CSS) program receiving services in a medical home

Measure Status:			Active	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective		80	85	90
Annual Indicator	74	72.7	73.5	70.5
Numerator				
Denominator				
Data Source	TDH FHW Title V CYSHCN Program Data	TDH FHW Title V CYSHCN Program Data	TDH FHW Title V CYSHCN Program Data	TDH FHW Title V CYSHCN Program Data
Data Source Year	FFY2016	FFY2017	FFY2018	FFY2019
Provisional or Final ?	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 11.4 - Number of children referred from the Tennessee Birth Defects Surveillance System (TNBDSS) program that were linked to appropriate supportive services

Measure Status:	Active

Baseline data was not available/provided.

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 12.1 - Number of adolescents on the Adolescent Advisory Council

Measure Status:			**Active**	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective		5	7	9
Annual Indicator	7	7	7	14
Numerator				
Denominator				
Data Source	Title V CYSHCN Program Data	Title V CYSHCN Program Data	Title V CYSHCN Program Data	Title V CYSHCN Program Data
Data Source Year	FFY2016	FFY2017	FFY2018	FFY2019
Provisional or Final ?	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 12.2 - Number of providers who receive technical assistance and information on transition for youth and young adults with and without special health care needs

Measure Status:		Active	
State Provided Data			
	2017	**2018**	**2019**
Annual Objective		100	240
Annual Indicator	0	215	450
Numerator			
Denominator			
Data Source	no data	TDH FHW Title V CYSHCN Program Data	TDH FHW Title V CYSHCN Program Data
Data Source Year	no data	FFY2018	FFY2019
Provisional or Final ?	Provisional	Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 12.3 - Percentage of youth served by the Children's Special Services (CSS) program age 14 and older who have an annual transition plan

Measure Status:		Active	
State Provided Data			
	2017	**2018**	**2019**
Annual Objective			80
Annual Indicator	65	60	54
Numerator			
Denominator			
Data Source	TDH FHW Title V CYSHCN Program Data	TDH FHW Title V CYSHCN Program Data	TDH FHW Title V CYSHCN Program Data
Data Source Year	FFY2017	FFY2018	FFY2019
Provisional or Final ?	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 12.4 - Number of youths and parents/legal guardians who have completed the Transition Readiness Assessment tool

Measure Status:	Active

Baseline data was not available/provided.

Field Level Notes for Form 10 ESMs:

None

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

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

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 14.2.1 - Number of child care facilities that voluntarily implement a tobacco-free campus policy

Measure Status:			**Active**	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective				570
Annual Indicator	441	474	501	306
Numerator				
Denominator				
Data Source	TDH FHW Chronic Disease Program Data	TDH FHW Chronic Disease Program Data	TDH FHW Chronic Disease Program Data	TDH FHW Chronic Disease Program Data
Data Source Year	FFY2016	FFY2017	FFY2018	FFY2019
Provisional or Final ?	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 14.2.2 - Percent of primary caregivers enrolled in home visiting who reported using any tobacco products at enrollments and were referred to tobacco cessation counseling or services within three months of enrollment

Measure Status:			**Active**	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective		10	93	98.5
Annual Indicator	1.7	97.8	100	100
Numerator				
Denominator				
Data Source	TDH FHW Early Childhood Section Program Data	TDH FHW Early Childhood Section Program Data	TDH FHW Early Childhood Section Program Data	TDH FHW Early Childhood Section Program Data
Data Source Year	FFY2016	FFY2017	FFY2018	FFY2019
Provisional or Final ?	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**

Field Note:
Data collection quality was poor in FY2016. Over the past year training was conducted for evidenced-based home visiting staff across the state to improve their understanding of what was considered a referral. Due to this training recent preliminary analysis shows that data collection quality has improved.

Form 10
State Performance Measure (SPM) Detail Sheets

State: Tennessee

SPM 1 - Percent of new mothers whose pregnancy was intended
Population Domain(s) – Women/Maternal Health

Measure Status:	Active
Goal:	To increase the percentage of new mothers whose pregnancy was intended
Definition:	**Numerator:** Number of mothers reporting that their pregnancy was intended **Denominator:** Number of mothers that responded to the survey **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Pregnancy Risk Assessment Monitoring System (PRAMS)
Significance:	Unintended pregnancy is associated with increased risks for mothers and infants. If a woman is not planning to get pregnant, she may have unhealthy behaviors or delay getting health care during pregnancy, which can in turn affect her health and that of her infant. Most unintended pregnancies result from not using contraception or from not using it consistently or correctly. Family planning and contraceptive services provide social, economic, and health benefits and by allowing men and women to time and space the number of children they want, contraception prevents unintended, often high-risk pregnancies—too close together, too often, too early or too late in life—that can lead to maternal and child death and injury.

SPM 2 - Percent of facilities implementing patient safety recommendations
Population Domain(s) – Women/Maternal Health

Measure Status:	Active
Goal:	To reduce severe maternal morbidity and mortality through improved quality of care.
Definition:	**Numerator:** Number of birthing facilities implementing patient safety recommendations **Denominator:** Number of birthing facilities in Tennessee **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	MICH-5: Reduce the rate of maternal mortality. Baseline 12.7 maternal deaths per 100,000 live births in 2007. Target is 11.4 maternal deaths per 100,000 live births.
Data Sources and Data Issues:	Maternal Mortality Review Information Application (MMRIA) and Vital Records Birth Statistical System
Significance:	Healthcare and other community-based agencies are strategically poised to identify at-risk populations for severe maternal morbidity and maternal mortality. Therefore, supporting these agencies is important in the secondary prevention of severe maternal morbidity and maternal deaths. This measure will be calculated as number of agencies funded with details on the populations they reach/serve.

SPM 3 - Number of non-clinical Maternal Morality Review Committee (MMRC) recommendations implemented
Population Domain(s) – Women/Maternal Health

Measure Status:	Active
Goal:	To reduce severe maternal morbidity and mortality.
Definition:	**Numerator:** Number of non-clinical MMRC recommendations implemented **Denominator:** Number of non-clinical MMRC recommendations **Unit Type:** Count **Unit Number:** 8
Healthy People 2020 Objective:	MICH-5: Reduce the rate of maternal mortality. Baseline 12.7 maternal deaths per 100,000 live births in 2007. Target is 11.4 maternal deaths per 100,000 live births.
Data Sources and Data Issues:	Maternal Mortality Review Information Application (MMRIA)
Significance:	This measure is important in determining the number and types of recommendations that are implemented at the community-level. This measure can also provide information on recommendations that are yet to be implemented.

SPM 4 - Percent of staff reporting high or very high understanding of suicide warning signs post training
Population Domain(s) – Women/Maternal Health

Measure Status:	Active
Goal:	To prevent suicide by recognizing the warning signs and connection people to care.
Definition:	**Numerator:** Number staff who increase understanding **Denominator:** Number of staff trained **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	MICH-5: Reduce the rate of maternal mortality. Baseline 12.7 maternal deaths per 100,000 live births in 2007. Target is 11.4 maternal deaths per 100,000 live births.
Data Sources and Data Issues:	FHW Program data
Significance:	.

SPM 5 - Percent of community level recommendations implemented
Population Domain(s) – Women/Maternal Health

Measure Status:	Active
Goal:	To reduce severe maternal morbidity and mortality through community-level interventions.
Definition:	**Numerator:** Number of recommendations addressed at the community level **Denominator:** Number of recommendations addressed at the community level **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	MICH-5: Reduce the rate of maternal mortality. Baseline 12.7 maternal deaths per 100,000 live births in 2007. Target is 11.4 maternal deaths per 100,000 live births.
Data Sources and Data Issues:	Maternal Mortality Review Information Application (MMRIA)
Significance:	Healthcare and other community-based agencies are strategically poised to identify at-risk populations for severe maternal morbidity and maternal mortality. Therefore, supporting these agencies is important in the secondary prevention of severe maternal morbidity and maternal deaths. This measure will be calculated as number of agencies funded with details on the populations they reach/serve.

SPM 6 - Percent of newborns who initiated breastfeeding
Population Domain(s) – Perinatal/Infant Health

Measure Status:	Active
Goal:	To increase the percent of Tennessee newborns who initiated breastfeeding
Definition:	**Numerator:** Number of Tennessee newborns who initiated breastfeeding **Denominator:** Number of Tennessee newborns **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	Related to Maternal, Infant, and Child Health (MICH) Objective 1.3: Reduce the rate of all infant deaths (within 1 year) (Baseline: 6.7 infant deaths per 1,000 live births; Target: 6.0 infant deaths per 1,000 live births)
Data Sources and Data Issues:	Tennessee Birth Statistical System
Significance:	Breastfeeding has a multitude of health benefits for both mother and infant. Initiation of breastfeeding has been associated with a reduction in infant mortality, so breastfeeding promotion and support warrants inclusion as a strategy of infant mortality reduction efforts.

SPM 7 - Percent of WIC infants breastfeeding at six months
Population Domain(s) – Perinatal/Infant Health

Measure Status:	Active
Goal:	To increase the percent of Tennessee WIC infants with any breastfeeding at six months
Definition:	**Numerator:** Number of Tennessee WIC infants breastfeeding at six months **Denominator:** Number of Tennessee WIC infants six months of age **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	Related to Maternal, Infant, and Child Health (MICH) Objective 1.3: Reduce the rate of all infant deaths (within 1 year) (Baseline: 6.7 infant deaths per 1,000 live births; Target: 6.0 infant deaths per 1,000 live births) Related to Maternal, Infant, and Child Health (MICH) Objective 34: Reduce the rate of all infant deaths (within 1 year) (Baseline: 6.7 infant deaths per 1,000 live births; Target: 6.0 infant deaths per 1,000 live births)
Data Sources and Data Issues:	FHW Program Data
Significance:	Breastfeeding has been associated with reductions in infant mortality, specifically Sudden Infant Death Syndrome (SIDS). Mothers participating in WIC are less likely to initiate breastfeeding or have shorter duration periods. As nearly half of all infants born in Tennessee are on WIC, the program plays a pivotal role in promotion and support of breastfeeding through counseling and education, which can positively impact breastfeeding initiation and continuation.

SPM 8 - Composite score of maternity care practices and policies
Population Domain(s) – Perinatal/Infant Health

Measure Status:	Active
Goal:	To increase the composite score of maternity care practices and policies among Tennessee birthing hospitals
Definition:	**Numerator:** Composite score of maternity care practices and policies **Denominator:** n/a **Unit Type:** Scale **Unit Number:** 100
Healthy People 2020 Objective:	Related to Maternal, Infant, and Child Health (MICH) Objective 1.3: Reduce the rate of all infant deaths (within 1 year) (Baseline: 6.7 infant deaths per 1,000 live births; Target: 6.0 infant deaths per 1,000 live births)
Data Sources and Data Issues:	CDC Maternity Practices in Infant Nutrition and Care Survey
Significance:	A woman's maternity care experience can influence breastfeeding initiation, exclusivity, and duration. Improving maternity care practices that support breastfeeding (e.g., written policies, staff training, cue-based feeding) can positively influence infant feeding decisions postpartum.

SPM 9 - Percent of time-critical presumed positive dried blood spot specimen results reported out by day of life 5
Population Domain(s) – Perinatal/Infant Health

Measure Status:	Active
Goal:	To improve average (days) for report out to day of life 5 for time-critical presumed positives
Definition:	**Numerator:** Number of time-critical presumed positives results reported out by day of life 5 **Denominator:** Number of time-critical presumed positives **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	FHW program data
Significance:	For time-critical conditions, it is imperative to reduce amount of time needed from sample collection to report as much as possible. Any delays could lead to meaningful gaps in treatment.

SPM 10 - Percent of dried blood spot specimen results reported out by day of life 7
Population Domain(s) – Perinatal/Infant Health

Measure Status:	Active
Goal:	To improve average (days) for report out to day of life 7 for all conditions
Definition:	**Numerator:** Number of dried blood spot specimen results reported out by day of life 7 **Denominator:** Number of dried blood spot specimen results **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	FHW Program data
Significance:	To allow for timely diagnosis and treatment, it is important for newborn screening results to be available as quickly as possible. With early identification and therapy, most infants with genetic and metabolic disorders can go on to live normal, healthy lives. The goal for all conditions screened for is to report by the infant's seventh day of life.

SPM 11 - Number of evidence-based home visiting workforce receiving IMH Endorsement ®
Population Domain(s) – Perinatal/Infant Health

Measure Status:	Active
Goal:	To increase number of evidence-based home visiting workforce receiving IMH Endorsement ®
Definition:	**Numerator:** Number of evidence-based home visiting workforce receiving IMH Endorsement ® **Denominator:** n/a **Unit Type:** Count **Unit Number:** 25
Data Sources and Data Issues:	FHW Program data
Significance:	The Infant Mental Health Endorsement® system that the Association of Infant Mental Health in Tennessee (AIMHiTN) facilitates in Tennessee establishes a professional standard for infant mental health professionals. Supporting the development of positive infant mental health helps guide the development of healthy social and emotional behaviors. Having more evidence-based home visiting staff with this training will support the attachment relationship between the infant and the caregiver(s).

SPM 12 - Percent of state LEA elementary and middle schools that provide or require daily physical education
Population Domain(s) – Child Health

Measure Status:	Active
Goal:	Increase the percentage of State LEA elementary and middle schools that provide or require daily physical education
Definition:	**Numerator:** Number of State LEA elementary and middle schools that provide or require daily physical education **Denominator:** Number of State LEA elementary and middle schools **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	NWS 10 (10.1, 10.2): Children ages 2-11 who have obesity; PA 4 (4.1, 4.2): Elementary and middle schools requiring daily physical education; PA 6: regularly scheduled elementary school recess
Data Sources and Data Issues:	The Coordinated School Health (CSH) annual Quality Physical Education Survey; the survey is completed by only one physical education teacher at each LEA school, and there is no independent verification or standard definition of what daily physical education might entail.
Significance:	Given the huge proportion of the week that most children spend in school, a policy for daily physical education can go a long way toward satisfying the daily standard for physical activity within the elementary and middle school age groups. The numerator value will be a simple count of LEA elementary and middle schools indicating on the Quality Physical Education Survey that they provide daily physical education for their students. The denominator will be the number of schools completing the survey and providing a valid response for the daily physical education question.

SPM 13 - Percent of state LEA secondary schools that do not sell less healthy foods and beverages
Population Domain(s) – Child Health

Measure Status:	Active
Goal:	Increase the percentage of state LEA secondary schools that do not sell less healthy foods and beverages
Definition:	**Numerator:** Number of state LEA secondary schools that do not sell less healthy foods and beverages **Denominator:** Number of state LEA secondary schools **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	NWS 10 (10.1, 10.2): Children ages 2-11 who have obesity; NWS 2 (2.1, 2.2): Schools that offer nutritious foods and beverages outside of school meals; NWS 14: Increase consumption of fruits; NWS 15: Increase consumption of healthy vegetables
Data Sources and Data Issues:	School Health Profiles (TDE Coordinated School Health). This survey is only conducted biennially in even number years within secondary schools (any school in which there is at least one grade from 6 to 12). There may also not be a complete definition of less healthy foods and beverages.
Significance:	Most children spend a huge proportion of their week in school, where at least lunch, if not breakfast and dinner, are available daily. Therefore, a policy prohibiting the sale of less healthy foods and beverages can go a long way toward satisfying the nutritional guidelines for students in this age group. Numerator values for this measure will be simple counts of school principals indicating that they have this policy. The denominator will be the total count of school principals responding to the survey and providing valid data for this question.

SPM 14 - Percent of children with two or more ACEs
Population Domain(s) – Child Health

Measure Status:	Active
Goal:	To decrease the percent of children who experience 2 or more ACEs
Definition:	**Numerator:** Number of children with 2 or more adverse childhood experiences **Denominator:** Number of children aged 0 -17 years **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	Can be linked to any of the HP2020 objectives listed in other measures under the ACEs priority.
Data Sources and Data Issues:	NSCH- Limitation(s): 1) Data available upon release from the NSCH.
Significance:	Adverse childhood experiences (ACEs) are traumatic events occurring before age 18. ACEs include all types of abuse and neglect as well as parental mental illness, substance use, divorce, incarceration, and domestic violence. A landmark study in the 1990s found a significant relationship between the number of ACEs a person experienced and a variety of negative outcomes in adulthood, including poor physical and mental health, substance abuse, and risky behaviors. The more ACEs experienced, the greater the risk for these outcomes. The NSCH conducts a survey annually, which included tools to estimate the percent of children who experience one or more ACEs of the nine ACEs including child maltreatment, mental depression, IPV etc.

SPM 15 - Percent of substantiated child maltreatment cases among families served by home visiting programs
Population Domain(s) – Child Health

Measure Status:	Active
Goal:	To decrease percentage of children enrolled in home visiting that experience child maltreatment (i.e., substantiated claims to DCS)
Definition:	**Numerator:** Number of children enrolled in a home visiting program who experience maltreatment (substantiated case) **Denominator:** Number of children enrolled in a home visiting program **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	IVP-38 “Reduce nonfatal child maltreatment” (Baseline: 9.4 victims of nonfatal child maltreatment per 1,000 children under age 18 years were reported in 2008, Target: 8.5 maltreatment victims per 1,000 children)
Data Sources and Data Issues:	The number of substantiated child maltreatment cases among children enrolled in home visiting (i.e., the numerator) comes from a merged DCS file; EBHV REDCap Data Collection System. Data Issues: Because this measure is collaborative, it can only move forward as the merge is completed by DCS.
Significance:	The Injury and Violence Prevention goal of Healthy People 2020 is “prevent unintentional injuries and violence, and reduce their consequences.” Childhood abuse- physical, emotional, or sexual- is one of the ten categories of adverse childhood experiences. Prevention strategies of this ACE include increasing parenting skills and the promotion of strong, caring adult relationships by means of such programming as home visiting. We have chosen to focus on this measure as home visiting is potentially a prevention strategy of ACEs that will impact the aforementioned HP strategy. Centers for Disease Control and Prevention, Kaiser Permanente. The ACE Study Survey Data [Unpublished Data]. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention; 2016. Healthy People 2020 [Internet]. Washington, DC: U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion [cited 06/18/20].

SPM 16 - Percent of caregiver substance abuse among families served by home visiting programs
Population Domain(s) – Child Health

Measure Status:	Active
Goal:	To decrease the percentage of caregiver substance abuse among home visiting enrollees
Definition:	**Numerator:** Primary caregivers who respond yes to the question of “having had a drink containing alcohol 4 or more times in a week,” or “having had 6 or more drinks on one occasion daily or almost daily,” or “had used a recreational drug or used prescription med **Denominator:** Number of primary caregivers **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	SA-7 “Increase the number of admissions to substance abuse treatment for injection drug use” (Baseline: 255,374 admissions to Level I and Level II trauma centers to substance abuse treatment programs for injection drug use were reported in 2006, Target: 280,911 admissions to Level I and Level II trauma centers); SA-8.2 “Increase the proportion of persons who need alcohol and/or illicit drug treatment and received specialty treatment for abuse or dependence in the past year” (Baseline: 10.8 percent of persons aged 12 years and over who need alcohol treatment and/or illicit drug treatment reported that they received specialty treatment for abuse or dependence in the past year in 2015, Target: 11.9 percent)
Data Sources and Data Issues:	EBHV REDCAP Data Collection System, Caregiver Annual Assessment
Significance:	Substance abuse in the household is considered to one of the ten primary adverse childhood experiences (ACES). Additionally, Healthy People 2020 had adopted substance abuse as priority topic area as it has been associated with violent crime, teen pregnancy and childhood abuse. Home visiting and other social emotional strategies can be utilized as interventions in reducing and even preventing substance misuse. Centers for Disease Control and Prevention, Kaiser Permanente. The ACE Study Survey Data [Unpublished Data]. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention; 2016. Child and Adolescent Health Measurement Initiative. 2017-2018 National Survey of Children’s Health (NSCH) data query. Data Resource Center for Child and Adolescent Health supported by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB).Retrieved [06/18/20] from [www.childhealthdata.org]. Healthy People 2020 [Internet]. Washington, DC: U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion [cited 06/18/20].

SPM 17 - Percent of caregivers who experience intimate partner violence and do not receive professional support services among families served by home visiting
Population Domain(s) – Child Health

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To increase the percentage of enrolled home visiting caregivers who experience intimate partner violence and receive professional services.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Numerator:</td><td>Number of primary caregivers who screen positive for IPV but are not referred to professional support services</td></tr>
<tr><td>Denominator:</td><td>Number of primary caregivers who screen positive for IPV</td></tr>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
</table>
</td></tr>
<tr><td>Healthy People 2020 Objective:</td><td>IVP-38 “Reduce violence by current or former intimate partners” (Developmental)</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>EBHV REDCAP Data Collection System, HITS Screen</td></tr>
<tr><td>Significance:</td><td>The Injury and Violence Prevention goal of Healthy People 2020 is “prevent unintentional injuries and violence, and reduce their consequences.” Injury and violence occurrences have been associated to premature death, an increase in years of potential life lost, depreciating mental health, and higher medical costs. This priority measure looks at how those that are and have previously experienced intimate partner violence are receiving professional services, which could possibly reduce the number of occurrences of the listed, negatively- associated health outcomes. The adverse child experience of witnessing domestic violence in the home could be mitigated by rehabilitative services received by a caregiver and thereby positively impact long-term health outcomes.

Centers for Disease Control and Prevention, Kaiser Permanente. The ACE Study Survey Data [Unpublished Data]. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention; 2016.

Child and Adolescent Health Measurement Initiative. 2017-2018 National Survey of Children’s Health (NSCH) data query. Data Resource Center for Child and Adolescent Health supported by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB).Retrieved [06/18/20] from [www.childhealthdata.org].

Healthy People 2020 [Internet]. Washington, DC: U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion [cited 06/18/20].</td></tr>
</table>

SPM 18 - Percent of caregivers with depression who receive referrals for services
Population Domain(s) – Child Health

Measure Status:	Active
Goal:	To increase number of primary caregivers with mental depression who receive referrals for services.
Definition:	**Numerator:** Number of primary caregivers enrolled in EBHV who received recommended services for depression **Denominator:** Number of primary caregivers enrolled in EBHV who had a positive screen for depression within 3 months of enrollment (for those not enrolled prenatally) or within 3 months of delivery (for those enrolled prenatally) and were referred for services. **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	MICH-34: (Developmental) Decrease the proportion of women delivering a live birth who experience postpartum depressive symptoms.
Data Sources and Data Issues:	EBHV- Limitation(s): 1) includes only participants of EBHV/CHANT in the state.
Significance:	Research has shown that people with two or more ACEs are more (~ four times) likely to develop depression. Similarly, depressed mothers are more likely to neglect their children, which itself is one of the 10 original ACEs. ACEs may have both, potentially a lifelong consequence on children and contribute to maternal depression. Ultimately, reductions in rates of maternal depression support improvement in a child's health and disrupts the intergenerational transmission of ACEs. Maternal depression screening is conducted once (using Edinburg depression tool) within 3 mos after enrollment for postnatally enrollees or 3 mos post-delivery for prenatally enrollees.

SPM 19 - Percent of high school students currently using cigarettes
Population Domain(s) – Adolescent Health

Measure Status:	Active
Goal:	To decrease the number of adolescents who smoke cigarettes
Definition:	**Numerator:** Number (weighted) of TN public high school students reporting current (past 30 day) use of cigarette(s) **Denominator:** Number (weighted) of TN public high school students responding to current cigarette use question **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	TU-2 Reduce tobacco use by adolescents TU-3 Reduce the initiation of tobacco use among children, adolescents, and young adults
Data Sources and Data Issues:	Youth Risk Behavior Surveillance System (YRBS), biennial survey
Significance:	This metric is one of the most important intermediate goals for tobacco control, denoting the current burden of combustible cigarette use among TN public high school students. Changes in this trend and its demographic distributions inform the Tobacco Control Program's goals, activities, and resource allocation. Achieving low prevalence of combustible cigarette use among adolescents is paramount to reducing the overall health burden tobacco places on Tennessee's broader population in the future.

SPM 20 - Percent of high school students currently using e-cigarettes
Population Domain(s) – Adolescent Health

Measure Status:	Active
Goal:	To reduce the number of adolescents currently using e-cigarettes
Definition:	**Numerator:** Number (weighted) of public high school students reporting current (past 30 day) use of e-cigarette(s) **Denominator:** Number (weighted) of public high school students responding to current e-cigarette use question **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	TU-2 Reduce tobacco use by adolescents TU-3 Reduce the initiation of tobacco use among children, adolescents, and young adults
Data Sources and Data Issues:	Youth Risk Behavior Surveillance System (YRBS), biennial survey
Significance:	Similar to combustible cigarette use, this metric is one of the most important intermediate goals for tobacco control, denoting the current burden of emerging tobacco product (including e-cigarette) use among TN public high school students. Changes in this trend and its demographic distributions inform the Tobacco Control Program's goals, activities, and resource allocation. Achieving low prevalence of e-cigarette use among adolescents is paramount to reducing the overall health burden tobacco use places on Tennessee's broader population in the future.

SPM 21 - Number of adolescents enrolled in cessation program
Population Domain(s) – Adolescent Health

Measure Status:	Active
Goal:	To increase the number of youth who enroll in tobacco cessation programs
Definition:	**Numerator:** Number of adolescent-aged unique enrollees to cessation program **Denominator:** n/a **Unit Type:** Count **Unit Number:** 125
Healthy People 2020 Objective:	TU-2 Reduce tobacco use by adolescents
Data Sources and Data Issues:	Tennessee Tobacco Quitline & American Lung Association N-O-T: Not On Tobacco Program
Significance:	Adolescent utilization of cessation programs in Tennessee has historically been low, despite a growing proportion of youth using or experimenting with e-cigarettes and other emerging products. Additionally, standardized guidelines and recommendations for health care professionals to promote and support cessation attempts among adolescents is absent. Given the emerging public health issue of youth e-cigarette and emerging product use, TUPCP seeks to fill a key gap in assisting adolescents to quit using tobacco products and e-cigarettes in Tennessee.

SPM 22 - Number of providers adopting the medical home approach in their practice
Population Domain(s) – Children with Special Health Care Needs

Measure Status:	Active
Goal:	To increase the number of providers adopting medical home approach in their practices
Definition:	**Numerator:** Number of providers adopting medical home approach in their practice **Denominator:** n/a **Unit Type:** Count **Unit Number:** 1,250
Healthy People 2020 Objective:	MICH-30.1 Increase the proportion of children who have access to a medical home – 63.3% MICH-30.2 Increase the proportion of children with special health care needs who have access to a medical home – 51.8% MICH-31.1 Increase the proportion of children aged 0 to 11 years with special health care needs who receive their care in family-centered, comprehensive, and coordinated systems – 22.4% MICH-31.2 Increase the proportion of children aged 12 to 17 years with special health care needs who receive their care in family-centered, comprehensive, coordinated systems – 15.1%
Data Sources and Data Issues:	Program plans to conduct a survey among providers. Limitation: Not all providers surveyed will respond.
Significance:	The more the healthcare providers adopting medical home approach in their practice, the more children receive care in medical home.

SPM 23 - Number of CYSHCN receiving care in a medical home
Population Domain(s) – Children with Special Health Care Needs

Measure Status:	Active
Goal:	To increase the number of CYSHCN receiving care in medical home
Definition:	**Numerator:** Number of CYSHCN receiving care in medical home **Denominator:** n/a **Unit Type:** Count **Unit Number:** 1,000
Healthy People 2020 Objective:	MICH-30.1 Increase the proportion of children who have access to a medical home – 63.3% MICH-30.2 Increase the proportion of children with special health care needs who have access to a medical home – 51.8% MICH-31.1 Increase the proportion of children aged 0 to 11 years with special health care needs who receive their care in family-centered, comprehensive, and coordinated systems – 22.4% MICH-31.2 Increase the proportion of children aged 12 to 17 years with special health care needs who receive their care in family-centered, comprehensive, coordinated systems – 15.1%
Data Sources and Data Issues:	Data source: PTBMIS Limitation: The question asked is “have you had annual exam at your primary care provider’s office in the past 12 months”. Having annual exam at PCP is not equivalent to medical home.
Significance:	It is important to ensure the children with special healthcare needs served by the Tennessee Children’s Special Services program receive preventive services in medical home setting.

SPM 24 - Number of families confident speaking to their provider
Population Domain(s) – Children with Special Health Care Needs

Measure Status:	Active
Goal:	To increase the number of families surveyed confident speaking to their provider
Definition:	**Numerator:** Number of families confident speaking to their provider **Denominator:** n/a **Unit Type:** Count **Unit Number:** 600
Healthy People 2020 Objective:	MICH-30.1 Increase the proportion of children who have access to a medical home – 63.3% MICH-30.2 Increase the proportion of children with special health care needs who have access to a medical home – 51.8% MICH-31.1 Increase the proportion of children aged 0 to 11 years with special health care needs who receive their care in family-centered, comprehensive, and coordinated systems – 22.4% MICH-31.2 Increase the proportion of children aged 12 to 17 years with special health care needs who receive their care in family-centered, comprehensive, coordinated systems – 15.1%
Data Sources and Data Issues:	Data source: The program plans to conduct a survey among families. Limitation: Not all families surveyed will return the survey with complete answers
Significance:	Family involvement is a key aspect of the medical home approach and the increase of family confidence in speaking with providers about their children's healthcare needs strengths the family roles.

SPM 25 - Number of providers providing resources and behavioral and mental health referrals
Population Domain(s) – Children with Special Health Care Needs

Measure Status:	Active
Goal:	To increase the number of providers providing resources and behavioral and mental health referrals
Definition:	**Numerator:** Number of providers providing resources and behavioral and mental health referrals **Denominator:** n/a **Unit Type:** Count **Unit Number:** 1,000
Healthy People 2020 Objective:	MICH-30.1 Increase the proportion of children who have access to a medical home – 63.3% MICH-30.2 Increase the proportion of children with special health care needs who have access to a medical home – 51.8% MICH-31.1 Increase the proportion of children aged 0 to 11 years with special health care needs who receive their care in family-centered, comprehensive, and coordinated systems – 22.4% MICH-31.2 Increase the proportion of children aged 12 to 17 years with special health care needs who receive their care in family-centered, comprehensive, coordinated systems – 15.1%
Data Sources and Data Issues:	Data source: The program plans to conduct a survey among providers. Limitation: Not all providers surveyed will return the survey with complete answers.
Significance:	Behavioral and mental health is an integral part of the medical home approach. Provider referrals increase the likelihood for the families to seek and received behavioral and mental health services.

SPM 26 - Number of care coordinators with increased knowledge
Population Domain(s) – Children with Special Health Care Needs

Measure Status:	Active
Goal:	To increase the number of care coordinators with increased knowledge of medical home best practices
Definition:	**Numerator:** Number of care coordinators with increased knowledge of medical home best practices **Denominator:** n/a **Unit Type:** Count **Unit Number:** 275
Healthy People 2020 Objective:	MICH-30.1 Increase the proportion of children who have access to a medical home – 63.3% MICH-30.2 Increase the proportion of children with special health care needs who have access to a medical home – 51.8% MICH-31.1 Increase the proportion of children aged 0 to 11 years with special health care needs who receive their care in family-centered, comprehensive, and coordinated systems – 22.4% MICH-31.2 Increase the proportion of children aged 12 to 17 years with special health care needs who receive their care in family-centered, comprehensive, coordinated systems – 15.1%
Data Sources and Data Issues:	Data source: The program plans to conduct a survey among care coordinators. Limitation: Not all coordinators surveyed will return the survey with complete answers.
Significance:	Care coordinators frequently interact with the providers and families and they can pass knowledge and recommendations to providers and families.

SPM 27 - Number of vendors with increased knowledge
Population Domain(s) – Children with Special Health Care Needs

Measure Status:	Active
Goal:	To increase the number of vendors with increased knowledge of medical home best practices
Definition:	**Numerator:** Number of vendors with increased knowledge of medical home best practices **Denominator:** n/a **Unit Type:** Count **Unit Number:** 850
Healthy People 2020 Objective:	MICH-30.1 Increase the proportion of children who have access to a medical home – 63.3% MICH-30.2 Increase the proportion of children with special health care needs who have access to a medical home – 51.8% MICH-31.1 Increase the proportion of children aged 0 to 11 years with special health care needs who receive their care in family-centered, comprehensive, and coordinated systems – 22.4% MICH-31.2 Increase the proportion of children aged 12 to 17 years with special health care needs who receive their care in family-centered, comprehensive, coordinated systems – 15.1%
Data Sources and Data Issues:	Data source: The program plans to conduct a survey among vendors. Limitation: Not all vendors surveyed will return the survey with complete answers.
Significance:	Increased knowledge among vendors on medical home best practices is expected to result in increased adoption in their practices.

SPM 28 - Number of children who complete an annual visit with their primary care provider
Population Domain(s) – Children with Special Health Care Needs

Measure Status:	Active
Goal:	To increase the number of children who complete an annual visit with their primary care provider
Definition:	**Numerator:** Number of children/youth completing annual primary care visit in the medical home **Denominator:** n/a **Unit Type:** Count **Unit Number:** 1,000
Healthy People 2020 Objective:	MICH-30.1 Increase the proportion of children who have access to a medical home – 63.3% MICH-30.2 Increase the proportion of children with special health care needs who have access to a medical home – 51.8% MICH-31.1 Increase the proportion of children aged 0 to 11 years with special health care needs who receive their care in family-centered, comprehensive, and coordinated systems – 22.4% MICH-31.2 Increase the proportion of children aged 12 to 17 years with special health care needs who receive their care in family-centered, comprehensive, coordinated systems – 15.1%
Data Sources and Data Issues:	Data source: CHANT REDCap data, Call Center data system Limitation: matching data from different data systems
Significance:	It is important to ensure that children and families receive annual medical exams and preventive care in an assigned medical home setting especially for continuity of care and detecting potential problems early.

SPM 29 - Number of YSHCN receiving transition services
Population Domain(s) – Children with Special Health Care Needs

Measure Status:	Active
Goal:	To increase the number of YSHCN receiving transition services
Definition:	**Numerator:** Number of YSHCN served by the Tennessee Children's Special Services receiving transition services **Denominator:** n/a **Unit Type:** Count **Unit Number:** 150
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 – 41.2%
Data Sources and Data Issues:	Data source: PTBMIS and REDCap Limitation: Restricted to YSHCN enrolled in the CSS program.
Significance:	Transition services, resources and planning are important for youth to mature to adulthood. The program will work with regional care coordinators to ensure all children enrolled in CSS program have an annual transition plan.

SPM 30 - Number of transition self-advocates
Population Domain(s) – Children with Special Health Care Needs

Measure Status:	Active
Goal:	To increase the number of youth who are transition self-advocates
Definition:	**Numerator:** Number of youth who are transition self-advocates **Denominator:** n/a **Unit Type:** Count **Unit Number:** 40
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 – 41.2%
Data Sources and Data Issues:	Data source: Survey. Limitation: Not all youth surveyed will complete the survey.
Significance:	Transition services, resources and planning are important for youth to mature to adulthood. Encourage youth to become self-advocates for their healthcare needs including transition planning will facilitate that process.

Form 10
State Outcome Measure (SOM) Detail Sheets

State: Tennessee

SOM 1 - Rate of pregnancy-related mortality to live births
Population Domain(s) – Women/Maternal Health

Measure Status:	Active
Goal:	To reduce the rate of pregnancy-related mortality
Definition:	**Numerator:** Pregnancy-related deaths **Denominator:** Live births **Unit Type:** Rate **Unit Number:** 100,000
Healthy People 2020 Objective:	MICH-5: Reduce the rate of maternal mortality. Baseline 12.7 maternal deaths per 100,000 live births in 2007. Target is 11.4 maternal deaths per 100,000 live births.
Data Sources and Data Issues:	Maternal Mortality Review Information Application (MMRIA) and Vital Records Birth Statistical System
Significance:	Maternal mortality is a sentinel event and an indicator of a nation's health. Maternal mortality rate is calculated as a ratio of maternal deaths within 365 days after the end of a pregnancy per 100,000 live births. In calculating maternal mortality rate, we can identify populations that are disproportionately affected by maternal deaths and monitor Tennessee's progress in decreasing maternal mortality and severe maternal morbidity.

SOM 2 - Number of pregnancy-associated, but not related, deaths
Population Domain(s) – Women/Maternal Health

Measure Status:	Active
Goal:	To decrease the pregnancy-associated, but not related deaths
Definition:	**Numerator:** Pregnancy-associated, but not related deaths **Denominator:** Live births **Unit Type:** Rate **Unit Number:** 100,000
Healthy People 2020 Objective:	MICH-5: Reduce the rate of maternal mortality. Baseline 12.7 maternal deaths per 100,000 live births in 2007. Target is 11.4 maternal deaths per 100,000 live births.
Data Sources and Data Issues:	Maternal Mortality Review Information Application (MMRIA) and Vital Records Birth Statistical File
Significance:	Maternal mortality is a sentinel event and an indicator of a nation's health. Maternal mortality rate is calculated as a ratio of maternal deaths within 365 days after the end of a pregnancy per 100,000 live births. In calculating maternal mortality rate, we can identify populations that are disproportionately affected by maternal deaths and monitor Tennessee's progress in decreasing maternal mortality and severe maternal morbidity.

SOM 3 - Rate of pregnancy-associated mortality
Population Domain(s) – Women/Maternal Health

Measure Status:	Active
Goal:	To decrease the pregnancy-associated mortality
Definition:	**Numerator:** Number of pregnancy-associated deaths **Denominator:** Live births **Unit Type:** Rate **Unit Number:** 100,000
Healthy People 2020 Objective:	MICH-5: Reduce the rate of maternal mortality. Baseline 12.7 maternal deaths per 100,000 live births in 2007. Target is 11.4 maternal deaths per 100,000 live births.
Data Sources and Data Issues:	Maternal Mortality Review Information Application (MMRIA) and Vital Records Birth Statistical System
Significance:	Maternal mortality is a sentinel event and an indicator of a nation's health. Rate of pregnancy-associated mortality rate is calculated as a ratio of maternal deaths within 365 days after the end of a pregnancy per 100,000 live births. In calculating maternal mortality rate, we can identify populations that are disproportionately affected by maternal deaths and monitor Tennessee's progress in decreasing maternal mortality and severe maternal morbidity.

SOM 4 - Number of public school 6th graders who are overweight or obese
Population Domain(s) – Child Health

Measure Status:	Active
Goal:	Decrease the percentage of public school 6th graders who are overweight or obese
Definition:	**Numerator:** Number of public school 6th graders who are overweight or obese **Denominator:** Number of TN public school 6th graders **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	NWS 10 (10.2): Children ages 6-11 who have obesity
Data Sources and Data Issues:	Weight Status Database (TN Coordinated School Health). These annual data are based on direct height and weight measurements for participating students only in grades K, 2, 4, 6, 8, and any one year of high school who have permission from their parent to be measured. Therefore, there could be significant self-selection bias.
Significance:	This statistic is a direct, core measure of the child obesity priority for school-aged children. Sixth graders were selected as a cross-section of the target group, as these students represent both late elementary and early middle school populations. Both overweight and obesity are included in order to present a broader view of the health concern. Values for the measure will derive from the official CSH annual report entitled, “Tennessee Public Schools: A Summary of Weight Status Data.” The report includes statistics on students who have been identified with a BMI in the overweight or obese range.

SOM 5 - Percent of adults with Major Depressive Episode
Population Domain(s) – Child Health

Measure Status:	Active
Goal:	Reduce the percent of adult depression.
Definition:	**Numerator:** Number of persons aged 18 years and over with Major Depressive Episode (MDE) **Denominator:** Number of persons aged 18 and over **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	Reduce the proportion of adults aged 18 years and older who experience major depressive episodes (MDEs) (MHMD-4.2). Baseline: 6.5 percent of adults aged 18 years and over experienced a major depressive episode in 2008. Target: 5.8) Increase the proportion of adults aged 18 years and older with major depressive episodes (MDEs) who receive treatment (MHMD-9.2). Baseline: 69.0 percent of adults aged 18 years and over with major depressive episodes received treatment in 2008. Target: 75.9)
Data Sources and Data Issues:	National Survey on Drug Use and Health (NSDUH), SAMHSA
Significance:	Research has shown that people with two or more ACEs are more (~ four times) likely to develop depression. Similarly, depressed mothers are more likely to neglect their children, which itself is one of the 10 original ACEs. ACEs may have both, potentially a lifelong consequence on children and contribute to maternal depression. Ultimately, reductions in rates of maternal depression support improvement in a child's health and disrupts the intergenerational transmission of ACEs. EBHV program refers primary caregivers who screened positive for depressive symptoms to mental services for EBHV enrollees. Mental health and physical health are closely connected. Mental health plays a major role in people's ability to maintain good physical health. Mental illnesses, such as depression and anxiety, affect people's ability to participate in health-promoting behaviors. In turn, problems with physical health, such as chronic diseases, can have a serious impact on mental health and decrease a person's ability to participate in treatment and recovery.

SOM 6 - Percent of adults reporting Chronic obstructive pulmonary disease (COPD)
Population Domain(s) – Child Health

Measure Status:	Active
Goal:	To decrease the rate of adults with COPD
Definition:	**Numerator:** Number of hospital discharges with a principal diagnosis of COPD (ICD-9-CM codes 490-492, 496) among adults aged 45 years and over **Denominator:** Number of persons aged 45 years and over **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	Reduce hospitalizations for chronic obstructive pulmonary disease (COPD) (RD-11). Baseline: 56.0 hospitalizations for COPD per 10,000 adults aged 45 years and over occurred in 2007 (age adjusted to the year 2000 standard population). Target: 50.1 hospitalizations per 10,000.
Data Sources and Data Issues:	National Hospital Discharge Survey (NHDS), CDC/NCHS; Population Estimates, Census
Significance:	Asthma and chronic obstructive pulmonary disease (COPD) are significant public health burdens. Specific methods of detection, intervention, and treatment exist that may reduce this burden and promote health. Approximately 14.8 million adults have been diagnosed with COPD, and approximately 12 million people have not yet been diagnosed[1]. The burden of respiratory diseases affects individuals and their families, schools, workplaces, neighborhoods, cities, and states. [1] National Institutes of Health, National Heart, Lung, and Blood Institute (NHLBI). Morbidity and mortality: 2012 chart book on cardiovascular, lung and blood diseases. Bethesda, MD: NHLBI; 2012 Feb [cited 2016 Aug 15]. Available from: https://www.nhlbi.nih.gov/files/docs/research/2012_ChartBook_508.pdf

SOM 7 - Percent of adults reporting cardiovascular disease
Population Domain(s) – Adolescent Health

Measure Status:	Active
Goal:	To decrease the number of adult Tennesseans with cardiovascular disease
Definition:	**Numerator:** Number (weighted) of adults reporting they have ever been told they have angina or coronary heart disease **Denominator:** Number (weighted) of adults responding to coronary heart disease question **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	HDS-2 Reduce coronary heart disease deaths
Data Sources and Data Issues:	Behavioral Risk Factor Surveillance System (BRFSS), annual survey
Significance:	Cardiovascular disease continues to be a leading cause of death among adult Tennesseans. By addressing tobacco and e-cigarette use among adolescents, future prevalence of cardiovascular disease will be reduced, which in turn will reduce the mortality rate from cardiovascular disease in the state.

SOM 8 - Age-adjusted mortality rate from tobacco-attributable cancers among Tennesseans aged 35+
Population Domain(s) – Adolescent Health

Measure Status:	Active
Goal:	To decrease the number of deaths in Tennessee from tobacco-attributable cancers
Definition:	**Numerator:** Number of deaths from tobacco-attributable cancers **Denominator:** Number of deaths **Unit Type:** Rate **Unit Number:** 100,000
Healthy People 2020 Objective:	C-1 Reduce the overall cancer death rate
Data Sources and Data Issues:	Tobacco-attributable cancer (or potentially all cancer) mortality rates will be derived from CDC Wonder
Significance:	Tobacco is the leading preventable cause of cancer death in Tennessee. By implementing the listed activities and effectively engaging partners, TUPCP aims to reduce Tennessee's mortality from tobacco-attributable cancers in the future.

Form 10
Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets

State: Tennessee

ESM 1.1 - Toolkit developed and distributed to help family planning clinics reduce barriers to care among males, teens and LGBTQ+ persons
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	One toolkit developed and distributed
Definition:	**Numerator:** n/a **Denominator:** n/a **Unit Type:** Text **Unit Number:** Yes/No
Data Sources and Data Issues:	Completion of this activity will be reported directly by program staff
Significance:	Males, teens and LGBTQ+ persons are considered priority populations by the Tennessee Department of Health's Title X Family Planning Program. The toolkit will be used by clinics to remove barriers to care among these populations and create a more welcoming environment, which in turn is expected to improve access to and utilization of family planning services among these populations.

ESM 1.2 - Percent of family planning providers trained to use reproductive life plan assessments
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	To increase the number of providers using a reproductive life plan assessment
Definition:	**Numerator:** Number of providers trained **Denominator:** Total number of providers **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	National Family Planning Training Center Training Tracking System
Significance:	A reproductive life plan (RLP) is a set of personal goals about having or not having children which is based on each individual's own values, goals, and resources. Family planning providers play a key role in helping both women and men to reflect on their reproductive intentions, to complete a RLP and to access appropriate services to meet their RLP goals. Reproductive life plan training is critical to ensuring a skilled family planning workforce that is able to provide client-centered, non-coercive, and culturally competent services.

ESM 1.3 - Percent of family planning visits that occur via telehealth at pilot sites
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	To increase access to family planning services
Definition:	**Numerator:** Number of family planning encounters occurring via telehealth **Denominator:** Total number of family planning encounters **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Tennessee Department of Health's Patient Tracking Billing Management Information System (PTBMIS). Updates to the PTBMIS system are currently being made so that staff can distinguish between in-office and telehealth visits. These updates will not be in place for several months. Once updates are completed, a specific baseline and goal will be determined.
Significance:	There are many barriers to accessing health care services, especially among poor and rural populations. These include lack of transportation, long travel distances, lack of child care, and lack of sick leave. Providing family planning services via telehealth is one way to address these barriers and help clients access needed services.

ESM 1.4 - Person-Centered Contraceptive Counseling Measure survey piloted at one Title X site
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	To increase patient-centered care in Title X clinics.
Definition:	**Numerator:** n/a **Denominator:** n/a **Unit Type:** Text **Unit Number:** Yes/No
Data Sources and Data Issues:	Completion of this activity will be reported directly by program staff
Significance:	The Person-Centered Contraceptive Counseling (PCCC) measure is a patient-reported outcome performance measure that assesses the patient-centeredness of contraceptive counseling (interpersonal connection, adequate information and decision support). The PCCC measure gives health care organizations, facilities, and providers the opportunity to measure patient-centeredness and implement quality improvement strategies to improve patient experience as needed. Results of the pilot will be used to improve services at the pilot site, and lessons learned during implementation will be used to develop a plan for wider use across additional Title X sites.

ESM 1.5 - Family planning information packet created for distribution at TennCare (medicaid) presumptive eligibility visits
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	Increase postpartum family planning access.
Definition:	**Numerator:** n/a **Denominator:** n/a **Unit Type:** Text **Unit Number:** Yes/No
Data Sources and Data Issues:	Completion of this activity will be reported directly by program staff
Significance:	Initiating appropriate contraception in the postpartum period is important to avoid negative outcomes related to short birth intervals (e.g. preterm birth, small for gestational age, miscarriage, stillbirth and infant death). The postpartum period is an optimal time to initiate contraception because patients are often reassessing their health care and may be motivated to prevent another pregnancy. Women often have a clear plan for postpartum contraception if counseling is done during the prenatal period, which then allows clinicians to ensure the desired method is available after delivery. A family planning information packet for distribution during TennCare presumptive eligibility visits will increase awareness of the importance of birth spacing and prepare women to both discuss postpartum contraception with their health care provider and to access contraception in the postpartum period.

ESM 1.6 - Number of presentations provided to Sexual Risk Avoidance Education and Rape Prevention Education sub-grantees on TDH-funded family planning services
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	Increase knowledge of how and where to access high-quality family planning serves
Definition:	**Numerator:** Number of presentations completed **Denominator:** n/a **Unit Type:** Count **Unit Number:** 22
Data Sources and Data Issues:	Completion of this activity will be reported directly by program staff
Significance:	Combined, the Sexual Risk Avoidance Education and Rape Prevention Education Programs provided services to over 63,000 teens and young adults in fiscal year 2019. Educating sub-grantee staff members about the Title X program will ensure that they are knowledgeable about the program and are able to answer questions from program participants about how and where to access high-quality family planning serves.

ESM 1.7 - Percent of Tennessee Breast and Cervical Screening Program vendors educated on TDH-funded family planning services
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	Increase knowledge of how and where to access high-quality family planning services.
Definition:	**Numerator:** Number of vendors educated **Denominator:** Total number of vendors **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Completion of this activity will be reported directly by program staff
Significance:	The Tennessee Breast and Cervical Screening Program (TBCSP) has close working relationships with approximately 300 health care providers offering cancer screening and diagnostic services across the state. Educating these vendors about the Title X program will ensure that they are knowledgeable about the program and are able to answer questions from all clients (both TBCSP and non-TBCSP) about how and where to access high-quality family planning serves.

ESM 1.8 - Percent of family planning providers trained on trauma-informed care
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	Accommodate the needs and concerns of those who have experienced trauma and reduce the possibility of re-traumatization
Definition:	**Numerator:** Number of providers trained **Denominator:** Total number of providers **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	National Family Planning Training Center Training Tracking System
Significance:	Various aspects of family planning can be especially stressful or triggering for survivors of sexual or gender-based violence, including pregnancy and contraceptive decision making. It is important for family planning providers to understand the ways in which sexual trauma can affect the patient's experience of receiving family planning care and to modify their practice in order to accommodate survivors' needs and concerns and reduce the possibility of re-traumatization. Training on trauma-informed care is critical to ensuring a skilled family planning workforce that is able to provide client-centered, non-coercive, and culturally competent services.

ESM 1.9 - Number of workgroup meetings held by the TDH Family Planning Program and the Tennessee Department of Mental Health and Substance Abuse (TDMHSA)
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	Increase collaboration between TDH and TDMHSA to address the family planning needs of patients with major mental disorders
Definition:	**Numerator:** Number of workgroup meetings **Denominator:** n/a **Unit Type:** Count **Unit Number:** 2
Data Sources and Data Issues:	Completion of this activity will be reported directly by program staff
Significance:	Title X recognizes the importance of assessing mental health issues during family planning visits – clients are routinely screened for substance use disorders, domestic violence, and depression (including postpartum depression), and offered community referrals for mental health services. While it is important to address the mental health needs of family planning patients, it is equally important to address the family planning needs of mental health patients. Evidence suggests that the family planning needs of patients with major mental disorders may not be routinely addressed in psychiatric settings. Yet patients with major mental disorders may have an enhanced risk when compared to groups of patients without mental disorders for both unwanted pregnancies and children placed with others to raise. In addition, alcohol and illicit substance use disorders, which are likely more common in those with major mental disorders, may also contribute to the risk for unwanted pregnancies and to the adverse consequences of those pregnancies. Collaboration between the Tennessee Department of Health's Title X Family Planning Program and the Tennessee Department of Mental Health and Substance Abuse would therefore be mutually beneficial, offering opportunities to increase awareness of services provided by each organization, as well as identifying opportunities and strategies to decrease barriers to and enhance both family planning and mental health services.

ESM 1.10 - Number of recommendations provided as real-time alerts
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	To provide real-time alerts to healthcare providers
Definition:	**Numerator:** Number of recommendations provided as real-time alerts **Denominator:** Total number of recommendations **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	MMRIA Files and MMR Program notes
Significance:	It is important to disseminate recommendations for preventing maternal death quickly to clinicians, health systems, patient advocates, and women and their families. This measure will be calculated using the recommendations for preventing maternal death (in MMRIA) and the number of recommendations provided as real-time alerts (in MMR program notes).

ESM 1.11 - Number of simulation trainings
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	To increase the number of simulation trainings completed among healthcare providers
Definition:	**Numerator:** Number of simulation trainings **Denominator:** Number of participating clinics/hospitals **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	MMRIA (Maternal Mortality Review Information Application) Files
Significance:	It is important for clinicians to perform obstetric simulation trainings so that labor and delivery teams are well prepared to handle an obstetric emergency response.

ESM 1.12 - Number of presentations completed by the speaker's bureau
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	To educate the public on preventing maternal death
Definition:	**Numerator:** Number of presentations completed **Denominator:** Number of meetings/conferences on maternal health issues **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Maternal Health Task Force (MHTF) Program Notes
Significance:	MHTF's major goal is to implement recommendations from the Maternal Mortality Review Committee. Consequently, the Maternal Health program will track the number of presentations and webinars on maternal health. This measure will measured by counting the number of presentations and webinars delivered within the specified timeframe.

ESM 1.13 - Number of high-risk obstetric consultations
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	To reduce maternal mortality rate
Definition:	**Numerator:** Number of high-risk OB consultations **Denominator:** Number of high-risk OB clinical practice women **Unit Type:** Count **Unit Number:** 10,210
Data Sources and Data Issues:	MMRIA Files and MMR Program notes
Significance:	Once women with high risk pregnancy are identified, it is imperative to connect them with specialized clinical care to prevent adverse pregnancy outcome such as severe maternal morbidity or maternal death. This measure will be calculated using the number of high-risk obstetrical consultations for women with high-risk pregnancy, including women with pre-eclampsia, multiple gestation, and substance used disorder.

ESM 1.14 - Number of Maternal Health Task Force members
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	To engage members of Maternal Health Task Force in implementing recommendations from the Maternal Mortality Review Committee
Definition:	**Numerator:** Number of Maternal Health Task Force members **Denominator:** n/a **Unit Type:** Count **Unit Number:** 100
Data Sources and Data Issues:	Maternal Health Task Force Program Files
Significance:	The goal of the MHTF is to implement recommendations from the Maternal Mortality Review Committee. The number of committee members and composition of the MHTF will inform the type implementations of MMRC recommendations.

ESM 1.15 - Number of community agencies funded to implement Maternal Mortality Review Committee (MMRC) recommendations
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	To fund community agencies in implementing recommendations that reduce maternal mortality
Definition:	**Numerator:** Number of community agencies funded to implement MMR recommendations **Denominator:** Number of community agencies that apply for implementation grants **Unit Type:** Count **Unit Number:** 5
Data Sources and Data Issues:	MMR Program Files
Significance:	Community agencies are strategically poised to identify at-risk populations for severe maternal morbidity and maternal mortality. Therefore, funding these agencies is important in the secondary prevention of severe maternal morbidity and maternal deaths. This measure will be calculated as number of agencies funded with details on the populations they reach/serve.

ESM 1.16 - Percent of CHANT and EBHV participants screened for depression
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	To screen pregnant and postpartum women for depression
Definition:	**Numerator:** Number of women screened for depression **Denominator:** Number of women participating in CHANT and EBHV **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	CHANT and EBHV databases
Significance:	Depression is a contributing factor to maternal death. By screening women for depression, the early childhood programs can provide referral for treatment to women who might have depression thereby reducing maternal deaths.

ESM 1.17 - Number of CHANT and EBHV staff trained on Question, Persuade, Refer suicide prevention
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	To prevent suicide deaths among pregnant and postpartum women
Definition:	**Numerator:** Number of CHANT and EBHV staff trained **Denominator:** n/a **Unit Type:** Count **Unit Number:** 275
Data Sources and Data Issues:	FHW Program data
Significance:	The QPR training is a gatekeeper training that provides participants with the skills to question and refer individuals who might be at risk for suicide for health intervention. Training the early childhood staff on QPR will further help them in recognizing suicidal behavior among their clients and preventing subsequent suicide deaths among pregnant and postpartum women.

ESM 1.18 - Number of women applying for presumptive eligibility
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	To increase access to care thereby reducing the risk of severe maternal morbidity and/or maternal death.
Definition:	**Numerator:** Number of women enrolling in TennCare with presumptive eligibility **Denominator:** n/a **Unit Type:** Count **Unit Number:** 12,700
Data Sources and Data Issues:	Tennessee's Presumptive Eligibility program
Significance:	Enrolling eligible women in TennCare under the presumptive eligibility program ensues that pregnant women have access to preconception, prenatal, and perinatal care, thus reducing the risk of severe maternal morbidity and/or maternal death.

ESM 1.19 - Percent of identified maternal deaths reviewed
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	To decrease maternal mortality and severe maternal morbidity
Definition:	**Numerator:** Number of identified maternal deaths reviewed **Denominator:** Number of identified maternal deaths **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Maternal Mortality Review Information Application (MMRIA)
Significance:	Maternal mortality is a sentinel event and an indicator of a nation's health. Maternal mortality rate is calculated as a ratio of maternal deaths within 365 days after the end of a pregnancy per 100,000 live births. In calculating maternal mortality rate, we can identify populations that are disproportionately affected by maternal deaths and monitor Tennessee's progress in decreasing maternal mortality and severe maternal morbidity.

ESM 1.20 - Number of recommendations implemented for preventing maternal deaths
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	To provide recommendation for preventing maternal deaths
Definition:	**Numerator:** Number of recommendations implemented **Denominator:** Number of total recommendations **Unit Type:** Count **Unit Number:** 13
Data Sources and Data Issues:	Maternal Mortality Review Information Application (MMRIA)
Significance:	Recommendations from the MMRC provide actionable plans in preventing future maternal deaths. This measure is important to determine the domain of recommendation for prevention of maternal death.

ESM 1.21 - Number of documents disseminated with health disparity data
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	To disseminate information on health disparities thus encouraging interventions that foster health equity
Definition:	**Numerator:** Number of documents distributed based on disparities in maternal health **Denominator:** n/a **Unit Type:** Count **Unit Number:** 4
Data Sources and Data Issues:	FHW Program data
Significance:	Documents (including infographics) on disparities in maternal health shows the gap in interventions and areas of need. These documents will also inform the public and stakeholders in maternal health on populations and health conditions that need target interventions, thus fostering health equity.

ESM 3.1 - Number of hospitals participating in the Opioid Exposed Newborns and/or Opioid Use Disorder projects NPM 3 – Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

Measure Status:	Active
Goal:	To ensure that hospitals participating in the Opioid Exposed Newborns and Opioid Use Disorder projects continue with implementation
Definition:	**Numerator:** Number of hospitals participating in the OEN and OUD projects **Denominator:** Number of birthing hospitals in Tennessee **Unit Type:** Scale **Unit Number:** 18
Data Sources and Data Issues:	Family Health and Wellness tracking tool
Significance:	By continuing the implementation of the Opioid Use Disorder (OUD) and Opioid Exposed Newborns (OEN) projects in participating hospitals, the quality of care available for infants in this vulnerable circumstance will be improved statewide. The goals for these projects include reducing the stigma surrounding OUD and promoting universal screening using evidence based screening tools in all pregnant women to screen for substance abuse disorders. The project also involves mapping state resources for pregnant women with OUD. Through detecting cases of infants exposed to opioids prenatally and identifying the parts of the state with resources available, one outcome will be opioid exposed infants increasingly being born at high level perinatal centers.

ESM 3.2 - Number of TIPQC learning sessions held
NPM 3 – Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

Measure Status:	Active
Goal:	To increase number of TIPQC learning sessions held
Definition:	**Numerator:** Number of TIPQC learning sessions held **Denominator:** n/a **Unit Type:** Count **Unit Number:** 3
Data Sources and Data Issues:	Family Health and Wellness tracking tool
Significance:	Offering obstetric health care providers opportunities for professional training and education is critical to ensuring the highest level of care for Tennessee mothers and infants. TIPQC learning sessions offer providers opportunities to increase their knowledgebase about new and emerging topics and stay abreast on the most current guidelines.

ESM 3.3 - Perinatal regionalization guidelines revised
NPM 3 – Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

Measure Status:	Active
Goal:	Review state's current maternal care guidelines for levels 1-4 and make revisions and additions as per latest guidance issued by SMFM/ACOG
Definition:	**Numerator:** n/a **Denominator:** n/a **Unit Type:** Text **Unit Number:** Yes/No
Data Sources and Data Issues:	Family Health and Wellness tracking tool
Significance:	It is critical for the state's maternal care guidelines to reflect the most up-to-date recommendations issued by The Society for Maternal-Fetal Medicine and The American College of Obstetricians and Gynecologists. Part of these recommendations will center on the importance of taking steps to ensure that VLBW infants are born at hospitals with a Level III+ Neonatal Intensive Care Unit (NICU).

ESM 3.4 - Number of regional perinatal center neonatal instructor hours delivered
NPM 3 – Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase number of regional perinatal center neonatal instructor hours delivered</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Numerator:</td><td>Number of regional perinatal center neonatal instructor hours delivered</td></tr>
<tr><td>Denominator:</td><td>n/a</td></tr>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>5,000</td></tr>
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</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Family Health and Wellness tracking tool</td></tr>
<tr><td>Significance:</td><td>It is crucial to offer professional education to hospital staff and healthcare providers through the state’s five regional perinatal centers. This will help ensure that the most up-to-date protocols and latest research are being implemented in these hospitals.</td></tr>
</table>

ESM 3.5 - Percent of newborns with a positive dried blood spot (DBS) screen who receive follow-up to definitive diagnosis and clinical case management
NPM 3 – Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

Measure Status:	Active
Goal:	Provide case management follow-up for 100 percent of newborns with abnormal screening results and unsatisfactory tests
Definition:	**Numerator:** Number of newborns with abnormal screening results who received follow-up to definitive diagnosis and case management **Denominator:** Number of newborns with abnormal screening results **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Newborn Screening Program case management system
Significance:	In order for the system to function properly, all newborns who have abnormal screening results must receive follow-up to diagnosis and clinical case management. The screen result alone is ineffective without prompt diagnosis and connection to services. For families to have access to the best care for their newborn, these steps must occur seamlessly 100 percent of the time a screen comes back as abnormal.

ESM 3.6 - Percent of facilities (with unsatisfactory dried blood spot rate >10 percent) who received education and consultative outreach
NPM 3 – Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

Measure Status:	Active
Goal:	Increase percent of facilities with unsatisfactory dried blood spot rate above 10 percent receiving education and consultative outreach
Definition:	**Numerator:** Number of facilities with unsatisfactory dried blood spot rate above 10 percent receiving education and consultative outreach **Denominator:** Number of facilities with unsatisfactory dried blood spot rate above 10 percent **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Data Source: Family Health and Wellness tracking tool; Limitation(s): This measure has not been tracked in the past and thus a system is not currently in place to capture it.
Significance:	All Tennessee facilities should have an unsatisfactory blood spot rate below 10 percent. A high percentage of unsatisfactory samples slows the screening process and can pose a barrier to timely results. For facilities with a rate higher than 10 percent, it is critical for the Department of Health to offer the necessary support and education to improve this rate below the threshold.

ESM 3.7 - Average number of hours transit time (from collection site to state laboratory) for NBS dried blood spot specimen
NPM 3 – Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

Measure Status:	Active
Goal:	Improve average NBS transit time (hrs) for dried blood spot to arrive at state laboratory from collection
Definition:	**Numerator:** Transit time for dried blood spot to arrive at state laboratory from collection **Denominator:** n/a **Unit Type:** Count **Unit Number:** 39
Data Sources and Data Issues:	Newborn Screening Program case management system
Significance:	Delays in timely transport of blood spot samples from the collecting facility to the state laboratory interfere with the screening process, potentially causing a lag in the detection and treatment of affected infants. For this reason, expediting this process as much as possible and identifying facilities with high transit times for targeted education is critical to ensuring infants receive timely care.

ESM 4.1 - Number of average monthly calls to Tennessee Breastfeeding Hotline (TBH)
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To increase the number of average monthly calls to the Tennessee Breastfeeding Hotline</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Numerator:</td><td>Number of average monthly calls to Tennessee Breastfeeding Hotline</td></tr>
<tr><td>Denominator:</td><td>n/a</td></tr>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>550</td></tr>
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</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Tennessee Breastfeeding Hotline</td></tr>
<tr><td>Significance:</td><td>The Tennessee Breastfeeding Hotline is a 24/7 service staffed by International Board Certified Lactation Consultants (IBCLCs) who provide lactation support to Tennessee breastfeeding families. By addressing common barriers and issues to breastfeeding continuation (e.g., milk supply, engorgement, breast pain), the TBH reinforces the goal to achieve higher breastfeeding rates over longer periods of time.</td></tr>
</table>

ESM 4.2 - Number of birthing hospitals with a Memorandum of Understanding (MOU) for onsite breastfeeding peer counselor support
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	To increase the number of Tennessee birthing hospitals with an MOU for onsite breastfeeding peer counselor support
Definition:	**Numerator:** Birthing hospitals with a Memorandum of Understanding (MOU) for onsite breastfeeding peer counselor support **Denominator:** n/a **Unit Type:** Count **Unit Number:** 12
Data Sources and Data Issues:	Breastfeeding program data (specifically housed within the Tennessee WIC Breastfeeding Peer Counselor Program)
Significance:	One of WIC's most effective breastfeeding promotion strategies is its Breastfeeding Peer Counselor (BFPC) Program, an evidence-based peer-to-peer model that connects pregnant and postpartum women with paraprofessional breastfeeding counselors. Evidence shows that participation in the WIC BFPC Program is associated with a higher rate of breastfeeding initiation and leads to longer breastfeeding duration and improved exclusivity.

ESM 4.3 - Percent of NICU-admitted infants breastfed at hospital discharge
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	To increase the percent of NICU-admitted infants born to Tennessee resident mothers who initiate breastfeeding
Definition:	**Numerator:** Number of NICU-admitted infants breastfed at hospital discharge **Denominator:** Number of NICU-admitted infants **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Tennessee Birth Statistical System
Significance:	Hospitalized infants, including those born preterm, are at the highest risk for not receiving human milk. Receipt of human milk for NICU infants has been shown to decrease the incidence of post-discharge complications and delays and improve short- and long-term outcomes.

ESM 4.4 - Number of Tennessee birthing hospitals that have implemented > 5 Steps to Breastfeeding Success NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	To increase the number of Tennessee birthing hospitals that have implemented more than 5 of the 10 Steps to Breastfeeding Success
Definition:	**Numerator:** Number of Tennessee birthing hospitals that have implemented > 5 Steps to Breastfeeding Success **Denominator:** n/a **Unit Type:** Count **Unit Number:** 42
Data Sources and Data Issues:	Tennessee Birthing Hospital Assessment
Significance:	The World Health Organization/UNICEF Baby-Friendly Hospital Initiative, endorsed by the American Academy of Pediatrics, recognizes hospitals that follow the 10 Steps to Successful Breastfeeding. Mothers breastfeed longer in hospitals that have more of the 10 Steps to Successful Breastfeeding implemented. Therefore, hospitals are a critical component to help mothers start and continue breastfeeding after discharge.

ESM 4.5 - Percent of health care providers who complete 20-hour lactation education training
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	To increase the percent of health care providers who enroll and complete 20-hour lactation education training
Definition:	**Numerator:** Number of health care providers who complete 20-hour lactation education training **Denominator:** Number of health care providers who enroll in 20-hour lactation education training **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Rector and Visitors of the University of Virginia. Accessed through http://www.scitent.com or https://bfconsortium.org
Significance:	Health care providers play a crucial role in breastfeeding promotion and support, influencing a woman's decision to breastfeed and/or her desire to continue. However, some providers lack the skills needed to assist with breastfeeding issues. Continued lactation education opportunities can improve a providers' knowledge, skills, and attitudes towards lactation care.

ESM 4.6 - Number of credentialed lactation professionals within WIC
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	To increase the number of credentialed lactation professionals within WIC (e.g., IBCLC, CLC, and CLS)
Definition:	**Numerator:** Number of credentialed lactation professionals within WIC **Denominator:** n/a **Unit Type:** Count **Unit Number:** 206
Data Sources and Data Issues:	WIC monitoring reports
Significance:	One barrier to breastfeeding is the lack of access to lactation professionals. Breastfeeding promotion and support is an integral part of the WIC Program. Increasing the number of trained lactation personnel will assist WIC mothers to make the best decision regarding infant feeding.

ESM 4.7 - Lactation education developed for health care curriculum
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	To provide comprehensive lactation training to health care students
Definition:	**Numerator:** Develop lactation education **Denominator:** n/a **Unit Type:** Text **Unit Number:** Yes/No
Data Sources and Data Issues:	Tennessee WIC Program
Significance:	Comprehensive lactation training is rarely provided in health care program curriculums, especially for students of color. Structured training and education to these budding health professionals on how to educate and assist mothers will help address racial disparities in breastfeeding by increasing initiation, exclusivity, and duration.

ESM 4.8 - WIC Breastfeeding Buddy Program piloted in three counties
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	To successfully pilot of WIC Breastfeeding Buddy Program within three counties
Definition:	**Numerator:** Pilot of WIC Breastfeeding Buddy Program within three counties **Denominator:** n/a **Unit Type:** Text **Unit Number:** Yes/No
Data Sources and Data Issues:	WIC Program
Significance:	A woman's social networks can serve as either a barrier or encouragement for breastfeeding. Social support can impact a mother's decision to breastfeed and help her overcome or manage breastfeeding issues. Women who are able to converse and seek guidance from other peers have a higher likelihood of breastfeeding success.

ESM 4.9 - Unique Designated Breastfeeding Expert for each county
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	To increase access to breastfeeding support in each county.
Definition:	**Numerator:** Number of counties with a unique Designated Breastfeeding Expert **Denominator:** n/a **Unit Type:** Text **Unit Number:** Yes/No
Data Sources and Data Issues:	WIC program DBE Tracking Spreadsheet
Significance:	One barrier to breastfeeding is the lack of access to lactation professionals. Lactation professionals can provide consistent and evidence-based advice to help mothers breastfeed effectively, affecting if they decide or how long they breastfeed.

ESM 4.10 - Number of minority-owned or rural businesses with Breastfeeding Welcomed Here (BFWH) designation NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	To increase the number of minority-owned or rural businesses with BFWH designation
Definition:	**Numerator:** Number of minority-owned or rural businesses with Breastfeeding Welcomed Here (BFWH) designation **Denominator:** n/a **Unit Type:** Count **Unit Number:** 953
Data Sources and Data Issues:	BFWH Tracking Spreadsheet
Significance:	Breastfeeding mothers need community-based support, including welcoming environments where breastfeeding is accepted. By recognizing public locations where mothers can breastfeed comfortably, not only could this impact breastfeeding duration but also increase the perception that breastfeeding is normal.

ESM 4.11 - WIC telehealth services implemented in rural areas
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	To implement telehealth services for nutrition and breastfeeding education for WIC participants in rural areas
Definition:	**Numerator:** Implement telehealth services for WIC services in rural areas **Denominator:** n/a **Unit Type:** Text **Unit Number:** Yes/No
Data Sources and Data Issues:	Tennessee WIC Program
Significance:	Breastfeeding mothers need community-based support, including welcoming environments where breastfeeding is accepted. By recognizing public locations where mothers can breastfeed comfortably, not only could this impact breastfeeding duration but also increase the perception that breastfeeding is normal.

ESM 4.12 - Mental Health resource referral list provided to Tennessee Breastfeeding Hotline (TBH)
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	To provide a referral list with mental health resources to TBH
Definition:	**Numerator:** Provide referral list with mental health resources to Tennessee Breastfeeding Hotline (TBH) **Denominator:** n/a **Unit Type:** Text **Unit Number:** Yes/No
Data Sources and Data Issues:	Tennessee WIC program
Significance:	Mothers who experience stress or who have mental health symptoms may be at risk of having breastfeeding difficulties. Providing mental health resources to Tennessee's 24/7 breastfeeding hotline will ensure mothers not only have access to breastfeeding support but also mental health resources as they navigate one of the most mentally and emotionally challenging periods.

ESM 4.13 - Breastfeeding Welcomed Here (BFWH)-designated businesses surveyed to assess workplace lactation policies
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	To implement a recognition process for BFWH-designated businesses with lactation workplace policies for employees
Definition:	**Numerator:** n/a **Denominator:** n/a **Unit Type:** Text **Unit Number:** Yes/No
Data Sources and Data Issues:	BFWH Tracking Spreadsheet
Significance:	Lack of lactation support in the workplace continues to be a significant barrier for mothers returning to work. BFWH businesses that have ideal workplace lactation policies will be recognized to celebrate businesses with policies and practices that seek support working mothers.

ESM 4.14 - Recognition process implemented for Breastfeeding Welcomed Here (BFWH)-designated businesses NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	To implement a recognition process for BFWH-designated businesses with lactation workplace policies for employees.
Definition:	**Numerator:** Implement recognition process for Breastfeeding Welcomed Here (BFWH)-designated businesses with lactation workplace policies for employees **Denominator:** n/a **Unit Type:** Text **Unit Number:** Yes/No
Data Sources and Data Issues:	FHW Program data
Significance:	Lack of lactation support in the workplace continues to be a significant barrier for mothers returning to work. BFWH businesses that have ideal workplace lactation policies will be recognized to celebrate businesses with policies and practices that seek support working mothers.

ESM 5.1 - Percent of hospitals receiving national recognition or implementing approved safe sleep policy
NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Measure Status:	Active
Goal:	Increase the number of hospitals teaching parents to place infants in a safe sleep environment.
Definition:	**Numerator:** Number of birthing hospitals (1) recognized as a National Cribs for Kids certified hospital or with an approved safe sleep policy, and (2) submitting crib audit reports with ≤ 10% of infants being found in an unsafe sleep environment **Denominator:** Number of birthing hospitals in Tennessee **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Family Health and Wellness tracking tool
Significance:	The infant sleep behaviors modeled by hospital staff after birth have been shown to be important in determining the practices new parents adopt when returning home. Because of this highly influential role, it is key to ensure that all birthing hospitals in Tennessee are exemplifying proper safe sleep behaviors and demonstrating to parents that babies should sleep alone, on their back, and in a crib, bassinet, or pack n' play. By increasing the number of hospitals that meet this standard, we can increase the number of Tennessee parents who benefit from a positive example of safe sleep and, by extension, the number who continue to put their infant to sleep safely at home.

ESM 5.2 - Number of educational materials distributed
NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Measure Status:	Active
Goal:	Increase distribution of safe sleep materials with particular focus on areas with the highest disparities
Definition:	**Numerator:** Number of safe sleep educational materials distributed **Denominator:** n/a **Unit Type:** Count **Unit Number:** 240,000
Data Sources and Data Issues:	Family Health and Wellness tracking tool
Significance:	The Division of Family Health and Wellness has developed a variety of safe sleep educational materials to increase awareness of best practices and demonstrate why these behaviors are safest for infants. Since it is not possible for our health educators to personally instruct everyone who cares for an infant, distributing these materials as widely as possible is the best way to get the information to those who need it. This measure will be tracked both as a running total, the current number of educational materials distributed, and as a ratio showing how many materials have been distributed compared to the total number of live births in Tennessee. The goal is that each live birth in Tennessee has multiple opportunities to encounter safe sleep educational materials (i.e. at the hospital, in the Welcome Baby booklet after returning home, advertised in their local convenience store, etc.).

ESM 5.3 - Number of elderly caregivers trained
NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Measure Status:	Active
Goal:	Expand availability of safe sleep training for elderly caregivers
Definition:	**Numerator:** Number of elderly caregivers trained in safe sleep practices **Denominator:** n/a **Unit Type:** Count **Unit Number:** 25
Data Sources and Data Issues:	Family Health and Wellness tracking tool
Significance:	Though most educational efforts focus on parents of infants, many young families rely on the help of grandparents and other older relatives to care for children. First-time mothers and fathers are also likely to hold the opinion of their parents in high regard when determining how to care for their new infant. For these reasons, it is critical that older Tennesseans be equipped with the best information and training, especially considering some of the recommendations have changed since their children were infants and their experience may not reflect the most current guidelines. The unit type was selected as percentage, but because of the difficulty in estimating the exact denominator, this measure will also be tracked as a raw number (total number of elderly caregivers that have gone through safe sleep training).

ESM 5.4 - Number of local housing authorities trained on Direct On Scene Education (DOSE)
NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Measure Status:	Active
Goal:	Increase the number of local housing authority agencies that have received Direct On-Scene Education training in targeted regions with highest disparities
Definition:	**Numerator:** Number of local housing authorities that have received Direct On-Scene Education training **Denominator:** Number of local housing authorities in Tennessee **Unit Type:** Count **Unit Number:** 7
Data Sources and Data Issues:	Family Health and Wellness tracking tool
Significance:	The Direct On-Scene Education Training was designed to teach first responders who enter a household with a pregnant woman or infant to look for possible unsafe sleep conditions and offer the residence safe sleep resources (including a safe sleep environment for the infant if needed). The training was expanded to also be offered to local housing authorities so that individuals who routinely enter residences to perform maintenance duties could also become equipped to offer safe sleep materials. Often, individuals entering the home to perform maintenance see the living area in its authentic, everyday state and have a unique opportunity to spot gaps in safe sleep practices where they exist. The DOSE program gives these professionals the tools to address these situations as they arise. This measure will be tracked as the total number of local housing authorities who have received DOSE training.

ESM 5.5 - Number of first responders trained on Direct On Scene Education (DOSE)
NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Measure Status:	Active
Goal:	Increase the number of first responders that have received Direct On-Scene Education training in targeted regions with highest disparities
Definition:	**Numerator:** Number of first responders that have received Direct On-Scene Education training **Denominator:** Number first responders in Tennessee **Unit Type:** Count **Unit Number:** 7
Data Sources and Data Issues:	Family Health and Wellness tracking tool
Significance:	The Direct On-Scene Education Training was designed to teach first responders who enter a household with a pregnant woman or infant to look for possible unsafe sleep conditions and offer the residence safe sleep resources (including a safe sleep environment for the infant if needed). First responders may enter a home to address one problem, but once inside the home it may become obvious that a family does not have a safe sleep environment for their infant and is not using safe sleep practices. The DOSE program gives these professionals the tools to address these situations as they arise. This measure will be tracked as the total number of first responders who have received DOSE training.

ESM 5.6 - Number of hospitals participating in the Safe to Sleep module
NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Measure Status:	Active
Goal:	Increase number of hospitals participating in the Safe to Sleep module
Definition:	**Numerator:** Number of hospitals participating in the Safe the Sleep module **Denominator:** n/a **Unit Type:** Count **Unit Number:** 15
Data Sources and Data Issues:	Family Health and Wellness tracking tool
Significance:	Infant sleep behaviors that are modeled in the hospital influence how parents choose to place their babies to sleep after returning home. For this reason, the health department encourages all birthing hospitals to have a safe sleep policy on hand describing how they will educate parents and model safe sleep. This will be tracked both as the raw number (total number of birthing hospitals participating) and the percent of all birthing hospitals.

ESM 5.7 - Maintain affiliate state licensure with the Alliance for the Advancement of Infant Mental Health
NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Measure Status:	Active
Goal:	To maintain affiliate state licensure with the Alliance for the Advancement of Infant Mental Health
Definition:	**Numerator:** n/a **Denominator:** n/a **Unit Type:** Text **Unit Number:** Yes/No
Data Sources and Data Issues:	FHW
Significance:	The Alliance for the advancement of Infant Mental Health is a global organization that includes the states and countries with infant mental health associations that have licensed the use of the Competency Guidelines® and/or Endorsement for Culturally Sensitive, Relationship-Focused Practice Promoting Infant & Early Childhood Mental Health® under their associations' names. The Alliance supports professionals who serve pregnant women, infants, young children, and families through workforce development. The Infant Mental Health Endorsement® system honors professionals who apply infant mental health principles to their practice. Currently, Tennessee is one of 31 US states with membership in the Alliance. Having more professionals with specialized training in infant mental health is critical to promoting the social and emotional development of infants and their families. Maintaining Tennessee's licensure as an affiliate state will help ensure that the state's infant health workforce continues to invest time in developing the skills they need to help build positive relationships between infants and their caregivers.

ESM 5.8 - Number of reflective supervision cohort groups held
NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Measure Status:	Active
Goal:	To provide reflective supervision cohort groups in each grand region of Tennessee (West, Middle and East) for the EBHV workforce
Definition:	**Numerator:** Number of reflective supervision cohort groups **Denominator:** n/a **Unit Type:** Count **Unit Number:** 72
Data Sources and Data Issues:	FHW
Significance:	The availability of the supervision cohort groups for the evidence-based home visiting workforce will be a crucial resource in building the infant mental health best practices among the professionals in this field. The cohort groups will allow for collaboration between home visiting professionals to make use of shared resources in the areas of training, sustainability, and the promotion of infant mental health principles.

ESM 8.1.1 - Number of physical activity clubs or completed built environment projects
NPM 8.1 – Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Measure Status:	Active
ESM Subgroup(s):	Children 6 through 11
Goal:	Increase the number of school and community based physical activity clubs or completed built environment projects
Definition:	**Numerator:** Number of physical activity clubs or completed built environment projects **Denominator:** n/a **Unit Type:** Count **Unit Number:** 812
Data Sources and Data Issues:	The CDHP/OPP tracking database of physical activity clubs and the OPP and Project Diabetes tracking databases of completed built environment projects. Historically, it has been difficult to determine what PA clubs are current and/or still active.
Significance:	Physical activity clubs and community built environment projects increase both access to and availability of physical activity opportunities in the community. Clubs have the additional benefit and reinforcement of being a fun, group activity. Values will be simple counts of the number of such clubs and projects as reported to TDH through LHDs and other sources.

ESM 8.1.2 - Number of LEAs receiving professional development on physical education and physical activity
NPM 8.1 – Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Measure Status:	Active
ESM Subgroup(s):	Children 6 through 11
Goal:	Increase the number of LEAs receiving professional development on physical education and physical activity, including CSPAP
Definition:	**Numerator:** Number of LEAs receiving professional development on physical education and physical activity, including CSPAP **Denominator:** n/a **Unit Type:** Count **Unit Number:** 50
Data Sources and Data Issues:	The Coordinated School Health (CSH) tracking database as well as the annual CSH District Application survey; no known issues
Significance:	Direct professional development among school and LEA staff is essential to producing opportunities to increase both physical education and physical activity within the school setting. CSPAP is a formal training curriculum with proven effectiveness. Values will be simple counts of LEAs receiving professional development.

ESM 8.1.3 - Number of Public Health Educators and LEA staff receiving professional education in healthy lifestyle choices before, during, and after school hours
NPM 8.1 – Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Measure Status:	Active
ESM Subgroup(s):	Children 6 through 11
Goal:	Increase the number of PHEs and LEA staff receiving professional education in healthy lifestyle choices before, during, and after school hours
Definition:	**Numerator:** Number of PHEs, LEAs, and LEA staff receiving professional education in healthy lifestyle choices before, during, and after school hours **Denominator:** n/a **Unit Type:** Count **Unit Number:** 250
Data Sources and Data Issues:	The Coordinated School Health (CSH) tracking database as well as the annual CSH District Application survey; no known issues
Significance:	Direct professional development among public health educators and LEA and school staff, especially physical education and health staff and nutrition and food service workers, is essential to producing opportunities to increase both physical activity and healthier food choices within the school setting. Values will be simple counts of PHEs, LEA staff, and LEAs receiving professional development.

ESM 8.1.4 - Number of Gold Sneaker certified childcare facilities
NPM 8.1 – Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Measure Status:	Active
ESM Subgroup(s):	Children 6 through 11
Goal:	Increase the number of TN Gold Sneaker certified childcare facilities
Definition:	**Numerator:** Number of TN Gold Sneaker certified childcare facilities **Denominator:** n/a **Unit Type:** Count **Unit Number:** 1,050
Data Sources and Data Issues:	Gold Sneaker Initiative tracking system, which is continuous and up to date; no known issues
Significance:	The Gold Sneaker Initiative provides a framework, guidance, and policies pertaining to healthy nutrition, physical activity, tobacco prevention, and other health issues for childcare providers. In addition, Gold Sneaker is now a requirement for one component of the DHS 3-Star Quality rating, which gives childcare facilities an additional incentive to be certified and to follow policies. Values will be a simple count of the number of current, active Gold Sneaker certified childcare centers.

ESM 8.1.5 - Number of Healthy Parks Healthy Person prescriptions written
NPM 8.1 – Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Measure Status:	Active
ESM Subgroup(s):	Children 6 through 11
Goal:	Increase the number of TN Healthy Parks Health Person (HPHP) prescriptions written
Definition:	**Numerator:** Number of TN Healthy Parks Health Person (HPHP) prescriptions written **Denominator:** n/a **Unit Type:** Count **Unit Number:** 350
Data Sources and Data Issues:	TDH EHR tracking of HPHP prescription check off box. This check off box has not yet been incorporated into the TDH EHR template.
Significance:	Studies have shown that when a doctor or other health care provider writes a prescription or recommends a certain course of action or behavior to a patient, the patient's likelihood of adopting that behavior increases tremendously. In that regard, there has been good success thus far with the HPHP prescription program encouraging patients to download and use the HPHP app. Values will derive from the number of times the TDH EHR system shows that the HPHP prescription program was used with a patient, provided that a check off box is developed for the system.

ESM 8.1.6 - Number of Healthy Parks Healthy Person app users
NPM 8.1 – Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Measure Status:	Active
ESM Subgroup(s):	Children 6 through 11
Goal:	Increase the number of TN Healthy Parks Health Person (HPHP) app users
Definition:	**Numerator:** Number of TN Healthy Parks Health Person (HPHP) app users **Denominator:** n/a **Unit Type:** Count **Unit Number:** 2,140
Data Sources and Data Issues:	TDEC HPHP app tracking database, which provides a continuous, current number of app users
Significance:	Physical activity is a critical component to maintaining healthy weight or losing excess weight. The HPHP provides an easy and fun way for people to use state parks to remain active, and the program provides incentives for participation as well. Studies have shown that the right incentives will help people to adopt healthier behaviors. Values will derive from the count of HPHP app users maintained by the TDEC app tracking database.

ESM 8.1.7 - Number of primary prevention plans with a goal related to reducing sugary drink consumption
NPM 8.1 – Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Measure Status:	Active
ESM Subgroup(s):	Children 6 through 11
Goal:	Increase the number of local communities who set a goal with Primary Prevention Plans from community needs assessment of reducing consumption of sugary drinks
Definition:	**Numerator:** Number of local communities who set a goal with Primary Prevention Plans from community needs assessment of reducing consumption of sugary drinks **Denominator:** n/a **Unit Type:** Count **Unit Number:** 20
Data Sources and Data Issues:	TDH Office of Primary Prevention (OPP) database of TN community primary prevention plans; no issues identified
Significance:	Concerted community planning and action steps are critical factors in changing long established local practices and policies related to unhealthy lifestyle behaviors. Doing a community needs assessment prior to developing an action plan assures that resources and efforts are prioritized where they will have the greatest impact. As consumption of sugar-sweetened beverages is a major contributor to overweight and obesity, this behavior warrants inclusion in community assessments and plans. Values for this measure will derive from simple counts determined by a search of the TDH OPP primary prevention plan database.

ESM 8.1.8 - Number of partners to develop and implement strategies that increase access to healthier community food and beverage options
NPM 8.1 – Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Measure Status:	Active
ESM Subgroup(s):	Children 6 through 11
Goal:	Increase the number of partners to develop and implement strategies that increase access to healthier community food and beverage options
Definition:	**Numerator:** Number of partners to develop and implement strategies that increase access to healthier community food and beverage options **Denominator:** n/a **Unit Type:** Count **Unit Number:** 315
Data Sources and Data Issues:	TDH/CDHP tracking database and program reports related to developing community partnerships; a tracking system must be developed that assures real time, complete reporting of active partnerships
Significance:	Concerted community planning and action among a diversified network of partners is critical to increasing availability of and access to healthier food and beverage options. Partnerships can leverage shared resources in an effective and efficient manner. Values for this measure will derive from a database and tracking system of program activities and partnerships, which is not yet fully developed.

ESM 8.1.9 - Number of LEAs that have a policy/protocal for joint use agreements of facilities
NPM 8.1 – Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Measure Status:	Active
ESM Subgroup(s):	Children 6 through 11
Goal:	Increase the number of LEAs that have a policy/protocol for joint use agreements of facilities after school hours
Definition:	**Numerator:** Number of LEAs that have a policy/guideline/protocol for joint use agreements of facilities after school hours **Denominator:** n/a **Unit Type:** Count **Unit Number:** 134
Data Sources and Data Issues:	TDE CSH annual District Application survey; no known data issues
Significance:	Physical activity is a critical factor in maintaining healthy weight or losing excess weight. Joint use agreements can support children and adults in sustaining a healthy level of physical activity by providing them with access to a variety of facilities and space where they can exercise at no or little expense. Values for this measure will derive from the CSH District Application, which is an annual and comprehensive survey of LEA practices, policies, and protocols.

ESM 8.1.10 - Number of LHDs receiving training, resources, and tools to promote the mental health benefits of physical activity
NPM 8.1 – Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Measure Status:	Active
ESM Subgroup(s):	Children 6 through 11
Goal:	Increase the number of LEAs receiving professional development on the mental health benefits of physical activity
Definition:	**Numerator:** Number of LEAs receiving professional development on the mental health benefits of physical activity **Denominator:** n/a **Unit Type:** Count **Unit Number:** 50
Data Sources and Data Issues:	TDH/CDHP and TDE CSH tracking databases and program reports related to professional development in LEAs; databases and tracking systems are under development
Significance:	Direct professional development among school and LEA staff is essential to promote the physical and mental health benefits of physical education and physical activity. TDH and TDE can provide the evidence-based training, technical assistance, and other resources that are critical to effective and useful professional development. Values for this measure will be simple counts derived from program report and tracking databases that are currently being developed.

ESM 8.1.11 - Number of LEAs receiving professional development on mental health benefits of physical activity
NPM 8.1 – Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Measure Status:	Active
ESM Subgroup(s):	Children 6 through 11
Goal:	To increase the number of LEAs receiving professional development on the mental health benefits of physical activity
Definition:	**Numerator:** Number of LEAs receiving professional development on the mental health benefits of physical activity **Denominator:** n/a **Unit Type:** Count **Unit Number:** 40
Data Sources and Data Issues:	TDH/CDHP and TDE CSH tracking databases and program reports related to professional development in LEAs; databases and tracking systems are under development
Significance:	Direct professional development among school and LEA staff is essential to promote the physical and mental health benefits of physical education and physical activity. TDH and TDE can provide the evidence-based training, technical assistance, and other resources that are critical to effective and useful professional development. Values for this measure will be simple counts derived from program report and tracking databases that are currently being developed.

ESM 8.1.12 - ACEs online curriculum developed and implemented
NPM 8.1 – Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Measure Status:	Active
ESM Subgroup(s):	Children 6 through 11
Goal:	To increase ACEs awareness
Definition:	**Numerator:** n/a **Denominator:** n/a **Unit Type:** Text **Unit Number:** Yes/No
Data Sources and Data Issues:	Building strong brains webpage, REDCap Portal
Significance:	Adverse childhood experiences (ACEs) are traumatic events occurring before age 18. ACEs include all types of abuse and neglect as well as parental mental illness, substance use, divorce, incarceration, and domestic violence. Becoming trauma-informed is a process using knowledge about the prevalence and impact of toxic stress (e.g., ACEs) to reexamine how we see, interpret, and interact with people.

ESM 8.1.13 - Trauma informed care online curriculum developed and implemented
NPM 8.1 – Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Measure Status:	Active
ESM Subgroup(s):	Children 6 through 11
Goal:	To increase trauma informed care
Definition:	**Numerator:** n/a **Denominator:** n/a **Unit Type:** Text **Unit Number:** Yes/No
Data Sources and Data Issues:	Building strong brains webpage, REDCap Portal
Significance:	TIC is a culture change process. It is not a therapy, intervention, or specific action; it is an all-encompassing paradigm shift. It's also important to remember that trauma-informed care is not just for service providers; it is universally applicable and everyone has a role to play! Thus, TDH aims to increase awareness of ACEs and create a trauma-sensitive culture in TN.

ESM 8.1.14 - Percent of child fatality teams provided ACEs refresher training
NPM 8.1 – Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Measure Status:	Active
ESM Subgroup(s):	Children 6 through 11
Goal:	To increase awareness of ACEs
Definition:	**Numerator:** Number of child fatality review teams that receive ACEs refresher training **Denominator:** Number of child fatality review teams **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	REDCap survey tool- Limitation(s): data collection tool is still under development
Significance:	Training on the science of ACEs is necessary to transform the organization and community partners into service delivery systems that are trauma informed and leaders who plan with prevention in mind. Over the course of the year, TDH will provide refresher training to its Child Fatality Review team members in the Building Strong Brains curriculum and will implement evidence based strategies for ACEs prevention and mitigation. This will increase awareness of ACEs.

ESM 8.1.15 - Number of families enrolled in a home visiting program
NPM 8.1 – Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Measure Status:	Active
ESM Subgroup(s):	Children 6 through 11
Goal:	To increase the percentage of families who have an improved protective factors score
Definition:	**Numerator:** Number of families enrolled in home visiting **Denominator:** n/a **Unit Type:** Count **Unit Number:** 2,700
Data Sources and Data Issues:	EBHV REDCAP Data Collection System, Annual Protective Factors Survey
Significance:	Protective factors are characteristics of strong parenting skills that reduce the effects of toxic stress and build resiliency in children. Protective factors have been shown to be essential in preventing ACES. Examples of protective factors include a parenting relationship that promotes literacy through healthy conversation and dedicated time to reading with an adult. A core activity of home visiting curriculum seeks to support parents in building resiliency for their families. This measure will demonstrate the capacity of home visiting to increase protective factors in families. Centers for Disease Control and Prevention, Kaiser Permanente. The ACE Study Survey Data [Unpublished Data]. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention; 2016. Healthy People 2020 [Internet]. Washington, DC: U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion [cited 06/18/20]. Kidcentral TN. “Adverse Childhood Experience: Protective Factors”. https://www.kidcentraltn.com/support/crisis-services-for-children/adverse-childhood-experience--protective-factors.html [accessed 06/19/20].

ESM 8.1.16 - Number of families enrolled in a home visiting program for at least 14 months
NPM 8.1 – Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Measure Status:	Active
ESM Subgroup(s):	Children 6 through 11
Goal:	To increase the percentage of families enrolled in home visiting for at least 14 months
Definition:	**Numerator:** Number of families in the denominator who were enrolled at least 14 months at the time of reporting **Denominator:** Number of families enrolled in home visiting during the reporting year **Unit Type:** Count **Unit Number:** 850
Data Sources and Data Issues:	EBHV REDCAP Data Collection System, Service Detail
Significance:	Evidence-based home visiting (EBHV) programming seeks to improve child health and well-being, parent health and well-being, child development and school readiness, family economic self-sufficiency, and positive parent-child relationships. EBHV proposes that the greatest impact can be made in these areas during the first five years of life. Furthermore, the length of time that a family is enrolled and engaged in home visiting services is associated with the positive parent and child outcomes mentioned earlier. An enrollment period of at least a year has been shown to achieve the greatest outcomes. National Home Visiting Resource Center. (2018). Home Visiting Primer. Arlington, VA: James Bell Associates and the Urban Institute. Maternal, Infant, and Early Childhood Home Visiting Technical Assistance Coordinating Center (MIECHV TACC). (July 2015). MIECHV Issue Brief on Family Enrollment and Engagement. MIECHV TACC.

ESM 8.1.17 - Percent of families with improved protective factors score
NPM 8.1 – Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Measure Status:	Active
ESM Subgroup(s):	Children 6 through 11
Goal:	To increase the percentage of families who have an improved protective factors score
Definition:	**Numerator:** Number of families enrolled in home visiting with an improved protective factors score at the time of reporting **Denominator:** Number of families enrolled in home visiting during the reporting year who have at least one protective factors score **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	EBHV REDCAP Data Collection System, Annual Protective Factors Survey
Significance:	Protective factors are characteristics of strong parenting skills that reduce the effects of toxic stress and build resiliency in children. Protective factors have been shown to be essential in preventing ACES. Examples of protective factors include a parenting relationship that promotes literacy through healthy conversation and dedicated time to reading with an adult. A core activity of home visiting curriculum seeks to support parents in building resiliency for their families. This measure will demonstrate the capacity of home visiting to increase protective factors in families. Centers for Disease Control and Prevention, Kaiser Permanente. The ACE Study Survey Data [Unpublished Data]. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention; 2016. Healthy People 2020 [Internet]. Washington, DC: U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion [cited 06/18/20]. Kidcentral TN. “Adverse Childhood Experience: Protective Factors”. https://www.kidcentraltn.com/support/crisis-services-for-children/adverse-childhood-experience--protective-factors.html [accessed 06/19/20].

ESM 8.1.18 - Percent of families enrolled in CHANT care coordination
NPM 8.1 – Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Measure Status:	Active
ESM Subgroup(s):	Children 6 through 11
Goal:	To increase the number of families enrolled into CHANT care coordination
Definition:	**Numerator:** Number of enrolled families **Denominator:** Total number of referrals received **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	CHANT REDCap Database Limitation(s): 1) includes only participants of CHANT in the state, 2) in any given reporting period, the numerator and denominator may not include the same sample since the receipt of services can take place in a different reporting period than the referral.
Significance:	Health status and related health behaviors are determined by influences at multiple levels: personal, organizational/institutional, environmental, and policy. Because significant and dynamic interrelationships exist among these different levels of health determinants, educational and community-based programs are most likely to succeed in improving health and wellness when they address influences at all levels and in a variety of environments/settings.

ESM 8.1.19 - Percent of uninsured people who enroll into a health insurance plan
NPM 8.1 – Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Measure Status:	Active
ESM Subgroup(s):	Children 6 through 11
Goal:	To increase the number of people who are enrolled in a health insurance plan
Definition:	**Numerator:** Number of clients who enroll in a health insurance plan **Denominator:** Number of clients that trigger the insurance pathway **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	CHANT REDCap Database Limitation(s): 1) includes only participants of CHANT in the state, 2) in any given reporting period, the numerator and denominator may not include the same sample since the receipt of services can take place in a different reporting period than the referral.
Significance:	Access to comprehensive, quality health care services is important for promoting and maintaining health, preventing and managing disease, reducing unnecessary disability and premature death, and achieving health equity for all Americans. Health insurance coverage helps patients enter the health care system. Lack of adequate coverage makes it difficult for people to get the health care they need and, when they do get care, burdens them with large medical bills. Uninsured people are more likely to have poor health status, less likely to receive medical care, more likely to be diagnosed later, more likely to die prematurely.

ESM 8.1.20 - Percent of people with an employment need referred to employment services
NPM 8.1 – Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Measure Status:	Active
ESM Subgroup(s):	Children 6 through 11
Goal:	To ncrease the percent of people referred to an employment services
Definition:	**Numerator:** Number of clients who are referred to an employment services **Denominator:** Number of clients that trigger the employment pathway **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	CHANT REDCap Database Limitation(s): 1) includes only participants of CHANT in the state, 2) in any given reporting period, the numerator and denominator may not include the same sample since the receipt of services can take place in a different reporting period than the referral.
Significance:	Multiple aspects of employment, including job security, the work environment, financial compensation, and job demands, may affect health. Job benefits such as health insurance, paid sick leave, and parental leave can affect the health of employed individuals. There exist several disparities in the workplace that may affect health. Those include education, gender, race and ethnicity.

ESM 8.1.21 - Percent of people with a housing need referred to a housing agency
NPM 8.1 – Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Measure Status:	Active
ESM Subgroup(s):	Children 6 through 11
Goal:	To reduce the number of clients without housing
Definition:	**Numerator:** Number of clients who are referred to a housing agency **Denominator:** Number of clients that trigger the housing pathway **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	CHANT REDCap Database Limitation(s): 1) includes only participants of CHANT in the state, 2) in any given reporting period, the numerator and denominator may not include the same sample since the receipt of services can take place in a different reporting period than the referral.
Significance:	Housing instability can encompass several challenges, such as having trouble paying rent, overcrowding, moving frequently, staying with relatives, or spending the bulk of household income on housing. These experiences may negatively affect physical health and make it harder to access health care. Households are considered to be cost burdened if they spend more than 30% of their income on housing.

ESM 8.1.22 - Percent of caregivers screened for depression
NPM 8.1 – Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Measure Status:	Active
ESM Subgroup(s):	Children 6 through 11
Goal:	To increase number of primary caregivers screened for maternal depression.
Definition:	**Numerator:** Number of primary caregivers enrolled in home visiting who are screened for depression **Denominator:** Number of primary caregivers enrolled in home visiting **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	EBHV and CHANT- Limitation(s): 1) includes only participants of EBHV/CHANT in the state.
Significance:	Research has shown that people with two or more ACEs are more (~ four times) likely to develop depression. Similarly, depressed mothers are more likely to neglect their children, which itself is one of the 10 original ACEs. ACEs may have both, potentially a lifelong consequence on children and contribute to maternal depression. Ultimately, reductions in rates of maternal depression support improvement in a child's health and disrupts the intergenerational transmission of ACEs. EBHV/CHANT programs conduct maternal depression screening once (using Edinburg depression tool) within 3 mos after enrollment for postnatally enrollees or 3 mos post-delivery for prenatally enrollees.

ESM 8.1.23 - Percent of caregivers who screen positive for depression and receive a referral to mental health services
NPM 8.1 – Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Measure Status:	Active
ESM Subgroup(s):	Children 6 through 11
Goal:	To increase the number of primary caregivers who are referred to mental services
Definition:	**Numerator:** Number of primary caregivers enrolled in home visiting who receive referral to mental services (and met the conditions specified in the denominator). **Denominator:** Number of primary caregivers enrolled in EBHV who screened for mental needs within 3 mos or enrollment; for those not enrolled prenatally, or within 3 months of delivery for those enrolled in EBHV prenatally. **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	EBHV- Limitation(s): 1) includes only participants of EBHV in the state, 2) in any given reporting period, the numerator and denominator do not need to include the same sample since the receipt of services can take place in a different reporting period than the depression screen/referral.
Significance:	Research has shown that people with two or more ACEs are more (~ four times) likely to develop depression. Similarly, depressed mothers are more likely to neglect their children, which itself is one of the 10 original ACEs. ACEs may have both, potentially a lifelong consequence on children and contribute to maternal depression. Ultimately, reductions in rates of maternal depression support improvement in a child's health and disrupts the intergenerational transmission of ACEs. EBHV program refers primary caregivers who screened positive for depressive symptoms to mental services - for EBHV enrollees.

ESM 11.1 - Number of people participating in the medical home learning collaborative
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
ESM Subgroup(s):	CSHCN
Goal:	Identify and share best practices around implementing the medical home model
Definition:	**Numerator:** Number of individuals participating in learning collaborative **Denominator:** n/a **Unit Type:** Count **Unit Number:** 375
Data Sources and Data Issues:	CYSHCN MCH/Title V Program data
Significance:	The utilization of the shared vision document helps the healthcare providers promote integrated and improved CYSHCN system of care in their practices, which is expected to improve medical home utilization.

ESM 11.2 - Number of medical home conference attendees
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
ESM Subgroup(s):	CSHCN
Goal:	To increase the number of medical practices using the medical home approach.
Definition:	**Numerator:** Number of conference attendees **Denominator:** n/a **Unit Type:** Count **Unit Number:** 200
Data Sources and Data Issues:	CYSHCN MCH/Title V Program data
Significance:	The more the healthcare providers adopting medical home approach in their practice, the more children receive care in medical home.

ESM 11.3 - Number of non-Medicaid providers who receive technical assistance on medical home implementation
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
ESM Subgroup(s):	CSHCN
Goal:	To increase the number of medical practices using the medical home approach.
Definition:	**Numerator:** Number of non-Medicaid providers receiving technical assistance **Denominator:** n/a **Unit Type:** Count **Unit Number:** 175
Data Sources and Data Issues:	CYSHCN MCH/Title V Program data; Limitation: identifying non-Medicaid providers
Significance:	Providers educated on the medical home approach are more likely to utilize it in their practices with the children they serve.

ESM 11.4 - Number of providers and families educated on the medical home approach
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
ESM Subgroup(s):	CSHCN
Goal:	Increase the number of healthcare providers implementing on medical home implementation.
Definition:	**Numerator:** Number of individuals receiving educational material **Denominator:** n/a **Unit Type:** Count **Unit Number:** 1,000
Data Sources and Data Issues:	CYSHCN MCH/Title V Program data
Significance:	It is important that families and providers receive education on medical home implementation and transition to create opportunities for systems change with potential of increasing knowledge, access and utilization of medical home.

ESM 11.5 - Number of resources provided to families and providers
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
ESM Subgroup(s):	CSHCN
Goal:	Increase the number of families and providers who have access to resources on dental home, behavioral/mental health, care coordination, respite and family engagement.
Definition:	**Numerator:** Number of resources provided **Denominator:** n/a **Unit Type:** Count **Unit Number:** 40
Data Sources and Data Issues:	CYSHCN MCH/Title V Program data
Significance:	Some providers and families may hesitate to embrace new changes. Education and training may facilitate the adoption of changes among providers.

ESM 11.6 - Number of medical home tool-kits distributed
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
ESM Subgroup(s):	CSHCN
Goal:	To increase the number of families and providers who have access to medical home resources.
Definition:	**Numerator:** Number of medical home tool-kits distributed **Denominator:** n/a **Unit Type:** Count **Unit Number:** 1,000
Data Sources and Data Issues:	CYSHCN MCH/Title V Program data
Significance:	Increased knowledge among providers on medical home best practices is expected to result in increased adoption in their practices.

ESM 11.7 - Number of care coordination tool-kits distributed
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
ESM Subgroup(s):	CSHCN
Goal:	To increase the number of families who have access to care coordination.
Definition:	**Numerator:** Number of care coordination tool-kits distributed **Denominator:** n/a **Unit Type:** Count **Unit Number:** 275
Data Sources and Data Issues:	CYSHCN MCH/Title V Program data
Significance:	Families who receive care coordination experience greater success in access and utilization of medical home and in turn are expected to have more positive health outcomes.

ESM 11.8 - Number of CYSHCN who receive CHANT/CSS care coordination
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
ESM Subgroup(s):	CSHCN
Goal:	To increase the number of children and youth with special health care needs receiving CHANT/CSS care coordination.
Definition:	**Numerator:** Number of CYSHCN receiving CHANT/CSS care coordination **Denominator:** n/a **Unit Type:** Count **Unit Number:** 4,500
Data Sources and Data Issues:	CYSHCN MCH/Title V Program data and CHANT Program data
Significance:	It is important to ensure the children with special healthcare needs served by the Tennessee Children's Special Services program receive care coordination services to assist in system navigation.

ESM 11.9 - Number of CSS authorized vendors who receive medical home resources
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
ESM Subgroup(s):	CSHCN
Goal:	To increase the number of medical providers receiving medical home best practice resources.
Definition:	**Numerator:** Number of CSS vendors receiving resources **Denominator:** n/a **Unit Type:** Count **Unit Number:** 850
Data Sources and Data Issues:	CYSHCN MCH/Title V Program data
Significance:	Increased knowledge among vendors on medical home best practices is expected to result in increased adoption in their practices.

ESM 11.10 - Number of families provided education and resources on importance of medical home access and utilization
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
ESM Subgroup(s):	CSHCN
Goal:	To increase the number of families who receive education and resources on the importance of coordinated and comprehensive care in the medical home.
Definition:	**Numerator:** Number of families provided education and resources **Denominator:** n/a **Unit Type:** Count **Unit Number:** 1,000
Data Sources and Data Issues:	Data Sources: CHANT program data and Call Center data; Limitations: Retrieving data from separate data systems
Significance:	It is important to ensure that children and families receive annual medical exams and preventive care in an assigned medical home setting. Providing education and knowledge on the importance of care in the medical home will be significant in increasing actual utilization of the medical home.

ESM 11.11 - Number of families receiving referrals to their child's primary care provider
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
ESM Subgroup(s):	CSHCN
Goal:	To increase the number of families referred to their child's primary care provider.
Definition:	**Numerator:** Number of referrals to the primary care providers **Denominator:** n/a **Unit Type:** Count **Unit Number:** 475
Data Sources and Data Issues:	CHANT program data and Call Center data
Significance:	It is important to ensure that children and families receive annual medical exams and preventive care in an assigned medical home setting. Identifying and providing referrals to the primary care provider will be significant in increasing actual utilization of the medical home.

ESM 11.12 - Number of families who schedule an annual visit with their child's primary care provider
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
ESM Subgroup(s):	CSHCN
Goal:	To increase the number families who schedule their child's primary care appointment.
Definition:	**Numerator:** Number of families who schedule appointments **Denominator:** n/a **Unit Type:** Count **Unit Number:** 475
Data Sources and Data Issues:	CHANT program data and Call Center data
Significance:	It is important to ensure that children and families receive annual medical exams and preventive care in an assigned medical home setting. Assisting families to schedule appointments will be significant in increasing actual utilization of the medical home.

ESM 11.13 - Number of children who complete an annual visit with their primary care provider
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
ESM Subgroup(s):	CSHCN
Goal:	To increase the number of children who complete an annual visit with their primary care provider.
Definition:	**Numerator:** Number children completing annual medical visit with their primary care provider **Denominator:** n/a **Unit Type:** Count **Unit Number:** 475
Data Sources and Data Issues:	CHANT program data and Call Center data
Significance:	It is important to ensure that children and families receive annual medical exams and preventive care in an assigned medical home setting especially for continuity of care and detecting potential problems early.

ESM 12.1 - Number of transition resources identified
NPM 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care

Measure Status:	Active
ESM Subgroup(s):	CSHCN
Goal:	To increase the number of youth with special health care needs that receive services necessary for successful transition.
Definition:	**Numerator:** Number of transition resources identified **Denominator:** n/a **Unit Type:** Count **Unit Number:** 65
Data Sources and Data Issues:	CYSHCN MCH/Title V Program data
Significance:	Families and youth need to be aware of the importance of a transition plan. The data repository will be developed in a manner that it will collect the type and number of resources identified.

ESM 12.2 - Number of transition resource kits disseminated
NPM 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care

Measure Status:	Active
ESM Subgroup(s):	CSHCN
Goal:	To increase the number of youth with special health care needs that receive resources necessary for successful transition.
Definition:	**Numerator:** Number of kits disseminated **Denominator:** n/a **Unit Type:** Count **Unit Number:** 2,400
Data Sources and Data Issues:	CYSHCN MCH/Title V Program data
Significance:	Youth who receive education and knowledge on transition planning are expected to be successful transitioning to adult independence.

ESM 12.3 - Number of youth with special health care needs receiving transition training
NPM 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care

Measure Status:	Active
ESM Subgroup(s):	CSHCN
Goal:	Number of YSHCN participating in transition training
Definition:	**Numerator:** Number of YSHCN participating in transition training **Denominator:** n/a **Unit Type:** Count **Unit Number:** 175
Data Sources and Data Issues:	CYSHCN MCH/Title V Program data
Significance:	The utilization of transition resources helps YSHCN have successful transition to adulthood.

ESM 12.4 - Number of Youth Advisory Council members with special healthcare needs
NPM 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care

Measure Status:	Active
ESM Subgroup(s):	CSHCN
Goal:	To increase the number of youth with special health care needs that serve on the Youth Advisory Council.
Definition:	**Numerator:** Number of Youth Advisory Council members with special healthcare needs **Denominator:** n/a **Unit Type:** Count **Unit Number:** 25
Data Sources and Data Issues:	CYSHCN MCH/Title V Program data
Significance:	The program is to recruit more members, both with and without special healthcare needs to join the Youth Advisory Council. This will contribute to diverse and equitable voices creating policies and self-advocacy opportunities for other YSHCN.

ESM 12.5 - Number of youth with special health care needs trained as mentors
NPM 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care

Measure Status:	Active
ESM Subgroup(s):	CSHCN
Goal:	To increase the number of youth with special health care needs that receive mentor other youth with special health care needs to serve as leaders on the Youth Advisory Council.
Definition:	**Numerator:** Number of youth with special health care needs trained as mentors **Denominator:** n/a **Unit Type:** Count **Unit Number:** 65
Data Sources and Data Issues:	CYSHCN MCH/Title V Program data
Significance:	The program is to encourage active participation and involvement of the youth and families in policy development.

ESM 12.6 - Number of parents and youth with special health care needs who receive leadership and self-advocacy training
NPM 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care

Measure Status:	Active
ESM Subgroup(s):	CSHCN
Goal:	To increase the number of parents and youth with special health care needs that receive leadership and self-advocacy training.
Definition:	**Numerator:** Number of parents and youth with special health care needs who receive leadership and self-advocacy training **Denominator:** n/a **Unit Type:** Count **Unit Number:** 150
Data Sources and Data Issues:	CYSHCN MCH/Title V Program data
Significance:	Youth and parents are provided leadership training and are able to provide mentoring and peer to peer support to other parents and youth with special health care needs. Trained parents and YSHCN are better equipped to become self-advocates and participate in the decision making process and policy development.

ESM 14.2.1 - Number of tobacco-free sports teams
NPM 14.2 – Percent of children, ages 0 through 17, who live in households where someone smokes

Measure Status:	Active
ESM Subgroup(s):	Adolescents 12 through 17
Goal:	To support smoke free environments as the social norm
Definition:	**Numerator:** Sports teams making initial tobacco-free pledge **Denominator:** n/a **Unit Type:** Count **Unit Number:** 88
Data Sources and Data Issues:	Tennessee Tobacco Control Program data
Significance:	The measure is significant in that it underlies the social norm change affected by youth leaders publicly pledging to their school, peers, and community to be tobacco free. The number of sports teams taking the tobacco-free pledge will consist of sports teams which are making their initial pledge (excluding re-pledges in subsequent years).

ESM 14.2.2 - Number of ambassadors recruited
NPM 14.2 – Percent of children, ages 0 through 17, who live in households where someone smokes

Measure Status:	Active
ESM Subgroup(s):	Adolescents 12 through 17
Goal:	Decrease tobacco use among youth through peer-to-peer intervention and youth advocates for anti-tobacco policy.
Definition:	**Numerator:** Number of ambassadors recruited **Denominator:** n/a **Unit Type:** Count **Unit Number:** 26
Data Sources and Data Issues:	Tobacco Control Program data
Significance:	Youth who are recruited to serve as TNSTRONG ambassadors represent an important component of the TCP's efforts to reach and influence local youth. Ambassadors are often leaders within their schools and communities and are trained on peer-to-peer intervention and policy change. The number of ambassadors recruited will be tracked annually and will consist of the total number of ambassadors inclusive of those in their second year (of a two year cycle).

ESM 14.2.3 - Number of youth councils
NPM 14.2 – Percent of children, ages 0 through 17, who live in households where someone smokes

Measure Status:	Active
ESM Subgroup(s):	Adolescents 12 through 17
Goal:	Increase anti-tobacco activities among youth.
Definition:	**Numerator:** Number of youth councils **Denominator:** n/a **Unit Type:** Count **Unit Number:** 80
Data Sources and Data Issues:	FHW Tobacco Control Program data
Significance:	Youth councils serve to further TCP's activities to prevent youth from initiating or using tobacco and e-cigarettes. Youth councils are currently defined as any youth-based group which has conducted at least one anti-tobacco activity within the past twelve months at the time of reporting. As mentioned previously, revisions to youth council guidelines may downwardly affect the number of youth councils reported by field staff moving forward.

ESM 14.2.4 - Number of youth-created PSAs
NPM 14.2 – Percent of children, ages 0 through 17, who live in households where someone smokes

Measure Status:	Active
ESM Subgroup(s):	Adolescents 12 through 17
Goal:	Increase youth exposure to anti-tobacco messaging and vest youth in program activities as ambassadors and leaders in their communities
Definition:	**Numerator:** Number of youth-created PSAs **Denominator:** n/a **Unit Type:** Count **Unit Number:** 10
Data Sources and Data Issues:	TDH Communications Office will track the number of youth created PSAs via Facebook, Twitter, and Instagram using designated hashtags.
Significance:	Youth-created PSAs serve to not only increase youth exposure to anti-tobacco messaging, but also vest youth in program activities as ambassadors and leaders in their communities. Because the COVID-19 pandemic has limited opportunities for youth to present peer-to-peer presentations in their schools, PSAs distributed through social media are a viable option for youth leaders to reach their peers and communities.

ESM 14.2.5 - Number of youth who attend the state anti-tobacco conference
NPM 14.2 – Percent of children, ages 0 through 17, who live in households where someone smokes

Measure Status:	Active
ESM Subgroup(s):	Adolescents 12 through 17
Goal:	Decrease tobacco use among youth through peer-to-peer intervention and youth advocates for anti-tobacco policy.
Definition:	**Numerator:** Youth attendees at annual TNSTRONG summit **Denominator:** n/a **Unit Type:** Count **Unit Number:** 400
Data Sources and Data Issues:	Tobacco Control Program - TNSTRONG Attendee Registration system
Significance:	TNSTRONG attendees, similar to ambassadors, are trained on peer-to-peer interventions and policy change, and are an essential component to reaching and influencing youth throughout Tennessee. TNSTRONG youth attendees are defined as school-aged individuals who attend the TNSTRONG event in their capacity as students (as opposed to presenters or chaperones).

ESM 14.2.6 - Number of trainings educating youth on tobacco issues
NPM 14.2 – Percent of children, ages 0 through 17, who live in households where someone smokes

Measure Status:	Active
ESM Subgroup(s):	Adolescents 12 through 17
Goal:	Prevent tobacco use in youth.
Definition:	**Numerator:** Number of trainings delivered to K-12 youth on tobacco issues **Denominator:** n/a **Unit Type:** Count **Unit Number:** 10
Data Sources and Data Issues:	FHW Tobacco Control Program data
Significance:	Youth trainings are a cornerstone of public health education, especially for preventing tobacco use. Public Health Educators (PHEs) will report into the TUPCP REDCap on the number of presentations to youth (K-12; College – under tobacco free holidays reporting) on tobacco topics and issues.

ESM 14.2.7 - Number of anti-tobacco social media posts
NPM 14.2 – Percent of children, ages 0 through 17, who live in households where someone smokes

Measure Status:	Active
ESM Subgroup(s):	Adolescents 12 through 17
Goal:	To decrease youth tobacco use.
Definition:	**Numerator:** Number of social media posts to TDH and TNSTRONG social media accounts **Denominator:** n/a **Unit Type:** Count **Unit Number:** 24
Data Sources and Data Issues:	TDH Communications Office will track the number of anti-tobacco focused social media posts via Facebook, Twitter, and Instagram using designated hashtags.
Significance:	Anti-tobacco messaging is another cornerstone of tobacco control efforts and impacts the rate at which youth experiment with and initiate smoking and tobacco use. Social media's influence and pervasiveness among adolescents enables TUPCP and youth advocates to reach the target population more effectively.

ESM 14.2.8 - Number of meetings with partners to increase screening and referral of adolescents using tobacco to cessation resources
NPM 14.2 – Percent of children, ages 0 through 17, who live in households where someone smokes

Measure Status:	Active
ESM Subgroup(s):	Adolescents 12 through 17
Goal:	Increase youth tobacco cessation.
Definition:	**Numerator:** Number of meetings with partner organizations regarding instituting protocols to screen adolescents for tobacco use and refer tobacco-users to cessation resources **Denominator:** n/a **Unit Type:** Count **Unit Number:** 2
Data Sources and Data Issues:	FHW Tobacco Control Program data
Significance:	Developing protocols with partner organizations to screen and refer youth who are at risk of tobacco use is an untapped means to address the growing youth e-cigarette use epidemic in Tennessee. TUPCP must first establish relationships with and gain a deeper understanding of partner organizations and their activities before working to establish screening and referral protocols.

ESM 14.2.9 - Number of meetings with partners to expand data collection
NPM 14.2 – Percent of children, ages 0 through 17, who live in households where someone smokes

Measure Status:	Active
ESM Subgroup(s):	Adolescents 12 through 17
Goal:	Increase data collection on youth tobacco use.
Definition:	**Numerator:** Number of meetings with partners on expanding data collection **Denominator:** n/a **Unit Type:** Count **Unit Number:** 2
Data Sources and Data Issues:	FHW Tobacco Control Program
Significance:	Tennessee lacks a state youth health survey that collects demographic information on youth sexual orientation. The absence of sexual orientation questions in Tennessee's YRBS limits researchers and program directors in determining the risk burden among Tennessee sexual minority youth. This, in turn, serves as a barrier to the implementation, monitoring, and improvement of programs meant to address risky behaviors among Tennessee's youth who are sexual minorities as well as reducing the disparities experienced by sexual and gender minority adults in the future. Similarly, Tennessee lacks a state-funded youth tobacco survey such as the YTS. Newly available state surveys may serve as a means to collect specific youth tobacco-use data which is otherwise unavailable through surveys such as the YRBS. By leveraging partnerships with vested organizations to expand data collection on demographic and tobacco-use behaviors, Tennessee's public service organizations, agencies, departments, and partners will be better equipped to address pressing public health issues which affect Tennessee's youth.

ESM 14.2.10 - Number of social media posts promoting text-based cessation services
NPM 14.2 – Percent of children, ages 0 through 17, who live in households where someone smokes

Measure Status:	Active
ESM Subgroup(s):	Adolescents 12 through 17
Goal:	To increase youth tobacco cessation.
Definition:	**Numerator:** Number of social media posts promoting text-based cessation services **Denominator:** n/a **Unit Type:** Count **Unit Number:** 24
Data Sources and Data Issues:	Tobacco Control Program data
Significance:	Cessation-supporting text services have been shown to be effective for youth and young adults who are experimenting with or currently using tobacco products. TDH and partner promotions of these services through social media aims to increase text service utilization.

ESM 14.2.11 - Number of meetings with partner organizations to enhance tobacco activities in coalition action plans
NPM 14.2 – Percent of children, ages 0 through 17, who live in households where someone smokes

Measure Status:	Active
Goal:	To expand the reach and impact of tobacco control activities via partner organizations and coalitions
Definition:	**Numerator:** Number of meetings with partner organizations regarding expanding or enhancing tobacco activities in coalition action plans **Denominator:** n/a **Unit Type:** Count **Unit Number:** 2
Data Sources and Data Issues:	TUPCP will track the number of partner meetings through an established SharePoint folder dedicated to housing meeting notes, attending organizations, outcomes, and next steps.
Significance:	Expanding and leveraging partnerships with existing Anti-Drug Coalitions located through the state will enable the TUPCP to increase the reach of its efforts and activities. Prior to implementing this partnership activity, TUPCP must first establish relationships with and gain a deeper understanding of partner organizations and their activities.

ESM 14.2.12 - Number of new materials added to partner media library
NPM 14.2 – Percent of children, ages 0 through 17, who live in households where someone smokes

Measure Status:	Active
ESM Subgroup(s):	Adolescents 12 through 17
Goal:	Expand reach of the anti-tobacco messaging campaigns
Definition:	**Numerator:** Number of new media materials added to partner media library **Denominator:** n/a **Unit Type:** Count **Unit Number:** 10
Data Sources and Data Issues:	Tobacco Control Program data
Significance:	Increasing the number of materials available will better equip partner organizations to expand the reach of the TUPCP's messaging campaigns. These campaigns serve an important role in raising awareness of resources available to Tennesseans and providing an evidence-based anti-tobacco messaging to encourage tobacco-users to quit.

ESM 14.2.13 - Number of meetings with potential new partner organizations
NPM 14.2 – Percent of children, ages 0 through 17, who live in households where someone smokes

Measure Status:	Active
ESM Subgroup(s):	Adolescents 12 through 17
Goal:	Improve anti-tobacco policies
Definition:	**Numerator:** Number of meetings with potential new partner organizations **Denominator:** n/a **Unit Type:** Count **Unit Number:** 2
Data Sources and Data Issues:	Tobacco Control Program data
Significance:	Expanding the reach of TUPCP's activities and action plan through partner organizations is essential to improving tobacco policies and related issues across the state at target institutions and among key stakeholders.

ESM 14.2.14 - Number of Question Persuade Refer (QPR) trainings
NPM 14.2 – Percent of children, ages 0 through 17, who live in households where someone smokes

Measure Status:	Active
ESM Subgroup(s):	Adolescents 12 through 17
Goal:	To decrease suicide through peer-to-peer intervention
Definition:	**Numerator:** Number of QPR trainings **Denominator:** n/a **Unit Type:** Count **Unit Number:** 2
Data Sources and Data Issues:	Tobacco Control Program
Significance:	QPR trainings serve as a means to teach youth a peer-to-peer intervention technique aimed at reducing suicide, especially among adolescents. Public Health Educators will deliver trainings throughout the state to educate individuals on three steps to help prevent suicide.

ESM 14.2.15 - Number of meetings with internal stakeholders on protocols for screening and referring adolescents for mental health disorders and services
NPM 14.2 – Percent of children, ages 0 through 17, who live in households where someone smokes

Measure Status:	Active
ESM Subgroup(s):	Adolescents 12 through 17
Goal:	To increase the number of youth in Tennessee who are screened and treated or referred to mental health and tobacco cessation services as appropriate
Definition:	**Numerator:** Number of meetings with internal stakeholders regarding existing protocols for screening and referring adolescents for mental health disorders and services **Denominator:** n/a **Unit Type:** Count **Unit Number:** 1
Data Sources and Data Issues:	TUPCP will track the number of partner meetings through an established SharePoint folder dedicated to housing meeting notes, attending organizations, outcomes, and next steps.
Significance:	Screening and referral for mental or behavioral health disorders is a potential gap in services for adolescents in Tennessee's local health departments. By ensuring adequate screening and referral is promulgated through TDH clinical protocols, more adolescents in the state may receive needed treatment for disorders that may have otherwise been undetected.

Form 10
Evidence-Based or -Informed Strategy Measure (ESM) (2016-2020 Needs Assessment Cycle)

2016-2020: ESM 1.1 - Number of press releases, PSAs and/or social media messages promoting preventive health care visits for women of reproductive age
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	To increase the number of press releases, PSAs and/or social media messages promoting preventive health care visits for women of reproductive age
Definition:	**Numerator:** Number of press releases, PSAs and/or social media messages promoting preventive health care visits for women of reproductive age **Denominator:** N/A **Unit Type:** Count **Unit Number:** 46
Data Sources and Data Issues:	TDH Office of Communications; TDH Reproductive and Women's Health Section program data
Significance:	The use of press releases and social media messages can help bring public awareness to the issue and general importance of preventive health care for women as well as to specific preventive care recommendations (e.g. Pap smears and mammograms). Social media and other emerging communication technologies have the potential to reach large and diverse populations and help reach individuals when, where and how they want to receive health messages. Social media is a way to expand reach, foster engagement and increase access to credible, science-based health messages in order to spread key messages and influence health decision making.

2016-2020: ESM 1.2 - Number of webinars for providers on increasing preventive care visits among women in their clinics
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	To Increase the number of webinars for providers on increasing preventive care visits among women in their clinics
Definition:	**Numerator:** Number of webinars for providers on increasing preventive care visits among women in their clinics **Denominator:** N/A **Unit Type:** Count **Unit Number:** 33
Data Sources and Data Issues:	TDH Reproductive and Women's Health Section program data
Significance:	Competing priorities and busy schedules can make it difficult for women to make time for their own health, especially for preventive health care, while changing recommendations can make it challenging for both patients and providers to navigate preventive care needs. Training primary care providers on how to leverage missed opportunities (such as acute care visits) for provision of preventive care and how to properly code such visits for reimbursement is one way to promote and increase preventive health care services among women of reproductive age.

2016-2020: ESM 1.3 - Number of site-level family planning utilization reports distributed to local health departments
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	To distribute quarterly site-level family planning utilization reports to local health departments
Definition:	**Numerator:** Number of quarterly site-level family planning utilization reports distributed to local health departments **Denominator:** N/A **Unit Type:** Count **Unit Number:** 4
Data Sources and Data Issues:	Tennessee Department of Health - Patient Tracking Billing Information Management System (PTBMIS)
Significance:	The number of Family Planning (FP) clients served by the department has been declining in recent years. Similar declines have been observed in FP programs nationwide, as well as in other health department programs such as WIC. Quarterly site-level family planning utilization reports are an effort to better understand the FP patient population at a very granular level (e.g. patient demographics, insurance status, and contraceptive methods at individual service sites). Better understanding of patient characteristics and trends among specific subgroups will help health department staff focus outreach efforts aimed at slowing and reversing declines in FP program utilization and providing these services to the greatest number of people possible. Family Planning visits offer an opportunity to not only help women avoid unintended pregnancies, but to also prepare for healthy pregnancies by addressing important preventive care issues among those of reproductive age.

2016-2020: ESM 1.4 - Number of region-level pregnancy-related service utilization reports distributed to regional health departments
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To distribute quarterly region-level pregnancy-related service utilization reports to regional health departments</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Numerator:</td><td>Number of quarterly region-level pregnancy-related service utilization reports distributed to regional health departments</td></tr>
<tr><td>Denominator:</td><td>N/A</td></tr>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>4</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Tennessee Department of Health - Patient Tracking Billing Information Management System (PTBMIS)</td></tr>
<tr><td>Significance:</td><td>Most health department clients seeking a pregnancy test would benefit from the full array of Family Planning (FP) services which include discussions about a reproductive life plan and a medical history. The FP visit not only helps women to avoid unintended pregnancies, but also to prepare for healthy pregnancies by addressing important preventive care issues among those of reproductive age. Title X funding provides the opportunity for any health department pregnancy test and subsequent counseling to be coded to the FP program regardless of test result. Tests provided through FP are an indicator that appropriate FP counseling was made available. Quarterly region-level pregnancy-related service utilization reports provide information to regional staff on the percentage of pregnancy tests provided through FP versus other services, encourages them to treat all pregnancy test patients as FP clients, and allows them to track their progress in meeting department goals (currently set at 85% by the end of CY2016).</td></tr>
</table>

2016-2020: ESM 5.1 - Number of safe sleep educational material distributed
NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Measure Status:	Active
Goal:	To increase the number of safe sleep educational materials distributed
Definition:	**Numerator:** Number of safe sleep educational materials distributed **Denominator:** n/a **Unit Type:** Count **Unit Number:** 325,000
Data Sources and Data Issues:	TDH FHW child fatality review program data
Significance:	Safe sleep educational materials play an important role in educating new parents and caregivers about ways to keep babies safe while sleeping. In 2014, there were 99 infant deaths that resulted from an unsafe sleep environment, account for approximately 18% of all infant deaths. By focusing on distributing safe sleep educational materials can increase the awareness to put babies into safe sleep environment and decrease the sleep-related infant death and reduce the overall infant mortality rate.

2016-2020: ESM 5.2 - Percent of infant deaths to be reviewed by child fatality review teams
NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Measure Status:	Active
Goal:	To maintain the percent of infant deaths to be reviewed by child fatality review teams
Definition:	**Numerator:** Number of reviewed infant deaths **Denominator:** Number of infant deaths met the review criteria **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	TDH FHW child death review database
Significance:	The overall 2014 infant mortality rate in Tennessee was 6.9 infant deaths per 1,000 live births, 15% higher than national rate. The deaths meeting the review criteria were all reviewed by CFR (Child Fatality Review) teams. Their careful review process results in a thorough description of the factors related to infant deaths. By reviewing these cases, it can provide a comprehensive depth of understanding of the deaths and reduce infant mortality.

2016-2020: ESM 5.3 - Percent of VLBW (Very Low Birth Weight) infants being delivered at Level III or IV birthing facilities

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

Measure Status:	Active
Goal:	Maintain that 80% of VLBW infants are being delivered at Level III or IV birthing facilities
Definition:	**Numerator:** VLBW infants are being delivered at Level III or IV birthing facilities **Denominator:** All VLBW infants **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Tennessee Department of Health, Births Statistical System
Significance:	Very low birth weight infants (<1,500 grams or 3.25 pounds) are at high risk of morbidity and mortality. VLBW infants are significantly more likely to survive when delivered at level III or IV birthing facilities.

2016-2020: ESM 5.4 - Percent of newborns with a positive metabolic screen who receive follow-up to definitive diagnosis and clinical management
NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Measure Status:	Active
Goal:	Maintain that at least 99% of newborns with a positive metabolic screen receive follow up to definitive diagnosis
Definition:	**Numerator:** Number of infants who received follow-up to a definitive diagnosis **Denominator:** Number of infants with a positive metabolic screen **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Neometrics/Natus newborn screening database
Significance:	Metabolic newborn screening is mandatory for all babies born in Tennessee unless there is a refusal for religious reasons. The Tennessee system includes the State Laboratory, the follow-up staff, and the tertiary centers for referrals and follow-up. The system is designed to provide our families and providers the resources and services needed to assure that a timely diagnosis is made in each case. Early and appropriate intervention for each infant is critical for improving outcome.

2016-2020: ESM 5.5 - Number of individuals served by the Tennessee Adolescent Pregnancy Prevention Program (TAPPP)
NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Measure Status:	Active
Goal:	To increase the number of individuals served by the Tennessee Adolescent Pregnancy Prevention Program (TAPPP)
Definition:	**Numerator:** Number of individuals served by the Tennessee Adolescent Pregnancy Prevention Program (TAPPP) **Denominator:** n/a **Unit Type:** Count **Unit Number:** 56,000
Data Sources and Data Issues:	TAPPP – Programmatic data collected from the 6 Regional and 2 Metro HD TAPPP Coordinators and County Health Educators using the state data reporting form. Abstinence Education Grant Program – Programmatic data collected from the 13 abstinence education program coordinators using the required federal data collection sheet.
Significance:	Adolescent childbearing has been associated with increased risks for poor birth outcomes, including preterm delivery, low birthweight, and infant mortality. Causes for poorer birth outcomes in adolescents have been attributed to lower rates of adequate prenatal care, poor weight gain and nutrition, higher rates of tobacco use, high risk health behaviors and socioeconomic background characteristics. Therefore, increasing the number of individuals who participate in programs that address adolescent pregnancy prevention and abstinence education are critical in reducing teen pregnancies and infant mortality rates.

2016-2020: ESM 6.1 - Number of unique page views to the Developmental Milestones and Developmental Screenings kidcentraltn.com sites
2016-2020: NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Measure Status:	Active
Goal:	To increase general awareness of the need for developmental screening
Definition:	**Numerator:** Number of site views from webpage and mobile app to the Developmental Milestones and Developmental Screenings site during the past 12 months **Denominator:** n/a **Unit Type:** Count **Unit Number:** 1,320
Data Sources and Data Issues:	Kidcentraltn.com annual site traffic report from ioStudio
Significance:	The audience of this strategy is the general public. Kidcentraltn.com is the state platform used to reach the general public across the state via the website, Facebook, twitter, and mobile app. By creating additional content and intentionally promoting this content, we can drive site views to the Developmental Screenings and Milestones screens.

2016-2020: ESM 6.2 - Number of health department nurses trained in the START Autism and MCHAT-R/F program
2016-2020: NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Measure Status:	Active
Goal:	To increase number of health department nurses trained in the START Autism and MCHAT-R/F program
Definition:	**Numerator:** Number of nurses trained in the START Autism and MCHAT-R/F program **Denominator:** N/A **Unit Type:** Count **Unit Number:** 627
Data Sources and Data Issues:	TDH Community Health Services training data
Significance:	The audience of this strategy is health department nurses and the clients of health departments. The Tennessee Early Intervention System and the Tennessee Chapter of the American Academy of Pediatrics have partnered with the health department to train nurse supervisors in the administration of the M-CHAT R screening tool for autism. It is assumed that trained nurse will administer the screening to the patients they see in clinic. Thus, training the health department nurses will increase the number of Tennessee children who receive a validated developmental screen at a primary care visit.

2016-2020: ESM 6.3 - Percent of Developmental Screenings performed across the state for participants enrolled in an Evidence-Based Home Visiting Program
2016-2020: NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Measure Status:	Active
Goal:	To increase the percent of Developmental Screenings performed across the state for participants enrolled in an Evidence-Based Home Visiting Program
Definition:	**Numerator:** Number of ASQ-3 and ASQ:SE or ASQ:SE-2 screens documented at home visits during the past 12 months **Denominator:** Number of index children enrolled in an Evidence Based Home Visiting Program for at least 6 months **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	TDH FHW REDCap data base for MIECHV
Significance:	The audience of this strategy is non-medical providers that serve the child population. The Tennessee Young Child Wellness Council is partnering with agencies to create a catalog of developmental screening tools being used across the state, the settings in which these tools are being administered, and the degree of specificity. The Division of Family Health and Wellness continues to partner with state and federally funded evidence based home visiting programs. As an integral part of service delivery, and in compliance with national home visiting models, home visitors routinely administer developmental screenings.

2016-2020: ESM 7.1.1 - Number of parents and caregivers receiving car seat education
2016-2020: NPM 7.1 – Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9

Measure Status:	Active
Goal:	To increase the number of parents of caregivers receiving car seat education
Definition:	**Numerator:** Number of parents and caregivers receiving car seat education **Denominator:** n/a **Unit Type:** Count **Unit Number:** 3,000
Data Sources and Data Issues:	Tennessee Department of Health Child Injury Prevention Program Data
Significance:	Motor vehicle crash injuries are a leading cause of death among children in the United States. In 2014, over 1,000 children ages 12 and under were seen in Tennessee emergency departments because of motor vehicle crashes. CDC research suggests that black and Hispanic children ages 12 and under are less likely to buckle up than white children. The consistent and correct use of car seats and boosters can reduce the risk of serious injury and death for infants, toddlers, and children up to age 8. Tennessee utilizes a recommended practice to distribute car seats with education programs to increase restraint and decrease injuries and deaths to child passengers.

2016-2020: ESM 7.1.2 - Number of counties that adopt Count It! Drop It! Lock It! educational programs
2016-2020: NPM 7.1 – Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9

Measure Status:	Active
Goal:	To increase the number of counties that adopt Count It! Drop It! Lock It! educational programs
Definition:	**Numerator:** Number of counties that adopt Count It! Drop It! Lock It! educational programs **Denominator:** n/a **Unit Type:** Count **Unit Number:** 95
Data Sources and Data Issues:	Tennessee Department of Health Injury Prevention Program reports
Significance:	Unintentional poisoning killed 635 U.S. Children in 2014; almost 90% of them were teenagers, ages 10-19. In 2014 117,959 U.S. children visited emergency departments for unintentional poisoning-related injuries (WISQARS). Reducing the amount of prescription drugs in the home can reduce access to these drugs by children. Research indicates the high availability of prescription drugs in Tennessee is contributing to the addiction problem across the state. According to the 2010 National Survey on Drug Use and Health, 70% of people who abused or misused prescription drugs got them from a friend or relative, either for free, by purchasing them, or by stealing them. People who abuse prescription drugs also obtain them from other sources including “pill mills,” or illegitimate pain clinics; prescription fraud; pharmacy theft; illegal online pharmacies; and “doctor shopping”. Some individuals who use prescription drugs for non-medical reasons believe these substances are safer than illicit drugs because they are prescribed by a physician and dispensed by a pharmacist. Communities that develop partnerships with schools, healthcare providers, pharmacists, law enforcement and other sectors to educate families about the importance of monitoring, securing, and properly disposing of prescription drugs can reduce access to unused prescription drugs and increase the perception of harm of the abuse of prescription drugs.

2016-2020: ESM 7.1.3 - Percent of families who receive injury prevention education through the AAP checklist among families participating in Evidence Based Home Visiting programs
2016-2020: NPM 7.1 – Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9

Measure Status:	Active
Goal:	To increase the percent of families who receive injury prevention education through the AAP checklist among families participating in Evidence Based Home Visiting programs
Definition:	**Numerator:** Number of children with at least one AAP screening completed **Denominator:** Number of children who reached first birthday during reporting period **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Tennessee Department of Health - Evidence Based Home Visiting Database
Significance:	Injury is a leading cause of child mortality and morbidity. In 2014, injuries resulted in more than 3,131 deaths and 2.3 million emergency department visits among 0-4 year olds in the US (CDC WISQARS). Home visitors can play an important role in increasing awareness about injury hazards, identifying risk and protective factors in the home setting, and teaching caregivers injury prevention methods. Using a childhood injury risk assessment tool, home visitors can identify risks and provide education on a wide range of injury topics. Home visiting is one strategy that shows promise for reducing rates of self-reported and substantiated child maltreatment and use of emergency rooms to treat child injuries.

2016-2020: ESM 7.2.1 - Number of schools in the top ten crash rate counties (among ages 15-18) that conduct evidence-informed teen safe driving programming
2016-2020: NPM 7.2 – Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19

Measure Status:	Active
Goal:	To increase the number of schools in the top ten crash rate counties (among ages 15-18) that conduct evidence-informed teen safe driving programming
Definition:	**Numerator:** Number of schools in the top ten crash rate counties that conduct evidence-informed teen safe driving programming **Denominator:** N/A **Unit Type:** Count **Unit Number:** 70
Data Sources and Data Issues:	ReduceTNCrashes.org web based teen safe driving program reports
Significance:	Motor vehicle crash injuries are a leading cause of hospitalization among children in the United States. In 2014, over 840 adolescents ages 15-24 were hospitalized in Tennessee because of motor vehicle crashes. Research shows that in order for young drivers to remain collision-free, parents must model safe driving behaviors and invest in meaningful guided practice over a long period of time to turn these skills into good driving habits. It is our hope that new drivers will have a solid foundation to develop safe, collision-free driving habits that will last a lifetime through teen safe driving programming. The evidence-informed teen safe driving program can reduce risk and keep people safer on the road.

2016-2020: ESM 7.2.2 - Number of drug disposal bins installed statewide
2016-2020: NPM 7.2 – Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19

Measure Status:	Active
Goal:	To increase the total number of drug disposal bins installed statewide
Definition:	**Numerator:** Number of drug disposal bins installed statewide **Denominator:** N/A **Unit Type:** Count **Unit Number:** 401
Data Sources and Data Issues:	Tennessee Department of Environment and Conservation Reports
Significance:	The diversion and abuse of prescription drugs contributes to the leading cause of death in Tennessee. In 2014, over 2,500 children ages 19 and under were admitted to the emergency department for poisoning. Young children are particularly at risk for accidental overdose due to the ingestion of prescription drugs, and unwanted medicine disposed in the trash can be stolen and used, potentially resulting in illness, injury, or death. There are few safe and convenient ways for consumers to properly dispose of unused prescription drugs that do not harm the solid or liquid waste system. Drug disposal bins are cited as one way to reduce the diversion and ingestion of unused prescription drugs while reducing damage to the local environment.

2016-2020: ESM 7.2.3 - Number of press releases, social media posts and presentations about adolescent falls
2016-2020: NPM 7.2 – Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19

Measure Status:	Active
Goal:	To increase the number of press releases, social media posts and presentations about adolescent falls
Definition:	**Numerator:** Number of press releases, social media posts and presentations about adolescent falls **Denominator:** N/A **Unit Type:** Count **Unit Number:** 22
Data Sources and Data Issues:	Tennessee Department of Health Media Communications and Media Relations Department and Injury Prevention Program data
Significance:	Traumatic Brain Injury (TBI) is a leading cause of death and disability in the United States. Falls disproportionately impact children ages 0-5 and over 18,000 children age 0-5 were treated in emergency rooms in 2014 for unintentional fall injury. Young children living in families with low socioeconomic status in older communities have a high risk for fall injuries and targeted interventions to low socioeconomic status parents of young, male, children may be warranted. Media posts and presentations that focus on risk factors such as furniture (e.g. bunk beds or walkers) playground equipment will be developed and delivered.

2016-2020: ESM 7.2.4 - Number of suicide-related articles, social media posts and trainings provided by TDH
2016-2020: NPM 7.2 – Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19

Measure Status:	Active
Goal:	To increase number of suicide-related articles, social media posts and trainings provided by TDH
Definition:	**Numerator:** Number of suicide-related articles, social media posts and trainings **Denominator:** N/A **Unit Type:** Count **Unit Number:** 28
Data Sources and Data Issues:	Tennessee Department of Health injury prevention program data
Significance:	Suicides among young people continues to be a serious problem. Suicide is the third leading cause of death for Tennessee residents ages 15-24 according to the U.S. Center for Disease Control and Prevention. Suicide is a relatively rare event and it is difficult to accurately predict which persons with these risk factors will ultimately commit suicide. However, by providing articles, social media posts and training can increase awareness of the signs and risk factors of suicide attempts.

2016-2020: ESM 8.1.1 - Number of Gold Sneaker-recognized childcare facilities in Tennessee
NPM 8.1 – Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Measure Status:	Active
Goal:	Increase the number of Gold Sneaker-recognized childcare facilities in Tennessee
Definition:	**Numerator:** Number of Tennessee licensed childcare facilities recognized by TDH as meeting the requirements set by the Gold Sneaker Initiative **Denominator:** N/A **Unit Type:** Count **Unit Number:** 825
Data Sources and Data Issues:	The Gold Sneaker facility tracking database is housed within the Division of Family Health and Wellness, and will be used to provide facility counts. The Gold Sneaker tracking database is updated as facilities receive application approval. However, at this time, there is no process for ensuring previously recognized facilities are still “active” (licensed, open, etc.). An evaluation and recertification process is currently being developed.
Significance:	Through the Gold Sneaker recognition process, facilities are required to adopt nine policies related to physical activity (4), nutrition (4), and adoption of a smoke-free facility campus (1). The first Gold Sneaker policy directly relates to the National Performance Measure – requiring children to participate in at least 60 minutes of physical activity per day. Additional Gold Sneaker policies are in concert with recommendations made by the American Academy of Pediatrics, Tennessee Child Care Resource & Referral Network, and Tennessee Department of Health and Human Services.

2016-2020: ESM 8.1.2 - Average number of monthly calls to the Tennessee Breastfeeding Hotline (TBH)
NPM 8.1 – Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Measure Status:	Active
Goal:	To increase the average number of monthly calls to the Tennessee Breastfeeding Hotline
Definition:	**Numerator:** Count of individual calls (not unique callers) to the TBH during the reporting period **Denominator:** Months in reporting period **Unit Type:** Count **Unit Number:** 650
Data Sources and Data Issues:	The Tennessee Breastfeeding Hotline is operated by Le Bonhuer Children's Hospital in Memphis, Tennessee. TBH monitors call volume through electronic tracking (iCarol). Additional data elements for consideration include: referral sources, reason/concern, caller demographics, and follow-up call outcomes.
Significance:	The Tennessee Breastfeeding Hotline is available 24 hours a day, seven days a week. The Hotline is staffed by International Board Certified Lactation Consultants and Certified Lactation Counselors who can provide up-to-date information and support and to address common questions and concerns about breastfeeding. Through consultation provided by the TBH, TDH continues its efforts to reduce barriers associated with breastfeeding, correct common misconceptions, and further promote breastfeeding as the optimal approach to infant feeding.

2016-2020: ESM 8.1.3 - Number of Baby Friendly-designated Tennessee birthing hospitals
NPM 8.1 – Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Measure Status:	Active
Goal:	To increase the number of Baby Friendly-designated Tennessee birthing hospitals
Definition:	**Numerator:** Number of Baby Friendly-designated Tennessee birthing hospitals **Denominator:** N/A **Unit Type:** Count **Unit Number:** 18
Data Sources and Data Issues:	Baby Friendly Hospital Initiative tracks completion of its 10 guidelines and evaluation criteria. A list of Baby Friendly Tennessee birthing hospitals is provided at: https://www.babyfriendlyusa.org/find-facilities/designated-facilities--by-state
Significance:	Baby-Friendly USA, Inc. and its implementation of the Baby-Friendly Hospital Initiative (BFHI) in the United States is predicated on the fact that human milk fed through the mother's own breast is the normal way for human infants to be nourished. There is an abundance of scientific evidence that points to lower risks for certain diseases and improved health outcomes for both mothers and babies who breastfeed. Breastfeeding is the natural biological conclusion to pregnancy and an important mechanism for the continued normal development of the infant. With the correct information and the right supports in place, under normal circumstances, most women who choose to breastfeed are able to successfully achieve their goal.

2016-2020: ESM 8.2.1 - Number of Physical Activity Clubs in K-12 schools
2016-2020: NPM 8.2 – Percent of adolescents, ages 12 through 17 who are physically active at least 60 minutes per day

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To increase the number of Run Clubs for 5th through 8th graders</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Numerator:</td><td>Tennessee Run Clubs with participants in grades 5th through 8th grade (identified through TDH partnerships)</td></tr>
<tr><td>Denominator:</td><td>N/A</td></tr>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>359</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Physical Activity Clubs are tracked by the TDH Chronic Disease Section. New PA clubs are submitted by local health department staff (health educators, coordinators, etc.) and are subsequently added to a tracking tool.</td></tr>
<tr><td>Significance:</td><td>A Physical Activity Club is a community or school-based physical activity opportunity that allows a young person to see their progress over time through better run/walk times or longer distances. Activities may include walking, jogging or running around school grounds on a walking track, competition track, athletic field, green space, or may occur at other locations such as state parks, swimming pools or any organized sport program. Physical Activity Clubs provide opportunities for students to be physically active as part of a goal to reach at least 60-minutes a day of moderate to vigorous physical activity.</td></tr>
</table>

2016-2020: ESM 8.2.2 - Number of school gardens in Tennessee public schools
2016-2020: NPM 8.2 – Percent of adolescents, ages 12 through 17 who are physically active at least 60 minutes per day

Measure Status:	Active
Goal:	To increase the number of school gardens in Tennessee public schools
Definition:	**Numerator:** number of school gardens in Tennessee public schools **Denominator:** N/A **Unit Type:** Count **Unit Number:** 576
Data Sources and Data Issues:	The number of school gardens in TN public schools is tracked by the Farm to School Specialist in the Office of School Nutrition. The Department of Health, through contract, receives updated reports provided by the Office of School Nutrition.
Significance:	School gardens are a proven strategy for improving children's attitudes towards and consumption of produce, as well as incorporating experiential nutrition and agriculture education into school curriculum. TDH recognizes that children making healthy food choices while at school will significantly impact the statewide priority of reducing the prevalence of obesity.

2016-2020: ESM 8.2.3 - Number of Healthy Parks Healthy Person app users
2016-2020: NPM 8.2 – Percent of adolescents, ages 12 through 17 who are physically active at least 60 minutes per day

Measure Status:	Active
Goal:	To increase the number of Healthy Parks Healthy Person app users
Definition:	**Numerator:** Number of Healthy Parks Healthy Person app users **Denominator:** N/A **Unit Type:** Count **Unit Number:** 4,928
Data Sources and Data Issues:	The Healthy Parks Healthy Person app is managed by the Tennessee Department of Environment and Conservation. TDH must request access to the data on an ad hoc basis, and does not monitor or control data quality. The current app has limited tracking capabilities. During the upcoming year staff will be working to upgrade the app's functionality.
Significance:	Physical activity is an important part of good health for everyone, regardless of age or ability. Healthy Parks Healthy Person remove barriers to physical activity by promoting places to be active. Allowing access to physical activity spaces and facilities is a recommended strategy in the Healthy People 2020 goals for the nation's health. According to HP 2020, physical activity levels are positively affected by structural environments including trails and parks. Additionally, the National Physical Activity Plan Alliance recommends that communities develop new, and enhance existing, community recreation, fitness, and park programs that provide and promote healthy physical activity opportunities. Physical activity contributes to students' overall health and well-being. Furthermore, participating in physical activity in safe and clean public spaces helps everyone to feel more connected to their community.

2016-2020: ESM 11.1 - Number of providers trained and provided information on medical home implementation
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
Goal:	To increase the number of providers trained and provided information on medical home implementation
Definition:	**Numerator:** Number of providers trained and provided information on medical home implementation **Denominator:** N/A **Unit Type:** Count **Unit Number:** 980
Data Sources and Data Issues:	Title V Children and Youth with Special Healthcare Needs (CYSHCN) program training participation log
Significance:	The American Academy of Pediatrics (AAP) specifies seven qualities essential to medical home care: accessible, family-centered, continuous, comprehensive, coordinated, compassionate and culturally effective. Ideally, medical home care is delivered within the context of a trusting and collaborative relationship between the child's family and a competent health professional familiar with the child and family and the child's health history. Our program believes in the importance of training and plans to train more providers on medical home concept and provide information on medical home implementation.

2016-2020: ESM 11.2 - Number of families that receive patient centered medical home training
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
Goal:	Increase the number of families that receive patient centered medical home training
Definition:	**Numerator:** Number of families that receive patient centered medical home training **Denominator:** N/A **Unit Type:** Count **Unit Number:** 785
Data Sources and Data Issues:	Title V Children and Youth with Special Healthcare Needs (CYSHCN) program training participation log
Significance:	The American Academy of Pediatrics (AAP) specifies seven qualities essential to medical home care: accessible, family-centered, continuous, comprehensive, coordinated, compassionate and culturally effective. Ideally, medical home care is delivered within the context of a trusting and collaborative relationship between the child's family and a competent health professional familiar with the child and family and the child's health history. This measure gauges the number of families that receive patient centered medical home training.

2016-2020: ESM 11.3 - Percentage of children served by the Children's Special Service (CSS) program receiving services in a medical home
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
Goal:	To increase the percentage of children served by the CSS program receiving services in a medical home
Definition:	**Numerator:** Number of children 0-20 years of age served by the CSS program receiving services in a medical home **Denominator:** Number of children 0-20 years of age served by the CSS program **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Tennessee Department of Health - Patient Tracking and Billing Management Information System (PTBMIS) - CSS Program data
Significance:	The American Academy of Pediatrics (AAP) specifies seven qualities essential to medical home care: accessible, family-centered, continuous, comprehensive, coordinated, compassionate and culturally effective. Ideally, medical home care is delivered within the context of a trusting and collaborative relationship between the child's family and a competent health professional familiar with the child and family and the child's health history. The measure is limited to the children served by the CSS program.

2016-2020: ESM 11.4 - Number of children referred from the Tennessee Birth Defects Surveillance System (TNBDSS) program that were linked to appropriate supportive services
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
Goal:	To increase the number of children referred from the TNBDSS program that were linked to appropriate supportive services
Definition:	**Numerator:** Number of children referred from the TNBDSS program that were linked to appropriate supportive services **Denominator:** N/A **Unit Type:** Count **Unit Number:** 100
Data Sources and Data Issues:	Tennessee Department of Health - CSS Program data captured in REDCap
Significance:	The American Academy of Pediatrics (AAP) specifies seven qualities essential to medical home care: accessible, family-centered, continuous, comprehensive, coordinated, compassionate and culturally effective. Ideally, medical home care is delivered within the context of a trusting and collaborative relationship between the child's family and a competent health professional familiar with the child and family and the child's health history. The measure is limited to the children identified with a birth defect and referred to the CSS program.

2016-2020: ESM 12.1 - Number of adolescents on the Adolescent Advisory Council
NPM 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care

Measure Status:	Active
Goal:	To expand the adolescent advisory council
Definition:	**Numerator:** Number of adolescents on the advisory council **Denominator:** N/A **Unit Type:** Count **Unit Number:** 15
Data Sources and Data Issues:	Children and Youth with Special Healthcare Needs (CYSHCN) program record
Significance:	The transition of youth to adulthood has become a priority issue nationwide as evidenced by the clinical report and algorithm developed jointly by the AAP, American Academy of Family Physicians and American College of Physicians to improve healthcare transitions for all youth and families. Over 90 percent of children with special health care needs now live to adulthood, but are less likely than their non-disabled peers to complete high school, attend college or to be employed. Health and health care are cited as two of the major barriers to making successful transitions. Our CSS program requires all children enrolled in the program have a transition plan in place by age of 14 years and updated every year afterward. The Youth Advisory Council will provide recommendations and advise the CSS program staff on transition concerns youth may face.

2016-2020: ESM 12.2 - Number of providers who receive technical assistance and information on transition for youth and young adults with and without special health care needs
NPM 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care

Measure Status:	Active
Goal:	To increase number of providers who receive technical assistance and information on transition for youth and young adults with and without special health care needs
Definition:	**Numerator:** Number of providers who receive technical assistance and information on transition for youth and young adults with and without special health care needs **Denominator:** N/A **Unit Type:** Count **Unit Number:** 450
Data Sources and Data Issues:	Children and Youth with Special Healthcare Needs (CYSHCN) program record
Significance:	The transition of youth to adulthood has become a priority issue nationwide as evidenced by the clinical report and algorithm developed jointly by the AAP, American Academy of Family Physicians and American College of Physicians to improve healthcare transitions for all youth and families. Over 90% of children with special health care needs now live to adulthood, but are less likely than their non-disabled peers to complete high school, attend college or to be employed. Health and health care are cited as two of the major barriers to making successful transitions. Our CSS program requires all children enrolled in the program have a transition plan in place by age 14 years and updated every year afterward. The Youth Advisory Council will provide recommendations and advise to CSS program staff on transition concerns youth may face.

2016-2020: ESM 12.3 - Percentage of youth served by the Children's Special Services (CSS) program age 14 and older who have an annual transition plan
NPM 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care

Measure Status:	Active
Goal:	To increase number of providers who receive technical assistance and information on transition for youth and young adults with and without special health care needs
Definition:	**Numerator:** Number of providers who receive technical assistance and information on transition for youth and young adults with and without special health care needs **Denominator:** N/A **Unit Type:** Count **Unit Number:** 100
Data Sources and Data Issues:	Children and Youth with Special Healthcare Needs (CYSHCN) program record
Significance:	The transition of youth to adulthood has become a priority issue nationwide as evidenced by the clinical report and algorithm developed jointly by the AAP, American Academy of Family Physicians and American College of Physicians to improve healthcare transitions for all youth and families. Over 90% of children with special health care needs now live to adulthood, but are less likely than their non-disabled peers to complete high school, attend college or to be employed. Health and health care are cited as two of the major barriers to making successful transitions. Our CSS program requires all children enrolled in the program have a transition plan in place by age 14 years and updated every year afterward. The Youth Advisory Council will provide recommendations and advise to CSS program staff on transition concerns youth may face.

2016-2020: ESM 12.4 - Number of youths and parents/legal guardians who have completed the Transition Readiness Assessment tool
NPM 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care

Measure Status:	Active
Goal:	Increase the number of youths and parents/legal guardians who have completed the Transition Readiness Assessment tool
Definition:	**Numerator:** Number of youths and parents/legal guardians who have completed the Transition Readiness Assessment tool **Denominator:** N/A **Unit Type:** Count **Unit Number:** 100
Data Sources and Data Issues:	Tennessee Department of Health - CSS Program data captured in REDCap
Significance:	The transition of youth to adulthood has become a priority issue nationwide as evidenced by the clinical report and algorithm developed jointly by the AAP, American Academy of Family Physicians and American College of Physicians to improve healthcare transitions for all youth and families. Over 90 percent of children with special health care needs now live to adulthood, but are less likely than their non-disabled peers to complete high school, attend college or to be employed. Health and health care are cited as two of the major barriers to making successful transitions. One of our CSS program's focuses is to endure children enrolled in the program have a transition plan in place by age of 14 years and updated every year afterward. The program is to develop a Transition Readiness Assessment tool and program staff will work with youth and parents/guardians to ensure the completion of the Transition Readiness Assessment tool before the children reach 12 years of age.

2016-2020: ESM 14.1.1 - Number of reproductive-aged female tobacco users (15-44 years) who received online or phone counseling services through the Tennessee Tobacco Quitline.
2016-2020: NPM 14.1 – Percent of women who smoke during pregnancy

Measure Status:	Active
Goal:	Increase the number of reproductive-aged female tobacco users (15-44 years) who received online or phone counseling services through the Tennessee Tobacco Quitline
Definition:	**Numerator:** Number of reproductive-aged female tobacco users (15-44 years) who received online or phone counseling services through the Tennessee Tobacco Quitline **Denominator:** N/A **Unit Type:** Count **Unit Number:** 1,275
Data Sources and Data Issues:	Tennessee Tobacco Quitline Vendor Reports. Due to Tennessee's external operation of the Quitline (current vendor is based out of state), data are not available in-house.
Significance:	Tobacco use is the number one cause of preventable death in the US and six of the top 10 leading causes of death of Tennessee residents were linked to smoking. In Tennessee, 21.9% of adult women smoke (BRFSS 2015). Tobacco cessation during preconception care can prevent adverse birth outcomes associated with prenatal smoking, such as low birth weight and preterm birth. Prenatal smoking rates have significantly declined in Tennessee, yet 14.3% of Tennessee women smoked during pregnancy in 2015. Smoking cessation also prevents nonsmoker exposure to secondhand and third hand smoke. Telephone-based cessation services like the Tennessee Tobacco Quitline adopt a public health-oriented approach by not only helping tobacco users who desire to quit, but also by actively promoting cessation among the general population.

2016-2020: ESM 14.2.1 - Number of child care facilities that voluntarily implement a tobacco-free campus policy
NPM 14.2 – Percent of children, ages 0 through 17, who live in households where someone smokes

Measure Status:	Active
Goal:	To increase the number of child care facilities that voluntarily implement a tobacco-free campus policy
Definition:	**Numerator:** Number of licensed childcare facilities in Tennessee who adopt Gold-Sneaker designated policies **Denominator:** N/A **Unit Type:** Count **Unit Number:** 795
Data Sources and Data Issues:	The Gold Sneaker facility tracking database is housed within the Division of Family Health and Wellness, and will be used to provide facility counts. The Gold Sneaker tracking database is updated as facilities receive application approval. However, at this time, there is no process for ensuring previously recognized facilities are still “active” (licensed, open, etc.). An evaluation and re-certification process is currently being developed.
Significance:	According to the Centers for Disease Control and Prevention (CDC), about 2 in 5 children (aged 3 to 11 years) are exposed to secondhand smoke (SHS). Secondhand smoke exposure increases the risk of infant death syndrome (SIDS), respiratory infections, ear infections, and asthma attacks in infants and children. Secondhand smoke exposure is still a serious problem within the home, the leading source of exposure among children. In Tennessee, roughly 30% of children live in a household where someone smokes. With initiatives such as Gold Sneaker, parents are educated about the dangers of secondhand smoke and the benefits of tobacco-free childcare centers and homes.

2016-2020: ESM 14.2.2 - Percent of primary caregivers enrolled in home visiting who reported using any tobacco products at enrollments and were referred to tobacco cessation counseling or services within three months of enrollment
NPM 14.2 – Percent of children, ages 0 through 17, who live in households where someone smokes

Measure Status:	Active
Goal:	To increase the percent of primary caregivers enrolled in home visiting who reported using any tobacco products at enrollments and were referred to tobacco cessation counseling or services within three months of enrollment
Definition:	**Numerator:** Number of primary caregivers enrolled in home visiting who reported using any tobacco products at enrollment and were referred to tobacco cessation counseling or services within 3 months of enrollment **Denominator:** Number of primary caregivers enrolled in home visiting who reported using any tobacco products at enrollment and were enrolled for at least 3 months **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Evidence-Based Home Visiting (EBHV) Referral Tracker (RedCAP); Despite high prevalence of smoking throughout state, data regarding referrals to smoking cessation referrals for evidence-based home visiting participants are not consistently documented in RedCAP. Quality improvement efforts are in development, but the number of EBHV participants who are referred to smoking cessation services is likely underestimated.
Significance:	Currently operating in 31 of the state's 95 counties, evidence-based home visiting programs are located in communities with higher rates of smoking, teen pregnancy, low birth weight, prematurity, and infant death. Smoking prevalence among mothers who reside in these select communities ranges from 6 percent to 31 percent. Home visitors assess a number of preventive health and prenatal practices, including prenatal tobacco use and use of tobacco in the home. Evidence-based home visiting services is one of the most effective and cost-effective interventions to help parents support their young children's health and development and prevent adverse childhood experiences.

Form 11
Other State Data

State: Tennessee

The Form 11 data are available for review via the link below.

Form 11 Data