Maternal and Child Health Services
Title V Block Grant

State Narrative for Tennessee

Application for 2011
Annual Report for 2009

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Table of Contents

I. General Requirements

A. Letter of Transmittal

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

B. Face Sheet

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

C. Assurances and Certifications

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

D. Table of Contents

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

E. Public Input

Three Public Hearings were conducted in Tipton County Health Department, Covington, TN on June 18, from 9:00AM-11:00 AM; Rutherford County Health Department, Murfreesboro, TN June 25, from 9:00-11:00 AM; and Sullivan County Health Department, Kingsport, TN June 30, from 9:00-11:00 AM.

The purpose of these hearings was to invite the public to offer comments on the Maternal and Child Health Block Grant Application and programs; participate in the development of the Supplemental Nutrition Programs' State Plan of Operation and other relevant health programs. Prior to these events, a mailing was sent to state legislators, over 2000 individuals and grass root organizations, vendors, and health care organizations across the state. E-Mail was routed to supervisory health department employees as well as physicians from the Tennessee Hospital Association. The hearing information was posted on the official WIC and MCH Websites with relevant fact sheets and information about all of the WIC, CSFP, and MCH Programs. Notices of the hearings were posted in the aforementioned clinics for the public and in some newspapers.

In Covington, the main concern of the participants was that the grocery stores did not always have enough stock. There were no concerns regarding the block grant application or MCH programs.

Rutherford County had six attendees from the nearby Middle Tennessee State University. They were instructors from the nursing and nutrition departments with their students. Two of the students transitioned from other degree programs to study nutrition. They were interested in the philosophical reasons why we serve participants certain foods and amounts. There were also questions regarding the children and youth with special health care needs population, the infant mortality rate in parts of the state and the role the community health councils play in promoting health initiatives. Of particular concern to one participant was access to care for children and youth with special health care needs.

Finally, in Kingsport, the participants were pleased with the programs and services. They had no complaints regarding appointments, services or foods.

Overall, the participants seem to have been pleased with the services offered. There was some concern however regarding the public hearings and the process used for notification.

II. Needs Assessment

In application year 2011, the 2010 Needs Assessment will be attached to this Section II.

An attachment is included in this section.

C. Needs Assessment Summary

The vision of the Tennessee MCH needs assessment is founded on the Life Course Perspective. We believe that health of mothers and children must be considered within a holistic biopsychosocial and developmental context over the entire life trajectory. The document will be used as a roadmap to guide and assess MCH activities and outcomes for the next 5 years.

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

2010 Tennessee MCH Priorities/Performance Measures

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

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

2005 Needs Assessment Tennessee MCH Priorities/Performance Measures

1. Increase percentage of children with complete, EPSDT annual examinations by 3% each year.
2. Reduce incidence of maltreatment of children younger than 18 (physical, sexual and emotional abuse, and neglect) to rate no more than 8 per 1000.

3. Reduce the number of babies born prematurely.
4. Reduce the number of pregnant women who smoke and use illicit drugs.
5. Reduce the number of overweight and obese children and adolescents.
6. Reduce the proportion of teens and young adults (ages 15-24) with Chlamydia trachmomatis infections, attending family planning clinics.
7. Increase percentage of adolescents with complete EPSDT annual examinations by 3% each year.
8. Reduce the number of high school students using tobacco (cigarettes and smokeless).
9. Reduce the number of high school students using alcohol.
10. Increase the number of youth with special health care needs, age 14 and older, who receive formal plans for transition to adulthood.

Rationale for discontinuing previous measures/priorities

Improvements/Successes since 2005:
Percent of EPSDT annual exams (children and teens)
Incidence of child maltreatment

The issue is covered as National Performance Measure, MCH Outcome Measure, Health Systems Capacity Indicator, or Health Status Indicator:
Premature births
Teens and young adults with Chlamydia trachomatis

Other:
Alcohol use among high school students is still an issue in Tennessee. According to the TN YRBS, current alcohol use by teens decreased significantly in 2007 but leveled off in 2009. Tennessee students show less alcohol risk than teens in other states, but much work remains. MCH has no current capacity in alcohol treatment or prevention. The Tennessee Department of Mental Health and Developmental Disabilities (DMHDD) continues to provide prevention and treatment services. MCH leadership recommended improved collaboration in alcohol prevention efforts with DMHDD, but to retire this as a MCH priority/measure for now.

III. State Overview
A. Overview

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

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

1. Geographic Description of the State

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

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

2. Demographic Information

Population: based on 2008 data

Tennessee is the sixteenth largest state with a population of 6,214,888 people.

Twenty-four percent or 1,491,573 are under 18 years.
13 percent or 807,935 are 65 years and older.
On average 86,000 babies are born each year in Tennessee and about 49% of those births are covered by TennCare the state Medicaid program.
Racially, the state is 80% White and 17% Black.
Hispanics are the largest ethnic minority representing three percent or 186,447 people.

Poverty Level: based on 2007 data

15.9 percent of Tennesseeans live below the poverty level compared to 13% of the nation
Twenty-three percent of children age 18 and under live in poverty, compared to 17.6 percent for the United States.
!2% of all families and 34% of female head of household families have incomes below the poverty level.
Many more Blacks (29.9%) and Hispanics (28%) are living below the poverty level as compared to Whites (12.8%).

Income: based on 2007 data, U.S. Census Bureau

Tennessee ranks 43rd in the nation on this measure.
Per capita personal income is 86.2 percent of the national average.
The median household income is $42,367 compared to $50,740 (US).

Unemployment: from "An Economic Report to the Governor", January 2010

Unemployment has been between 10 and 11 percent since the first quarter of 2009.
More than 150,000 jobs have been lost since the beginning of the recession.
The number of unemployed has almost doubled since 2007.
It is estimated that it will be at least 2 years for state economics to return to pre-recession levels.
Sales tax revenues which fund state government are significantly impacted by unemployment, limited tourism and decreased discretionary spending due to the recession.

Insurance Coverage: based on 2007 "Current Population Study"

15.6 percent of Tennessee women 18-64 years of age were uninsured, compared to the national average of 17.6 percent.

95,000 women age 40 to 64 are estimated to be uninsured and at or below 250% FPL (US Census).
Uninsured 18-64 year old women are three times less likely to have a Pap test in the past 3 years (ACOG).
Uninsured women with breast cancer have a 30-50 percent higher risk of dying than insured women (ACOG).
An estimated 775,000 people are uninsured in Tennessee.

Health Data

Pregnancy and Birth Data

49% of the births in Tennessee are unplanned or mistimed (PRAMS, 2008).
67 percent of Tennessee births reported that care began in the first trimester.
19,499 or 22.5 percent of mothers in the 10-17 age group received little or no prenatal care.
4,073 or 4.7 percent received no prenatal care.
The percent of black mothers with no care was 8.8 in 2007 -- more than twice that of whites.
Adolescent pregnancy rate increased from 13.2 (2004) to 13.9 (2007).

Black adolescent pregnancy rates are twice that of whites -- 18.4 vs. 9.2.
9.4 percent of births in 2007 were low birth weight babies (under 2500 grams).
14.9 percent were Black low birth weight babies as compared to 8.0 for whites.
27.2 percent of mothers reported tobacco use during pregnancy.

Infant Deaths

Tennessee's infant death rate is almost twice that for the nation at 8.3 per 100,000.
Black infant mortality was twice that of whites -- 16.4/100,000. There has been little change in the last 25 years.

Child Health Data: based on Tennessee Kids Count, 2008

39.1 percent (669,959) children are enrolled in TennCare for health care coverage.
27.8 percent live in households receiving food stamps.
38.8 percent of school age children receive free or reduced school lunch.
9.6 percent (7,950) of the ninth grade cohort drop out before finishing high school.
In 2008, there were 291,866 children under the age of 6 enrolled in TennCare.
For these TennCare enrolled children, 98% had completed EPSDT exams; 55,322 of these children received preventive dental care and 19,732 received dental treatment. Lead screening was completed on 62,347 children.

3. Priority Populations

The MCH priority populations for county health services are low income, medically underserved women, children and adolescents emphasizing outreach and service to African American and Hispanics who have no other financial resources or access to the health care system. While most special needs children have access to health care through private coverage or enrollment in the state Medicaid program called TennCare, more than 7,000 are enrolled in the state Children's Special Services program for assistance with other uncovered needs such as special formulas, adaptive equipment and co-pays and deductibles. These children remain a priority for MCH as well.

4. Existing Resources

Sections of the following were excerpted from the State Health Plan, November 2009.
Evidence points to there being a strong need to improve Tennesseans' health. While Tennessee has shown improvement in certain health outcome measurements, nationally, Tennessee is ranked 47th out of 51 jurisdictions (including all states and the District of Columbia) in terms of the overall health of its citizens. In 1990, it was ranked 37th and in 2007 it was ranked 46th. In other words, in comparison to these other jurisdictions, Tennessee is not keeping up. The comparatively poor health of Tennesseans negatively impacts not only the quality of life of our citizens, but a wide variety of other issues, including the economy of the state.
In the United States and in Tennessee, chronic health conditions such as diabetes, heart disease, and cancer are the leading cause of death and disability. There are several state government initiatives to address chronic disease, including smoking cessation, a new State Healthcare Report Card on Diabetes and Hypertension, and Coordinated School Health programs.

Smoking Cessation

Smoking is a major risk factor for heart disease, stroke, and lung cancer, and is the single most preventable cause of disease and death in the United States. Tennessee has one of the highest rates of smoking in the United States and also, not surprisingly, one of the highest rates of heart disease, stroke, and lung cancer. Additionally, smoking during pregnancy can lead to pregnancy complications and serious health problems in newborns. A parent who smokes is also a known risk factor for children developing asthma and other respiratory problems. The State's Smoking Cessation initiative is a combination of two programs overseen by the Tennessee Department of Health (TDOH) and an increase in the tobacco sales tax.

Tennessee Non-Smokers Protection Act -- Beginning October 1, 2007, Tennesseans were able to breathe smoke free at numerous restaurants, hotels, and many other establishments as a result of the Tennessee Non-Smokers Protection Act. This law, enforced by the TDOH, makes it illegal to smoke in most places where people work (http://health.state.tn.us/smokefreetennessee/).
Tennessee Tobacco QuitLine -- The Tennessee Tobacco QuitLine is a toll-free telephone service that provides personalized support for Tennesseans who want to quit smoking or chewing tobacco. Participants are assigned "quit coaches" who assist them in developing individualized quitting plans and work with them for an entire year. This free program has a 25 percent successful quit rate after 12 months. (http://health.state.tn.us/tobaccoquitline.htm; 1-800-QUIT NOW)
Increase in the Tobacco Sales Tax -- Effective July 1, 2007, the state tax on cigarettes increased from $0.20 to $0.62 per pack. Additional annual revenues from the increase are earmarked for education (estimate: $195 million), agricultural enhancements (estimate: $21 million) and trauma centers statewide (estimate: $12 million) (http://tennessee.gov/revenue/misc/cigtaxincrease.htm).

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

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

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

Tennessee law requires all public schools to include 90 minutes of physical education per week during school hours from kindergarten to 12th grade. All local education agencies (LEAs) are also required to screen students in grades K, 2, 4, 6, and 8 for vision, hearing, body mass index (BMI), and blood pressure. In the 2007-2008 academic year, the first year of implementation, 80.6 percent of schools were compliant. Some LEAs also conducted dental screenings (39 percent), BMI and blood pressure screenings in high school, and/or scoliosis screenings in 6th grade (41 percent). As a result of the required and optional screenings, 104,532 students were referred to doctors, with most referrals for BMI (45 percent), vision (27 percent), and dental (14 percent). Without these screenings these children might not have received care for their conditions.

Mental Health in Schools - The TDOE Office of Schools and Mental Health has a $301,010 eighteen month grant from the United States Department of Education Office of Safe and Drug Free Schools for Coordinated School Health coordinators to integrate schools' health and mental health systems. School staff, from teachers to administrators to bus drivers, will be trained to recognize signs of mental health problems and know how to make referrals to the appropriate person. In addition, in Project BASIC (Better Attitudes and Skills in Children) the Tennessee Department of Mental Health and Developmental Disabilities (TDMHDD) places child

development consultants in elementary schools to identify and refer children with severe emotional disturbance. TDMHDD also oversees and supports school based mental health services by providing liaisons who train teachers to provide positive behavioral supports and behavior plans. Liaisons also see youth for brief interventions and guide groups of children in anger management and communication skills enhancement.

Healthy Food Sold in Schools - In 2004 the General Assembly passed and Governor Bredesen signed into law new nutritional guidelines for food sold during school hours on public school grounds in Tennessee. As a result, Tennessee selectively prohibits, as set forth below, the sale of sodas, other high calorie beverages, high fat snack foods, salty snack foods, and other unhealthy foods at public schools (only water, 100 percent fruit juice, low-fat or no-fat milk, and low calorie drinks can be sold as school beverages).

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

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

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

Cover Tennessee -- Through the Cover Tennessee Act of 2006, Governor Bredesen and the General Assembly authorized the Department of Finance and Administration to establish the Cover Tennessee program to provide health insurance options to certain uninsured individuals in Tennessee (please go to this website, or call the telephone number shown, for details on all Cover Tennessee programs: http://www.covertn.gov/; 1-866-COVERTN). Cover Tennessee is an umbrella initiative designed for affordability and portability that includes four health insurance products and pharmacy assistance. These programs are:

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

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

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

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

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

TennderCare
A robust outreach program established in 2004 to increase EPSDT rates across the state, nurses and lay workers (122 Full Time Equivalents [FTE]) conduct home visits and community outreach (health fairs, school health programs, etc.), and telephone outreach for TennCare enrollees to provide information and facilitate transportation, appointments, explanation of benefits, etc. Also in 2004, a centralized telephone call center was established, with an additional staff of 14 lay workers, aiming to encourage appropriate service use (early prenatal care, EPSDT, etc.) and to provide information about TennCare.

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

In 2010, 2 teen pregnancy care coordination pilots and an outreach initiative to increase EPSDT rates among adolescents have been initiated in middle and high schools with large numbers of students receiving free or reduced lunch. There are expansion plans for 2010-11 including additional targeted outreach to adolescents and pregnant teens; establishment of a

TennCare/TennderCare/MCO collaborative to specifically focus on process and performance improvements; and new case finding and management enhancements with CSS participants and families.

Public Health System: Public health services are evolving into gap filling functions providing direct services to those who do not have public or private insurance and into population based, infrastructure and enabling services that support an integrated health care system to meet citizen needs. Services are provided in all 95 counties of the state through local and metropolitan health departments and private nonprofit agencies. These services include medical examinations, screening and treatment for sexually transmitted diseases, preventive health exams, screening for anemia, WIC, EPSDT, dental services, immunizations, education and counseling. Services are provided by nurse practitioners, physicians, certified nurse midwives, public health nurses, licensed practical nurses, nurse aides, educators, and counselors. No charges are made to clients at or below the federal poverty level. TennCare and other insurance are charged as appropriate.

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

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

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

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

The Department protects health through MCH by providing home visiting services to at risk families for more than 30 years emphasizing infant stimulation, child development, appropriate parenting and referral to community resources for needed services to improve pregnancy outcome and prevent child abuse. SIDS and child fatality are addressed by thorough case review and public education campaigns to teach safe sleep practices, for example. The state advisory

committee for Child Fatality Review recommends action that sometimes requires legislation such as the graduated driving license to reduce teen motor vehicle crashes as a means of protecting the health of Tennesseans.

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

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

MCH Priority Selection

The process for establishing MCH priorities in Tennessee included several iterative steps.

MCH Stakeholder Survey

A Professional Stakeholder Survey was developed for the Needs Assessment in 2005. This survey was reviewed, updated, and sent out January 7, 2010. A copy of the Professional Stakeholder Survey and Final Report is contained in the Needs Assessment Appendix A. MCH related information was used to design the 39 item questionnaire. Items on the survey were directly tied to the National Maternal and Child Health Performance Measures, and to a somewhat lesser extent, Healthy People 2010 MCH-related outcomes. The survey design process was also influenced by information obtained in meetings with TDH-MCH staff members.

County Health Council Priorities

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

2009 county health priority lists were received from 61 of 89 counties (68.5%) and all 6 Metro Councils. All the lists were reviewed and MCH-relevant health issues were derived. A table was created for each of the 8 regions, containing the counties and the priorities per county. The top 3 health priorities per region were determined by counting how many times a priority was listed. The Metros were counted separately from the regions (rural counties). Combined regional and Metro priorities were counted to arrive at the top County Health Council health priorities.

Children's Special Service Advisory Council

The Children's Special Service Advisory Council (see CSS Advisory Council list in Needs Assessment Appendix B) met April 23, 2010 and established health priorities for children and youth with special health care needs. Jacqueline Johnson (CSS Program Director) presented an update on CSS data and outreach efforts, and results from the National Survey of Children with Special Health Care Needs (NS CSHCN) and the Family Voices State survey. She also presented the current MCH National and State Performance Measures, along with a discussion on the MCH Pyramid and Life Course Perspective. Ms. Johnson reminded participants of the shift

in CSS from direct services toward enabling services. Attendees discussed their experiences with gaps and strengths of CSHCN services and needs. The group considered survey results, trends, and their own experience to arrive at their top priorities

Nominal group process was used to determine and rank the priorities. The group decided that medical home and transition to adulthood were the key issues for CYSHCN in Tennessee.

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

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

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

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

2010 Tennessee MCH Priorities/Performance Measures

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

B. Agency Capacity

Despite some significant public health and MCH resource challenges, Tennessee has a number of available resources and opportunities. An overview and some examples are described.

Budget and staffing

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

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

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

Edison, Contract & Accounting Process Changes

Edison is the State of Tennessee's Enterprise Resource Planning (ERP) system, an integrated software package used to perform administrative business functions such as financials and accounting, procurement, payroll, benefits, and personnel administration. In theory, such a system should save time and increase efficiency thereby saving money, and this supposition served as rationale for eliminating clerical positions. A stepwise implementation initiated in 2008 has been fraught with problems and delays, and while some processes have improved considerably (e.g., employee travel and reimbursement), others remain bogged in additional paperwork and duplicative work steps. It is expected that Edison will be of great benefit at some future time, but at present a number of domino effect inefficiencies have been created. For example, remaining clerical staff have assumed additional work while some functions previously completed by clerical staff have been absorbed by professional staff, thus making them less available for clinical and program management duties, and creating longer patient wait times and delays in meeting program benchmarks and deadlines.

Patient Tracking Billing Management Information System (PTBMIS)
& Data Management

TDOH does not have an electronic health record. PTBMIS is a mature but robust administrative data management system with some capacity to track limited clinical data and pharmaceutical inventories. A notable PTBMIS advantage -- all 95 county health departments are connected to

PTBMIS enabling virtually real time collection of statewide data. A notable PTBMIS disadvantage -- it is a proprietary system, data retrieval is cumbersome, and program revisions and upgrades are expensive and time consuming. Also, it has reached maximum expansion capacity, and estimates for meaningful upgrades range from $10 million for minimal improvements to $50-60 million for significant improvements including addition of an electronic health record. Thus, upgrades are not feasible at this time due to budget constraints.

Tennessee's Office of e-Health Initiatives has been awarded up to $24 million (ARRA funds) to support implementation of a new (2009) strategic plan to grow health information exchange (HIE) in the state through health information technology (HIT). The goal is to drive improvements in health care outcomes through coordinated statewide HIT that will enable vital, secure, decision-ready information to be available to clinicians at the point-of-care and benefit public health in general.

One early example of the state's commitment to HIE is the updated Tennessee Web Immunization System (TWIS). TWIS allows authorized users to obtain comprehensive immunization information on patients, update or initiate new patient records, links to other web sites to get comprehensive information on vaccines, vaccination strategies or current information from the Tennessee Immunization Program. TWIS is credited with helping to increase Tennessee's child immunization rates (4th best among the states) and won the 2009 Bull's Eye Award for Innovation and Excellence in Immunization from the Association of Immunization Managers for creation of a novel pre-registration strategy for clinicians to address the H1N1 pandemic flu threat. The award recognizes an outstanding immunization initiative and strategy that hits the mark of increasing immunization awareness and encouraging replication in other programs.

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

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

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

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

Literacy and Health Literacy
Health and education/literacy are inextricably linked. Literacy and health literacy are significant issues in Tennessee where 1 in 8 adults cannot read (Tennessee Literacy Coalition, 2010). Health literacy is the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions. Poor health literacy is associated with difficulty adhering to medication and treatment regimens, and is s strong predictor of poor health outcomes (Selden, et. al., 1999).

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

Policy Academy on State Strategies to Achieve Graduation for All - Tennessee was recently awarded $50,000 by the National Governors Association Center for Best Practices to fund development of a drop out prevention and recovery work plan and state policies and practices designed to increase graduation rates.

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

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

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

Few of Tennessee local health Department top executive leaders have advanced degrees. Of 130 executive leaders, only 25 have masters degrees, 2 have MDs, 1 has a JD, and there are none with other doctorates. The rest have bachelors or associate degrees.

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

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

In 2009, a University of Tennessee Health Sciences Center, College of Nursing (UTHSC CON)

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

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

Dr. Scott joined the MCH leadership team as a consultant in January, 2010. She comes as an experienced advanced practice nurse and educator, having worked most recently as a faculty member at Vanderbilt University School of Nursing, and continuing to maintain a part-time practice in Pediatric Pulmonology and Allergy at Vanderbilt. She has extensive expertise in school-based health care, injury prevention, asthma, and children with special health care needs. Dr. Scott has assumed a primary role in completion of the 5-year needs assessment and preparation of the Block Grant application. In the future, she will assist with the workforce development plan and implementation; and work to more formally integrate the Life Course Perspective and MCH priorities within established TDOH programs (e.g., WIC, family planning, chronic disease prevention, etc.).

Further, we have begun to reach out to other universities for assistance and collaboration, e.g., the aforementioned R-18 diabetes literacy collaborative grant. We have increased our active participation with MCH/HRSA grantees, e.g., participation and work with Vanderbilt investigators to inform LEND topics based on field staff training needs for the coming year; work with grantees at the Boling Center to include topics such as community-based obesity prevention strategies and to budget training slots for up to 50 local and distance TDOH participants. We have provided a letter of support, citing TDOH training needs, for an ETSU training grant proposal, as their recent accreditation enables Tennessee's first opportunity to apply for such funding. Additional training opportunities and funding will be sought as guidance from the training needs assessment emerges.

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

Nursing shortages
The current nursing shortage has significantly affected public health nursing. Contributing factors include, an aging population of nurses, a poorly funded public health system resulting in inadequate/noncompetitive salaries, reduced and/or eliminated public health nursing positions, bureaucratic hiring practices, limited public health advocacy, invisibility of public health nursing in media and marketing campaigns, and a growing shortage of nursing faculty adequately prepared to teach public health nursing (Quad Council, 2006).

Resource Map of Children's Services

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

Notable findings:

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

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

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

"The largest source of expenditures for children is TennCare, followed by the departments of Human Services, Education and Children's Services. Department of Mental Health funding for services for children are substantially below the other primary departments, but TennCare funding for mental/behavioral health services totaled $118,415,200 in FY 2007 and $112,193,000 in FY 2008."

In response to this outstanding report and other advocacy efforts, the Tennessee General Assembly voted to preserve programs that support children's health and well-being.

"Elected leaders in Tennessee have wisely established substantial Rainy Day and TennCare Reserve funds. It is hard to imagine a more valuable use of these dollars than ensuring we maintain basic services and supports to provide children with opportunities to thrive and become productive citizens. These services and supports enable children to remain with their families, succeed in school and become part of Tennessee's economic engine of the future. They do this by improving health and education opportunities and helping to reduce child abuse and involvement with child welfare and juvenile justice systems" (TCCY, 2010).

Direct Health Care Services

TDOH is the state's largest, direct service health care provider, logging 2.4 million visits and serving just over 1 million unduplicated Tennesseans annually. Children, infants and child-bearing age women represent two-thirds of this number. Each of Tennessee's 95 counties has one or more local health department clinics where traditional public health services are delivered via sliding-fee schedule. These services include surveillance and investigation of communicable disease and other outbreaks; well-child, EPSDT, immunization, women's health/reproductive

health, and WIC/nutrition clinics. Sliding-scale fee-based, primary care services are provided for uninsured adults (age 19-64 years) in 54 local health department sites. Fourteen of the 54 local health department clinic sites are designated as federally-funded, 330 health centers. Other federally qualified health centers (FQHCs) -- 23 federally funded health centers (not affiliated with the health department) provided primary and prenatal care for more than 300,000 unduplicated patients in 180 sites across the state in 2008-09 (Tennessee Primary Care Association, 2009).

TDOH administers supplemental Safety Net funding to faith-based, federally qualified, and other community clinics for primary and preventive care services, as well as emergency dental services, for uninsured adults. In 2009-10, $6 million was appropriated by the Tennessee General Assembly for this purpose. These are non-recurring funds and have ranged between $4-6 million for the past several years. Subsequent funding is uncertain.

Virtually 100% of the Tennessee residents live within 30 miles of a primary care source yet despite availability of these direct care services at either a local health department or a federally qualified health center, 94 of Tennessee's 95 counties were designated as medically underserved (partial or whole) in 2008 (Tennessee Health Access Plan, 2008).

Other key measures of access to care include:
31 counties were designated as Health Resource Shortage Areas.
30 counties were designated as obstetric shortage areas.
30 counties were declared pediatric primary care shortage areas.
30 counties have a shortage of providers accepting TennCare.
5 counties have no dentist.
10 counties have ratios of >10,000 residents/dentist
76 counties lack adequate mental health professionals (>20,000 residents/mental health provider).

The Bureau of Health Services Administration, Community Health Systems division, regularly monitors direct primary care service delivery capacity. Available data sets (e.g., licensure registries) and statewide telephone and electronic surveys (physicians, mid-level providers, and dentists) are used to assess needs and to identify service gaps. Working directly with various stakeholders such as universities, the Tennessee Hospital Association, Tennessee Primary Care Association, the Rural Health Partnership, etc., Community Health Systems staff administer various programs designed to recruit primary care providers to practice in underserved Tennessee localities.
National Health Service Corps Program (NHSC) -- In 2010, ninety-eight (98) health care professionals received NHSC support: 20 Physicians, 12 Dentists, 36 advanced practice nurses, 4 Physician Assistants, 2 Nurse Mid-Wives, and 18 mental health providers. Forty-two of the 98 are practicing at Federally Qualified Health Centers. Fifty-three of the 98 are located in rural areas.

Graduate Medical Education (GME) - Residency Stipend Program - Medical residents enrolled in a Tennessee primary care residency program (ETSU, Meharry, University of Tennessee, or Vanderbilt) are eligible for a $25,000 annual GME Stipend. Funds are made available through TennCare and expected to facilitate placement of 15 primary care providers in underserved areas in 2010.

J-1 Visa Waiver Programs - Foreign medical graduates receive a 2-year home residence waiver in exchange for a 3-year underserved area service obligation. Seven J-1 Visa physicians were successfully placed in Tennessee last year.

The Health Access Practice Incentive Grant Program (PIG) - Legislatively mandated and funded by unclaimed property, grants up to $50,000 can be awarded to physicians, dentists, or mid-level practitioners who agree to practice in a health resource shortage area for 3 years. These 100% state funds have been frozen since 2008 due to budget reductions.

State Loan Repayment Program (SLRP) - This program is funded by a 1:1 federal:state match for educational loan repayment to primary care practitioners in exchange for a 2-year service commitment in a Health Professional Shortage Area (HPSA). We expect to fund up to 10 awards in 2010-11.

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

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

Direct Health Care Services: Paradigm Shift

In 2009, MCH consultant, Dr. Donna Petersen, noted an imbalance in service delivery levels Tennessee's health departments. Using Pyramid criteria, the majority of services were notably "direct care" with far fewer services available to Tennesseans in the remaining categories. She subsequently recommended exploration of ways to reduce direct services and increase enabling, population-based, and infrastructure building activities in local health departments.
Notwithstanding continuing efforts, the following has been accomplished to date:
Two primary care clinics have been closed due to increased access provided by local FQHC expansions.
Prenatal care services provided in 3 local health department clinics have been discontinued and patients transitioned to private medical homes in collaboration with TennCare/Cover Kids for coverage expansions. One clinic remains, due to FQHC status, to serve uninsured women.
Children's Special Services specialty clinics (orthopedic, otolaryngology, speech, etc.) maintained by 4 regional health departments have been discontinued, alternate sources of care have been determined for patients in concert with TennCare/Cover Kids, and staff has been re-directed to patient navigation and case management activities.
CSS, HUGS, and CHAD services have been integrated. In the past, each of these programs had separate staff. Budget constraints led to service integration where staff may be responsible for providing services within all three programs.

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

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

increasing our collaboration with the division of Policy, Planning and Assessment (PPA), securing

part-time assistance of 2-PhD level statisticians

increasing collaboration with the division of Nutrition and Wellness

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

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

Home Visiting Services

Home visiting programs operated by MCH include HUGS, (Help Us Grow Successfully) CHAD, (Child Health and Development program), Healthy Start, and Nurse Family Partnership. (Descriptions of the home visiting programs are included in Appendix D of the Needs Assessment, 2009 MCH Home Visiting Report).

Key outcomes for MCH home visiting programs include improved birth spacing, child immunization and EPSDT rates, and decreased maltreatment or neglect reports. Funded by a combination of ARRA (American Recovery and Reinvestment Act of 2009) and TennCare reserve funds, services were maintained in every Tennessee county. Funding to continue these programs is uncertain beyond 2010. Good outcomes of these programs are contingent upon continued funding, well-staffed programs, a competent workforce, robust data collection systems, and continued training and educational programs.

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

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

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

Flood Response
On May 1, 2010, Tennessee experienced devastating floods that affected 48 of the state's 95 counties. The Tennessee Department of Health along with 24 other state agencies assisted the Tennessee Emergency Management Agency in responding to the emergency.

The Department designated staff to work in the state emergency operations center and the joint field office. The Department also readied EPI (epidemiology) Strike teams in the event they were requested by TEMA (Tennessee Emergency Management Agency) or regional health departments and coordinated care for patients injured during the flood whose homes were destroyed. The Department's Emergency Medical Services Division provided for special needs and medical transportation assistance at temporary shelters in the affected counties.

The Department of Health secured and allocated to several county health departments quantities of tetanus vaccine to ensure flood survivors were protected as they worked to repair and rebuild their homes.

As the flooding continued the Department released a series of news releases aimed at protecting the health of citizens affected by the floods. Topics included food safety, vector control, dangers

of high water, tetanus, water conservation and water safety, to name a few.

Following the floods, the Department concentrated efforts on mosquito monitoring, testing and abatement. The Department communicated the need to control the mosquito populations. The Department worked to secure federal funding and/or reimbursement for these activities.

Presently, the Department continues to closely examine opportunities to communicate public health messages and provide assistance in the aftermath of the flood.

C. Organizational Structure

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

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

An attachment is included in this section.

D. Other MCH Capacity

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

Services for Children with Special Health Care Needs, and Women's Health/Genetics are available upon request. The administration will change in January 2011 with the completion of Governor Phil N. Bredesen's second term as Tennessee's 48th Governor. Susan R. Cooper, MSN, RN., serves as the Commissioner of Health. Veronica Gunn, MD, MPH, FAAP, serves as the Chief Medical Officer for the Department of Health.

The Department of Health was one of the first departments established by state mandate. Services for women and children have always been a major part of local health department activity. By state law, there is a health department in every county; highly populated counties may have several health department sites. Title V has played an increasingly important, although often changing, role in providing services and funding for the county health department system, including services for children with special health care needs (CSHCN). Tennessee's local health departments in all 95 counties carry out health related programs for women, infants and children. The Department of Health is responsible for the overall administration of the Maternal and Child Health Block Grant funding and all the programs, projects, and activities which are components of maternal and child health.

Funds supporting maternal and child health activity include several special funding sources in addition to the MCH Block Grant. These grants are administered by staff in maternal and child health and women's health/genetics. The state's award for State Systems Development Initiative (SSDI) has been used to develop and update the computer network and data management infrastructure. This funding stream has benefited not only MCH but also the other sections of the Bureau of Health Services since SSDI funds were used for the integrated database on clients and services for program management called PTBMIS, which is used by all health service programs. SSDI funds have also been used in the past to upgrade the hardware and software used in the Genetic and Newborn Screening Program and to provide critical information from linked data sets.

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

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

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

Children's Special Services

Children's Special Services (CSS) is the state's Title V CYSHCN program. Children's Special Services addresses the special health care needs of children from birth to the age of 21 years who meet both medical and financial eligibility criteria. State statue defines children with special health care needs as: "A child under the age of 21 who is deemed chronically handicapped by any reason of physical infirmity, whether congenital or acquired, as a result of accident or disease, which requires medical, surgical, or dental treatment and rehabilitation, and is or may be totally or partially incapacitated for the receipt of a normal education or for self-support. This

definition shall not include those children whose sole diagnosis is blindness or deafness; nor shall this definition include children who are diagnosed as psychotic."

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

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

CSS provides reimbursement for medical care, supplies, pharmaceuticals, and therapies directly related to the child's diagnosis. Medical services are provided through a network of private and public, i.e., TennCare/Medicaid approved providers. Each family is required to apply for TennCare and CHIP, and is assisted with developing a medical home and locating specialty providers.

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

All families with children who are newly eligible for Supplemental Security Income (SSI) are contacted by CSS and provided information on CSS, mental health, developmental and intellectual disability, early intervention (TEIS), genetic services and other health department services that may be available. Approximately forty-one percent (2982) of the 7275 CSS enrollees have SSI.

CSS requires that all children applying for the CSS program apply for TennCare and CHIP; assists families in locating a medical home, specialists and related service providers within the MCOs' provider networks; keeps TennCare informed of underserved areas and works with the MCOs to identify out-of-network providers for CYSHCN. CSS participates in TennCare advocates' meetings to keep informed of changes and uses the network of state, regional, and local CSS staff for disseminating information. This route also allows direct CSS staff and parent interaction to ensure parent understanding of the changes and improve transition of services. CSS also helps families file appeals for denied medically necessary services.

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

Children's Special Services recognizes the need for parental involvement in all aspects of the program. Parents are involved as full participants in their child's care and as advisors to the program. One parent is a member of the CSS Advisory Committee. We are working with Family Voices and Vanderbilt School of Nursing on a plan to improve family participation: The goal is to better understand parent/family needs and how CSS can improve services to families of children

with special health care needs. Researchers and partners are working on focus group planning and surveys. CSS also recognizes the needs of parents of a recently diagnosed child to talk and meet with other parents of a similar or like diagnosed child, so those parents can impart their knowledge, understanding and experience. If a family cannot be referred to another parent of a similar or like diagnosis then the family is referred to the national Mothers Understanding Mothers (MUMS) organization. At present, CSS does not reimburse the $5.00 fee for using the MUMS service.

E. State Agency Coordination

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

MCH has always had a strong collaborative relationship with metropolitan health departments in the state. Since these entities have separate boards of health, the state's role is to provide needed service, focused funding, training and continuing education and participation as a partner in all planning and system change initiated to improve the public's health. The six designated metro health departments receive funds through the state's contractual system. Staff in Metro Health Departments who provide MCH services are regularly included in conference calls, quarterly meetings, in-service training and planning meetings about MCH programs and services. Metro Regional Directors participate as active partners with rural Regional Directors in public health planning and new initiatives. The primary difference between these two entities is that metros report to boards of health and the mayor, while rural regional directors report to the Assistant Commissioner, Bureau of Health Services Administration.

Examples of collaborative efforts:

TennCare/Medicaid: The Childhood Lead Poisoning Prevention Program has a cost-sharing protocol with TennCare for cases when an environmental investigation is conducted for a lead poisoned child on Medicaid. CSS requires that all children applying for the CSS program apply for TennCare; assists families in locating a medical home, specialists and related service providers within the MCOs' provider networks; keeps TennCare informed of underserved areas and works with the MCOs to identify out-of-network providers for CYSHCN. CSS participates in TennCare advocates' meetings to keep informed of changes and uses the network of state, regional, and local CSS staff for disseminating information. This route also allows direct CSS staff and parent interaction to ensure parent understanding of the changes and improve transition of services. CSS also helps families file appeals for denied medically necessary services. All local health departments are providing outreach, advocacy, and EPSDT screenings for TennCare enrollees. The clinics refer patients who may be eligible to TennCare. The family planning program informs patients who test positive for pregnancy about TennCare's presumptive eligibility benefit and refers eligible patients to the agency for application.

Department of Children's Services (DCS): This agency is responsible for the children in state custody. The Department of Health is providing the EPSDT screenings for all these children. Other collaborations with DCS include funding for both the Healthy Start and Child Health and Development home visiting programs. MCH gets referrals from DCS and makes home visits to the family. Also, DCS staff are involved on teams reviewing cases for the Child Fatality Review program. MCH staff is invited to attend the multidisciplinary teams to case manage clients. CSS regional coordinators work with the DCS Regional Health Unit nurses to coordinate health

services for CYSHCN in state custody.

Several MCH staff are members of the Children's Justice Task Force and the Child Sex Abuse Task Force, whose members are from many state government departments and community organizations. The Children's Justice Task Force, a multidisciplinary group of professionals and advocates focused on the welfare of children reported to have been abused or neglected, is charged with identifying existing problems and recommending solutions to DCS regarding the investigation and prosecution of child abuse and neglect. The Child Sex Abuse Task Force, a multidisciplinary group of professionals and advocates, is responsible for developing a plan of action for better coordination and integration of the goals, activities and funding of the Department of Children's Services pertaining to the detection, intervention, prevention and treatment of child sexual abuse.

Department of Human Services (DHS): DHS houses the Division of Vocational Rehabilitation, TN Services for the Blind and Visually Impaired and the TN Technology Access Project. These programs work in collaboration with the CSS program. The Deaf/Blind Coordinator has participated on the Newborn Hearing Screening (NHS) Task Force since 1997. DHS offices currently serve as the place of application for Medicaid and TennCare. DHS provides CSS proof that CSS applicants have applied to TennCare. MCH has collaborated with DHS since 1996 to build a statewide network of child care resource centers which include a child care health consultant. Services provided include: technical assistance and consultation, training, and lending resource library materials and are available to all child care providers in the State. In addition, MCH through its Early Childhood Comprehensive Systems Program and its Child Care Resource Centers assist DHS in providing technical assistance for state regulated day care centers. In 2007-2008, MCH enhanced its services to DHS by providing collaborative support to prevent childhood obesity and promote good social emotional development in child care populations.

Department of Education (DOE): The director of adolescent health serves on the advisory committee of the Coordinated School Health (CSHP) Program.

The Department of Education, Division of Special Education, is the lead agency for the IDEA Part C, TN Early Intervention System (TEIS) for infants and toddlers birth to 3 years old identified with or having a potential for a developmental delay. TEIS has been an active participant in collaboration with the CSS program since 1990. The programs coordinate referral and care coordination activities on infants and children requiring services from both agencies. An MCH staff person serves on the State IDEA Interagency Coordinating Council representing all MCH programs. TEIS staff serve on the NHS Task Force. The Tennessee Infant Parent Services (TIPS) program trains Parent Advisors to provide home-based services to infants and toddlers birth to 5 years identified with a vision and/or hearing loss, or other disability. TIPS and TEIS work closely with the NHS program and provide tracking, follow-up and intervention services for infants referred for or identified with a hearing loss after hospital hearing screening. The TEIS data collection system documents hearing follow-up. An MCH staff serves on the Part C (Early Intervention) Monitoring Review Committee. CSS central office and regional office staff participate in Early Intervention Administrators' Forums which include various agencies and promote interagency linkages at the program administrators' level. Local CSS staff participate in meetings for individual CYSHCN with DOE Part C and Part B personnel in developing coordinated care plans to insure the coordination of services. CSS staff keeps DOE staff, including school health nurses, informed of TennCare changes to insure continuity of care.

Head Start: A staff person representing Head Start and Early Head Start is an active member of the TEIS State Interagency Coordinating Council; MCH works through this committee with Head Start. The DOE Head Start Collaboration Officer is a member of the Childhood Lead Poisoning Prevention Program and the Early Childhood Comprehensive Systems Advisory Committees. These committees include state agency staff and advocates for children and meet regularly for discussion, information sharing and program policy coordination. The Director, along with Head Start health specialists and regional directors have been invited to attend the MCH video-

conferences to learn more about MCH programs and current diagnosis and treatment of conditions affecting children.

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 CYSHCN and family members to local mental health centers or other local mental health providers if appropriate. Mental health and social-emotional development are one of the five critical areas being addressed in the Early Childhood Comprehensive Systems, and TDMHDD staff participate on the Advisory Committee. MCH's Adolescent Health Program Director is assisting in implementing a suicide prevention training grant recently received by TMHDD.

The adolescent health director serves as a member of the Tennessee Suicide Prevention Network and works with a state intradepartmental committee and the state advisory committee composed of members from the private and public sector to prevent suicide. The director co-chaired a subcommittee to address youth suicide prevention. The committee developed a state plan to address youth suicide prevention.

Social Security Administration (SSA): MCH staff provide information on MCH programs to parents of CYSHCN 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).

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 CYSHCN constructed at no cost to families.

Vocational Rehabilitation: See Department of Human Services.

Child Fatality Review: The Child Fatality Review process is a statewide network of multidisciplinary, multi-agency teams in the 31 judicial districts in Tennessee to review all deaths of children 17 years of age or younger. Members of the local teams include: Department of Health regional health officer; Department of Human Services social services supervisor; Medical Examiner; prosecuting attorney appointed by the District Attorney General; local law enforcement officer; mental health professional; pediatrician or family practice physician; emergency medical services provider or firefighter; juvenile court representative; and representatives of other community agencies serving children. Members of the State Child Fatality team include: Department of Health commissioner; Attorney General; Department of Human Services commissioner; Tennessee Bureau of Investigation director; physician (nominated by Tennessee Medical Association); physician credentialed in forensic pathology; Department of Mental Health and Developmental Disabilities commissioner; Department of Education commissioner; judiciary member nominated by the Supreme Court Chief Justice; Tennessee Commission on Children and Youth chairperson; two members of the Senate; and two members of the House of Representatives.

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

Adolescent Health: The adolescent health director provides educational presentations to adolescent health coordinators and the advisory committee through quarterly teleconferences. The director serves on several committees including the intra-departmental committee of the Tennessee Suicide Prevention Network (TSPN). TSPN is a grass-roots association which works to eliminate the stigma of suicide and educate communities about the warning signs of suicide, with the ultimate intention of reducing suicide rates in the state of Tennessee.

The program director serves on the local and state Disproportionate Minority Confinement (DMC) committees. DMC's mission is to develop a comprehensive strategy for raising the awareness of disproportionate confinement of minority youth in the juvenile justice system and promote the best practices and policies to eradicate the problem of overrepresentation in secure confinement.

The program director serves on the Governor's Office of Children's Care Coordination (GOCCC), Teen Health subcommittee. A major effort is to coordinate activities of Maternal and Child Health programs, Division of Mental Health and Developmental Disabilities, the TENNderCare program, and community partners related to the annual Child Health Week campaign. With no specific budget for the campaign, efforts centered on getting agencies to highlight current activities for child health and well-being.

The program director serves on the Tennessee Alcohol and Drug Endangered Children (TADEC) committee. The Tennessee Alliance for Drug Endangered Children (TADEC) is a collaborative statewide multi-disciplinary effort to prevent drug related harm to children and rescue, defend, shelter and support Tennessee's children who suffer physical and psychological harm caused by the manufacture, distribution, sale and use of illegal drugs, and abuse of prescription drugs and alcohol.

The program director serves on the Tennessee Obesity Task Force (TOT) which is a work group organized to develop a strategic plan addressing obesity and related health problems in Tennessee.

Asthma Management: The overarching goal of the State of Tennessee Asthma Plan is to reduce the burden of asthma in Tennessee. STAT members, in conjunction with Early Childhood Comprehensive Systems, the TennCare Bureau and the Department of Education, developed and are implementing a comprehensive state plan to reduce the burden of asthma among Tennesseans. The plan includes surveillance and epidemiology; public awareness and education; medical management; and environmental management components. The program director currently collaborates with STAT nurses to make educational presentations across the state to medical providers, educators, parents, and youth. STAT plans to target pre-school children, school-aged children, and adults 30 and older.

Federally Qualified Health Centers: Community Health Centers are located in medically underserved areas of the state. There are 24 Federally Qualified Health Centers (FQHC) that operate 142 clinic sites in Tennessee. These community health centers, which provide primary health care, dental and mental health services to more than 280,400 patients. Referral systems exist between those community health centers and health departments located within the same county.

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 had difficulty in achieving desired EPSDT screening rates and is partnering with the Department to improve these rates. A Bureau of Health Services representative meets monthly with two groups in TennCare: (1) the EPSDT Workgroup comprised of representatives from all the managed care organizations; and (2) the Tennessee Chapter of the American Academy of Pediatrics representatives.

Folic Acid Education Campaign: Women's Health and Nutrition staff (central and regional offices)

are partnering with the March of Dimes, Girl Scouts, and members of the state folic acid council to educate the citizens of Tennessee on the need for folic acid. Central office staff developed and implemented many of the statewide activities. The Women's Health director serves on the state council.

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

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

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

Nutrition and Wellness/WIC: Collaborative efforts among MCH and Women's Health staff, Health Promotion, and Nutrition/WIC, as well as partnerships with March of Dimes and other outside agencies on activities addressing prevention of smoking in pregnant women include advertising the availability of the state's QUITLINE and other educational activities. CSS makes direct referrals to WIC on all clients under 5 or mothers of CYSHCN who are pregnant. CSS purchases special formula if they need amounts above the allowed allocations under the WIC program. CSS also assists in obtaining special foods for PKU children.

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

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

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.

Other federal grant programs under the administration of the Department which serve maternal and child health populations include WIC, family planning, newborn hearing screening and follow-

up, Early Comprehensive Childhood Systems (ECCS), sexually transmitted diseases programs including HIV/AIDS, immunizations, and PRAMS.

F. Health Systems Capacity Indicators

Introduction

Following each indicator a brief narrative refers to those sections of the document which provide information on the indicator, or includes information relative to the indicator. Data and data sources are noted on the forms.

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

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

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	28.9	28.9	29.6	26.6	24.8
Numerator	1366	1366	1188	1074	1000
Denominator	473085	473085	400744	403306	403000
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008

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

Notes - 2007

Data source is Final Inpatient Hospital Discharge Tennessee resident only and 2007 population estimates.

Narrative:

Data and data sources are noted on the forms.
The following are fully described in Sections 3 and 6 of the Needs Assessment document: Analysis of data, extent of the problem, activities and strategies, and MCH capacity.

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

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

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	66.8	62.9	83.6	71.8	72.9
Numerator	52414	53033	48559	75323	77120
Denominator	78503	84277	58058	104882	105835
Check this box if you cannot report the					

numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
State of Tennessee Tenncare (Medicaid) database.
Data source is the state of Tennessee TennCare EPSDT Data system.

Notes - 2007
State of Tennessee TennCare (Medicaid) database

Narrative:
Data and data sources are noted on the forms.
The following are described in Section 4 of the Needs Assessment document and Block Grant Section IV D SPM 7:
Analysis of data, extent of the problem, activities and strategies, and MCH capacity.

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

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

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	0.0	0.0	0.0	100.0	100.0
Numerator	0	0	0	34704	30753
Denominator	1	1	1	34704	30753
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

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

Notes - 2007
2007 data are not available; however, SCHIP children in Tennessee are enrollees in both TennCare and in CoverKids.

Narrative:
Data and data sources are noted on the forms.
The following are described in Section 4 of the Needs Assessment document and Block Grant Section IV D SPM 7:

Analysis of data, extent of the problem, activities and strategies, and MCH capacity.

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

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

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	74.1	76.8	83.8	93.2	88.5
Numerator	60360	64738	72498	73270	66760
Denominator	81454	84277	86558	78578	75470
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

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

Notes - 2007
2007 is updated/corrected due to methodological differences in calcuations. Update: 72627/80773 = 89.9
Calculation is now per Guidance:
Numerator Number of women (15-44) during the reporting year shose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index

Narrative:
Data and data sources are noted on the forms.
The following are described in Section 3 of the Needs Assessment document; Block Grant Section IV C NPM 8, 17, and 18; and Block Grant Section IV D SPM 6:
Analysis of data, extent of the problem, activities and strategies, and MCH capacity.

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

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

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	100.0	100.0	45.9	92.8	93.2

Numerator	758628	743387	375016	759672	790661
Denominator	758628	743387	816486	818194	848210
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

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

Notes - 2007
Methodology and data source changed for 2007 and 2008.
Numerator - Actual Medicaid data on number receiving a service are not available. As a proxy, used CMS-416 Report, FY 2007, line 9, "Total eligibles receiving at least one initial or periodic screen."
Denominator - Kaiser Family Foundation, TN, Ages 0-19, < 100 % poverty, 2006-2007 (Used as estimate).

Narrative:
Data and data sources are noted on the forms.
The following are fully described in Sections 4 of the Needs Assessment document; Block Grant section IV C NPM 13; and Block Grant section IV D SPM 4 and 7:
Analysis of data, extent of the problem, activities and strategies, and MCH capacity.

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

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

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	60.4	37.0	50.6	52.6	55.0
Numerator	86569	56418	77255	77122	84062
Denominator	143367	152680	152575	146517	152828
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
Data sources: TennCare EPSDT and claim system

Notes - 2007

Data source is the state of Tennessee TennCare EPSDT Data system.
Data are 1 year late due to TennCare EPSDT reports.

Narrative:
Data and data sources are noted on the forms.
The following are fully described in Needs Assessment Section 4; and Block Grant Section IV C NPM 9.
Analysis of data, extent of the problem, activities and strategies, and MCH capacity.

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

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

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	100.0	100.0	9.0	14.0	17.3
Numerator	19781	22392	1962	2838	3676
Denominator	19781	22392	21881	20343	21286
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

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

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

Notes - 2007
For both 2007 and 2008, the methodology and data sources were changed in response to directives received at the block grant review.
Data sources are CSS program database and federal database of SSI recipients.

Narrative:
Health Systems Capacity Indicator - SSI beneficiaries less than 16 In the state receiving services from the Children with Special Health Care Needs Program: All families with children who are newly eligible for Supplemental Security Income (SSI) are contacted by CSS and provided information on CSS, mental health, developmental and intellectual disabilities, early intervention (TEIS), genetic services and other health department services that may be available to them. Approximately forty-one percent of the 7,275 CSS enrollees have SSI (FY 2009). Program staff continue to contact families with newly diagnosed children and provide information on services available. Data for 2009 indicate 21,286 SSI recipients under age 16 live in the state. CSS staff contacted 3676 during this time period and provided information regarding CSS program requirements and other services and resources.

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

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of low birth weight (< 2,500 grams)	2008	matching data files	11	7.3	9.2

Notes - 2011
Data Source: TDH Birth and Death Records and TennCare Records

Narrative:
Data and data sources are noted on the forms.
The following are described in Section 3 of the Needs Assessment document and Block Grant Section IV C NPM 8, 7, 18; and Block Grant Section IV D SPM 6:
Analysis of data, extent of the problem, activities and strategies, and MCH capacity.

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

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Infant deaths per 1,000 live births	2008	matching data files	10.3	5.7	8

Notes - 2011
Data Source: TDH birth and death records and TennCare Records

Narrative:
Data and data sources are noted on the forms.
The following are described in Section 3 of the Needs Assessment document; Block Grant Section IV C NPM 8, 17, and 18; and Block Grant Section IV D SPM 6:
Analysis of data, extent of the problem, activities and strategies, and MCH capacity.

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

INDICATOR #05 ***Comparison of health***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-**	**ALL**

system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State				**MEDICAID**	
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2008	other	1	1	67.7

Notes - 2011
Breakdown of infants born to pregnant women receiving prenatal care beginning in the first semester per Medicaid and non-Medicaid is not available.

Narrative:
Data and data sources are noted on the forms.
The following are described in Section 3 of the Needs Assessment document; Block Grant Section IV C NPM 8, 17, and 18; and Block Grant Section IV D SPM 6:
Analysis of data, extent of the problem, activities and strategies, and MCH capacity.

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

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2008	other	1	1	93.2

Notes - 2011
Percent of pregnant women with adequate prenatal care per Medicaid and non-Medicaid is not available.

Narrative:
Data and data sources are noted on the forms.
The following are described in Section 3 of the Needs Assessment document; Block Grant Section IV C NPM 8, 17, and 18; and Block Grant Section IV D SPM 6:
Analysis of data, extent of the problem, activities and strategies, and MCH capacity.

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

INDICATOR #06	**YEAR**	**PERCENT OF**

The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.		**POVERTY LEVEL Medicaid**
Infants (0 to 1)	2009	185
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2009	250

Narrative:
Data and data sources are noted on the form.
Medicaid coverage in Tennessee continues to include: SSI eligible, TANF eligible, medically needy eligible; and pregnant women and infants under age 1 up to 185% of poverty, children from 1-6 at 133% of poverty, and children from 6 to 19 at 100% of poverty. SCHIP enrollees are in the Coverkids program.

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

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Medicaid Children (Age range 1 to 5) (Age range 6 to 19) (Age range to)	2009	 133 100
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children (Age range 1 to 5) (Age range 6 to 19) (Age range to)	2009	 250 250

Narrative:
Data and data sources are noted on the form.
Medicaid coverage in Tennessee continues to include: SSI eligible, TANF eligible, medically needy eligible; and pregnant women and infants under age 1 up to 185% of poverty, children from 1-6 at 133% of poverty, and children from 6 to 19 at 100% of poverty. SCHIP enrollees are in the Coverkids program.

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

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Pregnant Women	2009	185
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**

women.		
Pregnant Women	2009	250

Narrative:
Data and data sources are noted on the form.
Medicaid coverage in Tennessee continues to include: SSI eligible, TANF eligible, medically needy eligible; and pregnant women and infants under age 1 up to 185% of poverty, children from 1-6 at 133% of poverty, and children from 6 to 19 at 100% of poverty. SCHIP enrollees are in the Coverkids program.

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

DATABASES OR SURVEYS	**Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)**	**Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)**
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	No
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	2	No
Annual linkage of birth certificates and WIC eligibility files	2	No
Annual linkage of birth certificates and newborn screening files	3	Yes
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	3	No
Annual birth defects surveillance system	3	No
Survey of recent mothers at least every two years (like PRAMS)	3	No

Notes - 2011

Narrative:
9A Health Systems Capacity Indicator-Ability of states to assure that the MCH program and Title V agency have access to policy and program relevant information and data: Within the Department of Health, support functions such as data set development, data analysis, and research are located in the Office of Policy, Planning, and Assessment (PPA). This Office houses a number of data sets which are either maintained by their staff or extracted regularly from other

data systems. The state began collecting data for the CDC funded Pregnancy Risk Assessment Monitoring System (PRAMS) in May 2007. This new system is housed in PPA. WIC files are a component of PTBMIS. MCH staff has access to the output data within the PTBMIS files through a system of CUBES which is maintained by the Bureau of Health Services. Staff in the Bureau of Health Services and the Office of Policy, Planning, and Assessment are available to MCH for assistance. Data for newborn metabolic and hearing screening are handled through the Neometrics system for Women's Health/Genetics and the State Laboratory.

The MCH section does not have direct access to data, but there is access through PPA or the Bureau of Health Services (HSA), along with consultation from PPA epidemiologists.

The Tennessee Youth Risk Behavior Surveillance System (YRBS is administered by the Department of Education every two years. Results, trend analyses, and data users' guides are available on the TDE website.

The Genetics and Newborn Metabolic and Hearing Screening Programs use propriety software from Neometrics to manage program data. The Case Management System contains data on all abnormal metabolic screening results, demographics on the infants, and information on follow-up and treatment. The system generates a letter to both the parents and the primary care provider to repeat the specimen. The system allows tracking of each hospital's rate of unsatisfactory specimens. The Department has developed an ongoing process to link these data to the birth files. The system also is used for tracking newborn hearing screening results and follow up -- also linking to birth files. PPA staff developed a system for newborn hearing follow-up nurses to generate reports and special queries.

The Tennessee Birth Defects Registry (TDBR) is a system housed within PPA. The TBDR has initiated a system that involves sending public health nurses to selected hospitals to review infant medical records. The active review of medical records provides a depth of information not available through other passive sources (e.g., birth files and hospital discharge information). The TBDR is working toward adding birth defects information to the Department's web site. The TBDR data are the combined product of passive surveillance based on hospital discharge records and active medical records reviews conducted by public health nurses. Birth defects registry documents are on the Department of Health's web site.

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

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

Notes - 2011

Narrative:
Information on this indicator is in Block Grant Section IV D SPM 1.
The Tennessee Department of Education administers the YRBS on odd years. Results, interpretation, data user's guide, and trend analysis reports are available on the TDOE website.

IV. Priorities, Performance and Program Activities

A. Background and Overview

The Tennessee MCH performance measurement system is founded on principals of public health and includes: assessing needs and capacity, setting priorities, developing programs, allocating resources, establishing performance measures, and measuring outcomes. The needs assessment and performance measurement framework is founded on the Life Course Perspective. We believe that health of mothers and children must be considered within a holistic biopsychosocial and developmental context over the entire life trajectory. Programs and policies must work synergistically instead of in categories. We aim for a system where the activities and partnerships surrounding the national and state performance measures will have a collective contributory effect. Operating together, these performance measures are precursors to the 6 National outcome measures.

Sections C and D of the block grant narrative focus on national and state performance measures, with descriptions of how programs are making impact.

B. State Priorities

Quantitative and qualitative assessment revealed consistent findings regarding major health issues surrounding the three MCH populations. Potential priorities were derived from the MCH Stakeholder Survey, county health council priority lists, National MCH agenda, specific conditions for which State and National data sources revealed high morbidity and mortality, key informant interview, and Tennessee MCH leadership formal and informal brainstorming sessions.

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

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

Next, with critical and deliberate consensus building, we derived 7 Tennessee MCH priorities and wrote the following corresponding State Performance Measures.

2010 Tennessee MCH Priorities/Performance Measures

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

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

C. National Performance Measures

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

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

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	176	180	164	205	153
Denominator	176	180	164	205	153
Data Source				Tennessee Newborn Screening Data system	Tennessee Newborn Screening Data system
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	100	100	100	100	100

Notes - 2009
Data source is the state of Tennessee New Born Screening data system.

Notes - 2008
Data source is the state of Tennessee Newborn Screening data system.

Notes - 2007
Data source is the state of Tennessee New Born Screening data system.

a. Last Year's Accomplishments
Tennessee's Genetics and Newborn Screening (NBS) Program was established in 1968 with mandated PKU screening of all babies. The NBS Program continues to utilize an established network of tertiary level providers for referral, case management and treatment of infants and children with genetic and metabolic diseases. Close linkages exist among NBS Follow-up staff, the Centers and the Children's Special Services staff for referrals. An advisory committee guides program activities. Follow Up staff, located at the State Laboratory, is responsible for interfacing with the State Lab to identify, locate and follow up on unsatisfactory or abnormal results from the mandated screening. Referrals are made to the genetics and sickle cell centers as well as pediatric endocrinologists. Access to genetic screening, diagnostic testing and counseling services is available at 3 regional comprehensive genetic centers, 2 satellite Genetic Centers, 4 pediatric endocrinologists, 2 comprehensive sickle cell centers and 2 satellite sickle cell centers for individuals and families. If needed, local health department nurses assist in locating an infant needing follow-up.

This performance measure continues to be successfully met due to the state law requiring testing of all infants born in the state and the quality and efficiency of the State Laboratory and the NBS follow-up program. A newborn screening DVD continues to be available to health care providers in order to educate them about newborn screening testing, proper specimen collection and follow up protocols for abnormal and unsatisfactory results and referrals.

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

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

A new prenatal fact sheet was developed for parents for distribution in prenatal/obstetric classes. "What Parents Should Know about Newborn Screening" is on one side, and "What Parents Should Know about Newborn Hearing Screening" is on the other side. The educational flyer is on the Department's web site.

NBS staff performed a site visit at the Meharry Sickle Cell Center in June 2009. It was the first time the program staff had performed chart reviews and monitoring at an agency using an electronic medical records system. Meharry, the comprehensive sickle cell center, has built a new partnership with the Vanderbilt Pediatric Hematology Clinic in order to diagnose and treat infants and children with sickle cell and other hemoglobinopathies in the middle Tennessee catchment area. In addition, two new sickle cell support groups have been created at the Vanderbilt clinic. Those support groups meet at the Children's Hospital but are staffed by Meharry employees.

During the CY 2009, follow up staff called 2,407 presumed positive results to PCPs or NICU units and to the Centers. In addition, follow-up was done on 1,698 unsatisfactory samples, 1,099 samples which were collected before the infant was 24 hours of age, and 1,250 infants that needed follow up due to transfusions. Reports for infants on parenteral nutrition support were created and are currently being sent to tertiary centers on a regular basis. Provisional 2009 data indicate 87,144 infants were born in Tennessee during the calendar year. A total of 6,454 cases were opened and followed by the staff in 2009.

The State Lab began charging hospitals for repeats in January 2009. Since that policy change was implemented, there has been a significant decrease in the number of unsatisfactory samples

collected. Follow up staff continue to monitor the unsatisfactory collection rate by hospital. For the first time, the state unsatisfactory rate was 1.89% for 2009. Unsatisfactory rates per hospital are posted on the Newborn Screening Follow Up web site.

Table 4a, National Performance Measures Summary Sheet

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

b. Current Activities

The Genetics Advisory Committee (GAC)(members from the genetic centers, pediatric endocrinologists, hematologist, pediatrician/lawyer) met twice to guide the program and recommend changes in tests and procedures. Membership to the GAC was reassessed this year. In 2009, the committee was expanded and three new positions were added to the current roster by the Commissioner of Health; a neonatologist, a pulmonologist, and the parent of a child/infant with hearing loss and or special needs were added for four year terms.

Guidelines for screening on babies who have been transfused were developed, and shared with the GAC for review and input.

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

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

c. Plan for the Coming Year

The plan for the next year will be to continue to provide follow up as efficiently as possible. Recruitment for the vacant nursing position will continue. The NBS program will continue to perform and document all follow up for presumed positives, unsatisfactory results, and infants

transfused. Draft guidelines for infants with birth weights less than 1500 grams have been created and will go through the approval process this year. Once approved, the follow up program will create an educational program for NICU staff to facilitate implementation. Collaborative activities among NBS staff, tertiary centers, perinatal regional staff and hospital staff will be created in order to train NICU staff on the new guidelines. The NBS program will form a work group consisting of Genetics Advisory Committee members, NBS staff and other interested stakeholders to produce a written educational plan. The Genetics Advisory Committee plans two face to face meetings in November and in May.

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

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

Total Births by Occurrence:	**90885**					
Reporting Year:	**2008**					
Type of Screening Tests:	**(A) Receiving at least one Screen (1)**		**(B) No. of Presumptive Positive Screens**	**(C) No. Confirmed Cases (2)**	**(D) Needing Treatment that Received Treatment (3)**	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)		0.0				
Congenital Hypothyroidism (Classical)	90885	100.0	341	64	64	100.0
Galactosemia (Classical)	90885	100.0	165	28	28	100.0
Sickle Cell Disease		0.0				
Biotinidase Deficiency	90885	100.0	11	3	3	100.0
Cystic Fibrosis	68724	75.6	189	12	12	100.0
Hemoglobinopathies	90885	100.0	84	73	73	100.0
Congenital Adrenol Hyperplasia	90885	100.0	909	9	9	100.0
AminoAcids	90885	100.0	218	5	5	100.0
Fatty / Organic Acidimias	90885	100.0	179	11	11	100.0

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

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

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	70	62	62	62	62
Annual Indicator	59.3	60.0	60.7	60.7	60.7
Numerator	3703	3807	3381	3522	4415

Denominator	6244	6349	5570	5802	7275
Data Source				CSHCN Survey	CSHCN Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	62	62	62	62	62

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

a. Last Year's Accomplishments
CSS staff continued to work to ensure that children and parents become active participants in all levels of decision making. CSS and Family Voices developed a second statewide survey for children and youth with special health care needs. The survey was modeled on the CSHCN SLAITS model and will be conducted by phone. The results of this survey will be utilized as a guide for program staff to determine areas of focus or concern for CYSHCN. CSS program staff continued to educate families on interaction with medical providers concerning decision making for medical care while making a concerted effort to ensure satisfaction is achieved in each level of the process. CSS participants and their families continued to participate in the development of a Family Service Plan (FSP). This plan is an assessment tool from which a problem/needs list is identified and goals and objectives are developed to address those problems/needs. The FSP includes medical and non-medical assessments including an individual plan of care and the identification of community resources. CSS Care Coordinators continued to offer education and assistance to families and participants on interaction with health care providers and integrated system navigation.

The CSS program director and staff served on advisory committees and collaborated with The Tennessee Council of Developmental Disabilities, The Tennessee Technical Assistance and Resources for Enhancing Deaf Blind Supports (TREDS), Family Voices, Tennessee Early Intervention Services, The Governor's Office of Children's Care Coordination, State Genetic Coordinating Committee, Genetics Advisory Committee, Newborn Hearing and Screening Advisory Committee, and Early Childhood Comprehensive Systems where they actively participate in policy and program development for children and youth with special health care needs

Table 4a, National Performance Measures Summary Sheet

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

b. Current Activities

A work team was developed comprised of CSS Care Coordinators, Regional CSS Directors, State Directors, Nurse Consultants and Management Staff to determine the best practices and standards necessary for meeting this performance measure. Outcomes from this meeting led to a larger state wide meeting of regional and metro health directors, MCH directors, nursing directors, CSS directors and care coordinators. This meeting looked at the current programmatic requirements and made recommendations for change based on the Life Course Perspective and the MCHB Pyramid. Care Coordination standards are being developed to ensure all families receive education and training on interaction with medical providers concerning their involvement in making decisions for medical care that will maximize the potential for satisfaction.

CSS staff participated in the Family Voices Family to Family Conference. Parents presented to other parents of CYSHCN and discussed their interactions with their medical providers, educational personnel and basic information for parents with newly diagnosed CYSHCN.

c. Plan for the Coming Year

Care coordination best practices and standards will be developed and all care coordinators will be trained so that all regions of the state are operating under the same guidelines. Competencies will be developed that all coordinators will have to meet as part of their job duties. Program directors and care coordinators will be meeting with medical providers in their regions/counties to develop referral system for children with special health care needs. Family Service Plans will continue to address any specific needs the family or CYSHCN may have regarding decision making and satisfaction with the medical provider. Care coordinators will continue to provide resources and education to families on interaction with medical providers and how to be an integral part of the medical decisions for the participant. Families and CSS participants will be recruited to develop a parent advisory committee and to serve as facilitators and presenters at local and statewide training for CSS staff and CSS Advisory Committee meetings. Parents will also be encouraged to serve and participate on the CSS Advisory Committee in advisory/advocacy roles.

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

The family satisfaction survey results will be utilized to help guide further policy development.

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

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

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	75	63	64	65	65
Annual Indicator	60.0	60.7	52.7	52.7	52.7
Numerator	3746	3857	2935	3058	3833
Denominator	6244	6349	5570	5802	7275
Data Source				CSHCN Survey	CSHCN Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	65	65	65	65	65

Notes - 2009
Indicator data come from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

Notes - 2008
Indicator data come from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

a. Last Year's Accomplishments
Children's Special Services collaborated with the MCH Early Childhood Comprehensive Systems (ECCS) and the Governor's Office of Children's Care Coordination (GOCCC) to develop a medical home survey for providers. The survey was distributed to providers throughout Tennessee via e-mail listservs of the TN Chapter of American Academy of Pediatrics, TN Academy of Family Physicians, and the TN Primary Care Association. The responses to this survey provided insight for CSS regarding what providers perceive as barriers and gaps to providing a medical home to patients. The GOCCC, the Tennessee Council on Developmental Disabilities, the Tennessee Disability Coalition, Family Voices, TennCare Providers (MCOs) and Child Health Policymakers continued to collaborate and form partnerships to develop programs and policies that ensured children received coordinated, ongoing, comprehensive care within a medical home.

CSS program staff continued to assist families in the identification of pediatric/family practitioners

and specialists to provide coordinated ongoing comprehensive care within the medical home. Participants and families with children age 14-21 years of age were provided information and instructions that assisted them in transitioning from the pediatric or adolescent medical home to an adult provider.

CSS program continued to provide medical services for eligible participants with their primary care or specialty provider for services related to eligible diagnostic conditions. The CSS program continued to sign vendor authorization agreements with new primary and specialty providers to expand medical home options for participants.

CSS program staff continued to receive referrals, provide follow-up and enroll newborns identified through the State's Newborn Hearing and Screening, and Genetics Programs.

Table 4a, National Performance Measures Summary Sheet

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

b. Current Activities

CSS staff reviewed the Medical Home Provider Survey data and are working with ECCS and GOCCC staff to develop activities based on the results. CSS staff collaborates with state and local agencies to ensure that all children have a medical home in the county of residence, and with the MCO's to ensure that participants are assigned and receive services from a primary care provider and are referred to specialty providers as needed.

The CSS Family Service Plan (FSP) includes a comprehensive transition plan for all participants age 14-21 years old. The plan helps families identify and develop a medical home transitional process from pediatric to adolescent and adult providers. Based on results of on-site monitoring during the previous year, policies and procedures are being updated and developed to ensure the medical home is identified for all participants not just those of transitional age. CSS Care Coordinators will continue to assist the families to coordinate services between the primary, sub-specialty, and specialty providers in the development of a medical home for all participants.

CSS receives referrals from the Newborn Hearing, Screening and the Genetics Screening Programs. These families are contacted and assisted in applying for CSS or other eligible services. Emphasis is being placed on those families considered lost to follow-up. Care

coordinators conduct home visits to determine if the families have unmet needs and assist them in applying for services.

c. Plan for the Coming Year
CSS will participate in the development of a State Medical Home Plan and will be partnering with ECCS Medical Homes Workgroup and GOCCC staff to plan and host a medical home summit where all state and provider agencies who are working on medical home provisions are brought together to share initiatives, recommendations and solutions.

CSS will continue collaborating and working with other agencies to develop medical homes for all CYSHCN. CSS will continue to assist families in identifying and accessing medical homes, and will continue coordination of services between providers.

CSS will continue outreach efforts with insurance and primary care providers to establish medical homes. CSS will continue the facilitation of information exchange between the health care providers. Care coordinators will continue working with and enrolling families identified by newborn hearing and screening programs.

CSS staff will work to ensure that all participants have a portable medical history summary for CYSHCN that will provide their health care providers the most recent and pertinent medical history.

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

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

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	75	64	64	69	69
Annual Indicator	62.0	61.4	67.7	67.7	67.7
Numerator	3871	3897	3771	3928	4925
Denominator	6244	6349	5570	5802	7275
Data Source				CSHCN Survey	CSHCN Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	69	70	70	70	70

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

Notes - 2008

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

a. Last Year's Accomplishments
CSS continued to update and educate families and providers concerning the latest insurance information available including TennCare coverage and CHIP. CSS staff assists families in applying for the benefits and filing appeals if services are denied. CSS experienced a slight decrease in the number of children served; this decrease in enrollees was due to more children being covered by the TennCare and CHIP programs. This decrease had a direct impact on the types of services CSS is offering and was outlined in the Statewide meeting as a paradigm shift and focus on in the service delivery for this population. CSS was able to terminate the remaining specialty clinics in the regional health departments, and assist families in locating private providers for these services under their current MCO.

CSS continued to educate families and providers concerning medical insurance information while continuing to require application for TennCare and CHIP benefits. Due to disenrollment of participants from TennCare and State Statute providing for coverage of cystic fibrosis participants until their demise, CSS provided benefits for 35 individuals over 21 years of age who have cystic fibrosis and limited or no medical insurance.

CSS staff continued to work with the TennCare Liaison, MCO and CHIP representatives to resolve issues regarding benefits, providers and access to care for CYSHCN.

CSS conducted a social marketing and outreach strategy session for employees to create marketing messages for providers, families and community agencies. CSS provided electronic messaging in other family and child serving agencies with information regarding the program and other insurance and health care assistance programs.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Assure that all children applying for CSS services also apply for TennCare or CHIP products.		X		
2. Provide care coordination services to all CSS families statewide assisting families with access to medical care, utilization of services, transportation, etc.	X	X		
3. Work with TennCare, the managed care organizations, and providers to ensure service needs are met of this special population.	X	X		
4. Assist families with any needed appeals to public and private insurance providers for denied services.		X		
5. Monitor Federal and State public insurance programs for changes .		X	X	X
6. Recruit providers for CSS approved vendor list.		X		X
7.				
8.				
9.				
10.				

b. Current Activities
The CHIP temporarily closed for enrollment during the past year, and budgetary constraints prevented TennCare from expanding their medically needy enrollees. Based on those changes in the State health insurance plans, CSS has begun to see a slight increase in enrollment. CSS is in collaboration with CHIP and the MCOs to develop mechanisms that will provide families the information and assistance they need to understand program requirements and application for benefits. CSS staff was trained on all the CHIP products, and continue providing this information to participants and families. CSS continues to provide medical services as well as care coordination and provides education and resources to families regarding educating available public and private insurance options.

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

c. Plan for the Coming Year
CSS will be partnering with TennCare managed care organizations (MCOs) to ensure insurance is available to all eligible constituents by establishing a referral system that will allow participants with special health care needs to be referred to local MCO providers by CSS, or MCOs to refer participants to CSS for eligible medical services.

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

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

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

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

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

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	90	82	82	93	93
Annual Indicator	80.0	80.8	91.8	91.8	91.8
Numerator	4995	5128	5113	5326	6678
Denominator	6244	6349	5570	5802	7275
Data Source				CSHCN Survey	CSHCN Survey
Check this box if you cannot report the numerator because					

1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	93	93	93	93	93

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

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

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

CSS continued to identify challenges and barriers to providing services in certain areas of the state, and continued contractual agreements with the Tennessee Lions Charities for vision screening, referral and follow-up in the local head start and child care centers for over 19,000 children between the ages of 12 and 72 months of age. CSS continued contractual agreements with the University of Tennessee at Martin for a speech and language therapy program for children in underserved counties of Northwest Tennessee providing services to approximately 90 children per month.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Coordinate CSS services with other health department services.		X		X

2. Provide care coordination services, including referrals and linkages with community agencies, to all families participating in the program.	X	X	X	X
3. Work with regional and local health councils to identify needs and gaps in services in specific communities.		X	X	X
4. Work with state agencies such as the Department of Mental Health/Developmental Disabilities, and Education, local mental health centers, and school systems to develop a culturally competent system of care approach to services for the population.	X	X	X	X
5. Conduct parent satisfaction surveys.		X		X
6. CSHCN ages 0-3 will be referred to TEIS Part C early intervention services in the local communities.		X	X	X
7. CYSHCN ages 3-21 will be referred to local school districts for Part B Services in the local community.		X	X	X
8.				
9.				
10.				

b. Current Activities

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

c. Plan for the Coming Year

CSS will continue to update and disseminate the statewide resource directory annually. This resource directory allows care coordinators and families to access community based resources at the local county level. CSS will attempt to include all known local/community based resources that are available.

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

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

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

Tracking Performance Measures

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

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	50	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	1561	1561	1534	1245	1694

Denominator	1561	1561	1534	1245	1694
Data Source				CSHCN Survey	CSHCN Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	100	100	100	100	100

Notes - 2009
Data source is the National CSHCN Survey.

Notes - 2008
Data source is the National CSHCN Survey.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

a. Last Year's Accomplishments
CSS continued seeking and receiving technical assistance transition planning through Healthy Ready to Work. This assistance allowed CSS program staff to develop the resources necessary to create a statewide transitional plan that was used as a model for all individual transition plans. CSS collaborated with the Department of Children's Services, the Department of Education, the Department of Mental Health and Developmental Disabilities , the Tennessee Council on Developmental Disabilities and Family Voices to develop a statewide transition task force. This task force was established to formulate programmatic policies and procedures for transition plans for all children and child serving state agencies.

CSS worked to identify each and every need a participant and their family will have concerning transition from adolescence to adulthood. CSS staff worked on the development of a statewide and regional transitional team and continued to identify transitional resources within the community. A resource guide to transitions was developed and shared with other agencies, private providers, advocacy groups, families, and other entities interested in transitions to adulthood.

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

The Tennessee Council of Developmental Disabilities and Vanderbilt University developed a two-year non-degree college program for 18-26 year old students with intellectual disabilities and enrolled six students in the first cohort. Expansion of this program is expected in the next year with state universities offering similar programs. In the spring of 2009, a Special Needs Baseball Foundation (SNBF) was founded in Jackson Tennessee. This baseball league is for athletes with disabilities aged 4-15 years of age and allows an opportunity for sports participation that would

otherwise not be available to this population.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Include transition services in the individual care plans for those participants age 14 and older.	X	X		
2. Maintain listing of community referral resources.			X	X
3. Assist with all appropriate referrals for CYSHCN.		X		
4. Provide training and development opportunities for CSS staff on transition issues.		X	X	X
5. Provide updated resource material for CSS staff and CYSHCN.			X	X
6. Encourage youth to present at transition meetings and training events.			X	
7. Collaborate with state agencies, work groups and advisory committees for transition policy development.		X	X	X
8. Develop additional transition materials and resources, transition brochures and guides.			X	
9.				
10.				

b. Current Activities

CSS is continuing the development of a statewide transitional team and plans that can be utilized in the regional and metro areas. The team will be comprised of parents of children with special health care needs, CSS participants, staff and community agency representatives. Care Coordination standards are being established to standardize and enhance transitional services for the CSS participants. Field staff is being provided technical assistance based on the training received from Healthy Ready to Work. Age appropriate transitional plans will continue to be developed for all participants age 14 and older. A Medical History Summary Form will be provided to all CSS participants as a concise medical history that can be provided to medical providers as the participants transition from pediatric medical homes to adult medical homes. The Medical History Summary Form will also be made available to any CSS participant that reaches maximum treatment or terminates from the CSS program.

CSS staff continues to partner with pediatric providers to locate adult providers for CYSHCN who are aging off the program.

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

c. Plan for the Coming Year

CSS will continue to collaborate with Tennessee Department of Children's Services, Tennessee Department of Education, Tennessee Department of Mental Health and Developmental and Intellectual Disabilities, Juvenile Justice, Labor and Workforce, Children's Services and representatives from other child serving agencies on the Youth Transition Task Force that addresses all transition services necessary to transition from youth to adults. CSS will continue working with Tennessee Department of Education to include a medical home transition component in the Department of Education transition guidelines. CSS will continue collaborating with the Governor's Office of Children's Care Coordination, Family Voices, TennCare, Vocational Rehabilitation and the Department of Higher Education to develop model transition plans. All CSS

participants age 14-21 will have an individualized transition plan that includes components relative to medical home, independent living, higher education, employment and recreation.

CSS will strengthen the partnership with the Department of Education to provide input on the IEP and to and education transition plan for all CYSHCN

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

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

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

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	95	81	83	88	88
Annual Indicator	79.1	86.7	86.7	83.0	83.0
Numerator	90761	1300	1300	278	278
Denominator	114731	1500	1500	335	335
Data Source				NIS Survey	NIS Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	88	88	88	88	88

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

Notes - 2007
The data reported in 2007 are pre-populated with the data from 2006 and the CDC Immunization survey and is based on survey sample size for this performance measure.

a. Last Year's Accomplishments
Tennessee measures immunization at age 24 months through its annual immunization survey. The survey is a statistically valid sample of the immunization status of two-year-old children that is statistically valid for each of the state's administrative regions. The 2009 survey comprised 1503 children. The completion rate for the standard 4:3:1:3:3:1 Series defined by the Centers for Disease Control and Prevention in that survey was 80.8%. All health department staff have been trained to review the immunization status of any person presenting for any type of service at the clinics and provide needed immunizations, or assist with referrals to the primary care provider. There is no racial disparity between black and white children, as assessed in this survey, for the vaccines in the 4:3:1:3:3:1 series; however, a pronounced racial disparity continues for influenza vaccine, specifically. While use of influenza vaccine increased from 2008 to 2009, there were wide regional variations in coverage (from <16% in one region to >50% in another). The

Immunization Program shares its findings with TennCare and with the state chapters of the American Academy of Pediatrics and the Academy of Family Physicians. The Immunization Program has published the results of its survey of 24-month-old children on its web page.

The Department's contractual arrangement with TennCare to provide EPSDT exams has provided additional opportunities to provide immunizations and to check current status. At the end of 2009, new immunization requirements for pre-school, school and college were promulgated by the state, with effective dates for changes in mid-2010 and mid-2011. These new requirements include pneumococcal vaccine for children <5 years, one dose of hepatitis A vaccine for child care, and a resumption of the Hib vaccine requirement that had been suspended as a result of the national Hib vaccine shortage.

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

Table 4a, National Performance Measures Summary Sheet

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

b. Current Activities

Current activities include: (1) identifying high-risk children and assure they are completing their immunization series; (2) performing formal assessments during site visits (known as "VFC/AFIX visits") to all providers enrolled in the VFC program to ensure efficient service delivery of vaccines to those for whom they are recommended; (3) expanding the availability of the immunization registry web site in private physicians offices; (4) conducting immunization level assessments in population sub groups such as day care enrollees, identifying those at high risk of not completing immunizations and devising strategies to reach them; and (5) conducting follow-up on children born to hepatitis B infected women to ensure receipt of HBIG and hepatitis B vaccine as recommended.

$4.4 million from the recovery funds has been received to provide additional vaccines through health departments. These funds will be used for both children and adults. There will be a time-limited adult vaccination campaign primarily promoting tetanus-diptheria-pertussis (Tdap) and

pneumococcal polysacharride vaccines. For children, this will help fund the surge of children and teens ineligible for the Vaccines for Children Program who are expected to visit health departments in mid-2010 when new state school immunization requirements take effect. Most of these children have high insurance deductibles or co-pays for vaccination services.

c. Plan for the Coming Year

The strategy will be much the same as this year. The major emphasis will be on the VFC/AFIX visits to the providers' offices to assure appropriate adequate use of vaccines and compliance with federal VFC Program requirements. There will also be an emphasis on expanding the availability of the immunization registry web site and a new objective will be to increase the amount of private physician-administered vaccine doses that are reported to the immunization registry. Immunization level assessment activities will continue as well as the development of approaches to reach those less likely to complete immunizations on time. Follow-up of children born to hepatitis B infected women will also continue.

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

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

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	23	27	26.5	26.5	26
Annual Indicator	27.5	28.6	27.8	27.3	24.0
Numerator	3229	3392	3361	3328	2953
Denominator	117523	118599	120852	122020	123216
Data Source				TDH Hlth. Stats. Pop. Proj. & Birth Stat. Syst.	TDH Hlth. Stats. Pop. Proj. & Birth Stat. Syst.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	24	24	24	24	24

Notes - 2009

Data from Tennessee Department of Health Division of Health Statstics Population Projections and Birth Statistical System

Notes - 2008

Data from TDH Division of Health Statistics Population Projections and Birth Statistical System

Notes - 2007

The data reported in 2007 are pre-populated with the data from 2007 population estimates and the Tennessee Birth Master file for this performance measure.

a. Last Year's Accomplishments

The Family Planning Program provides contraceptive education and clinical services in 128 sites statewide; teens are a priority population especially for outreach. CY 2009 data from the Family Planning Annual Report show that the program served 32,842 clients ages 19 and under - a decrease of 2,966 from CY 2008. This decrease is three times the amount of the previous year's decline. Discussions are taking place to try to determine the reason for this continued decline of services in this age range.

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

Tennessee Adolescent Pregnancy Prevention Program (TAPPP) councils operate in three of the six metropolitan areas and in multi-county groupings in six of the seven rural regions. One rural region and one metro region dropped out of the program due to financial issues. They could no longer afford to staff the TAPPP program. The 9 TAPPP Coordinators serve as the community contacts/resource persons for adolescent pregnancy issues in their respective areas. All council memberships are broadly representative of the surrounding community. Each council participates in a wide range of activities, depending on local priorities and resources. Networking to provide community education and awareness activities for students, parents, and providers through classes in schools, in community agencies, health fairs, and media presentations is a TAPPP priority. Data for CY 2009 show that statewide staff provided family life education programs to over 78,600 students; provided education and training to over 19,300 adults; and worked with 5,853 parents and 5,631 professionals.

The Adolescent Health Advisory Committee is a collaborative of representatives from Maternal and Child Health, TENNderCare, the Division of Minority Health and Disparity Elimination, the Division of Alcohol and Drug Abuse Services, the Governor's Office of Children's Care Coordination, the Division of Special Populations, the Division of Clinical Leadership, and regional health department staff. Members are selected based on their expertise in one or more areas of youth health care, well-being and development. During FY 08-09, the Committee met quarterly and discussed best practice strategies to meet Healthy People 2010 health objectives for adolescents. Educational activities and advocacy for obesity prevention, nutrition and exercise counseling, and asset development were among the pertinent health issues addressed. The online "Adolescent and Young Adult Health in Tennessee Report" is updated bi-annually as the data become available.

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

Table 4a, National Performance Measures Summary Sheet

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

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

b. Current Activities

During the first half of FY10, 16,421 adolescents ages 19 and under were provided services through the statewide Family Planning Program, with services at 128 sites in all 95 counties. The Tennessee Adolescent Pregnancy Prevention Program (TAPPP) utilizes county and regional level health educators to provide community education. The number of educational contacts with adults, professionals, and parents remains consistent with last year's numbers. Presentations and consultations cover a variety of issues and topics such as community awareness of teen pregnancy, health department services, sexuality education curricula review and revision, teacher training on health issues and curricula, abstinence education, parenting concerns, and adolescent/child growth and development. The National Day to Prevent Teen Pregnancy has been a popular focal point for prevention messages. The primary event is teens gathering to take an online quiz about sexual risk taking and consequences; for 2010 additional online activities for teens were added.

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

c. Plan for the Coming Year

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

Originally, Congress appropriated funds for a new 5-year grant cycle from FY 2009 - FY 2013. However, the new administration withdrew all funding for state abstinence education during this time period. The healthcare reform legislation of 2010 adds a new Section 513 providing $375 million over five years through Administration for Children and Families for Personal Responsibility Education Grants for state programs "to educate adolescents on both abstinence and contraception for prevention of teenage pregnancy." The bill also restores funding for the Sec. 510 abstinence education grant program. There is no word yet on how this program will mesh with the new evidence-based teen pregnancy prevention funds. Community agencies across the state are applying for the various teen pregnancy prevention funds.

Tennessee's overall adolescent pregnancy rate for ages 10-17 has inched up from a 2004 low of 13.2 to 13.6 in 2008. There were 3,478 live births and 829 abortions and 19 fetal deaths, for a total of 4,326 pregnancies to this age group. With a rate of 33.6, Tennessee has exceeded the Healthy People 2010 target adolescent pregnancy rate of 46 per 1,000 females for the 15-17 age group. The pregnancy rates for black adolescents continue to be higher than that of white adolescents in all age groups: 25.1 for 10-17 year-olds (10.5 white); 63.0 for 15-17 year-olds (25.9 white); and 3.1 for 10-14 year-olds (0.6 white).

There were 3,478 births to females ages 10 through 17, accounting for 4.07 percent of all Tennessee births in 2008. The birth rate for this age group was 10.9 live births per 1,000 women. For 2007, the birth rate for mothers 10-17 was 11.1 live births per 1,000 women. The 2008 birth rate for the 15-17 age group was 27.3.

As with the pregnancy rate, the birth rate disparity gap between black and white persists. The 2008 rate for 10-17 year old black females is 18.7, and that for whites is 8.8. These numbers

reflect a slight increase for black females and a slight decrease for white females from previous years.

Of the 3,478 births among 10-17 years old in 2008, 99.4 percent of births to black females were out-of-wedlock, compared to 88.8 percent of births to white females. Six hundred twenty-four or 14.4 percent of the mothers 10-17 had had at least one other birth, and 358 or 10.3 percent had had another pregnancy. It is this last group that the family planning program targets with outreach and education efforts concerning birth spacing.

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

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

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	25	23	23	24	40
Annual Indicator	21.9	22.3	21.8	37.2	37.2
Numerator	71961	75789	3769	366	366
Denominator	329279	339485	17256	983	983
Data Source				Tennessee Oral Health Survey	Tennessee Oral Health Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	40	40	40	40	40

Notes - 2008
Data source is the 2008 Tennessee Oral Health Survey of children ages 5 - 11 years.

Notes - 2007
Thses data are from the Tennessee (Patient Tracking Billing Medical Informatin System) PTBMIS Database.

a. Last Year's Accomplishments
The School Based Dental Prevention Program (SBDPP) is a statewide, comprehensive dental prevention program for children in grades K-8 in schools with 50% or more free and reduced lunch. It consists of three parts: dental screening and referral, dental health education, and application of sealants. During FY 09 (July 1, 2008-June 30, 2009), school based dental prevention services were being delivered in all 13 regions. Data for FY 09 show that 126,251 children had dental screenings in 322 schools. Of these, 30,728 children were referred for unmet dental needs. Full dental exams were conducted on 66,500 children. A total number of 284,437 teeth were sealed on 50,900 children. 169,273 children received oral health education programs at their schools by a public health dental hygienist. Dental outreach activities include provision of informational material for TennCare enrollment purposes and follow-up contacts for all recipients identified as having an urgent unmet dental need.

Fixed and Mobile Dental Program: The Tennessee Department of Health (TDH) has 54 fixed dental clinics located in 53 rural counties. The scope of services includes comprehensive dental care to children and emergency dental care for adults. During FY 09, more than 25,300 children and more than 7,900 adults were treated in TDH dental clinics. The TDH operates three mobile dental clinics providing comprehensive dental services to underserved children at school sites. During FY 09, 576 children received more than $139,000 worth of dental services in TDH mobile dental clinics.

Cavity Free In Tennessee - Early Childhood Caries (ECC) Prevention Program targets regular Early and Periodic, Screening, Diagnosis and Treatment (EPSDT) visits with children at risk for ECC. In the first year of life, a child may visit a health care professional as many as six times as a part of EPSDT. Nurses and nurse practitioners can deliver preventive oral health services to children during these visits, as well as educate their parents or caregivers about keeping children's teeth healthy. These visits provide an opportunity for children to receive dental screenings, the application of fluoride varnish, and early dental referrals. Because many children do not access dental care until there is a need or until school-age, this program now allows many children to receive a preventive service they might not have otherwise received.

Children will continue to be referred to their dental provider for regularly scheduled visits for dental services or at any sign of need such as decay, eruption abnormalities, prolonged nonnutritive sucking, and other oral health concerns. While children, birth to 5 years old, are the target population for Cavity Free In Tennessee (CFIT), this program is available for children and teens in all seven rural regions of Tennessee. Currently all the rural regions are providing these expanded dental preventive services. From July 1, 2008-June 30, 2009 more than 13,900 at risk children have been screened, referred, and had fluoride varnish applied in Tennessee Department of Health medical clinics by nursing staff.

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

Table 4a, National Performance Measures Summary Sheet

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

b. Current Activities

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

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

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

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

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	3	3	2.5	2.5	2
Annual Indicator	4.0	5.4	3.9	3.4	2.2
Numerator	48	65	47	41	27
Denominator	1204737	1210629	1194718	1201009	1207621
Data Source				TDH Div. Hlth. Stats. Pop. Proj. & Death Stat. Sys	TDH Div. Hlth. Stats. Pop. Proj. & Death Stat. Sys
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	2	2	2	2	2

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

Notes - 2008
Data source: TDH Divsion of Health Statistics Population Projections and Death Statistical System

Notes - 2007
The data reported in 2007 are pre-populated with the data from 2007 population estimates and the Tennessee Death Master file for this performance measure.

a. Last Year's Accomplishments
The rate (per 100,000) of motor vehicle crash deaths to children 14 and younger decreased from 3.9 in 2007 to 3.4 in 2008. Tennessee's child passenger safety law of 2004 strengthened and

specified requirements for child restraint devices (CRDs). MCH programs continued to collaborate with other TDH divisions and state agencies(local law enforcement agencies, Safe Kids Coalition, Head Start Centers, school systems, and Governor's Highway Safety Office) to educate families about the law, and resources for purchasing and fitting CRDs. Each of the MCH home visiting programs (HUGS, CHAD, and Healthy Start) provides CRD education to families. Health department clinic clients are also educated about motor vehicle safety and CRD use as part of anticipatory guidance during the EPSDT exam.

There are 3 Child Passenger Safety centers (CPS) in each of the 3 grand regions of the State: East - East Tennessee State University in Johnson City; Middle -- Meharry Medical College in Nashville; West -- The Mayor's Office of Early Childhood and Youth in Memphis. The CPS centers are operated through the Governor's Highway Safety Office and serve as resources to the 90 fitting stations across the state. The fitting stations are staffed by certified CRD technicians who help families with CRD installation, and provision of CRDs when needed. Generally the centers can refer to the 3 main children's hospitals' rehabilitation centers in their areas for fitting a child with special health care needs, if needed.

The Departments of Safety and Transportation continued to offer safety check points, public information messages, training courses, impaired driving prevention programs and school-based events. Federally funded prevention programs include "Click It or Ticket," "Booze it and Lose it," and "Buckle Up in Your Truck."

The Nutrition and Wellness Division of the TN Department of Health oversees the Child Safety Fund Program. Funding for the program is collected from the fines levied to motorists who are in violation of the Tennessee child passenger restraint law. Governmental or nonprofit organizations are eligible to obtain the funds to provide services to children, 0-8 years old, in low income families that meet federal poverty guidelines. From July 2008 to March 2009, the Child Safety Seat Fund has received $189,234.38, in funds, expended $151,913.56 and purchased 3,184 child safety seats. Of the seats purchased, 2,353 have been distributed.

Table 4a, National Performance Measures Summary Sheet

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

b. Current Activities

Last year's activities continue as noted. The Child Safety Fund Program has distributed 3,349 safety seats in 2009. In 2010, Monroe Carell Jr. Children's Hospital at Vanderbilt opened a safety seat clinic for children with special health care needs. The clinic is staffed by physical and

occupational therapists who are certified CRD technicians. The clinic visit for fitting and the CRD is covered by private insurance and Tenn Care. They are collaborating with the Middle Tennessee CPS at Meharry on education and outreach.

c. Plan for the Coming Year

Activities will continue as described. Injury prevention will be included in the public health Core Competency workforce development training for MCH home visiting staff, including Children's Special Services nurses and workers. Health department clinic nurses and staff who work with young families and WIC clients will also participate. Components of training will include motivational interviewing and cultural competency as part of safety education/anticipatory guidance for parents. Training will also include learning to build collaborations with other agencies. For example, home visitors and health department staff will learn to mobilize partnerships with the CPS centers and fitting stations to encourage families to participate in their services.

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

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

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		32	34	36	30
Annual Indicator	29.3	28.0	31.4	37.9	37.9
Numerator	440	420	14705	31952	31952
Denominator	1500	1500	46777	84308	84308
Data Source				CDC/National immunization Survey	CDC National Immunization Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	40	45	50	50	55

Notes - 2008

Data source:
National Immunization Survey. Per the CDC NIS, the data from the NIS are provisional for the 2006 birth cohort used in this survey until final estimates are available August 2010. (We have marked "final" for the purpose of this report)
Tennessee live births 2006: TDH Office of Policy, Planning, and Assessment, Divsion of Health Statistics

Notes - 2007

The data reported in 2007 are pre-populated with the data from 2007 population estimates and the CDC Nutrition Surveilance file for this performance measure.

a. Last Year's Accomplishments

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

Breastfeeding counseling is a required nutrition education component of the WIC Program and all pregnant women are encouraged to breastfeed, unless contraindicated for health reasons. Breastfeeding education is offered individually and in group settings. WIC serves about 21,200 pregnant women and enrolls half of newborns in the state. Thirty percent of WIC delivered mothers are breastfeeding at time of postpartum certification. Presently, there are 7,629 breastfeeding mothers on the WIC program. WIC provides on-going breastfeeding information and counseling in the clinic, hospital, and home setting. Manual and electric pumps are issued to eligible mothers. Mothers who deliver prematurely or have a baby in the Neonatal Intensive Care Unit are given priority for hospital grade electric pumps.

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

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Breastfeeding coordinators and advocates in every region work with health care providers, health department staff and postpartum women to assist and promote breastfeeding.	X	X		
2. Breastfeeding data are routinely collected on WIC clients				X
3. USDA grant continues to be used to maintain an effective breastfeeding peer counselor program in selected counties.	X			X
4. Establish breastfeeding objectives in the Tennessee Obesity Prevention Plan.				X
5. Continue to partner with the Tennessee Initiative for Perinatal Quality Care (TIPQC) on their statewide breastfeeding initiative				X
6. Promote breastfeeding with the clients served in the home visiting programs.	X			
7.				
8.				
9.				
10.				

b. Current Activities

Tennessee has maintained funding the past 5 years for the WIC breastfeeding peer counselor program. A peer counselor is a paraprofessional, ideally a current or previous WIC client, who has successfully breastfed and has a desire to help other mothers succeed with breastfeeding. By combining peer support with the on-going breastfeeding promotion efforts in the WIC program, peer counselors have the potential to significantly impact breastfeeding rates among participants, and, most significantly, increase the harder to achieve breastfeeding duration rates. The long-range vision is to institutionalize peer counseling as a core service in WIC. Breastfeeding rates increased in 15 of 18 counties receiving grant funds to hire a peer counselor.

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

c. Plan for the Coming Year

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

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

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

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	98	98	98	98	98
Annual Indicator	97.0	88.9	91.1	94.2	97.8
Numerator	79010	80173	83570	85613	85231
Denominator	81454	90155	91754	90885	87146
Data Source				TN Newborn Screening Database	TN Newborn Screening Database
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	98	98	99	99	99

Notes - 2008

Data source is the 2008 newborn screening database and data includes births that are Tennessee residents and non Tennessee Residents.

Notes - 2007

Data source is the 2007 nenborn screening database and data includes births that are Tennessee residents and non residents.

a. Last Year's Accomplishments

The Newborn Hearing Screening Program reported 2008 data to the Centers for Disease Control and Prevention in February 2010. There were 90,885 occurrent (resident and non-resident) births

reported by vital records. 85,353 (94%) infants received a hearing screen in 2008 (97.8% in 2009); of those infants, 98% were screened prior to discharge or one month of age in 2008 and 2009. In 2008, 79 infants were diagnosed with permanent hearing loss; 89 in 2009. The expected incidence of hearing loss for Tennessee is 89-127 infants (National incidence 1:1000 to 3:1000). Tennessee's incidence was 0.87:1000 in 2008 and 0.71 in 2009. The number of follow-up hearing tests reported by individual providers and audiologists continued to improve. In 2009, 67 audiology groups/individuals performed 1,683 first retests on infants and 1,415 additional follow-up tests. Of the 67 reporting groups, 7 groups saw more that 100 infants each and 6 saw 50-99 infants each.

The Newborn Hearing Screening Program has been successful in meeting the majority of the National EHDI and Healthy People 2010 "1-3-6 Goals". Goal 1: HP2010 90% - EHDI 95%- should complete hearing screen by 1 month of age. Tennessee screened 98%. Goal 2: HP2010 70% - EHDI 90% should complete a diagnostic audiological evaluation by 3 months of age. Tennessee completed retesting on 69.8% with an additional 4.4% pending audiology results for a total of 73.9%. Goal 3: HP2010 85% - EHDI 90% should begin early intervention and habilitation services by 6 months of age. Tennessee was only able to document 12.9% enrolled in the Department of Education Early Intervention Systems (TEIS) Part C program in 2009. The program will continue to pursue the challenge of reporting due to release of information issues by some agencies. In July 2010, the NHS program will contract with an early intervention deaf education coordinator to contact families of children with hearing loss to assess services provided and make appropriate referrals and for parent support by the Family Voices parent consultants.

The Tennessee Early Intervention System (TEIS) consultant (on contract by TEIS to the University of Tennessee Center on Deafness) contacted 1,691 families in need of hearing retests to track follow-up status and make referrals if needed for audiological assessment. 45% of the infants had passed a rescreen, 3.7% were not interested in a retest, they were unable to locate 21% of the families. Two part time nurses hired with the CDC Tracking and Surveillance grant tracked 783 families of infants that had pending hearing results after an audiological assessment and were able to identify 14 infants with hearing loss.

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

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Promote newborn hearing screening in all birth facilities.			X	
2. Promote the use of the data collection system by all birthing facilities.			X	
3. Provide technical assistance and education to providers.				X
4. Revise, as needed, the directory of hearing providers.				X
5. Coordinate referrals and follow-up on infants with abnormal results.		X	X	
6. Coordinate the activities of the Newborn Hearing Screening Task Force.				X

7. Distribute educational materials for parents, providers, facilities, and intervention programs.			X	X
8. Utilize survey and assessment materials to monitor effectiveness of program components.				X
9. Conduct site visits to hospitals to monitor screening effectiveness, access to evaluation, and paret/provider satisfaction.				X
10. Integrate and/or coordinate data systems related to newborns and hearing.			X	X

b. Current Activities
In 2009, Hospital NHS Screening Guidelines were revised to reflect national recommendations and were distributed to all birthing hospitals with a NBHS training CD/DVD. These guidelines provide procedures for referrals, follow-up, and reporting.

Biannual meetings with the Newborn Hearing Task Force and subcommittees continue.

New colorful Family Notebooks were developed in cooperation with Family Voices and distributed to audiologists to share with families of children with hearing loss. In addition, a survey was developed and distributed to families of children with hearing loss to assess the families' hearing screening and follow-up experiences.

Hearing data are now matched to vital records births and deaths for accurate assessment of program activities. Links can now match hearing screening with the WIC program, and there are plans to match to the Immunization Registry. The matches will provide improved tracking by identifying new addresses, phone numbers, and primary care providers.

25 representatives attended the 2010 Early Hearing Detection and Intervention Conference (parents, audiologists, Part C early interventionists, hospital hearing screening staff, the TN-APP Chapter Champion, epidemiologists, and audiology students). 3 participants attended the Family Support NHS conference.

Program expansions in process include adding audiologist time for phone outreach in rural areas, a deaf educator to serve as a family outreach coordinator, and a bilingual parent consultant.

c. Plan for the Coming Year
During FY 11, the program will expand program operations by implementing the new contract positions (outreach audiologist, bilingual parent, and deaf educator for family outreach) and a language phone line service, created by HRSA funds. These activities are focused on reducing loss to follow-up and in communicating with non-English speaking families, especially Hispanic families.

Additional family surveys will be distributed to assess family experience with the newborn hearing screening system and identify areas in need of improvement. Non-staff members from the Hearing Task Force plan to visit the administrative staff of the Tennessee Early Intervention System (TEIS) to encourage better reporting of follow-up activities and services provided to infants and toddlers with hearing loss and to encourage the distribution and utilization of the Family Hearing Notebook. The Family Hearing Notebook is in the process of being translated into Spanish. There are plans to conduct site visits to hospitals and hearing providers, including otolaryngologists. The Memphis Shelby County area will be targeted for physician education on the need for timely follow-up. There will be a focus on educational visits and distribution of materials related to hearing loss and the importance of timely follow-up and reporting to primary care providers and otolaryngologists. A parent friendly DVD on the need for hearing screening and the importance of follow-up will be purchased or developed and will be available for hospital in-house TV education and available to clients and for prenatal classes.

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

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

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

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	7	6	6	6	6
Annual Indicator	6.4	6.4	6.4	4.9	3.7
Numerator	97933	97933	88283	72258	54759
Denominator	1530196	1530196	1386911	1474653	1479972
Data Source				UT CBER	UT CBER
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	3	3	3	3	3

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

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

Notes - 2007
Data source is National Survey of Children's Health.
93.6 % of children had health insurance according to the survey (WWW.nschdata.org)

a. Last Year's Accomplishments
Data on the percent of children in Tennessee without health insurance can be found in several national sources, but for varying age groups and income levels. U.S. Census Bureau, 2008 Annual Social and Economic Supplement, Current Population Survey data show that nationally 84.6% of all persons and 90% of children under age 18 were covered by some type of health insurance. U.S. Census data for a three-year average for 2006-2008 show that 4.3% of the 65,000 children under age 19 and at or below 200% of poverty were without health insurance in Tennessee. A 2009 survey from University of Tennessee Center for Business and Economic Research showed 4.9% of Tennessee children in 2008 and 3.7% in 2009 were without insurance.

The state's managed care program for Medicaid recipients remains the major source of health insurance coverage for children. For FY 2008, TennCare data show that there were 824,415 children ages 0-21 years on TennCare. Of these, 56,091 were less than age one, and 153,362

were ages 6-9. As of January 15, 2009, 695,080 children ages 0 to 21 years were enrolled in TennCare statewide.

The Department of Health has entered into participating provider agreements with all of the TennCare Managed Care Organizations (MCOs) to provide services to TennCare members. The Bureau also had agreements with selected MCOs to provide gate keeping primary care services in two rural regions. Since July 2001, TennCare has requested that the local health departments assist with providing Early Periodic Screening, Diagnosis and Treatment (EPSDT) screenings to TennCare enrollees. During federal FY 2008-09, health department clinics provided 64,461 EPSDT screenings to TennCare enrollees.

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

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

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

Tennessee's CoverKIDS Children's Health Insurance Program is available for uninsured children age 18 and younger whose families earn within 250% of the federal poverty level but are not eligible for TennCare. Maternity coverage is also available for pregnant women through CoverKIDS. Children in families with a household income greater than 250% of the federal poverty level may buy into the CoverKIDS plan with premiums. Benefits are similar to those offered to dependents of state employees. Enrollment in CoverKIDS was suspended for new applicants December 1, 2009, when membership reached the maximum that could be supported by the current state budget. Enrollment was resumed on March 1, 2010.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide outreach and advocacy services in all health department clients for TennCare enrollees.		X		
2. Provide EPSDT screenings for TennCare enrollees.	X			
3. Provide EPSDT screenings for children in State custody.	X			
4. Continue the EPSDT community outreach project.		X		
5. Provide presumptive eligibility for pregnant women in all health department clinics.		X		
6. Assist all children applying for CSS services with enrollment in		X		

TennCare.				
7. Assist TennCare enrollees with the TennCare appeals process.		X		
8.				
9.				
10.				

b. Current Activities
TennCare enrollment data for February 2010 show a total of 1,222,951 participants. Of these, 53,027 (4.3%) were infants less than one year of age, 224,290 were ages 1-5 (18.3%), and 146,151 were ages 6-9 (12.0%). Over 62% of enrollees were under age 21.

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

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

Data from March 2010 show that 43,178 children are enrolled in the CoverKIDS Program.

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

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

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

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		9	9	30	14
Annual Indicator	10.3	24.2	34.0	28.7	29.4
Numerator	20474	22265	53971	19807	21143
Denominator	197847	92164	158733	69015	71914
Data Source				TN. State WIC Database	State WIC database
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and					

therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	25	25	25	22	22

Notes - 2008
The numbers used in last year's 2008 report were for only a 6 month period due to CDC having problems with changes in their analytical program. The correct values were recently made available and are corrected here as final.

Notes - 2007
Data source is the State WIC database and is the calendar year data. Variation is due to calendar year data, decrease in the the total number of children within the age group of 2-5 years receiving WIC. Data categories may include children under the age of 2 years to 5 years.

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

Utilizing the state PTBMIS computer system, specific surveillance data was obtained and examined using the Centers for Disease Control and Prevention (CDC), Pediatric Nutrition Surveillance System [Ped NSS (pre2004 version)] to calculate provisional analysis. Final results were prepared by CDC. Preliminary information was supplied to 14 regional nutrition directors for the development of FY 09-10 nutrition services plans. Two different reports were initiated or made available at this regional level. The High/Low listing was supplied on a bi-monthly basis which showed only participants whose certification values were outside the range for age and gender. These listings also provided the BMI for all participants that appear on this report. A second set of reports was developed listing individuals with assessment values judged to potentially impact the development and wellness of the participants. In FY 09-10 each region developed an activity addressing overweight in their state plan.

In order to detect changes in the percentage of overweight and/or risk of overweight almost all of the clinic locations providing WIC services were equipped with electronic digital scales. Calibration procedures were in place to promote correct weight determinations in the clinics. Techniques used to assure accurate weight and hematology were periodically reviewed and/or technical assistance provided. In addition to tracking BMI, the incidence of anemia was followed if markedly unusual change in the incidence of anemia was reported. The anemia data were divided on the basis of age: children <24 months of age and those 24-60 months. This division was instituted to identify progress toward the goal of Healthy People 2020.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide data and provisional analysis to regional and local nutrition directors for program development.				X
2. Assist with training when policy/procedural changes are instituted.				X
3. Provide nutrition counseling to WIC participants with BMI at or above the 85 th percentile.	X			
4. Provide up to date information of overweight and anemia to local health department programs.				X

5. Monitor compliance with policy and completeness of data at regional and local WIC program levels.				X
6. Provide technical assistance on as needed basis to regional nutrition, nursing and clerical directors.				X
7. Continue to utilize the state PTBMIS computer system for surveillance.			X	X
8. Continue to examine (CDC) Pediatric Nutrition Surveillance System to calculate provisional analysis for program planning and development purposes.			X	X
9.				
10.				

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

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

c. Plan for the Coming Year
The reports will continue to be provided and upgraded. The state has begun using the new PedNSS reporting format and will continue in the coming year. Appropriate techniques used in assessment and data input will be followed. The incidence of anemia as well as BMI at the 85th percentile will be tracked and reported. Methods to specifically illustrate high percentages variables will be sought. Special attention to detect and reasons for identified condition will be followed up. Assistance with training, when policy/procedural changes are instituted, will be provided. When requested by regional staff, any technical assistance will also highlight the excellence of the work as well as areas where changes are needed.

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

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

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		9.7	9	7.5	13
Annual Indicator	16.2	15.8	19.4	15.4	15.3
Numerator	13158	13288	16774	13138	12525
Denominator	81454	84277	86558	85480	82078
Data Source				TN Birth Statistical System	TN Birth Statistical System
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					

Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	13	13	13	13	12

Notes - 2008
Data source: 2008 Tennessee Department of Health, Health Statistics Birth Statistical system.

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

Notes - 2007
Data source is the State vital records

a. Last Year's Accomplishments
Assisting pregnant women who smoke with cessation has long been a priority of staff within the Department of Health. Local health department nurses and nutritionists counseled pregnant women and provided education, information, and referral to community smoking cessation classes and to quitline resources. All 133 WIC clinics assess pregnant women for smoking status. May 2009 data show 22,100 pregnant women in the WIC program; this represents 26.9% of the total resident births. According to birth certificate data, 15.4% of births in 2008 were to women who smoked. This is a decrease from 16.2% for 2007. However, there is great variation across the state with higher smoking rates in the eastern counties. There also is wide disparity based on race. For the ten-year period 1999-2008, birth certificate data showed the percent for white females being over twice the percent for black females.

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

Opportunities in local health department clinics for educating and counseling pregnant women regarding smoking include pregnancy testing (87,195 in CY09), enrollment in TennCare/Medicaid through presumptive eligibility (17,889 in CY09), WIC, and the HUGS home visiting program. The prenatal care guidelines and protocols for nurses and the home visiting protocols provide guidance to staff on assisting pregnant women. The Department operates a centralized EPSDT/TennCare call center to contact TennCare pregnant women and mothers of infants regarding access to care, appointments, referrals, and education on healthy behaviors.

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

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**

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

b. Current Activities

The State is continuing to provide all the services described above with the exception of the provision of cessation medications. Funding for purchasing medications is no longer available. All health department clinics offer pregnancy testing. Currently, one county offers prenatal care services in an FQHC status health department clinic, predominately to non-TennCare eligible uninsured women, who are then delivered by private physicians. All clients qualifying for TennCare presumptive eligibility are provided with assistance in locating a local physician for prenatal care and delivery. They are enrolled in WIC or CSFP, the state's two supplemental food and nutrition programs. There are 133 WIC clinics statewide. Pregnant women are assessed for eligibility in one of the home visiting programs; all 95 counties have home visiting services for pregnant women. All these visits provide opportunity for counseling on the effects of smoking on the pregnant woman and her baby and offering assistance in stopping, including referral to the QuitLine. Additional information is in State Performance
Measure 1.

c. Plan for the Coming Year

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

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

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

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	6	6	6	5.2	5
Annual Indicator	7.5	8.7	6.9	5.6	7.4
Numerator	31	36	29	24	32
Denominator	411299	414947	422058	426040	430127
Data Source				TDH Div. Hlth. Stats. Pop. Proj. &	TDH Div. Hlth. Stats. Pop. Proj. & Death Stat.

				Death Stat. Sys	Sys
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	5	5	5	5	5

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

Notes - 2008
Data source: 2008 Tennessee Department of Health Division of Health Statistics
Population Projections and Death Statistical system

Notes - 2007
Data source is the State vital records registry.

a. Last Year's Accomplishments
The Director of Adolescent Health continued to participate as an active member of the Tennessee Suicide Prevention Network (TSPN), and attended the bi-monthly intra-departmental meetings to address suicide prevention issues. The Director also attended the Advisory Council meetings and their annual retreat in Montgomery Bell State Park, Burns, TN. Joe Varney, retired US army and current Suicide Prevention Program Manager at Fort Campbell discussed the rash of suicides from military servicemen and their family members. The TSPN task force will collaborate with him to develop strategies to reduce the phenomena and the negative impact to the families and community.

Activities included an educational table exhibit in the Cordell Hull building for Suicide Prevention month in September. Complimentary booklets, wallet sized contact cards, and magnets from the National Suicide Prevention Lifeline were distributed. Information included suicide warning signs, the 1-800-273-TALK number, and survivor information for those having attempted suicide or having lost someone to suicide.

Suicide prevention training was provided in several health department regions this past year. The SAMSHA youth suicide prevention grant, Tennessee Lives Count Juvenile Justice, awarded to the Tennessee Department of Mental Health and Developmental Disabilities (TDMHDD) was received and implemented. The grant proposal called for the provision of gatekeeper training to service providers that may have contact with a youth in the Juvenile Justice system as well as the potential to be in the system. Health department staff, including nurses have received the training in two departments. Over 900 nurses received training during the first grant cycle. It is anticipated that at least 500 other health department staff will receive it during this cycle. Teaching tools and informational materials were developed for training a variety of professionals who work with youth, including public health nurses, police officers, nurses, physicians, teachers, coaches and clergy.

The teen suicide rate has decreased from 10.3 in 2004 to 5.6 in 2008 per 100,000. This is a greater than 45% reduction. Teachers are mandated by Public Chapter 45 to receive 2 hours of in-service training on teen suicide prevention. During the past year over 20,000 teachers have received suicide awareness or gatekeeper training provided by TDMHDD, Mental Health Association of Middle Tennessee, National Alliance on Mental Illness, Mental Health Association of East Tennessee, or the Jason Foundation.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Finalize the adolescent health resource guide and post on Department's web site.				X
2. Partner with the Tennessee Suicide Prevention Network (TSPN).				X
3. Assist with carrying out the State Youth Suicide Prevention Plan.			X	X
4. Update and distribute fact sheets on adolescent suicide prevention statewide.				X
5. 5. Provide suicide prevention training for public health nurses.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Director of Adolescent Health continues collaboration with the Tennessee Suicide Prevention Network and has updated the educational fact sheets, including intentional injury. These are available on the Department website. The Director has developed a resource list with links to information and resources on many adolescent health topics, the National Suicide Prevention Lifeline number, and the "Teen Suicide Guide" from the National Office on Women's Health (information on stress, depression, self-esteem, body image, self-injury, and suicide). Readers who think about injuring themselves or about suicide are directed to the National Hopeline Network at 1-800-SUICIDE number or to their telephone directory for a local suicide crisis center. The resource list is being reviewed and once approved will be added to the Department's web site.

TDMHDD received a second youth suicide prevention grant focusing on youth in the Juvenile Justice system. The Tennessee Lives Count Juvenile Justice (TLCJJ) grant is now in its second year. Adults that work in the Juvenile Justice system, specifically all adults in the Youth Development Centers and Group homes, will receive advanced suicide gatekeeper training using the ASIST model. Youth in all group homes and residential facilities will receive peer youth suicide awareness training (A Promise for Tomorrow developed by the Jason Foundation).

Training of the public health nurses and nursing students in the college/ university settings continues.

c. Plan for the Coming Year

The Director of Adolescent Health will continue to partner with the Tennessee Department of Mental Health and Developmental Disabilities and the Tennessee Suicide Prevention Network. The Director polled the Adolescent Health Advisory Committee members asking them to rank the importance of several adolescent health topics. The Director will develop the top four ranked issues into trainings for the Adolescent Health Committee. One of the issues will be suicide

prevention. The trainings will be presented at the quarterly Adolescent Health Coordinator teleconferences and will include Power Point presentations to be posted on the Adolescent Health website.

TDMHDD will continue to distribute regional suicide prevention resource directories to all local health departments in Tennessee. Health departments may visit the TSPN/TLCJJ web site and download any resources available.

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

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

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	80	80	80	80	70
Annual Indicator	68.0	69.3	68.5	80.7	79.5
Numerator	922	1045	1036	1112	1083
Denominator	1356	1508	1513	1378	1362
Data Source				TN Birth Statistical System	TN Birth Statistical System
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	80	80	80	80	80

Notes - 2008
Data source: 2008 Tennessee Department of Health
Division of Health Statistics
Birth Statistical System.

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

Notes - 2007
Data source is the State vital records registry.

a. Last Year's Accomplishments
Data for the determination of the percentage of very low birth weight infants born in tertiary level facilities are compiled by Health Statistics. Information on facilities by level of care is collected on the Joint Annual Report of Hospitals and has only been used for statistical analysis. However, for 2008 and provisional 2009, the Regional Perinatal Centers were asked to list those hospitals in their geographic areas providing high risk (or Level III) care. Data from 2006-2008 show a range of 69.3% to 80.7% of VLBW babies delivered in tertiary level hospitals. Provisional data for 2009

(79.5) for this indicator show little change from 2008 (80.7). Provisional data for 2009 for total very low weight births, as compared to 2008, show a decrease of 16 infants; the rate changed from 1.6 to 1.7 with total births estimated to decrease in number by 3,614.

2008 data for live births 500-1499 grams in hospitals show that 68.6% were born in tertiary level hospitals. This percent has been consistent over the past few years.

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

The managed care environment for Tennessee Medicaid plays a role in the low rates of VLBW infants being born in tertiary level hospitals. Also contributing is the difficulty in capturing data on the level of care by facility. The system for determining level of care in the state is self-designation, not regulatory.

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

During state FY 2009, the five obstetrical perinatal centers had 13,910 deliveries for Tennessee residents (compared to 85,480 resident births for CY 2008), documented 1,067 telephone consultations and 21,937 onsite patient consultations, and taught 1,744 hours of education. Data from the five neonatal perinatal centers for the same time period show 2,732 in-born admissions to Tennessee residents, of which 479 were VLBW (2008 VLBW resident births were 1,378); 1,552 transports; 2,698 on-site consultations; and 3,613 hours of education taught.

The Tennessee Initiative for Perinatal Quality Care (TIPQC) began in 2007 to develop a statewide quality collaborative to improve birth outcomes in the state. The voluntary organization has grown to over 900 members, including perinatologists, neonatologists, hospitals at all levels of perinatal care, administrators, third party payors, state officials, and community constituents. Funded by the Governor's Office of Children's Care Coordination, over 170 physicians, nurses, advocates, payors, hospital administrators, government leaders, and families met in March 2009 to collaborate on ways to reduce infant mortality and morbidity. The first statewide neonatal project was on NICU admission temperature, followed by central line associated bloodstream infections.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue the perinatal regionalization system. 3. 4.	X			X
2. Coordinate the activities of the Perinatal Advisory Committee.				X
3. Update and revise perinatal program manuals as needed.				X
4. Partner with TIPQC.				X
5.				

6.				
7.				
8.				
9.				
10.				

b. Current Activities

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

TIPQC continued with the March 2009 annual meeting, continuation of the quality projects, the addition of new projects, and plans for the future. Teams from across the perinatal spectrum are engaging in statewide, evidence-based and data-driven quality improvement projects. New projects under development or being piloted include reducing elective deliveries before 39 weeks and the NICU human milk feeding project.

c. Plan for the Coming Year

The state will continue to contract with the five regional perinatal centers as in the past. The Perinatal Advisory Committee will continue to advise the Department on perinatal care issues and revise manuals as needed. A new work group will be formed to review and revise the "Transportation Guidelines" manual.

The Department will continue to partner with TIPQC on the planned quality improvement projects. Projects being developed for 2010 and 2011 include a breastfeeding awareness campaign and two NICU projects -- How's Your Baby? and Golden Hour (designed to improve the first hour of life by involving families and other key stakeholders).

Funding for the regional perinatal centers this year originates with American Reinvestment and Recovery Act (ARRA). Continuation funding for GOCCC and thus the regionalization program and TIPQC is uncertain.

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

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

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	90	90	90	90	70
Annual Indicator	60.4	62.5	63.7	67.7	69.1
Numerator	49163	52684	55134	54765	53453
Denominator	81454	84277	86558	80887	77408
Data Source				TN Birth Statistical System	TN Birth Statistical System
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and					

2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	70	80	80	90	90

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

Notes - 2007
Data source is the State vital records registry.The data is estimated.

2010
Addendum.
2007 was not finalized previously.
Update/final per TDH Divsion of Health Statistics Birth Statistical System:
55266/82538 = 67.0

a. Last Year's Accomplishments
Provisional 2009 birth certificate data show that 69.1% of pregnant women entered prenatal care in the first trimester (for those certificates with the data completed). 2008 birth certificate data show that 67.7% of pregnant women started prenatal care in the first trimester. However, these data are often not completed on the form, and continue to reflect problems in using the revised birth certificate format and an incompleteness of the data. Prior to implementation of the new format, over 80% of women were starting prenatal care in the first trimester. Forty-nine percent of the 2008 births in Tennessee were on TennCare/Medicaid. Their data on prenatal care are currently being reported by number of prenatal care visits rather than by trimester of entry into care. 2007 data show that 8% of TennCare enrollees (mothers) had no prenatal care; 40% had 10-12 visits; and 43% had more than 12 prenatal care visits.

The Department of Health has historically considered the reduction of infant mortality and improving birth outcomes as priorities. The role of the Department is to remain abreast of evidence-based best practices and to implement public health initiatives and programming consistent with those practices. All local health department clinics offer basic prenatal care, which includes pregnancy testing (81,195 in CY 2009), presumptive eligibility determination for TennCare (17,889 enrolled in CY 2009), WIC/nutrition services, counseling, information, and referrals to health care providers for medical care. The availability of these services in all counties increases the likelihood that pregnant women will enter into care early. Women are also referred for home visiting services as appropriate (HUGS, Healthy Start, or CHAD).

Under the managed care system in place under TennCare, most prenatal care is provided by private sector providers. Local health department clinics provided comprehensive prenatal care in 8 counties in 2009. Delivery services are by a private physician in the community. Many of these counties are serving primarily Hispanic clients; most do not have insurance or do not qualify for TennCare. During CY 2009, 1,945 pregnant women were provided comprehensive care, and of these, 96% were self pay (not on TennCare) and 54% were Hispanic.

Using funding from the State, the Governor's Office of Children's Care Coordination has worked to develop an initiative to improve birth outcomes in Tennessee. After first assessing need related to obstetrical care and infant mortality, and partnering with numerous agencies and providers; programs and projects using evidence-based models have been implemented in Memphis, Chattanooga, Nashville, and Northeast Tennessee. Currently-funded activities include

intervention for pregnant smokers, Centering Pregnancy clinical services, obstetrical faculty to increase capacity for services, health education for pregnant women, Tennessee Initiative for Perinatal Quality Care (TIPQC) to improve health outcomes for mothers and infants through quality improvement methodologies , education and outreach for pregnant Hispanic women, and pilot projects for fetal-infant mortality review teams.

The Campaign for Healthier Babies operating in Memphis since 1993 is a media/educational effort to improve rates of first trimester prenatal care entry and birth outcomes. The Campaign centers around a toll-free number promoted through television, newspaper, and print materials. Callers receive a free Happy Birthday Baby Book of information and merchandise coupons to be validated at prenatal visits. In CY 2009, 4,112 phone calls were received at the Shelby County Health Department, and 5,058 coupon books, along with folic acid, WIC, and other prenatal/infant educational information (10,450 brochures), were mailed.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide pregnancy testing, counseling, and referral, and presumptive eligibility in all local health department clinics.	X	X		
2. Provide home visiting services for pregnant women.	X	X		
3. Provide comprehensive prenatal care in 2 counties.	X			
4. Provide WIC/nutrition services in all local health department clinics.	X	X		
5. Work with the Campaign for Healthier Babies in West Tennessee.			X	X
6. Continue operating the toll free Baby Line.	X	X		
7. Coordinate with the Governor's Office of Children's Care Coordination on the efforts to expand the availability of obsterical services in targeted areas and on implementation of FIMR.	X			X
8.				
9.				
10.				

b. Current Activities

All previously described activities continue. Emphasis is placed on providing pregnancy testing, assisting with prenatal care or arranging referrals to community private health care providers and offering home visiting services. One FQHC status health department clinic continues to provide prenatal care. In all other counties pregnant women are seen by private providers. All clients qualifying for TennCare presumptive eligibility are provided with assistance in locating a physician and are enrolled in WIC or CSFP in local health department clinics. April 2010 WIC data show that 21,023 pregnant women were participating in WIC in 133 clinics.

The Governor's Office of Children's Care Coordination continued coordinating the funding available to improve birth outcomes by funding programs and projects in areas of high numbers of infant deaths. New projects for 2009-10 include a parenting skills program, wrap around services for substance-abusing African American women, health ambassador program at 5 HBCCs, and Sister Friends for pregnant teens.

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

Second year PRAMS data (2008 births) have been analyzed, the report is waiting for final

approval. Sample size was sufficient for analysis and release. The report will be widely distributed, and plans for action considered.

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

D. State Performance Measures

State Performance Measure 1: *Reduce the percentage of high school students using tobacco (cigarettes and smokeless tobacco).*

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

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		28	28	26	26
Annual Indicator	25.0	25.0	25.0	32.8	30.1
Numerator	385	385	385	649	642
Denominator	1540	1540	1540	1980	2135
Data Source				2007 Youth Risk Behavior Survey	2009 YRBS
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	26	26	26	26	

Notes - 2009
Data source: Tn 2009 YRBS
Percentage of students who smoked cigarettes, or cigars, or used chewing tobacco, snuff, or dip on one or more of the past 30 days.

Notes - 2008
Data source for 2008: 2007 Youth Risk Behavior Survey
Discrepancy noted in the question that was used from previous years "Have you ever smoked cigarettes daily, that is at least one cigaretted every day for 30 days?"
When the performance measure, and the state detail sheet was for any form of tobacco use.. 2008 was updated to reflect the correct question about use of cigarettes, cigars, chewing tobacco, snuff or dip on one or more of the past 30 days.

Notes - 2007
Data source is the Tennessee YRBSS conducted by Tennessee Department of Education. 2005 Youth Behaviorial Risk Surveillance Survey (YRBSS) was used for 2007 data.

a. Last Year's Accomplishments
The Department of Health continued its tobacco initiative (Smoke-Free Tennessee) which targeted reproductive age women and teens. The initiative included: 1) evaluating all health department clients, 13 years or older, on smoking status and implementing the evidence-based 5As or 5Rs approach; and 2) if a client expressed the desire to stop tobacco use, he/she was offered smoking cessation counseling through the Tennessee QuitLine, and/or pharmacologic treatment (for non-pregnant clients). This effort significantly increased the number of QuitLine users and persons agreeing to take smoking cessation medications. The Non-Smokers Protection Act that took place in Tennessee in October 2007 continues to alleviate secondhand

smoke in most restaurants and workplaces. Along with the increase in the cigarette tax from 20 cents to 62 cents in 2007, tobacco use control and prevention continue to be a priority with public health.

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

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

From August 2006 to March, 2010, the QuitLine has received a total of 36,934 calls. Twelve thousand eighty-five callers (33%) completed the intake process and were assigned to a Quit Coach. Of the callers assigned to a Quit Coach, 8,423 callers (70%) have enrolled into the "iCanQuit" tobacco cessation program, and 312 self-help information packets have been distributed.

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

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

Table 4b, State Performance Measures Summary Sheet

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

b. Current Activities

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

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

Collaboration on policy efforts continue to grow with the state advocacy coalition: Campaign for a Healthy and Responsible Tennessee (CHART) and other partner with 1,900 members in state and local coalitions.

The TUPCP continues to contract with the Tobacco Technical Assistance Consortium to facilitate a strategic planning. 2009-2014. More than 40 partners, representing tobacco regulation, enforcement, advocacy, health communication, community based programs, insurers, and health centers, created a 2009-2014 state plan for tobacco use prevention, control and cessation. The TUPCP Implementation Plan will address these goals: 1) Continue to provide leadership and coordination activities for state agencies, community programs, voluntary health agencies, and private partners. 2) Enhance the statewide surveillance system and outcome-based program evaluation. 3) Reduce tobacco use prevalence among adults and youth. 4) Reduce morbidity, mortality, and disability from tobacco-related chronic diseases by eliminating exposure to secondhand smoke exposure. 5) Increase access to cessation services, and 6) Identify and eliminate tobacco-related disparities among population groups.

c. Plan for the Coming Year

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

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

Synar compliance checks will continue.

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

State Performance Measure 2: *Reduce the percentage of high school students using alcohol.*

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

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		36	36	34	34
Annual Indicator	41.8	41.8	41.8	36.7	33.5
Numerator	643	643	644	700	679
Denominator	1540	1540	1540	1909	2027
Data Source				2007 Youth Risk Behavior Survey	2009 YRBS
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	34	34	34	34	

Notes - 2009
2009 Tennessee YRBS

Notes - 2008
2007 Youth Risk Behavior Survey

Notes - 2007
Data source is the Tennessee YRBSS conducted by Tennessee Department of Education
2005 Youth Behaviorial Risk Surveillance Survey (YRBSS) was used to estimate year 2007

a. Last Year's Accomplishments
The Tennessee Department of Mental Health and Developmental Disabilities, Division of Alcohol and Drug Abuse Services provided primary prevention programs for youth who do not require treatment for substance abuse. Prevention services were primarily focused on the target population youth under the age of 18. A variety of services were provided across the State of Tennessee including services targeted toward selective, indicated, and universal populations as well as each of the six Center for Substance Abuse Prevention strategies. Listed below are the accomplishments of each program.

The Intensive Focus Prevention Program (IFPP) targeted youth who may be at risk for developing alcohol, tobacco, or other drug use problems. 14,000 youth were served in 69 counties.

The Community Prevention Initiative (CPI) target population is at risk young people between the ages of 8 and 16 as well as their families who are at risk for becoming involved in alcohol and drug abuse. 11,000 youth were served in 22 counties.

The Deaf and Hard of Hearing Program targets deaf and hard of hearing youth, children of deaf parents, as well as parents of deaf youth. These populations have been found to be at increased risk for developing substance abuse problems due to their inability to interact in meaningful ways with the hearing world. 180 youth were served in 8 Middle Tennessee counties.

The Faith Initiative seeks to prevent substance use problems by promoting local church involvement in outreach, training, and education services which target children under the age of 18. 7,300 youth were served in West Tennessee.

The Tennessee Statewide Clearinghouse for Alcohol and Drug Information and Referral uses a variety of methods for information distribution including a library, toll-free telephone information and referral hotline, and an internet website. 200,000 Tennesseans were served.

The Tennessee Teen Institute is an annual five-day residential event that was held in three locations across Tennessee. Activities are designed to develop leadership, communication, and

planning skills that will enable participants to develop initiatives for helping other teens avoid substance abuse in their communities. 319 youth were served.

The Comprehensive Alcohol, Tobacco and other Drug Program uses the Skills Mastery and Resistance Training (SMART) Moves Curriculum. This curriculum teaches youth drug resistance skills by increasing self-awareness, decision-making, and interpersonal skills. 481 children were served.

Nurses for Newborns' goal is to improve pregnancy outcomes, ensure the health, growth and development of at-risk infants, and reduction of the use and misuse of tobacco, alcohol and other substances through in-home visitation services. 130 families were served.

The Big Brother Big Sisters of Middle Tennessee's (BBBSMT) mission is to help children reach their potential through professionally supported, one-to one relationships with measurable impact. The program has been shown to have positive effects including, increased self-confidence, improved school performance, and better interpersonal relationships with their families. Little Brothers and Sisters are also less likely to begin using illegal drugs, consume alcohol, skip school and classes, or engage in acts of violence. 3,823 youth were served.

The School-Based Mental Health/Substance Abuse Liaison (SBMHL) program is in nine schools across Tennessee and provides consultation with classroom teachers to assist them in structuring the classroom to enhance learning, training and education to school staff about a variety of mental health/substance abuse prevention topics. Other activities include liaison services between the school and specific children's families to promote school/family partnerships on behalf of the child's education plan, and information and support for the schools in navigating the mental health/substance abuse system. 2,623 children were served.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide prevention services through a variety of projects funded by the Department of Mental Health and Developmental Disabilities.	X	X		
2. Support Community Anti-Drug Coalitions.	X		X	
3. Train teens to develop and implement prevention programs in their communities.				X
4. Train and educate classroom teachers and school staff about mental health and substance abuse topics.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Prevention programs currently being provided include:

The Tennessee Prevention Network will provide selective and indicated evidence-based primary prevention services to 10,728 adolescents and young adults ages 15-24.

Community Anti-Drug Coalitions -- 15 coalitions will serve 1,935,629 persons by conducting

environmental community strategies.

The Tennessee Teen Institute, a peer prevention program, will provide 300 teen participants with the skills, education, and information necessary to develop and implement alcohol and drug abuse prevention programs in their own communities.

The Comprehensive Alcohol, Tobacco and other Drug Program will use the Skills Mastery and Resistance Training Moves Curriculum, a health and life skills program, to serve 450 children in groups of ages 6-9, 10-12, 13-15, and parents.

The School-Based Mental Health/Substance Abuse Liaison will serve 3,000 youth through consultation with classroom teachers, training and education to school staff, and liaison services between the school and families.

c. Plan for the Coming Year

During FY 2011, the Division intends to continue providing prevention services to targeted populations.

Tennessee Prevention Network will provide selective, evidence-based primary prevention services to select, high risk populations (high school dropouts, foster care children, juvenile offenders, and children of substance-abusing parents). An estimated 10,500 youth will be served. Services include classroom and small group education, mentoring, referrals, tutoring, service learning, student assistance programs, and alternative activities that provide for participation in activities that exclude substance use. (i.e., community service or rock climbing adventures).

Community Anti-Drug Coalitions will focus on changing the community environment by targeting community conditions, standards, institutions, structures, systems and policies that tend to support social and health consequences of substance abuse in a community. The targeted population includes the entire population of counties where anti-drug coalitions exist. Currently there are 45 anti-drug coalitions. The Division intends to contract with a large number of these coalitions utilizing several funding sources in an effort to serve an estimated 2,000,000 people.

Tennessee Teen Institute is a peer prevention program designed to provide teen participants with the skills, education, and information necessary to develop and implement alcohol and drug abuse prevention programs in their own communities. The comprehensive program includes a one week camp and at least one opportunity after the camp for participants to come together. The Institute program will target teens statewide and will include selective and indicated populations. 300 youth will be served.

The Comprehensive Alcohol, Tobacco and other Drug Program will use the Skills Mastery and Resistance Training Moves Curriculum, which is a health and life skills program that teaches youth to resist the pressures of drugs and alcohol, and premature sexual activity. The program targets youth between the ages 6- 15. 400 children will be served.

The School-Based Mental Health/Substance Abuse Liaison provides professionals with a background in social work and psychology to schools with the goal of promoting school success. Activities include consultation with classroom teachers to assist them in structuring the classroom to enhance learning, training and education to school staff on substance abuse/mental health prevention topics. 2,500 youth will be served.

State Performance Measure 3: *Reduce the incidence of maltreatment of children younger than age 18 including physical, sexual, emotional abuse and neglect to a rate no more than 8 per 1,000.*

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

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	7	7	7	7	7
Annual Indicator	11.4	10.7	8.3	7.4	7.4
Numerator	17500	17500	13528	10235	10235
Denominator	1530196	1635539	1635539	1390522	1390522
Data Source				Tennessee Dept. of Children's Services	Tennessee Dept. of Children's Services
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	7	7	7	7	

Notes - 2008
Data source : Tennessee Dept. of Children's Services

Notes - 2007
Reports from the Tennessee Department of Children's Services Child Protective Services Section.

a. Last Year's Accomplishments
Programs and health system activities that support this performance measure include: the mandatory reporting system; investigation by the Department of Children's Services (DCS) and prosecution; community based programs for prevention education; the Child Fatality Review System; and the county home visiting programs in local health departments and contract agencies.

2007 data regarding child abuse and neglect rates are the most current information reported by the Tennessee Commission on Children and Youth. In 2007, the rate of substantiated child abuse and neglect cases per 1,000 was 11.6. While responsibility for preventing and intervening in child abuse cases resides in DCS, MCH offers a variety of intervention programs at the county level to prevent and intervene before abuse occurs. The Child Health and Development Program (CHAD) offers services to parents and children under six years of age at risk of child abuse and neglect or with manifested developmental delays. Services are provided according to DCS Performance Standards and include assessments, screenings, home visiting, child development education, and parenting support. The Healthy Start Program is a nationally recognized, intensive home visiting program legislatively mandated through the Early Childhood Development Act of 1994. The Healthy Start Program is designed to support parents by providing education about prenatal care, child safety, child health, disease prevention, child development, and parenting skills. The Program provided services to families with an elevated risk of abuse prior to an abuse or neglect occurrence rather than a program referral being a result of such an occurrence. The program targets adolescent and first time parents who have been determined to be in need of support services. The Help Us Grow Successfully Program (HUGS) provides home visits to pregnant women and families of children up through age 5. All of the home visiting programs offer the opportunity to educate and counsel families and make referrals for additional services, as well as provide parent support, child development information, health care information and general

parent information. All home visitors are periodically trained on the signs, symptoms and mandatory reporting requirements for suspected child abuse. Children presenting to the local health departments for a variety of services including immunizations, WIC and EPSDT are assessed for needed services related to prevention of abuse and neglect.

During FY 2008-2009, the Health Department provided CHAD services in 22 counties with families being referred to this program by Child Protective Services. A total of 1,342 children in 948 families were served in FY 2009 by the program. The Healthy Start Program served 1,375 families with 1,553 children during FY 2008-2009. Eight program sites provided Healthy Start services in 30 counties. Program data show that 98.1% of the 1,553 children served remained in their parent's homes without report of suspected abuse or neglect. HUGS provided services in 89 counties. HUGS revised its guidelines and home visiting orientation manuals as well as provided the Ages and Stages developmental screening tools training to home visiting staff.

Tennessee has a statewide network of 11 Child Care Resource and Referral Centers, each of which provides technical assistance, training, and resources to child care providers. These consultants receive training concerning child abuse prevention, recognition and reporting.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide home visiting services to pregnant women and families of infant and young children.	X			
2. Provide technical assistance, training and resources to child care providers through the network of Child Care Resource and Referral Centers.				X
3. Make referrals for families accessing any type of health department programs and needing additional services		X		
4. Implement the long term plan for Early Childhood Comprehensive System Planning grant				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

CHAD services are provided out of local health departments in 22 counties of the East and Northeast regions. Healthy Start serves 30 counties out of a variety of community agencies (hospitals, mental health centers, universities, and child development centers). New Healthy Start employees receive the intensive Family Assessment Training provided by a National Healthy Families America trainer. The Healthy Start and CHAD programs continue to educate families on the issue of child abuse and neglect and help them to identify appropriate resources for their needs. The CHAD and Healthy Start Director serves on the Child Abuse Prevention Advisory Committee.

HUGS staffs provide services to all 95 counties. The program has automated its data collection and reporting system. New baseline assessment and encounter screens are being implemented. Referrals will be tracked electronically and the system has an internal reporting function that can be accessed for caseload summary information. The program's goals are to improve pregnancy outcomes, improve maternal and child health and wellness, improve child development and maintain or improve family strengths for all families.

The 11 Child Care Resource and Referral Centers continue to provide technical assistance, training, and resources to the over 5000 child care providers.

c. Plan for the Coming Year

Funding is uncertain for the home visiting programs. As long as funding remains, all home visiting programs (CHAD, Healthy Start and HUGS) will continue to provide services. During the next year, the CHAD and Healthy Start Programs will continue efforts to reduce infant and child mortality and promote family health. New quality assurance outcomes will be implemented in the programs to improve the child abuse and neglect prevention system in Tennessee. The Program Director will plan an Annual Conference for Healthy Start Program Coordinators and Family Support Workers Training. Both programs will continue to offer direct and educational services to first time parents with elevated child abuse and neglect rates.

HUGS will continue to look at ways to provide staff training including a SIDS grief counseling training and a training collaboration with Vanderbilt University MIND series (Mid-Tennessee Interdisciplinary Instruction in Neurodevelopmental and Related Disabilities - NDRD Training Project). The objective of the video conferences is to increase access to services for children and families. The video conferences address current information on specific conditions and diseases, including diagnosis and treatment and the role of the Tennessee Department of Health in translating needs into practice to influence health outcomes of Tennesseans.

Early Childhood Comprehensive Systems (ECCS) will continue to host meetings to provide public and private agency professionals the chance to collaborate to improve child health.

Parents in the 11 Child Care Resource and Referral Centers will assist the consultants with providing technical assistance, training, and resources to child care providers and other parents. They will promote the evidenced-based 5 Protective Factors for Families to prevent child abuse and neglect.

State Performance Measure 4: *Increase percentage of children with complete EPSDT annual examinations by 3 percent each year.*

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

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	80	89	90	92	92
Annual Indicator	88.1	88.2	73.3	94.0	96.3
Numerator	663876	664879	597536	734396	787793
Denominator	753474	753982	814643	781636	818335
Data Source				TennCare EPSDT data system	TennCare EPSDT data system
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	95	95	95	95	

Notes - 2008
Data source is the state of Tennessee TennCare EPSDT Data system.

Notes - 2007
Data source is the state of Tennessee TennCare EPSDT Data system.
Data is 1 year late due to TennCare EPSDT reports.

a. Last Year's Accomplishments
This performance measure is determined by the Bureau of TennCare and addresses a statewide measure across private providers as well as Department of Health. Over a 3.57% increase from the prior year was achieved with a 94.5% screening rate for 2008.

All 95 county health departments continue to provide EPSDT screenings to TennCare-eligible children. In FY 2008-09, 64,461 screenings were done by the health departments. The Department of Health assumed the responsibility of screening children in the custody of the Department of Children's Services (DCS) in June 2003. Data for 2008-09 from DCS show that 94.1% of children had been screened. The TENNderCare Community Outreach program, the TENNderCare Call Center and the TENNderCare Nursing Call Center raise awareness of the importance of EPSDT screening to parents of TennCare eligible children.

For state fiscal year 2009, 209,677 calls were completed to families regarding EPSDT services for their children. 8992 EPSDT appointments were scheduled by the Call Center staff for both private providers and health department clinics. It is projected that as many as 60,000 EPSDT screenings will be provided in Department of Health clinics in FY 2010.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide advocacy and outreach activities in all local health department clinics to TennCare enrollees, including information about the need for EPSDT.		X		
2. Provide EPSDT screening exams to TennCare enrollees in all local health department clinics.	X			
3. Assist families with referrals and appointments for screening with primary care providers		X		
4. Provide EPSDT screening exams for all children in custody of the Department of Children Services	X			
5. Implement the EPSDT community outreach project.		X		
6. Continue to operate the TENNderCare Call Center.		X		
7.				
8.				
9.				
10.				

b. Current Activities
The Department of Health operates three components to its outreach program to support the TENNderCare message, "Check In, Check Up, and Check Back." The Community Outreach Program is centered on community initiatives that promote awareness of the importance of children receiving checkups covered by TennCare. The TENNderCare Call Center, located in Nashville, has Call Center Operators on two shifts who provide individualized outreach to families of newly enrolled TennCare children and newly re-certified TennCare children. Parents are

provided education on the importance of TENNderCare services and are advised that the costs of these services are provided by TennCare. With agreement of the parent, the Call Center Operator will contact the member's primary care provider and make an appointment for the child and/or arrange transportation for the member. The Nursing Call Center provides telephone outreach to pregnant women covered by TennCare to discuss the importance of early contact and continuous prenatal care as well as the importance of the health screening for the baby.

All local health department clinics statewide will continue to provide EPSDT screening exams for TennCare enrolled children. The Department will also continue to provide EPSDT screening exams for the children in the custody of the Department of Children's Services.

c. Plan for the Coming Year
The TENNderCare Program will continue the three components of outreach. This should result in increased awareness to parents/guardians of TennCare eligible children about the importance of EPSDT screenings and preventive care. All local health department clinics statewide will continue to provide EPSDT screening exams for TennCare enrolled children. The Department will also continue to provide EPSDT screening exams for the children in the custody of the Department of Children's Services.

State Performance Measure 5: *Reduce the proportion of teens and young adults ages 15 to 24 with chlamydia trachomatis infections attending family planning clinics*

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

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	5.2	5.2	5.2	5.2	5.2
Annual Indicator	6.9	6.3	6.5	6.2	5.7
Numerator	1985	1720	1578	1543	1369
Denominator	28890	27346	24334	25073	23876
Data Source				State of Tennessee Infertility Prevention Project	State of Tennessee Infertility Prevention Project
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	5.2	5.2	5.2	5.2	

Notes - 2009
This is Calendar Year Data
Source: State of Tennessee Infertility Prevention Project Data System.

Notes - 2008
This is calendar year data
Source: State of Tennessee Infertility prevention project data system.

Notes - 2007

Data source is the Tennessee Department of Health.
Data source is the State of Tennessee STD infertility project data system

a. Last Year's Accomplishments
All family planning clinic sites provide testing for chlamydia and gonorrhea in accordance with protocols jointly established by the STD and Family Planning Programs. In CY 2009, family planning clinics did 46,027 chlamydia tests and 46,094 gonorrhea tests.
Through a cooperative agreement between CDC and the Office of Population Affairs, the Infertility Prevention Project (IPP) has funded and fostered strong collaboration among Title X family planning programs, STD programs, and state public health laboratories. Tennessee, through the family planning clinics and the sexually transmitted disease (STD) clinics, is providing screening and treatment statewide. Screening criteria are determined using CDC national recommendations, state-specific data, and available resources; the criteria are reviewed annually and revised as needed. Significant revisions were made in July 2008. Approximately 124,200 tests were sent to the State Laboratory in calendar year 2009. Both state appropriations and federal infertility project funds are available for the program.

Data for 2009 for family planning clinics show a 5.73% chlamydia positivity rate for ages 15-24. This compares to 6.15% for calendar year 2008.

Policies in place to improve treatment for chlamydia include the use of directly observed therapy (DOT) by non medical personnel (public health representatives/disease intervention specialists) using azithromycin for the treatment of chlamydia. This policy provides an option for dealing with the most difficult patients and contacts. Policy also has been in place since 2002 allowing expedited partner delivered therapy within the local health department clinics. Tennessee is one of the few states which have the legal authority to provide medications for partners.

Clinic staffs continue to conduct risk assessments and offer chlamydia urine screening to adolescents being provided EPSDT screening exams in the local health department clinics. All women under age 30 reporting to local health department clinics for a urine pregnancy test are offered screening for chlamydia and gonorrhea from their pregnancy test urine sample. This population of women who are also offered family planning if their pregnancy test is negative provides a target group who may never have used clinic services previously. Local health departments began offering this service on September 1, 2006.

From early 2009 through early 2010, the Health Loop clinics in Memphis changed ownership to Memphis/Shelby County Health Department or Memphis Health Center, or closed permanently. With the subsequent reshuffling of services, locations, and hours, usage numbers in family planning clinics declined through 2009 and early 2010. Beginning in March of 2010, an increase in family planning services was noted in these Memphis/Shelby County Health Department clinics. Since all these clinics offer screening for chlamydia and gonorrhea, the numbers during this time were lower than previously.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Screen for chlamydia in family planning and sexually transmitted disease clinics in local health departments.	X			
2. Provide risk assessments and screening for adolescents as part of the EPSDT screening exam.	X			
3. Participate on the Region IV Infertility Prevention Project Advisory Committee.				X
4. Encourage use of directly observed therapy by non-medical personnel.	X			

5. Encourage use of partner delivered therapy.	X			
6. Participate in the Region IV Chlamydia Awareness Month.	X		X	
7. Provide information to the public through the Department's web site.			X	
8.				
9.				
10.				

b. Current Activities

Chlamydia screening based on the state's screening criteria is continuing in all family planning and sexually transmitted diseases clinics statewide. Chlamydia screening is also offered to women who request a "walk-in" pregnancy test, and to sexually active adolescents screened during routine EPSDT visits. Representatives from all three programs (Family Planning, STD, and Laboratory) continue to participate on the Region IV infertility prevention project advisory committee. Staffs continue to promote the use of partner delivered therapy in the clinics.

The STD Program hired a new person to be the State Infertility Prevention Coordinator. She will work with the CDC, the Regional Training Center, the Family Planning Program, and the State Laboratory in implementing the goals and objectives of the screening program activities.

For April 2010 Chlamydia Awareness Month, the State released articles for statewide distribution on the prevalence of chlamydia and gonorrhea in Tennessee. Alignment Nashville out of the Mayor's Office provided screening for high school age students on May 12; this effort will continue throughout the year. The two non-profit agencies participating in the Title X Family Planning Program provided education and advertising for services at their clinic sites during April.

Program staffs have analyzed the 2008 and 2009 chlamydia data by geographic area, clinic type, ages, and program. The screening criteria have been revised, and will be implemented this summer.

c. Plan for the Coming Year

Plans include continuing all the activities described in the above sections, using urine-based testing in select youth detention facilities; using urine-based testing in appropriately targeted outreach screening initiatives; using directly observed therapy by non-medical staff for treating chlamydia; and encouraging partner-delivered therapy. For Chlamydia Awareness Month 2011, additional test kits (beyond their family planning clients) will be provided to both nonprofit agencies (Planned Parenthood agencies) in Memphis, Nashville, and Knoxville to provide targeted STD testing for chlamydia and gonorrhea. In early 2011 the Nashville Public Television station will be doing a documentary on sexually transmitted diseases.

State Performance Measure 6: *Reduce the number of babies born prematurely.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		12	11	10	10
Annual Indicator	12.7	12.4	11.7	11.5	11.3
Numerator	10241	10454	10162	9818	9227
Denominator	80583	84277	86558	85320	81669
Data Source				TDH Div. Hlth. Stats Birth Stat.	TDH Div. Hlth. Stats. Birth Stat. Syst.

				Sys	
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	10	10	10	10	

Notes - 2008
TDH Div. Health Statistics Birth Statistical System (Tennessee residents only).
Preterm defined as gestation 17-36 weeks.

Notes - 2007
Data source is the Tennessee Department of Health.
Data source is the State of Tennessee provisional birth master files, Tennessee residents only.

a. Last Year's Accomplishments
All local health department clinics offer basic prenatal care, which includes pregnancy testing, presumptive eligibility determination for TennCare/Medicaid, WIC/nutrition services, counseling, information, and referrals to health care providers for medical care. The availability of these services in all counties increases the likelihood that pregnant women will enter into care early. Pregnant women in all local health departments are referred for home visiting services as appropriate (HUGS, Healthy Start, or CHAD). Currently, all 95 counties provide home visiting services. The HUGS home visiting program's data system is providing information for evaluating results. Pregnant women who smoke are offered counseling and education through the WIC program and the Tobacco Use Prevention and Control Program. The Tennessee Tobacco QuitLine offers counseling for smokers across the state, and services have been tailored to serve pregnant women who smoke.

Under the TennCare managed care system, most prenatal care is provided by private providers. Over the last year, the number of local health department clinics providing full prenatal services has decreased from 8 to 1. One local health department FQHC status clinic continues to provide comprehensive prenatal care for primarily uninsured women. Data on WIC clients for May 2009 show that 22,143 pregnant women were participating in the WIC program.

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

Other important services which can impact the health of women and play a role in lowering the overall prematurity rate are screening for sexually transmitted diseases and family planning. All local health department clinics offer screening for sexually transmitted diseases, including chlamydia, gonorrhea, syphilis, and HIV, and family planning services, including education and counseling, physical exams, laboratory tests, and birth control methods.

Other activities impacting preterm births (Improving Birth Outcomes projects funded by the Governor's Office on Children's Care Coordination; Tennessee Initiative for Perinatal Quality Care/TIPQC; EPSDT Call Center; and TENNderCare outreach and advocacy) are discussed in other sections on the national and state performance measures. It is anticipated that data from the second year of PRAMS and the four pilot FIMR programs will assist in developing new initiatives to address the problem of preterm births in Tennessee. The 2008 PRAMS report is waiting for final Departmental approval. Year one PRAMS data were not analyzed by the CDC

due to a less than adequate response rate.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide pregnancy testing, counseling, and referral, and presumptive eligibility in all local health department clinics.	X	X		
2. Provide home visiting services for pregnant women.	X	X		
3. Provide comprehensive prenatal care in 8 counties.	X			
4. Provide WIC/nutrition services in all local heath department clinics.	X	X		
5. Continue the perinatal regionalization system.	X			X
6. Continue to counsel pregnant women on smoking cessation.	X	X		X
7. Coordinate with the Governor's Office of Children's Care Coordination on efforts to expand the availability of obstetrical services in targeted areas, operate the FIMR projects, and other infant mortality reduction activities.	X			X
8. Participate in the TIPQC Initiative.				X
9. Coordinate with PRAMS staff.			X	X
10. Implement FIMR in 4 geographic areas.			X	X

b. Current Activities

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

The programs and projects funded under the Governor's Initiative to Improve Birth Outcomes (discussed in NPM 18) are important activities in addressing this measure. This initiative funds evidenced-based programs or promising practices, utilizing proven strategies for improving birth outcomes; these programs serve over 25,000 women and children yearly.

The Tennessee Initiative for Perinatal Quality Care (TIPQC) is a statewide collaborative working with hospitals and providers across the state to optimize birth outcomes and implement improvement initiatives. The efforts of this collaborative have been recognized nationally as a model practice for improving birth outcomes. One project under development could potentially impact prematurity -- reducing elective deliveries before 39 weeks.

c. Plan for the Coming Year

The Department will continue to provide the services described above (perinatal regionalization, pregnancy testing, counseling, and referrals, WIC and nutrition services, home visiting services, prenatal care in selected counties, enrollment in TennCare under presumptive eligibility, TennCare outreach and advocacy, smoking cessation counseling, family planning, and sexually transmitted diseases screening and treatment).

Local and regional health departments will continue to assess the need for providing prenatal care within their clinics depending upon the availability of services within the private health care systems.

New TIPQC projects under development include human milk feeding in the NICU, breastfeeding awareness campaign, and family involvement in the NICU (How's Your Baby and Golden Hour).

The obstetric project on reducing elective deliveries before 39 weeks will be finalized and piloted.

State Performance Measure 7: *Increase percentage of adolescents with complete Early Periodic Screening, Diagnosis and Treatment(EPSDT) annual examinations by 5% each year.*

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

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		50	50	60	65
Annual Indicator	10.3	9.7	39.4	49.6	49.6
Numerator	62000	58313	117570	139597	145776
Denominator	600000	600000	298233	281670	293963
Data Source				TennCare EPSDT data system	TennCare EPSDT data system
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	65	65	65	65	

Notes - 2008
Data source is the state of Tennessee TennCare EPSDT Data system.
Teens defined by TennCare are 10-18 years of age

Notes - 2007
Data source is the State of Tennessee EPSDT data System and the Tennessee TennCare data.
Data includes Children age 10-18 years and the data is based on FY 2005-2006

a. Last Year's Accomplishments
Note that this screening percentage objective is determined by the Bureau of TennCare and covers performance by private providers as well as screening exams at the Department of Health clinics.

During this past year adolescents were a major focus group for targeted outreach by all participating partners and providers, including the Bureau of TennCare, Department of Health TENNderCare Community Outreach Program, and by all the TennCare Managed Care Organizations.

The 2007-2008 CMS-416 Annual EPSDT Participation Report shows that there were 293,387 total adolescents ages 10-18 eligible for EPSDT. Total screens for this age group were 148,977; the screening ratio was 57.6%.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide advocacy and outreach activities in all local heath department clinics to TennCare enrollees, including information about the need for EPSDT.		X		
2. Provide EPSDT screening exams for children of all ages in all local health department clinics.	X			

3. Assist families with referrals to appointments for screening with primary care providers.		X		
4. Provide EPSDT screening exams for all children in custody of the Department of Children Services.	X			
5. Implement the EPSDT community outreach project.		X		
6. Implement the EPSDT community outreach education and screening project.		X		
7.				
8.				
9.				
10.				

b. Current Activities

The Department of Health (DOH) TENNderCare Program has a special focus on EPSDT educational outreach to the adolescent population. All Regional TENNderCare programs include in the regional community outreach plans a section on strategies to target adolescent patients. TENNderCare Program contracts with the six (6) metropolitan health departments include a requirement to conduct outreach activities designed to reach pre-teen, teen and young adult populations.

Currently, the Regional TENNderCare Program Community Outreach Staff in all 13 DOH regions of the state participate in community events that target teens at colleges, vocational schools, sporting events, health fairs and other activities to educate teens on the importance of preventive health care and getting the EPSDT exam covered by TennCare. Teen conferences are conducted in several areas of the state and feature education on good health practices as well as health screenings.

A collaborative between the Department of Health, Bureau of TennCare and the three TennCare Managed Care Organizations (MCOs) began this year and is exploring barriers and successful strategies for outreach to adolescents.

c. Plan for the Coming Year

The DOH Regional TENNderCare Program will continue conducting and participating in outreach efforts targeting adolescents. The MCO/DOH Collaborative will continue to focus efforts on adolescent strategies and outreach.

The Department of Health Immunization Program has enacted new immunization requirements effective July 1, 2010, for children entering 7th grade. Communications explaining the new requirements have been disseminated to schools, parents and providers throughout the state. Parents are urged to schedule a complete check-up for a child during the immunization visit if it has been more than one year since the child received a well child exam. Providers are encouraged to talk to parents about this opportunity when scheduling immunization appointments for these children.

The Governor's Office of Children's Care Coordination (GOCCC) is conducting a quality improvement initiative with providers across the state that focuses on adolescent preventive care. The Tennessee Adolescent Health Quality Improvement Project will run from June 1, 2010 to September 30, 2010 and will focus on increasing the number of adolescents who receive preventive care services by minimizing the number of missed opportunities to deliver preventive care. The QI project is building on the state's new immunization requirements as an opportunity to address the annual well child visit when the child presents to a provider for the new immunizations.

State Performance Measure 9: *Reduce the number of overweight and obese children and adolescents.*

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

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		30	30	30	29
Annual Indicator	31.9	31.9	39.9	40.9	39.0
Numerator	491	491	615	194814	191090
Denominator	1540	1540	1540	476318	489975
Data Source				TDE CSH	TDE CSH
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	25	25	25	25	

Notes - 2009
Tennessee Department of Education Coordinated School Health Program BMI measurements K-12 students 2008-2009 school year.

Notes - 2008
Source:
Tennessee Department of Education Coordinated School Health Program BMI measurements K-12 students 2007-2008 school year

Notes - 2007
Data source is the Tennessee YRBSS conducted by Tennessee Department of Education 2005 Youth Behaviorial Risk Surveillance Survey (YRBSS) was used.

a. Last Year's Accomplishments
In the 2008-2009 school year, Coordinated School Health expanded to all Tennessee school districts and 4 special schools. CSH continues to implement wellness policies (including 90 minutes of physical activity per week and nutritional guidelines); comprehensive health education; school-specific wellness plans; and school health advisory councils.

During the 2008-2009 school year, CSH Coordinators collected a total of 225,461 measures of height and weight and calculated BMI on Tennessee students in grades K, 2, 4, 6, 8 and one year in high school. The Tennessee Department of Health, WIC and Nutrition Program participated in developing quality standards for measurements and reports home to parents. There was a reduction in combined overweight/obesity in 2008-2009 (39% of students with BMI > 85%) from 40.9% of students with BMI > 85% in 2007-2008.

The Gold Sneaker initiative continued to enhance policy related to physical activity and nutrition within licensed child care facilities across Tennessee. It is a collaboration among the Department of Health, Department of Human Services and Child Care Resource & Referral Centers. The primary focus is on physical activity. Facilities are encouraged to enact policies that include minimum requirements on physical activity, sedentary activities, breastfeeding, meal time, behaviors and portion sizes. Child care facilities that implement the proposed enhanced physical activity and nutrition policies will earn a "Gold Sneaker" award which designates them as a "Gold Sneaker" child care facility. Fifteen facilities have been awarded the Golden Sneaker designation. Such designation can be used for marketing purposes for the child care facilities, and local organizations will encourage parents to select such facilities. Facilities receive recognition through a certificate, decals, stickers and website recognition. Gold Sneaker training sessions have been added to Child Care Resource and Referral's menu of training topics. Training attendees will receive forms, instructions, checklists, curricula and materials for implementation in

their facilities.

In 2008, the TDH Nutrition and Wellness section was awarded a CDC obesity planning grant, the Nutrition, Physical Activity and Obesity (NPAO) program. The first year entailed developing partnerships, planning community needs assessments, building capacity through hiring staff, developing a surveillance plan, and assessing training needs.

Table 4b, State Performance Measures Summary Sheet

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

b. Current Activities
Last year's activities continue. The NPAO program further developed plans for an integrated data surveillance system and created a support team to develop an evaluation plan that includes an external evaluator.

"Communities Putting Prevention to Work" (CPPW) is a community capacity-building program for instituting population-based policy, systems, and environmental change in communities and schools to (1) decrease overweight/obesity prevalence; increase levels of physical activity; improve nutrition; and/or (2) decrease tobacco use and exposure to secondhand smoke. Nashville was awarded 7.5 million in Public Health Stimulus funds under the American Recovery and Reinvestment Act of 2009. This city-wide project is multi-focal and includes the following components and partnerships, which mirror national recommendations for community-based obesity prevention strategies: walkable communities; bikeways; The Golden Sneaker, bike sharing and access; urban gardens; and corner fresh markets.

c. Plan for the Coming Year
Current activities will continue.

The NPAO program leaders will disseminate their plan at the annual meeting of the Tennessee Public Health Association. The plan will also be widely distributed through all taskforce partnering organizations, other chronic disease programs within the Department of Health, and through

online distribution. The state plan will be implemented at both the state and the local level through existing Department of Health infrastructure, program partners, and contractual agreements. A mini grant process will be outlined, and criteria for awarding the mini grants will be created by the Department of Health in conjunction with the obesity taskforce. A minimum of one statewide project will be chosen for implementation, and on the local level, a minimum of six projects will be identified -- two projects within each grand division of the state -- middle, east and west; and within the grand divisions, one project will focus on a rural area and the other will focus on a semi-urban area. Training on basic implementation techniques and evaluation procedures will be available to all mini grantees, and will be provided by the Department of Health, the taskforce and the implementation facilitator. All mini-grantees will work in conjunction with the evaluation team to ensure outcomes are thoroughly assessed from each mini grant project.

Statewide, the early childhood portion of NPAO plan will be implemented through the Gold Sneaker program and an integration of state resources. A workgroup will be developed to integrate future planning and interventions via an evidenced-based and an integrated approach. These programs will coordinate to develop an integrated surveillance data plan and a surveillance data report.

The evaluation plan for the program will be maintained through the Tennessee Obesity Action Support Team (TOAST), a subgroup of the Tennessee Obesity taskforce. This is an external evaluation conducted by a contractor, as a multiyear contract. The web based system will continue to be available to all partners for documenting progress, resources and success stories.

State Performance Measure 10: *Increase the percentage of youth with special health care needs, age 14 and older, who receive formal plans for transition to adulthood.*

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

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	1234	1234	1534	1245	1694
Denominator	1234	1234	1534	1245	1694
Data Source				CSHCN Survey	CSHCN Survey
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	100	100	100	100	

Notes - 2008
Data source is the National CSHCN Survey.

Notes - 2007
Data source is the State of Tennessee CSS data system

a. Last Year's Accomplishments
CSS continued seeking and receiving technical assistance transition planning through Healthy Ready to Work. This assistance allowed CSS program staff to develop the resources necessary to create a statewide transitional plan that was used as a model for all individual transition plans. CSS collaborated with the Department of Children's Services, the Department of Education, the Department of Mental Health and Developmental Disabilities , the Tennessee Council on Developmental Disabilities and Family Voices to develop a statewide transition task force. This

task force was established to formulate programmatic policies and procedures for transition plans for all children and child serving state agencies.

CSS worked to identify each and every need a participant and their family will have concerning transition from adolescence to adulthood. CSS staff worked on the development of a statewide and regional transitional team and continued to identify transitional resources within the community. A resource guide to transitions was developed and shared with other agencies, private providers, advocacy groups, families, and other entities interested in transitions to adulthood.

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

The Tennessee Council of Developmental Disabilities and Vanderbilt University developed a two-year non-degree college program for 18-26 year old students with intellectual disabilities and enrolled six students in the first cohort. Expansion of this program is expected in the next year with state universities offering similar programs. In the spring of 2009, a Special Needs Baseball Foundation (SNBF) was founded in Jackson Tennessee. This baseball league is for athletes with disabilities aged 4-15 years of age and allows an opportunity for sports participation that would otherwise not be available to this population.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Include transition services in the individual care plans for those participants age 14 and older.	X	X		
2. Maintain listing of community referral resources.			X	X
3. Assist with all appropriate referrals for CYSHCN.		X		
4. Provide training and development opportunities for CSS staff on transition issues.		X	X	X
5. Provide updated resource material for CSS staff and CYSHCN.			X	X
6. Encourage youth to present at transition meetings and training events.			X	
7. Collaborate with state agencies, work groups, and advisory committees for transtion policy development.		X	X	X
8. Develop additional transition materials and resources, transition brochures and guides.			X	
9.				
10.				

b. Current Activities

CSS is continuing the development of a statewide transitional team and plans that can be utilized in the regional and metro areas. The team will be comprised of parents of children with special health care needs, CSS participants, staff and community agency representatives. Care Coordination standards are being established to standardize and enhance transitional services for the CSS participants. Field staff is being provided technical assistance based on the training received from Healthy Ready to Work. Age appropriate transitional plans will continue to be developed for all participants age 14 and older. A Medical History Summary Form will be provided to all CSS participants as a concise medical history that can be provided to medical providers as the participants transition from pediatric medical homes to adult medical homes. The Medical

History Summary Form will also be made available to any CSS participant that reaches maximum treatment or terminates from the CSS program.

CSS staff continues to partner with pediatric providers to locate adult providers for CYSHCN who are aging off the program.

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

c. Plan for the Coming Year

CSS will continue to collaborate with Tennessee Department of Children's Services, Tennessee Department of Education, Tennessee Department of Mental Health and Developmental and Intellectual Disabilities, Juvenile Justice, Labor and Workforce, Children's Services and representatives from other child serving agencies on the Youth Transition Task Force that addresses all transition services necessary to transition from youth to adults. CSS will continue working with Tennessee Department of Education to include a medical home transition component in the Department of Education transition guidelines. CSS will continue collaborating with the Governor's Office of Children's Care Coordination, Family Voices, TennCare, Vocational Rehabilitation and the Department of Higher Education to develop model transition plans. All CSS participants age 14-21 will have an individualized transition plan that includes components relative to medical home, independent living, higher education, employment and recreation. CSS will strengthen the partnership with the Department of Education to provide input on the IEP and to and education transition plan for all CYSHCN

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

E. Health Status Indicators

Introduction

Brief summaries follow each indicator, including where to locate full descriptions of the health issue in the needs assessment and block grant documents.

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

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	9.4	9.6	9.4	9.2	9.2
Numerator	7652	8100	8162	7834	7502
Denominator	81454	84277	86558	85454	81866
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					

Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
Data source
Tennessee Department of Health Division of Health Statistics Birth Statistical System

Notes - 2007
Data source is Tennessee Birthmaster files resident only

Narrative:
Data and sources are noted on the forms. The following are described in sections 3 and 5 of the needs assessment document; and block grant narrative sections 4 C NPM 8, 15, 17, and 18 and 4 D SPM 6:
analysis of data, extent of the problem, activities and strategies, and MCH capacity.

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

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	7.6	7.6	7.5	7.4	7.5
Numerator	5968	6446	6452	6085	5936
Denominator	78656	84277	86558	82708	79290
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
Data source
Tennesse Department of Health Division of Health Statistics Birth Statistical System

Notes - 2007
Data source is Tennessee Birthmaster files resident only

Narrative:
Data and sources are noted on the forms. The following are described in sections 3 and 5 of the needs assessment document; and block grant narrative sections 4 C NPM 8, 15, 17, and 18 and 4 D SPM 6:
analysis of data, extent of the problem, activities and strategies, and MCH capacity.

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

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	1.7	1.8	1.7	1.6	1.7
Numerator	1354	1508	1513	1378	1362

Denominator	81454	84277	86558	85454	81866
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
Data source
Tennessee Department of Health Division of Health Statistics Birth Statistical System

Notes - 2007
Data source is Tennessee Birthmaster files resident only

Narrative:
Data and sources are noted on the forms. The following are described in sections 3 and 5 of the needs assessment document; and block grant narrative sections 4 C NPM 8, 15, 17, and 18 and 4 D SPM 6:
analysis of data, extent of the problem, activities and strategies, and MCH capacity.

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

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	1.3	1.4	1.3	1.3	1.3
Numerator	1029	1166	1159	1043	1060
Denominator	78656	84277	86558	82708	79290
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
Data source
Tennessee Department of Health Division of Health Statistics Birth Statistical System

Notes - 2007
Data source is Tennessee Birthmaster files resident only

Narrative:
Data and sources are noted on the forms. The following are described in sections 3 and 5 of the needs assessment document; and block grant narrative sections 4 C NPM 8, 15, 17, and 18 and 4 D SPM 6:
analysis of data, extent of the problem, activities and strategies, and MCH capacity.

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

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	12.6	7.0	8.0	10.2	5.8
Numerator	150	85	96	122	70
Denominator	1188005	1210629	1194718	1201099	1207621
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

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

Notes - 2007
Data source
Tennessee Department of Health Population Projections and Death Statistical System
2007 corrected/updated to reflect final (provisional was not updated previously)
Actual final: 136/1194718 = 11.4

Narrative:
Data and sources are noted on the forms. The following are described in sections 3 and 5 of the needs assessment document; and block grant narrative section 4C NPM 10: analysis of data, extent of the problem, activities and strategies, and MCH capacity.

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

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	5.0	2.7	3.3	3.4	2.2
Numerator	59	33	39	41	27
Denominator	1188005	1210629	1194718	1201099	1207621
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average					

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

Notes - 2008
Data source is the 2008 Provisional Death files (Tennessee Resident).
2008 Population estimates.

Notes - 2007
Data source Tennessee Department of Health Divsion of Health Statistics Population Projections and Death Statistical System
Correction/update to actual final (provisional was not updated)
Actual 2007 final: 47/1194718 = 3.9

Narrative:
Data and sources are noted on the forms. The following are described in sections 3 and 5 of the needs assessment document; and block grant narrative section 4C NPM 10: analysis of data, extent of the problem, activities and strategies, and MCH capacity.

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

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	45.6	20.9	30.8	29.8	18.4
Numerator	372	172	257	250	156
Denominator	815796	821651	833229	839914	846897
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
TDH Division of Health Statistics Population Projections and Death Statistical System

Notes - 2007
Data source Tennessee Department of Health Divsion of Health Statistics Population Projections and Death Statistical System.
2007 was not updated/corrected to reflect final.
Acutal final:
307/833229=36.8

Narrative:
Data and sources are noted on the forms. The following are described in sections 3 and 5 of the needs assessment document:
analysis of data, extent of the problem, activities and strategies, and MCH capacity.

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

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	13,350.1	13,135.9	13,239.4	12,313.1	1,232.3
Numerator	158600	158253	158173	147882	14800
Denominator	1188005	1204737	1194718	1201009	1201000
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
TDH Division of Health Statistics Population Projections and Hospital Discharge Data System.
Large adjustment to final is due to methodolgical differences in calculation from provisional.
Actual final calculated per Guidance:
Numerator
Number of children age 14 years and younger who have a hospital discharge for non-fatal injuries
Denominator
Number of children age 14 years and younger in the state for the reporting period

Notes - 2007
Data source
Tennessee Department of Health Divsion of Health Statistics Population Projections and Hospital Discharge Data System.
Correction for 2007 due to methodological differences in calculation.
Correction/update uses Guidance:
Numerator
Number of children age 14 years and younger who have a hospital discharge for non-fatal injuries
Denominator
Number of children age 14 years and younger in the state for the reporting period
Actual final: 149319/1194718 = 12498

Narrative:
Data and sources are noted on the forms. The following are described in sections 3 of the needs assessment document:
analysis of data, extent of the problem, activities and strategies, and MCH capacity.

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

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	723.2	797.2	819.3	722.3	722.3
Numerator	8650	9604	9788	8675	8675

Denominator	1196148	1204737	1194718	1201009	1201009
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
TDH Division of Health Statistics Population Projections and Hospital Discharge Data System

Notes - 2007
Numerator Data source is 2007 Hospital Discharge, Tennessee resident only (Input and Output) and Denominator source is 2007 population estimates.

Narrative:
Data and sources are noted on the forms. The following are described in sections 3 of the needs assessment document:
analysis of data, extent of the problem, activities and strategies, and MCH capacity.

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

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	4,033.1	3,461.5	3,472.0	3,064.8	3,064.8
Numerator	32625	28239	28930	25742	25742
Denominator	808940	815796	833229	839914	839914
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
TDH Division of Health Statistics Population Projections and Hospital Discharge Data System

Notes - 2007
Data source is Hospital Discharge Tennessee resident only.
Data source is 2007 Hospital Discharge, Tennessee resident only (Input and Output) and 2007 population estimates.

Narrative:
Data and sources are noted on the forms. The following are described in sections 3 of the needs assessment document:
analysis of data, extent of the problem, activities and strategies, and MCH capacity.

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

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	33.2	36.5	40.0	42.1	42.1
Numerator	6648	7373	8153	8815	8815
Denominator	200015	201861	203767	209417	209417
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
Data source is the state STD program surveillance morbidity database which is the Communicable Disease Surveillance system and the 2008 Population estimates.

Notes - 2007
Data source is the state STD program surveillance which is the Communicable Disease Surveillance system.
and the 2007 Population estimates.

Narrative:
Data and sources are noted on the forms. The following are described in sections 3 of the needs assessment document; and section 4D SPM 5 of the block grant narrative: analysis of data, extent of the problem, activities and strategies, and MCH capacity.

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

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	8.7	10.1	10.4	11.8	11.8
Numerator	9092	10539	10859	12300	12300
Denominator	1046385	1043888	1041926	1045578	1045578
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008

Data source is the state STD program surveillance morbidity data systems,which is the Communicable Disease Surveillance system and the 2008 Population estimates.

Notes - 2007
Data source is the state STD program surveillance which is the Communicable Disease Surveillance system and the 2007 Population estimates.

Narrative:
Data and sources are noted on the forms. The following are described in sections 3 of the needs assessment document; and section 4 D SPM 5 block grant narrative: analysis of data, extent of the problem, activities and strategies, and MCH capacity.

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

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	80512	60681	17914	0	0	0	0	1917
Children 1 through 4	325371	246215	71196	0	0	0	0	7960
Children 5 through 9	399293	302732	87107	0	0	0	0	9454
Children 10 through 14	402445	307061	86982	0	0	0	0	8402
Children 15 through 19	430127	333339	89273	0	0	0	0	7515
Children 20 through 24	416770	327283	80750	0	0	0	0	8737
Children 0 through 24	2054518	1577311	433222	0	0	0	0	43985

Notes - 2011
Tennessee Division of Health Statistics Population Projections.

Tennessee Division of Health Statistics Population Projections.

Tennessee Division of Health Statistics Population Projections.

Tennessee Division of Health Statistics Population Projection

Tennessee Division of Health Statistics Population Projections.

Tennessee Division of Health Statistics Population Projections.

Narrative:
Demographic information is addressed in the needs assessment document sections 3, 4, and 5; and in the State Overview section of the block grant narrative.

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

HSI #06B - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	76441	4071	0
Children 1 through 4	307522	17849	0
Children 5 through 9	377624	21669	0
Children 10 through 14	384028	18417	0
Children 15 through 19	414365	15762	0
Children 20 through 24	399083	17687	0
Children 0 through 24	1959063	95455	0

Notes - 2011
Tennessee Division of Health Statistics Population Projections.

Tennessee Division of Health Statistics Population Projections.

Tennessee Division of Health Statistics Population Projections.

Tennessee Division of Health Statistics Population Projections

Tennessee Division of Health Statistics Population Projections.

Tennessee Division of Health Statistics Population Projections.

Narrative:
Demographic information is addressed in the needs assessment document sections 3, 4, and 5; and in the State Overview section of the block grant narrative.

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

HSI #07A - Demographics (Total live births)

CATEGORY Total live births	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Women < 15	122	68	50	0	0	0	0	4
Women 15 through 17	2953	1760	1031	0	0	0	0	162
Women 18 through 19	7396	4883	2135	0	0	0	0	378
Women 20 through 34	62980	46329	12308	0	0	0	0	4343
Women 35 or older	8500	6401	1265	0	0	0	0	834
Women of all	81951	59441	16789	0	0	0	0	5721

ages								

Notes - 2011
Tennessee Division of Health Statistics Birth Statistical System.

Tennessee Division of Health Statistics Birth Statistical System.

Tennessee Division of Health Statistics Birth Statistical System.

Tennessee Division of Health Statistics Birth Statistical System.

Tennessee Division of Health Statistics Birth Statistical System.

Narrative:
Demographic information is addressed in the needs assessment document sections 3, 4, and 5; and in the State Overview section of the block grant narrative.

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

HSI #07B - Demographics (Total live births)

CATEGORY Total live births	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Women < 15	88	18	16
Women 15 through 17	2242	269	442
Women 18 through 19	5778	481	1137
Women 20 through 34	48407	4938	9635
Women 35 or older	6545	589	1366
Women of all ages	63060	6295	12596

Notes - 2011
Tennessee Division of Health Statistics Birth Statistical System.

Tennessee Division of Health Statistics Birth Statistical System.

Tennessee Division of Health Statistics Birth Statistical System.

Tennessee Division of Health Statistics Birth Statistical System.

Tennessee Division of Health Statistics Birth Statistical System.

Narrative:
Demographic information is addressed in the needs assessment document sections 3, 4, and 5; and in the State Overview section of the block grant narrative. The number of live births to Hispanic women continues to increase.
Information on addressing cultural and language issues is in sections 3 and 4 of the needs assessment document.

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

HSI #08A - Demographics (Total deaths)

CATEGORY Total deaths	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	646	358	274	0	0	0	0	14
Children 1 through 4	88	65	22	0	0	0	0	1
Children 5 through 9	55	33	20	0	0	0	0	2
Children 10 through 14	60	38	22	0	0	0	0	0
Children 15 through 19	298	214	77	0	0	0	0	7
Children 20 through 24	485	359	119	0	0	0	0	7
Children 0 through 24	1632	1067	534	0	0	0	0	31

Notes - 2011
Tennessee Division of Health Statistics Death Statistical System.

Tennessee Division of Health Statistics Death Statistical System.

Tennessee Division of Health Statistics Death Statistical System.

Tennessee Division of Health Statistics Death Statistical System.

Tennessee Division of Health Statistics Death Statistical System.

Tennessee Division of Health Statistics Death Statistical System.

Narrative:
Information about child/infant deaths and Tennessee Child Death and Fetal Infant Mortality Review Teams is in sections 3 and 4 of the needs assessment document.

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

HSI #08B - Demographics (Total deaths)

CATEGORY Total deaths	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	597	49	0
Children 1 through 4	79	9	0
Children 5 through 9	50	5	0
Children 10 through 14	60	0	0

Children 15 through 19	286	12	0
Children 20 through 24	468	17	0
Children 0 through 24	1540	92	0

Notes - 2011
Tennessee Division of Health Statistics Death Statistical System.

Tennessee Division of Health Statistics Death Statistical System.

Tennessee Division of Health Statistics Death Statistical System.

Tennessee Division of Health Statistics Death Statistical System.

Narrative:
Information about child/infant deaths and Tennessee Child Death and Fetal Infant Mortality Review Teams is in sections 3 and 4 of the needs assessment document.

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

HSI #09A - Demographics (Miscellaneous Data)

CATEGORY Misc Data BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**	**Specific Reporting Year**
All children 0 through 19	1637748	1250028	352472	0	0	0	0	35248	2009
Percent in household headed by single parent	35.0	26.0	68.0	0.0	10.0	0.0	0.0	0.0	2008
Percent in TANF (Grant) families	6.9	3.7	18.5	0.0	0.0	0.0	0.0	0.0	2009
Number enrolled in Medicaid	364541	215831	132139	569	4914	0	11088	0	2009
Number enrolled in SCHIP	44831	27255	7310	42	761	32	0	9431	2009
Number living in foster home care	9835	6405	2692	26	16	8	293	395	2009
Number enrolled in food stamp program	496874	310122	180998	864	3659	0	1231	0	2009
Number enrolled in WIC	195005	127417	66234	45	1309	0	0	0	2009
Rate (per 100,000) of	2501.0	1675.0	5552.0	0.0	0.0	0.0	0.0	1165.0	2009

juvenile crime arrests									
Percentage of high school drop-outs (grade 9 through 12)	3.2	2.0	6.5	2.9	1.7	0.0	0.0	0.0	2009

Notes - 2011
Source: Census and Kid Count Data

Source: DHS Research Office

Source: TennCare Office

Source: Cover Kids - Governor's Office of Children's Care Coordination

Source: DHS Research Office

Source: Department of Health WIC Report Participation County by Race and Status.

Source: Department of Health Policy Planning and Assessment Office
Numerator - TBI Crime in Tennessee 2009 Report
Denominator - Health Statistics Population Projections

Source: Department of Education Research Office

Tennessee Department of Children's Services Research Office

Narrative:
Demographic information about MCH populations, including discussion of Tennessee children living in poverty, is included in sections 3 and 4 of the needs assessment document.

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

HSI #09B - Demographics (Miscellaneous Data)

CATEGORY Miscellaneous Data BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**	**Specific Reporting Year**
All children 0 through 19	1559980	77768	0	2009
Percent in household headed by single parent	26.0	38.0	0.0	2008
Percent in TANF (Grant) families	7.0	4.6	0.0	2009
Number enrolled in Medicaid	364541	40233	0	2009
Number enrolled in SCHIP	42540	2291	0	2009
Number living in foster home care	9404	431	0	2009
Number enrolled in food stamp program	465597	31782	0	2009
Number enrolled in WIC	195005	32927	0	2009
Rate (per 100,000) of juvenile crime arrests	0.0	0.0	0.0	2009

Percentage of high school drop-outs (grade 9 through 12)	3.2	3.9	0.0	2009

Notes - 2011
This Data is not available by ethnicity

Narrative:
Demographic information about MCH populations, including discussion of Tennessee children living in poverty, is included in sections 3 and 4 of the needs assessment document.

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

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	Total
Living in metropolitan areas	1152537
Living in urban areas	445435
Living in rural areas	38646
Living in frontier areas	0
Total - all children 0 through 19	484081

Notes - 2011

Narrative:
Geographic living area is included in the State Overview section of the block grant narrative.

Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

Poverty Levels	Total
Total Population	6163000.0
Percent Below: 50% of poverty	6.0
100% of poverty	15.5
200% of poverty	38.8

Notes - 2011
Data Source:
US Census 2008 population estimates

Narrative:
Demographic information about MCH populations, including discussion of Tennessee children living in poverty, is included in sections 3 and 4 of the needs assessment document.

Health Status Indicators 12: *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

Poverty Levels	Total
Children 0 through 19 years old	1637748.0
Percent Below: 50% of poverty	9.3
100% of poverty	21.8
200% of poverty	47.6

Notes - 2011
Data Source: US Census
*Available age range for TN 0-17

Data Source
US Census
*Available age range for TN 0-17

Data Source
US Census
* Available age range for TN 0-17

Narrative:
Demographic information about MCH populations, including discussion of Tennessee children living in poverty, is included in sections 3 and 4 of the needs assessment document.

F. Other Program Activities

The MCH section operates two hotlines. Both are staffed by the MCH and Women's Health sections. The Baby Line, a toll-free telephone line, answers questions, refers callers for pregnancy testing, TennCare and prenatal care within the area where they live, and responds to requests for printed material. The goal is to get women into care during the first trimester of pregnancy.

The Clearinghouse for Information on Adolescent Pregnancy Issues is a separate, central, toll-free telephone for professionals and parents seeking information on local resources, teen pregnancy statistics, resource materials, information on adolescent issues, and services. Professional staff of the agency respond to questions and concerns. Questions concern family planning and pregnancy information, medical information and relationship issues confronting the teen caller. Factual information and referral are provided as appropriate.
MCH has four mandated advisory committees: Perinatal Advisory Committee for the Perinatal Regionalization Program; Genetics Advisory Committee for the Newborn Metabolic Screening and the Newborn Hearing Screening Programs; the Children's Special Services Advisory Committee; and the Women's Health Advisory Committee. Other task forces and advisory groups for MCH programs (not mandated by law) include: Tennessee Childhood Lead Poisoning Prevention Advisory Committee, Adolescent Health Advisory Committee, Asthma Task Force, and Early Childhood Comprehensive Systems Work Group.

Quality Management System: The quality units at the local level are empowered to resolve problems whenever possible in addition to streamlining existing services. The State Quality Council meets yearly to review reports on QM activities, including aggregated trends and recommendations from quality units and quality teams. The Directors of MCH and Women's Health/Genetics serve on the State Quality Council. The statewide Quality Management Plan developed by the Bureau of Health Services is updated yearly. The quality management process, including record review and follow up, is conducted statewide to assure an optimum level of

services for all clients. Clinic-specific patient satisfaction surveys, in English and Spanish, are conducted for one week of every year in all rural clinics.

G. Technical Assistance

We are requesting Technical Assistance as our Five-Year Needs Assessment indicated. At this time four items for technical assistance are listed on Form 15:

(1) Assistance is needed in determining the best methods to provide expenditures by the four levels of the Pyramid. A variety of methods are used by Region IV States to provide this information. Comparability is not possible across states. Assistance requested to develop instructions for the states on compiling this information.

(2) CSS is redirecting field work to a holistic care coordination approach. Care Coordination skills need to address social/physical environments, disparities, cultural needs, self management support and, health literacy. (Wagner's Chronic Care Model).

(3) MCH workforce training is requested in Public Health Core Competencies to develop a workable training plan for current MCH staff at both central office and local levels. Our workforce has expressed the need to improve skills in communication, cultural competency, and community dimensions of practice. There are gaps in other domains as well.

(4) Assistance is requested on incorporating the Life Course Perspective into practice and programs using current limited funding. We need assistance on best methodologies to shift the current paradigm from direct service and categorical programs.

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

	FY 2009		FY 2010		FY 2011	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
1. Federal Allocation *(Line1, Form 2)*	11658473	8967477	11645007		11645007	
2. Unobligated Balance *(Line2, Form 2)*	5000000	0	3500000		3000000	
3. State Funds *(Line3, Form 2)*	13325000	13300000	13250000		13250000	
4. Local MCH Funds *(Line4, Form 2)*	0	0	0		0	
5. Other Funds *(Line5, Form 2)*	0	0	0		0	
6. Program Income *(Line6, Form 2)*	5371900	5884387	5800900		5900000	
7. Subtotal	35355373	28151864	34195907		33795007	
8. Other Federal Funds *(Line10, Form 2)*	6557014	7024247	7872484		7145900	
9. Total *(Line11, Form 2)*	41912387	35176111	42068391		40940907	

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

	FY 2009		FY 2010		FY 2011	
I. Federal-State MCH Block Grant Partnership	**Budgeted**	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
a. Pregnant Women	1202083	557125	1025877		668803	
b. Infants < 1 year old	4030513	3233523	4069313		3881695	
c. Children 1 to 22 years old	13047012	11964732	13813306		13848481	
d. Children with	5020463	3048058	3761550		3493503	

Special Healthcare Needs						
e. Others	10889455	8944973	10361360		10738025	
f. Administration	1165847	403453	1164501		1164500	
g. SUBTOTAL	35355373	28151864	34195907		33795007	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	0		0		0	
b. SSDI	93763		93763		92872	
c. CISS	100000		100000		105000	
d. Abstinence Education	0		993844		0	
e. Healthy Start	0		0		0	
f. EMSC	0		0		0	
g. WIC	0		0		0	
h. AIDS	0		0		0	
i. CDC	0		0		0	
j. Education	0		0		0	
k. Other						
Family Planning	6213251		6534877		6648028	
Newborn Hearing	150000		150000		300000	

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

	FY 2009		**FY 2010**		**FY 2011**	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
I. Direct Health Care Services	25597290	17476677	25988889		20979940	
II. Enabling Services	4101224	6536863	4322363		7847201	
III. Population-Based Services	2969851	2801110	1586690		3362603	
IV. Infrastructure Building Services	2687008	1337214	2297965		1605263	
V. Federal-State Title V Block Grant Partnership Total	35355373	28151864	34195907		33795007	

A. Expenditures

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

Maternal and Child Health Programs are organizationally aligned to the Bureau of Health

Services, Tennessee Department of Health. The Bureau of Health Services has developed detailed policies and procedures for use by local health departments, metropolitan health departments, regional public health offices and central office staff involved with budgeting of funds, collection of revenues, depositing revenues, accounts receivable, aging of accounts, charging patients and third parties, petty cash, posting receipts and contracting for services. Bureau of Health Services policies and procedures are available to all sites and are posted on the Department's Intra-Net for easy references. All policies and procedures have been developed in accordance with applicable state law and rules of the Department of Finance and Administration.

B. Budget

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

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

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

The maintenance of effort for the Maternal and Child Health Block Grant was established in 1989 in accordance with requirements of the block grant. The maintenance of effort, $13,125,024.28, was established through an analysis of 15 months of expenditures for Maternal and Child Health Programs, adjusted for differences between the state and federal fiscal years, as well as adjustments for accrued liabilities. The Tennessee Department of Health, Bureau of Health Services fully supports using state funds to meet the maintenance of effort and match requirements in support of Maternal and Child Health Program activities.

Tennessee fully utilizes Maternal and Child Health Block Grant funding within the 24 month allowable timeframe and meets all targeted maintenance and match requirements set forth in the block grant regulations. Any carry forward noted in the annual report will be used to support or expand Maternal and Child Health activities. Carry forward funding has been used to develop new services or to expand current programs. During recent years carry forward funding has been used to improve dental and other health care screening services, provide preventive fluoride varnish for children seen in health department clinics, fund increased program activity relative to infant mortality, teen pregnancy prevention and enhancement of breast and cervical screening for

reproductive age women. Funding was also used to increase home visiting services for pregnant women and families with high risk infants and young children as well as care coordination services for families with children with special health care needs.

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

For the detail sheets and objectives for the state performance measures developed from the 2010 needs assessment, refer to TVIS Forms, Form 11 and Form 16 under the section “New State Performance Measure Detail Sheets and Data.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.

Title V Block Grant Application
Forms (2-21)
State: TN
Application Year: 2011

FORM 2

MCH BUDGET DETAILS FOR FY 2011

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

STATE: TN

1. FEDERAL ALLOCATION $ 11,645,007

(Item 15a of the Application Face Sheet [SF 424])
Of the Federal Allocation (1 above), the amount earmarked for:

A.Preventive and primary care for children:

$ 3,493,503 (30 %)

B.Children with special health care needs:

$ 3,493,503 (30 %)

(If either A or B is less than 30%, a waiver request must accompany the application)[Sec. 505(a)(3)]

C.Title V admininstrative costs:

$ 1,164,500 (10 %)

(The above figure cannot be more than 10%)[Sec. 504(d)]

2. UNOBLIGATED BALANCE (Item 15b of SF 424) $ 3,000,000

3. STATE MCH FUNDS (Item 15c of the SF 424) $ 13,250,000

4. LOCAL MCH FUNDS (Item 15d of SF 424) $ 0

5. OTHER FUNDS (Item 15e of SF 424) $ 0

6. PROGRAM INCOME (Item 15f of SF 424) $ 5,900,000

7. TOTAL STATE MATCH (Lines 3 through 6) $ 19,150,000

(Below is your State's FY 1989 Maintainence of Effort Amount)
$ 13,125,024

8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP (SUBTOTAL) $ 33,795,007

(Total lines 1 through 6. Same as line 15g of SF 424)

9. OTHER FEDERAL FUNDS

(Funds under the control of the person responsible for the administration of the Title V program)

a. SPRANS:	$ 0
b. SSDI:	$ 92,872
c. CISS:	$ 105,000
d. Abstinence Education:	$ 0
e. Healthy Start:	$ 0
f. EMSC:	$ 0
g. WIC:	$ 0
h. AIDS:	$ 0
i. CDC:	$ 0
j. Education:	$ 0
k. Other:	
Family Planning	$ 6,648,028
Newborn Hearing	$ 300,000

10. OTHER FEDERAL FUNDS (SUBTOTAL of all Funds under item 9) $ 7,145,900

11. STATE MCH BUDGET TOTAL $ 40,940,907

(Partnership subtotal + Other Federal MCH Funds subtotal)

FORM NOTES FOR FORM 2

None

FIELD LEVEL NOTES

None

FORM 3

STATE MCH FUNDING PROFILE

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

STATE: TN

	FY 2006		FY 2007		FY 2008	
	BUDGETED	**EXPENDED**	**BUDGETED**	**EXPENDED**	**BUDGETED**	**EXPENDED**
1. Federal Allocation *(Line1, Form 2)*	$ 12,349,717	$ 10,888,584	$ 11,855,000	$ 14,682,820	$ 11,855,578	$ 9,502,319
2. Unobligated Balance *(Line2, Form 2)*	$ 9,000,000	$ 0	$ 7,500,000	$ 0	$ 7,500,000	$ 0
3. State Funds *(Line3, Form 2)*	$ 13,250,000	$ 13,300,000	$ 13,250,000	$ 13,325,000	$ 13,300,000	$ 13,250,000
4. Local MCH Funds *(Line4, Form 2)*	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0
5. Other Funds *(Line5, Form 2)*	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0
6. Program Income *(Line6, Form 2)*	$ 5,000,000	$ 5,128,306	$ 6,682,000	$ 5,371,883	$ 5,128,300	$ 5,800,931
7. Subtotal	$ 39,599,717	$ 29,316,890	$ 39,287,000	$ 33,379,703	$ 37,783,878	$ 28,553,250
	(THE FEDERAL-STATE TITLE BLOCK GRANT PARTNERSHIP)					
8. Other Federal Funds *(Line10, Form 2)*	$ 8,642,989	$ 9,545,574	$ 8,250,000	$ 7,742,714	$ 8,177,027	$ 7,122,906
9. Total *(Line11, Form 2)*	$ 48,242,706	$ 38,862,464	$ 47,537,000	$ 41,122,417	$ 45,960,905	$ 35,676,156
	(STATE MCH BUDGET TOTAL)					

FORM 3

STATE MCH FUNDING PROFILE

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

STATE: TN

	FY 2009		FY 2010		FY 2011	
	BUDGETED	**EXPENDED**	**BUDGETED**	**EXPENDED**	**BUDGETED**	**EXPENDED**
1. Federal Allocation *(Line1, Form 2)*	$ 11,658,473	$ 8,967,477	$ 11,645,007	$	$ 11,645,007	$
2. Unobligated Balance *(Line2, Form 2)*	$ 5,000,000	$ 0	$ 3,500,000	$	$ 3,000,000	$
3. State Funds *(Line3, Form 2)*	$ 13,325,000	$ 13,300,000	$ 13,250,000	$	$ 13,250,000	$
4. Local MCH Funds *(Line4, Form 2)*	$ 0	$ 0	$ 0	$	$ 0	$
5. Other Funds *(Line5, Form 2)*	$ 0	$ 0	$ 0	$	$ 0	$
6. Program Income *(Line6, Form 2)*	$ 5,371,900	$ 5,884,387	$ 5,800,900	$	$ 5,900,000	$
7. Subtotal	$ 35,355,373	$ 28,151,864	$ 34,195,907	$ 0	$ 33,795,007	$ 0
	(THE FEDERAL-STATE TITLE BLOCK GRANT PARTNERSHIP)					
8. Other Federal Funds *(Line10, Form 2)*	$ 6,557,014	$ 7,024,247	$ 7,872,484	$	$ 7,145,900	$
9. Total *(Line11, Form 2)*	$ 41,912,387	$ 35,176,111	$ 42,068,391	$ 0	$ 40,940,907	$ 0
	(STATE MCH BUDGET TOTAL)					

FORM NOTES FOR FORM 3

None

FIELD LEVEL NOTES

1. **Section Number:** Form3_Main
   Field Name: FedAllocExpended
   Row Name: Federal Allocation
   Column Name: Expended
   Year: 2009
   Field Note:
   The expended is based on true expenditures.

2. **Section Number:** Form3_Main
   Field Name: FedAllocExpended
   Row Name: Federal Allocation
   Column Name: Expended
   Year: 2008
   Field Note:
   The expended is based on true expenditures.

3. **Section Number:** Form3_Main
   Field Name: UnobligatedBalanceExpended
   Row Name: Unobligated Balance
   Column Name: Expended
   Year: 2009
   Field Note:
   The difference in expended amount will be used prior to the grant deadline.

4. **Section Number:** Form3_Main
   Field Name: UnobligatedBalanceExpended
   Row Name: Unobligated Balance
   Column Name: Expended
   Year: 2008
   Field Note:
   The difference in Expended amount will be used prior to the grant deadline.

5. **Section Number:** Form3_Main
   Field Name: StateMCHFundsExpended
   Row Name: State Funds
   Column Name: Expended
   Year: 2008
   Field Note:
   The expended is based on true expenditures.

6. **Section Number:** Form3_Main
   Field Name: ProgramIncomeExpended
   Row Name: Program Income
   Column Name: Expended
   Year: 2008
   Field Note:
   The expended is based on true expenditures.

7. **Section Number:** Form3_Main
   Field Name: OtherFedFundsExpended
   Row Name: Other Federal Funds
   Column Name: Expended
   Year: 2008
   Field Note:
   The expended is based on true expenditures.

FORM 4

BUDGET DETAILS BY TYPES OF INDIVIDUALS SERVED (I) AND SOURCES OF OTHER FEDERAL FUNDS (II)

[Secs 506(2)(2)(iv)]

STATE: TN

	FY 2006		FY 2007		FY 2008	
I. Federal-State MCH Block Grant Partnership	**BUDGETED**	**EXPENDED**	**BUDGETED**	**EXPENDED**	**BUDGETED**	**EXPENDED**
a. Pregnant Women	$ 2,534,382	$ 938,140	$ 864,314	$ 1,134,910	$ 1,209,084	$ 856,598
b. Infants < 1 year old	$ 5,623,160	$ 3,254,175	$ 4,360,857	$ 3,805,286	$ 4,194,011	$ 3,397,837
c. Children 1 to 22 years old	$ 13,345,105	$ 8,868,109	$ 18,582,751	$ 12,327,096	$ 11,320,907	$ 11,784,055
d. Children with Special Healthcare Needs	$ 6,929,950	$ 6,395,177	$ 6,560,929	$ 4,729,932	$ 8,236,885	$ 3,144,199
e. Others	$ 9,781,130	$ 9,029,602	$ 7,503,817	$ 10,280,949	$ 11,637,434	$ 8,651,635
f. Administration	$ 1,385,990	$ 831,687	$ 1,414,332	$ 1,101,530	$ 1,185,557	$ 718,926
g. SUBTOTAL	$ 39,599,717	$ 29,316,890	$ 39,287,000	$ 33,379,703	$ 37,783,878	$ 28,553,250
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	$ 0		$ 0		$ 0	
b. SSDI	$ 100,000		$ 100,000		$ 94,644	
c. CISS	$ 0		$ 100,000		$ 100,000	
d. Abstinence Education	$ 993,367		$ 993,000		$ 993,368	
e. Healthy Start	$ 0		$ 0		$ 0	
f. EMSC	$ 0		$ 0		$ 0	
g. WIC	$ 0		$ 0		$ 0	
h. AIDS	$ 0		$ 0		$ 0	
i. CDC	$ 0		$ 0		$ 0	
j. Education	$ 0		$ 0		$ 0	
k.Other						
CHAD	$ 717,336		$ 717,000		$ 717,336	
Family Planning	$ 5,979,357		$ 0		$ 6,121,679	
Newborn Hearing	$ 0		$ 0		$ 150,000	
New Born Hearing	$ 0		$ 150,000		$ 0	
Title X F. P.	$ 0		$ 6,190,000		$ 0	
CISS-SECCS	$ 100,000		$ 0		$ 0	
Hearing Screening	$ 150,000		$ 0		$ 0	
Lead	$ 602,929		$ 0		$ 0	
III. SUBTOTAL	$ 8,642,989		$ 8,250,000		$ 8,177,027	

FORM 4

BUDGET DETAILS BY TYPES OF INDIVIDUALS SERVED (I) AND SOURCES OF OTHER FEDERAL FUNDS (II)

[Secs 506(2)(2)(iv)]

STATE: TN

	FY 2009		FY 2010		FY 2011	
I. Federal-State MCH Block Grant Partnership	**BUDGETED**	**EXPENDED**	**BUDGETED**	**EXPENDED**	**BUDGETED**	**EXPENDED**
a. Pregnant Women	$ 1,202,083	$ 557,125	$ 1,025,877	$	$ 668,803	$
b. Infants < 1 year old	$ 4,030,513	$ 3,233,523	$ 4,069,313	$	$ 3,881,695	$
c. Children 1 to 22 years old	$ 13,047,012	$ 11,964,732	$ 13,813,306	$	$ 13,848,481	$
d. Children with Special Healthcare Needs	$ 5,020,463	$ 3,048,058	$ 3,761,550	$	$ 3,493,503	$
e. Others	$ 10,889,455	$ 8,944,973	$ 10,361,360	$	$ 10,738,025	$
f. Administration	$ 1,165,847	$ 403,453	$ 1,164,501	$	$ 1,164,500	$
g. SUBTOTAL	$ 35,355,373	$ 28,151,864	$ 34,195,907	$ 0	$ 33,795,007	$ 0
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	$ 0		$ 0		$ 0	
b. SSDI	$ 93,763		$ 93,763		$ 92,872	
c. CISS	$ 100,000		$ 100,000		$ 105,000	
d. Abstinence Education	$ 0		$ 993,844		$ 0	
e. Healthy Start	$ 0		$ 0		$ 0	
f. EMSC	$ 0		$ 0		$ 0	
g. WIC	$ 0		$ 0		$ 0	
h. AIDS	$ 0		$ 0		$ 0	
i. CDC	$ 0		$ 0		$ 0	
j. Education	$ 0		$ 0		$ 0	
k.Other						
Family Planning	$ 6,213,251		$ 6,534,877		$ 6,648,028	
Newborn Hearing	$ 150,000		$ 150,000		$ 300,000	
III. SUBTOTAL	$ 6,557,014		$ 7,872,484		$ 7,145,900	

FORM NOTES FOR FORM 4

None

FIELD LEVEL NOTES

1. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
   Field Name: PregWomenBudgeted
   Row Name: Pregnant Women
   Column Name: Budgeted
   Year: 2010
   Field Note:
   Budget amount is estimated.

2. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
   Field Name: PregWomenBudgeted
   Row Name: Pregnant Women
   Column Name: Budgeted
   Year: 2009
   Field Note:
   Amount is estimated.

3. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
   Field Name: PregWomenBudgeted
   Row Name: Pregnant Women
   Column Name: Budgeted
   Year: 2008
   Field Note:
   Budget amount is estimated.

4. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
   Field Name: PregWomenExpended
   Row Name: Pregnant Women
   Column Name: Expended
   Year: 2009
   Field Note:
   Expended amount is true expenditures.

5. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
   Field Name: PregWomenExpended
   Row Name: Pregnant Women
   Column Name: Expended
   Year: 2008
   Field Note:
   Expended amount is true expenditures.

6. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
   Field Name: Children_0_1Budgeted
   Row Name: Infants <1 year old
   Column Name: Budgeted
   Year: 2010
   Field Note:
   Budget amount is estimated.

7. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
   Field Name: Children_0_1Budgeted
   Row Name: Infants <1 year old
   Column Name: Budgeted
   Year: 2009
   Field Note:
   Amount is estimated.

8. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
   Field Name: Children_0_1Budgeted
   Row Name: Infants <1 year old
   Column Name: Budgeted
   Year: 2008
   Field Note:
   Budget amount is estimated.

9. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
   Field Name: Children_0_1Expended
   Row Name: Infants <1 year old
   Column Name: Expended
   Year: 2009
   Field Note:
   Expended amount is true expenditures

10. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
    Field Name: Children_0_1Expended
    Row Name: Infants <1 year old
    Column Name: Expended
    Year: 2008
    Field Note:
    Expended amount is true expenditures.

11. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
    Field Name: Children_1_22Budgeted
    Row Name: Children 1 to 22 years old
    Column Name: Budgeted
    Year: 2010
    Field Note:
    Budget amount is estimated.

12. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
    Field Name: Children_1_22Budgeted
    Row Name: Children 1 to 22 years old

Column Name: Budgeted
Year: 2009
Field Note:
Amount is estimated.

13. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
Field Name: Children_1_22Budgeted
Row Name: Children 1 to 22 years old
Column Name: Budgeted
Year: 2008
Field Note:
Budget amount is estimated.

14. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
Field Name: Children_1_22Expended
Row Name: Children 1 to 22 years old
Column Name: Expended
Year: 2008
Field Note:
Expended amount is true expenditures.

15. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
Field Name: CSHCNBudgeted
Row Name: CSHCN
Column Name: Budgeted
Year: 2010
Field Note:
Budget amount is estimated.

16. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
Field Name: CSHCNBudgeted
Row Name: CSHCN
Column Name: Budgeted
Year: 2009
Field Note:
Amount is estimated.

17. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
Field Name: CSHCNBudgeted
Row Name: CSHCN
Column Name: Budgeted
Year: 2008
Field Note:
Budget amount is estimated.

18. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
Field Name: CSHCNExpended
Row Name: CSHCN
Column Name: Expended
Year: 2009
Field Note:
Expended amount is true expenditures.

19. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
Field Name: CSHCNExpended
Row Name: CSHCN
Column Name: Expended
Year: 2008
Field Note:
Expended amount is true expenditures.

20. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
Field Name: AllOthersBudgeted
Row Name: All Others
Column Name: Budgeted
Year: 2010
Field Note:
Budget amount is estimated.

21. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
Field Name: AllOthersBudgeted
Row Name: All Others
Column Name: Budgeted
Year: 2009
Field Note:
Amount is estimated.

22. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
Field Name: AllOthersBudgeted
Row Name: All Others
Column Name: Budgeted
Year: 2008
Field Note:
Budget amount is estimated.

23. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
Field Name: AllOthersExpended
Row Name: All Others
Column Name: Expended
Year: 2009
Field Note:
Expended amount is true expenditures.

24. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
Field Name: AllOthersExpended
Row Name: All Others

Column Name: Expended
Year: 2008
Field Note:
Expended amount is true expenditures.

25. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
Field Name: AdminBudgeted
Row Name: Administration
Column Name: Budgeted
Year: 2010
Field Note:
Budget amount is estimated.

26. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
Field Name: AdminBudgeted
Row Name: Administration
Column Name: Budgeted
Year: 2009
Field Note:
Amount is estimated.

27. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
Field Name: AdminBudgeted
Row Name: Administration
Column Name: Budgeted
Year: 2008
Field Note:
Budget amount is estimated.

28. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
Field Name: AdminExpended
Row Name: Administration
Column Name: Expended
Year: 2009
Field Note:
Expended amount is true expenditures

29. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
Field Name: AdminExpended
Row Name: Administration
Column Name: Expended
Year: 2008
Field Note:
Expended amount is true expenditures.

FORM 5

STATE TITLE V PROGRAM BUDGET AND EXPENDITURES BY TYPES OF SERVICES

[Secs. 505(a)(2)(A-B) and 506(a)(1)(A-D)]

STATE: TN

TYPE OF SERVICE	FY 2006		FY 2007		FY 2008	
	BUDGETED	EXPENDED	BUDGETED	EXPENDED	BUDGETED	EXPENDED
I. Direct Health Care Services (Basic Health Services and Health Services for CSHCN.)	$ 28,670,195	$ 21,225,428	$ 28,443,788	$ 24,166,905	$ 27,355,528	$ 21,700,470
II. Enabling Services (Transportation, Translation, Outreach, Respite Care, Health Education, Family Support Services, Purchase of Health Insurance, Case Management, and Coordination with Medicaid, WIC, and Education.)	$ 4,593,567	$ 3,400,759	$ 4,557,292	$ 3,872,046	$ 4,382,930	$ 3,609,131
III. Population-Based Services (Newborn Screening, Lead Screening, Immunization, Sudden Infant Death Syndrome Counseling, Oral Health, Injury Prevention, Nutrition, and Outreach/Public Education.)	$ 3,326,376	$ 2,462,619	$ 3,300,108	$ 2,803,895	$ 3,173,846	$ 1,324,871
IV. Infrastructure Building Services (Needs Assessment, Evaluation, Planning, Policy Development, Coordination, Quality Assurance, Standards Development, Monitoring, Training, Applied Research, Systems of Care, and Information Systems.)	$ 3,009,579	$ 2,228,084	$ 2,985,812	$ 2,536,857	$ 2,871,574	$ 1,918,778
V. Federal-State Title V Block Grant Partnership Total (Federal-State Partnership only. Item 15g of SF 42r. For the "Budget" columns this is the same figure that appears in Line 8, Form 2, and in the "Budgeted" columns of Line 7 Form 3. For the "Expended" columns this is the same figure that appears in the "Expended" columns of Line 7, Form 3.)	$ 39,599,717	$ 29,316,890	$ 39,287,000	$ 33,379,703	$ 37,783,878	$ 28,553,250

FORM 5

STATE TITLE V PROGRAM BUDGET AND EXPENDITURES BY TYPES OF SERVICES

[Secs. 505(a)(2)(A-B) and 506(a)(1)(A-D)]

STATE: TN

TYPE OF SERVICE	FY 2009		FY 2010		FY 2011	
	BUDGETED	EXPENDED	BUDGETED	EXPENDED	BUDGETED	EXPENDED
I. Direct Health Care Services (Basic Health Services and Health Services for CSHCN.)	$ 25,597,290	$ 17,476,677	$ 25,988,889	$	$ 20,979,940	$
II. Enabling Services (Transportation, Translation, Outreach, Respite Care, Health Education, Family Support Services, Purchase of Health Insurance, Case Management, and Coordination with Medicaid, WIC, and Education.)	$ 4,101,224	$ 6,536,863	$ 4,322,363	$	$ 7,847,201	$
III. Population-Based Services (Newborn Screening, Lead Screening, Immunization, Sudden Infant Death Syndrome Counseling, Oral Health, Injury Prevention, Nutrition, and Outreach/Public Education.)	$ 2,969,851	$ 2,801,110	$ 1,586,690	$	$ 3,362,603	$
IV. Infrastructure Building Services (Needs Assessment, Evaluation, Planning, Policy Development, Coordination, Quality Assurance, Standards Development, Monitoring, Training, Applied Research, Systems of Care, and Information Systems.)	$ 2,687,008	$ 1,337,214	$ 2,297,965	$	$ 1,605,263	$
V. Federal-State Title V Block Grant Partnership Total (Federal-State Partnership only. Item 15g of SF 42r. For the "Budget" columns this is the same figure that appears in Line 8, Form 2, and in the "Budgeted" columns of Line 7 Form 3. For the "Expended" columns this is the same figure that appears in the "Expended" columns of Line 7, Form 3.)	$ 35,355,373	$ 28,151,864	$ 34,195,907	$ 0	$ 33,795,007	$ 0

FORM NOTES FOR FORM 5

None

FIELD LEVEL NOTES

1. **Section Number:** Form5_Main
   Field Name: DirectHCBudgeted
   Row Name: Direct Health Care Services
   Column Name: Budgeted
   Year: 2010
   Field Note:
   Budget amount is estimated.

2. **Section Number:** Form5_Main
   Field Name: DirectHCBudgeted
   Row Name: Direct Health Care Services
   Column Name: Budgeted
   Year: 2009
   Field Note:
   Budgeted amount is estimated.

3. **Section Number:** Form5_Main
   Field Name: DirectHCBudgeted
   Row Name: Direct Health Care Services
   Column Name: Budgeted
   Year: 2008
   Field Note:
   Budget amount is estimated

4. **Section Number:** Form5_Main
   Field Name: DirectHCExpended
   Row Name: Direct Health Care Services
   Column Name: Expended
   Year: 2009
   Field Note:
   Expended amount is true expenditures.

5. **Section Number:** Form5_Main
   Field Name: DirectHCExpended
   Row Name: Direct Health Care Services
   Column Name: Expended
   Year: 2008
   Field Note:
   Expended amount is true expenditures.

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

7. **Section Number:** Form5_Main
   Field Name: EnablingBudgeted
   Row Name: Enabling Services
   Column Name: Budgeted
   Year: 2009
   Field Note:
   Budgeted amount is estimated.

8. **Section Number:** Form5_Main
   Field Name: EnablingBudgeted
   Row Name: Enabling Services
   Column Name: Budgeted
   Year: 2008
   Field Note:
   Budgeted amount is estimated.

9. **Section Number:** Form5_Main
   Field Name: EnablingExpended
   Row Name: Enabling Services
   Column Name: Expended
   Year: 2009
   Field Note:
   Expended amount is true expenditures.

10. **Section Number:** Form5_Main
    Field Name: EnablingExpended
    Row Name: Enabling Services
    Column Name: Expended
    Year: 2008
    Field Note:
    Expended amount is true expenditures.

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

12. **Section Number:** Form5_Main
    Field Name: PopBasedBudgeted
    Row Name: Population-Based Services

Column Name: Budgeted
Year: 2009
Field Note:
Budgeted amount is estimated.

13. **Section Number:** Form5_Main
Field Name: PopBasedBudgeted
Row Name: Population-Based Services
Column Name: Budgeted
Year: 2008
Field Note:
Budget amount is estimated.

14. **Section Number:** Form5_Main
Field Name: PopBasedExpended
Row Name: Population-Based Services
Column Name: Expended
Year: 2008
Field Note:
Expended amount is true expenditures.

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

16. **Section Number:** Form5_Main
Field Name: InfrastrBuildBudgeted
Row Name: Infrastructure Building Services
Column Name: Budgeted
Year: 2009
Field Note:
Budgeted amount is estimated.

17. **Section Number:** Form5_Main
Field Name: InfrastrBuildBudgeted
Row Name: Infrastructure Building Services
Column Name: Budgeted
Year: 2008
Field Note:
Budget amount is estimated.

18. **Section Number:** Form5_Main
Field Name: InfrastrBuildExpended
Row Name: Infrastructure Building Services
Column Name: Expended
Year: 2009
Field Note:
Expended amount is true expenditures.

19. **Section Number:** Form5_Main
Field Name: InfrastrBuildExpended
Row Name: Infrastructure Building Services
Column Name: Expended
Year: 2008
Field Note:
Expended amount is true expenditures.

FORM 6

NUMBER AND PERCENTAGE OF NEWBORNS AND OTHERS SCREENED, CASES CONFIRMED, AND TREATED

Sect. 506(a)(2)(B)(iii)

STATE: TN

Total Births by Occurrence: 90,885 | **Reporting Year: 2008**

Type of Screening Tests	(A) Receiving at least one Screen (1)		(B) No. of Presumptive Positive Screens	(C) No. Confirmed Cases (2)	(D) Needing Treatment that Received Treatment (3)	
	No.	%			No.	%
Phenylketonuria						
Congenital Hypothyroidism	90,885	100	341	64	64	100
Galactosemia	90,885	100	165	28	28	100
Sickle Cell Disease						
Other Screening (Specify)						
Biotinidase Deficiency	90,885	100	11	3	3	100
Cystic Fibrosis	68,724	75.6	189	12	12	100
Hemoglobinopathies	90,885	100	84	73	73	100
Congenital Adrenol Hyperplasia	90,885	100	909	9	9	100
AminoAcids	90,885	100	218	5	5	100
Fatty / Organic Acidimias	90,885	100	179	11	11	100
Screening Programs for Older Children & Women (Specify Tests by name)						

(1) Use occurrent births as denominator.
(2) Report only those from resident births.
(3) Use number of confirmed cases as denominator.

FORM NOTES FOR FORM 6

Began screening for CF 4-1-08

FIELD LEVEL NOTES

1. **Section Number:** Form6_Main
   Field Name: BirthOccurence
   Row Name: Total Births By Occurence
   Column Name: Total Births By Occurence
   Year: 2011
   Field Note:
   Began screening for Cystic Fibrosis on April 1, 2008.
   Data source: 2008 Tennessee Newborn Screening database

2. **Section Number:** Form6_Other Screening Types
   Field Name: Other
   Row Name: All Rows
   Column Name: All Columns
   Year: 2011
   Field Note:
   Began screening for Cystic Fibrosis on April 1, 2008.

FORM 7

NUMBER OF INDIVIDUALS SERVED (UNDUPLICATED) UNDER TITLE V (BY CLASS OF INDIVIDUALS AND PERCENT OF HEALTH COVERAGE)

[Sec. 506(a)(2)(A)(i-ii)]

STATE: TN

Reporting Year: 2009

	TITLE V	PRIMARY SOURCES OF COVERAGE				
Types of Individuals Served	**(A) Total Served**	**(B) Title XIX %**	**(C) Title XXI %**	**(D) Private/Other %**	**(E) None %**	**(F) Unknown %**
Pregnant Women	9,808	28.1	0.1	0.1	70.9	0.3
Infants < 1 year old	82,078	69.7	0.0	0.2	59.6	0.1
Children 1 to 22 years old	264,056	40.4	0.0	0.8	58.7	0.1
Children with Special Healthcare Needs	7,275	20.9	0.0	1.2	77.9	0.0
Others	157,433	16.7	0.5	1.5	81.3	0.0
TOTAL	520,650					

FORM NOTES FOR FORM 7

None

FIELD LEVEL NOTES

1. **Section Number:** Form7_Main
   Field Name: Children_0_1_TS
   Row Name: Infants <1 year of age
   Column Name: Title V Total Served
   Year: 2011
   Field Note:
   Number of infants served under Title V includes all infants born in Tennessee, including non Tennessee residents.

FORM 8
DELIVERIES AND INFANTS SERVED BY TITLE V AND ENTITLED TO BENEFITS UNDER TITLE XIX
(BY RACE AND ETHNICITY)
[SEC. 506(A)(2)(C-D)]
STATE: TN

Reporting Year: 2009

I. UNDUPLICATED COUNT BY RACE

	(A) Total All Races	(B) White	(C) Black or African American	(D) American Indian or Native Alaskan	(E) Asian	(F) Native Hawaiian or Other Pacific Islander	(G) More than one race reported	(H) Other and Unknown
DELIVERIES								
Total Deliveries in State	82,800	59,442	16,790	205	476	41	0	5,846
Title V Served	82,800	59,442	16,790	205	476	41	0	5,846
Eligible for Title XIX	57,183	41,413	11,697	142	331	28	0	3,572
INFANTS								
Total Infants in State	80,512	60,681	17,914	201	466	40	0	1,210
Title V Served	80,512	60,681	17,914	201	466	40	0	1,210
Eligible for Title XIX	56,092	42,276	12,480	140	325	28	0	843

II. UNDUPLICATED COUNT BY ETHNICITY

				HISPANIC OR LATINO (Sub-categories by country or area of origin)				
	(A) Total NOT Hispanic or Latino	(B) Total Hispanic or Latino	(C) Ethnicity Not Reported	(B.1) Mexican	(B.2) Cuban	(B.3) Puerto Rican	(B.4) Central and South American	(B.5) Other and Unknown
DELIVERIES								
Total Deliveries in State	75,783	6,295						
Title V Served	75,783	6,295						
Eligible for Title XIX	52,798	4,385						
INFANTS								
Total Infants in State	76,441	4,071						
Title V Served	76,441	4,071						
Eligible for Title XIX	53,256	2,836						

FORM NOTES FOR FORM 8

Data Sources: TDOC Division of Health Statistics Birth Statistics System, Population Projections, PTBMIS MCH Population Data and TennCare/Medicaid Data.

The Data for Forms 7 and 8 are based on 2009 data. The data for Form 6 is based on 2008 data. Tennessee experienced a slight decrease in total births from 2008 to 2009.

FIELD LEVEL NOTES

1. **Section Number:** Form8_I. Unduplicated Count By Race
   Field Name: DeliveriesTotal_All
   Row Name: Total Deliveries in State
   Column Name: Total All Races
   Year: 2011
   Field Note:
   Data Source: TDOH Division of Health Statistics Birth Statistic System, PTBMIS MCH Population Data, and TennCare/Medicaid Data

   The data for form 8 Table I. Column A is more than 10% different than Form 6 Total Births by Occurrence because the data is for two different years, there was a decrease in total births from 2008 to 2009, and the total occurrences include all births in the state that received newborn screening and Table 8 total deliveries is data from the Birth Statistics Data.

2. **Section Number:** Form8_I. Unduplicated Count By Race
   Field Name: DeliveriesTotal_White
   Row Name: Total Deliveries in State
   Column Name: White
   Year: 2011
   Field Note:
   Notes Test

3. **Section Number:** Form8_I. Unduplicated Count By Race
   Field Name: InfantsTotal_All
   Row Name: Total Infants in State
   Column Name: Total All Races
   Year: 2011
   Field Note:
   Data Source: TDOH Division of Health Statistics Birth Statistic System, PTBMIS MCH Population Data, and TennCare/Medicaid Data

   The data for form 8 Table I. Column A is more than 10% different than Form 6 Total Births by Occurrence because the data is for two different years, there was a decrease in total births from 2008 to 2009, and the total occurrences include all births in the state that received newborn screening and Table 8 total deliveries is data from the Birth Statistics Data.

4. **Section Number:** Form8_II. Unduplicated Count by Ethnicity
   Field Name: DeliveriesTotal_TotalNotHispanic
   Row Name: Total Deliveries in State
   Column Name: Total Not Hispanic or Latino
   Year: 2011
   Field Note:
   Data not available by sub categories
   Data Source: TDOH Division of Health Statistics Population Projections, and TennCare/Medicaid Data

5. **Section Number:** Form8_II. Unduplicated Count by Ethnicity
   Field Name: DeliveriesTotal_TotalHispanic
   Row Name: Total Deliveries in State
   Column Name: Total Hispanic or Latino
   Year: 2011
   Field Note:
   Data not available by sub categories
   Data Source: TDOH Division of Health Statistics Population Projections, and TennCare/Medicaid Data

6. **Section Number:** Form8_II. Unduplicated Count by Ethnicity
   Field Name: DeliveriesTitleV_TotalNotHispanic
   Row Name: Title V Served
   Column Name: Total Not Hispanic or Latino
   Year: 2011
   Field Note:
   Data not available by sub-categories

7. **Section Number:** Form8_II. Unduplicated Count by Ethnicity
   Field Name: DeliveriesTitleV_TotalHispanic
   Row Name: Title V Served
   Column Name: Total Hispanic or Latino
   Year: 2011
   Field Note:
   Data not available by sub categories
   Data Source: TDOH Division of Health Statistics Population Projections, and TennCare/Medicaid Data

8. **Section Number:** Form8_II. Unduplicated Count by Ethnicity
   Field Name: DeliveriesTitleXIX_TotalNotHispanic
   Row Name: Eligible for Title XIX
   Column Name: Total Not Hispanic or Latino
   Year: 2011
   Field Note:
   Data not available by sub-categories
   Number eligible for Title XIX is based on actual Department of Health served under this title.

9. **Section Number:** Form8_II. Unduplicated Count by Ethnicity
   Field Name: DeliveriesTitleXIX_TotalHispanic
   Row Name: Eligible for Title XIX
   Column Name: Total Hispanic or Latino
   Year: 2011
   Field Note:
   Data not available by sub categories
   Data Source: TDOH Division of Health Statistics Population Projections, and TennCare/Medicaid Data

10. **Section Number:** Form8_II. Unduplicated Count by Ethnicity
    Field Name: InfantsTotal_TotalNotHispanic

Row Name: Total Infants in State
Column Name: Total Not Hispanic or Latino
Year: 2011
Field Note:
Data not available by sub-category

11. **Section Number:** Form8_II. Unduplicated Count by Ethnicity
Field Name: InfantsTotal_TotalHispanic
Row Name: Total Infants in State
Column Name: Total Hispanic or Latino
Year: 2011
Field Note:
Data not available by sub categories
Data Source: TDOH Division of Health Statistics Population Projections, and TennCare/Medicaid Data

12. **Section Number:** Form8_II. Unduplicated Count by Ethnicity
Field Name: InfantsTitleV_TotalNotHispanic
Row Name: Title V Served
Column Name: Total Not Hispanic or Latino
Year: 2011
Field Note:
Data not available by sub-category

13. **Section Number:** Form8_II. Unduplicated Count by Ethnicity
Field Name: InfantsTitleV_TotalHispanic
Row Name: Title V Served
Column Name: Total Hispanic or Latino
Year: 2011
Field Note:
Data not available by sub categories
Data Source: TDOH Division of Health Statistics Population Projections, and TennCare/Medicaid Data

14. **Section Number:** Form8_II. Unduplicated Count by Ethnicity
Field Name: InfantsTitleXIX_TotalNotHispanic
Row Name: Eligible for Title XIX
Column Name: Total Not Hispanic or Latino
Year: 2011
Field Note:
Data not available by sub-category

15. **Section Number:** Form8_II. Unduplicated Count by Ethnicity
Field Name: InfantsTitleXIX_TotalHispanic
Row Name: Eligible for Title XIX
Column Name: Total Hispanic or Latino
Year: 2011
Field Note:
Data not available by sub categories
Data Source: TDOH Division of Health Statistics Population Projections, and TennCare/Medicaid Data

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

	FY 2011	FY 2010	FY 2009	FY 2008	FY 2007
1. State MCH Toll-Free "Hotline" Telephone Number					
2. State MCH Toll-Free "Hotline" Name					
3. Name of Contact Person for State MCH "Hotline"					
4. Contact Person's Telephone Number					
5. Contact Person's Email					
6. Number of calls received on the State MCH "Hotline" this reporting period	0	0	0	0	0

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

	FY 2011	FY 2010	FY 2009	FY 2008	FY 2007
1. State MCH Toll-Free "Hotline" Telephone Number	(800) 428-2229	(800) 428-2229	(800) 428-2229	(800) 428-2229	(800) 428-2229
2. State MCH Toll-Free "Hotline" Name	TN Baby Line	TN Baby Line	TN Baby Line	TN Baby Line	Tn Baby Line
3. Name of Contact Person for State MCH "Hotline"	Deana Vaughn	Deana Vaughn	Deana vaughn	Deana Vaughn	Deana Vaughn
4. Contact Person's Telephone Number	(615) 741-0307	(615) 741-0370	(615) 741-0370	(615) 741-0370	(615) 741-0370
5. Contact Person's Email	Deana.Vaughn@tn.org	Deana.Vaughn@tn.gov			
6. Number of calls received on the State MCH "Hotline" this reporting period	0	0	34	22	18

FORM NOTES FOR FORM 9

None

FIELD LEVEL NOTES

None

FORM 10
TITLE V MATERNAL & CHILD HEALTH SERVICES BLOCK GRANT
STATE PROFILE FOR FY 2011
[SEC. 506(A)(1)]
STATE: TN

1. State MCH Administration:
(max 2500 characters)

Maternal and Child Health, within the Bureau of Health Services in the Tennessee Department of Health, consists of two sections. (1) Child and Adolescent Health - SIDS, Early Childhood Comprehensive Systems, Child Fatality Review, Fetal-Infant Mortality Review, Child Care Resource and Referral Centers, Childhood Lead Poisoning Prevention, services for CSHCN (called Children's Special Services and includes medical and other health needs and care coordination/case management). (2) The Women's Health/Genetics section includes comprehensive family planning services, prenatal care, adolescent pregnancy prevention, perinatal regionalization, women's health, newborn screening follow-up, newborn hearing screening follow-up, and the network of the genetics and sickle cell centers.

	Block Grant Funds
2. Federal Allocation (Line 1, Form 2)	$ 11,645,007
3. Unobligated balance (Line 2, Form 2)	$ 3,000,000
4. State Funds (Line 3, Form 2)	$ 13,250,000
5. Local MCH Funds (Line 4, Form 2)	$ 0
6. Other Funds (Line 5, Form 2)	$ 0
7. Program Income (Line 6, Form 2)	$ 5,900,000
8. Total Federal-State Partnership (Line 8, Form 2)	$ 33,795,007

9. Most significant providers receiving MCH funds:

Rural and Metro Health Departments
Genetics and Sickle Cell Centers
Community Based Agencies
Teaching Hospitals

10. Individuals served by the Title V Program (Col. A, Form 7)

a. Pregnant Women	9,808
b. Infants < 1 year old	82,078
c. Children 1 to 22 years old	264,056
d. CSHCN	7,275
e. Others	157,433

11. Statewide Initiatives and Partnerships:

a. Direct Medical Care and Enabling Services:
(max 2500 characters)

Direct services, provided statewide through health department clinics and nonprofit agencies, include pregnancy testing, family planning, nutrition services, immunizations and well child visits, EPSDT screening, follow-up and referral. All EPSDT screenings for children in state custody are done in health department clinics. Enabling services concentrate on access to care, care coordination, home visiting services, and newborn screening follow-up. In selected areas, prenatal care and primary care are available. The care coordination component of CSS provides special support and enables families to better meet their child's needs in a complex health care environment. Statewide home visiting services provide intensive services for pregnant women and families of infants and toddlers that emphasize education, parent support, infant stimulation, assessment and referral to assure that children are healthy, free from child abuse and ready for school. The HUGS home visiting program provides assistance with health care, social and educational needs. EPSDT efforts include the statewide community outreach initiative and Call Center.

b. Population-Based Services:
(max 2500 characters)

Child Fatality Teams in 31 judicial districts review all deaths of children under age 18 and make reports of recommendations for prevention efforts. The state child fatality review team reviews reports from the local teams, analyzes statistics of the incidence and causes of child deaths, and makes recommendations to the Governor and General Assembly to promote the safety and well being of children. The Childhood Lead Poisoning Prevention Program works to identify children with elevated blood lead levels and to educate citizens and health care providers, with the goal of preventing childhood lead poisoning. The Newborn Screening Program has a strong network of tertiary level providers for referral of abnormal results. Hearing screening in infants prior to hospital discharge is mandated by state statute. PRAMS is in year three of data collection with the year two report having just been released. Fetal-Infant Mortality Review teams are operational in three metro counties and one rural region.

c. Infrastructure Building Services:
(max 2500 characters)

Regional and County Health Councils operate in all 95 counties to assess needs and gaps, develop plans, seek resources, and implement strategies for action. Many of the targeted activities are for the MCH populations. The Tennessee Birth Defects Registry originated as a legislative requirement for the Tennessee Department of Health to maintain an ongoing statewide program for monitoring birth defects. The Department's Immunization Registry combines data from both the public and private sectors in an electronic format. The system permits primary care providers (PCP) to access care specific information to assure that an infant or child's immunization are up to date. Tennessee has a statewide network of Child Care Resources and Referral Centers each of which has a child care health consultant. The centers provide technical assistance, training, consultation, and resources to child care providers to improve the health and safety of child care.

12. The primary Title V Program contact person:

Name: Cathy Taylor, DrPH, MSN, RN
Title: Assistant Commissioner /Interim MCH Directot

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

Name: Jacqueline Johnson, MPA, BS
Title: Children's Special Services Program Director

Address	425 5th Avenue North, 4th Floor Cordell Hull Building	Address	425 5th Avenue North, 4th Floor Cordell Hull Building
City	Nashville	City	Nashville
State	TN	State	TN
Zip	37243	Zip	37243
Phone	615 253-3407	Phone	615 741-0361
Fax	615 532-2286	Fax	615 741-1063
Email	cathy.taylor@tn.gov	Email	jacqueline.johnson@tn.gov
Web		Web	

FORM NOTES FOR FORM 10

None

FIELD LEVEL NOTES

None

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

Form Level Notes for Form 11

None

PERFORMANCE MEASURE # 01

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

Annual Objective and Performance Data

	2005	2006	2007	2008	2009
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	176	180	164	205	153
Denominator	176	180	164	205	153
Data Source				Tennessee Newborn Screening Data system	Tennessee Newborn Screening Data system
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2010	2011	2012	2013	2014
Annual Performance Objective	100	100	100	100	100
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #1
   Field Name: PM01
   Row Name:
   Column Name:
   Year: 2009
   Field Note:
   Data source is the state of Tennessee New Born Screening data system.

2. **Section Number:** Form11_Performance Measure #1
   Field Name: PM01
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   Data source is the state of Tennessee Newborn Screening data system.

3. **Section Number:** Form11_Performance Measure #1
   Field Name: PM01
   Row Name:
   Column Name:
   Year: 2007
   Field Note:
   Data source is the state of Tennessee New Born Screening data system.

PERFORMANCE MEASURE # 02

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

Annual Objective and Performance Data

	2005	2006	2007	2008	2009
Annual Performance Objective	70	62	62	62	62
Annual Indicator	59.3	60.0	60.7	60.7	60.7
Numerator	3,703	3,807	3,381	3,522	4,415
Denominator	6,244	6,349	5,570	5,802	7,275
Data Source				CSHCN Survey	CSHCN Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2010	2011	2012	2013	2014
Annual Performance Objective	62	62	62	62	62
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #2
   Field Name: PM02
   Row Name:
   Column Name:
   Year: 2009
   Field Note:
   Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

2. **Section Number:** Form11_Performance Measure #2
   Field Name: PM02
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

3. **Section Number:** Form11_Performance Measure #2
   Field Name: PM02
   Row Name:
   Column Name:
   Year: 2007
   Field Note:
   Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

PERFORMANCE MEASURE # 03

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

Annual Objective and Performance Data

	2005	2006	2007	2008	2009
Annual Performance Objective	75	63	64	65	65
Annual Indicator	60.0	60.7	52.7	52.7	52.7
Numerator	3,746	3,857	2,935	3,058	3,833
Denominator	6,244	6,349	5,570	5,802	7,275
Data Source				CSHCN Survey	CSHCN Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2010	2011	2012	2013	2014
Annual Performance Objective	65	65	65	65	65
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #3
   Field Name: PM03
   Row Name:
   Column Name:
   Year: 2009
   Field Note:
   Indicator data come from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

2. **Section Number:** Form11_Performance Measure #3
   Field Name: PM03
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   Indicator data come from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

3. **Section Number:** Form11_Performance Measure #3
   Field Name: PM03
   Row Name:
   Column Name:
   Year: 2007
   Field Note:
   Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

PERFORMANCE MEASURE # 04

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

Annual Objective and Performance Data

	2005	2006	2007	2008	2009
Annual Performance Objective	75	64	64	69	69
Annual Indicator	62.0	61.4	67.7	67.7	67.7
Numerator	3,871	3,897	3,771	3,928	4,925
Denominator	6,244	6,349	5,570	5,802	7,275
Data Source				CSHCN Survey	CSHCN Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. ***(Explain data in a year note. See Guidance, Appendix IX.)***					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2010	2011	2012	2013	2014
Annual Performance Objective	69	70	70	70	70
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #4
   Field Name: PM04
   Row Name:
   Column Name:
   Year: 2009
   Field Note:
   Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

2. **Section Number:** Form11_Performance Measure #4
   Field Name: PM04
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

3. **Section Number:** Form11_Performance Measure #4
   Field Name: PM04
   Row Name:
   Column Name:
   Year: 2007
   Field Note:
   Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

PERFORMANCE MEASURE # 05

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

Annual Objective and Performance Data

	2005	2006	2007	2008	2009
Annual Performance Objective	90	82	82	93	93
Annual Indicator	80.0	80.8	91.8	91.8	91.8
Numerator	4,995	5,128	5,113	5,326	6,678
Denominator	6,244	6,349	5,570	5,802	7,275
Data Source				CSHCN Survey	CSHCN Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2010	2011	2012	2013	2014
Annual Performance Objective	93	93	93	93	93
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #5
   Field Name: PM05
   Row Name:
   Column Name:
   Year: 2009
   Field Note:
   Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

2. **Section Number:** Form11_Performance Measure #5
   Field Name: PM05
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

3. **Section Number:** Form11_Performance Measure #5
   Field Name: PM05
   Row Name:
   Column Name:
   Year: 2007
   Field Note:
   Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

PERFORMANCE MEASURE # 06

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

Annual Objective and Performance Data

	2005	2006	2007	2008	2009
Annual Performance Objective	50	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	1,561	1,561	1,534	1,245	1,694
Denominator	1,561	1,561	1,534	1,245	1,694
Data Source				CSHCN Survey	CSHCN Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. ***(Explain data in a year note. See Guidance, Appendix IX.)***					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2010	2011	2012	2013	2014
Annual Performance Objective	100	100	100	100	100
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #6
   Field Name: PM06
   Row Name:
   Column Name:
   Year: 2009
   Field Note:
   Data source is the National CSHCN Survey.

2. **Section Number:** Form11_Performance Measure #6
   Field Name: PM06
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   Data source is the National CSHCN Survey.

3. **Section Number:** Form11_Performance Measure #6
   Field Name: PM06
   Row Name:
   Column Name:
   Year: 2007
   Field Note:
   Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

PERFORMANCE MEASURE # 07

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

Annual Objective and Performance Data

	2005	2006	2007	2008	2009
Annual Performance Objective	95	81	83	88	88
Annual Indicator	79.1	86.7	86.7	83.0	83.0
Numerator	90,761	1,300	1,300	278	278
Denominator	114,731	1,500	1,500	335	335
Data Source				NIS Survey	NIS Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2010	2011	2012	2013	2014
Annual Performance Objective	88	88	88	88	88
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #7
   Field Name: PM07
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   Data source is the 2008 NIS. Sample size (completing household interviews and with adequate provider data = 335) for Tennessee is small, confidence intervals are wide.

2. **Section Number:** Form11_Performance Measure #7
   Field Name: PM07
   Row Name:
   Column Name:
   Year: 2007
   Field Note:
   The data reported in 2007 are pre-populated with the data from 2006 and the CDC Immunization survey and is based on survey sample size for this performance measure.

PERFORMANCE MEASURE # 08

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

Annual Objective and Performance Data

	2005	2006	2007	2008	2009
Annual Performance Objective	23	27	26.5	26.5	26
Annual Indicator	27.5	28.6	27.8	27.3	24.0
Numerator	3,229	3,392	3,361	3,328	2,953
Denominator	117,523	118,599	120,852	122,020	123,216
Data Source				TDH Hlth. Stats. Pop. Proj. & Birth Stat. Syst.	TDH Hlth. Stats. Pop. Proj. & Birth Stat. Syst.
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. ***(Explain data in a year note. See Guidance, Appendix IX.)***					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2010	2011	2012	2013	2014
Annual Performance Objective	24	24	24	24	24
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #8
   Field Name: PM08
   Row Name:
   Column Name:
   Year: 2009
   Field Note:
   Data from Tennessee Department of Health Division of Health Statstics Population Projections and Birth Statistical System

2. **Section Number:** Form11_Performance Measure #8
   Field Name: PM08
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   Data from TDH Division of Health Statistics Population Projections and Birth Statistical System

3. **Section Number:** Form11_Performance Measure #8
   Field Name: PM08
   Row Name:
   Column Name:
   Year: 2007
   Field Note:
   The data reported in 2007 are pre-populated with the data from 2007 population estimates and the Tennessee Birth Master file for this performance measure.

PERFORMANCE MEASURE # 09

Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

Annual Objective and Performance Data

	2005	2006	2007	2008	2009
Annual Performance Objective	25	23	23	24	40
Annual Indicator	21.9	22.3	21.8	37.2	37.2
Numerator	71,961	75,789	3,769	366	366
Denominator	329,279	339,485	17,256	983	983
Data Source				Tennessee Oral Health Survey	Tennessee Oral Health Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2010	2011	2012	2013	2014
Annual Performance Objective	40	40	40	40	40
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #9
   Field Name: PM09
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   Data source is the 2008 Tennessee Oral Health Survey of children ages 5 - 11 years.

2. **Section Number:** Form11_Performance Measure #9
   Field Name: PM09
   Row Name:
   Column Name:
   Year: 2007
   Field Note:
   Thses data are from the Tennessee (Patient Tracking Billing Medical Informatin System) PTBMIS Database.

PERFORMANCE MEASURE # 10

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

Annual Objective and Performance Data

	2005	2006	2007	2008	2009
Annual Performance Objective	3	3	2.5	2.5	2
Annual Indicator	4.0	5.4	3.9	3.4	2.2
Numerator	48	65	47	41	27
Denominator	1,204,737	1,210,629	1,194,718	1,201,009	1,207,621
Data Source				TDH Div. Hlth. Stats. Pop. Proj. & Death Stat. Sys	TDH Div. Hlth. Stats. Pop. Proj. & Death Stat. Sys
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. ***(Explain data in a year note. See Guidance, Appendix IX.)***					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2010	2011	2012	2013	2014
Annual Performance Objective	2	2	2	2	2
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #10
   Field Name: PM10
   Row Name:
   Column Name:
   Year: 2009
   Field Note:
   Data Source: Tennessee Department of Health Divsion of Health Statistics Population Projections and Death Statistical System

2. **Section Number:** Form11_Performance Measure #10
   Field Name: PM10
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   Data source: TDH Divsion of Health Statistics Population Projections and Death Statistical System

3. **Section Number:** Form11_Performance Measure #10
   Field Name: PM10
   Row Name:
   Column Name:
   Year: 2007
   Field Note:
   The data reported in 2007 are pre-populated with the data from 2007 population estimates and the Tennessee Death Master file for this performance measure.

PERFORMANCE MEASURE # 11

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

Annual Objective and Performance Data

	2005	2006	2007	2008	2009
Annual Performance Objective		32	34	36	30
Annual Indicator	29.3	28.0	31.4	37.9	37.9
Numerator	440	420	14,705	31,952	31,952
Denominator	1,500	1,500	46,777	84,308	84,308
Data Source				CDC/National immunization Survey	CDC National Immunization Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. ***(Explain data in a year note. See Guidance, Appendix IX.)***					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2010	2011	2012	2013	2014
Annual Performance Objective	40	45	50	50	55
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #11
   Field Name: PM11
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   Data source:
   National Immunization Survey. Per the CDC NIS, the data from the NIS are provisional for the 2006 birth cohort used in this survey until final estimates are available August 2010. (We have marked "final" for the purpose of this report)
   Tennessee live births 2006: TDH Office of Policy, Planning, and Assessment, Divsion of Health Statistics

2. **Section Number:** Form11_Performance Measure #11
   Field Name: PM11
   Row Name:
   Column Name:
   Year: 2007
   Field Note:
   The data reported in 2007 are pre-populated with the data from 2007 population estimates and the CDC Nutrition Surveilance file for this performance measure.

PERFORMANCE MEASURE # 12

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

Annual Objective and Performance Data

	2005	2006	2007	2008	2009
Annual Performance Objective	98	98	98	98	98
Annual Indicator	97.0	88.9	91.1	94.2	97.8
Numerator	79,010	80,173	83,570	85,613	85,231
Denominator	81,454	90,155	91,754	90,885	87,146
Data Source				TN Newborn Screening Database	TN Newborn Screening Database
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2010	2011	2012	2013	2014
Annual Performance Objective	98	98	99	99	99
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #12
   Field Name: PM12
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   Data source is the 2008 newborn screening database and data includes births that are Tennessee residents and non Tennessee Residents.

2. **Section Number:** Form11_Performance Measure #12
   Field Name: PM12
   Row Name:
   Column Name:
   Year: 2007
   Field Note:
   Data source is the 2007 nenborn screening database and data includes births that are Tennessee residents and non residents.

PERFORMANCE MEASURE # 13

Percent of children without health insurance.

Annual Objective and Performance Data

	2005	2006	2007	2008	2009
Annual Performance Objective	7	6	6	6	6
Annual Indicator	6.4	6.4	6.4	4.9	3.7
Numerator	97,933	97,933	88,283	72,258	54,759
Denominator	1,530,196	1,530,196	1,386,911	1,474,653	1,479,972
Data Source				UT CBER	UT CBER
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2010	2011	2012	2013	2014
Annual Performance Objective	3	3	3	3	3
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #13
   Field Name: PM13
   Row Name:
   Column Name:
   Year: 2009
   Field Note:
   Data Source: University of Tennessee Center for Business and Economic Research "The Impact of Tenn Care: A Survey of Recipients 2009. August, 2009

2. **Section Number:** Form11_Performance Measure #13
   Field Name: PM13
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   Data source is the University of Tennessee Center for Business and Economic Research "The Impact of TennCare: A Survey of Recipients August, 2009

3. **Section Number:** Form11_Performance Measure #13
   Field Name: PM13
   Row Name:
   Column Name:
   Year: 2007
   Field Note:
   Data source is National Survey of Children's Health.
   93.6 % of children had health insurance according to the survey (WWW.nschdata.org)

PERFORMANCE MEASURE # 14

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

Annual Objective and Performance Data

	2005	2006	2007	2008	2009
Annual Performance Objective		9	9	30	14
Annual Indicator	10.3	24.2	34.0	28.7	29.4
Numerator	20,474	22,265	53,971	19,807	21,143
Denominator	197,847	92,164	158,733	69,015	71,914
Data Source				TN. State WIC Database	State WIC database
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2010	2011	2012	2013	2014
Annual Performance Objective	25	25	25	22	22
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #14
   Field Name: PM14
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   The numbers used in last year's 2008 report were for only a 6 month period due to CDC having problems with changes in their analytical program. The correct values were recently made available and are corrected here as final.

2. **Section Number:** Form11_Performance Measure #14
   Field Name: PM14
   Row Name:
   Column Name:
   Year: 2007
   Field Note:
   Data source is the State WIC database and is the calendar year data. Variation is due to calendar year data, decrease in the the total number of children within the age group of 2-5 years receiving WIC. Data categories may include children under the age of 2 years to 5 years.

PERFORMANCE MEASURE # 15

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

Annual Objective and Performance Data

	2005	2006	2007	2008	2009
Annual Performance Objective		9.7	9	7.5	13
Annual Indicator	16.2	15.8	19.4	15.4	15.3
Numerator	13,158	13,288	16,774	13,138	12,525
Denominator	81,454	84,277	86,558	85,480	82,078
Data Source				TN Birth Statistical System	TN Birth Statistical System
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. ***(Explain data in a year note. See Guidance, Appendix IX.)***					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2010	2011	2012	2013	2014
Annual Performance Objective	13	13	13	13	12
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #15
   Field Name: PM15
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   Data source: 2008 Tennessee Department of Health, Health Statistics Birth Statistical system.

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

2. **Section Number:** Form11_Performance Measure #15
   Field Name: PM15
   Row Name:
   Column Name:
   Year: 2007
   Field Note:
   Data source is the State vital records

PERFORMANCE MEASURE # 16

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

Annual Objective and Performance Data

	2005	2006	2007	2008	2009
Annual Performance Objective	6	6	6	5.2	5
Annual Indicator	7.5	8.7	6.9	5.6	7.4
Numerator	31	36	29	24	32
Denominator	411,299	414,947	422,058	426,040	430,127
Data Source				TDH Div. Hlth. Stats. Pop. Proj. & Death Stat. Sys	TDH Div. Hlth. Stats. Pop. Proj. & Death Stat. Sys
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. ***(Explain data in a year note. See Guidance, Appendix IX.)***					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2010	2011	2012	2013	2014
Annual Performance Objective	5	5	5	5	5
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #16
   Field Name: PM16
   Row Name:
   Column Name:
   Year: 2009
   Field Note:
   Data source: Tennessee Department of Health
   Divsion of health Statistics
   Population Projections and Death Statistical System

2. **Section Number:** Form11_Performance Measure #16
   Field Name: PM16
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   Data source: 2008 Tennessee Department of Health Division of Health Statistics
   Population Projections and Death Statistical system

3. **Section Number:** Form11_Performance Measure #16
   Field Name: PM16
   Row Name:
   Column Name:
   Year: 2007
   Field Note:
   Data source is the State vital records registry.

PERFORMANCE MEASURE # 17

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

Annual Objective and Performance Data

	2005	2006	2007	2008	2009
Annual Performance Objective	80	80	80	80	70
Annual Indicator	68.0	69.3	68.5	80.7	79.5
Numerator	922	1,045	1,036	1,112	1,083
Denominator	1,356	1,508	1,513	1,378	1,362
Data Source				TN Birth Statistical System	TN Birth Statistical System
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. ***(Explain data in a year note. See Guidance, Appendix IX.)***					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2010	2011	2012	2013	2014
Annual Performance Objective	80	80	80	80	80
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #17
   Field Name: PM17
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   Data source: 2008 Tennessee Department of Health
   Division of Health Statistics
   Birth Statistical System.

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

2. **Section Number:** Form11_Performance Measure #17
   Field Name: PM17
   Row Name:
   Column Name:
   Year: 2007
   Field Note:
   Data source is the State vital records registry.

PERFORMANCE MEASURE # 18

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

Annual Objective and Performance Data

	2005	2006	2007	2008	2009
Annual Performance Objective	90	90	90	90	70
Annual Indicator	60.4	62.5	63.7	67.7	69.1
Numerator	49,163	52,684	55,134	54,765	53,453
Denominator	81,454	84,277	86,558	80,887	77,408
Data Source				TN Birth Statistical System	TN Birth Statistical System
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2010	2011	2012	2013	2014
Annual Performance Objective	70	80	80	90	90
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #18
   Field Name: PM18
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   Data source: 2008 Tennessee Department of Health
   Division of Health Statistics
   Birth Statistical System

2. **Section Number:** Form11_Performance Measure #18
   Field Name: PM18
   Row Name:
   Column Name:
   Year: 2007
   Field Note:
   Data source is the State vital records registry.The data is estimated.

   2010
   Addendum.
   2007 was not finalized previously.
   Update/final per TDH Divsion of Health Statistics Birth Statistical System:
   55266/82538 = 67.0

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

Form Level Notes for Form 11

None

STATE PERFORMANCE MEASURE # 1 - REPORTING YEAR

Reduce the percentage of high school students using tobacco (cigarettes and smokeless tobacco).

Annual Objective and Performance Data

	2005	2006	2007	2008	2009
Annual Performance Objective		28	28	26	26
Annual Indicator	25.0	25.0	25.0	32.8	30.1
Numerator	385	385	385	649	642
Denominator	1,540	1,540	1,540	1,980	2,135
Data Source				2007 Youth Risk Behavior Survey	2009 YRBS
Is the Data Provisional or Final?				Final	Final

Annual Objective and Performance Data

	2010	2011	2012	2013	2014
Annual Performance Objective	26	26	26	26	
Annual Indicator	Future year objectives for state performance measures from needs assessment period 2006-2010 are view-only. If you are continuing any of these measures in the new needs assessment period, you may establish objectives for those measures on Form 11 for the new needs assessment period.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_State Performance Measure #1
   Field Name: SM1
   Row Name:
   Column Name:
   Year: 2009
   Field Note:
   Data source: Tn 2009 YRBS
   Percentage of students who smoked cigarettes, or cigars, or used chewing tobacco, snuff, or dip on one or more of the past 30 days.

2. **Section Number:** Form11_State Performance Measure #1
   Field Name: SM1
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   Data source for 2008: 2007 Youth Risk Behavior Survey
   Discrepancy noted in the question that was used from previous years "Have you ever smoked cigarettes daily, that is at least one cigaretted every day for 30 days?"
   When the performance measure, and the state detail sheet was for any form of tobacco use..
   2008 was updated to reflect the correct question about use of cigarettes, cigars, chewing tobacco, snuff or dip on one or more of the past 30 days.

3. **Section Number:** Form11_State Performance Measure #1
   Field Name: SM1
   Row Name:
   Column Name:
   Year: 2007
   Field Note:
   Data source is the Tennessee YRBSS conducted by Tennessee Department of Education.
   2005 Youth Behaviorial Risk Surveillance Survey (YRBSS) was used for 2007 data.

STATE PERFORMANCE MEASURE # 2 - REPORTING YEAR

Reduce the percentage of high school students using alcohol.

Annual Objective and Performance Data

	2005	2006	2007	2008	2009
Annual Performance Objective		36	36	34	34
Annual Indicator	41.8	41.8	41.8	36.7	33.5
Numerator	643	643	644	700	679
Denominator	1,540	1,540	1,540	1,909	2,027
Data Source				2007 Youth Risk Behavior Survey	2009 YRBS
Is the Data Provisional or Final?				Final	Final

Annual Objective and Performance Data

	2010	2011	2012	2013	2014
Annual Performance Objective	34	34	34	34	
Annual Indicator	Future year objectives for state performance measures from needs assessment period 2006-2010 are view-only. If you are continuing any of these measures in the new needs assessment period, you may establish objectives for those measures on Form 11 for the new needs assessment period.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_State Performance Measure #2
   Field Name: SM2
   Row Name:
   Column Name:
   Year: 2009
   Field Note:
   2009 Tennessee YRBS

2. **Section Number:** Form11_State Performance Measure #2
   Field Name: SM2
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   2007 Youth Risk Behavior Survey

3. **Section Number:** Form11_State Performance Measure #2
   Field Name: SM2
   Row Name:
   Column Name:
   Year: 2007
   Field Note:
   Data source is the Tennessee YRBSS conducted by Tennessee Department of Education
   2005 Youth Behaviorial Risk Surveillance Survey (YRBSS) was used to estimate year 2007

STATE PERFORMANCE MEASURE # 3 - REPORTING YEAR

Reduce the incidence of maltreatment of children younger than age 18 including physical, sexual, emotional abuse and neglect to a rate no more than 8 per 1,000.

Annual Objective and Performance Data

	2005	2006	2007	2008	2009
Annual Performance Objective	7	7	7	7	7
Annual Indicator	11.4	10.7	8.3	7.4	7.4
Numerator	17,500	17,500	13,528	10,235	10,235
Denominator	1,530,196	1,635,539	1,635,539	1,390,522	1,390,522
Data Source				Tennessee Dept. of Children's Services	Tennessee Dept. of Children's Services
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2010	2011	2012	2013	2014
Annual Performance Objective	7	7	7	7	
Annual Indicator	Future year objectives for state performance measures from needs assessment period 2006-2010 are view-only. If you are continuing any of these measures in the new needs assessment period, you may establish objectives for those measures on Form 11 for the new needs assessment period.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_State Performance Measure #3
   Field Name: SM3
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   Data source : Tennessee Dept. of Children's Services

2. **Section Number:** Form11_State Performance Measure #3
   Field Name: SM3
   Row Name:
   Column Name:
   Year: 2007
   Field Note:
   Reports from the Tennessee Department of Children's Services Child Protective Services Section.

STATE PERFORMANCE MEASURE # 4 - REPORTING YEAR

Increase percentage of children with complete EPSDT annual examinations by 3 percent each year.

Annual Objective and Performance Data

	2005	2006	2007	2008	2009
Annual Performance Objective	80	89	90	92	92
Annual Indicator	88.1	88.2	73.3	94.0	96.3
Numerator	663,876	664,879	597,536	734,396	787,793
Denominator	753,474	753,982	814,643	781,636	818,335
Data Source				TennCare EPSDT data system	TennCare EPSDT data system
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2010	2011	2012	2013	2014
Annual Performance Objective	95	95	95	95	
Annual Indicator	Future year objectives for state performance measures from needs assessment period 2006-2010 are view-only. If you are continuing any of these measures in the new needs assessment period, you may establish objectives for those measures on Form 11 for the new needs assessment period.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_State Performance Measure #4
   Field Name: SM4
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   Data source is the state of Tennessee TennCare EPSDT Data system.

2. **Section Number:** Form11_State Performance Measure #4
   Field Name: SM4
   Row Name:
   Column Name:
   Year: 2007
   Field Note:
   Data source is the state of Tennessee TennCare EPSDT Data system.
   Data is 1 year late due to TennCare EPSDT reports.

STATE PERFORMANCE MEASURE # 5 - REPORTING YEAR

Reduce the proportion of teens and young adults ages 15 to 24 with chlamydia trachomatis infections attending family planning clinics

Annual Objective and Performance Data

	2005	2006	2007	2008	2009
Annual Performance Objective	5.2	5.2	5.2	5.2	5.2
Annual Indicator	6.9	6.3	6.5	6.2	5.7
Numerator	1,985	1,720	1,578	1,543	1,369
Denominator	28,890	27,346	24,334	25,073	23,876
Data Source				State of Tennessee Infertility Prevention Project	State of Tennessee Infertility Prevention Project
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2010	2011	2012	2013	2014
Annual Performance Objective	5.2	5.2	5.2	5.2	
Annual Indicator	Future year objectives for state performance measures from needs assessment period 2006-2010 are view-only. If you are continuing any of these measures in the new needs assessment period, you may establish objectives for those measures on Form 11 for the new needs assessment period.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_State Performance Measure #5
   Field Name: SM5
   Row Name:
   Column Name:
   Year: 2009
   Field Note:
   This is Calendar Year Data
   Source: State of Tennessee Infertility Prevention Project Data System.

2. **Section Number:** Form11_State Performance Measure #5
   Field Name: SM5
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   This is calendar year data
   Source: State of Tennessee Infertility prevention project data system.

3. **Section Number:** Form11_State Performance Measure #5
   Field Name: SM5
   Row Name:
   Column Name:
   Year: 2007
   Field Note:
   Data source is the Tennessee Department of Health.
   Data source is the State of Tennessee STD infertility project data system

STATE PERFORMANCE MEASURE # 6 - REPORTING YEAR

Reduce the number of babies born prematurely.

Annual Objective and Performance Data

	2005	2006	2007	2008	2009
Annual Performance Objective		12	11	10	10
Annual Indicator	12.7	12.4	11.7	11.5	11.3
Numerator	10,241	10,454	10,162	9,818	9,227
Denominator	80,583	84,277	86,558	85,320	81,669
Data Source				TDH Div. Hlth. Stats Birth Stat. Sys	TDH Div. Hlth. Stats. Birth Stat. Syst.
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2010	2011	2012	2013	2014
Annual Performance Objective	10	10	10	10	
Annual Indicator	Future year objectives for state performance measures from needs assessment period 2006-2010 are view-only. If you are continuing any of these measures in the new needs assessment period, you may establish objectives for those measures on Form 11 for the new needs assessment period.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_State Performance Measure #6
   Field Name: SM6
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   TDH Div. Health Statistics Birth Statistical System (Tennessee residents only).
   Preterm defined as gestation 17-36 weeks.

2. **Section Number:** Form11_State Performance Measure #6
   Field Name: SM6
   Row Name:
   Column Name:
   Year: 2007
   Field Note:
   Data source is the Tennessee Department of Health.
   Data source is the State of Tennessee provisional birth master files, Tennessee residents only.

STATE PERFORMANCE MEASURE # 7 - REPORTING YEAR

Increase percentage of adolescents with complete Early Periodic Screening, Diagnosis and Treatment(EPSDT) annual examinations by 5% each year.

Annual Objective and Performance Data

	2005	2006	2007	2008	2009
Annual Performance Objective		50	50	60	65
Annual Indicator	10.3	9.7	39.4	49.6	49.6
Numerator	62,000	58,313	117,570	139,597	145,776
Denominator	600,000	600,000	298,233	281,670	293,963
Data Source				TennCare EPSDT data system	TennCare EPSDT data system
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2010	2011	2012	2013	2014
Annual Performance Objective	65	65	65	65	
Annual Indicator	Future year objectives for state performance measures from needs assessment period 2006-2010 are view-only. If you are continuing any of these measures in the new needs assessment period, you may establish objectives for those measures on Form 11 for the new needs assessment period.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_State Performance Measure #7
   Field Name: SM7
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   Data source is the state of Tennessee TennCare EPSDT Data system.
   Teens defined by TennCare are 10-18 years of age

2. **Section Number:** Form11_State Performance Measure #7
   Field Name: SM7
   Row Name:
   Column Name:
   Year: 2007
   Field Note:
   Data source is the State of Tennessee EPSDT data System and the Tennessee TennCare data.
   Data includes Children age 10-18 years and the data is based on FY 2005-2006

STATE PERFORMANCE MEASURE # 9 - REPORTING YEAR

Reduce the number of overweight and obese children and adolescents.

Annual Objective and Performance Data

	2005	2006	2007	2008	2009
Annual Performance Objective		30	30	30	29
Annual Indicator	31.9	31.9	39.9	40.9	39.0
Numerator	491	491	615	194,814	191,090
Denominator	1,540	1,540	1,540	476,318	489,975
Data Source				TDE CSH	TDE CSH
Is the Data Provisional or Final?				Final	Final

Annual Objective and Performance Data

	2010	2011	2012	2013	2014
Annual Performance Objective	25	25	25	25	
Annual Indicator	Future year objectives for state performance measures from needs assessment period 2006-2010 are view-only. If you are continuing any of these measures in the new needs assessment period, you may establish objectives for those measures on Form 11 for the new needs assessment period.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_State Performance Measure #9
   Field Name: SM9
   Row Name:
   Column Name:
   Year: 2009
   Field Note:
   Tennessee Department of Education Coordinated School Health Program BMI measurements K-12 students 2008-2009 school year.

2. **Section Number:** Form11_State Performance Measure #9
   Field Name: SM9
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   Source:
   Tennessee Department of Education Coordinated School Health Program BMI measurements K-12 students 2007-2008 school year

3. **Section Number:** Form11_State Performance Measure #9
   Field Name: SM9
   Row Name:
   Column Name:
   Year: 2007
   Field Note:
   Data source is the Tennessee YRBSS conducted by Tennessee Department of Education 2005 Youth Behaviorial Risk Surveillance Survey (YRBSS) was used.

STATE PERFORMANCE MEASURE # 10 - REPORTING YEAR

Increase the percentage of youth with special health care needs, age 14 and older, who receive formal plans for transition to adulthood.

Annual Objective and Performance Data

	2005	2006	2007	2008	2009
Annual Performance Objective		100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	1,234	1,234	1,534	1,245	1,694
Denominator	1,234	1,234	1,534	1,245	1,694
Data Source				CSHCN Survey	CSHCN Survey
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2010	2011	2012	2013	2014
Annual Performance Objective	100	100	100	100	
Annual Indicator	Future year objectives for state performance measures from needs assessment period 2006-2010 are view-only. If you are continuing any of these measures in the new needs assessment period, you may establish objectives for those measures on Form 11 for the new needs assessment period.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_State Performance Measure #10
   Field Name: SM10
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   Data source is the National CSHCN Survey.

2. **Section Number:** Form11_State Performance Measure #10
   Field Name: SM10
   Row Name:
   Column Name:
   Year: 2007
   Field Note:
   Data source is the State of Tennessee CSS data system

FORM 12
TRACKING HEALTH OUTCOME MEASURES
[SECS 505 (A)(2)(B)(III) AND 506 (A)(2)(A)(III)]
STATE: TN

Form Level Notes for Form 12

None

OUTCOME MEASURE # 01

The infant mortality rate per 1,000 live births.

Annual Objective and Performance Data

	2005	2006	2007	2008	2009
Annual Performance Objective	7.5	7.5	7.5	7.5	7.5
Annual Indicator	8.7	8.7	8.2	8.0	7.9
Numerator	712	729	709	686	646
Denominator	81,454	84,277	86,558	85,480	82,078
Data Source				TDH Div. Hlth. Stats Birth & Death Stat. Sys	TDH Div. Hlth. Stats Birth & Death Stat. Sys
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2010	2011	2012	2013	2014
Annual Performance Objective	7.5	7	7	7	7
Annual Indicator					
Numerator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Denominator					

Field Level Notes

1. **Section Number:** Form12_Outcome Measure 1
   Field Name: OM01
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   Tennessee Department of Health Division of Health Statistics Birth and Death Statistical System

2. **Section Number:** Form12_Outcome Measure 1
   Field Name: OM01
   Row Name:
   Column Name:
   Year: 2007
   Field Note:
   Data source is state of Tennessee vital records(Tennessee Resident only)

OUTCOME MEASURE # 02

The ratio of the black infant mortality rate to the white infant mortality rate.

Annual Objective and Performance Data

	2005	2006	2007	2008	2009
Annual Performance Objective	2.1	2.1	2.1	2.1	2.1
Annual Indicator	2.2	2.3	2.4	2.5	2.7
Numerator	17.5	16.7	16.4	15	16.3
Denominator	8.1	7.4	6.9	6.1	6
Data Source				TDH Div. Hlth. Stats. Pop. Proj. & Death Stat. Sys	TDH Div. Hlth. Stats. Pop. Proj. & Death Stat. Sys
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2010	2011	2012	2013	2014
Annual Performance Objective	2.1	2.1	2.1	2.1	2.1
Annual Indicator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form12_Outcome Measure 2
   Field Name: OM02
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   Tennessee Department of Health Divsion of Health Statististics Birth and Death Statistical System

2. **Section Number:** Form12_Outcome Measure 2
   Field Name: OM02
   Row Name:
   Column Name:
   Year: 2007
   Field Note:
   Data source is state of Tennessee vital records(Tennessee Resident only)

OUTCOME MEASURE # 03

The neonatal mortality rate per 1,000 live births.

Annual Objective and Performance Data

	2005	2006	2007	2008	2009
Annual Performance Objective	4.3	4.3	4.3	4.3	4.3
Annual Indicator	5.6	5.8	5.1	4.9	4.6
Numerator	455	487	440	420	381
Denominator	81,454	84,277	86,558	85,480	82,078
Data Source				TDH Div. Hlth. Stats Birth & Death Stat. Sys	TDH Div. Hlth. Stats Birth & Death Stat. Sys
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. ***(Explain data in a year note. See Guidance, Appendix IX.)***					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2010	2011	2012	2013	2014
Annual Performance Objective	4.3	4.3	4.3	4.3	4.3
Annual Indicator					
Numerator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Denominator					

Field Level Notes

1. **Section Number:** Form12_Outcome Measure 3
   Field Name: OM03
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   Tennessee Department of Health Division of Health Statistics Birth and Death Statistical Systems

2. **Section Number:** Form12_Outcome Measure 3
   Field Name: OM03
   Row Name:
   Column Name:
   Year: 2007
   Field Note:
   Data source is state of Tennessee vital records(Tennessee Resident only)

OUTCOME MEASURE # 04

The postneonatal mortality rate per 1,000 live births.

Annual Objective and Performance Data

	2005	2006	2007	2008	2009
Annual Performance Objective	2.6	2.6	2.6	2.6	2.6
Annual Indicator	3.2	2.9	3.1	3.1	3.2
Numerator	257	242	269	266	265
Denominator	81,454	84,277	86,558	85,480	82,078
Data Source				TDH Div. Hlth. Stats Birth & Death Stat. Sys	TDH Div. Hlth. Stat. Birth & Death Stat. Syst.
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. ***(Explain data in a year note. See Guidance, Appendix IX.)***					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2010	2011	2012	2013	2014
Annual Performance Objective	2.6	2.6	2.6	2.6	2.6
Annual Indicator					
Numerator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Denominator					

Field Level Notes

1. **Section Number:** Form12_Outcome Measure 4
   Field Name: OM04
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   2008 TN. Provisional Death files (TN Resident only).
   2008 TN. Provisional Birth Master files (TN resident only).

2. **Section Number:** Form12_Outcome Measure 4
   Field Name: OM04
   Row Name:
   Column Name:
   Year: 2007
   Field Note:
   Data source is state of Tennessee vital records(Tennessee Resident only)

OUTCOME MEASURE # 05

The perinatal mortality rate per 1,000 live births plus fetal deaths.

Annual Objective and Performance Data

	2005	2006	2007	2008	2009
Annual Performance Objective	8.3	8	8	8	8
Annual Indicator	10.3	8.7	9.9	6.9	6.5
Numerator	839	729	861	594	539
Denominator	81,847	84,277	87,076	85,759	82,325
Data Source				TDH Div. Hlth. Stat. Birth, Death & Fetal Death St	TDH Div. Hlth. Stat. Birth, Death & Fetal Death St
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. ***(Explain data in a year note. See Guidance, Appendix IX.)***					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2010	2011	2012	2013	2014
Annual Performance Objective	8	8	7.5	7.5	7
Annual Indicator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form12_Outcome Measure 5
   Field Name: OM05
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   Tennessee Department of Health Division of Birth, Death, and Fetal Death Statistical System
   Updated methodology per Guidance:
   Numerator
   Number of fetal deaths 28 weeks or more gestation plus early neonatal deaths occurring under 7 days
   Denominator
   Live births plus fetal deaths

2. **Section Number:** Form12_Outcome Measure 5
   Field Name: OM05
   Row Name:
   Column Name:
   Year: 2007
   Field Note:
   Tennessee Department of Health Birth, Death, and Fetal Death Statistical System
   Correction/revision due to methodological differences in calculation.
   Current method used Guidance direction:
   Numerator
   Number of fetal deaths 28 weeks ormore gestational plus early neonatal deaths occurring under 7 days
   Denominator
   Live births plus fetal deaths

   2007 actual final 633/869555 = 7.3

OUTCOME MEASURE # 06

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

Annual Objective and Performance Data

	2005	2006	2007	2008	2009
Annual Performance Objective	20	20	15	15	15
Annual Indicator	22.1	21.7	20.1	21.6	18.0
Numerator	249	245	224	242	203
Denominator	1,124,607	1,130,488	1,114,294	1,120,539	1,127,109
Data Source				TDH Div. Hlth. Stat Population Proj. & Death Stat.	TDH Div. Hlth. Stat Population Proj. & Death Stat.
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. ***(Explain data in a year note. See Guidance, Appendix IX.)***					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2010	2011	2012	2013	2014
Annual Performance Objective	15	15	15	15	15
Annual Indicator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form12_Outcome Measure 6
   Field Name: OM06
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   Tennessee Department of Health Division of Health Statistics Population Projections and Death Statistical System

2. **Section Number:** Form12_Outcome Measure 6
   Field Name: OM06
   Row Name:
   Column Name:
   Year: 2007
   Field Note:
   Data source is state of Tennessee vital records

FORM 12
TRACKING HEALTH OUTCOME MEASURES
[SECS 505 (A)(2)(B)(III) AND 506 (A)(2)(A)(III)]
STATE: TN

Form Level Notes for Form 12

None

FORM 13
CHARACTERISTICS DOCUMENTING FAMILY PARTICIPATION IN CSHCN PROGRAMS
STATE: TN

1. Family members participate on advisory committee or task forces and are offering training, mentoring, and reimbursement, when appropriate.

3

2. Financial support (financial grants, technical assistance, travel, and child care) is offered for parent activities or parent groups.

3

3. Family members are involved in the Children with Special Health Care Needs elements of the MCH Block Grant Application process.

3

4. Family members are involved in service training of CSHCN staff and providers.

3

5. Family members hired as paid staff or consultants to the State CSHCN program (a family member is hired for his or her expertise as a family member).

0

6. Family members of diverse cultures are involved in all of the above activities.

3

Total Score: 15

Rating Key
0 = Not Met
1 = Partially Met
2 = Mostly Met
3 = Completely Met

FORM NOTES FOR FORM 13

None

FIELD LEVEL NOTES

None

FORM 14
LIST OF MCH PRIORITY NEEDS

[Sec. 505(a)(5)]

STATE: TN FY: 2011

Your State's 5-year Needs Assessment should identify the need for preventive and primary care services for pregnant women, mothers, and infants; preventive and primary care services for children and services for Children with Special Health Care Needs. With each year's Block Grant application, provide a list (whether or not the priority needs change) of the top maternal and child health needs in your state. Using simple sentence or phrase ,list below your State's needs. Examples of such statements are: "To reduce the barriers to the delivery of care for pregnant women, " and "The infant mortality rate for minorities should be reduced."

MCHB will capture annually every State's top 7 to 10 priority needs in an information system for comparison, tracking, and reporting purposes; you must list at least 7 and no more than 10. Note that the numbers listed below are for computer tracking only and are not meant to indicate priority order. If your State wishes to report more than 10 priority needs, list additional priority needs in a note at the form level.

1. Reduce the infant mortality rate
2. Reduce the percentage of obesity and overweight (BMI for age/gender greater than or equal to the 85th percentile) among Tennessee K-12 students
3. Reduce smoking in Tennesseans age 13 years and older
4. Decrease asthma hospitalizations for children 0-5 years
5. Improve MCH workforce capacity and competency by designing and implementing a workforce development program
6. Increase the percentage of youth with special health care needs age 14 and older who have formal plans for transition to adulthood
7. Reduce unintentional injury deaths in children and young people ages 0-24
8.
9.
10.

FORM NOTES FOR FORM 14

None

FIELD LEVEL NOTES

None

FORM 15
TECHNICAL ASSISTANCE(TA) REQUEST

STATE: TN **APPLICATION YEAR: 2011**

No.	Category of Technical Assistance Requested	Description of Technical Assistance Requested *(max 250 characters)*	Reason(s) Why Assistance Is Needed *(max 250 characters)*	What State, Organization or Individual Would You suggest Provide the TA (if known) *(max 250 characters)*
1.	**General Systems Capacity Issues** If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here: N/A	Assistance is needed in determining the best methods to provide expenditures by the four levels of the Pyramid.	A variety of methods are used by Region IV States to provide this information. Comparability is not possible across states. Assistance requested to develop instructions for the states on compiling this information.	MCHB
2.	**State Performance Measure Issues** If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here: 5	CSS is redirecting field work to a holistic care coordination approach, (Wagner's Chronic Care Model).	The Medicaid/TennCare now covers most direct services for CSS children. Care Coordination skills need to address social/physical environments, disparities, cultural needs, self management support and, health literacy.	MCHB
3.	**State Performance Measure Issues** If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here: 5	MCH workforce training in Public Health Core Competencies to develop a workable training plan for current MCH staff at both central office and local levels.	Our workforce has expressed the need to improve skills in communication, cultural competency, and community dimensions of practice. There are gaps in other domains as well.	MCHB
4.	**State Performance Measure Issues** If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here: 5	Incorporating Life Course Perspective into practice and programs using current limited funding.	We need assistance on best methodologies to shift the current paradigm from direct service and categorical programs.	MCHB
5.	**National Performance Measure Issues** If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here: 3	As part of the holistic care coordination approach, CSS will concentrate on medical homes for all children and youth with special health care needs.	Assistance is requested to develop a comprehensive measurement tool.	MCHB
6.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here:			
7.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here:			
8.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here:			
9.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here:			
10.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the			

	measure number here: _____			
11.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here: _____			
12.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here: _____			

FORM NOTES FOR FORM 15

None

FIELD LEVEL NOTES

None

FORM 16
STATE PERFORMANCE AND OUTCOME MEASURE DETAIL SHEET
STATE: TN

SP(Reporting Year) # 1

PERFORMANCE MEASURE:	Reduce the percentage of high school students using tobacco (cigarettes and smokeless tobacco).
STATUS:	Active
GOAL	To decrease the number of high school students using any form of tobacco.
DEFINITION	The number of high school students using any form of tobacco. **Numerator:** Number of high school students using tobacco (cigarettes and smokeless tobacco) each year. **Denominator:** Total number of high school age students who took the Tennessee Youth Tobacco Survey. **Units:** 100 **Text:** Percent
HEALTHY PEOPLE 2010 OBJECTIVE	
DATA SOURCES AND DATA ISSUES	Tennessee Youth Tobacco Survey (YBRSS)
SIGNIFICANCE	Tobacco is identified as a "gateway" drug often leading to experimentation and/or use of other substances known to be harmful to young people. With the recent court settlement with the tobacco companies, and known long term harmful affects of tobacco use on the health status and premature death of the users and persons experiencing second hand smoke. Tennessee will target a reduction in tobacco use by teens.

SP(Reporting Year) # 2

PERFORMANCE MEASURE:	Reduce the percentage of high school students using alcohol.
STATUS:	Active
GOAL	To reduce the percentage of high school students using alcohol.
DEFINITION	The number of high school students using alcohol as a percentage of the number completing the survey. **Numerator:** The number of high school students who had at least one drink of alcohol on one or more of the past 30 days. **Denominator:** The number of high school students taking the YRBS survey. **Units:** 100 **Text:** Percent
HEALTHY PEOPLE 2010 OBJECTIVE	
DATA SOURCES AND DATA ISSUES	Youth Risk Behavior Survey
SIGNIFICANCE	The State has established two sources of data regarding teen substance use and abuse. The Youth Behavior Risk Survey and a special survey conducted by the Bureau of Alcohol and Drugs in the Tennessee Department of Health. While prior studies indicate that use of these substances changes periodically, any use is prohibited by law and thought to be seriously harmful to young people. Our goal is to reduce substance use by adolescents in Tennessee.

SP(Reporting Year) # 3

PERFORMANCE MEASURE:	Reduce the incidence of maltreatment of children younger than age 18 including physical, sexual, emotional abuse and neglect to a rate no more than 8 per 1,000.
STATUS:	Active
GOAL	To reduce the incidence of maltreatment of children younger than age 18 including physical, sexual and emotional abuse and neglect to no more than the rate of 8 per 1000.
DEFINITION	**Numerator:** The number of children younger than age 18, who are victims of indicated abuse and neglect. **Denominator:** The total number of children under age 18 in a given year. **Units:** 1000 **Text:**
HEALTHY PEOPLE 2010 OBJECTIVE	
DATA SOURCES AND DATA ISSUES	Reports from the Department of Children's Services Child Protective Services Section.
SIGNIFICANCE	Children must be free from abuse and neglect in order to be healthy both physically and emotionally. Maternal and Child Health programs such as home visiting have proven to be effective in reducing abuse and neglect.

SP(Reporting Year) # 4

PERFORMANCE MEASURE:	Increase percentage of children with complete EPSDT annual examinations by 3 percent each year.
STATUS:	Active
GOAL	To increase the percentage of children with complete EPSDT annual examinations each year.
DEFINITION	The number of children enrolled in TennCare, ages 0 - 21 years, having had an annual examintion each year. **Numerator:** The number of children receiving EPSDT annual examinations **Denominator:** Number of children ages 0 - 21 years whom are eligible for EPSDT each year. **Units:** 100 **Text:** Percent
HEALTHY PEOPLE 2010 OBJECTIVE	
DATA SOURCES AND DATA ISSUES	Tenncare
SIGNIFICANCE	

SP(Reporting Year) # 5

PERFORMANCE MEASURE:	Reduce the proportion of teens and young adults ages 15 to 24 with chlamydia trachomatis infections attending family planning clinics
STATUS:	Active
GOAL	Reduce chlamydia trachomatis infections among teens and young adults ages 5 to 24 years (per 100) attending family planning clinics.
DEFINITION	**Numerator:** Number of teens and young adults identified with chlamydia trachomatis attending family planning clinics. **Denominator:** Total number of teens and young adults tested for chlamydia trachomatis in family planning clinics. **Units:** 100 **Text:** percent
HEALTHY PEOPLE 2010 OBJECTIVE	
DATA SOURCES AND DATA ISSUES	Region IV Chlamydia Screening project, STD Surveillance System
SIGNIFICANCE	The Region IV chlamydia project tracks positivity rates for those clients tested in the project. In Tennessee, all teens and young adults attending family planning clinics are tested for chlamydia. This measure has been changed from SP#8 to reflect the data being collected and to state the method being used to track changes in the population. Past years data have been included for the new measure.

SP(Reporting Year) # 6

PERFORMANCE MEASURE:	Reduce the number of babies born prematurely.
STATUS:	Active
GOAL	To reduce the number of live births born prematurely.
DEFINITION	Addressing certain known modifiable risk factors of preterm births can improve birth outcomes. **Numerator:** Number of live births with gestation less than 37 weeks in the calendar year. **Denominator:** Total number of live births in the calendar year. **Units:** 100 **Text:** Percent
HEALTHY PEOPLE 2010 OBJECTIVE	Objective 16-11. Reduce preterm births to 7.6%. (Baseline: 11.4 in 1997)
DATA SOURCES AND DATA ISSUES	State's Vital Records
SIGNIFICANCE	Prematurity is the leading cause of neonatal mortality in the U.S. Nearly 50% of preterm births have no known causes, but certain modifiable risk factors (medical, behavioral, and environmental) can be addressed.

SP(Reporting Year) # 7

PERFORMANCE MEASURE:	Increase percentage of adolescents with complete Early Periodic Screening, Diagnosis and Treatment(EPSDT) annual examinations by 5% each year.
STATUS:	Active
GOAL	To increase the percentage of adolescents with complete EPSDT annual examinations each year.
DEFINITION	The number of teens enrolled in TennCare,ages birth to 20, having had an annual examination each year. **Numerator:** The number of teens aged birth to 20 receiving EPSDT annual examinations. **Denominator:** Number of teens ages birth to 20 whom are eligible for EPSDT examinations each year. **Units:** 100 **Text:** Percent
HEALTHY PEOPLE 2010 OBJECTIVE	
DATA SOURCES AND DATA ISSUES	TennCare
SIGNIFICANCE	

SP(Reporting Year) # 9

PERFORMANCE MEASURE:	Reduce the number of overweight and obese children and adolescents.
STATUS:	Active
GOAL	Reduce the number of overweight and obese children and adolescents.
DEFINITION	Increasing healthy eating and physical activity among children and adolescents can reduce the number of children and adolescents who are overweight or obese. **Numerator:** 2003 Tennessee Youth Risk Behavior Survey data. **Denominator:** 2003 Tennessee Youth Risk Behavior data. **Units:** 100 **Text:** Percent
HEALTHY PEOPLE 2010 OBJECTIVE	19-3. Reduce the proportion of children and adolescents who are overweight or obese.
DATA SOURCES AND DATA ISSUES	2005 Tennessee Risk Behavior Survey (YBRSS)
SIGNIFICANCE	Maintenance of a healthy weight is a major goal in the effort to reduce the burden of illness and its consequent reduction in quality of life and life expectancy. Patterns of healthful eating behavior and physical activity begins in childhood.

SP(Reporting Year) # 10

PERFORMANCE MEASURE:	Increase the percentage of youth with special health care needs, age 14 and older, who receive formal plans for transition to adulthood.
STATUS:	Active
GOAL	To increase the percentage of youth with special health care needs, age 14-21 years, who receive formal plans necessary to transition to adult health care, post high school education, work and independence.
DEFINITION	**Numerator:** Number of youth in the Children's Special Services' program, age 14-21 years, who receive formal transition plans. **Denominator:** Number of youth in Children's Special Services, age 14 -21 years during the reporting period. **Units:** 100 **Text:** Percent
HEALTHY PEOPLE 2010 OBJECTIVE	Related to Objective 16.23:Increase the proportion of States and jurisdictions that have service systems for children with or at risk for chronic and disabling conditions as required by Public Law 101-239.
DATA SOURCES AND DATA ISSUES	Tennessee Department of Health's client tracking and encounter system, PTBMIS, will be used to determine what services are provided to the client.
SIGNIFICANCE	The transition from youth to adulthood has become a priority issue in Tennessee. This mirrors national priorities as evidenced by the President's "New Freedom Initiative: Delivering on the Promise" (March 2002). Most 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.

FORM 17
HEALTH SYSTEMS CAPACITY INDICATORS
FORMS FOR HSCI 01 THROUGH 04, 07 & 08 - MULTI-YEAR DATA
STATE: TN

Form Level Notes for Form 17

None

HEALTH SYSTEMS CAPACITY MEASURE # 01

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

	Annual Indicator Data				
	2005	**2006**	**2007**	**2008**	**2009**
Annual Indicator	28.9	28.9	29.6	26.6	24.8
Numerator	1,366	1,366	1,188	1,074	1,000
Denominator	473,085	473,085	400,744	403,306	403,000
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form17_Health Systems Capacity Indicator #01
   Field Name: HSC01
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   Tennessee Department of Health Division of Health Statistics Population Projections and Hospital Discharge Data System

2. **Section Number:** Form17_Health Systems Capacity Indicator #01
   Field Name: HSC01
   Row Name:
   Column Name:
   Year: 2007
   Field Note:
   Data source is Final Inpatient Hospital Discharge Tennessee resident only and 2007 population estimates.

HEALTH SYSTEMS CAPACITY MEASURE # 02

The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.

	Annual Indicator Data				
	2005	**2006**	**2007**	**2008**	**2009**
Annual Indicator	66.8	62.9	83.6	71.8	72.9
Numerator	52,414	53,033	48,559	75,323	77,120
Denominator	78,503	84,277	58,058	104,882	105,835
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form17_Health Systems Capacity Indicator #02
   Field Name: HSC02
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   State of Tennessee Tenncare (Medicaid) database.
   Data source is the state of Tennessee TennCare EPSDT Data system.

2. **Section Number:** Form17_Health Systems Capacity Indicator #02
   Field Name: HSC02
   Row Name:
   Column Name:
   Year: 2007
   Field Note:
   State of Tennessee TennCare (Medicaid) database

HEALTH SYSTEMS CAPACITY MEASURE # 03

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

	Annual Indicator Data				
	2005	**2006**	**2007**	**2008**	**2009**
Annual Indicator	0.0	0.0	0.0	100.0	100.0
Numerator	0	0	0	34,704	30,753
Denominator	1	1	1	34,704	30,753
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form17_Health Systems Capacity Indicator #03
   Field Name: HSC03
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   Data Source: State of Tennessee TennCare Program.
   Tennessee's SCHIP program is CoverKids and these data reflect the children less than one year of age in CoverKids who have received at least one periodic screen.

2. **Section Number:** Form17_Health Systems Capacity Indicator #03
   Field Name: HSC03
   Row Name:
   Column Name:
   Year: 2007
   Field Note:
   2007 data are not available; however, SCHIP children in Tennessee are enrollees in both TennCare and in CoverKids.

HEALTH SYSTEMS CAPACITY MEASURE # 04

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

	Annual Indicator Data				
	2005	**2006**	**2007**	**2008**	**2009**
Annual Indicator	74.1	76.8	83.8	93.2	88.5
Numerator	60,360	64,738	72,498	73,270	66,760
Denominator	81,454	84,277	86,558	78,578	75,470
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form17_Health Systems Capacity Indicator #04
   Field Name: HSC04
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   Tennessee Department of Health Divsion of Health Statistics Birth Statistical System
   Final 2008
   2008 methodolgy per Guidance:
   Numerator
   Number of women (15-44) during the reporting years whose observed to expected prenatal visits are greater than or equal to 80% on the Kotelchuck index
   Denominator
   All women (15-44) with a live birth during the reporting year

2. **Section Number:** Form17_Health Systems Capacity Indicator #04
   Field Name: HSC04
   Row Name:
   Column Name:
   Year: 2007
   Field Note:
   2007 is updated/corrected due to methodological differences in calcuations. Update: 72627/80773 = 89.9
   Calculation is now per Guidance:
   Numerator Number of women (15-44) during the reporting year shose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index

HEALTH SYSTEMS CAPACITY MEASURE # 07A

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

	Annual Indicator Data				
	2005	**2006**	**2007**	**2008**	**2009**
Annual Indicator	100.0	100.0	45.9	92.8	93.2
Numerator	758,628	743,387	375,016	759,672	790,661
Denominator	758,628	743,387	816,486	818,194	848,210
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form17_Health Systems Capacity Indicator #07A
   Field Name: HSC07A
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   Data Source:
   Numerator - 2008 TennCare program medical claims for children 0-20.
   Denominator - Eligible population: all TennCare members under 21.
   There is a large difference between 2007 and 2008 due to a large increase in enrollment for children/increased claims.

2. **Section Number:** Form17_Health Systems Capacity Indicator #07A
   Field Name: HSC07A
   Row Name:
   Column Name:
   Year: 2007
   Field Note:
   Methodology and data source changed for 2007 and 2008.
   Numerator - Actual Medicaid data on number receiving a service are not available. As a proxy, used CMS-416 Report, FY 2007, line 9, “Total eligibles receiving at least one initial or periodic screen.”
   Denominator - Kaiser Family Foundation, TN, Ages 0-19, < 100 % poverty, 2006-2007 (Used as estimate).

HEALTH SYSTEMS CAPACITY MEASURE # 07B

The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.

	Annual Indicator Data				
	2005	**2006**	**2007**	**2008**	**2009**
Annual Indicator	60.4	37.0	50.6	52.6	55.0
Numerator	86,569	56,418	77,255	77,122	84,062
Denominator	143,367	152,680	152,575	146,517	152,828
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form17_Health Systems Capacity Indicator #07B
   Field Name: HSC07B
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   Data sources: TennCare EPSDT and claim system

2. **Section Number:** Form17_Health Systems Capacity Indicator #07B
   Field Name: HSC07B
   Row Name:
   Column Name:
   Year: 2007
   Field Note:
   Data source is the state of Tennessee TennCare EPSDT Data system.
   Data are 1 year late due to TennCare EPSDT reports.

HEALTH SYSTEMS CAPACITY MEASURE # 08

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

	Annual Indicator Data				
	2005	**2006**	**2007**	**2008**	**2009**
Annual Indicator	100.0	100.0	9.0	14.0	17.3
Numerator	19,781	22,392	1,962	2,838	3,676
Denominator	19,781	22,392	21,881	20,343	21,286
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Provisional	Provisional

Field Level Notes

1. **Section Number:** Form17_Health Systems Capacity Indicator #08
   Field Name: HSC08
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   For both 2007 and 2008, the methodology and data sources were changed in response to directives received at the block grant review.

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

2. **Section Number:** Form17_Health Systems Capacity Indicator #08
   Field Name: HSC08
   Row Name:
   Column Name:
   Year: 2007
   Field Note:
   For both 2007 and 2008, the methodology and data sources were changed in response to directives received at the block grant review.
   Data sources are CSS program database and federal database of SSI recipients.

FORM 18
HEALTH SYSTEMS CAPACITY INDICATOR #05
(MEDICAID AND NON-MEDICAID COMPARISON)
STATE: TN

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
a) *Percent of low birth weight (< 2,500 grams)*	2008	Matching data files	11	7.3	9.2
b) *Infant deaths per 1,000 live births*	2008	Matching data files	10.3	5.7	8
c) *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*	2008	Other	1	1	67.7
d) *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*	2008	Other	1	1	93.2

FORM 18
HEALTH SYSTEMS CAPACITY INDICATOR #06(MEDICAID ELIGIBILITY LEVEL)
STATE: TN

INDICATOR #06 ***The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.***	**YEAR**	**PERCENT OF POVERTY LEVEL MEDICAID (Valid range: 100-300 percent)**
a) *Infants (0 to 1)*	2009	185
b) *Medicaid Children* (Age range 1 to 5) (Age range 6 to 19) (Age range _____ to _____)	2009	133 100 _____
c) *Pregnant Women*	2009	185

FORM 18
HEALTH SYSTEMS CAPACITY INDICATOR #06(SCHIP ELIGIBILITY LEVEL)
STATE: TN

INDICATOR #06 ***The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, SCHIP and pregnant women.***	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
a) *Infants (0 to 1)*	2009	250
b) *Medicaid Children* (Age range 1 to 5) (Age range 6 to 19) (Age range _____ to _____)	2009	250 250
c) *Pregnant Women*	2009	250

FORM NOTES FOR FORM 18

Medicaid versus non-medicaid data for entry into prenatal care by trimester or for Kotelchuck Index are not available.

FIELD LEVEL NOTES

1. **Section Number:** Form18_Indicator 05
   Field Name: LowBirthWeight
   Row Name: Percent of ow birth weight (<2,500 grams)
   Column Name:
   Year: 2011
   Field Note:
   Data Source: TDH Birth and Death Records and TennCare Records

2. **Section Number:** Form18_Indicator 05
   Field Name: InfantDeath
   Row Name: Infant deaths per 1,000 live births
   Column Name:
   Year: 2011
   Field Note:
   Data Source: TDH birth and death records and TennCare Records

3. **Section Number:** Form18_Indicator 05
   Field Name: CareFirstTrimester
   Row Name: Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester
   Column Name:
   Year: 2011
   Field Note:
   Breakdown of infants born to pregnant women receiving prenatal care beginning in the first semester per Medicaid and non-Medicaid is not available.

4. **Section Number:** Form18_Indicator 05
   Field Name: AdequateCare
   Row Name: Percent of pregnant women with adequate prenatal care
   Column Name:
   Year: 2011
   Field Note:
   Percent of pregnant women with adequate prenatal care per Medicaid and non-Medicaid is not available.

FORM 19
HEALTH SYSTEMS CAPACITY INDICATOR - REPORTING AND TRACKING FORM
STATE: TN

HEALTH SYSTEMS CAPACITY INDICATOR #09A (General MCH Data Capacity)
(The Ability of the State to Assure MCH Program Access to Policy and Program Relevant Informatioin)

DATABASES OR SURVEYS	Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3) *	Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)
ANNUAL DATA LINKAGES		
Annual linkage of infant birth and infant death certificates	3	No
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	2	No
Annual linkage of birth certificates and WIC eligibility files	2	No
Annual linkage of birth certificates and newborn screening files	3	Yes
REGISTRIES AND SURVEYS		
Hospital discharge survey for at least 90% of in-State discharges	3	No
Annual birth defects surveillance system	3	No
Survey of recent mothers at least every two years (like PRAMS)	3	No

*Where:
1 = No, the MCH agency does not have this ability.
2 = Yes, the MCH agency sometimes has this ability, but not on a consistent basis.
3 = Yes, the MCH agency always has this ability.

FORM 19
HEALTH SYSTEMS CAPACITY INDICATOR - REPORTING AND TRACKING FORM
STATE: TN

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

*Where:
1 = No
2 = Yes, the State participates but the sample size is not large enough for valid statewide estimates for this age group.
3 = Yes, the State participates and the sample size is large enough for valid statewide estimates for this age group.

Notes:

1. HEALTH SYSTEMS CAPACITY INDICATOR #09B was formerly reported as Developmental Health Status Indicator #05.

FORM NOTES FOR FORM 19

None

FIELD LEVEL NOTES

None

FORM 20
HEALTH STATUS INDICATORS #01-#05
MULTI-YEAR DATA
STATE: TN

Form Level Notes for Form 20

None

HEALTH STATUS INDICATOR MEASURE # 01A

The percent of live births weighing less than 2,500 grams.

	Annual Indicator Data				
	2005	**2006**	**2007**	**2008**	**2009**
Annual Indicator	9.4	9.6	9.4	9.2	9.2
Numerator	7,652	8,100	8,162	7,834	7,502
Denominator	81,454	84,277	86,558	85,454	81,866
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. ***(Explain data in a year note. See Guidance, Appendix IX.)***					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form20_Health Status Indicator #01A
   Field Name: HSI01A
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   Data source
   Tennessee Department of Health Division of Health Statistics Birth Statistical System

2. **Section Number:** Form20_Health Status Indicator #01A
   Field Name: HSI01A
   Row Name:
   Column Name:
   Year: 2007
   Field Note:
   Data source is Tennessee Birthmaster files resident only

HEALTH STATUS INDICATOR MEASURE # 01B

The percent of live singleton births weighing less than 2,500 grams.

	Annual Indicator Data				
	2005	**2006**	**2007**	**2008**	**2009**
Annual Indicator	7.6	7.6	7.5	7.4	7.5
Numerator	5,968	6,446	6,452	6,085	5,936
Denominator	78,656	84,277	86,558	82,708	79,290
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form20_Health Status Indicator #01B
   Field Name: HSI01B
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   Data source
   Tennesse Department of Health Division of Health Statistics Birth Statistical System

2. **Section Number:** Form20_Health Status Indicator #01B
   Field Name: HSI01B
   Row Name:
   Column Name:
   Year: 2007
   Field Note:
   Data source is Tennessee Birthmaster files resident only

HEALTH STATUS INDICATOR MEASURE # 02A

The percent of live births weighing less than 1,500 grams.

	Annual Indicator Data				
	2005	**2006**	**2007**	**2008**	**2009**
Annual Indicator	1.7	1.8	1.7	1.6	1.7
Numerator	1,354	1,508	1,513	1,378	1,362
Denominator	81,454	84,277	86,558	85,454	81,866
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form20_Health Status Indicator #02A
   Field Name: HSI02A
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   Data source
   Tennessee Department of Health Division of Health Statistics Birth Statistical System

2. **Section Number:** Form20_Health Status Indicator #02A
   Field Name: HSI02A
   Row Name:
   Column Name:
   Year: 2007
   Field Note:
   Data source is Tennessee Birthmaster files resident only

HEALTH STATUS INDICATOR MEASURE # 02B

The percent of live singleton births weighing less than 1,500 grams.

	Annual Indicator Data				
	2005	**2006**	**2007**	**2008**	**2009**
Annual Indicator	1.3	1.4	1.3	1.3	1.3
Numerator	1,029	1,166	1,159	1,043	1,060
Denominator	78,656	84,277	86,558	82,708	79,290
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form20_Health Status Indicator #02B
   Field Name: HSI02B
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   Data source
   Tennessee Department of Health Division of Health Statistics Birth Statistical System

2. **Section Number:** Form20_Health Status Indicator #02B
   Field Name: HSI02B
   Row Name:
   Column Name:
   Year: 2007
   Field Note:
   Data source is Tennessee Birthmaster files resident only

HEALTH STATUS INDICATOR MEASURE # 03A

The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.

	Annual Indicator Data				
	2005	**2006**	**2007**	**2008**	**2009**
Annual Indicator	12.6	7.0	8.0	10.2	5.8
Numerator	150	85	96	122	70
Denominator	1,188,005	1,210,629	1,194,718	1,201,099	1,207,621
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form20_Health Status Indicator #03A
   Field Name: HSI03A
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   Data source
   Tennessee Department of Health Divsion of Health Statistics Population Projections and Death Statistical System

2. **Section Number:** Form20_Health Status Indicator #03A
   Field Name: HSI03A
   Row Name:
   Column Name:
   Year: 2007
   Field Note:
   Data source
   Tennessee Department of Health Population Projections and Death Statistical System
   2007 corrected/updated to reflect final (provisional was not updated previously)
   Actual final: 136/1194718 = 11.4

HEALTH STATUS INDICATOR MEASURE # 03B

The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.

	Annual Indicator Data				
	2005	**2006**	**2007**	**2008**	**2009**
Annual Indicator	5.0	2.7	3.3	3.4	2.2
Numerator	59	33	39	41	27
Denominator	1,188,005	1,210,629	1,194,718	1,201,099	1,207,621
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form20_Health Status Indicator #03B
   Field Name: HSI03B
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   Data source is the 2008 Provisional Death files (Tennessee Resident).
   2008 Population estimates.

2. **Section Number:** Form20_Health Status Indicator #03B
   Field Name: HSI03B
   Row Name:
   Column Name:
   Year: 2007
   Field Note:
   Data source Tennessee Department of Health Divsion of Health Statistics Population Projections and Death Statistical System
   Correction/update to actual final (provisional was not updated)
   Actual 2007 final: 47/1194718 = 3.9

HEALTH STATUS INDICATOR MEASURE # 03C

The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.

	Annual Indicator Data				
	2005	**2006**	**2007**	**2008**	**2009**
Annual Indicator	45.6	20.9	30.8	29.8	18.4
Numerator	372	172	257	250	156
Denominator	815,796	821,651	833,229	839,914	846,897
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form20_Health Status Indicator #03C
   Field Name: HSI03C
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   TDH Division of Health Statistics Population Projections and Death Statistical System

2. **Section Number:** Form20_Health Status Indicator #03C
   Field Name: HSI03C
   Row Name:
   Column Name:
   Year: 2007
   Field Note:
   Data source Tennessee Department of Health Divsion of Health Statistics Population Projections and Death Statistical System.
   2007 was not updated/corrected to reflect final.
   Acutal final:
   307/833229=36.8

HEALTH STATUS INDICATOR MEASURE # 04A

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

	Annual Indicator Data				
	2005	**2006**	**2007**	**2008**	**2009**
Annual Indicator	13,350.1	13,135.9	13,239.4	12,313.1	1,232.3
Numerator	158,600	158,253	158,173	147,882	14,800
Denominator	1,188,005	1,204,737	1,194,718	1,201,009	1,201,000
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form20_Health Status Indicator #04A
   Field Name: HSI04A
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   TDH Division of Health Statistics Population Projections and Hospital Discharge Data System.
   Large adjustment to final is due to methodolgical differences in calculation from provisional.
   Actual final calculated per Guidance:
   Numerator
   Number of children age 14 years and younger who have a hospital discharge for non-fatal injuries
   Denominator
   Number of children age 14 years and younger in the state for the reporting period

2. **Section Number:** Form20_Health Status Indicator #04A
   Field Name: HSI04A
   Row Name:
   Column Name:
   Year: 2007
   Field Note:
   Data source
   Tennessee Department of Health Divsion of Health Statistics Population Projections and Hospital Discharge Data System.
   Correction for 2007 due to methodological differences in calculation.
   Correction/update uses Guidance:
   Numerator
   Number of children age 14 years and younger who have a hospital discharge for non-fatal injuries
   Denominator
   Number of children age 14 years and younger in the state for the reporting period
   Actual final: 149319/1194718 = 12498

HEALTH STATUS INDICATOR MEASURE # 04B

The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.

	Annual Indicator Data				
	2005	**2006**	**2007**	**2008**	**2009**
Annual Indicator	723.2	797.2	819.3	722.3	722.3
Numerator	8,650	9,604	9,788	8,675	8,675
Denominator	1,196,148	1,204,737	1,194,718	1,201,009	1,201,009
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form20_Health Status Indicator #04B
   Field Name: HSI04B
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   TDH Division of Health Statistics Population Projections and Hospital Discharge Data System

2. **Section Number:** Form20_Health Status Indicator #04B
   Field Name: HSI04B
   Row Name:
   Column Name:
   Year: 2007
   Field Note:
   Numerator Data source is 2007 Hospital Discharge, Tennessee resident only (Input and Output) and Denominator source is 2007 population estimates.

HEALTH STATUS INDICATOR MEASURE # 04C

The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.

	Annual Indicator Data				
	2005	**2006**	**2007**	**2008**	**2009**
Annual Indicator	4,033.1	3,461.5	3,472.0	3,064.8	3,064.8
Numerator	32,625	28,239	28,930	25,742	25,742
Denominator	808,940	815,796	833,229	839,914	839,914
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form20_Health Status Indicator #04C
   Field Name: HSI04C
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   TDH Division of Health Statistics Population Projections and Hospital Discharge Data System

2. **Section Number:** Form20_Health Status Indicator #04C
   Field Name: HSI04C
   Row Name:
   Column Name:
   Year: 2007
   Field Note:
   Data source is Hospital Discharge Tennessee resident only.
   Data source is 2007 Hospital Discharge, Tennessee resident only (Input and Output) and 2007 population estimates.

HEALTH STATUS INDICATOR MEASURE # 05A

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

	Annual Indicator Data				
	2005	**2006**	**2007**	**2008**	**2009**
Annual Indicator	33.2	36.5	40.0	42.1	42.1
Numerator	6,648	7,373	8,153	8,815	8,815
Denominator	200,015	201,861	203,767	209,417	209,417
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form20_Health Status Indicator #05A
   Field Name: HSI05A
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   Data source is the state STD program surveillance morbidity database which is the Communicable Disease Surveillance system and the 2008 Population estimates.

2. **Section Number:** Form20_Health Status Indicator #05A
   Field Name: HSI05A
   Row Name:
   Column Name:
   Year: 2007
   Field Note:
   Data source is the state STD program surveillance which is the Communicable Disease Surveillance system.
   and the 2007 Population estimates.

HEALTH STATUS INDICATOR MEASURE # 05B

The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.

	Annual Indicator Data				
	2005	**2006**	**2007**	**2008**	**2009**
Annual Indicator	8.7	10.1	10.4	11.8	11.8
Numerator	9,092	10,539	10,859	12,300	12,300
Denominator	1,046,385	1,043,888	1,041,926	1,045,578	1,045,578
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form20_Health Status Indicator #05B
   Field Name: HSI05B
   Row Name:
   Column Name:
   Year: 2008
   Field Note:
   Data source is the state STD program surveillance morbidity data systems,which is the Communicable Disease Surveillance system and the 2008 Population estimates.

2. **Section Number:** Form20_Health Status Indicator #05B
   Field Name: HSI05B
   Row Name:
   Column Name:
   Year: 2007
   Field Note:
   Data source is the state STD program surveillance which is the Communicable Disease Surveillance system and the 2007 Population estimates.

FORM 21
HEALTH STATUS INDICATORS
DEMOGRAPHIC DATA
STATE: TN

HSI #06A - Demographics (Total Population) *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

For both parts A and B: Reporting Year: 2009 Is this data from a State Projection? Yes Is this data final or provisional? Provisional

CATEGORY TOTAL POPULATION BY RACE	Total All Races	White	Black or African American	American Indian or Native Alaskan	Asian	Native Hawaiian or Other Pacific Islander	More than one race reported	Other and Unknown
Infants 0 to 1	80,512	60,681	17,914	0	0	0	0	1,917
Children 1 through 4	325,371	246,215	71,196	0	0	0	0	7,960
Children 5 through 9	399,293	302,732	87,107	0	0	0	0	9,454
Children 10 through 14	402,445	307,061	86,982	0	0	0	0	8,402
Children 15 through 19	430,127	333,339	89,273	0	0	0	0	7,515
Children 20 through 24	416,770	327,283	80,750	0	0	0	0	8,737
Children 0 through 24	2,054,518	1,577,311	433,222	0	0	0	0	43,985

HSI #06B - Demographics (Total Population) *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and ethnicity. (Demographics)*

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	Total NOT Hispanic or Latino	Total Hispanic or Latino	Ethnicity Not Reported
Infants 0 to 1	76,441	4,071	0
Children 1 through 4	307,522	17,849	0
Children 5 through 9	377,624	21,669	0
Children 10 through 14	384,028	18,417	0
Children 15 through 19	414,365	15,762	0
Children 20 through 24	399,083	17,687	0
Children 0 through 24	1,959,063	95,455	0

FORM 21
HEALTH STATUS INDICATORS
DEMOGRAPHIC DATA
STATE: TN

HSI #07A - Demographics (Total live births) *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

For both parts A and B: Reporting Year: 2009 Is this data from a State Projection? No Is this data final or provisional? Provisional

CATEGORY TOTAL LIVE BIRTHS BY RACE	Total All Races	White	Black or African American	American Indian or Native Alaskan	Asian	Native Hawaiian or Other Pacific Islander	More than one race reported	Other and Unknown
Women < 15	122	68	50	0	0	0	0	4
Women 15 through 17	2,953	1,760	1,031	0	0	0	0	162
Women 18 through 19	7,396	4,883	2,135	0	0	0	0	378
Women 20 through 34	62,980	46,329	12,308	0	0	0	0	4,343
Women 35 or older	8,500	6,401	1,265	0	0	0	0	834
Women of all ages	81,951	59,441	16,789	0	0	0	0	5,721

HSI #07B - Demographics (Total live births) *Live births to women (of all ages) enumerated by maternal age and ethnicity. (Demographics)*

CATEGORY TOTAL LIVE BIRTHS BY HISPANIC ETHNICITY	Total NOT Hispanic or Latino	Total Hispanic or Latino	Ethnicity Not Reported
Women < 15	88	18	16
Women 15 through 17	2,242	269	442
Women 18 through 19	5,778	481	1,137
Women 20 through 34	48,407	4,938	9,635
Women 35 or older	6,545	589	1,366
Women of all ages	63,060	6,295	12,596

FORM 21
HEALTH STATUS INDICATORS
DEMOGRAPHIC DATA
STATE: TN

HSI #08A - Demographics (Total deaths) *Deaths of Infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

For both parts A and B: Reporting Year: 2009 Is this data from a State Projection? No Is this data final or provisional? Provisional

CATEGORY TOTAL DEATHS BY RACE	Total All Races	White	Black or African American	American Indian or Native Alaskan	Asian	Native Hawaiian or Other Pacific Islander	More than one race reported	Other and Unknown
Infants 0 to 1	646	358	274	0	0	0	0	14
Children 1 through 4	88	65	22	0	0	0	0	1
Children 5 through 9	55	33	20	0	0	0	0	2
Children 10 through 14	60	38	22	0	0	0	0	0
Children 15 through 19	298	214	77	0	0	0	0	7
Children 20 through 24	485	359	119	0	0	0	0	7
Children 0 through 24	1,632	1,067	534	0	0	0	0	31

HSI #08B - Demographics (Total deaths) *Deaths of Infants and children aged 0 through 24 years enumerated by age subgroup and ethnicity. (Demographics)*

CATEGORY TOTAL DEATHS BY HISPANIC ETHNICITY	Total NOT Hispanic or Latino	Total Hispanic or Latino	Ethnicity Not Reported
Infants 0 to 1	597	49	0
Children 1 through 4	79	9	0
Children 5 through 9	50	5	0
Children 10 through 14	60	0	0
Children 15 through 19	286	12	0
Children 20 through 24	468	17	0
Children 0 through 24	1,540	92	0

FORM 21
HEALTH STATUS INDICATORS
DEMOGRAPHIC DATA
STATE: TN

HSI #09A - Demographics (Miscellaneous Data) *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

Is this data final or provisional? Provisional

CATEGORY Miscellaneous Data BY RACE	Total All Races	White	Black or African American	American Indian or Native Alaskan	Asian	Native Hawaiian or Other Pacific Islander	More than one race reported	Other and Unknown	Specific Reporting Year
All children 0 through 19	1,637,748	1,250,028	352,472	0	0	0	0	35,248	2009
Percent in household headed by single parent	35.0	26.0	68.0	0.0	10.0	0.0	0.0	0.0	2008
Percent in TANF (Grant) families	6.9	3.7	18.5	0.0	0.0	0.0	0.0	0.0	2009
Number enrolled in Medicaid	364,541	215,831	132,139	569	4,914	0	11,088	0	2009
Number enrolled in SCHIP	44,831	27,255	7,310	42	761	32	0	9,431	2009
Number living in foster home care	9,835	6,405	2,692	26	16	8	293	395	2009
Number enrolled in food stamp program	496,874	310,122	180,998	864	3,659	0	1,231	0	2009
Number enrolled in WIC	195,005	127,417	66,234	45	1,309	0	0	0	2009
Rate (per 100,000) of juvenile crime arrests	2,501.0	1,675.0	5,552.0	0.0	0.0	0.0	0.0	1,165.0	2009
Percentage of high school drop-outs (grade 9 through 12)	3.2	2.0	6.5	2.9	1.7	0.0	0.0	0.0	2009

HSI #09B - Demographics (Miscellaneous Data) *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by ethnicity.(Demographics)*

CATEGORY Miscellaneous Data BY HISPANIC ETHNICITY	Total NOT Hispanic or Latino	Total Hispanic or Latino	Ethnicity Not Reported	Specific Reporting Year
All children 0 through 19	1,559,980	77,768	0	2009
Percent in household headed by single parent	26.0	38.0	0.0	2008
Percent in TANF (Grant) families	7.0	4.6	0.0	2009
Number enrolled in Medicaid	364,541	40,233	0	2009
Number enrolled in SCHIP	42,540	2,291	0	2009
Number living in foster home care	9,404	431	0	2009
Number enrolled in food stamp program	465,597	31,782	0	2009
Number enrolled in WIC	195,005	32,927	0	2009
Rate (per 100,000) of juvenile crime arrests	0.0	0.0	0.0	2009
Percentage of high school drop-outs (grade 9 through 12)	3.2	3.9	0.0	2009

FORM 21
HEALTH STATUS INDICATORS
DEMOGRAPHIC DATA
STATE: TN

HSI #10 - Demographics (Geographic Living Area) *Geographic living area for all resident children aged 0 through 19 years old. (Demographics)*

Reporting Year: 2009 Is this data from a State Projection? No Is this data final or provisional? Provisional

GEOGRAPHIC LIVING AREAS	TOTAL
Living in metropolitan areas	1,152,537
Living in urban areas	445,435
Living in rural areas	38,646
Living in frontier areas	0
Total - all children 0 through 19	484,081

Note:
The Total will be determined by adding reported numbers for urban, rural and frontier areas.

FORM 21
HEALTH STATUS INDICATORS
DEMOGRAPHIC DATA
STATE: TN

HSI #11 - Demographics (Poverty Levels) *Percent of the State population at various levels of the federal poverty level. (Demographics)*

Reporting Year: 2008 Is this data from a State Projection? No Is this data final or provisional? Final

POVERTY LEVELS	TOTAL
Total Population	6,163,000.0
Percent Below: 50% of poverty	6.0
100% of poverty	15.5
200% of poverty	38.8

FORM 21
HEALTH STATUS INDICATORS
DEMOGRAPHIC DATA
STATE: TN

HSI #12 - Demographics (Poverty Levels) *Percent of the State population aged 0 through 19 at various levels of the federal poverty level. (Demographics)*

Reporting Year: 2008 Is this data from a State Projection? No Is this data final or provisional? Final

POVERTY LEVELS	TOTAL
Children 0 through 19 years old	1,637,748.0
Percent Below: 50% of poverty	9.3
100% of poverty	21.8
200% of poverty	47.6

FORM NOTES FOR FORM 21

Tennessee Division of Health Statistics Population Projections.
Tennessee Division of Health Statistics Birth Statistical System.
Tennessee Division of Health Statistics Death Statistical System.

HSI #10: US Department of Agriculture - Economic Research Service
US Census Data Population Estimates - County Characteristics

FIELD LEVEL NOTES

1. **Section Number:** Form21_Indicator 06A
   Field Name: S06_Race_Infants
   Row Name: Infants 0 to 1
   Column Name:
   Year: 2011
   Field Note:
   Tennessee Division of Health Statistics Population Projections.

2. **Section Number:** Form21_Indicator 06A
   Field Name: S06_Race_Children1to4
   Row Name: children 1 through 4
   Column Name:
   Year: 2011
   Field Note:
   Tennessee Division of Health Statistics Population Projections.

3. **Section Number:** Form21_Indicator 06A
   Field Name: S06_Race_Children5to9
   Row Name: children 5 through 9
   Column Name:
   Year: 2011
   Field Note:
   Tennessee Division of Health Statistics Population Projections.

4. **Section Number:** Form21_Indicator 06A
   Field Name: S06_Race_Children10to14
   Row Name: children 10 through 14
   Column Name:
   Year: 2011
   Field Note:
   Tennessee Division of Health Statistics Population Projection

5. **Section Number:** Form21_Indicator 06A
   Field Name: S06_Race_Children15to19
   Row Name: children 15 through 19
   Column Name:
   Year: 2011
   Field Note:
   Tennessee Division of Health Statistics Population Projections.

6. **Section Number:** Form21_Indicator 06A
   Field Name: S06_Race_Children20to24
   Row Name: children 20 through 24
   Column Name:
   Year: 2011
   Field Note:
   Tennessee Division of Health Statistics Population Projections.

7. **Section Number:** Form21_Indicator 06B
   Field Name: S06_Ethnicity_Infants
   Row Name: Infants 0 to 1
   Column Name:
   Year: 2011
   Field Note:
   Tennessee Division of Health Statistics Population Projections.

8. **Section Number:** Form21_Indicator 06B
   Field Name: S06_Ethnicity_Children1to4
   Row Name: children 1 through 4
   Column Name:
   Year: 2011
   Field Note:
   Tennessee Division of Health Statistics Population Projections.

9. **Section Number:** Form21_Indicator 06B
   Field Name: S06_Ethnicity_Children5to9
   Row Name: children 5 through 9
   Column Name:
   Year: 2011
   Field Note:
   Tennessee Division of Health Statistics Population Projections.

10. **Section Number:** Form21_Indicator 06B
    Field Name: S06_Ethnicity_Children10to14
    Row Name: children 10 through 14
    Column Name:
    Year: 2011
    Field Note:
    Tennessee Division of Health Statistics Population Projections

11. **Section Number:** Form21_Indicator 06B
    Field Name: S06_Ethnicity_Children15to19
    Row Name: children 15 through 19
    Column Name:
    Year: 2011

Field Note:
Tennessee Division of Health Statistics Population Projections.

12. **Section Number:** Form21_Indicator 06B
Field Name: S06_Ethnicity_Children20to24
Row Name: children 20 through 24
Column Name:
Year: 2011
Field Note:
Tennessee Division of Health Statistics Population Projections.

13. **Section Number:** Form21_Indicator 07A
Field Name: Race_Women15
Row Name: Women < 15
Column Name:
Year: 2011
Field Note:
Tennessee Division of Health Statistics Birth Statistical System.

14. **Section Number:** Form21_Indicator 07A
Field Name: Race_Women15to17
Row Name: Women 15 through 17
Column Name:
Year: 2011
Field Note:
Tennessee Division of Health Statistics Birth Statistical System.

15. **Section Number:** Form21_Indicator 07A
Field Name: Race_Women18to19
Row Name: Women 18 through 19
Column Name:
Year: 2011
Field Note:
Tennessee Division of Health Statistics Birth Statistical System.

16. **Section Number:** Form21_Indicator 07A
Field Name: Race_Women20to34
Row Name: Women 20 through 34
Column Name:
Year: 2011
Field Note:
Tennessee Division of Health Statistics Birth Statistical System.

17. **Section Number:** Form21_Indicator 07A
Field Name: Race_Women35
Row Name: Women 35 or older
Column Name:
Year: 2011
Field Note:
Tennessee Division of Health Statistics Birth Statistical System.

18. **Section Number:** Form21_Indicator 07B
Field Name: Ethnicity_Women15
Row Name: Women < 15
Column Name:
Year: 2011
Field Note:
Tennessee Division of Health Statistics Birth Statistical System.

19. **Section Number:** Form21_Indicator 07B
Field Name: Ethnicity_Women15to17
Row Name: Women 15 through 17
Column Name:
Year: 2011
Field Note:
Tennessee Division of Health Statistics Birth Statistical System.

20. **Section Number:** Form21_Indicator 07B
Field Name: Ethnicity_Women18to19
Row Name: Women 18 through 19
Column Name:
Year: 2011
Field Note:
Tennessee Division of Health Statistics Birth Statistical System.

21. **Section Number:** Form21_Indicator 07B
Field Name: Ethnicity_Women20to34
Row Name: Women 20 through 34
Column Name:
Year: 2011
Field Note:
Tennessee Division of Health Statistics Birth Statistical System.

22. **Section Number:** Form21_Indicator 07B
Field Name: Ethnicity_Women35
Row Name: Women 35 or older
Column Name:
Year: 2011
Field Note:
Tennessee Division of Health Statistics Birth Statistical System.

23. **Section Number:** Form21_Indicator 08A
Field Name: S08_Race_Infants
Row Name: Infants 0 to 1
Column Name:
Year: 2011

Field Note:
Tennessee Division of Health Statistics Death Statistical System.

24. **Section Number:** Form21_Indicator 08A
Field Name: S08_Race_Children1to4
Row Name: children 1 through 4
Column Name:
Year: 2011
Field Note:
Tennessee Division of Health Statistics Death Statistical System.

25. **Section Number:** Form21_Indicator 08A
Field Name: S08_Race_Children5to9
Row Name: children 5 through 9
Column Name:
Year: 2011
Field Note:
Tennessee Division of Health Statistics Death Statistical System.

26. **Section Number:** Form21_Indicator 08A
Field Name: S08_Race_Children10to14
Row Name: children 10 through 14
Column Name:
Year: 2011
Field Note:
Tennessee Division of Health Statistics Death Statistical System.

27. **Section Number:** Form21_Indicator 08A
Field Name: S08_Race_Children15to19
Row Name: children 15 through 19
Column Name:
Year: 2011
Field Note:
Tennessee Division of Health Statistics Death Statistical System.

28. **Section Number:** Form21_Indicator 08A
Field Name: S08_Race_Children20to24
Row Name: children 20 through 24
Column Name:
Year: 2011
Field Note:
Tennessee Division of Health Statistics Death Statistical System.

29. **Section Number:** Form21_Indicator 08B
Field Name: S08_Ethnicity_Infants
Row Name: Infants 0 to 1
Column Name:
Year: 2011
Field Note:
Tennessee Division of Health Statistics Death Statistical System.

30. **Section Number:** Form21_Indicator 08B
Field Name: S08_Ethnicity_Children1to4
Row Name: children 1 through 4
Column Name:
Year: 2011
Field Note:
Tennessee Division of Health Statistics Death Statistical System.

31. **Section Number:** Form21_Indicator 08B
Field Name: S08_Ethnicity_Children15to19
Row Name: children 15 through 19
Column Name:
Year: 2011
Field Note:
Tennessee Division of Health Statistics Death Statistical System.

32. **Section Number:** Form21_Indicator 08B
Field Name: S08_Ethnicity_Children20to24
Row Name: children 20 through 24
Column Name:
Year: 2011
Field Note:
Tennessee Division of Health Statistics Death Statistical System.

33. **Section Number:** Form21_Indicator 09A
Field Name: HSIRace_SingleParentPercent
Row Name: Percent in household headed by single parent
Column Name:
Year: 2011
Field Note:
Source: Census and Kid Count Data

34. **Section Number:** Form21_Indicator 09A
Field Name: HSIRace_TANFPercent
Row Name: Percent in TANF (Grant) families
Column Name:
Year: 2011
Field Note:
Source: DHS Research Office

35. **Section Number:** Form21_Indicator 09A
Field Name: HSIRace_MedicaidNo
Row Name: Number enrolled in Medicaid
Column Name:
Year: 2011

Field Note:
Source: TennCare Office

36. **Section Number:** Form21_Indicator 09A
Field Name: HSIRace_SCHIPNo
Row Name: Number enrolled in SCHIP
Column Name:
Year: 2011
Field Note:
Source: Cover Kids - Governor's Office of Children's Care Coordination

37. **Section Number:** Form21_Indicator 09A
Field Name: HSIRace_FoodStampNo
Row Name: Number enrolled in food stamp program
Column Name:
Year: 2011
Field Note:
Source: DHS Research Office

38. **Section Number:** Form21_Indicator 09A
Field Name: HSIRace_WICNo
Row Name: Number enrolled in WIC
Column Name:
Year: 2011
Field Note:
Source: Department of Health WIC Report Participation County by Race and Status.

39. **Section Number:** Form21_Indicator 09A
Field Name: HSIRace_JuvenileCrimeRate
Row Name: Rate (per 100,000) of juvenile crime arrests
Column Name:
Year: 2011
Field Note:
Source: Department of Health Policy Planning and Assessment Office
Numerator - TBI Crime in Tennessee 2009 Report
Denominator - Health Statistics Population Projections

40. **Section Number:** Form21_Indicator 09A
Field Name: HSIRace_DropOutPercent
Row Name: Percentage of high school drop-outs (grade 9 through 12)
Column Name:
Year: 2011
Field Note:
Source: Department of Education Research Office

41. **Section Number:** Form21_Indicator 09B
Field Name: HSIEthnicity_JuvenileCrimeRate
Row Name: Rate (per 100,000) of juvenile crime arrests
Column Name:
Year: 2011
Field Note:
This Data is not available by ethnicity

42. **Section Number:** Form21_Indicator 11
Field Name: S11_total
Row Name: Total Population
Column Name:
Year: 2011
Field Note:
Data Source:
US Census 2008 population estimates

43. **Section Number:** Form21_Indicator 12
Field Name: S12_50percent
Row Name: Percent Below: 50% of poverty
Column Name:
Year: 2011
Field Note:
Data Source: US Census
*Available age range for TN 0-17

44. **Section Number:** Form21_Indicator 12
Field Name: S12_100percent
Row Name: 100% of poverty
Column Name:
Year: 2011
Field Note:
Data Source
US Census
*Available age range for TN 0-17

45. **Section Number:** Form21_Indicator 12
Field Name: S12_200percent
Row Name: 200% of poverty
Column Name:
Year: 2011
Field Note:
Data Source
US Census
* Available age range for TN 0-17

46. **Section Number:** Form21_Indicator 09A
Field Name: HSIRace_FosterCare
Row Name: Number living in foster home care
Column Name:
Year: 2011

Field Note:
Tennessee Department of Children's Services Research Office

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

Form Level Notes for Form 11

None

STATE PERFORMANCE MEASURE # 1 - NEW FOR NEEDS ASSESSMENT CYCLE 2011-2015

Reduce the infant mortality rate

Annual Objective and Performance Data

	2005	2006	2007	2008	2009
Annual Performance Objective					
Annual Indicator					
Numerator					
Denominator					
Data Source					
Is the Data Provisional or Final?					

Annual Objective and Performance Data

	2010	2011	2012	2013	2014
Annual Performance Objective					
Annual Indicator					
Numerator					
Denominator					

While you may enter preliminary objectives for State Performance Measures for the Needs Assessment Period 2011-2015, this is not required until next year.

Field Level Notes

None

STATE PERFORMANCE MEASURE # 2 - NEW FOR NEEDS ASSESSMENT CYCLE 2011-2015

Reduce the percentage of obesity and overweight among Tennessee K-12 students

Annual Objective and Performance Data

	2005	2006	2007	2008	2009
Annual Performance Objective					
Annual Indicator					
Numerator					
Denominator					
Data Source					
Is the Data Provisional or Final?					

Annual Objective and Performance Data

	2010	2011	2012	2013	2014
Annual Performance Objective					
Annual Indicator					
Numerator					
Denominator					

While you may enter preliminary objectives for State Performance Measures for the Needs Assessment Period 2011-2015, this is not required until next year.

Field Level Notes

None

STATE PERFORMANCE MEASURE # 3 - NEW FOR NEEDS ASSESSMENT CYCLE 2011-2015

Reduce smoking in Tennesseans age 13 years and older

Annual Objective and Performance Data

	2005	2006	2007	2008	2009
Annual Performance Objective					
Annual Indicator					
Numerator					
Denominator					
Data Source					
Is the Data Provisional or Final?					

Annual Objective and Performance Data

	2010	2011	2012	2013	2014
Annual Performance Objective					
Annual Indicator					
Numerator					
Denominator					

While you may enter preliminary objectives for State Performance Measures for the Needs Assessment Period 2011-2015, this is not required until next year.

Field Level Notes

None

STATE PERFORMANCE MEASURE # 4 - NEW FOR NEEDS ASSESSMENT CYCLE 2011-2015

Decrease asthma hospitalizations for children 0-5 years

Annual Objective and Performance Data

	2005	2006	2007	2008	2009
Annual Performance Objective					
Annual Indicator					
Numerator					
Denominator					
Data Source					
Is the Data Provisional or Final?					

Annual Objective and Performance Data

	2010	2011	2012	2013	2014
Annual Performance Objective					
Annual Indicator					
Numerator					
Denominator					

While you may enter preliminary objectives for State Performance Measures for the Needs Assessment Period 2011-2015, this is not required until next year.

Field Level Notes

None

STATE PERFORMANCE MEASURE # 5 - NEW FOR NEEDS ASSESSMENT CYCLE 2011-2015

Improve MCH workforce capacity and competency by designing and implementing a workforce development program

Annual Objective and Performance Data

	2005	2006	2007	2008	2009
Annual Performance Objective					
Annual Indicator					
Numerator					
Denominator					
Data Source					
Is the Data Provisional or Final?					

Annual Objective and Performance Data

	2010	2011	2012	2013	2014
Annual Performance Objective					
Annual Indicator					
Numerator					
Denominator					

While you may enter preliminary objectives for State Performance Measures for the Needs Assessment Period 2011-2015, this is not required until next year.

Field Level Notes

None

STATE PERFORMANCE MEASURE # 6 - NEW FOR NEEDS ASSESSMENT CYCLE 2011-2015

Increase the percentage of youth with special health care needs age 14 years and older who have formal plans for transtion to adulthood.

Annual Objective and Performance Data

	2005	2006	2007	2008	2009
Annual Performance Objective					
Annual Indicator					
Numerator					
Denominator					
Data Source					
Is the Data Provisional or Final?					

Annual Objective and Performance Data

	2010	2011	2012	2013	2014
Annual Performance Objective					
Annual Indicator					
Numerator					
Denominator					

While you may enter preliminary objectives for State Performance Measures for the Needs Assessment Period 2011-2015, this is not required until next year.

Field Level Notes

None

STATE PERFORMANCE MEASURE # 7 - NEW FOR NEEDS ASSESSMENT CYCLE 2011-2015

Reduce unintentional injury death in children and young people ages 0-24

Annual Objective and Performance Data

	2005	2006	2007	2008	2009
Annual Performance Objective					
Annual Indicator					
Numerator					
Denominator					
Data Source					
Is the Data Provisional or Final?					

Annual Objective and Performance Data

	2010	2011	2012	2013	2014
Annual Performance Objective					
Annual Indicator					
Numerator					
Denominator					

While you may enter preliminary objectives for State Performance Measures for the Needs Assessment Period 2011-2015, this is not required until next year.

Field Level Notes

None

FORM 12
TRACKING HEALTH OUTCOME MEASURES
[SECS 505 (A)(2)(B)(III) AND 506 (A)(2)(A)(III)]
STATE: TN

Form Level Notes for Form 12

None

FORM 16
STATE PERFORMANCE AND OUTCOME MEASURE DETAIL SHEET
STATE: TN

SP(New for Needs Assessment cycle 2011-2015) # 1

PERFORMANCE MEASURE:	Reduce the infant mortality rate
STATUS:	Active
GOAL	To reduce the number of infant deaths
DEFINITION	Infant mortality (deaths to infants birth through 364 days of age). Rate per 1,000 **Numerator:** Number of deaths to infants from birth to 364 days of age **Denominator:** Number of live births **Units:** 1000 **Text:** Rate
HEALTHY PEOPLE 2010 OBJECTIVE	16-1c Reduction of infant deaths (within 1 year) to 4.5 per 1,000 live births
DATA SOURCES AND DATA ISSUES	Tennessee Department of Health Division of Health Statistics Birth and Death Statistical Systems
SIGNIFICANCE	The need is critical. Tennessee consistently ranks among the states with the highest rates of infant mortality. Of particular concern is the disparity between the black and white populations. In 2008, the infant mortality rate for births to black women was 2.46 times that of the rate for births to white women. This disparity has remained for the last two decades, even as the overall rate has declined.

SP(New for Needs Assessment cycle 2011-2015) # 2	
PERFORMANCE MEASURE:	Reduce the percentage of obesity and overweight among Tennessee K-12 students
STATUS:	Active
GOAL	Reduce childhood obesity and overweight
DEFINITION	Combined overweight and obesity is defined as BMI that is greater than or equal to the 85th percentile on CDC BMI charts for age and gender. **Numerator:** K-12 children measured with BMIs greater than or equal to the 85th percentile for age/gender **Denominator:** K-12 children measured **Units:** 100 **Text:** Percent
HEALTHY PEOPLE 2010 OBJECTIVE	HP 2010 19-3c Reduce the proportion of children and adolescents who are overweight or obese
DATA SOURCES AND DATA ISSUES	Tennessee Department of Education Coordinated School Health Program Annual BMI Surveillance in Tennessee Public Schools
SIGNIFICANCE	The need is critical. In 2008, 39% of Tennessee school children were overweight or obese (BMI > 85% for age and gender on CDC growth charts). Based on the 2007 National Survey of Children's Health, Tennessee children ages 10-17 ranked 4th in the Nation for childhood obesity and overweight, putting children at risk for associated adverse health and social consequences.

SP(New for Needs Assessment cycle 2011-2015) # 3	
PERFORMANCE MEASURE:	Reduce smoking in Tennesseans age 13 years and older
STATUS:	Active
GOAL	Reduce smoking in Tennessee
DEFINITION	Current cigarette use **Numerator:** Health Department patients who report not smoking in the last 30 days **Denominator:** Health Department patients who are screened for cigarette use **Units:** 100 **Text:** Percent
HEALTHY PEOPLE 2010 OBJECTIVE	27-1 Reduce tobacco use by adults 27-2 Reduce tobacco use by adolescents
DATA SOURCES AND DATA ISSUES	PTBMIS (Patient Tracking and Billing Management System)
SIGNIFICANCE	The need is critical. Every year, 14,600 Tennessee youth under 18 years of age become daily smokers. At this rate, 28,300 Tennessee youth alive today will die an early, preventable death because of a decision made as a youngster. More than 20% of all deaths in the United States are attributable to tobacco, making tobacco use the chief preventable cause of death. We opted to include the entire 13 and over population in this measure since tobacco smoke affects health and well-being throughout the entire lifespan.

SP(New for Needs Assessment cycle 2011-2015) # 4

PERFORMANCE MEASURE:	Decrease asthma hospitalizations for children 0-5 years
STATUS:	Active
GOAL	Decrease asthma hospitalizations for children 0-5 years.
DEFINITION	Hospitalizations are in-patient hospital stays, not including extended ED visits. **Numerator:** Number of resident asthma (ICD-9 codes 493.0 - 493.9) hospital discharges for children less than five years old. **Denominator:** Estimate of all children less than five years old in the state **Units:** 10000 **Text:** Rate
HEALTHY PEOPLE 2010 OBJECTIVE	24-2a Reduce hospitalization for asthma in children 0-5 to no more than 25 per 10,000.
DATA SOURCES AND DATA ISSUES	Tennessee Department of Health Statistics Population Projections and Hospital Discharge Data System
SIGNIFICANCE	The need is critical. Approximately 10% of children in Tennessee suffered from asthma in 2007. Although inpatient hospitalizations have decreased since 1997, emergency department (ED) visits and charges for both inpatient and outpatient hospitalizations have increased. Younger children with asthma have more hospitalizations than older children. In addition, there are significant gender, racial, socioeconomic and geographic disparities in childhood asthma. More school days are lost due to asthma than any other chronic condition, and in Tennessee 98% of emergency treatments in schools are for asthma.

SP(New for Needs Assessment cycle 2011-2015) # 5

PERFORMANCE MEASURE:	Improve MCH workforce capacity and competency by designing and implementing a workforce development program
STATUS:	Active
GOAL	Improve MCH workforce capacity and competency
DEFINITION	A workforce development program is defined as having regular optional and mandated courses founded on COL Public Health Core Competencies; workforce and academic linkages and input; a course/training tracking and documentation system; and a Public Health Core Competency tool for tracking and evaluation. The value of the measure for each of these is "yes/no." **Numerator:** not applicable **Denominator:** not applicable **Units:** No **Text:** Text
HEALTHY PEOPLE 2010 OBJECTIVE	23-10 (Developmental) Increase the proportion of Federal, Tribal, State, and local public health agencies that provide continuing education to develop competency in essential public health services for their employees.
DATA SOURCES AND DATA ISSUES	not applicable
SIGNIFICANCE	The need is critical. Our workforce has been focused and trained on direct clinical services for many years. TDH nursing leadership has requested help in developing competencies in public health basics and leadership. MCH program directors and home visiting staff have also expressed need for additional training and mentoring in order to increase competencies in enabling services, population-based services, and infrastructure building. The Public Health Accreditation Board includes workforce competency, training and development (Domain 8) in the proposed standards. The program will be founded on the 8 COL Public Health Core Competencies.

SP(New for Needs Assessment cycle 2011-2015) # 6	
PERFORMANCE MEASURE:	Increase the percentage of youth with special health care needs age 14 years and older who have formal plans for transtion to adulthood.
STATUS:	Active
GOAL	Increase the percentage of CYSHCN age 14 years and older who have formal plans for transtion to adulthood.
DEFINITION	A formal transition plan is written by the family, young person, CSS nurse or worker, and others who may need to be involved (such as teacher or health care provider). The CSS program has a template form for workers to use and includes specific transition topics and plans. **Numerator:** Number of CSS clients 14 and over with formal transition plans **Denominator:** Number of CSS clients 14 and older **Units:** 100 **Text:** Percent
HEALTHY PEOPLE 2010 OBJECTIVE	
DATA SOURCES AND DATA ISSUES	Tennessee Family Voices Survey NS CYSHCN
SIGNIFICANCE	The need is critical to provide a growing population of CYSHCN with the means to transition to adult health care, independent living and work. Nearly 90% of CYSHCN now survive to adulthood. Many respondents to the Family Voices Survey reported they are not having discussions with health care providers or educational staff regarding transition. Forty-eight percent (48%) reported that providers talked with them about planning for changing health care needs as the child ages, and forty-four percent (44%) reported their child's teacher discussed issues related to their child's transition to adulthood.

SP(New for Needs Assessment cycle 2011-2015) # 7

PERFORMANCE MEASURE:	Reduce unintentional injury death in children and young people ages 0-24
STATUS:	Active
GOAL	Reduce unintentional injury death in children and young people ages 0-24
DEFINITION	Death due to any type of unintentional injury **Numerator:** Number of deaths from all unintentional injuries for children and young people ages 0-24 **Denominator:** Number of children and youth ages 0-24 in the State for the reporting period. **Units:** 100000 **Text:** Rate
HEALTHY PEOPLE 2010 OBJECTIVE	15-13 Reduce deaths caused by unintentional injruies to no more than 20.8 per 100,000 population.
DATA SOURCES AND DATA ISSUES	Tennessee Department of Health Division of Health Statistics Population Projections and Death Statistical System.
SIGNIFICANCE	The need is critical. Injuries are the leading cause of death for U.S. and Tennessee children and young people ages 1-24, with motor vehicle injury as the number one cause for injury fatality. The rate of injury deaths in children has declined in the last 2 decades, yet rates of childhood injury deaths are greater in the US than in other developed countries. Nonfatal injuries contribute substantially to childhood morbidity, disability, and reduced quality of life; and lifetime costs are estimated to be over 50 billion dollars.