Maternal and Child Health Services Title V Block Grant

Tennessee

FY 2016 Application/ FY 2014 Annual Report

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I. General Requirements

I.A. Letter of Transmittal

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
DIVISION OF FAMILY HEALTH AND WELLNESS
8th FLOOR, ANDREW JOHNSON TOWER
710 JAMES ROBERTSON PARKWAY
NASHVILLE, TENNESSEE 37243

July 1, 2015

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

Dear Grants Management Officer:

Tennessee's Title V annual application and report are enclosed.

Please contact me directly if further information is needed.

Sincerely,

Michael D. Warren, MD MPH FAAP
Director, Division of Family Health and Wellness
Tennessee Department of Health

I.B. Face Sheet

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

I.C. Assurances and Certifications

The State certifies assurances and certifications, as specified in Appendix C of the 2015 Title V Application/Annual Report Guidance, are maintained on file in the States' MCH program central office, and will be able to provide them at HRSA's request.

I.D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published January 2015; expires December 31, 2017.

I.E. Application/Annual Report Executive Summary

NEEDS ASSESSMENT

Every five years, states are required to conduct a comprehensive needs assessment to identify priority needs of the maternal and child health (MCH) population and to determine the capacity of the public health system to meet those needs.

The Tennessee Department of Health (TDH) conducted the Needs Assessment for the 2016-2020 cycle during 2014/15 in conjunction with over 70 MCH stakeholders. Key components of the Needs Assessment included:

- Broad community input through 26 focus groups and 5 community meetings across Tennessee. The groups consisted of key MCH populations, including: health department consumers, under-represented minorities, families with young children, families of children and youth with special health care needs, and healthcare providers.
- Quantitative analysis of more than 160 key indicators of the MCH population.
- Synthesis of input and priority-setting by MCH stakeholder group.

As a result of the Needs Assessment, TDH identified priority needs for the MCH population for the 2016-2020 Block Grant cycle. These priorities include:

- Improve utilization of preventive care for women of childbearing age.
- Reduce infant mortality.
- Increase the number of infants and children receiving a developmental screen.
- Reduce the number of children and adolescents who are overweight/obese.
- Reduce the burden of injury among children and adolescents.
- Reduce the number of children exposed to adverse childhood experiences.
- Increase the number of children (both with and without special health care needs) who have a medical home.
- Reduce exposure to tobacco among the MCH population (pregnancy smoking and secondhand smoke exposure for children).

During the Needs Assessment, stakeholders identified several "emerging issues" among MCH population groups. Title V is already working on these issues and as they evolve, will continue to identify ways to address them.

- Substance abuse among women of childbearing age: Tennessee has high rates of opioid prescribing, misuse and abuse as well as drug-related overdose. Opioid misuse and abuse among women of childbearing age has led to an epidemic of Neonatal Abstinence Syndrome (NAS). TDH is working to identify and implement primary prevention strategies related to NAS, namely to 1) prevent opioid misuse/abuse from ever occurring,

and 2) prevent unintended pregnancies among women who are at high risk of opioid misuse/abuse.
- Electronic nicotine delivery systems: The use of electronic nicotine delivery systems (including e-cigarettes) among youth is on the rise. There are serious concerns about youth e-cigarette use related to long-term tobacco use, as well as unintentional nicotine poisoning among young children.
- Autism spectrum disorders: With the rising incidence of autism spectrum disorders, there is growing recognition of the need for early screening as well as more rapid diagnosis and connection to treatment. Additionally, public health and health care systems need to identify ways to improve the system of care for children with autism and their families.

KEY ACCOMPLISHMENTS AND PLANS FOR COMING YEAR

The MCH population is broken down into subpopulation categories called health domains. Each section below (organized by domain) highlights selected accomplishments for the previous year and contains a brief description of high-level strategies for the new grant cycle (2016-2020). Other accomplishments and additional details about specific planned activities can be found in the MCH Block Grant Report/Application.

Women's/Maternal Health

In 2013, 71.1% of women entered prenatal care in the first trimester, up from 69% in 2009. TDH has worked to facilitate referral of pregnant women to prenatal care through case management and home visiting programs as well as through presumptive Medicaid eligibility determination in local health departments. The percentage of women smoking during pregnancy declined to 16.1%, down from 18.6% in 2009. In 2013, the General Assembly appropriated $5 million annually to TDH (tobacco master settlement funding) to reduce the burden of tobacco-related morbidity and mortality in Tennessee. This funding is being used in all 95 counties and one of the focus areas is to reduce smoking among pregnant women. Despite these successes, challenges for this domain include: high rates of unintended pregnancy (47.5% in 2011), high percentage of obesity among women of childbearing age (30.2% in 2012), and high rates of maternal mortality (31.2 per 1,000 live births in 2012).

For FY 2016-20, the major priority for this domain is to increase preventive care for women of childbearing age. A focus on this priority will help to address the aforementioned challenges, improve the overall health of this population, and lead to improved birth outcomes. Tennessee's Title V Program will utilize these strategies to address this priority:

- Increase general awareness of the importance of an annual preventive health care visit for women of childbearing age.
- Engage primary care providers on the importance of promoting preventive health care visits for women of childbearing age.
- Continue to provide high-quality family planning services through local health departments in all 95 counties.
- Provide pregnancy-related services to women of childbearing age.

Perinatal/Infant Health

Tennessee's infant mortality rate dropped by 15% from 2009 (8.0 per 1,000 live births) to 2013 (6.0). The percentage of early elective deliveries and inductions among Tennessee births has dropped from more than 15% in 2012 to consistently below 2% in 2015. Nearly all (>99%) of Tennessee infants receive a newborn screen. The percentage of infants who are ever breastfed has increased to 74.9%, and in 2013, Tennessee utilized Title V funding to launch a statewide breastfeeding hotline offering 24/7 telephone support by lactation specialists. Despite these successes, challenges persist for this domain. These include: marked black/white disparities in infant mortality rates; high rates of sleep-related infant deaths (accounting for 20% of all infant deaths); and high rates of babies being born prematurely and at low birth weight.

In FY 2016-20, the major priority for this domain is to reduce infant mortality. This priority is a continuation from the

previous five-year cycle, as Tennessee's infant mortality rate still exceeds the national average. Title V will utilize these strategies to address this priority:

- Educate parents on safe sleep.
- Review infant deaths through multidisciplinary teams to enhance data collection.
- Support the system for regionalization of high risk perinatal care for pregnant women and infants.
- Provide follow-up for abnormal newborn screening results.
- Reduce unintended pregnancies.

Child Health

The percentage of Tennessee children without health insurance decreased to 2.4% in 2014 (down from 3.9% in 2010). Tennessee has a >90% completion rate on four of seven key childhood vaccines; for the remaining three vaccines, completion rates for 3 doses of each is approximately 95%. BMI data measured by school staff reveal that rates of overweight and obesity have decreased among K-12 students from 41% in the 2007-08 school year to 38.3% in 2013-14. Despite these successes, several key challenges remain, including: high rates of obesity among toddlers; high prevalence of adverse childhood experiences (ACEs) among Tennessee children (52% of children experience at least one ACE); and low rates of developmental screening.

Stakeholders identified four priority needs for this domain. For the 2016-20 cycle, Tennessee will focus on these four priority areas: 1) increase the number of infants and children receiving a developmental screen; 2) reduce the number of children who are overweight/obese; 3) reduce the burden of injury among children; and 4) reduce the number of children exposed to adverse childhood experiences Title V will utilize these strategies to address these priorities:

- Increase general awareness of the need for developmental screening.
- Support providers to integrate developmental screening as a part of routine care.
- Explore opportunities for incorporating developmental screening into settings outside of primary care.
- Increase general awareness of adverse childhood experiences (ACEs) in the community.
- Collect Tennessee-specific data on ACEs and utilize that data to inform program and policy decisions.
- Continue the Gold Sneaker voluntary recognition program for licensed child care centers.
- Operate the Tennessee Breastfeeding Hotline.
- Support the Office of Coordinated School Health in school-based efforts to promote physical activity and good nutrition.
- Promote the use of child safety seats.
- Promote safety in youth sports.
- Promote safe storage of medications.
- Disseminate child injury data to community partners.
- Provide injury prevention education to parents and caregivers.

Adolescent Health

The rate of teen births decreased 25% from 2010 to 2013. The percentage of adolescents receiving a preventive visit increased from 81.1% in 2007 to 85.9% in 2012. Similarly, adolescent vaccination rates increased from 2010 to 2013 (male and female HPV, Tdap, and meningococcal vaccines). Despite these successes, numerous opportunities for improvement exist in this domain. Tennessee has an increasing rate of youth suicide and the rate of deaths from motor vehicle crashes remains high. Additionally, more than a third of adolescents are overweight/obese, making them more likely to be overweight/obese as adults.

For the 2016-20 cycle, Tennessee will focus on these two priority areas related to improving adolescent health: 1) reduce the number of adolescents who are overweight/obese and 2) reduce the burden of injury among adolescents. Title V will utilize these strategies to address these priorities:

- Support the Office of Coordinated School Health in school-based efforts to promote physical activity and good nutrition.
- Collaborate with Chronic Disease Prevention and Health Promotion staff to engage communities in enhancing physical activity opportunities for youth.
- Reduce hospitalization rates due to motor vehicle accidents.
- Reduce hospitalization rates through promotion of proper storage and disposal of medications.
- Reduce hospitalization rates due to falls.
- Increase injury prevention information provided to the public.

Children and Youth with Special Healthcare Needs (CYSHCN)

Over the past five years, Tennessee has improved on four of the six national core measures related to children and youth with special health care needs and exceeds the national average on all measures. These include: families partner in shared decision-making (72.3%); CYSHCN have a medical home (45.9%); families of CYSHCN have adequate insurance (70.4%); CYSHCN receive early and continuous screening (79.1%); families of CYSHCN can easily access community-based services (71.5%); CYSHCN receive support for transitions to adult health care, work, and independence (41.8%). Despite Tennessee's relatively high performance on these outcome measures, there is substantial room for improvement on each measure.

In FY2016-20, the priority for this domain is to increase the number of children (both with and without special health care needs) who have a medical home. Title V will utilize these strategies to address these priorities:

- Support primary care providers in implementing a medical home approach to care.
- Increase general awareness of the importance of a medical home approach to care.
- Link families to medical homes through the Children's Special Services program.
- Enhance youth participation in the transition process.

Cross-Cutting/Life Course Issues

Tobacco exacts a major toll on the health of Tennessee's MCH population across the life course. Nearly one quarter (24.3%) of the adult population smokes, and 16.1% of women smoke during pregnancy. While pregnancy smoking has declined over the past few years, little progress has been made in the overall smoking rate among Tennesseans. High rates of smoking contribute to poor women's health and poor birth outcomes while secondhand smoke exposure leads to morbidity among Tennessee's children.

In FY2016-20, the priority for this domain is to reduce exposure to tobacco among the MCH population (pregnancy smoking and secondhand smoke exposure for children). Title V will utilize these strategies to address these priorities:

- Continue the Gold Sneaker voluntary recognition program for licensed child care centers (one of the policy areas is promotion of tobacco-free child care campuses).
- Collaborate with Tobacco Prevention and Control staff to promote the Tennessee Tobacco QuitLine.
- Refer participants in Title V programs to smoking cessation services where appropriate.

PLAN FOR MEASURING PROGRESS

MCH stakeholders identified at least one national performance measure (NPM) for each of the six MCH population domains. Tennessee's Title V program will report on the NPMs listed below each year. We will also develop evidence-based strategy measures for each priority; these will be reported in 2016. Additionally, we will develop a state performance measure (SPM) for the ACEs priority under the child health domain, since there is not a NPM available to adequately measure this priority.

Health Domain	Tennessee Priority	Related National Performance Measure
Women's and Maternal	Improve utilization of preventive care for women of childbearing age.	Percent of women with a past preventative medical visit.
Perinatal and Infant	Reduce infant mortality.	Percent of infants placed to sleep on their backs.
Child	Increase the number of infants and children receiving a developmental screen.	Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool.
Child	Reduce the number of children exposed to adverse childhood experiences.	No national performance measure relates to this priority. Tennessee will create a state performance measure for this priority in 2016.
Child and Adolescent	Reduce the number of children and adolescents who are overweight/obese.	Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day.
Child and Adolescent	Reduce the burden of injury among children and adolescents.	Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19.
CSHCN	Increase the number of children (both with and without special health care needs) who have a medical home.	Percent of children with and without special health care needs having a medical home. Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care.
Cross-cutting/Life Course	Reduce exposure to tobacco among the MCH population (pregnancy smoking and secondhand smoke exposure for children).	Percent of women who smoke during pregnancy. Percent of children who live in households where someone smokes.

II. Components of the Application/Annual Report

II.A. Overview of the State

Introduction

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

In 2013, the United States Census Bureau estimated Tennessee's population to be the 17th largest in the country at 6.54 million (74.9% White non-Hispanic, 17.0% Black or African American non-Hispanic, and 4.9% Hispanic). Tennessee's population grew by 2.4% from 2010 to 2013 (comparable with the national population increase of 2.5%). The 2010 census showed that 66.4% of the state's population lived in a metropolitan statistical area and 33.6% in rural areas. Nearly one quarter (24.4%) of the population lives in the two most populous metropolitan areas (Memphis and Nashville).

The 2013 American Community Survey reported that 17.6% of the state's population lived below the federal poverty level; this percentage was larger for children under 18 (25.3%) and families with related children under 18 years (21.4%). The highest rates of poverty (55.1%) were found among families with a female head of household, no husband present, and all children under age 5. Tennessee's poverty rates in all of these categories exceed those of the rest of the nation.

Health Status of Tennessee's MCH Population

According to America's Health Rankings, in 2014 Tennessee ranked 45th in the nation for overall health. Tennessee has historically ranked in the bottom ten states for this overall measure. The state ranks poorly on a number of key MCH population indicators, including:

- Children in poverty (45th)
- Low birthweight (44th)
- Teen birth rate (41st)
- Infant mortality (41st)
- Preterm birth (40th)

Despite Tennessee's recent improvements in many of these indicators, the state's progress is not keeping track with that of other states, and thus our relative rank is worsening. There is a need to accelerate our change to improve the health and well-being of the MCH population.

Three key factors (tobacco use, obesity, and physical inactivity) drive all of TN's top ten leading causes of death and influence two-thirds of the twenty-nine metrics making up TN's overall rank of 45th in Health in the US. Another key factor, substance abuse, contributes substantially to poor health outcomes including Neonatal Abstinence Syndrome and overdose deaths.

Women's/Maternal Health

In 2013, 22% of women 18 and older in Tennessee reported being current smokers. It is not surprising, then, that heart disease, cancer (particularly cancer of the trachea, lung, and bronchus), and chronic lower respiratory disease are the leading causes of death for women in Tennessee. Diabetes and hypertension are common among Tennessee women, affecting 12.0% and 38.1% of the population, respectively. Among women who become pregnant, 72.5% report beginning prenatal care in the first trimester. The most recent Pregnancy Risk Assessment Monitoring System (PRAMS) data indicate that 47.5% of pregnancies in Tennessee are unintended.

Perinatal/Infant Health

Each year, approximately 80,000 babies are born in Tennessee. Nine percent are born at low birthweight, with 1.6% born at very low birthweight. Sixteen percent of babies are born to mothers who smoked at some point during pregnancy. Breastfeeding rates have steadily improved, with 74.9% of Tennessee infants being ever breastfed (2014 Centers for Disease Control and Prevention (CDC) Breastfeeding Report Card). The infant mortality rate has improved by 15% over the past five years (from 8.0 in 2009 to 6.8 in 2013). Despite that progress, 6.8 of every 1,000 babies born will not live to see their first birthday. Over the past few years, Tennessee has seen a substantial increase in the number of infants born with NAS; in 2014, the case rate was 12.7 per 1,000 live births. Surveillance data indicate that more than two-thirds of the infants born with NAS were born to mothers who were using at least one substance known to cause NAS that was prescribed by a health care provider.

Child Health

Tennessee ranked 36th in overall child health and well-being in the Annie E. Casey 2014 Kids Count Data Book. Overweight/obesity remains a significant challenge for Tennessee; body mass index (BMI) data (collected by Coordinated School Health for the 2013-14 school year) indicate that 38.3% of K-12 students are overweight/obese. Recent trends are encouraging, however, as the percentage of overweight/obese students in 2013-14 represented a 6.8% relative reduction from the 2007-08 school year. Tennessee has historically had high childhood immunization rates. In the 2014 immunization survey of 24-month old children, Tennessee exceeded the HP 2020 objective of 90% on time coverage for 4 out of 7 vaccines in the 4:3:1:3*:3:1:4 series. Of note, there are no racial disparities for whole-series vaccination. There does remain a significant racial disparity in regards to influenza immunization, with 54.4% of White children receiving influenza vaccine as compared to 35.2% of Black children. ACEs are unfortunately quite common in Tennessee, with 52.9% of the population reporting at least one ACE. While the overall child fatality rate has decreased over the past five years, unintentional and intentional injuries remain a leading cause of death for Tennessee's children.

Adolescent Health

The rate of pregnancy among 10-17 year olds decreased by 46% from 2004-2013 in Tennessee. However, the rates of teen pregnancy for Black females is more than twice that of White females. In the 2013 Youth Risk Behavior Survey (YRBS), 47.5% of high school students reported ever having sexual intercourse; 32.6% reported having had two or more partners. Nine percent reported using alcohol or drugs before their last sexual encounter, and 38% of those who reported having had sex indicated that they (or their partner) did not use a condom the last time they had sexual intercourse. In the 2012-13 school year, 40.6% of high school students were noted to be overweight or obese. YRBS data from 2013 indicate that 17.6% of high school students reported not eating fruit in the past 7 days, 24.4% reported not eating vegetables in the past 7 days, and 26.8% reported drinking soda 4 or more times per day. While motor vehicle related hospitalizations and emergency department visits have generally remained unchanged over the past few years, motor vehicle deaths in this age group have declined over the past five years. Only 50.8% of high school students reported always wearing a seatbelt while riding in a car (YRBS, 2013).

Children and Youth with Special Healthcare Needs (CYSHCN)

The most recent National Survey of Children with Special Health Care Needs (2009/10) estimated that 255,692

CYSHCN live in Tennessee. The percentage of CYSHCN among children in Tennessee (17.2%) is higher than the national average (15.1%). Tennessee CYSHCN tend to rate higher than the national average on these MCHB core outcomes:

Outcome Measure	TN %	Nation %
CSHCN whose families are partners in shared decision-making for child's optimal health	72.3	70.3
CSHCN who receive coordinated, ongoing, comprehensive care within a medical home	45.9	43.0
CSHCN whose families have adequate private and/or public insurance to pay for the services they need	70.4	60.6
CSHCN who are screened early and continuously for special health care needs	79.1	78.6
CSHCN who can easily access community based services	71.5	65.1
Youth with special health care needs who receive the services necessary to make appropriate transitions to adult health care, work, and independence	41.8	40.0

Cross-Cutting Issues

Tobacco continues to be a major determinant of poor health across the lifespan of the MCH population. Nearly one quarter (24.3%) of Tennessee's adults smoke (BRFSS, 2013). According to the 2012 National Survey of Children's Health, 32.7% of Tennessee children (age 0-17) live in a household where someone smokes (compared to the national average of 24.1%). Pregnancy smoking is also problematic in Tennessee; 16.1% of women smoked during pregnancy in 2013, and in some counties the percentage was greater than 40%. Poverty is an important social determinant of health and is unfortunately quite prevalent across the MCH population in Tennessee (described previously in the Introduction).

Identifying the causes of mortality in a state is also important in understanding the health status for a population. In the supporting documents attached to this section, leading causes of death for Tennessee are compared with those in the United States as a whole (Source: CDC WONDER, 1999-2013). Among all the MCH populations, Tennesseans die at a higher rate for the causes listed in the table compared to the same cohort nationally. In the few cases where the relative order of cause of death in Tennessee is different from that of the rest of the nation, the rates of death in Tennessee still remain higher than the remainder of the country.

Health Disparities among Tennessee's MCH Population

Marked disparities exist among racial and ethnic populations for various MCH indicators in Tennessee. As shown in the table below, Black Non-Hispanic Tennesseans generally have higher rates of infant mortality risk factors compared to White Non-Hispanic and Hispanic populations.

	% Of Births with Risk Factor		
Risk Factors (2012)	**Black NH**	**White NH**	**Hispanic**
Low birthweight	14.0	8.1	6.2
Preterm birth	14.3	10.6	9.0
Teenage mother	14.6	8.8	9.9
Unmarried mother	78.7	33.9	50.9
No prenatal care	5.0	0.9	4.0
Late prenatal care	34.2	23.2	49.2
Smoked during pregnancy	6.8	16.8	1.8

Disparities also exist among the prevalence of overweight and obesity, another MCH priority. In Tennessee, Black non-Hispanic females have the highest rate of obesity among racial/gender groups (45.7%), compared with 29.9% of White non-Hispanic females. Black non-Hispanic males have a higher prevalence (35.0%) than their White counterparts (29.4%). A different disparity pattern emerges with adult tobacco use. Current smoking is highest among Black non-Hispanic males (36.9%), followed by White non-Hispanic males and females (26.7% and 24.5% respectively); Black non-Hispanic females have the lowest prevalence (15.7%). Among adolescents, smoking is far more prevalent among White non-Hispanics (35.0%) compared to Black non-Hispanics (16.5%).

In addition to racial/ethnic disparities, social determinants play an impact on the health and well-being of Tennesseans. Individuals are more likely to report a "fair" or "poor" health status if they have lower levels of income or education; nearly half of all individuals with incomes <$15,000 or with less than a high school education report fair/poor health, as compared to <10% of individuals with income >$50,000 or with a college degree (BRFSS, 2013).

Another important social determinant of health is the community/neighborhood environment. Disparities also exist across counties/regions and between urban and rural populations in Tennessee. For example, breastfeeding rates at hospital discharge are notably higher in metro/urban counties compared to rural counties in Tennessee. Smoking rates tend to be higher in rural counties than in metro/urban counties (and conversely, quit attempts are lower in rural populations). Pregnancy smoking rates follow a similar rural/urban disparity, with another caveat—pregnancy smoking rates tend to be higher in East Tennessee compared to West Tennessee. Tennessee's rural population is more likely to report fair/poor health, not having a personal doctor, and not having a checkup within the past year compared to urban populations. Life expectancy is lower in Tennessee's rural counties (compared to the nation, state, and Tennessee urban counties). "Place" is certainly an important consideration in understanding the health needs of the MCH population in Tennessee. Major population centers are linked by the interstate highway system. However, 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.

State Health Agency Priorities

Tennessee's Title V initiatives are housed within the Tennessee Department of Health (TDH), the cabinet-level public health agency. Additional information about organizational structure and capacity is found in Section II.B.b.i (Title V Program Capacity—Organizational Structure). The mission of TDH is to protect, promote, and improve the health and prosperity of people in Tennessee. The Departmental vision is to be a recognized and trusted leader, partnering and engaging to accelerate Tennessee to one of the nation's ten healthiest states.

Within TDH, Title V is administered by the Division of Family Health and Wellness (FHW). This Division manages the Department's portfolio of programs and initiatives related to Maternal and Child Health, Chronic Disease Prevention and Health Promotion, and Supplemental Nutrition.

TDH is currently emphasizing the "Big Three Plus One": tobacco use, obesity, physical inactivity and substance abuse. These indicators drive all of TN's top ten leading causes of death and influence two-thirds of the twenty-nine metrics making up TN's overall rank of 45th in Health in the US.

Public health efforts in Tennessee have long been focused on the MCH population. All of the current Departmental priorities (the "big three plus one") relate to the MCH population, and the Department is committed to improving the health and well-being of the MCH population across the life course.

The Department is also broadly focusing on primary prevention—preventing disease before it ever occurs. The Commissioner has encouraged employees to spend 5% of their time engaging community partners in primary prevention activities through the Primary Prevention Initiative (PPI). The first wave of topic areas included multiple projects related to the MCH population:

- Immunizations
- Infant Mortality
- Adolescent Pregnancy
- Substance Abuse
- Obesity
- Suicide Prevention
- Tobacco Prevention and Control
- Health Care Associated Infections
- Occupational Safety

As of May 2015, TDH staff in all 95 counties have participated in over 950 projects in Tennessee communities and a total of 15 successful PPI projects ("bright spots") have been replicated.

In addition to programmatic and policy efforts on these other public health topics, the Department has undertaken a major commitment to performance excellence using the Baldrige framework. As of April 2015, the Department had received Level 2 Baldrige recognition, and 26 individual county health departments, 2 public health regions, and 4 divisions/offices within the TDH Central Office are pursuing Baldrige recognition.

Health Facilities and Provider Availability

There are 66 birthing hospitals in Tennessee (hospitals with >50 deliveries/year) plus five non-hospital birthing centers.

As of June 2015, Tennessee has 16 critical access hospitals in place to preserve access to local primary and emergency health services. These hospitals are located in counties with less healthier populations (higher rates of obesity, diabetes, preventable hospitalizations, cardiovascular deaths and cancer deaths compared to the rest of the state and the nation). Additionally, these hospitals are located in counties with fewer physicians and with a higher proportion of patients who live in poverty and who are enrolled in Medicaid.

As of May 2014, 60 counties were designated as either whole- or partial-county federal health professional shortage areas (HPSAs) for Primary Care (based on low-income or geography). All but six counties are designated as federal HPSAs for dental and all but five counties are designated as federal HPSAs for mental health. Ninety-four of the 95 counties are designated as medically underserved areas or as having medically underserved populations.

The distribution of primary care providers varies across the state. A map with health resource shortage areas for obstetrics and pediatrics is attached to this section. As of June 2015, the following counts of full-time or part-time, actively licensed providers were available through the TDH Division of Health Licensure and Regulation:

- Obstetrics/Gynecology (includes GYN surgery): 785
- Family Medicine/General Practice: 2004
- Pediatrics (includes subspecialties): 1677

Health Insurance Coverage

The University of Tennessee Center for Business and Economic Research estimates that 7.2% of all Tennesseans were uninsured in 2014. This percentage is much lower for children under 18 (2.4%) as compared to adults 18 and older (8.7%). The percentages of uninsured children and adults have declined over the past five years (from highs of 3.9% and 12%, respectively, in 2010). The major reason that people report being uninsured is that they cannot afford health insurance (86% of those uninsured) rather than not being able to get to it (11%) or not needing insurance (12%). Not being able to afford insurance was cited more frequently among uninsured individuals earning less than $10,000 (94%) but was still a significant barrier even for individuals making more than $50,000 (59%).

Health Care Reform Efforts and ACA Implementation

Tennessee's modern efforts at health reform began in 1994 with the introduction of TennCare, Tennessee's Medicaid program. TennCare is the only program in the nation to enroll the entire state's Medicaid population in managed care. The TennCare program operates under a Section 1115 waiver from the Centers for Medicare and Medicaid Services (CMS) in the United States Department of Health and Human Services. Unlike traditional fee-for-service Medicaid, TennCare is an integrated, full-risk, managed care program.

TennCare provides health care for approximately 1.3 million Tennesseans and operates with an annual budget of approximately $10 billion. TennCare members are primarily low-income pregnant women, children and individuals who are elderly or have a disability. TennCare covers approximately 20 percent of the state's population, 50 percent of the state's births, and 50 percent of the state's children. TennCare is a critical and valuable partner in serving Tennessee's MCH population.

TennCare services are offered through managed care entities. Medical, behavioral and Long-Term Services and Supports are covered by "at-risk" Managed Care Organizations (MCOs). All of TennCare's MCOs are ranked among the top 100 Medicaid health plans in the country. The care provided by TennCare's MCOs is assessed annually by the National Committee for Quality Assurance (NCQA) as part of the state's accreditation process. The program continues to see improvements in quality measures - 81 percent of quality measures tracked by NCQA have seen improvements since 2007. In addition to the MCOs, there is a Pharmacy Benefits Manager for coverage of prescription drugs and a Dental Benefits Manager for coverage of services to children under age 21.

In 2013, Governor Haslam launched the Tennessee Health Care Innovation Initiative to change the way that the State pays for health care. Tennessee's publicly-funded health care expenditures have traditionally followed a fee-for-service model, thus rewarding efforts based on volume (and not necessarily on quality). The Governor's goal is to "move from paying for volume to paying for value."

Tennessee successfully competed for a State Innovation Model (SIM) grant from the Center for Medicare and Medicaid Services and this grant is funding the payment reform initiative. Efforts are being led by Health Care Finance and Administration (HCFA), the state agency responsible for, among other things, Medicaid and the Children's Health Insurance Program (CHIP). Key initiatives as part of the SIM project include the development of "episodes of care" and patient-centered medical homes.

In December 2014, Governor Haslam introduced a plan to help provide new health coverage options to the state's uninsured. He proposed "Insure Tennessee" as a two year pilot program to provide health care coverage to Tennesseans who currently do not have access to health insurance or have limited options. The program was designed to reward healthy behaviors, promote personal responsibility and incentivize preventative care and healthy choices. The plan would provide coverage to more than 200,000 uninsured Tennesseans earning less than 138

percent of the federal poverty level. Implementation of Insure Tennessee required approval by the Tennessee General Assembly as well as by the Department of Health and Human Services. A special session of the General Assembly convened in January 2015 to review the Insure Tennessee proposal; the proposal failed to pass out of committee. Legislative sponsors revived the proposal again in April 2015, but it failed to pass out of Committee.

Determination of Factors Impacting Health Services Delivery in the State

The Title V Director utilizes multiple methods to determine the importance, magnitude, value and priority of competing factors which impact health services delivery in the state. In 2014 and 2015, Tennessee's Title V Program completed the Needs Assessment that is required for the MCH Block Grant Report/Application. The needs assessment included 26 focus groups and 5 community meetings to gather input on priorities and capacity from consumers, parents of young children, parents of CYSHCN, under-represented populations, and healthcare providers. The assessment also included an analysis of more than 160 quantitative indicators describing the health of the six MCH population domains. A complete description of the needs assessment process and findings is included in the full needs assessment document. This assessment has informed the eight state priority needs on which Tennessee's Title V Program will focus for the upcoming five-year grant cycle. Ongoing needs assessment throughout the interim years will inform whether current programmatic efforts are working well to address the priority needs or whether modifications need to be made.

On a bi-monthly basis, the Title V director convenes a teleconference with the Regional MCH directors from the 13 public health regions across the state. These calls are an opportunity to hear about needs or challenges in counties and regions across the state. The call is also an opportunity to disseminate important program or policy updates related to the MCH population.

County health councils meet regularly to discuss important health topics in their local community. Public health staff actively participate in these councils, which provide a venue for sharing issues that impact local residents (including the MCH population). Local or regional public health staff can share information with the state Title V Program leadership when MCH-related issues arise. Conversely, the local councils sometimes ask Title V program staff (from the Regional or Central Office) to present on MCH-related topics of interest, allowing for the spread of program and policy information to the county level.

Title V Program staff have frequent communications with health care providers, on an individual level (typically around a particular case/patient) or through their professional organizations. For example, the Title V Director routinely participates in the board meeting for the Children's Hospital Alliance of Tennessee (CHAT), which represents the children's hospitals in Tennessee. Title V and other public health staff frequently present at professional association meetings (such as the state meeting of the Tennessee Chapter of the American Academy of Pediatrics, TNAAP). Title V has also partnered with TNAAP to host a forum at the annual TNAAP meeting to allow for dialogue between pediatric providers and state child- and family-serving agencies and programs (Title V, immunizations, child welfare, Medicaid, etc). All of these opportunities prove to be valuable in gaining insight into the current needs and challenges facing Tennessee's MCH population.

Current and Emerging MCH Issues

Based on the Five-Year Needs Assessment, Tennessee has identified these 8 priorities for the MCH population:

1. Improve utilization of preventive care for women of childbearing age.
2. Reduce infant mortality.
3. Increase the number of infants and children receiving a developmental screen.
4. Reduce the number of children and adolescents who are overweight/obese.
5. Reduce the burden of injury among children and adolescents.
6. Reduce the number of children exposed to adverse childhood experiences.
7. Increase the number of children (both with and without special health care needs) who have a medical home.

8. Reduce exposure to tobacco among the MCH population (pregnancy smoking and secondhand smoke exposure for children).

In addition to these priorities, a number of other "emerging" issues were identified during the needs assessment and through conversations with agency staff and key stakeholders. Title V program staff will continue to monitor these issues and, where possible, identify opportunities for programmatic or policy interventions. These issues include:

Substance abuse among women of childbearing age: Tennessee has high rates of opioid prescribing, misuse and abuse as well as drug-related overdose. Opioid misuse and abuse among women of childbearing age has led to an epidemic of NAS. TDH is working to identify and implement primary prevention strategies related to NAS, namely to 1) prevent opioid misuse/abuse from ever occurring, and 2) prevent unintended pregnancies among women who are at high risk of opioid misuse/abuse.

Electronic nicotine delivery systems: The use of electronic nicotine delivery systems (including e-cigarettes) among adolescents is on the rise. There are serious concerns about adolescents e-cigarette use related to long-term tobacco use, as well as unintentional nicotine poisoning among young children.

Autism spectrum disorders: With the rising incidence of autism spectrum disorders, there is growing recognition of the need for early screening as well as more rapid diagnosis and connection to treatment. Additionally, public health and health care systems need to identify ways to improve the system of care for children with autism and their families.

State Statues and Other Regulations Impacting Title V

Numerous state laws and regulations impact the operation of Title V services in Tennessee. Many of the laws provide Departmental authority to operate programs such as Family Planning, Children's Special Services (CSS, Tennessee's state Title V CYSHCN program), evidence-based home visiting, fetal infant mortality review (FIMR), child fatality review (CFR), or teen pregnancy prevention.

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

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

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

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

A list of MCH-related laws is included in the supporting documents section.

II.B. Five Year Needs Assessment Summary

II.B.1. Process

Introduction

The TDH Division of Family Health and Wellness is responsible for the administration of funds provided to the state by the federal Title V MCH Block Grant. This grant is divided into five year cycles. At the beginning of each cycle a comprehensive needs assessment is required, while an on-going Needs Assessment is expected during interim years. The comprehensive needs assessment summarized in this document and described fully in the accompanying *Title V Maternal and Child Health Block Grant Five Year Needs Assessment* fulfills the requirement for the 2016-2020 grant cycle.

Goals

The overarching goals of the Needs Assessment were to identify the health needs of the MCH population in Tennessee in order to set Tennessee's Title V Program priorities for the new grant cycle (FY2016-FY2020), determine performance objectives and develop measures to track progress, and to plan strategies and activities to address the chosen priorities. The Needs Assessment was deliberately designed to be inclusive to gather input from a diverse group of MCH stakeholders throughout the entire process.

Framework

Tennessee's Title V program utilized the "State Title V MCH Program Needs Assessment, Planning, Implementation and Monitoring Process" framework as depicted in the Title V Maternal and Child Health Block Grant to States Program Guidance. The framework is intended to be a continuous cycle and includes these key components:

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

By utilizing this framework, Tennessee's Title V Program leadership was able to acquire a realistic view of the state's MCH needs and public health system capacity in order to develop a five year plan based on key MCH priorities that align with the Title V authorizing legislation.

Methodology Overview

Tennessee began the five-year needs assessment planning process in summer 2014. The entire process was coordinated by Julie Traylor, a CDC/CSTE Applied Epidemiology Fellow assigned to FHW during 2013-15. Ms. Traylor established three leadership groups to guide the work of the needs assessment:

- The Title V Leadership Team consisted of the state Title V and CYSHCN directors as well as senior leadership from the TDH Division of Family Health and Wellness. This group approved the overall plan for the needs assessment (including data collection), performed the capacity assessment, provided program expertise at the large stakeholder prioritization meeting, and developed the final list of priorities based on stakeholder input.
- The Epidemiology Team consisted of staff epidemiologists from FHW and the TDH Division of Policy, Planning and Assessment. This team developed the methodology for all data collection and completed the analysis of

qualitative and quantitative data. They also provided data expertise at the stakeholder prioritization meeting and assisted program staff in developing objectives for the action plan.

- The MCH Stakeholder Group consisted of a diverse array of key MCH stakeholders from other departments within state government, local and regional health departments, advisory committees, professional organizations, providers, family organizations, and non-profit organizations. Group members provided input throughout the needs assessment and were key participants in the prioritization process.

A full list of all team members is included as Appendix A in the accompanying Needs Assessment document.

During the summer of 2014, the Title V Leadership and Epidemiology teams convened to develop a list of potential quantitative indicators for analysis. They populated this list based on previous MCH Block Grant performance and outcome measures, anticipated performance measures from the new Block Grant cycle, and various program or Departmental priorities. The only requirement for inclusion on the indicator list was that a trusted data source was available.

The Title V Director and Needs Assessment Coordinator facilitated an introductory meeting of the MCH Stakeholder Group (which was also broadcast via webinar) to provide background information on the MCH Block Grant, explain the purpose of the stakeholder group, describe the needs assessment process, review proposed topics for data analysis, and identify opportunities for involvement. Roughly forty stakeholders attended this introductory meeting. Based on stakeholder input, an additional 10 indicators were added to the quantitative data analysis plan.

The Epidemiology Team subsequently analyzed approximately 160 quantitative indicators proposed by leadership, program staff, and stakeholders. Simultaneously, the Needs Assessment Coordinator planned and/or facilitated 26 focus groups and 5 community meetings across the state to gather qualitative input on Tennessee's MCH population needs and the public health system's capacity to meet those needs. The Needs Assessment Coordinator and Epidemiology Team also analyzed the qualitative data from the focus groups and community meetings. Additional details about the quantitative and qualitative methods used in this Needs Assessment are described later ("Quantitative and Qualitative Methods").

Following the data analysis, the Needs Assessment Coordinator facilitated a day-long meeting of the MCH Stakeholder Group as well as various Tennessee Title V Program staff. Approximately 65 individuals attended the meeting, during which the results of the quantitative and qualitative data analyses were presented and stakeholders voted on potential priorities as well as national performance measures. This process is further described in "Interface Between Data Collection, Prioritization, and Action Plan Development."

The Title V Leadership Team subsequently met and determined the final list of priorities and national performance measures (based largely on the stakeholder input from the prioritization meeting). Stakeholders were again given the opportunity to provide input on the final list of priority needs and performance measures during the four-week public comment period (see section II.F.6, Public Input).

Stakeholder Involvement

The MCH Stakeholder Group played an integral role in the entire Needs Assessment process. They provided initial input on the structure of the Needs Assessment and the content of the quantitative data review; offered qualitative input at focus groups and community meetings (and in some cases hosted or co-facilitated the meetings); ranked potential priorities and performance measures at the prioritization meeting; and provided thoughtful comments during the public comment period prior to grant submission.

We firmly believe that continuous engagement of the stakeholder group throughout the process has enhanced the final product. As we solidify our action plan over the next year, we hope that their input and partnership will allow us to accomplish more than what we could in isolation. As additional stakeholders are identified, they will be invited to participate in this ongoing dialogue. Continued stakeholder engagement will allow for a more robust ongoing needs assessment in interim years.

Quantitative and Qualitative Methods

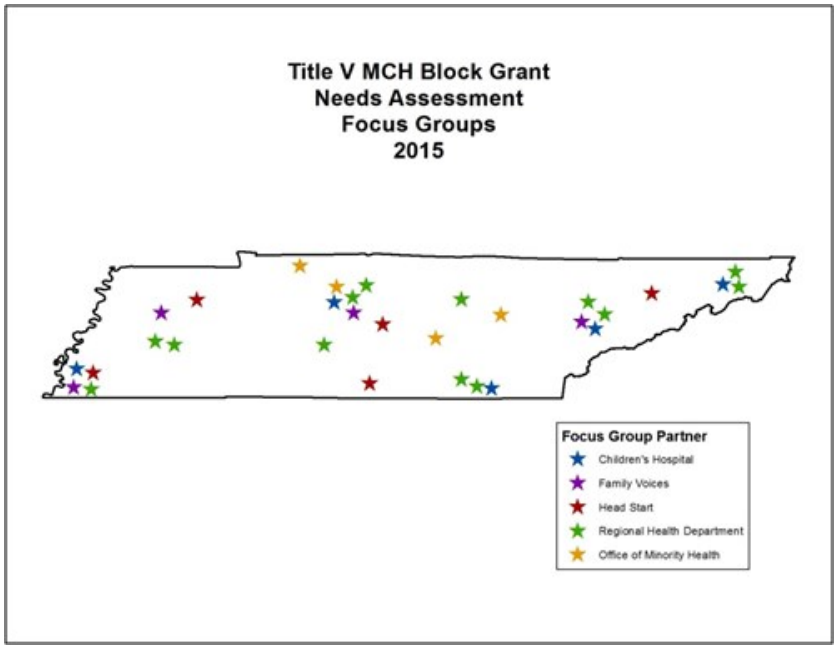
The Epidemiology Team divided the quantitative indicator list (based on prior program knowledge or interest). Epidemiologists identified a data source for each indicator and gathered data for the most recent years available (the goal was to have at least five data points per indicator to allow for trend analysis). Data were gathered from sources internal and external to TDH.

The epidemiologists graphed each quantitative indicator and where available made comparisons by race/ethnicity or geography. A complete presentation of all the quantitative data can be found in the accompanying needs assessment document.

Different methods of qualitative data collection were considered; ultimately the Title V Leadership Team decided that focus groups and community meetings would be used for this portion of the needs assessment. Focus groups were limited to twelve participants, whereas community meetings were open to up to fifty participants. The smaller groups allowed for more time to discuss topics in-depth, whereas the larger groups were able to capture a wider array of opinions.

Focus group sessions were held in conjunction with key MCH partners. The target populations (with number of sessions and key partners in parentheses) were: consumers of local health department services (13 sessions; Regional MCH health department staff); parents of young children (5 sessions; local Head Start agency staff); parents of CYSHCN (4 sessions; state Family Voices staff); and under-represented minority populations (4 sessions; TDH Office of Minority Health and Disparities Elimination). Additionally, five larger community meetings were held with providers who serve the MCH population. These meetings were hosted at five children's hospitals across Tennessee in conjunction with the Children's Hospital Alliance of Tennessee. For each type of session effort was made to host groups in different geographic areas of the state, as well as both rural and urban settings (see Figure 1).

Figure 1



Each partnering agency recruited participants and provided the space to hold the session. TDH provided food and $25 Dollar General incentive cards for the participants of focus groups. The Needs Assessment Coordinator facilitated all of the focus group sessions except those conducted in local health departments and with

underrepresented minorities. To ensure consistency across groups, the Coordinator trained all other facilitators on methodology for coordinating and facilitating the focus groups. The Title V Director conducted the provider community meetings. Focus group and community meeting questions were organized to assess needs and capacity. The complete list of questions is included as Appendix B in the full needs assessment document. Prior to the first focus group, the questions were pilot tested with TDH administrative staff to gauge how participants might interpret them and adjust if necessary. The Coordinator learned valuable lessons in focus group facilitation from the pilot, but no concerns were raised over the wording of questions.

Two people managed each focus group. One individual facilitated the group discussion and captured the group comments on a flip chart; the other made independent notes during the discussion. They independently recorded their notes and then the two sets of notes were compiled into one raw qualitative data set.

The Title V Director and the Needs Assessment Coordinator reviewed the raw data and based on the content of the responses, created a code list. They then coded each of the individual responses (over 2,000). The Needs Assessment Coordinator then utilized NVivo (a software package used to analyze qualitative data) as well as Microsoft Excel to determine the frequency of particular themes or issues using the coded data. The responses were analyzed by question (as asked to the focus group participants). The Needs Assessment Coordinator compiled the responses, in order of frequency, and presented these to the Title V Leadership Team, Epidemiology Team, and MCH Stakeholder Group.

To assess MCH program capacity and the extent of partnerships/collaborations, the Title V Director queried the Title V Leadership Team regarding the Department's ability to provide essential MCH services in accordance with the Title V legislative requirements. Leaders were also asked to submit any known legislative mandates related to Tennessee's MCH population and to provide a listing of key partnerships and collaborations related to MCH program activities. The various responses were compiled and shared at the stakeholder prioritization meeting for broad stakeholder input.

Data Sources

The needs assessment utilized program, survey, and population level data. Data was gathered from sources both within and outside the health department. Whenever possible, state and national level data was included for comparison purposes. A complete list of data sources can be found in Appendix C of the full needs assessment document.

Interface Between Data Collection, Prioritization, and Action Plan Development

A prioritization input meeting was held in early spring of 2015 and was attended by approximately 65 stakeholders. The Needs Assessment Coordinator and Title V Director provided an overview of the capacity assessment, legislative mandates, partnerships/collaborations, and qualitative data from the focus groups and community meetings.

After the initial presentation, stakeholders were divided into six groups and they rotated through six stations (each featuring quantitative data related to one of the MCH population domains). Each station was facilitated by FHW program staff and an epidemiologist. At each station, stakeholders had an opportunity to ask questions and offer feedback. Following each presentation, stakeholders were asked to complete a scoring matrix to rank potential priorities on a series of objective criteria. A copy of the scoring matrices can be found in Appendix D of the full needs assessment document. At each station, stakeholders could also nominate "write-in" priority topics that had not been previously included; these topics were compiled and all stakeholders were asked to vote on these prior to the end of the meeting. Attendees were also allowed to vote for one national performance measure within each domain; this input was used to help choose the national performance measures for this five year grant cycle.

At the end of the prioritization meeting, all attendees were asked to complete an evaluation (a copy of which can be found in Appendix E of the full needs assessment document). Overall the day was very well received. A list of free-

text comments from the evaluation meeting can be found in Appendix F of the full needs assessment document.

After the prioritization meeting, the Epidemiology Team analyzed the data from all the scoring matrices and calculated a composite score for each potential priority within each domain. The epidemiologists also tabulated the votes on the potential national performance measures. The Title V Leadership team utilized these data to determine the final list of priorities and national performance measures. A full listing of the rankings is in Appendix G of the full needs assessment document. Title V leaders and MCH program staff subsequently developed the state action plan based on the priority needs and performance measures. The priorities, performance measures, and action plan were then made available for public comment.

II.B.2. Findings

II.B.2.a. MCH Population Needs

The following state priority needs were identified as a result of the Needs Assessment process:

1. Improve utilization of preventive care for women of childbearing age.
2. Reduce infant mortality.
3. Increase the number of infants and children receiving a developmental screen.
4. Reduce the number of children and adolescents who are overweight/obese.
5. Reduce the burden of injury among children and adolescents.
6. Reduce the number of children exposed to adverse childhood experiences.
7. Increase the number of children (both with and without special health care needs) who have a medical home.
8. Reduce exposure to tobacco among the MCH population (pregnancy smoking and secondhand smoke exposure for children).

Details on the quantitative and qualitative data used to derive these priorities can be found in the accompanying needs assessment document. The narrative below describes the health status, strengths, and needs for each of the six MCH population domains. Note that the State Action Plan discusses Title V-specific programmatic approaches that are working well and should be continued as well as priority areas in which new or enhanced strategies/program efforts are needed.

Women's/Maternal Health

In general, there are high rates of chronic disease and poor health habits among Tennessee women. For example, nearly one third of women (30.2%) are obese (BRFSS, 2012). Poor nutrition contributes to this high rate of obesity; 41.6% and 21.2% of women report eating fruits and vegetables less than once a day, respectively (BRFSS, 2013). Diabetes, known to be associated with obesity, is more common among Tennessee women age 18-44 (4.5%) than nationally (3.3%, BRFSS 2012). The rates of obesity and diabetes increased between the 2011 and 2012 BRFSS cycles. For all of these indicators, Tennessee performs more poorly than the nation as a whole.

Obesity in a woman of childbearing age also has the potential to impact the health and well-being of her offspring. In 2013, 49.6% of births were to women who were overweight or obese before pregnancy, increasing the likelihood of maternal and infant complications; these numbers suggest that the BRFSS data may actually underestimate the obesity prevalence among Tennessee women.

Routine utilization of preventive care is important strategy for preventing chronic diseases like obesity. Ideally, primary prevention efforts will help to prevent obesity before it ever occurs; however, if a woman is overweight or obese, it is important that she connect with a health care provider on at least a routine basis to identify strategies for weight management and to manage any other comorbid conditions. In 2012, 74.7% of Tennessee women aged 18-

44 reported a preventive care visit in the past 12 months. Similarly, 80.1% reported receiving a Pap test within the past three years and 73.3% (over age 40) reported receiving a mammogram within the past two years. While these numbers are encouraging (and typically at or above the national rate), preventive care remains of paramount importance in preventing disease and disability among women. The impact of preventive care is not limited to the woman. Analysis of the perinatal periods of risk in Tennessee show that the highest attributable fraction of fetal and infant deaths is due to maternal health/prematurity. Thus, a focus on helping women become and stay healthy before and between pregnancies (preconception and interconception care, respectively) should also help improve the health and well-being of Tennessee's infants.

Perinatal/Infant Health

Tennessee's infant mortality rate, a longstanding public health priority, has improved substantially in the recent past. The rate decreased by 15% from 2009 to 2013, yet at 6.8 per 1,000 live births remains higher than the national average (6.1 in 2013). Despite these improvements, marked racial disparities remain. Black infants are more than twice as likely to die as white infants in Tennessee. Despite reductions in overall infant mortality, the prevalence of preterm birth and low birth weight have remained fairly stable over the past five years. Both of these risk factors are more common among black infants, contributing to the higher infant mortality rate in this population.

Tennessee has had a regionalized system of perinatal care since the late 1970's. In 2013, 82.4% of very low birth weight infants were born at an appropriate level of care (Level 3 or higher). This robust system of care has played an important role in providing care for the most critically ill mothers and neonates, thus contributing to Tennessee's reductions in infant mortality (as evidenced by a decrease in deaths related to prematurity).

While the number of sleep-related infant deaths has declined over the past few years (from 1.7 per 1,000 live births in 2010 to 1.3 in 2013), these preventable deaths still account for 20% of all infant deaths. Statewide child fatality review data indicate that side or stomach sleep positions (which are unsafe) are common among the sleep-related infant deaths. TDH implemented a massive statewide public awareness campaign and a hospital-based safe sleep project in 2014. While progress has been made in this area, sleep-related infant deaths remain a significant contributor to the state's high infant mortality rate.

Another important factor in improving birth outcomes and infant health is breastfeeding. Breastfeeding rates have steadily improved in Tennessee over the past five years; in 2013, 73.8% of infants were being breastfed at hospital discharge. Over the same time period, birthing hospitals have made improvements in their promotion and support of breastfeeding, with mPINC scores increasing from 57 to 75 from 2007 to 2013. Despite these improvements, there remain racial disparities in breastfeeding initiation and overall, Tennessee's breastfeeding initiation, exclusivity, and duration indicators lag behind the nation.

Child Health

Many health problems that begin in childhood can have long-term effects on the individual's health. While primary prevention of health problems is always desirable, consistent screening (secondary prevention) is also important in routine child health care. Developmental screening is part of the established standard for routine pediatric care, yet only 38.3% of Tennessee parents reported that their children had been screened for developmental, behavioral, and social delays (National Survey of Children's Health (NSCH), 2012). While this percentage is higher than the national score (30.8%), there remains significant opportunity for improvement to identify problems early and where possible, to address them and eliminate or mitigate later complications.

In recent years the link among ACEs, brain development and long term health has become clearer. In 2012 a question on ACEs was added to the NSCH. Based on the data from that survey an estimated 52.9% of children in Tennessee have experienced an ACE. These experiences may have a marked effect on the health of Tennesseans for years to come. This high rate of ACEs is corroborated by data from the Tennessee Department of Children's Services (DCS), which show a steady upward increase in substantiated child neglect allegations and a persistently

high level of confirmed maltreatment cases over the past five years. Efforts to improve the long-term health and well-being of the MCH population must therefore include efforts to reduce ACEs.

Overweight and obesity are highly prevalent among Tennessee's children and pose great threats for their lifelong health and well-being. In Tennessee, Coordinated School Health staff conduct annual BMI measurements of students in grades K-12 (even grade levels for K-8 and once during high school). In the 2013-14 school year, 38.3% of students were overweight or obese. Being overweight or obese during childhood greatly increases the risk of being overweight or obese during adulthood. Throughout the life span, excess weight leads to a host of morbidities involving multiple organ systems and ultimately to early mortality. Improving the weight status of Tennessee's children will have a major impact on the health of the overall population.

As with most states, injury is a leading cause of morbidity and mortality for Tennessee's children. Tennessee's rates of unintentional injury death (11.4 per 100,000 in 2013) exceed the national average (8.0 in 2013). Injury-related deaths, however, just represent the top of the "injury pyramid," in that for every injury death there are more hospitalizations, far more emergency department visits, and even more outpatient physician's office visits. Any effort to improve child health must include efforts to prevent injuries from ever occurring.

Adolescent Health

Given the high prevalence of overweight/obesity among Tennessee's children, the high rate of adolescent overweight/obesity is not surprising. In 2012, 34.1% of adolescents age 10-17 years were overweight or obese, compared to the national average of 31.3% (NSCH 2012). As has been previously described, obesity is linked to numerous short- and long-term health complications. Nearly one in ten high school students reports not eating a fruit or vegetable in the past 7 days, 23.8% reported drinking soda two or more times a day, and only 23.9% were active for 60 minutes or more per day during the past week. Tennessee performs more poorly than the rest of the nation on these indicators. Efforts to prevent or reduce obesity during adolescence are essential for improving the long-term health and well-being of Tennesseans.

Injury morbidity and mortality is typically high during adolescence due to increased risk-taking behavior. In Tennessee, the rate of unintentional injury deaths among adolescents (35.3 per 100,000) is higher than the national rate (30.8). Motor vehicle-related deaths contribute significantly to these deaths in Tennessee and nationally. Violence-related injury deaths are particularly notable in Tennessee, where the rate of weapon-related deaths and homicide deaths are substantially higher than the national rates. In 2013, one in ten high school students in Tennessee reported being a victim of sexual assault; this percentage is similar to the 2005 level and higher than the national rate of 7.3% (YRBS, 2013). Crime data from the Tennessee Bureau of Investigation show a decrease in the rate of adolescent sexual assault victims, suggesting that youth may not be reporting all sexual assaults to authorities. Suicide is also a concern among this population. In 2012 and 2013 the percentage of suicide attempts and completions among Tennessee adolescents was higher than the national average. Given these statistics, injury prevention is a necessary priority for promoting and improving the health of Tennessee's adolescents.

CYSHCN

According to the National Survey of Children with Special Health Care Needs (NS-CSHCN), the prevalence of children with special health care needs in Tennessee is slightly higher (17.2%) than that of the U.S (15.1%, NS-CSHCN 2010). While Tennessee's CYSHCN generally perform better on the six core outcomes for CYSHCN compared to children nationally, much opportunity remains for improvement.

In 2012, 49.9% of Tennessee CYSHCN reported having a medical home, compared to the national average of 46.8%. All children, but especially those with special health care needs, can benefit from use of the medical home approach to care outlined by the American Academy of Pediatrics. One important component of the medical home approach is a deliberate transition from pediatric to adult medical care. This is particularly important as more youth with chronic conditions are living into adulthood. In Tennessee, only 41.8% of youth with special health care needs

reported receiving services for transition to adult healthcare, work and independence (compared to 40.0% nationally, NS-CSHCN). Continued efforts to increase the percent of all children, especially CYSHCN, who have a medical home should result in improved health outcomes. An important and necessary component of those efforts will be a focus on transition to adulthood.

Cross-Cutting/Life Course

Tobacco is one of the leading contributors to poor health outcomes in Tennessee and impacts the MCH population across the life course. Cross-cutting efforts are needed to reduce the number of Tennesseans who use tobacco and who are exposed to tobacco at all ages. Of particular concern is the high percentage (16.1%) of women who smoke during pregnancy. While this number has decreased from 18.8% in 2008, more than one in six pregnancies in Tennessee are at increased risk of premature birth and low birth weight due to prenatal smoking. As prematurity and low birth weight are major contributors to Tennessee's high infant mortality rate, progress in this area would also impact the perinatal/infant health domain. A reduction in the percentage of women who smoke during pregnancy will not only impact the infant, but also would result in improved health outcomes for the mother.

Nearly one-third (32.7%) of Tennessee children and adolescents live in a household where someone smokes . This is substantially higher than the national average of 24.1% (NSCH, 2012). While this percentage represents a slight decrease from 33.5% in 2007, far too many children and adolescents are exposed to a substance that may have harmful (even fatal) consequences, including lung cancer, respiratory illnesses, and cardiovascular diseases. Unlike their adult counterparts, children and youth may have less control over their environment and are subjected to the dangers of tobacco even without smoking. Strategies to reduce secondhand smoke exposure among children and adolescents will likely, by extension, also impact adult tobacco consumption.

II.B.2.b Title V Program Capacity

The following section summarizes the adequacy and limitations of Tennessee's Title V Program capacity and partnership building efforts relative to addressing the state priority needs. A more detailed capacity assessment is contained in the accompanying needs assessment document.

II.B.2.b.i. Organizational Structure

Tennessee's Title V MCH and CSHCN programs are administered by TDH, the state health agency. The mission of TDH is to protect, promote, and improve the health and prosperity of people in Tennessee. The Department is a cabinet-level agency that reports to Governor Bill Haslam. In 2012, Governor Haslam appointed Dr. John Dreyzehner, MD MPH FACOEM as the Commissioner of TDH. Within TDH, Title V MCH and CYSHCN activities are administered by FHW, which is led by Dr. Michael Warren, MD MPH FAAP. Within FHW, the Director of CYSHCN Services is Jacqueline Johnson, MPA. Julie Traylor, MPH, CLC is the Title V MCH Block Grant Coordinator. FHW oversees TDH activities related to Maternal and Child Health, Chronic Disease Prevention and Health Promotion, and Supplemental Nutrition. Organizational charts for TDH and FHW are included in the supporting documents section.

The TDH Central Office is located in Nashville (the state capital); staff within FHW provide administrative leadership to Tennessee's Title V MCH and CSHCN programs, set program policy and monitor compliance with state and federal laws and rules, and offer technical assistance to staff in regional and local/metro health department offices regarding these programs. In addition to FHW, a number of other divisions/offices within the Central Office support MCH efforts across the State.

Title V funding is used in numerous ways to support the MCH population in Tennessee, as outlined in the accompanying needs assessment document. FHW program staff provide programmatic monitoring of all MCH-related services. Some program activities are administered directly by TDH staff in local or regional health

departments. Other services are administered through a contractual relationship; for example, TDH contracts with the six metropolitan health departments to provide core MCH services (e.g., Family Planning, Children's Special Services, targeted case management, etc) as well as with community non-profit agencies for services that cannot be provided by health department staff (e.g., evidence-based home visiting, Breastfeeding Hotline, Poison Control Center, etc). FHW program staff monitor all services for compliance with programmatic guidelines/policies and relevant state and federal laws.

II.B.2.b.ii. Agency Capacity

Agency Capacity

With local health departments in all 95 counties, robust community partnerships, and contractual arrangements with numerous service providers, TDH is well-positioned to protect and promote the health of all mothers and children, including CSHCN. The capacity for providing Title V services (specifically related to the state priority needs) is listed by the six population health domains below. Additional information on other MCH capacity is found in the full needs assessment document.

Women's/Maternal Health

Local health departments provide preventive services for women (such as clinical breast exams and pap smears); family planning; STI/HIV screening; and breast and cervical cancer screening. Local health department staff determine presumptive eligibility for Medicaid for all pregnant women. All 95 counties offer case management services for high-risk pregnant women. The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) is co-located in each county health department, providing nutrition education and support as well as referrals to health care for pregnant women and women with young children.

Perinatal/Infant Health

Local health departments perform newborn screens for infants who missed a screen in the hospital or who were referred for an abnormal screen; targeted case management for high-risk infants; and immunizations. TDH staff coordinate with Medicaid to administer the state's regionalized perinatal system, which offers 24/7 consultation and tertiary/quaternary care to high-risk pregnant women and infants. Perinatal center staff also perform outreach and education to equip outlying hospitals with the skills necessary to stabilize pregnant women and infants until transfer to a higher level of care. TDH administers a statewide safe sleep campaign aimed at reducing sleep-related infant deaths. The campaign includes a hospital component (with educational materials distributed to parents at all birthing hospitals throughout the state) as well as print and media educational materials. All newborns are screened (per state law) for a variety of heritable conditions through dried blood spot screening as well as for CCHD and congenital hearing loss. Follow-up nursing staff provide case management for infants with abnormal newborn screens and refer infants to specialty tertiary clinics as appropriate. Using funding from the Maternal, Infant and Early Childhood Home Visiting (MIECHV) program, TDH contracts with community agencies to provide evidence-based home visiting services for families in 50 of the highest-risk counties throughout the state. MIECHV funds are also used to support Welcome Baby, a universal outreach initiative that provides basic health, development and safety information to families of all new infants in Tennessee and outreach phone calls or visits to the most at-risk families. Breastfeeding is promoted through WIC visits as well as through breastfeeding peer counselors and partnerships with community entities (such as the state hospital association). The Tennessee Breastfeeding Hotline provides 24/7 telephone support for anyone with questions about breastfeeding.

Child Health

WIC services are co-located in all health departments, providing nutrition information and support as well as referrals to health care. MIECHV-funded evidence-based home visiting is available in 50 counties, and targeted case

management for high-risk children is available through all local health departments. TDH administers the Gold Sneaker program, a voluntary recognition for licensed child care centers that implement policies on nutrition, physical activity, and tobacco-free campuses. TDH staff provide technical support to center staff on policy implementation. TDH has partnered with the other child- and family-serving agencies in the Governor's Children's Cabinet on the creation and maintenance of kidcentral tn, a web-based portal for families with young children. The site features information on health, education, and development topics as well as a searchable directory of state services for families with young children.

CYSHCN

Local health departments provide care coordination for CYSHCN through the Children's Special Services (CSS) program. CSS also provides medical payments (as a payer of last resort) for services including: inpatient/outpatient hospitalizations, pharmacy, durable medical equipment, supplies, and rehabilitative therapy (including rehabilitation services for blind and disabled individuals under the age of 16 receiving benefits under Title XVI, the Supplemental Security Income Program, to the extent that medical assistance for such services is not provided under Title XIX (Medicaid). TDH has also used D70 Systems Integration grant funding to contract with the Tennessee chapter of the American Academy of Pediatrics (TNAAP) to train providers on the components of a pediatric medical home and to provide technical support for practices seeking to enhance their medical home activities.

Adolescent Health

Local health departments provide EPSDT periodic screens and immunizations for adolescents in all 95 counties. Health educators in local and regional health departments partner with communities to provide outreach and education related to improving teen health.

Cross-Cutting or Life Course

TDH funds the Tennessee Tobacco QuitLine, which provides telephonic smoking cessation services to callers throughout the state. TDH also administers legislatively-appropriated tobacco master settlement funds; these funds are allocated to all 95 counties and focus on 1) prevention of youth initiation of tobacco use, 2) smoking cessation during pregnancy, and 3) reduction of secondhand smoke exposure among children.

Statewide System of Services

Tennessee's Title V MCH and CYSHCN programs collaborate broadly to ensure a statewide system of services. These services reflect the principles of comprehensive, community-based, coordinated, and family-centered care. A description of Title V-funded system supports is described below.

Collaboration with Other State Agencies/Private Organizations

Title V has supported a partnership with the Tennessee Hospital Association, the March of Dimes, and the Tennessee Initiative for Perinatal Quality Care (TIPQC) for the "Healthy Tennessee Babies" campaign. This campaign initially focused on the prevention of early elective deliveries and inductions, and has evolved to include breastfeeding promotion and support as well as hospital-based efforts to educate families on safe sleep. Tennessee has used Title V funds to purchase safe sleep educational materials and portable cribs for distribution through local health departments and other state agencies.

Title V funds also provide salary support for the Tennessee Child Fatality Review (CFR) program. Local CFR teams review all deaths of children 18 and under; these multidisciplinary teams include local representatives from other state agencies (education, child welfare, mental health and substance abuse, and developmental disabilities). Tennessee also uses Title V funds to support death scene investigation training for first responders through a contract with Middle Tennessee State University.

State Title V staff provide in-kind time to administer the regionalized perinatal system (which is funded through an

agreement with Medicaid). Staff partner with clinical and educational staff at five regional perinatal centers for data collection, development of outreach/education plans, and special projects. Regional perinatal staff have been valuable partners for engaging healthcare providers on key MCH initiatives, such as the implementation of screening for CCHD in hospital nurseries.

TDH contracts with specialty tertiary centers to provide confirmatory testing, diagnostic, and follow-up services for infants identified through the newborn screening programs.

Beginning in state FY2016, TDH is partnering with the Office of Coordinated School Health (OCSH) within the Department of Education to fund a State School Nurse Consultant. The Title V-funded Nurse Consultant will work with local school health coordinators, local public health staff, and other community partners on school health-related issues.

State Support for Communities

Title V funds have long been used in Tennessee to provide enabling services in local health departments. Funds support core staff who provide services such as family planning, preventive health screenings, and care coordination. Local health departments in all 95 counties represent a local-state partnership that is funded, in part, by Title V. MCH populations have long been a priority for local health services in Tennessee.

Tennessee also uses Title V funds to support broad-based efforts that support the health of MCH populations in communities. TDH funds the Tennessee Breastfeeding Hotline with a combination of Title V and WIC funds. Title V funding has also been used to implement the Direct On Scene Education (DOSE) program in local communities; through this program, firefighters, EMS, and police officers provide safe sleep education (and portable cribs when needed) to families.

Coordination with health components of community-based systems

CSS employs care coordinators who work with CYSHCN and their families. The care coordinators serve as critical connectors between families and the health care system. CSS also partners with community-based health care providers to pay for direct services for CYSHCN (as a payer of last resort).

TDH newborn screening follow-up staff coordinate with specialty tertiary centers as well as community primary care providers to ensure appropriate follow-up for infants with abnormal newborn screens.

Title V staff convene subgroups of the Perinatal Advisory Committee to review and update (as needed) the Guidelines for Regional Perinatal Care, Guidelines for Transportation, and Guidelines for Education for Social Workers as well as Perinatal Nurses.

Coordination of health services with other services at the community level

CSS care coordinators work to connect CYSHCN and their families with appropriate community services to support needs related to the child's medical condition(s), including transition to an adult medical home. Care coordinators serve as a critical bridge between families and community organizations, promoting family-centered care and assuring that services are easily accessible by families.

II.B.2.b.iii. MCH Workforce Development and Capacity

MCH Workforce Development and Capacity

Title V-funded MCH and CSHCN staff work at multiple levels within TDH (Central Office, 7 Rural Regional Offices and 1 Metro Office, and local health departments in 95 counties). A detailed listing of position classifications, employee count, and full-time equivalents (FTEs) is included in the accompanying needs assessment document.

Title V Management

Tennessee's MCH-related programs are organized within FHW. The State Title V Director is Dr. Michael Warren, who leads the FHW team. Within FHW, a core leadership group oversees MCH-related program areas including Perinatal, Infant and Pediatric Care; Supplemental Nutrition; Children and Youth with Special Healthcare Needs; Early Childhood Initiatives; Injury Prevention and Detection; Reproductive and Women's Health; and Chronic Disease Prevention and Health Promotion. Brief descriptions of Tennessee's MCH leadership are included in the accompanying needs assessment document.

Title V Planning, Evaluation, and Data Analysis

Ongoing program planning is provided by individual program directors, in consultation with the section's Director and senior leadership within FHW. MCH program directors gather monthly for a Program Management meeting, during which staff outline program goals and objectives, map program activities to state priority measures, discuss opportunities for linkages between MCH programs, and work through challenges common across programs. The Program Management meetings also provide an opportunity for ongoing professional development among the Central Office MCH workforce.

In 2014, TDH partnered with faculty from four Tennessee public health programs (East Tennessee State University, University of Tennessee-Knoxville, Tennessee State University, and the University of Memphis) to provide FHW program staff with training in program evaluation. Faculty presented examples of program evaluation strategies and then worked in small group sessions with program management staff to help identify plans for evaluating FHW programs.

Over the past four years, TDH has recruited six epidemiologists to FHW (including four doctoral-level epidemiologists). The epidemiologists provide broad support for data analysis and program evaluation across the Division and specialized support in program areas such as home visiting, chronic disease prevention and health promotion, injury prevention and detection, reproductive and women's health, newborn screening, childhood lead poisoning prevention, and children and youth with special healthcare needs. FHW hosted a CSTE (Council on State and Territorial Epidemiologists) Applied Epidemiology Fellow in 2013-15; this fellow led the five-year Title V Needs Assessment and has now been hired full-time as Tennessee's MCH Block Grant and State Systems Development Initiative (SSDI) Grant Coordinator.

Additional data analysis support is provided through a number of collaborative relationships. The SSDI grant (managed by FHW) provides funding support for staff in the Department's Office of Policy, Planning, and Assessment. The section also receives a great deal of data support through the Department's Division of Quality Improvement; this Division has provided invaluable assistance in implementing data collection tools for home visiting programs administered by FHW.

Title V Parent and Family Involvement

FHW absolutely recognizes the vital nature of parental involvement throughout our section in program development, implementation, and evaluation. The Division has a longstanding collaborative relationship with the Tennessee Family Voices chapter. In 2011, FHW staff began an enhanced effort to integrate parent input in all aspects of services. Advances have been made over the past few years to further involvement of parents in planning, programming and implementation of Tennessee's Title V Programs. Tennessee had AMCHP Family Scholars in 2013 and 2015. The 2013 Scholar was selected to be part of the AMCHP Next Generation Advisory Workgroup. Family delegates have also attended the AMCHP meeting as part of the Tennessee delegation since 2013. Part-time parent and youth consultants were hired using the HRSA-funded D70 Systems Integration Grant. Additionally, parents and family members serve on various advisory committees. More detailed information is included in the full needs assessment document.

Other Title V Workforce Information

Additional Title V workforce information is included in the accompanying needs assessment document.

Mechanisms to Provide and Delivery Culturally Competent Services

Most FHW programs collect and analyze data according to different cultural groups (e.g. race, ethnicity, and language). These data are used to identify disparities and to help target service delivery to populations in need.

To help address MCH-related health disparities, Tennessee's Title V program has partnered with the University of Tennessee at Knoxville (UTK), a HRSA-MCHB grant recipient, to provide cultural competency training to health department staff. UTK completed the first round of training (regional and Central Office Leadership) in 2013 and is now holding additional sessions across the state to train front-line service delivery staff.

In 2014, the CYSHCN section supported (through the HRSA D70 grant) a statewide training for providers on Culturally Effective Care in partnership with TNAAP. Over 60 individuals attended and presentation topics included: "Cultural Preparedness for Pediatric Practice: Promoting Health Equity and Eliminating Health Disparities," "The Kurdish Community," "Culturally Effective Care for Latino Children in the Pediatric Medical Home," "Effective Health Communication: Health Literacy and Cross-Cultural Communication," "Disability Etiquette & Accessibility: Providing Healthcare Services to People with Disabilities," and "Patient-and Family- Centered Care."

In 2015, Title V staff partnered with the TDH Office of Minority Health and Disparities Elimination (OMHDE) to host four focus groups for disparate populations as part of the five-year Title V Needs Assessment. OMHDE staff identified community partner organizations and hosted two focus groups with primarily Hispanic participants and two with primarily African-American participants. CSHCN staff have also collaborated with OMHDE and the Office of Faith-Based initiatives to develop mechanisms to reach minority populations of CYSHCN and provide information regarding service availability.

FHW strives to secure resources to adequately meet the unique access, informational and service needs of culturally diverse groups. For example, safe sleep educational materials have been produced in English, Spanish, and Arabic to assure that we reach key populations at-risk throughout the state. FHW has now purchased safe sleep board books in Spanish (originally only available in English) for distribution at hospitals.

TDH staff have access to translation services through a telephone-based language line, allowing for improved communication with non-English speaking participants. Other services, such as the Tennessee Breastfeeding Hotline, are required (through their contract with TDH) to provide language line services. Some local health department staff are bilingual (English/Spanish). TDH also has access to the Tennessee Foreign Language Institute, which provides translation of written materials.

All TDH contracts include standard language on nondiscrimination. Contractors and grantees are required to post notices of nondiscrimination in conspicuous spaces available to all employees and applicants.

II.B.2.c. Partnerships, Collaboration, and Coordination

Tennessee's Title V program partners with numerous entities at the federal, state, and local level to serve the legislatively-defined MCH populations and to expand the capacity and reach of the state Title V MCH and CSHCN programs. Within TDH, FHW manages Title V/MCH and CSHCN initiatives as well as Chronic Disease Prevention and Health Promotion and Supplemental Nutrition; this organizational structure allows for robust collaboration and coordination across program areas. These and other relationships are described below and elsewhere in this Report/Application.

An abbreviated inventory of investments and partnerships is included below. Additional details about these partnerships can be found in the accompanying needs assessment document.

Other MCHB Investments include: SSDI; D70 CSHCN State Implementation Grant; MIECHV; Early Childhood

Systems of Care (ECCS) grant.

Other Federal Investments include: CDC-funded Core Violence and Injury Prevention (Core VIPP) grant; CDC-funded Sudden Death in the Young (SDY) Registry grant; USDA-funded WIC; USDA WIC Farmers Markets; Title X Family Planning grant; Administration for Children and Families Title V Abstinence Education grant.

State and Local MCH Programs: State and local health department staff are integral to Title V operation. Title V funding of staff in these departments has already been described. In addition, Title V staff in the Central Office routinely partner with local staff on project implementation (such as promotion of long-acting reversible contraceptives among high-risk populations).

Other State Health Department Program partnerships include: Chronic Disease Prevention and Health Promotion; Immunizations; Vital Records/Health Statistics.

Other Governmental Agency partnerships include: Medicaid; CHIP; Departments of Education, Children's Services, Human Services, Mental Health and Substance Abuse Services; Governor's Children's Cabinet; Tennessee Commission on Children and Youth.

Public Health and Health Professional Programs and Universities

Tennessee's Title V Program collaborates regularly with university partners across the state on project implementation, evaluation, and consultation. Title V staff participate on the Leadership Education in Neurodevelopmental Disabilities (LEND) Advisory Committee at Vanderbilt.

Family/Consumer Partnership and Leadership Programs

Note: This section was written collaboratively by Title V staff (including staff from the CYSHCN section) as well as leadership and staff from Family Voices. A more lengthy description of family/consumer partnerships can be found in the full needs assessment document (truncated here due to space limitations). Additionally, some information has already been described in the "MCH Workforce Development and Capacity" section.

Family and consumer partnership and engagement have increased substantially since Tennessee's last Needs Assessment. Family members and consumers partner with Title V and TDH in myriad ways, including: Title V paid consultant positions, membership/representation on various committees, participation in special workgroups/projects, leadership/workforce development opportunities, Title V strategic planning/needs assessment, and joint participation/coordination on community-based projects. Title V's family/consumer partners are diverse across many perspectives (race, ethnicity, family structure, diagnosis, etc).

Since July 2014, Title V and Family Voices have engaged over 1,100 professionals on topics related to the medical home (care coordination, transition planning, and cultural competency). Family Voices has trained (in part using D70 funds) approximately 1,400 family members on MCH core competencies including family-centered care, cultural competency, and developing others through teaching and mentoring. Family Voices trained over 200 family members in navigating the health care system and 59 family members are now mentors. This has resulted in 34 referrals for matches to the Parent to Parent program, and there are 32 active matches. The Family Voices D70 contract included line item funding available to compensate families (child care, stipends, and accommodations for disabilities).

During the Needs Assessment, Title V partnered with Family Voices to facilitate four focus groups for parents of CYSHCN. Twenty-seven parents participated in these groups, which were held across the state. Participants received a $25 incentive card as well as a boxed lunch.

The Needs Assessment identified a number of issues of particular importance to families of CYSHCN, including respite care, access to primary and specialty care (especially in rural communities), transportation, and medical homes. Family assessments conducted as part of the D70 trainings identified several important issues including

language barriers, engaging providers (family/provider relationships), and health literacy. Additionally, Title V and Family Voices staff routinely field calls from families on health insurance access/coverage as well as long-term supports/services. All of these inputs inform ongoing program operation, development, and improvement.

Family representatives who attend the CSS Advisory Committee (one as a member and the other as non-voting representatives) have the opportunity to influence program policy and implementation. Recent discussions have included modifications to policies on eligibility and coverage. A family member also moderated a panel discussion at the statewide CSS care coordinator training; topics discussed included what is working well with CSS, what CSS means to families, and how CSS can be improved.

As a result of Title V's partnership with families and consumers, a number of programmatic or policy outcomes have been achieved. These include:

- Implementation of autism spectrum disorder screening in local health departments
- Training for health department staff on caring for children with autism spectrum disorders
- Promotion of kidcentral tn
- Establishment of two parent support groups
- Identification of mechanisms to support parent travel and participation in MCH-related activities

Family Voices staff report that families have learned how to: partner with providers on decision-making for their child's care, have a voice, gain more information about their child's diagnosis, and set expectations for patient-centered and family-centered care. Families are more represented in decision-making and policy development through active participation in a variety of advisory committees, councils and boards as previously mentioned. Family participation on these entities has encouraged other family members and shown them opportunities for engaging the public health and health care system to facilitate positive change.

Family Voices is now an integral part of the Five Year Needs Assessment and the Block Grant development and review process. As has been previously described, Title V staff deliberately engaged families of CYSHCN in the qualitative portion of the Needs Assessment. In previous reporting years, Family Voices and Title V staff collaborated on the scoring of Form 13. Beginning with the new reporting format, the narrative on Family and Consumer partnerships is jointly written by Title V and Family Voices staff. Additionally, a Family Voices representative will accompany the Title V team to the Block Grant Review starting in CY2015.

Community health providers and Title V staff have benefitted from hearing from family members regarding their experiences with the health care and public health systems. Family members presented at several of the D70 medical home summits, and a family panel discussion was included at the 2015 statewide training for care coordinators working in local health departments.

Family members are involved in developing promising practices related to MCH practice in Tennessee. Belinda Hotchkiss, Family Faculty Advisor for the Vanderbilt LEND program, is working to shape and mold MCH professionals through the Family Faculty program. Tonya Bowman works with audiology and deaf education majors and has spoken to trainees at Vanderbilt and Meharry to share her family's experience. She has also presented during new employee orientation and has helped to develop scripting for providers to help improve communication with patients.

Other State and Local Public and Private Organizations

At the community level, local health department staff partner with numerous public and private organizations to address the needs of the MCH population. Those partnerships vary depending on the particular project and community need.

At the state level, Tennessee's Title V Program partners with multiple public and private organizations on MCH-related priorities. Recent partnerships have included:

- Tennessee Hospital Association (THA), March of Dimes, and TIPQC: Implementation of "Healthy Tennessee Babies Are Worth the Wait" campaign for reduction of early elective deliveries and inductions
- THA, Children's Hospital Alliance of Tennessee (CHAT), Hospital Alliance of Tennessee, Tennessee Public and Teaching Hospitals, and all 66 birthing hospitals across the state: Implementation of a safe sleep educational program (implementation of safe sleep hospital policy, distribution of safe sleep board book, education for staff and parents, monitoring of staff compliance with safe sleep policies)
- TNAAP: Medical Home Implementation Project funded through D70 Systems Integration grant; inclusion of state MCH-related updates in statewide pediatric meeting (upcoming meeting will feature updates from Tennessee's Title V Program, Medicaid, child welfare, and early intervention)
- TNAAP, Vanderbilt Treatment and Research Institute for Autism Spectrum Disorders (TRIAD): Training of local health department staff on screening and referral for autism spectrum disorders
- Enroll America: Placement of drop boxes for ACA enrollment cards in local health departments
- Tennessee Primary Care Association, community health centers across the state: Development of a Memorandum of Agreement for bi-directional referrals for primary care and family planning between local community health centers and local health departments

II.C. State Selected Priorities

No.	Priority Need	Priority Need Type (New, Replaced or Continued Priority Need for this five-year reporting period)	Rationale if priority need does not have a corresponding State or National Performance/Outcome Measure
1	Improve utilization of preventive care for women of childbearing age.	New	
2	Reduce infant mortality.	Continued	
3	Increase the number of infants and children receiving a developmental screen.	New	
4	Reduce the number of children exposed to adverse childhood experiences.	New	
5	Reduce the number of children and adolescents who are overweight/obese.	Continued	
6	Reduce the burden of injury among children and adolescents.	Replaced	
7	Increase the number of children (both with and without special health care needs) who have a medical home.	Replaced	
8	Reduce exposure to tobacco among the MCH population (pregnancy smoking and secondhand smoke exposure for children).	Replaced	

Methodology for Priority Selection

Selection of Tennessee's Title V Program priorities for 2016-2020 occurred as part of the Needs Assessment, following the analysis of quantitative and qualitative data on health needs and system capacity. Priority selection took place with input from the Title V Leadership and Epidemiology Teams as well as from the larger MCH Stakeholder Group.

For each MCH population domain, the Needs Assessment Coordinator compiled a list of potential priorities based on themes from the various focus groups/community meetings as well as input from the Title V Leadership Team. During the large MCH stakeholder group meeting in March 2015, stakeholders were asked to score each potential priority using four criteria:

1. Problem/issue has severe consequences
2. Many individuals are affected by the problem/issue

3. Addressing the problem/issue is acceptable to citizens
4. Resources are available to address the problem/issue

In addition to the priorities listed for each domain, “write-in” options were collected throughout the stakeholder meeting from small-group discussions.

For each priority, stakeholders were asked to provide a score of 1-4 (1=strongly disagree, 4=strongly agree) for each criterion. Thus, for each potential priority, the composite score (obtained by adding the four individual criterion scores) could range from 4 (lowest) to 16 (highest). The Epidemiology Team calculated average composite scores for each potential priority and then ranked these scores within each domain.

The Title V Leadership Team reviewed the composite rankings and determined the final list of priorities based on alignment with TDH priorities and ability of Tennessee’s Title V Program to influence the priority. The Title V Leadership Team gave first consideration to potential priorities ranked highest for each domain as the priority for that domain. In some cases, the highest-ranked potential priority was not chosen. This generally occurred when the scope of the highest-ranked potential priority was too narrow and a slightly lower-ranked priority captured the highest-ranking priority plus other relevant topics. In all cases, the leadership team selected either the first or second most highly ranked potential priority from the stakeholder-determined list. More detailed information on priority selection for each domain follows.

Women’s/Maternal Health: For this domain, the stakeholders ranked “chronic disease” highest (score=13.65), followed by preconception/intra-conception care (score=13.56). The Title V Leadership Team determined that framing the priority broadly as “preventive care for women of childbearing age” would actually address both of the highest-ranked potential priorities. Increasing utilization of preventive care for women of childbearing age would facilitate primary prevention of some chronic diseases (preventing them before they ever occur) as well as secondary and tertiary prevention (screening/early detection and treatment of existing diseases, respectively). A focus on preventive care for women of childbearing age would also facilitate preconception/interconception care. This is a new priority for the 2016-2020 cycle.

Perinatal/Infant Health: Stakeholders rated “immunizations” highest in this domain (score=14.28), followed by infant mortality (score=13.97). Tennessee has historically performed well on measures of early childhood immunization. While Tennessee’s Title V Program has a strong and productive working relationship with the state immunization program, program management is not directly under FHW (the TDH division that manages the Title V Program). Therefore, the Leadership Team decided not to make that a priority. While substantial progress has been made in reducing the state’s infant mortality rate (including a 15% reduction from 2009-2013), Tennessee’s infant mortality rate remains well above the national average and marked racial disparities exist. Choosing infant mortality as the priority would allow for a broad scope of activities aimed at helping all Tennessee infants reach their first birthday; these activities will no doubt include immunizations (an important component of infant and child health). The Leadership Team decided to continue infant mortality as a priority for the 2016-2020 cycle.

Child Health: In this domain, stakeholders ranked obesity highest (score=13.65), followed by developmental screening (score=13.12) and adverse childhood experiences (score=13.10). Obesity was also ranked highly by stakeholders in the adolescent domain, and developmental screening was ranked highest for the CYSHCN domain. The leadership team decided to include all three as priorities for the 2016-2020 cycle.

While there has been steady (if slow) progress as measured by the Coordinated School Health BMI data collection, more than a third of Tennessee’s K-12 students are overweight or obese, putting them at risk for numerous morbidities and early mortality. Obesity reduction is also one of the “big three” priorities for TDH. For these reasons the Leadership Team chose to continue the priority of childhood overweight/obesity from the previous grant cycle.

Developmental screening was ranked high as a potential priority in both the child and CYSHCN domain. There are ongoing investments related to improving developmental screening in Tennessee; these include the SAMHSA-

funded Project LAUNCH (managed by the Title V Program), implementation of autism screening in local health departments, and efforts by other state agencies (Education and Medicaid) to engage primary care providers in increasing developmental screening rates. Given these efforts and the substantial interest in improving developmental screening for CYSHCN, the Leadership Team felt that a broad focus on improving developmental screening rates among all children (and by extension, CYSHCN) would be beneficial. This is a new priority for the 2016-2020 cycle.

In recent years, there has been increasing interest in reducing ACEs in Tennessee. Tennessee is fortunate to have substantial federal investments in early childhood (Project LAUNCH, MIECHV formula and competitive funds, and ECCS funding), all of which are managed by Tennessee's Title V Program. Given the high ranking by the stakeholder group and the current energy around this topic, the Leadership Team chose to make reduction of ACEs a priority for the 2016-2020 cycle. This is a new priority for the 2016-2020 cycle.

For the Needs Assessment injury was listed under the crosscutting domain because the data spanned both child and adolescent age groups. It was subsequently ranked highest for the crosscutting domain; however the NPM for injury is in the child and adolescent health domains. Due to this, the Leadership Team decided to make injury a priority in both the child and adolescent domains. While there have been improvements in the childhood injury burden in Tennessee during the 2011-2015 cycle, the Needs Assessment revealed that the substantial contribution of unintentional and intentional injuries to childhood morbidity and mortality is still a concern. This influenced the Leadership Team's decision to expand the previous priority of unintentional injury to include intentional injury as well for the new 2016-2020 grant cycle. This expanded priority replaces the previous priority.

Adolescent Health: Obesity was ranked most highly by the stakeholders as a potential priority for 2016-2020 (score=13.86) for this domain. As previously described under the Child Health domain, Tennessee's rates of overweight/obesity among K-12 students remain unacceptably high and contribute to the state's high burden of chronic disease and poor health rankings. The leadership team decided to continue obesity as a priority for the Adolescent Health domain as well as the Child Health domain.

Stakeholders ranked two injury-related topics among the potential priorities (motor vehicle accidents and bullying, with scores of 12.9 and 12.15, respectively). While there were other more highly-ranked potential priorities, the leadership team noted the contribution of unintentional and intentional injuries to morbidity and mortality among Tennessee's adolescents. Additionally, there are substantial investments related to injury prevention in Tennessee; these include a robust child fatality review and a CDC-funded core violence and injury prevention program (managed by Tennessee's Title V Program). For these reasons, the Leadership Team elected to expand unintentional injury prevention (a previous priority) to include intentional injury as well for the 2016-2020 grant cycle.

Children and Youth with Special Health Care Needs: The stakeholder group ranked developmental screening (score=13.38) and medical home (score=12.87) most highly in the CYSHCN domain. As previously described, the Leadership Team selected developmental screening as a priority in the child health category; the team felt that a broad focus on developmental screening for all children (inclusive of CYSHCN) would adequately address the stakeholder concerns in this area.

Medical home was ranked by stakeholders as the second-highest potential priority. There have been substantial investments in medical home-related activities in Tennessee in the past few years, including the HRSA-funded D70 systems integration grant (managed by Tennessee's Title V Program) and the Tennessee Medicaid program's recent patient-centered medical home initiative (as part of payment reform). Given these efforts and the stakeholder rankings, the Leadership Team chose medical home as a priority for the CYSHCN domain for 2016-2020. This priority expands upon the previous priority of transition for CYSHCN, therefore it is replacing this priority in the 2016-2020 grant cycle. Of note, early and continuous screening (including developmental screening) is an important component of the pediatric medical home; thus a focus on enhancing a medical home approach to care should also result in increased developmental screening (for CYSHCN and all children).

Cross-Cutting/Life Course: For this domain, stakeholders ranked injury (score=13.18) and second-hand smoke exposure (score=12.80) as the highest potential priorities. The Leadership Team chose to align the injury priority with the child and adolescent health domains (as this is how MCHB has aligned the injury-related national performance measures). The rationale for selecting injury as a priority for those domains has been described previously.

The Leadership Team concurred with the stakeholders' recommendation for second-hand smoke exposure as a priority area for this domain. Decreasing tobacco use and related illness has long been a public health problem in Tennessee, where nearly a quarter of the adult population smoke and more than one in six pregnant women smoke during pregnancy. Tobacco utilization was a priority in the last grant cycle. Given the substantial burden of tobacco-related morbidity and mortality in Tennessee, the Leadership Team decided to continue to focus on tobacco in the 2016-2020 cycle; specifically, Tennessee's Title V Program will focus on reducing second-hand smoke exposure in children and reducing smoking during pregnancy.

Changes in Priorities from the Previous Cycle

Based on input from stakeholders and the need for ongoing improvement the following changes to the 2011-2015 priorities are being made.

Priority for 2011-2015	**Status for 2015-2020**
Infant Mortality	Continued
Childhood Overweight/Obesity	Continued
Tobacco Use	Continued
Unintentional Injuries among Tennesseans age 1-24	Replaced
Transition planning for CYSHCN	Replaced
Asthma	Removed
MCH Workforce Capacity	Removed

Based on data from the needs assessment it was recognized that not only unintentional but also intentional injuries need to be addressed. Therefore it was decided that the scope of this priority would be expanded.

The broader medical home priority for the 2016-2020 cycle replaces the transition priority from the previous cycle. Promotion and support of transition to adulthood is a key component of the medical home approach to care as defined by the American Academy of Pediatrics.

MCH workforce development was a priority in the 2011-2015 cycle. While not specifically articulated as a priority for 2016-2020, workforce development has become an integral part of the Title V Program operations in Tennessee and will continue in the upcoming grant cycle.

Asthma is the only priority from the previous cycle that is not being explicitly continued in 2016-2020. There are currently no funded efforts related to asthma management or control within Tennessee's Title V Program. TDH does not provide primary care, emergency care, or hospital care for pediatric asthma patients (except as a payer of last resort through the CYSHCN program). Though asthma is not specifically listed as a priority, Title V Program staff will continue to partner with stakeholders across the state in an effort to reduce the burden of asthma among Tennessee children and youth. Additionally, Tennessee's Title V CYSHCN program will continue to pay for medical care related to children enrolled in the program.

II.D. Linkage of State Selected Priorities with National Performance and Outcome Measures

NPM 1-Percent of women with a past year preventive medical visit

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	72.2	72.2	73.3	74.5	75.7

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	68.6	68.8	72.8	76.8	80.8

NPM 6-Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	38.3	38.3	38.3	50.0	50.0

NPM 7-Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	109.8	107.0	104.4	101.8	99.2

NPM 8-Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	42.0	42.6	43.2	43.7	44.3

NPM 11-Percent of children with and without special health care needs having a medical home

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	61.6	63.1	64.7	66.3	68.0

NPM 12-Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	42.8	43.9	45.0	46.1	47.3

NPM-14 A) Percent of women who smoke during pregnancy

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	15.7	15.3	14.9	14.5	14.1

NPM-14 B) Percent of children who live in households where someone smokes

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	32.2	31.7	31.2	30.7	30.2

Based on stakeholder input during the Five-Year Needs Assessment, Tennessee has selected the following national performance measures (NPMs) for the 2016-2020 cycle:

NPM 1: Percent of women with a past year preventive visit (BRFSS)

NPM 5: Percent of infants placed to sleep on their backs (PRAMS)

NPM 6: Percent of children, ages 10-71 months, receiving a developmental screening using a parent-completed screening tool (NSCH)

NPM 7: Rate of hospitalization for non-fatal injury per 100,000 children ages 0-9 (HDD); Rate of hospitalization for non-fatal injury per 100,000 adolescents ages 10-19 (HDD)

NPM 8: Percent of children ages 6-11 who are physically active at least 60 minutes per day (NSCH); Percent of adolescents ages 12-17 who are physically active at least 60 minutes per day (YRBS)

NPM 11: Percent of children with and without special health care needs having a medical home (NSCH)

NPM 12: Percent of adolescents with and without special health care needs who received services necessary to

make transitions to adult health care (NS-CSHCN)

NPM 14: Percent of women who smoke during pregnancy (NVSS); Percent of children who live in households where someone smokes (NSCH)

The narrative below describes the rationale for why these measures were selected and links the selected NPMs with Tennessee's identified priorities.

Women's/Maternal Health

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

NPM 1: Percent of women with a past year preventive visit

Rationale

Given the high burden of chronic disease among Tennessee's adult population, and the importance of preconception/interconception health on birth outcomes, a focus on preventive care for women of childbearing age is a priority for Tennessee. Preventive care encompasses a number of components, including physical exams, screening tests (including labs), and counseling. NPM 1 measures the percentage of women with a past year preventive visit. Increasing the percentage of women who complete preventive visits should improve not only the health of the mother (and thus reduce the chronic disease burden) but also improve birth outcomes by improving the mother's preconception/interconception health.

Perinatal/Infant Health

Priority: Reduce infant mortality.

NPM 5: Percent of infants placed to sleep on their backs

Rationale

Sleep-related infant deaths account for approximately 20% of all infant deaths in Tennessee. Data from the statewide child fatality review indicate that in 61% of cases, the infant was found not sleeping on their back. Given the known association between sleep position and risk of sleep-related infant death, tracking NPM 5 will allow us to monitor progress on reducing a known risk factor for these deaths (which in turn greatly influence our infant mortality rate).

Child Health

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

NPM 6: Percent of children, ages 10-71 months, receiving a developmental screening using a parent-completed screening-tool

Rationale

Developmental screening is a key strategy for early detection of motor, language, or social delays. Early detection in turn allows for early intervention, which in many cases should improve long-term outcomes for the individual and for the health care system. NPM 6 allows us to measure how many infants and young children are receiving a developmental screening using a parent-reported tool. These are typically done at well-child visits although there are certainly other venues in which these can be done (home visits, early child care settings, etc). A focus on this NPM will provide insight into gaps in screening and subsequently guide interventions to improve screening rates.

Priority: Reduce the number of children exposed to adverse childhood experiences.

NPM 7: There is not a national performance measure that relates directly to this priority. We plan to develop a state performance measure for this priority in the FY2017 application.

Rationale

ACEs not only represent traumatic and harmful experiences to children, but they have also been shown to have lifelong consequences in regards to later health outcomes. A deliberate effort to reduce ACEs should be important as we try to improve the health of the MCH population across the lifespan. The state performance measure that will be developed will help to quantify the burden of ACEs among Tennessee's children and allow us to track our success in efforts to reduce them.

Priority: Reduce the number of children and adolescents who are overweight/obese.

NPM 8: Percent of children ages 6-11 who are physically active at least 60 minutes per day

Rationale

Tennessee has one of the highest obesity rates in the nation. In order to reduce the number of Tennesseans who are obese, we must focus on preventing (or reducing) the number of children and adolescents who are overweight or obese. At the most basic level, the two main contributors to obesity are nutrition (calories in) and physical activity (calories out). NPM 8 measures the percentage of children ages 6-11 who are physically active at least 60 minutes per day (in accordance with current recommendations). Following our performance on this NPM will allow us to measure this key prevention strategy for reducing obesity among children (and subsequently adolescents and adults).

Priority: Reduce the burden of injury among children and adolescents.

NPM 7: Rate of injury-related hospital admissions per population aged 0 through 19 years

Rationale

Unintentional and intentional injuries are a leading cause of morbidity and mortality for children and adolescents. For every injury-related death, there are more hospital admissions, far more emergency department visits, and even more outpatient visits. NPM 7 measures injury-related hospital admissions. Tracking this NPM will help us to appropriately direct our injury prevention efforts (based on location and cause of injury) and to determine if our efforts are successful.

Adolescent Health

Priority: Reduce the number of children and adolescents who are overweight/obese.

NPM 8: Percent of adolescents ages 12-17 who are physically active at least 60 minutes per day

Rationale

Tennessee has one of the highest obesity rates in the nation. In order to reduce the number of Tennesseans who are obese, we must focus on preventing (or reducing) the number of children and adolescents who are overweight or obese. At the most basic level, the two main contributors to obesity are nutrition (calories in) and physical activity (calories out). NPM 8 measures the percentage of adolescents ages 12-17 who are physically active at least 60 minutes per day (in accordance with current recommendations). Following our performance on this NPM will allow us to measure this key prevention strategy for reducing obesity among adolescents (and subsequently adults).

Priority: Reduce the burden of injury among children and adolescents.

NPM 7: Rate of injury-related hospital admissions per population aged 0 through 19 years

Rationale

Unintentional and intentional injuries are a leading cause of morbidity and mortality for children and adolescents. For every injury-related death, there are more hospital admissions, far more emergency department visits, and even more outpatient visits. NPM 7 measures injury-related hospital admissions. Tracking this NPM will help us to appropriately direct our injury prevention efforts (based on location and cause of injury) and to determine if our efforts are successful.

CYSHCN

Priority: Increase the number of children (both with and without special health care needs) who have a medical home.

NPM 11: Percent of children with and without special health care needs having a medical home

Rationale

Patient-centered medical homes have been shown to improve health outcomes and reduce costs to the health care system. The notion of a primary care medical home was created in the MCH population and is particularly important for CYSHCN. NPM 11 tracks the percentage of children with and without special healthcare needs who have a medical home. Tracking this measure will allow us to determine if we are successful in connecting children with a usual source of care and supporting providers to utilize the medical home approach to care.

Priority: Increase the number of children (both with and without special health care needs) who have a medical home.

NPM 12: Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

Rationale

This is the second NPM related to our priority of increasing the number of children who have a medical home. Transition to adult care is a key component of the medical home approach to care. NPM 12 tracks the percentage of children with and without special health care needs who received services necessary to make transitions to adult health care. Monitoring this NPM will allow us to gauge our efforts to support parents, youth, and providers in deliberate and thoughtful transitions to adulthood.

Cross-cutting/Life Course

Priority: Reduce exposure to tobacco among the MCH population (pregnancy smoking and secondhand smoke exposure for children).

NPM 14: A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes

Rationale

Tobacco is one of the leading causes of morbidity and early mortality in Tennessee. Over one quarter of our adult population smokes. Tobacco exposure to the youngest part of the MCH population (through pregnancy smoking and secondhand smoke exposure to children and youth) has known harmful consequences. NPM 14 measures the percentage of women who smoke during pregnancy as well as the percentage of children who live in households where someone smokes. Tracking this measure will allow us to monitor efforts to prevent smoking among women of childbearing age, increase cessation efforts among pregnant women, and decrease tobacco use among adults (especially parents of young children).

II.E. Linkage of State Selected Priorities with State Performance and Outcome Measures

States are not required to provide a narrative discussion on the State Performance Measures (SPMs) until the FY2017 application

II.F. Five Year State Action Plan

II.F.1 State Action Plan and Strategies by MCH Population Domain

The following section contains a description of strategies and activities for the upcoming year (Application, FY16) as well as a report on prior year activities (Annual Report, FY14)). This section is organized by the six MCH population domains; the information within each domain is organized as follows:

1. Plan for Upcoming Year (Application FY16)
    a. Statement of Priority
    b. Objective for Related NPM/SPM
        i. Rationale for Objective
        ii. Current Performance
    c. Planned strategies and Activities
    d. MCHB Partnerships
    e. Other Key Partnerships
    f. Related Legislative Requirements
2. Reporting Year (Annual Report FY14)
    a. Interpretation of Performance Data (Form 10D)
    b. Summary of Activities Related to Performance Measure
3. Analysis of Progress/Challenges for Domain

At the state's discretion the previous NPMs from the last grant cycle were incorporated into the new population domain categories for reporting purposes. The reporting for these measures follows the same format as above.

The State Action Plan Table summarizes the organization by domain, priority, and performance measure.

State Action Plan Table						
Women/Maternal Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
Improve utilization of preventive care for women of childbearing age.	Increase the percentage of TN women of reproductive age who have had a preventive health care visit in the past year to 75.7% by FY2020 (Data Source: 2018 BRFSS).	Increase general awareness of the importance of an annual preventive health care visit for women of childbearing age. Engage primary care providers on the importance of promoting preventive health care visits for women of childbearing age. Continue to provide high-quality family planning services through local health departments in all 95 counties. Provide pregnancy-related services to women of childbearing age.	Rate of severe maternal morbidity per 10,000 delivery hospitalizations Maternal mortality rate per 100,000 live births Percent of low birth weight deliveries (<2,500 grams) Percent of very low birth weight deliveries (<1,500 grams) Percent of moderately low birth weight deliveries (1,500-2,499 grams) Percent of preterm births (<37 weeks) Percent of early preterm births (<34 weeks) Percent of late preterm births (34-36 weeks) Percent of early term births (37, 38 weeks)	Percent of women with a past year preventive medical visit		

			Perinatal mortality rate per 1,000 live births plus fetal deaths Infant mortality rate per 1,000 live births Neonatal mortality rate per 1,000 live births Post neonatal mortality rate per 1,000 live births Preterm-related mortality rate per 100,000 live births			

Women/Maternal Health

Women/Maternal Health - Plan for the Application Year

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

Objective for Priority: Increase the percentage of Tennessee women of reproductive age who have had a preventive health care visit in the past year from 72.1% to 75.7% by FY2020.

Rationale for Objective: Between 2011 and 2013, the percentage of Tennessee women aged 18-44 who had a preventive health care visit within the past year decreased from 75.7% to 72.1%, although based on overlapping 95% confidence intervals this difference was not statistically significant. Due to changes in BRFSS methodology implemented in 2011, it is not possible to examine longer term time trends for this performance measure. Because of the lag between when BRFSS data are collected and when those data become available for analysis, for the first grant year (i.e. FY2016 – October 1, 2015 through September 30, 2016) reporting will most likely be based on 2014 BRFSS data. Based on the recent trend described above and the fact that data collection will occur prior to implementation of this action plan, the objective for the first and second years is to maintain the percentage of preventive visits at the 2013 baseline level of 72.1%. For subsequent years the objective is to increase the percentage of preventive visits 5% by the fifth year of the grant – a roughly 1-2% relative improvement in the third, fourth and fifth years. Fifth year performance will most likely be based on 2018 BRFSS data. If the objective is met it will return the state to the 2011 pre-baseline level of 75.7%.

Current Performance: Compared to the US as a whole, Tennessee has a higher percentage of women of reproductive age who received a preventive health care visit within the past year (65.3% vs. 72.1%, respectively). However, this percentage has been slowly decreasing. It is important for this downward trend to be slowed/stopped and reversed, and for Tennessee to maintain its relatively high level of preventive care visits. Recent changes to cervical cancer screening guidelines, breast cancer screening guidelines, family planning services guidelines and questions regarding usefulness of pelvic exams have left both providers and clients confused in regards to the value of annual preventive health exams for women; this may be partly responsible for the downward trend in preventive visits.

Planned strategies and Activities: To achieve the objective listed above, the following strategies and activities are planned for FY16:

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

Activity 1a. Issue press releases, social media announcements, and public service announcements during National Women's Health Week in May.

Activity 1b. Collaborate with TDH Office of Communications to integrate preventive care messages for women in routine social media postings (Facebook, Twitter).

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

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

Strategy 3: Continue to provide high-quality family planning services through local health departments in all 95 counties.

Activity 3a. Provide in-house primary care services to family planning clients in health departments that provide primary care services.

Activity 3b. In health departments that do not provide primary care, refer family planning clients to primary care providers in the community.

Activity 3c. Maintain memoranda of understanding between local health departments and community health clinics to facilitate referral for primary care services.

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

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

Activity 4b. In conjunction with the TDH Call Center, provide the toll-free Title V hotline for women to obtain information about health care providers and health care services.

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

MCHB Partnerships: Women of childbearing age who are seen through MIECHV-funded home visiting programs will receive information on the importance of preconception/interconception care (including annual preventive visits).

Other Key Partnerships: Potential partners include: Federally Qualified Health Centers, Rural Health Association of Tennessee, Medicaid, Tennessee Primary Care Association, Susan G. Komen for the Cure, Tennessee Cancer Coalition, and American Cancer Society.

Related Legislative Requirements: These strategies and activities align with the Title V legislative requirements to:

- Provide and assure mothers access to quality maternal health services (501(a)(1)(A))
- Submit a plan responsive to the needs of preventive and primary care services for pregnant women and

mothers (505(a)(2)(A))

- Provide a toll-free hotline for information about health care providers and health care services (505(a)(5)(E))

Women/Maternal Health - Annual Report

NPM 1 - Percent of women with a past year preventive medical visit

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	72.2	72.2	73.3	74.5	75.7

NPM 18: Percent of infants born to pregnant women receiving prenatal care in the first trimester

Interpretation of Performance Data (Form 10D): Final 2013 birth data showed that 71.1% of women entered prenatal care in the first trimester, a slight increase from 70.1% in 2012. Preliminary 2014 data shows 70.4% of women entered care in the first trimester. Tennessee Title V Program staff will continue to monitor this measure as data are finalized. It is not clear at this time why early entry into prenatal care would have decreased in 2014, although it is important to note that these data are obtained from birth certificates, and there is variability by birthing facility in the quality of form completion.

Summary of Activities Related to Performance Measure: TDH has historically considered the reduction of infant mortality and improving birth outcomes as priorities. The role of the Department is to remain abreast of evidence-based best practices and to implement public health initiatives and programming consistent with those practices. All local health department clinics offer basic prenatal services including pregnancy testing (72,514 tests in CY 2014), presumptive eligibility determination for TennCare (19,754 enrolled in CY 2014), WIC/nutrition services (April 2015 WIC data show that 17,601 pregnant women were participating in the program in 125 clinics), 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 case management or home visiting services as appropriate (HUGS, Healthy Start, CHAD, or the federally funded home visiting projects). For FY2013, 1,945 pregnant women were provided HUGS/CHAD home visiting services through the local health department clinics. The federally-funded home visiting programs served 194 pregnant women in federal FY 2014. The eight Healthy Start home visiting projects served 111 pregnant women in FY 2014.

Approximately half of the births in Tennessee are paid for by TennCare. Under TennCare's managed care system, almost all prenatal care is provided in the private sector. The HEDIS report produced for Tennessee's Medicaid program shows that in 2014 80.7% of Medicaid pregnant women entered prenatal care in the first trimester or within 42 days of enrollment; this compares to 82.93% nationally. Only one of our local health department clinics provided comprehensive prenatal care in 2014, with delivery services provided by a private physician in the community. This clinic reported services to 37 women in FY 2014.

Funding continued for the Tennessee Initiative for Perinatal Quality Care (TIPQC). Projects related to perinatal health included: (1) increasing the use of antenatal steroids (in sustainment), (2) reducing early elective deliveries (in sustainment),(3) promoting breastfeeding, (4) increasing the use of 17OHP (new), and (5) reducing post-partum hemorrhage (under development).

During this past year, the toll free Tennessee Title V Program Hotline was moved from the FHW Central Office to the Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) call center. This call center is part of the TENNderCare program that operates through a contact with Medicaid. Call center staff offer assistance and

education to pregnant women and mothers of infants; these staff now also field calls from the Tennessee Title V Program Hotline.

The Division of Policy, Planning, and Assessment (PPA) within TDH continues to participate in the CDC PRAMS project through data collection and analysis.

SPM 3: Percentage of smoking among women of age 18-44

Interpretation of Performance Data (Form 10D): According to annual Tennessee BRFSS data, rates of smoking among women aged 18-45 have increased from 21.7% in 2010 to 23.9% in 2013, despite a recent 5.2% decline from 2012 to 2013. Overall, smoking prevalence in Tennessee has shown a significant decline from 1990-2010, but 2011 changes in BRFSS methodology make it difficult to provide conclusions on more recent data.

Summary of Activities Related to Performance Measure: TDH continued its media campaign promoting the Tennessee Tobacco QuitLine for pregnant women and women with children. The campaign is called "Jenny Smokes" and was modeled after a CDC Media Resource campaign targeting women of childbearing age that smoke. The "Jenny Smokes" campaign depicted a mother holding her newborn baby, stating that "Jenny smokes two packs a day, and so does her mom." The statewide campaign stressed the harms of second hand smoke that occurs to a newborn.

The Tennessee Tobacco QuitLine provided tobacco cessation counseling services and referral to all callers within the State of Tennessee. Prenatal patients on Medicaid were offered tobacco cessation services through their MCOs, including cessation medications. The MCOs promote the QuitLine, especially to patients who identify as being pregnant.

WIC provided all prenatal, postpartum and breastfeeding women with smoking cessation information including the Tobacco QuitLine number. They also educate families on the effects of secondhand smoke on children.

Tobacco Master Settlement Agreement funding was used to target the reduction of pregnancy smoking. Seventy-nine projects were implemented using the *Baby and Me Tobacco Free* program. This program provided prenatal counseling for smoking cessation as well as vouchers for diapers if the mother remains smoke-free after the baby is born.

Analysis of Progress/Challenges for this Domain

For the first time since the Tobacco Master Settlement Agreement dollars were available in Tennessee, funds were provided to TDH and allocated to all 95 counties in 2013 to fund projects across the state targeting three specific populations:

- Preventing children from beginning to smoke, particularly those in elementary schools and those making the transition to middle schools.
- Helping women who smoke during pregnancy to stop.
- Reducing infant/child exposure to second hand smoke.

Regional and county health councils have been assisting county health department staff plan and implement the selected programs in the counties. Although these projects cross domains, it is expected that there will be an impact on the family and thus on the mother.

Challenges to reaching women of childbearing age in Tennessee include ready access to affordable care for those who are not pregnant and uninsured. Challenges to improving the data on entry into prenatal care include assuring completeness of the birth certificate data. Prenatal care in Tennessee is provided in the private sector, not in the local health department clinics. The role of the health department clinics is to provide pregnancy testing and referrals, but many women will go directly into prenatal care with providers. Access to these women by health department staff is limited.

State Action Plan Table						
Perinatal/Infant Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
Reduce infant mortality.	Decrease the rate of infant death from 6.8 to 5.8 per 1,000 live births by FY2020.	Educate parents on safe sleep. Review infant deaths through multidisciplinary teams to enhance data collection. Support the system for regionalization of high risk perinatal care for pregnant women and infants. Provide follow-up for abnormal newborn screening results. Reduce unintended pregnancies.	Infant mortality rate per 1,000 live births Post neonatal mortality rate per 1,000 live births Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	Percent of infants placed to sleep on their backs		

Perinatal/Infant Health

Perinatal/Infant Health - Plan for the Application Year

PRIORITY: Reduce infant mortality.

Objective for Priority: Decrease the rate of infant death from 6.8 to 5.8 per 1,000 live births by FY2020.

Rationale for Objective: In Tennessee, the infant mortality rate has been decreasing at a slightly faster rate than the nation's. Maintaining this trend will reduce the state rate to 5.8 per 1,000 live births and place it below the nation's target rate of 6.0 per 1,000 live births set by HP2020.

Current Performance: The infant mortality rate in Tennessee has decreased within the last five years but has remained, on average, 18% above the national rate. The top leading causes of infant death are congenital anomalies, short gestation, unintentional injuries, SIDS and maternal pregnancy complication. These causes include

unsafe sleep, which accounts for approximately 20% of all infant deaths in the state.

Planned strategies and Activities: To achieve the objective listed above, the following strategies and activities are planned for FY16:

Strategy 1: Educate parents on safe sleep.

Activity 1a. Provide safe sleep educational materials to all birthing hospitals, home visitors, daycares and other agencies to educate caregivers about safe sleep. Agencies will be provided with flyers, door hangers, posters, educational flipcharts and Sleep Baby Safe and Snug board books.

Activity 1b. Collect and analyze data on the hospital safe sleep policy project through submission of an annual report from all birthing hospitals.

Activity 1c. Implement the Direct On Scene Education program in a minimum of 15 counties. Through this activity, first responder agencies will be provided with packets of safe sleep information and access to portable cribs for families that do not have a safe sleep environment. Once a first responder takes care of the emergency for which they were called, they will assess the home for a safe sleep environment and educate the parent about safe sleep.

Activity 1d. Display safe sleep floor talker in a minimum of 50 additional locations by September 30, 2016. Floor talkers are large stickers with a safe sleep message designed to be placed on the floor in businesses and clinics often visited by infant caregivers.

Activity 1e. Collaborate with WIC staff to promote the WIC safe sleep educational module to WIC parents. Data will be collected from the WIC pre- and post-tests to assess for an increase in knowledge or change of intent in behavior.

Activity 1f. Provide safe sleep education to all women that have a positive pregnancy test in the health department.

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

Activity 2a. Provide technical assistance and training to 34 child fatality review teams and 5 fetal and infant mortality review teams to review all infant deaths and collect data on circumstances surrounding the death. Provide annual training to the teams through quarterly new member webinars and annual in person education.

Activity 2b. Provide death scene investigation training to first responders to educate on information needed at the scene of an infant death. Training will be provided in person and online for firefighters, police, EMS and medical examiners. Attendees will receive a sudden unexplained infant death investigation (SUIDI) doll to utilize for reenactment of the death scene.

Strategy 3: Support the system for regionalization of high risk perinatal care for pregnant women and infants.

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

Activity 3b. Coordinate the Perinatal Advisory Committee meetings.

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

Activity 4a. FHW staff will provide follow-up on all abnormal newborn screening results and unsatisfactory tests.

Referrals are made to the genetics and sickle cell centers across the state. Access to genetic screening, diagnostic testing and counseling services is available at three comprehensive and two satellite Genetic Centers and two comprehensive and two satellite Sickle Cell Centers for individuals and families who have or who are at risk for genetic disorders.

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

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

Strategy 5: Reduce unintended pregnancies.

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

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

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

Activity 5d. The Tennessee Adolescent Pregnancy Prevention Program (TAPPP) will continue to utilize county and regional level health educators to provide school and community education. The program activities will cover topics such as community awareness of teen pregnancy, family life education, comprehensive sexuality education, professional training, abstinence education, healthy relationships, asset building in youth and adolescent growth and development.

MCHB Partnerships: The MIECHV-funded evidence-based home visiting programs provide safe sleep information to all families (as do all TDH-administered home visiting and case management programs). The federally-funded Healthy Start initiative (through Centerstone) provides safe sleep information to families in their service area. Healthy Start staff also participate in the safe sleep CoIIN initiative along with Title V Program staff. Newborn screening staff participate in efforts sponsored by NewSTEPs (funded by HRSA/MCHB Genetic Services Branch) to increase the quality and timeliness of newborn screening specimens.

Other Key Partnerships: The Department of Health has local health departments in all 95 counties across the state; staff in each local department provide pregnancy testing, necessary referrals for other services, WIC services for pregnant women, mothers, and infants, and EPSDT screenings. Numerous external collaborators support the work of this domain. A partnership between TDH, the Tennessee Initiative for Perinatal Quality Care (TIPQC), the Tennessee Hospital Association (THA), and March of Dimes has focused on reducing early elective deliveries and inductions as well as the promotion of breastfeeding and safe sleep. THA has partnered with TDH to engage hospitals in developing and implementing safe sleep policies. Title V Program staff routinely communicate with Medicaid and CHIP staff to identify strategies for connecting eligible populations to care.

Related Legislative Requirements: These strategies and activities align with the Title V legislative requirements to:

- Reduce infant mortality and the incidence of preventable diseases and handicapping conditions (501(a)(1)(B))

- Promote the health of mothers and infants by providing prenatal, delivery, and postpartum care for low income, at-risk pregnant women (501(a)(1)(B))
- Submit a plan responsive to the needs of preventive and primary care services for infants up to age one (505(a)(2)(A))

Perinatal/Infant Health - Annual Report

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	68.6	68.8	72.8	76.8	80.8

NPM 17: Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates

Interpretation of Performance Data (Form 10D): Data for the determination of the percentage of very low birth weight infants born in tertiary level facilities are compiled by Health Statistics and a Title V Program staff epidemiologist. Information on facilities by level of care is collected on the Joint Annual Report of Hospitals and is used for statistical analysis. Data from 2010-2013 show a range of 82.9% to 82.4% of VLBW babies delivered in tertiary level hospitals. Provisional data for 2014 (79.8%) for this indicator are within the range. The number of very low weight births in the state has remained stable from 2010 (1,245) to 2014 provisional (1,249). The percent of births which were very low births weight has also remained stable over this time period (range 1.5%-1.6%).

Summary of Activities Related to Performance Measure: The state has five regional perinatal centers providing specialty care for high risk pregnant women and infants, as well as consultation for all health care providers within their respective geographic area. This system has been in place since the 1970s and is well established and recognized. Consultations are provided 24 hours a day, and the centers also provide education and training for health care providers. Contracts between TennCare and the managed care organizations require that the MCOs work with the perinatal center(s) operating in their geographic area. Funding is provided to the centers by Medicaid but program and reporting and management is coordinated by Title V.

An advisory committee, established by legislation and coordinated by MCH staff, advises TDH 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.

All services within the regional perinatal centers continued during the past year. During 2014 all four of the perinatal guidelines manuals were reviewed and updated by work groups of experts from across the state. All four were approved by the Perinatal Advisory Committee and are available on the Department's web site. The guidelines align with the latest recommendations from the American Academy of Pediatrics (AAP) and the American Congress of Obstetricians and Gynecologists (ACOG).

During state FY 2014, the five obstetrical perinatal centers had 15,074 deliveries for Tennessee residents (compared to 81,259 resident births statewide for CY 2014 (provisional)), provided 59,030 outpatient consultation visits and 1,741 inpatient referrals to the Regional Center, and provided 1,703 hours of education. Data from the five neonatal perinatal centers for the same time period show 3,817 in-born admissions to Tennessee residents, of which

814 were VLBW (2014 VLBW provisional resident births statewide were 1,254); 1,062 transports; 1,782 NICU discharged infants seen in follow-up clinic; and 3,383 hours of education provided.

The Tennessee Initiative for Perinatal Quality Care (TIPQC) began in 2008 to develop a statewide quality collaborative to improve birth outcomes in Tennessee. The voluntary organization has grown to over 1,900 members, including perinatologists, neonatologists, hospitals at all levels of perinatal care, administrators, third party payers, state officials, and community constituents. In February 2014, over 300 physicians, nurses, advocates, payers, hospital administrators, government leaders, and families met for the TIPQC Annual Meeting to collaborate on ways to improve birth outcomes through sharing their quality improvement projects. TIPQC projects have included NICU admission temperature, reduction of central line associated bloodstream infections, human milk for the NICU infant, breastfeeding promotion, registry for undetected CCHD, antenatal steroids, reduction of early elective deliveries, and NAS.

In 2012, the March of Dimes, Tennessee Hospital Association, Tennessee Center for Patient Safety, TIPQC, and TDH formed a “Healthy Tennessee Babies” partnership to increase awareness and educate providers and parents about the benefits of waiting until at least 39 weeks for delivery. All birthing hospitals in the state agreed to a hard stop policy for non-medically necessary deliveries before 39 weeks. The project has continued since that time, and data from all facilities submitted to the Tennessee Center for Patient Safety show that the rate has been below 5% since April 2013, and 2014 data show rates below 2% for 9 out of 12 months. While the original partnership formed to focus efforts on reducing early elective deliveries, the partners have continued to work together and have focused on additional topics including safe sleep, breastfeeding, and newborn screening.

NPM 1: The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for conditions(s) mandated by their State-sponsored newborn screening programs

Interpretation of Performance Data (Form 10D): For many years, staff have provided follow-up services on abnormal test results at or just below 100%. Staff have linked birth and death certificate data with newborn screening data to identify causes for missed screenings; these include many cases in which death occurred at <24 hours of age or the infant was born at home.

Summary of Activities Related to Performance Measure: Tennessee’s Genetics and Newborn Screening (NBS) Program was established in 1968 with mandated phenylketonuria (PKU) screening of all babies. Since that time, screening has expanded to cover 30 of the 31 core conditions and 24 of the 26 secondary conditions recommended for screening by the Secretary’s Committee on Heritable Disorders in Newborns and Children. Tennessee's Genetics Advisory Committee (GAC) met twice (October 2013 and May 2014) to guide the program and recommend changes in tests and procedures. The committee includes members representing a variety of pediatric subspecialties (genetics, endocrinology, pulmonology, hematology, neonatology, and immunology) from across the state.

In FY14, MCH staff continued to provide follow-up services and were responsible for interfacing with the State Laboratory to identify, locate and follow-up on unsatisfactory or abnormal results from the screening panel. If needed, local health department nurses assist in locating an infant needing follow-up. Referrals for confirmatory / diagnostic testing and counseling services are made for individuals and families to tertiary centers across the state. These centers include 3 regional comprehensive genetic centers, 2 satellite genetic centers, 4 pediatric endocrinology centers, 5 pulmonology centers, 2 comprehensive sickle cell centers and 2 satellite sickle cell centers. Close linkages exist among NBS follow-up staff, the centers, and Children’s Special Services (Tennessee's Title V CSHCN program) staff for referrals.

This performance measure continues to be successfully met due to the state law requiring testing of all infants and the quality and efficiency of the State Laboratory and the NBS follow-up program. A DVD continues to be available to

health care providers to educate them about newborn screening tests, proper specimen collection and follow up protocols for abnormal and unsatisfactory results. A video is available that follows a blood spot sample from collection, lab processing and testing, to follow up for reporting of positive results to a genetics center and is posted on the NBS web site (http://www.tn.gov/health/article/MCH-nbs-reports). For 2014, the State's unsatisfactory rate for dried blood spots was 3.47 percent. Hospitals were notified monthly of their unsatisfactory rates, and reports were posted quarterly on the NBS web site (http://www.tn.gov/health/article/MCH-nbs-reports). Information for parents and healthcare providers about screening is located on the Department's web site.

In 2014, newborn screening follow-up staff developed a one-page graphical report that illustrates each hospital's performance related to screening completeness, unsatisfactory specimens, timeliness of specimen collection, and specimen transit time. These reports were sent monthly to each facility. Follow up staff provided assistance with development and implementation of quality improvement to reduce the unsatisfactory rate; priority was given to hospitals with >1% unsatisfactory rate. All hospital birthing facilities received an onsite visit from a member of the follow-up team in 2014.

NPM 12: Percentage of newborns that have been screened for hearing before hospital discharge

Interpretation of Performance Data (Form 10D): Data for 2010–2014 show that a range of 96.2% – 97.5% of infants born in Tennessee were screened for hearing at birth. In 2014, newborn screening data indicate that 98.2% of infants were screened before one month of age. The newborn screening program is issuing monthly reports to hospitals on screening rates; these reports include percent of births screened for hearing. Facilities which are not showing improvement or are showing decreases are contacted by program staff and assistance is offered to identify and address any problems. Staff have begun to visit hospitals across the state and are using data, including hearing, metabolic, and CCHD screening results, for review at each visit. The program epidemiologist has developed new quality improvement data reports to evaluate program performance and identify areas of improvement.

Summary of Activities Related to Performance Measure: The Early Hearing Detection and Intervention (EHDI) program focused on reducing the number of infants lost to follow-up or lost to documentation (LTF/LTD) by 5% statewide to meet the 1-3-6 goals outlined by the Joint Commission on Infant Hearing Statement, HRSA and CDC EHDI. There were 86,879 births (FY13-14); 97% received a hearing screen (98.2% < one month of age). Of the 3,799 infants that did not pass the screen, 65.1% received follow-up (71% <3 months of age). Fifty-one infants were diagnosed with permanent hearing loss; 63% were enrolled in early intervention (59% enrolled < 6 months of age). The 34.9% of infants that were LTF/LTD continue to be tracked.

Statewide follow-up was conducted by partners that included the Tennessee Early Intervention System Part C (TEIS) hearing coordinator; two UT Knoxville audiology graduate students; and a CSS staff member in the West Tennessee Region. The audiology students were assigned to Memphis/Shelby County due to the high LTF/LTD rate.

Tennessee EHDI utilized HRSA Newborn Hearing grant funds to subcontract with the University of Tennessee Center on Deafness for an audiology coordinator (0.75 FTE) and a deaf educator/family outreach coordinator (0.25 FTE). Coordinators conduct hearing-related statewide training and provide support to birthing hospitals, midwives, primary care providers, audiologists, early interventionists, educators, parents, families and others.

Funds were also utilized to subcontract with the Tennessee Disability Coalition (TDC) Family Voices (FV) program for five part-time parent hearing consultants to provide community outreach and individual support to families of children with hearing loss. In July 2014, TDC adopted the Hands & Voices Guide by Your Side (GBYS) model of parent to parent support. Staff received formal GBYS training, developed procedures, conducted calls/home visits to 30 families, and conducted outreach activities to more than 300 individuals.

Epidemiological support was provided through the Tennessee CDC EHDI Information System (EHDI-IS) grant awarded to the Department's Policy Planning and Assessment Division (PPA). Tennessee EHDI-IS includes record-level data collected by the Newborn Screening Program (including metabolic, hearing and CCHD screening

records), birth certificate data, and data elements from the Women, Infants, and Children (WIC) and the Immunization Registry. Numerous quality improvement reports have been created to evaluate program performance and identify areas of improvement for providers (hospitals, medical providers, audiologists, midwives and Part C TEIS service coordinators).

Activities were conducted with the goal of reducing LTF/LTD by 5% in each of the nine TEIS districts. From January to August 2014, the audiology coordinator led a four-member team to train stakeholders in six regional EHDI Task Force meetings on how to utilize quality improvement strategies to develop small steps of change to improve services and/or reduce the number of infants lost to follow-up/lost to documentation (LTF/LTD) after a referred hearing screen. A total of 144 stakeholders participated and developed 28 Plan-Do-Study-Act (PDSA) work plans. Participants included hospital hearing screeners, audiologists, Tennessee Early Intervention System (TEIS) service coordinators, educators, health department home visiting and WIC nurses, parents of children with hearing loss, and members of GBYS and H&V. Plans were to utilize scripts for hearing screeners, audiologists and medical providers when consulting with parents; collaboration to make referrals directly from the hospital to the audiologists; a trial of an electronic reporting form by hospitals/audiologists; improve timely referral for parent support; increase outreach and collaboration with primary care providers; and assure follow-up of hearing referrals conducted by TEIS and Early Head Start screening.

NPM 11: The percent of mothers who breastfeed their infants at 6 months of age

Interpretation of Performance Data (Form 10D): The National Immunization Survey provides annual data for this measure. The survey question defines breastfeeding as “breastfeeding to any extent with or without the addition of complementary liquids or solids”. Based on the data collected, Tennessee observed a decline between 2011 and 2013 in mothers breastfeeding their infant until at least 6 months of age. The estimated percentage dropped from 35.5% to 29.9%, respectively. However 2014 data indicates a large increase to 40.7%. This puts Tennessee much closer to the national rate of 49.9%.

Summary of Activities Related to Performance Measure: In November 2013, TDH launched the Tennessee Breastfeeding Hotline, a 24/7 toll-free telephone service staffed by certified lactation counselors (CLCs) and international board-certified lactation consultants (IBCLCs). The hotline is funded jointly through Title V and WIC administrative funds. Anyone can call the hotline (1-855-4-BF-MOMS) although the majority of calls come from new mothers. Calls are answered live (or returned within thirty minutes of the call). Throughout FY14, call volume increased to 343 calls/month by September 2014. Hotline staff also perform follow-up calls at 4, 8, and 12 weeks.

Title V funds supported a statewide breastfeeding summit in November 2013 in Johnson City, TN. The summit was also broadcast live to audiences in Nashville, Chattanooga, and Memphis. Attendees included local primary care providers and staff, health department staff, and hospital perinatal and lactation staff.

Title V funds are being used to fund 10% of an FTE to support the state breastfeeding coalition (a breastfeeding promotion/support organization consisting of volunteer leaders from across the state).

TDH partnered with the Tennessee Hospital Association (using funds from the CDC 1305 chronic disease/school health grant) to support hospital-based efforts to promote and support breastfeeding. Hospitals were encouraged to implement as many of the “Ten Steps to Successful Breastfeeding” as feasible in their institution.

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

Breastfeeding counseling is a required nutrition education component of the WIC Program and all pregnant women are encouraged to breastfeed, unless contraindicated for health reasons. Breastfeeding education is offered individually via online modules, face to face, and in group settings. Last year, WIC served an average of 19,937 pregnant women per month and enrolled about 54% of newborns in the state. Thirty-eight percent (38%) of WIC delivered mothers were breastfeeding at time of postpartum certification. There were 8348 breastfeeding mothers on the WIC program. WIC provides on-going breastfeeding information and counseling in the clinic, hospital, and home setting. Manual and electric pumps are issued to eligible mothers. Mothers who deliver prematurely or have a baby in the Neonatal Intensive Care Unit were given priority for hospital grade electric pumps.

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

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

Interpretation of Performance Data (Form 10D): In Tennessee, there were 117 sleep-related infant deaths in 2013. This represents a rate of sleep-related infant mortality of 1.5 per 1,000 live births, a decline of 17% compared to 2010 (1.8 per 1,000 live births). Sleep-related causes account for approximately 20% of all infant deaths.

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

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

TDH developed a safe sleep floor talker; these are large stickers to be placed on the floor of the baby aisles in stores or other businesses frequented by women. Almost 200 safe sleep floor talkers were placed between October 2013 and September 2014.

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

Seven hundred and fifty-four cribs were provided to the local health departments to distribute to families that cannot afford one.

WIC continued to print a safe sleep message on all of the infant WIC vouchers (~38,000/month).

Safe sleep information was given out to all new mothers through the Welcome Baby Project. The Welcome Baby Project is an initiative in which all new mothers receive a letter from the Tennessee First Lady and included in that letter is information about safe sleep and other pertinent topics for new parents.

All home visiting staff in Tennessee were provided with a safe sleep educational flipchart to teach parents about safe sleep. The flipchart has a script on one side and information for the parent on the other side. This ensures all parents are taught the same information.

Analysis of Progress/Challenges for this Domain

Breastfeeding promotion and support are integral parts of the WIC Program. In addition to the work in the local health departments and the Tennessee Breastfeeding Hotline (mentioned earlier), there is collaboration with the

Tennessee Hospital Association for Hospital training and coaching, a mass media campaign and healthcare provider online continuing education. The Division's Home Visiting Program has provided for 50 staff to become Certified Lactation Counselors. The Chronic Disease Program assists businesses to become "breastfeeding friendly" and the Primary Prevention Initiative has conducted 283 community projects to promote and "normalize" breastfeeding. All local, regional and state health offices have a "Mother's Room" for lactating employees. Although there has been an increase in the breastfeeding rate in Tennessee, there is a great challenge that we face—to change the culture and normalize breastfeeding especially among the lower socioeconomic population.

Newborn screening in Tennessee has a long and successful history. The partnerships with the State Laboratory, the Genetics and Sickle Cell Centers, and members of the Genetics Advisory Committee have assisted with expanding and building the program. The State now screens for almost all diseases on the HHS recommended universal screening panel, with SCID to be added later this year. Most recently, the State has begun providing laboratory and follow-up services six days a week and established a courier pickup service all across the state. Matching birth files to newborn screening files, the program is posting to the website monthly reports by hospital showing percentage of infants with dried blood spot, CCHD, and hearing screening, unsatisfactory specimen rate, age at collection, and transit time from collection to Lab. The major challenge is to continue to investigate and determine what new tests should be added to the screening panel.

Improvements in infant mortality are likely the result of a multi-pronged approach by numerous state and local partners. Tennessee has supported a regionalized system of perinatal care since the late 1970's and regional perinatal staff have been very active in enhancing the ability of small, outlying hospitals to stabilize infants for transport. Robust child fatality and fetal infant mortality review programs have yielded valuable data for identifying specific contributors to infant mortality, such as unsafe sleep. A recent focus on safe sleep has involved partnerships with all birthing hospitals as well as a number of community partners. The Tennessee Initiative for Perinatal Quality Care (TIPQC) has supported numerous improvements in hospital- and clinic-based quality improvement, resulting in decreased rate of central line-associated bloodstream infections, a sustained reduction in early elective deliveries, and increased use of human milk for very low birth weight infants.

State Action Plan Table						
Child Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
Increase the number of infants and children receiving a developmental screen.	By FY2020, 50.0 percent of Tennessee children ages 10 months to 5 years will be screened for developmental, behavioral, and social delays, as measured using a parent completed screening tool (National Survey of Children's Health).	Increase general awareness of the need for developmental screening. Support providers to integrate developmental screening as a part of routine care. Explore opportunities for incorporating developmental screening into settings outside of primary care.	Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL) Percent of children in excellent or very good health	Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool		
Reduce the number of children exposed to adverse childhood experiences.	By FY2020, reduce the percentage of Tennessee children age 0-17 experiencing two or more	Increase general awareness of adverse childhood experiences (ACEs) in the community.				

	adverse childhood experiences to 24.75%. (Data source: National Survey of Children's Health)	Collect Tennessee-specific data on ACEs and utilize that data to inform program and policy decisions.				
Reduce the number of children and adolescents who are overweight/obese.	By FY2020, reduce the percentage of students in grades K-8 identified as overweight / obese by 5% from 38.2% (2012-2013 school year) to 36.2%. (Data Source: Office of Coordinated School Health and YRBS)	Continue the Gold Sneaker voluntary recognition program for licensed child care centers (recognizing that overweight / obese preschoolers are more likely to grow up to be overweight / obese children). Operate the Tennessee Breastfeeding Hotline (recognizing the impact of breastfeeding on long-term overweight / obesity risk for children). Support the Office of Coordinated School Health in school-based efforts to promote physical	Percent of children in excellent or very good health Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)	Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day		

		activity and good nutrition.				
Reduce the burden of injury among children and adolescents.	By FY2020, reduce hospitalization rates for unintentional injuries among children age 0-9 to 99.2 per 100,000.	Promote the use of child safety seats. Promote safety in youth sports. Promote safe storage of medications. Disseminate child injury data to community partners. Provide injury prevention education to parents and caregivers.	Child Mortality rate, ages 1 through 9 per 100,000 Adolescent mortality rate ages 10 through 19 per 100,000 Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000 Adolescent suicide rate, ages 15 through 19 per 100,000	Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19		

Child Health

Child Health - Plan for the Application Year

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

Objective for Priority: Increase the percent of children ages 10 months to 5 years screened for developmental, behavioral, and social delays, as measured using a parent completed screening tool from 38.3% to 57.9% by FY2020.

Rationale for Objective: The American Academy of Pediatrics (AAP) recommends that all children be screened for developmental delay beginning at 9 months of age.

The data for this measure is collected through the National Survey of Children's Health. This survey was last implemented in 2011/12, and will next be administered in 2016, with data available in 2017. For year 1, the goal is to maintain the current screening rate of 38.3%. With the next NSCH administration, an updated observation is expected in 2017. Between the 2007 and 20011/12 administrations of the NSCH, there was a 32% increase in developmental screenings. Following this trend, it is anticipated that an additional increase of 32% percent in the number of young children screened for developmental delays will be observed in year 2 (FY2017; (five years since previous administration)). This would result in 50% of children 9 months to 5 years of age being screened for delays. As the NCHS will then be administered annually, more modest increases of 5% each year are anticipated. With this assumption, the goal for year 3 is 52.5%, 55.1% for year 4, and 57.9% by year 5.

Current Performance: Despite the AAP recommendation that all children be screened for developmental delays starting at 9 months, less than one third (30.8%) of children age 10 months to five years receive a developmental

screening using a parent-completed screening tool. Although Tennessee outperforms the nation (38.3% vs. 30.8% respectively), substantial room for improvement remains.

Planned strategies and Activities: To achieve the objective listed above, the following strategies and activities are planned for FY16:

Strategy 1: Increase general awareness of the need for developmental screening.

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

Activity 1b. Promote developmental milestones and the importance of developmental screening through the use of the kidcentraltn website.

Strategy 2: Support providers to integrate developmental screening as a part of routine care.

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

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

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

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

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

Activity 3a. Explore inclusion of developmental screens into the Quality Rating and Improvement System (QRIS) standards for child care settings with partners at Department of Human Services.

MCHB Partnerships: Title V Program staff will implement, monitor and improve the inclusion of developmental screenings in home visiting programs, including MIECHV. In partnership with Early Childhood Comprehensive Systems (ECCS), Title V Program staff will identify ways to measure the benchmark related to School Readiness and Achievement (the percentage of children who received developmental screening and did not need follow up or referral).

Other Key Partnerships: Title V Program staff will work with the Tennessee Young Child Wellness Council (TNYCWC) to identify, endorse, and promote the best tools for developmental and behavioral screening among a variety of child-serving professionals. Partnering with Project LAUNCH staff, Title V Program staff will monitor the local activities occurring in Memphis including: piloting the implementation of developmental screens in 6-8 childcare centers; developing a plan for providing effective technical assistance to childcare centers who want to implement Ages and Stages-3 screenings; and engaging in discussions about how to track and measure results of screenings and referrals.

Related Legislative Requirements: These strategies and activities align with the Title V legislative requirements to:

- Provide and assure children access to quality child health services (501(a)(1)(A))
- Increase the number of low-income children receiving health assessments and follow-up diagnostic and treatment services (501(a)(1)(B))
- Submit a plan responsive to the needs of preventive and primary care services for children (505(a)(2)(A))

PRIORITY: Reduce the number of children exposed to adverse childhood experiences.

Objective for State Priority: Reduce the percentage of children ages 0-17 experiencing two or more adverse childhood experiences from 27.5% to 24.75% by FY2020.

Rationale for Objective: In 2012 the National Survey of Children's Health reported that among Tennessee children 27.5% have experienced two or more ACEs. This is a higher prevalence than what is seen nationally (22.6%). New data on this measure will not be available until 2017. The goal for the next grant cycle is to reduce the number of children who experience ACEs by 10%. This would result in a percentage at or below 24.75% by FY2020. Given the current activities in Tennessee to raise awareness of ACEs, this is thought to be a modest and achievable goal.

Current Performance: Currently, 27.5% of Tennessee children ages 0-17 have experienced two or more adverse childhood experiences, compared to 22.6% of children nationally. While no historical data exists, 32.6% of Tennesseans over age 18 had experienced at least two ACEs in 2012 (BRFSS).

Planned strategies and Activities: To achieve the objective listed above, the following strategies and activities are planned for FY16:

Strategy 1: Increase general awareness of adverse childhood experiences (ACEs) in the community.

Activity 1a. Under the leadership of the Title V Program staff, disseminate the Tennessee ACEs Report to early childhood and health professionals in order to raise awareness of the implications of ACEs.

Activity 1b. Present information about the CDC ACEs Study and the impact on Tennesseans to a wide variety of professionals.

Activity 1c. Disseminate ACEs Handout, How to Protect Your Child from Toxic Stress, and webinar developed in partnership with the TNAAP to increase parents understanding of ACEs and strategies to protect their child.

Activity 1d. Support three Regional Professional Development Opportunities/Kick-off Meetings (one in each Grand Region of the state) to introduce the Early Learning and Wellness Professional Development Collaborative and increase knowledge of implementing trauma-informed practices across early childhood practitioners.

Strategy 2: Collect Tennessee-specific data on ACEs and utilize that data to inform program and policy decisions.

Activity 2a. Continue to collect and analyze data from BRFSS data sets, specifically 2014 data to determine if consistent with 2012 data.

Activity 2b. Support local community initiatives including the Shelby County ACEs Task Force and the response to the Davidson County ACEs Community Health Improvement Plan.

Activity 2c. Partner with DCS to apply for grants and distribute funding to support communities in the Appalachia (Northeast) and Delta (Southwest) areas of the state in order to gather data about ACEs and design locally driven interventions to mitigate ACEs in these communities.

Activity 2d. Include ACEs screening in the children's care coordination model being designed for implementation by all the local health departments.

MCHB Partnerships: MIECHV-funded agencies will continue to screen families enrolling in home visiting programs for ACEs, in order to explore their impact on parental skills and abilities, and arrange support services if needed. Utilizing MIECHV funds, TDH will continue to support the dissemination of Welcome Baby packets, which include the "How to Protect Your Child from Toxic Stress" handout, to all newborns in the state. In partnership with ECCS, Title V Program staff will identify ways to measure the benchmark related to household violence (percentage of families which screen positive for domestic violence and are referred).

Other Key Partnerships: In partnership with the TNYCWC, Title V Program staff will identify opportunities to support professionals to screen caregivers' health and wellness including maternal depression, substance abuse, domestic violence, and trauma.

Related Legislative Requirements: These strategies and activities align with the Title V legislative requirements to:

- Reduce the incidence of preventable diseases and handicapping conditions among children (501(a)(1)(B))
- Reduce the need for inpatient and long-term care services (501(a)(1)(B))
- Promote the health of children by providing preventive and primary care services for low income children (501(a)(1)(B))
- Submit a plan responsive to the needs of preventive and primary care services for children (505(a)(2)(A))

PRIORITY: Reduce the number of children who are overweight/obese.

Objective for State Priority: Reduce the percentage of students in grades K-8 who are overweight/obese from 38.2% (2012-2013 school year) to 36.2% by FY2020.

Rationale for Objective: The objective stated for FY2020 was determined based on trend analysis of the Coordinated School Health Annual Report 2013-2014 and the Youth Risk Behavior Surveillance System's weight status data. According to NSCH, Tennessee is the 11th most obese state for children.

Current Performance: Coordinated School Health reports that during the 2013-2014 academic year, 38.3% of K-12 students are either overweight or obese. Obesity rates are decreasing in Tennessee as well as the rest of the nation; however, progress is slow. Based on YRBS data, Tennessee is showing a decline in childhood overweight and obesity of approximately 1% annually. However, disparities exist when considering children living in poverty. The prevalence of obesity among Tennessee's children ages 2-4 served by WIC is 15.4% (WIC Data System, 2014). Additional data indicate that rural counties show a higher prevalence of overweight and obesity and that overweight/obesity increases with the grade level (K<2nd<4th, etc.). Across the 95 Tennessee counties, childhood obesity/overweight prevalence ranges from 23.4% to 51.7%.

Planned strategies and Activities: To achieve the objective listed above, the following strategies and activities are planned for FY16:

Strategy 1: Continue the Gold Sneaker voluntary recognition program for licensed child care centers (recognizing that overweight/obese preschoolers are more likely to grow up to be overweight/obese children).

Activity 1a. Recruit child care facilities statewide by educating Facility Directors about the benefits of deciding to pursue Gold Sneaker certification.

Activity 1b. Provide technical assistance to child care centers to help in the development and implementation of policies related to physical activity, nutrition, and tobacco exposure.

Activity 1c. Collaborate with the TDH Early Childhood Nurse Consultant (funded through ECCS) and the Department of Human Services to explore the possibility of adding Gold Sneaker requirements to child care licensing standards.

Strategy 2: Operate the Tennessee Breastfeeding Hotline (recognizing the impact of breastfeeding on long-term overweight/obesity risk for children).

Activity 2a. Utilize Title V funding to support the contract with the Hotline vendor.

Activity 2b. Promote use of the Breastfeeding Hotline to providers and to the general public.

Activity 2c. Include hotline magnets or other promotional material in the "Welcome Baby" mailer that is

distributed to the family of every newborn in Tennessee.

Strategy 3: Support the Office of Coordinated School Health in school-based efforts to promote physical activity and good nutrition.

Activity 3a. Utilize Title V funding to support a State School Nurse Consultant to be housed in the Department of Education, Office of Coordinated School Health.

Activity 3b. Encourage collaboration between the Office of Coordinated School Health and local health departments that are focusing on obesity-related primary prevention community activities.

MCHB Partnerships: MIECHV funding is utilized to support the Welcome Baby outreach initiative. One component of Welcome Baby is a universal mailing to families of all newborns in Tennessee; this mailing will include promotional material for the Tennessee Breastfeeding Hotline. TDH is utilizing ECCS funding to support an Early Childhood Nurse Consultant; one of the consultant's tasks is to interface with entities that credential early childhood care centers and promote health standards within those centers.

Other Key Partnerships: Title V Program staff partner extensively with the Department of Education (Office of Coordinated School Health and Office of School Nutrition) to support school-based initiatives aimed at increasing physical activity and improving healthy food availability and consumption. WIC staff are key to Title V's promotion and support of breastfeeding in Tennessee.

Related Legislative Requirements: These strategies and activities align with the Title V legislative requirements to:

- Reduce the incidence of preventable diseases and handicapping conditions among children (501(a)(1)(B))
- Reduce the need for inpatient and long-term care services (501(a)(1)(B))
- Promote the health of children by providing preventive and primary care services for low income children (501(a)(1)(B))
- Submit a plan responsive to the needs of preventive and primary care services for children (505(a)(2)(A))

PRIORITY: Reduce the burden of injury among children.

Objective for State Priority: Reduce hospitalization rates for unintentional injuries among children age 0-9 to 99.2 per 100,000 by FY2020.

Rationale for Objective: The injury-related hospitalization rates for children ages 0-9 have fluctuated over the last five years. However, in reviewing the recent data, an annual reduction of 2.5% is reasonable and achievable (~23 hospitalizations/year).

Current Performance: In 2012, the rate of hospitalizations for unintentional injuries for children age 0-9 was 112.6 per 100,000. This represents a decrease from a recent high rate of 137.7 per 100,000 (in 2008) but a slight increase from the lowest recent value (108.3 per 100,000 in 2010). Tennessee's rate of 112.6 per 100,000 in 2012 was substantially lower than the national rate (175.5). The leading causes of hospitalizations for ages 0-9 in 2012 were falls, motor vehicle accidents and poisonings.

Planned strategies and Activities: To achieve the objective listed above, the following strategies and activities are planned for FY16:

Strategy 1: Promote the use of child safety seats.

Activity 1a. The injury prevention program will provide funding and technical assistance to community agencies to purchase and distribute car seats. Agencies will ensure seats are installed correctly when distributing them to caregivers.

Activity 1b: The injury prevention program will provide agencies with supplies needed to determine the correct seat needed including tape measures and growth charts.

Activity 1c: The injury prevention program will create a child safety seat infographic to promote the correct use of car seats to parents and caregivers.

Strategy 2: Promote safety in youth sports.

Activity 2a. The injury prevention program will promote training and resources to youth sports coaches to recognize symptoms of sudden cardiac arrest.

Activity 2b. The injury prevention program will collaborate with the Vanderbilt youth sports injury prevention program to sponsor a statewide youth sports safety conference.

Strategy 3: Promote safe storage of medications.

Activity 3a. Promote safe storage of medications to at least ten counties through the Count it, Lock it, Drop it initiative. The goal of Count It, Lock It, Drop It™ is to increase the number of individuals tracking medication, securing medication in a locked medicine box, and increasing the utilization of medicine drop boxes. Through the program, medical professionals will be encouraged to counsel patients and their families on the importance of tracking medication (i.e. Count It), locking it up (Lock It), and disposing of it properly (Drop It).

Activity 3b. Promote safe storage of medications through the secure medication drop off boxes. Staff will collaborate with Tennessee Department of Environment and Conservation (TDEC) to place an additional 10 boxes in the community by September 30, 2016.

Activity 3c. Continue to utilize Title V funding to support (in part) the operation of the Tennessee Poison Center.

Strategy 4: Disseminate child injury data to community partners.

Activity 4a. Complete a child injury data report and distribute to home visiting staff and partners.

Activity 4b. Complete infographics on select child death topics.

Strategy 5: Provide injury prevention education to parents and caregivers.

Activity 5a. Discuss injury prevention topics with families served through TDH home visiting programs. Topics to be discussed include: child safety seat use, safe sleep, drowning, smoke detector use and gun storage.

MCHB Partnerships: MIECHV-funded home visiting programs incorporate injury prevention programming into their interactions with families. Additionally, TDH is utilizing ECCS funding to support an Early Childhood Nurse Consultant; one of the consultant's tasks is to interface with entities that credential early childhood care centers and promote health standards within those centers (including standards related to safety and injury prevention).

Other Key Partnerships: Tennessee's Title V Program partially funds the state's network of Child Care Resource and Referral (CCR&R) centers, which provide technical support to child care providers and parents. Each center has a child health consultant, and messages about child health (including injury prevention) are made available to parents and child care providers. Title V funds also partially support the Tennessee Poison Center.

Related Legislative Requirements: These strategies and activities align with the Title V legislative requirements to:

- Reduce the incidence of preventable diseases and handicapping conditions among children (501(a)(1)(B))
- Reduce the need for inpatient and long-term care services (501(a)(1)(B))
- Promote the health of children by providing preventive and primary care services for low income children (501(a)(1)(B))
- Submit a plan responsive to the needs of preventive and primary care services for children (505(a)(2)(A))

NPM 6 - Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	38.3	38.3	38.3	50	50

NPM 7 - Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	109.8	107	104.4	101.8	99.2

NPM 8 - Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	42	42.6	43.2	43.7	44.3

NPM 13: Percentage of children without health insurance

Interpretation of Performance Data (Form 10D): This data comes from the University of Tennessee Center for Business and Economic Research. In 2014, 2.4% of Tennessee children were uninsured; this is the lowest value in the past five years (down from a high of 3.9% in 2010). The American Community Survey (conducted by the U.S. Census) showed that in 2013 4.0% of children under age 19 and at or below 200% of poverty were without health insurance in Tennessee.

Summary of Activities Related to Performance Measure: TennCare, the state's managed care program for Medicaid recipients, continued as the major source of health insurance coverage for children. TennCare enrollment data for February 2014 show a total of 733,426 participants under age 21.

County health departments assisted persons with completion of the TennCare application and made referrals to the federally facilitated marketplace for TennCare enrollment of any families with children who may qualify. All local health department clinics provided pregnancy testing and prenatal presumptive eligibility determination and enrollment for women who met criteria for this Medicaid eligibility category. Eligibility begins immediately (day of application) for 45 days when the woman meets prenatal presumptive eligibility criteria. The presumptive eligible woman was urged by Department of Health staff to go to the federally facilitated marketplace as soon as possible to complete her application for full TennCare benefits that will go beyond the 45 days to cover her throughout her pregnancy and after the birth of the baby. Referrals were made to the ACA Navigator agencies in the state and to Enroll America for individuals who requested in-person and/or telephone assistance with TennCare enrollment through the federally facilitated marketplace.

County health departments in two Department of Health regions are primary care provider (gatekeeper) sites for TennCare Managed Care Organizations and were assigned TennCare members. The assigned members are persons of all ages. During FY 2014, the health department clinics performed 62,116 EPSDT screenings to TennCare eligibles under the age of 21.

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

NPM 7: 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

Interpretation of Performance Data (Form 10D): For this measure the state uses survey data from the Tennessee Immunization Program (TIP). This survey design uses a random selection of participants from birth certificates. Using this data we are able to get more timely information on immunization coverage in the population. Since 2013 the percentage of completion of the CDC NIS 4:3:1:3*:3:1:4 series has hovered around 73%. Previously the measure had been as high as 82.2% (2011). Differences in these statistics likely relate to the methodology used to calculate completion rates. We have reached Healthy People 2020 objectives for 90% coverage of 4 of the 7 vaccines: falling short with the 4th doses of DTaP and pneumococcal vaccines and with Hib completion; however, completion rates for 3 doses of each of these 3 vaccines is approximately 95%.

Summary of Activities Related to Performance Measure: Although nationally published measurements and ratings use the National Immunization Survey (NIS), the Tennessee Immunization Program (TIP) measures immunization by the second birthday through its own annual immunization survey. The 2014 survey evaluated 1,450 children for completion of the CDC NIS 4:3:1:3*:3:1:4 series, including a change in Hib measurement to require full series completion (3 or 4 doses depending on brand). Using the old analytic method, coverage would have improved from 75.4% in 2013 to 77.9% in 2014; however, the series result was lower using the more accurate Hib completion method: 73.1%. We have reached Healthy People 2020 objectives for 90% coverage of 4 of the 7 vaccines: falling short with the 4th doses of DTaP and pneumococcal vaccines and with Hib completion; however, completion rates for 3 doses of each of these 3 vaccines is approximately 95%. TIP continues to support local health department (LHD) efforts to actively recall children ages 20-24 months seen at LHD clinics and missing their fourth DTaP dose; however, impact is limited because just 3.6% of this age group receive all immunizations in the LHD. LHD staff have been trained to review the immunization status of any person presenting for any type of service at the clinics and provide needed immunizations, or assist with referrals to the primary care provider. As in 2013, the 2014 survey showed no statistically significant racial disparity between black and white children for the vaccines in the basic series. The pronounced racial disparity in influenza vaccine continues to be unacceptably wide. Wide regional variations in influenza coverage exist. The Director of TIP shares these findings with the state Medicaid agency (TennCare) and with the state chapters of the American Academy of Pediatrics and the Academy of Family Physicians. In 2014, the Office of Minority Health conducted focus groups among young minority mothers to better understand their concerns and possible reasons for the disparity; a variety of fears and lack of belief in its benefit were expressed. There will be opportunities to share this information and share examples of activities by clinics that have succeeded in universal high influenza coverage rates.

The Department's contractual arrangement with TennCare to provide EPSDT exams has provided additional opportunities to provide immunizations and to check current status. The Tdap requirement for all students entering 7th grade has provided an essential opportunity to address all preteen immunizations. Educational outreach and collaboration with school nurses continued in 2014 with talks at statewide meetings and monthly conference calls with school health officials. These steps have improved their capacity to educate students and work more effectively with healthcare providers.

TIP introduced a popular new tool in its immunization information system (IIS) in April 2013: the Immunization Certificate Validation Tool. This feature enables any IIS user to evaluate and print a valid state immunization certificate for any preschool or school-aged child whose records are in the IIS. If the child's record is not up to state requirements, the tool produces a failed validation report highlighting to the user precisely what the missing or invalid dose is so he or she may address the need and complete the record. This feature was in its first full year of use in 2014 and has become an essential convenience that also improves immunization practice. The end of the fiscal year was spent preparing to transition to a new IIS application managed by an external vendor expected to meet all federal functional IIS standards and to provide a higher level of performance and clinical decision support to IIS users.

NPM 9: Percent of third grade children who have received protective dental sealants on at least one permanent molar tooth

Interpretation of Performance Data (Form 10D): This data comes from a statewide survey conducted in 2008 by the Tennessee Department of Health Oral Health Service section. The survey included a sample of children ages 5-11 years old, representing approximately 551,000 Tennesseans in this age group. At that time it estimated that 37.2% of children in Tennessee had sealants. Oral Health Services had planned to conduct this type of survey every 5 years, but staffing has not permitted this.

Summary of Activities Related to Performance Measure: The TDH 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. The SBDPP provides dental screenings and referrals, dental health education, dental sealants, and fluoride varnish. During FY 2014 (July 1, 2013-June 30, 2014) 162,441 children received a dental screening with 22,987 children being referred for dental services, because of unmet dental needs. 179,107 children were provided dental education information and 15,101 were provided with a fluoride varnish application. 41,213 children received dental sealants with a total of 224,666 teeth sealed. Although some third grade children were provided the sealant services, the number was not carved out as a tracking performance measure.

TDH had 44 fixed and 1 mobile dental clinic providing dental services during FY 2014. The dental clinics' scope of services included comprehensive dental care to children under the age of 21 and emergency dental care for adults. During FY 2014 the TDH dental clinics provided 16,607 children and 6,252 adults with 155,069 dental services. TDH offers additional services to prenatal patients in a number of the health department dental clinics. TDH has partnered with the University of Tennessee Health Science Center Dental College and the Meharry Medical College School of Dentistry to have their fourth year dental students rotate through three of our health department dental clinics. The students provide comprehensive dental services to an expanded target population at the dental sites.

The TDH Cavity Free In Tennessee program targets Early Childhood Caries (ECC) through the Early and Periodic, Screening, Diagnosis and Treatment (EPSDT) program in our health departments. In the first year of life, a child may visit a health care professional as many as six times as a part of the EPSDT program; whereas the same children may not access dental care until there is a need or until school age. The TDH Public Health Nurses provide oral health screenings, fluoride varnish, and oral health education to these children as well as educate their parents. During FY 2014, the Cavity Free In Tennessee program provided services to 16,542 children.

SPM 2: Percentage of obesity and overweight among Tennessee K-12 students

Interpretation of Performance Data (Form 10D): Data from Coordinated School Health indicate that 38.3% of K-12 students were overweight or obese in the 2013-14 school year, which is a 6.6% decline from the 2007-2008 school year. Despite this decline, Tennessee continues to rank poorly in childhood obesity rates (46th nationally).

Summary of Activities Related to Performance Measure: The Gold Sneaker initiative continued statewide enhancing policy related to physical activity and nutrition within licensed child care facilities across Tennessee. Gold Sneaker is a collaboration between the Department of Health and the Department of Human Services. Facilities are

encouraged to enact voluntary policies that include minimum requirements on physical activity, sedentary activities, breastfeeding, meal time behaviors and portion sizes. Child care facilities that implement the proposed enhanced physical activity and nutrition policies will earn a "Gold Sneaker" award which designates them as a "Gold Sneaker" child care facility. Facilities receive recognition through a certificate, decals and website recognition. Gold Sneaker training sessions were available to providers online as well as in person. As of the end of FY2014, 306 facilities had earned the Gold Sneaker certification.

The "Breastfeeding Welcomed Here" campaign continued with 192 businesses across the state having taken the pledge, and an ongoing goal of 50 new businesses to take the pledge annually. This campaign's aim is for businesses to demonstrate their support for breastfeeding by making a commitment through a pledge, and then displaying a clearly visible window decal. TDH also partnered with the Tennessee Hospital Association on hospital-based efforts as described in the NPM 11 Breastfeeding section.

Additional strategies addressing childhood obesity included environmental and system change efforts ranging from development of walking tracks, trails and community gardens to promotion of the healthy USDA Food Service Guidelines, including sodium reduction, in schools. Funding from Project Diabetes as well as the CDC Chronic Disease and School Health grant helped to support these efforts across the state.

NPM 14: Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index at or above the 85th percentile

Interpretation of Performance Data (Form 10D): Although there has been an increase in the breastfeeding rate among infants and a small improvement in the national childhood obesity rate, Tennessee WIC has seen very little change among the WIC population for two to five year olds since 2011.

Summary of Activities Related to Performance Measure: The Tennessee WIC Program continued to extract data using the program provided by CDC. Regional and clinic health department staff review monthly reports for identification of trends as well as chart focused reviews.

All prenatal participants were encouraged to breastfeed their infants. Breastfeeding peer counselors (47 total) worked with new moms to help increase the duration of breastfeeding to assist in the prevention of childhood obesity. The number of CLC trained providers grew by an additional 12 staff to 90. The Tennessee Breastfeeding Hotline also contributed to the increased duration of breastfeeding.

WIC families also received information on healthy meals, snacks, and healthy choices when eating away from home. Cooking demonstrations were provided in many clinic locations to provide experience and tasting of new food items. Emphasis on increasing consumption of vegetable and fruits and tasting new foods was also emphasized in group sessions as well as individual sessions.

WIC provided core nutrition messages on WIC food instruments (vouchers) to encourage more vegetable and fruit consumption, use of low fat and nonfat milk, and incorporation of more whole grain products. The "MyPlate" materials were used to assist with WIC nutrition education activities. Staff encouraged physical activity as a part of the nutrition education activities for 2 to 5 year olds. Nutrition education was provided face to face and in groups for high risk participants and online for low risk WIC participants.

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

Interpretation of Performance Data (Form 10D): This data comes from the TDH Hospital Discharge Data System. The rate in 2011 and 2012 exceeded 1,800 visits per 100,000 children. In 2013 there was a significant decrease to 1640.9. Data for 2014 is not yet available.

Summary of Activities Related to Performance Measure: In FY14, MCH sponsored regional health representatives to attend Vanderbilt's 5th annual Pediatric Asthma Education Conference. The MCH Director provided introductory

remarks at the conference, including information on the asthma burden in Tennessee and primary and secondary prevention opportunities aimed at reducing the asthma burden.

TDH distributed asthma awareness and management messages via the Department's Twitter and Facebook accounts during the annual Child Health Week celebration. TDH also maintained an asthma page on the Department's web site.

The MCH director held preliminary conversations with provider organizations and payers about population-level initiatives that might be implemented in order to reduce the burden of asthma among Tennessee children. A statewide stakeholder kickoff meeting was planned for Spring 2015.

Children's Special Services (Tennessee's Title V CSHCN program) sponsored five children to attend a Pediatric Asthma Camp. The five-day camp offered on-site medical supervision by teams of volunteer physicians, nurses and respiratory therapists to help monitor the campers and teach them how to better manage their asthma with daily educational sessions. Camp activity staff were expertly oriented to meet the specialized needs of children with asthma and they coordinated a program that included arts and crafts, archery, hiking, games, swimming, and more.

TDH continued to promote use of the Tobacco QuitLine, as cigarette smoke is a known trigger for asthma exacerbations. Staff also promoted smoke-free childcare campuses through the Gold Sneaker voluntary recognition program for licensed child care centers. One of the criteria for Gold Sneaker recognition is that the child care center agrees to maintain a smoke-free campus 24 hours a day, 7 days a week. Elimination of secondhand smoke in these environments should help reduce asthma exacerbations among young children.

Analysis of Progress/Challenges for this Domain

Numerous efforts have contributed to the improvement of child health in Tennessee over the past few years. Extensive community outreach and enrollment assistance through TennCare and CHIP have resulted in fewer children without health insurance. The TDH Immunization Program has diligently focused on reducing missed opportunities for immunization when children present to the health department for any service. Immunization staff have also established crucial partnerships with community providers to increase utilization of the state immunization registry and the registry has been upgraded to be more useful and user-friendly.

Tennessee is fortunate to have the Coordinated School Health model implemented in every local school district. School health coordinators work with school nurses, faculty, and other school staff to promote healthy school environments. Coordinated School Health conducts annual measurements of BMI for students in grades K, 2, 4, 6, and 8 as well as one year in high school. These data have provided timely, state-specific data to inform school- and community-based efforts to prevent and reduce obesity.

Despite these successes, rates of obesity among toddlers has been slow to change. We hope that this will improve in the future as breastfeeding rates improve, but much work remains. Additionally, adult health risk behaviors influence this population. Toddlers and young children observe parental behavior, such as fruit and vegetable consumption, and mimic that behavior. Far too often, this behavior is unhealthy.

State Action Plan Table						
Adolescent Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
Reduce the number of children and adolescents who are overweight/obese.	By FY2020, reduce the percentage of students in grades 9-12 identified as overweight / obese by 5%, from 40.6% (2012-2013) to 38.6%. (Data Source: Office of Coordinated School Health and YRBS)	Support the Office of Coordinated School Health in school-based efforts to promote physical activity and good nutrition. Collaborate with Chronic Disease Prevention and Health Promotion staff to engage communities in enhancing physical activity opportunities for youth.	Percent of children in excellent or very good health Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)	Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day		
Reduce the burden of injury among children and adolescents.	By FY2020, reduce hospitalization rates for unintentional injuries among adolescents age 10-19 to 128.1 per 100,000.	Reduce hospitalization rates due to motor vehicle accidents. Reduce hospitalization rates through promotion of proper storage and disposal of medications. Reduce	Child Mortality rate, ages 1 through 9 per 100,000 Adolescent mortality rate ages 10 through 19 per 100,000 Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000	Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19		

		hospitalization rates due to falls. Increase injury prevention information provided to the public.	Adolescent suicide rate, ages 15 through 19 per 100,000			

Adolescent Health

Adolescent Health - Plan for the Application Year

PRIORITY: Reduce the number of adolescents who are overweight/obese.

Objective for State Priority: Reduce the percentage of students in grades 9-12 who are overweight/obese from 40.6% (2012-2013) to 38.6% by FY2020.

Rationale for Objective: The objective stated for FY2020 was determined by trend analysis of Coordinated School Health Annual Reports and Youth Risk Behavior Surveillance System weigh status data.

Current Performance: Tennessee continues to rank poorly in childhood obesity rates (46th nationally), and unfortunately, many children and adolescents in Tennessee practice behaviors that promote overweight and obesity. In 2013, Tennessee high school students *self-reported* that only 41.4% were physically active throughout a normal week and only 18.3% reported eating adequate amounts of fruits and vegetables (5 or more in past 7 days). In the 2013 Youth Risk Behavior Survey, 34.1% of students stated that they watched more than 3 hours of television per day and 36.2% stated that they used computers for more than 3 hours per day.

Planned strategies and Activities: To achieve the objective listed above, the following strategies and activities are planned for FY16:

Strategy 1: Support the Office of Coordinated School Health in school-based efforts to promote physical activity and good nutrition.

Activity 1a. Utilize Title V funding to support a State School Nurse Consultant to be housed in the Department of Education, Office of Coordinated School Health.

Activity 1b. Encourage collaboration between the Office of Coordinated School Health and local health departments that are focusing on obesity-related primary prevention community activities.

Strategy 2: Collaborate with Chronic Disease Prevention and Health Promotion staff to engage communities in enhancing physical activity opportunities for youth.

Activity 2a. Identify funding for community-based run clubs that promote lifelong physical activity.

Activity 2b. Promote joint use agreements that encourage after-hours use of school facilities for recreational activity.

MCHB Partnerships: Not applicable

Other Key Partnerships: Ongoing partnership with the Department of Education's Office of Coordinated School Health staff will be critical, as will partnerships with the local health departments, schools and the TDH Chronic Disease Prevention programs.

Related Legislative Requirements: These strategies and activities align with the Title V legislative requirements to:

- Reduce the incidence of preventable diseases and handicapping conditions among children (501(a)(1)(B))
- Reduce the need for inpatient and long-term care services (501(a)(1)(B))
- Promote the health of children by providing preventive and primary care services for low income children (501(a)(1)(B))
- Submit a plan responsive to the needs of preventive and primary care services for children (505(a)(2)(A))

PRIORITY: Reduce the burden of injury among adolescents.

Objective for State Priority: Reduce hospitalization rates for unintentional injuries among adolescents age 10-19 to 128.1 per 100,000 by FY2020.

Rationale for Objective: The injury-related hospitalization rates for adolescents ages 10-19 have generally declined over the last five years. In reviewing the recent data, an annual reduction of 4% is reasonable and achievable.

Current Performance: In 2013, the rate of hospitalizations for unintentional injuries for adolescents age 10-19 was 151.1 per 100,000. This represents a decrease from a recent high rate of 215.1 per 100,000 (in 2008). Tennessee's rate of 151.1 per 100,000 in 2013 was substantially lower than the national rate (225.3 in 2012, the last year for which national data was available). While this is a positive trend for hospitalizations, unintentional injury continues to be a leading cause of morbidity and mortality among this age group in the U.S. and in Tennessee. The leading cause of unintentional injury hospitalization among Tennessee adolescents in 2013 was motor vehicle crashes, accounting for 38% of all hospitalizations. Falls and struck by/against account for 16% and 9% of injury hospitalizations for this age group, respectively. This is followed by poisoning, with 5% of unintentional injury hospitalizations for this age group.

Planned strategies and Activities: To achieve the objective listed above, the following strategies and activities are planned for FY16:

Strategy 1: Reduce hospitalization rates due to motor vehicle accidents.

Activity 1a. In the ten counties with the highest motor vehicle crash rates, increase the number of schools who utilize ReduceTNCrashes.Org to conduct a teen safe driving program from 22 to 30.

Activity 1b. Partner with 7 trauma centers and 25 school districts to conduct the Battle of the Belt program to increase observed seatbelt use among adolescents age 10-19.

Activity 1c. Partner with the Tennessee Teen Safe Driving Coalition, other state agencies and the Tennessee AAA Motor Club to provide Graduated Driver's License education to 1000 caregivers of teen drivers.

Strategy 2: Reduce hospitalization rates through promotion of proper storage and disposal of medications.

Activity 2a. Partner with the Coffee County Anti-Drug Coalition to recruit 10 county coalitions or health councils to conduct the "Count It! Lock It! Drop It!" prescription drug abuse prevention program.

Activity 2b. Partner with the Tennessee Department of Environment and Conservation to increase the number of counties with drug disposal bins from 75 counties to 85 counties (out of 95 total).

Strategy 3: Reduce hospitalization rates due to falls.

Activity 3a. Conduct a webinar to educate 50 injury prevention professionals about the adolescent fall risk and protective factors.

Activity 3b. Present on fall prevention among 10-19 year olds to the Injury Prevention Planning Group Falls Subcommittee.

Strategy 4: Increase injury prevention information provided to the public.

Activity 4a. Lead the statewide Injury Prevention Planning Group, the Teen Safe Driving Coalition, and the Battle of the Belt Trauma Hospital Committee, to plan, implement, and evaluate evidence-based teen safe driving activities and programs.

Activity 4b. Partner with trauma centers and select hospitals throughout Tennessee to promote and implement the Battle of the Belt or other evidence-based activities in school districts in those counties where teen crash rates are high.

Activity 4c. Utilize the ReduceTNCrashes.Org program to increase general traffic safety programs in school districts.

MCHB Partnerships: Not applicable

Other Key Partnerships: Many of these activities are coordinated through strong partnerships with agencies that provide infrastructure, administrative, and program delivery support. With Battle of the Belt, partners such as Coordinated School Health, Health Occupations Student Association, trauma system hospitals, ReduceTNCrashes.Org, the Governor's Highway Safety Office, and others are critical to the success of the program. The Graduated Driver's License education project includes partners such as AAA Motor Club, State Farm, the Tennessee Teen Safe Driving Coalition, The University of Tennessee, and other stakeholders. The respective members of the Falls Prevention Coalition serve as a stakeholder group to assess teen fall prevention and provide support for those efforts. Finally, the statewide Injury Prevention Planning Group and its subcommittees provide guidance and support to all injury prevention programs.

Related Legislative Requirements: These strategies and activities align with the Title V legislative requirements to:

- Reduce the incidence of preventable diseases and handicapping conditions among children (501(a)(1)(B))
- Reduce the need for inpatient and long-term care services (501(a)(1)(B))
- Promote the health of children by providing preventive and primary care services for low income children (501(a)(1)(B))
- Submit a plan responsive to the needs of preventive and primary care services for children (505(a)(2)(A))

Adolescent Health - Annual Report

NPM 7 - Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	109.8	107	104.4	101.8	99.2

NPM 8 - Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	42	42.6	43.2	43.7	44.3

NPM 8: The rate of birth (per 1,000) for teenagers aged 15 through 17 years.

Interpretation of Performance Data (Form 10D): Between 2010 and 2013, the teen birth rate in Tennessee decreased 25%, from 20 births per 1,000 girls aged 15-17 years old to 15/1,000. This represents almost 700 fewer teen births among this age group in 2013 compared to 2010. However, in 2013, the teen birth rate in Tennessee was still higher than in the United States as a whole (15/1,000 compared to 12/1,000, respectively).

Summary of Activities Related to Performance Measure: The Family Planning Program continued to provide contraceptive education and clinical services in 126 sites statewide. Teens were a priority population, especially for outreach. CY 2014 data from the Family Planning Annual Report demonstrated that the program served 8,103 clients ages 17 and under and 10,351 clients ages 18-19.

The state continued to provide EPSDT visits for children and adolescents in the local health departments, under contract with TennCare/Medicaid. During FY 2014, the health department clinics performed 62,116 EPSDT screenings, of which 14,122 were to adolescents ages 10-20. These exams include assessment regarding sexual activity and referral for family planning services as appropriate.

Tennessee Adolescent Pregnancy Prevention Programs (TAPPP) operated in two of the six metropolitan areas and in multi-county groupings in six of the seven rural regions. Eight TAPPP Coordinators served as the community contacts/resource persons for adolescent pregnancy issues in their respective areas. All TAPPP Coordinators were involved in county health councils which were broadly representative of the surrounding community. Each council participated in a wide range of activities, depending on local priorities and resources. Public health staff provided community education and awareness activities for students, parents, and providers through classes in schools, programs in community agencies, attendance at health fairs, and promotion through media campaigns. Data for FY 13-14 showed that statewide staff provided family life education, abstinence education and healthy relationship programs to over 25,620 students; provided education and training to over 7,000 adults; worked with 4,840 teen and adult parents and provided training to 2,499 professionals.

TDH received $1,037,995 in federal Title V Abstinence Education funding to implement evidence-based, age appropriate and medically accurate abstinence programs in both school and community-based settings. The program served children ages 10-17. Targeted counties include those identified as having high teen pregnancy and birth rates, high Chlamydia rates, high rates of mothers in poverty and high school dropout rates. Thirteen community-based agencies were awarded funds to provide abstinence education, as defined by Section 510 of the Social Security Act (Section 510 (b)(2) A-H elements). All sites incorporated service learning projects as a tool to build self-esteem, promote community involvement and emphasize the importance of future life goals.

TDH was responsible for the implementation of the Pregnancy Assistance Fund (PAF) federal grant which provided funds, through a state contract, with Shelby County for implementation of the Teen Pregnancy and Parenting Success (TPPS) program. During FY 13-14, the TPPS serviced over 450 pregnant and/or parenting teens, provided educational assistance to increase high school graduation, GED attainment and college enrollment and referred teens to available community resources and services. TPPS implemented an incentive point system for teens to access and purchase needed baby supplies through one of four contracted "Baby Stores." Teens were awarded points for attending scheduled prenatal care visits, being enrolled in a home visitation program and attending educational classes. The PAF grant ended August 30, 2014.

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

Interpretation of Performance Data (Form 10D): In 2013, motor vehicle accidents were the leading cause of injury death among children ages 1-14 in Tennessee. There were 36 motor vehicle fatalities among youth 14 years of age and younger in 2013, and the mortality rate for this age group was 2.9 per 100,000 population. This was a 16%

increase from 2010 (2.5 per 100,000) and higher than the U.S. rate of 1.9 per 100,000.

Summary of Activities Related to Performance Measure: The Child Safety Fund Program (funded through child safety seat violation fines and managed by Title V) continued to purchase and distribute child restraint devices. From October 2013 to September 2014, payments were made to 43 different agencies for a total of $188,125 to purchase and distribute infant restraint systems, convertible car seats and booster seats. Many of the agencies receiving funds also hosted car seat safety checks to assist parents with ensuring their seat was installed correctly.

The Monroe Carell Jr. Children's Hospital at Vanderbilt operated a safety seat clinic for children with special health care needs. The clinic is staffed by physical and occupational therapists who are certified child restraint device technicians. The clinic visit for the fitting and the restraint device is covered to some degree by private insurance and TennCare (Medicaid). The Children's Hospital collaborates with the Middle Tennessee Child Passenger Safety Center at Meharry to provide education and outreach.

The Ollie the Otter Program has taught seat belt and booster seat safety in elementary schools across Tennessee and involved hundreds of middle and high school service learning volunteers to implement the program. A total of 408 presentations were delivered through this program.

A press release was distributed statewide on July 1, 2014 to educate parents about the dangers of heat-related deaths in locked cars. The "Look Before You Lock" release warned parents to check vehicles for children to ensure that no children are left in a vehicle in hot weather.

NPM 16: The rate (per 100,000) of suicide deaths among youths aged 15 through 19

Interpretation of Performance Data (Form 10D): In 2013, suicide was the third leading cause of death among Tennessee youths between the ages of 15 and 19. Forty Tennessee youths aged 15-19 years committed suicide in 2013, and the suicide mortality rate for this age group was 9.5 deaths per 100,000 population. This was a 34% increase compared to 2010 (7.1 per 100,000) and was higher than the U.S. rate of 8.3 per 100,000.

Summary of Activities Related to Performance Measure: Data from the 2013 Tennessee Youth Risk Behavior Survey (YRBS) indicated that in the previous 12 months, 28% of students surveyed felt sad or hopeless for two weeks or more; 15% seriously considered attempting suicide; 14% made a suicide plan; 9% attempted suicide; and 4% attempted suicide resulting in injury, poisoning or overdose requiring medical treatment.

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

TDH Injury Prevention staff and Tennessee Suicide Prevention Network (TSPN) collaborated in 2014 on a proposal to participate in a week long training on evaluating suicide prevention efforts in Tennessee. The goal of this effort was to evaluate the state suicide prevention strategic plan to identify strengths and weaknesses.

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

In 2014, TDH compiled a statewide injury prevention resource directory and included suicide prevention contact information as part of that resource. The directory focused on injury prevention efforts aimed at children.

In 2014, TDH Injury Prevention staff also created a PowerPoint for health educators on suicide-related prevention primary prevention activities. Health educators implemented some of those activities in the community including a gun safety campaign in Blount County directed to retailers and firing ranges. This campaign educated retailers how

to recognize and respond to signs of suicidal ideation by gun buyers.

Analysis of Progress/Challenges for this Domain

The data regarding teen pregnancy indicates that progress is being made, but there is still much work to be done. The teen population is often difficult to reach outside of a school setting. Through years of community outreach and engagement efforts TDH has become a trusted source of information and services. Discussions about sex and reproductive health may be particularly difficult with teens, as issues of confidentiality and trust are frequent barriers. Establishing a rapport with these young people is crucial in the establishment of a lifelong health-seeking trajectory. The local health department is strategic in addressing the unique needs of this population and offers “teen friendly” clinics. Through specialized training, health department staff are able to discuss difficult topics and encourage all teens to reach out to a trusted adult when making decisions that affect their health now and in the future. Additionally, teens are empowered with knowledge regarding issues such as: avoidance of coercion, the threat of human trafficking, how to avoid an unintended pregnancy, nutrition guidance, and general health promotion strategies.

Tennessee’s rate of motor vehicle-related deaths among adolescents has fluctuated in the recent past. While the most recent year’s performance is encouraging, additional efforts are needed to reduce these deaths. Tennessee’s graduated driver’s license laws provide strong policy support for keeping young drivers safe. Additionally, strong partnerships with the regional trauma centers and high schools on programs like “Battle of the Belt” are likely to yield additional improvement on this indicator.

The rate of suicides among Tennessee youth is increasing. The reasons for this trend are not entirely clear. Increasing use of social media and cyber-bullying may play a role, as teens may experience near-constant exposure to taunts or threats. A reluctance by adolescents to seek help from trusted adults or medical professionals may reduce the likelihood for early intervention when distress occurs. There are general challenges with obtaining reliable data on suicide; some families or medical examiners may be reluctant to list suicide on the death certificate given the sensitivity around the subject, particularly in rural areas.

State Action Plan Table						
Children with Special Health Care Needs						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
Increase the number of children (both with and without special health care needs) who have a medical home.	By FY2020, increase the percent of children age 0-17 years (with and without special healthcare needs) having a medical home to 68%. (Data source: National Survey of Children's Health)	Support primary care providers in implementing a medical home approach to care. Increase general awareness of the importance of a medical home approach to care. Link families to medical homes through the Children's Special Services program.	Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system Percent of children in excellent or very good health Percent of children ages 19 through 35 months, who have received the 4:3:1:3(4):3:1:4 series of routine vaccinations Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	Percent of children with and without special health care needs having a medical home		

			Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine			
Increase the number of children (both with and without special health care needs) who have a medical home.	By FY2020, increase the percent of children age 0-17 years (with and without special healthcare needs) having a medical home to 68%. (Data source: National Survey of Children's Health)	Support primary care providers in implementing a medical home approach to care. Enhance youth participation in the transition process.	Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system Percent of children in excellent or very good health	Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care		

Children with Special Health Care Needs

Children with Special Health Care Needs - Plan for the Application Year

PRIORITY: Increase the number of children (both with and without special healthcare needs) who have a medical home.

Objective for State Priority: Increase the percent of children age 0-17 years (with and without special healthcare needs) having a medical home to from 60.1% to 68% by FY2020.

Rationale for Objective: In 2012, 60.1% of Tennessee children age 0-17 years were reported to have a medical home (National Survey of Children's Health). Numerous efforts are currently underway in Tennessee to increase the number of children who have a medical home; these include: the HRSA D70-funded systems integration efforts (partnership between Tennessee's Title V Program and the Tennessee Chapter of the American Academy of Pediatrics); Medicaid's new patient-centered medical home initiative; and longstanding efforts by CSS to connect

CYSHCN with a medical home. With these efforts in mind, we believe a 12.5% relative increase (to 68.0%) by FY2020 is reasonable.

Current Performance: In 2012, 60.1% of Tennessee children age 0-17 years were reported to have a medical home; this represents a slight decrease from the prior survey (2007). In both survey years, Tennessee outperformed the nation. In 2012, the percentage of children having a medical home was 54.4% nationally (compared to 60.1% in Tennessee).

Planned strategies and Activities: To achieve the objective listed above, the following strategies and activities are planned for FY16:

Strategy 1: Support primary care providers in implementing a medical home approach to care.

Activity 1a. The CYSHCN program will continue partnering with Tennessee Chapter of the American Academy of Pediatrics to provide opportunities for training and National Committee for Quality Assurance (NCQA) certification of pediatric providers.

Activity 1b. The CYSHCN program will partner with Niswonger Children's Hospital on a care coordination pilot to reduce emergency room and inpatient hospital utilization.

Activity 1c. Collaborate with the National Center for Medical Home Implementation to provide technical assistance to the CYSHCN program and pediatric providers.

Activity 1d. CYSHCN staff will collaborate with the Tennessee Chapter of the American Academy of Pediatrics and Family Voices to update and provide electronic access to the Transition Toolkit.

Activity 1e. CYSHCN staff will partner with two local Federally Qualified Health Centers to increase transition from pediatric providers to adult providers.

Activity 1f. CYSHCN staff will utilize "Got Transition" to provide technical assistance to the program and pediatric providers on developing transition policies.

Activity 1g. CYSHCN staff will partner with Tennessee Chapter of American Academy of Pediatrics and the Tennessee Academy of Family Physicians to provide educational opportunities and support on developing the Six Core Elements of Health Care Transition in providers' written health care transition policies.

Strategy 2: Increase general awareness of the importance of a medical home approach to care.

Activity 2a. CYSHCN staff will maintain the electronic Medical Home Toolkit as a resource for providers and families.

Activity 2b. CYSHCN staff will continue to partner with Family Voices to coordinate the Parent to Parent program and to provide families with information and support on accessing ongoing, comprehensive care in a medical home.

Activity 2c. CYSHCN staff will continue to partner with Family Voices to provide workshops and resources for families that include health advocacy, resources, system navigation, and partnering in the decision making process.

Activity 2d. CYSHCN staff will partner with Family Voices and The Tennessee Disability Multicultural Alliance to develop transition resources particularly for multi-cultural families.

Strategy 3: Link families to medical homes through Children's Special Services, Tennessee's Title V CYSHCN program.

Activity 3a. Assist families to identify and access medical homes.

Activity 3b. Continue to collaborate with Family Voices in the development and implementation of a satisfaction survey measuring CSS participants' satisfaction and components of their medical home.

Activity 3c. CSS staff will work with Medicaid to identify health homes and provide referral and resources to connect families to primary and specialty care providers.

Activity 3d. CSS care coordinators will work with families to develop (and renew annually) a transition plan for all program participants starting at age 14.

Activity 3e. CYSHCN program staff will regularly apprise CSS Advisory Committee members of any challenges associated with transitioning youth from pediatric to adult medical homes and solicit committee members' advice on solutions.

Strategy 4: Enhance youth participation in the transition process.

Activity 4a. CYSHCN program staff will partner with Family Voices to create a youth advisory group.

Activity 4b. In conjunction with Family Voices, CYSHCN will provide training and conferences for youth and families with special health care needs regarding transition to adult health care providers.

Activity 4c. CYSHCN staff will actively encourage youth participation in policy and advocacy opportunities.

MCHB Partnerships: The CYSHCN program partners with MIECHV-funded home visiting programs to provide care coordination and medical payment for children referred to CSS. CYSHCN staff are also currently working with MIECHV staff to develop care coordination standards for use across programs in local health departments (CSS as well as targeted case management programs).

Other Key Partnerships: Through the D70 Integrated Systems Grant, the CYSHCN program has formed partnerships with Family Voices, TNAAP, and the Tennessee Academy of Family Physicians (TNAFP). The focus of the partnership with Family Voices is to increase family participation in advocacy and policy development, to develop a parent to parent network providing mentoring and support to other families of CYSHCN and to provide opportunities for parent and family training and participation. The partnership with TNAAP includes training for medical providers around patient and family centered medical homes, care coordination, culturally sensitive care, and transition to adult health care. TNAAP also focused on identifying and implementing strategies for collaboration with medical providers for NCQA certification. Collaborative efforts with TNAFP include identifying mechanisms for creating a transition model for transferring youth from pediatric to adult providers.

Related Legislative Requirements: These strategies and activities align with the Title V legislative requirements to:

- Provide and assure children (in particular those with low income or with limited availability of health services) access to quality child health services (501(a)(1)(A))
- Reduce the incidence of preventable diseases and handicapping conditions among children (501(a)(1)(B))
- Promote the health of children by providing preventive and primary care services for low income children (501(a)(1)(B))
- Provide rehabilitation services for blind and disabled individuals under the age of 16 receiving benefits under title XVI, to the extent medical assistance for such services is not provided under title XIX (501(a)(1)(C))
- Provide and promote family-centered, community-based, coordinated care for children with special health care needs and to facilitate the development of community-based systems of services for such children and their families (501(a)(1)(D))
- Submit a plan responsive to the needs of children with special health care needs (505(a)(2)(A))

Children with Special Health Care Needs - Annual Report

NPM 11 - Percent of children with and without special health care needs having a medical home

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	61.6	63.1	64.7	66.3	68

NPM 12 - Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	42.8	43.9	45	46.1	47.3

NPM 2: 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

Interpretation of Performance Data (Form 10D): Data are collected from the National Survey of Children with Special Health Care Needs (NS-CSHCN), which underwent changes in the questionnaire's wording in 2009-2010. Therefore, data from 2009-2010 are not comparable to earlier versions of the survey. In 2009-10, 72.3% of families reported that they partner in decision making at all levels and are satisfied with the services they receive. While we cannot compare these results to the 2005-06 NS-CSHCN (60.7%), there was almost 12% increase in the number of families who reported they partnered in the decision making process at all levels. During this same time period, Tennessee ranked 2% higher than the national average for this measure.

Summary of Activities Related to Performance Measure: Through the D70 State Implementation Grant for CYSHCN, Family Voices and the CYSHCN program collaborated to provide Family and Patient Centered Workshops. These workshops allowed patients and families to learn more about partnering in the decision making process. Eighty individuals participated in these workshops. The workshops also provided a forum to educate families on how to "tell their story". Parents were provided training and checklist tools so they would be better able to advocate for their child's care needs and reinforce expectations with their health care provider for comprehensive and coordinated care. Parents were also provided training and tools to assess components of the practice to determine if the components of the Medical Home were being met.

CYSHCN staff worked to ensure that children and parents become active participants in all levels of decision-making. Children's Special Services (CSS, Tennessee's Title V CSHCN program) participants and their families continued to participate in the development of a Family Service Plan (FSP) to assess problems/needs and identify goals and objectives 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 system navigation. Family Service Plans will continue to be developed with families and participants to address strategies for participation in decision making and interaction with health care providers.

The CYSHCN director served on advisory committees and/or collaborated with The Tennessee Council of Developmental Disabilities, the Tennessee Technical Assistance and Resources for Enhancing Deaf Blind Supports, Family Voices, Tennessee Early Intervention Services, Genetics Advisory Committee, and the Newborn Hearing

Screening Task Force. Through these collaborations, the CYSHCN director actively participated in policy and program development for children and youth with special health care needs.

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

Parents attended and participated in the CSS Advisory Committee meetings. Program participants and their families presented on selected topics of interest. CYSHCN staff continued requesting parent/family participation and attendance at AMCHP and other leadership development training opportunities.

The D70 Grant provided for three contracted parent/youth consultant positions. The addition of these positions enhanced participation by and decision-making capability of youth and parents of CYSHCN. The consultants served as a resource for other parents. They assisted parents to navigate the health care system and provided on-going recommendations to incorporate parental input into program operations. A youth with special health care needs was hired to assist with the coordination of family and youth activities and the development of the parent/youth advisory committee. The youth coordinator has participated in the patient and family-centered workshops and will continue to lead the youth advisory group in becoming self-advocates and learning how to partner in the decision making process.

NPM 3: The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home

Interpretation of Performance Data (Form 10D): Data are collected from the NS-CSHCN. The measurement changed slightly from the 2005-06 survey, however it remains comparable. In the 2005-06 NS-CSHCN, 52.7% of CYSHCN received coordinated, ongoing, comprehensive care within a medical home; this decreased to 45.9% in 2009-10. Although there was a 6.6% decrease between 2005-06 and 2009-10, Tennessee families reporting receipt of care in a medical home was slightly higher (2.9%) than the national level.

Summary of Activities Related to Performance Measure: The CYSHCN director collaborated with TNAAP to develop plans for three medical home summits. The medical home summits were intended to improve health care service delivery for CYSHCN by increasing the number of primary care providers implementing medical home concepts in their practices across Tennessee.

The first Medical Home Summit focused on care coordination and through collaborative efforts CSS staff and local health care providers were brought together and resources provided to increase the knowledge of medical home concepts. Provider practices that participated in this Summit were provided an opportunity to work towards certification as a medical home and all attendees received training on Care Coordination in the Medical Home, Best Practices in Disease Management, Screening for CYSHCN, Family Impact and Developing a Provider Culture of Dynamic Quality Improvement. Twenty-two practices participated in the summit and a joint QI collaborative; at the end of the collaborative, the practices will have the opportunity to become NCQA certified medical homes. Comprehensive medical home educational resources and tools were developed for all Tennessee pediatricians and family physicians who choose to implement medical home concepts in their practice.

The second Medical Home Summit focused on Culturally Effective Care and shared the work of the National Center for Cultural Competence in order to provide strategies to design, implement, and evaluate culturally and linguistically competent medical home services. This summit helped providers address the diversity among children and youth with special health care needs. A total of 60 participants were in attendance, and representatives from 20 practices participated in this summit.

The Tennessee Medical Homes Website was developed and launched and can be accessed at www.tennesseemedicalhome.com. This website is housed by the Tennessee Chapter of the American Academy of Pediatrics.

CYSHCN staff hosted a CYSHCN exhibit booth at the 66th Annual Conference of the Tennessee Academy of Family Physicians to target the large number of providers attending the conference and provide medical home information and resources for recruitment of adult providers for youth with special health care needs.

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

CSS program staff collaborated with other agencies to assist families with identifying and accessing medical homes. CSS program staff also assisted with coordination of services between providers. Staff conducted outreach with insurance and primary care providers to establish medical homes and payment sources for CYSHCN, and facilitated information exchanges between the health care providers and families. Care coordinators provided follow-up for infants that were identified by the Newborn Screening Program and enrolled the infants into the CSS program.

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

NPM 4: 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

Interpretation of Performance Data (Form 10D): Data are collected from the NS-CSHCN, which has held consistent questions for this performance measure for the 2001, 2005-2006, and 2009-2010 surveys. In 2005-06 NS-CSHCN, 67.7% of CYSHCN lived in families that had adequate private and/or public insurance to pay for the services they need; this increased to 70.4% in 2009-10.

Summary of Activities Related to Performance Measure: The CYSHCN director partnered with other departmental staff and TennCare agency staff to ensure that families had the ability to apply for insurance coverage through the Federal Health Insurance Market Place. CSS program staff provided assistance to families on accessing coverage through the marketplace and referred participants with special health care needs to local managed care organizations (MCOs). The CSS program continued to receive referrals from the MCOs for eligible medical services.

The CYSHCN director and CSS program staff partnered with the MCOs to ensure insurance is available to all eligible participants and established a referral system that allowed participants with special health care needs to receive referrals to the MCOs by CSS and also allows for the MCOs to refer to CSS.

The CYSHCN director provided information, including CSS program eligibility requirements and information about other government sponsored insurance programs to the local human services offices. Staff also provided narrative and electronic information for inclusion in newsletters and other printed resource material published by the TennCare MCOs, the Academy of Family Physicians, and the Tennessee Chapter of the American Academy of Pediatrics.

CSS continued to provide reimbursement for medical services (as a payer of last resort), care coordination and education and resources to families regarding available public and private insurance options. CSS staff assessed and determined insurance status of all participants during six-month and annual eligibility reviews and provided necessary assistance in applying for coverage and appealing denied services.

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

The CYSHCN director and CSS program staff conducted social marketing and outreach activities that included contacting child-serving agencies, local health care providers, and community resource agencies to provide information regarding CSS, TennCare, Health Insurance Market Place and CHIP in their informational brochures provided to families.

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

CSS program staff provided notification of open enrollment on the Health Insurance Market Place to families and CYSHCN. Program staff assisted families to apply for emergency Medicaid coverage when admitted to the hospital.

The Transition Summit planned in collaboration with Tennessee Chapter of the American Academy of Pediatrics included breakout sessions on insurance including TennCare and other third party payer sources.

NPM 5: Percentage 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

Interpretation of Performance Data (Form 10D): Data are collected from the NS-CSHCN, which has undergone extensive revisions to its questionnaire for this performance measure between the 2001, 2005-2006, and 2009-2010 surveys. Therefore, data from 2009-10 are not comparable. In 2005-06, 91.8% of CYSHCN families reported the community-based service systems are organized so they can use them easily. In 2009-10, 71.5% of CYSHCN families reported the community-based service systems are organized so they can use them easily.

Summary of Activities Related to Performance Measure: CYSHCN staff, Family Voices and TNAAP staff met quarterly to discuss the advances made towards developing a system of services for CYSHCN. The team participated in two QI initiatives with John Snow regarding measuring and evaluating the Integrated Systems grant activities. The team also participated in monthly webinars with other states to discuss and learn what other states were initiating.

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

CSS program staff continued to identify needed services available within the community that are easily accessible. Staff worked closely with MCOs, insurance companies, and other providers for improving access to local services. In addition, CSS program staff continued to collaborate with agencies to facilitate referral and access to the CSS program and partner agencies' services. CSS program staff participated in statewide and local health fairs and community resource fairs; attended parent teacher meetings at schools; and contacted local health care providers and other community agencies in an effort to increase awareness of community based services for children and families. Notification of available services and resources to all families of recently SSA eligible participants continued.

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

CSS staff routinely referred families to kidcentraltn, a web portal developed by the Governor's Children's Cabinet (accessible at www.kidcentraltn.com). The site was designed to be a "one-stop shop" for families to find credible information about health, education, and development and to locate state-funded services through a searchable database.

An electronic resource directory of CYSHCN resources was developed and is housed on the CYSHCN web site. The directory contains resources for all 95 counties in the State and can be accessed by families, providers or others searching for community based resources. The directory allows care coordinators and families to access community based resources at the local/county level, and also contains many state and federal resources. The directory includes all known local/community based resources and may be accessed at http://www.tn.gov/health/article/MCH-cyshcn-directory.

Patient and family centered care workshops were conducted and provided a forum for parents and families to develop and increase their knowledge of navigating health care and community support systems. One-on-one coaching was provided to assist families in accessing needed services and follow-up sessions were conducted to determine if services were easily accessible or useful. The parent to parent network also provided resources and referrals at parents' request.

CYSHCN staff identified fact sheets and other resources for CYSHCN that provided diagnosis-specific information and also basic information for families that have just been notified of their child's diagnosis.

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

TDH contracted with Family Voices to conduct a survey of CSS participants. The survey included questions regarding community based services. Analysis and survey results will be provided to TDH for use in program planning and development to ensure that community based services are organized in ways that families can easily use them.

NPM 6: 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

Interpretation of Performance Data (Form 10D): Data are collected from the NS-CSHCN, which has asked consistent questions for this performance measure for the 2005-2006 and 2009-2010 surveys. In 2005-06, 39.6% of CYSHCN received the services necessary to make transitions to all aspects of adult life; this increased to 41.8% in 2009-10.

Summary of Activities Related to Performance Measure: CYSHCN program staff collaborated with state agencies, advisory groups and work groups regarding youth transition issues and program and policy development to ensure that all CYSHCN receive appropriate transition planning.

Through the D70 grant, CYSHCN staff partnered with Family Voices of Tennessee and youth consultants to develop a workshop for youth that were of transition age or that had already transitioned to adult health care providers. Fifteen additional youth were trained through this collaboration on transition from pediatric to adult providers.

CYSHCN staff collaborated with Mercy Clinic and a student from Belmont University to develop a transition module that is being utilized by the clinic staff to educate and assist youth transition from pediatric to adult providers.

CYSCHN staff, Family Voices and the Tennessee Chapter of the American Academy of Pediatrics (TNAAP) partnered to develop a transition tool kit. The transition toolkit will be marketed to providers, families and community partners. The toolkit is housed on the tennesseemedicalhome.com website.

CYSHCN staff continued to monitor national developments regarding transition standards and best practices and

incorporated those initiatives into the CSS program where feasible.

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

CYSHCN collaborated with TNAAP and the CSS program staff to identify health care providers to ensure transitioning youth have a medical home.

CYSHCN staff and TNAAP staff started the planning process for a Transition Summit including youth, parents, and medical providers.

SPM 6: Percentage of youth (14 and older) enrolled in the state CSHCN program who have formal plans for transition to adulthood

Interpretation of Performance Data (Form 10D): Data are taken from the TDH Patient Tracking and Billing Management Information System (PTBMIS). In 2011, the state performance measure was changed to capture only the number of children enrolled in the state program age 14 and older who received formal transition plans. According to PTBMIS data, the percentage increased from 15.3% to 19.7% from 2012 to 2013, respectively, which was below the annual performance objective. In 2014, 70.6% of program participants age 14 and above were noted to have formal transition plans. Note: data were not reported in 2011 due to changes in the State Performance Measure data source.

Summary of Activities Related to Performance Measure: CYSHCN staff provided training to CSS staff on the standards and requirements for conducting transition planning with CSS program participants. The CSS program continued to utilize the American Academy of Pediatrics emergency preparedness guidelines for CYSHCN as part of the individualized transition plan and continued to partner with pediatric providers to locate adult providers for CYSHCN who were aging off the program.

CYSHCN staff provided age appropriate transition plans for CSS program participants age 14 and older. The transition planning process is conducted annually and includes the following domains: Medical, Independent Living, Financial, Legal, Education/Vocation, Employment, Social/Recreation, Family Resources and any Additional Resources requested by the youth or their family. A portable Health History Summary Form was completed and provided to all transitioning participants as a concise medical history that contains pertinent health care information and can be utilized as the participant transitions from pediatric to adult providers.

TDH contracted with Family Voices to conduct a survey of CSS participants. The survey included questions regarding transition services. Analysis and survey results will be provided to TDH for use in program planning and development to ensure that community based services are organized in ways that families can easily use them.

CYSHCN and CSS program staff identified the needs of participants and their families concerning transition from adolescence to adulthood and included them in the CYSHCN resource directory that is housed on the TDH website. Staff continued to identify transition resources within the state for youth and their families and update the website as necessary.

CYSHCN collaborated with TNAAP and the CSS program staff to identify health care providers to ensure transitioning youth have a medical home.

Analysis of Progress/Challenges for this Domain

Based on the results from the NS-CSHCN, Tennessee has continued to improve performance over time for four of the CYSHCN measures and exceeds the national performance on all measures. Although there was a decrease on two of the measures, the results cannot be compared to the earlier surveys because of changes in the questionnaire

or the methodology. During the past year, many system changes have been instituted, starting with the provision of patient and family focused workshops around partnering in the decision making process, self-advocacy and assessing medical home components of provider practices. Progress has also been made relative to providing opportunities for families to have a voice in policy making and creating opportunities for parents and youth to serve on advisory boards. The collaboration with TNAAP has also provided an educational opportunity for pediatric providers to learn more about medical home certification and practice care coordination. Families have access to insurance by applying for coverage through the Health Insurance Market Place, and assistance is available with applying for TennCare and CHIP. Access to information on community based systems was enhanced through the development of the on-line resource directory and kidcentraltn. Invaluable partnerships have been formed with Family Voices, TNAAP, and the Tennessee Chapter of Family Physicians and other provider agencies serving CYSHCN.

However, challenges continue for this domain. Access to adult health care providers for youth transitioning to adulthood continues to be an issue. Barriers exist in locating adult providers that have knowledge of the “childhood” disease, getting youth to follow up with appointments and medication regimens, and transportation. Youth that make the transition to adult health care also report many barriers, including not being allowed to have their families involved in their care, insurance challenges, and having to be responsible for their own care.

Challenges in data collection and access continue as well. The National Survey is conducted every four years and it sometimes takes an additional year or more to receive the data. By the time the data is released, the measures are no longer relevant.

State Action Plan Table						
Cross-Cutting/Life Course						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
Reduce exposure to tobacco among the MCH population (pregnancy smoking and secondhand smoke exposure for children).	By FY2020, decrease the percentage of women who smoke during pregnancy to 14.1% and the percentage of children who live in households where someone smokes to 30.2%.	Continue the Gold Sneaker voluntary recognition program for licensed child care centers (one of the policy areas is promotion of tobacco-free child care campuses). Collaborate with Tobacco Prevention and Control staff to promote the Tennessee Tobacco QuitLine. Refer participants in Title V programs to smoking cessation services where appropriate.	Rate of severe maternal morbidity per 10,000 delivery hospitalizations Maternal mortality rate per 100,000 live births Percent of low birth weight deliveries (<2,500 grams) Percent of very low birth weight deliveries (<1,500 grams) Percent of moderately low birth weight deliveries (1,500-2,499 grams) Percent of preterm births (<37 weeks) Percent of early preterm births (<34 weeks) Percent of late preterm births (34-36 weeks) Percent of early term births (37, 38 weeks)	A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes		

			Perinatal mortality rate per 1,000 live births plus fetal deaths Infant mortality rate per 1,000 live births Neonatal mortality rate per 1,000 live births Post neonatal mortality rate per 1,000 live births Preterm-related mortality rate per 100,000 live births Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births Percent of children in excellent or very good health			

Cross-Cutting/Life Course

Cross-Cutting/Life Course - Plan for the Application Year

PRIORITY: Reduce exposure to tobacco among the MCH population (pregnancy smoking and secondhand smoke exposure for children).

Objective for State Priority: Decrease the percentage of women who smoke during pregnancy to from 16.1% (2013) to14.1% and the percentage of children who live in households where someone smokes from 32.7% (2012) to 30.2% by FY2020.

Rationale for Objective: Title V Program staff developed annual objectives based on linear trend calculation and percent decreases over the last five years. We anticipate a continued decreasing trend among pregnant smokers with continued support of tobacco cessation program efforts. With limited data from the National Survey of Children's Health, other data sources (such as the Birth Statistical System, Behavioral Risk Factor Surveillance System and Youth Risk Behavior Surveillance System) were used to establish targets for secondhand smoke exposure.

Current Performance: Tennessee currently ranks 46th nationally in tobacco use among adults. The American Lung Association ranks Tennessee poorly in tobacco prevention and control spending, smoke-free air laws, access to cessation services, and tobacco taxes. Efforts over the new grant cycle will address all areas of need across the state, including at-risk populations, high tobacco-use areas, and policy change. Secondhand smoke exposure among children and adolescents is significantly higher in Tennessee than the national average. Annual administration of the NSCH in Tennessee will greatly assist in understanding the prevalence of secondhand smoke exposure in the home.

Planned strategies and Activities: To achieve the objective listed above, the following strategies and activities are planned for FY16:

Strategy 1: Continue the Gold Sneaker voluntary recognition program for licensed child care centers (one of the policy areas is promotion of tobacco-free child care campuses).

Activity 1a. Recruit child care facilities statewide by educating Facility Directors about the benefits of deciding to pursue Gold Sneaker certification.

Activity 1b. Provide technical assistance to child care centers to help in the development and implementation of policies related to tobacco exposure.

Activity 1c. Collaborate with the TDH Early Childhood Nurse Consultant (funded through ECCS) and the Department of Human Services to explore the possibility of adding Gold Sneaker requirements to child care licensing standards.

Strategy 2: Collaborate with Tobacco Prevention and Control staff to promote the Tennessee Tobacco QuitLine.

Activity 2a. Promote the QuitLine as a resource in publications and presentations.

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

Activity 2c. Utilize Title V funding to purchase promotional materials for distribution to pediatric providers during CDC "Tips from Former Smokers" media buys.

Activity 2d. Establish a partnership with women's health providers to distribute information about the dangers of pregnancy smoking to pregnant women (or women seeking preconception/interconception care).

Strategy 3: Refer participants in Title V programs to smoking cessation services where appropriate.

Activity 3a. Continue to refer participants in Family Planning, home visiting, and CSS to the Tobacco QuitLine and other community-based cessation services.

Activity 3b. Participate in the CoIIN related to pregnancy smoking.

Activity 3c. Support integration of smoking assessment and cessation resources into the TDH electronic health record (currently under development).

MCHB Partnerships: MIECHV-funded home visiting programs include information about the dangers of smoking during pregnancy and secondhand smoke. TDH is utilizing ECCS funding to support an Early Childhood Nurse Consultant; one of the consultant's tasks is to interface with entities that credential early childhood care centers and promote health standards within those centers (including tobacco-free child care campuses).

Other Key Partnerships: WIC staff assess for smoking status and make referrals for cessation where appropriate. Staff in the Reproductive and Women's Health section facilitate a Cervical Cancer Elimination Committee; one of the Committee's activities is to encourage girls and women to avoid smoking as a strategy for preventing cervical

cancer.

Related Legislative Requirements: These strategies and activities align with the Title V legislative requirements to:

- Provide and assure mothers access to quality maternal health services (501(a)(1)(A))
- Submit a plan responsive to the needs of preventive and primary care services for pregnant women and mothers (505(a)(2)(A))
- Reduce the incidence of preventable diseases and handicapping conditions among children (501(a)(1)(B))
- Reduce the need for inpatient and long-term care services (501(a)(1)(B))
- Submit a plan responsive to the needs of preventive and primary care services for children (505(a)(2)(A))

Cross-Cutting/Life Course - Annual Report

NPM-14 A) Percent of women who smoke during pregnancy

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	15.7	15.3	14.9	14.5	14.1

NPM-14 B) Percent of children who live in households where someone smokes

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	32.2	31.7	31.2	30.7	30.2

NPM 15: Percentage of women who smoke in the last three months of pregnancy

Interpretation of Performance Data (Form 10D): Over the last five years 2010-2014, data from the Tennessee Birth Statistical System indicate a 17% reduction in the percent of mothers who report smoking during the last trimester of pregnancy. In 2014, approximately one-quarter (25.1%) of pregnant mothers report quitting tobacco use prior to pregnancy (among those who used tobacco within three months of pregnancy), and another 21.9% of pregnant smokers report smoking during the first trimester but not during the last trimester. Overall, the rate of smoking at any time during pregnancy was 15.0% in 2014.

Summary of Activities Related to Performance Measure: Providing pregnant women with cessation resources, medication and support has long been a priority of staff within TDH. Local health department nurses and WIC nutritionists have continued to counsel pregnant women and provide education, information, and referral to community smoking cessation classes and to QuitLine resources. All WIC clinics assessed pregnant, postpartum and breastfeeding women for smoking status.

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

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

TDH is using tobacco master settlement funds to support projects across the state aimed at reducing pregnancy smoking. There were 71 pregnancy smoking reduction projects implemented across the state. Baby and Me Tobacco Free was implemented in 67 counties. Other pregnancy smoking reduction efforts include the Tennessee Intervention for Pregnant Smokers (TIPS) and Smart Moms, which were implemented across 4 counties.

TDH home visiting programs provided education and information about the effects of secondhand smoke to parents and family members and promoted the Tobacco QuitLine. Home visitors in the Northeast region (the region with the highest rate of pregnancy smoking) participated in the national Collaborative Improvement and Innovation Network (CoIIN) to identify strategies to increase referral of women to the QuitLine and to increase smoking cessation among those women who enrolled.

Analysis of Progress/Challenges for this Domain

There have been multiple efforts to reduce pregnancy smoking over the past few years. In 2013, the General Assembly appropriated $5 million annually for three years to TDH (through tobacco master settlement funding) to support community-based interventions related to tobacco prevention. One of the key priority areas was reduction of pregnancy-related smoking. Projects have been implemented in all 95 counties and each county must focus on pregnancy-related smoking for at least one of the three years.

TDH has continued to utilize CDC funding to support the state Tobacco Prevention and Control Program, including the Tennessee Tobacco QuitLine. While the QuitLine provides a valuable resource for smoking cessation, it is woefully underused, especially by pregnant women. Title V is participating in the CoIIN initiative related to pregnancy smoking; specifically, staff are working to enhance referrals to the QuitLine in two counties with the highest rates of pregnancy smoking.

While pregnancy smoking rates are decreasing, the generally high burden of tobacco use among Tennessee adults poses an ongoing challenge in this domain. Additional focused effort is needed to reduce the percentage of Tennessee adults who smoke (and by extension, smoking among pregnant women).

Other Programmatic Activities

TDH uses Title V dollars to fund (entirely or in part) a variety of services offered to women and children. Many are discussed in the State Action Plan section; other programs and efforts not described are outlined below.

Childhood Lead Poisoning Prevention Program

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

Child Care Resource and Referral Centers

Tennessee's Child Care Resource Centers assist child care providers to improve the quality of child care. These Centers are the result of a collaborative involving the Tennessee Departments of Human Services and Health and the Tennessee Developmental Disabilities Council. There are ten child care resource centers serving providers in all 95 counties. Areas emphasized by the centers are: developmentally appropriate practice, health and safety, and the inclusion of children with special needs. Services include: training, technical assistance and consultation, and a

lending resource library.

Child Fatality Review

Tennessee's review system is designed to identify why children are dying and what preventive measures can be taken. Multi-disciplinary, multi-agency child fatality review teams in the 31 judicial districts review all deaths of children 17 years of age or younger. The state child fatality prevention team reviews the reports and recommendations from the local teams, analyzes statistics of the incidence and causes of child deaths, and makes recommendations to the Governor and General Assembly to promote the safety and well-being of children. Over 99% of all deaths are reviewed annually. The annual Child Fatality Review state reports can be found online at: http://www.tn.gov/health/article/MCH-childFatality-resources.

Fetal Infant Mortality Review (FIMR)

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

Injury Prevention Program

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

Home Visiting Programs

Tennessee's home visiting programs emphasize child health and development, child abuse and neglect prevention, education and parental support. Healthy Start services are available in 30 counties and target first time parents. The program provides intensive home visiting services prenatally through the child's fifth birthday with goals of preventing child abuse and neglect and promoting family health. CHAD (Child Health and Development) is a home-based prevention and intervention service in 22 Tennessee counties. The services are provided to children ages birth to 6 years who are at risk of abuse or neglect, are at risk of developmental delay and/or have an identified delay. Pregnant women under age 18 may be enrolled during pregnancy to prevent or reduce the risk of abuse or developmental delay to the unborn child. The Help Us Grow Successfully (HUGS) program (targeted case management) is available in all 95 counties, serving pregnant and postpartum women and children under six. The Healthier Beginnings program, funded with federal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) dollars, began in 2012. TDH received an MIECHV Expansion grant in March, 2012 which expanded evidence-based home visiting programs to 30 of the most at-risk counties with an additional 1200 children to be served. Additionally, these funds are supporting Welcome Baby, a universal outreach initiative to newborns based on risk factors identified from the birth file. The purpose of Welcome Baby is to connect parents of newborns to home visiting and other community resources. Annually, close to 20,000 newborns are expected to receive an outreach contact in the 30 counties where evidence-based home visiting programs have been established.

Family Planning Program

Comprehensive family planning services, including medical examinations, laboratory tests, education and counseling, and contraceptive supplies are provided in all 95 counties through state and metropolitan health departments. These services include Pap smears, screening and treatment for sexually transmitted diseases, breast exams, and screening for anemia.

Breast and Cervical Cancer Screening Program

The Tennessee Breast and Cervical Screening Program provides clinical breast exams, mammograms and Pap tests for eligible Tennessee women free of charge. Eligibility is based on age, income, and insurance coverage. Participating statewide providers, including local health departments and primary care clinics, provide screening services and referrals if additional tests are needed. The program continues to target 12,000 women each year due to funding limitations.

Partnerships with TennCare (Medicaid)

Local health departments provide outreach and assistance to TennCare enrollees; staff provide presumptive Medicaid eligibility determination for pregnant women, assist enrollees with formal appeals to TennCare, assist in scheduling medical appointments and transportation, and provide EPSDT exams for TennCare children. Staff enrolls eligible clients from the Tennessee Breast and Cervical Cancer Early Detection Program in TennCare for coverage of treatment services.

Hotlines

TDH directly operates 2 hotlines specifically related to the MCH population. The Title V toll-free hotline (formerly known as the “Baby Line”), answers questions, refers callers for pregnancy testing, TennCare and prenatal care, and responds to requests for information. The Clearinghouse for Information on Adolescent Pregnancy Issues is a separate, central, toll-free telephone for professionals seeking information on local resources, teen pregnancy statistics, resource materials, information on adolescent issues, and services. A third hotline, the Tennessee Breastfeeding Hotline, is contracted out to one of the state’s children’s hospitals. The hotline provides 24/7 toll-free access to certified lactation counselors. As of July 2015, the Breastfeeding Hotline receives approximately 400 calls per month.

Advisory Committees

MCH has 4 mandated advisory committees: Perinatal Advisory Committee; Genetics Advisory Committee for newborn screening; the Children's Special Services Advisory Committee; and the Women's Health Advisory Committee. Other task forces and advisory groups for MCH programs (not mandated) include: Public Health Advisory Committee on Infant Mortality, Childhood Lead Poisoning Prevention Advisory Committee, and Young Child Wellness Council.

II.F.2 MCH Workforce Development and Capacity

Title V-funded MCH and CSHCN staff work at multiple levels within the Tennessee Department of Health (Central Office, 7 Rural Regional Offices and 1 Metro Office, and local health departments in 95 counties).

A full description of the current MCH workforce (including position classifications, employee counts, and full-time equivalents) is found in the accompanying Needs Assessment document. This needs assessment document also contains detailed information regarding Tennessee’s Title V Program leadership team.

State-level program planning is provided by individual program directors, in consultation with Tennessee’s Title V Director and senior leadership within FHW. MCH program directors gather monthly for a Program Management meeting, during which staff outline program goals and objectives, map program activities to state priority measures, discuss opportunities for linkages between MCH programs, and work through challenges common across programs. The Program Management meetings also provide an opportunity for ongoing professional development among the Central Office MCH workforce. For example, the group has worked through the Johns Hopkins MCH Public Health Leadership modules. These monthly meetings also provide an opportunity to familiarize staff with Departmental operations. Recent presentations have included contract development and monitoring as well as emergency preparedness. The Division’s epidemiology staff is presenting an “Epidemiology 101” series in 2015 to

provide all program leadership with a working understanding of basic epidemiology principles and techniques.

In 2014, TDH partnered with faculty from four Tennessee public health programs (East Tennessee State University, University of Tennessee-Knoxville, Tennessee State University, and the University of Memphis) to provide FHW program staff with training in program evaluation. Faculty presented examples of program evaluation strategies and then worked in small group sessions with program management staff to help identify plans for evaluating FHW programs.

Over the past four years, TDH has recruited six epidemiologists to FHW (including four doctoral-level epidemiologists). The epidemiologists provide broad support for data analysis and program evaluation across the Division and specialized support in program areas such as home visiting, chronic disease prevention and health promotion, injury prevention and detection, reproductive and women's health, newborn screening, childhood lead poisoning prevention, and children and youth with special healthcare needs. FHW hosted a CSTE (Council of State and Territorial Epidemiologists) Applied Epidemiology Fellow in 2013-15 (Julie Traylor). Ms. Traylor led the five-year Title V Needs Assessment and has now been hired full-time as Tennessee's MCH Block Grant and SSDI Grant Coordinator.

Additional data analysis support is provided through a number of collaborative relationships. The SSDI grant (managed by FHW) provides funding support for staff in the Department's Office of Policy, Planning, and Assessment. FHW also receives a great deal of data support through the Department's Division of Quality Improvement; this Division has provided invaluable assistance in implementing data collection tools for home visiting programs administered by FHW.

To enhance our ability to provide culturally competent services, Tennessee's Title V Program has partnered with the University of Tennessee at Knoxville (UTK), a HRSA-MCHB grant recipient, to provide cultural competency training to health department staff. Since March 2012, selected Department of Health staff in all 13 regions are participating in the half-day training provided by UTK. The workshop takes an in-depth look at individual cultural competence. It is specifically designed to increase awareness, knowledge, and skills in dealing with clients, patients, and co-workers whose world view is different from one's self. The emphasis is on the health-related professions. UTK completed the first round of training (regional and Central Office Leadership) in 2013 and is now holding additional sessions across the state to provide the training to front-line service delivery staff.

As part of ongoing efforts to systemically address workforce development, all MCH-related Central Office and Field Staff are completing the MCH Leadership Competencies Self-Assessment and utilizing the findings to complete at least one module in the MCH Navigator. (This was actually a state performance measure in the last five-year Block Grant cycle). In 2014, Tennessee's Title V program partnered with Title V leadership in Maryland and Oklahoma to publish an article in the Maternal and Child Health Journal ("Use of Competency-Based Self-Assessments and the MCH Navigator for MCH Workforce Development: Three States' Experiences").

An additional collaborative workforce development effort has been directed at the home visiting workforce. The Tennessee Home Visiting Professional Development Plan was successfully developed and implemented which included a number of key components to improve the quality of home visiting services provision including: development and dissemination of core competencies for home visitors to assure key knowledge, skills and attitudes exist among all home visitors; development of an on-line module-based course Orientation to Core Competencies with over 220 home visitors and care coordinators completing; creation of an infrastructure for the Child Development Associate (CDA) Credential to be awarded to Home Visitors in partnership with Tennessee State University with 12 home visitors actively pursuing; the first ever statewide Home Visiting Institute in August of 2014 with 400 participants in attendance; and offering of a continuum of learning opportunities, encompassing education, training and materials designed to support individuals on key health and wellness topics including tobacco cessation, contraceptive use, safe sleep practices, prevention of adverse childhood experiences, and prevention of shaken baby syndrome and acute head trauma.

FHW staff are always encouraged to take advantage of external workforce development activities. In the past several years, four FHW staff (including three members of our senior leadership team) have completed LEAD Tennessee, a statewide, 12-month development initiative which includes six one-day summits of intense, personally tailored, high impact learning focused on twelve core leadership competencies. The goal of LEAD Tennessee is to increase the state's leadership bench strength by providing agencies with a continuous pipeline of motivated and prepared leaders that share a common language and mindset about great leadership. The Division's Deputy Director, Melissa Blair, participated in the MCH Public Health Leadership Institute at the University of North Carolina-Chapel Hill. PHLI is an executive education program designed to significantly expand self-awareness and quickly build practical skills for effectively leading, managing people, and building partnerships to advocate for and create the MCH systems of tomorrow. Additionally, Jacqueline Johnson, state CYSHCN Director, is currently participating in the AMCHP Leadership Institute for CYSHCN Directors. This program promotes valuable components for both new and experienced directors. The Division Director, Dr. Michael Warren, currently serves on the AMCHP Workforce Development Committee, on the Advisory Committee for the National MCH Workforce Development Center and also as a mentor in the AMCHP New Director Mentor Program.

Title V funding is used to support ongoing training of local and regional health department staff who provide services to the MCH population. Examples include an annual professional development conference for CYSHCN care coordination staff and an annual "Spring Update" training session for women's health and family planning staff. Tennessee has also utilized Title V funding to support the broader MCH workforce outside of public health. For example, TDH hosted a statewide Infant Care Summit in 2013 to enhance community clinicians' ability to promote and support breastfeeding.

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

- Survey of hospitals regarding knowledge and understanding of the CDC Maternity Practices in Infant Nutrition and Care (mPINC) breastfeeding survey
- Literature review and development of white paper on the impact of physical activity on academic performance
- Analysis of grandparent and other caregiver knowledge/attitudes regarding infant safe sleep

II.F.3. Family Consumer Partnership

FHW absolutely recognizes the vital nature of parental involvement throughout our section in program development, implementation, and evaluation. The Division has a longstanding collaborative relationship with the Tennessee Family Voices chapter. In 2011, FHW staff began an enhanced effort to integrate parent input in all aspects of MCH services. Advances have been made over the past few years to further involvement of parents in planning, programming and implementing Tennessee's Title V Programs. Tennessee had AMCHP Family Scholars in 2013 (Belinda Hotchkiss) and 2015 (Kara Adams). Ms. Hotchkiss was also named in 2014 to be part of the AMCHP Next Generation Advisory Workgroup. Family delegates have attended the AMCHP meeting as part of the Tennessee delegation since 2013.

Through the HRSA-funded D70 Systems Integration Grant, TDH has worked with Family Voices to establish a parent to parent network and to build skill and capacity for parents to be active, engaged partners in their child's health. The D70 grant allowed TDH to fund Kara Adams as a part-time parent consultant with office space located within FHW. The CSHCN Program has also been implementing a number of activities in partnership with Family Voices to further expand parent involvement including development of training and leadership opportunities. Significant accomplishments include:

- Eighty parents and family members participated in Family and Patient Centered Workshops that provided

training for parents on partnering in decision-making, telling their story, advocating for their child's needs and reinforcing expectations with their health care provider for comprehensive and coordinated care.

- In addition to the parent consultant described above, grant funds were used to support a youth consultant to assist with the coordination of family and youth activities and the development of the parent/youth advisory committee. The youth coordinator has participated in the patient and family-centered workshops and will continue to lead the youth advisory group in becoming self-advocates and learning how to partner in the decision making process.
- The Tennessee Parent-to-Parent Network was re-launched statewide and provides parent matching, mentoring and training in self-advocacy for parents and CYSHCN. Family Voices has developed a parent mentor training manual, trained over 30 prospective parent mentors, and facilitated twelve matches since its inception.

Through the newborn hearing screening grant, TDH supports part-time parent staff positions. These parents serve as critical liaisons to other parents of children with hearing loss. Parents also serve on the newborn hearing screening and follow-up task force.

Family representatives routinely attend and participate in the Genetics Advisory Committee (GAC) and Children's Special Services (CSS) Advisory Committee Meetings. The GAC meetings focus on the state's newborn screening and follow-up program and members advise the Department on program operations and the addition of screening tests to the state's testing panel. The CSS Advisory Committee meetings focus on issues related to the management and operation of the CSS program (Tennessee's Title V CSHCN Program) as well as broader issues impacting all CYSHCN (such as transition to adulthood).

In 2015, TDH partnered with Family Voices to host four focus groups with families of CYSHCN as part of the five-year Title V Needs Assessment. The 2015 AMCHP Family Scholar, Kara Adams, co-presented findings from these focus groups with TDH staff at the stakeholder meeting during which key MCH stakeholders provided input on the selection of priority areas and national performance measures.

In 2015, family members were invited to participate in the annual statewide professional development training for Children's Special Services staff. Parents spoke about how Tennessee's Title V CSHCN program had impacted their family and provided care coordinators and administrative staff with guidance on how to engage families and partner in the care of their child with special health care needs.

For the past few years, Tennessee's Title V Program staff and Family Voices staff have independently completed "Form 13" which described the extent of family participation in state Title V CYSHCN programs. The results would then be compared and if discrepancies were present, Title V and Family Voices staff would review and arrive at a consensus on how Form 13 should be scored prior to submission of the Block Grant. Beginning with the FY14/FY16 Report/Application in 2015, Title V and Family Voices staff are meeting to jointly write the "Family/Consumer Partnership" section of the State Action Plan as well as the section on family/consumer partnerships in the Needs Assessment Summary. Additionally, a staff member from Family Voices will accompany Title V staff to the Block Grant Review with HRSA staff.

II.F.4. Health Reform

TDH Efforts to Engage Third-Party Payers

TDH currently has negotiated written agreements with all three Medicaid managed care organizations (MCOs) currently operating in the State (Amerigroup, BlueCare, United Healthcare Community Plan). The Department developed arrangements whereby traditional public health services, including family planning, STI screening and treatment, EPSDT, and tuberculosis screening and treatment are provided and generally reimbursed without a primary care provider referral.

TDH also has current contracts with Blue Cross Blue Shield (ACA/Marketplace plan and the private insurance plan) and Community Health Alliance's ACA/Marketplace plan. The Department is currently negotiating with four other ACA/Marketplace plans and high volume private insurance plans in order to expand the ability to bill third party insurance carriers.

TDH Efforts for Outreach and Enrollment

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

In 2014, TDH conducted meetings with SEEDCO and Advanced Patient Advocacy, the two Tennessee CMS-funded ACA navigators that provide ACA enrollment services statewide; Cherokee Health Systems (an FQHC that provides enrollment services in 22 counties in East Tennessee); and Enroll America, a statewide agency that works with SEEDCO and Advanced Patient Advocacy to assist individuals with appointments with navigators. TDH staff also met with the Tennessee Department of Human Services (DHS), a state agency that has at least one Certified Application Counselor (CAC) in every county in the state. From these meetings, a map was developed that indicated the locations of these agencies and subcontract agencies across the state along with a listing of associated ACA outreach referral sources. The map and list of referral sources was shared with both local and regional health department leadership. Local staff has this map and resource listing as a tool to assist patients in finding navigator and application assistance services.

CACs are also available in 15 counties (Stewart County and all 14 counties of the Upper Cumberland Region) as well as in metro health departments. These CACs provide outreach and on-site enrollment services in communities across the state. Additionally, the TDH Breast and Cervical Cancer Screening Program (partially funded by Tennessee's Title V Program) and the Ryan White HIV/AIDS Program each have one CAC in each rural region to assist with outreach and on-site enrollment efforts. Care coordinators for CSS also assist with enrollment through the marketplace and with appeals for third-party payer denials.

TDH has collaborated with Enroll America to provide all health departments with enrollment interest cards. Interested clients completed the cards, which were then secured in drop boxes in the lobby/registration areas. These cards were then forwarded to Enroll America's office in Memphis, where staff scheduled enrollment appointments. As of April 2015, 317 individuals from 45 county health departments had been assisted through this mechanism. Enroll America noted that this number surpassed their outcomes from partner arrangements in other states. They further stated that they are extremely pleased with the results, particularly since rural markets are included in the outreach, and they plan to promote the TDH "model" as a national model for outreach in other states.

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

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

- **Children's Special Services**: Title V funding supports care coordination as well as reimbursement for direct services (inpatient/outpatient hospitalizations, physician office visits, laboratory testing, medications, supplies, durable medical equipment, and therapies). Payment for medical services is available for children with a chronic physical diagnosis whose family income is at or below 200% of the federal poverty level.
- **Breast and Cervical Cancer Screening**: Title V funding is used to support screening and diagnostic services for uninsured or underinsured women at or below 250% of the federal poverty level. This funding augments other federal funding (CDC) as well as dedicated state appropriations and funding from the Susan G. Komen Foundation.

- **Family Planning**: Title V funding augments federal Title X funding, state appropriations, and patient billing collections. In CY2014, 79.2% of individuals served through the program were at or below 100% of the federal poverty level and 95% were at or below 250% of the federal poverty level.

II.F.5. Emerging Issues

A major issue that has recently emerged in Tennessee is the epidemic of maternal substance misuse/abuse and a resulting epidemic of Neonatal Abstinence Syndrome (NAS). NAS is a withdrawal condition that occurs when infants are born to women who used addictive substances during pregnancy.

In 2012, hospitals in East Tennessee began contacting TDH to report an increasing number of cases of NAS being seen in their newborn nurseries and neonatal intensive care units. Analysis of hospital discharge data revealed a marked increase of NAS diagnoses over the past decade. The Commissioner of Health convened a special subcabinet working group consisting of cabinet-level representatives from TennCare, Children's Services, Human Services, Mental Health and Substance Abuse Services, and Safety. The group immediately identified the need for more real-time data on the epidemic, and Tennessee became the first state in the nation to conduct public health surveillance for NAS on January 1, 2013.

Over the past two years, more than 2,000 cases of NAS have been reported to TDH. A Title V-funded epidemiologist manages the surveillance system and compiles weekly reports, which are posted online every Monday (http://www.tn.gov/health/article/nas-summary-archive). In addition to providing data on the incidence of NAS, the surveillance reports contain information on the source of maternal exposure believed to have caused the NAS diagnosis. These data show that, in more than two-thirds of cases, the mother was taking at least one substance prescribed to her by a healthcare provider.

Nearly all NAS births in Tennessee are paid for by TennCare. The first year of life costs for a NAS infant ($44,043 in CY2013) are more than 10 times that of an otherwise healthy infant. Medicaid claims data reveal that while nearly 13% of female Medicaid enrollees ages 15-44 had claims for more than 30 days of a prescription opioid within the past year, 85% of those women did not have an identifiable claim for contraception.

TDH, along with other state agencies and community partners, are working to slow and ultimately reverse the NAS epidemic. The subcabinet is focusing on primary prevention strategies—namely, preventing substance abuse/misuse among women of childbearing age, and preventing unintended pregnancy among women at high risk of addiction or dependence.

Efforts to address NAS have included:

- Local health educators have partnered with local correctional institutions to provide health promotion and health education sessions to female inmates. To date, 59 sessions have been held with 1,146 women trained in 21 counties. As a result of this training, 222 women have requested placement of voluntary long-acting reversible contraceptives (such as intrauterine devices or implantable hormonal contraception).
- TDH is partnering with the Department of Mental Health and Substance Abuse Services to train local health department staff on the SBIRT (Screening, Brief Intervention and Referral to Treatment) model. Patients coming into local health departments for family planning or primary care receive a brief screening and those who screen positive receive a brief intervention (motivational interviewing). If appropriate, health department staff refer the patient to the local community mental health clinic for additional evaluation and treatment.
- In 2014, TDH sponsored five research projects aimed at answering key research questions related to the NAS epidemic, including:
    - Risk factors for NAS deliveries
    - Optimal management of women at high risk for NAS delivery

- Optimal management of infants with NAS
- Barriers to contraception among opioid-using women
- Provider knowledge and behavior related to opioid prescribing and NAS prevention

Title V funding was used to support these small research grants. The projects should be completed in mid-summer 2015. One project has already been completed and published in Pediatrics; the study authors found that prenatal smoking as well as concomitant SSRI (selective serotonin reuptake inhibitor) use significantly increased the risk for delivering a NAS infant.

The Governor's Children's Cabinet is sponsoring a pilot project in two counties with high incidence of NAS. The project is focusing on the development of a single plan of care across multiple child- and family-serving agencies.

Tennessee's Title V Program has been engaged in NAS-related efforts from the beginning. The Title V Director and a Title V-funded epidemiologist led the creation of the state's NAS surveillance system and are responsible for the ongoing reporting. Title V staff are working collaboratively with staff from other state government agencies and community organizations to implement strategies for prevention as well as efforts to coordinate high-quality care for NAS infants and their families.

II.F.6. Public Input

PROCESS

In keeping with the Tennessee Department of Health's commitment to offering ample time for public comment on the annual Maternal and Child Health (MCH) Block Grant, a near-final draft of the 2016 Application/2014 Report was made available online for four weeks (from June 15, 2015 to July 10, 2015).

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

Departments/Offices within Tennessee Department of Health (TDH):

- Commissioner's Executive Leadership Team
- Family Health and Wellness Staff
- Regional Health Officers
- Regional MCH Directors
- Regional Nursing Supervisors
- State Immunization Program
- State Dental Program
- Communicable and Environmental Diseases and Emergency Preparedness
- Policy, Planning and Assessment

Departments/Organizations External to TDH:

- Perinatal Advisory Committee
- Genetics Advisory Committee
- Children's Special Services Advisory Committee
- Department of Education
- Office of Coordinated School Health
- State Head Start Collaborative Office
- Department of Children's Services

- Department of Human Services
- Department of Mental Health and Substance Abuse Services
- Tennessee Commission on Children and Youth
- CHIP (CoverKids)
- Medicaid (TennCare)
- Family Voices
- March of Dimes
- Tennessee Hospital Association
- Tennessee Initiative for Perinatal Quality Care (TIPQC)
- Regional Perinatal Centers
- University of Tennessee—Knoxville
- Belmont University
- Vanderbilt TRIAD
- Vanderbilt LEND
- University of TN at Memphis Boling Center
- Head Start
- TN Chapter, American Academy of Pediatrics
- TN Academy of Family Physicians
- TN Chapter, American Congress of Obstetricians and Gynecologists
- Cumberland Pediatric Foundation
- Volunteer State Health Plan (Blue Cross)
- United Healthcare
- Governor's Children's Cabinet
- Office of the First Lady
- Children's Hospital Alliance of Tennessee (CHAT)
- Shelby County Breastfeeding Coalition
- Julie's Village
- East TN Breastfeeding Coalition
- TN Commission on Children and Youth
- Prevent Child Abuse Tennessee
- TN Developmental Disabilities Council
- TN Autism Team
- Young Child Wellness Council
- Newborn Hearing Task Force
- Various pediatric healthcare providers
- Various TDH grantees
- MCHB Grantees (Shelby County Health Department, Metro Nashville Health Department, Tennessee Disability Coalition, Vanderbilt University EMSC, UT Knoxville LEND, Vanderbilt LEND, UT Knoxville Leadership Training Pediatric Nutrition, St. Jude Sickle Cell Treatment Demonstration Program, Vanderbilt University Sickle Cell Program, Disability Law and Advocacy Center of Tennessee)

Characteristic of Respondents

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

MCH Block Grant Review Status

Respondents were asked whether they had read a draft of the MCH Block Grant before (in prior years). Nearly fifty

percent of respondents indicated that they had read a draft of the grant before (compared to approximately forty percent of respondents last year).

Summary of Public Comments

The document titled Tennessee Attachments in the supporting documents section contains a summary of the responses obtained during the public comment period for the 2016 Application/2014 Report.

Response to Public Comment

Seventy-three individuals responded via the online survey tool. A number of other individuals responded via email to share narrative updates, edits, or suggested re-wording.

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

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

Mechanism for Ongoing Feedback

After transmittal of the application, the entire document will be made available on the MCH website. The website will also contain contact information for the MCH Director so that anyone who would like to comment on the application may do so. The electronic survey will continue to be available throughout the year and reviewed on at least a quarterly basis by MCH leadership.

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

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

II.F.7. Technical Assistance

After careful review of the State Action Plan for FY2016-20, Tennessee anticipates the potential need for technical assistance as shown in the table below.

Domain	Description of Technical Assistance Requested	Reason(s) Why Assistance Is Needed
Child Health	We are requesting assistance in identifying best practices for communicating developmental screening results (done outside the primary care medical home) to the primary care provider.	As we explore opportunities for incorporating developmental screening into settings outside of primary care, it will be very important to be sure that the results are communicated back to the primary care medical home for interpretation and any necessary follow-up.
Cross-Cutting/Life Course	We are requesting assistance in identifying strategies for increasing referral of pregnant women to the Tobacco QuitLine, and then subsequently increasing the uptake of free cessation programs.	Analysis of existing data shows few calls to the QuitLine by pregnant women. Pilot efforts to increase referral have shown limited success. We have had even more difficulty in having follow-through to acceptance of smoking cessation services even when women are referred to the QuitLine.

III. Budget Narrative

	2012		2013	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$ 11,539,865	$ 4,655,248	$ 11,539,865	$ 11,231,410
Unobligated Balance	$ 3,100,000	$ 0	$ 5,500,000	$ 0
State Funds	$ 13,250,000	$ 21,966,127	$ 13,250,000	$ 16,560,796
Local Funds	$ 0	$ 0	$ 0	$ 0
Other Funds	$ 0	$ 0	$ 0	$ 0
Program Funds	$ 5,550,000	$ 3,236,496	$ 5,650,000	$ 3,331,071
SubTotal	$ 33,439,865	$ 29,857,871	$ 35,939,865	$ 31,123,277
Other Federal Funds	$ 11,831,199	$ 10,697,095	$ 160,809,386	$ 143,519,514
Total	$ 45,271,064	$ 40,554,966	$ 196,749,251	$ 174,642,791

	2014		2015	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$ 11,539,865	$ 15,054,289	$ 11,562,887	$
Unobligated Balance	$ 7,500,000	$ 0	$ 5,500,000	$
State Funds	$ 13,250,000	$ 31,087,436	$ 14,200,000	$
Local Funds	$ 0	$ 0	$ 0	$
Other Funds	$ 0	$ 0	$ 0	$
Program Funds	$ 3,250,000	$ 4,113,120	$ 3,350,000	$
SubTotal	$ 35,539,865	$ 50,254,845	$ 34,612,887	$
Other Federal Funds	$ 161,158,344		$ 147,748,378	$
Total	$ 196,698,209	$ 50,254,845	$ 182,361,265	$

Due to limitations in TVIS this year, States are not able to report their FY14 Other Federal Funds Expended on Form 2, Line 9. States are encouraged to provide this information in a field note on Form 2.

	2016	
	Budgeted	Expended
Federal Allocation	$ 11,709,246	$
Unobligated Balance	$ 5,300,000	$
State Funds	$ 30,000,000	$
Local Funds	$ 0	$
Other Funds	$ 0	$
Program Funds	$ 4,200,000	$
SubTotal	$ 51,209,246	$
Other Federal Funds	$ 149,414,701	$
Total	$ 200,623,947	$

III.A. Expenditures

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

The Department has developed detailed policies and procedures for use by local health departments, metropolitan health departments, regional public health offices and central office staff involved with budgeting of funds, collection of revenues, depositing revenues, accounts receivable, aging of accounts, charging patients and third parties,change funds, posting receipts and contracting for services. Departmental policies and procedures are available to all sites and are posted on the Department's Intra-Net for easy references. All policies and procedures have been developed in accordance with applicable state law and rules of the Department of Finance and Administration.

III.B. Budget

Tennessee state law requires all departments to submit a complete financial plan and base budget request for the ensuing fiscal year that outlines proposed expenditures for the administration, operation and maintenance of programs. Budget guidelines are prepared annually by the Department of Finance and Administration. The Department’s Financial Management Section, in cooperation with all programs, is responsible for the preparation of

the budget documents. The base budget request becomes law after it is approved by the General Assembly and signed by the Governor. A work program budget is then developed for each program.

The Department of Health uses a cost allocation system for the local health departments. Costs are allocated using two specific methods, the direct cost allocation method and the resource based relative value method (RBRVS). The direct cost allocation method is used when costs can be directly allocated to one or more programs. Any cost can be directly allocated when coded correctly on the appropriate accounting document. Direct cost allocation is used primarily for costs that arise from administrative support staff in the Department's central and regional offices and for selected contract expenditures. The RBRVS cost allocation method is used to allocate costs which cannot be directly allocated to one or more programs. These costs arise from the delivery of direct health or patient care services in rural health departments. RBRVS adds weighted encounter activities using relative value units and allocates costs based on the percentage of activity for each program. RBRVS is a federally approved cost allocation method for the Tennessee Department of Health. RBRVS is linked at the service delivery level to AS 400 computers at the regional and central offices.

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

The maintenance of effort for the Maternal and Child Health Block Grant was established in 1989 in accordance with requirements of the block grant. The maintenance of effort, $13,125,024.28, was established through an analysis of 15 months of expenditures for Maternal and Child Health Programs, adjusted for differences between the state and federal fiscal years, as well as adjustments for accrued liabilities. The Tennessee Department of Health fully supports using state funds to meet the maintenance of effort and match requirements in support of Maternal and Child Health Program activities.

Tennessee fully utilizes Maternal and Child Health Block Grant funding within the 24 month allowable timeframe and meets all targeted maintenance and match requirements set forth in the block grant regulations. Any carry forward noted in the annual report will be used to support or expand Maternal and Child Health activities. Carry forward funding has been used to develop new services or to expand current programs. During recent years carry forward funding has been used to improve dental and other health care screening services, provide preventive fluoride varnish for children seen in health department clinics, fund increased program activity relative to infant mortality, teen pregnancy prevention and enhancement of breast and cervical screening for reproductive age women. Funding was also used to increase home visiting services for pregnant women and families with high risk infants and young children as well as care coordination services for families with children with special health care needs.

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - Tennessee Title V-Medicaid IAA_MOU.pdf

V. Supporting Documents

The following supporting documents have been provided to supplement the narrative discussion.

Supporting Document #01 - Tennessee Attachments.pdf

Supporting Document #02 - Tennessee Needs Assessment 2016-2020.pdf

VI. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Tennessee

	FY16 Application Budgeted	FY14 Annual Report Expended
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 11,709,246	$ 15,054,289
A. Preventive and Primary Care for Children	$ 3,512,774 (30%)	$ 4,530,996 (30.1%)
B. Children with Special Health Care Needs	$ 3,883,698 (33.2%)	$ 5,124,814 (34%)
C. Title V Administrative Costs	$ 800,000 (6.8%)	$ 566,074 (3.8%)
2. UNOBLIGATED BALANCE (Item 18b of SF-424)	$ 5,300,000	$ 0
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 30,000,000	$ 31,087,436
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0	$ 0
5. OTHER FUNDS (Item 18e of SF-424)	$ 0	$ 0
6. PROGRAM INCOME (Item 18f of SF-424)	$ 4,200,000	$ 4,113,120
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 34,200,000	$ 35,200,556
A. Your State's FY 1989 Maintenance of Effort Amount	$ 13,125,024	
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Same as item 18g of SF-424)	$ 51,209,246	$ 50,254,845
9. OTHER FEDERAL FUNDS		
Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9)	$ 149,414,701	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 200,623,947	$ 50,254,845

	FY14 Annual Report Budgeted
1. FEDERAL ALLOCATION	$ 11,539,865
A. Preventive and Primary Care for Children	$ 3,461,960
B. Children with Special Health Care Needs	$ 3,461,960
C. Title V Administrative Costs	$ 1,153,986
2. UNOBLIGATED BALANCE	$ 7,500,000
3. STATE MCH FUNDS	$ 13,250,000
4. LOCAL MCH FUNDS	$ 0
5. OTHER FUNDS	$ 0
6. PROGRAM INCOME	$ 3,250,000
7. TOTAL STATE MATCH	$ 16,500,000

	FY16 Application Budgeted
9. OTHER FEDERAL FUNDS	
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI);	$ 96,374
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Community-Based Integrated Service Systems (CISS);	$ 140,000
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Abstinence Education Grant Program;	$ 1,516,850
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC);	$ 118,993,480
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > ACA Maternal, Infant and Early Childhood Home Visiting Program;	$ 11,712,682
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning;	$ 6,062,300
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention;	$ 250,000

Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State and Local Healthy Homes and Childhood Lead Poisoning Prevention Programs (CLPPPs);	$ 237,682
Department of Health and Human Services (DHHS) > Substance Abuse and Mental Health Services Administration > Project LAUNCH;	$ 800,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > D70;	$ 484,960
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > SDY;	$ 200,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Inj Surv & Prev;	$ 247,686
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > 1305 Chron Dis ;	$ 1,197,129
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > 1305 Chron Dis;	$ 1,301,602
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Tob Use Prev Cont;	$ 1,113,945
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Support State QL;	$ 450,290
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Prev Health BG;	$ 2,505,510
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Br & Cerv Cancer;	$ 1,187,135
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prev Educ;	$ 640,250
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Cap Bldg NPAO;	$ 276,826

Form Notes For Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**Federal Allocation, A. Preventive and Primary Care for Children:**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**
	Field Note: This figure represents actual expenditures.	
2.	**Field Name:**	**Federal Allocation, B. Children with Special Health Care Needs:**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**
	Field Note: This figure represents actual expenditures.	
3.	**Field Name:**	**Federal Allocation, C. Title V Administrative Costs:**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**
	Field Note: This figure represents actual expenditures.	
4.	**Field Name:**	**2. UNOBLIGATED BALANCE**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**
	Field Note: This figure represents actual expenditures.	
5.	**Field Name:**	**3. STATE MCH FUNDS**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**
	Field Note: This figure represents actual state expenditures. Additionally, with the new Block Grant Guidance, Title V staff worked with TDH Fiscal staff to identify programs that serve the MCH population. This list is broader than the one used during the previous application and therefore the actual expenditures are much greater than what was budgeted (as the budgeted figure was based on a smaller program list).	

6.	**Field Name:**	**6. PROGRAM INCOME**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**
	Field Note: This figure represents actual program income.	
7.	**Field Name:**	**1.FEDERAL ALLOCATION**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**
	Field Note: This figure represents actual expenditures.	

Data Alerts: None

Form 3a

Budget and Expenditure Details by Types of Individuals Served

State: Tennessee

	FY16 Application Budgeted	FY14 Annual Report Expended
I. TYPES OF INDIVIDUALS SERVED		
IA. Federal MCH Block Grant		
1. Pregnant Women	$ 300,475	$ 399,050
2. Infants < 1 year	$ 763,323	$ 1,013,745
3. Children 1-22 years	$ 2,971,793	$ 3,946,742
4. CSHCN	$ 3,902,366	$ 5,182,606
5. All Others	$ 2,971,289	$ 3,946,072
Federal Total of Individuals Served	$ 10,909,246	$ 14,488,215
IB. Non Federal MCH Block Grant		
1. Pregnant Women	$ 29,210	$ 30,065
2. Infants < 1 year	$ 1,159,011	$ 1,192,919
3. Children 1-22 years	$ 8,500,346	$ 8,749,032
4. CSHCN	$ 3,705,861	$ 3,814,280
5. All Others	$ 20,805,572	$ 21,414,260
Non Federal Total of Individuals Served	$ 34,200,000	$ 35,200,556
Federal State MCH Block Grant Partnership Total	$ 45,109,246	$ 49,688,771

Form Notes For Form 3a:

None

Field Level Notes for Form 3a:

1.	**Field Name:**	**IA. Federal MCH Block Grant, 3. Children 1-22 years**
	Fiscal Year:	**2016**
	Column Name:	**Application Budgeted**
	Field Note: The discrepancy between the amount budgeted for Children 1-22 Years on Form 3A and the amount budgeted for Preventive and Primary Care for Children (Form 2, Line 1A) is due to classification of particular programs that span multiple populations. For example, childhood lead poisoning prevention serves Children 1-22 but is counted under the CSHCN category on Form 2 because children with elevated blood lead levels have, or are at risk for having, special health care needs. Another example would be funds used for family planning. These funds are used, in part, to serve children age 1-22, but also serve other populations (and therefore are not counted in the "Preventive and Primary Care for Children" category on Form 2).	
2.	**Field Name:**	**IA. Federal MCH Block Grant, 4. CSHCN**
	Fiscal Year:	**2016**
	Column Name:	**Application Budgeted**
	Field Note: The discrepancy between the amount budgeted for CSHCN on Form 3A and the amount budgeted for CSHCN (Form 2, Line 1A) is due to classification of particular programs that span multiple populations. For example, child health services delivered in local health departments serve infants, children 1-22, and CSHCN but are counted under the "Preventive and Primary Care for Children" category on Form 2. Another example would be childhood lead poisoning prevention program, which serves Children 1-22, but is counted under the CSHCN category on Form 2 because children with elevated blood lead levels have, or are at risk for having, special health care needs.	
3.	**Field Name:**	**IA. Federal MCH Block Grant, 3. Children 1-22 years**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**
	Field Note: The discrepancy between the amount expended for Children 1-22 Years on Form 3A and the amount expended for Preventive and Primary Care for Children (Form 2, Line 1A) is due to classification of particular programs that span multiple populations. For example, childhood lead poisoning prevention serves Children 1-22 but is counted under the CSHCN category on Form 2 because children with elevated blood lead levels have, or are at risk for having, special health care needs. Another example would be funds used for family planning. These funds are used, in part, to serve children age 1-22, but also serve other populations (and therefore are not counted in the "Preventive and Primary Care for Children" category on Form 2).	
4.	**Field Name:**	**IA. Federal MCH Block Grant, 4. CSHCN**
	Fiscal Year:	**2014**

Column Name:	Annual Report Expended

Field Note:
The discrepancy between the amount expended for CSHCN on Form 3A and the amount expended for CSHCN (Form 2, Line 1A) is due to classification of particular programs that span multiple populations. For example, child health services delivered in local health departments serve infants, children 1-22, and CSHCN but are counted under the “Preventive and Primary Care for Children” category on Form 2. Another example would be childhood lead poisoning prevention program, which serves Children 1-22, but is counted under the CSHCN category on Form 2 because children with elevated blood lead levels have, or are at risk for having, special health care needs.

Data Alerts: None

Form 3b
Budget and Expenditure Details by Types of Services

State: Tennessee

	FY16 Application Budgeted	FY14 Annual Report Expended
II. TYPES OF SERVICES		
IIA. Federal MCH Block Grant		
1. Direct Services	$ 833,667	$ 1,071,824
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 205,851	$ 264,657
B. Preventive and Primary Care Services for Children	$ 10,339	$ 13,292
C. Services for CSHCN	$ 617,477	$ 793,875
2. Enabling Services	$ 8,780,458	$ 11,288,820
3. Public Health Services and Systems	$ 2,095,121	$ 2,693,645
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 157,086
Physician/Office Services		$ 72,322
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 254,576
Dental Care (Does Not Include Orthodontic Services)		$ 97
Durable Medical Equipment and Supplies		$ 67,203
Laboratory Services		$ 305,505
Other		
Orthodontic; interpreter		$ 215,035
Direct Services Total		$ 1,071,824
Federal Total	$ 11,709,246	$ 15,054,289

IIB. Non-Federal MCH Block Grant

1. Direct Services	$ 1,176,616	$ 1,211,039
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 560,681	$ 577,084
B. Preventive and Primary Care Services for Children	$ 15,055	$ 15,496
C. Services for CSHCN	$ 600,880	$ 618,459
2. Enabling Services	$ 24,842,772	$ 25,569,573
3. Public Health Services and Systems	$ 8,180,612	$ 8,419,944
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 142,633
Physician/Office Services		$ 51,415
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 224,612
Dental Care (Does Not Include Orthodontic Services)		$ 88
Durable Medical Equipment and Supplies		$ 61,125
Laboratory Services		$ 511,154
Other		
Orthodontic; interpreter		$ 220,012
Direct Services Total		$ 1,211,039
Non-Federal Total	$ 34,200,000	$ 35,200,556

Form Notes For Form 3b:

None

Field Level Notes for Form 3b:

None

Form 4

Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated

State: Tennessee

Total Births by Occurrence 87,181

1a. Core RUSP Conditions

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Propionic acidemia	86,574 (99.3%)	28	0	0 (0%)
Methylmalonic acidemia (methylmalonyl-CoA mutase)	86,574 (99.3%)	28	1	1 (100.0%)
Methylmalonic acidemia (cobalamin disorders)	86,574 (99.3%)	28	0	0 (0%)
Isovaleric acidemia	86,574 (99.3%)	25	1	1 (100.0%)
3-Methylcrotonyl-CoA carboxylase deficiency	86,574 (99.3%)	29	7	7 (100.0%)
3-Hydroxy-3-methyglutaric aciduria	86,574 (99.3%)	29	0	0 (0%)
Holocarboxylase synthase deficiency	86,574 (99.3%)	28	0	0 (0%)
ß-Ketothiolase deficiency	86,574 (99.3%)	0	0	0 (0%)
Glutaric acidemia type I	86,574 (99.3%)	14	0	0 (0%)
Carnitine uptake defect/carnitine transport defect	86,574 (99.3%)	35	1	1 (100.0%)
Medium-chain acyl-CoA dehydrogenase deficiency	86,574 (99.3%)	24	6	6 (100.0%)
Very long-chain acyl-CoA dehydrogenase deficiency	86,574 (99.3%)	45	1	1 (100.0%)
Long-chain L-3 hydroxyacyl-CoA dehydrogenase deficiency	86,574 (99.3%)	0	0	0 (0%)

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Trifunctional protein deficiency	86,574 (99.3%)	0	0	0 (0%)
Argininosuccinic aciduria	86,574 (99.3%)	12	2	2 (100.0%)
Citrullinemia, type I	86,574 (99.3%)	12	1	1 (100.0%)
Maple syrup urine disease	86,574 (99.3%)	55	1	1 (100.0%)
Homocystinuria	86,574 (99.3%)	88	1	1 (100.0%)
Classic phenylketonuria	86,574 (99.3%)	13	5	5 (100.0%)
Tyrosinemia, type I	86,574 (99.3%)	0	0	0 (0%)
Primary congenital hypothyroidism	86,574 (99.3%)	360	56	56 (100.0%)
Congenital adrenal hyperplasia	86,574 (99.3%)	556	4	4 (100.0%)
S,S disease (Sickle cell anemia)	86,574 (99.3%)	29	28	28 (100.0%)
S, βeta-thalassemia	86,574 (99.3%)	4	4	4 (100.0%)
S,C disease	86,574 (99.3%)	15	15	15 (100.0%)
Biotinidase deficiency	86,574 (99.3%)	12	3	3 (100.0%)
Critical congenital heart disease	83,783 (96.1%)	115	3	3 (100.0%)
Cystic fibrosis	86,574 (99.3%)	530	18	18 (100.0%)
Hearing loss	84,653 (97.1%)	3,897	57	57 (100.0%)

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Classic galactosemia	86,574 (99.3%)	6	2	2 (100.0%)

1b. Secondary RUSP Conditions

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Methylmalonic acidemia with homocystinuria	86,574 (99.3%)	28	0	0 (0%)
Malonic acidemia	86,574 (99.3%)	6	0	0 (0%)
Isobutyrylglycinuria	86,574 (99.3%)	23	0	0 (0%)
2-Methylbutyrylglycinuria	86,574 (99.3%)	25	0	0 (0%)
3-Methylglutaconic aciduria	86,574 (99.3%)	29	0	0 (0%)
2-Methyl-3-hydroxybutyric aciduria	86,574 (99.3%)	29	1	1 (100.0%)
Short-chain acyl-CoA dehydrogenase deficiency	86,574 (99.3%)	21	1	1 (100.0%)
Medium/short-chain L-3-hydroxyacl-CoA dehydrogenase deficiency	86,574 (99.3%)	6	0	0 (0%)
Glutaric acidemia type II	86,574 (99.3%)	21	0	0 (0%)
2,4 Dienoyl-CoA reductase deficiency	86,574 (99.3%)	2	0	0 (0%)
Carnitine palmitoyltransferase type I deficiency	86,574 (99.3%)	3	0	0 (0%)
Carnitine palmitoyltransferase type II deficiency	86,574 (99.3%)	2	0	0 (0%)
Carnitine acylcarnitine translocase deficiency	86,574 (99.3%)	2	0	0 (0%)

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Argininemia	86,574 (99.3%)	12	0	0 (0%)
Citrullinemia, type II	86,574 (99.3%)	12	0	0 (0%)
Hypermethioninemia	86,574 (99.3%)	88	0	0 (0%)
Benign hyperphenylalaninemia	86,574 (99.3%)	13	1	1 (100.0%)
Biopterin defect in cofactor biosynthesis	86,574 (99.3%)	13	0	0 (0%)
Biopterin defect in cofactor regeneration	86,574 (99.3%)	13	0	0 (0%)
Tyrosinemia, type II	86,574 (99.3%)	114	0	0 (0%)
Tyrosinemia, type III	86,574 (99.3%)	114	0	0 (0%)
Various other hemoglobinopathies	86,574 (99.3%)	13	10	10 (100.0%)
Galactoepimerase deficiency	86,574 (99.3%)	23	0	0 (0%)
Galactokinase deficiency	86,574 (99.3%)	23	0	0 (0%)

2. Other Newborn Screening Tests

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Newborn Hearing	84,653 (97.1%)	3,897	57	57 (100.0%)
Hyperornithinemia-Hyperammonemia-Homocitrullinuria Syndrome	86,574 (99.3%)	2	0	0 (0%)
Nonketotic Hyperglycinemia	86,574 (99.3%)	10	0	0 (0%)
Carbamoyl Phosphate Synthetase I Deficiency	86,574 (99.3%)	2	0	0 (0%)
Ornithine Transcarbamylase Deficiency	86,574 (99.3%)	2	0	0 (0%)

3. Screening Programs for Older Children & Women

None

4. Long-Term Follow-Up

Tennessee's Newborn Screening Follow-Up Program has a case management section which provides short-term follow-up to monitor all cases with abnormal tests through to confirmatory testing and treatment initiation. The State contracts with tertiary specialty centers to assure follow-up and confirmatory testing for all infants with abnormal screens. The centers are required, by contract, to report the results (whether disease was confirmed) back to the State, and for cases in which disease was confirmed, the center reports the date on which treatment was started. Currently, the State does not monitor confirmed diagnosed infants beyond notification of diagnosis and treatment initiation by the contracted tertiary specialty center. However, the State provides infrastructure funding at each center to support long-term treatment, genetic testing for vulnerable individuals, and education/outreach.

Form Notes For Form 4:

In CY2014, 99.3% of infants received a screen with a dried blood spot (DBS). Of the 607 infants without a DBS: 200 died on day of birth, 25 died on day one of life, 17 died @ 2-7 days of age, 5 died >7 days of age. 228 were home births (3 died on day of birth, which is included in the 200 above).

Field Level Notes for Form 4:

None

Form 5a
Unduplicated Count of Individuals Served under Title V

State: Tennessee

Reporting Year 2014

		Primary Source of Coverage				
Types Of Individuals Served	(A) Title V Total Served	(B) Title XIX %	(C) Title XXI %	(D) Private / Other %	(E) None %	(F) Unknown %
1. Pregnant Women	25,680	58.8	0.1	6.4	34.7	0.0
2. Infants < 1 Year of Age	86,574	30.8	0.0	0.7	68.5	0.0
3. Children 1 to 22 Years of Age	221,478	30.6	0.0	3.9	65.5	0.0
4. Children with Special Health Care Needs	5,237	4.3	0.0	1.1	94.6	0.0
5. Others	129,932	14.0	0.4	3.7	81.9	0.0
Total	468,901					

Form Notes For Form 5a:

None

Field Level Notes for Form 5a:

1.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2014**
	Field Note: The number of infants served under Title V is at least 86,574. Newborn Screening is provided through Title V, and therefore, at least the number of infants receiving screens (86,574 in CY2014) receive Title V services. TDH tracks encounters for Title V services provided through local health departments; the number of infants who received these services is 52,670. It is estimated that most of these infants would be included in the total listed above (86,574); however, some infants who receive Title V services through the health departments may have moved to Tennessee after birth and therefore would not have received a newborn screen in Tennessee. Therefore, the explanation above is that "at least" 86,574 infants were served through Title V; the number may actually be greater. For the row labeled "Infants <1 year old," the values listed for "primary sources of coverage" are extrapolated from infants seen in local health departments; this data is not collected for newborn screening.	

Form 5b
Total Recipient Count of Individuals Served by Title V

State: Tennessee

Reporting Year 2014

Types Of Individuals Served	Total Served
1. Pregnant Women	81,609
2. Infants < 1 Year of Age	87,181
3. Children 1 to 22 Years of Age	904,389
4. Children with Special Health Care Needs	22,244
5. Others	402,005
Total	1,497,428

Form Notes For Form 5b:

Counts for this form were obtained from various programs within the TDH Division of Family Health and Wellness (in accordance with the instructions for Form 5B, which indicate that we should include individuals who receive services that are supported by other Federal programs under the control of the Title V administrator, as reported on Line 9 of Form 2). Additional detail is available upon request.

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women**
	Fiscal Year:	**2014**
	Field Note: The actual number of pregnant women served was 97,061. However, the grant guidance indicated that the number reported for each participant category could not exceed the total number of individuals in that population. Therefore, we are reporting the total number of pregnancies for CY2014 (81,609), obtained by adding the total number of births, reported fetal deaths, and induced terminations of pregnancy.	
2.	**Field Name:**	**Infants Less Than One Year**
	Fiscal Year:	**2014**
	Field Note: The actual number of infants <1 year of age served was 139,867. However, the grant guidance indicated that the number reported for each participant category could not exceed the total number of individuals in that population. Therefore, we are reporting the total number of births by occurrence (87,181).	

Form 6

Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: Tennessee

Reporting Year 2014

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 & Unknown
1. Total Deliveries in State	79,954	60,954	16,863	127	1,675	150	0	185
Title V Served	79,954	60,954	16,863	127	1,675	150	0	185
Eligible for Title XIX	41,500	28,195	12,601	79	468	61	0	96
2. Total Infants in State	77,617	55,036	16,948	0	0	0	0	5,633
Title V Served	52,670	35,559	10,129	53	294	33	0	6,602
Eligible for Title XIX	26,569	5,350	18,600	0	0	0	2,619	0

II. Unduplicated Count by Ethnicity

	(A) Total Not Hispanic or Latino	(B) Total Hispanic or Latino	(C) Ethnicity Not Reported	(D) Total All Ethnicities
1. Total Deliveries in State	73,042	6,850	62	79,954
Title V Served	73,042	6,850	62	79,954
Eligible for Title XIX	36,701	4,771	28	41,500
2. Total Infants in State	69,611	8,006	0	77,617
Title V Served	41,830	4,899	5,941	52,670
Eligible for Title XIX	25,365	1,204	0	26,569

Form Notes For Form 6:

None

Field Level Notes for Form 6:

1.	**Field Name:**	**2. Total Infants in State**
	Fiscal Year:	**2014**
	Column Name:	**Total All Races**
	Field Note: The data source for "Total infants in State" is 2013 US Census Data. Note that this value differs by >10% from the total number of occurrent births on Form 4 (newborn screening). This discrepancy is due to several reasons. 1) The occurrent birth data is from CY2014, while the total infant count is from 2013 Census data. 2) The occurrent birth count also includes infants born in TN but whose mothers (and thus the infants) do not reside in TN. When the birth data are re-calculated to include only a) infants born in TN who will reside in TN and b) infants born outside of TN but who will reside in TN, that total is 81,600, which is ~5% different from the census count.	
2.	**Field Name:**	**2. Title V Served**
	Fiscal Year:	**2014**
	Column Name:	**Total All Races**
	Field Note: Data Source: TDH PTBMIS	

Form 7

State MCH Toll-Free Telephone Line and Other Appropriate Methods Data

State: Tennessee

	Application Year 2016	Reporting Year 2014
A. State MCH Toll-Free Telephone Lines		
1. State MCH Toll-Free "Hotline" Telephone Number	(877) 808-5460	(800) 428-2229
2. State MCH Toll-Free "Hotline" Name	TENNderCare Call Center	TN Baby Line
3. Name of Contact Person for State MCH "Hotline"	Michael D. Warren	Michael D. Warren
4. Contact Person's Telephone Number	(615) 741-7353	(615) 741-7353
5. Number of Calls Received on the State MCH "Hotline"		45
B. Other Appropriate Methods		
1. Other Toll-Free "Hotline" Names		
2. Number of Calls on Other Toll-Free "Hotlines"		
3. State Title V Program Website Address		
4. Number of Hits to the State Title V Program Website		
5. State Title V Social Media Websites		
6. Number of Hits to the State Title V Program Social Media Websites		

Form Notes For Form 7:

In FY15, Title V arranged to have the toll-free hotline routed to the TENNderCare Call Center, a call center managed within TDH. Operators provide assistance in connecting callers with insurance coverage and with finding providers.

Form 8
State MCH and CSHCN Directors Contact Information

State: Tennessee

Application Year 2016

1. Title V Maternal and Child Health (MCH) Director

Name	Michael D. Warren, MD MPH
Title	Director, Title V/MCH
Address 1	8th Floor Andrew Johnson Tower
Address 2	710 James Robertson
City / State / Zip Code	Nashville / TN / 37243
Telephone	(615) 741-7353
Email	michael.d.warren@tn.gov

2. Title V Children with Special Health Care Needs (CSHCN) Director

Name	Jacqueline Johnson, MPA
Title	Director, CYSHCN
Address 1	8th Floor Andrew Johnson Tower
Address 2	710 James Robertson
City / State / Zip Code	Nashville / TN / 37243
Telephone	(615) 741-7353
Email	jacqueline.johnson@tn.gov

3. State Family or Youth Leader (Optional)

Name	
Title	
Address 1	
Address 2	
City / State / Zip Code	
Telephone	
Email	

Form Notes For Form 8:

None

Form 9
List of MCH Priority Needs

State: Tennessee

Application Year 2016

No.	Priority Need	Priority Need Type (New, Replaced or Continued Priority Need for this five-year reporting period)	Rationale if priority need does not have a corresponding State or National Performance/Outcome Measure
1.	Improve utilization of preventive care for women of childbearing age.	New	
2.	Reduce infant mortality.	Continued	
3.	Increase the number of infants and children receiving a developmental screen.	New	
4.	Reduce the number of children exposed to adverse childhood experiences.	New	
5.	Reduce the number of children and adolescents who are overweight/obese.	Continued	
6.	Reduce the burden of injury among children and adolescents.	Replaced	
7.	Increase the number of children (both with and without special health care needs) who have a medical home.	Replaced	
8.	Reduce exposure to tobacco among the MCH population (pregnancy smoking and secondhand smoke exposure for children).	Replaced	

Form Notes For Form 9:

None

Field Level Notes for Form 9:

Field Name: Priority Need 1
Field Note:
Field Name: Priority Need 2
Field Note:
Field Name: Priority Need 3
Field Note:
Field Name: Priority Need 4
Field Note: This priority does not have a NPM. We plan to create a SPM for this measure next year.
Field Name: Priority Need 5
Field Note:
Field Name: Priority Need 6
Field Note:
Field Name: Priority Need 7
Field Note:
Field Name: Priority Need 8
Field Note:
Field Name: Priority Need 9

Field Note:

Field Name:

Priority Need 10

Field Note:

Form 10a
National Outcome Measures (NOMs)

State: Tennessee

Form Notes for Form 10a NPMs and NOMs:

None

NOM-1 Percent of pregnant women who receive prenatal care beginning in the first trimester

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	71.6 %	0.2 %	54,489	76,103
2012	70.4 %	0.2 %	53,419	75,885
2011	69.9 %	0.2 %	51,605	73,832
2010	70.6 %	0.2 %	52,663	74,579
2009	69.5 %	0.2 %	54,058	77,795

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM-1 Notes:

None

Data Alerts: None

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

Data Source: State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	179.3	5.1 %	1,230	68,598
2011	170.0	4.8 %	1,252	73,655
2010	164.1	4.7 %	1,199	73,053
2009	169.7	4.8 %	1,274	75,064
2008	167.6	4.7 %	1,291	77,050

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM-2 Notes:

None

Data Alerts: None

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

FAD Not Available for this measure.

State Provided Data	
	2014
Annual Indicator	20.0
Numerator	16
Denominator	79,954
Data Source	Tennessee Department of Health; Division of Policy, Planning and Assessment; Birth and Death Statistical Systems.
Data Source Year	2013

NOM-3 Notes:

The numerator includes female deaths with an obstetric cause of death [defined as underlying cause of death (UCD) ICD-10 codes A34, O00-O95, O98-O99] that occurred during pregnancy or within 42 days of the end of pregnancy. Deaths with the above ICD-10 codes as the UCD that occurred in women who were not pregnant, who died more than 42 days since the end of pregnancy, or whose pregnancy status was missing or unknown were excluded from the analysis. The pregnancy status variable was added to the TN death certificate midway through 2012.

Data Alerts: None

NOM-4.1 Percent of low birth weight deliveries (<2,500 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	9.1 %	0.1 %	7,307	79,962
2012	9.2 %	0.1 %	7,377	80,318
2011	9.0 %	0.1 %	7,176	79,554
2010	9.0 %	0.1 %	7,179	79,451
2009	9.2 %	0.1 %	7,539	82,172

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM-4.1 Notes:

None

Data Alerts: None

NOM-4.2 Percent of very low birth weight deliveries (<1,500 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	1.7 %	0.1 %	1,320	79,962
2012	1.6 %	0.0 %	1,258	80,318
2011	1.5 %	0.0 %	1,187	79,554
2010	1.6 %	0.0 %	1,245	79,451
2009	1.7 %	0.0 %	1,364	82,172

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM-4.2 Notes:

None

Data Alerts: None

NOM-4.3 Percent of moderately low birth weight deliveries (1,500-2,499 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	7.5 %	0.1 %	5,987	79,962
2012	7.6 %	0.1 %	6,119	80,318
2011	7.5 %	0.1 %	5,989	79,554
2010	7.5 %	0.1 %	5,934	79,451
2009	7.5 %	0.1 %	6,175	82,172

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM-4.3 Notes:

None

Data Alerts: None

NOM-5.1 Percent of preterm births (<37 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	11.1 %	0.1 %	8,826	79,691
2012	11.2 %	0.1 %	8,961	79,807
2011	11.1 %	0.1 %	8,729	78,903
2010	11.4 %	0.1 %	8,988	78,936
2009	11.3 %	0.1 %	9,231	81,518

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM-5.1 Notes:

None

Data Alerts: None

NOM-5.2 Percent of early preterm births (<34 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	3.1 %	0.1 %	2,495	79,691
2012	3.2 %	0.1 %	2,589	79,807
2011	3.0 %	0.1 %	2,400	78,903
2010	3.1 %	0.1 %	2,409	78,936
2009	3.1 %	0.1 %	2,545	81,518

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM-5.2 Notes:

None

Data Alerts: None

NOM-5.3 Percent of late preterm births (34-36 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	7.9 %	0.1 %	6,331	79,691
2012	8.0 %	0.1 %	6,372	79,807
2011	8.0 %	0.1 %	6,329	78,903
2010	8.3 %	0.1 %	6,579	78,936
2009	8.2 %	0.1 %	6,686	81,518

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM-5.3 Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	26.2 %	0.2 %	20,856	79,691
2012	27.8 %	0.2 %	22,149	79,807
2011	28.9 %	0.2 %	22,784	78,903
2010	30.1 %	0.2 %	23,721	78,936
2009	31.5 %	0.2 %	25,645	81,518

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM-6 Notes:

None

Data Alerts: None

NOM-7 Percent of non-medically indicated early elective deliveries

Data Source: CMS Hospital Compare

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013/Q2-2014/Q1	4.0 %			

Legends:

Indicator results were based on a shorter time period than required for reporting

NOM-7 Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	7.0	0.3 %	558	80,281
2012	7.2	0.3 %	582	80,674
2011	7.5	0.3 %	595	79,909
2010	6.6	0.3 %	524	79,743
2009	6.8	0.3 %	561	82,469

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM-8 Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	6.8	0.3 %	544	79,992
2012	7.2	0.3 %	582	80,371
2011	7.4	0.3 %	592	79,588
2010	7.9	0.3 %	626	79,495
2009	8.0	0.3 %	657	82,211

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM-9.1 Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	4.2	0.2 %	333	79,992
2012	4.3	0.2 %	349	80,371
2011	4.6	0.2 %	365	79,588
2010	4.6	0.2 %	368	79,495
2009	4.8	0.2 %	396	82,211

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM-9.2 Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	2.6	0.2 %	211	79,992
2012	2.9	0.2 %	233	80,371
2011	2.9	0.2 %	227	79,588
2010	3.3	0.2 %	258	79,495
2009	3.2	0.2 %	261	82,211

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM-9.3 Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	193.8	15.6 %	155	79,992
2012	209.0	16.1 %	168	80,371
2011	214.9	16.5 %	171	79,588
2010	245.3	17.6 %	195	79,495
2009	255.4	17.7 %	210	82,211

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM-9.4 Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	123.8	12.5 %	99	79,992
2012	164.2	14.3 %	132	80,371
2011	154.6	14.0 %	123	79,588
2010	171.1	14.7 %	136	79,495
2009	153.3	13.7 %	126	82,211

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM-9.5 Notes:

None

Data Alerts: None

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

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2009	5.6 %	1.1 %	4,474	79,825
2008	3.4 %	0.8 %	2,774	81,407

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or a confidence interval width >20% and should be interpreted with caution

NOM-10 Notes:

None

Data Alerts: None

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

Data Source: State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	17.4	0.5 %	1,191	68,605
2011	12.4	0.4 %	916	73,656
2010	10.0	0.4 %	731	73,053
2009	8.1	0.3 %	605	75,065
2008	5.6	0.3 %	433	77,050

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM-11 Notes:

None

Data Alerts: None

NOM-12 Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner. (DEVELOPMENTAL)

FAD Not Available for this measure.

NOM-12 Notes:

None

Data Alerts: None

NOM-13 Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

FAD Not Available for this measure.

NOM-13 Notes:

None

Data Alerts: None

NOM-14 Percent of children ages 1 through 17 who have decayed teeth or cavities in the past 12 months

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	17.4 %	1.4 %	241,820	1,392,837

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

NOM-14 Notes:

None

Data Alerts: None

NOM-15 Child Mortality rate, ages 1 through 9 per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	21.1	1.7 %	156	738,334
2012	22.4	1.7 %	166	739,838
2011	20.0	1.7 %	147	736,697
2010	22.0	1.7 %	163	740,978
2009	20.0	1.7 %	148	738,731

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM-15 Notes:

None

Data Alerts: None

NOM-16.1 Adolescent mortality rate ages 10 through 19 per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	35.5	2.1 %	299	841,885
2012	40.3	2.2 %	340	844,247
2011	37.1	2.1 %	315	848,300
2010	38.2	2.1 %	327	856,127
2009	42.4	2.2 %	363	855,924

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM-16.1 Notes:

None

Data Alerts: None

NOM-16.2 Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2013	16.9	1.2 %	214	1,267,375
2010_2012	18.9	16.5 %	243	1,285,474
2009_2011	19.2	16.8 %	250	1,302,264
2008_2010	21.7	19.2 %	285	1,312,853
2007_2009	28.1	25.3 %	368	1,307,973

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM-16.2 Notes:

None

Data Alerts: None

NOM-16.3 Adolescent suicide rate, ages 15 through 19 per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2013	8.7	7.1 %	110	1,267,375
2010_2012	7.8	6.3 %	100	1,285,474
2009_2011	7.8	6.3 %	102	1,302,264
2008_2010	7.2	5.8 %	94	1,312,853
2007_2009	7.1	5.7 %	93	1,307,973

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM-16.3 Notes:

None

Data Alerts: None

NOM-17.1 Percent of children with special health care needs

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	24.5 %	1.5 %	363,515	1,486,878
2007	22.8 %	1.3 %	333,269	1,459,756
2003	19.0 %	1.1 %	263,907	1,388,714

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

NOM-17.1 Notes:

None

Data Alerts: None

NOM-17.2 Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system

Data Source: National Survey of Children with Special Health Care Needs (NS-CSHCN)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2009_2010	20.6 %	1.9 %	47,496	230,292

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

NOM-17.2 Notes:

None

Data Alerts: None

NOM-17.3 Percent of children diagnosed with an autism spectrum disorder

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	1.7 %	0.5 %	20,826	1,251,005
2007	0.8 %	0.4 %	9,697	1,219,888

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM-17.3 Notes:

None

Data Alerts: None

NOM-17.4 Percent of children diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	10.4 %	1.2 %	129,363	1,248,342
2007	8.1 %	1.0 %	98,986	1,221,246

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM-17.4 Notes:

None

Data Alerts: None

NOM-18 Percent of children with a mental/behavioral condition who receive treatment or counseling

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	61.8 %	5.5 %	90,451	146,425
2007	65.5 %	6.3 %	71,153	108,700
2003	61.7 %	5.9 %	56,103	90,913

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

NOM-18 Notes:

None

Data Alerts: None

NOM-19 Percent of children in excellent or very good health

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	84.0 %	1.3 %	1,249,445	1,486,878
2007	84.3 %	1.3 %	1,230,196	1,459,756
2003	85.4 %	1.0 %	1,186,178	1,388,714

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM-19 Notes:

None

Data Alerts: None

NOM-20 Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	34.1 %	2.5 %	225,970	662,707
2007	36.5 %	2.2 %	228,141	625,327
2003	35.3 %	2.0 %	214,000	606,877

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Data Source: WIC

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	30.5 %	0.2 %	16,197	53,069

Legends:

Indicator has a denominator <50 or a relative standard error ≥30% and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	32.3 %	1.1 %	80,308	248,583
2011	32.5 %	1.0 %	86,503	266,111
2009	31.8 %	1.1 %	85,127	267,892
2007	34.9 %	1.2 %	94,046	269,544
2005	31.8 %	1.8 %	82,408	259,109

Legends:
Indicator has an unweighted denominator <100 and is not reportable
Indicator has a confidence interval width >20% and should be interpreted with caution

NOM-20 Notes:

None

Data Alerts: None

NOM-21 Percent of children without health insurance

Data Source: American Community Survey (ACS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	5.7 %	0.4 %	84,902	1,492,149
2012	5.6 %	0.4 %	83,030	1,492,012
2011	5.8 %	0.4 %	86,513	1,489,552
2010	5.3 %	0.3 %	79,838	1,499,117
2009	5.8 %	0.3 %	85,685	1,489,741

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM-21 Notes:

None

Data Alerts: None

NOM-22.1 Percent of children ages 19 through 35 months, who have received the 4:3:1:3(4):3:1:4 series of routine vaccinations

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	68.5 %	3.5 %	79,216	115,715
2012	73.1 %	3.5 %	86,800	118,788
2011	70.4 %	3.4 %	85,567	121,578
2010	61.8 %	3.4 %	78,476	127,008
2009	44.8 %	3.4 %	55,979	124,975

Legends:
Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6
Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM-22.1 Notes:

None

Data Alerts: None

NOM-22.2 Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013_2014	60.2 %	2.0 %	836,358	1,390,019
2012_2013	56.4 %	2.3 %	789,668	1,400,851
2011_2012	50.4 %	2.7 %	695,541	1,379,253
2010_2011	56.6 %	3.8 %	777,299	1,373,320
2009_2010	48.9 %	3.9 %	617,746	1,263,285

Legends:
Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6
Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM-22.2 Notes:

None

Data Alerts: None

NOM-22.3 Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

Data Source: National Immunization Survey (NIS) - Female

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	48.9 %	4.9 %	100,795	206,067
2012	54.3 %	5.6 %	111,424	205,037
2011	46.0 %	4.8 %	94,235	204,894
2010	33.1 %	4.1 %	66,953	202,352
2009	43.6 %	4.3 %	88,296	202,644

Legends:
Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6
Estimates with 95% confidence interval half-widths > 10 might not be reliable

Data Source: National Immunization Survey (NIS) - Male

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	28.9 %	4.2 %	62,537	216,557
2012	20.3 %	4.5 %	43,779	215,386
2011	NR	NR	NR	NR

Legends:
Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6
Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM-22.3 Notes:

None

Data Alerts: None

NOM-22.4 Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	80.0 %	2.7 %	338,276	422,624
2012	77.4 %	3.2 %	325,269	420,423
2011	67.6 %	3.2 %	283,974	420,127
2010	58.7 %	3.2 %	243,261	414,201
2009	48.0 %	3.1 %	199,390	415,570

Legends:
Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6
Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM-22.4 Notes:

None

Data Alerts: None

NOM-22.5 Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	67.8 %	3.1 %	286,448	422,624
2012	69.4 %	3.4 %	291,733	420,423
2011	63.3 %	3.3 %	265,999	420,127
2010	50.6 %	3.2 %	209,556	414,201
2009	52.1 %	3.1 %	216,515	415,570

Legends:
Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6
Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM-22.5 Notes:

None

Data Alerts: None

Form 10a
National Performance Measures (NPMs)

State: Tennessee

NPM-1 Percent of women with a past year preventive medical visit

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	72.2	72.2	73.3	74.5	75.7

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	68.6	68.8	72.8	76.8	80.8

NPM-6 Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	38.3	38.3	38.3	50.0	50.0

NPM-7 Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	109.8	107.0	104.4	101.8	99.2

NPM-8 Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	42.0	42.6	43.2	43.7	44.3

NPM-11 Percent of children with and without special health care needs having a medical home

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	61.6	63.1	64.7	66.3	68.0

NPM-12 Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	42.8	43.9	45.0	46.1	47.3

NPM-14 A) Percent of women who smoke during pregnancy

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	15.7	15.3	14.9	14.5	14.1

NPM-14 B) Percent of children who live in households where someone smokes

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	32.2	31.7	31.2	30.7	30.2

Form 10b

State Performance/Outcome Measure Detail Sheet

State: Tennessee

States are not required to create SOMs/SPMs until the FY 2017 Application/FY 2015 Annual Report.

Form 10c

Evidence-Based or Informed Strategy Measure Detail Sheet

State: Tennessee

States are not required to create ESMs until the FY 2017 Application/FY 2015 Annual Report.

Form 10d
National Performance Measures (NPMs) (Reporting Year 2014 & 2015)

State: Tennessee

Form Notes for Form 10d NPMs and SPMs

None

NPM 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.

	2011	2012	2013	2014	2015
Annual Objective	100.0	100.0	100.0	100.0	100.0
Annual Indicator	100.0	99.5	100.0	100.0	
Numerator	170	182	154	170	
Denominator	170	183	154	170	
Data Source	Department of Health	Department of Health	Department of Health Newborn Screening Program	Department of Health Newborn Screening Program	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2012**
	Field Note: Note: Identified one infant with Nonketotic Hyperglycinemia (NKH) in 2012 who did not receive treatment. There is limited treatment available with poor outcomes. Family chose to remove infant from life support, discontinue medications and provide palliative care through hospice.	
2.	**Field Name:**	**2011**
	Field Note: Data Source: Tennessee Department of Health, Newborn Screening Program	

Data Alerts: None

NPM 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)

	2011	2012	2013	2014	2015
Annual Objective	62.0	75.0	75.0	72.3	72.3
Annual Indicator	72.3	72.3	72.3	72.3	
Numerator	183,180	183,180	183,180	183,180	
Denominator	253,333	253,333	253,333	253,333	
Data Source	2009/10 CSHCN Survey	2009/10 CSHCN Survey	2009/10 CSHCN Survey	2009/10 CSHCN Survey	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2015**
	Field Note: Since the most recent data available from which to base the objective are from 2012, the annual objective is set at the 2012 indicator level until more data are available.	
2.	**Field Name:**	**2014**
	Field Note: See Notes - 2011 Since the most recent data available from which to base the objective are from 2012, the annual objective is set at the 2012 indicator level until more data are available.	
3.	**Field Name:**	**2013**
	Field Note: See Notes - 2011	
4.	**Field Name:**	**2012**
	Field Note: See Notes - 2011	
5.	**Field Name:**	**2011**

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

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

Data Alerts: None

NPM 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)

	2011	2012	2013	2014	2015
Annual Objective	55.0	50.0	50.0	45.9	45.9
Annual Indicator	45.9	45.9	45.9	45.9	
Numerator	113,064	113,064	113,064	113,064	
Denominator	246,352	246,352	246,352	246,352	
Data Source	2009/10 CSHCN Survey	2009/10 CSHCN Survey	2009/10 CSHCN Survey	2009/10 CSHCN Survey	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2015**
	Field Note: Since the most recent data available from which to base the objective are from 2012, the annual objective is set at the 2012 indicator level until more data are available.	
2.	**Field Name:**	**2014**
	Field Note: See Notes - 2011 Since the most recent data available from which to base the objective are from 2012, the annual objective is set at the 2012 indicator level until more data are available.	
3.	**Field Name:**	**2013**
	Field Note: See Notes - 2011	
4.	**Field Name:**	**2012**
	Field Note: See Notes - 2011	
5.	**Field Name:**	**2011**

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

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

Data Alerts: None

NPM 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)

	2011	2012	2013	2014	2015
Annual Objective	70.0	75.0	75.0	70.4	70.4
Annual Indicator	70.4	70.4	70.4	70.4	
Numerator	174,402	174,402	174,402	174,402	
Denominator	247,879	247,879	247,879	247,879	
Data Source	2009/10 CSHCN Survey	2009/10 CSHCN Survey	2009/10 CSHCN Survey	2009/10 CSHCN Survey	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2015**
	Field Note: Since the most recent data available from which to base the objective are from 2012, the annual objective is set at the 2012 indicator level until more data are available.	
2.	**Field Name:**	**2014**
	Field Note: See Notes - 2011 Since the most recent data available from which to base the objective are from 2012, the annual objective is set at the 2012 indicator level until more data are available.	
3.	**Field Name:**	**2013**
	Field Note: See Notes - 2011	
4.	**Field Name:**	**2012**
	Field Note: See Notes - 2011	
5.	**Field Name:**	**2011**
	Field Note: For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.	

Data Alerts: None

NPM 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)

	2011	2012	2013	2014	2015
Annual Objective	93.0	75.0	71.5	71.5	71.5
Annual Indicator	71.5	71.5	71.5	71.5	
Numerator	179,700	179,700	179,700	179,700	
Denominator	251,473	251,473	251,473	251,473	
Data Source	2009/10 CSHCN Survey	2009/10 CSHCN Survey	2009/10 CSHCN Survey	2009/10 CSHCN Survey	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2015**
	Field Note: Since the most recent data available from which to base the objective are from 2012, the annual objective is set at the 2012 indicator level until more data are available.	
2.	**Field Name:**	**2014**
	Field Note: See Notes - 2011 Since the most recent data available from which to base the objective are from 2012, the annual objective is set at the 2012 indicator level until more data are available.	
3.	**Field Name:**	**2013**
	Field Note: See Notes - 2011	
4.	**Field Name:**	**2012**
	Field Note: See Notes - 2011	
5.	**Field Name:**	**2011**

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

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

Data Alerts: None

NPM 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.

	2011	2012	2013	2014	2015
Annual Objective	40.0	45.0	45.0	41.8	41.8
Annual Indicator	41.8	41.8	41.8	41.8	
Numerator	40,413	40,413	40,413	40,413	
Denominator	96,752	96,752	96,752	96,752	
Data Source	2009/10 CSHCN Survey	2009/10 CSHCN Survey	2009/10 CSHCN Survey	2009/10 CSHCN Survey	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2015**
	Field Note: Since the most recent data available from which to base the objective are from 2012, the annual objective is set at the 2012 indicator level until more data are available.	
2.	**Field Name:**	**2014**
	Field Note: See Notes - 2011 Since the most recent data available from which to base the objective are from 2012, the annual objective is set at the 2012 indicator level until more data are available.	
3.	**Field Name:**	**2013**
	Field Note: See Notes - 2011	
4.	**Field Name:**	**2012**
	Field Note: See Notes - 2011	
5.	**Field Name:**	**2011**

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

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

Data Alerts: None

NPM 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.

	2011	2012	2013	2014	2015
Annual Objective	80.0	85.0	80.0	80.0	80.0
Annual Indicator	82.2	73.4	73.3	72.7	
Numerator	305	262	222	189	
Denominator	371	357	303	260	
Data Source	2010 NIS Survey	2011 NIS Survey	2012 NIS Survey	2013 NIS Survey	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**
	Field Note: CDC's calculated estimate was 72.6% +/- 6.7.	
2.	**Field Name:**	**2013**
	Field Note: CDC's calculated estimate was 73.1 +/- 6.8.	
3.	**Field Name:**	**2012**
	Field Note: Data Source: 2011 National Immunization Survey (NIS). We are using the earlier definition of the NIS reported estimate that takes into account only whether the child has had 3 doses of vaccine, irrespective of the brand. NOTE: Annual performance objective for 2012 should be 80, consistent with Healthy People 2020 benchmarks.	
4.	**Field Name:**	**2011**
	Field Note: Data Source: 2010 National Immunization Survey (NIS). We are using the earlier definition of the NIS reported estimate that takes into account only whether the child has had 3 doses of vaccine, irrespective of the brand.	

Data Alerts: None

NPM 08 - The rate of birth (per 1,000) for teenagers aged 15 through 17 years.

	2011	2012	2013	2014	2015
Annual Objective	20.0	19.5	18.0	17.4	13.5
Annual Indicator	18.5	17.4	15.3	13.9	
Numerator	2,287	2,117	1,855	1,688	
Denominator	123,785	121,665	121,107	121,107	
Data Source	Department of Health	Department of Health	TDH Office of Health Statistics Birth Statistical System and US Census	TDH Office of Health Statistics Birth Statistical System and US Census	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**
	Field Note: 2014 population projections/estimates not currently available; 2013 population data were used to calculate the 2014 birth rate. Results should be interpreted with caution.	
2.	**Field Name:**	**2012**
	Field Note: Data sources: TDH Office of Health Statistics Birth Statistical System and 2012 US Census	
3.	**Field Name:**	**2011**
	Field Note: Data sources: TDH Office of Health Statistics Birth Statistical System and 2011 US Census	

Data Alerts: None

NPM 09 - Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

	2011	2012	2013	2014	2015
Annual Objective	40.0	40.0	40.0	28.1	28.1
Annual Indicator	37.2	37.2	37.2	37.2	
Numerator	366	366	366	366	
Denominator	983	983	983	983	
Data Source	Tennessee Oral Health Survey	Tennessee Oral Health Survey	Tennessee Oral Health Survey	Tennessee Oral Health Survey	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2013**
	Field Note: Data Source: 2008 Tennessee Oral Health Survey of children ages 5-11 years. This survey is conducted every FIVE years as Central Office staffing permits. Source for objective for future years: HP 2020, OH-12.2: increase the proportion of children aged 6-9 years who have received dental sealnts on one or more of their permanent first molar teeth	
2.	**Field Name:**	**2012**
	Field Note: Data Source: 2008 Tennessee Oral Health Survey of children ages 5-11 years. This survey is conducted every FIVE years as Central Office staffing permits.	
3.	**Field Name:**	**2011**
	Field Note: Data Source: 2008 Tennessee Oral Health Survey of children ages 5-11 years. This survey is conducted every FIVE years.	

Data Alerts: None

NPM 10 - The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.

	2011	2012	2013	2014	2015
Annual Objective	1.7	2.4	3.5	1.7	1.7
Annual Indicator	3.7	1.7	2.9	2.0	
Numerator	46	21	36	25	
Denominator	1,237,679	1,241,590	1,240,434	1,240,434	
Data Source	Department of Health	Department of Health	TDH Office of Health Statistics Death Statistical System and US Census	TDH Office of Health Statistics Death Statistical System and US Census	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**
	Field Note: 2014 population projections/estimates not currently available; 2013 population data were used to calculate the 2014 mortality rate. Results should be interpreted with caution.	
2.	**Field Name:**	**2012**
	Field Note: Data sources: TDH Office of Health Statistics Death Statistical System and 2012 US Census	
3.	**Field Name:**	**2011**
	Field Note: Data sources: TDH Office of Health Statistics Death Statistical System and 2011 US Census	

Data Alerts: None

NPM 11 - The percent of mothers who breastfeed their infants at 6 months of age.

	2011	2012	2013	2014	2015
Annual Objective	37.5	36.0	40.0	30.0	45.0
Annual Indicator	35.5	30.8	29.9	40.7	
Numerator					
Denominator					
Data Source	CDC/National Immunization Survey-2008 Birth Cohort	CDC/National Immunization Survey-2009 Birth Cohort	CDC/National Immunization Survey-2010 Birth Cohort	CDC/National Immunization Survey-2011 Birth Cohort	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**
	Field Note: http://www.cdc.gov/breastfeeding/pdf/2014breastfeedingreportcard.pdf	
2.	**Field Name:**	**2013**
	Field Note: http://www.cdc.gov/breastfeeding/pdf/2013breastfeedingreportcard.pdf	
3.	**Field Name:**	**2012**
	Field Note: http://www.cdc.gov/breastfeeding/pdf/2012BreastfeedingReportCard.pdf	
4.	**Field Name:**	**2011**
	Field Note: http://www.cdc.gov/breastfeeding/pdf/2011BreastfeedingReportCard.pdf	

Data Alerts: None

NPM 12 - Percentage of newborns who have been screened for hearing before hospital discharge.

	2011	2012	2013	2014	2015
Annual Objective	98.0	99.0	99.0	99.0	99.0
Annual Indicator	97.5	96.2	97.2	97.0	
Numerator	82,313	82,809	83,457	84,056	
Denominator	84,393	86,068	85,838	86,679	
Data Source	Department of Health	Department of Health	Tennessee Department of Health, Newborn Screening Program	Tennessee Department of Health, Newborn Screening Program	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2012**
	Field Note: Data Source: Tennessee Department of Health, Newborn Screening Program	
2.	**Field Name:**	**2011**
	Field Note: Data Source: Tennessee Department of Health, Newborn Screening Program	

Data Alerts: None

NPM 13 - Percent of children without health insurance.

	2011	2012	2013	2014	2015
Annual Objective	3.7	2.3	2.5	3.5	2.2
Annual Indicator	2.4	2.7	3.7	2.4	
Numerator	35,743	40,700	55,319	36,104	
Denominator	1,489,292	1,507,407	1,495,108	1,504,333	
Data Source	UT CBER	UT CBER	UT CBER	UT CBER	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**
	Field Note: Data Source: The Impact of TennCare, A Survey of Recipients, 2014. Available at: http://cber.bus.utk.edu/tncare/tncare14.pdf (Table 2a, page 3)	
2.	**Field Name:**	**2013**
	Field Note: Data Source: "The Impact of TennCare, A Survey of Recipients, 2013." http://cber.bus.utk.edu/tncare/tncare13.pdf (Table 2a, page 3)	
3.	**Field Name:**	**2012**
	Field Note: Data Source: “The Impact of TennCare, A Survey of Recipients, 2012.” Available at http://cber.bus.utk.edu/tncare/tncare12.pdf (Table 2a, page 3)	
4.	**Field Name:**	**2011**
	Field Note: Data Source: “The Impact of TennCare, A Survey of Recipients, 2011.” Available at http://cber.bus.utk.edu/tncare/tncare11.pdf (Table 1a, page 3) There has also been a decrease in the number and percentage of uninsured Tennesseans versus previous reporting periods. Per the report explanation (also on page 3): “The slight decrease in the total uninsured rate is attributable to the not-so-slight decrease in the uninsured rate of children, a result possibly driven by increased TennCare and CoverKids enrollments as well as sampling changes.”	

Data Alerts: None

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

	2011	2012	2013	2014	2015
Annual Objective	15.0	10.0	10.2	10.4	10.2
Annual Indicator	10.7	10.4	10.5	10.4	
Numerator	19,967	18,890	19,128	18,667	
Denominator	186,444	182,282	182,297	179,490	
Data Source	Department of Health	Department of Health	Department of Health PedNSS/TN WIC Database	Department of Health PedNSS/TN WIC Database	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2012**
	Field Note: Data Source: Tennessee Department of Health, PedNSS/TN WIC Database.	
2.	**Field Name:**	**2011**
	Field Note: Data Source: Tennessee Department of Health, PedNSS/TN WIC Database.	

Data Alerts: None

NPM 15 - Percentage of women who smoke in the last three months of pregnancy.

	2011	2012	2013	2014	2015
Annual Objective	13.5	13.0	12.5	12.8	12.0
Annual Indicator	13.6	13.1	12.9	11.8	
Numerator	10,782	10,433	10,178	9,506	
Denominator	79,234	79,928	79,001	80,731	
Data Source	Department of Health	Department of Health	TDH Office of Health Statistics Birth Statistical System	TDH Office of Health Statistics Birth Statistical System	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2012**
	Field Note: Data source: TDH Office of Health Statistics Birth Statistical System	
2.	**Field Name:**	**2011**
	Field Note: Data source: TDH Office of Health Statistics Birth Statistical System	

Data Alerts: None

NPM 16 - The rate (per 100,000) of suicide deaths among youths aged 15 through 19.

	2011	2012	2013	2014	2015
Annual Objective	5.0	7.0	7.0	8.9	8.9
Annual Indicator	7.3	9.0	9.5	10.0	
Numerator	31	38	40	42	
Denominator	426,828	421,428	419,093	419,093	
Data Source	Department of Health	Department of Health	TDH Office of Health Statistics Death Statistical System and US Census	TDH Office of Health Statistics Death Statistical System and US Census	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**
	Field Note: 2014 population projections/estimates not currently available; 2013 population data were used to calculate the 2014 mortality rate. Results should be interpreted with caution.	
2.	**Field Name:**	**2012**
	Field Note: Data sources: TDH Office of Health Statistics Death Statistical System and 2012 US Census	
3.	**Field Name:**	**2011**
	Field Note: Data sources: TDH Office of Health Statistics Death Statistical System and 2011 US Census	

Data Alerts: None

NPM 17 - Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

	2011	2012	2013	2014	2015
Annual Objective	83.0	84.5	72.0	83.5	84.5
Annual Indicator	70.9	80.9	82.4	79.8	
Numerator	843	1,014	1,087	997	
Denominator	1,189	1,254	1,319	1,249	
Data Source	Department of Health	Department of Health	TDH Office of Health Statistics Birth Statistical System	TDH Office of Health Statistics Birth Statistical System	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2012**
	Field Note: Data source: TDH Office of Health Statistics Birth Statistical System	
2.	**Field Name:**	**2011**
	Field Note: Data Source: Tennessee Department of Health, Division of Health Statistics, Birth Statistical System	

Data Alerts: None

NPM 18 - Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

	2011	2012	2013	2014	2015
Annual Objective	75.0	70.0	71.0	72.0	72.0
Annual Indicator	69.6	70.1	71.2	70.4	
Numerator	51,094	52,878	53,618	53,331	
Denominator	73,445	75,458	75,339	75,708	
Data Source	Department of Health	Department of Health	TDH Office of Health Statistics Birth Statistical System	TDH Office of Health Statistics Birth Statistical System	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2012**
	Field Note: Data source: TDH Office of Health Statistics Birth Statistical System	
2.	**Field Name:**	**2011**
	Field Note: Data Source: Tennessee Department of Health, Division of Health Statistics, Birth Statistical System	

Data Alerts: None

Form 10d
State Performance Measures (SPMs) (Reporting Year 2014 & 2015)

State: Tennessee

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

	2011	2012	2013	2014	2015
Annual Objective	7.0	1.0	1.0	1.0	1.0
Annual Indicator	1.4	1.5	1.5	1.5	
Numerator	109	121	117	117	
Denominator	79,462	80,202	79,954	79,954	
Data Source	Department of Health	Department of Health	Department of Health Child Fatality Review and Birth Statistical System	Department of Health Child Fatality Review and Birth Statistical System	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2014**
	Field Note: The data shown is for CY2013. Data is not yet available for CY2014. The review of CY2014 deaths is expected to be complete later in CY2015.	
2.	**Field Name:**	**2013**
	Field Note: Data Source: Number of sleep related deaths (numerator) comes from the Child Fatality Review. The number of births (denominator) comes from the Tennessee Department of Health, Division of Health Statistics, Birth and Death Statistical Systems.	
3.	**Field Name:**	**2012**
	Field Note: Data Source: Number of sleep related deaths (numerator) comes from the Child Fatality Review. The number of births (denominator) comes from the Tennessee Department of Health, Division of Health Statistics, Birth and Death Statistical Systems.	
4.	**Field Name:**	**2011**

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

Data Alerts: None

SPM 2 - Percentage of obesity and overweight among Tennessee K-12 students

	2011	2012	2013	2014	2015
Annual Objective	25.0	25.0	38.0	38.4	38.1
Annual Indicator		38.6	38.5	38.3	
Numerator		106,880	126,208	121,999	
Denominator		276,877	327,487	318,335	
Data Source	Department of Education	Office of Coordinated School Health	Department of Health	Department of Health	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2014**
	Field Note: Data are for 2013-14 school year.	
2.	**Field Name:**	**2013**
	Field Note: Data are for 2012-13 school year. Data Source: "BMI School Summary Data State and County 2012-13" Available online at: http://www.tn.gov/education/schoolhealth/data_reports/doc/BMI_School_Summary_2012-13.pdf	
3.	**Field Name:**	**2012**
	Field Note: Data are for 2011-12 school year. Data Source: "A Summary of Weight Status Data Tennessee Public Schools, 2011-2012 School Year." Available online at: http://www.tn.gov/education/schoolhealth/data_reports/doc/BMI_Sum_Data_State_Co_2013.pdf	
4.	**Field Name:**	**2011**
	Field Note: Data Source: Tennessee Department of Education, Office of Coordinated School Health. BMI measurements of K-12 students during the 2009-2010 and 2010-11 school year have been collected but have not yet been released; those data will be uploaded once made available from the Department of Education.	

Data Alerts: None

SPM 3 - Percentage of smoking among women of age 18-44.

	2011	2012	2013	2014	2015
Annual Objective	20.0	20.0	20.0	19.0	19.0
Annual Indicator	23.6	25.2	23.9	23.9	
Numerator	269,595	278,516	281,550	281,550	
Denominator	1,141,863	1,105,002	1,176,006	1,176,006	
Data Source	Department of Health	Department of Health	BRFSS	BRFSS	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2014**
	Field Note: BRFSS data from 2014 not yet available; the data shown here are from 2013.	
2.	**Field Name:**	**2012**
	Field Note: Data source: Tennessee Department of Health; Division of Policy, Planning and Assessment; Office of Health Statistics; Behavioral Risk Factor Surveillance System (BRFSS). Analysis limited to women aged 18-44 years. Smoking is defined as smoking within the past 30 days (i.e. current smoking). Due to changes in BRFSS methodology implemented in 2011, estimates for 2011 and after cannot be compared to those from earlier years. Any shifts in estimates from previous years to 2011 may be the result of the new methodology and not a true change in the population.	
3.	**Field Name:**	**2011**
	Field Note: Data Source: Behavioral Risk Factor Surveillance System (BRFSS).	

Data Alerts: None

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

	2011	2012	2013	2014	2015
Annual Objective	20.0	1,700.0	1,750.0	1,850.0	1,550.0
Annual Indicator	1,828.1	1,894.0	1,640.9	1,640.9	
Numerator	5,928	6,141	5,285	5,285	
Denominator	324,270	324,238	322,072	322,072	
Data Source	Department of Health	Department of Health	TDH Office of Health Statistics Hospital Discharge Database	TDH Office of Health Statistics Hospital Discharge Database	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2014**
	Field Note: Data for 2014 is not available at this time. These data are from 2013.	
2.	**Field Name:**	**2012**
	Field Note: Data sources: TDH Office of Health Statistics Hospital Discharge Data System and 2012 US Census	
3.	**Field Name:**	**2011**
	Field Note: Data sources: TDH Office of Health Statistics Hospital Discharge Data System and 2012 US Census	

Data Alerts: None

SPM 5 - Number of MCH staff who have completed a self-assessment and based on the assessment have identified and completed a module in the MCH Navigator system.

	2011	2012	2013	2014	2015
Annual Objective	0.0	0.0	140.0	180.0	221.0
Annual Indicator			173.0	201.0	
Numerator		134			
Denominator					
Data Source		Department of Health	Department of Health	Department of Health	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2014**
	Field Note: See 2013 notes.	
2.	**Field Name:**	**2013**
	Field Note: Data Source: The State MCH Director maintains a log of which staff in the Central Office and in the regions have completed a self-assessment and a module in the Navigator.	
3.	**Field Name:**	**2012**
	Field Note: Data Source: The State MCH Director maintains a log of which staff in the Central Office and in the regions have completed a self-assessment and a module in the Navigator.	
4.	**Field Name:**	**2011**
	Field Note: This SPM has been changed. Therefore data is not reported for 2011 but will be reported in future years.	

Data Alerts: None

SPM 6 - Percentage of youth (14 and older) enrolled in the state CSHCN program who have formal plans for transtion to adulthood.

	2011	2012	2013	2014	2015
Annual Objective	45.0	45.0	45.0	55.0	75.0
Annual Indicator		15.3	19.7	70.6	
Numerator		125	481	569	
Denominator		817	2,441	806	
Data Source		TDH PTBMIS	TDH PTBMIS	TDH PTBMIS	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2013**
	Field Note: The data for this form was taken from the TDH Patient Tracking Billing Management Information System (PTBMIS). The denominator is the total number of individuals on the Children's Special Servives (CSS) program age 14 and older. The numerator is the number of transition plans that have been conducted.	
2.	**Field Name:**	**2012**
	Field Note: The data for this form was taken from the TDH Patient Tracking Billing Management Information System (PTBMIS). The denominator is the total number of individuals on the Children's Special Servives (CSS) program age 14 and older. The numerator is the number of initial transition plans that have been conducted since the policy and form was approved February 13, 2013.	
3.	**Field Name:**	**2011**
	Field Note: This SPM has been changed. Therefore data is not reported for 2011 but will be reported in future years.	

Data Alerts: None

SPM 7 - Rate of unintentional injury death in children and young people ages 0-24 (per 100,000).

	2011	2012	2013	2014	2015
Annual Objective	14.0	18.5	16.0	17.5	13.5
Annual Indicator	16.9	17.7	16.5	14.5	
Numerator	342	360	338	297	
Denominator	2,025,215	2,038,481	2,043,906	2,043,906	
Data Source	Department of Health	Department of Health	TDH Office of Health Statistics Death Statistical System and US Census	TDH Office of Health Statistics Death Statistical System and US Census	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2014**
	Field Note: 2014 population projections/estimates not currently available; 2013 population data were used to calculate the 2014 mortality rate. Results should be interpreted with caution.	
2.	**Field Name:**	**2012**
	Field Note: Data sources: TDH Office of Health Statistics Death Statistical System and 2012 US Census	
3.	**Field Name:**	**2011**
	Field Note: Data sources: TDH Office of Health Statistics Death Statistical System and 2011 US Census	

Data Alerts: None

Form 11
Other State Data

State: Tennessee

While the Maternal and Child Health Bureau (MCHB) will populate the data elements on this form for the States, the data are not available for the FY 2016 application and FY 2014 annual report.

State Action Plan Table

State: Tennessee

Please click the link below to download a PDF of the State Action Plan Table.
State Action Plan Table