

**Maternal and Child
Health Services Title V
Block Grant**

Tennessee

**FY 2017 Application/
FY 2015 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, 2016

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,

A handwritten signature in black ink, appearing to read "M. Warren".

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

States are required to conduct a comprehensive needs assessment every five years 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. During the years between the comprehensive needs assessments states are expected to conduct on-going needs assessments in order identify any significant changes in needs and capacity.

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.

As a part of our ongoing needs assessment, the state hosts MCH stakeholder meetings twice a year. These meetings are open to anyone who is connected to the MCH population. During these meetings participants are asked to develop the action plan for the coming year by considering program and population level data.

Another part of the state's effort to continually assess needs is the public comment survey that is sent out with a copy of the grant application/report annually. This survey collects information on emerging health concerns, unmet health needs, health care system capacity, and general recommendations for the grant.

KEY ACCOMPLISHMENTS AND PLANS FOR COMING YEAR

The MCH population is broken down into subpopulation categories called health domains. There are six domains:

- Women's and Maternal Health
- Perinatal and Infant Health
- Child Health
- Adolescent Health
- Children with Special Health Care Needs
- Cross-cutting and Life Course

Each section below (organized by domain) highlights selected accomplishments for the previous year and contains a brief description of high-level strategies for the current 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 2015, 70.0% of women entered prenatal care in the first trimester, up slightly from 69.6% in 2011. 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 14.1% in 2014, down from 17.6% in 2010. 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 (35.2% in 2015), and high rates of maternal mortality (19.6 per 100,000 live births in 2014).

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 is utilizing these strategies to address this priority:

- Increase general awareness of the importance of preventive health care visits for women of childbearing age.
- Engage primary care providers on the importance of promoting preventive health care 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 2014 (6.9). Most notably the number of sleep-related deaths decreased by almost 25% from 2012-2014. The percentage of early elective deliveries and inductions among Tennessee births has dropped from more than 15% in 2012 to consistently below 1% in 2016. 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; 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 is utilizing these strategies to address this priority:

- Educate parents and caregivers on safe sleep.
- Review infant deaths through multidisciplinary teams to enhance data collection.
- Support quality improvement and regionalization efforts to improve perinatal outcomes.
- Provide follow-up for abnormal newborn screening results.
- Reduce unintended pregnancies.

Child Health

The percentage of Tennessee children without health insurance decreased to 1.5% in 2015 (down from 3.9% in 2010). Tennessee has a >90% completion rate on four (Polio, MMR, HepB, and Varicella) of seven key childhood vaccines. 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 is focusing 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 is utilizing these strategies to address these priorities:

- Increase general awareness among parents and caregivers 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.

- Provide injury prevention education to parents and caregivers.

Adolescent Health

The rate of teen births (adolescents aged 15-17) decreased 30% from 2010 to 2014. The percentage of adolescents receiving a preventive visit increased from 81.1% in 2007 to 85.9% in 2012. Similarly, from 2011 to 2014 adolescent vaccination rates increased for meningococcal, Tdap, and HPV (among females) vaccines; HPV vaccination rates increased among males from 2012 to 2014. 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 is focusing 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 is utilizing 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.
- Increase evidence based or evidence informed activities related to motor vehicle safety being implemented in schools.
- Increase awareness of proper storage and disposal of medications.
- Increase general awareness of the causes of adolescent hospitalizations due to falls.
- Increase awareness of the signs and risk factors of suicide attempts.

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 is utilizing 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 Children's Special Services, Tennessee's Title V CYSHCN program.
- Support 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. Based on 2014 BRFSS data, nearly one quarter (24.2%) of the adult population smoke. Among women who gave birth in Tennessee 15.0% reported smoking during pregnancy in 2014. 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 is utilizing 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.

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 2014, the United States Census Bureau estimated Tennessee's population to be the 17th largest in the country at 6.5 million (74.6% White non-Hispanic, 17.1% Black or African American non-Hispanic, and 5.0% Hispanic). Tennessee's population grew by 3.2% from 2010 to 2014 (comparable with the national population increase of 3.3%). 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 (24.5%) of the population lives in the two most populous metropolitan counties: Shelby (Memphis) and Davidson (Nashville).

The 2014 American Community Survey reported that 17.4% of the state's population lived below the federal poverty level; this percentage was larger for children under 18 (25.8%) and families with related children under 18 years (21.7%). The highest rates of poverty (55.2%) 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 nation.

Health Status of Tennessee's MCH Population

According to America's Health Rankings, in 2015 Tennessee ranked 43rd 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 (42nd)
- Infant mortality (36th)
- Preterm birth (41st)

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 43rd 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 2014, 22.6% 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 depression are common among Tennessee women, affecting 12.8% and 26.3% of the population, respectively. Among women who become pregnant, 70.4% 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; 8.9% are born at low birthweight and 1.5% are born at very low birthweight. Fifteen 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 12.7% over the past five years (from 7.9 in 2010 to 6.9 in 2014). Despite that progress, 6.9 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 2015, the case rate was 12.9 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 2015 Kids Count Data Book. Overweight/obesity remains a significant challenge for Tennessee; body mass index (BMI) data (collected by Coordinated School Health for the 2014-15 school year) indicate that 38.6% of K-12 students are overweight/obese. Recent trends are encouraging; however, as the percentage of overweight/obese students in 2014-15 represented a 6.3% relative reduction from the 2007-08 school year. Tennessee has historically had high childhood immunization rates. In the 2015 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 54.6% of White children receiving influenza vaccine as compared to 31.9% of Black children. ACEs are unfortunately quite common in Tennessee, with 52.6% 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 53.6% from 2005-2014 in Tennessee. However, the rates of teen pregnancy for Black females is nearly twice that of White females (10.7 vs. 5.5 respectively, 2014). 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 noted in Table 1 (see Attachment 1 under supporting documents).

Cross-Cutting Issues

Tobacco continues to be a major determinant of poor health across the lifespan of the MCH population. Nearly one quarter (24.2%) of Tennessee's adults smoke (BRFSS, 2014). 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; 15.0% of women smoked during pregnancy in 2014, 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, 2010-2014). 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 typically are 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 Table 2 (see Attachment 1 in the supporting documents section), Black Non-Hispanic Tennesseans generally have higher rates of infant mortality risk factors compared to White Non-Hispanic and Hispanic populations.

Disparities exist within obesity and overweight prevalence, another MCH priority. Race/ethnicity, age, education, and income all show distinct patterns for increased risk. Increases in educational attainment and income prove to be protective, while Black non-Hispanic and Hispanic individuals are at increased likelihood for being obese. Black non-Hispanic males (40.4%) and females (41.0%) display higher prevalence rates of obesity than their White non-Hispanic male (30.5%) and female (28.6%) counterparts. Disparities also exist among Tennessee adult tobacco users, with education and income-level showing the greatest differences. Adult smokers are most likely to have less than high school education (43.6%), with decreasing prevalence as educational attainment increases. Additionally, adult smoking rates are inversely proportional to income level. 38.2% of smokers report an income level less than \$15,000, while those making at least \$75,000 are 4.5 times less likely to smoke (8.4%). According to 2014 BRFSS data, there is not a significant difference in smoking prevalence among White non-Hispanic (25.7%) and Black non-Hispanic males (26.6%). Among females, non-Hispanic White women exhibit the highest prevalence (23.7%),

followed by other race non-Hispanic (18.5%) and Black non-Hispanic (17.1%). Among adolescents, tobacco use is far more prevalent among White non-Hispanic males (35.3%) compared to White non-Hispanic females (19.6%), Black non-Hispanic males (18.1%) and Black non-Hispanic females (15.6%).

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, 2014).

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 the Needs Assessment Summary (Title V Program Capacity—Organizational Structure section). 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 43rd 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 engage 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 April 30, 2016, TDH staff in all 95 counties have participated in 1,881 projects in Tennessee communities and a total of 66 projects have replicated TDH-designated "Bright Spot" projects. TDH staff has also worked cooperatively alongside numerous external partners, engaging in 104 community-led projects.

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 2016, the Department had received Level 2 Baldrige recognition, and 53 individual county health departments, 4 public health regions, and 5 divisions/offices within the TDH Central Office (including Family Health and Wellness) have received Baldrige recognition.

Health Facilities and Provider Availability

There are 67 birthing hospitals in Tennessee (hospitals with >50 deliveries/year) plus five non-hospital birthing centers.

As of May 2016, Tennessee has 16 Critical Access Hospitals designated to preserve access to local primary and emergency health services. These hospitals are located in rural counties with less healthier populations that demonstrate higher rates of obesity, diabetes, preventable hospitalizations, cardiovascular deaths and cancer deaths as compared to state and national benchmarks. Additionally, these hospitals are located in rural counties with fewer physicians and with a higher proportion of patients who live in poverty and a higher Medicaid population.

As of May 2016, 67 counties are federally designated as either whole or partial-county Health Professional Shortage Areas (HPSAs) for Primary Care (based on either the low-income population or geography). All but six of the state's 95 counties are designated as federal Dental HPSAs and all but five counties are designated as federal Mental Health HPSAs. Ninety-four of the state's 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 May 2016, 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): 774
- Family Medicine/General Practice: 1946
- Pediatrics (includes subspecialties and Med/Peds): 1605

Health Insurance Coverage

The University of Tennessee Center for Business and Economic Research estimates that 6.6% of all Tennesseans were uninsured in 2015. This percentage is much lower for children under 18 (1.5%) as compared to adults 18 and older (8.2%). The percentages of uninsured children and adults have declined over the past five years (from highs of 2.4% and 12%, respectively, in 2011). The major reason that people report being uninsured is that they cannot afford health insurance (83% of those uninsured) rather than not getting to it (9%) or not needing insurance (9%). Not being able to afford insurance was cited more frequently among uninsured individuals earning less than \$10,000 (89%) but was still a significant barrier even for individuals making more than \$50,000 (64%).

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 is focusing during this 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 participates 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:

- 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).

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 Statutes 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

Needs Assessment Update (as submitted with the FY 2017 Application/FY 2015 Annual Report)

Introduction

This application year (FY2017) is the second year of the FY2016-2020 grant cycle. During interim years of the grant cycle an ongoing needs assessment is conducted as a way of continuously monitoring and assessing the needs of the MCH population as well as the capacity of the system to meet those needs. The ongoing needs assessment is considered an annual follow up to the comprehensive needs assessment that is completed every five years in conjunction with the beginning of a new grant cycle. The process and findings of the most recent comprehensive needs assessment, completed in 2015, have been described previously. An explanation of Tennessee's ongoing needs assessment is described below.

Process

Ongoing Needs Assessment Activities

The Tennessee Title V Program has multiple mechanisms for continually assessing health needs and system capacity. The first is through the longstanding public comment survey distributed every spring. This survey is distributed with a draft of the annual application/report prior to the summer submission. Respondents are asked to provide feedback through mostly open ended questions.

The second mechanism is through meetings of the MCH Stakeholder Group and the Tennessee MCHB Grantees. During the planning of the 2015 comprehensive Needs Assessment it was decided that a MCH Stakeholder Group was needed to provide feedback and partnership to Tennessee's Title V Program. This group was formed and has continued to meet twice a year in-person since its inception. It is an open group; anyone is welcome to join at any time. Special effort is made to invite those who serve the MCH population. During meetings the group reviews population and program measures, and then utilizes that information to develop the annual action plan.

The Tennessee MCHB Grantees group was formed after the last Title V MCH Block Grant review after staff identified the need to intentionally engage with all other MCHB grantees in Tennessee. Tennessee's Title V Program reached out to the other MCHB grantees in the state and began convening meetings quarterly. There are two in-person meetings, and two web based meetings per year. These meetings provide an opportunity to align the programs in Tennessee so that we can better support our maternal and child population.

In addition to these intentional activities, ongoing needs assessment occurs through other mechanisms throughout the years. A variety of MCH stakeholders are represented on various departmental advisory committees (Genetics, Perinatal, and Children's Special Services Advisory Committees). These subject matter experts (which include family members) advise the Department on program/policy issues and also identify emerging issues that warrant further consideration/action. An additional needs assessment opportunity is regular interaction between TDH Central Office staff and those staff in regional and local health departments. Through routine conference calls or in-person site visits, Central Office staff hear firsthand about "on the ground" issues and needs in communities across the state.

Survey Data Collection and Analysis

During the annual public comment period in the spring, data is collected through an online survey. The survey is distributed widely throughout the TDH programs as well as other departments within state, local and regional health departments, advisory committees, providers, family organizations, and non-profit organizations. Recipients are asked to forward the survey broadly to anyone who might be interested in responding. Respondents provide feedback on emerging issues, health disparities, the capacity of the health care system to meet the needs of the population, and general recommendations to the Title V program. Responses are broken down by health domain. The findings of this survey are described below.

Findings: MCH Population Needs

A total of 108 individuals completed the survey. The highest proportion of respondents were local health department staff, followed by community service providers, and then health care providers. A question regarding emerging health concerns and unmet needs was asked for each of the six MCH domains. A summary of responses can be found below. The full text responses can be found under Attachment 6 within the document titled *Tennessee Attachments* in the supporting documents section.

Women's/Maternal Health

Among the 53 responses to this question the top three themes that emerged were substance abuse, obesity, and preconception care. These findings correlate with the findings from our 2015 Five Year Needs Assessment and relate to our priority of preconception care for women of childbearing age, which is the priority for this domain.

Perinatal/Infant Health

There were 46 responses to this question. Among those responses, the most frequent were substance abuse leading to neonatal abstinence syndrome, tobacco use particularly pregnancy smoking and secondhand smoke exposure among children, and infant mortality with particular concern for the racial disparity. The current action plan addresses these needs.

Child Health

Of the 46 responses to this question, the majority centered around the high burden of obesity, adverse childhood experiences (ACEs), and a need for more physical activity and better nutrition. Again, these responses align well with the needs that were identified through the 2015 Five Year Needs Assessment as well as the current action plan.

Adolescent Health

A total of 46 participants provided responses to this question. Once again, obesity surfaced as the top concern, followed by reproductive health including teen pregnancy and STIs, and lastly substance abuse and tobacco use. Although reproductive health is not a priority within this domain, preconception health (which includes reproductive health) is a priority for all women of reproductive age within the women's and maternal health domain. The same is true with tobacco use; although it is not a priority within this domain it is the priority for the cross-cutting domain. The other areas are covered by the current action plan.

CYSHCN

The 26 individuals who responded to this question provided important insight into the needs of CYSHCN. The top theme that emerged was support when transitioning between child and adult care, followed by service limitations in

rural settings, and caregiver support. Transition is an explicit priority for this domain. Service limitations in rural areas and the need for caregiver support were identified during the 2015 Five Year Needs Assessment. Since then there have been ongoing conversations around how to best address these needs. Although they are not currently detailed in the action plan, TDH staff (particularly those at the local level) are working diligently to try to address this concern.

Cross-Cutting/Life Course

Among the 36 respondents who provided input on this question, the majority noted ACEs as the greatest concern, followed by tobacco use, and substance abuse. Tobacco use is the priority for this domain. Although ACEs is not a priority for this domain, it is a priority for the child health domain. Substance abuse is not a priority for any one domain; however it is addressed throughout the action plan in the context of the other priorities.

Overall this survey data is most useful when considered in the context of other internal and external sources such as vital records, the National Survey of Children's Health etc. It is used as a way to identify emerging problems from the public perspective.

Findings: Title V Program Capacity

Tennessee's Title V program capacity and partnership-building efforts relative to addressing the state priority needs were described in the 2015 full Needs Assessment and the Needs Assessment summary. Updates since that time are included here.

Organizational Structure

In April 2016, the Title V Director (Dr. Michael Warren) was appointed to serve as the TDH Deputy Commissioner for Population Health. With transmission of this Block Grant Application/Report, Dr. Morgan McDonald will assume the role of Title V Director. Dr. McDonald is trained in Internal Medicine and Pediatrics and serves as the TDH Assistant Commissioner for Family Health and Wellness.

Loraine Lucinski, who previously served as the section chief for Early Childhood Initiatives, has been promoted to be the FHW Deputy Director for Child Health. In this role, she oversees the Early Childhood, CYSHCN, and Perinatal/Infant/Pediatric care sections. Angela McKinney Jones was hired to serve as the section chief for Early Childhood Initiatives.

In 2015, the TDH Traumatic Brain Injury program was moved to FHW. This program is funded by both state appropriations and a federal grant, and provides educational and support services for individuals (including children) with traumatic brain injury. The move of this program to FHW aligns nicely with injury efforts related to falls and motor vehicle crashes, as well as care coordination efforts for children and youth who have sustained traumatic brain injuries.

Updated organizational charts for TDH and FHW are included in the supporting documents section.

Agency Capacity

There have been no substantial changes in agency capacity since the comprehensive Needs Assessment in 2015.

MCH Workforce Development and Capacity

Changes in Tennessee's MCH Workforce Development and Capacity since the Needs Assessment are described below.

Title V Management

As previously stated, the Title V Director was promoted within TDH and Dr. Morgan McDonald will now assume the role of Title V Director.

Title V Planning, Evaluation, and Data Analysis

A doctoral-level epidemiologist was hired in 2015 to support the Childhood Lead Poisoning Prevention Program. FHW staff are currently engaged with CDC staff to recruit a CDC MCH Epi assignee.

FHW epidemiologists have been integrally involved in developing and implementing a microcephaly surveillance system as part of the Zika virus response. Those staff have also developed a plan for entering Tennessee patients into the CDC's US Zika Pregnancy Registry.

In 2016, TDH finalized a partnership with the Public Health Information Access Project through the National Library of Medicine (NLM). TDH staff will now have full-text access to over 240 peer-reviewed journals (including MCH-related journals). Additionally, a partnership with East Tennessee State University will facilitate inter-library loan access to other articles not available through the NLM project. MCH Block Grant funds were used to partially support the first year of the NLM project.

Title V Parent and Family Involvement

Strong family partnerships have continued since the Needs Assessment. In 2016, CYSHCN staff partnered with Family Voices of Tennessee and the Vanderbilt LEND program to develop a Youth Advisory Council. The Council met for the first time in March 2016 and will provide valuable youth input on MCH/CYSHCN programming.

Findings: Partnerships, Collaboration, and Coordination

Tennessee's Title V program continues to partner 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.

As described in the Five Year Needs Assessment, a unique feature of Tennessee's Title V program is that it is housed alongside the TDH Chronic Disease Prevention and Health Promotion and Supplemental Nutrition programs.

Since the Needs Assessment, the Early Childhood Comprehensive Systems (ECCS) grant has ended; TDH elected not to apply for the new round of funding due to limitations in technology capacity. The D70 CSHCN State Implementation Grant ended in Spring 2016; TDH plans to apply for the next round of funding once announced. The other MCHB investments remain as previously described.

In Spring 2016, TDH reorganization resulted in FHW being moved into a new "Population Health" cluster with Policy, Planning and Assessment (vital records, population-based data and surveys); Rural Health; Minority Health and

Disparities Elimination; and Grants Coordination/Strategic Alignment. FHW was already partnering with these internal entities, and this reorganization should only enhance existing collaborative efforts.

FHW continues to partner with Family Voices to engage families in Title V efforts. Since July 2014, Title V and Family Voices have engaged over 2700 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 2,800 family members on MCH core competencies including family-centered care, cultural competency, and developing others through teaching and mentoring. Family Voices trained over 750 family members in navigating the health care system and 76 family members are now mentors. This has resulted in 80 referrals for matches to the Parent to Parent program. There are 38 active matches (ongoing; family currently receiving support) and an additional estimated 35 successful matches have been successfully completed. While the D70 funding has ended, FVTN is committed to finding alternative funding to sustain this important parent-to-parent program.

At the request of FHW staff, family members participated in Cohort 4 of the National MCH Workforce Development Center to develop a more congruent system of behavioral/primary health care for children and families in Tennessee.

Family Voices collaborated with FHW CYSHCN staff to provide parental perspective on a medical home guide booklet for families entitled, "Partnering with Your Provider." Family Voices staff and other Tennessee families provided stories on personal experiences with the Medical Home. In collaboration with the Tennessee ADA Network Administrator, Family Voices helped revise the section on "use of interpreters" by providing accurate, up-to-date information from the ADA as well as statewide resources and fact sheets from Disability Rights Tennessee, the state's Protection and Advocacy organization. This guide, originally developed by the Region 4 Midwest Genetics Collaborative, has been adapted (with permission) for use in Tennessee.

Five-Year Needs Assessment Summary (as submitted with the FY 2016 Application/FY 2014 Annual Report)

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

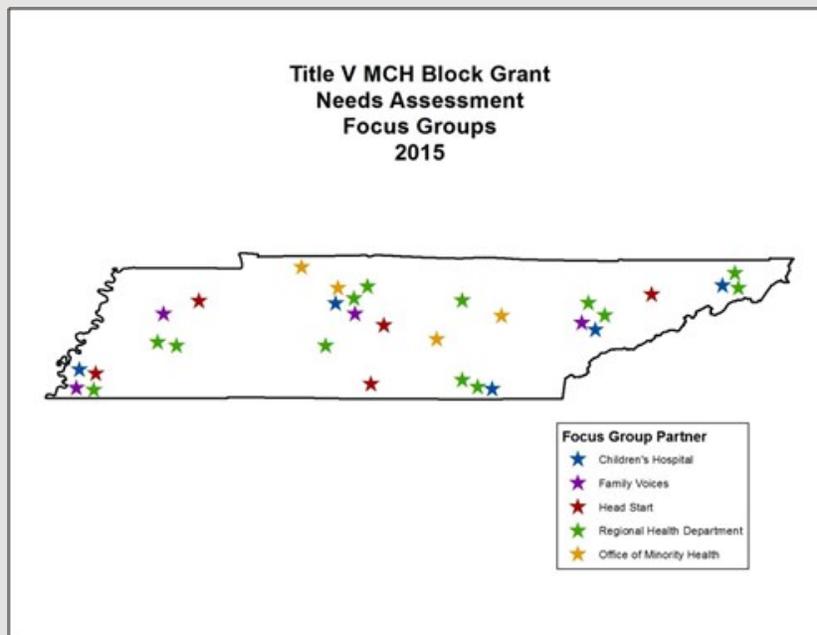
The Epidemiology Team divided the quantitative indicator list (based on prior program knowledge or interest). Epidemiologists identified a data source for each indicator and gathered data for the most recent years available (the goal was to have at least five data points per indicator to allow for trend 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
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 exposed to adverse childhood experiences.
5	Reduce the number of children and adolescents who are overweight/obese.
6	Reduce the burden of injury among children and adolescents.
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).

Methodology for Priority Selection

Selection of Tennessee's Title V Program priorities for 2016-2020 occurred as part of the 2015 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 2016-2020
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.

Changes to Priorities during the 2016-2020 Grant Cycle

Based on input from the Title V Leadership and Epidemiology Teams, as well as the larger stakeholder group Tennessee's Title V Program is proposing no changes to the priority list for this application (FY2017). The priorities listed are still considered to be the priorities that need the most focus and the capacity to work on them is still present.

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
- NPM 5 - Percent of infants placed to sleep on their backs
- NPM 6 - Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool
- NPM 7 - Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19
- NPM 8 - Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day
- NPM 11 - Percent of children with and without special health care needs having 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
- NPM 14 - A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes

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 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

- SPM 1 - Percentage of children ages 0-17 experiencing two or more adverse childhood experiences
- SPM 2 - Percentage of infants born to Tennessee resident mothers who initiate breastfeeding
- SPM 3 - Percent of live births that were the result of an unintended pregnancy

To address Tennessee's unique MCH needs three state performance measures (SPM) were developed based on the findings of the Five-Year Needs Assessment. The narrative below describes the rationale for why these measures were selected and links the selected SPMs with Tennessee's identified priorities.

Child Health

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

SPM 1: Percentage of children ages 0-17 experiencing two or more adverse childhood experiences

Rationale

Adverse childhood experiences (ACEs) are psychosocial risk factors that affect a person's short and long term health and socioeconomic outcomes. Some of the health outcomes that exhibit a dose-response relationship with ACEs include obesity, smoking, unintended pregnancy, substance abuse and suicide attempts, all of which relate to priorities for this grant cycle. Promoting protective factors such as safe, stable, and nurturing relationships early in life has been shown to help prevent, reduce, and mitigate risk. Utilizing this upstream approach will provide Tennessee the ability to impact many priorities at once.

Child Health

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

SPM 2: Percentage of infants born to Tennessee resident mothers who initiate breastfeeding

Rationale

The 2015 Needs Assessment revealed that obesity is a major concern for children, adolescents, and women of childbearing age in Tennessee. Breastfeeding is one way to lower the risk of obesity for a mother and child. The association between breastfeeding and obesity has been shown to be a dose-response relationship in that the longer and more exclusive breastfeeding is the more protective it is against obesity. Breastfeeding has also been shown to lower the risk of SIDS, which relates to another of Tennessee's priorities - reducing infant mortality.

Women's/Maternal Health

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

SPM 3: Percent of live births that were the result of an unintended pregnancy

Rationale

Preconception care and family planning are important aspects of preventive care for women. In Tennessee, like the US, almost half of pregnancies are unintended. Unintended pregnancies are associated with risk factors such as delayed prenatal care, reduced breastfeeding, maternal depression, increased risk for intimate partner violence, and poor developmental outcomes for children. Many of these risk factors are priorities in Tennessee during this grant cycle; therefore a decrease in unintended pregnancies could improve outcomes in priority areas.

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, FY17) as well as a report on prior year activities (Annual Report, FY15). 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, FY17)
 - a. Statement of Priority
 - b. Objective for Related NPM/SPM
 - i. Rationale for Objective
 - ii. Current Performance
 - c. Planned Strategies (including ESMs) and Activities
 - d. MCHB Partnerships
 - e. Other Key Partnerships
 - f. Related Legislative Requirements
2. Reporting Year (Annual Report, FY15)
 - 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 State Action Plan Table summarizes the plan for the coming year (Application, FY17) by domain, priority, and performance measure.

Women/Maternal Health

State Action Plan Table

State Action Plan Table - Women/Maternal Health - Entry 1

Priority Need

Improve utilization of preventive care for women of childbearing age.

NPM

Percent of women with a past year preventive medical visit

Objectives

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).

Strategies

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

Engage primary care providers on the importance of promoting preventive health care 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.

ESMs

ESM 1.1 - Number of press releases, PSAs and/or social media messages promoting preventive health care visits for women of reproductive age

ESM 1.2 - Number of webinars for providers on increasing preventive care visits among women in their clinics

ESM 1.3 - Number of quarterly site-level family planning utilization reports distributed to local health departments

ESM 1.4 - Number of region-level pregnancy-related service utilization reports distributed to regional health departments

NOMs

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

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

NOM 4.1 - Percent of low birth weight deliveries (<2,500 grams)

NOM 4.2 - Percent of very low birth weight deliveries (<1,500 grams)

NOM 4.3 - Percent of moderately low birth weight deliveries (1,500-2,499 grams)

NOM 5.1 - Percent of preterm births (<37 weeks)

NOM 5.2 - Percent of early preterm births (<34 weeks)

NOM 5.3 - Percent of late preterm births (34-36 weeks)

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

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

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

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

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

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

State Action Plan Table - Women/Maternal Health - Entry 2

Priority Need

Improve utilization of preventive care for women of childbearing age.

SPM

Percent of live births that were the result of an unintended pregnancy

Objectives

Decrease the percentage of live births that were the result of an unintended pregnancy to 44.8% by FY2020.

Strategies

See strategies and ESMs related to this SPM listed under State Action Plan Table - Women's/Maternal Health - Entry 1.

Measures

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	72.2	72.2	73.3	74.5	75.7	77.3

Data Source: Behavioral Risk Factor Surveillance System (BRFSS)

Multi-Year Trend					
Year	Annual Indicator	Standard Error	Numerator	Denominator	
2014	74.0 %	2.1 %	839,995	1,135,664	
2013	72.2 %	1.9 %	822,111	1,139,338	
2012	74.7 %	1.6 %	845,711	1,132,728	
2011	75.8 %	3.0 %	859,713	1,134,614	
2010	78.3 %	1.8 %	882,068	1,126,941	
2009	75.9 %	1.9 %	854,450	1,126,466	

Legends:

- 📌 Indicator has an unweighted denominator <30 and is not reportable
- ⚡ Indicator has a confidence interval width >20% and should be interpreted with caution

ESM 1.1 - Number of press releases, PSAs and/or social media messages promoting preventive health care visits for women of reproductive age

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	10.0	10.0	10.0	10.0	10.0

ESM 1.2 - Number of webinars for providers on increasing preventive care visits among women in their clinics

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	2.0	2.0	2.0	2.0	2.0

ESM 1.3 - Number of quarterly site-level family planning utilization reports distributed to local health departments

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	4.0	4.0	4.0	4.0	4.0

ESM 1.4 - Number of region-level pregnancy-related service utilization reports distributed to regional health departments

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	4.0	4.0	4.0	4.0	4.0

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. In 2014, the percentage of Tennessee women aged 18-44 who had a preventive health care visit within the past year was 74.0%. Although slightly higher than the percentage observed in 2013, this difference was not statistically significant. 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 year 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 FY17:

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

ESM 1: Increase the number of press releases, PSAs and/or social media messages promoting preventive health care visits for women of reproductive age from 7 to 10 by September 30th, 2017.

Activity 1a: Issue press releases, social media announcements, and/or 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 (e.g. Facebook, Twitter).

Activity 1c: Request Governor's proclamation promoting National Women's Health Week in May.

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

ESM 2: Increase the number of webinars for providers on increasing preventive care visits among women in their clinics from 1 to 2 with at least 30 attendees by September 30th, 2017.

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

Activity 2b: Promote the use of One Key Question as a way for providers to fully support women's preventive reproductive health needs using the following strategies: (1) incorporate One Key Question into electronic health records; (2) include documentation of the use of One Key Question as part of Family Planning site visit chart reviews; (3) provide a presentation on One Key Question at the annual Spring Update conference for Reproductive and Women's Health providers; (4) create an infographic on One Key Question for distribution to providers.

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

ESM 3: Distribute quarterly site-level family planning utilization reports by September 30th, 2017.

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

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

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

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

ESM 4: Distribute quarterly region-level pregnancy-related service utilization reports by September 30th, 2017.

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.

Activity 4d: Distribute a program policy/change memorandum requesting an increase in the percentage of health department pregnancy tests coded to Family Planning, as well as create quarterly regional-level reports allowing staff to track their progress.

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: American Congress of Obstetricians and Gynecologists (ACOG), Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN), 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 18: Percent of infants born to pregnant women receiving prenatal care in the first trimester

Interpretation of Performance Data (Form 10D): Final 2014 birth data showed that 70.4% of pregnant women,

whose pregnancy resulted in a live birth, entered prenatal care in the first trimester, a decrease from 71.1% in 2013. Preliminary 2015 data shows a slight decrease again to 70.0% of women entering prenatal care in the first trimester. Since 2010 the rate has stagnated around 70%.

Summary of Activities Related to Performance Measure: The Department of Health has historically considered the reduction of infant mortality and improving birth outcomes as priorities. The role of the Department is to remain abreast of evidence-based best practices and to implement public health initiatives and programming consistent with those practices. All local health department clinics offer basic prenatal services, which includes pregnancy testing (67,164 tests from March 2015 – February 2016), presumptive eligibility determination for TennCare (13,873 enrolled during the same time period), WIC/nutrition services (January 2016 WIC data show that 15,847 pregnant women were participating in WIC in 130 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 home visiting services as appropriate (HUGS, Healthy Start, CHAD, or the federally funded home visiting projects). For FFY 2015, 444 pregnant women were provided home visiting services through the federally funded evidence-based home visiting programs and the Healthy Start home visiting projects.

Under the managed care system in place under TennCare, almost all prenatal care is provided by private sector providers. The HEDIS report produced for Tennessee's Medicaid program provides data on pregnant women enrolled in TennCare. In 2015, 80.23% of Medicaid pregnant women entered prenatal care in the first trimester or within 42 days of enrollment; this compares to 81.93% nationally.

Funding continued for TIPQC (Tennessee Initiative for Perinatal Quality Care). Quality improvement projects related to pregnant women this past year included: (1) reducing early elective deliveries (in sustainment), (2) breastfeeding promotion: delivery and postpartum and (3) developing the obstetric hemorrhage project (will kick off in spring 2016).

The toll free Baby Line operates within the call center for EPSDT/TennCare. Under a contract with TennCare, staff in the EPSDT call center have for many years contacted all TennCare pregnant women and mothers of infants, offering assistance and education. These staff are also servicing the Baby Line.

The Department continues to participate in the collection and analysis of information and data for the CDC PRAMS project.

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: The Tennessee Anti-Tobacco Advocacy Initiative hosts and maintains an interactive website that assisted local, state and national partners with information related to tobacco control, position statements, trainings, legislation, media campaigns, and talking points on state and national tobacco related policy issues. The website also hosted web links to other tobacco control organizations such as: The Tennessee Department of Health, The Centers for Disease Control and Prevention, The Campaign for Tobacco - Free Kids, Truth Initiative, Americans for Non-Smokers' Rights, American Heart and Lung Associations, and The U.S. Department of Health and Human Services.

Three statewide trainings were hosted by the Tobacco Prevention and Control Program in each of the grand divisions of the state. Training was held in the Jackson, Cookeville, and Knoxville public health departments. All Tobacco Coordinators and other local partners were encouraged to attend. During the trainings, participants received updates on state and national tobacco control initiatives, current information on Electronic Nicotine Delivery Systems (ENDS), work plan reporting technical assistance, and the opportunity to collaborate on tobacco control measures during rural and metro group discussion breakout sessions.

The Tennessee Anti-Tobacco Advocacy met with statewide leaders and decision makers, attended health fairs, and created educational materials such as brochures, signs, posters and radio ads. Through these actions, they were able to educate the public on the dangers of secondhand smoke exposure, promote support for tobacco control policies, promote sustainability of tobacco use prevention, encourage cessation funding, and educate the public about the continued need for policies such as The Tennessee Non-Smokers Protection Act.

Tobacco Settlement Funding was used to provide services to women who smoke through programs such as: Baby and Me, TIPS (Tennessee Intervention for Pregnant Smokers), SMART Moms, Colorado Counseling Model, Nurturing Parents, and Public CO Screenings and Education.

The Tennessee Quitline provided tobacco quitline cessation counseling services (phone or web based) and referred callers to face to face cessation counseling services.

The Tobacco Prevention and Control Program partnered with Encore for the promotion of the Quitline through their managed care organizations. TennCare enrollees received Quitline educational materials which encouraged program participation. All TennCare patients are now offered covered tobacco cessation services.

The Department of Health partnered with the Tennessee Office of Coordinated School Health for promotion of tobacco prevention education and referral to the Tennessee Tobacco Quitline through Health Educators statewide.

Health Educators worked closely with WIC clinics providing smoking cessation education through education materials and trainings for WIC participants who smoke encouraging use of the quitline.

The Tobacco Prevention and Control Program also partnered with the Home Visiting Program by supplying staff with tobacco control educational materials. These materials promote use of the Quitline and educate about the effects of secondhand smoke as it relates to infants, children, parents and other family members. This information is for both staff and their Home Visiting clients.

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.

Perinatal/Infant Health

State Action Plan Table

State Action Plan Table - Perinatal/Infant Health - Entry 1

Priority Need

Reduce infant mortality.

NPM

Percent of infants placed to sleep on their backs

Objectives

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

Strategies

Educate parents and caregivers on safe sleep.

Review infant deaths through multidisciplinary teams to enhance data collection.

Support quality improvement and regionalization efforts to improve perinatal outcomes.

Provide follow-up for abnormal newborn screening results.

Reduce unintended pregnancies.

ESMs

ESM 5.1 - Number of safe sleep educational material distributed

ESM 5.2 - Percent of infant deaths to be reviewed by child fatality review teams

ESM 5.3 - Percent of VLBW (Very Low Birth Weight) infants being delivered at Level III or IV birthing facilities

ESM 5.4 - Percent of newborns with a positive metabolic screen who receive follow-up to definitive diagnosis and clinical management

ESM 5.5 - Number of individuals served by the Tennessee Adolescent Pregnancy Prevention Program (TAPPP)

NOMs

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

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

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

Measures

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	80	81	82	83	84	85

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	78.4 %	2.0 %	58,650	74,823
2012	77.4 %	1.9 %	57,077	73,773
2009	65.6 %	2.3 %	50,974	77,746
2008	62.7 %	2.3 %	50,673	80,786

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

ESM 5.1 - Number of safe sleep educational material distributed

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	80,000.0	80,000.0	80,000.0	80,000.0	80,000.0

ESM 5.2 - Percent of infant deaths to be reviewed by child fatality review teams

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	100.0	100.0	100.0	100.0	100.0

ESM 5.3 - Percent of VLBW (Very Low Birth Weight) infants being delivered at Level III or IV birthing facilities

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	80.0	80.0	80.0	80.0	80.0

ESM 5.4 - Percent of newborns with a positive metabolic screen who receive follow-up to definitive diagnosis and clinical management

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	100.0	100.0	100.0	100.0	100.0

ESM 5.5 - Number of individuals served by the Tennessee Adolescent Pregnancy Prevention Program (TAPPP)

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	45,500.0	46,000.0	46,500.0	47,000.0	47,500.0

Perinatal/Infant Health - Plan for the Application Year

PRIORITY: Reduce infant mortality.

Objective for Priority: Decrease the rate of infant death from 6.9 in 2014 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 2014 infant mortality rate in Tennessee was 6.9 infant deaths per 1,000 live births, 15% above the national rate. The top leading causes of infant death are congenital anomalies, short gestation, unintentional injuries, maternal pregnancy complication and SIDS. These causes include unsafe sleep, which accounts for approximately 18% 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 FY17:

Strategy 1: Educate parents and caregivers on safe sleep.

ESM 1: Distribute a minimum of 80,000 safe sleep educational materials by September 30, 2017.

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

Activity 1b: Increase the number of educational materials distributed through the Direct On Scene Education program from 700 to 1200 by September 30, 2017. 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.

Activity 1c: Increase the number of safe sleep floor talkers placed in stores, clinics, health departments, daycares and other agencies from 650 to 1000 by September 30th, 2017.

Activity 1d: Increase the number of WIC parents completing the safe sleep educational module from 1000 to 5000 by September 30, 2017.

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

ESM 2: Local Child Fatality Review (CFR) teams will review 100% of infant deaths by September 30th, 2017.

Activity 2a: Provide necessary documents 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.

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

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

Activity 2d: 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 quality improvement and regionalization efforts to improve perinatal outcomes.

ESM 3: Maintain that 80% of VLBW infants are being delivered at Level III or IV birthing facilities through September 30, 2017.

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

Activity 3b: Provide technical assistance to the regional perinatal centers. The five Regional Perinatal

Centers will provide perinatal care for high risk pregnant women and newborns if no other appropriate facility is available to manage significant high risk conditions. Funding from the state (Medicaid) is used to provide consultation and referral for facilities and 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 3c: Coordinate the Perinatal Advisory Committee meetings.

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

ESM 4: Increase the percent of newborns with a positive metabolic screen who receive follow-up to definitive diagnosis and clinical management from 99.5% to 100% by September 30, 2017.

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.

ESM 5: Increase the number of individuals served by the Tennessee Adolescent Pregnancy Prevention Program (TAPPP) from 45,000 to 47,000 by September 30, 2017.

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, and 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. 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 provides 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. Tennessee's Early Hearing and Detection Intervention program, called the Newborn Hearing Screening program, collaborates with Tennessee's Early Intervention System (TEIS), located in the Tennessee Department of Education, by referring all children with identified hearing loss to TEIS through use of a shared database.

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 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 the 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. Since 2010 the highest annual percentage of VLBW babies delivered at tertiary level hospitals was 82.9% in 2010, ranging from as low as 70.9% in 2011. The most recent primary data for 2015 indicates a percentage of 79.3%.

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 to all health care providers within the respective geographic area. This system has been in place in the state since the 1970s and is well established and recognized. Medical staffs in all five centers are available for 24 hour consultation for both high risk obstetrical and neonatal care. Education and training for providers within the geographic areas are provided by all the centers. An

advisory committee, established by legislation and coordinated by Maternal and Child Health staff, advises the Department on issues and concerns related to perinatal care. The state is responsible for the development, revision, and dissemination of guidelines for regionalization of perinatal care, guidelines for perinatal transportation, and educational objectives for nurses and social workers working in perinatal care.

All services within the regional perinatal centers continued during the past year. During 2015, a work group of obstetrical providers reviewed the national recommendations for maternal levels of care and adapted them into the Tennessee regionalization guidelines. A new section for birthing centers was added. These were approved at the June 2016 meeting of the Perinatal Advisory Committee.

During state FY 2015, the five obstetrical perinatal centers had 14,661 deliveries for Tennessee residents (compared to 76,959 provisional resident births statewide for CY 2015), provided 61,784 outpatient consultation visits, had 1,896 inpatient referrals to the Regional Center, and provided 1,908 hours of education. Data from the five neonatal perinatal centers for the same time period show 3,816 in-born admissions to Tennessee residents, of which 521 were VLBW (2014 VLBW resident births statewide were 1,260); 1,182 transports; 2,256 NICU discharged infants seen in follow-up clinic; and 4,193 hours of education taught.

The Tennessee Initiative for Perinatal Quality Care (TIPQC) began in 2008 to develop a statewide quality collaborative to improve birth outcomes in the state. The voluntary organization has grown to over 1,900 members, including perinatologists, neonatologists, hospitals at all levels of perinatal care, administrators, third party payors, state officials, and community constituents. In February 2015, almost 300 physicians, nurses, advocates, payors, hospital administrators, government leaders, and families met to collaborate on ways to improve birth outcomes through sharing of their quality improvement projects. TIPQC projects have included NICU admission temperature, reduction of central line associated bloodstream infections, human milk for the NICU infant, breastfeeding promotion, NICU nutrition and growth, registry for undetected CCHD, antenatal steroids, reduction of early elective deliveries, and NAS.

The multi-agency partnership (March of Dimes, Tennessee Hospital Association, and Tennessee Center for Patient Safety, TIPQC, and the Department of Health) has continued to increase awareness and educate providers and parents about the benefits of waiting until at least 39 weeks for delivery. These efforts have been very successful; data from the past three years show that all 65 birthing hospitals have sustained a rate below 5% (the national goal) for early elective delivery.

NPM 1: 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

Interpretation of Performance Data (Form 10D): For many years, staff has 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 32 core conditions and 24 of the 26 secondary conditions recommended for screening by the Secretary's Committee on Heritable Disorders in Newborns and Children (U. S. Department of Health and Human Services). Tennessee's Genetics Advisory Committee (GAC) (members from the genetic centers, pediatric endocrinologists, hematologist, pediatrician/lawyer, neonatologist, pediatric cardiologist, and pediatric pulmonologist) met three times during the reporting period to guide the program and recommend changes in tests

and procedures.

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

This performance measure continues to be successfully met due to the state law requiring testing of all infants born in the state and the quality and efficiency of the State Laboratory and the NBS follow-up program. The follow up program has implemented a quality assurance system to assure the timely screening of all infants. Hospital-level quality reports indicating newborn screening completion, specimen satisfactoriness, timeliness of collection, and transit time are sent monthly. Statewide roll-up reports are posted monthly on the department's website to promote transparency (<http://tn.gov/health/article/MCH-nbs-reports>). Information for parents and health care providers about newborn screening is located on the Department's web site.

During 2014-2015, the State Laboratory and the follow-up worked toward adding Severe Combined Immunodeficiency Disease (SCID) screening to the state's NBS panel. A work group was formed with local and regional experts, and an immunologist was recruited to provide expert guidance with establishing the protocols and the algorithm for follow-up and referrals and for forming the referral network of immunologists. SCID screening started January 2016. Also during early fall of 2015, a work group was formed to begin the process of setting up the screening and follow-up systems for adding lysosomal storage disorders to the screening panel.

During CY 2015, the program followed-up on 1,791 presumed positive results for disease; 156 were confirmed with disease. Preliminary CCHD results for 2015 show that 591 infants failed and/or were referred; 5 were diagnosed with CCHD. Preliminary hearing screening results for 2015 show that 4,083 infants failed and/or were referred; 68 were diagnosed with hearing loss. In addition, follow-up was done on 2,417 unsatisfactory samples. For 2015, the State's unsatisfactory rate for dried blood spots was 2.67 percent. Provisional 2015 birth data indicate that 90,206 tests were performed on infants born in Tennessee.

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

Interpretation of Performance Data (Form 10D): Approximately 98% of all babies born in Tennessee receive a hearing screen. Among those screened, nearly 98% completed their screen prior to one month of age. NPM12 is the percentage of babies that received a hearing screen within one month of age among all births in Tennessee (including babies that do not receive a hearing screen at all). This measure is quite consistent over time, ranging from 95.6% to 96.3% from 2011 to 2015.

Summary of Activities Related to Performance Measure: Program specific goals for this time period focused on reducing by 5% by March 31, 2016, the percentage of infants that were lost to follow-up or lost to documentation of follow-up (LTF/LTD) for each of the 1-3-6 time periods for screening, diagnosis and early intervention. Trainings on small steps of change targeting activities to reduce LTF/LTD were held in each of six regions across the state. Stakeholders included hospitals; audiologists; medical providers; early interventionists (TEIS Service Coordinators and private programs); families of children with hearing loss (Hands and Voices members, GBYS Parent Guides, individual parents); University-based Audiology Programs; Schools for the Deaf; midwives; and staff for the Title V Children's Special Services, home visiting and WIC programs. Trainings were organized and supervised by the Newborn Hearing Screening Coordinator along with contract staff from the University of Tennessee Center on Deafness.

A Quality Improvement office was created within the Pediatric Case Management and Follow-Up Program for newborn screening, including blood spot, hearing, and critical congenital heart disease (CCHD) screening. Quality improvement is being achieved through shared collaborative learning of evidence based strategies for the improvement of timeliness in the newborn screening process in several areas (collection of dried blood spots, transport of specimens and information, and receipt of specimens in the State Laboratory). A number of the activities will benefit EHDI reporting by hospitals. To reduce the transport time of specimens (including hearing results), a courier service was provided to hospitals beginning in April 2015. The percent of blood spot and hearing forms received by the lab less than 48 hours from collection has greatly increased. Site visits were conducted to selected hospitals to review collection and reporting activities. In 2014 the program created new monthly quality reports for each hospital. These are provided to each hospital and are posted on the Department's website. The reports include the number of births and the percentage of blood spot, hearing and CCHD screens completed. A report of babies not screened is sent to the hospitals, and the hospitals are to complete and return information with dates of screen or the reason not screened.

To reduce the percentage of infants lost to follow-up/lost to documentation (LTF/LTD) at all stages of the EHDI process, statewide quality improvement activities continued in 2015 in six regions. The small steps of change quality improvement model of Plan-Do-Study-Act (PDSA) was utilized. The aim for each region was to reduce the percent of lost to follow-up/lost to documentation by 5% by March 31, 2016. A four-member training team was led by the Audiology Consultant, U.T. Knoxville Center on Deafness. Each region developed new or revised PDSA small steps of change projects. Participants included hospital hearing screeners, audiologists, parents of children with hearing loss, midwives, Early Head Start staff, Tennessee Early Intervention System (TEIS) Part C staff, deaf educators, schools for the deaf and hard of hearing, and University-based audiology programs. A total of 28 new plans were developed. Follow-up conference calls were conducted to each of the six regional task force groups to assess the current status of PDSA plan testing, implementation, and evaluation and to offer professional support where needed.

98.3% of infants born from January-June 2015 received a hearing screening; among those screened, 98.3% of infants were screened prior to one month of age. It is anticipated that the new and refined small steps of change projects targeting hospitals, audiologists, and TEIS will help to facilitate improvements in all of these rates.

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

Interpretation of Performance Data (Form 10D): NIS 2015 data indicate that 43.1 percent of infants born in Tennessee in 2012 were being breastfed at 6 months of age, up from 40.7 percent reported for the previous year. Despite an increase over the past five years, breastfeeding rates at 6 months remain lower than Healthy People 2020's objective of 60.6 percent.

Summary of Activities Related to Performance Measure: The number of Breastfeeding Peer Counselors increased to 68 from 45 peer counselors statewide. Collaboration with HUGS continued, and networking and support of TIPQC breastfeeding projects was accomplished.

Utilizing the CDC funded chronic disease prevention and school health promotion grant, FHW staff partnered with the TN Hospital Association to engage hospitals and increase the number of hospital implementing practices and policies that promote and support breastfeeding. One thousand physicians and nurses took a 20 hour course to learn strategies to assist and support breastfeeding moms and their babies.

The TN Breastfeeding Hotline (24/7) provided counseling, resources and support to breastfeeding moms and their families as well as to healthcare providers. The Hotline has increased the number of breastfeeding trained (IBCLC and CLC) staff to cover all of the calls. Call volume averaged well over 400 calls per month.

World Breastfeeding Week/ National Breastfeeding Month activities were conducted in each county (95) of the state during the month of August. Activities included the Big Latch On, breastfeeding promotion displays, breastfeeding teas for moms and family members and story time for families at local libraries.

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

Interpretation of Performance Data (Form 10D): The number of sleep-related deaths has significantly decreased by almost 25% in the past two years from 130 deaths in 2012 to 99 deaths in 2014. A statewide public awareness campaign began in 2012. In 2014, all birthing hospitals implemented safe sleep policies that requires staff to educate all new parents about safe sleep and model safe sleep behavior.

Summary of Activities Related to Performance Measure: Safe Sleep promotional materials were distributed to health departments, home visiting programs, day care centers, clinics, hospitals, Department of Children's Services and other community agencies. In addition to the posters, flyers, door hangers, onesies, and dry erase boards, the safe sleep message is also available on magnets, bag tags, and nightlights. Educational flip charts were also distributed to these community agencies to use.

TDH provided 1,400 pack-n-plays to Regional and Metro Health departments to distribute to families that did not have a safe sleep environment and were under poverty guidelines. The health departments collaborated with groups such as home visiting programs, hospitals and first responder agencies to identify families in need of a safe sleep environment through the Direct On-Scene Education (DOSE) Program.

During this report year, 406 Floor talkers were placed in businesses. Partnerships with programs such as "Gold Sneaker" allowed for an increase in sharing the safe sleep message. Gold Sneaker is a designation given to daycares that meet certain minimum health and safety requirements. Gold Sneaker facilities in areas with the highest sleep-related deaths were offered floor talkers and other safe sleep materials. Some other agencies that have placed floor talkers include police departments, court houses, hospitals, health departments and doctor's offices.

All birthing hospitals continued to implement their safe sleep policies; providing education for staff and new parents in addition to modeling safe sleep behavior in their hospital. The hospitals continued to provide the Sleep Baby Safe and Snug book to all new mothers in addition to other safe sleep materials; a total of 86,000 books were distributed during the report year. The safe sleep program at TDH continued to provide educational flipcharts to hospitals to assist them with teaching parents about safe sleep. All birthing hospitals were also encouraged to apply for a national safe sleep certification offered through the Cribs for Kids program. Twelve hospitals received the national certification with 5 at gold level, 1 at silver level, and 6 at bronze level. TDH provided support for hospitals that wanted to apply including answering questions about the application process and uploading materials onto the application site for the hospitals.

From October 2014 through September 2015 81,496 Welcome Baby packets were distributed. The packets are sent to all new mothers and include information about safety topics and resources for new mothers. The packets included information about safe sleep.

TDH hosted an educational webinar to agencies interested in the DOSE program. TDH also conducted 2 DOSE trainings in rural counties to expand the program. The DOSE program has been expanded to Shelby County, East Region, and many of the rural counties in Mid-Cumberland and South Central. 480 DOSE packets were handed out during the grant year. Twenty-eight individual agencies are participating representing 18 counties. First responders also distributed safe sleep kits and educated families at car seat checks and community activities.

TDH developed an online educational module on safe sleep and breastfeeding for WIC parents. The module was piloted at metro and rural health department WIC classes prior to being made available to WIC parents to complete on their own. WIC parents completed a pre and post-test when completing the module and data was collected from these tests to determine the change in intent or behavior after completing the module. A module was not created for daycare providers because a national online module already exists; therefore the existing training has been promoted to daycare providers. In addition, the safe sleep educational flipchart has been offered to daycare providers to ensure a consistent message is taught to parents. Training for Department of Children's services employees was conducted and recorded. It is now available on Edison (the state's online system for employees).

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, normalize breastfeeding, and reduce barriers to 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 added in 2016. The State provides laboratory and follow-up services six days a week and uses a courier pickup service for specimens 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.

Child Health

State Action Plan Table

State Action Plan Table - Child Health - Entry 1

Priority Need

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

NPM

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

Objectives

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).

Strategies

Increase general awareness among parents and caregivers 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.

ESMs

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

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

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

NOMs

NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

NOM 19 - Percent of children in excellent or very good health

State Action Plan Table - Child Health - Entry 2

Priority Need

Reduce the burden of injury among children and adolescents.

NPM

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

Objectives

By FY2020, reduce hospitalization rates for unintentional injuries among children age 0-9 to 99.2 per 100,000.

Strategies

Promote the use of child safety seats.

Promote safe storage of medications.

Provide injury prevention education to parents and caregivers.

ESMs

ESM 7.1 - Number of parents and caregivers receiving car seat education

ESM 7.2 - Number of counties that adopt Count It! Drop It! Lock It! educational programs

ESM 7.3 - Percent of families who receive injury prevention education through the AAP checklist among families participating in Evidence Based Home Visiting programs

ESM 7.4 - Number of schools in the top ten crash rate counties (among ages 15-18) that conduct evidence-informed teen safe driving programming

ESM 7.5 - Number of drug disposal bins installed statewide

ESM 7.6 - Number of press releases, social media posts and presentations about adolescent falls

ESM 7.7 - Number of suicide-related articles, social media posts and trainings provided by TDH

NOMs

NOM 15 - Child Mortality rate, ages 1 through 9 per 100,000

NOM 16.1 - Adolescent mortality rate ages 10 through 19 per 100,000

NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000

NOM 16.3 - Adolescent suicide rate, ages 15 through 19 per 100,000

State Action Plan Table - Child Health - Entry 3

Priority Need

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

NPM

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

Objectives

By FY2020, reduce the percentage of students in grades K-8 identified as overweight/obese from 38.2% (2012-2013 school year) to 36.2%.

Strategies

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).

Increase support for breastfeeding initiation and duration (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 activity and good nutrition.

ESMs

ESM 8.1 - Number of Gold Sneaker-recognized childcare facilities in Tennessee

ESM 8.2 - Average number of monthly calls to the Tennessee Breastfeeding Hotline (TBH)

ESM 8.3 - Number of Baby Friendly-designated Tennessee birthing hospitals

ESM 8.4 - Number of Run Clubs for 5th through 8th graders

ESM 8.5 - Number of school districts (LEAs) that received CSPAP training

ESM 8.6 - Number of school districts (LEAs) that received Smarter Lunchroom training

ESM 8.7 - Number of shared-use agreements (any type) between two or more entities in Tennessee

NOMs

NOM 19 - Percent of children in excellent or very good health

NOM 20 - Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)

State Action Plan Table - Child Health - Entry 4

Priority Need

Reduce the number of children exposed to adverse childhood experiences.

SPM

Percentage of children ages 0-17 experiencing two or more adverse childhood experiences

Objectives

By FY2020, reduce the percentage of Tennessee children age 0-17 experiencing two or more adverse childhood experiences to 24.75%. (Data source: National Survey of Children's Health)

Strategies

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.

State Action Plan Table - Child Health - Entry 5

Priority Need

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

SPM

Percentage of infants born to Tennessee resident mothers who initiate breastfeeding

Objectives

By FY2020, increase percentage of infants born to Tennessee resident mothers who initiate breastfeeding to 44.8%.

Strategies

See strategies and ESMS related to this SPM listed under State Action Plan Table - Child Health - Entry 3.

Measures

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	2021
Annual Objective	38.3	38.3	38.3	50	50	50

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	38.3 %	3.2 %	150,143	391,762
2007	29.0 %	2.8 %	112,111	386,431

Legends:

 Indicator has an unweighted denominator <30 and is not reportable

 Indicator has a confidence interval width >20% and should be interpreted with caution

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

Annual Objectives

	2017	2018	2019	2020	2021
Annual Objective	599.0	617.0	636.0	655.0	675.0

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

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	467.0	485.0	504.0	524.0	544.0

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

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	90.0	90.0	91.0	92.0	92.0

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	109.8	107	104.4	101.8	99.2	96.7

Data Source: State Inpatient Databases (SID) - CHILD

Multi-Year Trend					
Year	Annual Indicator	Standard Error	Numerator	Denominator	
2013	107.4	3.6 %	890	829,094	
2012	104.6	3.5 %	895	855,498	
2011	166.5	4.4 %	1,414	849,524	
2010	161.1	4.4 %	1,343	833,694	
2009	158.8	4.4 %	1,307	823,320	
2008	184.3	4.8 %	1,468	796,612	

Legends:
 Indicator has a numerator ≤10 and is not reportable
 Indicator has a numerator <20 and should be interpreted with caution

ESM 7.1 - Number of parents and caregivers receiving car seat education

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	2,550.0	2,600.0	2,650.0	2,700.0	2,750.0

ESM 7.2 - Number of counties that adopt Count It! Drop It! Lock It! educational programs

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	45.0	48.0	51.0	54.0	57.0

ESM 7.3 - Percent of families who receive injury prevention education through the AAP checklist among families participating in Evidence Based Home Visiting programs

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	85.0	87.0	89.0	91.0	93.0

ESM 7.4 - Number of schools in the top ten crash rate counties (among ages 15-18) that conduct evidence-informed teen safe driving programming

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	55.0	57.0	59.0	61.0	63.0

ESM 7.5 - Number of drug disposal bins installed statewide

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	170.0	174.0	178.0	182.0	186.0

ESM 7.6 - Number of press releases, social media posts and presentations about adolescent falls

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	5.0	6.0	7.0	7.0	8.0

ESM 7.7 - Number of suicide-related articles, social media posts and trainings provided by TDH

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	6.0	7.0	8.0	9.0	10.0

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	49.4	50.7	52	53.3	54.6	55.9

Data Source: National Survey of Children's Health (NSCH) - CHILD

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	45.4 %	3.0 %	224,507	494,298
2007	35.6 %	2.6 %	169,940	477,711
2003	33.5 %	2.4 %	153,682	458,521

Legends:
 Indicator has an unweighted denominator <30 and is not reportable
 Indicator has a confidence interval width >20% and should be interpreted with caution

ESM 8.1 - Number of Gold Sneaker-recognized childcare facilities in Tennessee

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	480.0	525.0	570.0	615.0	660.0

ESM 8.2 - Average number of monthly calls to the Tennessee Breastfeeding Hotline (TBH)

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	475.0	500.0	525.0	550.0	575.0

ESM 8.3 - Number of Baby Friendly-designated Tennessee birthing hospitals

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	3.0	3.0	4.0	4.0	5.0

ESM 8.4 - Number of Run Clubs for 5th through 8th graders

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	60.0	75.0	90.0	105.0	120.0

ESM 8.5 - Number of school districts (LEAs) that received CSPAP training

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	70.0	75.0	80.0	85.0	90.0

ESM 8.6 - Number of school districts (LEAs) that received Smarter Lunchroom training

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	140.0	146.0	146.0	146.0	146.0

ESM 8.7 - Number of shared-use agreements (any type) between two or more entities in Tennessee

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	1,675.0	1,700.0	1,725.0	1,750.0	1,775.0

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 2011/12 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 FY17:

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

ESM 1: Increase the number of unique page views to the developmental milestones and developmental screening pages on kidcentraltn.com sites from 581 to 599 by September 30th, 2017.

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

Activity 1b: Utilize kidcentraltn website to promote developmental milestones and the importance of developmental screening.

Activity 1c: Continue to partner with the Child Care Resource and Referral (CCR&R) Network to promote the Learn the Signs, Act Early program.

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

ESM 2: Increase the number of health department nurses trained in the START Autism and MCHAT-R/F program from 449 to 467 by September 30th, 2017.

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.

ESM 3: Increase the number of developmental screenings performed across the state for participants enrolled in an Evidence-Based Home Visiting Program from 88% to 90% by September 30th, 2017.

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.

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

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

MCHB Partnerships: Title V Program staff will implement, monitor and improve the inclusion of developmental screenings in home visiting programs, including MIECHV.

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 burden of injuries 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 2014, the rate of hospitalizations for unintentional injuries for children age 0-9 was 103.7 per 100,000. This represents a decrease from a recent high rate of 112.2 per 100,000 in 2012. Tennessee's rate of 103.7 per 100,000 in 2014 was substantially lower than the national rate (165.3). The leading causes of

unintentional injury hospitalizations for ages 0-9 in 2014 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 FY17:

Strategy 1: Promote the use of child safety seats.

ESM 1: Increase the number of parents and caregivers receiving car seat education from 2500 to 2550 parents by September 30th, 2017.

Activity 1a: Provide funding and technical assistance to community agencies to purchase and distribute car seats. Agencies will ensure seats are installed correctly when distributing them to caregivers.

Activity 1b: Disseminate a child safety seat infographic to promote the correct use of car seats to parents and caregivers.

Strategy 2: Promote safe storage of medications.

ESM 2: Increase the number of counties that adopt Count It! Drop It! Lock It! educational programs from 37 to 45 by September 30th, 2017.

Activity 2a: Promote safe storage of medications to at least 37 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.

Activity 2b: Promote safe storage of medications through the secure medication drop off boxes. Staff will collaborate with the Tennessee Department of Environment and Conservation (TDEC) to place an additional 10 boxes in the community by September 30, 2017.

Activity 2c: Continue to utilize Title V funding to support (in part) the operation of the Tennessee Poison Center.

Strategy 3: Provide injury prevention education to parents and caregivers.

ESM 3: Among families participating in evidence based home visiting programs increase the percent of families who receive injury prevention education through the AAP checklist from 83% to 85% by September 30th, 2017.

Activity 3a: 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.

Activity 3b: Complete a child injury data report and distribute to home visiting staff and partners.

Activity 3c: Develop and distribute infographics on a minimum of 3 child injury topics.

MCHB Partnerships: MIECHV-funded home visiting programs incorporate injury prevention programming into their interactions with families.

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. The Title V Program also collaborates with the Department of Human Services to promote health standards within child care centers (including standards related to safety and injury prevention).

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 FY17:

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).

ESM 1: Increase the number of Gold Sneaker-recognized childcare facilities in Tennessee from 435 to 500 by September 2017.

Activity 1a: Recruit childcare facilities statewide by educating facility directors about the benefits of Gold Sneaker certification.

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

Activity 1c: Collaborate with the Department of Human Services to explore the possibility of adding Gold Sneaker requirements to childcare licensing standards.

Activity 1d: Develop and implement evaluation processes that support existing Gold Sneaker facilities.

Activity 1e: Initiate a Gold Sneaker advisory group to assist in the development of a re-certification process for Gold Sneaker facilities.

Activity 1f: Provide Gold Sneaker training to public health educators at the statewide health promotion meeting. Additional trainings will be provided as requested, with the goal to train at least 25 public health educators statewide.

Strategy 2: Increase support for breastfeeding initiation and duration (recognizing the impact of breastfeeding on long-term overweight/obesity risk for children).

ESM 2a: Increase the average number of monthly calls to the Tennessee Breastfeeding Hotline from 450 (FFY 2016) to 500 (FFY 2017) by September 2017.

ESM 2b: Increase the number of Baby Friendly-designated Tennessee birthing hospitals from 2 to 3 by September 2017.

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: Monitor, assess and update breastfeeding hotline messaging to ensure it remains a positive resource for mothers.

Activity 2d: Include hotline magnets or other promotional material in the "Welcome Baby" mailer that is distributed to the family of every newborn in Tennessee.

Activity 2e: Partner with the Tennessee Hospital Association (THA) to offer 20 continuing medical education credits (CMEs) to medical providers for breastfeeding education.

Activity 2f: Collaborate with THA to provide technical assistance to EMPOWER and CHAMPS grantees; support grantee hospitals' pursuit of Baby Friendly designation.

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

ESM 3: Increase the number of K-12 Run Clubs from 42 to 60 by September 2017.

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: Collaborate with the Office of Coordinated School Health and local health departments that are focusing on obesity-related primary prevention community activities to increase the number of run clubs that promote lifelong physical activity.

Activity 3c: Provide resources (toolkit and mobile application) to schools planning to implement a run

club. Promote resources through webinars, conference calls, group trainings, and other avenues as they arise.

Activity 3d: Develop and implement evaluation processes that support school-based run clubs.

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.

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 is key to Title V's promotion and support of breastfeeding in Tennessee. The Title V Program also collaborates with the Department of Human Services to promote health standards within early childhood care centers.

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 exposed to adverse childhood experiences.

Objective for 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 FY17:

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

ESM 1: Increase the number of presentations on ACEs to lay and professional audiences in Tennessee from 30 to 32 by September 30th, 2017.

Activity 1a: Under the leadership of the Title V Program staff, disseminate the Tennessee ACEs Report and present information about the CDC ACEs Study to early childhood and health

professionals in order to raise awareness of the implications of ACEs.

Activity 1b: 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 1c: 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.

Activity 1d: Provide ongoing leadership to the Tennessee ACEs Collaborative formed in 2015.

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

ESM 2: Increase the percent of primary caregivers enrolled in evidence-based home visiting programs that are screened for adverse childhood experiences from 80.0% to 81.6% by September 30th, 2017.

Activity 2a: Continue to collect Tennessee specific data such as from Evidence-Based Home Visiting Programs, and compare to state and nationally representative data sources such as BRFS.

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.

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))

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NPM 13: Percentage of children without health insurance

Interpretation of Performance Data (Form 10D): According to the University of Tennessee Center for Business and Economic Research (UTCBER), the estimated number of uninsured persons in Tennessee under 18 years of age decreased to 21,959 in 2015. This is a decrease of 14,145 from 2014 and is less than half the estimated 55,319 uninsured children in 2013. UTCBER states that this decrease coincides with the establishment of the Affordable Care Act and availability of the Health Insurance Marketplace in late 2013 through 2014.

Summary of Activities Related to Performance Measure: In Fiscal Year 2015, the Tennessee Department of Health (TDH) engaged TennCare/Medicaid eligible individuals in a variety of outreach and health department focused activities, including providing EPSDT services through all county health departments in the state; enrolling pregnant girls and women in Prenatal Presumptive Eligibility Medicaid and referring them to the Federally Facilitated Marketplace (FFM) for full Medicaid enrollment; Primary Prevention Impact Services educational outreach to parents/guardians of TennCare eligible individuals to promote the importance of EPSDT exams; and Medicaid program advocacy assistance to individuals who may be eligible for Medicaid program enrollment. Home visitation to TennCare members not up to date on EPSDT screens was discontinued due to the level of outreach already conducted to these members by TennCare Managed Care Organizations. TDH expanded participating provider agreement arrangements to include Community Health Alliance, an ACA plan, and Cigna Healthcare, an ACA and private insurance plan in the state, which expands the Department's ability to provide services, in particular vaccine services, to children throughout the state, regardless of payor status. Negotiations with other private insurance/ACA plans continued in FY2015.

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): The results provided are the CDC National Immunization Survey of 19-35 month old children results from Calendar Year 2014, published in MMWR in 2015. As defined by the CDC, the combined 7-vaccine series (4:3:1:3*:3:1:4) includes ≥4 doses of DTaP, ≥3 doses of Polio, ≥1 dose of measles-containing vaccine, Hib full series, ≥3 HepB, ≥1 Var, and ≥4 PCV. (In 2013 data, referred to as 4:3:1:4:3:1:4-FS).

Due to the modest sample size, 95% confidence intervals extend on either side of the point estimate by 7.7 percentage points. Therefore, there is no statistically significant difference in the results from the previous year's reports, with a 95% chance that the actual coverage value falls somewhere within the range of 64.1% to 79.5%.

Summary of Activities Related to Performance Measure: The entire reporting period was focused primarily upon implementation of the state's new immunization information system, TennIIS. Training and education opportunities for our users in public health and in private immunization provider included numerous in-person training sessions held in all regions of the state, as well as frequent live webinars, recorded trainings and a written user guide.

The system's go-live date was delayed from October to November 10, 2014, for technical issues. After go-live, the rest of the reporting year was spent getting the system stabilized and identifying and correcting bugs that temporarily disrupted help desk services to users and also disrupted use of the state's Immunization Certificate Validation Tool. Intensive work with the vendor eventually resolved all of these issues and by the end of the reporting period, these basic systems were working properly. A new feature, vaccine forecasting, now accurately displays vaccines due or overdue for any child, based upon their TennIIS immunization record. Vaccine forecasts improve the quality of immunization services by reducing the chances of missed opportunities or improperly timed vaccines.

Several staff had to be dedicated to re-establishing active data exchange with our immunization data trading

partners, including many clinics, hospitals and all health departments. Once existing partners were re-connected, our focus turned to onboarding of new electronic immunization data exchange partners. We were awarded a PPHF Interoperability Grant from the CDC to support accelerated work to onboard new partners. These initiatives represent the most efficient way to increase the quality and quantity of immunization data in TennNIS, which, in turn, will improve vaccine forecasts for each patient and make the system increasingly valuable in ensuring quality immunization care to all persons in Tennessee.

Work also continues on the promotion of HPV vaccine through the Cervical Cancer Free TN initiative that includes a close partnership between Immunization and the TDH Breast and Cervical Cancer Program and other community partners. During the reporting year we collectively put on two Teal for Two educational conferences for healthcare providers, covering cervical cancer screening and effective HPV vaccination strategies. The TIP Director continues to speak regularly to other professional groups to promote vaccination of children, teens and adults, with a focus on influenza, HPV and vaccines for pregnant women. Audiences during this reporting period included the state Academy of Pediatrics, state Academy of Family Physicians, state School Nursing Association and state public health women's health practitioners.

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): In 2008, the Tennessee Department of Health (TDH), Oral Health Services Section conducted a statewide oral health survey of a sample of children ages 5-11 years, representing approximately 551,000 Tennessee children in this age group. The survey goals were to establish age-specific data for the prevalence of dental caries, sealants, dental injuries, estimates of treatment needs and to describe variations according to age, sex, race, and socioeconomic status. Oral Health Services has planned to conduct this type of survey every 5 years, but staffing has not permitted.

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 2015 (July 1, 2014-June 30, 2015) 81,728 children received a dental screening/exam with 15,519 children being referred for dental services, because of unmet dental needs. 186,168 children were provided dental education information and 24,267 were provided with a fluoride varnish application. 49,125 children received dental sealants with a total of 298,345 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 42 fixed and 1 mobile dental clinic providing dental services during FY 2015. 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 2015 the TDH dental clinics provided 20,879 children and 6,799 adults with 199,618 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 2015 the Cavity Free In Tennessee provided services to 17,019 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 38.6% of K-12 students were overweight or obese in the 2014-15 school year. Over the past three years, Tennessee students have shown a small, statistically insignificant decrease in the overall overweight/obesity prevalence.

Summary of Activities Related to Performance Measure: The Breastfeeding Welcomed Here campaign continues to be successful. Between October 1, 2014 and September 30, 2015 211 new businesses took the pledge to be a Breastfeeding Welcomed Here site. Education and support was provided to all 65 OB hospitals to improve breastfeeding rates and outreach/education. Monthly OB webinars were provided for hospital staff. Four hospitals were recruited to participate in the EMPower Breastfeeding Initiative based on their readiness toward Baby Friendly designation. THA hosts monthly calls with these (4) hospital directors to share strategies and ideas in overcoming barriers.

TDH partnered with TIPQC to support participation in the Wave 2 breastfeeding quality improvement collaborative project. Since the Wave 2 Hospital Collaborative Kick-off, 30 hospitals have enrolled in the TIPQC collaborative (representing 73.1% of all TN births). Hospitals are in the process of tracking compliance regarding adherence to Baby Friendly policies. Working in partnership with TDH, subscriptions were purchased by THA for 1,000 users to access 20 hours of online lactation education for hospital staff and providers at no charge to the individual user. The online course is provided through a license with University of Virginia. This online lactation education meets the 20 hour educational requirement for Baby Friendly USA designation. These hours also apply towards CLC and IBCLC certification/re-certification. To date, over 900 individuals have been enrolled in the education modules. Additional subscriptions may be purchased in Year 3 to further expand education for staff and expand training opportunities to physicians. Additionally, five webinars were completed between March 2015 and January 2016 and on May 29, 2015, a Baby Friendly workshop was attended by 54 individuals representing 22 hospitals or health systems.

Gold Sneaker continues to be promoted through multiple TDH programs including through the Chronic Disease Prevention and School Health grant, the Preventive Health and Health Services Block grant, the Tobacco Prevention grant and through the TDH Primary Prevention Initiative. Between October 1, 2014 and September 30, 2015 86 new licensed child care facilities were designated as Gold Sneaker sites. The program is also in the process implementing an evaluation strategy and developing a recertification process.

Partnerships with Parks and Recreation has continued; PHEs continue to promote the online "Park Location Finder" and "Recreational Joint Use Agreement Finder" tools developed by the TN Recreation and Parks Association (TRPA) to communities, health care, and schools to encourage physical activity. A barrier to the "Park Location Finder" website is that it is not routinely updated by TRPA.

Efforts with State Parks include a partnership with Henry Horton State Park, which has completed the initial scoring process to become REAL Certified with Eat REAL Tennessee (part of the United States Healthful Food Council - USHFC). Other state park restaurants are in the planning and preparation stages for future Eat REAL Tennessee scoring. The USHFC developed Responsible Epicurean and Agricultural Leadership (REAL) Certified to be the trusted, nationally recognized mark of excellence for food and foodservice operators committed to holistic nutrition and environmental stewardship.

The Junior Ranger program, encouraging children to get outside and play, continues as do Run Clubs at state parks. Currently there are twelve state park lead run clubs engaging 36 schools and 508 club and event participants.

State funded Project Diabetes grants continue. The smaller two-year Project Diabetes grants ended June 30, 2015; however there have still been 16 larger grants working on their third year deliverables. Those grants will end June 30, 2016. Approximately 36 new grantees will initiate their contracts starting July 1, 2016.

In partnership with the Department of Education a meeting was held in September 2015 attended by school cafeteria managers, PHEs and Coordinated School Health coordinators. School nutrition strategies were discussed and success stories from each county were highlighted. PHEs continue working on program-level (nutrition education) and system-level work (Smarter Lunchroom Movement) in partnership with LEAs. Also, TDH staff work closely with both Coordinated School Health as well as School Nutrition to promote SLM and other health food and beverage access/consumption strategies.

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): Overall in 2015, 30.4 percent of WIC child participants (aged 2 to less than 5 years) had a BMI at or above the 85th percentile. Since 2011, the proportion of WIC child participants who are overweight or obese has remained stagnant.

Summary of Activities Related to Performance Measure: Central Office WIC staff provided region-specific reports on overweight and obesity for children 2 years through 4 years of age. At the annual WIC field staff meeting a presentation on the data was given by the newly hired Epidemiologist. Additionally, a Nutrition Intern from the University of Tennessee provided a presentation on barriers to service for children after 1 year of age. The Intern identified modifiable and non-modifiable issues which were reported during phone interviews and focus groups. Field staff also received a review of the use of the Auto Growth Chart and the need for accuracy in data entry.

Core nutrition messages provided by USDA were included on WIC food instruments for all children one through 4 years of age. "My Plate" materials were used to assist with nutrition education activities. Age appropriate physical activity information was also provided to families during nutrition education sessions. The nutrition education sessions included face-to-face and groups for high risk participants and groups and online sessions for low risk participants.

An online module for "safe sleep and breastfeeding" was developed in collaboration with the Injury Prevention section and WIC breastfeeding staff.

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): The rate of asthma-related emergency department visits declined over the previous five-year block grant reporting cycle. There was variation in the year-to-year trends but with this outcome, it is likely more appropriate to look at longer-term trends rather than year-to-year variation. Individual year circumstances (such as severity of the influenza season) may influence emergency department visit rates despite other improvements in the care of children with asthma.

Summary of Activities Related to Performance Measure: In October 2014, TDH continued to lead the statewide celebration of Child Health Week (in conjunction with National Child Health Day). During the week, the Department's social media outreach included asthma awareness and education messages.

Throughout the year, TDH staff provided asthma education and technical assistance to home visitors, tobacco

settlement teams, county level wellness committees, program staff, professional groups and others as needed in the form of presentations, consults, print materials, teleconferences, and webinars.

Central Office as well as regional/local health department staff continued to promote use of the Tobacco QuitLine, as cigarette smoke is a known trigger for asthma exacerbations.

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

In summer 2015, MCH staff facilitated the first meeting of a reconstituted statewide asthma collaborative, consisting of stakeholders from across the state including: primary care providers, hospital-based providers, family representatives, payors (including the state Medicaid agency), Coordinated School Health, and public health staff. The group held a brainstorming session to identify priority areas for focus during the coming year. Two priorities identified were the need to create statewide asthma action plan standards and to work with Coordinated School Health to develop a single medication form for all school districts.

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

Adolescent Health

State Action Plan Table

State Action Plan Table - Adolescent Health - Entry 1

Priority Need

Reduce the burden of injury among children and adolescents.

NPM

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

Objectives

By FY2020, reduce hospitalization rates for unintentional injuries among adolescents age 10-19 to 128.1 per 100,000.

Strategies

Increase evidence based or evidence informed activities related to motor vehicle safety being implemented in schools.

Increase awareness of proper storage and disposal of medications.

Increase general awareness of the causes of adolescent hospitalizations due to falls.

Increase awareness of the signs and risk factors of suicide attempts.

ESMs

ESM 7.1 - Number of parents and caregivers receiving car seat education

ESM 7.2 - Number of counties that adopt Count It! Drop It! Lock It! educational programs

ESM 7.3 - Percent of families who receive injury prevention education through the AAP checklist among families participating in Evidence Based Home Visiting programs

ESM 7.4 - Number of schools in the top ten crash rate counties (among ages 15-18) that conduct evidence-informed teen safe driving programming

ESM 7.5 - Number of drug disposal bins installed statewide

ESM 7.6 - Number of press releases, social media posts and presentations about adolescent falls

ESM 7.7 - Number of suicide-related articles, social media posts and trainings provided by TDH

NOMs

NOM 15 - Child Mortality rate, ages 1 through 9 per 100,000

NOM 16.1 - Adolescent mortality rate ages 10 through 19 per 100,000

NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000

NOM 16.3 - Adolescent suicide rate, ages 15 through 19 per 100,000

State Action Plan Table - Adolescent Health - Entry 2

Priority Need

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

NPM

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

Objectives

By FY2020, reduce the percentage of students in grades 9-12 identified as overweight/obese from 40.6% (2012-2013) to 38.6%.

Strategies

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.

ESMs

ESM 8.1 - Number of Gold Sneaker-recognized childcare facilities in Tennessee

ESM 8.2 - Average number of monthly calls to the Tennessee Breastfeeding Hotline (TBH)

ESM 8.3 - Number of Baby Friendly-designated Tennessee birthing hospitals

ESM 8.4 - Number of Run Clubs for 5th through 8th graders

ESM 8.5 - Number of school districts (LEAs) that received CSPAP training

ESM 8.6 - Number of school districts (LEAs) that received Smarter Lunchroom training

ESM 8.7 - Number of shared-use agreements (any type) between two or more entities in Tennessee

NOMs

NOM 19 - Percent of children in excellent or very good health

NOM 20 - Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)

Measures

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	184.8	176.4	168	159.6	151.2	142.8

Data Source: State Inpatient Databases (SID) - ADOLESCENT

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	210.0	5.0 %	1,791	852,895
2012	215.9	5.1 %	1,819	842,692
2011	267.8	5.7 %	2,227	831,562
2010	284.6	5.9 %	2,327	817,574
2009	301.7	6.1 %	2,469	818,450
2008	333.2	6.4 %	2,694	808,454

Legends:
 Indicator has a numerator ≤10 and is not reportable
 Indicator has a numerator <20 and should be interpreted with caution

ESM 7.1 - Number of parents and caregivers receiving car seat education

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	2,550.0	2,600.0	2,650.0	2,700.0	2,750.0

ESM 7.2 - Number of counties that adopt Count It! Drop It! Lock It! educational programs

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	45.0	48.0	51.0	54.0	57.0

ESM 7.3 - Percent of families who receive injury prevention education through the AAP checklist among families participating in Evidence Based Home Visiting programs

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	85.0	87.0	89.0	91.0	93.0

ESM 7.4 - Number of schools in the top ten crash rate counties (among ages 15-18) that conduct evidence-informed teen safe driving programming

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	55.0	57.0	59.0	61.0	63.0

ESM 7.5 - Number of drug disposal bins installed statewide

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	170.0	174.0	178.0	182.0	186.0

ESM 7.6 - Number of press releases, social media posts and presentations about adolescent falls

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	5.0	6.0	7.0	7.0	8.0

ESM 7.7 - Number of suicide-related articles, social media posts and trainings provided by TDH

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	6.0	7.0	8.0	9.0	10.0

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	26.9	27.7	28.5	29.3	30.1	30.9

Data Source: Youth Risk Behavior Surveillance System (YRBSS) - ADOLESCENT

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	25.4 %	1.5 %	62,206	244,725
2011	30.2 %	1.3 %	85,505	283,153
2009	24.2 %	1.1 %	68,868	284,213
2007	24.3 %	1.2 %	71,018	291,987

Legends:
 Indicator has an unweighted denominator <100 and is not reportable
 Indicator has a confidence interval width >20% and should be interpreted with caution

Data Source: National Survey of Children's Health (NSCH) - ADOLESCENT

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	23.9 %	2.5 %	120,480	504,540
2007	24.3 %	2.3 %	120,039	494,076
2003	17.7 %	1.8 %	81,588	462,165

Legends:
 Indicator has an unweighted denominator <30 and is not reportable
 Indicator has a confidence interval width >20% and should be interpreted with caution

ESM 8.1 - Number of Gold Sneaker-recognized childcare facilities in Tennessee

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	480.0	525.0	570.0	615.0	660.0

ESM 8.2 - Average number of monthly calls to the Tennessee Breastfeeding Hotline (TBH)

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	475.0	500.0	525.0	550.0	575.0

ESM 8.3 - Number of Baby Friendly-designated Tennessee birthing hospitals

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	3.0	3.0	4.0	4.0	5.0

ESM 8.4 - Number of Run Clubs for 5th through 8th graders

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	60.0	75.0	90.0	105.0	120.0

ESM 8.5 - Number of school districts (LEAs) that received CSPAP training

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	70.0	75.0	80.0	85.0	90.0

ESM 8.6 - Number of school districts (LEAs) that received Smarter Lunchroom training

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	140.0	146.0	146.0	146.0	146.0

ESM 8.7 - Number of shared-use agreements (any type) between two or more entities in Tennessee

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	1,675.0	1,700.0	1,725.0	1,750.0	1,775.0

Adolescent Health - Plan for the Application Year**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 2014, the rate of hospitalizations for unintentional injuries for adolescents age 10-19 was 137.0 per 100,000. This represents a decrease from a recent high rate of 171.8 per 100,000 in 2010. Tennessee's rate of 137.0 per 100,000 in 2014 was substantially lower than the national rate (185.0). 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 2014 was motor vehicle crashes, accounting for 41% of all hospitalizations. Falls account for 14% of unintentional injury hospitalizations for this age group. 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 FY17:

Strategy 1: Increase evidence based or evidence informed activities related to motor vehicle safety being implemented in schools.

ESM 1: Increase the number of schools in the top ten crash rate counties (among ages 15-18) that conduct evidence-informed teen safe driving programming from 45 to 55 by September 30th, 2017.

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 30 to 40.

Activity 1b: Partner with 7 trauma centers and 20 school districts to conduct the Battle of the Belt program to increase observed seatbelt use among adolescents age 10-19.

Activity 1c: Partner with schools to provide Graduated Driver's License education to 1000 teens and caregivers.

Strategy 2: Increase awareness of proper storage and disposal of medications.

ESM 2: Increase the total number of drug disposal bins installed statewide from 145 to 170 by September 30th, 2017.

Activity 2a: Partner with the Coffee County Anti-Drug Coalition to recruit 8 additional 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 88 counties to 90 counties.

Activity 2c: Continue to utilize Title V funding to support (in part) the operation of the Tennessee Poison

Strategy 3: Increase general awareness of the causes of adolescent hospitalizations due to falls.

ESM 3: Increase the number of press releases, social media posts and presentations about adolescent falls from 5 to 6 by September 30th, 2017.

Activity 3a: Issue press releases and social media announcements about adolescent falls during fall prevention week.

Activity 3b: Collaborate with TDH Office of Communications to integrate routine social media postings (e.g. Facebook, Twitter) around topics that cause adolescent falls such as sports.

Activity 3c: Participate in the child safety CoIIN to decrease falls due to sports.

Strategy 4: Increase awareness of the signs and risk factors of suicide attempts.

ESM 4: Increase number of articles, social media posts and trainings provided by TDH from 5 to 6.

Activity 4a: Provide Question, Persuade and Refer (QPR) trainings to TDH staff by offering lunch and learn sessions.

Activity 4b: Disseminate referral resources to school staff for students exhibiting signs of suicidal behavior.

Activity 4c: Post social media messages on Facebook and Twitter during suicide prevention awareness month.

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))

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 FY17:

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

ESM 1a: Increase the number of school districts that have received the Comprehensive School Physical Activity Program (CSPAP) training [from 65] to 70 by September 2017.

ESM 1b: Increase the number of school districts or Local Education Agencies that have received the Smarter Lunchroom training [from 135] to 140 by September 2017.

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.

Activity 1c: Develop and implement evaluation processes that support increased physical activity before, during and after school; increase access to healthier food and beverage options.

Activity 1d: Assess level of implementation, attitudes, and knowledge among schools and staff that have participated in the Smarter Lunchroom Movement. Results will further inform strategies and determine where follow-up technical assistance is needed.

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

ESM 2: Increase the number of joint-use policies (any type) [from 1650] to 1700 by September 2017.

Activity 2a: 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))

Adolescent Health - Annual Report

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 2014, the teen birth rate in Tennessee decreased significantly, from 20 births per 1,000 girls aged 15-17 years old to 12/1,000. This represents almost 1000 fewer teen births among this age group in 2013 compared to 2010. However, in 2014, the teen birth rate in Tennessee was still higher than in the United States as a whole.

Summary of Activities Related to Performance Measure: MCH programs offered clinical and educational services to the adolescent population, in addition to offering support, technical assistance, and training to community agencies and other groups working towards lowering teen pregnancy and birth rates.

The Tennessee Adolescent Pregnancy Prevention Program (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 contact/resource persons for adolescent pregnancy issues in their respective areas. All TAPPP Coordinators were involved in county healthy councils which were broadly representative of the surrounding community. Each council participated in a wide range of activities, depending on local priorities and resources. Health educators provided community education and awareness activities for youth, adults, professionals and parents. These activities included school and community presentations, community events and media campaigns. Data for FY 14-15 showed that statewide staff provided family life education, abstinence education, positive youth development, growth and development and healthy relationships programs to 26,669 adolescents (13-17 years) and 11,337 children (<13); provided education and training to 3,727 adults; worked with 8,326 teen and adult parents and provided training to 1,626 professionals.

The Abstinence Education Grant Program (AEGP) provided comprehensive, evidence-based, age appropriate and medically accurate educational programs to middle school aged children (10-14 years) expanding to high school. The programs adhered to the federal A-H guidelines and used approved curricula that covered: abstinence as a life style choice, educated decision-making, healthy relationships, refusal skills, positive youth development and leadership for service. Service learning projects were conducted to emphasize community involvement, support for local organizations and promotion of school and community volunteerism. On October 17, 2014, AEGP received \$1,171,086 from the U.S. Department of Health and Human Services to implement abstinence education through September 30, 2016.

The Family Planning Program provided contraceptive education and clinical services in 128 sites statewide. Services provided included: medical examinations, laboratory tests, counseling, contraception, Pap smears, sexually transmitted infection (STI) screening and treatment, and cancer screening. The Reproductive and Women's Health Section of MCH provided a Spring Update Training for approximately 240 nursing staff, physicians and other medical providers covering: LARCs for teens, STD guidelines, HPV vaccine uptake and contraceptive

management. Teens were considered a priority population and were a focus for outreach efforts.

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): The rate of motor vehicle fatalities among children ages 14 and under has fluctuated throughout the last five years starting with a rate of 2.5 in 2010 that decreased to a low 1.7 in 2012. The most recent preliminary data indicates the rate is 2.1 deaths per 100,000 children for 2015.

Summary of Activities Related to Performance Measure: During the reporting year, there were 526 infant restraint systems distributed, 961 convertible seats distributed, 398 combination child seat/booster seats distributed, and 438 booster seats distributed by 29 agencies. The total number of child restraint devices distributed was 2,337. All funded agencies are required to have a child safety seat technician on staff and assist the parent/guardian to ensure the seats are installed correctly when they distribute them. In addition, many of the funded agencies have conducted child safety seat fitting clinics in which parents come to ensure their seat is installed correctly.

The Ollie the Otter program teaches booster seat and seat belt education to elementary school students in classrooms in all 95 counties and completes over 350 school and community events annually. Currently, there are 24 Ollie Otter mascots active across Tennessee, and approximately 300 seat belt safety advocate volunteers are trained annually to implement programs. From October 1, 2014 to September 30, 2015, 394 events were held with a total attendance of 88,022. Tennessee Tech University, which manages the program, estimates that approximately 55,000 of those were ages 14 and under.

The Injury Prevention Planning Group works closely with the Safe Kids Coalition (Cumberland Valley) Leaders, Governor's Highway Safety Office, Coordinated School Health, Tennessee Commission for Children and Youth, Tennessee Highway Patrol and others to promote child restraint education and enforcement to coalition leaders during quarterly meetings and to community stakeholders. The Safe Kids Coalition of Cumberland Valley is represented on the statewide injury coalition and has partnered with the Nashville Police Department, Local Fire Departments, Governor's Highway Safety Office, EMS, and others to support six child safety seat trainings, serving approximately 50 families from October 2014 to September 2015.

The Injury Prevention Coalition also maintains a Policy Subcommittee which met quarterly in 2014-2015. The policy subcommittee monitored policy regarding injury, including child safety seat policy. No changes were proposed to the policy in 2014-2015.

A child motor vehicle crash Infographic was developed to highlight data on child deaths and restraint use. The infographic highlights statistics related to motor vehicle crash deaths of children ages 0-17 including gender, restraint use and top locations of crashes. The infographic was distributed to key stakeholders involved with motor vehicle crash prevention.

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

Interpretation of Performance Data (Form 10D): The rate of death due to suicide for ages 15-19 has increased from a rate of 7.1 in 2010 to 10.7 in 2014. This trend mirrors the national trend which also shows an increase in deaths due to suicide.

Summary of Activities Related to Performance Measure:

TDH has continued to partner with the Tennessee Suicide Prevention Network (TSPN) and the Department of Mental Health to provide education to schools and the community. The TDH injury epidemiologist gathered data and statistics for the two groups to utilize during presentations. TDH injury epidemiologist also completed an annual report on suicide for Department of Mental Health. In addition, an infographic on deaths due to child suicide was created and distributed to community partners and state agencies to increase awareness of suicide deaths among children. TDH also participated in the CDC "one picture, five words" suicide prevention social media campaign. The campaign required agencies to take a picture and only use five words to represent suicide prevention awareness.

Suicide has continued as one of the topics the local health departments can choose for their primary prevention initiative (PPI) projects. In the reporting timeframe, there were 3 projects completed and 12 projects that were started and are ongoing. Projects included activities such as partnering with the Tennessee Suicide Prevention Network (TSPN) to procure Suicide Prevention Month Awareness proclamations, participating in a middle school health fair to distribute materials with a suicide prevention message and creating awareness with messages on billboards for suicide prevention awareness month.

TDH staff has continued to serve on the state's intra departmental suicide prevention committee. The committee has explored ideas for increasing signs of suicide among TDH employees. The TDH representative on the committee attended training to become a certified Question, Persuade and Refer (QPR) trainer.

The TSPN executive director has continued to serve as a member of the child fatality review team. In addition, he provided a webinar presentation for the local child fatality review team members on how to become involved in suicide prevention in their local community.

TDH staff has continued to assist TSPN with activities and evaluation by providing the most current suicide statistics. In addition TDH staff provides data analysis and interpretation. TDH staff has also analyzed preliminary emergency department data to determine emerging trends in suicide attempts.

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, as well as legal restrictions within schools. 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.

Children with Special Health Care Needs

State Action Plan Table

State Action Plan Table - Children with Special Health Care Needs - Entry 1

Priority Need

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

NPM

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

Objectives

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)

Strategies

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, Tennessee's Title V CYSHCN program.

ESMs

ESM 11.1 - Number of providers trained and provided information on medical home implementation

ESM 11.2 - Number of families that receive patient centered medical home training

ESM 11.3 - Percentage of children served by the Children's Special Service (CSS) program receiving services in a medical home

NOMs

NOM 17.2 - Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system

NOM 19 - Percent of children in excellent or very good health

NOM 22.1 - Percent of children ages 19 through 35 months, who completed the combined 7-vaccine series (4:3:1:3*:3:1:4)

NOM 22.2 - Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza

NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

State Action Plan Table - Children with Special Health Care Needs - Entry 2

Priority Need

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

NPM

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

Objectives

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)

Strategies

Support youth participation in the transition process.

ESMs

ESM 12.1 - Number of adolescents on the Adolescent Advisory Council

NOMs

NOM 17.2 - Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system

NOM 19 - Percent of children in excellent or very good health

Measures

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

Annual Objectives

	2016	2017	2018	2019	2020	2021
Annual Objective	61.6	63.1	64.7	66.3	68	69.7

Data Source: National Survey of Children's Health (NSCH) - CSHCN

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	49.9 %	3.6 %	174,136	348,790
2007	53.0 %	3.4 %	168,486	317,776

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: National Survey of Children's Health (NSCH) - NONCSHCN

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	63.4 %	1.9 %	694,074	1,095,699
2007	63.8 %	1.8 %	694,993	1,088,681

Legends:
 Indicator has an unweighted denominator <30 and is not reportable
 Indicator has a confidence interval width >20% and should be interpreted with caution

ESM 11.1 - Number of providers trained and provided information on medical home implementation

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	475.0	525.0	575.0	625.0	675.0

ESM 11.2 - Number of families that receive patient centered medical home training

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	307.0	337.0	367.0	397.0	427.0

ESM 11.3 - Percentage of children served by the Children's Special Service (CSS) program receiving services in a medical home

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	80.0	85.0	90.0	95.0	100.0

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	2021
Annual Objective	42.8	43.9	45	46.1	47.3	48.5

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	41.8 %	3.8 %	40,413	96,752
2005_2006	39.6 %	3.1 %	34,477	87,141

Legends:

- 🚩 Indicator has an unweighted denominator <30 and is not reportable
- ⚡ Indicator has a confidence interval width >20% and should be interpreted with caution

ESM 12.1 - Number of adolescents on the Adolescent Advisory Council

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	5.0	7.0	9.0	11.0	13.0

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

PRIORITY: Increase the number of children (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 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 FY17:

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

ESM 1: Increase the number of providers trained and provided information on medical home

implementation from 420 to 475 by September 30th, 2017.

Activity 1a: The CYSHCN program will continue partnering with Tennessee Chapter of the American Academy of Pediatrics and the Tennessee Academy of Family Physicians to provide opportunities for training and National Committee for Quality Assurance (NCQA) certification as patient centered medical homes to eligible providers and facilities.

Activity 1b: CYSHCN staff will collaborate with the National Center for Medical Home Implementation and utilize "Got Transition" to provide technical assistance to the CYSHCN program and providers on developing transition policies.

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

Activity 1d: CYSHCN staff will partner with Family voices to support practices and provide opportunities to develop and implement family engagement policies.

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

ESM 2: Increase the number of families that receive patient centered medical home training from 279 to 307 by September 30, 2017.

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 and refer families to the Parent to Parent program and to provide families with information and support on accessing ongoing, comprehensive care in a medical home.

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.

Activity 2e: CYSHCN staff will continue to partner with Tennessee Chapter of the American Academy of Pediatrics, Tennessee Academy of Family Physicians, Family Voices, Tennessee Voices for Children and the Department of Mental Health and Substance Services to provide educational opportunities on the availability of behavioral health resources.

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

ESM 3: Increase the percentage of children served by the CSS program receiving services in a medical home from 60% to 80% by September 30th, 2017.

Activity 3a: Provide training and care coordination resources to assist families to identify and access medical homes.

Activity 3b: Utilize the results of the CSS program participant satisfaction survey to increase medical home utilization.

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: CSS program staff will work with youth to complete the Transition Readiness Assessment tool.

Strategy 4: Support youth participation in the transition process.

ESM 4: Maintain and expand the youth advisory council by September 30th, 2017.

Activity 4a: CYSHCN program staff will collaborate with Family Voices and LEND to recruit and retain members to serve on 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.

Activity 4d: CYSHCN will add a link to the Transition Took Kit to the Kidcentraltn website.

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: 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 support family participation in advocacy and policy development, to support and promote the parent to parent network that provides mentoring and support to other families of CYSHCN and to support and provide opportunities for parent and family training and participation. The partnership with TNAAP includes support for training of 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. The CYSHCN program has also partnered with the Tennessee Department of Mental Health and Substance Abuse Services to identify and disseminate best practice models of primary care and behavioral health integration. The CYSHCN program is partnering with TennCare to ensure that children have access and are receiving services in a patient centered medical home. The CYSHCN Director collaborates with TEIS by chairing the State Interagency Coordinating Committee. This committee creates the TEIS strategic plan and reviews the annual report that is required by the U.S. Department of Education. The CYSHCN Director has also provided training to the TEIS staff on when to refer children to CSS.

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 2: The percent of children with special health care needs age 0 to 18 years whose family partners 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: A Parent Summit was held where parent leaders from across the state received training from a nationally recognized parent leader. Training, workshops and one on one coaching and mentoring on partnering in the decision making process for families of children and youth with special health care needs were also held. The trainings and workshops were facilitated by CYSHCN and Family Voices staff. One-on-one coaching and mentoring trainings were held as a part of the Parent-to-Parent Network and occurred state wide at Monroe Carrel Jr. Children's Hospital at Vanderbilt, Centennial Children's Hospital, Erlanger Children's Hospital, LeBonhuer Children's Hospital and East Tennessee Children's Hospital. In partnership with the Multi-Cultural Alliance of Vanderbilt Pathfinders, a one day training for Egyptian families was also held to train parents how to partner in the decision making process.

The CSS Advisory Committee includes one parent/consumer representative. However at the regular meetings, parents from Family Voices and also the CYSHCN Family Delegate attend and provide valued input into the policy discussions. The CYSHCN program was also represented at AMCHP by a Family Delegate and the state also was represented by a family scholar.

Web-based care coordination training and educational resources have been developed and are housed on TNAAP's website accessible at: http://tnaap.org/tennessee_medical_home/carecoordination#resources. Providers are notified of the resources at regularly scheduled meetings and through email and other promotional material.

The satisfaction survey for CSS participants and families has been developed, data cleaned and actual phone surveys conducted. However there are still several activities related to the survey that must be completed prior to the final data analysis and report.

CSS program staff continued to provide resources for eligible program participants on how to partner in the decision making process and interact with health care providers.

The D70 Grant provided for three contracted parent/youth consultant positions. The addition of these positions provided additional opportunities for parents and families to receive training and coaching on the decision-making

process. The consultants served as a resource for other parents and assisted parents in navigating the health care system and provided on-going recommendations to incorporate parental input into program operations. The parent/youth consultants conducted workshops and participated in conferences and workshops designed to engage other parents and youth leaders, and provide the family voice in decision making processes.

Collaborations with state agencies and advisory committees continued with a major focus on service delivery improvement and development of streamlined programmatic policy for children and youth with special health care needs.

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: CSS program staff provided care coordination for eligible CSS program participants and provided educational information to health care providers in their local counties. CYSHCN program staff in conjunction with the Early Childhood staff and local care coordinators partnered to develop an integrated care coordination model for the health department home visitation and care coordination programs. This group continues to meet and have established some common themes and forms that can be integrated into all programs. CYSHCN staff met with several child serving agencies providing services to CYSHCN and have been instrumental in coordinating efforts with other agencies and health care providers to develop a statewide standard care plan notebook for all CYSHCN. The electronic Medical Home Tool Kit has been updated and is promoted as a referral source for providers and families. The CSS program staff provided this information to families and providers in an effort to create awareness of the medical home concept. The toolkit is housed on TNAAP's web site and is accessible at: <http://www.tennesseehome.com/tnaap/>. The site is also linked from the CYSHCN web site at: <http://tn.gov/health/article/MCH-cyshcn-integrated>. Staff continued to promote the Medical Homes 101: Building Medical Homes That Work - presentation developed by Family Voices of Tennessee as a resource for families and CYSHCN through the patient and family centered trainings and workshops. CYSHCN coordinated collaborative efforts with insurance and health care providers to establish medical homes and payment sources for CYSHCN, and continue to assist families to identify and access medical homes. Trainings were held state-wide in pediatric hospitals and pediatric resident programs. Medical Home presentations were also conducted at the Tennessee Young Child Wellness Council, the Tennessee Primary Care Association and to private provider offices. The second Medical Home Summit focusing on Culturally Effective Care looking at the culture of family/provider partnerships and family engagement was held. Over 60 individuals participated in the summit; at least one-third were physicians. Tennessee Pediatric Society Foundation (TPSF) staff were trained and certified as NCQA Content Experts and continued to provide training and assist other health care providers in the state to become certified medical homes.

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: CYSHCN staff provided notification to all CSS staff and sent notices to other advocacy agencies of open enrollment for the Health Insurance Market Place. Program staff provided training and information to the local admissions and billing staff of several children's hospitals on emergency Medicaid applications and worked with families to ensure that adequate insurance was available for treatment and services.

CSS program staff conducts a routine assessment of needs during the application process and assist families with application for insurance both private and public.

CSS program staff continued to conduct outreach and marketing activities on the local and regional level by meeting with health care providers, hosting back to school events and attending community events geared towards children and families. State CYSHCN staff has collaborated with other state and community agencies to identify activities and provide opportunities to provide notification of available resources. CYSHCN partnered with the Tennessee Council on Developmental Disabilities and the Tennessee Department of Intellectual and Developmental Disabilities around family support activities and provided a list of available resource to all attendees.

The CSS program as a payor of last resort provided medical reimbursement for medical services to eligible program participants as necessary.

Parent and Youth Consultants at Family Voices assisted other families to become self-advocates for insurance benefits by notifying them of open enrollment and also assisting with applying for TennCare and other available insurance resources.

The state-wide Parent Summit provided breakouts on insurance benefits and health care coverage for families of CYSHCN.

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: Training and workshops for families of children and youth with special health care needs were conducted to develop and increase parents' knowledge of navigating health care and community support systems. One-on-one coaching was also provided to assist families in accessing needed medical services and follow-up sessions were conducted to determine if the services were easily accessible or useful. These trainings and workshops were facilitated by CYSHCN staff and Family Voices staff. Trainings were held at Monroe Carrel Jr. Children's Hospital at Vanderbilt, Centennial Children's Hospital, the Multi-Cultural Training Alliance and a Parent Summit was held where parent leaders from across the state received training from a

nationally recognized parent leader.

The satisfaction survey for CSS participants and families has been developed, data cleaned and actual phone surveys conducted. However there are still several activities related to the survey that must be completed prior to the final data analysis and report.

CYSHCN has partnered with Family Voices and Vanderbilt LEND to develop a youth advisory committee. LEND faculty and students developed a project aimed at forming the committee. Preliminary activities, including identifying advisory groups currently in existence and recruiting members to serve in this capacity, have been completed.

CSS program staff continued to participate in statewide health fairs and community resource fairs. Staff also attended parent teacher conferences at schools and visited doctor's offices and other community agencies in an effort to increase awareness of services for children and families.

CSS program staff continue to work with the Early Childhood Section in the Family Health and Wellness Division and other internal and external partners including the Tennessee Autism Planning Team, Tennessee Disability Pathfinders staff and the Department of Intellectual and Developmental Disabilities, to develop a community based system of services that is accessible and organized for ease of use.

The CYSHCN director continued to work towards identifying challenges and barriers to providing services in certain areas of the state and provided improvement strategies when barriers identified.

A contract was executed with Vanderbilt Kennedy Center - Pathfinders to the house the electronic resource directory on their existing site. This provided an opportunity for families, community agencies and health care providers to access the community based resource guide and additional resources for families, children and youth with special needs.

CYSHCN, Tennessee Pediatric Society Foundation (TPSF) and Family Voices continued to hold strategic planning meetings and develop opportunities to provide outreach efforts on cultural diversity and collaborated on identifying and building a stronger system of community based services.

Care Coordination standards, training and best practices were developed and provided to public and private providers to help families navigate community based services.

The Tennessee Parent to Parent Network program was launched statewide and provides parent matching, one-on-one mentoring and training in self-advocacy for parents and CYSHCN.

Family Voices staff conducted the Title V Needs Assessment for parents and families of CYSHCN and assisted in selecting the NPMS for the Block Grant.

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 and the Early Childhood staff have partnered with local health department staff to create a care coordination integration model for all health department care coordinators. As part of this model, care coordination standards are being developed. These standards will include transition services for youth age 14 and older.

The CYSHCN Director, the D70 Director and the CSS Program director collaborated with state and local agencies to develop a transition toolkit that can be used across agencies that provide services for children with special needs. Those agencies included Family Voices, Tennessee Pediatric Society Foundation, Tennessee Council on Developmental Disabilities, Tennessee Department of Intellectual and Developmental Disabilities, Tennessee Department of Mental Health and Substance Abuse Services and The Tennessee Department of Children's Services.

This collaborative effort has identified several toolkits that are available and have provided that information to families and providers. The CYSHCN section has also provided the "Got Transition" tip sheets to health care providers and care coordinators. Links to many of the resources are included on the CYSHCN website at <https://www.tn.gov/health/article/MCH-cyshcn-css>.

A Transition Summit was held on April 24, 2015. The conference focused on medical transition from pediatric to adult providers. Breakout sessions included topics around elements of successful transition. Conference attendees included health care providers, care coordinators, families and youth who conducted a transition forum and provided their personal experiences with transitioning from pediatric to adult providers. Dr. Carl Cooley, co-founder and former director of Got Transition, the National Health Care Transition Center, presented during the summit.

CSS program staff continued to develop age appropriate transition plans for all participants age 14 and older and provided the Health History Summary Form to all participants with a transition plan. CSS program staff also worked with local providers to ensure that youth identified an adult provider for health care transition.

CYSHCN provided CSS program staff with updates from local and national transition groups regarding best practices and transition standards. Those practices and standards were incorporated into the individual transition plan where appropriate.

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): This data is taken from the TDH Patient Tracking 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 and who received formal transition plans. According to PTBMIS data, the percentage increased from 15.3% to 19.7% from 2012 to 2014 respectively. In 2014, 70.6% of program participants age 14 and above were noted to have formal transition plans. In 2015, 58.4% of program participants received a formal transition plan. This decrease in the overall percentage of participants receiving a formal transition plan may be attributed to the increase in the total number of participants age 14 and older. Note: data were not reported in 2011 due to changes in the State Performance Measure data source.

Summary of Activities Related to Performance Measure: The CYSHCN Director, the D70 Director and the CSS Program director collaborated with state and local agencies to develop a transition toolkit that can be used across agencies that provide services for children with special needs. Those agencies included Family Voices, Tennessee Pediatric Society Foundation, Tennessee Council on Developmental Disabilities, Tennessee Department of Intellectual and Developmental Disabilities, Tennessee Department of Mental Health and Substance Abuse Services and The Tennessee Department of Children's Services.

This collaborative effort has identified several toolkits that are available and have provided that information to families and providers. The CYSHCN section has also provided the "Got Transition" tip sheets to health care providers and care coordinators. Links to many of the resources are included on the CYSHCN website at <https://www.tn.gov/health/article/MCH-cyshcn-css>.

The CSS program care coordinators were also provided an opportunity for professional development on transition issues; especially those directly related to conservator, guardianship and transition resources in their local communities. Program coordinators were also provided information regarding open enrollment for the Affordable Care Act to assist youth with applying for available insurance coverage.

A Transition Summit was held on April 24, 2015. The conference focused on medical transition from pediatric to adult providers. Breakout sessions included topics around elements of successful transition. Conference attendees included health care providers, care coordinators, families and youth who conducted a transition forum and provided their personal experiences with transitioning from pediatric to adult providers. Dr. Carl Cooley, co-founder and former director of Got Transition, the National Health Care Transition Center, presented during the summit.

The American Academy of Pediatrics Emergency Preparedness Guidelines were provided to all CSS program care coordinators and a training was held on working with families of children with special needs to develop an emergency plan. Care coordinators were also provided updated transition material.

CYSHCN staff began participating in a workgroup to facilitate the coordination of transition services from school to post-secondary education or training, which is targeted towards post-secondary training and/or integrated employment for youth with disabilities. The work group includes state agency representatives from the Department of Human Services/Division of Rehabilitation Services, Department of Education, Tennessee Council on Developmental Disabilities, Bureau of TennCare, Department of Labor and Workforce Development and the Department of Intellectual and Developmental Disabilities. The workgroup through the memorandum of understanding has defined relationships, policies and procedures among these agencies to promote systemic change regarding services to improve post-secondary training and or integrated employment outcomes for youth with disabilities.

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, 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 "childhood" diseases, 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 challenges associated with being responsible for their own care.

There are challenges in data availability as well. The National Survey of Children with Special Health Care Needs is administered very infrequently. This makes it very difficult to measure a programs progress in a timely manner.

Cross-Cutting/Life Course

State Action Plan Table

State Action Plan Table - Cross-Cutting/Life Course - Entry 1

Priority Need

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

NPM

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

Objectives

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%.

Strategies

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 federally-funded programs to smoking cessation services where appropriate.

ESMs

ESM 14.1 - Number of child care facilities that voluntarily implement a tobacco-free campus policy

ESM 14.2 - Number of tobacco users who call the Tennessee Tobacco Quitline

ESM 14.3 - Percent of primary caregivers enrolled in home visiting who reported using any tobacco products at enrollments and were referred to tobacco cessation counseling or services within three months of enrollment

NOMs

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

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

NOM 4.1 - Percent of low birth weight deliveries (<2,500 grams)

NOM 4.2 - Percent of very low birth weight deliveries (<1,500 grams)

NOM 4.3 - Percent of moderately low birth weight deliveries (1,500-2,499 grams)

NOM 5.1 - Percent of preterm births (<37 weeks)

NOM 5.2 - Percent of early preterm births (<34 weeks)

NOM 5.3 - Percent of late preterm births (34-36 weeks)

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

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

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

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

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

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

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

NOM 19 - Percent of children in excellent or very good health

Measures

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	14.4	13.9	13.4	12.9	12.4	11.9

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	14.9 %	0.1 %	12,127	81,149
2013	16.1 %	0.1 %	12,756	79,490
2012	16.4 %	0.1 %	13,059	79,740
2011	17.1 %	0.1 %	13,479	78,948
2010	17.6 %	0.1 %	13,877	78,831
2009	18.4 %	0.1 %	15,019	81,487

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

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	30.2	29.6	29.0	28.4	27.8	27.2

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	32.7 %	1.6 %	480,684	1,468,036
2007	33.5 %	1.5 %	482,993	1,443,570
2003	37.5 %	1.5 %	440,767	1,177,057

Legends:

- 📄 Indicator has an unweighted denominator <30 and is not reportable
- ⚡ Indicator has a confidence interval width >20% and should be interpreted with caution

ESM 14.1 - Number of child care facilities that voluntarily implement a tobacco-free campus policy

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	480.0	525.0	570.0	615.0	660.0

ESM 14.2 - Number of tobacco users who call the Tennessee Tobacco Quitline

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	12,650.0	13,800.0	14,950.0	16,100.0	17,250.0

ESM 14.3 - Percent of primary caregivers enrolled in home visiting who reported using any tobacco products at enrollments and were referred to tobacco cessation counseling or services within three months of enrollment

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	10.0	20.0	30.0	40.0	50.0

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

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

Objective for State Priority: Decrease the percentage of women who smoke during pregnancy from 16.1% (2013) to 14.1% 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 47th 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 FY17:

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).

ESM 1 Objective: Increase the # of child care facilities that voluntarily implement a tobacco free campus policy from 435 (projected end of FY16) to 480 by September 2017.

- 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: Educate parents about the dangers of secondhand and thirdhand smoke exposure and the benefits of tobacco-free childcare centers and homes.

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

ESM 2: Increase the # of tobacco users who call the TN Tobacco Quitline from 11,500 (projected end of FY16) to 12,650 by September 2017.

- Activity 2a: Promote the QuitLine as a resource through CDC media outreach, 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
- Activity 2d: Establish a partnership with women's health providers to distribute information about the dangers of prenatal smoking and the availability of the TN Quitline as a smoking cessation resource to women seeking preconception/interconception care.

Strategy 3: Refer participants in federally-funded programs to smoking cessation services where appropriate.

ESM 3: Increase the percent of primary caregivers enrolled in home visiting who reported using any tobacco products at enrollment and were referred to tobacco cessation counseling or services within three months of enrollment from 1.3% (projected end of FY16) to 10% by September 30, 2017.

- Activity 3a: Continue to screen participants in home visiting to the Tobacco QuitLine and other community-based cessation services.
- Activity 3b: Continue to refer participants in home visiting to the Tobacco QuitLine and other community-based cessation services.
- Activity 3c: Collaborate with healthcare providers to promote smoking cessation services among pregnant women (CollN).

Activity 3d: Support integration of smoking assessment and cessation resources into the TDH electronic health record (EPI).

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

Interpretation of Performance Data (Form 10D): Provisional 2015 birth data indicate that 11.2% of Tennessee resident women reported smoking during the last three months of pregnancy. Since 2010, both the number and proportion of women who reported smoked during the last three months of pregnancy have significantly decreased.

Summary of Activities Related to Performance Measure: The Baby and Me Tobacco Free Program is in 85 of the counties in the state of Tennessee. There were 349 births among the 2,100 women enrolled in the first year of the BMTF program. Through the first year, the program retention rate (those women not dropping from program) is 66%. The Tennessee percentage of LBW births for all women who smoked during pregnancy was 13.5%. The expected number of LBW births for those enrolled in BMTF would be 47. Instead, 22 LBW births were reported, 25 less than expected number. The 2014 average hospital charge for a low birth weight birth is \$98,314 compared to a normal birth weight hospital charge of \$8,239. The total one year hospital charges savings among women enrolled and successfully stopping smoking during pregnancy was \$2.25 million. In 2015 in Rutherford County the SMART Moms program reported eighty-eight percent (88%) of the participants either quit or reduced their tobacco use. The average healthcare cost savings to Rutherford County with 23 women quitting tobacco is estimated to be \$2,071,725.

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.

Interpretation of Performance Data (Form 10D): The number of staff who have completed a module in the MCH Navigator system has consistently increased each year since 2012.

Summary of Activities Related to Performance Measure: All new Family Health and Wellness (FHW) staff in the Central Office continued to complete the MCH Core Competency Self-Assessment, and based on the results of the self-assessment, completed at least one relevant module in the MCH Navigator. Regional MCH/FHW leadership and program staff also used the self-assessment and Navigator modules with new field staff.

The State MCH Director convened regular (bi-monthly) conference calls with the Regional MCH Directors. The calls provided a venue for sharing updates and information between regions; each call also offered an opportunity to present information on one of the current state MCH priorities.

The Division of Family Health and Wellness hosted practicum/internship experiences for students in MPH or related public health programs. Student projects included: development of a breastfeeding toolkit to serve as a "cross-walk" for hospitals between the CDC mPINC survey tool and evidence-based practices and policies; focus groups with WIC participants to better understand changes in WIC participation across the state; and analysis of primary prevention activities being completed by local health department staff.

The State MCH Program continued to partner with the University of Tennessee-Knoxville to provide training on cultural competency to local health department staff. UT-K is funded through the Maternal and Child Health Bureau for Leadership Education in Maternal and Child Health Nutrition. The State MCH Program has partnered with UT-K since the last five-year MCH Block Grant cycle to increase the capacity of local, regional and state health department staff to provide culturally competent services to Tennessee's MCH population.

The State MCH Director continued to participate in the AMCHP Workforce Development Committee and on the National MCH Workforce Development Center Advisory Committee.

SPM 7: Rate of unintentional injury death in children and young people ages 0-24 (per 100,000)

Interpretation of Performance Data (Form 10D): The rate of injury deaths for ages 0-24 has decreased every year for the past 5 years from a rate of 19.7 in 2010 to 16.3 in 2014.

Summary of Activities Related to Performance Measure: The Injury Prevention 101 Training was held in Nashville, TN on July 28th, 2015. Findings from the Graduated Driver's License research were shared with 25 participants; a panel of policy experts shared information about current injury prevention advocacy efforts; a model hospital-based injury prevention program was shared; and the Vanderbilt Injury Prevention Department "Be In the Zone" texting and driving school-based prevention program was shared with participants.

Battle of the Belt was promoted to high schools in partnership with seven trauma centers throughout Tennessee. Sixteen schools participated in the program and a total of 32 unannounced seatbelt checks were made on campuses and observed seat belt use increased an average of 8.03% as a result of the program.

TDH funded 29 community agencies to purchase and distribute a total of 2,337 child safety seats. There 526 infant seats, 961 convertible seats, 398 combination child safety seat/booster seat and booster seats distributed.

TDH Home Visiting programs also provided safety messaging and injury prevention materials to home visiting clients. 81.2% of families enrolled in evidence based home visiting had completed a safety checklist at least once by the child's first birthday. In addition, all births in Tennessee received a Welcome Baby packet through the home visiting program that included information on safety topics such as safe sleep and lead poisoning prevention.

The prescription drug conference abuse prevention was held in Maryville, TN. Information was provided on topics such as statewide prescription drug data, the Controlled Substance Monitoring Database, Chronic Pain Management Guidelines, and Neonatal Abstinence Syndrome. Information was also shared on prescription drugs and suicide and prescription drug abuse in the workplace.

All birthing hospitals continued to implement their safe sleep policies; providing education for staff and new parents in addition to modeling safe sleep behavior in their hospital. The hospitals continued to provide the Sleep Baby Safe and Snug book to all new mothers in addition to other safe sleep materials. The safe sleep program at TDH continued to provide educational flipcharts to hospitals to assist them with teaching parents about safe sleep. All birthing hospitals were also encouraged to apply for a national safe sleep certification offered through the Cribs for Kids program. Twelve hospitals received the national certification with 5 at gold level, 1 at silver level, and 6 at bronze level. TDH provided support for hospitals that wanted to apply including answering questions about the application process and uploading materials onto the application site for the hospitals.

TDH hosted an educational webinar to agencies interested in the Direct On Scene Education (DOSE) program. TDH also conducted 2 DOSE trainings in rural counties to expand the program. The DOSE program has been expanded to Shelby County, East Region, and many of the rural counties in Mid-Cumberland and South Central. 480 DOSE packets were handed out during the grant year. Twenty-eight individual agencies are participating representing 18 counties. First responders also distributed safe sleep kits and educated families at car seat checks and community activities

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. Many counties have seen marked success by using the Baby and Me Tobacco Free programming.

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 projects are located in 5 sites (Davidson, Hamilton, Knox 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 31 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 serves approximately 12,000 women each year.

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 March 2016, the Breastfeeding Hotline receives approximately 500 calls per month.

Advisory Committees

MCH has 3 mandated advisory committees: Perinatal Advisory Committee; Genetics Advisory Committee for newborn screening; and the Children's Special Services Advisory Committee. Other task forces and advisory groups for MCH programs (not mandated) include the Childhood Lead Poisoning Prevention Advisory Committee and the 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).

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. Most recently, Division epidemiologists presented a series of "Epidemiology 101" workshops 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 five years, TDH has recruited eight 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 is now a full-time state employee, serving as Tennessee's MCH Block Grant and SSDI Grant Coordinator. FHW is currently applying for a CDC MCH Epi Assignee to help build surge capacity for MCH epidemiology-related issues.

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. The first round of training focused on regional and Central Office Leadership and subsequent sessions (ongoing) are providing the training to front-line service delivery staff.

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.

In September and October 2015 the Tennessee Early Learning and Wellness Professional Development Collaborative hosted three "Kick Off" events in each of the grand regions of Tennessee: Knoxville, Jackson and Nashville to introduce the new collaborative to early childhood partners and to provide a time for conversation and networking among partners. A total of 163 people attended these meetings representing a variety of agencies and services including TN Department of Health, TN Department of Human Services, higher education, evidence based

home visiting, HUGS, Prevent Child Abuse Tennessee, family child care, Imagination Library, Early Success Coalition, Child Care Resource and Referral, Tennessee's Early Childhood Training Alliance, Tennessee Commission on Children and Youth.

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 Title V 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:

- Development of an online toolkit to "crosswalk" CDC Maternity Practices in Infant Nutrition and Care (mPINC) survey results with evidence-based strategies to improve hospital-based breastfeeding promotion and support
- Educational materials on preventing unintended pregnancy for adolescents and adolescent health care providers
- Quantitative and qualitative analysis of trends in WIC participation

II.F.3. Family Consumer Partnership

Title V Parent and Family Involvement

FHW absolutely recognizes the vital nature of parental involvement throughout our division 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 (2013-16), 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.
- FHW collaborated with Family Voices of Tennessee and LEND to create the Youth Advisory Committee. This committee first met on March 7, 2016; 9 youth and 8 professionals/family members (including LEND trainees, Family Voices staff, 3 TDH representatives and 2 representatives from other organizations) were in attendance. Additionally, there were 4 parents, 1 personal assistant and 1 ASL interpreter. This committee will be maintained by FHW CYSHCN.
- 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 76 prospective parent mentors, and facilitated 74 matches since its inception.
- Family Voices provides training, outreach and one-on-one assistance to families of CYSHCN. This past year FVTN assisted 541 families on partnering and shared decision-making, 556 families on navigating systems and accessing community services, and 341 on accessing a medical home.
- Family Voices hosted a Parent Summit in 2015. Thirty-eight emerging and established family leaders attended. This Summit was facilitated by Eileen Forlenza, AMCHP President.

Through the newborn hearing screening grant, TDH contracts with Family Voices to operate a Guide By Your Side (GBYS) Program for parents of children with hearing loss. GBYS is a national model of parent-to-parent support. 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.

In the previous five-year MCH Block Grant cycle, 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.

Since the FY14/FY16 Report/Application in 2015, Title V and Family Voices staff have jointly written 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 accompanies 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), United Healthcare (private insurance plan), and Cigna (ACA/Marketplace plan and private insurance plan). The Department is currently negotiating with two 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 in 95 counties with enrollment interest cards. Interested clients complete the cards, which are then secured in drop boxes in the lobby/registration areas. These cards are then forwarded to Enroll America’s office in Nashville, where Enroll America staff schedule enrollment appointments (face to face and by telephone). Enroll America has noted that enrollments in Tennessee have surpassed their outcomes from partner arrangements in other states. Particularly because rural markets are included in the Tennessee outreach, Enroll America has promoted the TDH “model” as a national model for outreach in other states.

In September 2015, TDH enhanced collaboration with Enroll America through the Get Covered Academy which supported training efforts statewide for TDH staff. TDH expanded CAC representation by training at least two CACs in every county health department to conduct Medicaid enrollment and Cover Kids enrollment (state CHIP program) via the Federally Facilitated Marketplace (FFM) for pregnant girls and women. Enroll America was extensively involved in development and presentation of the training module. Training sessions were held at seven locations across Tennessee in December 2015, with representatives from 95 county health departments in attendance. The program was implemented January 1, 2016 and offers Medicaid enrollment assistance to every pregnant girl/woman who presents to a county health department for Medicaid prenatal presumptive eligibility or Cover Kids eligibility. The purpose of this unique outreach effort is to minimize any opportunity for a gap in Medicaid coverage since presumptive eligibility is a short-term eligibility and those enrolled in presumptive eligibility must complete the full Medicaid enrollment application to gain ongoing Medicaid coverage. Results of the new enrollment assistance outreach program have been very positive and TDH county/regional staff have embraced the opportunity to complete Medicaid enrollment or Cover Kids enrollment for pregnant girls/women. Enroll America staff continue to be pleased with the results of the trainings through Get Covered Academy. Monthly webinars, which include a presentation by Enroll America staff, are being held through the remainder of 2016 to train new staff about Medicaid enrollment assistance through the FFM.

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 CY2015, 78.5% 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 three years, more than 3,000 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 average first year of life cost for a NAS infant (\$48,854 in CY2014) are nearly 10 times that of an otherwise healthy infant. Medicaid claims data reveal that while nearly 12% 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. These sessions include information on NAS as well as strategies for NAS prevention. Local health department staff work with jail staff to arrange for appointments for inmates around the time of release. Several hundred inmates have voluntarily requested contraceptives from the health department as a part of this effort.
- 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 were completed in 2015 and a summary of the projects can be found at: <http://www.tn.gov/health/article/nas-research-projects>. One of the projects was accepted for publication 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.

MIECHV staff are working to incorporate training on substance use disorder into home visiting professional development activities. Staff recently completed a supplemental funding application aimed at increasing the capacity of home visitors to support families with substance use disorder and to better understand the impact of

parental substance use on infant and child development.

II.F.6. Public Input

Process

Tennessee's Title V Program offers four main mechanisms for the public to provide feedback on the annual application/report. The first is through participating in in-person stakeholder meetings that are hosted twice a year. These meetings are open to the public, with special effort being made to reach out to those serving the maternal and child population. During the meetings participants utilize health data to develop the action plan, and are asked to identify how they or their organizations can partner with the Title V Program to achieve measurable progress on the stakeholder identified priority areas.

The second opportunity to provide feedback is through membership on an advisory committee. The division convenes three committees including 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. Furthermore, these meetings are subject to the State's Open Meetings Law and are open for attendance by members of the general public. In addition to these long standing committees the Title V CYSHCN program established a youth advisory committee over the last year which will be utilized for input moving forward.

Another avenue we use to gather ongoing feedback is through FHW Program staff. Program staff seek input throughout the year from representatives of local and regional health departments, and by extension, their clients and communities. Regional MCH Directors are convened via conference call every other month. On each call, 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.

Lastly we gather feedback through an annual survey that is distributed with the draft of the application/report each spring. The survey asks respondents to describe any emerging issues, health disparities, the capacity of the health care system to meet the needs of the population, and general recommendations to the Title V program. In keeping with the Tennessee Department of Health's commitment to offering ample time for public comment, a draft of the 2017 Application/2015 Report was made available online for 30 days (from June 3, 2016 to July 4, 2016). Announcement of the posting was made available on the Tennessee Department of Health's website, as well as by email. The notice 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
- Division of Community Health Services
- Division of Communicable and Environmental Diseases and Emergency Preparedness
 - Tennessee Immunization Program
- Division of Family Health and Wellness
- Division of Policy, Planning and Assessment

- Regional Health Officers
- Regional MCH Directors
- Regional Nursing Supervisors
- Tennessee Dental Program

Departments/Organizations External to TDH:

- Academy of Family Physicians, Tennessee Chapter
- Advisory Committee – Children's Special Services
- Advisory Committee - Genetics
- Advisory Committee - Perinatal
- American Academy of Pediatrics, Tennessee Chapter
- American Congress of Obstetricians and Gynecologists, Tennessee Chapter
- Belmont University
- Children's Hospital Alliance of Tennessee (CHAT)
- Cumberland Pediatric Foundation
- Department of Children's Services
- Department of Education (DOE)
 - Office of Coordinated School Health
- Department of Human Services
- Department of Mental Health and Substance Abuse Services
- East Tennessee Breastfeeding Coalition
- Family Voices
- Governor's Children's Cabinet
- Head Start
- Julie's Village
- March of Dimes
- 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)
- Medicaid (TennCare)
- Newborn Hearing Task Force
- Office of the First Lady
- Prevent Child Abuse Tennessee
- Regional Perinatal Centers
- SCHIP (CoverKids)
- Shelby County Breastfeeding Coalition
- Tennessee Autism Team
- Tennessee Commission on Children and Youth
- Tennessee Developmental Disabilities Council
- Tennessee Hospital Association (THA)
- Tennessee Initiative for Perinatal Quality Care (TIPQC)
- Health Insurance Companies
 - United Healthcare
 - Volunteer State Health Plan (Blue Cross)
- University of Tennessee at Memphis Boling Center
- University of Tennessee—Knoxville
- Vanderbilt TRIAD

- Various pediatric healthcare providers
- Various TDH grantees
- Young Child Wellness Council

Annual Survey

All of the responses obtained during the public comment period for the 2017 Application/2015 Report can be found in *Attachment 6* within the document titled *Tennessee Attachments* found in the supporting documents section. A total of one-hundred and eight individuals responded, compared to seventy-three respondents last year. Thirty-two of those 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.

Survey – Demographics

Respondents were asked to best describe their role (selecting multiple categories, if appropriate). They could choose from the roles listed below as well as “write in” their role if they did not feel that it was adequately captured by one of the options provided. A total of one-hundred participants responded to this question. In the list below, number to the right of the role indicates how many respondents chose that category.

Role:

- Parent of child with special health care needs (7)
- Local health department employee (44)
- Regional health department employee (11)
- State health department (Central Office) employee (1)
- Other state agency employee (9)
- Community service provider (25)
- Insurance or managed care organization employee (1)
- Health care provider (17)
- Elected official (0)

Respondents were also asked to indicate the region where they live or work. A total of one-hundred and seven participants responded to this question. Responses were received from all regions of the state: East (n=42), Middle (n=39), and West (n=19). Additionally, 7 respondents chose "statewide" as their location.

Lastly respondents were asked to indicate whether they had ever read a draft of Tennessee’s MCH Block Grant Application/Annual Report in prior years. Nearly forty percent of respondents indicated that they had read a draft of the grant before.

Response to Public Comments

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 state website. The website will also contain contact information for the MCH Director, so that contact is available throughout the year.

II.F.7. Technical Assistance

After careful consideration and review of the Action Plan, Tennessee anticipates the potential need for technical assistance in revising the Title V/Medicaid Interagency Agreement. Specifically, we need federal guidance on the guidelines/restrictions for the agreement and then examples from other states with strong agreements. Tennessee's Title V/Medicaid Interagency Agreement was last updated in 2007. The document needs to be updated to address current MCH priorities and needs and to explore funding strategies to assure sustainability of critical MCH programs.

III. Budget Narrative

	2013		2014	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	\$11,539,865	\$11,231,410	\$11,539,865	\$15,054,289
Unobligated Balance	\$5,500,000	\$0	\$7,500,000	\$0
State Funds	\$13,250,000	\$16,560,796	\$13,250,000	\$31,087,436
Local Funds	\$0	\$0	\$0	\$0
Other Funds	\$0	\$0	\$0	\$0
Program Funds	\$5,650,000	\$3,331,071	\$3,250,000	\$4,113,120
SubTotal	\$35,939,865	\$31,123,277	\$35,539,865	\$50,254,845
Other Federal Funds	\$160,809,386	\$143,519,514	\$161,158,344	
Total	\$196,749,251	\$174,642,791	\$196,698,209	\$50,254,845

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.

	2015		2016	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	\$11,562,887	\$12,908,500	\$11,709,246	
Unobligated Balance	\$5,500,000	\$0	\$5,300,000	
State Funds	\$14,200,000	\$29,957,475	\$30,000,000	
Local Funds	\$0	\$0	\$0	
Other Funds	\$0	\$0	\$0	
Program Funds	\$3,350,000	\$4,392,222	\$4,200,000	
SubTotal	\$34,612,887	\$47,258,197	\$51,209,246	
Other Federal Funds	\$147,748,378	\$140,407,856	\$149,414,701	
Total	\$182,361,265	\$187,666,053	\$200,623,947	

	2017	
	Budgeted	Expended
Federal Allocation	\$11,749,682	
Unobligated Balance	\$5,300,000	
State Funds	\$30,000,000	
Local Funds	\$0	
Other Funds	\$0	
Program Funds	\$4,400,000	
SubTotal	\$51,449,682	
Other Federal Funds	\$163,167,051	
Total	\$214,616,733	

III.A. Expenditures

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

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

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 Budget Management Office, in cooperation with all programs, is responsible for the preparation of the budget documents. The base budget request becomes law after it is approved by the General Assembly and signed by the Governor. A work program budget is then developed for each program.

The Department of Health uses a cost allocation system for the local health departments. Costs are allocated using two specific methods, the direct cost allocation method and the resource based relative value method (RBRVS). The direct cost allocation method is used when costs can be directly allocated to one or more programs. Any cost can be directly allocated when coded correctly on the appropriate accounting document. Direct cost allocation is used primarily for costs that arise from administrative support staff in the Department's central and regional offices and for selected contract expenditures. The RBRVS cost allocation method is used to allocate costs which cannot be

directly allocated to one or more programs. These costs arise from the delivery of direct health or patient care services in rural health departments. RBRVS adds weighted encounter activities using relative value units and allocates costs based on the percentage of activity for each program. RBRVS is a federally approved cost allocation method for the Tennessee Department of Health. RBRVS is linked at the service delivery level to AS 400 computers at the regional and central offices.

Program encounter data are entered at local health departments for direct patient care services using 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 typically 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 and fund increased program activity relative to infant mortality. Carry forward funding has also been used in teen pregnancy prevention and for breast and cervical screening for reproductive age women. Funding has also supported home visiting services for pregnant women and families with high risk infants and young children as well as care coordination services for families with children with special health care needs.

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - [Tennessee Title V-Medicaid IAA_MOU with Cover Page.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

	FY17 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	\$ 11,749,682	
A. Preventive and Primary Care for Children	\$ 3,524,905	(30%)
B. Children with Special Health Care Needs	\$ 4,112,389	(35%)
C. Title V Administrative Costs	\$ 800,000	(6.8%)
2. UNOBLIGATED BALANCE (Item 18b of SF-424)	\$ 5,300,000	
3. STATE MCH FUNDS (Item 18c of SF-424)	\$ 30,000,000	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	\$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	\$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	\$ 4,400,000	
7. TOTAL STATE MATCH (Lines 3 through 6)	\$ 34,400,000	
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)	\$ 51,449,682	
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)	\$ 163,167,051	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	\$ 214,616,733	

OTHER FEDERAL FUNDS	FY17 Application Budgeted
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	\$ 95,375
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)	\$ 132,166,939
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	\$ 6,707,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	\$ 250,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State and Local Healthy Homes and Childhood Lead Poisoning Prevention Programs (CLPPPs)	\$ 211,401
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) > Centers for Disease Control and Prevention (CDC) > Injury Prevention and Control	\$ 247,686
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State Public Health Actions-1305 Chronic Disease	\$ 2,508,803
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Tobacco Control Programs	\$ 1,564,235
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventive Health and Health Services Block Grant	\$ 2,463,434
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Breast and Cervical Cancer Early Detection Program (NBCCEDP)	\$ 1,692,396
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	\$ 640,250

OTHER FEDERAL FUNDS	FY17 Application Budgeted
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Tramatic Brain Injury	\$ 250,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Implementation Grants for Systems of Services for CYSHCN	\$ 0
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Sudden Death in the Young	\$ 200,000

	FY15 Application Budgeted		FY15 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	\$ 11,562,887		\$ 12,908,500	
A. Preventive and Primary Care for Children	\$ 3,468,866	(30%)	\$ 4,390,107	(34%)
B. Children with Special Health Care Needs	\$ 3,468,866	(30%)	\$ 4,063,989	(31.5%)
C. Title V Administrative Costs	\$ 1,156,288	(10%)	\$ 850,751	(6.6%)
2. UNOBLIGATED BALANCE (Item 18b of SF-424)	\$ 5,500,000		\$ 0	
3. STATE MCH FUNDS (Item 18c of SF-424)	\$ 14,200,000		\$ 29,957,475	
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)	\$ 3,350,000		\$ 4,392,222	
7. TOTAL STATE MATCH (Lines 3 through 6)	\$ 17,550,000		\$ 34,349,697	
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)	\$ 34,612,887		\$ 47,258,197	
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)	\$ 147,748,378		\$ 140,407,856	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	\$ 182,361,265		\$ 187,666,053	

OTHER FEDERAL FUNDS	FY15 Annual Report Expended
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	\$ 109,239
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Community-Based Integrated Service Systems (CISS)	\$ 166,948
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Abstinence Education Grant Program	\$ 1,021,905
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	\$ 115,057,191
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > ACA Maternal, Infant and Early Childhood Home Visiting Program	\$ 9,154,566
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	\$ 5,540,134
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	\$ 192,066
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)	\$ 137,402
Department of Health and Human Services (DHHS) > Substance Abuse and Mental Health Services Administration > Project LAUNCH	\$ 765,221
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Injury Prevention and Control	\$ 255,224
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State Public Health Actions-1305 Chronic Disease	\$ 2,051,410
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Tobacco Control Programs	\$ 1,588,685
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventive Health and Health Services Block Grant	\$ 1,715,576
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Breast and Cervical Cancer Early Detection Program (NBCCEDP)	\$ 1,497,082
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	\$ 513,477

OTHER FEDERAL FUNDS	FY15 Annual Report Expended
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Implementation Grants for Systems of Services for CYSHCN	\$ 341,645
Department of Health and Human Services (DHHS) > Office of Adolescent Health > Support for Pregnant and Parenting Teens	\$ 173,353
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Sudden Death in the Young	\$ 126,732

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:	2015
	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:	2015
	Column Name:	Annual Report Expended
	Field Note:	This figure represents actual expenditures.
3.	Field Name:	Federal Allocation, C. Title V Administrative Costs:
	Fiscal Year:	2015
	Column Name:	Annual Report Expended
	Field Note:	This figure represents actual expenditures.
4.	Field Name:	2. UNOBLIGATED BALANCE
	Fiscal Year:	2015
	Column Name:	Annual Report Expended
	Field Note:	This figure represents actual expenditures.
5.	Field Name:	3. STATE MCH FUNDS
	Fiscal Year:	2015
	Column Name:	Annual Report Expended
	Field Note:	This figure represents actual expenditures.
6.	Field Name:	6. PROGRAM INCOME
	Fiscal Year:	2015
	Column Name:	Annual Report Expended

Field Note:

This figure represents actual program income.

7. **Field Name:** 1.FEDERAL ALLOCATION

Fiscal Year: 2015

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

I. TYPES OF INDIVIDUALS SERVED

IA. Federal MCH Block Grant	FY17 Application Budgeted	FY15 Annual Report Expended
1. Pregnant Women	\$ 177,616	\$ 195,591
2. Infants < 1 year	\$ 813,210	\$ 895,504
3. Children 1-22 years	\$ 3,016,678	\$ 3,321,954
4. CSHCN	\$ 3,699,886	\$ 4,074,300
5. All Others	\$ 3,242,292	\$ 3,570,400
Federal Total of Individuals Served	\$ 10,949,682	\$ 12,057,749

IB. Non Federal MCH Block Grant	FY17 Application Budgeted	FY15 Annual Report Expended
1. Pregnant Women	\$ 143,046	\$ 142,836
2. Infants < 1 year	\$ 1,166,886	\$ 1,165,179
3. Children 1-22 years	\$ 7,381,629	\$ 7,370,835
4. CSHCN	\$ 4,137,074	\$ 4,131,025
5. All Others	\$ 21,571,365	\$ 21,539,821
Non Federal Total of Individuals Served	\$ 34,400,000	\$ 34,349,696
Federal State MCH Block Grant Partnership Total	\$ 45,349,682	\$ 46,407,445

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:	2017
	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:	2017
	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, but is 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:	2015
	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:	2015
	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

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY17 Application Budgeted	FY15 Annual Report Expended
1. Direct Services	\$ 1,013,940	\$ 1,113,940
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	\$ 202,731	\$ 222,725
B. Preventive and Primary Care Services for Children	\$ 14,125	\$ 15,518
C. Services for CSHCN	\$ 797,084	\$ 875,697
2. Enabling Services	\$ 9,767,251	\$ 10,730,551
3. Public Health Services and Systems	\$ 968,491	\$ 1,064,009
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		\$ 175,445
Physician/Office Services		\$ 46,897
Hospital Charges (Includes Inpatient and Outpatient Services)		\$ 325,159
Dental Care (Does Not Include Orthodontic Services)		\$ 446
Durable Medical Equipment and Supplies		\$ 75,525
Laboratory Services		\$ 266,343
Other		
Orthodontic; Interpreter		\$ 224,125
Direct Services Line 4 Expended Total		\$ 1,113,940
Federal Total	\$ 11,749,682	\$ 12,908,500

IIB. Non-Federal MCH Block Grant	FY17 Application Budgeted	FY15 Annual Report Expended
1. Direct Services	\$ 1,130,620	\$ 1,128,966
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	\$ 585,875	\$ 585,017
B. Preventive and Primary Care Services for Children	\$ 1,958	\$ 1,955
C. Services for CSHCN	\$ 542,787	\$ 541,994
2. Enabling Services	\$ 24,366,697	\$ 24,301,110
3. Public Health Services and Systems	\$ 8,932,683	\$ 8,919,621
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		\$ 107,590
Physician/Office Services		\$ 35,901
Hospital Charges (Includes Inpatient and Outpatient Services)		\$ 208,746
Dental Care (Does Not Include Orthodontic Services)		\$ 226
Durable Medical Equipment and Supplies		\$ 50,239
Laboratory Services		\$ 562,451
Other		
Orthodontic; Interpreter		\$ 163,813
Direct Services Line 4 Expended Total		\$ 1,128,966
Non-Federal Total	\$ 34,430,000	\$ 34,349,697

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: 87,441

1. 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
Core RUSP Conditions	87,010 (99.5%)	1,782	154	154 (100.0%)

Program Name(s)				
Propionic acidemia	Methylmalonic acidemia (methylmalonyl-CoA mutase)	Methylmalonic acidemia (cobalamin disorders)	Isovaleric acidemia	3-Methylcrotonyl-CoA carboxylase deficiency
3-Hydroxy-3-methylglutaric aciduria	Holocarboxylase synthase deficiency	β-Ketothiolase deficiency	Glutaric acidemia type I	Carnitine uptake defect/carnitine transport defect
Medium-chain acyl-CoA dehydrogenase deficiency	Very long-chain acyl-CoA dehydrogenase deficiency	Long-chain L-3 hydroxyacyl-CoA dehydrogenase deficiency	Trifunctional protein deficiency	Argininosuccinic aciduria
Citrullinemia, type I	Maple syrup urine disease	Homocystinuria	Classic phenylketonuria	Tyrosinemia, type I
Primary congenital hypothyroidism	Congenital adrenal hyperplasia	S,S disease (Sickle cell anemia)	S, β-thalassemia	S,C disease
Biotinidase deficiency	Cystic fibrosis	Classic galactosemia		

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	84,632 (96.8%)	4,082	66	66 (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
CCHD	86,089 (98.5%)	89	2	2 (100.0%)
Methylmalonic acidemia with homocystinuria	87,010 (99.5%)	31	0	0 (0%)
Malonic acidemia	87,010 (99.5%)	8	0	0 (0%)
Isobutyrylglycinuria	87,010 (99.5%)	18	0	0 (0%)
2-Methylbutyrylglycinuria	87,010 (99.5%)	24	0	0 (0%)
3-Methylglutaconic aciduria	87,010 (99.5%)	23	0	0 (0%)
2-Methyl-3-hydroxybutyric aciduria	87,010 (99.5%)	23	0	0 (0%)
Short-chain acyl-CoA dehydrogenase deficiency	87,010 (99.5%)	15	0	0 (0%)
Medium/short-chain L-3-hydroxyacyl-CoA dehydrogenase deficiency	87,010 (99.5%)	8	0	0 (0%)
Glutaric acidemia type II	87,010 (99.5%)	15	1	1 (100.0%)
2, 4 Dienoyl-CoA reductase deficiency	87,010 (99.5%)	5	0	0 (0%)
Carnitine palmitoyltransferase type I deficiency	87,010 (99.5%)	0	0	0 (0%)
Carnitine palmitoyltransferase type II deficiency	87,010 (99.5%)	5	0	0 (0%)
Carnitine acylcarnitine translocase deficiency	87,010 (99.5%)	5	0	0 (0%)
Argininemia	87,010 (99.5%)	3	0	0 (0%)
Citrullinemia, type II	87,010 (99.5%)	6	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
Hypermethioninemia	87,010 (99.5%)	82	1	1 (100.0%)
Benign hyperphenylalaninemia	87,010 (99.5%)	11	4	4 (100.0%)
Biopterin defect in cofactor biosynthesis	87,010 (99.5%)	11	0	0 (0%)
Biopterin defect in cofactor regeneration	87,010 (99.5%)	11	0	0 (0%)
Tyrosinemia, type II	87,010 (99.5%)	147	1	1 (100.0%)
Tyrosinemia, type III	87,010 (99.5%)	147	0	0 (0%)
Various other hemoglobinopathies	87,010 (99.5%)	10	8	8 (100.0%)
Galactosepimerase deficiency	87,010 (99.5%)	24	0	0 (0%)
Galactokinase deficiency	87,010 (99.5%)	24	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:

None

Field Level Notes for Form 4:

1.	Field Name:	Core RUSP Conditions - Receiving At Lease One Screen
	Fiscal Year:	2015
	Column Name:	Core RUSP Conditions

Field Note:

In CY2015, 99.5% of infants received a screen with a dried blood spot (DBS). Of the 431 infants without a DBS: 188 died on day of birth, 17 died on day one of life, 7 died at 2-7 days of age, 1 died >7 days of age. Of the 432 without a DBS, 154 were home births (3 died on day of birth, which is included in the 188 above).

Data Alerts: None

Form 5a
Unduplicated Count of Individuals Served under Title V
State: Tennessee

Reporting Year 2015

Types Of Individuals Served	(A) Title V Total Served	Primary Source of Coverage				
		(B) Title XIX %	(C) Title XXI %	(D) Private / Other %	(E) None %	(F) Unknown %
1. Pregnant Women	22,642	57.8	0.1	9.8	32.3	0.0
2. Infants < 1 Year of Age	50,103	32.4	0.0	0.7	66.9	0.0
3. Children 1 to 22 Years of Age	216,168	32.9	0.0	6.9	60.2	0.0
4. Children with Special Health Care Needs	4,997	2.0	0.0	0.5	97.5	0.0
5. Others	126,114	15.8	0.3	5.5	78.4	0.0
Total	420,024					

Form Notes for Form 5a:

None

Field Level Notes for Form 5a:

None

Form 5b
Total Recipient Count of Individuals Served by Title V
State: Tennessee

Reporting Year 2015

Types Of Individuals Served	Total Served
1. Pregnant Women	57,213
2. Infants < 1 Year of Age	78,350
3. Children 1 to 22 Years of Age	608,825
4. Children with Special Health Care Needs	22,004
5. Others	507,163
Total	1,273,555

Form Notes for Form 5b:

Numbers quantifying the total population served were provided by programs (under the control of the Title V Director) who provide services to the maternal and child health population in Tennessee.

Field Level Notes for Form 5b:

1.	Field Name:	Infants Less Than One Year
	Fiscal Year:	2015

Field Note:

Based on program data the number of infants <1 served was greater than the population estimate for that age group. Therefore the number was limited to the population estimate.

Form 6
Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: Tennessee

Reporting Year 2015

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	81,609	62,096	17,061	151	1,774	198	0	329
Title V Served	81,609	62,096	17,061	151	1,774	198	0	329
Eligible for Title XIX	42,224	28,634	12,680	90	534	92	0	194
2. Total Infants in State	77,891	55,173	16,842	0	0	0	0	5,876
Title V Served	50,103	36,439	10,268	67	332	35	0	2,962
Eligible for Title XIX	53,973	40,176	9,263	0	0	0	4,534	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	74,542	6,982	85	81,609
Title V Served	74,542	6,982	85	81,609
Eligible for Title XIX	37,284	4,899	41	42,224
2. Total Infants in State	69,822	8,069	0	77,891
Title V Served	43,090	5,373	1,640	50,103
Eligible for Title XIX	42,075	11,898	0	53,973

Form Notes for Form 6:

None

Field Level Notes for Form 6:

1.	Field Name:	2. Total Infants in State
	Fiscal Year:	2015
	Column Name:	Total All Races

Field Note:

The data source for "Total infants in State" is 2014 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 CY2015, while the total infant count is from 2014 Census data. 2) The occurrent birth count also includes infants born in Tennessee but whose mothers (and thus the infants) do not reside in Tennessee. When the birth data are re-calculated to include only a) infants born in Tennessee who will reside in Tennessee and b) infants from outside of Tennessee but who will reside in Tennessee, that total is 87,010, which is ~5% different from the census count.

2.	Field Name:	2. Title V Served
	Fiscal Year:	2015
	Column Name:	Total All Races

Field Note:

Data Source: Tennessee Department of Health - Patient Tracking Billing Management Information System (PTBMIS)

Form 7
State MCH Toll-Free Telephone Line and Other Appropriate Methods Data

State: Tennessee

A. State MCH Toll-Free Telephone Lines	2017 Application Year	2015 Reporting Year
1. State MCH Toll-Free "Hotline" Telephone Number	(877) 808-5460	(877) 808-5460
2. State MCH Toll-Free "Hotline" Name	TENnderCare Call Center	TENnder Care Call Center
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"		255

B. Other Appropriate Methods	2017 Application Year	2015 Reporting Year
1. Other Toll-Free "Hotline" Names	Tennessee Breastfeeding Hotline	Tennessee Breastfeeding Hotline
2. Number of Calls on Other Toll-Free "Hotlines"		5,051
3. State Title V Program Website Address	http://www.kidcentraltn.com/	
4. Number of Hits to the State Title V Program Website		
5. State Title V Social Media Websites	https://www.facebook.com/TNDeptofHealth/	
6. Number of Hits to the State Title V Program Social Media Websites		

Form Notes for Form 7:

None

Form 8
State MCH and CSHCN Directors Contact Information
State: Tennessee

1. Title V Maternal and Child Health (MCH) Director	
Name	Morgan McDonald, MD FAAP FACP
Title	Director, Title V/MCH
Address 1	Andrew Johnson Tower, 8th Floor
Address 2	710 James Robertson
City/State/Zip	Nashville / TN / 37243
Telephone	(615) 532-8672
Extension	
Email	morgan.mcdonald@tn.gov

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Jacqueline Johnson, MPA
Title	Director, CYSHCN
Address 1	Andrew Johnson Tower, 8th Floor
Address 2	710 James Robertson
City/State/Zip	Nashville / TN / 37243
Telephone	(615) 741-0361
Extension	
Email	jacqueline.johnson@tn.gov

3. State Family or Youth Leader (Optional)

Name	
Title	
Address 1	
Address 2	
City/State/Zip	
Telephone	
Extension	
Email	

Form Notes for Form 8:

None

Form 9
List of MCH Priority Needs
State: Tennessee

Application Year 2017

No.	Priority Need
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 exposed to adverse childhood experiences.
5.	Reduce the number of children and adolescents who are overweight/obese.
6.	Reduce the burden of injury among children and adolescents.
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).

Form 9 State Priorities-Needs Assessment Year - 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:

None

**Form 10a
National Outcome Measures (NOMs)**

State: Tennessee

Form Notes for Form 10a NPMs, NOMs, SPMs, SOMs, and ESMs.

The Federally Available Data (FAD) for this measure is divided in to two separate groups: 1) children with special health care needs and 2) children without special health care needs. However, the objectives for this measure were set based on the combined data for both groups. Therefore the objectives cover both children with and without special health care needs.

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
2014	74.2 %	0.2 %	56,654	76,364
2013	71.6 %	0.2 %	54,489	76,103
2012	70.4 %	0.2 %	53,419	75,885
2011	69.9 %	0.2 %	51,605	73,832
2010	70.6 %	0.2 %	52,663	74,579
2009	69.5 %	0.2 %	54,058	77,795

Legends:

-  Indicator has a numerator <10 and is not reportable
-  Indicator has a numerator <20, a confidence interval width >20%, 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
2013	186.3	5.3 %	1,283	68,876
2012	179.3	5.2 %	1,230	68,598
2011	170.0	4.8 %	1,252	73,655
2010	164.1	4.8 %	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.

NOM 3 - Notes:

None

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
2014	9.0 %	0.1 %	7,297	81,441
2013	9.1 %	0.1 %	7,307	79,962
2012	9.2 %	0.1 %	7,377	80,318
2011	9.0 %	0.1 %	7,176	79,554
2010	9.0 %	0.1 %	7,179	79,451
2009	9.2 %	0.1 %	7,539	82,172

Legends:
 Indicator has a numerator <10 and is not reportable
 Indicator has a numerator <20, a confidence interval width >20%, 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
2014	1.6 %	0.0 %	1,260	81,441
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
2014	7.4 %	0.1 %	6,037	81,441
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
2014	10.8 %	0.1 %	8,780	81,497
2013	11.1 %	0.1 %	8,826	79,691
2012	11.2 %	0.1 %	8,961	79,807
2011	11.1 %	0.1 %	8,729	78,903
2010	11.4 %	0.1 %	8,988	78,936
2009	11.3 %	0.1 %	9,231	81,518

Legends:

 Indicator has a numerator <10 and is not reportable

 Indicator has a numerator <20, a confidence interval width >20%, 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
2014	3.1 %	0.1 %	2,492	81,497
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
2014	7.7 %	0.1 %	6,288	81,497
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
2014	26.1 %	0.2 %	21,293	81,497
2013	26.2 %	0.2 %	20,856	79,691
2012	27.8 %	0.2 %	22,149	79,807
2011	28.9 %	0.2 %	22,784	78,903
2010	30.1 %	0.2 %	23,721	78,936
2009	31.5 %	0.2 %	25,645	81,518

Legends:
 Indicator has a numerator <10 and is not reportable
 Indicator has a numerator <20, a confidence interval width >20%, 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
2014/Q2-2015/Q1	2.0 %			
2014/Q1-2014/Q4	3.0 %			
2013/Q4-2014/Q3	3.0 %			
2013/Q3-2014/Q2	3.0 %			
2013/Q2-2014/Q1	4.0 %			

Legends:
📅 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
2013	4.8 %	1.0 %	3,677	77,144
2012	6.7 %	1.1 %	5,139	77,036
2009	5.6 %	1.1 %	4,474	79,825
2008	3.4 %	0.8 %	2,774	81,407

Legends:

- 🚩 Indicator has an unweighted denominator <30 and is not reportable
- ⚡ Indicator has an unweighted denominator between 30 and 59 or has a confidence interval width that is inestimable or >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
2013	22.9	0.6 %	1,577	68,881
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
2014	20.6	1.7 %	152	738,611
2013	21.1	1.7 %	156	738,334
2012	22.4	1.7 %	166	739,838
2011	20.0	1.7 %	147	736,697
2010	22.0	1.7 %	163	740,978
2009	20.0	1.7 %	148	738,731

Legends:
 Indicator has a numerator <10 and is not reportable
 Indicator has a numerator <20 and should be interpreted with caution

NOM 15 - Notes:

None

Data Alerts: None

NOM 16.1 - Adolescent mortality rate ages 10 through 19 per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	36.7	2.1 %	309	841,738
2013	35.5	2.1 %	299	841,885
2012	40.3	2.2 %	340	844,247
2011	37.1	2.1 %	315	848,300
2010	38.2	2.1 %	327	856,127
2009	42.4	2.2 %	363	855,924

Legends:

- 🚩 Indicator has a numerator <10 and is not reportable
- ⚡ Indicator has a numerator <20 and should be interpreted with caution

NOM 16.1 - Notes:

None

Data Alerts: None

NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2012_2014	15.5	1.1 %	195	1,260,128
2011_2013	16.9	1.2 %	214	1,267,375
2010_2012	18.9	1.2 %	243	1,285,474
2009_2011	19.2	1.2 %	250	1,302,264
2008_2010	21.7	1.3 %	285	1,312,853
2007_2009	28.1	1.5 %	368	1,307,973

Legends:

- 🚩 Indicator has a numerator <10 and is not reportable
- ⚡ Indicator has a numerator <20 and should be interpreted with caution

NOM 16.2 - Notes:

None

Data Alerts: None

NOM 16.3 - Adolescent suicide rate, ages 15 through 19 per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2012_2014	9.8	0.9 %	123	1,260,128
2011_2013	8.7	0.8 %	110	1,267,375
2010_2012	7.8	0.8 %	100	1,285,474
2009_2011	7.8	0.8 %	102	1,302,264
2008_2010	7.2	0.7 %	94	1,312,853
2007_2009	7.1	0.7 %	93	1,307,973

Legends:
 Indicator has a numerator <10 and is not reportable
 Indicator has a numerator <20 and should be interpreted with caution

NOM 16.3 - Notes:

None

Data Alerts: None

NOM 17.1 - Percent of children with special health care needs

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
2014	5.2 %	0.3 %	77,115	1,493,436
2013	5.7 %	0.4 %	84,902	1,492,149
2012	5.6 %	0.4 %	83,030	1,492,012
2011	5.8 %	0.4 %	86,513	1,489,552
2010	5.3 %	0.3 %	79,838	1,499,117
2009	5.8 %	0.3 %	85,685	1,489,741

Legends:

 Indicator has an unweighted denominator <30 and is not reportable

 Indicator has a confidence interval width 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 completed the combined 7-vaccine series (4:3:1:3*:3:1:4)

Data Source: National Immunization Survey (NIS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	71.9 %	3.9 %	84,560	117,608
2013	68.5 %	3.5 %	79,216	115,715
2012	73.1 %	3.5 %	86,800	118,788
2011	70.4 %	3.4 %	85,567	121,578
2010	61.8 %	3.4 %	78,476	127,008
2009	44.8 %	3.4 %	55,979	124,975

Legends:

- 🚩 Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval 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
2014_2015	61.8 %	2.0 %	871,825	1,409,807
2013_2014	60.2 %	2.0 %	836,358	1,390,019
2012_2013	56.4 %	2.3 %	789,668	1,400,851
2011_2012	50.4 %	2.7 %	695,541	1,379,253
2010_2011	56.6 %	3.8 %	777,299	1,373,320
2009_2010	48.9 %	3.9 %	617,746	1,263,285

Legends:

-  Estimate not reported because unweighted sample size for the denominator < 30 or 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
2014	47.8 %	5.0 %	98,562	206,365
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
2014	30.5 %	4.3 %	65,903	216,320
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
2014	86.0 %	2.3 %	363,547	422,685
2013	80.0 %	2.7 %	338,276	422,624
2012	77.4 %	3.2 %	325,269	420,423
2011	67.6 %	3.2 %	283,974	420,127
2010	58.7 %	3.2 %	243,261	414,201
2009	48.0 %	3.1 %	199,390	415,570

Legends:

-  Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval 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
2014	74.0 %	3.0 %	312,756	422,685
2013	67.8 %	3.1 %	286,448	422,624
2012	69.4 %	3.4 %	291,733	420,423
2011	63.3 %	3.3 %	265,999	420,127
2010	50.6 %	3.2 %	209,556	414,201
2009	52.1 %	3.1 %	216,515	415,570

Legends:

- 🚩 Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval 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	2021
Annual Objective	72.2	72.2	73.3	74.5	75.7	77.3

Data Source: Behavioral Risk Factor Surveillance System (BRFSS)

Multi-Year Trend					
Year	Annual Indicator	Standard Error	Numerator	Denominator	
2014	74.0 %	2.1 %	839,995	1,135,664	
2013	72.2 %	1.9 %	822,111	1,139,338	
2012	74.7 %	1.6 %	845,711	1,132,728	
2011	75.8 %	3.0 %	859,713	1,134,614	
2010	78.3 %	1.8 %	882,068	1,126,941	
2009	75.9 %	1.9 %	854,450	1,126,466	

Legends:

-  Indicator has an unweighted denominator <30 and is not reportable
-  Indicator has a confidence interval width >20% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

1.	Field Name:	2017
Field Note:		
Although the percent of women with a visit in the past year increased between 2013 and 2014, this difference was not statistically significant and does not demonstrate a sustained trend. Therefore, the objectives for 2016 through 2021 have not been adjusted. As additional data become available objectives may be changed if deemed necessary.		

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	80.0	81.0	82.0	83.0	84.0	85.0

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	78.4 %	2.0 %	58,650	74,823
2012	77.4 %	1.9 %	57,077	73,773
2009	65.6 %	2.3 %	50,974	77,746
2008	62.7 %	2.3 %	50,673	80,786

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

Field Level Notes for Form 10a NPMs:

None

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	2021
Annual Objective	38.3	38.3	38.3	50.0	50.0	50.0

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	38.3 %	3.2 %	150,143	391,762
2007	29.0 %	2.8 %	112,111	386,431

Legends:
 Indicator has an unweighted denominator <30 and is not reportable
 Indicator has a confidence interval width >20% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

None

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	109.8	107.0	104.4	101.8	99.2	96.7

Data Source: State Inpatient Databases (SID) - CHILD

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	107.4	3.6 %	890	829,094
2012	104.6	3.5 %	895	855,498
2011	166.5	4.4 %	1,414	849,524
2010	161.1	4.4 %	1,343	833,694
2009	158.8	4.4 %	1,307	823,320
2008	184.3	4.8 %	1,468	796,612

Legends:

-  Indicator has a numerator ≤10 and is not reportable
-  Indicator has a numerator <20 and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

None

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	184.8	176.4	168.0	159.6	151.2	142.8

Data Source: State Inpatient Databases (SID) - ADOLESCENT

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	210.0	5.0 %	1,791	852,895
2012	215.9	5.1 %	1,819	842,692
2011	267.8	5.7 %	2,227	831,562
2010	284.6	5.9 %	2,327	817,574
2009	301.7	6.1 %	2,469	818,450
2008	333.2	6.4 %	2,694	808,454

Legends:
 Indicator has a numerator ≤10 and is not reportable
 Indicator has a numerator <20 and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

None

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	49.4	50.7	52.0	53.3	54.6	55.9

Data Source: National Survey of Children's Health (NSCH) - CHILD

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	45.4 %	3.0 %	224,507	494,298
2007	35.6 %	2.6 %	169,940	477,711
2003	33.5 %	2.4 %	153,682	458,521

Legends:
 Indicator has an unweighted denominator <30 and is not reportable
 Indicator has a confidence interval width >20% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

None

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	26.9	27.7	28.5	29.3	30.1	30.9

Data Source: National Survey of Children's Health (NSCH) - ADOLESCENT

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	23.9 %	2.5 %	120,480	504,540
2007	24.3 %	2.3 %	120,039	494,076
2003	17.7 %	1.8 %	81,588	462,165

Legends:
 Indicator has an unweighted denominator <30 and is not reportable
 Indicator has a confidence interval width >20% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

None

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	61.6	63.1	64.7	66.3	68.0	69.7

Data Source: National Survey of Children's Health (NSCH) - CSHCN

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	49.9 %	3.6 %	174,136	348,790
2007	53.0 %	3.4 %	168,486	317,776

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: National Survey of Children's Health (NSCH) - NONCSHCN

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	63.4 %	1.9 %	694,074	1,095,699
2007	63.8 %	1.8 %	694,993	1,088,681

Legends:
 Indicator has an unweighted denominator <30 and is not reportable
 Indicator has a confidence interval width >20% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

None

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	2021
Annual Objective	42.8	43.9	45.0	46.1	47.3	48.5

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	41.8 %	3.8 %	40,413	96,752
2005_2006	39.6 %	3.1 %	34,477	87,141

Legends:
 Indicator has an unweighted denominator <30 and is not reportable
 Indicator has a confidence interval width >20% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

None

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	14.4	13.9	13.4	12.9	12.4	11.9

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	14.9 %	0.1 %	12,127	81,149
2013	16.1 %	0.1 %	12,756	79,490
2012	16.4 %	0.1 %	13,059	79,740
2011	17.1 %	0.1 %	13,479	78,948
2010	17.6 %	0.1 %	13,877	78,831
2009	18.4 %	0.1 %	15,019	81,487

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

Field Level Notes for Form 10a NPMs:

None

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	30.2	29.6	29.0	28.4	27.8	27.2

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	32.7 %	1.6 %	480,684	1,468,036
2007	33.5 %	1.5 %	482,993	1,443,570
2003	37.5 %	1.5 %	440,767	1,177,057

Legends:
 Indicator has an unweighted denominator <30 and is not reportable
 Indicator has a confidence interval width >20% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

None

Form 10a
State Performance Measures (SPMs)
State: Tennessee

SPM 1 - Percentage of children ages 0-17 experiencing two or more adverse childhood experiences

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	27.5	27.5	24.8	24.8	22.3

Field Level Notes for Form 10a SPMs:

None

SPM 2 - Percentage of infants born to Tennessee resident mothers who initiate breastfeeding

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	80.0	82.0	84.0	86.0	88.0

Field Level Notes for Form 10a SPMs:

None

SPM 3 - Percent of live births that were the result of an unintended pregnancy

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	51.6	49.9	48.2	46.5	44.8

Field Level Notes for Form 10a SPMs:

None

Form 10a
Evidence-Based or-Informed Strategy Measures (ESMs)

State: Tennessee

ESM 1.1 - Number of press releases, PSAs and/or social media messages promoting preventive health care visits for women of reproductive age

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	10.0	10.0	10.0	10.0	10.0

Field Level Notes for Form 10a ESMs:

None

ESM 1.2 - Number of webinars for providers on increasing preventive care visits among women in their clinics

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	2.0	2.0	2.0	2.0	2.0

Field Level Notes for Form 10a ESMs:

None

ESM 1.3 - Number of quarterly site-level family planning utilization reports distributed to local health departments

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	4.0	4.0	4.0	4.0	4.0

Field Level Notes for Form 10a ESMs:

None

ESM 1.4 - Number of region-level pregnancy-related service utilization reports distributed to regional health departments

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	4.0	4.0	4.0	4.0	4.0

Field Level Notes for Form 10a ESMs:

None

ESM 5.1 - Number of safe sleep educational material distributed

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	80,000.0	80,000.0	80,000.0	80,000.0	80,000.0

Field Level Notes for Form 10a ESMs:

None

ESM 5.2 - Percent of infant deaths to be reviewed by child fatality review teams

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	100.0	100.0	100.0	100.0	100.0

Field Level Notes for Form 10a ESMs:

None

ESM 5.3 - Percent of VLBW (Very Low Birth Weight) infants being delivered at Level III or IV birthing facilities

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	80.0	80.0	80.0	80.0	80.0

Field Level Notes for Form 10a ESMs:

None

ESM 5.4 - Percent of newborns with a positive metabolic screen who receive follow-up to definitive diagnosis and clinical management

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	100.0	100.0	100.0	100.0	100.0

Field Level Notes for Form 10a ESMs:

None

ESM 5.5 - Number of individuals served by the Tennessee Adolescent Pregnancy Prevention Program (TAPPP)

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	45,500.0	46,000.0	46,500.0	47,000.0	47,500.0

Field Level Notes for Form 10a ESMs:

None

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

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	599.0	617.0	636.0	655.0	675.0

Field Level Notes for Form 10a ESMs:

None

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

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	467.0	485.0	504.0	524.0	544.0

Field Level Notes for Form 10a ESMs:

None

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

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	90.0	90.0	91.0	92.0	92.0

Field Level Notes for Form 10a ESMs:

None

ESM 7.1 - Number of parents and caregivers receiving car seat education

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	2,550.0	2,600.0	2,650.0	2,700.0	2,750.0

Field Level Notes for Form 10a ESMs:

None

ESM 7.2 - Number of counties that adopt Count It! Drop It! Lock It! educational programs

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	45.0	48.0	51.0	54.0	57.0

Field Level Notes for Form 10a ESMs:

None

ESM 7.3 - Percent of families who receive injury prevention education through the AAP checklist among families participating in Evidence Based Home Visiting programs

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	85.0	87.0	89.0	91.0	93.0

Field Level Notes for Form 10a ESMs:

None

ESM 7.4 - Number of schools in the top ten crash rate counties (among ages 15-18) that conduct evidence-informed teen safe driving programming

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	55.0	57.0	59.0	61.0	63.0

Field Level Notes for Form 10a ESMs:

None

ESM 7.5 - Number of drug disposal bins installed statewide

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	170.0	174.0	178.0	182.0	186.0

Field Level Notes for Form 10a ESMs:

None

ESM 7.6 - Number of press releases, social media posts and presentations about adolescent falls

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	5.0	6.0	7.0	7.0	8.0

Field Level Notes for Form 10a ESMs:

None

ESM 7.7 - Number of suicide-related articles, social media posts and trainings provided by TDH

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	6.0	7.0	8.0	9.0	10.0

Field Level Notes for Form 10a ESMs:

None

ESM 8.1 - Number of Gold Sneaker-recognized childcare facilities in Tennessee

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	480.0	525.0	570.0	615.0	660.0

Field Level Notes for Form 10a ESMs:

None

ESM 8.2 - Average number of monthly calls to the Tennessee Breastfeeding Hotline (TBH)

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	475.0	500.0	525.0	550.0	575.0

Field Level Notes for Form 10a ESMs:

None

ESM 8.3 - Number of Baby Friendly-designated Tennessee birthing hospitals

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	3.0	3.0	4.0	4.0	5.0

Field Level Notes for Form 10a ESMs:

None

ESM 8.4 - Number of Run Clubs for 5th through 8th graders

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	60.0	75.0	90.0	105.0	120.0

Field Level Notes for Form 10a ESMs:

None

ESM 8.5 - Number of school districts (LEAs) that received CSPAP training

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	70.0	75.0	80.0	85.0	90.0

Field Level Notes for Form 10a ESMs:

None

ESM 8.6 - Number of school districts (LEAs) that received Smarter Lunchroom training

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	140.0	146.0	146.0	146.0	146.0

Field Level Notes for Form 10a ESMs:

None

ESM 8.7 - Number of shared-use agreements (any type) between two or more entities in Tennessee

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	1,675.0	1,700.0	1,725.0	1,750.0	1,775.0

Field Level Notes for Form 10a ESMs:

None

ESM 11.1 - Number of providers trained and provided information on medical home implementation

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	475.0	525.0	575.0	625.0	675.0

Field Level Notes for Form 10a ESMs:

None

ESM 11.2 - Number of families that receive patient centered medical home training

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	307.0	337.0	367.0	397.0	427.0

Field Level Notes for Form 10a ESMs:

None

ESM 11.3 - Percentage of children served by the Children’s Special Service (CSS) program receiving services in a medical home

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	80.0	85.0	90.0	95.0	100.0

Field Level Notes for Form 10a ESMs:

None

ESM 12.1 - Number of adolescents on the Adolescent Advisory Council

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	5.0	7.0	9.0	11.0	13.0

Field Level Notes for Form 10a ESMs:

None

ESM 14.1 - Number of child care facilities that voluntarily implement a tobacco-free campus policy

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	480.0	525.0	570.0	615.0	660.0

Field Level Notes for Form 10a ESMs:

None

ESM 14.2 - Number of tobacco users who call the Tennessee Tobacco Quitline

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	12,650.0	13,800.0	14,950.0	16,100.0	17,250.0

Field Level Notes for Form 10a ESMs:

None

ESM 14.3 - Percent of primary caregivers enrolled in home visiting who reported using any tobacco products at enrollments and were referred to tobacco cessation counseling or services within three months of enrollment

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	10.0	20.0	30.0	40.0	50.0

Field Level Notes for Form 10a ESMs:

None

Form 10b
State Performance Measure (SPM) Detail Sheets
State: Tennessee

SPM 1 - Percentage of children ages 0-17 experiencing two or more adverse childhood experiences
Population Domain(s) – Child Health

Goal:	To reduce the percentage of children ages 0-17 experiencing two or more adverse childhood experiences									
Definition:	<table border="1" style="width: 100%;"> <tr> <td style="width: 25%;">Numerator:</td> <td>Number of children with 2 or more adverse childhood experiences</td> </tr> <tr> <td>Denominator:</td> <td>Number of children age 0 through 17</td> </tr> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> </table>		Numerator:	Number of children with 2 or more adverse childhood experiences	Denominator:	Number of children age 0 through 17	Unit Type:	Percentage	Unit Number:	100
Numerator:	Number of children with 2 or more adverse childhood experiences									
Denominator:	Number of children age 0 through 17									
Unit Type:	Percentage									
Unit Number:	100									
Data Sources and Data Issues:	National Survey of Children's Health (NSCH)									
Significance:	<p>Traumatic events experienced during childhood (Adverse Childhood Experiences, ACEs) have been shown to have an impact on adult health outcomes such as heart disease, stroke and cancer, as well as socioeconomic outcomes such as educational attainment and income. Reducing the occurrence of ACEs during childhood can improve health outcomes and increase productivity for future generations. 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%).</p>									

SPM 2 - Percentage of infants born to Tennessee resident mothers who initiate breastfeeding
Population Domain(s) – Child Health

Goal:	Increase the percentage of infants born to Tennessee resident mothers who initiate breastfeeding									
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>Number of newborns to Tennessee-resident mothers who report breastfeeding initiation (“yes” response) on the child’s birth certificate</td> </tr> <tr> <td>Denominator:</td> <td>Number of live births to Tennessee-resident mothers</td> </tr> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> </table>	Numerator:	Number of newborns to Tennessee-resident mothers who report breastfeeding initiation (“yes” response) on the child’s birth certificate	Denominator:	Number of live births to Tennessee-resident mothers	Unit Type:	Percentage	Unit Number:	100	
Numerator:	Number of newborns to Tennessee-resident mothers who report breastfeeding initiation (“yes” response) on the child’s birth certificate									
Denominator:	Number of live births to Tennessee-resident mothers									
Unit Type:	Percentage									
Unit Number:	100									
Data Sources and Data Issues:	Breastfeeding initiation rates are determined utilizing the Birth Statistical System (BSS) – a data warehouse for all information captured on a child’s birth certificate. BSS is housed within the Division of Policy, Planning and Assessment (TDH). Data source is considered complete and timely.									
Significance:	Benefits of breastfeeding have been well documented in recent years, including risk reduction for allergies/asthma, increased antibodies to fight off viruses and bacteria, lower risk of SIDS, and much more. Additionally, breastfed babies and mothers have been shown to be at less risk for obesity and developing various chronic diseases. Breastfeeding initiation is considered an early indicator of breastfeeding fidelity throughout the first year of life.									

SPM 3 - Percent of live births that were the result of an unintended pregnancy

Population Domain(s) – Women/Maternal Health

Goal:	Decrease the number of live births that were the result of an unintended pregnancy									
Definition:	<table border="1"> <tr> <td style="background-color: #2e75b6; color: white;">Numerator:</td> <td>Number of mothers reporting that their pregnancy was either unintended or that they weren't sure how they felt about becoming pregnant</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Denominator:</td> <td>Number of live births to Tennessee-resident mothers</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Unit Type:</td> <td>Percentage</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Unit Number:</td> <td>100</td> </tr> </table>		Numerator:	Number of mothers reporting that their pregnancy was either unintended or that they weren't sure how they felt about becoming pregnant	Denominator:	Number of live births to Tennessee-resident mothers	Unit Type:	Percentage	Unit Number:	100
Numerator:	Number of mothers reporting that their pregnancy was either unintended or that they weren't sure how they felt about becoming pregnant									
Denominator:	Number of live births to Tennessee-resident mothers									
Unit Type:	Percentage									
Unit Number:	100									
Data Sources and Data Issues:	Pregnancy Risk Assessment Monitoring System (PRAMS)									
Significance:	<p>Although most pregnancies result in good maternal and fetal outcomes, some pregnancies may result in adverse health effects for the woman, fetus, or neonate. Although some of these outcomes cannot be prevented, optimizing a woman's health and knowledge before planning and conceiving a pregnancy may eliminate or reduce the risk. Approximately half of all pregnancies in Tennessee are unintended. Therefore, the challenge of preconception care lies not only in addressing pregnancy planning for women who seek medical care and consultation specifically in anticipation of a planned pregnancy but also in educating and screening all reproductively capable women on an ongoing basis to identify potential maternal and fetal risk. In essence, family planning and preconception care are an important part of general preventive care for all women of reproductive age.</p>									

Form 10b
State Outcome Measure (SOM) Detail Sheets
State: Tennessee

No State Outcome Measures were created by the State.

Form 10c
Evidence-Based or –Informed Strategy Measure (ESM) Detail Sheets

State: Tennessee

ESM 1.1 - Number of press releases, PSAs and/or social media messages promoting preventive health care visits for women of reproductive age

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

Goal:	To increase the number of press releases, PSAs and/or social media messages promoting preventive health care visits for women of reproductive age									
Definition:	<table border="1"> <tr> <td style="background-color: #2e75b6; color: white;">Numerator:</td> <td>Number of press releases, PSAs and/or social media messages promoting preventive health care visits for women of reproductive age</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Denominator:</td> <td>N/A</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Unit Type:</td> <td>Count</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Unit Number:</td> <td>10</td> </tr> </table>		Numerator:	Number of press releases, PSAs and/or social media messages promoting preventive health care visits for women of reproductive age	Denominator:	N/A	Unit Type:	Count	Unit Number:	10
Numerator:	Number of press releases, PSAs and/or social media messages promoting preventive health care visits for women of reproductive age									
Denominator:	N/A									
Unit Type:	Count									
Unit Number:	10									
Data Sources and Data Issues:	TDH Office of Communications; TDH Reproductive and Women’s Health Section program data									
Significance:	The use of press releases and social media messages can help bring public awareness to the issue and general importance of preventive health care for women as well as to specific preventive care recommendations (e.g. Pap smears and mammograms). Social media and other emerging communication technologies have the potential to reach large and diverse populations and help reach individuals when, where and how they want to receive health messages. Social media is a way to expand reach, foster engagement and increase access to credible, science-based health messages in order to spread key messages and influence health decision making.									

ESM 1.2 - Number of webinars for providers on increasing preventive care visits among women in their clinics

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

Goal:	To Increase the number of webinars for providers on increasing preventive care visits among women in their clinics									
Definition:	<table border="1"> <tr> <td style="background-color: #2e75b6; color: white;">Numerator:</td> <td>Number of webinars for providers on increasing preventive care visits among women in their clinics</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Denominator:</td> <td>N/A</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Unit Type:</td> <td>Count</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Unit Number:</td> <td>2</td> </tr> </table>		Numerator:	Number of webinars for providers on increasing preventive care visits among women in their clinics	Denominator:	N/A	Unit Type:	Count	Unit Number:	2
Numerator:	Number of webinars for providers on increasing preventive care visits among women in their clinics									
Denominator:	N/A									
Unit Type:	Count									
Unit Number:	2									
Data Sources and Data Issues:	TDH Reproductive and Women’s Health Section program data									
Significance:	<p>Competing priorities and busy schedules can make it difficult for women to make time for their own health, especially for preventive health care, while changing recommendations can make it challenging for both patients and providers to navigate preventive care needs. Training primary care providers on how to leverage missed opportunities (such as acute care visits) for provision of preventive care and how to properly code such visits for reimbursement is one way to promote and increase preventive health care services among women of reproductive age.</p>									

ESM 1.3 - Number of quarterly site-level family planning utilization reports distributed to local health departments

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

Goal:	To distribute quarterly site-level family planning utilization reports to local health departments									
Definition:	<table border="1"> <tr> <td style="background-color: #2e75b6; color: white;">Numerator:</td> <td>Number of quarterly site-level family planning utilization reports distributed to local health departments</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Denominator:</td> <td>N/A</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Unit Type:</td> <td>Count</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Unit Number:</td> <td>4</td> </tr> </table>		Numerator:	Number of quarterly site-level family planning utilization reports distributed to local health departments	Denominator:	N/A	Unit Type:	Count	Unit Number:	4
Numerator:	Number of quarterly site-level family planning utilization reports distributed to local health departments									
Denominator:	N/A									
Unit Type:	Count									
Unit Number:	4									
Data Sources and Data Issues:	Tennessee Department of Health - Patient Tracking Billing Information Management System (PTBMIS)									
Significance:	<p>The number of Family Planning (FP) clients served by the department has been declining in recent years. Similar declines have been observed in FP programs nationwide, as well as in other health department programs such as WIC. Quarterly site-level family planning utilization reports are an effort to better understand the FP patient population at a very granular level (e.g. patient demographics, insurance status, and contraceptive methods at individual service sites). Better understanding of patient characteristics and trends among specific subgroups will help health department staff focus outreach efforts aimed at slowing and reversing declines in FP program utilization and providing these services to the greatest number of people possible. Family Planning visits offer an opportunity to not only help women avoid unintended pregnancies, but to also prepare for healthy pregnancies by addressing important preventive care issues among those of reproductive age.</p>									

ESM 1.4 - Number of region-level pregnancy-related service utilization reports distributed to regional health departments

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

Goal:	To distribute quarterly region-level pregnancy-related service utilization reports to regional health departments									
Definition:	<table border="1"> <tr> <td style="background-color: #2e75b6; color: white;">Numerator:</td> <td>Number of quarterly region-level pregnancy-related service utilization reports distributed to regional health departments</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Denominator:</td> <td>N/A</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Unit Type:</td> <td>Count</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Unit Number:</td> <td>4</td> </tr> </table>		Numerator:	Number of quarterly region-level pregnancy-related service utilization reports distributed to regional health departments	Denominator:	N/A	Unit Type:	Count	Unit Number:	4
Numerator:	Number of quarterly region-level pregnancy-related service utilization reports distributed to regional health departments									
Denominator:	N/A									
Unit Type:	Count									
Unit Number:	4									
Data Sources and Data Issues:	Tennessee Department of Health - Patient Tracking Billing Information Management System (PTBMIS)									
Significance:	<p>Most health department clients seeking a pregnancy test would benefit from the full array of Family Planning (FP) services which include discussions about a reproductive life plan and a medical history. The FP visit not only helps women to avoid unintended pregnancies, but also to prepare for healthy pregnancies by addressing important preventive care issues among those of reproductive age. Title X funding provides the opportunity for any health department pregnancy test and subsequent counseling to be coded to the FP program regardless of test result. Tests provided through FP are an indicator that appropriate FP counseling was made available. Quarterly region-level pregnancy-related service utilization reports provide information to regional staff on the percentage of pregnancy tests provided through FP versus other services, encourages them to treat all pregnancy test patients as FP clients, and allows them to track their progress in meeting department goals (currently set at 85% by the end of CY2016).</p>									

ESM 5.1 - Number of safe sleep educational material distributed
NPM 5 – Percent of infants placed to sleep on their backs

Goal:	To increase the number of safe sleep educational materials distributed									
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>Number of safe sleep educational materials distributed</td> </tr> <tr> <td>Denominator:</td> <td>n/a</td> </tr> <tr> <td>Unit Type:</td> <td>Count</td> </tr> <tr> <td>Unit Number:</td> <td>80,000</td> </tr> </table>		Numerator:	Number of safe sleep educational materials distributed	Denominator:	n/a	Unit Type:	Count	Unit Number:	80,000
Numerator:	Number of safe sleep educational materials distributed									
Denominator:	n/a									
Unit Type:	Count									
Unit Number:	80,000									
Data Sources and Data Issues:	TDH FHW child fatality review program data									
Significance:	<p>Safe sleep educational materials play an important role in educating new parents and caregivers about ways to keep babies safe while sleeping. In 2014, there were 99 infant deaths that resulted from an unsafe sleep environment, account for approximately 18% of all infant deaths. By focusing on distributing safe sleep educational materials can increase the awareness to put babies into safe sleep environment and decrease the sleep-related infant death and reduce the overall infant mortality rate.</p>									

ESM 5.2 - Percent of infant deaths to be reviewed by child fatality review teams
NPM 5 – Percent of infants placed to sleep on their backs

Goal:	To maintain the percent of infant deaths to be reviewed by child fatality review teams									
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>Number of reviewed infant deaths</td> </tr> <tr> <td>Denominator:</td> <td>Number of infant deaths met the review criteria</td> </tr> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> </table>		Numerator:	Number of reviewed infant deaths	Denominator:	Number of infant deaths met the review criteria	Unit Type:	Percentage	Unit Number:	100
Numerator:	Number of reviewed infant deaths									
Denominator:	Number of infant deaths met the review criteria									
Unit Type:	Percentage									
Unit Number:	100									
Data Sources and Data Issues:	TDH FHW child death review database									
Significance:	<p>The overall 2014 infant mortality rate in Tennessee was 6.9 infant deaths per 1,000 live births, 15% higher than national rate. The deaths meeting the review criteria were all reviewed by CFR (Child Fatality Review) teams. Their careful review process results in a thorough description of the factors related to infant deaths. By reviewing these cases, it can provide a comprehensive depth of understanding of the deaths and reduce infant mortality.</p>									

ESM 5.3 - Percent of VLBW (Very Low Birth Weight) infants being delivered at Level III or IV birthing facilities

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

Goal:	Maintain that 80% of VLBW infants are being delivered at Level III or IV birthing facilities									
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>VLBW infants are being delivered at Level III or IV birthing facilities</td> </tr> <tr> <td>Denominator:</td> <td>All VLBW infants</td> </tr> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> </table>		Numerator:	VLBW infants are being delivered at Level III or IV birthing facilities	Denominator:	All VLBW infants	Unit Type:	Percentage	Unit Number:	100
Numerator:	VLBW infants are being delivered at Level III or IV birthing facilities									
Denominator:	All VLBW infants									
Unit Type:	Percentage									
Unit Number:	100									
Data Sources and Data Issues:	Tennessee Department of Health, Births Statistical System									
Significance:	Very low birth weight infants (<1,500 grams or 3.25 pounds) are at high risk of morbidity and mortality. VLBW infants are significantly more likely to survive when delivered at level III or IV birthing facilities.									

ESM 5.4 - Percent of newborns with a positive metabolic screen who receive follow-up to definitive diagnosis and clinical management

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

Goal:	Maintain that at least 99% of newborns with a positive metabolic screen receive follow up to definitive diagnosis									
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>Number of infants who received follow-up to a definitive diagnosis</td> </tr> <tr> <td>Denominator:</td> <td>Number of infants with a positive metabolic screen</td> </tr> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> </table>		Numerator:	Number of infants who received follow-up to a definitive diagnosis	Denominator:	Number of infants with a positive metabolic screen	Unit Type:	Percentage	Unit Number:	100
Numerator:	Number of infants who received follow-up to a definitive diagnosis									
Denominator:	Number of infants with a positive metabolic screen									
Unit Type:	Percentage									
Unit Number:	100									
Data Sources and Data Issues:	Neometrics/Natus newborn screening database									
Significance:	Metabolic newborn screening is mandatory for all babies born in Tennessee unless there is a refusal for religious reasons. The Tennessee system includes the State Laboratory, the follow-up staff, and the tertiary centers for referrals and follow-up. The system is designed to provide our families and providers the resources and services needed to assure that a timely diagnosis is made in each case. Early and appropriate intervention for each infant is critical for improving outcome.									

ESM 5.5 - Number of individuals served by the Tennessee Adolescent Pregnancy Prevention Program (TAPPP)

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

Goal:	To increase the number of individuals served by the Tennessee Adolescent Pregnancy Prevention Program (TAPPP)									
Definition:	<table border="1"> <tr> <td style="background-color: #2e75b6; color: white;">Numerator:</td> <td>Number of individuals served by the Tennessee Adolescent Pregnancy Prevention Program (TAPPP)</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Denominator:</td> <td>n/a</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Unit Type:</td> <td>Count</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Unit Number:</td> <td>47,500</td> </tr> </table>		Numerator:	Number of individuals served by the Tennessee Adolescent Pregnancy Prevention Program (TAPPP)	Denominator:	n/a	Unit Type:	Count	Unit Number:	47,500
Numerator:	Number of individuals served by the Tennessee Adolescent Pregnancy Prevention Program (TAPPP)									
Denominator:	n/a									
Unit Type:	Count									
Unit Number:	47,500									
Data Sources and Data Issues:	<p>TAPPP – Programmatic data collected from the 6 Regional and 2 Metro HD TAPPP Coordinators and County Health Educators using the state data reporting form.</p> <p>Abstinence Education Grant Program – Programmatic data collected from the 13 abstinence education program coordinators using the required federal data collection sheet.</p>									
Significance:	<p>Adolescent childbearing has been associated with increased risks for poor birth outcomes, including preterm delivery, low birthweight, and infant mortality. Causes for poorer birth outcomes in adolescents have been attributed to lower rates of adequate prenatal care, poor weight gain and nutrition, higher rates of tobacco use, high risk health behaviors and socioeconomic background characteristics. Therefore, increasing the number of individuals who participate in programs that address adolescent pregnancy prevention and abstinence education are critical in reducing teen pregnancies and infant mortality rates.</p>									

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

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

Goal:	To increase general awareness of the need for developmental screening									
Definition:	<table border="1"> <tr> <td style="background-color: #2e75b6; color: white;">Numerator:</td> <td>Number of site views from webpage and mobile app to the Developmental Milestones and Developmental Screenings site during the past 12 months</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Denominator:</td> <td>n/a</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Unit Type:</td> <td>Count</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Unit Number:</td> <td>675</td> </tr> </table>		Numerator:	Number of site views from webpage and mobile app to the Developmental Milestones and Developmental Screenings site during the past 12 months	Denominator:	n/a	Unit Type:	Count	Unit Number:	675
Numerator:	Number of site views from webpage and mobile app to the Developmental Milestones and Developmental Screenings site during the past 12 months									
Denominator:	n/a									
Unit Type:	Count									
Unit Number:	675									
Data Sources and Data Issues:	Kidcentraltn.com annual site traffic report from ioStudio									
Significance:	The audience of this strategy is the general public. Kidcentraltn.com is the state platform used to reach the general public across the state via the website, Facebook, twitter, and mobile app. By creating additional content and intentionally promoting this content, we can drive site views to the Developmental Screenings and Milestones screens.									

ESM 6.2 - Number of health department nurses trained in the START Autism and MCHAT-R/F program
NPM 6 – Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Goal:	To increase number of health department nurses trained in the START Autism and MCHAT-R/F program									
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>Number of nurses trained in the START Autism and MCHAT-R/F program</td> </tr> <tr> <td>Denominator:</td> <td>N/A</td> </tr> <tr> <td>Unit Type:</td> <td>Count</td> </tr> <tr> <td>Unit Number:</td> <td>545</td> </tr> </table>		Numerator:	Number of nurses trained in the START Autism and MCHAT-R/F program	Denominator:	N/A	Unit Type:	Count	Unit Number:	545
Numerator:	Number of nurses trained in the START Autism and MCHAT-R/F program									
Denominator:	N/A									
Unit Type:	Count									
Unit Number:	545									
Data Sources and Data Issues:	TDH Community Health Services training data									
Significance:	<p>The audience of this strategy is health department nurses and the clients of health departments. The Tennessee Early Intervention System and the Tennessee Chapter of the American Academy of Pediatrics have partnered with the health department to train nurse supervisors in the administration of the M-CHAT R screening tool for autism. It is assumed that trained nurse will administer the screening to the patients they see in clinic. Thus, training the health department nurses will increase the number of Tennessee children who receive a validated developmental screen at a primary care visit.</p>									

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

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

Goal:	To increase the percent of Developmental Screenings performed across the state for participants enrolled in an Evidence-Based Home Visiting Program									
Definition:	<table border="1"> <tr> <td style="background-color: #2e75b6; color: white;">Numerator:</td> <td>Number of ASQ-3 and ASQ:SE or ASQ:SE-2 screens documented at home visits during the past 12 months</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Denominator:</td> <td>Number of index children enrolled in an Evidence Based Home Visiting Program for at least 6 months</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Unit Type:</td> <td>Percentage</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Unit Number:</td> <td>100</td> </tr> </table>		Numerator:	Number of ASQ-3 and ASQ:SE or ASQ:SE-2 screens documented at home visits during the past 12 months	Denominator:	Number of index children enrolled in an Evidence Based Home Visiting Program for at least 6 months	Unit Type:	Percentage	Unit Number:	100
Numerator:	Number of ASQ-3 and ASQ:SE or ASQ:SE-2 screens documented at home visits during the past 12 months									
Denominator:	Number of index children enrolled in an Evidence Based Home Visiting Program for at least 6 months									
Unit Type:	Percentage									
Unit Number:	100									
Data Sources and Data Issues:	TDH FHW REDCap data base for MIECHV									
Significance:	<p>The audience of this strategy is non-medical providers that serve the child population. The Tennessee Young Child Wellness Council is partnering with agencies to create a catalog of developmental screening tools being used across the state, the settings in which these tools are being administered, and the degree of specificity. The Division of Family Health and Wellness continues to partner with state and federally funded evidence based home visiting programs. As an integral part of service delivery, and in compliance with national home visiting models, home visitors routinely administer developmental screenings.</p>									

ESM 7.1 - Number of parents and caregivers receiving car seat education

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

Goal:	To increase the number of parents of caregivers receiving car seat education	
Definition:	Numerator:	Number of parents and caregivers receiving car seat education
	Denominator:	n/a
	Unit Type:	Count
	Unit Number:	2,750
Data Sources and Data Issues:	Tennessee Department of Health Child Injury Prevention Program Data	
Significance:	<p>Motor vehicle crash injuries are a leading cause of death among children in the United States. In 2014, over 1,000 children ages 12 and under were seen in Tennessee emergency departments because of motor vehicle crashes. CDC research suggests that black and Hispanic children ages 12 and under are less likely to buckle up than white children. The consistent and correct use of car seats and boosters can reduce the risk of serious injury and death for infants, toddlers, and children up to age 8. Tennessee utilizes a recommended practice to distribute car seats with education programs to increase restraint and decrease injuries and deaths to child passengers.</p>	

ESM 7.2 - Number of counties that adopt Count It! Drop It! Lock It! educational programs
NPM 7 – Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19

Goal:	To increase the number of counties that adopt Count It! Drop It! Lock It! educational programs									
Definition:	<table border="1"> <tr> <td style="background-color: #2e75b6; color: white;">Numerator:</td> <td>Number of counties that adopt Count It! Drop It! Lock It! educational programs</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Denominator:</td> <td>n/a</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Unit Type:</td> <td>Count</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Unit Number:</td> <td>57</td> </tr> </table>		Numerator:	Number of counties that adopt Count It! Drop It! Lock It! educational programs	Denominator:	n/a	Unit Type:	Count	Unit Number:	57
Numerator:	Number of counties that adopt Count It! Drop It! Lock It! educational programs									
Denominator:	n/a									
Unit Type:	Count									
Unit Number:	57									
Data Sources and Data Issues:	Tennessee Department of Health Injury Prevention Program reports									
Significance:	<p>Unintentional poisoning killed 635 U.S. Children in 2014; almost 90% of them were teenagers, ages 10-19. In 2014 117,959 U.S. children visited emergency departments for unintentional poisoning-related injuries (WISQARS). Reducing the amount of prescription drugs in the home can reduce access to these drugs by children. Research indicates the high availability of prescription drugs in Tennessee is contributing to the addiction problem across the state. According to the 2010 National Survey on Drug Use and Health, 70% of people who abused or misused prescription drugs got them from a friend or relative, either for free, by purchasing them, or by stealing them. People who abuse prescription drugs also obtain them from other sources including “pill mills,” or illegitimate pain clinics; prescription fraud; pharmacy theft; illegal online pharmacies; and “doctor shopping”. Some individuals who use prescription drugs for non-medical reasons believe these substances are safer than illicit drugs because they are prescribed by a physician and dispensed by a pharmacist.</p> <p>Communities that develop partnerships with schools, healthcare providers, pharmacists, law enforcement and other sectors to educate families about the importance of monitoring, securing, and properly disposing of prescription drugs can reduce access to unused prescription drugs and increase the perception of harm of the abuse of prescription drugs.</p>									

ESM 7.3 - Percent of families who receive injury prevention education through the AAP checklist among families participating in Evidence Based Home Visiting programs

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

Goal:	To increase the percent of families who receive injury prevention education through the AAP checklist among families participating in Evidence Based Home Visiting programs									
Definition:	<table border="1"> <tr> <td style="background-color: #2e75b6; color: white;">Numerator:</td> <td>Number of children with at least one AAP screening completed</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Denominator:</td> <td>Number of children who reached first birthday during reporting period</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Unit Type:</td> <td>Percentage</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Unit Number:</td> <td>100</td> </tr> </table>		Numerator:	Number of children with at least one AAP screening completed	Denominator:	Number of children who reached first birthday during reporting period	Unit Type:	Percentage	Unit Number:	100
Numerator:	Number of children with at least one AAP screening completed									
Denominator:	Number of children who reached first birthday during reporting period									
Unit Type:	Percentage									
Unit Number:	100									
Data Sources and Data Issues:	Tennessee Department of Health - Evidence Based Home Visiting Database									
Significance:	<p>Injury is a leading cause of child mortality and morbidity. In 2014, injuries resulted in more than 3,131 deaths and 2.3 million emergency department visits among 0-4 year olds in the US (CDC WISQARS). Home visitors can play an important role in increasing awareness about injury hazards, identifying risk and protective factors in the home setting, and teaching caregivers injury prevention methods.</p> <p>Using a childhood injury risk assessment tool, home visitors can identify risks and provide education on a wide range of injury topics. Home visiting is one strategy that shows promise for reducing rates of self-reported and substantiated child maltreatment and use of emergency rooms to treat child injuries.</p>									

ESM 7.4 - Number of schools in the top ten crash rate counties (among ages 15-18) that conduct evidence-informed teen safe driving programming

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

Goal:	To increase the number of schools in the top ten crash rate counties (among ages 15-18) that conduct evidence-informed teen safe driving programming									
Definition:	<table border="1"> <tr> <td style="background-color: #2e75b6; color: white;">Numerator:</td> <td>Number of schools in the top ten crash rate counties that conduct evidence-informed teen safe driving programming</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Denominator:</td> <td>N/A</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Unit Type:</td> <td>Count</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Unit Number:</td> <td>63</td> </tr> </table>		Numerator:	Number of schools in the top ten crash rate counties that conduct evidence-informed teen safe driving programming	Denominator:	N/A	Unit Type:	Count	Unit Number:	63
Numerator:	Number of schools in the top ten crash rate counties that conduct evidence-informed teen safe driving programming									
Denominator:	N/A									
Unit Type:	Count									
Unit Number:	63									
Data Sources and Data Issues:	ReduceTNCrashes.org web based teen safe driving program reports									
Significance:	<p>Motor vehicle crash injuries are a leading cause of hospitalization among children in the United States. In 2014, over 840 adolescents ages 15-24 were hospitalized in Tennessee because of motor vehicle crashes. Research shows that in order for young drivers to remain collision-free, parents must model safe driving behaviors and invest in meaningful guided practice over a long period of time to turn these skills into good driving habits. It is our hope that new drivers will have a solid foundation to develop safe, collision-free driving habits that will last a lifetime through teen safe driving programming. The evidence-informed teen safe driving program can reduce risk and keep people safer on the road.</p>									

ESM 7.5 - Number of drug disposal bins installed statewide

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

Goal:	To increase the total number of drug disposal bins installed statewide	
Definition:	Numerator:	Number of drug disposal bins installed statewide
	Denominator:	N/A
	Unit Type:	Count
	Unit Number:	186
Data Sources and Data Issues:	Tennessee Department of Environment and Conservation Reports	
Significance:	<p>The diversion and abuse of prescription drugs contributes to the leading cause of death in Tennessee. In 2014, over 2,500 children ages 19 and under were admitted to the emergency department for poisoning. Young children are particularly at risk for accidental overdose due to the ingestion of prescription drugs, and unwanted medicine disposed in the trash can be stolen and used, potentially resulting in illness, injury, or death. There are few safe and convenient ways for consumers to properly dispose of unused prescription drugs that do not harm the solid or liquid waste system. Drug disposal bins are cited as one way to reduce the diversion and ingestion of unused prescription drugs while reducing damage to the local environment.</p>	

ESM 7.6 - Number of press releases, social media posts and presentations about adolescent falls
NPM 7 – Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19

Goal:	To increase the number of press releases, social media posts and presentations about adolescent falls									
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>Number of press releases, social media posts and presentations about adolescent falls</td> </tr> <tr> <td>Denominator:</td> <td>N/A</td> </tr> <tr> <td>Unit Type:</td> <td>Count</td> </tr> <tr> <td>Unit Number:</td> <td>8</td> </tr> </table>	Numerator:	Number of press releases, social media posts and presentations about adolescent falls	Denominator:	N/A	Unit Type:	Count	Unit Number:	8	
Numerator:	Number of press releases, social media posts and presentations about adolescent falls									
Denominator:	N/A									
Unit Type:	Count									
Unit Number:	8									
Data Sources and Data Issues:	Tennessee Department of Health Media Communications and Media Relations Department and Injury Prevention Program data									
Significance:	Traumatic Brain Injury (TBI) is a leading cause of death and disability in the United States. Falls disproportionately impact children ages 0-5 and over 18,000 children age 0-5 were treated in emergency rooms in 2014 for unintentional fall injury. Young children living in families with low socioeconomic status in older communities have a high risk for fall injuries and targeted interventions to low socioeconomic status parents of young, male, children may be warranted. Media posts and presentations that focus on risk factors such as furniture (e.g. bunk beds or walkers) playground equipment will be developed and delivered.									

ESM 7.7 - Number of suicide-related articles, social media posts and trainings provided by TDH
NPM 7 – Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19

Goal:	To increase number of suicide-related articles, social media posts and trainings provided by TDH									
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>Number of suicide-related articles, social media posts and trainings</td> </tr> <tr> <td>Denominator:</td> <td>N/A</td> </tr> <tr> <td>Unit Type:</td> <td>Count</td> </tr> <tr> <td>Unit Number:</td> <td>10</td> </tr> </table>		Numerator:	Number of suicide-related articles, social media posts and trainings	Denominator:	N/A	Unit Type:	Count	Unit Number:	10
Numerator:	Number of suicide-related articles, social media posts and trainings									
Denominator:	N/A									
Unit Type:	Count									
Unit Number:	10									
Data Sources and Data Issues:	Tennessee Department of Health injury prevention program data									
Significance:	<p>Suicides among young people continues to be a serious problem. Suicide is the third leading cause of death for Tennessee residents ages 15-24 according to the U.S. Center for Disease Control and Prevention. Suicide is a relatively rare event and it is difficult to accurately predict which persons with these risk factors will ultimately commit suicide. However, by providing articles, social media posts and training can increase awareness of the signs and risk factors of suicide attempts.</p>									

ESM 8.1 - Number of Gold Sneaker-recognized childcare facilities in Tennessee

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

Goal:	Increase the number of Gold Sneaker-recognized childcare facilities in Tennessee									
Definition:	<table border="1"> <tr> <td style="background-color: #2e75b6; color: white;">Numerator:</td> <td>Number of Tennessee licensed childcare facilities recognized by TDH as meeting the requirements set by the Gold Sneaker Initiative</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Denominator:</td> <td>N/A</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Unit Type:</td> <td>Count</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Unit Number:</td> <td>660</td> </tr> </table>		Numerator:	Number of Tennessee licensed childcare facilities recognized by TDH as meeting the requirements set by the Gold Sneaker Initiative	Denominator:	N/A	Unit Type:	Count	Unit Number:	660
Numerator:	Number of Tennessee licensed childcare facilities recognized by TDH as meeting the requirements set by the Gold Sneaker Initiative									
Denominator:	N/A									
Unit Type:	Count									
Unit Number:	660									
Data Sources and Data Issues:	<p>The Gold Sneaker facility tracking database is housed within the Division of Family Health and Wellness, and will be used to provide facility counts. The Gold Sneaker tracking database is updated as facilities receive application approval. However, at this time, there is no process for ensuring previously recognized facilities are still “active” (licensed, open, etc.). An evaluation and recertification process is currently being developed.</p>									
Significance:	<p>Through the Gold Sneaker recognition process, facilities are required to adopt nine policies related to physical activity (4), nutrition (4), and adoption of a smoke-free facility campus (1). The first Gold Sneaker policy directly relates to the National Performance Measure – requiring children to participate in at least 60 minutes of physical activity per day. Additional Gold Sneaker policies are in concert with recommendations made by the American Academy of Pediatrics, Tennessee Child Care Resource & Referral Network, and Tennessee Department of Health and Human Services.</p>									

ESM 8.2 - Average number of monthly calls to the Tennessee Breastfeeding Hotline (TBH)
NPM 8 – Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day

Goal:	To increase the average number of monthly calls to the Tennessee Breastfeeding Hotline									
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>Count of individual calls (not unique callers) to the TBH during the reporting period</td> </tr> <tr> <td>Denominator:</td> <td>Months in reporting period</td> </tr> <tr> <td>Unit Type:</td> <td>Count</td> </tr> <tr> <td>Unit Number:</td> <td>575</td> </tr> </table>	Numerator:	Count of individual calls (not unique callers) to the TBH during the reporting period	Denominator:	Months in reporting period	Unit Type:	Count	Unit Number:	575	
Numerator:	Count of individual calls (not unique callers) to the TBH during the reporting period									
Denominator:	Months in reporting period									
Unit Type:	Count									
Unit Number:	575									
Data Sources and Data Issues:	The Tennessee Breastfeeding Hotline is operated by Le Bonhuer Children’s Hospital in Memphis, Tennessee. TBH monitors call volume through electronic tracking (iCarol). Additional data elements for consideration include: referral sources, reason/concern, caller demographics, and follow-up call outcomes.									
Significance:	The Tennessee Breastfeeding Hotline is available 24 hours a day, seven days a week. The Hotline is staffed by International Board Certified Lactation Consultants and Certified Lactation Counselors who can provide up-to-date information and support and to address common questions and concerns about breastfeeding. Through consultation provided by the TBH, TDH continues its efforts to reduce barriers associated with breastfeeding, correct common misconceptions, and further promote breastfeeding as the optimal approach to infant feeding.									

ESM 8.3 - Number of Baby Friendly-designated Tennessee birthing hospitals

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

Goal:	To increase the number of Baby Friendly-designated Tennessee birthing hospitals									
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>Number of Baby Friendly-designated Tennessee birthing hospitals</td> </tr> <tr> <td>Denominator:</td> <td>N/A</td> </tr> <tr> <td>Unit Type:</td> <td>Count</td> </tr> <tr> <td>Unit Number:</td> <td>5</td> </tr> </table>		Numerator:	Number of Baby Friendly-designated Tennessee birthing hospitals	Denominator:	N/A	Unit Type:	Count	Unit Number:	5
Numerator:	Number of Baby Friendly-designated Tennessee birthing hospitals									
Denominator:	N/A									
Unit Type:	Count									
Unit Number:	5									
Data Sources and Data Issues:	<p>Baby Friendly Hospital Initiative tracks completion of its 10 guidelines and evaluation criteria. A list of Baby Friendly Tennessee birthing hospitals is provided at: https://www.babyfriendlyusa.org/find-facilities/designated-facilities--by-state</p>									
Significance:	<p>Baby-Friendly USA, Inc. and its implementation of the Baby-Friendly Hospital Initiative (BFHI) in the United States is predicated on the fact that human milk fed through the mother’s own breast is the normal way for human infants to be nourished. There is an abundance of scientific evidence that points to lower risks for certain diseases and improved health outcomes for both mothers and babies who breastfeed. Breastfeeding is the natural biological conclusion to pregnancy and an important mechanism for the continued normal development of the infant. With the correct information and the right supports in place, under normal circumstances, most women who choose to breastfeed are able to successfully achieve their goal.</p>									

ESM 8.4 - Number of Run Clubs for 5th through 8th graders

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

Goal:	To increase the number of Run Clubs for 5th through 8th graders									
Definition:	<table border="1"> <tr> <td style="background-color: #2e75b6; color: white;">Numerator:</td> <td>Tennessee Run Clubs with participants in grades 5th through 8th grade (identified through TDH partnerships)</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Denominator:</td> <td>N/A</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Unit Type:</td> <td>Count</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Unit Number:</td> <td>120</td> </tr> </table>		Numerator:	Tennessee Run Clubs with participants in grades 5th through 8th grade (identified through TDH partnerships)	Denominator:	N/A	Unit Type:	Count	Unit Number:	120
Numerator:	Tennessee Run Clubs with participants in grades 5th through 8th grade (identified through TDH partnerships)									
Denominator:	N/A									
Unit Type:	Count									
Unit Number:	120									
Data Sources and Data Issues:	<p>The Tennessee Department of Health, Division of Family Health and Wellness, tracks Run Clubs through a variety of sources: Coordinated School Health, Primary Prevention Initiative, Tennessee Department of Environment and Conservation (TDEC), and others. The tracking database was created in spring 2016 and continues to undergo revisions. TDH also recognizes that many Run Clubs new to the database may have been in existence for some time, but TDH was not aware of them.</p>									
Significance:	<p>Run Clubs, especially those that are school-based, offer students another avenue to be physically active. Run Clubs offer a noncompetitive alternative to formal sports, focusing on participation, group cohesion, and establishing a healthy lifestyle throughout one's life. Tennessee continues to evaluate the degree in which Run Clubs promote physical activity, and ultimately, Tennessee's success in having all children ages 6-17 engage in 60 minutes of physical activity each day.</p>									

ESM 8.5 - Number of school districts (LEAs) that received CSPAP training

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

Goal:	To increase the number of school districts (LEAs) that received CSPAP training									
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>Number of school districts (LEAs) that have received CSPAP training</td> </tr> <tr> <td>Denominator:</td> <td>N/A</td> </tr> <tr> <td>Unit Type:</td> <td>Count</td> </tr> <tr> <td>Unit Number:</td> <td>90</td> </tr> </table>		Numerator:	Number of school districts (LEAs) that have received CSPAP training	Denominator:	N/A	Unit Type:	Count	Unit Number:	90
Numerator:	Number of school districts (LEAs) that have received CSPAP training									
Denominator:	N/A									
Unit Type:	Count									
Unit Number:	90									
Data Sources and Data Issues:	Trainings are offered and tracked by the PA/PE Specialist working within the Office of Coordinated School (TN DOE). TDH, through contract, receives updated reports provided by the Office of Coordinated School Health.									
Significance:	A Comprehensive School Physical Activity Program (CSPAP) is a multi-component approach by which school districts and schools use all opportunities for students to be physically active, meet the nationally-recommended 60 minutes of physical activity each day, and develop the knowledge, skills, and confidence to be physically active for a lifetime. In order for Tennessee schools to adopt and implement CSPAP, school staff must be trained in its policies, strategies, and components.									

ESM 8.6 - Number of school districts (LEAs) that received Smarter Lunchroom training
NPM 8 – Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day

Goal:	To increase the number of school districts (LEAs) that received Smarter Lunchroom training									
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>Total number of Tennessee school districts (LEAs) who have received Smarter Lunchroom training</td> </tr> <tr> <td>Denominator:</td> <td>N/A</td> </tr> <tr> <td>Unit Type:</td> <td>Count</td> </tr> <tr> <td>Unit Number:</td> <td>146</td> </tr> </table>		Numerator:	Total number of Tennessee school districts (LEAs) who have received Smarter Lunchroom training	Denominator:	N/A	Unit Type:	Count	Unit Number:	146
Numerator:	Total number of Tennessee school districts (LEAs) who have received Smarter Lunchroom training									
Denominator:	N/A									
Unit Type:	Count									
Unit Number:	146									
Data Sources and Data Issues:	Trainings are offered and tracked by the PA/PE Specialist working within the Office of Coordinated School (TN DOE). TDH, through contract, receives updated reports provided by the Office of Coordinated School Health.									
Significance:	The Smarter Lunchrooms Movement creates sustainable research-based lunchrooms that guide smarter choices. Its guiding principles and practice have been proven effective in a number of schools across the nation (Cornell Center for Behavioral Economics in Child Nutrition Programs). TDH recognizes that children making healthy food choices while at school will significantly impact the statewide priority of reducing the prevalence of obesity.									

ESM 8.7 - Number of shared-use agreements (any type) between two or more entities in Tennessee
NPM 8 – Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day

Goal:	To increase the number of shared-use agreements (any type) between two or more entities in Tennessee									
Definition:	<table border="1"> <tr> <td style="background-color: #2e75b6; color: white;">Numerator:</td> <td>Number of shared-use agreements of any type (policy, written, verbal, open or mixed)</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Denominator:</td> <td>N/A</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Unit Type:</td> <td>Count</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Unit Number:</td> <td>1,775</td> </tr> </table>		Numerator:	Number of shared-use agreements of any type (policy, written, verbal, open or mixed)	Denominator:	N/A	Unit Type:	Count	Unit Number:	1,775
Numerator:	Number of shared-use agreements of any type (policy, written, verbal, open or mixed)									
Denominator:	N/A									
Unit Type:	Count									
Unit Number:	1,775									
Data Sources and Data Issues:	The TN Recreational Joint Facility Use Finder is housed at the Tennessee Recreation and Parks Association. TDH must request access to the data on an ad hoc basis, and does not monitor or control data quality. During the upcoming year staff will be working to update the joint use tracking system.									
Significance:	Physical activity is an important part of good health for everyone, regardless of age or ability. Joint use agreements remove barriers to physical activity by providing places to be active. In fact, allowing access to school physical activity spaces and facilities is a recommended strategy in the Healthy People 2020 goals for the nation's health. By working together to share facilities, schools and communities can achieve multiple benefits. From the perspective of school staff, joint use agreements provide a venue for students to get more physical activity. Physical activity contributes to students' health and reduces truancy. Furthermore, participating in physical activity in safe and clean public spaces helps everyone to feel more connected to their community.									

ESM 11.1 - Number of providers trained and provided information on medical home implementation
NPM 11 – Percent of children with and without special health care needs having a medical home

Goal:	To increase the number of providers trained and provided information on medical home implementation									
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>Number of providers trained and provided information on medical home implementation</td> </tr> <tr> <td>Denominator:</td> <td>N/A</td> </tr> <tr> <td>Unit Type:</td> <td>Count</td> </tr> <tr> <td>Unit Number:</td> <td>675</td> </tr> </table>		Numerator:	Number of providers trained and provided information on medical home implementation	Denominator:	N/A	Unit Type:	Count	Unit Number:	675
Numerator:	Number of providers trained and provided information on medical home implementation									
Denominator:	N/A									
Unit Type:	Count									
Unit Number:	675									
Data Sources and Data Issues:	Title V Children and Youth with Special Healthcare Needs (CYSHCN) program training participation log									
Significance:	<p>The American Academy of Pediatrics (AAP) specifies seven qualities essential to medical home care: accessible, family-centered, continuous, comprehensive, coordinated, compassionate and culturally effective. Ideally, medical home care is delivered within the context of a trusting and collaborative relationship between the child’s family and a competent health professional familiar with the child and family and the child’s health history. Our program believes in the importance of training and plans to train more providers on medical home concept and provide information on medical home implementation.</p>									

ESM 11.2 - Number of families that receive patient centered medical home training

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

Goal:	Increase the number of families that receive patient centered medical home training									
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>Number of families that receive patient centered medical home training</td> </tr> <tr> <td>Denominator:</td> <td>N/A</td> </tr> <tr> <td>Unit Type:</td> <td>Count</td> </tr> <tr> <td>Unit Number:</td> <td>500</td> </tr> </table>		Numerator:	Number of families that receive patient centered medical home training	Denominator:	N/A	Unit Type:	Count	Unit Number:	500
Numerator:	Number of families that receive patient centered medical home training									
Denominator:	N/A									
Unit Type:	Count									
Unit Number:	500									
Data Sources and Data Issues:	Title V Children and Youth with Special Healthcare Needs (CYSHCN) program training participation log									
Significance:	<p>The American Academy of Pediatrics (AAP) specifies seven qualities essential to medical home care: accessible, family-centered, continuous, comprehensive, coordinated, compassionate and culturally effective. Ideally, medical home care is delivered within the context of a trusting and collaborative relationship between the child’s family and a competent health professional familiar with the child and family and the child’s health history. This measure gauges the number of families that receive patient centered medical home training.</p>									

ESM 11.3 - Percentage of children served by the Children's Special Service (CSS) program receiving services in a medical home

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

Goal:	To increase the percentage of children served by the CSS program receiving services in a medical home									
Definition:	<table border="1"> <tr> <td style="background-color: #2e75b6; color: white;">Numerator:</td> <td>Number of children 0-20 years of age served by the CSS program receiving services in a medical home</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Denominator:</td> <td>Number of children 0-20 years of age served by the CSS program</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Unit Type:</td> <td>Percentage</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Unit Number:</td> <td>100</td> </tr> </table>		Numerator:	Number of children 0-20 years of age served by the CSS program receiving services in a medical home	Denominator:	Number of children 0-20 years of age served by the CSS program	Unit Type:	Percentage	Unit Number:	100
Numerator:	Number of children 0-20 years of age served by the CSS program receiving services in a medical home									
Denominator:	Number of children 0-20 years of age served by the CSS program									
Unit Type:	Percentage									
Unit Number:	100									
Data Sources and Data Issues:	Tennessee Department of Health - Patient Tracking and Billing Management Information System (PTBMIS) - CSS Program data									
Significance:	<p>The American Academy of Pediatrics (AAP) specifies seven qualities essential to medical home care: accessible, family-centered, continuous, comprehensive, coordinated, compassionate and culturally effective. Ideally, medical home care is delivered within the context of a trusting and collaborative relationship between the child's family and a competent health professional familiar with the child and family and the child's health history. The measure is limited to the children served by the CSS program.</p>									

ESM 12.1 - Number of adolescents on the Adolescent Advisory Council

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

Goal:	To expand the adolescent advisory council	
Definition:	Numerator:	Number of adolescents on the advisory council
	Denominator:	N/A
	Unit Type:	Count
	Unit Number:	13
Data Sources and Data Issues:	Children and Youth with Special Healthcare Needs (CYSHCN) program record	
Significance:	<p>The transition of youth to adulthood has become a priority issue nationwide as evidenced by the clinical report and algorithm developed jointly by the AAP, American Academy of Family Physicians and American College of Physicians to improve healthcare transitions for all youth and families. Over 90 percent of children with special health care needs now live to adulthood, but are less likely than their non-disabled peers to complete high school, attend college or to be employed. Health and health care are cited as two of the major barriers to making successful transitions. Our CSS program requires all children enrolled in the program have a transition plan in place by age of 14 years and updated every year afterward. The Youth Advisory Council will provide recommendations and advise the CSS program staff on transition concerns youth may face.</p>	

ESM 14.1 - Number of child care facilities that voluntarily implement a tobacco-free campus policy
NPM 14 – A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes

Goal:	To increase the number of child care facilities that voluntarily implement a tobacco-free campus policy									
Definition:	<table border="1"> <tr> <td style="background-color: #2e75b6; color: white;">Numerator:</td> <td>Number of licensed childcare facilities in Tennessee who adopt Gold-Sneaker designated policies</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Denominator:</td> <td>N/A</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Unit Type:</td> <td>Count</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Unit Number:</td> <td>660</td> </tr> </table>		Numerator:	Number of licensed childcare facilities in Tennessee who adopt Gold-Sneaker designated policies	Denominator:	N/A	Unit Type:	Count	Unit Number:	660
Numerator:	Number of licensed childcare facilities in Tennessee who adopt Gold-Sneaker designated policies									
Denominator:	N/A									
Unit Type:	Count									
Unit Number:	660									
Data Sources and Data Issues:	The Gold Sneaker facility tracking database is housed within the Division of Family Health and Wellness, and will be used to provide facility counts. The Gold Sneaker tracking database is updated as facilities receive application approval. However, at this time, there is no process for ensuring previously recognized facilities are still “active” (licensed, open, etc.). An evaluation and re-certification process is currently being developed.									
Significance:	According to the Centers for Disease Control and Prevention (CDC), about 2 in 5 children (aged 3 to 11 years) are exposed to secondhand smoke (SHS). Secondhand smoke exposure increases the risk of infant death syndrome (SIDS), respiratory infections, ear infections, and asthma attacks in infants and children. Secondhand smoke exposure is still a serious problem within the home, the leading source of exposure among children. In Tennessee, roughly 30% of children live in a household where someone smokes. With initiatives such as Gold Sneaker, parents are educated about the dangers of secondhand smoke and the benefits of tobacco-free childcare centers and homes.									

ESM 14.2 - Number of tobacco users who call the Tennessee Tobacco Quitline

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

Goal:	Increase the number of tobacco users who call the Tennessee Tobacco Quitline									
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>Number of calls with Tennessee area code who called Quitline</td> </tr> <tr> <td>Denominator:</td> <td>N/A</td> </tr> <tr> <td>Unit Type:</td> <td>Count</td> </tr> <tr> <td>Unit Number:</td> <td>17,250</td> </tr> </table>		Numerator:	Number of calls with Tennessee area code who called Quitline	Denominator:	N/A	Unit Type:	Count	Unit Number:	17,250
Numerator:	Number of calls with Tennessee area code who called Quitline									
Denominator:	N/A									
Unit Type:	Count									
Unit Number:	17,250									
Data Sources and Data Issues:	Tennessee Tobacco Quitline Vendor Reports. Due to Tennessee’s external operation of the Quitline (current vendor is based out of state), data are not available in-house.									
Significance:	<p>Tobacco use is the number one cause of preventable death in the US. In fact, six of the top 10 leading causes of death of Tennessee residents were linked to smoking. In Tennessee, about 24% of adults (BRFSS 2014) and nearly 25% of youth (YRBSS 2013) smoke. Although prenatal smoking rates have significantly declined in Tennessee, approximately 15% of Tennessee resident women smoked during pregnancy in 2014. Smoking cessation not only reduces the risk of chronic diseases, such as cancer and heart disease, but also prevents nonsmoker’s exposure to secondhand and third hand smoke. Telephone-based cessation services, like the Tennessee Tobacco Quitline, adopt a more public health-oriented approach not only by helping tobacco users who desire to quit but also by actively promoting cessation among the general population.</p>									

ESM 14.3 - Percent of primary caregivers enrolled in home visiting who reported using any tobacco products at enrollments and were referred to tobacco cessation counseling or services within three months of enrollment

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

Goal:	To increase the percent of primary caregivers enrolled in home visiting who reported using any tobacco products at enrollments and were referred to tobacco cessation counseling or services within three months of enrollment									
Definition:	<table border="1"> <tr> <td style="background-color: #2e75b6; color: white;">Numerator:</td> <td>Number of primary caregivers enrolled in home visiting who reported using any tobacco products at enrollment and were referred to tobacco cessation counseling or services within 3 months of enrollment</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Denominator:</td> <td>Number of primary caregivers enrolled in home visiting who reported using any tobacco products at enrollment and were enrolled for at least 3 months</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Unit Type:</td> <td>Percentage</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Unit Number:</td> <td>100</td> </tr> </table>		Numerator:	Number of primary caregivers enrolled in home visiting who reported using any tobacco products at enrollment and were referred to tobacco cessation counseling or services within 3 months of enrollment	Denominator:	Number of primary caregivers enrolled in home visiting who reported using any tobacco products at enrollment and were enrolled for at least 3 months	Unit Type:	Percentage	Unit Number:	100
Numerator:	Number of primary caregivers enrolled in home visiting who reported using any tobacco products at enrollment and were referred to tobacco cessation counseling or services within 3 months of enrollment									
Denominator:	Number of primary caregivers enrolled in home visiting who reported using any tobacco products at enrollment and were enrolled for at least 3 months									
Unit Type:	Percentage									
Unit Number:	100									
Data Sources and Data Issues:	Evidence-Based Home Visiting (EBHV) Referral Tracker (RedCAP); Despite high prevalence of smoking throughout state, data regarding referrals to smoking cessation referrals for evidence-based home visiting participants are not consistently documented in RedCAP. Quality improvement efforts are in development, but the number of EBHV participants who are referred to smoking cessation services is likely underestimated.									
Significance:	Currently operating in 31 of the state’s 95 counties, evidence-based home visiting programs are located in communities with higher rates of smoking, teen pregnancy, low birth weight, prematurity, and infant death. Smoking prevalence among mothers who reside in these select communities ranges from 6 percent to 31 percent. Home visitors assess a number of preventive health and prenatal practices, including prenatal tobacco use and use of tobacco in the home. Evidence-based home visiting services is one of the most effective and cost-effective interventions to help parents support their young children’s health and development and prevent adverse childhood experiences.									

**Form 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	100.0
Numerator	170	182	154	170	156
Denominator	170	183	154	170	156
Data Source	Department of Health	Department of Health	Department of Health Newborn Screening Program	Department of Health Newborn Screening Program	Department of Health Newborn Screening Program
Provisional Or Final ?				Provisional	Provisional

Field Level Notes for Form 10d NPMs:

1.	Field Name:	2012
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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.

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	72.3
Numerator	183,180	183,180	183,180	183,180	183,180
Denominator	253,333	253,333	253,333	253,333	253,333
Data Source	2009/10 CSHCN Survey				
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

-
1. **Field Name:** 2015
-
- 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.
-
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	45.9
Numerator	113,064	113,064	113,064	113,064	113,064
Denominator	246,352	246,352	246,352	246,352	246,352
Data Source	2009/10 CSHCN Survey				
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

-
1. **Field Name:** 2015
-
- 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.
-
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	70.4
Numerator	174,402	174,402	174,402	174,402	174,402
Denominator	247,879	247,879	247,879	247,879	247,879
Data Source	2009/10 CSHCN Survey				
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

-
1. **Field Name:** 2015
-
- 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.
-
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	71.5
Numerator	179,700	179,700	179,700	179,700	179,700
Denominator	251,473	251,473	251,473	251,473	251,473
Data Source	2009/10 CSHCN Survey				
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

-
1. **Field Name:** 2015
-
- 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.
-
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	41.8
Numerator	40,413	40,413	40,413	40,413	40,413
Denominator	96,752	96,752	96,752	96,752	96,752
Data Source	2009/10 CSHCN Survey				
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

-
1. **Field Name:** 2015
-
- 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.
-
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	71.8
Numerator	305	262	222	189	196
Denominator	371	357	303	260	273
Data Source	2010 NIS Survey	2011 NIS Survey	2012 NIS Survey	2013 NIS Survey	2014 NIS Survey
Provisional Or Final ?				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	14.0	12.3
Numerator	2,287	2,117	1,855	1,696	1,486
Denominator	123,785	121,665	121,107	121,186	121,186
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	TDH Office of Health Statistics Birth Statistical System and US Census
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d NPMs:

1.	Field Name:	2015
	Field Note:	2015 population projections/estimates not currently available; 2014 population data were used to calculate the 2015 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	37.2
Numerator	366	366	366	366	366
Denominator	983	983	983	983	983
Data Source	Tennessee Oral Health Survey				
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1.	Field Name:	2013
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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 sealants on one or more of their permanent first molar teeth

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	2.3	2.1
Numerator	46	21	36	28	26
Denominator	1,237,679	1,241,590	1,240,434	1,240,204	1,240,204
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	TDH Office of Health Statistics Death Statistical System and US Census
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d NPMs:

1.	Field Name:	2012
	Field Note:	Data sources: TDH Office of Health Statistics Death Statistical System and 2012 US Census
2.	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	37.0	40.7	43.1
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	CDC/National Immunization Survey-2012 Birth Cohort
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1.	Field Name:	2015
	Field Note:	https://www.cdc.gov/breastfeeding/data/nis_data/rates-any-exclusive-bf-state-2012.htm
2.	Field Name:	2014
	Field Note:	https://www.cdc.gov/breastfeeding/data/nis_data/rates-any-exclusive-bf-state-2011.htm
3.	Field Name:	2013
	Field Note:	https://www.cdc.gov/breastfeeding/data/nis_data/rates-any-exclusive-bf-state-2010.htm
4.	Field Name:	2012
	Field Note:	http://www.cdc.gov/breastfeeding/pdf/2012BreastfeedingReportCard.pdf
5.	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	97.2	98.0
Numerator	82,313	82,809	83,457	84,745	86,353
Denominator	84,393	86,068	85,838	87,184	88,078
Data Source	Department of Health	Department of Health	Tennessee Department of Health, Newborn Screening Program	Tennessee Department of Health, Newborn Screening Program	Tennessee Department of Health, Newborn Screening Program
Provisional Or Final ?				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	1.5
Numerator	35,743	40,700	55,319	36,104	21,959
Denominator	1,489,292	1,507,407	1,495,108	1,504,333	1,463,933
Data Source	UT CBER				
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1.	Field Name:	2015
	Field Note:	Data Source: The Impact of TennCare, A Survey of Recipients, 2015. Available at: http://cber.haslam.utk.edu/tncare/tncare15.pdf (Table 2a, page 3)
2.	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)
3.	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)
4.	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)
5.	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	30.4
Numerator	19,967	18,890	19,128	18,667	19,174
Denominator	186,444	182,282	182,297	179,490	63,000
Data Source	Department of Health	Department of Health	Department of Health PedNSS/TN WIC Database	Department of Health PedNSS/TN WIC Database	TN WIC Database
Provisional Or Final ?				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	11.2
Numerator	10,782	10,433	10,178	9,506	8,559
Denominator	79,234	79,928	79,001	80,731	76,279
Data Source	Department of Health	Department of Health	TDH Office of Health Statistics Birth Statistical System	TDH Office of Health Statistics Birth Statistical System	TDH Office of Health Statistics Birth Statistical System
Provisional Or Final ?				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	10.7	8.3
Numerator	31	38	40	45	35
Denominator	426,828	421,428	419,093	419,617	419,617
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	TDH Office of Health Statistics Death Statistical System and US Census
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d NPMs:

1.	Field Name:	2015
	Field Note:	2015 population projections/estimates not currently available; 2014 population data were used to calculate the 2015 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	77.1	79.3
Numerator	843	1,014	1,087	972	985
Denominator	1,189	1,254	1,319	1,260	1,242
Data Source	Department of Health	Department of Health	TDH Office of Health Statistics Birth Statistical System	TDH Office of Health Statistics Birth Statistical System	TDH Office of Health Statistics Birth Statistical System
Provisional Or Final ?				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	70.0
Numerator	51,094	52,878	53,618	53,331	49,430
Denominator	73,445	75,458	75,339	75,708	70,565
Data Source	Department of Health	Department of Health	TDH Office of Health Statistics Birth Statistical System	TDH Office of Health Statistics Birth Statistical System	TDH Office of Health Statistics Birth Statistical System
Provisional Or Final ?				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	1.2	1.2
Numerator	109	121	117	99	99
Denominator	79,462	80,202	79,954	81,168	81,168
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	Department of Health Child Fatality Review and Birth Statistical System
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d SPMs:

-
1. **Field Name:** 2015
-
- Field Note:**
The data shown is for CY2014. Data is not yet available for CY2015. The review of CY2015 deaths is expected to be complete later in CY2016.
-
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	38.6
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	Department of Health
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d SPMs:

1.	Field Name:	2015
	Field Note:	Data are for 2014-15 school year.
2.	Field Name:	2014
	Field Note:	Data are for 2013-14 school year.
3.	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
4.	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
5.	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	24.2
Numerator	269,595	278,516	281,550	281,550	294,036
Denominator	1,141,863	1,105,002	1,176,006	1,176,006	1,215,026
Data Source	Department of Health	Department of Health	BRFSS	2013 BRFSS	2014 BRFSS
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d SPMs:

1.	Field Name:	2015
	Field Note:	BRFSS data from 2015 not yet available; the data shown here are from 2014.
2.	Field Name:	2014
	Field Note:	BRFSS data from 2014 not yet available; the data shown here are from 2013.
3.	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.
4.	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	1,762.4	1,762.4
Numerator	5,928	6,141	5,285	5,684	5,684
Denominator	324,270	324,238	322,072	322,512	322,512
Data Source	Department of Health	Department of Health	TDH Office of Health Statistics Hospital Discharge Database	TDH Office of Health Statistics Hospital Discharge Database	TDH Office of Health Statistics Hospital Discharge Database
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d SPMs:

1.	Field Name:	2015
	Field Note:	Data for 2015 is not available at this time. These data are from 2014.
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	210.0
Numerator		134			
Denominator					
Data Source		Department of Health	Department of Health	Department of Health	Department of Health
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d SPMs:

1.	Field Name:	2015
	Field Note:	See 2013 notes.
2.	Field Name:	2014
	Field Note:	See 2013 notes.
3.	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.
4.	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.
5.	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	58.4
Numerator		125	481	569	606
Denominator		817	2,441	806	1,038
Data Source		TDH PTBMIS	TDH PTBMIS	TDH PTBMIS	TDH PTBMIS
Provisional Or Final ?				Final	Final

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	16.3	12.4
Numerator	342	360	338	334	254
Denominator	2,025,215	2,038,481	2,043,906	2,048,247	2,048,247
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	TDH Office of Health Statistics Death Statistical System and US Census
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d SPMs:

1.	Field Name:	2015
	Field Note:	2015 population projections/estimates not currently available; 2014 population data were used to calculate the 2015 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 current application/annual report.

State Action Plan Table

State: Tennessee

Please click the link below to download a PDF of the full version of the State Action Plan Table.

[State Action Plan Table](#)

Abbreviated State Action Plan Table

State: Tennessee

Women/Maternal Health

State Priority Needs	NPMs	ESMs	SPMs
Improve utilization of preventive care for women of childbearing age.	NPM 1 - Well-Woman Visit	ESM 1.1 ESM 1.2 ESM 1.3 ESM 1.4	
Improve utilization of preventive care for women of childbearing age.			SPM 3

Perinatal/Infant Health

State Priority Needs	NPMs	ESMs	SPMs
Reduce infant mortality.	NPM 5 - Safe Sleep	ESM 5.1 ESM 5.2 ESM 5.3 ESM 5.4 ESM 5.5	

Child Health

State Priority Needs	NPMs	ESMs	SPMs
Increase the number of infants and children receiving a developmental screen.	NPM 6 - Developmental Screening	ESM 6.1 ESM 6.2 ESM 6.3	
Reduce the number of children exposed to adverse childhood experiences.			SPM 1
Reduce the burden of injury among children and adolescents.	NPM 7 - Injury Hospitalization	ESM 7.1 ESM 7.2 ESM 7.3 ESM 7.4 ESM 7.5 ESM 7.6 ESM 7.7	
Reduce the number of children and adolescents who are overweight/obese.	NPM 8 - Physical Activity	ESM 8.1 ESM 8.2 ESM 8.3 ESM 8.4 ESM 8.5 ESM 8.6 ESM 8.7	
Reduce the number of children and adolescents who are overweight/obese.			SPM 2

Adolescent Health

State Priority Needs	NPMs	ESMs	SPMs
Reduce the burden of injury among children and adolescents.	NPM 7 - Injury Hospitalization	ESM 7.1 ESM 7.2 ESM 7.3 ESM 7.4 ESM 7.5 ESM 7.6 ESM 7.7	
Reduce the number of children and adolescents who are overweight/obese.	NPM 8 - Physical Activity	ESM 8.1 ESM 8.2 ESM 8.3 ESM 8.4 ESM 8.5 ESM 8.6 ESM 8.7	

Children with Special Health Care Needs

State Priority Needs	NPMs	ESMs	SPMs
Increase the number of children (both with and without special health care needs) who have a medical home.	NPM 11 - Medical Home	ESM 11.1 ESM 11.2 ESM 11.3	
Increase the number of children (both with and without special health care needs) who have a medical home.	NPM 12 - Transition	ESM 12.1	

Cross-Cutting/Life Course

State Priority Needs	NPMs	ESMs	SPMs
Reduce exposure to tobacco among the MCH population (pregnancy smoking and secondhand smoke exposure for children).	NPM 14 - Smoking	ESM 14.1 ESM 14.2 ESM 14.3	