Maternal and Child Health Services Title V Block Grant

Tennessee

FY 2018 Application/ FY 2016 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

June 30, 2017

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,

Morgan F. McDonald, MD FAAP FACP
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 to 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. Work is being done to understand the landscape of these issues and identify the most effective 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).
- 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 the ongoing needs assessment, the state hosts MCH stakeholder meetings twice a year. These meetings are open to anyone, and effort is made to extend the invitation broadly. During the meetings, participants are asked to consider the progress made on performance measures during the past year, and then based on that

evaluation make recommendations for the next year's action plan.

Another part of the state's effort to 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.

The Ongoing Needs Assessment has identified two more emerging issues that need to be monitored, evaluated and addressed:

- Zika Virus: Congenital Zika infection: With the spectrum of neurologic birth defects now being attributed to congenital Zika infection, states have been called upon to improve surveillance of birth defects, develop coordination systems to link families to services, and monitor outcomes.
- Maternal Mortality: Tennessee now joins over 26 states who have implemented a formal maternal mortality review team to provide prevention recommendations to prevent loss of life when mother and child are most vulnerable.

KEY PLANS AND ACCOMPLISHMENTS

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

An overview of accomplishments during FY16 and plans for FY18 are provided below for each domain. More detailed information can be found in the full MCH Services Title Block Grant Report/Application.

Women's/Maternal Health

For this grant cycle (FY 2016-20), the priority for this domain is to increase preventive care for women of childbearing age. Tennessee's MCH/Title V Program is utilizing these strategies to address this priority during FY18:

- 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.

During FY16 significant progress was made on increasing the number of family planning clients in the local health departments. Health departments were provided quarterly reports that described how many women came to their department for a pregnancy test and were connected to the family planning program. Through these reports opportunities for improvement were identified and implemented. These changes resulted in the first increase in family planning clients in 10 years. Family planning is an important component of preventive care. However, increasing preventive care visits in the general population continues to be a challenge. In recent years, changes in well-woman clinical recommendations and uncertainty around the Affordable Care Act essential benefits package have created confusion and concerns about access to care. Likewise, women often see their roles as caregivers to others before themselves. Generating messages that are clear and engage the culture are a priority for this program.

Perinatal/Infant Health

For this grant cycle (FY 2016-20), the 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. The MCH/TitleV Program is utilizing these strategies to address this priority during FY18:

- 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.

FY16 saw much success around the strategy of perinatal regionalization. During this year 84% of very low birth weight infants were born at a level III or IV birthing facility, which exceeded the goal of 80%. All other measures were also met or exceeded for this domain. One area that was challenging was increasing utilization of the WIC safe sleep and breastfeeding module. This module is specific to Tennessee and therefore not on the national WIC website. This causes participants to have to access another platform if they want to take the module. To remedy this issue, Tennessee has been working with WIC at a national level to add it to their website for all states to utilize. TDH staff are also working to engage disproportionately affected communities in focus groups on safe sleep, improve access to 17-OHP and birth spacing to prevent premature delivery, and promoting a new Tennessee BEST for Babies initiative to hospitals that demonstrate excellence in breastfeeding, avoiding early elective delivery, and safe sleep education.

Child Health

For this grant cycle (FY 2016-20), 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. The MCH/Title V Program is utilizing these strategies to address these priorities during FY18:

- Increase general awareness among parents and caregivers of the need for developmental screening.
- Encourage and 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.
- Enhance the Gold Sneaker voluntary recognition program for licensed child care centers.
- Increase support for breastfeeding initiation and duration.
- 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 safe storage of medications.
- Provide injury prevention education to parents and caregivers.

In FY16 training on the Ages and Stages Questionnaire was provided to TDH central office staff through partnerships with the Tennessee Chapter of the American Academy of Pediatrics and the Tennessee Early Intervention System. Central office staff are now training health department staff and home visitors, so that they can administer the survey, discuss results with families, and refer to the medical home or other resources as necessary. During this time Tennessee has also seen a significant increase in breastfeeding initiation. Based on birth certificate data the

percentage increased from 66.6% in 2011 to 78.2% in 2015.

Adolescent Health

For this grant cycle (FY 2016-20), 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. The MCH/Title V Program is utilizing these strategies to address these priorities during FY18:

- 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 implementation of evidence based or evidence informed activities related to motor vehicle safety 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.

During FY16 TDH helped to facilitate the granting of funds to a local drug coalition that will allow the Count It, Lock It, Drop It program, which provides safe drug disposal bins, to be expanded to all counties in Tennessee. However the transition from ICD-9 to ICD-10 has created data challenges. The change affected how injuries are coded and therefore how rates are calculated. Based on these changes objectives will need be revised to more accurately reflect the new coding system. In order to increase nutritious food options and consumption at schools across Tennessee, culinary trainings were held to share healthy cooking techniques and methods of displaying healthy foods that make them more appealing to students.

Children and Youth with Special Healthcare Needs (CYSHCN)

For this grant cycle (FY 2016-20), Tennessee is focusing on these two priority areas related to improving the health of CYSHCN: 1) increase the number of children (both with and without special health care needs) who have a medical home and 2) increase the number of children (both with and without special health care needs) who receive services necessary to make transitions to adult health care. The MCH/Title V Program is utilizing these strategies to address these priorities during FY18:

- 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.
- Identify adult medical home practices to provide care for youth and young adults with special health care needs.
- Incorporate health care transition planning into written plans of care for children with special health care needs.
- Support youth participation in the transition process.

In FY16 the TDH partnered with Family Voices and the Vanderbilt Leadership Education in Neurodevelopmental Disabilities (LEND) program to create a Youth Advisory Board consisting of CYSHCN. This group of youth will provide input on what resources are needed to make transition to adult care a smooth process. One challenge with this group is that the leaders are LEND trainees. Because of the trainee's schedules there tends to be gaps of time when the group does not meet. TDH is working with Family Voices and LEND to address this issue and make meetings more consistent.

Cross-Cutting/Life Course Issues

For this grant cycle (FY 2016-20), the priority for this domain is to reduce exposure to tobacco among the MCH population, with a focus on reducing pregnancy smoking and secondhand smoke exposure for children. The MCH/Title V Program is utilizing these strategies to address this priority during FY18:

- Enhance 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.

From 2014 to 2015 there was nearly a 5% decrease in pregnancy smoking, from 15.0% to 14.3%. This is an encouraging trend; however continued effort is needed to drive the rate down even further. TDH is working with the Tennessee Quitline vendor to collect information on pregnancy status for all callers to identify opportunities for improvement in quit rate for this population. There is also work being done in the home visiting programs to identity pregnant women who smoke and refer them to cessation services. Lastly, TDH has implemented Baby and Me Tobacco Free counseling and incentive program for pregnant women in 88 of 95 counties.

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 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 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 second most populous city in the state – Memphis. Outside greater Memphis, the region is mostly agricultural.

In 2016, the United States Census Bureau estimated Tennessee's population to be the 17th largest in the country.[1] Roughly 6.6 million (74.6% White non-Hispanic, 17.1% Black or African American non-Hispanic, and 5.0% Hispanic). Tennessee's population grew by 4.8% from 2010 to 2016 (comparable with the national population increase of 4.7%).[2] The 2010 census showed that 66.4% of the state's population lived in a metropolitan statistical area and 33.6% in rural areas.[3] Nearly one quarter (24.5%) of the population lives in the two most populous metropolitan counties: (Shelby (Memphis) and Davidson (Nashville)).[4]

The 2015 American Community Survey reported that 14.7% of the state's population lived below the federal poverty level; this percentage was larger for children under 18 (20.7%) and families with related children under 18 years (17.1%). The highest rates of poverty (43.9%) 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.[5]

Health Status of Tennessee's MCH Population

In 2016, according to America's Health Rankings, Tennessee ranked 44th in the nation for overall health.[6] Historically Tennessee has ranked in the bottom ten states for this overall measure. Unfortunately the state ranks poorly on some key MCH population indicators, including:

- Low birthweight (43rd)
- Children in poverty (41st)
- Infant mortality (39th)

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

- Excessive drinking (1st)
- High school graduation (11th)
- Pertussis case rate (13th)

Based on America's Women and Children Report, a sub report of America's Health Rankings Report, Tennessee

ranked in the lowest quintile at 42th overall in 2016. When the population is broken down into women, infants, and children, slight improvements are observed. Although infants still rank in the lowest quintile at 44th, women and children see a slight improvement to the second to lowest quintile at 37th and 32nd respectively.[7]

Three key factors (tobacco use, obesity, and physical inactivity) drive all of TN's top ten leading causes of death and influence one-third of the thirty-four metrics making up TN's overall rank of 44th in Health in the US. Another key factor, substance abuse, contributes substantially to poor health outcomes, including Neonatal Abstinence Syndrome and has resulted in a significant increase in overdose deaths. Likewise, violent crime continues to have a significantly negative impact on the health of Tennesseans.[8]

An analysis of the national performance and outcome measures of this grant broken down by MCH subpopulation are described below. A table showing the results is also included in the supporting documents section. Rates for each measure by year can be viewed on Form 10a National Outcome Measures (NOMs) and Form 10a National Performance Measures (NPMs).[9]

Women's/Maternal Health

There has been a statistically significant increase in the percent of women with a past year preventive care visit. However the rate of severe maternal morbidity continues to worsen at a statistically significant rate. The rate has increased from 167 per 10,000 delivery hospitalizations in 2008 to 181 in 2014.[9]

Perinatal/Infant Health

Tennessee has seen marked improvements in many areas of perinatal and infant health. Areas that have achieved statistically significant progress include: infants placed to sleep on their backs, early prenatal care, late preterm births, early term births, non-medically indicated early elective deliveries, and infant mortality. Areas that have not seen statistically significant change include: low birth weight deliveries, early preterm births, perinatal mortality and fetal deaths, preterm-related mortality, and sleep-related Sudden Unexplained Infant Death (SUID). This analysis is based on the most recent years of data available for each measure; specific years of data vary by measure. To see which years were used in the analysis for a given measure please refer to Form 10a National Outcome Measures (NOMs) and Form 10a National Performance Measures (NPMs). [9]

Child Health

There have been statistically significant improvements in two areas of the child health domain: non-fatal injury hospitalizations and influenza vaccinations. The other indicators of child health have not statistically improved or worsened, these include: physical activity, developmental screening, tooth decay, child mortality, mental/behavioral health treatment, children in excellent or very good health, overweight and obesity rates, insurance coverage, and vaccination coverage. Though it should be noted that Tennessee had 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. Unfortunately, the results of the 2016 Immunization Status Survey of 24-Month Old Children in Tennessee for the first time in recent years showed a disparity between white and black children in on-time completion of the whole series approaching statistical significance. Black children were found to be significantly less likely to receive a full series of the vaccines that require a booster dose in the second year of life (Tdap, PCV, HiB). There also remains a significant racial disparity in regards to influenza immunization, with 50.0% white children receiving influenza vaccine as compared to 29.8% of black children. [9,10]

Adolescent Health

There have been many statistically significant improvements observed among the adolescent health measures. These include: non-fatal injury hospitalizations, motor vehicle mortality, HPV vaccination, Tdap vaccination, and meningococcal conjugate vaccination. There were two measures that did not see statistically significant changes: physical activity and mortality. Alarmingly, the adolescent suicide rate continues to worsen at a statistically significant rate. [9]

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 MCHB core outcomes and key indicators, see table below. [9]

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

National Survey of Children with Special Health Care Needs. NS-CSHCN 2009/10. Data query from the Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website. Retrieved 03/24/17 from www.childhealthdata.org.

Cross-Cutting and Life Course

Tobacco reduction is the focus of Tennessee's cross-cutting domain. There have been statistically significant improvements in pregnancy smoking. However, the amount of children living households where someone smokes inside has not improved, albeit it has not worsened either. The smoking rate among high school youth has been decreased from 20.9% in 2009 to 11.5% in 2015, based data from on the Youth Risk Behavior Surveillance System.[9,[11]]

Health Disparities among Tennessee's MCH Population

Significant disparities exist among racial and ethnic populations for various MCH indicators in Tennessee. Based on data from the birth certificate, minority women in Tennessee, particularly non-Hispanic Blacks and Hispanics, fair worse than their non-Hispanic White counterparts on several indicators. These indicators include: late or no prenatal care, low birth weight infants, and teen births. Black non-Hispanic women also see higher rates of preterm births and lower rates of breastfeeding compared to other groups. One area that minority women fair better in is pregnancy smoking. This behavior is substantially more common among non-Hispanic Whites than any other group. It also should be noted that Hispanic and Other non-Hispanics have the highest breastfeeding rates among all the groups. The table below details the breakdown among racial/ethnic groups regarding these indicators.

Risk Factors	Race/Ethnicity %			
	White Non-Hispanic	Black Non-Hispanic	Hispanic	Other Non-Hispanic
Overweight Pre Pregnancy	24	26	31	20
No prenatal care	1	4	2	1
Late prenatal care (started 2nd or 3rd trimester)	31	39	50	42
Smoked during pregnancy (any trimester)	18	9	3	3
Primary C-Section	29	31	26	32
Low birthweight (<2500g)	7	12	6	8
Preterm birth (<37 weeks)	9	12	8	7
Breastfeeding	80	66	86	90
Teenage mother (15-19 years)	7	11	9	3

Tennessee Department of Health, Division of Policy, Planning, and Assessment, Office of Health Statistics. Birth Statistical System, 2015 Nashville, TN; Prepared by the Division of Family Health and Wellness.

In addition to racial/ethnic disparities, social determinants play an impact on the health and well-being of Tennesseans. Based on Behavioral Risk Factor Surveillance System (BRFSS) 2015 data, individuals in Tennessee 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.[12] There are also discrepancies in educational attainment. Based on the 2015 American Community Survey (ACS) 27.2% of Whites hold a bachelor's degree compared to 18.4% of Blacks, and 13.2% of Hispanics.[13] Similarly disparities are seen in housing and food insecurity. The National Survey of Children's Health provides data on children enrolled in a supplemental nutrition program and how often a child has moved residences. The results of those measures for the 2011-2012 survey are below.

Risk Factors	Race/Ethnicity %			
	White Non-Hispanic	Black Non-Hispanic	Hispanic	Other Non-Hispanic
Overweight Pre Pregnancy	24	26	31	20
No prenatal care	1	4	2	1

National Survey of Children's Health. NSCH 2011/2012. Data query from the Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website. Retrieved [06/28/17] from www.childhealthdata.org.

State Health Agency Priorities

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

TDH is currently prioritizing the “Big Four” population health initiatives: 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 44th in Health in the US.[8]

Public health efforts in Tennessee have long been focused on the MCH population. All of the current Departmental priorities (the “big four”) 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 “TDH way” is focused outside the clinic walls, on reshaping places and spaces in our communities, in order to engineer and guide healthier, safer behaviors. 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 March 1, 2017, TDH staff in all 95 counties have participated in 2,497 projects in Tennessee communities and a total of 113 projects have replicated TDH-designated "Bright Spot" projects. TDH staff has also worked cooperatively alongside numerous external partners, engaging in 176 community-led projects.

In March 2017, the Department unveiled “Primary Prevention 2.0.” A series of training webinars were presented through the month of March for all TDH staff to learn about the enhancements occurring with the state’s Primary Prevention efforts. These training webinars are being followed with onsite trainings for local staff to further learn about the enhancements and the new planning process being implemented that allows the local health department to develop an annual primary prevention plan for their local health department to implement. Other enhancements being unveiled with Primary Prevention 2.0 include: a resource guide to help implement meaningful primary prevention work; a primary prevention SharePoint site that allows TDH staff access to primary prevention best practice materials to help them replicate these initiatives in their local communities; quarterly training webinars on primary prevention best practices from across the country; monthly primary prevention emails to assist with prevention work; and the creation of a REDcap-based reporting system for primary prevention work.

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 2017, the Department had received Level 3 Baldrige recognition, and 85 individual county health departments, 6 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 68 birthing hospitals and centers in Tennessee (hospitals/centers with >50 deliveries/year).[14]

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 healthy populations that demonstrate higher rates of obesity, diabetes, preventable hospitalizations, cardiovascular deaths and cancer deaths as compared to state and national benchmarks. Additionally, these hospitals are located in rural counties with fewer physicians and with a higher proportion of patients who live in poverty and a higher Medicaid population.

As of May 2017, 89 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 two (2) of the state's 95 counties are designated as federal Dental HPSAs and all but five (5) counties are designated as federal Mental Health HPSAs. Ninety-four of the state's 95 counties are designated as either whole or partial-county Medically Underserved Areas (MUA).

The distribution of primary care providers varies across the state. A map with health resource shortage areas for obstetrics and pediatrics can be found in the supporting documents section. 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[15]:

- Obstetrics/Gynecology (includes GYN surgery): 814
- Family Medicine/General Practice: 1953
- Pediatrics (includes subspecialties and Med/Peds): 1658

Health Insurance Coverage

The 2015 ACS estimates that 10.3% of Tennesseans are uninsured. That number drops significantly for residents under 18 years old to 4.2%.[16] The University of Tennessee Center for Business and Economic Research also estimates insurance coverage for the state. This survey uses a much smaller sample than the ACS (5,000 compared to 71,194); however it does offer additional information regarding reasons for uninsured status. The survey estimates that 5.5% of all Tennesseans were uninsured in 2016. Again this percentage is much lower for children under 18 (1.8%) as compared to adults 18 and older (6.6%). The major reasons that people report being uninsured is that they cannot afford health insurance (80%, down from 83% in 2015), not needing insurance (17%) or not getting round to it (16%). Not being able to afford insurance was cited more frequently among uninsured individuals earning less than $20,000 (86%) but was still a significant barrier even for individuals making more than $40,000 (79%).[17]

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 enrolls 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. Since the passage of the Affordable Care Act, there have been several unsuccessful attempts by the Governor to expand Medicaid to Tennesseans earning less than 138 percent of the federal poverty level.

TennCare provides health care for approximately 1.5 million Tennesseans and operates with an annual budget of approximately $11 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. [18]

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.[18]

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. HCFA will implement 75 episodes of care in 11 waves by the end of 2019.[19] HCFA has sought input from the Tennessee Department of Health in the development of each of the episode waves in order to assure consideration of potential population health impact. The MCH/Title V Director has participated in the Technical Advisory Group for several of the episodes, including the Perinatal Episode (part of Wave 1) and the Neonatal Episode (Wave 6).

Determination of Factors Impacting Health Services Delivery in the State

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

County health councils meet regularly to discuss important health topics in their local community. Public health staff actively participate in these councils, which provide a venue for sharing issues that impact local residents (including the MCH population). Local or regional public health staff share information with the state MCH/Title V Program

leadership when MCH-related issues arise and at bi-monthly regional director and regional medical director meetings. Conversely, the local councils sometimes ask MCH/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.

MCH/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 MCH/Title V Director participates in the board meetings for the Children's Hospital Alliance of Tennessee (CHAT), which represents the children's hospitals in Tennessee and bi-monthly meetings with TennCare and TNAAP. MCH/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). MCH/Title V has also partnered with TNAAP for the last several years 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 (MCH/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 stakeholders. MCH/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.

Based on the Ongoing Needs Assessment two additional issues have been identified: Zika virus and maternal mortality.

Congenital Zika infection: With the spectrum of neurologic birth defects now being attributed to congenital Zika infection, states have been called upon to improve surveillance of birth defects, develop coordination systems to link families to services, and monitor outcomes.

Maternal Mortality: Tennessee now joins over 26 states who have implemented a formal maternal mortality review team to provide prevention recommendations to prevent loss of life when mother and child are most vulnerable.

State Statues and Other Regulations Impacting MCH/Title V

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

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.

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[1] U.S. Census Bureau, American Fact Finder. https://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml

[2] U.S. Census Bureau, Quick Facts. https://www.census.gov/quickfacts/table/PST045216/47,00

[3] U.S. Census Bureau, 2010 Census Urban and Rural Classification and Urban Area Criteria; Lists of Population, Land Area, and Percent Urban and Rural in 2010 and Changes from 2000 to 2010

[4] U.S. Census Bureau, QuickFacts. TN. 2014V estimates

[5] U.S. Census Bureau, 2015 American Community Survey 2014 TN. Selected Economic Characteristics

[6] America' Health Rankings. http://www.americashealthrankings.org/explore/2016-annual-report/measure/Overall/state/TN

[7] America's Health Rankings. http://www.americashealthrankings.org/explore/2016-health-of-women-and-children-report/measure/overall_mch/state/TN

[8] America's Health Rankings. http://www.americashealthrankings.org/explore/2016-annual-report/measure/Overall/state/TN

[9] HRSA MCHB State Information. https://mchb.tvisdata.hrsa.gov/State/Detail/TN

[10] Tennessee Department of Health. Immunization Survey of 24-Month Old Children. https://www.tn.gov/health/article/cedep-reports

[11] Centers for Disease Control and Prevention, Youth Risk Behavior Survey. https://nccd.cdc.gov/youthonline/App/Results.aspx?TT=B&OUT=0&SID=HS&QID=H33&LID=LL&YID=RY&LID2=&YID2=&COL=&ROW1=&ROW2=&HT=&LCT=&FS=&FR=&FG=&FI=&FP=&FSL=&FRL=&FGL=&FIL

[12] Centers for Disease Control and Prevention, Behavior Risk Factor Surveillance System. 2015. https://www.cdc.gov/brfss/brfssprevalence/index.html

[13] U.S. Census Bureau, 2015 American Communities Survey, https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_15_1YR_S1501&prodType=table

[14] Tennessee Department of Health, Division of Policy, Planning, and Assessment, Office of Health Statistics. Birth Statistical System, 2015 Nashville, TN

[15] Tennessee Department of Health. Division of Health Licensure and Regulation. https://apps.health.tn.gov/licensurereports/

[16] U.S. Census Bureau, 2015 American Community Survey 1-Year Estimates https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_15_SPL_K202701&prodType=table

[17] UT CBER, The Impact of TennCare A Survey of Recipients, 2016 http://cber.haslam.utk.edu/tncare.htm

[18] Tennessee Department of Finance and Administration. Bureau of TennCare. http://www.tn.gov/tenncare/article/tenncare-overview

[19] Tennessee Department of Finance and Administration. Bureau of TennCare https://tn.gov/hcfa/topic/episodes-of-care

II.B. Five Year Needs Assessment Summary and Updates

FY 2018 Application/FY 2016 Annual Report Update

Introduction

This application year (FY2018) is the third 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 MCH/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 MCH/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, as well as parents. During the meeting, the group reviews progress on the NOMs, NPMs, SPMs and ESMs. At the fall meeting, a progress report on the ~~priori~~completed year is given and used to identify opportunities to partner together to meet the goals set for the current year. In the spring, the stakeholder meeting is utilized to present a draft action plan for the coming year and solicit feedback.

The Tennessee MCHB Grantees group was formed after the August 2015 MCH Services Title V Block Grant review when staff identified the need to intentionally engage with all other MCHB grantees in Tennessee. Tennessee's MCH/Title V Program annually request an updated list of grantees from MCHB, and then uses that list to invite all grantees to attend two in person 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. The meetings are held directly before the MCH Stakeholder Meetings so that grantees can stay and provide input to the MCH Block Grant as well.

In addition to these intentional activities, ongoing needs assessment occurs through other mechanisms throughout the year. 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 health needs of the population, the capacity of the health care system to meet those needs, and emerging issues to the MCH/Title V program. Responses are broken down by health domain. The findings of the survey are described below.

Findings: MCH Population Needs

A total of 139 individuals completed the survey. The highest proportions of respondents were health department staff, followed by community service providers, and then other governmental agencies (outside TDH). A question regarding health needs was asked for each of the six MCH domains. A summary of responses can be found below.

Women's/Maternal Health

Among the 41 responses to this question the top three themes that emerged were substance abuse, obesity, and mental health. 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 28 responses to this question. Among those responses, the most frequent were substance abuse leading to neonatal abstinence syndrome, prematurity and low birth weight. The current action plan addresses these needs.

Child Health

Of the 33 responses to this question, the majority centered on the high burden of obesity, a need for more physical activity, and adverse childhood experiences (ACEs). 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 26 participants provided responses to this question. The need for sex education was brought up most frequently, followed by concern over the obesity rate, and lastly substance abuse. 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 other areas are covered by the current action plan.

CYSHCN

The 33 individuals who responded to this question provided important insight into the needs of CYSHCN. The top theme that emerged was concern over access to care particularly specialist for those residing in rural areas;

transportation was also mentioned frequently followed by obesity and asthma. Service limitations in rural areas 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 15 respondents who provided input on this question, the majority noted tobacco use as the greatest concern, followed by obesity, and substance abuse. Tobacco use is the priority for this domain. Although obesity is not a priority for this domain, it is a priority for the child and adolescent health domains. Substance abuse is not a priority for any one ~~domain,~~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 health problems from the public perspective.

Findings: MCH/Title V Program Capacity

Tennessee's MCH/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 prior Title V Director (Dr. Michael Warren) was appointed to serve as the TDH Deputy Commissioner for Population Health. At that time, Dr. Morgan McDonald assumed 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 served as FHW Deputy Director for Child Health until February 2017 when she left to provide national level technical assistance to home visiting programs. In this role, she oversaw the Early Childhood, CYSHCN, and Perinatal/Infant/Pediatric care sections. Angela McKinney Jones continues to serve as the section chief for Early Childhood Initiatives. Margaret Major continues in her role as section chief for Perinatal/Infant/Pediatric Care section, and Jacqueline Johnson continues in her role as section chief for CYSCHN.

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, including concussions.

In 2016, the Birth Defects Registry transitioned from the Division of Policy, Planning, and Assessment to FHW. This was facilitated with dedicated funding for Zika Pregnancy Registry and Neurologic Birth Defects Registry, and aligned with FHW operations with newborn screening case management and programming in CYSHCN.

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.

MCH/Title V Management

There are no updates since the last application for FY2017.

MCH/Title V Planning, Evaluation, and Data Analysis

A doctoral-level epidemiologist was hired in 2015 to support the Childhood Lead Poisoning Prevention Program. An additional epidemiologist was added to FHW to support the tobacco and chronic disease prevention teams in 2016. Most recently, a senior epidemiologist and program staff have been hired to support the birth defects registry and surveillance efforts. FHW ~~staff are~~staff is currently engaged with CDC staff to recruit a CDC MCH Epi assignee.

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. MCH program and epidemiologist leads have been instrumental in developing workforce development opportunities in the use of the public health library and teaching of literature reviews for both FHW and TDH.

MCH/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 MCH/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 MCH/Title V and CYSHCN programs.

As described in the Five Year Needs Assessment, a unique feature of Tennessee's MCH/Title V program is that it is housed alongside the TDH Chronic Disease Prevention and Health Promotion, as well as the 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” column 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 has enhanced existing collaborative efforts, particularly related to new strategies related to racial disparities in infant mortality and health outcomes such as breast cancer mortality.

FHW continues to partner with Family Voices to engage families in MCH/Title V efforts. Since July 2014, MCH/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 and the TDH are 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.

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

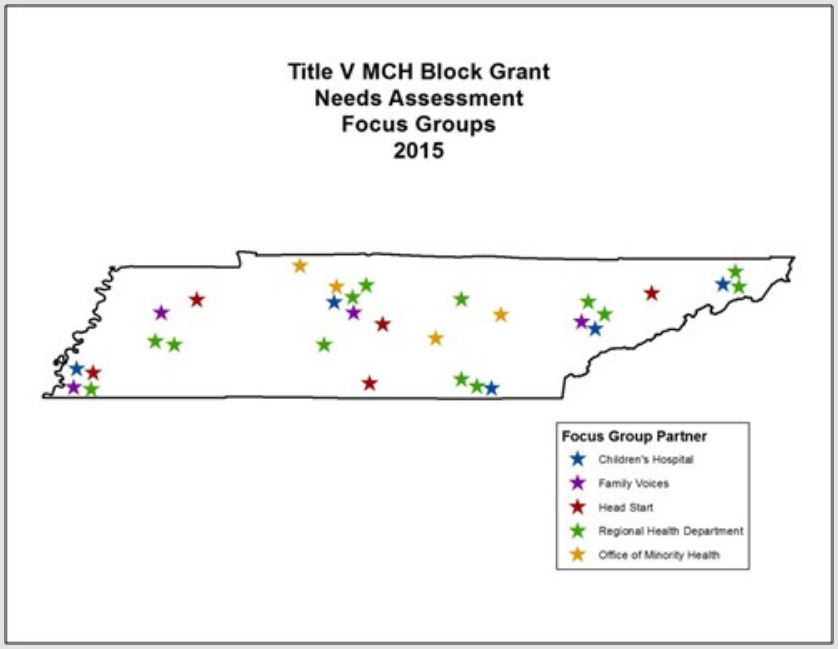
The Epidemiology Team divided the quantitative indicator list (based on prior program knowledge or interest). Epidemiologists identified a data source for each indicator and gathered data for the most recent years available (the goal was to have at least five data points per indicator to allow for trend 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).
9	Increase the number of children (with and without special healthcare needs) who receive services necessary to make transitions to adult care.

Methodology for Priority Selection

Selection of Tennessee's MCH//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 MCH/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 MCH/Title V Leadership Team. During the 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 those scores within each domain.

The MCH/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 MCH/Title V Program to influence the priority. The MCH/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 MCH/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 MCH/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 MCH/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, 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 four" 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 MCH/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), all of which are managed by the division of FHW. 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 MCH/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 MCH/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 seven 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 MCH/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 were 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 MCH/Title V Program operations in Tennessee and will continue in the this 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 MCH/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, MCH/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 MCH/Title V CYSHCN program will continue to pay for medical care related to children enrolled in the program. And lastly, activities developed to reduce secondhand smoke exposure for children, which is the priority in the cross-cutting domain, will no doubt improve the health of children with asthma.

Changes to Priorities during the 2016-2020 Grant Cycle
The MCH/Title V Program has decided to add an additional priority to the list this year (FY2018 application). The added priority is to increase transition services (from pediatric to adult care) for both children with and without special healthcare needs. Activities supporting transition were actually included under the medical home priority for the past two years (FY2016-2017); however the MCH/Title V Leadership felt it would be clearer if it was called out as a separate priority.

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 a mother (and thus reduce the chronic disease burden) but also improve birth outcomes by improving a 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 will 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 measures 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 completed (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 performance on this NPM measures a 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 to appropriately direct injury prevention efforts (based on location and cause of injury) and to determine if intervention 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 performance on this NPM will measure a 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 to appropriately direct injury prevention efforts (based on location and cause of injury) and to determine if intervention 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 will measure the success rate of 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 healthcare needs) who receive services necessary to make transitions to adult care.**

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

Rationale

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 help to gauge the success of 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. Almost 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 help 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 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 (FFY18), as well as a report on the accomplishments and challenges of the previous year (FFY16). This section is organized by the six MCH population domains; the information within each domain is organized as follows:

1. Plan for the Application Year (FFY2018)
    a. Statement of Priority
    b. Planned Strategies and Activities
    c. MCHB Partnerships
    d. Other Key Partnerships
    e. Related Legislative Requirements
2. Annual Report (FFY2016)
    a. Report on Activities
    b. Interpretation of Performance Data (Form 10A)

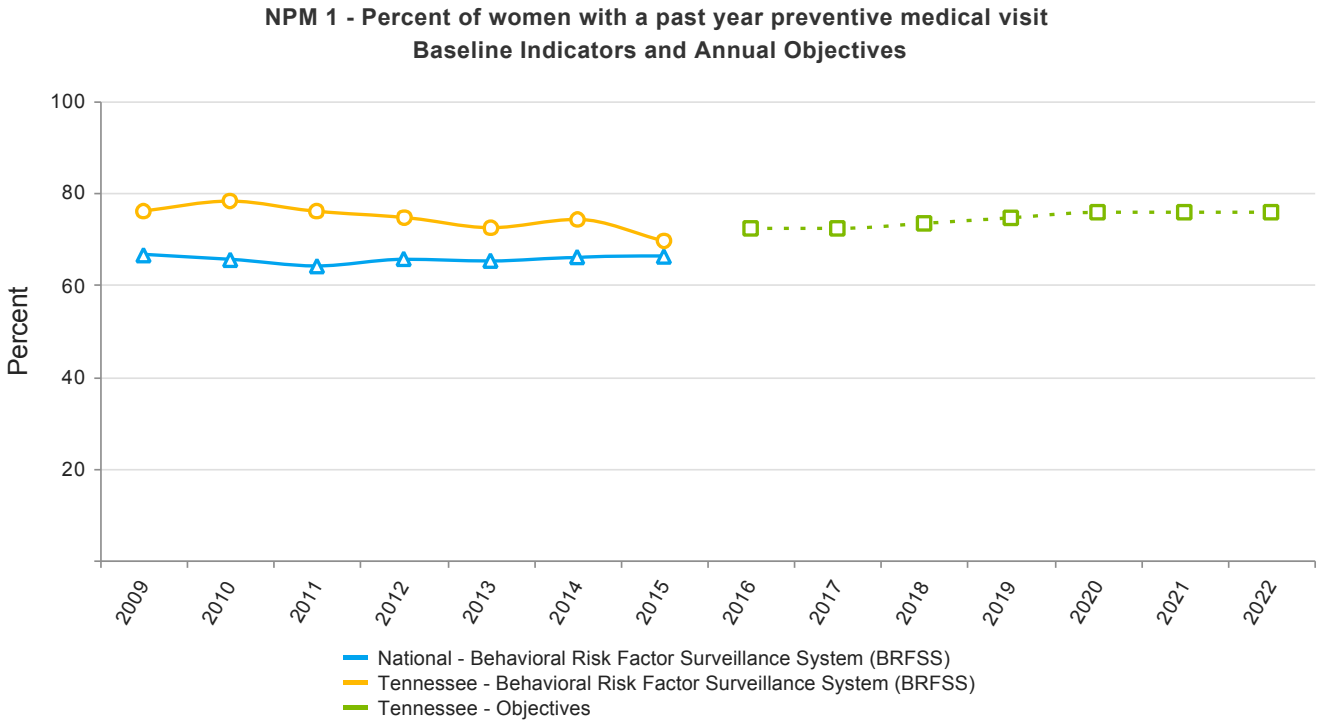
The State Action Plan Table summarizes the plan for the application year by domain, priority, and performance measure.

Women/Maternal Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations	SID-2014	181.1	NPM 1
NOM 3 - Maternal mortality rate per 100,000 live births	NVSS	Data Not Available	NPM 1
NOM 4.1 - Percent of low birth weight deliveries (<2,500 grams)	NVSS-2015	9.2 %	NPM 1
NOM 4.2 - Percent of very low birth weight deliveries (<1,500 grams)	NVSS-2015	1.6 %	NPM 1
NOM 4.3 - Percent of moderately low birth weight deliveries (1,500-2,499 grams)	NVSS-2015	7.6 %	NPM 1
NOM 5.1 - Percent of preterm births (<37 weeks)	NVSS-2015	11.0 %	NPM 1
NOM 5.2 - Percent of early preterm births (<34 weeks)	NVSS-2015	3.1 %	NPM 1
NOM 5.3 - Percent of late preterm births (34-36 weeks)	NVSS-2015	7.9 %	NPM 1
NOM 6 - Percent of early term births (37, 38 weeks)	NVSS-2015	26.6 %	NPM 1
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2014	6.8	NPM 1
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2014	6.9	NPM 1
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2014	4.3	NPM 1
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2014	2.6	NPM 1
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2014	230.4	NPM 1

National Performance Measures



Federally Available Data	
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)	
	2016
Annual Objective	72.2
Annual Indicator	69.6
Numerator	794,110
Denominator	1,140,291
Data Source	BRFSS
Data Source Year	2015

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	72.2	73.3	74.5	75.7	75.7	75.7

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	9
Numerator	
Denominator	
Data Source	TDH FHW Womens Health Section Program Data
Data Source Year	FFY2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	9.0	9.0	9.0	9.0	9.0	9.0

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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	TDH FHW Womens Health Section Program Data
Data Source Year	FFY2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	2.0	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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	TDH FHW Womens Health Section Program Data
Data Source Year	FFY2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	4.0	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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	4
Numerator	
Denominator	
Data Source	TDH FHW Womens Health Section Program Data
Data Source Year	FFY2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	4.0	4.0	4.0	4.0	4.0	4.0

State Performance Measures

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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	51.6
Numerator	
Denominator	
Data Source	PRAMS
Data Source Year	2013
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	51.6	49.9	48.2	46.5	46.5	46.5

State Action Plan Table

State Action Plan Table (Tennessee) - 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	Status
ESM 1.1 - Number of press releases, PSAs and/or social media messages promoting preventive health care visits for women of reproductive age	Active
ESM 1.2 - Number of webinars for providers on increasing preventive care visits among women in their clinics	Active
ESM 1.3 - Number of quarterly site-level family planning utilization reports distributed to local health departments	Active
ESM 1.4 - Number of region-level pregnancy-related service utilization reports distributed to regional health departments	Active

NOMs

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

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

NOM 4.1 - 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 (Tennessee) - 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.

Women/Maternal Health - Plan for the Application Year

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

Planned strategies and Activities: To achieve the objective listed above, the following strategies and activities are planned for FY18:

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

Activity 1a: Promote National Women's Health Week in May through press releases, social media, and/or public service announcements.

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

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

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

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

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

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) partner with other Public Health Programs (WIC, Home Visiting, Primary Care, STD) to incorportate the One Key Question into their client screening/history.

Activity 2c: Create and distribute a resource card for both providers and clients with links and Apps that help guide evidenced based care and wellness.

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

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

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.

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

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

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

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

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))

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

Accomplishments and Challenges (FFY2016 Strategies and Activities)

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

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

Report 1a: A press release was completed for Women's Health Week in May of 2016 and daily messages reminding women to make their health a priority were posted on the TDH Facebook and Twitter accounts during Women's Health Week.

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

Report 1b: In addition to promotion of preventive care messages for women during Women's Health Week, collaborative efforts between TDH Office of Communications and the Reproductive and Women's Health section have been successful with integrating preventive care messages for women during the months of October (Breast Cancer Awareness Month) and January (Cervical Cancer Awareness Month).

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

Report 1c: The Governor's proclamation promoting Women's Health Week was not accomplished due to not allowing adequate time for submission and review by the Governor.

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

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.

Report 2a: 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 was not provided because the Women's Health Clinical Trainer position was vacant for much of FY2016.

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 inforgraphic on One Key Question for distribution to providers.

Report 2b: Over 250 providers from across the state were provided training regarding One Key Question and information on how to leverage missed opportunities with clients. A video for clients has been shared with the local health departments to use in waiting rooms that addresses the One Key Question and is available in both English and Spanish.

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

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

Report 3a: All local health departments continue to provide quality family planning services across the state and served 74,922 unduplicated women during calendar year 2016.

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

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

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

Report 3c: Due to numerous startup projects and data requests the site-level reports for family planning clinics have not been completed. Technical assistance was requested from the Office of Population Affairs (OPA) to assist with determining and defining key variables that should be included in such a report.

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

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

Report 4a: All local health department clinics continue to 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.

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

Report 4c: The local health departments continue to 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.

Report 4d: Following the distribution of a program memorandum requesting an increase in the percentage of health department pregnancy tests completed under the Title X program, quarterly regional-level reports were shared with staff allowing them track their progress. After circulation of 4 reports, 12 out of 13 regions surpassed the goal of completing 85% of the pregnancy test visits through the Title X program resulting in a rate of 92% state-wide.

Data Interpretation (of data listed on Form 10A):

In calendar year 2015, 69.6% of women between the ages of 18 and 44 years reported having a preventive health care visit within the past year. This was a decrease from the baseline of 72.1% in 2013, however the change was not a statistically significant. Therefore the objective to maintain the percent of preventive visits at baseline was met.

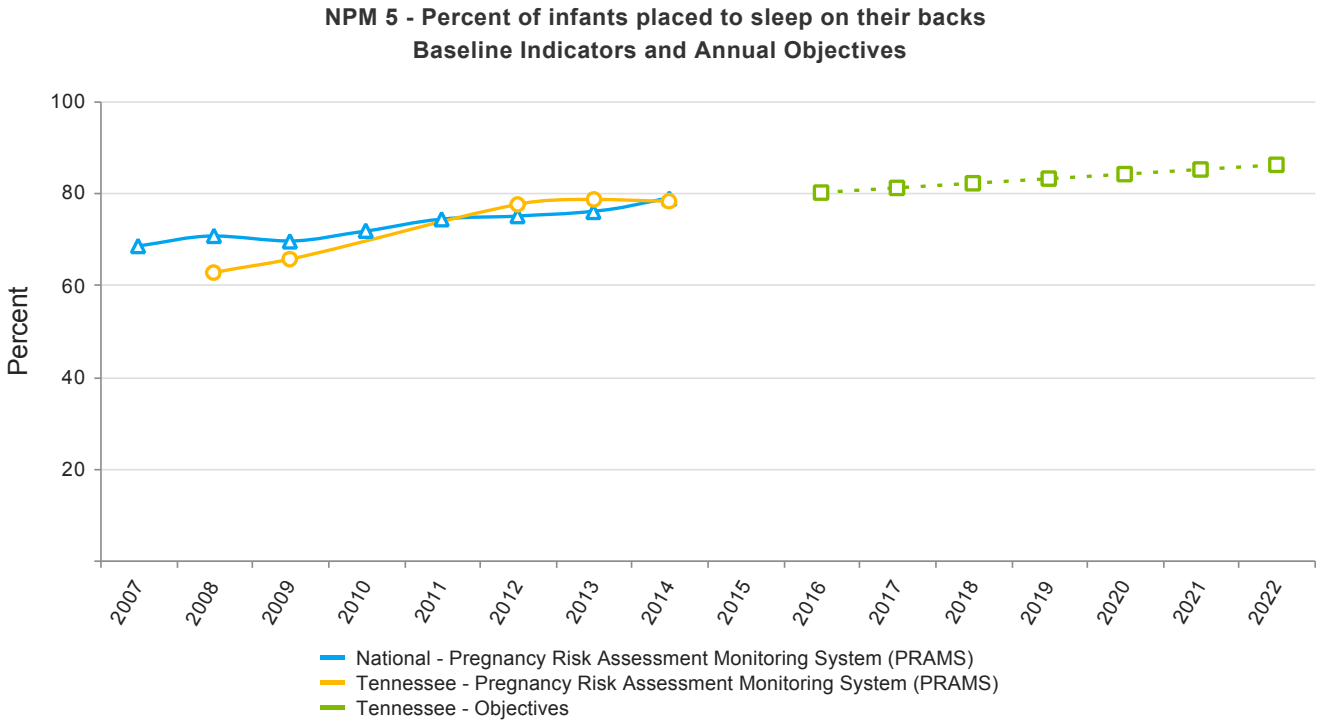
During FY16 six press releases were issued for National Women's Health Week in May 2016, which was one less than the ESM 1.1 objective. Although ESM 1.2 and ESM 1.3 were not met, ESM 1.4 was successfully completed. This strategy was to create and distribute pregnancy-related service utilization reports to all the regions. A memo requesting an increase in the percentage of health department pregnancy tests completed through Title X Family Planning was included with the first report. Subsequent reports showed a 15% increase in pregnancy tests coded to Title X Family Planning in Q1-Q2 2016 compared to the same time period in 2015. This was the first increase in Title X Family Planning clients in at least 10 years.

Perinatal/Infant Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2014	6.9	NPM 5
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2014	2.6	NPM 5
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2014	111.5	NPM 5

National Performance Measures



Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2016
Annual Objective	80
Annual Indicator	78.0
Numerator	58,899
Denominator	75,553
Data Source	PRAMS
Data Source Year	2014

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	81.0	82.0	83.0	84.0	85.0	86.0

Evidence-Based or –Informed Strategy Measures

ESM 5.1 - Number of safe sleep educational material distributed

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	226,881
Numerator	
Denominator	
Data Source	TDH FHW Injury Prevention Section Program Data
Data Source Year	FFY2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	80,000.0	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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	100
Numerator	
Denominator	
Data Source	TDH FHW Injury Section Program Data - CFR Report
Data Source Year	CY2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	100.0	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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	84
Numerator	
Denominator	
Data Source	TDH PPA - Birth Statistical System
Data Source Year	FFY2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	80.0	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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	100
Numerator	
Denominator	
Data Source	TDH FHW Perinatal Health Section Program Data
Data Source Year	CY2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	100.0	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)

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	45,881
Numerator	
Denominator	
Data Source	TDH FHW Womens Health Section Program Data
Data Source Year	FFY2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	45,500.0	46,000.0	46,500.0	47,000.0	47,500.0	48,000.0

State Action Plan Table

State Action Plan Table (Tennessee) - 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	Status
ESM 5.1 - Number of safe sleep educational material distributed	Active
ESM 5.2 - Percent of infant deaths to be reviewed by child fatality review teams	Active
ESM 5.3 - Percent of VLBW (Very Low Birth Weight) infants being delivered at Level III or IV birthing facilities	Active
ESM 5.4 - Percent of newborns with a positive metabolic screen who receive follow-up to definitive diagnosis and clinical management	Active
ESM 5.5 - Number of individuals served by the Tennessee Adolescent Pregnancy Prevention Program (TAPPP)	Active

NOMs

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

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

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

Perinatal/Infant Health - Plan for the Application Year

PRIORITY: Reduce infant mortality.

Planned strategies and Activities: To achieve the objective listed above, the following strategies and activities are planned for FY18:

Strategy 1: Educate parents and caregivers on safe sleep.

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

Activity 1b: Increase the number of educational materials distributed through the Direct On Scene Education (DOSE) program from 1300 to 1800 by September 30, 2018. 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 for their infant child.

Activity 1c Increase the number of safe sleep floor talkers placed in stores, clinics, health departments, daycares and other agencies from 800 to 1200 by September 30th, 2018.

Activity 1d: Increase the number of WIC parents completing the new safe sleep educational module from 0 to 2500 by September 30, 2018.

Activity 1e: Increase the number of non-birthing hospitals providing safe sleep education from 3 to 25 by September 30th, 2018.

Activity 1f: Develop a safe sleep crib card and disseminate to a minimum of 20 birthing hospitals by September 30th, 2018.

Activity 1g: Translate the safe sleep materials into a minimum of two additional languages and make translated materials available on the safe sleep website by September 30th, 2018.

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

Activity 2a: Provide necessary documents to 34 child fatality review (CFR) teams and 5 fetal and infant mortality review (FIMR) teams to review all infant deaths and collect data on circumstances surrounding these deaths.

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 to be gathered at the scene of an infant death. Training will be provided in-person and online for firefighters, police, EMS and medical examiners. 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.

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 health care providers within the respective perinatal region, professional education for hospital staff and for other health care providers within the region, and maternal-fetal and neonatal transport.

Activity 3c: Coordinate the Perinatal Advisory Committee meetings.

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

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

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

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

Strategy 5: Reduce unintended pregnancies.

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

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

Activity 5c: The abstinence education program will continue to encourage youth to participate in community

service learning projects. The service learning experience improves the adolescent's knowledge of global and local societal needs, encourages unity among participants, incorporates community activities that enhance personal growth and accomplishments and fosters asset building, positive self-worth and healthy decision making.

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

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

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

Priority: Reduce infant mortality.

Accomplishments and Challenges (FFY 2016 Strategies and Activities)

Strategy 1: Educate parents and caregivers on safe sleep.

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

Report 1a: During FY2016, 226,881 safe sleep flyers, door hangers, posters, educational flipcharts and Sleep Baby Safe and Snug board books were disseminated to hospitals, daycares, Department of Children's services and other agencies serving infants. In addition, a safe sleep church bulletin insert was created and distributed to multiple churches.

Activity 1b: Increase the number of educational materials distributed through the Direct On Scene Education program from 400 to 700 by September 30, 2016. 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.

Report 1b: The Direct on Scene Education (DOSE) program exceeded the goal of distributing 700 kits by distributing 1127 Safe Sleep education kits. The DOSE program utilizes first responders to educate parents and caregivers about safe sleep by providing safe sleep kits and portable cribs. The kits are an envelope that includes a safe sleep flyer, door hanger, and dry erase board. In addition, the participating first responder agencies have distributed 26 portable cribs.

Activity 1c: Increase the number of safe sleep floor talkers placed in stores, clinics, health departments, daycares and other agencies from 379 to 600 by September 30th, 2016.

Report 1c. The goal of placing 600 floor talkers was exceeded by placing 668 floor talkers in stores, clinics, health departments, daycares and other agencies across Tennessee. Floor talkers are large vinyl stickers with the American Academy of Pediatrics safe sleep recommendations that can be placed on any smooth flat surface.

Activity 1d: Increase the number of WIC parents completing the safe sleep educational module from 176 to 1000 by September 30, 2016.

Report 1d: The WIC safe sleep and breastfeeding educational module was changed from an in person educational tool to an online educational module. The program exceeded the goal of 1000 WIC parents completing the module. The module was made available to WIC parents statewide in December 2015. During FY2016 a total of 1952 WIC parents participated in the online safe sleep educational module that included information on safe sleep and breastfeeding.

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

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.

Report 2a: Tennessee's 34 local child fatality teams continued to review infant deaths. Local child fatality review teams were notified of infant deaths monthly with a total of 511 infant deaths reviewed in federal fiscal year 2016. In addition, the teams were provided necessary documents such as birth and death certificates, autopsy reports and information from the death scene investigation. The review process resulted in a new state prevention plan of action.

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

Report 2b: New member orientation webinars were held each quarter, as well as the Child Fatality Review manual being available both electronically and as a hard copy. New member orientations were held on 9/21/2015 with 15 participants, 12/17/2016 with 13 participants, 4/26/2016 with 8 participants and 8/2/2016 with 6 participants There was also an in person training held on June 1st with 100 individuals in attendance.

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

Report 2c: Data quality reports were provided to the local child fatality review teams in February 2016, May 2016, June 2016, July 2016, and August 2016. The reports notify local teams of specific data fields in the child death database that were marked missing or unknown. Teams were sent the data quality reports and asked to make changes to improve data quality.

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.

Report 2d: There were two in person trainings and one online training available for firefighters, police, EMS, and medical examiners. The in person trainings follow a train the trainer model and occurred in May 2016 with around 100 in attendance. The online training was completed by 60 participants. Attendees at the in person trainings were offered a Sudden Unexplained Infant Death Investigation (SUIDI) doll if they did not have one, 114 SUIDI dolls were handed out at the trainings. The dolls are utilized by the first responders to do a doll reenactment at the death scene. The doll reenactment assists the medical examiner in determining the cause of death.

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

Activity 3a: Fund the statewide perinatal quality improvement collaborative to engage obstetrics, neonatal,

and pediatric stakeholders in applying quality improvement methodologies related to perinatal outcomes.

Report 3a: During the last quarter of FY 15, the TDH provided $60,000 for each Regional Perinatal Center from the TennCare agreement funding for infant mortality to purchase simulation equipment to use in both obstetrics and neonatal training and education. All the equipment was received by June 30 of FY 15; training sessions using these new resources were conducted for staff in hospitals throughout the state during the FY 16 year. On July 1, 2016, the State Legislature approved new state funding for each Perinatal Center to expand personnel capacity for both neonatal and obstetrics outreach education.

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.

Report 3b: During the year, a work group of experts in perinatal care completed the revision to the regionalization guidelines, and a separate work group began the process of revising the educational objectives for nurses working in perinatal care.

Activity 3c: Coordinate the Perinatal Advisory Committee meetings.

Report 3c: Perinatal Advisory Committee meetings were held in December and June. The revision of the regionalization guidelines was approved, adding maternal level IV and a section on birth centers to the document.

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

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

Report 4a: All newborn screening test results which were abnormal or unsatisfactory were sent to the follow-up staff for action. Providers were contacted and referrals made to the tertiary centers across the state for confirmation testing, counseling, and long tern follow-up. In January 2016, SCID was added to the newborn screening panel (only one case has been confirmed).

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

Report 4b: Hospital-specific monthly reports were generated on: age at collection of dried blood spot, transit time to lab, and percent of births tested for metabolic disorders, hearing, and CCHD. This was done by matching newborn screening data to preliminary birth files. These reports also included a list of infants for which no newborn screening tests and information was submitted to the State Laboratory. Hospitals were requested to investigate and respond. In the fall of 2016, the state Medicaid agency proposed incorporation of newborn screening quality metrics into its pay for performance model for neonatal care with the coordination of the MCH Director.

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

Report 4c: Four meetings of the Genetic Advisory Committee were held during the year: August, January, May, and October. Important input was provided to the Department on additions to the screening panel (SCID, LSDs, X-ALD).

Strategy 5: Reduce unintended pregnancies.

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

Report 5a: The Title X Family Planning Program in local health departments provided education to family planning clients on reproductive health and contraceptive use. Training was provided in March 2016 that included information on utilizing the “One Key Question” (would you like to become pregnant in the next year) to help initiate the conversation on contraception use in local clinics. A new intrauterine device (IUD), that is less expensive, Liletta, was added as a form of IUD contraception offered by local family planning clinics and community health centers in order to expand availability of funds. Training was provided for each family planning clinic to learn how to insert Liletta. Infant mortality funds (through interagency contract with Medicaid) were utilized to provide training and devices to Federally Qualified Health Centers throughout the state.

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

Report 5b: The Spring Update was held in March 2016 that included 262 health care professionals. Information at the update included “One Key Question”, Youth-friendly clinics, providing inclusive and affirmative health care environments. The TAPPP and abstinence education program held a two day training in March 2016 for coordinators, grantees and health educators with 50 attendees. For the abstinence education program, 17,082 adolescents, parents and professionals were served with 43,098 program hours

provided, and 6,461 service learning hours completed.

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

Report 5c: During the report year, 13 school and community based organizations received funding in high risk communities. As a part of the abstinence education program, all participants must complete a service-learning project such as food drives, pet toys for animals at the humane society, community clean-ups and gift for seniors in assisted living facilities. The abstinence education program includes a focus on personal growth and development, healthy relationship building and self-care.

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

Report 5d: Six regional and two metropolitan health departments participate in TAPPP and provide community resources to increase awareness of teen pregnancy, family life education, comprehensive sexuality education, professional training, abstinence education, healthy relationships, asset building in youth and adolescent growth and development. Each participating area hosted local events throughout the year and educational opportunities for youth, parents and professionals to increase knowledge and resource availably. In FY2016, 74,146 children, youth, parents and professionals were served through TAPPP.

Data Interpretation (of data listed on Form 10A):

Based on the most recent PRAMS data available, CY2013, 78% of infants were placed to sleep on their backs. An evaluation of performance during FY2016 is not available since data for the performance year is not available.

All objectives were exceeded for the ESMs. The number of safe sleep educational materials distributed was 226,881; almost triple the objective of 80,000. For infant death reviews, 100% of infant deaths were reviewed in calendar year 2015 by child fatality review teams. As far as very low birth weight infants being delivered at a level III or IV birthing facility, 84% were delivered at the appropriate level of care, which exceeds the objective of 80%. For newborn screening, based on preliminary data for calendar year 2016 there were 85,562 births in total of which 85,258 received a dried blood spot screen, 83,145 were screened for CCHD, and 84,523 were screening for hearing. Lastly during FY 2015, 45,881 individuals were served by the TAPPP, which exceeded the objective of 45,000 for FY2016.

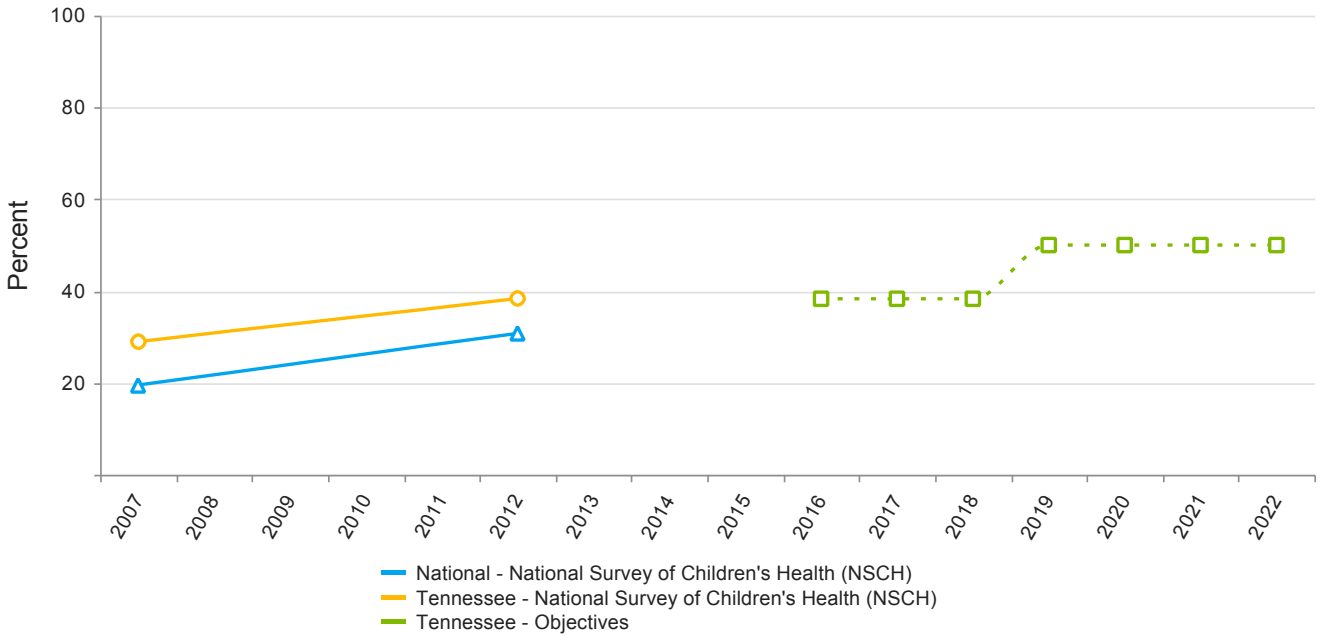
Child Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)	NSCH	Data Not Available	NPM 6
NOM 15 - Child Mortality rate, ages 1 through 9 per 100,000	NVSS-2015	18.3	NPM 7
NOM 16.1 - Adolescent mortality rate ages 10 through 19 per 100,000	NVSS-2015	39.8	NPM 7
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000	NVSS-2013_2015	14.1	NPM 7
NOM 16.3 - Adolescent suicide rate, ages 15 through 19 per 100,000	NVSS-2013_2015	9.8	NPM 7
NOM 19 - Percent of children in excellent or very good health	NSCH-2011_2012	84.0 %	NPM 6 NPM 8
NOM 20 - Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)	NSCH-2011_2012	34.1 %	NPM 8
NOM 20 - Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)	WIC-2014	30.3 %	NPM 8
NOM 20 - Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)	YRBSS-2015	35.7 %	NPM 8

National Performance Measures

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



Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2016
Annual Objective	38.3
Annual Indicator	38.3
Numerator	150,143
Denominator	391,762
Data Source	NSCH
Data Source Year	2011_2012

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	38.3	38.3	50.0	50.0	50.0	50.0

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	797
Numerator	
Denominator	
Data Source	TDH FHW Early Childhood Section Program Data
Data Source Year	FFY2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	599.0	617.0	636.0	655.0	675.0	696.0

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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	450
Numerator	
Denominator	
Data Source	TDH CHS Program Data
Data Source Year	FFY2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	467.0	485.0	504.0	524.0	544.0	566.0

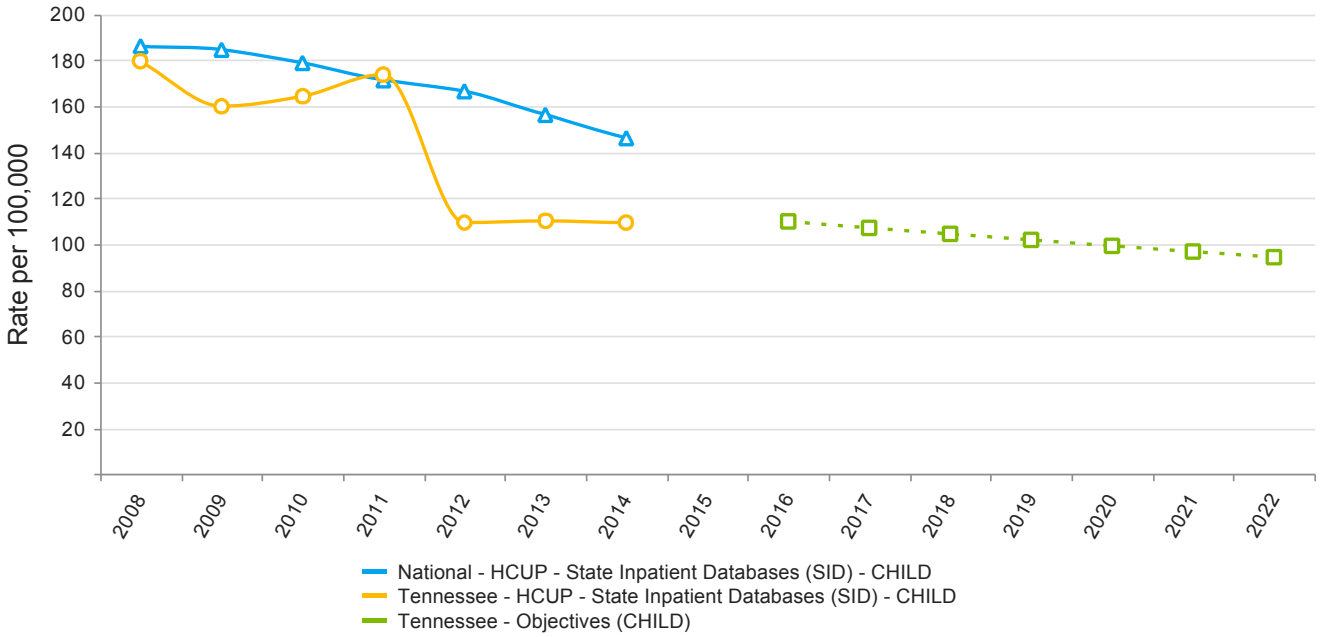
ESM 6.3 - Percent of Developmental Screenings performed across the state for participants enrolled in an Evidence-Based Home Visiting Program

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	89.2
Numerator	
Denominator	
Data Source	TDH FHW Early Childhood Section Program Data
Data Source Year	FY2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	90.0	90.0	91.0	92.0	92.0	93.0

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



NPM 7 - Child Health

Federally Available Data	
Data Source: HCUP - State Inpatient Databases (SID) - CHILD	
	2016
Annual Objective	109.8
Annual Indicator	109.1
Numerator	893
Denominator	818,595
Data Source	SID-CHILD
Data Source Year	2014

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	107.0	104.4	101.8	99.2	96.7	94.3

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	2,836
Numerator	
Denominator	
Data Source	TDH FHW Injury Prevention Section Program Data
Data Source Year	FFY2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	2,836.0	2,850.0	2,875.0	2,900.0	2,925.0	2,950.0

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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	36
Numerator	
Denominator	
Data Source	TDH FHW Injury Prevention Section Program Data
Data Source Year	FFY2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	45.0	48.0	51.0	54.0	57.0	60.0

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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	81
Numerator	
Denominator	
Data Source	TDH FHW Early Childhood Section Program Data
Data Source Year	FY2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	85.0	87.0	89.0	91.0	93.0	95.0

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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	46
Numerator	
Denominator	
Data Source	ReduceTNCrashes.org Safe Driving Report
Data Source Year	FFY2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	55.0	57.0	59.0	61.0	63.0	65.0

ESM 7.5 - Number of drug disposal bins installed statewide

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	206
Numerator	
Denominator	
Data Source	TN Depart of Environment and Conservation Report
Data Source Year	FFY2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	170.0	225.0	240.0	255.0	270.0	295.0

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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	8
Numerator	
Denominator	
Data Source	TN Depart of Environment and Conservation Report
Data Source Year	FFY2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	5.0	6.0	7.0	7.0	8.0	8.0

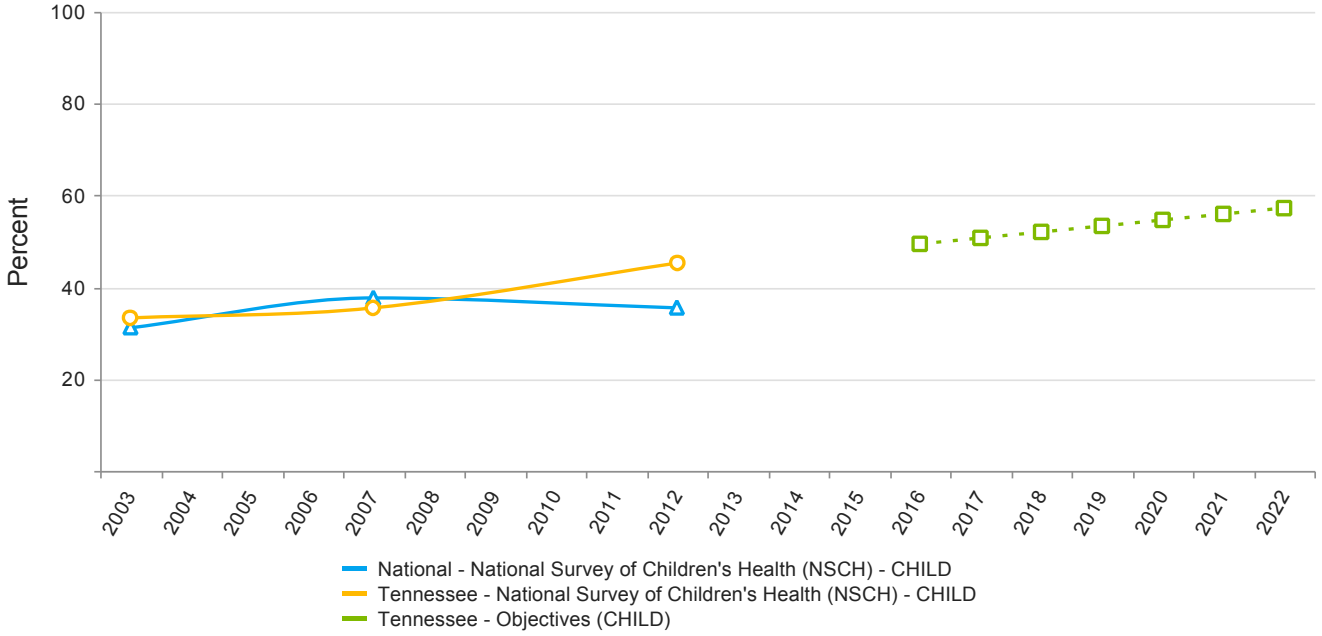
ESM 7.7 - Number of suicide-related articles, social media posts and trainings provided by TDH

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	11
Numerator	
Denominator	
Data Source	TDH FHW Injury Prevention Section Program Data
Data Source Year	FFY2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	11.0	11.0	12.0	12.0	13.0	13.0

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



NPM 8 - Child Health

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - CHILD	
	2016
Annual Objective	49.4
Annual Indicator	45.4
Numerator	224,507
Denominator	494,298
Data Source	NSCH-CHILD
Data Source Year	2011_2012

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	50.7	52.0	53.3	54.6	55.9	57.2

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	441
Numerator	
Denominator	
Data Source	TDH FHW Chronic Disease Program Data
Data Source Year	FFY2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	480.0	525.0	570.0	615.0	660.0	705.0

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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	485
Numerator	
Denominator	
Data Source	TDH FHW SupplementalNutrition Section Program Data
Data Source Year	FFY2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	475.0	500.0	525.0	550.0	575.0	600.0

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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	2
Numerator	
Denominator	
Data Source	Baby Friendly USA, Inc.
Data Source Year	CY2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	3.0	3.0	4.0	4.0	5.0	5.0

ESM 8.4 - Number of Physical Activity Clubs in K-12 schools

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	47
Numerator	
Denominator	
Data Source	TDH FHW Chronic Disease Program Data
Data Source Year	FFY2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	60.0	125.0	150.0	175.0	200.0	225.0

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

Measure Status:	Inactive - Replaced

State Provided Data	
	2016
Annual Objective	
Annual Indicator	68
Numerator	
Denominator	
Data Source	TN Depart of Education - Coordinated School Health
Data Source Year	FFY2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	70.0	75.0	80.0	85.0	90.0	90.0

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

Measure Status:	Inactive - Replaced

State Provided Data	
	2016
Annual Objective	
Annual Indicator	136
Numerator	
Denominator	
Data Source	TN Depart of Education - Coordinated School Health
Data Source Year	FFY2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	140.0	146.0	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

Measure Status:	Inactive - Replaced

State Provided Data	
	2016
Annual Objective	
Annual Indicator	1,591
Numerator	
Denominator	
Data Source	Tennessee Recreation and Parks Association
Data Source Year	FFY2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	1,675.0	1,700.0	1,725.0	1,750.0	1,775.0	1,775.0

ESM 8.8 - Number of school gardens in Tennessee public schools

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	0.0	395.0	420.0	470.0	495.0	520.0

ESM 8.9 - Number of Healthy Parks Healthy Person app users

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	0.0	800.0	900.0	1,000.0	1,100.0	1,200.0

State Performance Measures

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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	27.5
Numerator	
Denominator	
Data Source	NSCH
Data Source Year	2011_2012
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	27.5	27.5	24.8	24.8	22.3	22.3

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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	78.2
Numerator	
Denominator	
Data Source	TDH PPA - Birth Statistical System
Data Source Year	CY2015
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	80.0	82.0	84.0	86.0	88.0	90.0

State Action Plan Table

State Action Plan Table (Tennessee) - 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	Status
ESM 6.1 - Number of unique page views to the Developmental Milestones and Developmental Screenings kidcentraltn.com sites	Active
ESM 6.2 - Number of health department nurses trained in the START Autism and MCHAT-R/F program	Active
ESM 6.3 - Percent of Developmental Screenings performed across the state for participants enrolled in an Evidence-Based Home Visiting Program	Active

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 (Tennessee) - 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	Status
ESM 7.1 - Number of parents and caregivers receiving car seat education	Active
ESM 7.2 - Number of counties that adopt Count It! Drop It! Lock It! educational programs	Active
ESM 7.3 - Percent of families who receive injury prevention education through the AAP checklist among families participating in Evidence Based Home Visiting programs	Active
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	Active
ESM 7.5 - Number of drug disposal bins installed statewide	Active
ESM 7.6 - Number of press releases, social media posts and presentations about adolescent falls	Active
ESM 7.7 - Number of suicide-related articles, social media posts and trainings provided by TDH	Active

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 (Tennessee) - 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	Status
ESM 8.1 - Number of Gold Sneaker-recognized childcare facilities in Tennessee	Active
ESM 8.2 - Average number of monthly calls to the Tennessee Breastfeeding Hotline (TBH)	Active
ESM 8.3 - Number of Baby Friendly-designated Tennessee birthing hospitals	Active
ESM 8.4 - Number of Physical Activity Clubs in K-12 schools	Active
ESM 8.5 - Number of school districts (LEAs) that received CSPAP training	Inactive
ESM 8.6 - Number of school districts (LEAs) that received Smarter Lunchroom training	Inactive
ESM 8.7 - Number of shared-use agreements (any type) between two or more entities in Tennessee	Inactive
ESM 8.8 - Number of school gardens in Tennessee public schools	Active
ESM 8.9 - Number of Healthy Parks Healthy Person app users	Active

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 (Tennessee) - 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 (Tennessee) - 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.

Child Health - Plan for the Application Year

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

Planned Strategies and Activities: To achieve the objective listed above, the following strategies and activities are planned for FY18:

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

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

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

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

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

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

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

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

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

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

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

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

Activity 3a: Explore inclusion of developmental screening administration into the Gold Sneaker Initiative designation standards at Department of Health.

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.

Planned strategies and Activities: To achieve the objective listed above, the following strategies and activities are planned for FY18:

Strategy 1: Promote the use of child safety seats.

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

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

Activity 1c: Create a list of organizations that provide child safety seats to parents and caregivers in Tennessee. Disseminate the list to a minimum of 40 community partners.

Strategy 2: Promote safe storage of medications.

Activity 2a: Promote safe storage and disposal of medications through the Count it, Lock it™, Drop it

initiative. The goal of Count It, Lock It, Drop It™ is to increase the number of individuals tracking medication, securing medication in a locked medicine box, and utilizing medicine drop boxes. Staff will conduct four presentations to promote Count It, Lock It, Drop It™ to increase safe storage and disposal of medication.

Activity 2b: Partner with a minimum of 25 hospitals by September 30, 2018 to promote safe storage of medications to patients.

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.

Activity 3a: Discuss injury prevention topics with a minimum of 83% of eligible families served through TDH evidence-based home visiting programs. Topics to be discussed include: 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. Collaborate with the Department of Human Services to promote health standards within those 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.

Planned strategies and Activities: To achieve the objective listed above, the following strategies and activities are planned for FY18:

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

Activity 1a: Recruit 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).

Activity 2a: Promote breastfeeding among the general population through various campaigns (e.g., Breastfeeding Welcomed Here and Primary Prevention Initiatives).

Activity 2b: Enhance the awareness and utilization of the Breastfeeding Hotline among the general public, providers, and new families (e.g., hotline magnets and/or other promotional material in the "Welcome Baby" mailer).

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

Activity 2d: Collaborate with THA to provide technical assistance to birthing hospitals (including EMPower and CHAMPS grantees) pursuing Baby-Friendly designation or the adoption of other hospital policies to improve breastfeeding practices (e.g. Best for Babies recognition).

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

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

Activity 3b: 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. Collaborate with the Department of Human Services to promote health standards within those 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.

Planned Strategies and Activities: To achieve the objective listed above, the following strategies and activities are planned for FY18:

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

Activity 1a: Under the leadership of the Title V Program staff, disseminate the Tennessee ACEs Briefs related to the "Big 4" (TDH priorities areas of obesity, physical activity, substance abuse, and tobacco use) and present information about the CDC ACEs Study to early childhood and health professionals in order to raise awareness of the implications of ACEs.

Activity 1b: Disseminate ACEs Handout, How to Protect Your Child from Toxic Stress in the Welcome Baby packets to increase parents' understanding of ACEs and strategies to protect their child.

Activity 1c: Provide ongoing leadership to the Building Strong Brains, Tennessee's ACEs Initiative formed in 2015.

Activity 1d: Provide ACEs training to the 34 Child Fatality Review teams during their annual meeting.

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

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 BRFSS.

Activity 2b: Collect ACEs data in underserved and at risk populations such as home visiting and compare to state and national measures.

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))

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

Accomplishments and Challenges (FFY2016 Strategies and Activities)

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

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

Report 1a: Our Welcome Baby Program Manager reviewed published developmental screening materials for inclusion in the Welcome Baby mailer packet. This resulted in the selection of a CDC developmental milestones brochure in July 2016. The Welcome Baby Team is now working with the CDC for rights to include our logo on the brochure and to arrange print services. This information will be included in the packet for Nov 2017, to be sent in calendar year 2018.

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

Report 1b: TDH maintains two seats on the kidcentraltn Content Steering Committee and attends quarterly meetings to determine featured content on the site. TDH representatives review site analytics report and sponsor developmental screening for monthly featured content. We review and edit copy that has been created for developmental screening, and all health articles, ensuring accuracy of information and content quality. The TDH kidcentraltn administrator embeds videos within pages content to drive page views.

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

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

Report 2a: TDH Division of Family Health and Wellness, in partnership with the Division of Community Health Services and the local health departments, is in the process of developing an integrated care coordination model. This integrated approach will be implemented statewide. We have ensured that developmental screening, behavioral screening, and community referral pathways are included in this model.

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.

Report 2b: TDH has held several in-person meetings with the Department of Education, Tennessee Early Intervention Services to build a data sharing agreement. This data sharing arrangement would need to be approved by both Department's legal teams. It would benefit multiples programs in the Department of Health that rely on or could enhance

outcomes analysis if there was access to educational attainment and developmental screening data. These programs include Newborn Hearing, Evidence-Based Home Visiting , Project LAUNCH, Zika Birth Defects Surveillance, among others. Data sharing across state entities continues to pose security, logistic, and interface challenges.

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.

Report 2c: TDH partnered with TNAAP, TEIS, and the Tennessee Young Child Wellness Council to train health department nurses in the M-CHAT screening tool. AS of September 30, 2016, 449 nurses across the state had been trained in this Autism checklist.

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.

Report 2d: TNAAP and TEIS are partnering for START, a pediatric provider education program that encourages providers to implement developmental screening into routine care. TDH is in full support of the START training and is exploring pathways of providing additional funding to START to further the integration of developmental screening by increasing training.

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

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

Report 3a: TDH made recommendations to the Quality Rating and Improvement System to include administration of timely developmental screening in the standards for quality rating among child care programs. While our recommendations were not adopted, we continue to partner with the 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.

Report 3b: TDH has implemented a train-the-trainer model to ensure sustainability of the ASQ-3 administration. Three program directors were trained to administer the ASQ-3 training in November 2016. Trainings are planned across the state for spring and summer 2017.

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

Report 3c: To better understand the collaboration between evidence based home visiting agencies and the medical homes for children they serve, TDH modified the data collection forms and data system used to collect evidence based home visiting data. These changes

increase the frequency which the families are asked about their medical home and collect referral linkage information for developmental screenings. These changes were planned and developed in year 1; data system changes went live Oct 1, 2016.

Data Interpretation (of data listed on Form 10A):

Data from NPM 6 comes from the National Survey of Children's Health. The most recent data from that survey is for 2011/2012. Therefore an evaluation of the performance during FY16 is not available. Once data from the performance year is available, the statewide impact of community efforts to promote timely development screening among parents, physicians, and service providers will be measured.

For ESM 1 the goal was to drive page views to the developmental milestones and screening site of kidcentraltn.com, a state-supported family resource. During the report year there was an increase in unique page views from 564 to 797, a gain of 41%. For ESM 3 a partnership was developed with the Evidence-Based Home Visiting program to promote screening for enrolled participants using the ASQ-3. During FY16, we saw an increase in screening rates from 86% to 89.2%, exceeding our goal of 88%.

Priority: Reduce the burden of injuries among children.

Accomplishments and Challenges (FFY 2016 Strategies and Activities)

Strategy 1: Promote the use of child safety seats.

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

Report 1a: From October 1, 2015 to May 10, 2016, TDH provided $141,667 to 28 agencies, who then distributed 2,501 car seats. The car seat safety funds are state funds generated from fines paid for traffic citations. Agencies conduct education while ensuring that seats are properly installed. Each agency is required to have a certified child safety seat technician on staff.

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

Report 1b: An infographic titled “The Road to Crash Prevention” was created which contained general safe driving information along with child safety seat education. Some of the agencies that distribute car seats have created car seat flyers to educate parents and caregivers about child safety seats.

Strategy 2: Promote safe storage of medications.

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.

Report 2a: TDH staff partnered with the Prevention Alliance of Tennessee, and the Department of Mental Health and Substance Abuse Services to promote Count It! Lock It! Drop It! (CLD) to existing and new substance abuse coalitions, county health councils, and other community groups. CLD teaches patients to count their medication, store it when not using it and discard of it appropriately when it is no longer needed. There are currently 36 groups who conduct Count It! Lock It! Drop It! in Tennessee. As a condition of the program, each county must obtain and use drug drop boxes. Additional funds were utilized from the CDC Violence and Injury Grant to purchase CLD Starter Kits for 8 new counties this year. In addition, Blue Cross and Blue Shield of Tennessee gave a $1.2 million grant to a community coalition to expand CLD to all 95 counties.

Activity 2b: Promote safe storage of medications through the secure medication drop off boxes. Staff will collaborate with Tennessee Department of Environment and Conservation (TDEC) to place an additional 10 boxes in the community by September 30, 2016.

Report 2b: Staff collaborated with Tennessee Department of Environment and Conservation, the Tennessee Department of Mental Health and Substance Abuse Services, and the Prevention Alliance of Tennessee to increase the number of secure medication drop boxes in the state. As of October 1, 2016, there were 208 boxes in 95 of 95 counties. This is an increase of 60 boxes and 7 counties since February 2, 2016.

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

Report 2c: TDH provided $279,000 in Title V funding to support a portion of the operation of the Tennessee Poison Center.

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

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.

Report 3a: Home visitors provided injury prevention information to 81% of families who are enrolled in evidence-based home visiting programs. The AAP Safety Checklist is utilized by home visitors and covers several injury prevention topics, including child restraints, safe sleep, smoke detectors and fall prevention.

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

Report 3b: A child injury data report was completed and distributed to100% of evidence-based home visiting staff. The report provided data on childhood injuries including injury deaths, hospitalizations, and emergency department visits. The report highlighted causes of injuries and injury prevention efforts in Tennessee.

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

Report 3c: Infographic flyers were developed around suicide, motor vehicle crashes, and infant safe sleep. Three thousand were distributed by TDH to partners and stakeholders who impact child health. In addition, the Tennessee Suicide Prevention Network printed and distributed an additional 10,000 copies of the suicide prevention infographic flyer.

Data Interpretation (of data listed on Form 10A):

An increase in the rate of child injury hospitalizations per 100,000 was seen from 103.7 in 2014 to 124.1 in 2015, likely due to the change in the injury coding definition during the transition from ICD-9 to ICD-10. Since this increase surpasses the 2016 goal of 109.8 per 100,000, this objective may be adjusted to account for the change in coding.

One of the ESMs was exceeded, ESM 7.1, however the others were not met for injury in the child domain. Although the ESM objectives 7.2 and 7.3 were not met, they were only missed by a narrow margin. For ESM 7.2, 36 of 37 counties were involved in the CLD initiative. Moving forward a grant received by a partner will likely help meet the objective. Likewise, 81% of families received injury education through the home visiting program, slightly below the objective of 83%. Stakeholders have been a valuable asset in generating ideas on how to grow the program and achieve the objectives moving forward.

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

Accomplishments and Challenges (FFY2016 Strategies and Activities)

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

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

Report 1a: The Gold Sneaker program director contacted a minimum of 25 childcare facility directors on a monthly basis to provide an overview of the Gold Sneaker Initiative and encouraged them to pursue Gold Sneaker designation.

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

Report 1b: Due to reorganization with the Division of Family Health and Wellness at the Tennessee Department of Health, in May 2016 the Gold Sneaker initiative was assigned a fulltime Program Director who is available for technical assistance. Technical assistance included provision of training for Early Childcare staff, health educators and other health department staff. The program director also developed and managed the Child Health Week campaign, developed educational materials including an online newsletter, and maintains the Gold Sneaker and Child Health Week online web sites.

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

to child care licensing standards.

Report 1c: The Tennessee Department of Health is still awaiting the final decision as to whether or not the Gold Sneaker policies are to be added to Department of Human Services childcare licensing standards. Due to competing priorities with DHS, this activity was delayed. Additionally, the point person who spearheaded this activity departed TDH.

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

Report 1d: No evaluation system ensuring policy compliance for designated Gold Sneaker facilities was developed in FY2016. A Gold Sneaker evaluation plan has been drafted and is currently under review. A re-designation process has also been drafted and is currently under review.

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

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

Report 2a: Title V and WIC continued joint funding and support of the Tennessee Breastfeeding Hotline (TBH). In FFY2016, there were 5,910 calls to the TBH, averaging close to 500 calls per month. Of total calls received, 5,032 (85.1%) were from Tennessee residents within 94 of Tennessee's 95 counties. Nearly 73% of callers indicated that they were referred to TBH by a hospital. The top three primary reasons for calling TBH were: medications and breastfeeding, not making enough milk, and breast or nipple pain. TBH staff handled 90% of those without additional medical referral and provided a total of 10,148 referrals to other resources, with the majority made to breast pump suppliers, additional resources on hand expression of breast milk, and techniques for breast compression to increase milk flow.

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

Report 2b: The Hotline was promoted by the Tennessee Hospital Association through media campaign targeting counties in West and East Tennessee with lower breastfeeding initiation rates. Through their website, THA also provided an mPINC tool kit to assist birthing hospitals. The Healthy Tennessee Babies website received 4,438 page views, with 21.9% of those views to specifically access information from the Tennessee Hospitals Breastfeeding Toolkit. Regional Breastfeeding Coordinators, identified Designated Breastfeeding Experts in all local and regional health offices and WIC Breastfeeding Peer Counselors covering 65 counties promoted the Hotline. The Hotline information was also disseminated through the local county health councils at community events. During National Breastfeeding Awareness Month all 95 counties held events in which the Hotline was featured.

Activity 2c: Monitor, assess and update breastfeeding hotline messaging to ensure it remains a positive resource for mothers.

Report 2c: Hotline messaging was updated to reflect more accurate information for callers. The Hotline has been available 24 hours a day, 7 days per week. This information was added to remind all users that calls are accepted at any time of day or night. All promotional materials and the TBH website were updated with "24/7".

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.

Report 2d: The Breastfeeding Hotline magnets were included in the Welcome Baby Initiative mailers which were distributed to 80,517 newborn parents, who were residents of Tennessee. A "Breastfeeding is the Best" flyer with the Hotline graphic was also included in the packet.

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

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

Report 3a: Title V funding was utilized to support a full-time State School Nurse Consultant. This position is housed in the Department of Education, Office of Coordinated School Health. The School Nurse Consultant provides consultation and technical assistance to school administrators, school nurses, health care providers and others regarding the delivery of quality health care in Tennessee schools. The School Nurse Consultant also plans, implements, and participates in educational programs regarding 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.

Report 3b: In FY2016 TDH was aware of seventy-two physical activity clubs, which would include run clubs. A challenge developed around how to conduct statewide surveillance on the existence of physical activity clubs that would allow TDH to determine which LEAs need further support to implement clubs. To address this challenge, we are developing a process to register physical activity clubs across the state. Physical activity clubs support the Comprehensive School Physical Activity Program (CSPAP) approach to support healthy schools.

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

Report 3c: The run club toolkit has been downloaded by internal and external stakeholders 134 times since it went live in February 2016. TDH applied for external funding for a “run club” app, which was ultimately not funded. However, the Department then released a Request for Information to gather development and expense information for a run club app, should future funding become available. The Office of Coordinated School Health provided promotional support of the run club toolkit via inclusion in the CSH newsletter and a run club toolkit presentation was offered as a breakout session at the Coordinated

School Health Institute held in May 2016.

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

Report 3d: The pre/post program evaluation survey included as part of the run club toolkit is available online or as a printable document. Thus far there has been one submission online; however, paper-based surveys are not currently tracked.

Data Interpretation (of data listed on Form 10A):

Overall, Tennessee continues to see modest improvements in overall child health and primary prevention indicators that promote healthy weight among children. By the end of FY2016, there were 441 Gold Sneaker-recognized childcare facilities, compared to 376 in FY2015. Breastfeeding initiation rose to 78.2% in 2015, from 75.9% in 2014. Average monthly calls to the Tennessee Breastfeeding Hotline also increased by nearly 14% from this time last year. Two hospitals in Tennessee remain Baby-Friendly-designated (Erlanger and St. Thomas Midtown), and four others remain in the workgroup to pursue this award. According to the 2014-2015 Coordinated School Health BMI Report, the prevalence of obesity among kindergartners rose from 2013-2014, but the five-year data show a negative trend (decreasing obesity prevalence).

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

Accomplishments and Challenges (FFY2016 Strategies and Activities)

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

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

Report 1a: Thirty-nine presentations on ACEs and their potential life-long effects were given across Tennessee by TDH staff, with more by partner agencies. In addition, the Tennessee ACEs report is publicly available online (https://tn.gov/assets/entities/health/attachments/Tennessee_ACE_Final_Report_with_Au

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.

Report 1b: A total of 77,031 new parents received ACEs information in the mail after the birth of their baby as part of their Welcome Baby Initiative mailer. However, specific promotion of the webinar has not been implemented.

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.

Report 1c: Three Regional Professional Development Kick-off meetings were held in the early fall of 2016 to educate/train home visitors and other early childhood practitioners on trauma-informed care and ACEs.

Activity 1d: Support the formation and provide ongoing leadership to the Tennessee ACEs Collaborative formed in 2015.

Report 1d: TDH staff serve on the Building Strong Brains Public Sector Work Group (formerly known as Tennessee ACEs Collaborative), and have received Frameworks and Train the Trainer trainings to effectively discuss ACEs.

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

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 BRFSS.

Report 2a: The 2014 BRFSS data has been analyzed, and 61.0% of adult Tennesseans experienced at least one ACE; 16.3% experienced 4 or more. A statewide report of findings is pending.

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.

Report 2b: Community partners, including the Davidson County ACES Community Health Improvement Plan and Shelby County ACEs Awareness Foundation, continue to be engaged in ACEs prevention and mitigation activities.

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.

Report 2c: In a collaboration with the Tennessee Commission on Children and Youth, the Department of Children's Services granted $1.25 million to 13 community partners to further ACEs prevention work across the state. This funding was a revision to original plans to have funding focused in Northeast and Southwest Tennessee.

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

Report 2d: Implementation of the children's care coordination model has been delayed due to unforeseen transitions in the state Medicaid agency, funding uncertainty, and increased planning time to account for complex implementation concerns. However, the ACEs screener will be a part of the program that is scheduled to begin piloting in FY18.

Data Interpretation (of data listed on Form 10A):

As the National Survey of Children's Health has not been updated since 2011/12, the SPM measuring the percentage of children experiencing 2 or more ACEs remains unchanged at 27.5%. However, activities in Tennessee show an increase in awareness and screening for ACEs. In FY16, 39 presentations were held to educate community partners, and 83% of newly enrolled Evidence Based Home Visiting Participants were screened for ACEs, exceeding the objectives set for these ESMs.

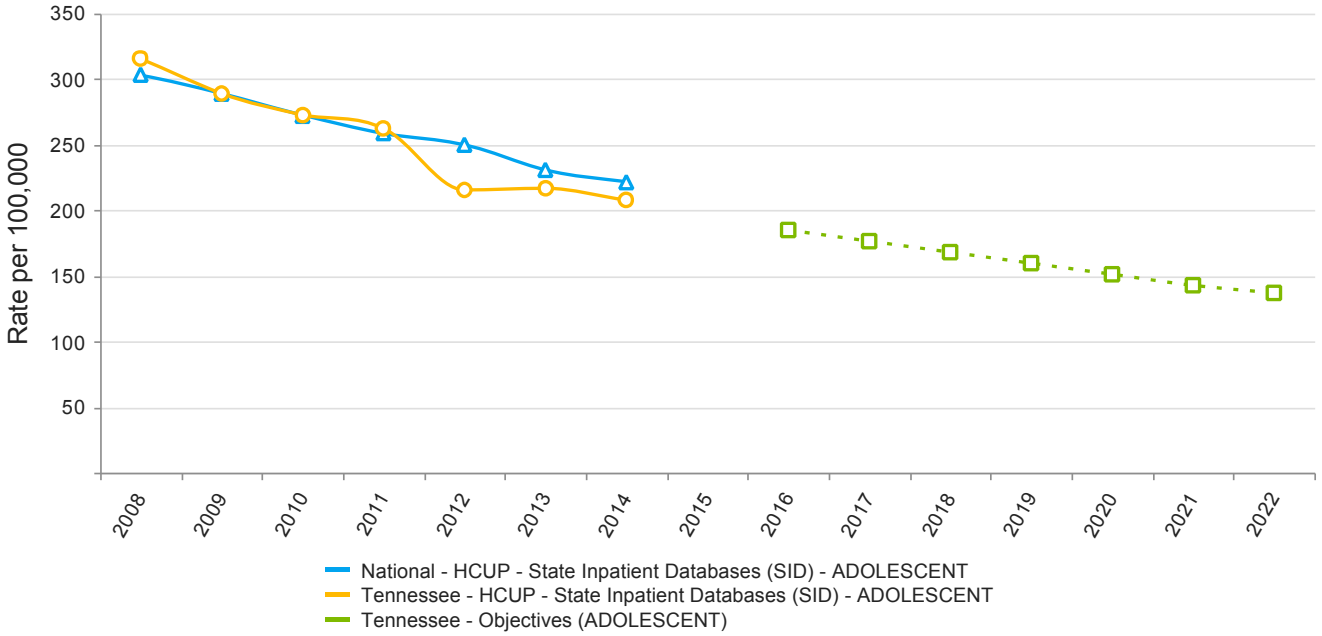
Adolescent Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 15 - Child Mortality rate, ages 1 through 9 per 100,000	NVSS-2015	18.3	NPM 7
NOM 16.1 - Adolescent mortality rate ages 10 through 19 per 100,000	NVSS-2015	39.8	NPM 7
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000	NVSS-2013_2015	14.1	NPM 7
NOM 16.3 - Adolescent suicide rate, ages 15 through 19 per 100,000	NVSS-2013_2015	9.8	NPM 7
NOM 19 - Percent of children in excellent or very good health	NSCH-2011_2012	84.0 %	NPM 8
NOM 20 - Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)	NSCH-2011_2012	34.1 %	NPM 8
NOM 20 - Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)	WIC-2014	30.3 %	NPM 8
NOM 20 - Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)	YRBSS-2015	35.7 %	NPM 8

National Performance Measures

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



NPM 7 - Adolescent Health

Federally Available Data	
Data Source: HCUP - State Inpatient Databases (SID) - ADOLESCENT	
	2016
Annual Objective	184.8
Annual Indicator	207.7
Numerator	1,746
Denominator	840,564
Data Source	SID-ADOLESCENT
Data Source Year	2014

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	176.4	168.0	159.6	151.2	142.8	137.0

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	2,836
Numerator	
Denominator	
Data Source	TDH FHW Injury Prevention Section Program Data
Data Source Year	FFY2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	2,836.0	2,850.0	2,875.0	2,900.0	2,925.0	2,950.0

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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	36
Numerator	
Denominator	
Data Source	TDH FHW Injury Prevention Section Program Data
Data Source Year	FFY2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	45.0	48.0	51.0	54.0	57.0	60.0

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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	81
Numerator	
Denominator	
Data Source	TDH FHW Early Childhood Section Program Data
Data Source Year	FY2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	85.0	87.0	89.0	91.0	93.0	95.0

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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	46
Numerator	
Denominator	
Data Source	ReduceTNCrashes.org Safe Driving Report
Data Source Year	FFY2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	55.0	57.0	59.0	61.0	63.0	65.0

ESM 7.5 - Number of drug disposal bins installed statewide

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	206
Numerator	
Denominator	
Data Source	TN Depart of Environment and Conservation Report
Data Source Year	FFY2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	170.0	225.0	240.0	255.0	270.0	295.0

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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	8
Numerator	
Denominator	
Data Source	TN Depart of Environment and Conservation Report
Data Source Year	FFY2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	5.0	6.0	7.0	7.0	8.0	8.0

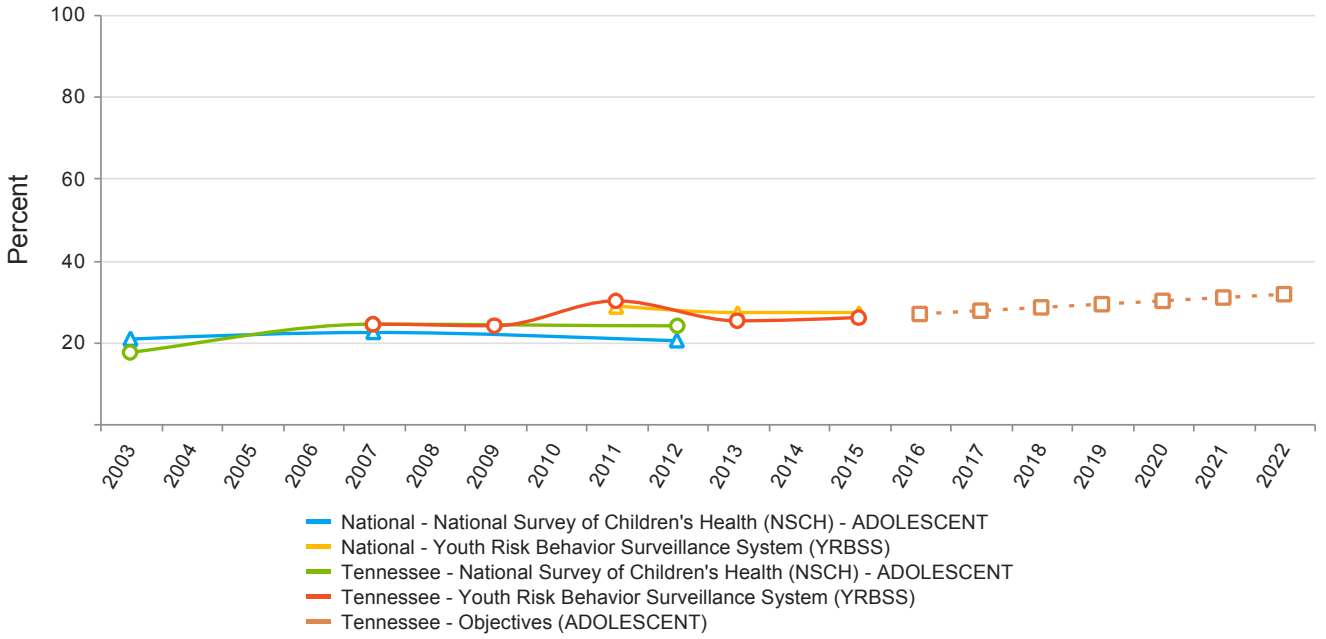
ESM 7.7 - Number of suicide-related articles, social media posts and trainings provided by TDH

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	11
Numerator	
Denominator	
Data Source	TDH FHW Injury Prevention Section Program Data
Data Source Year	FFY2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	11.0	11.0	12.0	12.0	13.0	13.0

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



NPM 8 - Adolescent Health

Federally Available Data	
Data Source: Youth Risk Behavior Surveillance System (YRBSS)	
	2016
Annual Objective	26.9
Annual Indicator	25.9
Numerator	70,480
Denominator	272,118
Data Source	YRBSS-ADOLESCENT
Data Source Year	2015

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - ADOLESCENT	
	2016
Annual Objective	26.9
Annual Indicator	23.9
Numerator	120,480
Denominator	504,540
Data Source	NSCH-ADOLESCENT
Data Source Year	2011_2012

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	27.7	28.5	29.3	30.1	30.9	31.7

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	441
Numerator	
Denominator	
Data Source	TDH FHW Chronic Disease Program Data
Data Source Year	FFY2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	480.0	525.0	570.0	615.0	660.0	705.0

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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	485
Numerator	
Denominator	
Data Source	TDH FHW SupplementalNutrition Section Program Data
Data Source Year	FFY2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	475.0	500.0	525.0	550.0	575.0	600.0

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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	2
Numerator	
Denominator	
Data Source	Baby Friendly USA, Inc.
Data Source Year	CY2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	3.0	3.0	4.0	4.0	5.0	5.0

ESM 8.4 - Number of Physical Activity Clubs in K-12 schools

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	47
Numerator	
Denominator	
Data Source	TDH FHW Chronic Disease Program Data
Data Source Year	FFY2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	60.0	125.0	150.0	175.0	200.0	225.0

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

Measure Status:	Inactive - Replaced

State Provided Data	
	2016
Annual Objective	
Annual Indicator	68
Numerator	
Denominator	
Data Source	TN Depart of Education - Coordinated School Health
Data Source Year	FFY2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	70.0	75.0	80.0	85.0	90.0	90.0

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

Measure Status:	Inactive - Replaced

State Provided Data	
	2016
Annual Objective	
Annual Indicator	136
Numerator	
Denominator	
Data Source	TN Depart of Education - Coordinated School Health
Data Source Year	FFY2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	140.0	146.0	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

Measure Status:	Inactive - Replaced

State Provided Data	
	2016
Annual Objective	
Annual Indicator	1,591
Numerator	
Denominator	
Data Source	Tennessee Recreation and Parks Association
Data Source Year	FFY2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	1,675.0	1,700.0	1,725.0	1,750.0	1,775.0	1,775.0

ESM 8.8 - Number of school gardens in Tennessee public schools

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	0.0	395.0	420.0	470.0	495.0	520.0

ESM 8.9 - Number of Healthy Parks Healthy Person app users

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	0.0	800.0	900.0	1,000.0	1,100.0	1,200.0

State Action Plan Table

State Action Plan Table (Tennessee) - 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	Status
ESM 7.1 - Number of parents and caregivers receiving car seat education	Active
ESM 7.2 - Number of counties that adopt Count It! Drop It! Lock It! educational programs	Active
ESM 7.3 - Percent of families who receive injury prevention education through the AAP checklist among families participating in Evidence Based Home Visiting programs	Active
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	Active
ESM 7.5 - Number of drug disposal bins installed statewide	Active
ESM 7.6 - Number of press releases, social media posts and presentations about adolescent falls	Active
ESM 7.7 - Number of suicide-related articles, social media posts and trainings provided by TDH	Active

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 (Tennessee) - 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	Status
ESM 8.1 - Number of Gold Sneaker-recognized childcare facilities in Tennessee	Active
ESM 8.2 - Average number of monthly calls to the Tennessee Breastfeeding Hotline (TBH)	Active
ESM 8.3 - Number of Baby Friendly-designated Tennessee birthing hospitals	Active
ESM 8.4 - Number of Physical Activity Clubs in K-12 schools	Active
ESM 8.5 - Number of school districts (LEAs) that received CSPAP training	Inactive
ESM 8.6 - Number of school districts (LEAs) that received Smarter Lunchroom training	Inactive
ESM 8.7 - Number of shared-use agreements (any type) between two or more entities in Tennessee	Inactive
ESM 8.8 - Number of school gardens in Tennessee public schools	Active
ESM 8.9 - Number of Healthy Parks Healthy Person app users	Active

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)

Adolescent Health - Plan for the Application Year

PRIORITY: Reduce the burden of injury among adolescents.

Planned strategies and Activities: To achieve the objective listed above, the following strategies and activities are planned for FY18:

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

Activity 1a: In the ten counties with the highest teen motor vehicle crash rates, increase the number of schools that utilize ReduceTNCrashes.Org to conduct a teen safe driving program from 14 to 30.

Activity 1b: Partner with 15 schools to conduct the Checkpoints™ program to increase the number of teen/parent driving agreements.

Activity 1c: Partner with schools to provide Graduated Driver's License education to 2000 teens and caregivers.

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

Activity 2a: Promote safe storage and disposal of medications through the Count it, Lock it, Drop™ it initiative. The goal of Count It, Lock It, Drop It™ is to increase the number of individuals tracking medication, securing medication in a locked medicine box, and utilizing medicine drop boxes. Staff will conduct presentations to promote Count It, Lock It, Drop It™ to increase safe storage and disposal of medication.

Activity 2b: Partner with a minimum of 25 hospitals by September 30, 2018 to promote safe storage of medications to patients.

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

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

Activity 3a: Increase the number of youth sports leagues that apply for Safe Stars recognition from 0 to 25 by September 30, 2018.

Activity 3b: Collaborate with TDH Office of Communications to integrate routine social media postings (e.g. Facebook, Twitter) around activities that place adolescents at risk for falls (such as sports).

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.

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

Activity 4b: Disseminate a suicide prevention infographic to schools and community agencies.

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 Checkpoints, 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.

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

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

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

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

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

Activity 1d: Assess the implementation of, attitudes towards, and knowledge of the Smarter Lunchroom Movement among schools and staff that have participated in trainings. 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.

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

Priority: Reduce the burden of injury among adolescent.

Accomplishments and Challenges (FFY 2016 Strategies and Activities)

Strategy 1: Increase evidence based or evidence informed activities being implemented in schools.

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

Report 1a: As of September 30, 2016, there were a total of 46 projects utilizing www.reducetncrashes.org in the ten counties with the highest motor vehicle crash rates. Three of these counties, Rutherford, Hamilton, and Sumner, have hosted graduated drivers license (GDL) Officer Recognition events to recognize and support officers, judicial leaders, and school resource officers who support teen safe driving education and enforcement.

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

Report 1b: A total of 10 school districts registered for Battle of the Belt in December 2015. Average increase in seat belt usage rates among those schools who conducted checks was 6.03%. In addition to Battle of the Belt, TDH implemented a pilot of the Checkpoints program to give schools an additional option for evidence based motor vehicle crash prevention programming. The Checkpoints program utilizes parent and teen agreements to increase compliance with the GDL requirements which includes seat belt use.

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

Report 1c: Coordinated School Health Coordinators in Shelby and Davidson Counties were provided a total of 34,200 Teen Safe Driving educational items to promote GDL and components of GDL such as seat belt use, eliminating distracted driving, and skills to reduce teen crashes. Other schools in counties with the high teen crash rates received over 70,000 GDL wallet brochures. A Child Safety CoIIN Teen Safe Driving Strategy Team was established to reduce teen fatality and injury. This team implemented a pilot program with a high school in middle Tennessee to require students to attend a Parent Teen education program to be eligible for a school parking pass. During the required education session, the attendees create a Parent-Teen Agreement to increase GDL compliance.

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

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

Report 2a: Currently there are 36 counties implementing Count It, Lock it, Drop It in Tennessee. All participating counties have secure medication drop boxes. The injury prevention program utilized CDC injury prevention grant funds to provide materials to 8 new counties. In addition, Blue Cross Blue Shield of Tennessee has granted a local drug coalition $1.2 million to expand the program to all counties in Tennessee.

Activity 2b: Partner with the Tennessee Department of Environment and Conservation to increase the number of counties with drug disposal bins from 75 counties to 85 counties.

Report 2b: As of the end of FY2016, there are 208 drug disposal bins in 95 of 95 counties. This is an increase of 60 boxes and 7 counties since February 2, 2016.

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

Report 2c: TDH provided $279,000 in Title V funding to support a portion of the operation of the Tennessee Poison Center.

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

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

Report 3a: In partnership with The Tennessee Disability Coalition and Project Brain, 5 tweets and 2 Facebook posts were shared about youth concussion throughout the grant year.

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.

Report 3b: On October 10, 2015 a tweet was posted highlighting falls as the one of the most common reasons that adolescents visit the emergency room. Tips for parents to prevent youth falls were shared in the tweet. In partnership with Project Brain, 5 tweets and 2 Facebook posts were shared about youth concussion.

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

Report 3c: TDH staff are participating in the Adolescent Falls Child Safety CoIIN with a goal to reduce adolescent concussion. One goal of the project is to encourage schools to create a voluntary policy to monitor and document staff concussion training required by Tennessee law. A sample survey of schools was conducted to determine compliance with the Tennessee concussion law.

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

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

Report 4a: TDH staff provided Question, Persuade, Refer (QPR) Training to 9 TDH Human Resources staff and others on April 7th, 2016. QPR training was conducted on April 29th in Knoxville, Tennessee and for 135 nurses in the East Region on April 29, 2016.

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

Report 4b: TDH staff serves as the Chair of the Tennessee Suicide Prevention Network (TSPN) Intra-State Departmental Group, which includes the Department of Education Director of Coordinated School Health and Counseling. Staff has partnered with TSPN to promote 1-800-273-TALK hotline to school officials and educated injury prevention professionals about the benefits of teacher training on suicide prevention and intervention. A group of key suicide prevention stakeholders was convened in September to explore additional data sources and resources to utilize for prevention.

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

Report 4c: A Suicide Prevention Week post was made to Facebook on September 8, 2015 that included a link to Suicide Prevention Week information. A suicide prevention tweet was posted on September 9, 2015 to highlight suicide is the number 10 cause of death in Tennessee and to provide help through our partnership with TSPN. A tweet was posted on October 23, 2015 sharing the warning signs of suicide.

Data Interpretation (of data listed on Form 10A):

The Injury Program and partners met all our adolescent health ESM objectives for Year 1, including exceeding our 2021 objective in ESM 7.5. We have seen a slight increase in adolescent injury hospitalizations from 203.4 per 100,000 in 2014 to 206.6 per 100,000 in 2015. This small increase is likely due to injury coding changes in the transition from ICD-9 to ICD-10, and should ultimately keep us on track to meet our 2016 objective. Specifically in the adolescent age group, motor vehicle crashes and fall-related hospitalizations have decreased from 41% and 15% to 29% and 10% respectively, while poisonings have increased from 5% to 27%. These large annual variations are also likely due mostly to the change in coding of these conditions, but may also indicate a legitimate change in injury patterns.

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

Accomplishments and Challenges (FFY16 Strategies and Activities)

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

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

Report 1a: Title V funding was utilized to support a full-time State School Nurse Consultant. This position is housed in the Department of Education, Office of Coordinated School Health.

The School Nurse Consultant provides consultation and technical assistance to school administrators, school nurses, health care providers and others regarding the delivery of quality health care in Tennessee schools. The School Nurse Consultant also plans, implements, and participates in educational programs regarding 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.

Report 1b: A new Healthy Meals Consortium was created in March 2016 and organized by Department of Education School Nutrition (with support from TDH), Coordinated School Health and other stakeholders. The Consortium was created to establish a forum for stakeholders to collaborate on various issues related to healthy eating and children.

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

Report 1c: A survey is included as part of the run club toolkit. The survey can be conducted with students, parents and club coaches and is available online or as a printable document. Culinary trainings, conducted by School Nutrition, took place in May 2016 with 182 local school personnel in attendance. Culinary trainings focused on healthy cooking techniques and methods of displaying foods in an appealing way.

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

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

Report 2a: TDH plans to address updating the joint-use website with support of local partners during this next fiscal year. This activity was not addressed during this time period. However, after increasing the size of the Central Office staff, the new Health Educator 3 position will be assigned this task as part of her work duties.

Data Interpretation (of data listed on Form 10A):

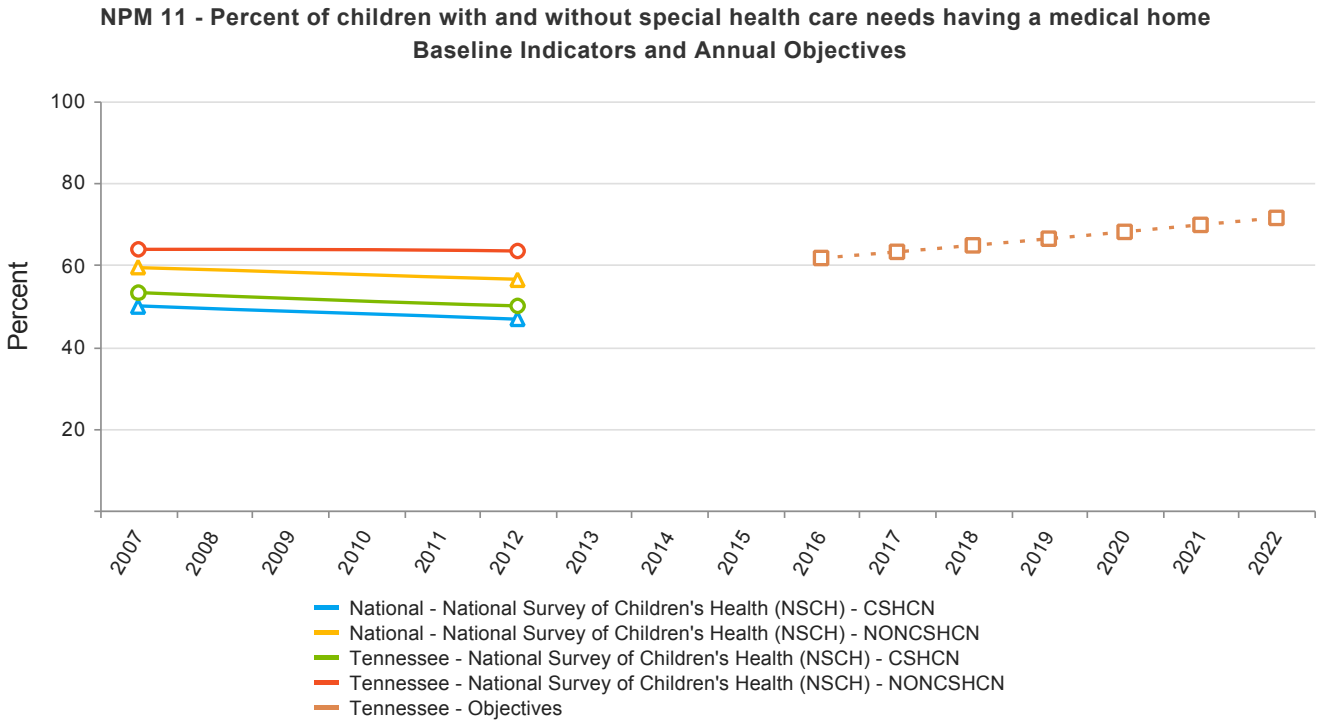
According to the 2015 Tennessee Youth Risk Behavior Survey, 18.5% of high school aged youth did not participate in at least 60 minutes of physical activity on at least 1 day in the past week. This represents a decrease from 19.6% in 2013; however, the prevalence of obesity reported in 2015 was 18.6%, up from 16.9% in 2013. There was no change in the number of shared-use agreements listed on the TRPA Joint Use Facility Finder due to a lack of site maintenance. CDC 1305 Grant funds are currently being leveraged to promote shared-use agreements while also developing/maintaining a robust tracking mechanism. Nearly all (136/146) Tennessee public school districts have received Smarter Lunchroom training, and TDH continues to work with Coordinated School Health to reach all LEAs. The number of LEAs receiving CSPAP training increased to 68 districts. TDH continues to promote, monitor and track the adoption of Run Clubs across Tennessee. To date, 47 Run Clubs have been identified.

Children with Special Health Care Needs

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 17.2 - Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system	NS-CSHCN-2009_2010	20.6 %	NPM 11 NPM 12
NOM 19 - Percent of children in excellent or very good health	NSCH-2011_2012	84.0 %	NPM 11 NPM 12
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)	NIS-2015	70.1 %	NPM 11
NOM 22.2 - Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza	NIS-2015_2016	61.8 %	NPM 11
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NISF-2015	59.7 %	NPM 11
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NISM-2015	38.2 %	NPM 11
NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine	NIS-2015	79.7 %	NPM 11
NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine	NIS-2015	76.7 %	NPM 11

National Performance Measures



Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - CSHCN	
	2016
Annual Objective	61.6
Annual Indicator	49.9
Numerator	174,136
Denominator	348,790
Data Source	NSCH-CSHCN
Data Source Year	2011_2012

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	63.1	64.7	66.3	68.0	69.7	71.4

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	420
Numerator	
Denominator	
Data Source	TDH FHW Title V CYSHCN Program Data
Data Source Year	FFY2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	475.0	525.0	575.0	625.0	675.0	725.0

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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	279
Numerator	
Denominator	
Data Source	TDH FHW Title V CYSHCN Program Data
Data Source Year	FFY2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	307.0	337.0	367.0	397.0	427.0	457.0

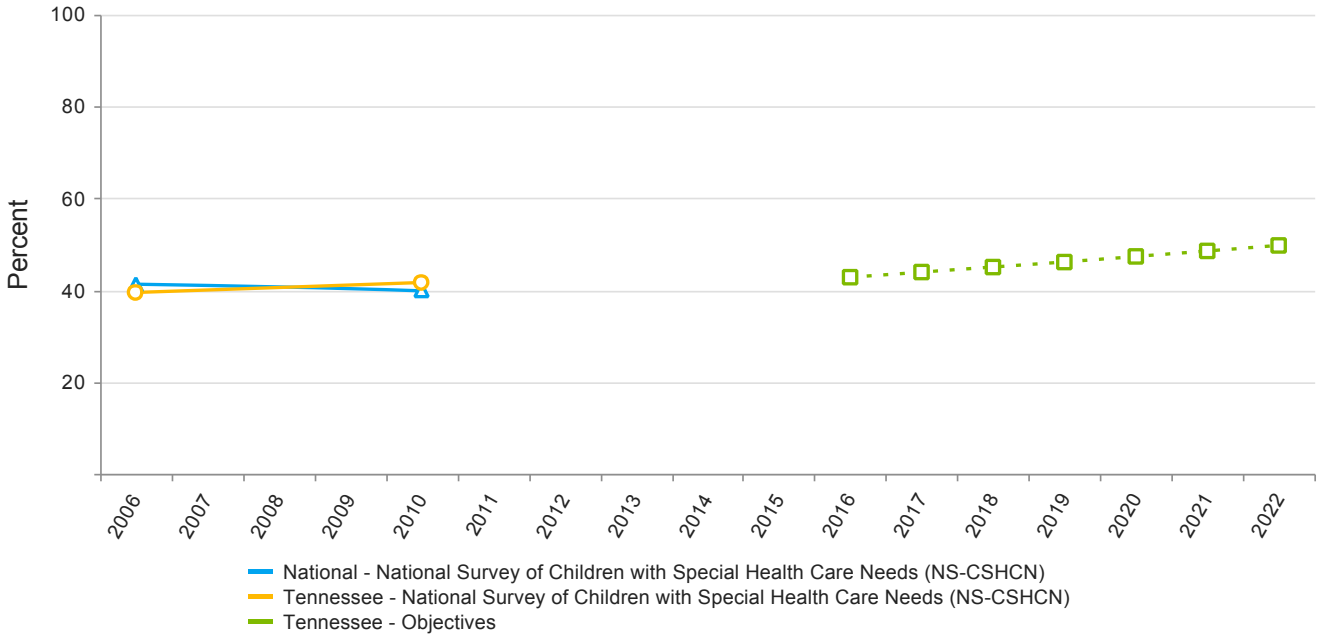
ESM 11.3 - Percentage of children served by the Children's Special Service (CSS) program receiving services in a medical home

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	74
Numerator	
Denominator	
Data Source	TDH FHW Title V CYSHCN Program Data
Data Source Year	FFY2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	80.0	85.0	90.0	95.0	100.0	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
Baseline Indicators and Annual Objectives



Federally Available Data	
Data Source: National Survey of Children with Special Health Care Needs (NS-CSHCN)	
	2016
Annual Objective	42.8
Annual Indicator	41.8
Numerator	40,413
Denominator	96,752
Data Source	NS-CSHCN
Data Source Year	2009_2010

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	43.9	45.0	46.1	47.3	48.5	49.7

Evidence-Based or –Informed Strategy Measures

ESM 12.1 - Number of adolescents on the Adolescent Advisory Council

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	7
Numerator	
Denominator	
Data Source	Title V CYSHCN Program Data
Data Source Year	FFY2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	5.0	7.0	9.0	11.0	13.0	15.0

ESM 12.2 - Number of providers who receive technical assistance and information on transition for youth and young adults with and without special health care needs

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	0.0	100.0	125.0	150.0	175.0	200.0

ESM 12.3 - Number of providers who receive technical assistance and information on transition for youth and young adults with and without special health care needs

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	0.0	75.0	80.0	85.0	90.0	95.0

State Action Plan Table

State Action Plan Table (Tennessee) - 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	Status
ESM 11.1 - Number of providers trained and provided information on medical home implementation	Active
ESM 11.2 - Number of families that receive patient centered medical home training	Active
ESM 11.3 - Percentage of children served by the Children's Special Service (CSS) program receiving services in a medical home	Active

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 (Tennessee) - Children with Special Health Care Needs - Entry 2

Priority Need

Increase the number of children (with and without special healthcare needs) who receive services necessary to make transitions to adult care.

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	Status
ESM 12.1 - Number of adolescents on the Adolescent Advisory Council	Active
ESM 12.2 - Number of providers who receive technical assistance and information on transition for youth and young adults with and without special health care needs	Active
ESM 12.3 - Number of providers who receive technical assistance and information on transition for youth and young adults with and without special health care needs	Active

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

DOMAIN: Children and Youth with Special Health Care Needs

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

Planned strategies and Activities: To achieve the objective listed above, the following strategies and activities are planned for FY18:

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

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

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

Activity 1c: CYSHCN staff will identify and provide educational resources to practices seeking medical home certification.

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

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

Activity 2b: CYSHCN staff will continue to partner with Family Voices to coordinate 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 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.

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 patient-centered medical homes and provide referral and resources to connect families to primary and specialty care providers.

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))

PRIORITY: Increase the number of children (with and without special healthcare needs) who receive services necessary to make transitions to adult health care.

Planned strategies and Activities: To achieve the objective listed above, the following strategies and activities are planned for FY18:

Strategy 1: Identify adult medical home practices to provide care for youth and young adults with special health care needs.

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

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

Strategy 2: Incorporate health care transition planning into written plans of care for children with special health care needs.

Activity 2a: CYSHCN staff will continue to work with the Tennessee Chapter of the American Academy of Pediatrics (TNAAP) to ensure policies and processes for transition planning and preparation are available to pediatric providers.

Activity 2b: CSS care coordinators will work with families to develop (and renew annually) a transition plan for all program participants starting at age 14.

Activity 2c: CSS program staff will work with youth to complete the Transition Readiness Assessment tool.

Strategy3: Support youth participation in the transition process.

Activity 3a: CYSHCN program staff will collaborate with Family Voices and LEND to recruit and retain members to serve on a youth advisory group.

Activity 3b: In conjunction with Family Voices, CYSHCN will provide training and conferences for youth and families with special health care needs regarding transition to adult health care providers.

Activity 3c: CYSHCN staff will actively encourage youth participation in policy and advocacy opportunities.

Activity 3d: CYSHCN will collaborate with the LEND program at the Boling Center in West Tennessee to replicate the youth advisory council in other areas of the state.

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))

Priority: Increase the number of children (with and without special healthcare needs) who having a medical home.

Accomplishments and Challenges (FFY2016 Strategies and Activities)

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

Activity 1a: The CYSHCN program will continue partnering with Tennessee Chapter of the American Academy of Pediatrics and the Tennessee Academy of Family Physicians to provide opportunities for training and National Committee for Quality Assurance (NCQA) certification of providers and to provide educational opportunities and support on developing the Six Core Elements of Health Care Transition in providers' written health care transition plans.

Report 1a: TDH through the D70 grant provided an opportunity for TNAAP staff to become trained and certified by NCQA to provide technical assistance for local primary care providers seeking NCQA certification. Funding from the D70 grant was also utilized to develop a medical home pilot project with East Tennessee State University (ETSU). This project provided an assessment of the general pediatrics department and a detailed work plan with specific activities that will help the clinic become certified as a NCQA patient centered medical home and also provided principles that will guide improved management of the children receiving services in this clinic.

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.

Report 1b: TDH staff requested technical assistance from the National Center for Medical Home Implementation and Got Transition on transition policies and also on the development for strategies and activities for the Strategy 1 and 2 of the Children and Youth with Special Health Care Needs Domain. Resources were shared with TNAAP and Family Voices as part of the discussions around the development of the Transition Tool Kit. A challenge for this activity has been creating a mechanism to actually provide the resources to providers.

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

Report 1c: The Transition Tool Kit was updated and a link provided on the CYSHCN website. http://tn.gov/health/article/MCH-cyshcn-integrated.

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

Report 1d: TDH has not had an opportunity to partner with the Federally Qualified Health Centers around increasing transition from pediatric to adult providers. Both of the identified FQHCs provide both pediatric and adult health care and appear to refer adolescents as needed to the adult side of care.

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

Report 1e: Technical assistance on NCQA patient centered medical home certification was provided through the D70 grant to Niswonger Children's Hospital and to East Tennessee State University Department of Pediatrics. There were challenges with moving from the technical assistance to a pilot project due to a lack of funding. The D70 grant ended in March 2016 and new funds were not allocated to continue this project.

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

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

Report 2a: The Medical Home Tool Kit currently resides on TNAAP's website with links from the CYSHCN website: http://tn.gov/health/article/MCH-cyshcn-integrated. Challenges for maintaining the tool kit are based on funding availability. The changes and updates were previously funded by the D70 grant.

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

Report 2b: TDH continued to partner with Family Voices to coordinate the Parent to Parent Program until March 30, 2016 when the D70 grant ended. Family Voices has agreed to sustain this program and continues to staff, provide mentor training and provide referrals for families seeking assistance. With additional microcephaly funding announced at the end of FY16, TDH has again been able to partner with Family Voices to assist families affected by neurodevelopmental disabilities in particular.

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

Report 2c: Workshops and resources continue to be provided by Family Voices. Funding for these activities from TDH ended March 30, 2016, however with the collaboration of TDH and Family Voices, parent support groups were developed; training was provided on the six core outcomes for CYSHCN, leadership skills, and patient centered medical homes.

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

Report 2d: TDH and Family Voices partnered with the Multi-Cultural Disability Alliance to host a workshop for the Ethiopian Community. TDH also provided resources for the alliance through D70 funding. The challenge for continuing this activity or having similar activities for other minority populations or multi-cultural populations has been the lack of funding.

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.

Report 2e: TDH participated in the National Center for Workforce Development at the University of North Carolina Chapel Hill and collaborated with TNAAP, TNAFP, Family Voices, Tennessee voices, Department of Mental Health and Substance Abuse Services, Department of Education, Primary Care Association, TennCare, Tennessee Commission on Children and Youth, Tennessee Association of Mental Health Organizations, Project LAUNCH and other agencies to develop a project for examining best practices and standards around behavioral and primary care integration in Tennessee. Two state-wide meetings were held that included medical providers, behavioral health providers, payors and other agency representatives to discuss what is currently being done in Tennessee. The project has ended, however the activity around creating a tool kit will be continued by Project LAUNCH.

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

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

Report 3a: Families who indicate they are not receiving services in a medical home are referred to a primary care provider based upon their insurance coverage. Care Coordinators partner with TennCare to ensure that all eligible participants have knowledge of their primary care provider and referrals are made as necessary. Challenges occur for those individuals that do not have private insurance and are not eligible for TennCare or other Affordable Care insurance plans. The CSS program is unable to pay for routine medical coverage for this population, however they are seen in the health departments and FQHCs.

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

Report 3b: The satisfaction survey was developed. However the contracted agency was unable to administer the survey due to an increase in the amount of funding necessary to administer the survey by phone. The CSS program is exploring other avenues to develop and administer a satisfaction survey to the population served.

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.

Report 3c: CSS staff collaborates with families, MCO's and the assigned primary care provider to ensure that participants receive necessary referrals and resources to receive care by their primary care provider. Staff also participate in health fairs and provide referral

information to the public regarding eligibility for TennCare and opportunities to apply for Affordable Care plans during open enrollment.

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.

Report 3d: All CSS participants age 14 and older participate in developing an annual transition plan with identified goals, objectives, timelines and responsible persons. This plan covers eight domains including, medical/health, independent living, financial, legal, educational/vocational, employment, social/recreational, and family resources.

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

Report 3e: There has not been an opportunity for the CSS staff to present to the Advisory Committee during this time frame.

Strategy 4: Support youth participation in the transition process.

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

Report 4a: Youth advisory members were recruited from the STEP program at Vanderbilt University, the CSS program and youth participants with Family Voices programs.

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.

Report 4b: A conference has not been held, although one is being planned for spring of 2017. Challenges with this activity include LEND participants graduated from the program in April 2016 and the new cohort did not begin until September 2016, the D70 program director position has been vacant since April 2016, and funding to host a conference was unavailable due to the D70 grant ending in March 2016.

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

Report 4c: TDH is continuing to partner with Family Voices and LEND to develop and disseminate training for youth on advocacy and leadership skills.

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

Report 4d: A link to the Transition Tool Kit is provided on the CYSHCN website: http://tn.gov/health/article/MCH-cyshcn-integrated but has not been added to the kidcentraltn.com website.

Data Interpretation (of data listed on Form 10A):

Data from NPM11 and 12 comes from the National Survey of Children's Health. The most recent data from that survey is for 2011/2012. Therefore an evaluation of the performance during FY16 is not available. Once data from the performance year is available, the statewide impact of efforts to promote medical homes for children (ESM 11), as well as transition services (ESM 12) will be measured.

All ESMs have been met or exceeded for this domain. For ESM 11.1, the number of providers trained on medical home implementation increased from 358 in FY16 to 420 in FY17, which surpassed the objective of 375. ESM 11.2 provided to 279 families with patient-centered medical home training in FY16. For ESM 11.3, a data field was added in the Patient Tracking Billing Management Information System (PTBMIS) in January 2016 to record the information on whether children have received annual exams at their medical homes. From Jan – Sept 2016, 74% of children served by the Children's Special Service (CSS) program received services in a medical home. For ESM 12.1, a CYSHCN Advisory Council was formed and the first meeting was held in March 2016. Currently the Advisory Council is comprised of 7 youth members, all of which are with special healthcare needs.

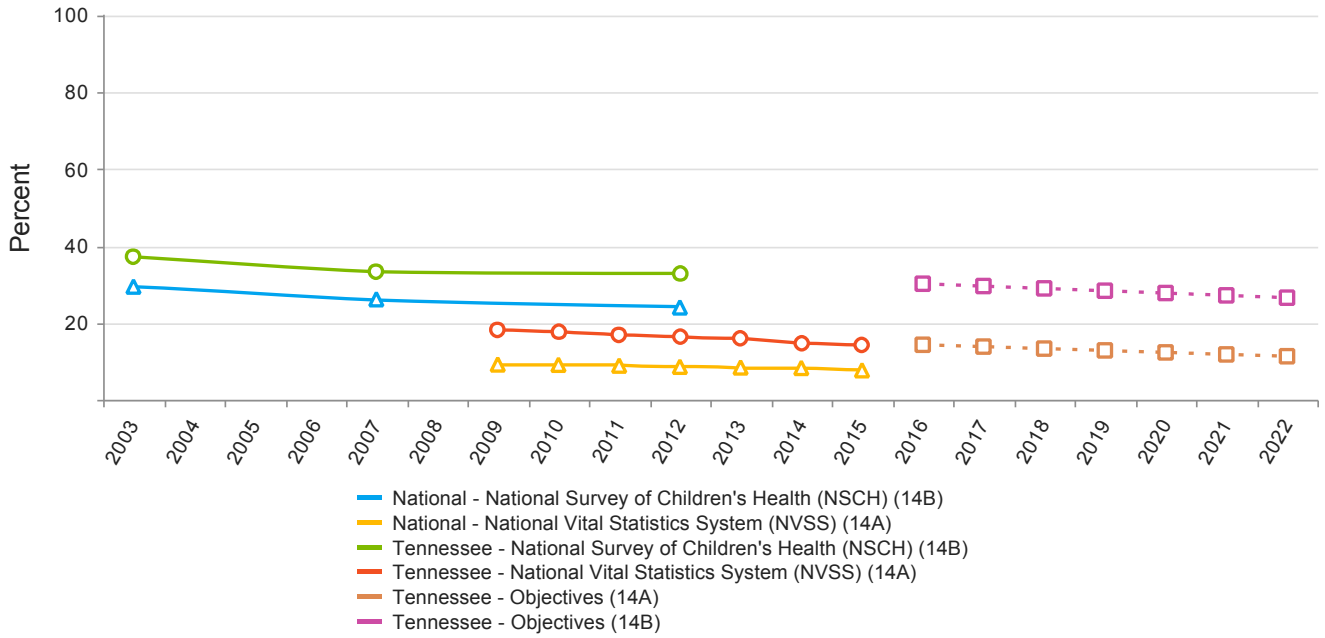
Cross-Cutting/Life Course

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations	SID-2014	181.1	NPM 14
NOM 3 - Maternal mortality rate per 100,000 live births	NVSS	Data Not Available	NPM 14
NOM 4.1 - Percent of low birth weight deliveries (<2,500 grams)	NVSS-2015	9.2 %	NPM 14
NOM 4.2 - Percent of very low birth weight deliveries (<1,500 grams)	NVSS-2015	1.6 %	NPM 14
NOM 4.3 - Percent of moderately low birth weight deliveries (1,500-2,499 grams)	NVSS-2015	7.6 %	NPM 14
NOM 5.1 - Percent of preterm births (<37 weeks)	NVSS-2015	11.0 %	NPM 14
NOM 5.2 - Percent of early preterm births (<34 weeks)	NVSS-2015	3.1 %	NPM 14
NOM 5.3 - Percent of late preterm births (34-36 weeks)	NVSS-2015	7.9 %	NPM 14
NOM 6 - Percent of early term births (37, 38 weeks)	NVSS-2015	26.6 %	NPM 14
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2014	6.8	NPM 14
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2014	6.9	NPM 14
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2014	4.3	NPM 14
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2014	2.6	NPM 14
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2014	230.4	NPM 14
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2014	111.5	NPM 14
NOM 19 - Percent of children in excellent or very good health	NSCH-2011_2012	84.0 %	NPM 14

National Performance Measures

NPM 14 - A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes
Baseline Indicators and Annual Objectives



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

Federally Available Data	
Data Source: National Vital Statistics System (NVSS)	
	2016
Annual Objective	14.4
Annual Indicator	14.3
Numerator	11,577
Denominator	80,953
Data Source	NVSS
Data Source Year	2015

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	13.9	13.4	12.9	12.4	11.9	11.4

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

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2016
Annual Objective	30.2
Annual Indicator	32.7
Numerator	480,684
Denominator	1,468,036
Data Source	NSCH
Data Source Year	2011_2012

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	29.6	29.0	28.4	27.8	27.2	26.6

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	441
Numerator	
Denominator	
Data Source	TDH FHW Chronic Disease Section Program Data
Data Source Year	FFY2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	480.0	525.0	570.0	615.0	660.0	705.0

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

Measure Status:	Inactive - Replaced

State Provided Data	
	2016
Annual Objective	
Annual Indicator	16,536
Numerator	
Denominator	
Data Source	Tennessee Tobacco Quitline Report
Data Source Year	FFY2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	12,650.0	13,800.0	14,950.0	16,100.0	17,250.0	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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	1.7
Numerator	
Denominator	
Data Source	TDH FHW Early Childhood Section Program Data
Data Source Year	FFY2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	10.0	93.0	94.0	95.0	95.0	95.0

ESM 14.4 - Number of reproductive-aged female tobacco users (15-44 years) who received online or phone counseling services through the Tennessee Tobacco Quitline.

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	0.0	720.0	800.0	880.0	975.0	1,075.0

State Action Plan Table

State Action Plan Table (Tennessee) - 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	Status
ESM 14.1 - Number of child care facilities that voluntarily implement a tobacco-free campus policy	Active
ESM 14.2 - Number of tobacco users who call the Tennessee Tobacco Quitline	Inactive
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	Active
ESM 14.4 - Number of reproductive-aged female tobacco users (15-44 years) who received online or phone counseling services through the Tennessee Tobacco Quitline.	Active

NOMs

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

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

NOM 4.1 - 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

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).

Planned strategies and Activities: To achieve the objective listed above, the following strategies and activities are planned for FY18:

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

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

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

Activity 1c: Educate parents about harm resulting from the use of Electronic Nicotine Delivery Systems (ENDS), the dangers of secondhand and thirdhand smoke exposure, and the benefits of tobacco-free childcare centers and homes.

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

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

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: Continue collaboration with women's health providers to distribute information about the dangers of prenatal smoking, including ENDS use, and the availability of the TN Quitline, Baby and Me Tobacco Free, Power to Quit, etc. as smoking cessation resources to women seeking preconception/interconception care.

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

Activity 3a: Continue to screen participants in home visiting to the Tobacco QuitLine and other community-based cessation services.

Activity 3b: Continue to refer participants in home visiting to the Tobacco QuitLine and other community-based cessation services.

Activity 3c: Support integration of smoking assessment, including ENDS use, and cessation resources into the TDH Electronic Health Record (EPI).

Activity 3d: Provide quality improvement education and technical support to home visiting staff regarding

available tobacco cessation services.

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))

DOMAIN: Cross-Cutting/Life Course

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

Accomplishments and Challenges (FFY2016 Strategies and Activities)

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

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

Report 1a: In FY16, health educators across the state reached out to childcare facility directors via phone, site visits, and oral presentations to discuss the benefits of becoming a Gold Sneaker designated facility. Their outreach resulted in 65 new Gold Sneaker designated facilities. In August 2016, Gold Sneaker became a Primary Prevention Initiative (PPI) within Central Office at TDH, training 14 staff to contact and educate childcare directors about the benefits of being a Gold Sneaker facility. Local Health Departments have partnered with their local Head Start Program in providing education regarding Gold Sneaker designated facilities. The partnership provides an opportunity to engage parents and caregivers on the dangers of second and thirdhand smoke to children and local cessation services available to them including the Tennessee Quitline.

Currently there is no recertification requirement for Gold Sneaker designated facilities. This will be changing in FY17; a recertification requirement and process will be put in place.

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

Report 1b: Technical assistance was provided to facilities that desired to implement the enhanced policies related to tobacco exposure. Health educators assisted facilities with the application process and provided training -- onsite or via webinar -- to all facility staff. TDH also directed facilities to the Gold Sneaker webpage for more information and access to brochures, newsletters, and other downloadable materials.

Activity 1c: Educate parents about the dangers of secondhand smoke exposure and the benefits of tobacco-free childcare centers and homes.

Report 1c: Presentations and printed materials on the dangers of second and third-hand smoke in cars, homes and public places were available (online and on-site) for parents of day care children. Tennessee Tobacco QuitLine (TTQL), hence referred to as QuitLine, materials were also made available for parents or caregivers wanting to quit tobacco use. Additional information for parents was also available on the main Gold Sneaker website under the “Gold Sneaker Initiative Parents” link at

http://tn.gov/health/topic/goldsneaker.

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

Activity 2a: Promote the QuitLine as a resource through CDC media outreach, publications, and presentations.

Report 2a: The QuitLine was heavily promoted through 14 media types with 51 media campaigns including print and digital media. Across the state, community partners included the QuitLine in newsletters and oral presentations. An extra media buy was purchased to air the CDC Tips advertisement statewide, which featured a Tennessee resident's story during times when predominately women were watching major networks.

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

Report 2b: The Tennessee Tobacco Use Prevention and Control Program (TUPCP) collaborated with the QuitLine vendor on the feasibility of receiving referrals directly through electronic health record. During FY16, the vendor completed a Quitline e-Referral Technical Assessment. Planning meetings were limited due to vendor updates to their computer system and networks. Once the vendor's system is restored, collaboration between the vendor, TUPCP and Vanderbilt will resume.

Activity 2c: Utilize Title V funding to purchase promotional materials for distribution to pediatric providers.

Report 2c: TUPCP collaborated with the Metro Davidson Health Department on their partnership with the Clinicians Efforts Against Secondhand Smoke Exposure (CEASE) program. The CEASE module was developed to help pediatric clinicians tailor their office setting to address family tobacco use in a routine and effective manner. Clinicians participating in CEASE refer parents to the QuitLine using the fax referral form. The TPCP collaborated with the Quitline vendor to provide Clinical Office Training to Help the Tobacco Dependent Patient. Training included how to refer a client to the Quitline and what happens once a client calls the Quitline. The training provided information on utilization of the fax referral form and the Quitline referral portal. Further discussion on the type of materials needed to enhance the clinician's implementation of the CEASE program will take place during FY17.

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.

Report 2d: Health Educators and Regional Tobacco Coordinators reached over 1,000 perinatal healthcare providers and distributed information regarding the dangers of prenatal smoking and the fax referral form to refer smokers to the QuitLine. Outreach included partnering with hospitals, non-profit agencies (e.g. March of Dimes), and physician offices through lunch and learns, quit kits to give to their patients, resource guides, quit

cards, and training in the 5A's Counseling approach. For FY16, 2,498 women completed intake with the Quitline (72 reported being pregnant) compared to 1,403 women in FY15 (76 reported being pregnant).

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

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

Report 3a: TUPCP and the Evidence-based Home Visiting (EBHV) Program met to discuss the protocol for helping participants who report tobacco use quit, as well as enhanced guidance to EBHV grantees on how to complete QuitLine referrals. As a result, the QuitLine vendor conducted two trainings: a "Clinical Office Training to Help the Tobacco Dependent Patient" and "Utilization of the QuitLine Fax Referral Form" in a train-the-trainer format. In FY17, EBHV staff will conduct onsite trainings with field staff to address documentation and provision of Quitline information to increase fax referrals and ultimately reduce tobacco use among women in their program.

Activity 3b: Collaborate with healthcare providers to promote smoking cessation services among pregnant women (CoIIN).

Report 3b: TDH collaborated with the health departments in Johnson and Hancock counties through the CoIIN initiative to promote cessation among pregnant women. A small, informal survey conducted among Johnson, Hancock, and Hawkins residents enrolled in Baby and Me Tobacco Free (BMTF) concluded that the majority did not utilize the QuitLine due to limited cellphone minutes. QuitLine in this capacity wasn't the best form of cessation for that area. Therefore, promotion of QuitLine's online counseling to all reproductive-aged women was chosen as a remedy to cellphone minute limitations. Plans in FY17 include online counseling enrollment, increase awareness to health care providers at local mental health and behavioral centers of Quitline and free Nicotine Replacement Therapy (NRT), and the expansion of Quitline promotion to other counties within the Northeast counties.

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

Report 3c: Currently TDH has implemented EPI 1.0 (Electronic Public Health Information) Initiative in six local health departments in the Northeast region as well as a tuberculosis clinic. The TUPCP continues discussion with the EPI leads for integration of tobacco use data and QuitLine referrals within the EPI system.

Data Interpretation (of data listed on Form 10A):

In 2015, 14.3% of Tennessee resident mothers reported prenatal smoking, a 4.9% decrease from 2014 (15.0%). Although none of the current ESMs directly connect to NPM 14a, all three ESMs track progress in achieving Tennessee's target for NPM 14b. Data from NPM 14b comes from the National Survey of Children's Health. The

most recent data from that survey is for 2011/2012. Therefore an evaluation of the performance during FY16 is not available. However, with Quitline services, an increase in tobacco cessation referrals among the MCH population, and more childcare facilities with tobacco-free campuses, these ESMs feed into the objective to reduce exposure to secondhand smoke and prevent adverse birth outcomes and premature death or disease in Tennessee's children.

Tennessee met or exceeded the objective for all ESMs related to our strategies aimed at preventing secondhand smoke exposure among children and reducing tobacco use. At the end of FY2016, there were 441 Gold Sneaker designated childcare facilities compared to 376 (FY2015), with 65 new facilities voluntarily implementing a tobacco-free campus in FY2016. Call volume to the Tennessee Tobacco Quitline substantially increased, reaching over 16,000 calls for FY2016. Finally, 1.7% of primary caregivers enrolled in home visiting who reported tobacco use were referred to tobacco cessation counseling within three months of enrollment, exceeding our objective of 1.3%. With a new tobacco benchmark for evidence-based home visiting programs, there will be more alignment of cessation referrals to the Tennessee Tobacco Quitline for these participants.

Other Programmatic Activities

TDH uses MCH/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 causes of child death and prioritize preventive measures. 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.

Maternal Mortality Review
Maternal mortality review was mandated by the Tennessee State Legislature in Spring of 2016 to begin in January of 2017. Using support from CDC, Association for Maternal and Child Health Programs, and state expertise with other death review programs, the review committee was established, and a first meeting held in May 2017.The committee will be responsible for reviewing all deaths within a year of pregnancy and making prevention recommendations. As mentioned in other areas of the report, TDH also funds the Tennessee Infant Perinatal Quality Collaborative. The maternal arm of TIPQC has focused on maternal mortality clinical initiatives such as OB hemorrhage.

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 develop projects on four chosen priority areas: child abuse and neglect, teen motor vehicle crashes, traumatic brain injury including concussion, and sexual violence. 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 provides targeted case management 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 a 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 served annually.

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 and breast exams. TDH also provides training on counseling and insertion technique for external providers desiring to expand availability of log acting reversible contraception.

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 hotlines specifically related to the MCH population. The Primary Prevention Impact Services Call Center (MCH/Title V toll-free hotline) responds to request for information and refers callers for pregnancy testing, TennCare, and prenatal care as needed. 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 2017, the Breastfeeding Hotline receives approximately 500 calls per month. TDH also contracts for the services of the tobacco quitline, which provides cessation counseling to all state residents, including pregnant women and women of childbearing age.

Advisory Committees

MCH has three legislatively mandated advisory committees: Perinatal Advisory Committee; Genetics Advisory Committee for newborn screening; and the Children's Special Services Advisory Committee. The Birth Defects Advisory Committee is transitioning to MCH programs as it is being re-constituted. Other task forces and advisory groups for MCH programs (not mandated) include the Childhood Lead Poisoning Prevention Advisory Committee, the Young Child Wellness Council, and the Preventive Health Block Grant Advisory 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 6 Metro Offices, and local health departments in all 95 counties).

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

Over the past five years, TDH has recruited eleven 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 MCH/Title V Needs Assessment and is now a full-time state employee, serving as Tennessee's MCH Block Grant and SSDI Grant Coordinator. FHW 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 as well as funding for the MCH block grant coordinator. The SSDI grant also provides funding for Digital Library access to FHW and TDH staff. Initial training was provided to FHW staff in an all staff gathering, and additional training has been initiated to further develop skillsets in literature searches and evidence evaluation. FHW also receives data support through the Department's Division of Quality Improvement. The Office of Performance Management has also provided support in LEAN process implementation for women's health and CYSHCN.

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

Several professional development efforts are underway for the evidence based home visiting and care coordination workforce. In March of 2017, a workforce survey was conducted to determine specific areas of training that are of interest to the home visiting workforce. From this survey, training opportunities are being developed. During 2017, four separate training opportunities are being offered in each region of the state to minimize travel and time out of

the office. The first opportunity is the Poverty Workshop. This was offered to give attendees a better understanding of the struggles faced by many of the individuals our programs serve and offers an actual simulation of different experiences faced by those in poverty. The next opportunity is "Relationship Based Practice." This training opportunity is based on the feedback from home visitors who have consistently had high retention with the families they serve and attribute their high retention to building a relationship with the families they are working with and building trust. This training will introduce key skills including reflective supervision and motivational interviewing. The third training opportunity is focused on building skills to effectively use the Ages and Stages Questionnaire as well as the Edinburgh Depression Screen. The final in-person training opportunity is "Tobacco Referral." Home Visitors and home based care coordinators are uniquely positioned to discuss tobacco use with the families with whom they are working. This training will focus on ways to address tobacco use with families while maintaining good rapport. In addition, attendees will be given several strategies for engaging the family in activities that promote bonding while reducing stress in an attempt to reduce cravings. Finally, attendees will be given referral resources to ensure they can connect families with local resources. Additional resources for training have also been acquired online through AchieveOnDemand. AchieveOnDemand's online professional development courses are aligned with the Infant Mental Health certification process.

The Department of Health has taken a leadership role in the Building Strong Brains: Tennessee's ACEs Initiative and has set a goal of increasing the workforce's knowledge of ACEs. Staff members in each region have been trained in the standardized ACEs curriculum that shares key information about the brain science behind ACEs, the importance of safe and nurturing relationships during early childhood, and strategies for reducing the impact of ACEs. By the end of 2017, the regional staff that have been trained in the ACEs standardized curriculum will train all TDH county level staff on the curriculum. Knowledge dissemination is the first step in ensuring that all health department services are ACEs informed. Over the next few years, the Department of Health will continue to expand our understanding of ACEs and further explore how we can ensure that ACEs are considered as we make program, policy, and procedure decisions.

FHW staff are also encouraged to take advantage of external workforce development activities. 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, participated in the AMCHP Leadership Institute for CYSHCN Directors. This program promotes valuable components for both new and experienced directors. Ms. Johnson also participated in the health equity institute offered by the University of Washington.

MCH/Title V funding is used to support ongoing training of local and regional health department staff who provide services to the MCH population. Examples include an annual professional development conference for CYSHCN care coordination staff and an annual "Spring Update" training session for women's health and family planning staff. Tennessee has also utilized MCH/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. MCH staff have also been instrumental in planning the first and second in person conference for state public health educators to develop capacity in the health department priorities of tobacco prevention, physical activity promotion, obesity reduction, and prevention of opioid use.

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
- Literature synthesis for statewide provider, payer, and advocate groups which have developed to address the recurrent prematurity prevention initiatives of17-OHP utilization and access to immediate post-partum long-acting contraception
- Educational materials on preventing unintended pregnancy for adolescents and adolescent health care providers
- Development of "one key question" outreach to providers encouraging them to act to reduce unintended pregnancy
- Mapping of tobacco retailers in relation to school and engaging youth in tobacco prevention activities
- Focus groups to gain understanding of decision making of minority fathers regarding breastfeeding initiation

II.F.3. Family Consumer Partnership

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, beginning with an enhanced effort to integrate parent input in all aspects of MCH and FHW services. Advances have been made over the past few years to further involvement of parents in planning, programming and implementing Tennessee's Title V Programs. 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. Susan Morley is the current Family Delegate and attended AMCHP in 2017 and is working in conjunction with Family Voices to ensure that family members are engaged and involved in many of the decision making aspects of program and policy initiatives with the Department of Health. Staff at Family Voices have presented and co-presented at many local and national conferences around moving family engagement from the hospital advisory setting to state policy level leadership and advocacy opportunities.

Through the HRSA-funded D70 Systems Integration Grant (2013-16), TDH 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:

- Over 279 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. Nine 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. FHW CYSHCN staff and Family Voices are continuing to maintain this committee and have held two additional meetings on advocacy and creating guidelines. Parents of the youth involved have volunteered to serve in an advisory capacity to Family Health and Wellness. Moving forward, sustainment of this activity will be funded by the Maternal and Child Health CYSHCN Program.

- 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 100 prospective parent mentors, and facilitated approximately 200 matches since its inception.

- Family Voices provides training, outreach and one-on-one assistance to families of CYSHCN. This past year FVTN assisted 460 families on partnering and shared decision-making, 500 families on navigating systems and accessing community services, and 382 on accessing a medical home. In 2016 the total number of families served was 16,912. The total number of professionals served was 13,668, including 1803 who attended trainings. The newsletter was sent to 16,975 individuals and organizations.

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. During a strategic planning conference, Family Voices determined the need for a parent summit in the Memphis-West Tennessee area and in East Tennessee and will be working on securing funds to plan and facilitate these events.

Through the newborn hearing screening grant, TDH previously contracted 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. Family Voices developed their own program, Parent Empowerment Access and Resources (PEARS), and are utilizing this model when working with parents of children with hearing loss. Parents also serve on the newborn hearing screening and follow-up task force.

Family representatives routinely attend and participate in the Genetics Advisory Committee (GAC) and Children's Special Services (CSS) Advisory Committee Meetings. The GAC meetings focus on the state's newborn screening and follow-up program, and members advise the Department on program operations and the addition of screening tests to the state's testing panel. The CSS Advisory Committee meetings focus on issues related to the management and operation of the CSS program (Tennessee's Title V CSHCN Program) as well as broader issues impacting all CYSHCN (such as transition to adulthood). The current family delegate serves as a parent-co investigator on quality and safety Patient Centered Outcomes Research Institute (PCORI) grant.

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. Family members continue to participate on the Maternal and Child Health Block Grant Stakeholder group for children and youth with special health care needs and the other seven domains. Family Voices staff conducted focus groups for the Infant Mortality program and partnered with Hope House and Faith Family to recruit families from diverse cultures and backgrounds. Family Voices staff has also been targeted to work with families on issues related to violence by the Injury and Prevention section of Family Health and Wellness.

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

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 has 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 has developed arrangements whereby traditional public health services, including family planning, STI screening and treatment, EPSDT, and tuberculosis screening and treatment are provided in county health departments and generally reimbursed without a primary care provider referral. TDH has current contracts with all three TennCare (Medicaid) MCO plans (Amerigroup, BlueCare, United Healthcare Community Plan), DentaQuest (TennCare dental), Magellan (TennCare pharmacy), Humana (private insurance and ACA), Cigna (private insurance), Medicare (flu/pneumonia credentialed in all county health departments and all Federally Qualified Health Centers are credentialed part A providers), and Blue Cross Blue Shield (ACA marketplace and private insurance). Contract discussions are pending with Aetna private insurance.

Over the two years, the Department has greatly expanded its ability to bill third party insurance by negotiating contracts with carriers. Nonetheless, the state has been significantly impacted by increasing premiums in the federally-run health insurance marketplace. There are three marketplace plans in the state, and increasingly only one plan is offered in any given area. One of the plans has announced that it will withdraw market coverage in 2018, and the plans have experienced significant increases in premiums statewide. State and federal discussions are rapidly evolving and have the potential to dramatically affect insurance coverage and access for Tennesseans.

The scope of MCH/Title V partnership with TennCare extends far beyond reimbursement for MCH services in local health departments. The agencies partner together in multiple population health priorities. For example, TennCare partially funds infant mortality reduction initiatives through MCH/Title V programs such as group prenatal care pilots, FIMR teams, safe sleep promotion, and training in long acting reversible contraception insertion. The MCH/Title V director meets regularly with TennCare in context such as the NAS subcabinet, the Perinatal Advisory Committee, TIPQC, and a quarterly meeting held jointly with TNAAP. TennCare has intentionally included input from TDH and the MCH/Title V Program regarding the implementation of its episodes of care model for payment reform. TennCare funding also supports TDH outreach efforts and partially supports the HUGS care coordination services. The agencies collaborate on multiple other MCH related efforts such as lead screening and EPSDT outreach.

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.

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

Clinical Application Coordinators (CACs) are also available in 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 for marketplace plans. Additionally, the TDH Breast and Cervical Cancer Screening Program (partially funded by Tennessee's MCH/Title V Program) and the Ryan White HIV/AIDS

Program each have one CAC in each rural region to assist with outreach and on-site enrollment efforts. Care coordinators for CSS also assist with enrollment through the marketplace and with appeals for third-party payer denials.

TDH has collaborated with Enroll America to provide all health departments in 95 counties with enrollment interest cards. Enroll America has noted that enrollments in Tennessee 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, were held through the remainder of 2016 to train new staff about Medicaid enrollment assistance through the FFM. TDH continues collaboration with Enroll America.

In 2016 (CY), TDH assisted 3,424 pregnant women with presumptive eligibility enrollment assistance and 12,609 pregnant women with Medicaid and CoverKids enrollment assistance. TDH conducts routine training with local staff on changes in the Medicaid enrollment process to ensure that eligible persons can be served.

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

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

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

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

Family Planning: MCH/Title V funding augments federal Title X funding, state appropriations, and patient billing collections. In CY2016, 77% 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.

EPSDT: MCH/Title V funding provides funding for EPSDT visits for uninsured children in local health departments. Likewise, children seen in WIC, immunization clinic, or adolescents in family planning clinics are offered EPSDT services if desired by the family in cooperation with TennCare to increase screening rates across the state. TDH

provided 8.7% of TennCare EPSDT visits in the state in 2016.TDH is enhancing efforts to connect EPSDT visits to the medical home.

II.F.5. Emerging Issues

Substance Abuse and Neonatal Abstinence Syndrome (NAS)

A major emerging issue over the last several years in Tennessee is the epidemic of 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 continues to meet to make prevention recommendations and coordinate planning. The group first 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. The surveillance system reports cases by region weekly, posts them online (http://www.tn.gov/health/article/nas-summary-archive) and distributes this to agency and community partners.

From 2000 to 2012, the rate of NAS increased 15 fold, as measured by Hospital Discharge Data. The rate measured by surveillance data has not shown a statistically significant increase over the four years since surveillance began. While the count of NAS cases remains high, we are somewhat reassured that the rate is not increasing significantly. This may indicate that the NAS epidemic is reaching a plateau; additional time will be needed to determine this with certainty. The latest annual report can be found here: https://www.tn.gov/assets/entities/health/attachments/NAS_Annual_report_2016_FINAL.pdf.

Since 2013, there has been a shift in the exposure sources associated with NAS, with more mothers of NAS infants taking medications prescribed by a provider (nearly 80%) in recent years. The fact that nearly 70% of mothers of all NAS infants were receiving medication assisted treatment in 2016 is suggestive that women with a history of substance use disorder are becoming more engaged with medical providers before and during pregnancy. The patterns of exposure highlight opportunities for primary prevention.

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. Healthcare providers should explore non-opioid treatment modalities in women of childbearing age and should promote effective contraceptive methods to prevent unintended pregnancies among women who use opioids. TDH is currently working with state and national partners to promote these strategies.

TDH, along with other state agencies and community partners, is 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.

In addition to surveillance, FHW 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.

- Pilot project in East Tennessee providing support for women in recovery to prevent recurrent NAS
- Pilot project in Sullivan County to fund a nurse dedicated to NAS initiatives, including: wrap around services for families at time of discharge of NAS infant, prevention partnership with local drug coalition, and provision of family planning services at medication assisted therapy.
- Partnership with Governor's Children's Cabinet, which is developing a single plan of care across multiple child- and family-serving agencies focusing first on families affected by NAS.
- In 2014-15, 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. 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

Adverse Childhood Experiences (ACEs)

Building Strong Brains: Tennessee Adverse Childhood Experiences (ACEs) Initiative is a major statewide effort to establish Tennessee as a national model for how a state can promote culture change in early childhood based on a philosophy that preventing and mitigating adverse childhood experiences, and their impact, is a promising approach to helping Tennessee children lead productive, healthy lives and ensure the future prosperity of the state. Leaders from state government, the business world, advocates, insurers, academia and nonprofit foundations are organized as public and private sector steering groups to guide implementation and provide leadership at the state, regional and community levels. TDH has taken a leadership role in staff training and in facilitating statewide conversations on ACEs prevention and mitigation.

Zika Virus

In 2015, severe congenital microcephaly associated with Zika virus infection during pregnancy was reported in Central and South America. During 2016, that suspicion was confirmed and a spectrum of neurologic birth defects was associated with congenital Zika infection. In response to this, state MCH leadership have worked in close collaboration with state and federal vector and infectious disease experts to develop systems of surveillance for Zika infection and congenital Zika infection. In February 2016, microcephaly became a reportable condition in Tennessee, and this was expanded to all neurologic birth defects in January 2017. The state has utilized funding from multiple CDC grants to recruit an epidemiologist, nurse case manager, and program director to support the Zika Pregnancy Registry, the Enhanced Microcephaly and Zika associated Birth Defects Surveillance System, and the Tennessee Birth Defects Registry. This will enable linkage from both the electronic reporting system and the electronic birth file (to be rolled out in the next two months) directly to the newborn screening case management system. This will facilitate both surveillance, linkage to care (specialist, family navigators, early intervention systems, and children's special services), and outcomes monitoring. In 2016, 61 cases of travel associated Zika infection were reported in the state of Tennessee. To date, seven births in the state have occurred to women with probable Zika infection, and outcomes are being monitored. This crisis has demonstrated the essential function of public health systems (newborn screening, CYSHCN, family engagement) that could quickly be modified and enhanced to meet growing population need.

Maternal Mortality

After several years of advocacy by state OBGYNs and other stakeholders, the Tennessee General Assembly passed legislation enabling a maternal mortality review committee to be convened by TDH. Drawing on years of experience with child death review, FHW staff has been instrumental in constructing the review committee and process. The first meeting took place in May of 2017, and cases are currently being collected for the next review in the fall. The committee is geographically, ethnically, and professionally diverse in order to bring a spectrum of expertise to provide prevention recommendations through reports and related activities. The committee draws on experience from the maternal arm of TIPQC as well in its clinical efforts to reduce morbidity from projects such as obstetric hemorrhage management.

II.F.6. Public Input

Process

Tennessee's MCH/Title V Program offers four main mechanisms for the public to provide feedback on the annual application/report. The first is through participating in in-person stakeholder meetings that are held twice each year. These meetings are open to the public, with special effort being made to reach out to those serving the maternal and child population as well as parents. During the meetings, participants evaluate the progress made on measures. At the fall meeting, that evaluation is utilized to identify partnership opportunities between the MCH/Title V Program and the other stakeholders that will help to achieve measurable progress. At the spring meeting the information is used to develop the action plan for the coming year. Both meetings have an average of 75 stakeholders in attendance.

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 MCH/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 MCH/Title V CYSHCN program recently established a youth advisory committee, which will be utilized for input moving forward.

Another avenue used to gather ongoing feedback is through FHW Program staff. Program staff seek input throughout the year from representatives of local and regional health departments, and by extension, their clients and communities. Regional MCH Directors are convened via conference call every other month. On each call, 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, feedback is gathered through an annual survey that is distributed with the draft of the application/report each spring. The survey asks respondents to describe health needs of the population, the capacity of the health care system to meet those needs, and emerging issues. Respondents are also given the opportunity to provide specific feedback on the application/report.

The draft application/report was posted to the TDH website. Notice of the posting and link to the survey was emailed to stakeholders (see list below), and those individuals were asked to forward to their contacts. Recipients were asked to forward broadly to anyone who might be interested in responding. A reminder email was sent out halfway thru the 30 day public comment period.

<u>Departments/Offices within Tennessee Department of Health (TDH):</u>

- Commissioner's Executive Leadership Team
- Division of Community Health Services
    - Office of Oral Health Services

    - Regional MCH Directors
    - Regional Nursing Supervisors
- 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
- Office of Minority Health and Disparities Elimination
- Program Leads within the Division of Family Health and Wellness

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 of Tennessee
- Governor's Children's Cabinet
- Head Start
- Julie's Village
- March of Dimes
- MCHB Grantees
    - Healthy Tomorrows Partnership for Children Program – East Tennessee State University
    - Emergency Medical Services for Children – Vanderbilt University
    - Healthy Start – Centerstone
    - Family Professional Partnership – Family Voices of Tennessee
    - LEND – University of Tennessee Health Science Center
    - LEND – Vanderbilt University
    - MCH Nutrition Training Program – University of Tennessee
    - Traumatic Brain Injury Protection and Advocacy – Disability Law and Advocacy Center of Tennessee
    - Comprehensive Communication Intervention for Children with Autism – Vanderbilt University
    - MCH Field Research – University of Memphis
    - MCH Field Research – Vanderbilt University
- 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)
    - TennCare managed care plans
- University of Tennessee at Memphis Boling Center
- University of Tennessee
- Vanderbilt TRIAD
- Various pediatric healthcare providers
- Various TDH grantees
- Young Child Wellness Council

Annual Survey

Survey – Demographics

A total of 139 individuals responded to the 2017 survey, compared to 108 respondents in 2016. Responses were received from individuals in 42 of the 95 counties in Tennessee. The majority of respondents were female (89%), and ages ranged from 21 to 69 years. The racial and ethnic breakdown was 90% White and 10% Black, with 1.5% identifying as Hispanic. Among the respondents, 76% were parents, and 37% were parents of children with special health care needs. For over half of the respondents, this was the first year they had read the grant. The majority of respondents identified themselves as health department staff, followed by community service providers, and then other government agencies (outside TDH).

Response to Public Comments

The public comments are reviewed by the MCH/Title V Director, MCH/Title V CYSHCN Director, and MCH/Title V Coordinator. Based on this review adjustments are made the application/report as necessary.

Public Availability

The application/report is posted on the TDH website in draft form during the public comment period. After transmittal of the application/report, the draft on the website is replaced with the final document.

Mechanism for Ongoing Feedback

As previously stated, two in-person stakeholder meetings are held per year as a mechanism for ongoing feedback. Contact information for the MCH Director is also provided on the TDH website, so that contact is available on an ongoing basis.

II.F.7. Technical Assistance

After ongoing consideration and review of the Action Plan, Tennessee anticipates the potential need for technical assistance in revising the Title V/Medicaid Interagency Agreement. Over the past year, guiding documents and state examples have been provided by HRSA. Initial conversations with the state Medicaid agency occurred specifically to confirm that the most recent Tennessee Title V/Medicaid Interagency Agreement (2007) is still in effect, as evidenced by ongoing collaborations and inter-agency contracts. Leadership in both organizations are aware of the need to update this document, and this has not yet been able to occur given the uncertainty of federal direction in the Medicaid program. It is anticipated that the agreement will be able to be addressed more fully in the year to come.

In addition, Tennessee anticipates the need for technical assistance specific to program evaluation. TDH dedicates significant federal and state effort to the priorities of tobacco control and obesity reduction. Over the last 3 years, the state legislature has appropriated $5 million per year to county level efforts to prevent youth initiation, reduce pregnancy smoking and reduce second hand smoke. As the program is entering its fourth year, it has demonstrated significant results as well as a need for more formalized evaluation planning. Likewise, Tennessee has funded multiple local initiatives to increase physical activity and enable healthy eating throughout the state. Communities choose to tackle these problems in different ways, and there is a need to synthesize the lessons learned from local initiatives into a cohesive evaluation in order to provide guidance for future endeavors.

III. Budget Narrative

	2014		2015	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$11,539,865	$15,054,289	$11,562,887	$12,908,500
Unobligated Balance	$7,500,000	$0	$5,500,000	$0
State Funds	$13,250,000	$31,087,436	$14,200,000	$29,957,475
Local Funds	$0	$0	$0	$0
Other Funds	$0	$0	$0	$0
Program Funds	$3,250,000	$4,113,120	$3,350,000	$4,392,222
SubTotal	$35,539,865	$50,254,845	$34,612,887	$47,258,197
Other Federal Funds	$161,158,344		$147,748,378	$140,407,856
Total	$196,698,209	$50,254,845	$182,361,265	$187,666,053

Due to limitations in TVIS this year, States are not able to report their FY14 Other Federal Funds Expended on Form 2, Line 9. States are encouraged to provide this information in a field note on Form 2.

	2016		2017	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$11,709,246	$14,204,467	$11,749,682	
Unobligated Balance	$5,300,000	$0	$5,300,000	
State Funds	$30,000,000	$34,700,768	$30,000,000	
Local Funds	$0	$0	$0	
Other Funds	$0	$0	$0	
Program Funds	$4,200,000	$5,670,305	$4,400,000	
SubTotal	$51,209,246	$54,575,540	$51,449,682	
Other Federal Funds	$149,414,701	$137,880,577	$163,167,051	
Total	$200,623,947	$192,456,117	$214,616,733	

	2018	
	Budgeted	Expended
Federal Allocation	$12,749,682	
Unobligated Balance	$0	
State Funds	$30,000,000	
Local Funds	$0	
Other Funds	$0	
Program Funds	$4,400,000	
SubTotal	$47,149,682	
Other Federal Funds	$158,886,385	
Total	$206,036,067	

III.A. Expenditures

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

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 and Letter.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

Supporting Document #03 - Child Fatality Report 2017.pdf

Supporting Document #04 - Primary Prevention Initiative 2017.05.01.pdf

VI. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Tennessee

	FY18 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 12,749,682	
A. Preventive and Primary Care for Children	$ 4,525,870	(35.4%)
B. Children with Special Health Care Needs	$ 4,092,339	(32%)
C. Title V Administrative Costs	$ 744,298	(5.9%)
2. UNOBLIGATED BALANCE (Item 18b of SF-424)	$ 0	
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)	$ 47,149,682	
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)	$ 158,886,385	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 206,036,067	

OTHER FEDERAL FUNDS	FY18 Application Budgeted
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 57,530
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Community-Based Integrated Service Systems (CISS)	$ 0
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Abstinence Education Grant Program	$ 1,645,551
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 129,142,848
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > ACA Maternal, Infant and Early Childhood Home Visiting Program	$ 9,935,297
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 6,710,000
Department of Health and Human Services (DHHS) > Office of Adolescent Health > Support for Pregnant and Parenting Teens	$ 0
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 143,825
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Sudden Death in the Young (SDY) Registry	$ 200,000
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)	$ 475,364
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Zika Surveillance Systems Grant Program	$ 400,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Traumatic Brain Injury	$ 250,000
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	$ 250,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State Public Health Actions-1305 Chronic Disease	$ 2,508,500
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Tobacco Control Programs	$ 1,506,829

OTHER FEDERAL FUNDS	FY18 Application Budgeted
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventive Health and Health Services Block Grant	$ 2,527,977
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Breast and Cervical Cancer Early Detection Program (NBCCEDP)	$ 1,692,414
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	$ 640,250

	FY16 Annual Report Budgeted		FY16 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 11,709,246		$ 14,204,467	
A. Preventive and Primary Care for Children	$ 3,512,774	(30%)	$ 5,042,288	(35.4%)
B. Children with Special Health Care Needs	$ 3,883,698	(33.2%)	$ 4,559,290	(32%)
C. Title V Administrative Costs	$ 800,000	(6.8%)	$ 829,225	(5.9%)
2. UNOBLIGATED BALANCE (Item 18b of SF-424)	$ 5,300,000		$ 0	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 30,000,000		$ 34,700,768	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0		$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0		$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 4,200,000		$ 5,670,305	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 34,200,000		$ 40,371,073	
A. Your State's FY 1989 Maintenance of Effort Amount $ 13,125,024				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Same as item 18g of SF-424)	$ 51,209,246		$ 54,575,540	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.				
10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9)	$ 149,414,701		$ 137,880,577	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 200,623,947		$ 192,456,117	

OTHER FEDERAL FUNDS	FY16 Annual Report Budgeted	FY16 Annual Report Expended
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 96,374	$ 107,847
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Community-Based Integrated Service Systems (CISS)	$ 140,000	$ 195,166
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Abstinence Education Grant Program	$ 1,516,850	$ 1,215,541
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 118,993,480	$ 111,003,532
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	$ 9,607,542
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 6,062,300	$ 6,947,943
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 250,000	$ 224,568
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State and Local Healthy Homes and Childhood Lead Poisoning Prevention Programs (CLPPPs)	$ 237,682	$ 201,696
Department of Health and Human Services (DHHS) > Substance Abuse and Mental Health Services Administration > Project LAUNCH	$ 800,000	$ 772,051
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > D70	$ 484,960	$ 0
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > SDY	$ 200,000	$ 158,971
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Inj Surv & Prev	$ 247,686	$ 304,709
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > 1305 Chron Dis	$ 1,197,129	$ 2,100,237

OTHER FEDERAL FUNDS	FY16 Annual Report Budgeted	FY16 Annual Report Expended
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > 1305 Chron Dis	$ 1,301,602	$ 0
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Tob Use Prev Cont	$ 1,113,945	$ 162,104
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Support State QL	$ 450,290	$ 424,016
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Prev Health BG	$ 2,505,510	$ 3,049,463
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Br & Cerv Cancer	$ 1,187,135	$ 888,094
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prev Educ	$ 640,250	$ 517,097
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Cap Bldg NPAO	$ 276,826	$ 0

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**1.FEDERAL ALLOCATION**
	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**
	Field Note: The amount reported represents expenditures from federal fiscal year 2016 (October 1, 2015-September 30, 2016). Since awards are granted in two year overlapping cycles, the reported expenditures include funds from the 2016 and 2015 federal fiscal year awards (October 1, 2015-September 30, 2017 as well as October 1, 2014-September 30, 2016). These award numbers are B04MC2932601 and B04MC2812801 respectively. The methodology used has been consistent from year to year and thus expenditure reporting is both complete and comparable year to year.	
2.	**Field Name:**	**Federal Allocation, A. Preventive and Primary Care for Children:**
	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**
	Field Note: The amount reported represents expenditures from federal fiscal year 2016 (October 1, 2015-September 30, 2016). Since awards are granted in two year overlapping cycles, the reported expenditures include funds from the 2016 and 2015 federal fiscal year awards (October 1, 2015-September 30, 2017 as well as October 1, 2014-September 30, 2016). These award numbers are B04MC2932601 and B04MC2812801 respectively. The methodology used has been consistent from year to year and thus expenditure reporting is both complete and comparable year to year.	
3.	**Field Name:**	**Federal Allocation, B. Children with Special Health Care Needs:**
	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**
	Field Note: The amount reported represents expenditures from federal fiscal year 2016 (October 1, 2015-September 30, 2016). Since awards are granted in two year overlapping cycles, the reported expenditures include funds from the 2016 and 2015 federal fiscal year awards (October 1, 2015-September 30, 2017 as well as October 1, 2014-September 30, 2016). These award numbers are B04MC2932601 and B04MC2812801 respectively. The methodology used has been consistent from year to year and thus expenditure reporting is both complete and comparable year to year.	
4.	**Field Name:**	**2. UNOBLIGATED BALANCE**
	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**

	Field Note: The amount reported represents expenditures from federal fiscal year 2016 (October 1, 2015-September 30, 2016). Since awards are granted in two year overlapping cycles, the reported expenditures include funds from the 2016 and 2015 federal fiscal year awards (October 1, 2015-September 30, 2017 as well as October 1, 2014-September 30, 2016). These award numbers are B04MC2932601 and B04MC2812801 respectively. The methodology used has been consistent from year to year and thus expenditure reporting is both complete and comparable year to year.	
5.	**Field Name:**	**3. STATE MCH FUNDS**
	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**
	Field Note: The amount reported represents expenditures from federal fiscal year 2016 (October 1, 2015-September 30, 2016). Since awards are granted in two year overlapping cycles, the reported expenditures include funds from the 2016 and 2015 federal fiscal year awards (October 1, 2015-September 30, 2017 as well as October 1, 2014-September 30, 2016). These award numbers are B04MC2932601 and B04MC2812801 respectively. The methodology used has been consistent from year to year and thus expenditure reporting is both complete and comparable year to year.	
6.	**Field Name:**	**6. PROGRAM INCOME**
	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**
	Field Note: The amount reported represents expenditures from federal fiscal year 2016 (October 1, 2015-September 30, 2016). Since awards are granted in two year overlapping cycles, the reported expenditures include funds from the 2016 and 2015 federal fiscal year awards (October 1, 2015-September 30, 2017 as well as October 1, 2014-September 30, 2016). These award numbers are B04MC2932601 and B04MC2812801 respectively. The methodology used has been consistent from year to year and thus expenditure reporting is both complete and comparable year to year.	

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	FY18 Application Budgeted	FY16 Annual Report Expended
1. Pregnant Women	$ 410,562	$ 457,409
2. Infants < 1 year	$ 676,836	$ 754,066
3. Children 1-22 years	$ 2,653,881	$ 2,956,699
4. CSHCN	$ 4,164,498	$ 4,639,683
5. All Others	$ 4,099,607	$ 4,567,385
Federal Total of Individuals Served	$ 12,005,384	$ 13,375,242

IB. Non Federal MCH Block Grant	FY18 Application Budgeted	FY16 Annual Report Expended
1. Pregnant Women	$ 1,918,348	$ 2,251,331
2. Infants < 1 year	$ 889,675	$ 1,044,103
3. Children 1-22 years	$ 6,276,753	$ 7,366,257
4. CSHCN	$ 4,476,177	$ 5,253,141
5. All Others	$ 20,839,047	$ 24,456,241
Non Federal Total of Individuals Served	$ 34,400,000	$ 40,371,073
Federal State MCH Block Grant Partnership Total	$ 46,405,384	$ 53,746,315

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:	**2018**
	Column Name:	**Application Budgeted**
	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 family planning funds are used, in part, to serve children age 1-22 but also serve other populations (and therefore are not counted in the "Preventive and Primary Care for Children" category on Form 2).	
2.	**Field Name:**	**IA. Federal MCH Block Grant, 4. CSHCN**
	Fiscal Year:	**2018**
	Column Name:	**Application Budgeted**
	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 funds are used, in part, to serve CSHCN but also serve infant and child populations (and therefore are not counted in the "CSHCN" category on Form 2).	
3.	**Field Name:**	**IA. Federal MCH Block Grant, 3. Children 1-22 years**
	Fiscal Year:	**2016**
	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 family planning funds are used, in part, to serve children age 1-22 but also serve other populations (and therefore are not counted in the "Preventive and Primary Care for Children" category on Form 2).	
4.	**Field Name:**	**IA. Federal MCH Block Grant, 4. CSHCN**
	Fiscal Year:	**2016**
	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 funds are used, in part, to serve CSHCN but also serve infant and child populations (and therefore are not counted in the "CSHCN" category on Form 2).	

Form 3b
Budget and Expenditure Details by Types of Services

State: Tennessee

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY18 Application Budgeted	FY16 Annual Report Expended
1. Direct Services	$ 854,997	$ 952,556
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 240,823	$ 268,302
B. Preventive and Primary Care Services for Children	$ 17,865	$ 19,904
C. Services for CSHCN	$ 596,309	$ 664,350
2. Enabling Services	$ 10,926,330	$ 12,173,064
3. Public Health Services and Systems	$ 968,355	$ 1,078,847
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		$ 150,599
Physician/Office Services		$ 41,151
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 242,711
Dental Care (Does Not Include Orthodontic Services)		$ 953
Durable Medical Equipment and Supplies		$ 51,438
Laboratory Services		$ 266,906
Other		
Orthodontic; Interpreter		$ 198,798
Direct Services Line 4 Expended Total		$ 952,556
Federal Total	$ 12,749,682	$ 14,204,467

IIB. Non-Federal MCH Block Grant	FY18 Application Budgeted	FY16 Annual Report Expended
1. Direct Services	$ 1,566,617	$ 1,838,547
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 469,996	$ 551,578
B. Preventive and Primary Care Services for Children	$ 5,398	$ 6,334
C. Services for CSHCN	$ 1,091,223	$ 1,280,635
2. Enabling Services	$ 21,967,093	$ 25,780,090
3. Public Health Services and Systems	$ 10,866,290	$ 12,752,436
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		$ 282,952
Physician/Office Services		$ 105,718
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 443,641
Dental Care (Does Not Include Orthodontic Services)		$ 1,471
Durable Medical Equipment and Supplies		$ 107,003
Laboratory Services		$ 509,461
Other		
Orthodontic; Interpreter		$ 388,301
Direct Services Line 4 Expended Total		$ 1,838,547
Non-Federal Total	$ 34,400,000	$ 40,371,073

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: 86,518

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	86,175 (99.6%)	1,633	182	182 (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-methyglutaric aciduria	Holocarboxylase synthase deficiency	ß-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, βeta-thalassemia	S,C disease
Biotinidase deficiency	Critical congenital heart disease	Cystic fibrosis	Hearing loss	Severe combined immunodeficiences
Classic galactosemia	Mucopolysaccharidosis, type I			

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
Methylmalonic acidemia with homocystinuria	86,175 (99.6%)	45	0	0 (0%)
Malonic acidemia	86,175 (99.6%)	11	0	0 (0%)
Isobutyrylglycinuria	86,175 (99.6%)	34	1	1 (100.0%)
2-Methylbutyrylglycinuria	86,175 (99.6%)	18	0	0 (0%)
3-Methylglutaconic aciduria	86,175 (99.6%)	40	0	0 (0%)
2-Methyl-3-hydroxybutyric aciduria	86,175 (99.6%)	40	0	0 (0%)
Short-chain acyl-CoA dehydrogenase deficiency	86,175 (99.6%)	33	7	7 (100.0%)
Medium/short-chain L-3-hydroxyacl-CoA dehydrogenase deficiency	86,175 (99.6%)	11	0	0 (0%)
Glutaric acidemia type II	86,175 (99.6%)	33	7	7 (100.0%)
2,4 Dienoyl-CoA reductase deficiency	86,175 (99.6%)	3	0	0 (0%)
Carnitine palmitoyltransferase type I deficiency	86,175 (99.6%)	0	0	0 (0%)
Carnitine palmitoyltransferase type II deficiency	86,175 (99.6%)	1	0	0 (0%)
Carnitine acylcarnitine translocase deficiency	86,175 (99.6%)	1	0	0 (0%)
Argininemia	86,175 (99.6%)	3	0	0 (0%)
Citrullinemia, type II	86,175 (99.6%)	16	0	0 (0%)
Hypermethioninemia	86,175 (99.6%)	48	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
Benign hyperphenylalaninemia	86,175 (99.6%)	8	0	0 (0%)
Biopterin defect in cofactor biosyntheses	86,175 (99.6%)	8	0	0 (0%)
Biopterin defect in cofactor regeneration	86,175 (99.6%)	8	0	0 (0%)
Tyrosinemia, type II	86,175 (99.6%)	91	0	0 (0%)
Tyrosinemia, type III	86,175 (99.6%)	91	0	0 (0%)
Various other hemoglobinopathies	86,175 (99.6%)	16	0	0 (0%)
Galactoepimerase deficiency	86,175 (99.6%)	24	2	2 (100.0%)
Galactokinase deficiency	86,175 (99.6%)	24	0	0 (0%)
T-Cell related lymphocyte deficiencies	86,175 (99.6%)	119	9	9 (100.0%)
Hearing Loss	86,030 (99.4%)	4,349	122	122 (100.0%)
Critical Congenital Heart Disease	84,578 (97.8%)	91	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 confirm, the center reports the date on which treatment was started. Currently, the State does not monitor confirmed diagnosed infants beyond notification of diagnosis and treatment initiation by the contracted tertiary specialty center. However, the State provides infrastructure funding at each center to support long-term treatment, genetic testing for vulnerable individuals, and education/outreach.

Form Notes for Form 4:

In CY2016, 99.6% of infants received a Dried Blood Spot (DBS) test. Of the 343 infants who did not receive a DBS test 171 died within 1 day of life.

Field Level Notes for Form 4:

None

Data Alerts: None

Form 5a
Unduplicated Count of Individuals Served under Title V

State: Tennessee

Reporting Year 2016

		Primary Source of Coverage				
Types Of Individuals Served	(A) Title V Total Served	(B) Title XIX %	(C) Title XXI %	(D) Private / Other %	(E) None %	(F) Unknown %
1. Pregnant Women	21,405	53.0	0.0	13.0	34.0	0.0
2. Infants < 1 Year of Age	50,558	34.0	0.0	1.0	65.0	0.0
3. Children 1 to 22 Years of Age	224,557	33.0	0.0	8.0	59.0	0.0
4. Children with Special Health Care Needs	5,255	0.0	0.0	0.0	100.0	0.0
5. Others	117,357	16.0	0.0	7.0	77.0	0.0
Total	419,132					

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 2016

Types Of Individuals Served	Total Served
1. Pregnant Women	69,261
2. Infants < 1 Year of Age	86,518
3. Children 1 to 22 Years of Age	1,549,879
4. Children with Special Health Care Needs	13,137
5. Others	1,356,455
Total	3,075,250

Form Notes for Form 5b:

This data is collected from programs under the control of the MCH/Title V Director.

Field Level Notes for Form 5b:

None

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

State: Tennessee

Reporting Year 2016

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	81,374	61,648	16,714	141	1,792	178	0	901
Title V Served	81,374	61,648	16,714	141	1,792	178	0	901
Eligible for Title XIX	41,317	27,926	12,314	80	556	81	0	360
2. Total Infants in State	78,350	55,686	16,757	0	0	0	0	5,907
Title V Served	50,588	38,066	10,469	52	318	37	0	1,646
Eligible for Title XIX	21,057	13,016	8,041	0	0	0	0	0

II. Unduplicated Count by Ethnicity

	(A) Total Not Hispanic or Latino	(B) Total Hispanic or Latino	(C) Ethnicity Not Reported	(D) Total All Ethnicities
1. Total Deliveries in State	73,965	7,260	149	81,374
Title V Served	73,965	7,260	149	81,374
Eligible for Title XIX	36,268	4,957	92	41,317
2. Total Infants in State	70,267	8,083	0	78,350
Title V Served	43,333	5,768	1,487	50,588
Eligible for Title XIX	19,090	1,967	0	21,057

Form Notes for Form 6:

None

Field Level Notes for Form 6:

None

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

State: Tennessee

A. State MCH Toll-Free Telephone Lines	2018 Application Year	2016 Reporting Year
1. State MCH Toll-Free "Hotline" Telephone Number	(877) 548-3861	(877) 808-5460
2. State MCH Toll-Free "Hotline" Name	Primary Prevention Impact Services Call Center	TENNder Care Call Center
3. Name of Contact Person for State MCH "Hotline"	Morgan McDonald	Morgan McDonald
4. Contact Person's Telephone Number	(615) 532-8672	(615) 532-8672
5. Number of Calls Received on the State MCH "Hotline"		181

B. Other Appropriate Methods	2018 Application Year	2016 Reporting Year
1. Other Toll-Free "Hotline" Names	Tennessee Breastfeeding Hotline	Tennessee Breastfeeding Hotline
2. Number of Calls on Other Toll-Free "Hotlines"		5,910
3. State Title V Program Website Address	https://www.kidcentraltn.com/	https://www.kidcentraltn.com/
4. Number of Hits to the State Title V Program Website		700,930
5. State Title V Social Media Websites	https://www.facebook.com/TNDeptofHealth	https://www.facebook.com/TNDeptofHealth
6. Number of Hits to the State Title V Program Social Media Websites		0

Form Notes for Form 7:

Data on the number of hits to the state Title V program social media website was not able to be obtained.

Form 8
State MCH and CSHCN Directors Contact Information

State: Tennessee

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

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

3. State Family or Youth Leader (Optional)	
Name	
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 2018

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).
9.	Increase the number of children (with and without special healthcare needs) who receive services necessary to make transitions to adult care.

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.

None

NOM 1 - Percent of pregnant women who receive prenatal care beginning in the first trimester

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	74.2 %	0.2 %	55,756	75,125
2014	74.2 %	0.2 %	56,654	76,364
2013	71.6 %	0.2 %	54,489	76,103
2012	70.4 %	0.2 %	53,419	75,885
2011	69.9 %	0.2 %	51,605	73,832
2010	70.6 %	0.2 %	52,663	74,579
2009	69.5 %	0.2 %	54,058	77,795

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 1 - Notes:

None

Data Alerts: None

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

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	181.1	5.3 %	1,213	66,987
2013	185.8	5.2 %	1,280	68,876
2012	179.0	5.2 %	1,228	68,598
2011	169.9	4.8 %	1,251	73,655
2010	163.9	4.8 %	1,197	73,053
2009	169.3	4.8 %	1,271	75,064
2008	167.4	4.7 %	1,290	77,050

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 2 - Notes:

None

Data Alerts: None

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

FAD Not Available for this measure.

State Provided Data	
	2016
Annual Indicator	23.8
Numerator	58
Denominator	243,937
Data Source	TDH PPA - Birth Statistical System
Data Source Year	2013-2015

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
2015	9.2 %	0.1 %	7,460	81,384
2014	9.0 %	0.1 %	7,297	81,441
2013	9.1 %	0.1 %	7,307	79,962
2012	9.2 %	0.1 %	7,377	80,318
2011	9.0 %	0.1 %	7,176	79,554
2010	9.0 %	0.1 %	7,179	79,451
2009	9.2 %	0.1 %	7,539	82,172

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, 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
2015	1.6 %	0.0 %	1,318	81,384
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
2015	7.6 %	0.1 %	6,142	81,384
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
2015	11.0 %	0.1 %	8,959	81,538
2014	10.8 %	0.1 %	8,780	81,497
2013	11.1 %	0.1 %	8,826	79,691
2012	11.2 %	0.1 %	8,961	79,807
2011	11.1 %	0.1 %	8,729	78,903
2010	11.4 %	0.1 %	8,988	78,936
2009	11.3 %	0.1 %	9,231	81,518

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, 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
2015	3.1 %	0.1 %	2,495	81,538
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
2015	7.9 %	0.1 %	6,464	81,538
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
2015	26.6 %	0.2 %	21,662	81,538
2014	26.1 %	0.2 %	21,293	81,497
2013	26.2 %	0.2 %	20,856	79,691
2012	27.8 %	0.2 %	22,149	79,807
2011	28.9 %	0.2 %	22,784	78,903
2010	30.1 %	0.2 %	23,721	78,936
2009	31.5 %	0.2 %	25,645	81,518

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, 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
2015/Q2-2016/Q1	2.0 %			
2015/Q1-2015/Q4	2.0 %			
2014/Q4-2015/Q3	2.0 %			
2014/Q3-2015/Q2	2.0 %			
2014/Q2-2015/Q1	2.0 %			
2014/Q1-2014/Q4	3.0 %			
2013/Q4-2014/Q3	3.0 %			
2013/Q3-2014/Q2	3.0 %			
2013/Q2-2014/Q1	4.0 %			

Legends:

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
2014	6.8	0.3 %	554	81,875
2013	7.0	0.3 %	558	80,281
2012	7.2	0.3 %	582	80,674
2011	7.5	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
2014	6.9	0.3 %	561	81,602
2013	6.8	0.3 %	544	79,992
2012	7.2	0.3 %	582	80,371
2011	7.4	0.3 %	592	79,588
2010	7.9	0.3 %	626	79,495
2009	8.0	0.3 %	657	82,211

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.1 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	4.3	0.2 %	349	81,602
2013	4.2	0.2 %	333	79,992
2012	4.3	0.2 %	349	80,371
2011	4.6	0.2 %	365	79,588
2010	4.6	0.2 %	368	79,495
2009	4.8	0.2 %	396	82,211

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.2 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	2.6	0.2 %	212	81,602
2013	2.6	0.2 %	211	79,992
2012	2.9	0.2 %	233	80,371
2011	2.9	0.2 %	227	79,588
2010	3.3	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
2014	230.4	16.8 %	188	81,602
2013	193.8	15.6 %	155	79,992
2012	209.0	16.1 %	168	80,371
2011	214.9	16.5 %	171	79,588
2010	245.3	17.6 %	195	79,495
2009	255.4	17.7 %	210	82,211

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.4 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	111.5	11.7 %	91	81,602
2013	123.8	12.5 %	99	79,992
2012	164.2	14.3 %	132	80,371
2011	154.6	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
2014	5.8 %	1.1 %	4,524	77,863
2013	4.8 %	1.0 %	3,677	77,144
2012	6.7 %	1.1 %	5,139	77,036
2009	5.6 %	1.1 %	4,474	79,825
2008	3.4 %	0.8 %	2,774	81,407

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or 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: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	26.8	0.6 %	1,816	67,673
2013	22.9	0.6 %	1,589	69,339
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
2015	18.3	1.6 %	135	739,432
2014	20.6	1.7 %	152	738,611
2013	21.1	1.7 %	156	738,334
2012	22.4	1.7 %	166	739,838
2011	20.0	1.7 %	147	736,697
2010	22.0	1.7 %	163	740,978
2009	20.0	1.7 %	148	738,731

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 15 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	39.8	2.2 %	335	840,920
2014	36.7	2.1 %	309	841,738
2013	35.5	2.1 %	299	841,885
2012	40.3	2.2 %	340	844,247
2011	37.1	2.1 %	315	848,300
2010	38.2	2.1 %	327	856,127
2009	42.4	2.2 %	363	855,924

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.1 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013_2015	14.1	1.1 %	177	1,259,614
2012_2014	15.5	1.1 %	195	1,260,128
2011_2013	16.9	1.2 %	214	1,267,375
2010_2012	18.9	1.2 %	243	1,285,474
2009_2011	19.2	1.2 %	250	1,302,264
2008_2010	21.7	1.3 %	285	1,312,853
2007_2009	28.1	1.5 %	368	1,307,973

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.2 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013_2015	9.8	0.9 %	124	1,259,614
2012_2014	9.8	0.9 %	123	1,260,128
2011_2013	8.7	0.8 %	110	1,267,375
2010_2012	7.8	0.8 %	100	1,285,474
2009_2011	7.8	0.8 %	102	1,302,264
2008_2010	7.2	0.7 %	94	1,312,853
2007_2009	7.1	0.7 %	93	1,307,973

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.3 - Notes:

None

Data Alerts: None

NOM 17.1 - Percent of children with special health care needs

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
2014	30.3 %	0.2 %	16,491	54,429
2012	30.5 %	0.2 %	16,187	53,033
2010	31.8 %	0.2 %	18,198	57,153
2008	30.3 %	0.2 %	15,619	51,616

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
2015	35.7 %	1.2 %	94,125	263,806
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
2015	4.3 %	0.3 %	63,432	1,493,057
2014	5.2 %	0.3 %	77,115	1,493,436
2013	5.7 %	0.4 %	84,902	1,492,149
2012	5.6 %	0.4 %	83,030	1,492,012
2011	5.8 %	0.4 %	86,513	1,489,552
2010	5.3 %	0.3 %	79,838	1,499,117
2009	5.8 %	0.3 %	85,685	1,489,741

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width 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
2015	70.1 %	3.8 %	82,260	117,280
2014	71.9 %	3.9 %	84,560	117,608
2013	68.5 %	3.5 %	79,216	115,715
2012	73.1 %	3.5 %	86,800	118,788
2011	70.4 %	3.4 %	85,567	121,578
2010	61.8 %	3.4 %	78,476	127,008
2009	44.8 %	3.4 %	55,979	124,975

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval 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) - Flu

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015_2016	61.8 %	1.9 %	865,797	1,400,513
2014_2015	61.8 %	2.0 %	871,825	1,409,807
2013_2014	60.2 %	2.0 %	836,358	1,390,019
2012_2013	56.4 %	2.3 %	789,668	1,400,851
2011_2012	50.4 %	2.7 %	695,541	1,379,253
2010_2011	56.6 %	3.8 %	777,299	1,373,320
2009_2010	48.9 %	3.9 %	617,746	1,263,285

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 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) - Teen (Female)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	59.7 %	4.5 %	124,256	208,054
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) - Teen (Male)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	38.2 %	4.6 %	83,053	217,516
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) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	79.7 %	2.7 %	339,136	425,570
2014	86.0 %	2.3 %	363,547	422,685
2013	80.0 %	2.7 %	338,276	422,624
2012	77.4 %	3.2 %	325,269	420,423
2011	67.6 %	3.2 %	283,974	420,127
2010	58.7 %	3.2 %	243,261	414,201
2009	48.0 %	3.1 %	199,390	415,570

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval 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) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	76.7 %	2.9 %	326,284	425,570
2014	74.0 %	3.0 %	312,756	422,685
2013	67.8 %	3.1 %	286,448	422,624
2012	69.4 %	3.4 %	291,733	420,423
2011	63.3 %	3.3 %	265,999	420,127
2010	50.6 %	3.2 %	209,556	414,201
2009	52.1 %	3.1 %	216,515	415,570

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval 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

Federally Available Data	
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)	
	2016
Annual Objective	72.2
Annual Indicator	69.6
Numerator	794,110
Denominator	1,140,291
Data Source	BRFSS
Data Source Year	2015

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	72.2	73.3	74.5	75.7	75.7	75.7

Field Level Notes for Form 10a NPMs:

None

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

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2016
Annual Objective	80
Annual Indicator	78.0
Numerator	58,899
Denominator	75,553
Data Source	PRAMS
Data Source Year	2014

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	81.0	82.0	83.0	84.0	85.0	86.0

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

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2016
Annual Objective	38.3
Annual Indicator	38.3
Numerator	150,143
Denominator	391,762
Data Source	NSCH
Data Source Year	2011_2012

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	38.3	38.3	50.0	50.0	50.0	50.0

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)

Federally Available Data	
Data Source: HCUP - State Inpatient Databases (SID) - CHILD	
	2016
Annual Objective	109.8
Annual Indicator	109.1
Numerator	893
Denominator	818,595
Data Source	SID-CHILD
Data Source Year	2014

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	107.0	104.4	101.8	99.2	96.7	94.3

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)

Federally Available Data	
Data Source: HCUP - State Inpatient Databases (SID) - ADOLESCENT	
	2016
Annual Objective	184.8
Annual Indicator	207.7
Numerator	1,746
Denominator	840,564
Data Source	SID-ADOLESCENT
Data Source Year	2014

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	176.4	168.0	159.6	151.2	142.8	137.0

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)

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - CHILD	
	2016
Annual Objective	49.4
Annual Indicator	45.4
Numerator	224,507
Denominator	494,298
Data Source	NSCH-CHILD
Data Source Year	2011_2012

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	50.7	52.0	53.3	54.6	55.9	57.2

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)

Federally Available Data	
Data Source: Youth Risk Behavior Surveillance System (YRBSS)	
	2016
Annual Objective	26.9
Annual Indicator	25.9
Numerator	70,480
Denominator	272,118
Data Source	YRBSS-ADOLESCENT
Data Source Year	2015

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - ADOLESCENT	
	2016
Annual Objective	26.9
Annual Indicator	23.9
Numerator	120,480
Denominator	504,540
Data Source	NSCH-ADOLESCENT
Data Source Year	2011_2012

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	27.7	28.5	29.3	30.1	30.9	31.7

Field Level Notes for Form 10a NPMs:

None

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

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - CSHCN	
	2016
Annual Objective	61.6
Annual Indicator	49.9
Numerator	174,136
Denominator	348,790
Data Source	NSCH-CSHCN
Data Source Year	2011_2012

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	63.1	64.7	66.3	68.0	69.7	71.4

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

Federally Available Data	
Data Source: National Survey of Children with Special Health Care Needs (NS-CSHCN)	
	2016
Annual Objective	42.8
Annual Indicator	41.8
Numerator	40,413
Denominator	96,752
Data Source	NS-CSHCN
Data Source Year	2009_2010

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	43.9	45.0	46.1	47.3	48.5	49.7

Field Level Notes for Form 10a NPMs:

None

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

Federally Available Data	
Data Source: National Vital Statistics System (NVSS)	
	2016
Annual Objective	14.4
Annual Indicator	14.3
Numerator	11,577
Denominator	80,953
Data Source	NVSS
Data Source Year	2015

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	13.9	13.4	12.9	12.4	11.9	11.4

Field Level Notes for Form 10a NPMs:

None

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

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2016
Annual Objective	30.2
Annual Indicator	32.7
Numerator	480,684
Denominator	1,468,036
Data Source	NSCH
Data Source Year	2011_2012

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	29.6	29.0	28.4	27.8	27.2	26.6

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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	27.5
Numerator	
Denominator	
Data Source	NSCH
Data Source Year	2011_2012
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	27.5	27.5	24.8	24.8	22.3	22.3

Field Level Notes for Form 10a SPMs:

None

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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	78.2
Numerator	
Denominator	
Data Source	TDH PPA - Birth Statistical System
Data Source Year	CY2015
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	80.0	82.0	84.0	86.0	88.0	90.0

Field Level Notes for Form 10a SPMs:

None

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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	51.6
Numerator	
Denominator	
Data Source	PRAMS
Data Source Year	2013
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	51.6	49.9	48.2	46.5	46.5	46.5

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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	9
Numerator	
Denominator	
Data Source	TDH FHW Womens Health Section Program Data
Data Source Year	FFY2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	9.0	9.0	9.0	9.0	9.0	9.0

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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	TDH FHW Womens Health Section Program Data
Data Source Year	FFY2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	2.0	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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	TDH FHW Womens Health Section Program Data
Data Source Year	FFY2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	4.0	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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	4
Numerator	
Denominator	
Data Source	TDH FHW Womens Health Section Program Data
Data Source Year	FFY2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	4.0	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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	226,881
Numerator	
Denominator	
Data Source	TDH FHW Injury Prevention Section Program Data
Data Source Year	FFY2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	80,000.0	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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	100
Numerator	
Denominator	
Data Source	TDH FHW Injury Section Program Data - CFR Report
Data Source Year	CY2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	100.0	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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	84
Numerator	
Denominator	
Data Source	TDH PPA - Birth Statistical System
Data Source Year	FFY2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	80.0	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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	100
Numerator	
Denominator	
Data Source	TDH FHW Perinatal Health Section Program Data
Data Source Year	CY2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	100.0	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)

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	45,881
Numerator	
Denominator	
Data Source	TDH FHW Womens Health Section Program Data
Data Source Year	FFY2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	45,500.0	46,000.0	46,500.0	47,000.0	47,500.0	48,000.0

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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	797
Numerator	
Denominator	
Data Source	TDH FHW Early Childhood Section Program Data
Data Source Year	FFY2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	599.0	617.0	636.0	655.0	675.0	696.0

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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	450
Numerator	
Denominator	
Data Source	TDH CHS Program Data
Data Source Year	FFY2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	467.0	485.0	504.0	524.0	544.0	566.0

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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	89.2
Numerator	
Denominator	
Data Source	TDH FHW Early Childhood Section Program Data
Data Source Year	FY2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	90.0	90.0	91.0	92.0	92.0	93.0

Field Level Notes for Form 10a ESMs:

None

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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	2,836
Numerator	
Denominator	
Data Source	TDH FHW Injury Prevention Section Program Data
Data Source Year	FFY2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	2,836.0	2,850.0	2,875.0	2,900.0	2,925.0	2,950.0

Field Level Notes for Form 10a ESMs:

None

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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	36
Numerator	
Denominator	
Data Source	TDH FHW Injury Prevention Section Program Data
Data Source Year	FFY2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	45.0	48.0	51.0	54.0	57.0	60.0

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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	81
Numerator	
Denominator	
Data Source	TDH FHW Early Childhood Section Program Data
Data Source Year	FY2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	85.0	87.0	89.0	91.0	93.0	95.0

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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	46
Numerator	
Denominator	
Data Source	ReduceTNCrashes.org Safe Driving Report
Data Source Year	FFY2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	55.0	57.0	59.0	61.0	63.0	65.0

Field Level Notes for Form 10a ESMs:

None

ESM 7.5 - Number of drug disposal bins installed statewide

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	206
Numerator	
Denominator	
Data Source	TN Depart of Environment and Conservation Report
Data Source Year	FFY2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	170.0	225.0	240.0	255.0	270.0	295.0

Field Level Notes for Form 10a ESMs:

None

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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	8
Numerator	
Denominator	
Data Source	TN Depart of Environment and Conservation Report
Data Source Year	FFY2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	5.0	6.0	7.0	7.0	8.0	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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	11
Numerator	
Denominator	
Data Source	TDH FHW Injury Prevention Section Program Data
Data Source Year	FFY2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	11.0	11.0	12.0	12.0	13.0	13.0

Field Level Notes for Form 10a ESMs:

None

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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	441
Numerator	
Denominator	
Data Source	TDH FHW Chronic Disease Program Data
Data Source Year	FFY2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	480.0	525.0	570.0	615.0	660.0	705.0

Field Level Notes for Form 10a ESMs:

None

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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	485
Numerator	
Denominator	
Data Source	TDH FHW SupplementalNutrition Section Program Data
Data Source Year	FFY2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	475.0	500.0	525.0	550.0	575.0	600.0

Field Level Notes for Form 10a ESMs:

None

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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	2
Numerator	
Denominator	
Data Source	Baby Friendly USA, Inc.
Data Source Year	CY2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	3.0	3.0	4.0	4.0	5.0	5.0

Field Level Notes for Form 10a ESMs:

None

ESM 8.4 - Number of Physical Activity Clubs in K-12 schools

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	47
Numerator	
Denominator	
Data Source	TDH FHW Chronic Disease Program Data
Data Source Year	FFY2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	60.0	125.0	150.0	175.0	200.0	225.0

Field Level Notes for Form 10a ESMs:

None

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

Measure Status:	Inactive - Replaced

State Provided Data	
	2016
Annual Objective	
Annual Indicator	68
Numerator	
Denominator	
Data Source	TN Depart of Education - Coordinated School Health
Data Source Year	FFY2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	70.0	75.0	80.0	85.0	90.0	90.0

Field Level Notes for Form 10a ESMs:

None

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

Measure Status:	Inactive - Replaced

State Provided Data	
	2016
Annual Objective	
Annual Indicator	136
Numerator	
Denominator	
Data Source	TN Depart of Education - Coordinated School Health
Data Source Year	FFY2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	140.0	146.0	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

Measure Status:	Inactive - Replaced

State Provided Data	
	2016
Annual Objective	
Annual Indicator	1,591
Numerator	
Denominator	
Data Source	Tennessee Recreation and Parks Association
Data Source Year	FFY2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	1,675.0	1,700.0	1,725.0	1,750.0	1,775.0	1,775.0

Field Level Notes for Form 10a ESMs:

None

ESM 8.8 - Number of school gardens in Tennessee public schools

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	0.0	395.0	420.0	470.0	495.0	520.0

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2017**
	Column Name:	**Annual Objective**
	Field Note: ESM added for FY18	

ESM 8.9 - Number of Healthy Parks Healthy Person app users

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	0.0	800.0	900.0	1,000.0	1,100.0	1,200.0

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2017**
	Column Name:	**Annual Objective**
	Field Note: ESM added for FY18	

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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	420
Numerator	
Denominator	
Data Source	TDH FHW Title V CYSHCN Program Data
Data Source Year	FFY2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	475.0	525.0	575.0	625.0	675.0	725.0

Field Level Notes for Form 10a ESMs:

None

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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	279
Numerator	
Denominator	
Data Source	TDH FHW Title V CYSHCN Program Data
Data Source Year	FFY2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	307.0	337.0	367.0	397.0	427.0	457.0

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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	74
Numerator	
Denominator	
Data Source	TDH FHW Title V CYSHCN Program Data
Data Source Year	FFY2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	80.0	85.0	90.0	95.0	100.0	100.0

Field Level Notes for Form 10a ESMs:

None

ESM 12.1 - Number of adolescents on the Adolescent Advisory Council

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	7
Numerator	
Denominator	
Data Source	Title V CYSHCN Program Data
Data Source Year	FFY2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	5.0	7.0	9.0	11.0	13.0	15.0

Field Level Notes for Form 10a ESMs:

None

ESM 12.2 - Number of providers who receive technical assistance and information on transition for youth and young adults with and without special health care needs

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	0.0	100.0	125.0	150.0	175.0	200.0

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2017**
	Column Name:	**Annual Objective**
	Field Note: ESM added for FY2018	

ESM 12.3 - Number of providers who receive technical assistance and information on transition for youth and young adults with and without special health care needs

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	0.0	75.0	80.0	85.0	90.0	95.0

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2017**
	Column Name:	**Annual Objective**
	Field Note: ESM added for FY2018	

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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	441
Numerator	
Denominator	
Data Source	TDH FHW Chronic Disease Section Program Data
Data Source Year	FFY2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	480.0	525.0	570.0	615.0	660.0	705.0

Field Level Notes for Form 10a ESMs:

None

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

Measure Status:	Inactive - Replaced

State Provided Data	
	2016
Annual Objective	
Annual Indicator	16,536
Numerator	
Denominator	
Data Source	Tennessee Tobacco Quitline Report
Data Source Year	FFY2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	12,650.0	13,800.0	14,950.0	16,100.0	17,250.0	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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	1.7
Numerator	
Denominator	
Data Source	TDH FHW Early Childhood Section Program Data
Data Source Year	FFY2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	10.0	93.0	94.0	95.0	95.0	95.0

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**

Field Note:
Data collection quality was poor in FY2016. Over the past year training was conducted for evidenced-based home visiting staff across the state to improve their understanding of what was considered a referral. Due to this training recent preliminary analysis shows that data collection quality has improved.

ESM 14.4 - Number of reproductive-aged female tobacco users (15-44 years) who received online or phone counseling services through the Tennessee Tobacco Quitline.

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	0.0	720.0	800.0	880.0	975.0	1,075.0

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2017**
	Column Name:	**Annual Objective**
	Field Note: ESM added for FY2018	

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

Measure Status:	Active
Goal:	To reduce the percentage of children ages 0-17 experiencing two or more adverse childhood experiences
Definition:	**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:	NSCH
Significance:	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%).

SPM 2 - Percentage of infants born to Tennessee resident mothers who initiate breastfeeding
Population Domain(s) – Child Health

Measure Status:	Active
Goal:	Increase the percentage of infants born to Tennessee resident mothers who initiate breastfeeding
Definition:	**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

Measure Status:	Active
Goal:	Decrease the number of live births that were the result of an unintended pregnancy
Definition:	**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:	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.

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 Measures (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

Measure Status:	Active
Goal:	To increase the number of press releases, PSAs and/or social media messages promoting preventive health care visits for women of reproductive age
Definition:	**Numerator:** Number of press releases, PSAs and/or social media messages promoting preventive health care visits for women of reproductive age **Denominator:** N/A **Unit Type:** Count **Unit Number:** 9
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

Measure Status:	Active
Goal:	To Increase the number of webinars for providers on increasing preventive care visits among women in their clinics
Definition:	**Numerator:** Number of webinars for providers on increasing preventive care visits among women in their clinics **Denominator:** N/A **Unit Type:** Count **Unit Number:** 2
Data Sources and Data Issues:	TDH Reproductive and Women's Health Section program data
Significance:	Competing priorities and busy schedules can make it difficult for women to make time for their own health, especially for preventive health care, while changing recommendations can make it challenging for both patients and providers to navigate preventive care needs. Training primary care providers on how to leverage missed opportunities (such as acute care visits) for provision of preventive care and how to properly code such visits for reimbursement is one way to promote and increase preventive health care services among women of reproductive age.

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

Measure Status:	Active
Goal:	To distribute quarterly site-level family planning utilization reports to local health departments
Definition:	**Numerator:** Number of quarterly site-level family planning utilization reports distributed to local health departments **Denominator:** N/A **Unit Type:** Count **Unit Number:** 4
Data Sources and Data Issues:	Tennessee Department of Health - Patient Tracking Billing Information Management System (PTBMIS)
Significance:	The number of Family Planning (FP) clients served by the department has been declining in recent years. Similar declines have been observed in FP programs nationwide, as well as in other health department programs such as WIC. Quarterly site-level family planning utilization reports are an effort to better understand the FP patient population at a very granular level (e.g. patient demographics, insurance status, and contraceptive methods at individual service sites). Better understanding of patient characteristics and trends among specific subgroups will help health department staff focus outreach efforts aimed at slowing and reversing declines in FP program utilization and providing these services to the greatest number of people possible. Family Planning visits offer an opportunity to not only help women avoid unintended pregnancies, but to also prepare for healthy pregnancies by addressing important preventive care issues among those of reproductive age.

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

Measure Status:	Active
Goal:	To distribute quarterly region-level pregnancy-related service utilization reports to regional health departments
Definition:	**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:	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).

ESM 5.1 - Number of safe sleep educational material distributed
NPM 5 – Percent of infants placed to sleep on their backs

Measure Status:	Active
Goal:	To increase the number of safe sleep educational materials distributed
Definition:	**Numerator:** Number of safe sleep educational materials distributed **Denominator:** n/a **Unit Type:** Count **Unit Number:** 250,000
Data Sources and Data Issues:	TDH FHW child fatality review program data
Significance:	Safe sleep educational materials play an important role in educating new parents and caregivers about ways to keep babies safe while sleeping. In 2014, there were 99 infant deaths that resulted from an unsafe sleep environment, account for approximately 18% of all infant deaths. By focusing on distributing safe sleep educational materials can increase the awareness to put babies into safe sleep environment and decrease the sleep-related infant death and reduce the overall infant mortality rate.

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

Measure Status:	Active
Goal:	To maintain the percent of infant deaths to be reviewed by child fatality review teams
Definition:	**Numerator:** Number of reviewed infant deaths **Denominator:** Number of infant deaths met the review criteria **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	TDH FHW child death review database
Significance:	The overall 2014 infant mortality rate in Tennessee was 6.9 infant deaths per 1,000 live births, 15% higher than national rate. The deaths meeting the review criteria were all reviewed by CFR (Child Fatality Review) teams. Their careful review process results in a thorough description of the factors related to infant deaths. By reviewing these cases, it can provide a comprehensive depth of understanding of the deaths and reduce infant mortality.

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

Measure Status:	Active
Goal:	Maintain that 80% of VLBW infants are being delivered at Level III or IV birthing facilities
Definition:	**Numerator:** VLBW infants are being delivered at Level III or IV birthing facilities **Denominator:** All VLBW infants **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Tennessee Department of Health, Births Statistical System
Significance:	Very low birth weight infants (<1,500 grams or 3.25 pounds) are at high risk of morbidity and mortality. VLBW infants are significantly more likely to survive when delivered at level III or IV birthing facilities.

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

Measure Status:	Active
Goal:	Maintain that at least 99% of newborns with a positive metabolic screen receive follow up to definitive diagnosis
Definition:	**Numerator:** Number of infants who received follow-up to a definitive diagnosis **Denominator:** Number of infants with a positive metabolic screen **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Neometrics/Natus newborn screening database
Significance:	Metabolic newborn screening is mandatory for all babies born in Tennessee unless there is a refusal for religious reasons. The Tennessee system includes the State Laboratory, the follow-up staff, and the tertiary centers for referrals and follow-up. The system is designed to provide our families and providers the resources and services needed to assure that a timely diagnosis is made in each case. Early and appropriate intervention for each infant is critical for improving outcome.

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

Measure Status:	Active
Goal:	To increase the number of individuals served by the Tennessee Adolescent Pregnancy Prevention Program (TAPPP)
Definition:	**Numerator:** Number of individuals served by the Tennessee Adolescent Pregnancy Prevention Program (TAPPP) **Denominator:** n/a **Unit Type:** Count **Unit Number:** 48,000
Data Sources and Data Issues:	TAPPP – Programmatic data collected from the 6 Regional and 2 Metro HD TAPPP Coordinators and County Health Educators using the state data reporting form. Abstinence Education Grant Program – Programmatic data collected from the 13 abstinence education program coordinators using the required federal data collection sheet.
Significance:	Adolescent childbearing has been associated with increased risks for poor birth outcomes, including preterm delivery, low birthweight, and infant mortality. Causes for poorer birth outcomes in adolescents have been attributed to lower rates of adequate prenatal care, poor weight gain and nutrition, higher rates of tobacco use, high risk health behaviors and socioeconomic background characteristics. Therefore, increasing the number of individuals who participate in programs that address adolescent pregnancy prevention and abstinence education are critical in reducing teen pregnancies and infant mortality rates.

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

Measure Status:	Active
Goal:	To increase general awareness of the need for developmental screening
Definition:	**Numerator:** Number of site views from webpage and mobile app to the Developmental Milestones and Developmental Screenings site during the past 12 months **Denominator:** n/a **Unit Type:** Count **Unit Number:** 800
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

Measure Status:	Active
Goal:	To increase number of health department nurses trained in the START Autism and MCHAT-R/F program
Definition:	**Numerator:** Number of nurses trained in the START Autism and MCHAT-R/F program **Denominator:** N/A **Unit Type:** Count **Unit Number:** 566
Data Sources and Data Issues:	TDH Community Health Services training data
Significance:	The audience of this strategy is health department nurses and the clients of health departments. The Tennessee Early Intervention System and the Tennessee Chapter of the American Academy of Pediatrics have partnered with the health department to train nurse supervisors in the administration of the M-CHAT R screening tool for autism. It is assumed that trained nurse will administer the screening to the patients they see in clinic. Thus, training the health department nurses will increase the number of Tennessee children who receive a validated developmental screen at a primary care visit.

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

Measure Status:	Active
Goal:	To increase the percent of Developmental Screenings performed across the state for participants enrolled in an Evidence-Based Home Visiting Program
Definition:	**Numerator:** Number of ASQ-3 and ASQ:SE or ASQ:SE-2 screens documented at home visits during the past 12 months **Denominator:** Number of index children enrolled in an Evidence Based Home Visiting Program for at least 6 months **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	TDH FHW REDCap data base for MIECHV
Significance:	The audience of this strategy is non-medical providers that serve the child population. The Tennessee Young Child Wellness Council is partnering with agencies to create a catalog of developmental screening tools being used across the state, the settings in which these tools are being administered, and the degree of specificity. The Division of Family Health and Wellness continues to partner with state and federally funded evidence based home visiting programs. As an integral part of service delivery, and in compliance with national home visiting models, home visitors routinely administer developmental screenings.

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

Measure Status:	Active
Goal:	To increase the number of parents of caregivers receiving car seat education
Definition:	**Numerator:** Number of parents and caregivers receiving car seat education **Denominator:** n/a **Unit Type:** Count **Unit Number:** 2,950
Data Sources and Data Issues:	Tennessee Department of Health Child Injury Prevention Program Data
Significance:	Motor vehicle crash injuries are a leading cause of death among children in the United States. In 2014, over 1,000 children ages 12 and under were seen in Tennessee emergency departments because of motor vehicle crashes. CDC research suggests that black and Hispanic children ages 12 and under are less likely to buckle up than white children. The consistent and correct use of car seats and boosters can reduce the risk of serious injury and death for infants, toddlers, and children up to age 8. Tennessee utilizes a recommended practice to distribute car seats with education programs to increase restraint and decrease injuries and deaths to child passengers.

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

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To increase the number of counties that adopt Count It! Drop It! Lock It! educational programs</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Numerator:</td><td>Number of counties that adopt Count It! Drop It! Lock It! educational programs</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>60</td></tr>
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</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Tennessee Department of Health Injury Prevention Program reports</td></tr>
<tr><td>Significance:</td><td>Unintentional poisoning killed 635 U.S. Children in 2014; almost 90% of them were teenagers, ages 10-19. In 2014 117,959 U.S. children visited emergency departments for unintentional poisoning-related injuries (WISQARS). Reducing the amount of prescription drugs in the home can reduce access to these drugs by children. Research indicates the high availability of prescription drugs in Tennessee is contributing to the addiction problem across the state. According to the 2010 National Survey on Drug Use and Health, 70% of people who abused or misused prescription drugs got them from a friend or relative, either for free, by purchasing them, or by stealing them. People who abuse prescription drugs also obtain them from other sources including “pill mills,” or illegitimate pain clinics; prescription fraud; pharmacy theft; illegal online pharmacies; and “doctor shopping”. Some individuals who use prescription drugs for non-medical reasons believe these substances are safer than illicit drugs because they are prescribed by a physician and dispensed by a pharmacist.

Communities that develop partnerships with schools, healthcare providers, pharmacists, law enforcement and other sectors to educate families about the importance of monitoring, securing, and properly disposing of prescription drugs can reduce access to unused prescription drugs and increase the perception of harm of the abuse of prescription drugs.</td></tr>
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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

Measure Status:	Active
Goal:	To increase the percent of families who receive injury prevention education through the AAP checklist among families participating in Evidence Based Home Visiting programs
Definition:	**Numerator:** Number of children with at least one AAP screening completed **Denominator:** Number of children who reached first birthday during reporting period **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Tennessee Department of Health - Evidence Based Home Visiting Database
Significance:	Injury is a leading cause of child mortality and morbidity. In 2014, injuries resulted in more than 3,131 deaths and 2.3 million emergency department visits among 0-4 year olds in the US (CDC WISQARS). Home visitors can play an important role in increasing awareness about injury hazards, identifying risk and protective factors in the home setting, and teaching caregivers injury prevention methods. Using a childhood injury risk assessment tool, home visitors can identify risks and provide education on a wide range of injury topics. Home visiting is one strategy that shows promise for reducing rates of self-reported and substantiated child maltreatment and use of emergency rooms to treat child injuries.

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

Measure Status:	Active
Goal:	To increase the number of schools in the top ten crash rate counties (among ages 15-18) that conduct evidence-informed teen safe driving programming
Definition:	**Numerator:** Number of schools in the top ten crash rate counties that conduct evidence-informed teen safe driving programming **Denominator:** N/A **Unit Type:** Count **Unit Number:** 65
Data Sources and Data Issues:	ReduceTNCrashes.org web based teen safe driving program reports
Significance:	Motor vehicle crash injuries are a leading cause of hospitalization among children in the United States. In 2014, over 840 adolescents ages 15-24 were hospitalized in Tennessee because of motor vehicle crashes. Research shows that in order for young drivers to remain collision-free, parents must model safe driving behaviors and invest in meaningful guided practice over a long period of time to turn these skills into good driving habits. It is our hope that new drivers will have a solid foundation to develop safe, collision-free driving habits that will last a lifetime through teen safe driving programming. The evidence-informed teen safe driving program can reduce risk and keep people safer on the road.

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

Measure Status:	Active
Goal:	To increase the total number of drug disposal bins installed statewide
Definition:	**Numerator:** Number of drug disposal bins installed statewide **Denominator:** N/A **Unit Type:** Count **Unit Number:** 295
Data Sources and Data Issues:	Tennessee Department of Environment and Conservation Reports
Significance:	The diversion and abuse of prescription drugs contributes to the leading cause of death in Tennessee. In 2014, over 2,500 children ages 19 and under were admitted to the emergency department for poisoning. Young children are particularly at risk for accidental overdose due to the ingestion of prescription drugs, and unwanted medicine disposed in the trash can be stolen and used, potentially resulting in illness, injury, or death. There are few safe and convenient ways for consumers to properly dispose of unused prescription drugs that do not harm the solid or liquid waste system. Drug disposal bins are cited as one way to reduce the diversion and ingestion of unused prescription drugs while reducing damage to the local environment.

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

Measure Status:	Active
Goal:	To increase the number of press releases, social media posts and presentations about adolescent falls
Definition:	**Numerator:** Number of press releases, social media posts and presentations about adolescent falls **Denominator:** N/A **Unit Type:** Count **Unit Number:** 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

Measure Status:	Active
Goal:	To increase number of suicide-related articles, social media posts and trainings provided by TDH
Definition:	**Numerator:** Number of suicide-related articles, social media posts and trainings **Denominator:** N/A **Unit Type:** Count **Unit Number:** 13
Data Sources and Data Issues:	Tennessee Department of Health injury prevention program data
Significance:	Suicides among young people continues to be a serious problem. Suicide is the third leading cause of death for Tennessee residents ages 15-24 according to the U.S. Center for Disease Control and Prevention. Suicide is a relatively rare event and it is difficult to accurately predict which persons with these risk factors will ultimately commit suicide. However, by providing articles, social media posts and training can increase awareness of the signs and risk factors of suicide attempts.

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

Measure Status:	Active
Goal:	Increase the number of Gold Sneaker-recognized childcare facilities in Tennessee
Definition:	**Numerator:** Number of Tennessee licensed childcare facilities recognized by TDH as meeting the requirements set by the Gold Sneaker Initiative **Denominator:** N/A **Unit Type:** Count **Unit Number:** 705
Data Sources and Data Issues:	The Gold Sneaker facility tracking database is housed within the Division of Family Health and Wellness, and will be used to provide facility counts. The Gold Sneaker tracking database is updated as facilities receive application approval. However, at this time, there is no process for ensuring previously recognized facilities are still “active” (licensed, open, etc.). An evaluation and recertification process is currently being developed.
Significance:	Through the Gold Sneaker recognition process, facilities are required to adopt nine policies related to physical activity (4), nutrition (4), and adoption of a smoke-free facility campus (1). The first Gold Sneaker policy directly relates to the National Performance Measure – requiring children to participate in at least 60 minutes of physical activity per day. Additional Gold Sneaker policies are in concert with recommendations made by the American Academy of Pediatrics, Tennessee Child Care Resource & Referral Network, and Tennessee Department of Health and Human Services.

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

Measure Status:	Active
Goal:	To increase the average number of monthly calls to the Tennessee Breastfeeding Hotline
Definition:	**Numerator:** Count of individual calls (not unique callers) to the TBH during the reporting period **Denominator:** Months in reporting period **Unit Type:** Count **Unit Number:** 600
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

Measure Status:	Active
Goal:	To increase the number of Baby Friendly-designated Tennessee birthing hospitals
Definition:	**Numerator:** Number of Baby Friendly-designated Tennessee birthing hospitals **Denominator:** N/A **Unit Type:** Count **Unit Number:** 5
Data Sources and Data Issues:	Baby Friendly Hospital Initiative tracks completion of its 10 guidelines and evaluation criteria. A list of Baby Friendly Tennessee birthing hospitals is provided at: https://www.babyfriendlyusa.org/find-facilities/designated-facilities--by-state
Significance:	Baby-Friendly USA, Inc. and its implementation of the Baby-Friendly Hospital Initiative (BFHI) in the United States is predicated on the fact that human milk fed through the mother's own breast is the normal way for human infants to be nourished. There is an abundance of scientific evidence that points to lower risks for certain diseases and improved health outcomes for both mothers and babies who breastfeed. Breastfeeding is the natural biological conclusion to pregnancy and an important mechanism for the continued normal development of the infant. With the correct information and the right supports in place, under normal circumstances, most women who choose to breastfeed are able to successfully achieve their goal.

ESM 8.4 - Number of Physical Activity Clubs in K-12 schools
NPM 8 – Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day

Measure Status:	Active
Goal:	To increase the number of Run Clubs for 5th through 8th graders
Definition:	**Numerator:** Tennessee Run Clubs with participants in grades 5th through 8th grade (identified through TDH partnerships) **Denominator:** N/A **Unit Type:** Count **Unit Number:** 225
Data Sources and Data Issues:	Physical Activity Clubs are tracked by the TDH Chronic Disease Section. New PA clubs are submitted by local health department staff (health educators, coordinators, etc.) and are subsequently added to a tracking tool.
Significance:	A Physical Activity Club is a community or school-based physical activity opportunity that allows a young person to see their progress over time through better run/walk times or longer distances. Activities may include walking, jogging or running around school grounds on a walking track, competition track, athletic field, green space, or may occur at other locations such as state parks, swimming pools or any organized sport program. Physical Activity Clubs provide opportunities for students to be physically active as part of a goal to reach at least 60-minutes a day of moderate to vigorous physical activity.

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

Measure Status:	Inactive - Replaced
Goal:	To increase the number of school districts (LEAs) that received CSPAP training
Definition:	**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

Measure Status:	Inactive - Replaced
Goal:	To increase the number of school districts (LEAs) that received Smarter Lunchroom training
Definition:	**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

Measure Status:	Inactive - Replaced
Goal:	To increase the number of shared-use agreements (any type) between two or more entities in Tennessee
Definition:	**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 8.8 - Number of school gardens in Tennessee public schools
NPM 8 – Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day

Measure Status:	Active
Goal:	To increase the number of school gardens in Tennessee public schools
Definition:	**Numerator:** number of school gardens in Tennessee public schools **Denominator:** N/A **Unit Type:** Count **Unit Number:** 520
Data Sources and Data Issues:	The number of school gardens in TN public schools is tracked by the Farm to School Specialist in the Office of School Nutrition. The Department of Health, through contract, receives updated reports provided by the Office of School Nutrition.
Significance:	School gardens are a proven strategy for improving children's attitudes towards and consumption of produce, as well as incorporating experiential nutrition and agriculture education into school curriculum. TDH recognizes that children making healthy food choices while at school will significantly impact the statewide priority of reducing the prevalence of obesity.

ESM 8.9 - Number of Healthy Parks Healthy Person app users
NPM 8 – Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day

Measure Status:	Active
Goal:	To increase the number of Healthy Parks Healthy Person app users
Definition:	**Numerator:** Number of Healthy Parks Healthy Person app users **Denominator:** N/A **Unit Type:** Count **Unit Number:** 1,200
Data Sources and Data Issues:	The Healthy Parks Healthy Person app is managed by the Tennessee Department of Environment and Conservation. TDH must request access to the data on an ad hoc basis, and does not monitor or control data quality. The current app has limited tracking capabilities. During the upcoming year staff will be working to upgrade the app's functionality.
Significance:	Physical activity is an important part of good health for everyone, regardless of age or ability. Healthy Parks Healthy Person remove barriers to physical activity by promoting places to be active. Allowing access to physical activity spaces and facilities is a recommended strategy in the Healthy People 2020 goals for the nation's health. According to HP 2020, physical activity levels are positively affected by structural environments including trails and parks. Additionally, the National Physical Activity Plan Alliance recommends that communities develop new, and enhance existing, community recreation, fitness, and park programs that provide and promote healthy physical activity opportunities. Physical activity contributes to students' overall health and well-being. Furthermore, participating in physical activity in safe and clean public spaces helps everyone to feel more connected to their community.

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

Measure Status:	Active
Goal:	To increase the number of providers trained and provided information on medical home implementation
Definition:	**Numerator:** Number of providers trained and provided information on medical home implementation **Denominator:** N/A **Unit Type:** Count **Unit Number:** 725
Data Sources and Data Issues:	Title V Children and Youth with Special Healthcare Needs (CYSHCN) program training participation log
Significance:	The American Academy of Pediatrics (AAP) specifies seven qualities essential to medical home care: accessible, family-centered, continuous, comprehensive, coordinated, compassionate and culturally effective. Ideally, medical home care is delivered within the context of a trusting and collaborative relationship between the child's family and a competent health professional familiar with the child and family and the child's health history. Our program believes in the importance of training and plans to train more providers on medical home concept and provide information on medical home implementation.

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

Measure Status:	Active
Goal:	Increase the number of families that receive patient centered medical home training
Definition:	**Numerator:** Number of families that receive patient centered medical home training **Denominator:** N/A **Unit Type:** Count **Unit Number:** 457
Data Sources and Data Issues:	Title V Children and Youth with Special Healthcare Needs (CYSHCN) program training participation log
Significance:	The American Academy of Pediatrics (AAP) specifies seven qualities essential to medical home care: accessible, family-centered, continuous, comprehensive, coordinated, compassionate and culturally effective. Ideally, medical home care is delivered within the context of a trusting and collaborative relationship between the child's family and a competent health professional familiar with the child and family and the child's health history. This measure gauges the number of families that receive patient centered medical home training.

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

Measure Status:	Active
Goal:	To increase the percentage of children served by the CSS program receiving services in a medical home
Definition:	**Numerator:** Number of children 0-20 years of age served by the CSS program receiving services in a medical home **Denominator:** Number of children 0-20 years of age served by the CSS program **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Tennessee Department of Health - Patient Tracking and Billing Management Information System (PTBMIS) - CSS Program data
Significance:	The American Academy of Pediatrics (AAP) specifies seven qualities essential to medical home care: accessible, family-centered, continuous, comprehensive, coordinated, compassionate and culturally effective. Ideally, medical home care is delivered within the context of a trusting and collaborative relationship between the child's family and a competent health professional familiar with the child and family and the child's health history. The measure is limited to the children served by the CSS program.

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

Measure Status:	Active
Goal:	To expand the adolescent advisory council
Definition:	**Numerator:** Number of adolescents on the advisory council **Denominator:** N/A **Unit Type:** Count **Unit Number:** 15
Data Sources and Data Issues:	Children and Youth with Special Healthcare Needs (CYSHCN) program record
Significance:	The transition of youth to adulthood has become a priority issue nationwide as evidenced by the clinical report and algorithm developed jointly by the AAP, American Academy of Family Physicians and American College of Physicians to improve healthcare transitions for all youth and families. Over 90 percent of children with special health care needs now live to adulthood, but are less likely than their non-disabled peers to complete high school, attend college or to be employed. Health and health care are cited as two of the major barriers to making successful transitions. Our CSS program requires all children enrolled in the program have a transition plan in place by age of 14 years and updated every year afterward. The Youth Advisory Council will provide recommendations and advise the CSS program staff on transition concerns youth may face.

ESM 12.2 - Number of providers who receive technical assistance and information on transition for youth and young adults with and without special health care needs
NPM 12 – Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

Measure Status:	Active
Goal:	To increase number of providers who receive technical assistance and information on transition for youth and young adults with and without special health care needs
Definition:	**Numerator:** Number of providers who receive technical assistance and information on transition for youth and young adults with and without special health care needs **Denominator:** N/A **Unit Type:** Count **Unit Number:** 200
Data Sources and Data Issues:	Children and Youth with Special Healthcare Needs (CYSHCN) program record
Significance:	The transition of youth to adulthood has become a priority issue nationwide as evidenced by the clinical report and algorithm developed jointly by the AAP, American Academy of Family Physicians and American College of Physicians to improve healthcare transitions for all youth and families. Over 90% of children with special health care needs now live to adulthood, but are less likely than their non-disabled peers to complete high school, attend college or to be employed. Health and health care are cited as two of the major barriers to making successful transitions. Our CSS program requires all children enrolled in the program have a transition plan in place by age 14 years and updated every year afterward. The Youth Advisory Council will provide recommendations and advise to CSS program staff on transition concerns youth may face.

ESM 12.3 - Number of providers who receive technical assistance and information on transition for youth and young adults with and without special health care needs
NPM 12 – Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

Measure Status:	Active
Goal:	To increase number of providers who receive technical assistance and information on transition for youth and young adults with and without special health care needs
Definition:	**Numerator:** Number of providers who receive technical assistance and information on transition for youth and young adults with and without special health care needs **Denominator:** N/A **Unit Type:** Count **Unit Number:** 95
Data Sources and Data Issues:	Children and Youth with Special Healthcare Needs (CYSHCN) program record
Significance:	The transition of youth to adulthood has become a priority issue nationwide as evidenced by the clinical report and algorithm developed jointly by the AAP, American Academy of Family Physicians and American College of Physicians to improve healthcare transitions for all youth and families. Over 90% of children with special health care needs now live to adulthood, but are less likely than their non-disabled peers to complete high school, attend college or to be employed. Health and health care are cited as two of the major barriers to making successful transitions. Our CSS program requires all children enrolled in the program have a transition plan in place by age 14 years and updated every year afterward. The Youth Advisory Council will provide recommendations and advise to CSS program staff on transition concerns youth may face.

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

Measure Status:	Active
Goal:	To increase the number of child care facilities that voluntarily implement a tobacco-free campus policy
Definition:	**Numerator:** Number of licensed childcare facilities in Tennessee who adopt Gold-Sneaker designated policies **Denominator:** N/A **Unit Type:** Count **Unit Number:** 705
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

Measure Status:	Inactive - Replaced
Goal:	Increase the number of tobacco users who call the Tennessee Tobacco Quitline
Definition:	**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:	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.

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

Measure Status:	Active
Goal:	To increase the percent of primary caregivers enrolled in home visiting who reported using any tobacco products at enrollments and were referred to tobacco cessation counseling or services within three months of enrollment
Definition:	**Numerator:** Number of primary caregivers enrolled in home visiting who reported using any tobacco products at enrollment and were referred to tobacco cessation counseling or services within 3 months of enrollment **Denominator:** Number of primary caregivers enrolled in home visiting who reported using any tobacco products at enrollment and were enrolled for at least 3 months **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Evidence-Based Home Visiting (EBHV) Referral Tracker (RedCAP); Despite high prevalence of smoking throughout state, data regarding referrals to smoking cessation referrals for evidence-based home visiting participants are not consistently documented in RedCAP. Quality improvement efforts are in development, but the number of EBHV participants who are referred to smoking cessation services is likely underestimated.
Significance:	Currently operating in 31 of the state's 95 counties, evidence-based home visiting programs are located in communities with higher rates of smoking, teen pregnancy, low birth weight, prematurity, and infant death. Smoking prevalence among mothers who reside in these select communities ranges from 6 percent to 31 percent. Home visitors assess a number of preventive health and prenatal practices, including prenatal tobacco use and use of tobacco in the home. Evidence-based home visiting services is one of the most effective and cost-effective interventions to help parents support their young children's health and development and prevent adverse childhood experiences.

ESM 14.4 - Number of reproductive-aged female tobacco users (15-44 years) who received online or phone counseling services through 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

Measure Status:	Active
Goal:	Increase the number of reproductive-aged female tobacco users (15-44 years) who received online or phone counseling services through the Tennessee Tobacco Quitline
Definition:	**Numerator:** Number of reproductive-aged female tobacco users (15-44 years) who received online or phone counseling services through the Tennessee Tobacco Quitline **Denominator:** N/A **Unit Type:** Count **Unit Number:** 1,075
Data Sources and Data Issues:	Tennessee Tobacco Quitline Vendor Reports. Due to Tennessee's external operation of the Quitline (current vendor is based out of state), data are not available in-house.
Significance:	Tobacco use is the number one cause of preventable death in the US and six of the top 10 leading causes of death of Tennessee residents were linked to smoking. In Tennessee, 21.9% of adult women smoke (BRFSS 2015). Tobacco cessation during preconception care can prevent adverse birth outcomes associated with prenatal smoking, such as low birth weight and preterm birth. Prenatal smoking rates have significantly declined in Tennessee, yet 14.3% of Tennessee women smoked during pregnancy in 2015. Smoking cessation also prevents nonsmoker exposure to secondhand and third hand smoke. Telephone-based cessation services like the Tennessee Tobacco Quitline adopt a public health-oriented approach by not only helping tobacco users who desire to quit, but also by actively promoting cessation among the general population.

Form 11
Other State Data

State: Tennessee

The Form 11 data are available for review via the link below.

Form 11 Data

State Action Plan Table

State: Tennessee

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

State Action Plan Table - Entry View

State Action Plan Table - Legal Size Paper View

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 *Inactive* ESM 8.6 *Inactive* ESM 8.7 *Inactive* ESM 8.8 ESM 8.9	
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 *Inactive* ESM 8.6 *Inactive* ESM 8.7 *Inactive* ESM 8.8 ESM 8.9	

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 (with and without special healthcare needs) who receive services necessary to make transitions to adult care.	NPM 12 - Transition	ESM 12.1 ESM 12.2 ESM 12.3	

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 *Inactive* ESM 14.3 ESM 14.4	