

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

**Tennessee**

**FY 2019 Application/  
FY 2017 Annual Report**

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## I. General Requirements

### I.A. Letter of Transmittal



June 30, 2018

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

Dear Grants Management Officer,

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

Please contact me directly if further information is needed.

Sincerely,

A handwritten signature in cursive script that reads 'Morgan F. McDonald'.

Morgan F. McDonald, MD FAAP FACP  
Director, Division of Family Health and Wellness  
Tennessee Department of Health

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## **I.B. Face Sheet**

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

## **I.C. Assurances and Certifications**

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

## **I.D. Table of Contents**

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

## **II. Logic Model**

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

### **III. Components of the Application/Annual Report**

#### **III.A. Executive Summary**

##### **III.A.1. Program Overview**

##### **Needs Assessment**

At the beginning of a new five year grant cycle, states are required to conduct a comprehensive needs assessment to identify priority needs of the maternal and child 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 (maternal and child health) 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 part of the ongoing needs assessment, the state hosts MCH stakeholder meetings twice each year. These meetings are open to anyone, and effort is made to extend the invitation broadly. During the meetings, participants are asked to consider the progress made on performance measures during the past year, and then based on that evaluation make recommendations for the next year's action plan.

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.

##### **Needs and Priorities**

States are required to identify at least one priority in each of the population health domains. There are a total of six domains:

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

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 (ACEs).
- Increase the number of children (both with and without special health care needs) who have a medical home.
- Increase the number of children (with and without special health care needs) who receive services necessary to make transitions to adult health care.
- Reduce exposure to tobacco among the MCH population (pregnancy smoking and secondhand smoke exposure for children).

## **Program Planning**

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

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

The variety of MCH content areas in FHW pairs well with the subject areas of this grant. Due to this, each priority has a team within FHW that consist of program and epidemiology staff. Each team consists of at least two staff members but some are larger. The teams take the lead on developing and reporting on the action plan and corresponding measures. However this is done in conjunction with the MCH Stakeholders group. This group was formed during the last needs assessment and has met twice a year since then. The group reviews the action plan and measurement progress, and suggests changes for the coming year. They also partner with the MCH/Title V Program to complete the activities outlined in the action plan and work towards the objective for each measure. This is all done under the guidance of the MCH Title V Director who oversees all aspects of program planning.

## **Performance Reporting**

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

## **Assuring Comprehensive, Coordinated, Family-Centered Services**

The MCH/Title V Program assures comprehensive and coordinated services in a number of ways. Core services such as WIC, family planning, breast and cervical cancer screening, preventive care for children (EPSDT and immunizations), health promotion, community outreach and the care coordination services of Help Us Grow Successfully (HUGS) and Children's Special Services (CSS) are offered in all county health departments. Rural health departments report to regional office and to the Community Health Services (CHS) division of the state health department. Metro health departments are independent and accountable to local governments but operate closely via contract with TDH. This organizational structure assures that Title V and other state and federal funds are administered comprehensively to all 95 counties and that program fidelity is maintained via direct management or

contract. Regular communication occurs with the Regional Leadership Team (metro and regional directors and CHS leadership), the Medical Leadership Team (metro and regional health officers), Nursing Leadership Team (metro and regional nursing leads), and the MCH regional directors to assure multi-directional transmission of key information and provide opportunities for sharing of ideas. Other core Title V services such as newborn screening provide services to the entire state but are centrally located at the state lab to assure excellent communication between the lab and the FHW clinical follow up team for lead, genetic disorders, hearing loss, and congenital heart disease.

The MCH/Title V Program continues to work with families to assure comprehensive coordinated family-centered services by providing education around the importance of receiving services in a patient-centered medical home, and how to partner with providers in the decision making process. The program provides the "Partnering with your Provider Booklet" statewide for distribution at community events, as well as medical providers for distribution in their practices. Staff has also collaborated with the Bureau of TennCare, the state Medicaid agency, in their Primary Care Transformation Strategy "Patient-Centered Medical Home". This strategy has over 60 provider/practices seeking National Committee on Quality Assurance (NCQA) certification. Providers commit to activities such as patient centered access, team based care, population health management, care management support, care coordination and care transitions, and performance measurement and quality improvement; all designed to improve patient outcomes.

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

## **Partnerships**

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

For example, a multitude of local, state, and national partnerships have emerged statewide regarding the opioid crisis and prevention of neonatal abstinence syndrome. The NAS subcabinet continues to meet regularly with representatives from TDH, Department of Mental Health and Substance Abuse (TDMHSA), Department of Education (DOE), Department of Children's Services (DCS), TennCare, Department of Human Services (DHS) and several others to review NAS surveillance data and research and to plan interventions together. TDH has partnered with the PAC, regional perinatal centers, rural hospitals, Tennessee Hospital Association and the Tennessee Initiative for Perinatal Quality Care (TIPQC) to share best practice and information regarding treatment of drug exposed mothers and infants. Local drug coalitions, law enforcement, multiple state agencies and insurance companies have

partnered to fund and promote medication take back sites in all 95 counties. The response to the opioid epidemic has been complex and growing, involving legislative action, law enforcement, regulation education, prevention messaging, and treatment.

Infant mortality reductions efforts have likewise relied extensively on partnerships. For example, DOE, DCS, EMS entities, the medical community, and the judicial system have been critical to maintaining the Child Fatality Review. Local review teams in all judicial districts serve on a volunteer basis and are essential to determining cause of death for infants and children. This data guides the priorities for the upcoming years, and the local review teams serve as bodies to dissemination information to local communities as well. Given the recent rise in the infant mortality rate in the state, the infant mortality strategic plan is currently being revised with the assistance of numerous partners including Tennessee Chapter of the American Academy of Pediatrics (TNAAP), TIPQC, the PAC, academic partners such as Vanderbilt University and Children's Hospital, the Children's Hospital Alliance of Tennessee, the Tennessee Breastfeeding Coalition, federally qualified health centers, MCH directors statewide, and community advocacy groups.

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

### **Leveraging of Federal and Non-Federal Funds**

Aligning Title V funds within the Division of Family Health and Wellness allows for planning across programs to address population health priorities by leveraging both federal and state funds. This occurs for all priority areas. For example, reducing and mitigating the effect of ACEs is a priority area for Tennessee Title V since the most recent needs assessment, and activity around this topic has escalated dramatically over the last 5 years in all areas of the state. Title V state and federal funds have been used to support data collection and dissemination, workforce training of thousands of health department staff, and facilitation of multiple partnership meetings across the state. Assuring supportive infrastructure for families is essential to preventing ACEs, and FHW has an active role in this via WIC food security (federal), family planning (federal Title X, reimbursement, and state and federal MCH), investment in the built environment (state Project Diabetes). Positive youth development is promoted via federal rape prevention education funding, state and federal adolescent pregnancy prevention funding, and state funding for youth tobacco prevention councils in 68 counties. Specific programs in FHW also address social determinants of health, enhance parenting skills, and improve community linkages. These include state Healthy Start and federal MIECHV evidence based home visiting programs and the care coordination programs of HUGS and CSS. TDH also participates in several inter-agency and community partnerships targeting ACEs including the Children's Cabinet's "no wrong door" Single Team Single Plan approach to service coordination, the Three Branches Institute, the Young Child Wellness Council, and the Early Success Coalition via federally funded Project LAUNCH.



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

MCH/Title V federal funds are essential to meet state and local needs in a manner that is intentional, flexible and accountable. States are held accountable for planning and progress in priority areas and must report how both state and federal funds are spent. A needs assessment occurs every five years and is updated annually by review of available data and input of stakeholders. Similarly, the action plan to address the needs with available state and federal resources and a wide range of partners is revised annually. Tennessee has consistently met both maintenance of effort and state funding match requirements of the federal MCH/Title V block grant, ensuring that both funding sources are utilized for MCH needs. The flexibility of the block grant is particularly critical to meet emerging needs when obtaining needed funding from annual appropriation cycles can be significantly delayed. Examples in recent years include the Zika response when MCH funded infrastructure for newborn screening had to be utilized for case management and core MCH programs such as family planning were critical for prevention. Although essential for an initial response, existing funding was not nearly adequate for a complete response and additional federal funds did need to be allocated both for surveillance as well as to build capacity related to birth defects.

### **III.A.3. MCH Success Story**

The U.S. has one of the highest rates of maternal deaths in the developed world. Tennessee has responded by using MCH/Title V block grant resources to develop a process to analyze each pregnancy-related death and make recommendations to prevent future tragedies.

Tennessee's General Assembly demonstrated its commitment to the process by including a position expansion (the review coordinator) and a funding appropriation for the position in its legislation. However, many expenses associated with the review committee were not included, and MCH/Title V Block Grant funding has been critical to fill in these gaps. The flexible nature of the block grant to address this state priority has been necessary to pay for travel for team participation in the review, to build data infrastructure to house data from the review, to analyze data from the review, to provide workforce development and trainings, and to provide quality improvement support for facilities to participate in state and national collaboratives to improve clinical practice and ultimately improve outcomes for women.

Maternal mortality review in Tennessee would not have been possible without MCH/Title V funding. From the beginning, MCH/Title V has assured the infrastructure for statewide partnership and initial data analysis to show the need for the review process. Now that the review process is in place, it could not continue without the ongoing support of MCH/Title V to fill in the gaps where state funding is not available.

### III.B. 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 near the borders to Virginia and North Carolina. Middle Tennessee consists of 39 counties, has the largest land area, and is characterized by rolling hills and fertile stream valleys. Middle Tennessee is the least densely populated of the three Grand Divisions, yet houses Nashville, the state's capitol and largest city. West Tennessee, bordered by the Mississippi River on the west and the Tennessee River on the east, contains 21 counties. 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 2017, the United States Census Bureau estimated Tennessee's population to be the 17<sup>th</sup> largest in the country,<sup>[1]</sup> roughly 6.7 million people (74.2% White non-Hispanic, 17.1% Black or African American non-Hispanic, and 5.2% Hispanic). Tennessee's population grew by 4.8% from 2010 to 2016 (comparable with the national population increase of 4.7%).<sup>[2]</sup> The 2010 census showed that 66.4% of the state's population lived in a metropolitan statistical area and 33.6% in rural areas.<sup>[3]</sup> Nearly one quarter (24.5%) of the population lives in the two most populous metropolitan counties: (Shelby (Memphis) and Davidson (Nashville)).<sup>[4]</sup>

The 2016 American Community Survey reported that 15.8% of the state's population lived below the federal poverty level; this percentage was larger for children under 18 (22.6%) and families with related children under 18 years (22.4%). The highest rates of poverty (50.3%) 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.<sup>[5]</sup>

#### Health Status of Tennessee's MCH Population

In 2017, according to America's Health Rankings, Tennessee ranked 45<sup>th</sup> in the nation for overall health.<sup>[6]</sup> Historically Tennessee has ranked in the bottom ten states for this overall measure. Unfortunately the state ranks poorly on several key MCH population indicators, including:

- Low birthweight (41<sup>st</sup>)
- Children in poverty (42<sup>nd</sup>)
- Infant mortality (38<sup>th</sup>)

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

- Excessive drinking (6<sup>th</sup>)
- High school graduation (9<sup>th</sup>)
- Pertussis case rate (12<sup>th</sup>)

Based on America's Women and Children Report, a sub report of America's Health Rankings Report, Tennessee ranked in the lowest quintile at 43<sup>rd</sup> overall in 2017. When the population is broken down into women, infants, and children, slight improvements are observed. Although infants still rank in the lowest quintile at 47<sup>th</sup>, women and

children saw a slight ranking improvement to the second to lowest quintile at 34<sup>th</sup> and 31<sup>st</sup> respectively.<sup>[7]</sup>

### 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. FHW is responsible for programmatic implementation of core public health services within 95 local health departments (ie. Family planning, breast and cervical cancer screening, Children's Special Services, WIC) in addition to health promotion activities in all 95 county health departments (tobacco prevention, lead prevention and case follow up, etc) as well as management of programs external to the department such as Evidence Based Home Visiting and expanding systems capacity for priorities spanning from perinatal care to diabetes prevention programs.

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 44<sup>th</sup> in Health in the US.<sup>8</sup>

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.” Enhancements unveiled with Primary Prevention 2.0 included: an annual primary prevention plan for local health departments and 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.

Components of the State's Systems of Care for Underserved and Vulnerable Populations

As of May 2018, Tennessee has 14 Critical Access Hospitals designated to preserve access to local primary and emergency health services. This is down from 16 in May 2016. 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 2018, 91 counties are federally designated as either whole or partial-county Health Professional Shortage Areas (HPSAs) for Primary Care (based on either the low-income population or geography). This is up from 89 counties in May 2017. All but two of the state’s 95 counties are designated as federal Dental HPSAs and all but five counties are designated as federal Mental Health HPSAs. Seventy of the state’s 95 counties are designated as either whole or partial-county Medically Underserved Areas (MUA). This is down from 94 counties in 2016. TDH facilitates state funding for Federally Qualified Health Centers as well as Faith and Charitable Care Centers as has strong relationships with both the Tennessee Primacy Care Association (FQHCs) and Tennessee Charitable Care Network (faith based clinics) which has facilitated grants and population health planning among the entities.

The distribution of primary care providers varies across the state. A map with health resource shortage areas for obstetrics and pediatrics can be found in the supporting documents section. As of May 2018, the following counts of full-time or part-time, actively licensed providers were available through the TDH Division of Health Licensure and Regulation<sup>[8]</sup>:

<b>Specialty</b>	<b>Midlevel Provider</b>	<b>Physicians</b>
General Practice	246	445
Obstetrics	258	441
Family Medicine	1431	1975
Pediatrics	432	661

There are 66 birthing hospitals and centers in Tennessee (hospitals/centers with >50 deliveries/year). This is down from 68 in 2016.<sup>[9]</sup> There are five regional perinatal centers, and TDH works closely with these networks of hospitals to implement measures to assure care and delivery at the appropriate level of care.

TDH works closely with TennCare, the state's Medicaid agency. TennCare provides health care for approximately 1.4

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

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

### State Statutes and Other Regulations Impacting MCH/Title V

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

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

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

- <sup>[1]</sup> U.S. Census Bureau, American Fact Finder. <https://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml>
- <sup>[2]</sup> U.S. Census Bureau, Quick Facts. <https://www.census.gov/quickfacts/table/PST045216/47,00>
- <sup>[3]</sup> 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
- <sup>[4]</sup> U.S. Census Bureau, QuickFacts. TN. 2014V estimates
- <sup>[5]</sup> U.S. Census Bureau, 2016 American Community Survey 2015 TN. Selected Economic Characteristics
- <sup>[6]</sup> America' Health Rankings. <http://www.americashealthrankings.org/explore/2016-annual-report/measure/Overall/state/TN>
- <sup>[7]</sup> America's Health Rankings. [http://www.americashealthrankings.org/explore/2016-health-of-women-and-children-report/measure/overall\\_mch/state/TN](http://www.americashealthrankings.org/explore/2016-health-of-women-and-children-report/measure/overall_mch/state/TN)
- <sup>[8]</sup> Tennessee Department of Health. Division of Health Disparities. Healthcare Provider Census.
- <sup>[9]</sup> Tennessee Department of Health, Division of Policy, Planning, and Assessment, Office of Health Statistics. Birth Statistical System, 2013-2017 Nashville, TN

### **III.C. Needs Assessment**

#### **FY 2019 Application/FY 2017 Annual Report Update**

##### Introduction

This application year (FY2019) is the fourth 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.

##### **Ongoing Needs Assessment Activities**

The Tennessee MCH/Title V Program has multiple mechanisms for continually assessing health needs and system capacity. The main 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 and anyone is welcome to join at any time. Special effort is made to invite those who serve the MCH population, as well as parents (including parent of CYSHCN, foster parents, and grandparents) and youth. During the meeting, the group reviews progress on the NOMs, NPMs, SPMs and ESMs. At the fall meeting, a progress report on the past year is presented. The stakeholders use this report to identify opportunities to partner together, in order to meet the goals set for the current year. At the spring meeting, a draft action plan is presented for the coming year. Stakeholders review the draft and suggest improvements to the plan. After the meeting the priority teams make edits to the plan based on the stakeholders' feedback.

The Tennessee MCHB Grantees group was formed after the August 2015 federal/state MCH/Title V Program review when staff identified the need to intentionally connect 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 the maternal and child population's needs are supported. 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. Regular meetings are also held with other state and local agencies, advocacy groups, professional organizations, health services delivery professionals, and other partners to share data and gather input on current activities. 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.

##### **Changes in Health Status and Needs**

The information below is based on the National Outcome and Performance Measures for this grant, which is established in the federal grant guidance. For each measure the change in trend was evaluated for statistical significance. Below are the details of that analysis. To see the actual numbers reported for each measure refer to Form 10a National Outcome Measures (NOMs) and Form 10a National Performance Measures (NPMs).

### Women's/Maternal Health

Over the past several years, teen births as well as pregnancy smoking have been decreasing in Tennessee. However, fewer women are attending preventive care visits and the rate of severe maternal morbidity continues to worsen. No change was observed in infants being born with fetal alcohol exposure or women experiencing postpartum depressive symptoms.

### Perinatal/Infant Health

Out of all the health domains, perinatal and infant health has seen the most improvement over the past few years among the measures being tracked. Tennessee has seen improvements in infants sleeping on their backs, pregnant women receiving early prenatal care and a decrease in early term births. There has also been a decrease in infant mortality rates, including: neonatal, post neonatal mortality, and pre-term related mortality. Although there have been many improvements, there has been no change in low birth weight, preterm birth, perinatal mortality, and sleep-related sudden unexplained infant death (SUID).

### Child Health

Many of the measures for this domain come from the National Survey of Child Health. This survey was recently revised and therefore many of the measures for this domain have new baselines. Therefore, for this submission year only a few measures could be evaluated. There were two measures that showed improvement: hospitalization for non-fatal injury and insurance coverage for children. There was no change in child mortality.

### Adolescent Health

Similarly to the child health domain, Tennessee has seen an improvement in the adolescent rate of hospitalization for non-fatal injuries, and no change in adolescent mortality. However, the percent of adolescents who are obese continues to rise.

### Children and Youth with Special Healthcare Needs (CYSHCN)

All of the measures for this domain have new baselines; therefore not trends were able to be evaluated.

### **Changes in MCH/Title V Program Capacity**

In 2017 there have been several expansions to capacity. First, the Comprehensive Cancer Screening program has been moved to the FHW division. This program sits within the Chronic Disease Prevention and Health Promotion section within FHW. The reorganization makes it easier for the Comprehensive Cancer Screening program to connect with the programs in the Chronic Disease Prevention and Health Promotion section. Having this program located in the division also makes for natural collaborate with the Reproductive and Women's Health program (which includes the Breast and Cervical Cancer Screening program). Secondly, three new epidemiology positions have been created and filled. These include an additional Reproductive and Women's Health epidemiologist funded

through the Abstinence Education grant, an epidemiologist for the newly formed Child Health Access and Navigation in Tennessee (CHANT) program which is described further below, and the addition of a CDC MCH Epidemiology Assignee.

Over the last two years, TDH has been in the planning process to streamline three programs which have a significant redundancy among them and with TennCare MCO services. The newly formed Community Health Access and Navigation in Tennessee (CHANT) program is a combination of three existing programs: CSS, HUGS, and the TENNderCare outreach program to TennCare and TennCare eligible children and families. The need for program integration was recognized first by local teams, who have been instrumental in the development of CHANT. This re-organization has provided a significant opportunity to address social determinants of health in a standardized manner via a screening and assessment tool that triggers individual pathways modeled after the Agency for Healthcare Research and Quality's Pathways Community HUB Model. The newly formed program will provide outreach to at risk families and care coordination/navigation via the pathways model while continuing to provide funding as a payor of last resort for income qualifying families of children with special healthcare needs. CHANT is scheduled to pilot in two counties during the summer of 2018 with full roll out across the state to follow.

In 2016, TDH finalized a partnership with the Public Health Information Access Project through the National Library of Medicine (NLM). TDH staff now has full-text access to over 240 peer-reviewed journals (including MCH-related journals). Additionally, a partnership with East Tennessee State University facilitates 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.

### **Partnerships and Collaborations**

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.

Since the end of D70 funding, a CYSHSN staff person dedicated Family/Youth Engagement and Involvement has been hired whose primary responsibility is to work with Family Voices to ensure opportunities for family and youth training on patient centered medical homes, transition and policy/advocacy. Title V funds have also been used to expand the division contract with family voices to provide consultation and training for all programs within FHW. In addition, several programs continue to expand their own advisory and family groups to better inform programs and services, including recruitment of regular parent participants in the Perinatal Advisory Committee and Genetics Advisory Committee. Likewise, in the comprehensive redesign of the CSS, HUGS, and Community Outreach programs into the streamlined Community Health Access and Navigation in Tennessee (CHANT) program has incorporated family engagement in the design process to assure that the needs of children and families are being met appropriately.

### **Operationalization of Five-Year Needs Assessment Process and Findings**

The MCH/Title V Program operationalizes the Needs Assessment (both Five-Year and Ongoing) in two main ways: priority setting and priority monitoring. Both assessments include the review of quantitative, qualitative, and program capacity data. The core objective of the Five-Year Needs Assessment is to identify priorities. The Ongoing Needs Assessment complements this by monitoring changes in health needs that may warrant additional priorities, as well

as how effective the action plan activities are on improving health. By monitoring progress, the program is able to identify which activities are most effective and which are not. Based on this information the activities are continued, retired, or replaced. Both the Five-Year and Ongoing Needs Assessment are critical to the effectiveness of this program.

### **Organizational Structure and Leadership Changes**

In 2018 one of the divisions within the Department of Health was reorganized. The former Division of Policy Planning and Assessment has been reorganized into two divisions: Division of Vital Records and Statistics, and Division of Population Health Assessment. FHW worked closely with PPA for data access to programs such as PRAMS, BRFSS etc. FHW will continue to collaborate with both newly formed divisions under the new structure.

### **Emerging Public Health Issues**

Several critical public health issues have gained even more importance to the MCH community during the reporting year.

Overdoses as a piece of the opioid epidemic have continued to climb in Tennessee, and NAS continues to increase but at a much slower rate since 2013. TDH has established a strong data and informatics infrastructure, which has been critical to provide communities and stakeholders with information and monitor multiple aspects of the epidemic. FHW has engaged across the department in prevention activities and partners with agencies and coalitions related to both the broader public health crisis as well as needs specific to the MCH population. TDH has continued to look for opportunities to promote primary prevention – from the growing investment in ACEs prevention as an upstream means to prevent addiction to the prevention of unintended pregnancy as a means to prevent neonatal abstinence syndrome. Both of these MCH specific priorities in particular have been expanded in recent years. As previously described, the language of ACEs has been thoughtfully articulated in a coordinated way across the state, resulting in an increase in state appropriation for both ACEs prevention grants in multiple sectors as well as dedicated funding for home visiting as a proven mitigation approach. Healthy spacing of pregnancy is an evidence based strategy for decreasing infant mortality and maternal morbidity, and the reach of services has expanded beyond the health department to a statewide initiative to expand access to family planning services in a client centered approach. This has included the pursuit of new partnerships with providers of medication assisted therapy, working with the state legislature to offer comprehensive, culturally appropriate and client centered contraception information with the prescription of opioids, and working with birth facilities via THA and TIPQC to offer all methods of postpartum contraception including postpartum long acting reversible contraception.

In the priority areas of infant mortality and maternal mortality reduction, racial disparities are striking and are an emerging public health issue in Tennessee. The infant mortality rate for black children has persistently been at least twice the rate of white infants for the past five years. Although the rate of maternal deaths in black mothers declined from 155.6 (2015) to 103.9 (2016) per 100,000, it still far exceeds the relatively stable rate of 90.1 per 100,000 (2016) for white mothers. These are two examples driving a comprehensive examination of FHW programs in the context of health equity. The Division has drawn from multiple examples nationwide, from across the department, and from external partners with the goal of developing an AIM statement and framework for examining and addressing health disparities across all program areas during this report year, This will include routine examination of disparities MCH related data, a means of examining key processes, prioritization of training needs, and a plan for internal and external engagement going forward.



## **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 prior~~ 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; 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 CYSHCN.

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.

## **FY 2017 Application/FY 2015 Annual Report Update**

### 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

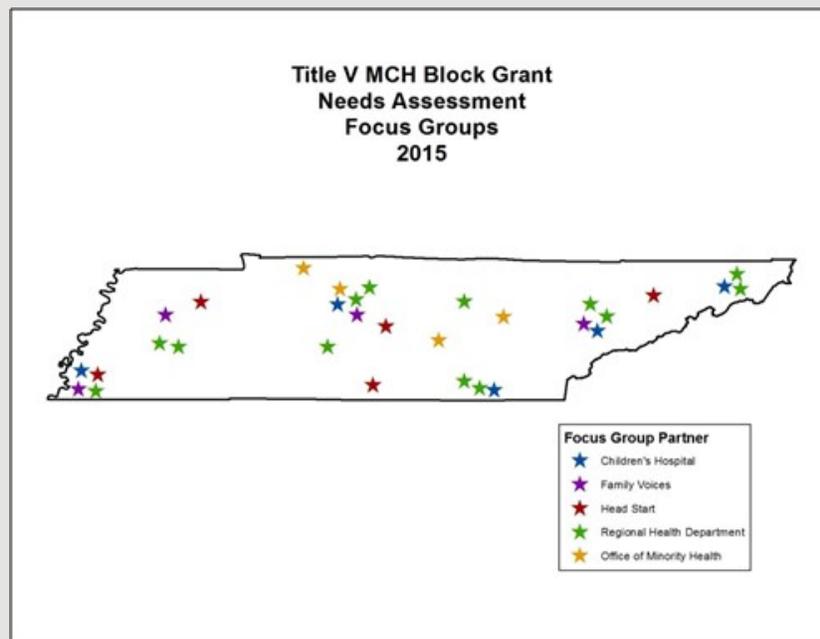
The Epidemiology Team divided the quantitative indicator list (based on prior program knowledge or interest). Epidemiologists identified a data source for each indicator and gathered data for the most recent years available (the goal was to have at least five data points per indicator to allow for trend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

### III.D. Financial Narrative

	2015		2016	
	Budgeted	Expended	Budgeted	Expended
<b>Federal Allocation</b>	\$11,562,887	\$12,908,500	\$11,709,246	\$14,204,467
<b>State Funds</b>	\$14,200,000	\$29,957,475	\$30,000,000	\$34,700,768
<b>Local Funds</b>	\$0	\$0	\$0	\$0
<b>Other Funds</b>	\$0	\$0	\$0	\$0
<b>Program Funds</b>	\$3,350,000	\$4,392,222	\$4,200,000	\$5,670,305
<b>SubTotal</b>	\$29,112,887	\$47,258,197	\$45,909,246	\$54,575,540
<b>Other Federal Funds</b>	\$147,748,378	\$140,407,856	\$149,414,701	\$137,880,577
<b>Total</b>	\$176,861,265	\$187,666,053	\$195,323,947	\$192,456,117

	2017		2018	
	Budgeted	Expended	Budgeted	Expended
<b>Federal Allocation</b>	\$11,749,682	\$11,714,889	\$12,749,682	
<b>State Funds</b>	\$30,000,000	\$32,875,484	\$30,000,000	
<b>Local Funds</b>	\$0	\$0	\$0	
<b>Other Funds</b>	\$0	\$0	\$0	
<b>Program Funds</b>	\$4,400,000	\$2,647,702	\$4,400,000	
<b>SubTotal</b>	\$46,149,682	\$47,238,075	\$47,149,682	
<b>Other Federal Funds</b>	\$163,167,051	\$143,415,868	\$158,886,385	
<b>Total</b>	\$209,316,733	\$190,653,943	\$206,036,067	

	2019	
	Budgeted	Expended
<b>Federal Allocation</b>	\$12,750,000	
<b>State Funds</b>	\$32,000,000	
<b>Local Funds</b>	\$0	
<b>Other Funds</b>	\$0	
<b>Program Funds</b>	\$2,881,646	
<b>SubTotal</b>	\$47,631,646	
<b>Other Federal Funds</b>	\$174,823,962	
<b>Total</b>	\$222,455,608	

### III.D.1. 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 provide site visits and program monitoring at contract agencies in order to assure compliance with the contract's scope of services. Fiscal monitoring of contract agencies is the responsibility of the Department of Health's Internal Audit staff.

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

The Tennessee MCH/Title V Program met all legislative requirements in regards to the spending of grant funds. This includes a maintenance of effort in the amount of \$13,125,024 set by the state in 1989. This figure is based on the amount the state was spending on maternal and child health programs in 1989. The state is required to continue to contribute at least that amount to maternal and child health programs in order to receive this federal grant. The state exceeded that amount in FY2017. The state is also required to match the federal dollars 3 to 4. For every 4 federal dollars the state receives they must contribute 3 dollars. For FY2017 Tennessee received \$11,714,889 federal dollars, therefore the required state match amount was \$8,768,167. The state exceeded that match amount in FY2017. The last requirement is that states spend at least 30% of federal grant funds on preventive and primary care for children, 30% on children with special health care needs, and no more than 10% on administrative cost. Tennessee met all of these thresholds during FY2017. It also should be noted that none of the services paid by the grant were reimbursable by other agencies (namely Medicaid) or providers. This is assured through eligibility determination processes for programs such as CSS as well as regular communication with TennCare regarding the reimbursement services of the MCOs. There has been active engagement of TennCare as it has expanded services such as Baby and Me Tobacco Free voucher incentive program and the payment models for immediate postpartum contraception. These services were not routinely paid for with MCH/Title V in the past although MCH/Title V has seen these as priority strategies for the benefit of targeted populations.

During FY2017 MCH/MCH/Title V Block Grant federal dollars supported programs across the health domains as illustrated below. Some of the programs span multiple domains, and therefore are repeated among the domains. Many of these programs such as breast and cervical cancer screening, family planning, and evidence based home visiting also have state funding allocations.

#### Women and Maternal Health

- Breast and Cervical Cancer Screening Program
- Family Planning Program
- Women's Health Services (local health department)

#### Perinatal and Infant Health

- Lead Poisoning Prevention Program

- Child Fatality Review and Prevention Program
- Genetic Centers
- Newborn Screening Follow Up

#### Child Health

- Child Fatality Review and Prevention Program
- Health Start (Tennessee program, not federal Healthy Start)
- Maternal, Infant, and Early Childhood Home Visiting Program
- Child Health and Development Program
- Child Health Services (local health department)

#### Adolescent Health

- Adolescent Pregnancy Prevention
- Positive Youth Development Programming (Rape Prevention Education, Tobacco prevention, Suicide and Injury Prevention, Obesity Prevention)

#### Children and Youth with Special Health Care Needs

- Children's Special Services (Tennessee's MCH/Title V CSHCN Program)
- Lead Poisoning Prevention Program
- Genetic Centers
- Newborn Screening Follow Up

There was a discrepancy of more than 10% between what was budgeted and what was expended for Children with Special Health Care Needs and as Program Income on Form 2. This was due to a difference in the budgeted and actual federal allocation. The actual allocation was slightly less, so adjustments had to be made to the spending. Spending particularly for direct services is driven by needs in the local health departments.

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

### III.D.2. 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. TDH monitors its MOE annually and has exceeded requirements in all reporting years.

Tennessee fully utilizes Maternal and Child Health Block Grant funding within the 24 month allowable timeframe and meets all targeted maintenance and match requirements set forth in the 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 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.

Budgeting and planning takes into account emerging priorities and public input to the degree to which funds allow. For example, the development of a maternal mortality review process has required both state and federal MCH block grant funding, and that investment need is expected to increase in the coming fiscal year. Likewise, both qualitative and

quantitative measures have demonstrated a need to more comprehensively address social determinants of health for women, children and the CYSHCN population. This has led to the development of the CHANT approach to streamline three programs for the MCH population to standardize a population level approach to identifying individual needs enabling families to meet them in order to improve health outcomes. The CYSHCN population and CSS program will continue to be a focus of CHANT. Part of the universal assessment for all referrals to CHANT will include developmental screening. Those with identified health needs will continue to receive services of care coordination as well as payor of last resort. Meanwhile, local health departments provide direct services for the priority MCH populations, which has continued to be a significant proportion of both state and federal MCH funding allocation.

The Tennessee MCH/Title V Program is not proposing major changes to the reported budget for this year. The budget will mirror that of the FY2017 expenditures. However, how these funds are expended within each line item may change depending on emerging needs and the evolution of CHANT for the CYSHCN and larger MCH population. This budget aligns with Tennessee's priorities for the grant. Federal dollars are used to extend the reach of state dollars. The federal allocation allows Tennessee to serve more of the maternal and child health population.

The MCH/Title V director leverages other federal dollars from the programs listed below which are under the director's control. There are a few changes to the list: the State Public Health Actions to Prevent and Control Diabetes, Heart Disease, Obesity and Associated Risk Factors and Promote School Health (1305-grant), Pregnancy Assistance Funds, and Integrated Care Systems for CSHCN have been removed. Added to the list for FY2019 is:

#### Other Federal Programs

- Abstinence Education Grant
- Breast and Cervical Cancer Screening Grant
- Childhood Lead Poisoning Prevention
- Injury Surveillance and Prevention
- Family Planning (Title X)
- Maternal, Infant, Early Childhood Home Visiting Program
- Preventive Health Services Block Grant
- Project LAUNCH (ending in August 2018)
- Rape Prevention and Education
- State Systems Development Initiative
- Sudden Death in the Young Registry
- Tobacco Quitline
- Tobacco Use Prevention and Control
- Traumatic Brain Injury
- Universal Newborn Hearing
- Women, Infants, and Children

The required state match and maintenance of effort is monitored throughout the year by the Division of Administrative Services. All programs of the TDH must be free from discrimination. The Department's non-discrimination policy for 2018-2019 is below.

#### TDH Non-Discrimination Statement:

Title VI of the Civil Rights Act of 1964 requires that federally assisted programs be free of discrimination. In accordance with Federal civil rights laws, the Tennessee Department of Health does not tolerate harassment and discrimination based upon any protected class including race, color, national origin, sex, age, disability or reprisal or

retaliation, in any program or activity conducted or funded by TDH. Such harassment and discrimination constitutes misconduct which undermines the integrity of the employment relationship and is subject to disciplinary action, up to and including dismissal.

### **III.E. Five-Year State Action Plan**

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

**State: Tennessee**

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

[State Action Plan Table - Entry View](#)

[State Action Plan Table - Legal Size Paper View](#)

### **III.E.2. State Action Plan Narrative Overview**

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

##### **Partnership and Leadership Roles in Accomplishing the Grant's Goals and Mission**

The purpose of the MCH/Title V Program is to broadly support and improve the health of the maternal and child population in Tennessee. This is done by identifying priority needs and working with partners to leverage program capacity to meet those needs, which ultimately improves health outcomes for mothers, children, and families across the state. Tennessee's MCH/Title V Program works to convene MCH stakeholders so that all programs serving this population can be strategically aligned statewide through collaboration and partnership. This strategic alignment is imperative in order to assure greatest impact.

##### **Framework and Approach to Addressing the MCH Priorities**

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

Population Health Domains:

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

Using quantitative and qualitative information from its five year needs assessment process, Tennessee identified nine priority areas for the 2016-2020 Block Grant Cycle:

- 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 (ACEs).
- Increase the number of children (both with and without special health care needs) who have a medical home.
- Increase the number of children (with and without special health care needs) who receive services necessary to make transitions to adult health care.
- Reduce exposure to tobacco among the MCH population (pregnancy smoking and secondhand smoke exposure for children).

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

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

Title V-funded MCH and CSHCN staff work 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 twelve epidemiologists to FHW (including five doctoral-level epidemiologists). The epidemiologists provide broad support for data analysis and program evaluation across the Division and specialized support in program areas such as home visiting, chronic disease prevention and health promotion, injury prevention and detection, reproductive and women's health, newborn screening, childhood lead poisoning prevention, and children and youth with special healthcare needs. 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 matched a CDC MCH Epi Assignee in December of 2017 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 were developed. During 2017, four separate training opportunities were offered in each region of the state to minimize travel and time out of the office.

The first opportunity was the Poverty Workshop. This was offered to give attendees a better understanding of the struggles faced by many of the individuals TDH programs serve and offers an actual simulation of different experiences faced by those in poverty. The next opportunity was "Relationship Based Practice." This training opportunity was 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 introduced key skills including reflective supervision and motivational interviewing. The third training opportunity was 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 was "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 focused on ways to address tobacco use with families while maintaining good rapport. In addition, attendees were given several strategies for engaging the family in activities that promote bonding while reducing stress in an attempt to reduce cravings and were 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. Training topics for 2018 include reproductive life plan, implicit bias, and implementation of the Talk with Me Baby language nutrition program.

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. Over half of all TDH staff have been trained in the ACEs standardized curriculum. Knowledge dissemination is the first step in ensuring that all health department services are ACEs informed. Over the next few years, the Department of Health will continue to expand our understanding of ACEs and further explore how we can ensure that ACEs are considered as we make program, policy, and procedure decisions.

FHW staff are also encouraged to take advantage of external workforce development activities. All FHW central office staff are now required to complete at least 3 professional development activities over the course of their annual performance review. Academic partnerships with ETSU and CDC/Harvard School of Public Health have facilitated two evaluation skill building workshops. All central office FHW staff have participated in ACEs training and health disparities training. Some staff participates in LEAD Tennessee, a statewide, 12-month development initiative which includes six one-day summits of intense, personally tailored, high impact learning focused on twelve core leadership competencies. The goal of LEAD Tennessee is to increase the state's leadership bench strength by providing agencies with a continuous pipeline of motivated and prepared leaders that share a common language and mindset about great leadership. Jacqueline Johnson, state CYSHCN Director, participated in the AMCHP Leadership Institute for CYSHCN Directors. This program promotes valuable components for both new and experienced directors. Ms. Johnson also participated in the health equity institute offered by the University of Washington.

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

promotion.

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 overview of health equity approaches in all fifty states
- Literature synthesis for statewide provider, payer, and advocate groups which have developed to address the recurrent prematurity prevention initiatives of 17-OHP utilization and access to immediate post-partum long-acting contraception
- Educational materials on preventing unintended pregnancy for adolescents and adolescent health care providers
- Development of "one key question" outreach to providers encouraging them to act to reduce unintended pregnancy
- Mapping of tobacco retailers in relation to school and engaging youth in tobacco prevention activities
- Focus groups to gain understanding of decision making of minority fathers regarding breastfeeding initiation

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

FHW recognizes the vital nature of parental involvement throughout our division in program development, implementation, and evaluation. The Division has a longstanding collaborative relationship with 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. Tori Goddard is the current Family Delegate and attended AMCHP in 2018 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.

FHW is currently contracting with Family Voices to ensure continuous support in program and policy development and has recently begun the process of hiring a full time youth advisory coordinator. With the added funding, Family Voices will also be able to hire two Parent-2-Parent resource mentors and provide training for newly diagnosed families. The contract will also allow the Division of FHW to expand its capacity to receive feedback and family engagement and involvement on many activities including recruitment, retaining, and evaluating the Youth Advisory Committee, promoting outreach and training to families of CYSHN. This collaborative effort provided for an increase in the number of individuals receiving training and educational material during FY 2017. There were 615 professionals trained and 558 families on comprehensive patient-centered medical home aspects, youth transition and increasing family and youth advisory committees in medical homes.

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

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

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

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

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

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

- Women, Infants, and Children (WIC)
- Newborn Bloodspot Screening
- Newborn Hearing Screening.
- Tobacco Quitline
- Neonatal Abstinence Syndrome

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

By ensuring access to MCH data, FHW epidemiologists are able to analyze and present information so that programs can then use it to make informed decisions. The data collection and analysis that is completed by FHW epidemiologists first and foremost informs program planning. However, it is also used to monitor program effectiveness by measuring process and outcome measures. It is also often used to assess the health status for a certain groups prior to program development and to inform stakeholders of key health indicators. For example, access to MCH data allows for assessment, program development, and progress monitoring of the MCH Block grant Action Plan. The needs assessment at the beginning of the grant cycle informs the selection of priorities and then action plan development, while the ongoing assessment monitors for changes in health status which feeds back into action plan revision. This data is presented routinely to external groups including the bi-annual public MCH stakeholder meetings.

The SSDI grant also supports key MCH data priority needs. For example, a TDH MCH Data Book is in the process of development. This will include key MCH indicators for the state of Tennessee broken down by a various stratifiers such as geography, race/ethnicity etc. The book would be produced annually and shared publicly. The SSDI

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

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

#### Health Care Delivery System

##### TennCare

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

TennCare services are offered through managed care entities. Medical, behavioral and Long-Term Services and Supports are covered by "at-risk" Managed Care Organizations (MCOs). All of TennCare's MCOs 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.

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), Cigna (private insurance), Aetna (private insurance) Oscar Health Plan (ACA marketplace), Medicare (flu/pneumonia credentialed in all county health departments and all Federally Qualified Health Centers are credentialed part A providers), and Blue Cross Blue Shield (ACA marketplace and private insurance). Contract discussions are pending with Aetna private insurance.

In 2017, TDH has also partnered with the TennCare MCOs to set up an electronic portal for referral of pregnant women who smoke to connect them with cessation counseling and incentives which are billable services reimbursed by the MCOs. TDH was able to prove efficacy of this model with state tobacco prevention funds and then partner with the MCOs to sustain this important public health intervention as a billable service. This has been a significant achievement for TDH, TennCare, and the MCOs.

Over the past five years, the Department has greatly expanded its ability to bill third party insurance by negotiating contracts with carriers. Nonetheless, the state has been significantly impacted by increasing premiums in the federally-run health insurance marketplace. There are three marketplace plans in the state, and increasingly only one plan is offered in any given area. One of the plans announced that it will withdraw market coverage in 2018, and most 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. TennCare representatives routinely participate in the Perinatal Advisory Committee to discuss issues such as delivery at appropriate levels of care, implementation of the LOCATe tool, NAS management, and back transport policies.

TennCare, TDH, and the MCOs also meet at least quarterly with the Tennessee Chapter of the American Academy of Pediatrics to coordinate efforts around EPSDT, immunizations, PCMH, and emerging population health priorities. In addition, the MCH/Title V director meets regularly with TennCare in context such as the NAS subcabinet, TIPQC, and on an ad hoc basis. TennCare has intentionally included input from TDH and the MCH/Title V Program regarding the implementation of its episodes of care model for payment reform. TennCare funding also supports TDH outreach efforts and partially supports the HUGS care coordination services, and TDH has worked extensively with TennCare and the MCOs to align service delivery via CHANT. The agencies collaborate on multiple other MCH related efforts such as lead screening and EPSDT outreach. Over the last reporting year, there has been ongoing joint action to minimize barriers to contraception and particularly voluntary long acting reversible contraception in the immediate post-partum period, co-authorship of the legislatively mandated diabetes report, and co-authorship of a 2017 legislatively mandated report on neonatal abstinence syndrome.

### **TDH Efforts for Outreach and Enrollment**

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

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

Clinical Application Coordinators (CACs) are also available in 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 were positive and TDH county/regional staff has 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. In August 2017, at the sunset of Enroll America, TDH engaged Tennessee Health Campaign (THCC), which adopted Enroll America's best practices and tools for outreach and enrollment. THCC has continued to provide comment cards and boxes to local health departments to support enrollment assistance efforts.

In 2017 (CY), TDH assisted 17,053 pregnant women with presumptive eligibility enrollment assistance and 15,155 pregnant women with Medicaid and CoverKids enrollment assistance. TDH conducts routine training with local staff on changes in the Medicaid enrollment process to ensure that eligible persons can be served.

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

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

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

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

*Family Planning:* MCH/Title V funding augments federal Title X funding, state appropriations, and patient billing collections. In CY2017, 77% of individuals served through the program were at or below 100% of the federal poverty level and 96% 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 8.4% (70,114) of TennCare EPSDT visits in the state in FFY 2017. TennCare, TDH, and the MCOs share data to outreach to target counties to increase adherence to the AAP periodicity schedule. TDH is enhancing efforts to connect EPSDT visits to the medical home via CHANT pathways.

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

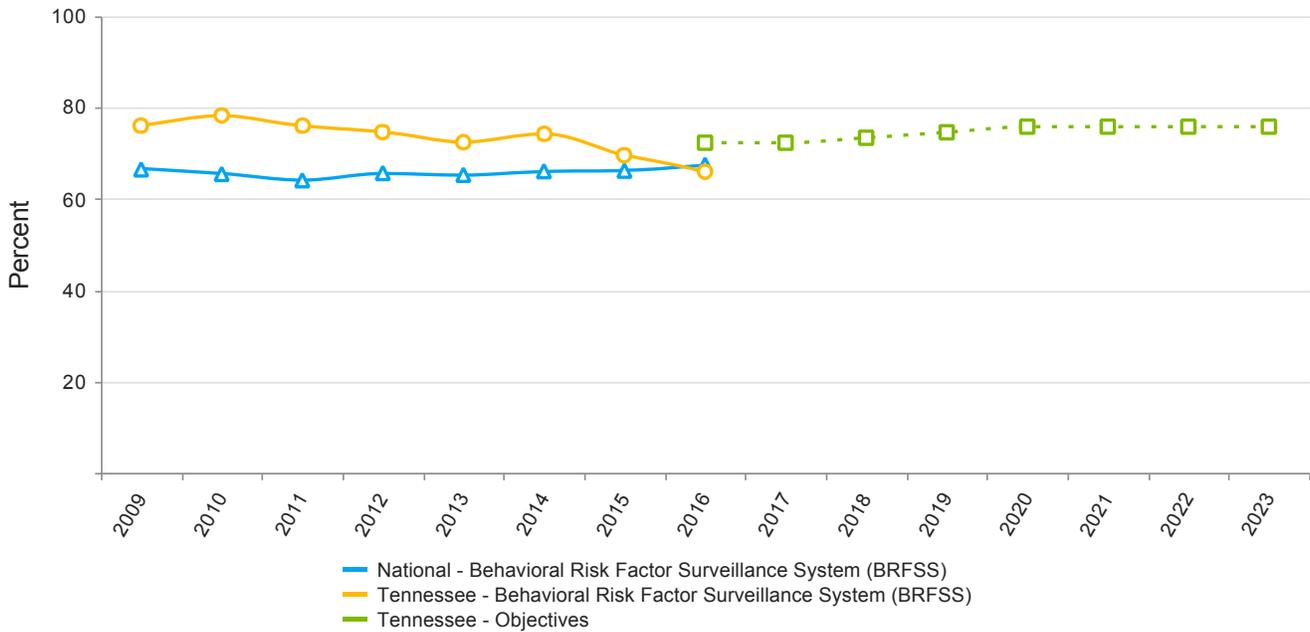
#### **Women/Maternal Health**

#### **Linked National Outcome Measures**

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations	SID-2015	166.7	NPM 1 NPM 14.1
NOM 3 - Maternal mortality rate per 100,000 live births	NVSS-2012_2016	26.7	NPM 1 NPM 14.1
NOM 4 - Percent of low birth weight deliveries (<2,500 grams)	NVSS-2016	9.3 %	NPM 1 NPM 14.1
NOM 5 - Percent of preterm births (<37 weeks)	NVSS-2016	11.3 %	NPM 1 NPM 14.1
NOM 6 - Percent of early term births (37, 38 weeks)	NVSS-2016	27.2 %	NPM 1 NPM 14.1
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2015	6.4	NPM 1 NPM 14.1
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2015	7.0	NPM 1 NPM 14.1
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2015	4.1	NPM 1 NPM 14.1
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2015	2.9	NPM 1 NPM 14.1
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2015	189.8	NPM 1 NPM 14.1
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2015	153.0	NPM 14.1
NOM 10 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy	PRAMS-2015	5.5 %	NPM 1
NOM 11 - The rate of infants born with neonatal abstinence syndrome per 1,000 hospital births	SID-2015	16.9	NPM 1
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2016	89.2 %	NPM 14.1
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2016	28.0	NPM 1
NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth	PRAMS-2015	15.4 %	NPM 1

**National Performance Measures**

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



**Federally Available Data**

**Data Source: Behavioral Risk Factor Surveillance System (BRFSS)**

	2016	2017
Annual Objective	72.2	72.2
Annual Indicator	69.6	66.0
Numerator	794,110	760,359
Denominator	1,140,291	1,152,528
Data Source	BRFSS	BRFSS
Data Source Year	2015	2016

**Annual Objectives**

	2018	2019	2020	2021	2022	2023
Annual Objective	73.3	74.5	75.7	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**

<b>Measure Status:</b>	<b>Active</b>
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<b>State Provided Data</b>		
	<b>2016</b>	<b>2017</b>
Annual Objective		
Annual Indicator	6	46
Numerator		
Denominator		
Data Source	TDH FHW Womens Health Section Program Data	TDH FHW Womens Health Section Program Data
Data Source Year	FFY2016	FFY2017
Provisional or Final ?	Final	Final

<b>Annual Objectives</b>						
	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>2023</b>
Annual Objective	9.0	20.0	20.0	20.0	20.0	20.0

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

<b>Measure Status:</b>	<b>Active</b>
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<b>State Provided Data</b>		
	<b>2016</b>	<b>2017</b>
Annual Objective		
Annual Indicator	0	7
Numerator		
Denominator		
Data Source	TDH FHW Womens Health Section Program Data	TDH FHW Womens Health Section Program Data
Data Source Year	FFY2016	FFY2017
Provisional or Final ?	Final	Final

<b>Annual Objectives</b>						
	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>2023</b>
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**

<b>Measure Status:</b>	<b>Active</b>
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<b>State Provided Data</b>		
	<b>2016</b>	<b>2017</b>
Annual Objective		4
Annual Indicator	0	2
Numerator		
Denominator		
Data Source	TDH FHW Womens Health Section Program Data	TDH FHW Womens Health Section Program Data
Data Source Year	FFY2016	FFY2017
Provisional or Final ?	Final	Final

<b>Annual Objectives</b>						
	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>2023</b>
Annual Objective	4.0	2.0	2.0	2.0	2.0	2.0

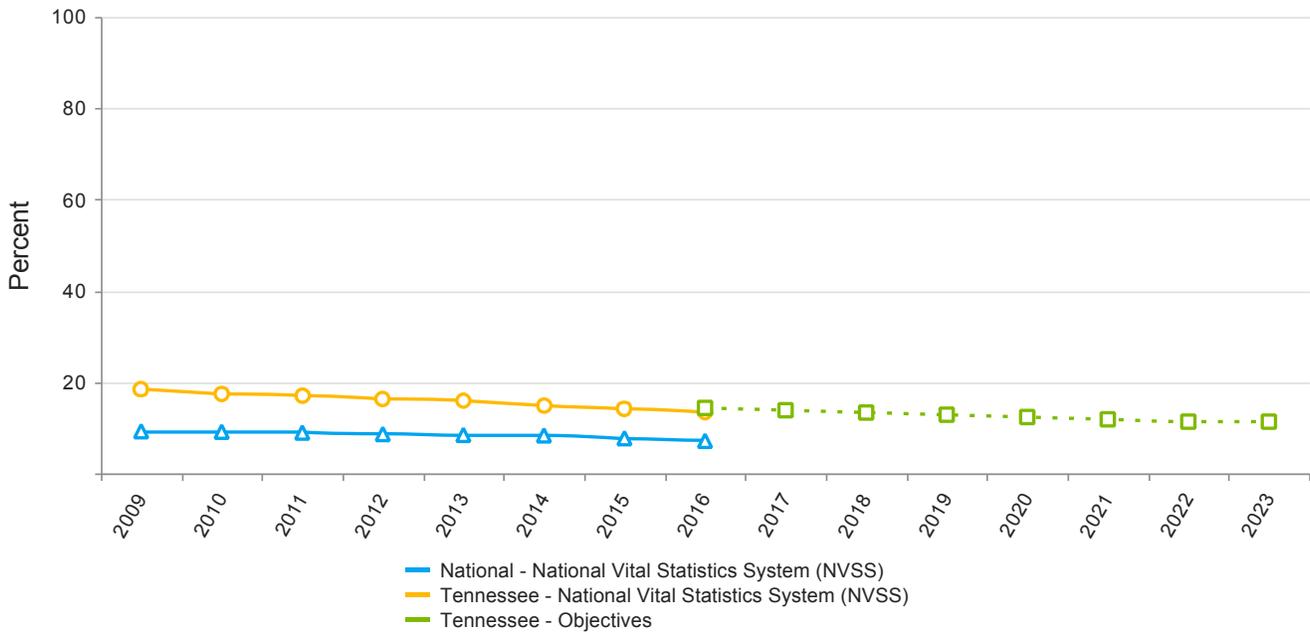
**ESM 1.4 - Number of region-level pregnancy-related service utilization reports distributed to regional health departments**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>		
	<b>2016</b>	<b>2017</b>
Annual Objective		4
Annual Indicator	4	4
Numerator		
Denominator		
Data Source	TDH FHW Womens Health Section Program Data	TDH FHW Womens Health Section Program Data
Data Source Year	FFY2016	FFY2017
Provisional or Final ?	Final	Final

<b>Annual Objectives</b>						
	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>2023</b>
Annual Objective	4.0	2.0	2.0	2.0	2.0	2.0

**NPM 14.1 - Percent of women who smoke during pregnancy  
Baseline Indicators and Annual Objectives**



**Federally Available Data**

**Data Source: National Vital Statistics System (NVSS)**

	2016	2017
Annual Objective	14.4	13.9
Annual Indicator	14.3	13.4
Numerator	11,577	10,771
Denominator	80,953	80,306
Data Source	NVSS	NVSS
Data Source Year	2015	2016

**Annual Objectives**

	2018	2019	2020	2021	2022	2023
Annual Objective	13.4	12.9	12.4	11.9	11.4	11.4

**Evidence-Based or –Informed Strategy Measures**

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

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>	
	<b>2017</b>
Annual Objective	
Annual Indicator	624
Numerator	
Denominator	
Data Source	Tennessee Tobacco Quitline Report
Data Source Year	FFY2017
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>2023</b>
Annual Objective	720.0	800.0	880.0	975.0	1,075.0	1,075.0

**State Performance Measures**

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

<b>Measure Status:</b>	<b>Active</b>
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<b>State Provided Data</b>		
	<b>2016</b>	<b>2017</b>
Annual Objective		51.6
Annual Indicator	51.6	54.1
Numerator		
Denominator		
Data Source	PRAMS	PRAMS
Data Source Year	2013	2014
Provisional or Final ?	Final	Final

<b>Annual Objectives</b>						
	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>2023</b>
Annual Objective	49.9	48.2	46.5	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

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

#### Objectives

Increase the percentage of TN women of reproductive age who have had a preventive health care visit in the past year.

#### 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 women's health 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

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

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

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

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

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

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

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

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

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

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

---

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

---

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

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

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

Priority Need

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

NPM

NPM 14.1 - Percent of women who smoke during pregnancy

Objectives

Decrease smoking among pregnant women.

Strategies

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

ESMs

Status

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

## NOMs

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

---

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

---

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

---

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

---

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

---

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

---

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

---

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

---

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

---

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

---

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

---

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

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

Priority Need

Improve utilization of preventive care for women of childbearing age.

SPM

SPM 3 - 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.

Strategies

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

## Women/Maternal Health - Annual Report

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

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

In calendar year 2016, 66.0% of women between the ages of 18 and 44 years reported having a preventive health care visit within the past year. This was not a statistically significant difference compared to the 2013 baseline of 72.1%, and the objective of maintaining the percent of preventive visits from baseline was met. There were 46 press releases, PSAs and social media messages promoting women's preventive health care issued during fiscal year 2017 – 37 more than the ESM 1.1 goal. In addition, 9 webinars related to this topic were also conducted and/or promoted – 5 more than the ESM1.2 goal. For ESM 1.3, two site-level FP utilization reports were created. Although this was shy of the goal of 4 such reports, the RWH section was able to produce quarterly reports on actual education and outreach activities taking place within each Health Department region and county in order to help staff assess their efforts in recruiting patients to the program. For ESM1.4, quarterly reports of region-level pregnancy-related service utilization have continued to be produced and the percentage of pregnancy tests coded to the Title X Family Planning has been maintained at or above 92% through the second quarter of calendar year 2017.

### Accomplishments and Challenges (based on FY2017 Action Plan)

#### 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:** During National Women's Health Week TDH's social media sites promoted National Women's Health Week: Steps for Better Health (which encourages women to make their health a priority) and the National Health Week Quiz (which addresses healthy behaviors and the importance of talking to a healthcare provider). During the week over 40 preventive health care activities were conducted statewide focusing on teen pregnancy prevention, breast and cervical cancer screening, STI screening and treatment, HPV vaccine and health department services and resources for women.

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:** The Reproductive and Women's Health (RWH) section collaborated with the TDH Office of Communications and regional and local health departments to provide 46 press releases, PSAs and social media messages on social media sites and the TDH website. These postings promoted a wide range of women's health issues including HPV vaccination, National Women's Health Week, breast and cervical cancer screening, Teen Pregnancy Prevention Month, Let's Talk Month and preconception and inter-conception health.

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

**Report 1c:** This activity was not conducted.

**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:** The Reproductive and Women's Health (RWH) section partnered with the March of Dimes to provide a webinar titled "Maximizing Use of Progesterone to Prevent Preterm Birth." Free Continuing Education Units (CEUs) were offered to over 70 providers who viewed the webinar (which has been archived and will continue to be available through April of 2018). RWH also promoted several national webinars for providers, including: a 4 part Women's Preventive Health web series, "Ensuring Holistic Continuity of Care in Women's Health," "Teen Rights to Access Sexual and Reproductive Health Care: Putting Laws into Clinical Practice," "Addressing Unplanned Pregnancy in Public Colleges," "Updated Recommendations for Zika Prevention in Primary Care and Family Planning Setting" and "Quality Contraceptive Services: An Overview of Current Approaches and Tools." In addition to these webinars, the RWH section regularly promotes the Family Planning National Training Center website ([fpntc.org](http://fpntc.org)) which offers free CEUs on topics related to the provision of quality family planning services.

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 (EHR); (2) include documentation of the use of One Key Question as part of Family Planning site visit chart reviews; (3) provide a presentation on One Key Question at the annual Spring Update conference for Reproductive and Women's Health providers; (4) create an infographic on One Key Question for distribution to providers.

**Report 2b:** The One Key Question has been incorporated into Tennessee Department of Health's EHR through required completion of a reproductive life plan at every family planning visit. During chart reviews that are conducted by Family Planning Administrators and the Women's Health Clinical Trainer we are now checking for completion of a reproductive life plan at each visit. One Key Question was discussed at the 2017 Spring Update, and the topic was also being presented at a Breastfeeding Coalition meeting at the Tennessee Hospital Association on October 19, 2017. A draft infographic of the One Key Question has been created.

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

Activity 3a: Provide in-house preventive care services to family planning clients at all health departments, and when necessary provide referrals to community health clinics if a needed preventive health

service is not available at the local health department.

**Report 3a:** During fiscal year 2017, all local health departments continue to provide quality family planning services across the state and served 74,618 unduplicated women. Each of these family planning clients was offered preventive health exams and referrals were made as needed based on examination findings.

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:** The RWH Epidemiologist generated bi-annual site-level reports that were distributed to Family Planning Administrators (FPAs). Reports provided clinic and client demographic data and trends used for targeting outreach efforts and promoting Family Planning clinic utilization and preventive reproductive health services. Quarterly REDCap Outreach and Education Reports were generated and distributed to FPAs providing information on where outreach activities and events were conducted, topics that were discussed, and number of participants served. The reports are used to determine barriers to services and gaps in outreach efforts.

#### **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 by TennCare and provided women with information about health care providers and health care services. There were a total of 5,944 calls completed.

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 both non-pregnant and 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:** Quarterly reports of region-level pregnancy-related service utilization have continued to be produced and the percentage of pregnancy tests coded to the Title X Family Planning has been maintained at or above 92% through the second quarter of calendar year 2017.

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), Tennessee Initiative for Perinatal Quality Care (TIPQC), Federally Qualified Health Centers, Rural Health Association of Tennessee, TennCare, Tennessee Primary Care Association, Susan G. Komen for the Cure, Tennessee Cancer Coalition, American Cancer Society, A Step Ahead, Sister Reach, Coordinated School Health, Alignment Nashville, East TN State University (ETSU) and Westberg Institute for Faith Community Nursing.

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

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

In CY2016, 13.4% of Tennessee resident mothers reported smoking during pregnancy, a 6.3% decrease from CY2015 (14.3%). Among primary caregivers enrolled in home visiting who reported tobacco use, 97.8% were referred to tobacco cessation counseling within three months of enrollment, a significant increase from FY2016 (1.3%) due to the implementation of a consistent definition of a referral.

#### **Accomplishments and Challenges (based on FY2017 Action Plan)**

##### **Strategy 1: Refer participants in federally-funded programs to smoking cessation services where appropriate.**

Activity 1a: Continue to screen participants in home visiting to the Tobacco QuitLine and other community-based cessation services.

**Report 1a:** The home visiting program continues to screen participants for tobacco use, provide education regarding the impact of tobacco use during pregnancy, second hand and third hand smoke. The Tobacco team has expanded the capacity of home visitors to assist in smoking cessation and prevention by providing three regional trainings regarding tobacco impacts, printed and online resources and referral mechanism to the Baby and Me Tobacco-Free program.

Activity 1b: Continue to refer participants in home visiting to the Tobacco QuitLine and other community-based cessation services.

**Report 1b:** Evidence Based home visitors continue to refer primary caregivers enrolled in home visiting services to tobacco cessation counseling. Over the past year, extensive efforts have been made to ensure that home visitors have the tools they need to refer primary caregivers to tobacco cessation including: conducting a survey to determine specific workforce training needs as it relates to tobacco referral and cessation, dissemination of a tobacco toolkit including brochures and planning tools, and three one day training events to educate the workforce about the best ways to discuss quitting with caregivers.

Activity 1c: Collaborate with healthcare providers to promote smoking cessation services among pregnant women (CollN).

**Report 1c:** This activity has been discontinued. The Tobacco CollN focusing on reducing women who smoke during pregnancy became duplicative when the Baby and Me Tobacco-Free as it was implemented across Tennessee using designated Tobacco Master Settlement funds. Baby and Me Tobacco-Free is in its first year of full implementation as a fee reimbursement model in 94 of 95 counties.

Activity 1d: Support integration of smoking assessment and cessation resources into the TDH electronic health record (EPI).

**Report 1d:** The TDH electronic health record (EPI) continues to be rolled out across the state. Implementation started in the northeast corner of the state and has now moved into the southeast region. Progress will continue until EPI is implemented across the state. Staff continues to work with the EPI team to ensure that appropriate chronic disease prevention prompts, such as tobacco use and referral are included in the EPI system. The implementation of EPI in the northeast part of the state in particular has enabled tracking of a pilot program to provide nicotine replacement therapy to women of childbearing age to improve interconception health.

MCHB Partnerships: MIECHV and state 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))

**Women/Maternal Health - 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 and continue to promote preventative health care for women throughout the year 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 in church bulletins.

**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) continue to include documentation of the use of One Key Question as part of Family Planning site visit chart reviews; (3) partner with other Public Health Programs (WIC, Home Visiting, Primary Care, STD) to incorporate the One Key Question into their client screening/history.

**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: Engage pregnant women to address medical and social serve needs via CHANT.

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

Planned strategies and Activities: To achieve the objective listed above, the following strategies and activities are planned for FY19:

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

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

Activity 2b: Continue the partnership with Vanderbilt University Medical Center to expand pilot 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. Include new resources as they are available (Ex. QR-coded resources).

MCHB Partnerships: MIECHV-funded home visiting programs include information about the dangers of smoking during pregnancy and secondhand smoke. TDH is monitoring performance metrics among grantees such as tobacco screening and referral rates.

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))

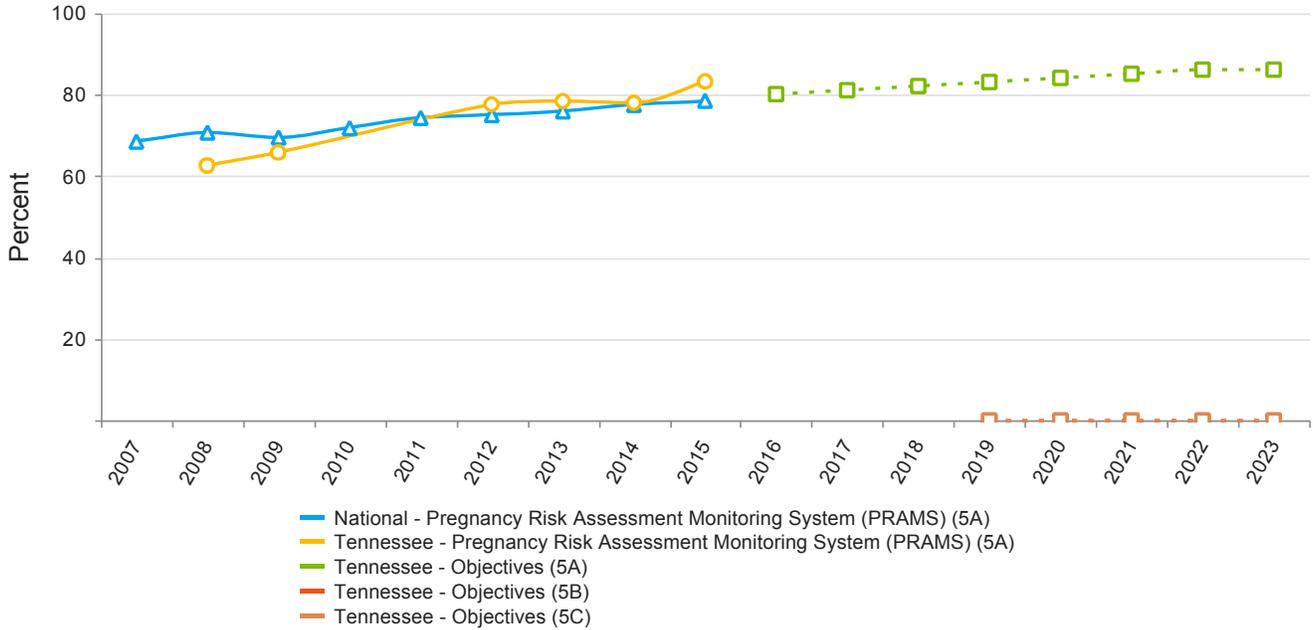
## Perinatal/Infant Health

### Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2015	7.0	NPM 5
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2015	2.9	NPM 5
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2015	153.0	NPM 5

**National Performance Measures**

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



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

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

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	82.0	83.0	84.0	85.0	86.0	86.0

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

**FAD for this measure is not available for the State.**

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

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	0.0	0.0	0.0	0.0	0.0

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

**FAD for this measure is not available for the State.**

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

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	0.0	0.0	0.0	0.0	0.0

**Evidence-Based or –Informed Strategy Measures**

**ESM 5.1 - Number of safe sleep educational material distributed**

<b>Measure Status:</b>	<b>Active</b>
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<b>State Provided Data</b>		
	<b>2016</b>	<b>2017</b>
Annual Objective		
Annual Indicator	226,881	257,694
Numerator		
Denominator		
Data Source	TDH FHW Injury Prevention Section Program Data	TDH FHW Injury Prevention Section Program Data
Data Source Year	FFY2016	FFY2017
Provisional or Final ?	Final	Final

<b>Annual Objectives</b>						
	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>2023</b>
Annual Objective	80,000.0	240,000.0	240,000.0	240,000.0	240,000.0	240,000.0

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

<b>Measure Status:</b>	<b>Active</b>
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<b>State Provided Data</b>		
	<b>2016</b>	<b>2017</b>
Annual Objective		100
Annual Indicator	100	100
Numerator		
Denominator		
Data Source	TDH FHW Injury Section Program Data - CFR Report	TDH FHW Injury Prevention Section Program Data
Data Source Year	CY2016	CY2017
Provisional or Final ?	Final	Final

<b>Annual Objectives</b>						
	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>2023</b>
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**

<b>Measure Status:</b>	<b>Active</b>
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<b>State Provided Data</b>		
	<b>2016</b>	<b>2017</b>
Annual Objective		80
Annual Indicator	84	85
Numerator		
Denominator		
Data Source	TDH PPA - Birth Statistical System	TDH PPA - Birth Statistical System
Data Source Year	FFY2016	FFY2017
Provisional or Final ?	Final	Final

<b>Annual Objectives</b>						
	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>2023</b>
Annual Objective	80.0	85.0	85.0	85.0	85.0	85.0

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

<b>Measure Status:</b>	<b>Active</b>
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<b>State Provided Data</b>		
	<b>2016</b>	<b>2017</b>
Annual Objective		100
Annual Indicator	100	100
Numerator		
Denominator		
Data Source	TDH FHW Perinatal Health Section Program Data	TDH FHW Perinatal Health Section Program Data
Data Source Year	CY2016	CY2017
Provisional or Final ?	Final	Final

<b>Annual Objectives</b>						
	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>2023</b>
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)**

<b>Measure Status:</b>	<b>Active</b>
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<b>State Provided Data</b>		
	<b>2016</b>	<b>2017</b>
Annual Objective		
Annual Indicator	45,881	47,159
Numerator		
Denominator		
Data Source	TDH FHW Womens Health Section Program Data	TDH FHW Womens Health Section Program Data
Data Source Year	FFY2016	FFY2017
Provisional or Final ?	Final	Final

<b>Annual Objectives</b>						
	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>2023</b>
Annual Objective	46,000.0	46,500.0	47,000.0	47,500.0	48,000.0	48,500.0

## State Action Plan Table

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

#### Priority Need

Reduce infant mortality.

#### NPM

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

#### Objectives

Decrease the rate of infant death.

#### 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

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

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

## Perinatal/Infant Health - Annual Report

**PRIORITY:** Reduce infant mortality.

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

NPM – Percent of infants placed to sleep on their backs.

83 percent of infants placed to sleep on their backs in CY2015, the most recent PRAMS data available. Therefore, comparison between FY2017 actual performance and FY2017 objective of 80 percent of infants placed to sleep on their backs is not available because of data delay.

All goals have been met or exceeded the objectives set for the ESMs. The number of safe sleep educational material distributed was 257,697, which exceeded the objective of 80,000 in FY2017. In CY2016, 100 percent of infant deaths were reviewed by child fatality review teams, which met the objective set. Data from the time period 7/1/2016 to 6/30/2017 show that 85 percent of VLBW infants were delivered at Level III or IV birthing facilities; this exceeded the objective of 80 percent for FY2017.

FY2017 data for newborn screening show that of 86,364 births, 85,851 received a dried blood spot screen, 83,910 were screened for CCHD, and 85,132 were screening for hearing. In FY 2016, 47,159 individuals were served by the TAPPP, exceeds the objective of 45,500 in FY2017.

### Accomplishments and Challenges (based on FY2017 Action Plan)

#### Strategy 1: Educate parents and caregivers on safe sleep.

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

**Report 1a:** During the FY 2017 a total of 257,697 safe sleep educational items including flyers, door hangers, posters, educational flipcharts, and Sleep Baby Safe and Snug board books were distributed to hospitals, daycare centers, Department of Children's Services, local health departments, churches and other community agencies serving families with infants. A safe sleep church bulletin insert has been created to educate the faith based community on safe sleep. A safe sleep crib card was created to educate patients at the birthing hospitals. A two-sided version of the door hanger was created with resources on the back. Safe sleep materials have been provided to disparate populations through the Kappa Alpha Psi fraternity and housing developments.

Activity 1b: Increase the number of educational materials distributed through the Direct On Scene Education program from 700 to 1200 by September 30, 2017. Through this activity, first responder agencies will be provided with packets of safe sleep information and access to portable cribs for families that do not have a safe sleep environment.

**Report 1b:** The Direct On Scene Education (DOSE) program exceeded the goal of 1200 kits by distributing 1312 DOSE kits in FY17. 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 distributed 49 portable cribs.

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

**Report 1c:** There have been 778 total floor talkers placed across the state, includes doctor's offices, daycare providers, health departments, local stores, hospitals and other local agencies. Floor talker placement has been added as a primary prevention activity for central office employees to place them in their communities. While we did not reached the goal of 1000 placed, Dollar General agreed to create their own version of the floor talker to go on shelves and place in over 800 stores in Tennessee.

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

**Report 1d:** A total of 5,083 participants have completed the online safe sleep educational module. The first version of the module was completed by 4,721 WIC parents. A new Safe Sleep online educational module was created on the national wichealth.org platform and was made available for WIC participants to complete starting in July 2017. 362 participants have completed that module.

## **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:** The 34 multidisciplinary child fatality review teams continue to review and collect data on all infant deaths. There have been a total of 679 infant deaths reviewed during FY17. In addition, the teams were provided necessary documents such as birth and death certificates, autopsy reports and information from the death scene investigation. An annual report was created with the data collected from the reviews.

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

**Report 2b:** There were new member orientation webinars hosted for CFR teams on October 24, 2016, January 24, 2017, May 9, 2017, July 11, 2017, and September 13, 2017, with an average of 6 participants for each. An in person training was provided on May 23, 2017 with over 80 participants. Two in person trainings were conducted with the East region CFR teams with 12-15 individuals in attendance.

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

**Report 2c:** The data quality reports were provided to the CFR coordinator monthly for 2016 deaths

starting in January 2017. Cases identified with missing or unknown data fields are sent back to the local teams with education about how to answer the questions.

**Activity 2d:** Provide death scene investigation (DSI) 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:** Two in person DSI trainings were held on November 9, 2016 in Nashville, TN and April 18, 2017 in Memphis, TN. Over 90 participants attended each training. SUIDI Dolls were offered to attendees. The dolls are utilized by first responders for doll reenactments at the death scene. The investigator takes a photo of the doll representing how the infant was placed and found, which 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:** The Department of Health continues to contract with Vanderbilt to coordinate the work of the Tennessee Initiative for Perinatal Quality Care. Under the direction of the Oversight Committee, hospital teams have created and implemented new quality improvement projects, continued with existing projects, collected data to track progress and outcomes, attended learning collaboratives, and participated in the annual educational conference. Topics being addressed include breastfeeding, maternal hemorrhage, NICU nutrition, postpartum contraception, opioid use in pregnancy, and hospital acquired infections.

**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:** Throughout the year, MCH staff have continued to work closely with the five Regional Perinatal Centers, the Perinatal Advisory Committee, and the work groups which reviewed and revised the regionalization guidelines and the educational objectives for perinatal nurses. In state fiscal year 2017, the five Centers provided direct care for 5,306 high-risk neonates and 15,765 high-risk maternal patients. Over 8,900 hours of education and training were provided to staff at community hospitals to help them prepare for recognizing and treating complex medical conditions.

**Activity 3c:** Coordinate the Perinatal Advisory Committee meetings.

**Report 3c:** The Perinatal Advisory Committee met three times during the federal fiscal year (November 9, 2016, March 31, 2017, and July 13, 2017). Highlights for the year included their review and revision of the perinatal regionalization guidelines and the educational objectives for nurses working in perinatal care and adding a new section for birth centers to both documents. The Committee also investigated the tools available for hospital assessment of levels of perinatal care and decided to implement the CDC LOCATe tool in 2018 statewide.

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

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

**Report 4a:** All babies born in Tennessee are required to be screened for metabolic conditions, hearing, and CCHD by the birthing facility. All newborn screening test results which are abnormal or unsatisfactory are sent to the follow-up staff for action. Providers are contacted and referrals made to the tertiary centers across the state for confirmation testing, counseling, and long term follow-up. During this past year (July 2017), the State added screening for five lysosomal disorders to the screening panel. An education toolkit was developed and distributed to all birthing facilities on the processes of the newborn screening system.

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

**Report 4b:** Weekly, the program epidemiologist receives a preliminary birth file which is matched to the file for newborn screening tests received from birth facilities to identify any babies born in the state who did not have a dried blood spot screening test sent to the State Lab. The quality improvement (QI) nurse sends these facilities a report on those babies and informs them of the need of a dried blood spot screening for those babies. About two months later the epidemiologist matches the records in the provisional birth file, which is more complete but less timely in capturing birth events in Tennessee, with the newborn screening records and identifies infants who did not receive one or more of the three types of newborn screening – i.e., dried blood spot, hearing loss and critical congenital heart disease. The QI nurse sends a report to the birthing facilities and asks for information on why, and these records are tracked to assure a response is received.

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

**Report 4d:** The Genetics Advisory Committee met four times during this past federal fiscal year. Much of the work centered on laboratory and follow-up procedures for adding lysosomal

disorders to the newborn screening panel, including obtaining information from other states already screening for these disorders, creating procedures, validating tests, and determining appropriate follow-up. The meetings also included information on implementation of screening for SCID and changes in the cystic fibrosis testing algorithm.

### **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 FY 2017 that included: Liletta insertion training for 15 metro and regional providers; Nexplanon insertion training for 11 regional providers; Nexplanon Train the Trainer Certification for 1 TDH Nurse Practitioner; comprehensive contraception training for 3 private providers; the 2017 Family Planning Spring Update for 224 TDH providers; and the March of Dimes webinar “Maximizing Use of Progesterone to Prevent Preterm Birth” for approximately 70 providers. Infant mortality funds (through interagency contract with Medicaid) were utilized to purchase 6 realistic pelvic models and supplies for IUC insertion simulation.

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 April 2017 that included 224 health care professionals. Information at the update included: Controversies in Well Women Exams, Family Planning Billing and Coding, Family Planning Options Counseling, Increasing the Male Population in Family Planning Clinics and Zika Virus Update. For the abstinence education program, 16,778 adolescents, parents and professionals were served with 42,927 program hours provided, and 6,203 service learning hours completed. The Tennessee Adolescent Pregnancy Prevention Program (TAPPP) Program Director presented at the TN Department of Health (TDH) Health Educator Conference and the Coordinated School Health (CSH) Institute providing education and resources to over 200 school and health department educators. TAPPP purchased approximately 50 “Making a Difference, 5th Edition” evidence-based teen pregnancy prevention curricula for regional and county health educators.

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, eighteen (18) projects were funded for Abstinence Education all targeting at risk children age 10 to 19, for program implementation. There are seventeen (17) contracts designated for school and community-based projects and one (1) contract with the TN Department of Education (DOE) Office of Coordinated School Health (CSH) to provide education and training for students, teachers and health education professionals. 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 gifts for seniors in assisted living facilities. The abstinence education program includes a focus on personal growth and development, healthy relationship building and self-care. Approximately 6,203 hours of service learning activities was completed.

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

**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 availability. In FY2017, over 1,100 TAPPP activities were conducted reaching 77,351 children, youth, parents and professionals.

MCHB Partnerships: The MIECHV-funded evidence-based home visiting programs provide safe sleep information to all families (as do all TDH-administered home visiting and case management programs). The federally-funded Healthy Start initiative (through Centerstone) provides safe sleep information to families in their service area.

Newborn screening staff participate in efforts sponsored by NewSTEPS (funded by HRSA/MCHB Genetic Services Branch) to increase the quality and timeliness of newborn screening specimens.

Other Key Partnerships: The Department of Health has local health departments in all 95 counties across the state; staff in each local department provides pregnancy testing, necessary referrals for other services, WIC services for pregnant women, mothers, and infants, and EPSDT screenings. Numerous external collaborators support the work of this domain. A partnership between TDH, the Tennessee Initiative for Perinatal Quality Care (TIPQC), the Tennessee Hospital Association (THA), and March of Dimes has focused on reducing early elective deliveries and inductions as well as the promotion of breastfeeding and safe sleep. THA has partnered with TDH to engage hospitals in developing and implementing safe sleep policies. Title V Program staff routinely communicate with Medicaid and CHIP staff to identify strategies for connecting eligible populations to care. Tennessee's Early Hearing and Detection Intervention program, called the Newborn Hearing Screening program, collaborates with Tennessee's Early Intervention System (TEIS), located in the Tennessee Department of Education, by referring all children with identified hearing loss to TEIS through use of a shared database.

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

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

**Perinatal/Infant Health - Application Year**

**PRIORITY: Reduce infant mortality.**

Planned strategies and Activities: To achieve the objective listed above, the following strategies and activities are planned for FY19:

**Strategy 1: Educate parents and caregivers on safe sleep.**

- Activity 1a: Disseminate safe sleep flyers, door hangers, posters, educational flipcharts and *Sleep Baby Safe and Snug* board books to hospitals, daycares, Department of Children's Services, Girl Scouts, Red Cross, generational caregivers and other agencies serving infants.
- Activity 1b: Increase the number of educational materials distributed through the Direct On Scene Education (DOSE) program from 1600 to 1900 by September 30, 2019. Through this activity, first responder agencies and local housing authorities will be provided with packets of safe sleep information and access to portable cribs for families that do not have a safe sleep environment for their infant child.
- Activity 1c: Increase the number of safe sleep floor talkers placed in stores, clinics, health departments, daycares and other agencies from 800 to 1000 by September 30th, 2019.
- Activity 1d: Increase the number of WIC parents completing the new safe sleep educational module from 500 to 800 by September 30, 2019.
- Activity 1e: Increase the number of non-birthing hospitals providing safe sleep education from 3 to 10 by September 30<sup>th</sup>, 2019.
- Activity 1f: Disseminate Spanish and English safe sleep crib card to a minimum of 40 birthing hospitals by September 30<sup>th</sup>, 2019.
- Activity 1g: Engage at least 3 additional local fraternity and sorority chapters to participate in safe sleep education initiatives by September 30<sup>th</sup>, 2019.
- Activity 1h: Translate a minimum of two safe sleep materials into additional languages and make available on the safe sleep website by September 30<sup>th</sup>, 2019.

**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. If needed, agencies will be provided with a doll for doll reenactments.

**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))

## Child Health

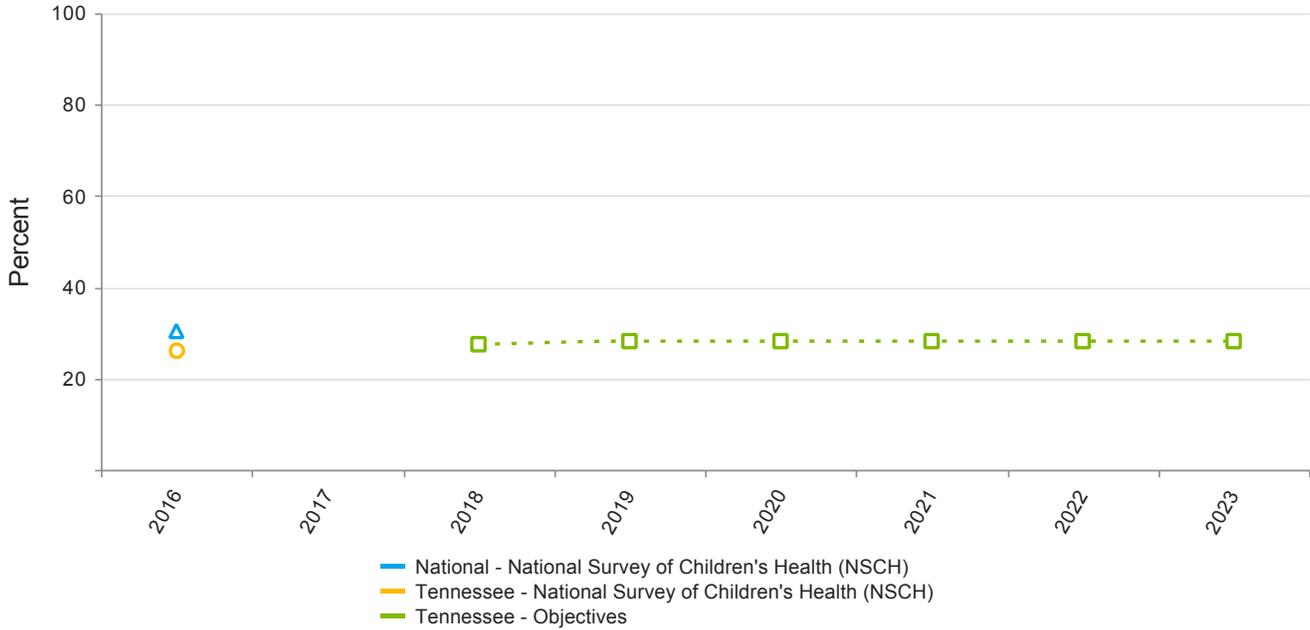
### Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations	SID-2015	166.7	NPM 14.2
NOM 3 - Maternal mortality rate per 100,000 live births	NVSS-2012_2016	26.7	NPM 14.2
NOM 4 - Percent of low birth weight deliveries (<2,500 grams)	NVSS-2016	9.3 %	NPM 14.2
NOM 5 - Percent of preterm births (<37 weeks)	NVSS-2016	11.3 %	NPM 14.2
NOM 6 - Percent of early term births (37, 38 weeks)	NVSS-2016	27.2 %	NPM 14.2
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2015	6.4	NPM 14.2
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2015	7.0	NPM 14.2
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2015	4.1	NPM 14.2
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2015	2.9	NPM 14.2
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2015	189.8	NPM 14.2
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2015	153.0	NPM 14.2
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-2016	23.2	NPM 7.1
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000	NVSS-2016	39.9	NPM 7.1
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000	NVSS-2014_2016	15.1	NPM 7.1
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000	NVSS-2014_2016	11.3	NPM 7.1

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2016	89.2 %	NPM 6 NPM 8.1 NPM 14.2
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	NSCH-2016	19.2 %	NPM 8.1
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	WIC-2014	14.9 %	NPM 8.1
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	YRBSS-2015	18.6 %	NPM 8.1

**National Performance Measures**

**NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year**  
**Baseline Indicators and Annual Objectives**



Federally Available Data		
Data Source: National Survey of Children's Health (NSCH)		
	2016	2017
Annual Objective		
Annual Indicator		26.2
Numerator		53,746
Denominator		205,002
Data Source		NSCH
Data Source Year		2016

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

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	27.5	28.2	28.2	28.2	28.2	28.2

**Evidence-Based or –Informed Strategy Measures**

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

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>		
	<b>2016</b>	<b>2017</b>
Annual Objective		
Annual Indicator	979	953
Numerator		
Denominator		
Data Source	TDH FHW Early Childhood Section Program Data	TDH FHW Early Childhood Section Program Data
Data Source Year	FFY2016	FFY2017
Provisional or Final ?	Final	Final

<b>Annual Objectives</b>						
	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>2023</b>
Annual Objective	800.0	1,200.0	1,200.0	1,200.0	1,200.0	1,320.0

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

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>		
	<b>2016</b>	<b>2017</b>
Annual Objective		
Annual Indicator	450	526
Numerator		
Denominator		
Data Source	TDH CHS Program Data	TDH CHS Program Data
Data Source Year	FFY2016	FFY2017
Provisional or Final ?	Final	Final

<b>Annual Objectives</b>						
	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>2023</b>
Annual Objective	485.0	504.0	524.0	544.0	566.0	588.0

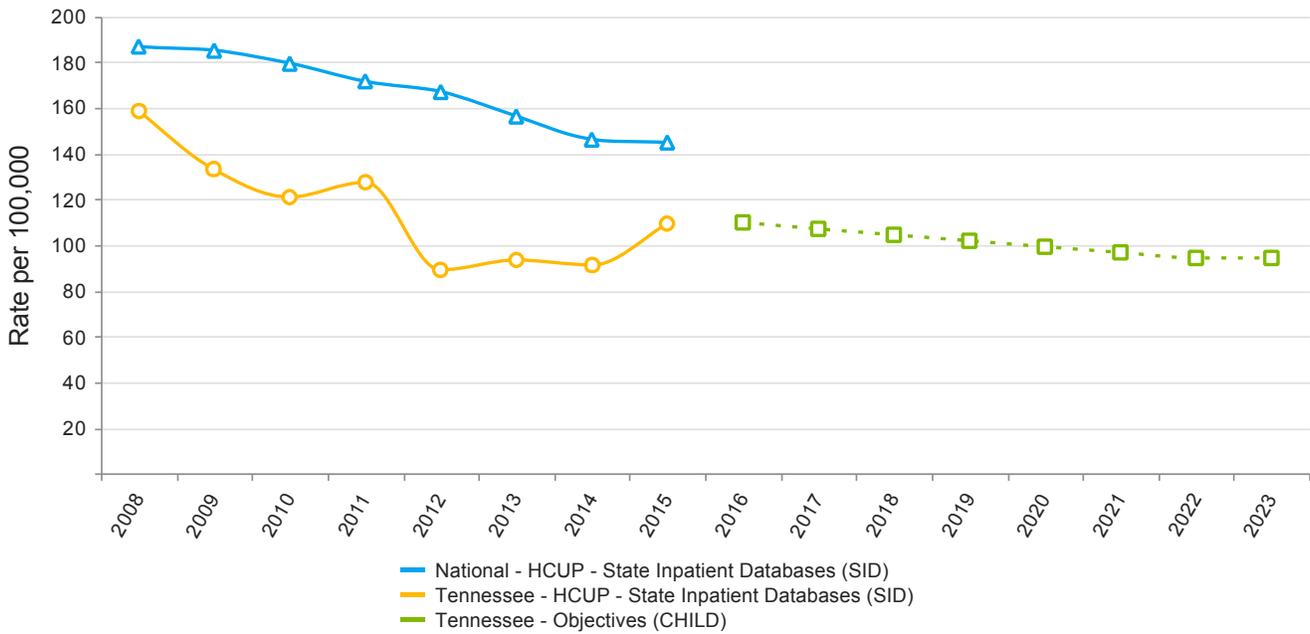
**ESM 6.3 - Percent of Developmental Screenings performed across the state for participants enrolled in an Evidence-Based Home Visiting Program**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>		
	<b>2016</b>	<b>2017</b>
Annual Objective		90
Annual Indicator	89.2	76.1
Numerator		
Denominator		
Data Source	TDH FHW Early Childhood Section Program Data	TDH FHW Early Childhood Section Program Data
Data Source Year	FFY2016	FFY2017
Provisional or Final ?	Final	Final

<b>Annual Objectives</b>						
	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>2023</b>
Annual Objective	90.0	91.0	92.0	92.0	93.0	93.0

**NPM 7.1 - Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9  
Baseline Indicators and Annual Objectives**



**Federally Available Data**

Data Source: HCUP - State Inpatient Databases (SID)

	2016	2017
Annual Objective	109.8	107
Annual Indicator	109.1	109.1
Numerator	893	672
Denominator	818,595	615,938
Data Source	SID-CHILD	SID-CHILD
Data Source Year	2014	2015

**Annual Objectives**

	2018	2019	2020	2021	2022	2023
Annual Objective	104.4	101.8	99.2	96.7	94.3	94.3

**Evidence-Based or –Informed Strategy Measures**

**ESM 7.1.1 - Number of parents and caregivers receiving car seat education**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>		
	<b>2016</b>	<b>2017</b>
Annual Objective		2,836
Annual Indicator	2,836	2,098
Numerator		
Denominator		
Data Source	TDH FHW Injury Prevention Section Program Data	TDH FHW Injury Prevention Section Program Data
Data Source Year	FFY2016	FFY2017
Provisional or Final ?	Final	Final

<b>Annual Objectives</b>						
	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>2023</b>
Annual Objective	2,850.0	2,875.0	2,900.0	2,925.0	2,950.0	2,950.0

**ESM 7.1.2 - Number of counties that adopt Count It! Drop It! Lock It! educational programs**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>		
	<b>2016</b>	<b>2017</b>
Annual Objective		
Annual Indicator	36	61
Numerator		
Denominator		
Data Source	TDH FHW Injury Prevention Section Program Data	TDH FHW Injury Prevention Section Program Data
Data Source Year	FFY2016	FFY2017
Provisional or Final ?	Final	Final

<b>Annual Objectives</b>						
	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>2023</b>
Annual Objective	48.0	93.0	93.0	93.0	93.0	93.0

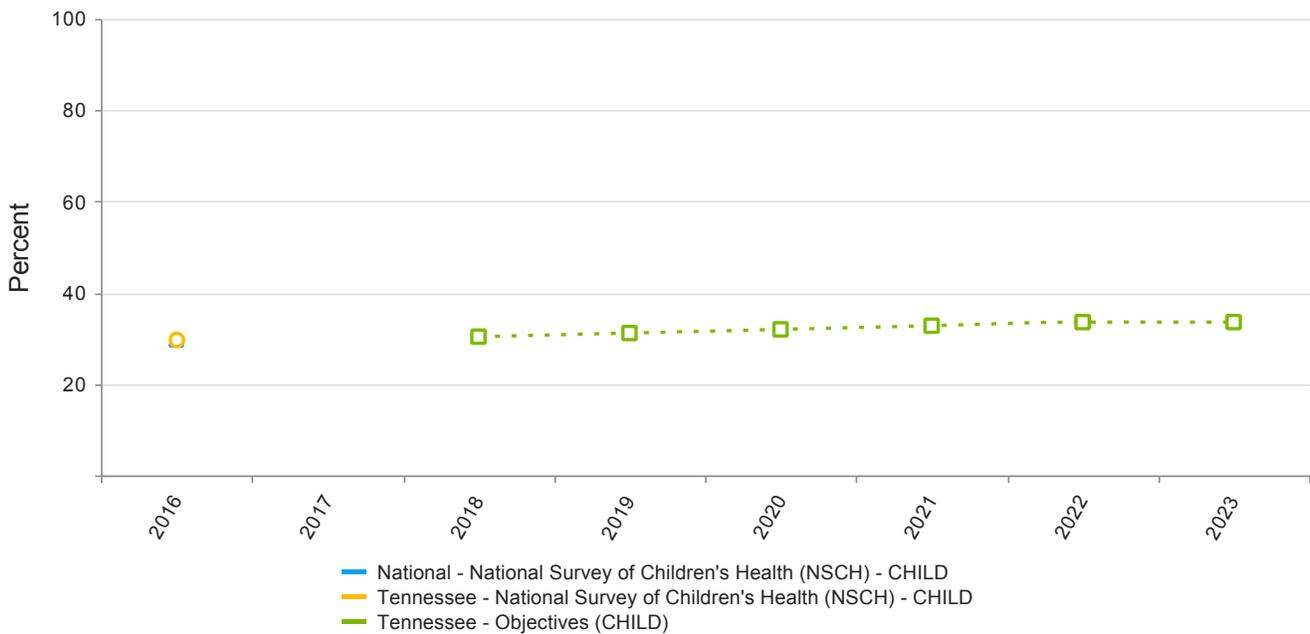
**ESM 7.1.3 - Percent of families who receive injury prevention education through the AAP checklist among families participating in Evidence Based Home Visiting programs**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>		
	<b>2016</b>	<b>2017</b>
Annual Objective		85
Annual Indicator	81	36
Numerator		
Denominator		
Data Source	TDH FHW Early Childhood Section Program Data	TDH FHW Early Childhood Section Program Data
Data Source Year	FFY2016	FFY2017
Provisional or Final ?	Final	Final

<b>Annual Objectives</b>						
	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>2023</b>
Annual Objective	87.0	89.0	91.0	93.0	95.0	95.0

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



Federally Available Data		
Data Source: National Survey of Children's Health (NSCH) - CHILD		
	2016	2017
Annual Objective		
Annual Indicator		29.6
Numerator		152,452
Denominator		514,521
Data Source		NSCH-CHILD
Data Source Year		2016

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

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	30.4	31.2	32.0	32.8	33.6	33.6

**Evidence-Based or –Informed Strategy Measures**

**ESM 8.1.1 - Number of Gold Sneaker-recognized childcare facilities in Tennessee**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>		
	<b>2016</b>	<b>2017</b>
Annual Objective		
Annual Indicator	441	474
Numerator		
Denominator		
Data Source	TDH FHW Chronic Disease Program Data	TDH FHW Chronic Disease Program Data
Data Source Year	FFY2016	FFY2017
Provisional or Final ?	Final	Final

<b>Annual Objectives</b>						
	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>2023</b>
Annual Objective	525.0	575.0	625.0	675.0	725.0	775.0

**ESM 8.1.2 - Average number of monthly calls to the Tennessee Breastfeeding Hotline (TBH)**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>		
	<b>2016</b>	<b>2017</b>
Annual Objective		
Annual Indicator	485	523
Numerator		
Denominator		
Data Source	TDH FHW Supplemental Nutrition Section Program Data	TDH FHW Supplemental Nutrition Section Program Data
Data Source Year	FFY2016	FFY2017
Provisional or Final ?	Final	Final

<b>Annual Objectives</b>						
	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>2023</b>
Annual Objective	500.0	525.0	550.0	575.0	600.0	625.0

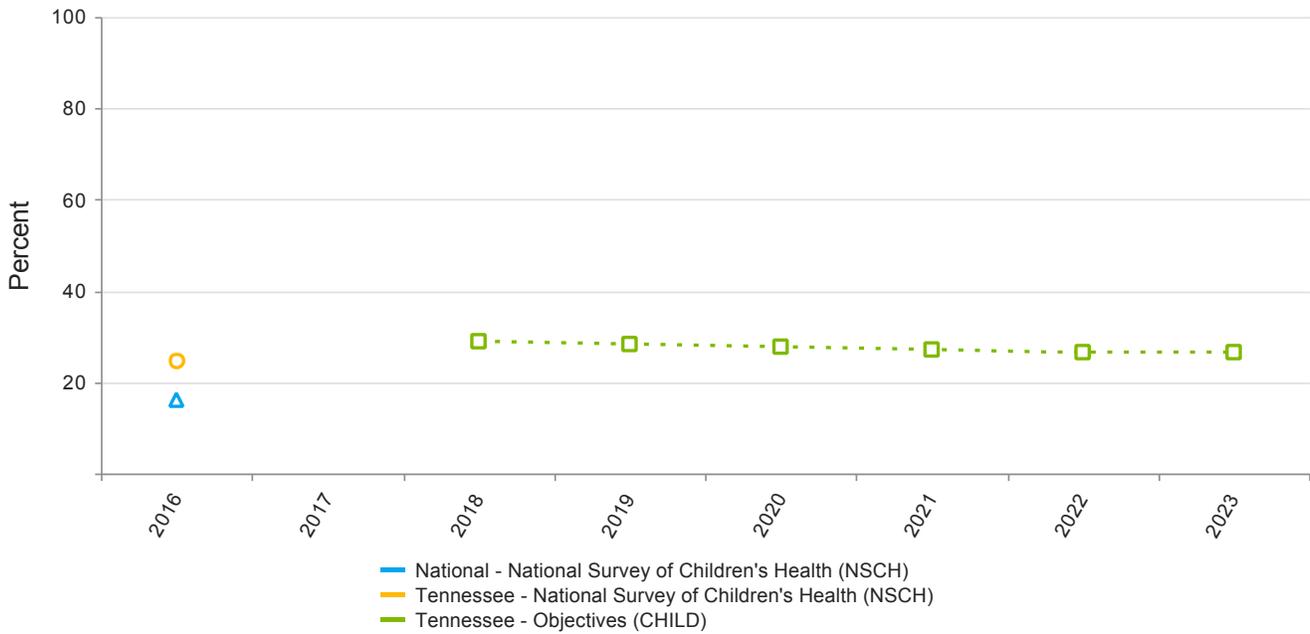
**ESM 8.1.3 - Number of Baby Friendly-designated Tennessee birthing hospitals**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>		
	<b>2016</b>	<b>2017</b>
Annual Objective		
Annual Indicator	2	2
Numerator		
Denominator		
Data Source	Baby Friendly USA, Inc.	Baby Friendly USA, Inc.
Data Source Year	FFY2016	FFY2017
Provisional or Final ?	Final	Final

<b>Annual Objectives</b>						
	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>2023</b>
Annual Objective	3.0	8.0	10.0	12.0	14.0	16.0

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



**NPM 14.2 - Child Health**

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH)		
	2016	2017
Annual Objective		
Annual Indicator		24.9
Numerator		362,200
Denominator		1,457,726
Data Source		NSCH
Data Source Year		2016

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

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	29.0	28.4	27.8	27.2	26.6	26.6

**Evidence-Based or –Informed Strategy Measures**

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

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>		
	<b>2016</b>	<b>2017</b>
Annual Objective		480
Annual Indicator	441	474
Numerator		
Denominator		
Data Source	TDH FHW Chronic Disease Section Program Data	TDH FHW Chronic Disease Section Program Data
Data Source Year	FFY2016	FFY2017
Provisional or Final ?	Final	Final

<b>Annual Objectives</b>						
	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>2023</b>
Annual Objective	525.0	570.0	615.0	660.0	705.0	705.0

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

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>		
	<b>2016</b>	<b>2017</b>
Annual Objective		10
Annual Indicator	1.7	97.8
Numerator		
Denominator		
Data Source	TDH FHW Early Childhood Section Program Data	TDH FHW Early Childhood Section Program Data
Data Source Year	FFY2016	FFY2017
Provisional or Final ?	Final	Final

<b>Annual Objectives</b>						
	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>2023</b>
Annual Objective	93.0	94.0	95.0	95.0	95.0	95.0

**State Performance Measures**

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

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>		
	<b>2016</b>	<b>2017</b>
Annual Objective		27.5
Annual Indicator	27.5	27.5
Numerator		
Denominator		
Data Source	NSCH	NSCH
Data Source Year	2011_2012	2011_2012
Provisional or Final ?	Final	Final

<b>Annual Objectives</b>						
	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>2023</b>
Annual Objective	27.5	24.8	24.8	22.3	22.3	22.3

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

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>		
	<b>2016</b>	<b>2017</b>
Annual Objective		80
Annual Indicator	78.2	79.8
Numerator		
Denominator		
Data Source	TDH PPA - Birth Statistical System	TDH PPA - Birth Statistical System
Data Source Year	CY2015	CY2016
Provisional or Final ?	Final	Final

<b>Annual Objectives</b>						
	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>2023</b>
Annual Objective	82.0	84.0	86.0	88.0	90.0	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

NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

#### Objectives

Increase 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.

#### Strategies

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.

#### 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, ages 0 through 17, 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

NPM 7.1 - Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9

Objectives

Reduce hospitalization rates for unintentional injuries among children age 0-9.

Strategies

Promote the use of child safety seats.

Promote safe storage of medications.

Provide injury prevention education to parents and caregivers.

ESMs

Status

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

Active

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

Active

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

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

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

Objectives

Reduce the percentage of students in grades K-8 identified as overweight/obese.

Strategies

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).

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 8.1.1 - Number of Gold Sneaker-recognized childcare facilities in Tennessee

Active

ESM 8.1.2 - Average number of monthly calls to the Tennessee Breastfeeding Hotline (TBH)

Active

ESM 8.1.3 - Number of Baby Friendly-designated Tennessee birthing hospitals

Active

NOMs

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

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

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

Priority Need

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

NPM

NPM 14.2 - Percent of children, ages 0 through 17, who live in households where someone smokes

Objectives

Decrease exposure to tobacco among children.

Strategies

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

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

ESMs

Status

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

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

## NOMs

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

---

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

---

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

---

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

---

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

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

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

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

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

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

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

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NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

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

Priority Need

Reduce the number of children exposed to adverse childhood experiences.

SPM

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

Objectives

Reduce the percentage of Tennessee children age 0-17 experiencing two or more adverse childhood experiences.

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 6

Priority Need

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

SPM

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

Objectives

Increase percentage of infants born to Tennessee resident mothers who initiate breastfeeding.

Strategies

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

## Child Health - Annual Report

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

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

NPM 6 - We saw a decrease in National Performance Measure 6 in year 2. The decrease can be explained by the measure's limited scope in that children do participate in developmental screenings, but it is more often than not administered by a healthcare provider and not a parent, and those provider completed screenings would not be captured by this measure.

ESM 6.1 - Evidence-based Strategy Measure 6.1 exceeded its year 2 objective as well as improved from year one's standings. Web- directed activities within the kidcentraltn site has increased visits to the developmental-based topics.

ESM 6.2- This was our first year to complete ESM 6.2, and we exceeded the goal with 526 nurses completing the START and MCHAT training.

ESM 6.3 - Recently, our data collection system went through an update, and some of the data was not converted in upgrade, resulting in many of our measures reported decreased numbers due to missing data. This is possibly the explanation for the decrease that we saw for ESM 6.3 in year 2.

### Accomplishments and Challenges (based on FY2017 Action Plan)

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

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

**Report 1a:** The Welcome Baby packet is in the process of being revised to include extensive information about the importance of developmental screening and developmental milestones to educate caregivers. The new Welcome Baby packet will be distributed in June of 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 reports and sponsor developmental screening for monthly featured content. We review and edit what 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. TDH is in the process of installing loop playing of kidcentral videos in local health department waiting rooms.

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

**Report 1c:** The Learn the Signs: Act Early allocated funds have gone toward the production of materials and their distribution to parents and child care professionals throughout Tennessee. Training for child care professionals is now offered through the TN Child Care Provider Training mechanism within the CCR&R system, as well as technical assistance is offered to parents on developmental milestones as part of a family engagement initiative.

### **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 in all 95 county health departments. The model will address recipients' needs for developmental screening and behavioral health screening and make appropriate referrals.

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:** Tennessee Birth Defects Surveillance System (TNBDSS) has been providing infants that were identified for developmental services on a quarterly basis.

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:** The Office of Early Childhood worked with TNAAP to train health department staff from HUGS, CSS, and TNCare Outreach teams on developmental screening using the ASQ-3 and ASQ-SE. In addition, staff was trained on the use of the Edinburgh Depression Screening.

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. Over 500 TDH nurses were trained in the START Autism and MCHAT-R/F program.

### **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 have expanded partnership conversations with the Department of Human Services and are considering other mechanisms for expanded screening in daycares.

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

**Report 3b:** Developmental screening continues to be a major emphasis in evidence based home visiting programs as all sites are required to administer developmental screening at prescribed intervals using the ASQ and ASQ-SE. Also, evidence based home visiting sites took part in regional screening training that included three instruments: ASQ, ASQ-SE, and the Edinburg Depression Screening.

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

**Report 3c:** Effective October 1, 2016, in alignment with MIECHV data collection requirements, TDH now collects data on the percentage of children having the most recently expected well child visit. To date (provisional), 74.4% of children served by Evidence Based Home Visiting Programs completed the most recently expected well child visit.

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. Partnering and contract opportunities with the Department of Human Services have expanded with the change of staff in both agencies.

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.

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

The Injury Program and partners met all our adolescent health ESM objectives for Year 2, except ESM objectives ESM 7.3 and 7.4. However, these were due to changes in injury partner reporting methods. We did exceed our 2022 objectives for ESM 7.2 and ESM 7.5. We have seen a continued decrease in child nonfatal injury hospitalizations from 124.1 per 100,000 population in 2011 to 113.8 per 100,000 population in 2014, then increased to 130.2 in 2015. Specifically, nonfatal hospitalization rates due to motor vehicle crashes, poisoning and falls hospitalizations have increased from 14.3, 14.8 and 30.7 (respectively) in 2014 to 14.9, 20.7 and 34.5 in 2015. The U.S. transitioned from ICD-9-CM to ICD-10-CM on October 1, 2015. The reader should consider this as a possible cause of any changes that appear to occur between the third and fourth quarters of 2015. We are working with partners to revise data collection methods for ESMs 7.3 and 7.4 that will provide more accurate assessment of progress.

## Accomplishments and Challenges (based on FY2017 Action Plan)

### Strategy 1: Promote the use of child safety seats.

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

**Report 1a:** From October 1, 2016 to September 30, 2017, TDH provided \$123,523 to 33 agencies, who then distributed 2,713 car seats. The car seat safety funds are 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: Disseminate a child safety seat infographic to promote the correct use of car seats to parents and caregivers.

**Report 1b:** An infographic titled "The Road to Crash Prevention" was disseminated which contained general safe driving information along with child safety seat education. A PowerPoint slide presentation was also created and shared with Tennessee Young Child Wellness Council members and made available for injury prevention partners that contained car seat safety information.

### 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. CDL 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 61 groups who conduct CLD in Tennessee. As a condition of the program, each county must obtain and use drug drop boxes and educate families to and secure medication in locked medicine boxes.

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

**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 September 30, 2017, there were 236 in 95 of 95 counties. Thirty-four (34) new bins were installed throughout Tennessee and 97,237 pounds of medications were collected from counties throughout Tennessee this year.

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

**Report 2c:** TDH provided both state and federal dollars to support 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 35.9% of families who are enrolled in evidence-based home visiting programs. The updated AAP Safety Checklist is utilized by home visitors and covers several injury prevention topics, including child restraints, safe sleep, smoke detectors and fall prevention. While only 35.9% of families with children enrolled in home visiting were documented as having had at least one AAP safety checklist completed, this was due to changes in the data collection process. The question about the AAP safety checklist was built into REDCap but inadvertently omitted on the paper data collection forms. This data collection problem was not discovered until July, so the 35.9% number only reflects data collected from July to September. We suspect the actual percentage of families who received injury prevention education was much higher and anticipate this number to exceed the goal next year.

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 to evidence based home visiting staff. The report provided data on child abuse and neglect deaths, hospitalizations and emergency department visits.

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

**Report 3c:** Infographics were developed and distributed on suicide, safe sleep and motor vehicle accidents. In addition, two separate infographics were created and distributed for daycare providers and pediatricians on the top causes of child injury deaths.

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

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

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

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

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

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

Overall, Tennessee continues to see modest improvements in child health and primary prevention indicators that promote healthy weight among children. By the end of FY2017, there were 474 Gold Sneaker-recognized childcare facilities compared to 441 in FY2016. Breastfeeding initiation rose to 79.8% in 2016 from 78.2% in 2015. Average monthly calls to the Tennessee Breastfeeding Hotline also increased nearly 8% from last year. Two TN hospitals were Baby-Friendly-designated (Erlanger and St. Thomas Midtown), and 3 other facilities were on track to receive this distinction. The 2015-16 Coordinated School Health Weight Status Report indicated that the incidence of overweight and obesity rose steadily with age from 29.5% of kindergartners to 42.9% of 6<sup>th</sup> graders, which was significantly lower overall compared to 2007-08. The 2016 National Survey of Children's Health showed that 29.6% of TN children age 6-11 were physically active at least 60 minutes every day, similar to the national figure of 29.8%.

**Accomplishments and Challenges (based on FY2017 Action Plan)**

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

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

**Report 1a:** The Gold Sneaker program director and regional health educators recruit a minimum of 35 licensed childcare facilities monthly. Currently there are 469 designated Gold Sneaker facilities with a capacity for 28,062 children.

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

**Report 1b:** The program director and regional health educators provide in-person Gold Sneaker training to licensed Tennessee childcare directors and teaching staff regarding the implementation of the nine required Gold Sneaker health policies. A newly developed re-designation training is being conducted for centers that have been designated for a minimum of three years. This training provides a refresher of the nine policies and an opportunity to discuss and address challenges of implementation. Additional educational resources that may assist childcare centers with implementation are also accessed via the Gold Sneaker web site, Gold Sneaker newsletters and brochures.

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

**Report 1c:** In 2017, Gold Sneaker policies were added to the Department of Human Services Report Card. Childcare facilities wishing to obtain a 3-star rating must implement Gold Sneaker policies.

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

**Report 1d:** The Gold Sneaker Initiative is evaluated every three years with an in-depth survey emailed to each designated or recognized Gold Sneaker facility. Barriers to implementing policies are self-reported. The new re-designation training will be conducted every three years. Participants provide feedback via survey at the conclusion of each training.

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

**Report 1e:** In 2016, a Gold Sneaker Advisory Committee was formed comprised of internal TDH staff and external members. The committee meets at least quarterly when working on a project. The Gold Sneaker program director engages the committee by maintaining communication, on at least a bi-annual basis by email informing members of activities and program progress.

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.

**Report 1f:** The program director trained 85 Public Health Educators during the past year regarding Gold Sneaker implementation. Gold Sneaker was discussed during two resource sessions for Public Health Educators during the statewide 2017 Health Promotion

Conference.

**Strategy 2: Increase support for breastfeeding initiation and duration (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:** Tennessee Breastfeeding Hotline (TBH) continues to be supported in part with Title V funding. Current contract will continue to June 30, 2018.

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

**Report 2b:** TBH promoted the hotline at multiple events reaching professional and general public audiences. TDH continues to promote the Hotline in all County Health Department clinics and in many venues to obstetric and pediatric care teams. TDH contracted with the Tennessee Hospital Association to facilitate distribution of promotional materials to hospitals statewide and to launch radio PSAs and billboards in areas with lower breastfeeding rates.

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

**Report 2c:** TDH launched a You-Tube video <https://www.youtube.com/watch?v=yEuDz1InieA> promoting the hotline, current views are 1,500 and it was linked to the TDH Facebook page (33 likes).

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:** TDH Committee met to develop materials for the mailer which will include information on how to breastfeed and the hotline as a resource in the materials.

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

**Report 2e:** As of October 6, 2017, 2,864 medical providers have been enrolled, representing 74 facilities across Tennessee.

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

**Report 2f:** Two Baby Friendly USA designated hospitals were designated in Tennessee. Three of the four EMPOWER facilities are on track for designation although this had not been completed as of September 2017.

**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:** As of September 2017, TDH was aware of 111 physical activity clubs, which include run clubs. A process is being developed 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. Promote resources through webinars, conference calls, group trainings, and other avenues as they arise.

**Report 3c:** The run club toolkit has been downloaded by internal and external stakeholders 206 times since it went live in February 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.

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 and provision of food and nutrition education. The Title V Program also collaborates with the Department of Human Services to promote health standards within early childhood care centers.

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

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

- Submit a plan responsive to the needs of preventive and primary care services for children (505(a)(2)(A))

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

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

Data for the SPM, percentage of children experiencing two or more ACEs remains unchanged, as new data has not yet become available from the National Survey of Children's Health. High risk populations experience more ACEs than the general population. TDH continues to educate both professional and lay audiences on the potential impact of ACEs on young children through the Building Strong Brains Initiative.

### **Accomplishments and Challenges (based on FY2017 Action Plan)**

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

Activity 1a: Under the leadership of the Title V Program staff, disseminate the Tennessee ACEs 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:** Four ACEs briefs based on the 2014 data have been developed focusing on the connection between ACEs and the following factors: employment, alcohol use and abuse, tobacco use, and obesity. The report was shared across early childhood and health professionals through the Home Visiting Leadership Alliance and other professional organizations. In addition, several different ACEs publications were developed in collaboration with Building Strong Brains and were widely distributed across the State. This included several external presentations, including an ACEs presentation to the state Senate Health and Welfare Committee. State Title V took the lead among 5 other agencies and professional entities.

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:** The ACEs Handout, How to Protect Your Child from Toxic Stress, continues to be distributed through Welcome Baby packets that are disseminated to families with new babies. Approximately 80,000 families receive the Welcome Baby information each year.

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:** The Early Childhood Team provided three training events on Poverty including a poverty simulation this year utilizing the work of Ruby Payne in her book, "A Framework for Understanding Poverty." Poverty, while not specifically an ACE, is a contributing factor

leading to many ACEs, and the poverty simulation provided the early childhood workforce with knowledge and experience about poverty's impact on the population being served in many of our programs.

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

**Report 1d:** TDH continues to be a member of the Building Strong Brains, TN's ACEs Initiative Steering Committee. Building Strong Brains has made great strides toward its goal of changing the culture of Tennessee so the state's overarching early childhood philosophy, policies, programs, and practices utilize the latest brain science to prevent and mitigate the impact of adverse childhood experiences.

**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:** In FY17, 90% of Evidence Based Home Visiting Programs were screened for ACEs within 6 months of enrollment. 78.9% of EBHV participants aged 18-44 reported experiencing at least one ACE, compared to 71.2% of female Tennesseans in the same age group (BRFSS 2014).

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:** The Office of Early Childhood continues to be involved in Shelby and Davidson Counties ACEs' efforts. In addition, the Department continues to serve on the Steering Committee for the statewide Building Strong Brains, TN's ACEs Initiative.

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:** Building Strong Brains, TN's ACEs Initiative, supported 16 Innovation Grants in FY17. The Innovation Grants fund a variety of different programs that use brain science to prevent and mitigate the impact of adverse childhood experiences by informing early childhood philosophy, policies, programs, and practices.

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

**Report 2d:** The Children's Care Coordination model is currently in development and ACEs will be an educational topic that all care coordination staff will be trained to discuss with families. The information shared with families will include a discussion of ACEs and their impact on families as well as ways to mitigate and prevent ACEs.

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:** Reduce exposure to tobacco among the MCH population (secondhand smoke exposure for children).

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

Newly released 2016 data from the National Survey of Children's Health estimates that nearly 1 out of every 4 children in Tennessee (24.8%) live in a household where someone smokes. Tennessee met or exceeded the objective for all but one ESM related to the strategies aimed at preventing secondhand smoke exposure among children and reducing tobacco use. At the end of FY2017, there were 461 Gold Sneaker designated childcare facilities compared to 441 (FY2016). Call volume to the Tennessee Tobacco QuitLine reached over 18,000 calls, a 9% increase from the previous fiscal year.

#### **Accomplishments and Challenges (based on FY2017 Action Plan)**

##### **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:** There has been continuous education on the benefits of childcare facilities to become Gold Sneaker certified. All daycare facilities in Grainger, Morgan, and Scott that were previously not certified have all been certified. Roane County has begun to show interest in becoming certified. In Shelby, 13 facilities were trained in the Gold Sneaker Initiative, 8 facilities have submitted application as of 7/29/17.

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

**Report 1b:** One of the challenges across the state is facilities not being able to attend the Gold Sneaker training in person. Staff has been able to provide child care facilities with an

online training resource, which is in the process of being updated. Staff has also set in person trainings at flexible dates and times (evenings/weekends) to enable more Public Health Educators to be trained in each county. The Central Office staff as well as county and metro staff involved in Gold Sneaker regularly asks child care facilities about their concerns, questions, or comments about moving the certification process forward.

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

**Report 1c:** Counties and metro statewide continuously educate on the benefits of Gold Sneaker certification to child care facility directors. County and metro staff participate in community health fairs and local events provide education to child care facility staff and parents about the dangers of secondhand and third hand smoking. There have been over 500 attendees at these trainings events who have received resource tools.

## **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 Tennessee QuitLine is promoted on all program material distributed, the TDH website and in partnership with any CDC or local media that occurs, such as CDC TIPS and local Tobacco Master Settlement funded media.

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 collaborative between Vanderbilt University Medical Center, QuitLine and TDH continues to move forward. Staff has been facilitating meetings between the QuitLine and Vanderbilt to ensure all technical and security needs are addressed. There was a pilot of a portion of the electronic referral system, but the key component of the interoperability of the two systems has not been piloted yet. There was a delay while VUMC transitioned to a new health record system, but the project is on track to pilot a fully interoperable system during the next fiscal year.

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

**Report 2c:** To date, Title V funding has not been used to purchase tobacco-related promotional materials. However, efforts to promote effective programs such as CEASE have been ongoing through provider networks.

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:** Statewide, health educators work to partner with health agencies and provider offices by

continuously providing the OB/GYN information for their clients that are of child bearing age, pregnant and/or parenting. The information contains the dangers of tobacco use, dangers of second hand smoke and the TN QuitLine Card. Some health educators also partner with WIC to provide cessation resources at events for pregnant women. Education about the benefits of stopping tobacco, use during pregnancy and staying tobacco free after their baby is born is shared.

TN QuitLine cards and educational brochures about second hand smoke are usually delivered to doctor offices and health agencies to distribute to their patients. The purpose of delivering these educational materials is to increase awareness and referral of women into the QuitLine program.

Health educators also discuss with providers the TN QuitLine Fax Referral system and the new electronic means of providing referrals. They also provide education on the 5 A's intervention framework (Ask, Advise, Assess, Assist and Arrange) and are given easy-to-use cards to utilize with patients. The promotion of this effort focuses on the fact that it only takes "5 minutes to provide the 5 A's."

MCHB Partnerships: MIECHV and state 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))

## Child Health - 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 FY19:

#### **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: Revise and renew contract with the Department of Human Services to promote trainings in child development and developmental screenings through the Child Care Resource and Referral (CCR&R) Network.
- Activity 1c: Incorporate developmental screening pathways into the enhanced model of care coordination in the Community Health Access and Navigation in Tennessee (CHANT) integrated model of services.
- Activity 1d: Implement the Talk with Me Baby initiative in WIC clinics across the state to promote language nutrition and awareness of infant development.

#### **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, clinical staff, care coordinators, and EBHV staff.
- 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.
- Activity 2f: Collaborate with TennCare and the TennCare MCOs to incorporate a PCMH pathways into the

enhanced model of care coordination in the Community Health Access and Navigation in Tennessee (CHANT) integrated model of 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 3b: Increase coordination and collaboration between child's medical home and child serving agencies.

Activity 3c: Explore inclusion of developmental screening administration and language nutrition/Talk with Me Baby into the Gold Sneaker Initiative and designation standards at Department of Health.

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 Departments of Human Services and Education to identify, endorse, and promote the best tools for developmental and behavioral screening among a variety of child-serving professionals.

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 FY19:

**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: Assess community agencies who distribute car safety seats to document how need is determined and how car seat availability is communicated to communities they serve.

**Strategy 2: Promote safe storage of medications.**

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

Activity 2b: Partner with a minimum of 25 hospitals by September 30, 2019 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 FY19:

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

**overweight/obese children).**

- Activity 1a: Recruit a minimum of 50 childcare facilities statewide by educating facility directors about the benefits of Gold Sneaker certification or re-designation.
- 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 implement the Gold Sneaker Three Star requirement and to continue exploring the possibility of adding Gold Sneaker requirements to childcare licensing standards.
- Activity 1d: Continue evaluation processes that support existing Gold Sneaker facilities.
- Activity 1e: Continue Gold Sneaker Advisory Group collaboration to assist in the ongoing certification and re-designation process for Gold Sneaker facilities.
- Activity 1f: Provide a minimum of 1-2 Gold Sneaker trainings for public health educators and 2-4 trainings with DHS staff statewide, as required.

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

- Activity 2a: Promote breastfeeding among the general population through public outreach campaigns (e.g., Breastfeeding Welcomed Here outreach to employers and businesses, Tennessee Hospital Association, Tennessee Breastfeeding Coalition, and Primary Prevention Initiatives).
- 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 (as funding allows).
- Activity 2d: Collaborate with THA to provide technical assistance to birthing hospitals pursuing Baby-Friendly designation or the adoption of other hospital policies to improve breastfeeding practices (e.g. Best for Babies recognition).

**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, state, regional and local health departments that are focusing on obesity-related primary prevention to increase the number of physical activity clubs that promote lifelong physical activity.

Activity 3c: Provide resources (toolkits) to schools planning to implement a run club, physical activity club or other CSPAP activity. Promote resources through webinars, conference calls, group trainings, and other avenues, as they arise.

Activity 3d: Continue evaluating processes that support school-based physical activity/clubs strategies.

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 and assures the availability of a Designated Breastfeeding Expert in every county available regardless of WIC eligibility. 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 FY19:

**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: Review and update ACEs Handout, How to Protect Your Child from Toxic Stress in the Welcome Baby packets to increase parents' understanding of ACEs and strategies to protect their child, and promote the concept of resilience.

Activity 1c: Explore alternate ways to educate parents and other caregivers on ACEs, with a focus on non-English speakers. This will include translation of new Welcome Baby packet into Spanish This will i

Activity 1d: Provide ongoing leadership to Building Strong Brains, Tennessee's ACEs Initiative formed in

2015, as well as the steering committee for ACEs Innovations grants made statewide.

Activity 1e: 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 and disseminate Tennessee specific data such as from Evidence-Based Home Visiting Programs, and compare to state and nationally representative data sources such as BRFSS and NSCH.

Activity 2b: Collect ACEs data in underserved and at risk populations such as home visiting and compare to state and national measures. Disseminate findings to appropriate stakeholders serving these populations.

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: Reduce exposure to tobacco among the MCH population (secondhand smoke exposure for children).**

Planned strategies and Activities: To achieve the objective listed above, the following strategies and activities are planned for FY19:

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

Activity 1a: Recruit a minimum of 50 childcare facilities statewide by educating Facility Directors about the benefits of deciding to pursue Gold Sneaker certification or re-designation.

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

Activity 1c: Provide information for center staff and parents to educate about harm resulting from the use of Electronic Nicotine Delivery Systems (ENDS), the dangers of secondhand and thirdhand smoke exposure, and the benefits of tobacco-free childcare centers and homes, and provide tobacco-free signage.

**Strategy 2: Refer participants in federally-funded programs to smoking cessation services where appropriate.**

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

Activity 3b: Refer 98.5% of smoking participants in home visiting to the Tobacco QuitLine and other community-based cessation services within three months of enrollment.

Activity 3c: Support integration of smoking assessment, including ENDS use, and cessation resources into the TDH electronic health record (EPI) as it is scheduled to be deployed statewide during this reporting year.

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 monitoring performance metrics among grantees such as tobacco screening and referral rates.

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))

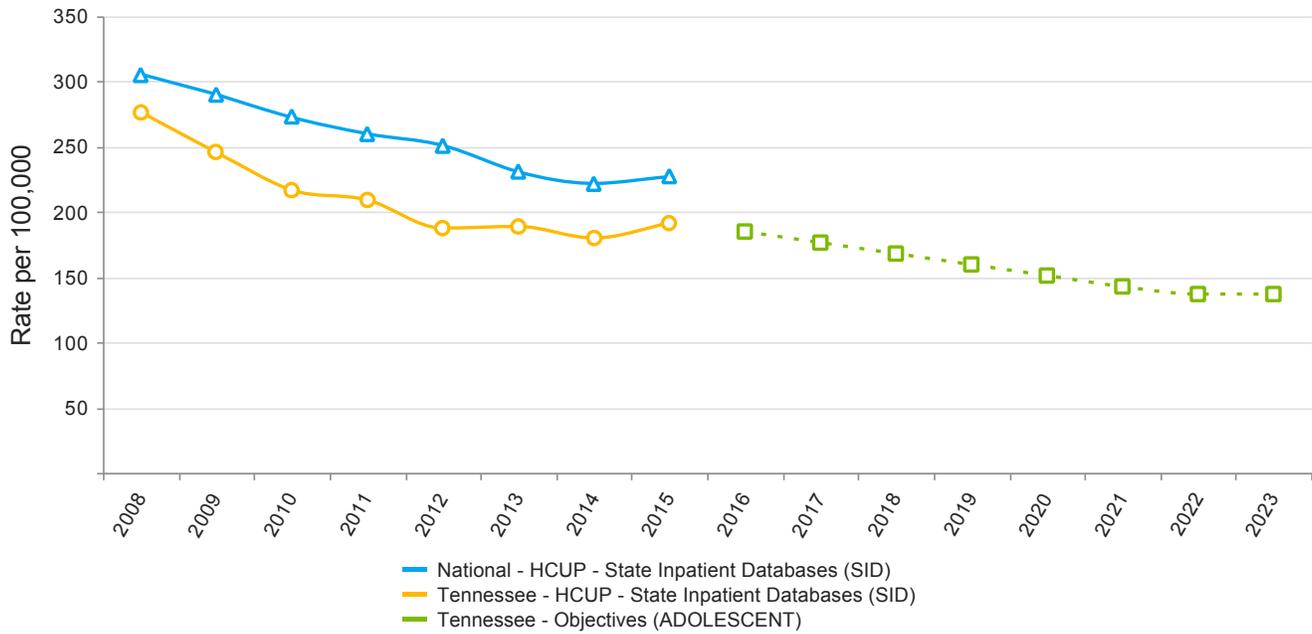
## Adolescent Health

### 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-2016	23.2	NPM 7.2
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000	NVSS-2016	39.9	NPM 7.2
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000	NVSS-2014_2016	15.1	NPM 7.2
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000	NVSS-2014_2016	11.3	NPM 7.2
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2016	89.2 %	NPM 8.2
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	NSCH-2016	19.2 %	NPM 8.2
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	WIC-2014	14.9 %	NPM 8.2
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	YRBSS-2015	18.6 %	NPM 8.2

National Performance Measures

NPM 7.2 - Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19  
Baseline Indicators and Annual Objectives



Federally Available Data		
Data Source: HCUP - State Inpatient Databases (SID)		
	2016	2017
Annual Objective	184.8	176.4
Annual Indicator	207.7	191.6
Numerator	1,746	1,206
Denominator	840,564	629,323
Data Source	SID-ADOLESCENT	SID-ADOLESCENT
Data Source Year	2014	2015

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	168.0	159.6	151.2	142.8	137.0	137.0

**Evidence-Based or –Informed Strategy Measures**

**ESM 7.2.1 - Number of schools in the top ten crash rate counties (among ages 15-18) that conduct evidence-informed teen safe driving programming**

<b>Measure Status:</b>	<b>Active</b>
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<b>State Provided Data</b>		
	<b>2016</b>	<b>2017</b>
Annual Objective		55
Annual Indicator	46	43
Numerator		
Denominator		
Data Source	ReduceTNCrashes.org Safe Driving Report	ReduceTNCrashes.org Safe Driving Report
Data Source Year	FFY2016	FFY207
Provisional or Final ?	Final	Final

<b>Annual Objectives</b>						
	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>2023</b>
Annual Objective	57.0	59.0	61.0	63.0	65.0	65.0

**ESM 7.2.2 - Number of drug disposal bins installed statewide**

<b>Measure Status:</b>	<b>Active</b>
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<b>State Provided Data</b>		
	<b>2016</b>	<b>2017</b>
Annual Objective		
Annual Indicator	206	236
Numerator		
Denominator		
Data Source	TN Depart of Environmental and Conservation Report	TN Depart of Environmental and Conservation Report
Data Source Year	FFY2016	FFY2017
Provisional or Final ?	Final	Final

<b>Annual Objectives</b>						
	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>2023</b>
Annual Objective	225.0	326.0	341.0	356.0	371.0	371.0

**ESM 7.2.3 - Number of press releases, social media posts and presentations about adolescent falls**

<b>Measure Status:</b>	<b>Active</b>
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<b>State Provided Data</b>		
	<b>2016</b>	<b>2017</b>
Annual Objective		
Annual Indicator	8	9
Numerator		
Denominator		
Data Source	TN Depart of Environment and Conservation Report	TN Depart of Environment and Conservation Report
Data Source Year	FFY2016	FFY2017
Provisional or Final ?	Final	Final

<b>Annual Objectives</b>						
	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>2023</b>
Annual Objective	6.0	7.0	7.0	8.0	8.0	8.0

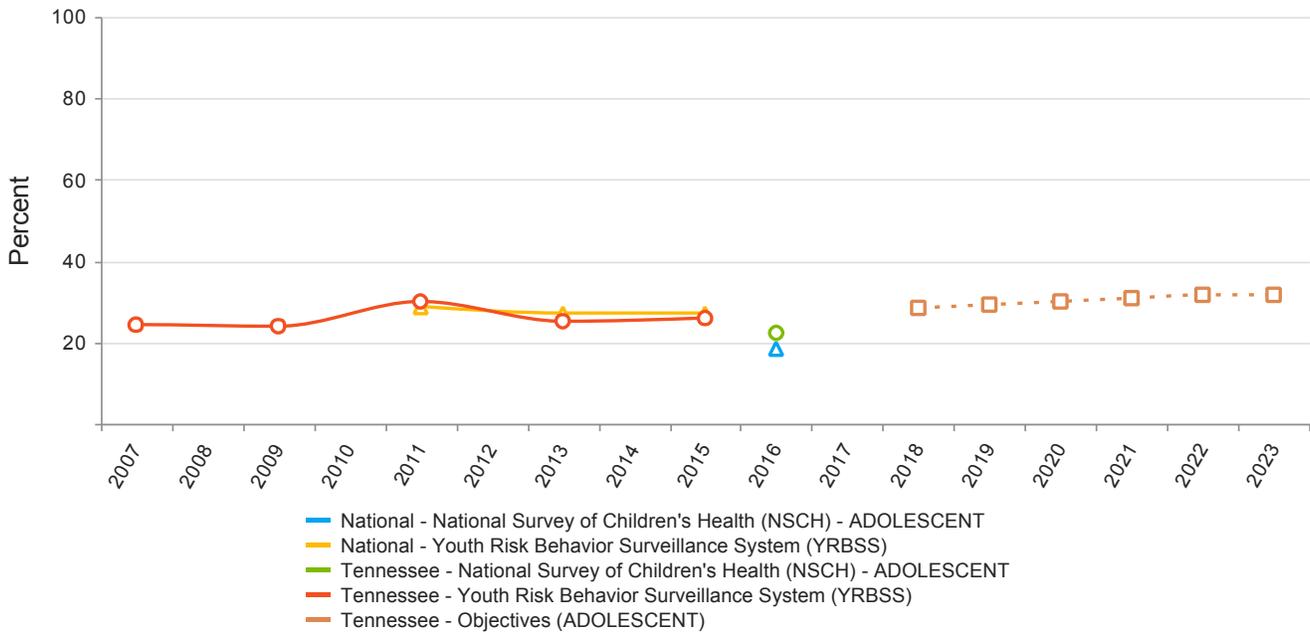
**ESM 7.2.4 - Number of suicide-related articles, social media posts and trainings provided by TDH**

<b>Measure Status:</b>	<b>Active</b>
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<b>State Provided Data</b>		
	<b>2016</b>	<b>2017</b>
Annual Objective		
Annual Indicator	11	19
Numerator		
Denominator		
Data Source	TDH FHW Injury Prevention Section Program Data	TDH FHW Injury Prevention Section Program Data
Data Source Year	FFY2016	FFY2017
Provisional or Final ?	Final	Final

<b>Annual Objectives</b>						
	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>2023</b>
Annual Objective	11.0	20.0	22.0	24.0	26.0	26.0

**NPM 8.2 - Percent of adolescents, ages 12 through 17 who are physically active at least 60 minutes per day**  
**Baseline Indicators and Annual Objectives**



Federally Available Data		
Data Source: Youth Risk Behavior Surveillance System (YRBSS)		
	2016	2017
Annual Objective	26.9	27.7
Annual Indicator	25.9	25.9
Numerator	70,480	70,480
Denominator	272,118	272,118
Data Source	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT
Data Source Year	2015	2015

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH) - ADOLESCENT		
	2016	2017
Annual Objective		
Annual Indicator		22.4
Numerator		107,989
Denominator		481,757
Data Source		NSCH-ADOLESCENT
Data Source Year		2016

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

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	28.5	29.3	30.1	30.9	31.7	31.7

**Evidence-Based or –Informed Strategy Measures**

**ESM 8.2.1 - Number of Physical Activity Clubs in K-12 schools**

<b>Measure Status:</b>	<b>Active</b>
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<b>State Provided Data</b>		
	<b>2016</b>	<b>2017</b>
Annual Objective		
Annual Indicator	47	111
Numerator		
Denominator		
Data Source	TDH FHW Chronic Disease Program Data	TDH FHW Chronic Disease Program Data
Data Source Year	FFY2016	FFY2017
Provisional or Final ?	Final	Final

<b>Annual Objectives</b>						
	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>2023</b>
Annual Objective	125.0	234.0	259.0	284.0	309.0	334.0

**ESM 8.2.2 - Number of school gardens in Tennessee public schools**

<b>Measure Status:</b>	<b>Active</b>
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<b>State Provided Data</b>	
	<b>2017</b>
Annual Objective	
Annual Indicator	337
Numerator	
Denominator	
Data Source	DOE - Farm to School Program
Data Source Year	FFY2017
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>2023</b>
Annual Objective	395.0	451.0	476.0	501.0	526.0	551.0

**ESM 8.2.3 - Number of Healthy Parks Healthy Person app users**

<b>Measure Status:</b>	<b>Active</b>
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<b>State Provided Data</b>	
	<b>2017</b>
Annual Objective	
Annual Indicator	1,661
Numerator	
Denominator	
Data Source	TDEC Healthy Parks Healthy Person App
Data Source Year	FFY2017
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>2023</b>
Annual Objective	1,800.0	2,935.0	3,035.0	3,135.0	3,235.0	3,335.0

**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**

NPM 7.2 - Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19

**Objectives**

Reduce hospitalization rates for unintentional injuries among adolescents age 10-19

**Strategies**

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.

ESMs	Status
ESM 7.2.1 - Number of schools in the top ten crash rate counties (among ages 15-18) that conduct evidence-informed teen safe driving programming	Active
ESM 7.2.2 - Number of drug disposal bins installed statewide	Active
ESM 7.2.3 - Number of press releases, social media posts and presentations about adolescent falls	Active
ESM 7.2.4 - 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

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

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

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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

NPM 8.2 - Percent of adolescents, ages 12 through 17 who are physically active at least 60 minutes per day

Objectives

Reduce the percentage of students in grades 9-12 identified as overweight/obese.

Strategies

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

ESMs

Status

ESM 8.2.1 - Number of Physical Activity Clubs in K-12 schools	Active
ESM 8.2.2 - Number of school gardens in Tennessee public schools	Active
ESM 8.2.3 - Number of Healthy Parks Healthy Person app users	Active

NOMs

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

## Adolescent Health - Annual Report

**PRIORITY:** Reduce the burden of injury among adolescents.

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

The Injury Program and partners met all our adolescent health ESM objectives for Year 2, except ESM objectives ESM 7.3 and 7.4. However, these were due to changes in injury partner reporting methods. We did exceed our 2022 objectives for ESM 7.2 and ESM 7.5. We have seen a continued decrease in adolescent nonfatal injury hospitalizations from 228.1 per 100,000 population in 2012 to 210.5 per 100,000 population in 2014, then increased to 237.0 in 2015. Specifically, nonfatal hospitalization rates due to motor vehicle crashes, poisoning, and falls hospitalizations have increased from 57.2, 54.6 and 20.6 (respectively) in 2014 to 62.9, 62.4 and 22.2 in 2015. The U.S. transitioned from ICD-9-CM to ICD-10-CM on October 1, 2015. The reader should consider this as a possible cause of any changes that appear to occur between the third and fourth quarters of 2015. We are working with partners to correct data collection methods for ESMs 7.3 and 7.4 that will provide more accurate assessment of progress.

### Accomplishments and Challenges (based on FY2017 Action Plan)

#### Strategy 1: Increase evidence based or evidence informed activities related to motor vehicle safety 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 30 to 40.

**Report 1a:** A total of 43 schools registered for ReduceTNCrashes.Org, with 23 of those residing in the ten counties with the highest motor vehicle crash rates. Also, 10 of those schools in Williamson County conducted the evidence-based Checkpoints™ program, completing 2,000 parent-teen driving agreements to address teen driving risks.

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

**Report 1b:** A total of six school districts registered to compete in the Battle of the Belt Program. Eleven seatbelt observations were made during the program and the overall observed seatbelt use increased 5.42% for the winning school. Other evidence-based REDUCE TN CRASHES programs were also adopted by schools including the Vanderbilt “Be In The Zone” texting prevention (11 schools) and Checkpoints™ Program to increase parent-teen driving agreements to reduce teen driving risks (10 schools).

Activity 1c: Partner with schools to provide Graduated Driver’s License (GDL) education to 1000 teens and caregivers.

**Report 1c:** Ten schools in Williamson County conducted the Checkpoints™ program, completing over 2,000 parent-teen driving agreements to address teen driving risks and Graduated Driver License requirements. Twenty-two administrators, teachers, and School Resource Officers (SROs) were trained to implement the program which included GDL Wallet Brochures and slides specific to GDL education. Preliminary pre and posttest

data suggests that both parents and teens intention to enforce/comply with GDL laws increased as a result of the program.

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

Activity 2a: Partner with the Coffee County Anti-Drug Coalition to recruit 8 additional county coalitions or health councils to conduct the “Count It! Lock It! Drop It!” prescription drug abuse prevention program.

**Report 2a:** As of September 30<sup>th</sup>, 2017, 61 counties have implemented the Count It, Lock It, Drop It™ program that includes education and securing medication in locked medicine boxes. This is an increase of 25 counties since year 1 and through the support of a Blue Cross and Blue Shield Grant to Count It, Lock It, Drop It, the group is funded to expand to all 95 counties.

Activity 2b: Partner with the Tennessee Department of Environment and Conservation to increase the number of counties with drug disposal bins from 88 counties to 90 counties.

**Report 2b:** The number of counties with drug disposal bins increased from 88 counties to all 95 counties (100%). Thirty-four (34) new bins were installed throughout Tennessee and 97,237 pounds of medications were collected. A total of 238 drug disposal bins are now available throughout the state.

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

**Report 2c:** TDH provided \$279,532 in Title V funding to support a portion of the operation of the Tennessee Poison Center.

**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:** Eight (8) social media messages were posted during the month of September to support fall prevention efforts. In partnership with Project Brain and the Tennessee Disability Coalition, the following were posted: Sept. 8 – Excessive Brain Cell Growth Following Injury May Cause Seizures (Twitter); Sept. 8 – Childhood Injury Prevention Week/Helmet Safety (Twitter) Sept. 15 – Concussion Awareness Day (Twitter); Sept. 14, 18 & 20 – Project Brain Awareness (Twitter & Facebook); Sept. 22 – Project Brain Awareness (Facebook).

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:** Nine (9) Social media messages and/or press releases were posted on the Tennessee Department of Health Twitter and Facebooks sites that included: May 23 - Recall on

Ride On Toys Fall Hazards (Twitter); May 23 –YouTube Series on SafeKids Sports League Safety (Twitter); Aug. - 17 Sports Safety (Twitter); July 19 - Safe Stars Sports League Safety Initiative Launch (Facebook); and Sept. 19 - Helmet Safety (Facebook). Also, earned media for the Safe Stars Sports League Safety Program included: July 14 – Press release; July 19 – News Channel 5 interview; July 14 – Nashville Public Radio interview.

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

**Report 3c:** The Falls Prevention CoIIN team is working on three projects that focus on decreasing falls due to sports including Safe Stars, Return to Learn and concussion reporting. The Safe Stars Initiative is a youth sports league safety rating system. Leagues are designated as gold, silver or bronze based on specific safety criteria. A webinar on “Return to Learn” was presented in July 2017. The archived version will be linked to the department’s sports concussion webpage. A RedCap database is being developed for use by athletic trainers to track concussions during practice and play.

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

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

**Report 4a:** TDH staff members throughout the state (315) were provided QPR suicide prevention training to better recognize suicidal symptoms and make appropriate referrals. Training was provided to 100% of local health department nurses and some doctors and administrators. Also QPR training was made available to Central Office State Health Department employees as a “Personal Primary Prevention” project.

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

**Report 4b:** A suicide prevention infographic was printed (1,000) and distributed to educate schools and other partners that included referral sources. The department also chaired a Youth Suicide Prevention Data Working Group to compile and share youth suicide data and share with stakeholders including statewide Injury Community Implementation Group (ICIG) members who meet quarterly and serve as an advisory group for injury prevention efforts.

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

**Report 4c:** Ten (10) social media messages were posted on Tennessee Department of Health Twitter and Facebook sites that included: Sept. 6 - Suicide Hotline (Twitter); Suicide Prevention Hotline (Facebook); Sept. 10 - World Suicide Prevention Day (Twitter & Facebook); Sept. 13 Suicide warning signs (Twitter); Sept. 13 – Suicide Awareness Day (Facebook); Sept. 22 - Suicide Prevention Hotline (Twitter & Facebook). Other social media messages included: Feb. 9 - Regular Exercise helps depression in youth (Facebook); and Feb. 17 – Suicide Crisis Text Line (Facebook)

MCHB Partnerships: Not applicable

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

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

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

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

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

The 2016 National Survey of Children's Health showed that 22.4% of TN adolescents age 12-17 were physically active at least 60 minutes every day, higher than the national figure of 18.5%. The 2015-16 Coordinated School Health Weight Status Report indicated that prevalence of overweight and obesity was similar for 8<sup>th</sup> grade (43.4%) and high school (42.0%) students with little change overall since 2007-08. The number of shared-use agreements listed on the Tennessee Recreation and Parks Joint Use Facility Finder remained the same due to a lack of site maintenance. Once the evaluation team is fully staffed in FY2018, CDC 1305 Grant funds will be leveraged to promote shared-use agreements and develop/maintain a robust tracking mechanism. Nearly all (136/146) Tennessee public school districts have received Smarter Lunchroom or similar training, and the number of LEAs receiving CSPAP training increased to 87 districts from 68 last year. TDH is working with Coordinated School Health to include all LEAs in these 2 trainings. Also, TDH continues to promote, monitor, and track the adoption of Run Clubs across the state. The number of such clubs more than doubled to 111 at the end of FY 2017.

#### **Accomplishments and Challenges (based on FY2017 Action Plan)**

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

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

**Report 1a:** The School Nurse Consultant 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:** The 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, with a specific focus on increasing access to summer meals.

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

**Report 1c:** Culinary trainings, conducted by School Nutrition, took place in January and February 2017 with approximately 140 local school personnel in attendance. The culinary trainings focused on knife skills, how to season food without salt, taste tests and school gardens.

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

**Report 1d:** Between July 2016 and June 2017, School Nutrition provided 315 school food service personnel 1 hour of Smarter Lunchroom training during their in-service training. An evaluation was done of this training which resulting in an enhanced emphasis on food preparation training.

## **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:** Staff is engaged in ongoing efforts to promote joint-use, shared-use, and open-use policies at the local level. Program staff is in the process of developing a new system to track joint-use policy and promote available sites to local communities. The previous joint use assessment is now out of date. By developing a new tracking system, local communities can report changes as they occur.

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 are 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 - 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 FY19:

**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 and/or other providers by September 30, 2019 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 5 to 25 by September 30, 2019.
- 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 CollIN 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, state, regional and local health departments that are focusing on obesity-related primary prevention.

Activity 1c: Develop and implement strategies that support increased physical activity before, during and after school.

Activity 1d: Develop and implement strategies that increase access to healthier food and beverage options.

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))

## Children with Special Health Care Needs

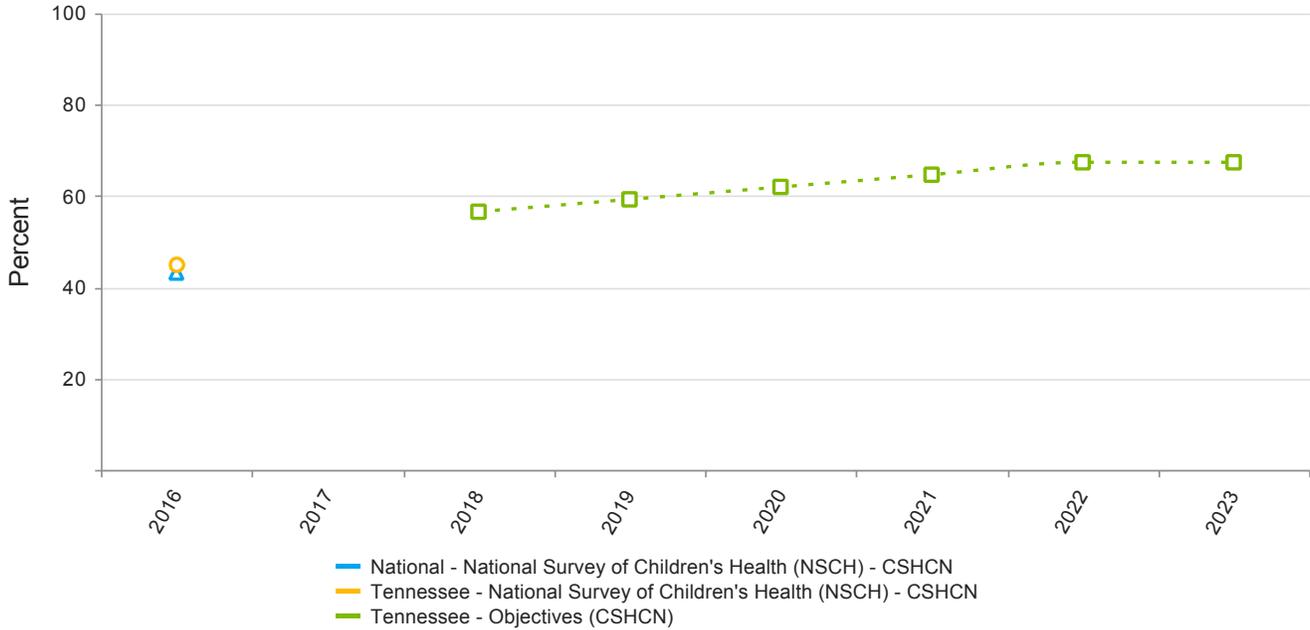
### Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	NSCH-2016	20.4 %	NPM 11 NPM 12
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH-2016	48.7 %	NPM 11
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2016	89.2 %	NPM 11
NOM 25 - Percent of children, ages 0 through 17, who were not able to obtain needed health care in the last year	NSCH-2016	2.1 %	NPM 11

**National Performance Measures**

**NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home**

**Baseline Indicators and Annual Objectives**



**NPM 11 - Children with Special Health Care Needs**

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH) - CSHCN		
	2016	2017
Annual Objective		
Annual Indicator		44.8
Numerator		125,986
Denominator		281,120
Data Source		NSCH-CSHCN
Data Source Year		2016

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

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	56.5	59.2	61.9	64.6	67.3	67.3

**Evidence-Based or –Informed Strategy Measures**

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

<b>Measure Status:</b>	<b>Active</b>
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<b>State Provided Data</b>		
	<b>2016</b>	<b>2017</b>
Annual Objective		
Annual Indicator	420	615
Numerator		
Denominator		
Data Source	TDH FHW Title V CYSHCN Program Data	TDH FHW Title V CYSHCN Program Data
Data Source Year	FFY2016	FFY2017
Provisional or Final ?	Final	Final

<b>Annual Objectives</b>						
	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>2023</b>
Annual Objective	525.0	730.0	780.0	830.0	880.0	930.0

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

<b>Measure Status:</b>	<b>Active</b>
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<b>State Provided Data</b>		
	<b>2016</b>	<b>2017</b>
Annual Objective		
Annual Indicator	279	558
Numerator		
Denominator		
Data Source	TDH FHW Title V CYSHCN Program Data	TDH FHW Title V CYSHCN Program Data
Data Source Year	FFY2016	FFY2017
Provisional or Final ?	Final	Final

<b>Annual Objectives</b>						
	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>2023</b>
Annual Objective	337.0	635.0	665.0	695.0	725.0	755.0

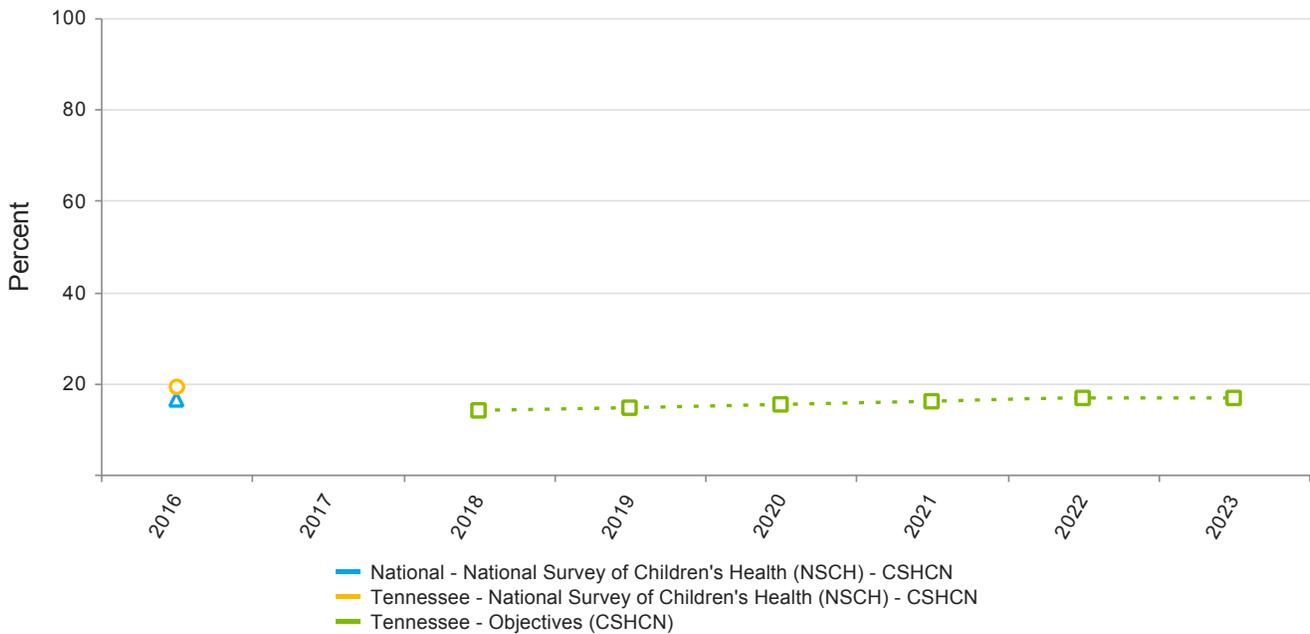
**ESM 11.3 - Percentage of children served by the Children's Special Service (CSS) program receiving services in a medical home**

<b>Measure Status:</b>	<b>Active</b>
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<b>State Provided Data</b>		
	<b>2016</b>	<b>2017</b>
Annual Objective		80
Annual Indicator	74	72.7
Numerator		
Denominator		
Data Source	TDH FHW Title V CYSHCN Program Data	TDH FHW Title V CYSHCN Program Data
Data Source Year	FFY2016	FFY2017
Provisional or Final ?	Final	Final

<b>Annual Objectives</b>						
	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>2023</b>
Annual Objective	85.0	90.0	95.0	100.0	100.0	100.0

**NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care**  
**Baseline Indicators and Annual Objectives**



**NPM 12 - Children with Special Health Care Needs**

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH) - CSHCN		
	2016	2017
Annual Objective		
Annual Indicator		19.2
Numerator		16,734
Denominator		87,214
Data Source		NSCH-CSHCN
Data Source Year		2016

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

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	14.1	14.7	15.4	16.1	16.8	16.8

**Evidence-Based or –Informed Strategy Measures**

**ESM 12.1 - Number of adolescents on the Adolescent Advisory Council**

<b>Measure Status:</b>	<b>Active</b>
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<b>State Provided Data</b>		
	<b>2016</b>	<b>2017</b>
Annual Objective		5
Annual Indicator	7	7
Numerator		
Denominator		
Data Source	Title V CYSHCN Program Data	Title V CYSHCN Program Data
Data Source Year	FFY2016	FFY2017
Provisional or Final ?	Final	Final

<b>Annual Objectives</b>						
	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>2023</b>
Annual Objective	7.0	9.0	11.0	13.0	15.0	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**

<b>Measure Status:</b>	<b>Active</b>
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<b>State Provided Data</b>	
	<b>2017</b>
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	no data
Data Source Year	no data
Provisional or Final ?	Provisional

<b>Annual Objectives</b>						
	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>2023</b>
Annual Objective	100.0	240.0	265.0	290.0	315.0	340.0

**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**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>	
	<b>2017</b>
Annual Objective	0
Annual Indicator	65
Numerator	
Denominator	
Data Source	TDH FHW Title V CYSHCN Program Data
Data Source Year	FFY2017
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>2023</b>
Annual Objective	75.0	80.0	85.0	90.0	95.0	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

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Objectives

Increase the percent of children age 0-17 years (with and without special healthcare needs) having a medical home.

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 Children's Special Services, Tennessee's MCH/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), ages 0 through 17, who receive care in a well-functioning system

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NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

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NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

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NOM 25 - Percent of children, ages 0 through 17, who were not able to obtain needed health care in the last year

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

Priority Need

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

NPM

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care

Objectives

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

Strategies

- 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.

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), ages 0 through 17, who receive care in a well-functioning system



## Children with Special Health Care Needs - Annual Report

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

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

The objective for NPM 11 (i.e. the percent of children with and without special health care needs having a medical home) was set at 63.1% for FY 2017. According to the 2016/2017 NSCH, only 54.1% of TN children 0-17 had a medical home. Despite the various activities with multiple partners across the state, Tennessee has not improved in this measurement. The significant changes of the NSCH survey method this year made the survey results not comparable to previous years. We have not received guidance from NSCH regarding how much the change of method affects the data. We believe this change in survey methodology could be another factor contributing at least partially to measured lack of progress for this NPM.

During this FY we worked with our partners and trained or provided information on medical home implementation to 195 providers (ESM 11.1), which made the total number for this project period to be 615. 279 families received patient centered medical home training (ESM 11.2) during this FY – a total of 558 for the project period.

Among the children enrolled in the Children's Special Service (CSS) program, 69% reported that they received services in a medical home (ESM 11.3). This was a slight drop from 74% from last FY and was also lower than the objective of 80%.

### Accomplishments and Challenges (based on FY2017 Action Plan)

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

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

**Report 1a:** Due to funding reductions, the CYSHCN program and TNAAP were unable to enter into contractual agreements to provide additional training for NCQA certification as patient centered medical homes to eligible providers and facilities. CYSHCN and TNAAP continue to support and encourage providers to participate in the Tennessee Medical Home project which provides tools, resources, and training opportunities for pediatric clinicians and practices related to medical home implementation. CYSHCN and TNAAP continue to promote the National Center for Medical Home Implementation Technical Assistance Center focused on ensuring all children and youth—particularly those with special health care needs—receive care within a medical home. CYSHCN and TNAAP also are partnering with the TennCare Bureau on the State Innovation Model (SIM) grant that is focusing on increasing the number of certified medical homes in Tennessee. CYSHCN, TNAAP, and TennCare meet quarterly to review progress and share strategies in PCMH implementation for families with TennCare coverage.

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:** CYSHCN received technical assistance from the National Center for Medical Home Implementation and Got Transition on families partnering with medical providers and transition policies for health care providers. The information received continues to be shared with health care providers, TNAAP and Family Voices. CYSHCN has distributed over 5000 *Partnering with Your Doctor: The Medical Home Approach* booklets to providers and families.

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

**Report 1c:** CYSHCN staff has had preliminary conversations with the local Federally Qualified Health Care Centers around developing a model transition plan. The two facilities that the program will be partnering with both have pediatric and adult practices and refer adolescents and youth as needed to the adult providers.

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

**Report 1d:** CYSHCN program staff continues to partner with Family Voices around development and implementation of family and engagement policies. CYSHCN recently hired dedicated staff that will work with Family Voices on family engagement and involvement and will develop a work plan for including family members in CYSHCN and Family Health and Wellness initiatives and activities. CYSHCN contracted with Family Voices to ensure sustainability of family engagement and involvement with Family Health and Wellness programs and activities.

## **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 previously housed on TNAAP's website with links from the CYSHCN website has been removed. TNAAP and CYSHCN refer physicians to The National Center for Medical Home Initiatives for Children with Special Needs. The tool kit previously developed with D70 funds was unable to be updated and maintained due to a lack of dedicated funding. However TDH continues to maintain a medical home tool kit at: <http://tn.gov/health/topic/MCH-mh>

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

**Report 2b:** CYSHCN continues to partner with Family Voices to coordinate and refer families to the Parent to Parent program and provide families with information and support on accessing ongoing, comprehensive care in a medical home. Mentor training and

referrals for families seeking assistance continue and families are matched with a mentor and receive support and education around their child's diagnosis.

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

**Report 2c:** CYSHCN continued to partner with Family Voices to provide workshops, training and resources for families. The Tennessee Family-to-Family Health Information Center 2016 Data Report indicates that Family Voices served a total of 16,912 families and provided 1803 trainings between June 1, 2015 and May 31, 2016.

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:** CYSHCN continued to support Family Voices and the Tennessee Disability Multicultural Alliance to develop resources particularly for multi-cultural families. The CYSHCN program contracts with the Tennessee Disability Pathfinders to provide a resource directory for children with disabilities and special needs. The contract also provides for one program staff person who is bilingual and conducts workshops and training with ESL families and children statewide. CYSHCN program staff continues to serve on the Disability Multicultural Alliance and provide information, updates and training material as requested.

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:** CYSHCN continues to partner with TNAAP, TAFP, Tennessee Voices for Children and the Department of Mental Health and Substance Abuse Services on behavioral health initiatives. The CYSHCN director serves as the department's representative on the statutorily designated Council of Children's Mental Health steering committee and is responsible for assisting in planning quarterly meetings and statewide initiatives for behavioral and mental health programs for children and youth. The CYSHCN director continues to serve on the Project Launch Workgroup that is creating the primary and behavioral health care tool kit.

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

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

**Report 3a:** 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, uninsured individuals can be seen by safety net providers in health departments and FQHCs.

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

**Report 3b:** The CSS program has been unable to evaluate data from the satisfaction survey.

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

**Report 3e:** Care coordinators for the CSS program have made available copies of the Transition Readiness Assessment Tool for Youth and Parents/Caregivers and refer families to the Got Transition website. A test of the tool has been added to REDCap and when coordinators have electronic equipment available, they will be able to conduct the assessment in the home with the youth/family. The coordinators continue to provide an annual transition plan that begins at age 14 which includes assessment and planning for health care and for transition to adult independence.

#### **Strategy 4: Support youth participation in the transition process.**

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

**Report 4a:** CYSHCN has continued the collaboration with Family Voices and LEND to recruit and retain members to serve on the CYSHCN Youth Advisory Committee. Currently there are seven active members on the committee and one who participates virtually due to being away at school. CYSHCN is working to increase the total number to 15.

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 2019. Challenges with this activity include LEND participants graduated from the program in April 2017 and the new cohort did not begin until September 2017, the end of the D70 grant and no dedicated funding for the Advisory Committee. The Integrated System of Services program director position has recently been filled and a new contract is being executed with Family Voices to hire a dedicated Youth Advisor this individual will collaborate with the Integrated System of Services Director to ensure the Youth Advisory Committee activities are planned and conducted in the absence of the LEND students and will work to develop and facilitate the Youth/Family conference.

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

**Report 4c:** The CYSHCN and Family Voices staff conducted a Youth Advisory Committee meeting where the youth were provided training on self-advocacy and policy development. The youth developed elevator speeches and role played with staff to develop confidence and comfort with telling their story to legislative members. The Youth that attended this meeting also attended Disability Day on the Hill and met with members of the Tennessee General Assembly to discuss disability issues in general and issues regarding their individual diagnoses.

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

**Report 4d:** A link to the Transition Tool Kit has been added to the Kidcentraltn website.

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

Other Key Partnerships: The CYSHCN program has formed partnerships with Family Voices, TNAAP, and the Tennessee Academy of Family Physicians (TNAFP). The focus of the partnership with Family Voices is to support family participation in advocacy and policy development, to support and promote the parent to parent network that provides mentoring and support to other families of CYSHCN and to support and provide opportunities for parent and family training and participation. The partnership with TNAAP includes support for training of medical providers around patient and family centered medical homes, care coordination, culturally sensitive care, and transition to adult health care. TNAAP also focused on identifying and implementing strategies for collaboration with medical providers for NCQA certification. Collaborative efforts with TNAFP include identifying mechanisms for creating a transition model for transferring youth from pediatric to adult providers. The CYSHCN program has also partnered with the Tennessee Department of Mental Health and Substance Abuse Services to identify and disseminate best practice models of primary care and behavioral health integration. The CYSHCN program is partnering with TennCare to ensure that children have access and are receiving services in a patient centered medical home. The CYSHCN Director collaborates with TEIS by chairing the State Interagency Coordinating Committee. This committee creates the TEIS strategic plan and reviews the annual report that is required by the U.S. Department of Education. The CYSHCN

Director has also provided training to the TEIS staff on when to refer children to CSS.

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

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

## Children with Special Health Care Needs - Application Year

**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 MCH/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 implementing the CHANT patient centered medical home pathway.

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 will utilize the Child Health Access and Navigation in Tennessee (CHANT) patient centered medical home pathway to facilitate collaborative efforts with TennCare and the Managed Care Organizations (MCOs). This collaboration will ensure that children have access to, and are receiving services in a patient centered medical home. This collaboration will also provide for streamlined care coordination and enhance treatment and service provision for this population. Children receiving services through the CSS program will automatically be referred to their identified primary care provider and the CSS care coordinators will work with the assigned MCO case manager to make sure that care is accessible, coordinated and patient-centered. This collaboration with TennCare and the MCOs is designed to provide a transformative model of patient care and coordination for Tennessee CYSHCN.

The CYSHCN Director collaborates with TEIS by serving on 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.

**Strategy 3: 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))

**Cross-Cutting/Systems Building**

**Cross-Cutting/Systems Building - Annual Report**

No content was entered for the Cross-Cutting/Systems Building - Annual Report in the State Action Plan Narrative by Domain section.

**Cross-Cutting/Systems Building - Application Year**

No content was entered for the Cross-Cutting/Systems Building - Application in the State Action Plan Narrative by Domain section.

### III.F. Public Input

#### Public Comment – During Report/Application Development

Tennessee's MCH/Title V Program offers four main mechanisms for the public to provide feedback on the annual application/report. The first is through participating in in-person stakeholder meetings that are held twice each year. These meetings are open to the public, with special effort being made to reach out to those serving the maternal and child population as well as parents (including parents of CYSHCN, foster parents, and grandparents). 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 or public participation in advisory committees. The division convenes multiple advisory committees commissions by Tennessee statute including the Genetics Advisory Committee (focused on newborn screening), Perinatal Advisory Committee (focused on perinatal health and the regionalization system), the Birth Defects Registry Advisory Committee 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 or the Governor and provide topic-specific expertise to the respective committees. Furthermore, these meetings are subject to the State's Open Meetings Law and are open for attendance by members of the general public. The Title V director and program staff are in regular communication with committee members, members of the public, and members of the General Assembly on topic areas of interest to those committees. In addition to these long standing committees, the MCH/Title V CYSHCN program established a youth advisory committee in 2017, and sections of the Division operate advisory committees for grants such as the Preventive Health and Health Services Block Grant.

Another avenue used to gather ongoing feedback is through FHW program staff. Program staff seek input throughout the year from representatives of local and regional health departments, and by extension, their clients and communities. Regional MCH Directors are convened via conference call every other month. On each call, all central office program representatives and regional MCH Directors are offered the opportunity to present updates for their program/region. These highlights focus on information that increases understanding and collaborative efforts between programs, as well as updates that affect all MCH programs. Additionally, Central Office program regularly visit each of the Department's 13 regions to individually meet with front-line program staff. The visits are separate from required monitoring visits, and are aimed to provide opportunities for Central Office staff to see firsthand the unique needs of Tennessee communities and to understand how state-level staff can best support front-line staff.

Lastly, feedback is gathered through an annual survey that is posted online with the draft of the report/application each spring. Notice of the posting is communicated via email to MCH stakeholders and they are asked to share the notice broadly with their contacts. The survey asks respondents to provide comments on each section of the draft. It also asks them to provide demographic information so that the diversity of respondents can be assessed. This demographic information includes: county of residence, gender, age, race, ethnicity, organization affiliation, and whether or not they are a parent. Below is a summary of the comments from this year's draft.

#### Feedback from Annual Survey/Online Posting of 2017 Report/2019 Application Draft

The draft application/report was posted to the TDH website. Notice of the posting and link to the survey was emailed to MCH stakeholders (see list below). The survey was open for three weeks in June of 2018. A reminder email to

complete the survey was sent out halfway thru the public comment period.

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

- 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
  - Head Start
- 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
- 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

Commenter Demographics:

A total of 58 individuals provided comments on the draft report/application via the online posting and survey. Of those who provided their demographic information 89% were female, with an average age of 50 and a range of 23 to 70 years old. The racial breakdown was 69% white, 30% black, and 1% other. There were two people who identified themselves as Hispanic. Overall 77% noted they were parents, with 23% of those being parents of children with special health care needs. Of the respondents 78% indicated they read the draft report/application for this year, and 47% noted that this was their first time ever reading the report/application. A list of organizations that the respondents represented is below.

Organization Affiliations:

- Camelot
- Centerstone
- Children's Hospital Alliance of Tennessee
- City of Memphis
- CJ Barber Shop
- Health Insurance
  - Amerigroup Tennessee
  - BlueCare
- Knox County Juvenile Court
- Master Gardeners
- Memphis Health Center, Inc.
- State of Tennessee

- Department of Education
- Shelby County Schools
  - Department of Health
- Central Office
- Regional Health Departments
- Southeast
- Jackson Madison County Regional Health Department
- Knox County Health Department
- Metro Nashville Public Health Department
- Shelby County Health Department
- Sullivan County Regional Health Department
- Local Health Department
  - TennCare (Medicaid)
  - Tennessee Commission on Children and Youth
  - Tennessee Council on Developmental Disabilities
  - University of Tennessee
- University of Knoxville
- University of Tennessee Health Science Center – Memphis
- East Tennessee State University
- Tennessee Initiative for Perinatal Quality Care
- Tennessee Hospital Association
- The Center for Family Development
- The Works, Inc.
- Tennessee Chapter of the American Academy of Pediatrics
- Tennessee Disability Coalition / Family Voices of Tennessee

Comments:

#### Executive Summary

Overall the respondents agreed with the chosen priorities and performance measures. However there was a desire to have more male/father engagement throughout the program. The consolidating of the CSS, HUGS, and Community Outreach programs was thought to be a good idea, a more lean and efficient way to serve the population. Many comments appreciated that this section acknowledged that partnerships are critical to the work being done by the Tennessee MCH/Title V Program. Lastly the suggestion was made to including the action plan in the executive summary. It was also noted that even more work needs to be done around ensuring more stakeholders/communities and ensuring that they know about the in-person stakeholder meetings that they are welcomed to participate in.

#### Overview of the State

Overall the comments in the section noted an appreciation of the one page measurement snapshot. Stakeholders expressed agreement with current work being done as well as a desire to be able to do more programming in schools, have more information on how funds are allocated for the grant, and have more information on maternal mortality burden and prevention efforts.

#### Needs Assessment Update

The comments here affirmed the appropriateness of the priorities in particular infant mortality, NAS, ACEs, early childhood intervention/early childhood programming, child obesity, and transition from pediatric to adult healthcare providers'. It was noted that some stakeholders would like to see more topics related to the intersection at education and health, as well as a presentation of maternal mortality data including a plan for prevention moving forward. Lastly commenters requested that a root cause analysis for each of the priorities be completed and recommendations on how to improve outcomes based on the causes be presented.

#### Women's/Maternal Health

A suggestion was made to use media to market the services/programming provided by this program. There is a concern that more strategic intervention needs to occur around NAS because the issue seems to be worsening. Lastly there is a desire to identify barriers to preconception chronic disease screening and access to prenatal care, so that those barriers can be addressed.

#### Perinatal/Infant Health

In this section the concern over the need to address barriers to prenatal care was reiterated. Some comments requested more detail on the factors influencing infant mortality. However it was noted there are many initiatives around this issue and that improvements have been made in this area due to them.

#### Child Health

The need for work around social determinants of health was brought up in this section. Social determinants of health are the social conditions that affect a person or communities health. There was also a comment around wanting day care providers to administer developmental screening tools, and also be inclusive of children with known developmental delays. There is a desire to see a workgroup be formed to work on this issue. Lastly there was a comment on the need for a discussion on mental health crisis in the emergency department for this population.

#### Adolescent Health

Comments noted an appreciation for the work being done around tobacco reduction for this population, in particular the TNSTRONG initiative which engages youth in peer-to-peer education and advocacy for prevention of tobacco and nicotine addiction across Tennessee. Other comments noted a desire to see prevention efforts specifically for this population around substance abuse and early sexual initiation.

#### CYSHCN

Respondents noted appreciating the information and support provided to these children and families through workshops in their medical homes and schools. There was a desire to include these children in the same activities typically developing children are included in. There was a comment about how the MCH Stakeholder meetings made it possible to connect with other organizations to build collaborations in particular around training providers and caregivers how to administer different development screening tools. The Council on Developmental Disabilities specifically recommended partnership opportunities including contribution to Welcome Baby materials, and working with DHS and Child Care Resource Centers on developmental screening.

### **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. The Title V Director has had an opportunity to address many of these comments in the report public comment period individually if the respondent communicated his/her contact information. As a whole, the comments verified many of the priority areas needs as well as the strategies that the state has adopted. The public comment period also identified the difficulty of communicating the breadth of MCH priorities and the large scope of the action plan. The length of the report made it difficult for some to find the information they were most interested in. In years to come, the Tennessee Title V program will consider adding a topic specific index for data updates and programmatic information and additional links to programmatic web sites.

The comments to the report have also opened opportunities for new partnerships and ideas for strategies. The program has already been in follow up for several of these areas and will continue to do so in the years to come. The multiple avenues for public comment, including on the report itself, have proved extremely valuable for engaging a very broad contingency of stakeholders across the state in all priority areas who have shaped both the ongoing needs assessment as well as the ongoing activities in all priority areas.

### **Public Comment Process – After Report/Application Submission**

After submission of the application/report, the draft on the website is replaced with the final document. Contact information for the MCH Director is also provided; so that comments can be made/contact with the director is available on an ongoing basis.

### **III.G. Technical Assistance**

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. 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 comprehensive approach to health equity. The Division of Family Health and Wellness is committed to developing a framework for use by its nearly 30 different programs by the fall of 2018. The Division has already reviewed material from dozens of states and jurisdictions in an initial survey, and a representative leadership team has been assembled. As next steps are planned, additional input from HRSA may be requested.

#### **IV. Title V-Medicaid IAA/MOU**

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - [Tennessee Title V-Medicaid IAA\\_MOU with Letter.pdf](#)

## V. Supporting Documents

The following supporting documents have been provided to supplement the narrative discussion.

Supporting Document #01 - [MCH-Related Mandates.pdf](#)

Supporting Document #02 - [Glossary.pdf](#)

Supporting Document #03 - [Ob Peds shortage areas 2016.pdf](#)

Supporting Document #04 - [PP Plan Overview 2017-2018.pdf](#)

Supporting Document #05 - [Dec 11\\_ELT\\_recognition\\_Performance Excellence\\_comptroller\\_EDS\\_121417.pdf](#)

## VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - [Tennessee Organizational Charts.pdf](#)

## VII. Appendix

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**Form 2**  
**MCH Budget/Expenditure Details**

State: Tennessee

	FY19 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	\$ 12,750,000	
A. Preventive and Primary Care for Children	\$ 3,853,809	(30.2%)
B. Children with Special Health Care Needs	\$ 3,917,993	(30.7%)
C. Title V Administrative Costs	\$ 788,680	(6.2%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	\$ 8,560,482	
3. STATE MCH FUNDS (Item 18c of SF-424)	\$ 32,000,000	
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)	\$ 2,881,646	
7. TOTAL STATE MATCH (Lines 3 through 6)	\$ 34,881,646	
A. Your State's FY 1989 Maintenance of Effort Amount \$ 13,125,024		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	\$ 47,631,646	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS(Subtotal of all funds under item 9)	\$ 174,823,962	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	\$ 222,455,608	

OTHER FEDERAL FUNDS	FY19 Application Budgeted
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	\$ 100,000
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Abstinence Education Grant Program	\$ 2,174,303
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	\$ 131,729,969
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	\$ 2,508,803
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Tobacco Control Programs	\$ 1,506,829
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventive Health and Health Services Block Grant	\$ 2,513,815
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Breast and Cervical Cancer Early Detection Program (NBCCEDP)	\$ 1,692,396
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	\$ 640,250
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	\$ 21,866,791
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) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	\$ 250,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Sudden Death in the Young (SDY) Registry	\$ 262,744
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State and Local Healthy Homes and Childhood Lead Poisoning Prevention Programs (CLPPPs)	\$ 475,362
Department of Health and Human Services (DHHS) > Substance Abuse and Mental Health Services Administration > Project LAUNCH	\$ 1,292,700
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Traumatic Brain Injury	\$ 250,000

OTHER FEDERAL FUNDS	FY19 Application Budgeted
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Zika Surveillance Systems Grant Program	\$ 600,000

	FY17 Annual Report Budgeted		FY17 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	\$ 11,749,682		\$ 11,714,889	
A. Preventive and Primary Care for Children	\$ 3,524,905	(30%)	\$ 3,540,937	(30.2%)
B. Children with Special Health Care Needs	\$ 4,112,389	(35%)	\$ 3,599,910	(30.7%)
C. Title V Administrative Costs	\$ 800,000	(6.8%)	\$ 724,651	(6.2%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	\$ 8,437,294		\$ 7,865,498	
3. STATE MCH FUNDS (Item 18c of SF-424)	\$ 30,000,000		\$ 32,875,484	
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)	\$ 4,400,000		\$ 2,647,702	
7. TOTAL STATE MATCH (Lines 3 through 6)	\$ 34,400,000		\$ 35,523,186	
A. Your State's FY 1989 Maintenance of Effort Amount \$ 13,125,024				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	\$ 46,149,682		\$ 47,238,075	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.				
10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9)	\$ 163,167,051		\$ 143,415,868	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	\$ 209,316,733		\$ 190,653,943	

OTHER FEDERAL FUNDS	FY17 Annual Report Budgeted	FY17 Annual Report Expended
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	\$ 95,375	\$ 100,605
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Community-Based Integrated Service Systems (CISS)	\$ 140,000	\$ 0
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Abstinence Education Grant Program	\$ 1,516,850	\$ 1,382,362
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	\$ 132,166,939	\$ 113,801,038
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	\$ 9,213,558
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	\$ 6,707,000	\$ 6,268,312
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	\$ 250,000	\$ 283,476
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State and Local Healthy Homes and Childhood Lead Poisoning Prevention Programs (CLPPPs)	\$ 211,401	\$ 242,600
Department of Health and Human Services (DHHS) > Substance Abuse and Mental Health Services Administration > Project LAUNCH	\$ 800,000	\$ 1,216,455
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Injury Prevention and Control	\$ 247,686	\$ 193,189
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State Public Health Actions-1305 Chronic Disease	\$ 2,508,803	\$ 2,564,479
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Tobacco Control Programs	\$ 1,564,235	\$ 1,464,872
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventive Health and Health Services Block Grant	\$ 2,463,434	\$ 2,093,334

OTHER FEDERAL FUNDS	FY17 Annual Report Budgeted	FY17 Annual Report Expended
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Breast and Cervical Cancer Early Detection Program (NBCCEDP)	\$ 1,692,396	\$ 3,217,915
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	\$ 640,250	\$ 707,719
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Tramatic Brain Injury	\$ 250,000	\$ 309,922
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Implementation Grants for Systems of Services for CYSHCN	\$ 0	\$ 0
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Zika Surveillance Systems Grant Program		\$ 170,847
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Sudden Death in the Young	\$ 200,000	\$ 185,185

**Form Notes for Form 2:**

None

**Field Level Notes for Form 2:**

None

**Data Alerts:**

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- The value in Line 1B, Children with Special Health Care Needs, Annual Report Expended is greater or less than 10% of the Annual Report Budgeted. Please correct or add a field level note indicating the reason for the discrepancy.
- The value in Line 6, Program Income, Annual Report Expended is greater or less than 10% of the Annual Report Budgeted. Please add a field level note indicating the reason for the discrepancy.

**Form 3a**  
**Budget and Expenditure Details by Types of Individuals Served**  
**State: Tennessee**

**I. TYPES OF INDIVIDUALS SERVED**

IA. Federal MCH Block Grant	FY19 Application Budgeted	FY17 Annual Report Expended
1. Pregnant Women	\$ 7,603	\$ 6,986
2. Infants < 1 year	\$ 610,148	\$ 560,613
3. Children 1 through 21 Years	\$ 3,197,954	\$ 2,938,328
4. CSHCN	\$ 3,917,993	\$ 3,599,910
5. All Others	\$ 4,227,622	\$ 3,884,401
Federal Total of Individuals Served	\$ 11,961,320	\$ 10,990,238

IB. Non-Federal MCH Block Grant	FY19 Application Budgeted	FY17 Annual Report Expended
1. Pregnant Women	\$ 246,019	\$ 231,870
2. Infants < 1 year	\$ 1,428,381	\$ 1,346,230
3. Children 1 through 21 Years	\$ 6,490,027	\$ 6,116,763
4. CSHCN	\$ 4,581,329	\$ 4,317,840
5. All Others	\$ 19,933,987	\$ 18,787,514
Non-Federal Total of Individuals Served	\$ 32,679,743	\$ 30,800,217
Federal State MCH Block Grant Partnership Total	\$ 44,641,063	\$ 41,790,455

**Form Notes for Form 3a:**

None

**Field Level Notes for Form 3a:**

1.	<b>Field Name:</b>	<b>IA. Federal MCH Block Grant, 3. Children 1 through 21 years</b>
	<b>Fiscal Year:</b>	<b>2019</b>
	<b>Column Name:</b>	<b>Application Budgeted</b>
	<b>Field Note:</b>	The discrepancy between the amount budgeted for Children 1-21 Years on Form 3a and the amount budgeted for Preventive and Primary care for Children (Form 2, Line 1A) is due to classification of particular programs that span multiple populations. For example, family planning funds are used, in part, to serve children age 1-22 but also serve other populations (and therefore are not counted in the "Preventive and Primary Care for Children" category on Form 2).
2.	<b>Field Name:</b>	<b>IA. Federal MCH Block Grant, 4. CSHCN</b>
	<b>Fiscal Year:</b>	<b>2019</b>
	<b>Column Name:</b>	<b>Application Budgeted</b>
	<b>Field Note:</b>	The discrepancy between the amount budgeted for CSHCN on Form 3a and the amount budgeted for for CSHCN (Form 2, Line 1A) is due to classification of particular programs that span multiple populations. For example, child health funds are used, in part, to serve CSHCN but also serve infant and child populations (and therefore are not counted in the "CSHCN" category on Form 2).
3.	<b>Field Name:</b>	<b>IA. Federal MCH Block Grant, 3. Children 1 through 21 years</b>
	<b>Fiscal Year:</b>	<b>2017</b>
	<b>Column Name:</b>	<b>Annual Report Expended</b>
	<b>Field Note:</b>	The discrepancy between the amount expended for Children 1-21 Years on Form 3a and the amount expended for for Preventive and Primary care for Children (Form 2, Line 1A) is due to classification of particular programs that span multiple populations. For example, family planning funds are used, in part, to serve children age 1-22 but also serve other populations (and therefore are not counted in the "Preventive and Primary Care for Children" category on Form 2).
4.	<b>Field Name:</b>	<b>IA. Federal MCH Block Grant, 4. CSHCN</b>
	<b>Fiscal Year:</b>	<b>2017</b>
	<b>Column Name:</b>	<b>Annual Report Expended</b>
	<b>Field Note:</b>	The discrepancy between the amount expended for CSHCN on Form 3a and the amount expended for for CSHCN (Form 2, Line 1A) is due to classification of particular programs that span multiple populations. For example, child health funds are used, in part, to serve CSHCN but also serve infant and child populations (and therefore are not counted in the "CSHCN" category on Form 2).

**Data Alerts:**

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- Children 1 through 21 Years, Application Budgeted does not equal Form 2, Line 1A, Preventive and Primary Care for Children Application Budgeted. A field-level note indicating the reason for the discrepancy was provided.
- Children 1 through 21 Years, Annual Report Expended does not equal Form 2, Line 1A, Preventive and Primary Care for Children, Annual Report Expended. A field - level note indicating the reason for the discrepancy was provided.

**Form 3b**  
**Budget and Expenditure Details by Types of Services**

State: Tennessee

**II. TYPES OF SERVICES**

IIA. Federal MCH Block Grant	FY19 Application Budgeted	FY17 Annual Report Expended
1. Direct Services	\$ 1,678,563	\$ 1,542,288
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	\$ 342,034	\$ 314,266
B. Preventive and Primary Care Services for Children	\$ 21,090	\$ 19,377
C. Services for CSHCN	\$ 1,315,439	\$ 1,208,645
2. Enabling Services	\$ 8,754,577	\$ 8,043,835
3. Public Health Services and Systems	\$ 2,316,860	\$ 2,128,766
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		\$ 261,418
Physician/Office Services		\$ 90,995
Hospital Charges (Includes Inpatient and Outpatient Services)		\$ 415,801
Dental Care (Does Not Include Orthodontic Services)		\$ 771
Durable Medical Equipment and Supplies		\$ 84,826
Laboratory Services		\$ 434,000
Other		
Orthodontic; Interpreter		\$ 254,477
Direct Services Line 4 Expended Total		\$ 1,542,288
<b>Federal Total</b>	<b>\$ 12,750,000</b>	<b>\$ 11,714,889</b>

IIB. Non-Federal MCH Block Grant	FY19 Application Budgeted	FY17 Annual Report Expended
1. Direct Services	\$ 1,270,844	\$ 1,197,753
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	\$ 448,732	\$ 422,924
B. Preventive and Primary Care Services for Children	\$ 34,356	\$ 32,380
C. Services for CSHCN	\$ 787,756	\$ 742,449
2. Enabling Services	\$ 24,470,626	\$ 23,063,235
3. Public Health Services and Systems	\$ 9,140,179	\$ 8,614,496
4. Select the types of Non-Federally-supported "Direct Services", as reported in II.B.1. Provide the total amount of Non-Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		\$ 114,146
Physician/Office Services		\$ 38,089
Hospital Charges (Includes Inpatient and Outpatient Services)		\$ 221,465
Dental Care (Does Not Include Orthodontic Services)		\$ 599
Durable Medical Equipment and Supplies		\$ 53,300
Laboratory Services		\$ 596,720
Other		
Orthodontic; Interpreter		\$ 173,434
Direct Services Line 4 Expended Total		\$ 1,197,753
<b>Non-Federal Total</b>	\$ 34,881,649	\$ 32,875,484

**Form Notes for Form 3b:**

None

**Field Level Notes for Form 3b:**

None

**Form 4**  
**Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated**

**State: Tennessee**

**Total Births by Occurrence: 87,402**

**Data Source Year: 2017**

**1. Core RUSP Conditions**

<b>Program Name</b>	<b>(A) Aggregate Total Number Receiving at Least One Screen</b>	<b>(B) Aggregate Total Number Presumptive Positive Screens</b>	<b>(C) Aggregate Total Number Confirmed Cases</b>	<b>(D) Aggregate Total Number Referred for Treatment</b>
Core RUSP Conditions	87,041 (99.6%)	5,840	340	340 (100.0%)

<b>Program Name(s)</b>				
3-Hydroxy-3-methylglutaric aciduria	3-Methylcrotonyl-CoA carboxylase deficiency	Argininosuccinic aciduria	Biotinidase deficiency	Carnitine uptake defect/carnitine transport defect
Citrullinemia, type I	Classic galactosemia	Classic phenylketonuria	Congenital adrenal hyperplasia	Critical congenital heart disease
Cystic fibrosis	Glutaric acidemia type I	Glycogen Storage Disease Type II (Pompe)	Hearing loss	Holocarboxylase synthase deficiency
Homocystinuria	Isovaleric acidemia	Long-chain L-3 hydroxyacyl-CoA dehydrogenase deficiency	Maple syrup urine disease	Medium-chain acyl-CoA dehydrogenase deficiency
Methylmalonic acidemia (cobalamin disorders)	Methylmalonic acidemia (methylmalonyl-CoA mutase)	Mucopolysaccharidosis Type 1	Primary congenital hypothyroidism	Propionic acidemia
S, βeta-Thalassemia	S,C disease	S,S disease (Sickle cell anemia)	Severe combined immunodeficiencies	β-Ketothiolase deficiency
Trifunctional protein deficiency	Tyrosinemia, type I	Very long-chain acyl-CoA dehydrogenase deficiency		

**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	87,041 (99.6%)	48	0	0 (0%)
Malonic acidemia	87,041 (99.6%)	17	1	1 (100.0%)
Isobutyrylglycinuria	87,041 (99.6%)	27	1	1 (100.0%)
2-Methylbutyrylglycinuria	87,041 (99.6%)	2	0	0 (0%)
3-Methylglutaconic aciduria	87,041 (99.6%)	51	0	0 (0%)
2-Methyl-3-hydroxybutyric aciduria	87,041 (99.6%)	51	0	0 (0%)
Short-chain acyl-CoA dehydrogenase deficiency	87,041 (99.6%)	27	0	0 (0%)
Medium/short-chain L-3-hydroxyacyl-CoA dehydrogenase deficiency	87,041 (99.6%)	17	0	0 (0%)
Glutaric acidemia type II	87,041 (99.6%)	27	0	0 (0%)
2,4 Dienoyl-CoA reductase deficiency	87,041 (99.6%)	1	0	0 (0%)
Carnitine palmitoyltransferase type I deficiency	87,041 (99.6%)	1	0	0 (0%)
Carnitine palmitoyltransferase type II deficiency	87,041 (99.6%)	2	0	0 (0%)
Carnitine acylcarnitine translocase deficiency	87,041 (99.6%)	2	0	0 (0%)
Argininemia	87,041 (99.6%)	0	0	0 (0%)
Citrullinemia, type II	87,041 (99.6%)	9	0	0 (0%)
Hypermethioninemia	87,041 (99.6%)	10	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	87,041 (99.6%)	17	3	3 (100.0%)
Biopterin defect in cofactor biosynthesis	87,041 (99.6%)	17	3	3 (100.0%)
Biopterin defect in cofactor regeneration	87,041 (99.6%)	17	3	3 (100.0%)
Tyrosinemia, type II	87,041 (99.6%)	55	0	0 (0%)
Tyrosinemia, type III	87,041 (99.6%)	55	0	0 (0%)
Various other hemoglobinopathies	87,041 (99.6%)	13	13	13 (100.0%)
Galactosepimerase deficiency	87,041 (99.6%)	29	0	0 (0%)
Galactokinase deficiency	87,041 (99.6%)	29	0	0 (0%)
T-Cell related lymphocyte deficiencies	87,041 (99.6%)	65	4	4 (100.0%)

### 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 to monitor all cases with abnormal tests through to confirmatory testing and treatment initiation. The State contracts with tertiary specialty centers to assure follow-up and confirmatory testing for all infants with abnormal screens. The centers are required, by contract, to report the results (whether disease was confirmed) back to the State, and for cases in which disease was confirmed, the center reports the date on which treatment was started. Currently, the State does not monitor confirmed diagnosed infants beyond notification of diagnosis and treatment initiation by the contracted tertiary specialty center. However, the State provides infrastructure funding at each center to support long-term treatment, genetic testing for vulnerable individuals, and education/outreach.

**Form Notes for Form 4:**

None

**Field Level Notes for Form 4:**

None

**Data Alerts: None**

**Form 5a  
Count of Individuals Served by Title V**

**State: Tennessee**

**Annual Report Year 2017**

		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	21,881	53.0	0.0	13.0	34.0	0.0
2. Infants < 1 Year of Age	24,601	36.0	0.0	1.0	63.0	0.0
3. Children 1 through 21 Years of Age	128,044	32.0	0.0	9.0	59.0	0.0
3a. Children with Special Health Care Needs	2,452	0.0	0.0	0.0	100.0	0.0
4. Others	106,632	16.0	0.0	8.0	76.0	0.0
Total	281,158					

**Form Notes for Form 5a:**

None

**Field Level Notes for Form 5a:**

1.	<b>Field Name:</b>	<b>Pregnant Women Total Served</b>
	<b>Fiscal Year:</b>	<b>2017</b>
	<b>Field Note:</b>	The majority of this count comes from women's health services in LHD, including family planning.
2.	<b>Field Name:</b>	<b>Infants Less Than One Year Total Served</b>
	<b>Fiscal Year:</b>	<b>2017</b>
	<b>Field Note:</b>	The majority of this count comes from TennCare (Medicaid) outreach efforts, well child visits in the LHD (mostly for TennCare enrollees), and general child health services in the LHD.
3.	<b>Field Name:</b>	<b>Children 1 through 21 Years of Age</b>
	<b>Fiscal Year:</b>	<b>2017</b>
	<b>Field Note:</b>	The majority of this count comes from TennCare (Medicaid) outreach efforts, as well as general child health services and reproductive health services in the LHD.
4.	<b>Field Name:</b>	<b>Children with Special Health Care Needs</b>
	<b>Fiscal Year:</b>	<b>2017</b>
	<b>Field Note:</b>	This count comes from Children's Special Services, Tennessee's MCH/Title V Children with Special Health Care Needs program, in local health departments.
5.	<b>Field Name:</b>	<b>Others</b>
	<b>Fiscal Year:</b>	<b>2017</b>
	<b>Field Note:</b>	The majority of this count comes from women's health services in LHD.

**Data Alerts: None**

**Form 5b**  
**Total Percentage of Populations Served by Title V**

**State: Tennessee**

**Annual Report Year 2017**

Populations Served by Title V	Total % Served
1. Pregnant Women	86
2. Infants < 1 Year of Age	100
3. Children 1 through 21 Years of Age	7
3a. Children with Special Health Care Needs	2
4. Others	8

**Form Notes for Form 5b:**

The MCH/Title V Program is not able to de-duplicate between programs, therefore the program with the highest reach in each population category was used for the numerator. This likely results in an underestimation of reach.

**Field Level Notes for Form 5b:**

1.	<b>Field Name:</b>	<b>Pregnant Women</b>
	<b>Fiscal Year:</b>	<b>2017</b>
	<b>Field Note:</b>	The numerator for this category is based on those served by the perinatal centers, the denominator is the number of live births, fetal deaths, and intentional terminations of pregnancy in the state for 2017.
2.	<b>Field Name:</b>	<b>Infants Less Than One Year</b>
	<b>Fiscal Year:</b>	<b>2017</b>
	<b>Field Note:</b>	The numerator for this category is based on those served by the newborn screening program, the denominator is the number of infants in the state based on census estimates for 2016.
3.	<b>Field Name:</b>	<b>Children 1 Through 21 Years of Age</b>
	<b>Fiscal Year:</b>	<b>2017</b>
	<b>Field Note:</b>	The numerator for this category is based on those served by child health in the local health departments, the denominator is the number of children in the state based on census estimates for 2016.
4.	<b>Field Name:</b>	<b>Children With Special Health Care Needs</b>
	<b>Fiscal Year:</b>	<b>2017</b>
	<b>Field Note:</b>	The numerator for this category is based on those served by the newborn screening follow-up program, the denominator is the number of children with special health care needs in the state based prevalence estimates from the National Survey Children's Health for 2016.
5.	<b>Field Name:</b>	<b>Others</b>
	<b>Fiscal Year:</b>	<b>2017</b>
	<b>Field Note:</b>	The numerator for this category is based on those served by women's health in the local health departments, the denominator is the number of individuals in the state based on census estimates for 2016.

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

State: Tennessee

Annual Report Year 2017

**I. Unduplicated Count by Race/Ethnicity**

	(A) Total	(B) Non- Hispanic White	(C) Non- Hispanic Black or African American	(D) Hispanic	(E) Non- Hispanic American Indian or Native Alaskan	(F) Non- Hispanic Asian	(G) Non- Hispanic Native Hawaiian or Other Pacific Islander	(H) Non- Hispanic Multiple Race	(I) Other & Unknown
1. Total Deliveries in State	133,568	61,648	61,648	7,260	141	1,792	178	0	901
Title V Served	133,568	61,648	61,648	7,260	141	1,792	178	0	901
Eligible for Title XIX	46,274	27,926	12,314	4,957	80	556	81	0	360
2. Total Infants in State	86,433	55,686	16,757	8,083	0	0	0	0	5,907
Title V Served	56,356	38,066	10,469	5,768	52	318	37	0	1,646
Eligible for Title XIX	27,558	13,016	8,041	1,967	0	0	0	4,534	0

**Form Notes for Form 6:**

None

**Field Level Notes for Form 6:**

None

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

**State: Tennessee**

<b>A. State MCH Toll-Free Telephone Lines</b>	<b>2019 Application Year</b>	<b>2017 Annual Report Year</b>
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>B. Other Appropriate Methods</b>	<b>2019 Application Year</b>	<b>2017 Annual Report Year</b>
1. Other Toll-Free "Hotline" Names	Tennessee Breastfeeding Hotline	Breastfeeding Hotline
2. Number of Calls on Other Toll-Free "Hotlines"		6,287
3. State Title V Program Website Address	<a href="https://www.kidcentraltn.com/">https://www.kidcentraltn.com/</a>	<a href="http://www.kidcentraltn.com">www.kidcentraltn.com</a>
4. Number of Hits to the State Title V Program Website		813,792
5. State Title V Social Media Websites	<a href="https://www.facebook.com/TNDeptofHealth">https://www.facebook.com/TNDeptofHealth</a>	<a href="https://www.facebook.com/TNDeptofHealth">https://www.facebook.com/TNDeptofHealth</a>
6. Number of Hits to the State Title V Program Social Media Websites		7,167

**Form Notes for Form 7:**

For the State Social Media Website (<https://www.facebook.com/TNDeptofHealth>) the number presented is not "hits" but "likes".

**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	
City/State/Zip	Nashville / TN / 37243
Telephone	(615) 741-0361
Extension	
Email	jacqueline.johnson@tn.gov

### 3. State Family or Youth Leader (Optional)

Name	Tori Goddard
Title	AMCHP Family Delegate
Address 1	5004 Indiana Avenue
Address 2	
City/State/Zip	Nashville / TN / 37209
Telephone	(615) 335-7800
Extension	
Email	torigoddard@yahoo.com

**Form Notes for Form 8:**

None

**Form 9**  
**List of MCH Priority Needs**

**State: Tennessee**

**Application Year 2019**

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**

<b>No.</b>	<b>Priority Need</b>	<b>Priority Need Type (New, Replaced or Continued Priority Need for this five-year reporting period)</b>	<b>Rationale if priority need does not have a corresponding State or National Performance/Outcome Measure</b>
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
2016	74.2 % ⚡	0.2 % ⚡	51,493 ⚡	69,385 ⚡
2015	74.2 %	0.2 %	55,756	75,125
2014	74.2 %	0.2 %	56,654	76,364
2013	71.6 %	0.2 %	54,489	76,103
2012	70.4 %	0.2 %	53,419	75,885
2011	69.9 %	0.2 %	51,605	73,832
2010	70.6 %	0.2 %	52,663	74,579
2009	69.5 %	0.2 %	54,058	77,795

**Legends:**

- 🚫 Indicator has a numerator <10 and is not reportable
- ⚡ Indicator has a numerator <20, a confidence interval width >20%, 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
2015	166.7	5.9	806	48,340
2014	160.3	5.0	1,033	64,430
2013	163.3	5.0	1,089	66,676
2012	156.5	4.9	1,034	66,091
2011	148.4	4.6	1,039	70,038
2010	139.5	4.5	970	69,538
2009	144.1	4.5	1,044	72,462
2008	141.0	4.4	1,054	74,738

**Legends:**

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

**NOM 2 - Notes:**

None

**Data Alerts: None**

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2012_2016	26.7	2.6	108	404,457

**Legends:**

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

**NOM 3 - Notes:**

None

**Data Alerts: None**

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	9.3 %	0.1 %	7,431	80,084
2015	9.2 %	0.1 %	7,460	81,384
2014	9.0 %	0.1 %	7,297	81,441
2013	9.1 %	0.1 %	7,307	79,962
2012	9.2 %	0.1 %	7,377	80,318
2011	9.0 %	0.1 %	7,176	79,554
2010	9.0 %	0.1 %	7,179	79,451
2009	9.2 %	0.1 %	7,539	82,172

**Legends:**

- Indicator has a numerator <10 and is not reportable
- Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

**NOM 4 - Notes:**

None

**Data Alerts: None**

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	11.3 %	0.1 %	9,085	80,340
2015	11.0 %	0.1 %	8,959	81,538
2014	10.8 %	0.1 %	8,780	81,497
2013	11.1 %	0.1 %	8,826	79,691
2012	11.2 %	0.1 %	8,961	79,807
2011	11.1 %	0.1 %	8,729	78,903
2010	11.4 %	0.1 %	8,988	78,936
2009	11.3 %	0.1 %	9,231	81,518

**Legends:**

- Indicator has a numerator <10 and is not reportable
- Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

**NOM 5 - Notes:**

None

**Data Alerts: None**

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	27.2 %	0.2 %	21,868	80,340
2015	26.6 %	0.2 %	21,662	81,538
2014	26.1 %	0.2 %	21,293	81,497
2013	26.2 %	0.2 %	20,856	79,691
2012	27.8 %	0.2 %	22,149	79,807
2011	28.9 %	0.2 %	22,784	78,903
2010	30.1 %	0.2 %	23,721	78,936
2009	31.5 %	0.2 %	25,645	81,518

**Legends:**

- Indicator has a numerator <10 and is not reportable
- Indicator has a numerator <20, a confidence interval width >20%, 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
2016/Q2-2017/Q1	2.0 %			
2015/Q2-2016/Q1	2.0 %			
2015/Q1-2015/Q4	2.0 %			
2014/Q4-2015/Q3	2.0 %			
2014/Q3-2015/Q2	2.0 %			
2014/Q2-2015/Q1	2.0 %			
2014/Q1-2014/Q4	3.0 %			
2013/Q4-2014/Q3	3.0 %			
2013/Q3-2014/Q2	3.0 %			
2013/Q2-2014/Q1	4.0 %			

**Legends:**  
🚩 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
2015	6.4	0.3	521	81,958
2014	6.8	0.3	554	81,875
2013	7.0	0.3	558	80,281
2012	7.2	0.3	582	80,674
2011	7.5	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
2015	7.0	0.3	568	81,685
2014	6.9	0.3	561	81,602
2013	6.8	0.3	544	79,992
2012	7.2	0.3	582	80,371
2011	7.4	0.3	592	79,588
2010	7.9	0.3	626	79,495
2009	8.0	0.3	657	82,211

**Legends:**

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

**NOM 9.1 - Notes:**

None

**Data Alerts: None**

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

Data Source: National Vital Statistics System (NVSS)

### Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	4.1	0.2	335	81,685
2014	4.3	0.2	349	81,602
2013	4.2	0.2	333	79,992
2012	4.3	0.2	349	80,371
2011	4.6	0.2	365	79,588
2010	4.6	0.2	368	79,495
2009	4.8	0.2	396	82,211

#### Legends:

 Indicator has a numerator <10 and is not reportable

 Indicator has a numerator <20 and should be interpreted with caution

#### NOM 9.2 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	2.9	0.2	233	81,685
2014	2.6	0.2	212	81,602
2013	2.6	0.2	211	79,992
2012	2.9	0.2	233	80,371
2011	2.9	0.2	227	79,588
2010	3.3	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
2015	189.8	15.3	155	81,685
2014	230.4	16.8	188	81,602
2013	193.8	15.6	155	79,992
2012	209.0	16.1	168	80,371
2011	214.9	16.5	171	79,588
2010	245.3	17.6	195	79,495
2009	255.4	17.7	210	82,211

**Legends:**

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

**NOM 9.4 - Notes:**

None

**Data Alerts: None**

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	153.0	13.7	125	81,685
2014	111.5	11.7	91	81,602
2013	123.8	12.5	99	79,992
2012	164.2	14.3	132	80,371
2011	154.6	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
2015	5.5 %	1.0 %	4,299	78,404
2014	5.8 %	1.1 %	4,524	77,863
2013	4.8 %	1.0 %	3,677	77,144
2012	6.7 %	1.1 %	5,139	77,036
2009	5.6 %	1.1 %	4,474	79,825
2008	3.4 %	0.8 %	2,774	81,407

**Legends:**

- Indicator has an unweighted denominator <30 and is not reportable
- Indicator has an unweighted denominator between 30 and 59 or 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 hospital births**

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	16.9	0.6	793	46,904
2014	15.3	0.5	959	62,637
2013	12.5	0.4	815	65,309
2012	8.9	0.4	584	65,480
2011	6.0	0.3	414	69,570
2010	5.4	0.3	375	69,409
2009	4.3	0.2	311	72,741
2008	3.0	0.2	225	75,307

**Legends:**

- Indicator has a numerator  $\leq 10$  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 year**

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

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	8.9 %	1.6 %	124,646	1,402,272

**Legends:**

- Indicator has an unweighted denominator <30 and is not reportable
- Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

**NOM 14 - Notes:**

None

**Data Alerts: None**

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	23.2	1.8	172	741,404
2015	18.3	1.6	135	739,432
2014	20.6	1.7	152	738,611
2013	21.1	1.7	156	738,334
2012	22.4	1.7	166	739,838
2011	20.0	1.7	147	736,697
2010	22.0	1.7	163	740,978
2009	20.0	1.7	148	738,731

**Legends:**

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

**NOM 15 - Notes:**

None

**Data Alerts: None**

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	39.9	2.2	336	842,341
2015	39.8	2.2	335	840,920
2014	36.7	2.1	309	841,738
2013	35.5	2.1	299	841,885
2012	40.3	2.2	340	844,247
2011	37.1	2.1	315	848,300
2010	38.2	2.1	327	856,127
2009	42.4	2.2	363	855,924

**Legends:**

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

**NOM 16.1 - Notes:**

None

**Data Alerts: None**

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014_2016	15.1	1.1	191	1,262,485
2013_2015	14.1	1.1	177	1,259,614
2012_2014	15.5	1.1	195	1,260,128
2011_2013	16.9	1.2	214	1,267,375
2010_2012	18.9	1.2	243	1,285,474
2009_2011	19.2	1.2	250	1,302,264
2008_2010	21.7	1.3	285	1,312,853
2007_2009	28.1	1.5	368	1,307,973

**Legends:**

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

**NOM 16.2 - Notes:**

None

**Data Alerts: None**

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014_2016	11.3	0.9	142	1,262,485
2013_2015	10.1	0.9	127	1,259,614
2012_2014	9.8	0.9	123	1,260,128
2011_2013	8.7	0.8	110	1,267,375
2010_2012	7.8	0.8	100	1,285,474
2009_2011	7.8	0.8	102	1,302,264
2008_2010	7.2	0.7	94	1,312,853
2007_2009	7.1	0.7	93	1,307,973

**Legends:**

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

**NOM 16.3 - Notes:**

None

**Data Alerts: None**

**NOM 17.1 - Percent of children with special health care needs (CSHCN), ages 0 through 17**

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

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	19.0 %	1.9 %	282,585	1,488,549

**Legends:**

- Indicator has an unweighted denominator <30 and is not reportable
- Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

**NOM 17.1 - Notes:**

None

**Data Alerts: None**

**NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system**

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

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	20.4 %	4.5 %	57,394	281,120

**Legends:**

- 🚩 Indicator has an unweighted denominator <30 and is not reportable
- ⚡ Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

**NOM 17.2 - Notes:**

None

**Data Alerts: None**

**NOM 17.3 - Percent of children, ages 3 through 17, diagnosed with an autism spectrum disorder**

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

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	1.8 % ⚡	0.8 % ⚡	21,252 ⚡	1,212,557 ⚡

**Legends:**

- 🚩 Indicator has an unweighted denominator <30 and is not reportable
- ⚡ Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

**NOM 17.3 - Notes:**

None

**Data Alerts: None**

**NOM 17.4 - Percent of children, ages 3 through 17, diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)**

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

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	10.1 %	1.6 %	121,186	1,201,276

**Legends:**

- Indicator has an unweighted denominator <30 and is not reportable
- Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

**NOM 17.4 - Notes:**

None

**Data Alerts: None**

**NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling**

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

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	48.7 % ⚡	7.9 % ⚡	71,834 ⚡	147,604 ⚡

**Legends:**

- 🚩 Indicator has an unweighted denominator <30 and is not reportable
- ⚡ Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

**NOM 18 - Notes:**

None

**Data Alerts: None**

**NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health**

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

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	89.2 %	1.6 %	1,326,511	1,486,938

**Legends:**

- Indicator has an unweighted denominator <30 and is not reportable
- Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

**NOM 19 - Notes:**

None

**Data Alerts: None**

**NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)**

Data Source: WIC

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	14.9 %	0.2 %	8,083	54,429
2012	15.3 %	0.2 %	8,130	53,033
2010	16.0 %	0.2 %	9,126	57,153
2008	14.7 %	0.2 %	7,596	51,616

**Legends:**

- Indicator has a denominator <50 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	18.6 %	1.0 %		
2013	16.9 %	0.9 %		
2011	15.2 %	0.8 %		
2009	15.8 %	1.0 %		
2007	16.8 %	0.9 %		
2005	14.4 %	1.3 %		

**Legends:**

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

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

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	19.2 %	2.8 %	111,864	583,745

**Legends:**

- Indicator has an unweighted denominator <30 and is not reportable
- Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

**NOM 20 - Notes:**

None

**Data Alerts: None**

**NOM 21 - Percent of children, ages 0 through 17, without health insurance**

Data Source: American Community Survey (ACS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	3.5 %	0.3 %	52,909	1,502,677
2015	4.3 %	0.3 %	63,432	1,493,057
2014	5.2 %	0.3 %	77,115	1,493,436
2013	5.7 %	0.4 %	84,902	1,492,149
2012	5.6 %	0.4 %	83,030	1,492,012
2011	5.8 %	0.4 %	86,513	1,489,552
2010	5.3 %	0.3 %	79,838	1,499,117
2009	5.8 %	0.3 %	85,685	1,489,741

**Legends:**

- Indicator has an unweighted denominator <30 and is not reportable
- Indicator has a confidence interval width 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
2016	67.4 %	3.8 %	80,590	119,570
2015	70.1 %	3.8 %	82,260	117,280
2014	71.9 %	3.9 %	84,560	117,608
2013	68.5 %	3.5 %	79,216	115,715
2012	73.1 %	3.5 %	86,800	118,788
2011	70.4 %	3.4 %	85,567	121,578
2010	61.8 %	3.4 %	78,476	127,008
2009	44.8 %	3.4 %	55,979	124,975

**Legends:**

- Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval 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, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza**

**Data Source: National Immunization Survey (NIS) – Flu**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2016_2017	57.4 %	2.0 %	799,927	1,393,844
2015_2016	61.8 %	1.9 %	865,797	1,400,513
2014_2015	61.8 %	2.0 %	871,825	1,409,807
2013_2014	60.2 %	2.0 %	836,358	1,390,019
2012_2013	56.4 %	2.3 %	789,668	1,400,851
2011_2012	50.4 %	2.7 %	695,541	1,379,253
2010_2011	56.6 %	3.8 %	777,299	1,373,320
2009_2010	48.9 %	3.9 %	617,746	1,263,285

**Legends:**

- 🚫 Estimate not reported because unweighted sample size for the denominator < 30 or 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
2016	55.3 %	5.0 %	115,437	208,907
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
2016	55.3 %	4.7 %	120,542	217,843
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
2016	89.3 %	2.2 %	381,010	426,750
2015	79.7 %	2.7 %	339,136	425,570
2014	86.0 %	2.3 %	363,547	422,685
2013	80.0 %	2.7 %	338,276	422,624
2012	77.4 %	3.2 %	325,269	420,423
2011	67.6 %	3.2 %	283,974	420,127
2010	58.7 %	3.2 %	243,261	414,201
2009	48.0 %	3.1 %	199,390	415,570

**Legends:**

-  Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval 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
2016	76.3 %	3.0 %	325,708	426,750
2015	76.7 %	2.9 %	326,284	425,570
2014	74.0 %	3.0 %	312,756	422,685
2013	67.8 %	3.1 %	286,448	422,624
2012	69.4 %	3.4 %	291,733	420,423
2011	63.3 %	3.3 %	265,999	420,127
2010	50.6 %	3.2 %	209,556	414,201
2009	52.1 %	3.1 %	216,515	415,570

**Legends:**

-  Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval 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**

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	28.0	0.4	5,766	206,065
2015	30.6	0.4	6,267	204,782
2014	33.2	0.4	6,756	203,551
2013	34.8	0.4	7,105	204,285
2012	38.4	0.4	7,910	205,905
2011	40.8	0.4	8,497	208,285
2010	43.5	0.5	9,254	212,929
2009	48.4	0.5	10,378	214,436

**Legends:**

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

**NOM 23 - Notes:**

None

**Data Alerts: None**

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

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	15.4 %	1.6 %	12,063	78,110
2014	13.6 %	1.6 %	10,620	78,096
2013	18.1 %	1.8 %	13,695	75,835
2012	17.2 %	1.6 %	13,157	76,677

**Legends:**

- Indicator has an unweighted denominator <30 and is not reportable
- Indicator has an unweighted denominator between 30 and 59 or a confidence interval width >20% and should be interpreted with caution

**NOM 24 - Notes:**

None

**Data Alerts: None**

**NOM 25 - Percent of children, ages 0 through 17, who were not able to obtain needed health care in the last year**

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

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	2.1 % ⚡	0.8 % ⚡	30,908 ⚡	1,471,004 ⚡

**Legends:**

- 🚩 Indicator has an unweighted denominator <30 and is not reportable
- ⚡ Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

**NOM 25 - Notes:**

None

**Data Alerts: None**

**Form 10a**  
**National Performance Measures (NPMs)**  
**State: Tennessee**

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

Federally Available Data		
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)		
	2016	2017
Annual Objective	72.2	72.2
Annual Indicator	69.6	66.0
Numerator	794,110	760,359
Denominator	1,140,291	1,152,528
Data Source	BRFSS	BRFSS
Data Source Year	2015	2016

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	73.3	74.5	75.7	75.7	75.7	75.7

**Field Level Notes for Form 10a NPMs:**

None

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

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

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	82.0	83.0	84.0	85.0	86.0	86.0

**Field Level Notes for Form 10a NPMs:**

None

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

**FAD for this measure is not available for the State.**

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

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	0.0	0.0	0.0	0.0	0.0

**Field Level Notes for Form 10a NPMs:**

1.	<b>Field Name:</b>	<b>2017</b>
	<b>Column Name:</b>	<b>State Provided Data</b>

**Field Note:**

Data will be available from PRAMS next year.

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

**FAD for this measure is not available for the State.**

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

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	0.0	0.0	0.0	0.0	0.0

**Field Level Notes for Form 10a NPMs:**

1.	<b>Field Name:</b>	<b>2017</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	Data will be available from PRAMS next year.

**NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year**

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH)		
	2016	2017
Annual Objective		
Annual Indicator		26.2
Numerator		53,746
Denominator		205,002
Data Source		NSCH
Data Source Year		2016

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

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	27.5	28.2	28.2	28.2	28.2	28.2

**Field Level Notes for Form 10a NPMs:**

None

**NPM 7.1 - Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9**

Federally Available Data		
Data Source: HCUP - State Inpatient Databases (SID)		
	2016	2017
Annual Objective	109.8	107
Annual Indicator	109.1	109.1
Numerator	893	672
Denominator	818,595	615,938
Data Source	SID-CHILD	SID-CHILD
Data Source Year	2014	2015

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	104.4	101.8	99.2	96.7	94.3	94.3

**Field Level Notes for Form 10a NPMs:**

None

**NPM 7.2 - Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19**

Federally Available Data		
Data Source: HCUP - State Inpatient Databases (SID)		
	2016	2017
Annual Objective	184.8	176.4
Annual Indicator	207.7	191.6
Numerator	1,746	1,206
Denominator	840,564	629,323
Data Source	SID-ADOLESCENT	SID-ADOLESCENT
Data Source Year	2014	2015

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	168.0	159.6	151.2	142.8	137.0	137.0

**Field Level Notes for Form 10a NPMs:**

None

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

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH) - CHILD		
	2016	2017
Annual Objective		
Annual Indicator		29.6
Numerator		152,452
Denominator		514,521
Data Source		NSCH-CHILD
Data Source Year		2016

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

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	30.4	31.2	32.0	32.8	33.6	33.6

**Field Level Notes for Form 10a NPMs:**

None

**NPM 8.2 - Percent of adolescents, ages 12 through 17 who are physically active at least 60 minutes per day**

Federally Available Data		
Data Source: Youth Risk Behavior Surveillance System (YRBSS)		
	2016	2017
Annual Objective	26.9	27.7
Annual Indicator	25.9	25.9
Numerator	70,480	70,480
Denominator	272,118	272,118
Data Source	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT
Data Source Year	2015	2015

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH) - ADOLESCENT		
	2016	2017
Annual Objective		
Annual Indicator		22.4
Numerator		107,989
Denominator		481,757
Data Source		NSCH-ADOLESCENT
Data Source Year		2016

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

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	28.5	29.3	30.1	30.9	31.7	31.7

**Field Level Notes for Form 10a NPMs:**

None

**NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - Children with Special Health Care Needs**

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH) - CSHCN		
	2016	2017
Annual Objective		
Annual Indicator		44.8
Numerator		125,986
Denominator		281,120
Data Source		NSCH-CSHCN
Data Source Year		2016

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

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	56.5	59.2	61.9	64.6	67.3	67.3

**Field Level Notes for Form 10a NPMs:**

None

**NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care - Children with Special Health Care Needs**

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH) - CSHCN		
	2016	2017
Annual Objective		
Annual Indicator		19.2
Numerator		16,734
Denominator		87,214
Data Source		NSCH-CSHCN
Data Source Year		2016

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

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	14.1	14.7	15.4	16.1	16.8	16.8

**Field Level Notes for Form 10a NPMs:**

None

**NPM 14.1 - Percent of women who smoke during pregnancy**

Federally Available Data		
Data Source: National Vital Statistics System (NVSS)		
	2016	2017
Annual Objective	14.4	13.9
Annual Indicator	14.3	13.4
Numerator	11,577	10,771
Denominator	80,953	80,306
Data Source	NVSS	NVSS
Data Source Year	2015	2016

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	13.4	12.9	12.4	11.9	11.4	11.4

**Field Level Notes for Form 10a NPMs:**

None

**NPM 14.2 - Percent of children, ages 0 through 17, who live in households where someone smokes - Child Health**

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH)		
	2016	2017
Annual Objective		
Annual Indicator		24.9
Numerator		362,200
Denominator		1,457,726
Data Source		NSCH
Data Source Year		2016

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

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	29.0	28.4	27.8	27.2	26.6	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**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>		
	<b>2016</b>	<b>2017</b>
Annual Objective		27.5
Annual Indicator	27.5	27.5
Numerator		
Denominator		
Data Source	NSCH	NSCH
Data Source Year	2011_2012	2011_2012
Provisional or Final ?	Final	Final

<b>Annual Objectives</b>						
	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>2023</b>
Annual Objective	27.5	24.8	24.8	22.3	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**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>		
	<b>2016</b>	<b>2017</b>
Annual Objective		80
Annual Indicator	78.2	79.8
Numerator		
Denominator		
Data Source	TDH PPA - Birth Statistical System	TDH PPA - Birth Statistical System
Data Source Year	CY2015	CY2016
Provisional or Final ?	Final	Final

<b>Annual Objectives</b>						
	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>2023</b>
Annual Objective	82.0	84.0	86.0	88.0	90.0	90.0

**Field Level Notes for Form 10a SPMs:**

None

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

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>		
	<b>2016</b>	<b>2017</b>
Annual Objective		51.6
Annual Indicator	51.6	54.1
Numerator		
Denominator		
Data Source	PRAMS	PRAMS
Data Source Year	2013	2014
Provisional or Final ?	Final	Final

<b>Annual Objectives</b>						
	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>2023</b>
Annual Objective	49.9	48.2	46.5	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**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>		
	<b>2016</b>	<b>2017</b>
Annual Objective		
Annual Indicator	6	46
Numerator		
Denominator		
Data Source	TDH FHW Womens Health Section Program Data	TDH FHW Womens Health Section Program Data
Data Source Year	FFY2016	FFY2017
Provisional or Final ?	Final	Final

<b>Annual Objectives</b>						
	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>2023</b>
Annual Objective	9.0	20.0	20.0	20.0	20.0	20.0

**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**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>		
	<b>2016</b>	<b>2017</b>
Annual Objective		
Annual Indicator	0	7
Numerator		
Denominator		
Data Source	TDH FHW Womens Health Section Program Data	TDH FHW Womens Health Section Program Data
Data Source Year	FFY2016	FFY2017
Provisional or Final ?	Final	Final

<b>Annual Objectives</b>						
	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>2023</b>
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**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>		
	<b>2016</b>	<b>2017</b>
Annual Objective		4
Annual Indicator	0	2
Numerator		
Denominator		
Data Source	TDH FHW Womens Health Section Program Data	TDH FHW Womens Health Section Program Data
Data Source Year	FFY2016	FFY2017
Provisional or Final ?	Final	Final

<b>Annual Objectives</b>						
	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>2023</b>
Annual Objective	4.0	2.0	2.0	2.0	2.0	2.0

**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**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>		
	<b>2016</b>	<b>2017</b>
Annual Objective		4
Annual Indicator	4	4
Numerator		
Denominator		
Data Source	TDH FHW Womens Health Section Program Data	TDH FHW Womens Health Section Program Data
Data Source Year	FFY2016	FFY2017
Provisional or Final ?	Final	Final

<b>Annual Objectives</b>						
	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>2023</b>
Annual Objective	4.0	2.0	2.0	2.0	2.0	2.0

**Field Level Notes for Form 10a ESMs:**

None

**ESM 5.1 - Number of safe sleep educational material distributed**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>		
	<b>2016</b>	<b>2017</b>
Annual Objective		
Annual Indicator	226,881	257,694
Numerator		
Denominator		
Data Source	TDH FHW Injury Prevention Section Program Data	TDH FHW Injury Prevention Section Program Data
Data Source Year	FFY2016	FFY2017
Provisional or Final ?	Final	Final

<b>Annual Objectives</b>						
	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>2023</b>
Annual Objective	80,000.0	240,000.0	240,000.0	240,000.0	240,000.0	240,000.0

**Field Level Notes for Form 10a ESMs:**

None

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

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>		
	<b>2016</b>	<b>2017</b>
Annual Objective		100
Annual Indicator	100	100
Numerator		
Denominator		
Data Source	TDH FHW Injury Section Program Data - CFR Report	TDH FHW Injury Prevention Section Program Data
Data Source Year	CY2016	CY2017
Provisional or Final ?	Final	Final

<b>Annual Objectives</b>						
	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>2023</b>
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**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>		
	<b>2016</b>	<b>2017</b>
Annual Objective		80
Annual Indicator	84	85
Numerator		
Denominator		
Data Source	TDH PPA - Birth Statistical System	TDH PPA - Birth Statistical System
Data Source Year	FFY2016	FFY2017
Provisional or Final ?	Final	Final

<b>Annual Objectives</b>						
	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>2023</b>
Annual Objective	80.0	85.0	85.0	85.0	85.0	85.0

**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**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>		
	<b>2016</b>	<b>2017</b>
Annual Objective		100
Annual Indicator	100	100
Numerator		
Denominator		
Data Source	TDH FHW Perinatal Health Section Program Data	TDH FHW Perinatal Health Section Program Data
Data Source Year	CY2016	CY2017
Provisional or Final ?	Final	Final

<b>Annual Objectives</b>						
	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>2023</b>
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)**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>		
	<b>2016</b>	<b>2017</b>
Annual Objective		
Annual Indicator	45,881	47,159
Numerator		
Denominator		
Data Source	TDH FHW Womens Health Section Program Data	TDH FHW Womens Health Section Program Data
Data Source Year	FFY2016	FFY2017
Provisional or Final ?	Final	Final

<b>Annual Objectives</b>						
	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>2023</b>
Annual Objective	46,000.0	46,500.0	47,000.0	47,500.0	48,000.0	48,500.0

**Field Level Notes for Form 10a ESMs:**

None

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

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>		
	<b>2016</b>	<b>2017</b>
Annual Objective		
Annual Indicator	979	953
Numerator		
Denominator		
Data Source	TDH FHW Early Childhood Section Program Data	TDH FHW Early Childhood Section Program Data
Data Source Year	FFY2016	FFY2017
Provisional or Final ?	Final	Final

<b>Annual Objectives</b>						
	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>2023</b>
Annual Objective	800.0	1,200.0	1,200.0	1,200.0	1,200.0	1,320.0

**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**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>		
	<b>2016</b>	<b>2017</b>
Annual Objective		
Annual Indicator	450	526
Numerator		
Denominator		
Data Source	TDH CHS Program Data	TDH CHS Program Data
Data Source Year	FFY2016	FFY2017
Provisional or Final ?	Final	Final

<b>Annual Objectives</b>						
	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>2023</b>
Annual Objective	485.0	504.0	524.0	544.0	566.0	588.0

**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**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>		
	<b>2016</b>	<b>2017</b>
Annual Objective		90
Annual Indicator	89.2	76.1
Numerator		
Denominator		
Data Source	TDH FHW Early Childhood Section Program Data	TDH FHW Early Childhood Section Program Data
Data Source Year	FFY2016	FFY2017
Provisional or Final ?	Final	Final

<b>Annual Objectives</b>						
	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>2023</b>
Annual Objective	90.0	91.0	92.0	92.0	93.0	93.0

**Field Level Notes for Form 10a ESMs:**

None

**ESM 7.1.1 - Number of parents and caregivers receiving car seat education**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>		
	<b>2016</b>	<b>2017</b>
Annual Objective		2,836
Annual Indicator	2,836	2,098
Numerator		
Denominator		
Data Source	TDH FHW Injury Prevention Section Program Data	TDH FHW Injury Prevention Section Program Data
Data Source Year	FFY2016	FFY2017
Provisional or Final ?	Final	Final

<b>Annual Objectives</b>						
	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>2023</b>
Annual Objective	2,850.0	2,875.0	2,900.0	2,925.0	2,950.0	2,950.0

**Field Level Notes for Form 10a ESMs:**

None

**ESM 7.1.2 - Number of counties that adopt Count It! Drop It! Lock It! educational programs**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>		
	<b>2016</b>	<b>2017</b>
Annual Objective		
Annual Indicator	36	61
Numerator		
Denominator		
Data Source	TDH FHW Injury Prevention Section Program Data	TDH FHW Injury Prevention Section Program Data
Data Source Year	FFY2016	FFY2017
Provisional or Final ?	Final	Final

<b>Annual Objectives</b>						
	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>2023</b>
Annual Objective	48.0	93.0	93.0	93.0	93.0	93.0

**Field Level Notes for Form 10a ESMs:**

None

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

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>		
	<b>2016</b>	<b>2017</b>
Annual Objective		85
Annual Indicator	81	36
Numerator		
Denominator		
Data Source	TDH FHW Early Childhood Section Program Data	TDH FHW Early Childhood Section Program Data
Data Source Year	FFY2016	FFY2017
Provisional or Final ?	Final	Final

<b>Annual Objectives</b>						
	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>2023</b>
Annual Objective	87.0	89.0	91.0	93.0	95.0	95.0

**Field Level Notes for Form 10a ESMs:**

None

**ESM 7.2.1 - Number of schools in the top ten crash rate counties (among ages 15-18) that conduct evidence-informed teen safe driving programming**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>		
	<b>2016</b>	<b>2017</b>
Annual Objective		55
Annual Indicator	46	43
Numerator		
Denominator		
Data Source	ReduceTNCrashes.org Safe Driving Report	ReduceTNCrashes.org Safe Driving Report
Data Source Year	FFY2016	FFY2017
Provisional or Final ?	Final	Final

<b>Annual Objectives</b>						
	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>2023</b>
Annual Objective	57.0	59.0	61.0	63.0	65.0	65.0

**Field Level Notes for Form 10a ESMs:**

None

**ESM 7.2.2 - Number of drug disposal bins installed statewide**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>		
	<b>2016</b>	<b>2017</b>
Annual Objective		
Annual Indicator	206	236
Numerator		
Denominator		
Data Source	TN Depart of Environmental and Conservation Report	TN Depart of Environmental and Conservation Report
Data Source Year	FFY2016	FFY2017
Provisional or Final ?	Final	Final

<b>Annual Objectives</b>						
	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>2023</b>
Annual Objective	225.0	326.0	341.0	356.0	371.0	371.0

**Field Level Notes for Form 10a ESMs:**

None

**ESM 7.2.3 - Number of press releases, social media posts and presentations about adolescent falls**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>		
	<b>2016</b>	<b>2017</b>
Annual Objective		
Annual Indicator	8	9
Numerator		
Denominator		
Data Source	TN Depart of Environment and Conservation Report	TN Depart of Environment and Conservation Report
Data Source Year	FFY2016	FFY2017
Provisional or Final ?	Final	Final

<b>Annual Objectives</b>						
	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>2023</b>
Annual Objective	6.0	7.0	7.0	8.0	8.0	8.0

**Field Level Notes for Form 10a ESMs:**

None

**ESM 7.2.4 - Number of suicide-related articles, social media posts and trainings provided by TDH**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>		
	<b>2016</b>	<b>2017</b>
Annual Objective		
Annual Indicator	11	19
Numerator		
Denominator		
Data Source	TDH FHW Injury Prevention Section Program Data	TDH FHW Injury Prevention Section Program Data
Data Source Year	FFY2016	FFY2017
Provisional or Final ?	Final	Final

<b>Annual Objectives</b>						
	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>2023</b>
Annual Objective	11.0	20.0	22.0	24.0	26.0	26.0

**Field Level Notes for Form 10a ESMs:**

None

**ESM 8.1.1 - Number of Gold Sneaker-recognized childcare facilities in Tennessee**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>		
	<b>2016</b>	<b>2017</b>
Annual Objective		
Annual Indicator	441	474
Numerator		
Denominator		
Data Source	TDH FHW Chronic Disease Program Data	TDH FHW Chronic Disease Program Data
Data Source Year	FFY2016	FFY2017
Provisional or Final ?	Final	Final

<b>Annual Objectives</b>						
	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>2023</b>
Annual Objective	525.0	575.0	625.0	675.0	725.0	775.0

**Field Level Notes for Form 10a ESMs:**

None

**ESM 8.1.2 - Average number of monthly calls to the Tennessee Breastfeeding Hotline (TBH)**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>		
	<b>2016</b>	<b>2017</b>
Annual Objective		
Annual Indicator	485	523
Numerator		
Denominator		
Data Source	TDH FHW Supplemental Nutrition Section Program Data	TDH FHW Supplemental Nutrition Section Program Data
Data Source Year	FFY2016	FFY2017
Provisional or Final ?	Final	Final

<b>Annual Objectives</b>						
	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>2023</b>
Annual Objective	500.0	525.0	550.0	575.0	600.0	625.0

**Field Level Notes for Form 10a ESMs:**

None

**ESM 8.1.3 - Number of Baby Friendly-designated Tennessee birthing hospitals**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>		
	<b>2016</b>	<b>2017</b>
Annual Objective		
Annual Indicator	2	2
Numerator		
Denominator		
Data Source	Baby Friendly USA, Inc.	Baby Friendly USA, Inc.
Data Source Year	FFY2016	FFY2017
Provisional or Final ?	Final	Final

<b>Annual Objectives</b>						
	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>2023</b>
Annual Objective	3.0	8.0	10.0	12.0	14.0	16.0

**Field Level Notes for Form 10a ESMs:**

None

**ESM 8.2.1 - Number of Physical Activity Clubs in K-12 schools**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>		
	<b>2016</b>	<b>2017</b>
Annual Objective		
Annual Indicator	47	111
Numerator		
Denominator		
Data Source	TDH FHW Chronic Disease Program Data	TDH FHW Chronic Disease Program Data
Data Source Year	FFY2016	FFY2017
Provisional or Final ?	Final	Final

<b>Annual Objectives</b>						
	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>2023</b>
Annual Objective	125.0	234.0	259.0	284.0	309.0	334.0

**Field Level Notes for Form 10a ESMs:**

None

**ESM 8.2.2 - Number of school gardens in Tennessee public schools**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>	
	<b>2017</b>
Annual Objective	
Annual Indicator	337
Numerator	
Denominator	
Data Source	DOE - Farm to School Program
Data Source Year	FFY2017
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>2023</b>
Annual Objective	395.0	451.0	476.0	501.0	526.0	551.0

**Field Level Notes for Form 10a ESMs:**

None

**ESM 8.2.3 - Number of Healthy Parks Healthy Person app users**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>	
	<b>2017</b>
Annual Objective	
Annual Indicator	1,661
Numerator	
Denominator	
Data Source	TDEC Healthy Parks Healthy Person App
Data Source Year	FFY2017
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>2023</b>
Annual Objective	1,800.0	2,935.0	3,035.0	3,135.0	3,235.0	3,335.0

**Field Level Notes for Form 10a ESMs:**

None

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

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>		
	<b>2016</b>	<b>2017</b>
Annual Objective		
Annual Indicator	420	615
Numerator		
Denominator		
Data Source	TDH FHW Title V CYSHCN Program Data	TDH FHW Title V CYSHCN Program Data
Data Source Year	FFY2016	FFY2017
Provisional or Final ?	Final	Final

<b>Annual Objectives</b>						
	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>2023</b>
Annual Objective	525.0	730.0	780.0	830.0	880.0	930.0

**Field Level Notes for Form 10a ESMs:**

None

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

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>		
	<b>2016</b>	<b>2017</b>
Annual Objective		
Annual Indicator	279	558
Numerator		
Denominator		
Data Source	TDH FHW Title V CYSHCN Program Data	TDH FHW Title V CYSHCN Program Data
Data Source Year	FFY2016	FFY2017
Provisional or Final ?	Final	Final

<b>Annual Objectives</b>						
	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>2023</b>
Annual Objective	337.0	635.0	665.0	695.0	725.0	755.0

**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**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>		
	<b>2016</b>	<b>2017</b>
Annual Objective		80
Annual Indicator	74	72.7
Numerator		
Denominator		
Data Source	TDH FHW Title V CYSHCN Program Data	TDH FHW Title V CYSHCN Program Data
Data Source Year	FFY2016	FFY2017
Provisional or Final ?	Final	Final

<b>Annual Objectives</b>						
	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>2023</b>
Annual Objective	85.0	90.0	95.0	100.0	100.0	100.0

**Field Level Notes for Form 10a ESMs:**

None

**ESM 12.1 - Number of adolescents on the Adolescent Advisory Council**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>		
	<b>2016</b>	<b>2017</b>
Annual Objective		5
Annual Indicator	7	7
Numerator		
Denominator		
Data Source	Title V CYSHCN Program Data	Title V CYSHCN Program Data
Data Source Year	FFY2016	FFY2017
Provisional or Final ?	Final	Final

<b>Annual Objectives</b>						
	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>2023</b>
Annual Objective	7.0	9.0	11.0	13.0	15.0	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**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>	
	<b>2017</b>
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	no data
Data Source Year	no data
Provisional or Final ?	Provisional

<b>Annual Objectives</b>						
	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>2023</b>
Annual Objective	100.0	240.0	265.0	290.0	315.0	340.0

**Field Level Notes for Form 10a ESMs:**

None

**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**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>	
	<b>2017</b>
Annual Objective	0
Annual Indicator	65
Numerator	
Denominator	
Data Source	TDH FHW Title V CYSHCN Program Data
Data Source Year	FFY2017
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>2023</b>
Annual Objective	75.0	80.0	85.0	90.0	95.0	95.0

**Field Level Notes for Form 10a ESMs:**

None

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

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>	
	<b>2017</b>
Annual Objective	
Annual Indicator	624
Numerator	
Denominator	
Data Source	Tennessee Tobacco Quitline Report
Data Source Year	FFY2017
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>2023</b>
Annual Objective	720.0	800.0	880.0	975.0	1,075.0	1,075.0

**Field Level Notes for Form 10a ESMs:**

None

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

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>		
	<b>2016</b>	<b>2017</b>
Annual Objective		480
Annual Indicator	441	474
Numerator		
Denominator		
Data Source	TDH FHW Chronic Disease Section Program Data	TDH FHW Chronic Disease Section Program Data
Data Source Year	FFY2016	FFY2017
Provisional or Final ?	Final	Final

<b>Annual Objectives</b>						
	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>2023</b>
Annual Objective	525.0	570.0	615.0	660.0	705.0	705.0

**Field Level Notes for Form 10a ESMs:**

None

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

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>		
	<b>2016</b>	<b>2017</b>
Annual Objective		10
Annual Indicator	1.7	97.8
Numerator		
Denominator		
Data Source	TDH FHW Early Childhood Section Program Data	TDH FHW Early Childhood Section Program Data
Data Source Year	FFY2016	FFY2017
Provisional or Final ?	Final	Final

<b>Annual Objectives</b>						
	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>2023</b>
Annual Objective	93.0	94.0	95.0	95.0	95.0	95.0

**Field Level Notes for Form 10a ESMs:**

1.	<b>Field Name:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>State Provided Data</b>

**Field Note:**

Data collection quality was poor in FY2016. Over the past year training was conducted for evidenced-based home visiting staff across the state to improve their understanding of what was considered a referral. Due to this training recent preliminary analysis shows that data collection quality has improved.

**Form 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**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	To reduce the percentage of children ages 0-17 experiencing two or more adverse childhood experiences								
<b>Definition:</b>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%;"><b>Numerator:</b></td> <td>Number of children with 2 or more adverse childhood experiences</td> </tr> <tr> <td><b>Denominator:</b></td> <td>Number of children age 0 through 17</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> </table>	<b>Numerator:</b>	Number of children with 2 or more adverse childhood experiences	<b>Denominator:</b>	Number of children age 0 through 17	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100
<b>Numerator:</b>	Number of children with 2 or more adverse childhood experiences								
<b>Denominator:</b>	Number of children age 0 through 17								
<b>Unit Type:</b>	Percentage								
<b>Unit Number:</b>	100								
<b>Data Sources and Data Issues:</b>	NSCH								
<b>Significance:</b>	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**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	Increase the percentage of infants born to Tennessee resident mothers who initiate breastfeeding								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Numerator:</b></td> <td>Number of newborns to Tennessee-resident mothers who report breastfeeding initiation (“yes” response) on the child’s birth certificate</td> </tr> <tr> <td><b>Denominator:</b></td> <td>Number of live births to Tennessee-resident mothers</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> </table>	<b>Numerator:</b>	Number of newborns to Tennessee-resident mothers who report breastfeeding initiation (“yes” response) on the child’s birth certificate	<b>Denominator:</b>	Number of live births to Tennessee-resident mothers	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100
<b>Numerator:</b>	Number of newborns to Tennessee-resident mothers who report breastfeeding initiation (“yes” response) on the child’s birth certificate								
<b>Denominator:</b>	Number of live births to Tennessee-resident mothers								
<b>Unit Type:</b>	Percentage								
<b>Unit Number:</b>	100								
<b>Data Sources and Data Issues:</b>	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.								
<b>Significance:</b>	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**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	Decrease the number of live births that were the result of an unintended pregnancy								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Numerator:</b></td> <td>Number of mothers reporting that their pregnancy was either unintended or that they weren't sure how they felt about becoming pregnant</td> </tr> <tr> <td><b>Denominator:</b></td> <td>Number of live births to Tennessee-resident mothers</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> </table>	<b>Numerator:</b>	Number of mothers reporting that their pregnancy was either unintended or that they weren't sure how they felt about becoming pregnant	<b>Denominator:</b>	Number of live births to Tennessee-resident mothers	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100
<b>Numerator:</b>	Number of mothers reporting that their pregnancy was either unintended or that they weren't sure how they felt about becoming pregnant								
<b>Denominator:</b>	Number of live births to Tennessee-resident mothers								
<b>Unit Type:</b>	Percentage								
<b>Unit Number:</b>	100								
<b>Data Sources and Data Issues:</b>	Pregnancy Risk Assessment Monitoring System (PRAMS)								
<b>Significance:</b>	<p>Although most pregnancies result in good maternal and fetal outcomes, some pregnancies may result in adverse health effects for the woman, fetus, or neonate. Although some of these outcomes cannot be prevented, optimizing a woman's health and knowledge before planning and conceiving a pregnancy may eliminate or reduce the risk. Approximately half of all pregnancies in Tennessee are unintended. Therefore, the challenge of preconception care lies not only in addressing pregnancy planning for women who seek medical care and consultation specifically in anticipation of a planned pregnancy but also in educating and screening all reproductively capable women on an ongoing basis to identify potential maternal and fetal risk. In essence, family planning and preconception care are an important part of general preventive care for all women of reproductive age.</p>								

**Form 10b**  
**State Outcome Measure (SOM) Detail Sheets**  
**State: Tennessee**

No State Outcome Measures were created by the State.

**Form 10c**  
**Evidence-Based or –Informed Strategy 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, ages 18 through 44, with a preventive medical visit in the past year**

<b>Measure Status:</b>	Active									
<b>Goal:</b>	To increase the number of press releases, PSAs and/or social media messages promoting preventive health care visits for women of reproductive age									
<b>Definition:</b>	<table border="1" style="width: 100%;"> <tr> <td style="width: 30%;"><b>Numerator:</b></td> <td>Number of press releases, PSAs and/or social media messages promoting preventive health care visits for women of reproductive age</td> </tr> <tr> <td><b>Denominator:</b></td> <td>N/A</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Count</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>46</td> </tr> </table>		<b>Numerator:</b>	Number of press releases, PSAs and/or social media messages promoting preventive health care visits for women of reproductive age	<b>Denominator:</b>	N/A	<b>Unit Type:</b>	Count	<b>Unit Number:</b>	46
<b>Numerator:</b>	Number of press releases, PSAs and/or social media messages promoting preventive health care visits for women of reproductive age									
<b>Denominator:</b>	N/A									
<b>Unit Type:</b>	Count									
<b>Unit Number:</b>	46									
<b>Data Sources and Data Issues:</b>	TDH Office of Communications; TDH Reproductive and Women’s Health Section program data									
<b>Significance:</b>	<p>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.</p>									

**ESM 1.2 - Number of webinars for providers on increasing preventive care visits among women in their clinics**  
**NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	To Increase the number of webinars for providers on increasing preventive care visits among women in their clinics								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Numerator:</b></td> <td>Number of webinars for providers on increasing preventive care visits among women in their clinics</td> </tr> <tr> <td><b>Denominator:</b></td> <td>N/A</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Count</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>7</td> </tr> </table>	<b>Numerator:</b>	Number of webinars for providers on increasing preventive care visits among women in their clinics	<b>Denominator:</b>	N/A	<b>Unit Type:</b>	Count	<b>Unit Number:</b>	7
<b>Numerator:</b>	Number of webinars for providers on increasing preventive care visits among women in their clinics								
<b>Denominator:</b>	N/A								
<b>Unit Type:</b>	Count								
<b>Unit Number:</b>	7								
<b>Data Sources and Data Issues:</b>	TDH Reproductive and Women’s Health Section program data								
<b>Significance:</b>	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, ages 18 through 44, with a preventive medical visit in the past year**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	To distribute quarterly site-level family planning utilization reports to local health departments								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Numerator:</b></td> <td>Number of quarterly site-level family planning utilization reports distributed to local health departments</td> </tr> <tr> <td><b>Denominator:</b></td> <td>N/A</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Count</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>4</td> </tr> </table>	<b>Numerator:</b>	Number of quarterly site-level family planning utilization reports distributed to local health departments	<b>Denominator:</b>	N/A	<b>Unit Type:</b>	Count	<b>Unit Number:</b>	4
<b>Numerator:</b>	Number of quarterly site-level family planning utilization reports distributed to local health departments								
<b>Denominator:</b>	N/A								
<b>Unit Type:</b>	Count								
<b>Unit Number:</b>	4								
<b>Data Sources and Data Issues:</b>	Tennessee Department of Health - Patient Tracking Billing Information Management System (PTBMIS)								
<b>Significance:</b>	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, ages 18 through 44, with a preventive medical visit in the past year**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	To distribute quarterly region-level pregnancy-related service utilization reports to regional health departments								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Numerator:</b></td> <td>Number of quarterly region-level pregnancy-related service utilization reports distributed to regional health departments</td> </tr> <tr> <td><b>Denominator:</b></td> <td>N/A</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Count</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>4</td> </tr> </table>	<b>Numerator:</b>	Number of quarterly region-level pregnancy-related service utilization reports distributed to regional health departments	<b>Denominator:</b>	N/A	<b>Unit Type:</b>	Count	<b>Unit Number:</b>	4
<b>Numerator:</b>	Number of quarterly region-level pregnancy-related service utilization reports distributed to regional health departments								
<b>Denominator:</b>	N/A								
<b>Unit Type:</b>	Count								
<b>Unit Number:</b>	4								
<b>Data Sources and Data Issues:</b>	Tennessee Department of Health - Patient Tracking Billing Information Management System (PTBMIS)								
<b>Significance:</b>	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 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	To increase the number of safe sleep educational materials distributed								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Numerator:</b></td> <td>Number of safe sleep educational materials distributed</td> </tr> <tr> <td><b>Denominator:</b></td> <td>n/a</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Count</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>300,000</td> </tr> </table>	<b>Numerator:</b>	Number of safe sleep educational materials distributed	<b>Denominator:</b>	n/a	<b>Unit Type:</b>	Count	<b>Unit Number:</b>	300,000
<b>Numerator:</b>	Number of safe sleep educational materials distributed								
<b>Denominator:</b>	n/a								
<b>Unit Type:</b>	Count								
<b>Unit Number:</b>	300,000								
<b>Data Sources and Data Issues:</b>	TDH FHW child fatality review program data								
<b>Significance:</b>	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 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	To maintain the percent of infant deaths to be reviewed by child fatality review teams								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Numerator:</b></td> <td>Number of reviewed infant deaths</td> </tr> <tr> <td><b>Denominator:</b></td> <td>Number of infant deaths met the review criteria</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> </table>	<b>Numerator:</b>	Number of reviewed infant deaths	<b>Denominator:</b>	Number of infant deaths met the review criteria	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100
<b>Numerator:</b>	Number of reviewed infant deaths								
<b>Denominator:</b>	Number of infant deaths met the review criteria								
<b>Unit Type:</b>	Percentage								
<b>Unit Number:</b>	100								
<b>Data Sources and Data Issues:</b>	TDH FHW child death review database								
<b>Significance:</b>	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 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	Maintain that 80% of VLBW infants are being delivered at Level III or IV birthing facilities								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Numerator:</b></td> <td>VLBW infants are being delivered at Level III or IV birthing facilities</td> </tr> <tr> <td><b>Denominator:</b></td> <td>All VLBW infants</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> </table>	<b>Numerator:</b>	VLBW infants are being delivered at Level III or IV birthing facilities	<b>Denominator:</b>	All VLBW infants	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100
<b>Numerator:</b>	VLBW infants are being delivered at Level III or IV birthing facilities								
<b>Denominator:</b>	All VLBW infants								
<b>Unit Type:</b>	Percentage								
<b>Unit Number:</b>	100								
<b>Data Sources and Data Issues:</b>	Tennessee Department of Health, Births Statistical System								
<b>Significance:</b>	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 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding**

<b>Measure Status:</b>	Active	
<b>Goal:</b>	Maintain that at least 99% of newborns with a positive metabolic screen receive follow up to definitive diagnosis	
<b>Definition:</b>	<b>Numerator:</b>	Number of infants who received follow-up to a definitive diagnosis
	<b>Denominator:</b>	Number of infants with a positive metabolic screen
	<b>Unit Type:</b>	Percentage
	<b>Unit Number:</b>	100
<b>Data Sources and Data Issues:</b>	Neometrics/Natus newborn screening database	
<b>Significance:</b>	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 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	To increase the number of individuals served by the Tennessee Adolescent Pregnancy Prevention Program (TAPPP)								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Numerator:</b></td> <td>Number of individuals served by the Tennessee Adolescent Pregnancy Prevention Program (TAPPP)</td> </tr> <tr> <td><b>Denominator:</b></td> <td>n/a</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Count</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>48,500</td> </tr> </table>	<b>Numerator:</b>	Number of individuals served by the Tennessee Adolescent Pregnancy Prevention Program (TAPPP)	<b>Denominator:</b>	n/a	<b>Unit Type:</b>	Count	<b>Unit Number:</b>	48,500
<b>Numerator:</b>	Number of individuals served by the Tennessee Adolescent Pregnancy Prevention Program (TAPPP)								
<b>Denominator:</b>	n/a								
<b>Unit Type:</b>	Count								
<b>Unit Number:</b>	48,500								
<b>Data Sources and Data Issues:</b>	<p>TAPPP – Programmatic data collected from the 6 Regional and 2 Metro HD TAPPP Coordinators and County Health Educators using the state data reporting form.</p> <p>Abstinence Education Grant Program – Programmatic data collected from the 13 abstinence education program coordinators using the required federal data collection sheet.</p>								
<b>Significance:</b>	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 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	To increase general awareness of the need for developmental screening								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Numerator:</b></td> <td>Number of site views from webpage and mobile app to the Developmental Milestones and Developmental Screenings site during the past 12 months</td> </tr> <tr> <td><b>Denominator:</b></td> <td>n/a</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Count</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>1,320</td> </tr> </table>	<b>Numerator:</b>	Number of site views from webpage and mobile app to the Developmental Milestones and Developmental Screenings site during the past 12 months	<b>Denominator:</b>	n/a	<b>Unit Type:</b>	Count	<b>Unit Number:</b>	1,320
<b>Numerator:</b>	Number of site views from webpage and mobile app to the Developmental Milestones and Developmental Screenings site during the past 12 months								
<b>Denominator:</b>	n/a								
<b>Unit Type:</b>	Count								
<b>Unit Number:</b>	1,320								
<b>Data Sources and Data Issues:</b>	Kidcentraltn.com annual site traffic report from ioStudio								
<b>Significance:</b>	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 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	To increase number of health department nurses trained in the START Autism and MCHAT-R/F program								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Numerator:</b></td> <td>Number of nurses trained in the START Autism and MCHAT-R/F program</td> </tr> <tr> <td><b>Denominator:</b></td> <td>N/A</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Count</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>588</td> </tr> </table>	<b>Numerator:</b>	Number of nurses trained in the START Autism and MCHAT-R/F program	<b>Denominator:</b>	N/A	<b>Unit Type:</b>	Count	<b>Unit Number:</b>	588
<b>Numerator:</b>	Number of nurses trained in the START Autism and MCHAT-R/F program								
<b>Denominator:</b>	N/A								
<b>Unit Type:</b>	Count								
<b>Unit Number:</b>	588								
<b>Data Sources and Data Issues:</b>	TDH Community Health Services training data								
<b>Significance:</b>	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 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	To increase the percent of Developmental Screenings performed across the state for participants enrolled in an Evidence-Based Home Visiting Program								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Numerator:</b></td> <td>Number of ASQ-3 and ASQ:SE or ASQ:SE-2 screens documented at home visits during the past 12 months</td> </tr> <tr> <td><b>Denominator:</b></td> <td>Number of index children enrolled in an Evidence Based Home Visiting Program for at least 6 months</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> </table>	<b>Numerator:</b>	Number of ASQ-3 and ASQ:SE or ASQ:SE-2 screens documented at home visits during the past 12 months	<b>Denominator:</b>	Number of index children enrolled in an Evidence Based Home Visiting Program for at least 6 months	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100
<b>Numerator:</b>	Number of ASQ-3 and ASQ:SE or ASQ:SE-2 screens documented at home visits during the past 12 months								
<b>Denominator:</b>	Number of index children enrolled in an Evidence Based Home Visiting Program for at least 6 months								
<b>Unit Type:</b>	Percentage								
<b>Unit Number:</b>	100								
<b>Data Sources and Data Issues:</b>	TDH FHW REDCap data base for MIECHV								
<b>Significance:</b>	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 7.1.1 - Number of parents and caregivers receiving car seat education**

**NPM 7.1 – Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	To increase the number of parents of caregivers receiving car seat education								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Numerator:</b></td> <td>Number of parents and caregivers receiving car seat education</td> </tr> <tr> <td><b>Denominator:</b></td> <td>n/a</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Count</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>2,950</td> </tr> </table>	<b>Numerator:</b>	Number of parents and caregivers receiving car seat education	<b>Denominator:</b>	n/a	<b>Unit Type:</b>	Count	<b>Unit Number:</b>	2,950
<b>Numerator:</b>	Number of parents and caregivers receiving car seat education								
<b>Denominator:</b>	n/a								
<b>Unit Type:</b>	Count								
<b>Unit Number:</b>	2,950								
<b>Data Sources and Data Issues:</b>	Tennessee Department of Health Child Injury Prevention Program Data								
<b>Significance:</b>	<p>Motor vehicle crash injuries are a leading cause of death among children in the United States. In 2014, over 1,000 children ages 12 and under were seen in Tennessee emergency departments because of motor vehicle crashes. CDC research suggests that black and Hispanic children ages 12 and under are less likely to buckle up than white children. The consistent and correct use of car seats and boosters can reduce the risk of serious injury and death for infants, toddlers, and children up to age 8. Tennessee utilizes a recommended practice to distribute car seats with education programs to increase restraint and decrease injuries and deaths to child passengers.</p>								

**ESM 7.1.2 - Number of counties that adopt Count It! Drop It! Lock It! educational programs**  
**NPM 7.1 – Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	To increase the number of counties that adopt Count It! Drop It! Lock It! educational programs								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Numerator:</b></td> <td>Number of counties that adopt Count It! Drop It! Lock It! educational programs</td> </tr> <tr> <td><b>Denominator:</b></td> <td>n/a</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Count</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>93</td> </tr> </table>	<b>Numerator:</b>	Number of counties that adopt Count It! Drop It! Lock It! educational programs	<b>Denominator:</b>	n/a	<b>Unit Type:</b>	Count	<b>Unit Number:</b>	93
<b>Numerator:</b>	Number of counties that adopt Count It! Drop It! Lock It! educational programs								
<b>Denominator:</b>	n/a								
<b>Unit Type:</b>	Count								
<b>Unit Number:</b>	93								
<b>Data Sources and Data Issues:</b>	Tennessee Department of Health Injury Prevention Program reports								
<b>Significance:</b>	<p>Unintentional poisoning killed 635 U.S. Children in 2014; almost 90% of them were teenagers, ages 10-19. In 2014 117,959 U.S. children visited emergency departments for unintentional poisoning-related injuries (WISQARS). Reducing the amount of prescription drugs in the home can reduce access to these drugs by children. Research indicates the high availability of prescription drugs in Tennessee is contributing to the addiction problem across the state. According to the 2010 National Survey on Drug Use and Health, 70% of people who abused or misused prescription drugs got them from a friend or relative, either for free, by purchasing them, or by stealing them. People who abuse prescription drugs also obtain them from other sources including “pill mills,” or illegitimate pain clinics; prescription fraud; pharmacy theft; illegal online pharmacies; and “doctor shopping”. Some individuals who use prescription drugs for non-medical reasons believe these substances are safer than illicit drugs because they are prescribed by a physician and dispensed by a pharmacist.</p> <p>Communities that develop partnerships with schools, healthcare providers, pharmacists, law enforcement and other sectors to educate families about the importance of monitoring, securing, and properly disposing of prescription drugs can reduce access to unused prescription drugs and increase the perception of harm of the abuse of prescription drugs.</p>								

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

**NPM 7.1 – Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	To increase the percent of families who receive injury prevention education through the AAP checklist among families participating in Evidence Based Home Visiting programs								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Numerator:</b></td> <td>Number of children with at least one AAP screening completed</td> </tr> <tr> <td><b>Denominator:</b></td> <td>Number of children who reached first birthday during reporting period</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> </table>	<b>Numerator:</b>	Number of children with at least one AAP screening completed	<b>Denominator:</b>	Number of children who reached first birthday during reporting period	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100
<b>Numerator:</b>	Number of children with at least one AAP screening completed								
<b>Denominator:</b>	Number of children who reached first birthday during reporting period								
<b>Unit Type:</b>	Percentage								
<b>Unit Number:</b>	100								
<b>Data Sources and Data Issues:</b>	Tennessee Department of Health - Evidence Based Home Visiting Database								
<b>Significance:</b>	<p>Injury is a leading cause of child mortality and morbidity. In 2014, injuries resulted in more than 3,131 deaths and 2.3 million emergency department visits among 0-4 year olds in the US (CDC WISQARS). Home visitors can play an important role in increasing awareness about injury hazards, identifying risk and protective factors in the home setting, and teaching caregivers injury prevention methods.</p> <p>Using a childhood injury risk assessment tool, home visitors can identify risks and provide education on a wide range of injury topics. Home visiting is one strategy that shows promise for reducing rates of self-reported and substantiated child maltreatment and use of emergency rooms to treat child injuries.</p>								

**ESM 7.2.1 - Number of schools in the top ten crash rate counties (among ages 15-18) that conduct evidence-informed teen safe driving programming**

**NPM 7.2 – Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19**

<b>Measure Status:</b>	Active									
<b>Goal:</b>	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									
<b>Definition:</b>	<table border="1"> <tr> <td style="background-color: #2e75b6; color: white;"><b>Numerator:</b></td> <td>Number of schools in the top ten crash rate counties that conduct evidence-informed teen safe driving programming</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;"><b>Denominator:</b></td> <td>N/A</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;"><b>Unit Type:</b></td> <td>Count</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;"><b>Unit Number:</b></td> <td>65</td> </tr> </table>		<b>Numerator:</b>	Number of schools in the top ten crash rate counties that conduct evidence-informed teen safe driving programming	<b>Denominator:</b>	N/A	<b>Unit Type:</b>	Count	<b>Unit Number:</b>	65
<b>Numerator:</b>	Number of schools in the top ten crash rate counties that conduct evidence-informed teen safe driving programming									
<b>Denominator:</b>	N/A									
<b>Unit Type:</b>	Count									
<b>Unit Number:</b>	65									
<b>Data Sources and Data Issues:</b>	ReduceTNCrashes.org web based teen safe driving program reports									
<b>Significance:</b>	<p>Motor vehicle crash injuries are a leading cause of hospitalization among children in the United States. In 2014, over 840 adolescents ages 15-24 were hospitalized in Tennessee because of motor vehicle crashes. Research shows that in order for young drivers to remain collision-free, parents must model safe driving behaviors and invest in meaningful guided practice over a long period of time to turn these skills into good driving habits. It is our hope that new drivers will have a solid foundation to develop safe, collision-free driving habits that will last a lifetime through teen safe driving programming. The evidence-informed teen safe driving program can reduce risk and keep people safer on the road.</p>									

**ESM 7.2.2 - Number of drug disposal bins installed statewide**

**NPM 7.2 – Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	To increase the total number of drug disposal bins installed statewide								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Numerator:</b></td> <td>Number of drug disposal bins installed statewide</td> </tr> <tr> <td><b>Denominator:</b></td> <td>N/A</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Count</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>371</td> </tr> </table>	<b>Numerator:</b>	Number of drug disposal bins installed statewide	<b>Denominator:</b>	N/A	<b>Unit Type:</b>	Count	<b>Unit Number:</b>	371
<b>Numerator:</b>	Number of drug disposal bins installed statewide								
<b>Denominator:</b>	N/A								
<b>Unit Type:</b>	Count								
<b>Unit Number:</b>	371								
<b>Data Sources and Data Issues:</b>	Tennessee Department of Environment and Conservation Reports								
<b>Significance:</b>	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 7.2.3 - Number of press releases, social media posts and presentations about adolescent falls**  
**NPM 7.2 – Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	To increase the number of press releases, social media posts and presentations about adolescent falls								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Numerator:</b></td> <td>Number of press releases, social media posts and presentations about adolescent falls</td> </tr> <tr> <td><b>Denominator:</b></td> <td>N/A</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Count</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>9</td> </tr> </table>	<b>Numerator:</b>	Number of press releases, social media posts and presentations about adolescent falls	<b>Denominator:</b>	N/A	<b>Unit Type:</b>	Count	<b>Unit Number:</b>	9
<b>Numerator:</b>	Number of press releases, social media posts and presentations about adolescent falls								
<b>Denominator:</b>	N/A								
<b>Unit Type:</b>	Count								
<b>Unit Number:</b>	9								
<b>Data Sources and Data Issues:</b>	Tennessee Department of Health Media Communications and Media Relations Department and Injury Prevention Program data								
<b>Significance:</b>	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 7.2.4 - Number of suicide-related articles, social media posts and trainings provided by TDH**  
**NPM 7.2 – Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	To increase number of suicide-related articles, social media posts and trainings provided by TDH								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Numerator:</b></td> <td>Number of suicide-related articles, social media posts and trainings</td> </tr> <tr> <td><b>Denominator:</b></td> <td>N/A</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Count</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>26</td> </tr> </table>	<b>Numerator:</b>	Number of suicide-related articles, social media posts and trainings	<b>Denominator:</b>	N/A	<b>Unit Type:</b>	Count	<b>Unit Number:</b>	26
<b>Numerator:</b>	Number of suicide-related articles, social media posts and trainings								
<b>Denominator:</b>	N/A								
<b>Unit Type:</b>	Count								
<b>Unit Number:</b>	26								
<b>Data Sources and Data Issues:</b>	Tennessee Department of Health injury prevention program data								
<b>Significance:</b>	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 8.1.1 - Number of Gold Sneaker-recognized childcare facilities in Tennessee**

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

<b>Measure Status:</b>	Active								
<b>Goal:</b>	Increase the number of Gold Sneaker-recognized childcare facilities in Tennessee								
<b>Definition:</b>	<table border="1"> <tr> <td style="background-color: #2e75b6; color: white;"><b>Numerator:</b></td> <td>Number of Tennessee licensed childcare facilities recognized by TDH as meeting the requirements set by the Gold Sneaker Initiative</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;"><b>Denominator:</b></td> <td>N/A</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;"><b>Unit Type:</b></td> <td>Count</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;"><b>Unit Number:</b></td> <td>775</td> </tr> </table>	<b>Numerator:</b>	Number of Tennessee licensed childcare facilities recognized by TDH as meeting the requirements set by the Gold Sneaker Initiative	<b>Denominator:</b>	N/A	<b>Unit Type:</b>	Count	<b>Unit Number:</b>	775
<b>Numerator:</b>	Number of Tennessee licensed childcare facilities recognized by TDH as meeting the requirements set by the Gold Sneaker Initiative								
<b>Denominator:</b>	N/A								
<b>Unit Type:</b>	Count								
<b>Unit Number:</b>	775								
<b>Data Sources and Data Issues:</b>	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.								
<b>Significance:</b>	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 8.1.2 - Average number of monthly calls to the Tennessee Breastfeeding Hotline (TBH)**

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

<b>Measure Status:</b>	Active								
<b>Goal:</b>	To increase the average number of monthly calls to the Tennessee Breastfeeding Hotline								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Numerator:</b></td> <td>Count of individual calls (not unique callers) to the TBH during the reporting period</td> </tr> <tr> <td><b>Denominator:</b></td> <td>Months in reporting period</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Count</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>625</td> </tr> </table>	<b>Numerator:</b>	Count of individual calls (not unique callers) to the TBH during the reporting period	<b>Denominator:</b>	Months in reporting period	<b>Unit Type:</b>	Count	<b>Unit Number:</b>	625
<b>Numerator:</b>	Count of individual calls (not unique callers) to the TBH during the reporting period								
<b>Denominator:</b>	Months in reporting period								
<b>Unit Type:</b>	Count								
<b>Unit Number:</b>	625								
<b>Data Sources and Data Issues:</b>	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.								
<b>Significance:</b>	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 8.1.3 - Number of Baby Friendly-designated Tennessee birthing hospitals**

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

<b>Measure Status:</b>	Active								
<b>Goal:</b>	To increase the number of Baby Friendly-designated Tennessee birthing hospitals								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Numerator:</b></td> <td>Number of Baby Friendly-designated Tennessee birthing hospitals</td> </tr> <tr> <td><b>Denominator:</b></td> <td>N/A</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Count</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>16</td> </tr> </table>	<b>Numerator:</b>	Number of Baby Friendly-designated Tennessee birthing hospitals	<b>Denominator:</b>	N/A	<b>Unit Type:</b>	Count	<b>Unit Number:</b>	16
<b>Numerator:</b>	Number of Baby Friendly-designated Tennessee birthing hospitals								
<b>Denominator:</b>	N/A								
<b>Unit Type:</b>	Count								
<b>Unit Number:</b>	16								
<b>Data Sources and Data Issues:</b>	<p>Baby Friendly Hospital Initiative tracks completion of its 10 guidelines and evaluation criteria. A list of Baby Friendly Tennessee birthing hospitals is provided at:  <a href="https://www.babyfriendlyusa.org/find-facilities/designated-facilities--by-state">https://www.babyfriendlyusa.org/find-facilities/designated-facilities--by-state</a></p>								
<b>Significance:</b>	<p>Baby-Friendly USA, Inc. and its implementation of the Baby-Friendly Hospital Initiative (BFHI) in the United States is predicated on the fact that human milk fed through the mother's own breast is the normal way for human infants to be nourished. There is an abundance of scientific evidence that points to lower risks for certain diseases and improved health outcomes for both mothers and babies who breastfeed. Breastfeeding is the natural biological conclusion to pregnancy and an important mechanism for the continued normal development of the infant. With the correct information and the right supports in place, under normal circumstances, most women who choose to breastfeed are able to successfully achieve their goal.</p>								

**ESM 8.2.1 - Number of Physical Activity Clubs in K-12 schools**

**NPM 8.2 – Percent of adolescents, ages 12 through 17 who are physically active at least 60 minutes per day**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	To increase the number of Run Clubs for 5th through 8th graders								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Numerator:</b></td> <td>Tennessee Run Clubs with participants in grades 5th through 8th grade (identified through TDH partnerships)</td> </tr> <tr> <td><b>Denominator:</b></td> <td>N/A</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Count</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>334</td> </tr> </table>	<b>Numerator:</b>	Tennessee Run Clubs with participants in grades 5th through 8th grade (identified through TDH partnerships)	<b>Denominator:</b>	N/A	<b>Unit Type:</b>	Count	<b>Unit Number:</b>	334
<b>Numerator:</b>	Tennessee Run Clubs with participants in grades 5th through 8th grade (identified through TDH partnerships)								
<b>Denominator:</b>	N/A								
<b>Unit Type:</b>	Count								
<b>Unit Number:</b>	334								
<b>Data Sources and Data Issues:</b>	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.								
<b>Significance:</b>	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 8.2.2 - Number of school gardens in Tennessee public schools**

**NPM 8.2 – Percent of adolescents, ages 12 through 17 who are physically active at least 60 minutes per day**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	To increase the number of school gardens in Tennessee public schools								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Numerator:</b></td> <td>number of school gardens in Tennessee public schools</td> </tr> <tr> <td><b>Denominator:</b></td> <td>N/A</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Count</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>551</td> </tr> </table>	<b>Numerator:</b>	number of school gardens in Tennessee public schools	<b>Denominator:</b>	N/A	<b>Unit Type:</b>	Count	<b>Unit Number:</b>	551
<b>Numerator:</b>	number of school gardens in Tennessee public schools								
<b>Denominator:</b>	N/A								
<b>Unit Type:</b>	Count								
<b>Unit Number:</b>	551								
<b>Data Sources and Data Issues:</b>	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.								
<b>Significance:</b>	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 8.2.3 - Number of Healthy Parks Healthy Person app users**

**NPM 8.2 – Percent of adolescents, ages 12 through 17 who are physically active at least 60 minutes per day**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	To increase the number of Healthy Parks Healthy Person app users								
<b>Definition:</b>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%;"><b>Numerator:</b></td> <td>Number of Healthy Parks Healthy Person app users</td> </tr> <tr> <td><b>Denominator:</b></td> <td>N/A</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Count</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>3,335</td> </tr> </table>	<b>Numerator:</b>	Number of Healthy Parks Healthy Person app users	<b>Denominator:</b>	N/A	<b>Unit Type:</b>	Count	<b>Unit Number:</b>	3,335
<b>Numerator:</b>	Number of Healthy Parks Healthy Person app users								
<b>Denominator:</b>	N/A								
<b>Unit Type:</b>	Count								
<b>Unit Number:</b>	3,335								
<b>Data Sources and Data Issues:</b>	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.								
<b>Significance:</b>	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, ages 0 through 17, who have a medical home**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	To increase the number of providers trained and provided information on medical home implementation								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Numerator:</b></td> <td>Number of providers trained and provided information on medical home implementation</td> </tr> <tr> <td><b>Denominator:</b></td> <td>N/A</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Count</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>930</td> </tr> </table>	<b>Numerator:</b>	Number of providers trained and provided information on medical home implementation	<b>Denominator:</b>	N/A	<b>Unit Type:</b>	Count	<b>Unit Number:</b>	930
<b>Numerator:</b>	Number of providers trained and provided information on medical home implementation								
<b>Denominator:</b>	N/A								
<b>Unit Type:</b>	Count								
<b>Unit Number:</b>	930								
<b>Data Sources and Data Issues:</b>	Title V Children and Youth with Special Healthcare Needs (CYSHCN) program training participation log								
<b>Significance:</b>	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, ages 0 through 17, who have a medical home**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	Increase the number of families that receive patient centered medical home training								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Numerator:</b></td> <td>Number of families that receive patient centered medical home training</td> </tr> <tr> <td><b>Denominator:</b></td> <td>N/A</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Count</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>755</td> </tr> </table>	<b>Numerator:</b>	Number of families that receive patient centered medical home training	<b>Denominator:</b>	N/A	<b>Unit Type:</b>	Count	<b>Unit Number:</b>	755
<b>Numerator:</b>	Number of families that receive patient centered medical home training								
<b>Denominator:</b>	N/A								
<b>Unit Type:</b>	Count								
<b>Unit Number:</b>	755								
<b>Data Sources and Data Issues:</b>	Title V Children and Youth with Special Healthcare Needs (CYSHCN) program training participation log								
<b>Significance:</b>	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, ages 0 through 17, who have a medical home**

<b>Measure Status:</b>	Active									
<b>Goal:</b>	To increase the percentage of children served by the CSS program receiving services in a medical home									
<b>Definition:</b>	<table border="1"> <tr> <td style="background-color: #2e75b6; color: white;"><b>Numerator:</b></td> <td>Number of children 0-20 years of age served by the CSS program receiving services in a medical home</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;"><b>Denominator:</b></td> <td>Number of children 0-20 years of age served by the CSS program</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;"><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;"><b>Unit Number:</b></td> <td>100</td> </tr> </table>		<b>Numerator:</b>	Number of children 0-20 years of age served by the CSS program receiving services in a medical home	<b>Denominator:</b>	Number of children 0-20 years of age served by the CSS program	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100
<b>Numerator:</b>	Number of children 0-20 years of age served by the CSS program receiving services in a medical home									
<b>Denominator:</b>	Number of children 0-20 years of age served by the CSS program									
<b>Unit Type:</b>	Percentage									
<b>Unit Number:</b>	100									
<b>Data Sources and Data Issues:</b>	Tennessee Department of Health - Patient Tracking and Billing Management Information System (PTBMIS) - CSS Program data									
<b>Significance:</b>	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, ages 12 through 17, who received services necessary to make transitions to adult health care**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	To expand the adolescent advisory council								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Numerator:</b></td> <td>Number of adolescents on the advisory council</td> </tr> <tr> <td><b>Denominator:</b></td> <td>N/A</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Count</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>15</td> </tr> </table>	<b>Numerator:</b>	Number of adolescents on the advisory council	<b>Denominator:</b>	N/A	<b>Unit Type:</b>	Count	<b>Unit Number:</b>	15
<b>Numerator:</b>	Number of adolescents on the advisory council								
<b>Denominator:</b>	N/A								
<b>Unit Type:</b>	Count								
<b>Unit Number:</b>	15								
<b>Data Sources and Data Issues:</b>	Children and Youth with Special Healthcare Needs (CYSHCN) program record								
<b>Significance:</b>	<p>The transition of youth to adulthood has become a priority issue nationwide as evidenced by the clinical report and algorithm developed jointly by the AAP, American Academy of Family Physicians and American College of Physicians to improve healthcare transitions for all youth and families. Over 90 percent of children with special health care needs now live to adulthood, but are less likely than their non-disabled peers to complete high school, attend college or to be employed. Health and health care are cited as two of the major barriers to making successful transitions. Our CSS program requires all children enrolled in the program have a transition plan in place by age of 14 years and updated every year afterward. The Youth Advisory Council will provide recommendations and advise the CSS program staff on transition concerns youth may face.</p>								

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

**NPM 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care**

<b>Measure Status:</b>	Active									
<b>Goal:</b>	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									
<b>Definition:</b>	<table border="1"> <tr> <td style="background-color: #2e75b6; color: white;"><b>Numerator:</b></td> <td>Number of providers who receive technical assistance and information on transition for youth and young adults with and without special health care needs</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;"><b>Denominator:</b></td> <td>N/A</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;"><b>Unit Type:</b></td> <td>Count</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;"><b>Unit Number:</b></td> <td>365</td> </tr> </table>		<b>Numerator:</b>	Number of providers who receive technical assistance and information on transition for youth and young adults with and without special health care needs	<b>Denominator:</b>	N/A	<b>Unit Type:</b>	Count	<b>Unit Number:</b>	365
<b>Numerator:</b>	Number of providers who receive technical assistance and information on transition for youth and young adults with and without special health care needs									
<b>Denominator:</b>	N/A									
<b>Unit Type:</b>	Count									
<b>Unit Number:</b>	365									
<b>Data Sources and Data Issues:</b>	Children and Youth with Special Healthcare Needs (CYSHCN) program record									
<b>Significance:</b>	<p>The transition of youth to adulthood has become a priority issue nationwide as evidenced by the clinical report and algorithm developed jointly by the AAP, American Academy of Family Physicians and American College of Physicians to improve healthcare transitions for all youth and families. Over 90% 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.</p>									

**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, ages 12 through 17, who received services necessary to make transitions to adult health care**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	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								
<b>Definition:</b>	<table border="1"> <tr> <td style="background-color: #2e75b6; color: white;"><b>Numerator:</b></td> <td>Number of providers who receive technical assistance and information on transition for youth and young adults with and without special health care needs</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;"><b>Denominator:</b></td> <td>N/A</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;"><b>Unit Type:</b></td> <td>Count</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;"><b>Unit Number:</b></td> <td>95</td> </tr> </table>	<b>Numerator:</b>	Number of providers who receive technical assistance and information on transition for youth and young adults with and without special health care needs	<b>Denominator:</b>	N/A	<b>Unit Type:</b>	Count	<b>Unit Number:</b>	95
<b>Numerator:</b>	Number of providers who receive technical assistance and information on transition for youth and young adults with and without special health care needs								
<b>Denominator:</b>	N/A								
<b>Unit Type:</b>	Count								
<b>Unit Number:</b>	95								
<b>Data Sources and Data Issues:</b>	Children and Youth with Special Healthcare Needs (CYSHCN) program record								
<b>Significance:</b>	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 14.1.1 - Number of reproductive-aged female tobacco users (15-44 years) who received online or phone counseling services through the Tennessee Tobacco Quitline.**

**NPM 14.1 – Percent of women who smoke during pregnancy**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	Increase the number of reproductive-aged female tobacco users (15-44 years) who received online or phone counseling services through the Tennessee Tobacco Quitline								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Numerator:</b></td> <td>Number of reproductive-aged female tobacco users (15-44 years) who received online or phone counseling services through the Tennessee Tobacco Quitline</td> </tr> <tr> <td><b>Denominator:</b></td> <td>N/A</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Count</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>1,075</td> </tr> </table>	<b>Numerator:</b>	Number of reproductive-aged female tobacco users (15-44 years) who received online or phone counseling services through the Tennessee Tobacco Quitline	<b>Denominator:</b>	N/A	<b>Unit Type:</b>	Count	<b>Unit Number:</b>	1,075
<b>Numerator:</b>	Number of reproductive-aged female tobacco users (15-44 years) who received online or phone counseling services through the Tennessee Tobacco Quitline								
<b>Denominator:</b>	N/A								
<b>Unit Type:</b>	Count								
<b>Unit Number:</b>	1,075								
<b>Data Sources and Data Issues:</b>	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.								
<b>Significance:</b>	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.								

**ESM 14.2.1 - Number of child care facilities that voluntarily implement a tobacco-free campus policy**  
**NPM 14.2 – Percent of children, ages 0 through 17, who live in households where someone smokes**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	To increase the number of child care facilities that voluntarily implement a tobacco-free campus policy								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Numerator:</b></td> <td>Number of licensed childcare facilities in Tennessee who adopt Gold-Sneaker designated policies</td> </tr> <tr> <td><b>Denominator:</b></td> <td>N/A</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Count</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>705</td> </tr> </table>	<b>Numerator:</b>	Number of licensed childcare facilities in Tennessee who adopt Gold-Sneaker designated policies	<b>Denominator:</b>	N/A	<b>Unit Type:</b>	Count	<b>Unit Number:</b>	705
<b>Numerator:</b>	Number of licensed childcare facilities in Tennessee who adopt Gold-Sneaker designated policies								
<b>Denominator:</b>	N/A								
<b>Unit Type:</b>	Count								
<b>Unit Number:</b>	705								
<b>Data Sources and Data Issues:</b>	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.								
<b>Significance:</b>	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 14.2.2 - Percent of primary caregivers enrolled in home visiting who reported using any tobacco products at enrollments and were referred to tobacco cessation counseling or services within three months of enrollment**  
**NPM 14.2 – Percent of children, ages 0 through 17, who live in households where someone smokes**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	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								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Numerator:</b></td> <td>Number of primary caregivers enrolled in home visiting who reported using any tobacco products at enrollment and were referred to tobacco cessation counseling or services within 3 months of enrollment</td> </tr> <tr> <td><b>Denominator:</b></td> <td>Number of primary caregivers enrolled in home visiting who reported using any tobacco products at enrollment and were enrolled for at least 3 months</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> </table>	<b>Numerator:</b>	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	<b>Denominator:</b>	Number of primary caregivers enrolled in home visiting who reported using any tobacco products at enrollment and were enrolled for at least 3 months	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100
<b>Numerator:</b>	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								
<b>Denominator:</b>	Number of primary caregivers enrolled in home visiting who reported using any tobacco products at enrollment and were enrolled for at least 3 months								
<b>Unit Type:</b>	Percentage								
<b>Unit Number:</b>	100								
<b>Data Sources and Data Issues:</b>	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.								
<b>Significance:</b>	Currently operating in 31 of the state’s 95 counties, evidence-based home visiting programs are located in communities with higher rates of smoking, teen pregnancy, low birth weight, prematurity, and infant death. Smoking prevalence among mothers who reside in these select communities ranges from 6 percent to 31 percent. Home visitors assess a number of preventive health and prenatal practices, including prenatal tobacco use and use of tobacco in the home. Evidence-based home visiting services is one of the most effective and cost-effective interventions to help parents support their young children’s health and development and prevent adverse childhood experiences.								

**Form 11**  
**Other State Data**  
**State: Tennessee**

The Form 11 data are available for review via the link below.

[Form 11 Data](#)