

**Title V Maternal and Child Health Services Block Grant
Five Year Needs Assessment
2016-2020**

**Tennessee Department of Health
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Introduction

The Tennessee Department of Health (TDH) Division of Family Health and Wellness is responsible for the administration of funds provided to the state by the federal Title V Maternal and Child Health (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. This comprehensive needs assessment fulfills the requirement for the 2016-2020 grant cycle.

Tennessee MCH Needs Assessment 2015 Process

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 MCH/Title V priorities for the next five years, determine performance objectives and develop measures to track progress, and to plan strategies and activities to address the stated priorities. The Needs Assessment was deliberately intended to be inclusive to incorporate the input of diverse 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 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 leadership was able to acquire a realistic view of the state's MCH public health system in order to develop a five year plan based on key MCH priorities and in alignment 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 CSHCN 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 the TDH Division of Family Health and Wellness and the 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.

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, as well as 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 roughly 160 quantitative indicators proposed by leadership, program staff, and stakeholders. Simultaneously, the Needs Assessment Coordinator planned and/or facilitated 31 focus groups and community meetings across the state to gather qualitative input on MCH priority needs and capacity. 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 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 priority needs 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 has 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.

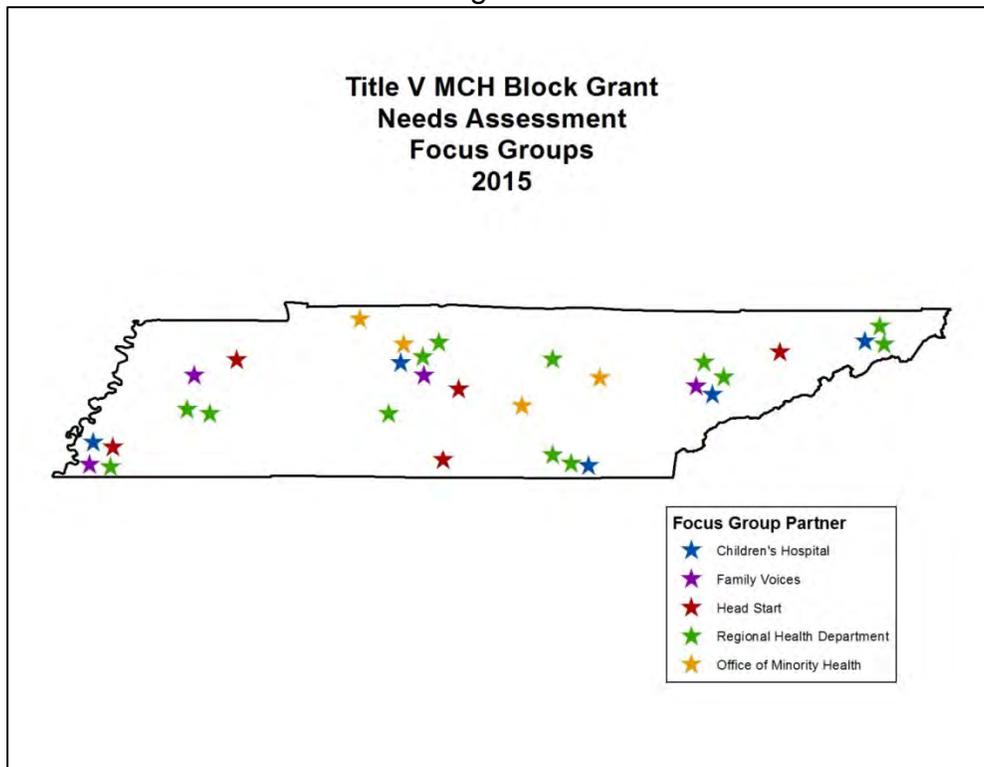
The epidemiologists graphed each quantitative indicator and where available made comparisons by race/ethnicity or geography. A complete presentation of all the quantitative data can be found in the full needs assessment document.

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 Disparity 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 coordinated all 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 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. 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 Excel to determine 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.

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 MCH 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. 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). Overall the day was very well received. Responses indicated that attendees: had a better understanding of the MCH Block Grant after attending the meeting; felt that correct priorities were discussed; felt

that a broad range of issues were discussed; and felt that they had ample opportunity for input and that their input was valued. The item with the lowest score (3.7 out of 4) related to diverse representation among the stakeholders; even though this score was not truly low, we will explore strategies for broadening the stakeholder group as we move ahead. A list of free-text comments from the evaluation meeting can be found in Appendix F.

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 candidate 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. 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.

Tennessee MCH Needs Assessment 2015 Findings: 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)

Detail on the quantitative and qualitative data used to derive these priorities can be found in the full 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 prevalences 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 back 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 (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 adverse childhood experiences (ACEs), brain development and long term health has become clearer. In 2012 a question on ACEs was added to the National Survey of Children's Health. 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 adolescent (35.3 per 100,000) is higher than the national rate (30.8). Motor vehicle-related deaths contribute significantly to these deaths in TN 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, 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-CYSHCN 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 2009/10). 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 (16.3%) 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.

Tennessee MCH Needs Assessment 2015

Findings: Title V Program Capacity

Organizational Structure

Tennessee's Title V MCH and CSHCN programs are administered by the Tennessee Department of Health (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 the Division of Family Health and Wellness (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, is the 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 Appendix H.

The TDH Central Office is located in Nashville (the state capital); staff within FHW provide administrative leadership to 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 Title V MCH and CSHCN programs. In addition to FHW, a number of other offices/divisions within the Central Office support MCH efforts across the State. Those include:

- Office of Compliance
- Office of General Counsel
- Office of Minority Health and Disparities Elimination
- Office of Communications
- Legislative Affairs
- Policy, Planning and Assessment
- Communicable and Environmental Diseases and Emergency Preparedness
- Community Health Services
- Health Licensure and Regulation
- Public Health Informatics
- Office of Human Resources
- Health Planning
- Office of Patient Care Advocacy
- Division of Administrative Services

The state is organized into thirteen public health regions (see Appendix I). Seven rural regions (each consisting of multiple counties) report directly to TDH, and six metropolitan health departments report to their own municipal government but have a contractual arrangement with the Department.

TDH is the responsible entity for administration of programs carried out with allotments under Title V. Within TDH, the Division of Family Health and Wellness is primarily

responsible for development of the annual Maternal and Child Health Block Grant Application and Annual Report. Title V funding is used in numerous ways to support the MCH population in Tennessee, as outlined in the table below.

Service Type	Examples
Direct Services	<ul style="list-style-type: none"> • Medical payments for CYSHCN (pharmacy, inpatient/outpatient, supplies, etc) • Screening and diagnostic services for women (mammograms, diagnostic biopsies) • Lab tests in local health departments (blood lead, family planning)
Enabling Services	<ul style="list-style-type: none"> • Care coordination for: at-risk families and children with special health care needs (provided by local health department staff), women with breast or cervical cancer • Case management by local/regional health department staff for children with elevated blood lead levels • Local health department staff (nurses, advanced practice nurses, physicians) involved in provision of immunizations, well-child checkups, family planning services, breast and cervical cancer screening services • Clinic supplies for local health departments (for women’s health, oral health and child health services) • Tertiary follow-up for newborn screening program through contracts with various medical centers • Contracts with medical specialty camps for CYSHCN (Diabetes Camp, Asthma Camp, Sickle Cell Camp) • Contracts with community agencies for evidence-based home visiting • Contract with community non-profit for wrap-around and recovery support services for mothers of infants with neonatal abstinence syndrome (NAS)
Public Health Services and Systems	<ul style="list-style-type: none"> • Salaries for administrative staff in Central Office (handle contracts, invoices) • Salaries for program staff in Central Office (involved in the development of standards and guidelines, needs assessment, program planning, implementation, evaluation, policy development, quality assurance and improvement, workforce development, and population-based disease prevention and health promotion campaigns) • Central Office supplies and equipment • Travel funding for Advisory Committee members (Children’s Special Services Advisory Committee, Genetics Advisory Committee, Perinatal Advisory Committee) • Training (internal staff training for MCH-related programs, external stakeholder training such as training for death scene investigators involved in child fatality review) • Promotional materials (safe sleep, medical home, newborn

	screening, etc) <ul style="list-style-type: none"> • Contract for Tennessee Breastfeeding Hotline (partial funding) • Contract for Tennessee Poison Control Center (partial funding) • Contract for statewide blood lead database (captures tracking and referral)
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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 as well as for relevant state and federal laws. On a monthly basis, program staff review all charges assigned to their respective program area to assure that the charge is related to the program and when services are contracted, program staff assure that the invoiced charges are aligned with the approved budget and within the allowable charges specified in the contract.

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 promote and protect the health of all mothers and children, including CSHCN. The capacity for providing Title V services is listed by the six population health domains below.

Women’s/Maternal Health: Local health departments provide preventive services for women (such as clinical breast exams and pap smears); pregnancy testing; breastfeeding promotion and support; 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. The Tennessee Breastfeeding Hotline is available 24/7 to provide telephonic support to women with questions about breastfeeding.

Perinatal/Infant Health: Local health departments provide well-child screenings (Early Periodic Screening, Diagnosis and Treatment, EPSDT, periodic screens) for infants in all 95 counties; 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. WIC services are co-located in all health

departments, providing nutrition information and support as well as referrals to health care. Department 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 critical congenital heart disease and congenital hearing loss. The TDH State Lab provides testing for all dried blood spot specimens and coordinates closely with nursing follow-up staff housed within FHW. Follow-up nursing staff provide case management for infants with abnormal newborn screens and refer infants to specialty tertiary clinics as appropriate. Nursing staff also work with hospitals and birthing centers to improve the quality of newborn screening (screening completion, submission of satisfactory specimens, and timely submission of specimens). 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 partnerships with community entities (such as the state hospital association). As previously described, the Tennessee Breastfeeding Hotline provides 24/7 telephone support for anyone with questions about breastfeeding. WIC breastfeeding peer counselors are available in some counties, and all counties have a designated breastfeeding expert available to support mothers who are nursing.

Child Health: Local health departments provide EPSDT periodic screens, dental sealants and immunizations for children in all 95 counties. WIC services are co-located in all health departments, providing nutrition information and support as well as referrals to health care. Local health departments also screen for elevated blood lead levels and provide case management for children with elevated blood lead levels as well as general education on prevention of childhood lead poisoning. MIECHV-funded evidence-based home visiting is available in 50 counties, and targeted case management for high-risk children is available through each local health department. 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. To date, 306 sites have earned Gold Sneaker designation. TDH contracts with specialty clinics to provide long-term follow-up for children diagnosed through the newborn screening program and the network of genetic/sickle cell clinics. 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. TDH contracts with the Tennessee Department of Environment and Conservation (TDEC) to conduct environmental investigations for children with elevated blood lead levels.

CYSHCN: Local health departments provide care coordination for children and youth with special health care needs (CYSHCN) through the Children's Special Services (CSS) program. CSS was established by statute in 1929 and operates in all 95 counties. 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). Through the D70 Systems Integration Grant, TDH has partnered with Family Voices to establish a parent-to-parent (P2P) network to match parents of children with similar diagnoses. Family Voices has also provided training to parent leaders to build capacity for engaging the public health and health care system. TDH has also used D70 funds 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. Family planning services (including confidential services) and STI/HIV screening and treatment are also available in local health departments. Health educators in local and regional health departments partner with communities to provide outreach and education related to teen pregnancy prevention. Pregnant adolescents are one of the high-risk populations served through the targeted case management program available through all county health departments.

Cross-Cutting or Life Course: Myriad initiatives support MCH populations across the life course. Multidisciplinary teams across the state review all deaths of children under age 18 through the Child Fatality Review process. Local teams review deaths and make recommendations to a state team, which reviews aggregate data on the incidence and causes of child deaths and makes recommendations to the Governor and General Assembly for programs and policies to prevent future child deaths. TDH funds the Tennessee Tobacco QuitLine, which provides telephonic smoking cessation services to callers throughout the state. TDH also contracts with Vanderbilt University Medical Center to operate the Tennessee Poison Control Center, a comprehensive poison resource center that serves as the statewide poison emergency information and resource center for the public and health care professionals. TDH administers Project Diabetes, a state-funded initiative aimed at promoting upstream prevention activities (namely related to physical activity and nutrition) to reduce the burden of diabetes in Tennessee; many of the funded projects specifically target the child and adolescent

populations. Within TDH, FHW manages a number of injury prevention efforts targeted at various populations across the life course, including: prevention of sleep-related infant deaths, prevention of teen motor vehicle collisions, prevention of poisonings (specifically prescription drug overdose) among all age groups, and prevention of senior adult falls.

Statewide System of Services

Tennessee's MCH and CYSHCN programs collaborate broadly to ensure a statewide system of services. These services reflect the principles of comprehensive, community-based, coordinated, 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 critical congenital heart disease (CCHD) in hospital nurseries. Title V funds also support the Perinatal Advisory Committee (member travel and meeting supplies); this Committee advises TDH on the administration of the regionalized perinatal system.

TDH contracts with specialty tertiary centers to provide confirmatory testing, diagnostic, and follow-up services for infants identified through the newborn screening programs. Title V funds support these efforts to ensure continuity of care from testing to diagnosis to treatment. These funds also support the Genetics Advisory Committee (member travel and meeting supplies), which advises the Department on the operation of the newborn screening and genetics program.

Title V funds support a contract with the University of Tennessee-Knoxville to maintain a database for tracking all blood lead levels reported to TDH. This database supports statewide case management for children with elevated blood lead levels. TDH also utilizes Title V funds to support a contract with the Tennessee Department of Environment and Conservation, which conducts environmental investigations in cases of extremely high or persistently elevated blood lead levels.

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.

Title V staff have partnered with birthing hospitals to implement and maintain a public health surveillance system for Neonatal Abstinence Syndrome (NAS). In 2013, Tennessee became the first state to make NAS a reportable condition. Over 2,000 cases were reported in the first two years of the surveillance system.

State Support for Communities: Title V funds have long been used in Tennessee to provide enabling services in local health departments. Funds support core staffing 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 mix 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: Tennessee's Title V CSHCN program, Children's Special Services (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).

The CSS Advisory Committee, comprised of medical providers and family representatives, advises the Department on the implementation of the CSS program as well as broader CYSHCN services. Medical professionals on the Committee represent the most common specialties encountered by CSS participants. Committee members help assure that CSS program policies align with the latest medical recommendations and also that program services are family-centered.

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. Through the Genetics Advisory Committee, medical consultants advise the Department on the newborn screening panel as well as follow-up protocols.

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.

TDH is utilizing Title V funding to support the implementation of Screening, Brief Intervention and Referral to Treatment (SBIRT) in local health departments as part of primary prevention efforts to reduce the burden of NAS. Local health department use validated screening tools to screen for possible substance abuse/misuse. Through a collaboration with the Department of Mental Health and Substance Abuse Services, TDH is coordinating referrals with community mental health centers for individuals who screen positive during a health department visit.

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). 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.

Title V staff are leading a collaboration with staff at the Vanderbilt University Kennedy Center to enhance the Tennessee Disability Pathfinder. The Pathfinder is an online resource directory containing information on community-based resources for individuals with disabilities. Title V funding will support dedicated staff time for assisting families with referrals to community services.

Local health department staff frequently refer patients and families to community-based services based on individual- or family-level assessments of need. For example, a health department nurse might refer a family to community services that provide emergency housing support or food packages.

MCH Workforce Development and Capacity

Title V-funded MCH and CSHCN staff work at multiple levels within the Tennessee Department of Health (Central Office, 7 Rural Regional Offices and 1 Metro Office, and local health departments in 95 counties). The MCH and CSHCN workforce for FY2014 is illustrated in the table below. A detailed listing of position classifications, employee count, and full-time equivalents (FTEs) are included in Appendix J.

Location	Number of Employees	Full-time Equivalents
Central Office (Nashville)	58	30.0
Shelby County Metro	1	1.0
West Regional Office	15	3.5
South Central Regional Office	2	1.1
Mid-Cumberland Regional Office	3	2.2
Upper Cumberland Regional Office	10	3.8
Southeast Regional Office	11	5.9
East Regional Office	16	5.8
Northeast Regional Office	17	2.2
Local health departments (across state)	54	10.1
TOTAL	187	65.6

In addition to the FTEs listed above, Title V-funded staff work in six metropolitan health departments through contractual arrangements with TDH. Those staff are counted as contractors (rather than TDH employees) and thus are not counted in the above table.

In addition to the staff and full-time equivalents listed above, the Department allocates other staff time to Title V through the resource-based relative value unit system (RBRVS). 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. 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.

Title V Management: Tennessee's MCH-related programs are organized in the Division of Family Health and Wellness within the Tennessee Department of Health. In December 2010, Dr. Michael Warren joined the Department of Health as Director of Title V/Maternal and Child Health. Dr. Warren is a general pediatrician by training, having completed medical school at East Carolina University, residency and a chief

resident year at Vanderbilt, and an academic general pediatrics fellowship and MPH at Vanderbilt. He served on the faculty at the Vanderbilt University School of Medicine, where he designed the Community-Oriented Resident Education (CORE) program, a community pediatrics and advocacy training curriculum developed with funding from the American Academy of Pediatrics. Prior to joining the Department of Health, Dr. Warren served as Medical Director in the Governor's Office of Children's Care Coordination, where he worked with a number of state child- and family-serving agencies on issues including strengthening of medical home services, implementation of quality improvement activities focused on improving adolescent health, coordination of EPSDT services, and infant mortality reduction initiatives. As Director of Title V/MCH, Dr. Warren oversees MCH programs in the Central Office and provides leadership and direction for MCH initiatives in all 95 counties.

Additional MCH leadership for the section is provided by Melissa Blair (Deputy Director), Kelly Luskin (Reproductive and Women's Health), Rachel Heitmann (Injury Prevention and Detection), Jacqueline Johnson (CSHCN), Peggy Lewis (WIC), Margaret Major (Perinatal, Infant, and Pediatric Care) and Loraine Lucinski (Early Childhood).

With the merging of the MCH and Nutrition and Wellness sections Melissa Blair was named Deputy Director of this newly created Division. Ms. Blair has over 20 years of state government experience having most recently served as the Director of Nutrition and Wellness Section in the Department of Health and provides oversight for WIC, and Chronic Disease Programs within the division. Ms. Blair has a Bachelor's degree in merchandising and home economics and a Master's in Human Ecology with a minor in Business.

Rachel Heitmann oversees the Division's initiatives related to Injury Prevention and Detection (Core Violence and Injury Prevention Program, Lead Poisoning Prevention, Fetal Infant Mortality Review, Child Fatality Review, and Sudden Infant Death Syndrome Prevention). Ms. Heitmann joined the MCH Section in 2010, having previously worked in the Department with the Traumatic Brain Injury program for five years. Prior to joining the department, she worked in a residential setting for clients with mental illness, substance abuse, and traumatic brain injury. She has a Master's Degree in Mental Health Counseling.

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

Peggy Lewis serves as the State WIC Director, a position she has held since 2002. She is a licensed dietitian/nutritionist with a Master's Degree in Foods and Nutrition. Prior to her current role, she has served as a regional WIC Director in Tennessee and as a clinical dietitian and WIC Program Manager at an Ohio hospital. She has also

taught Nutrition and Food Service courses at the undergraduate level and has served as President of the National WIC Association.

Kelly Luskin serves as the Director of Reproductive and Women's Health. Kelly is a women's health nurse practitioner and worked in a clinical setting providing direct care prior to joining the Department in 2012. Mrs. Luskin oversees Family Planning, Adolescent Pregnancy Prevention, and the Breast and Cervical Cancer Screening Program. She holds an MSN degree and is a board-certified Women's Health Nurse Practitioner.

Margaret Major has worked with the Department of Health since 1972 in a variety of roles, including Nutrition Consultant, Assistant MCH Director, Acting MCH Director, and Director of Family Planning. Ms. Major is currently the Director of Perinatal, Infant, and Pediatric Care, providing oversight for Perinatal Regionalization, Newborn Screening, and Childhood Lead Poisoning Prevention. Ms. Major holds a Bachelor's degree in Food Science/Nutrition and a Master's in Public Administration/Health Services.

Loraine Lucinski joined the Department in September 2011 and began leading the Early Childhood Systems Initiatives Team in January 2013. The Early Childhood Systems Team oversees a number of early childhood programs including the Early Childhood Comprehensive Systems Initiative, the Maternal, Infant and Early Childhood Home Visiting (MIECHV) Program, state funded home visiting programs, the Medicaid Targeted Case Management Program for high risk infants and mothers and the new Universal Parent Outreach Initiative, Welcome Baby. Ms. Lucinski holds a Bachelor Degree in Developmental Psychology, a Master's Degree in Public Health and a Graduate Certificate in Maternal and Child Health Epidemiology.

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. For example, the group has worked through the Johns Hopkins MCH Public Health Leadership modules. These monthly meetings also provide an opportunity to familiarize staff with Departmental operations. Recent presentations have included contract development and monitoring as well as emergency preparedness. The Division's epidemiology staff is presenting an "Epidemiology 101" series in 2015 to provide all program leadership with a working understanding of basic epidemiology principles and techniques.

In 2014, TDH partnered with faculty from four Tennessee public health programs (East Tennessee State University, University of Tennessee-Knoxville, Tennessee State University, and the University of Memphis) to provide FHW program staff with training in program evaluation. Faculty presented examples of program evaluation strategies and

then worked in small group sessions with program management staff to help identify plans for evaluating FHW programs.

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

Additional data analysis support is provided through a number of collaborative relationships. The SSDI grant (managed by FHW) provides funding support for staff in the Department's Office of Policy, Planning, and Assessment. 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 MCH.

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 TN Family Voices chapter. In 2011, MCH staff began an enhanced effort to integrate parent input in all aspects of MCH services. Advances have been made over the past few years to further involvement of parents in planning, programming and implementing 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 also attended the AMCHP meeting as part of the Tennessee delegation since 2013.

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

Through the newborn hearing screening grant, TDH supports part-time parent staff positions. These parents serve as critical liaisons to other parents of children with hearing loss. Parents also serve on the newborn hearing screening and follow-up task force.

Family representatives routinely attend and participate in the Genetics Advisory Committee (GAC) and Children's Special Services (CSS) Advisory Committee Meetings. The GAC meetings focus on the state's newborn screening and follow-up program and members advise the Department on program operations and the addition of screening tests to the state's testing panel. The CSS Advisory Committee meetings focus on issues related to the management and operation of the CSS program (Tennessee's Title V CSHCN Program) as well as broader issues impacting all CYSHCN (such as transition to adulthood).

In 2015, TDH partnered with Family Voices to host four focus groups with families of CYSHCN as part of the five-year Title V Needs Assessment. The 2015 AMCHP Family Scholar, Kara Adams, co-presented findings from these focus groups with TDH staff at the stakeholder meeting during which key MCH stakeholders provided input on the selection of priority areas and national performance measures. Family Voices staff also collaborated with TDH staff to write a portion of the annual Block Grant (section II.B.2.c on family/consumer partnerships and collaborations).

Other Title V Workforce Information: As part of ongoing efforts to systemically address workforce development, all MCH-related Central Office and Field Staff are completing the MCH Leadership Competencies Self-Assessment and utilizing the findings to complete at least one module in the MCH Navigator. (This was actually a state performance measure in the last five-year Block Grant cycle).

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

FHW staff are always encouraged to take advantage of external workforce development activities. In the past several years, four FHW staff (including three members of our senior leadership team) have completed LEAD Tennessee, a statewide, 12-month development initiative which includes six one-day summits of intense, personally tailored, high impact learning focused on twelve core leadership competencies. The goal of LEAD Tennessee is to increase the state's leadership bench strength by providing agencies with a continuous pipeline of motivated and prepared leaders that share a common language and mindset about great leadership. The Division's Deputy

Director, Melissa Blair, participated in the MCH Public Health Leadership Institute at the University of North Carolina-Chapel Hill. PHLI is an executive-education program designed to significantly expand self-awareness and quickly build practical skills for effectively leading, managing people, and building partnerships, to advocate for and create the MCH systems of tomorrow. Additionally, Jacqueline Johnson, state CYSHCN Director, is currently participating in the AMCHP Leadership Institute for CYSHCN Directors. This program promotes valuable components for both new and experienced directors. The Division Director, Dr. Michael Warren, currently serves on the AMCHP Workforce Development Committee, on the Advisory Committee for the National MCH Workforce Development Center and also as a mentor in the AMCHP New Director Mentor Program.

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 part of the routine collection of participant information across programs such as Family Planning, home visiting, newborn screening, Children's Special Services, Child Fatality Review and Childhood Lead Poisoning Prevention. 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. Since March 2012, selected Department of Health staff in all 13 regions are participating in the half-day training provided by UTK. The workshop takes an in-depth look at individual cultural competence. It is specifically designed to increase awareness, knowledge, and skills in dealing with clients, patients, and co-workers whose world view is different from one's self. The emphasis is on the health-related professions. UTK completed the first round of training (regional and Central Office Leadership) in 2013 and is now holding additional sessions across the state to provide the training to front-line service delivery staff.

In 2014, the CYSHCN section supported (through the HRSA D70 grant) a statewide training for providers on Culturally Effective Care in partnership with the TN Chapter of the American Academy of Pediatrics (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."

Other program-specific training supports culturally competent service delivery. For example, WIC provides annual staff training on cultural competency. Additionally, new staff members receive training through the WIC e-Learning system as well as ongoing training through this system.

In 2015, Title V staff partnered with the TDH Office of Minority Health and Disparity 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 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 agree that “no person shall be subject to discrimination on the grounds of handicap or disability, age, race, color, religion, sex, national origin, or any other classification protected by Federal, Tennessee State constitutional, or statutory law.” Contractors and grantees are required to post notices of nondiscrimination in conspicuous spaces available to all employees and applicants.

Tennessee MCH Needs Assessment 2015

Findings: 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 the state Title V MCH and CSHCN programs. Within TDH, the Division of Family Health and Wellness includes 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.

Other MCHB Investments: FHW manages the State Systems Development Initiative (SSDI) grant; the D70 CSHCN State Implementation Grant; the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) grants; and the Early Childhood Systems of Care (ECCS) grant. SSDI funds provide salary support for the MCH Block Grant and SSDI Grant Coordinator and also funds salary support for staff in the Division of Policy, Planning and Assessment (the TDH division responsible for vital records and health statistics). D70 CSHCN funds have been used to build a Parent to Parent Network and build family leadership capacity (in partnership with Family Voices) as well as to provide technical assistance to pediatric providers on medical home implementation (in partnership with TNAAP). TDH is utilizing MIECHV funds to provide evidence-based home visiting services in 30 at-risk counties to 2,375 families, build capacity of home visitors through professional development opportunities (home visiting summit and credentialed learning pathways), and implement the Welcome Baby universal outreach initiative (reaching all births in Tennessee).

Other Federal Investments: FHW also manages the CDC-funded Core Violence and Injury Prevention (CVIPP) grant, which focuses on: teen motor vehicle crashes, sleep-related infant deaths, poisoning (specifically drug overdose), and senior adult falls. CVIPP funds have been used to provide safe sleep educational materials to Title V staff, including home visitors. CDC also funds Tennessee's Sudden Death in the Young registry program, which augments the existing Title V-funded statewide child fatality review. In 2015, FHW received CDC Center for Environmental Health funding for improving use of lead surveillance data on children 0-5 to identify the highest risk areas and target appropriate population-based prevention interventions wherever needs are identified. The Division also collaborates closely with other staff in the Department on a CDC grant aimed specifically at preventing prescription drug overdoses. FHW administers the USDA-funded Special Supplemental Nutrition Program for Women, Infants and Children (WIC), which is offered in all 95 county health departments. USDA also provides funding for WIC Farmers Markets in selected counties. The HHS Office of Population Affairs funds Title X Family Planning services in Tennessee; Title V funds are combined along with state funds and program revenue to operate the statewide family planning program through local health departments. Tennessee also receives funding from the HHS Administration for Children and Families (ACF) Title V Abstinence

Education Program; these funds support community abstinence education and youth development projects in 13 high-risk communities across the state.

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 Programs: TDH's Chronic Disease Prevention and Health Promotion efforts are also housed within FHW, so those staff work alongside Title V staff every day. This leads to extensive collaboration on activities like promotion of smoking cessation for pregnant women and working with hospitals to support breastfeeding. The State Immunization Program works closely with Title V staff on promotion of the human papillomavirus (HPV) vaccine for adolescents and young adults (and is part of the Title V-organized Cervical-Free Cancer Tennessee chapter). Staff in vital records and health statistics are key partners for Title V, supplying data from birth and death certificates (for processes like child fatality review and for miscellaneous data requests) as well as data from population surveys such as the Behavioral Risk Factor Surveillance System (BRFSS) and the Pregnancy Risk Assessment Monitoring System (PRAMS).

Other Governmental Agencies: Title V staff within TDH routinely partner with other governmental agencies that address the needs of the MCH population. Title V staff attend and participate in the Medicaid-led Maternity Workgroup, a collaborative workgroup consisting of Medicaid staff and representatives from the three managed care organizations, to plan programs and initiatives related to women's health. Medicaid staff have also been key partners in the HRSA-sponsored Collaborative Improvement and Innovation Network (CoIIN). Medicaid funds the state's regionalized perinatal system, which is administered through TDH.

At the local level, Medicaid funds TDH staff to perform targeted case management in high-risk populations, and local health department staff provide presumptive eligibility determination for Medicaid pregnancy coverage. Local health department staff perform Early Periodic Screening Diagnosis and Treatment (EPSDT) periodic screens. Local TDH outreach staff work to help potentially eligible applicants enroll into Medicaid and to connect enrolled members to their primary care medical home. A copy of the current Inter-Agency Agreement between Medicaid and Title V is attached to the Block Grant Report/Application.

The Department of Education (DOE) operates the Coordinated School Health program in all school districts throughout Tennessee. Title V staff partner with CSH staff at the state level on special projects (such as the revision of school health procedure and screening guidelines) and at the local level (providing health education to local schools). The CDC-funded CVIPP program in TDH partners with local schools to administer the "Battle of the Belt" program, aimed at increasing seatbelt usage among high school

students. DOE staff also administer Head Start and the IDEA Part B and Part C services. The state Head Start Collaboration Office worked with Title V to conduct focus groups for families with young children as part of the five-year Title V Needs Assessment. TDH staff routinely refer children to Part B and C services and Central Office staff from both departments work together to increase developmental screening and referrals.

Title V staff also partner with the Department of Mental Health and Substance Abuse Services (DMHSAS). A major focus in the past year has been on implementing Screening, Brief Intervention and Referral to Treatment (SBIRT) throughout local health departments. DMHSAS provided staff resources and training materials during the pilot phase of the project.

Staff from the state's child welfare agency (Department of Children's Services, DCS) actively participate in the local and state Child Fatality Review teams. DCS staff have partnered closely with TDH to implement a safe sleep protocol for infants entering foster care.

The Department of Human Services (DHS) is the state social services agency. DHS administers the Child Care Resource and Referral (CCR&R) network and TDH staff provide technical assistance on the inclusion of health and safety standards into child care licensing regulations.

TennCare, DMHSAS, DCS, and DHS have all been important partners in the state's efforts to reduce the burden of Neonatal Abstinence Syndrome (NAS). These agencies actively participate in the NAS subcabinet workgroup and have implemented programmatic or policy initiatives aimed at curbing the NAS epidemic.

Public Health and Health Professional Programs and Universities: Title V collaborates regularly with university partners across the state on project implementation, evaluation, and consultation. Examples of such collaboration include: program evaluation training for FHW staff by faculty from four Tennessee universities (UT Knoxville, University of Memphis, Tennessee State University, and East TN State University) in 2013; partnership with Tennessee Tech University to provide web hosting for a youth motor vehicle safety intervention (Battle of the Belt); and collaboration with Middle Tennessee State University to provide training on death scene investigation for first responders. FHW also hosts students for internship and practicum experiences.

Title V staff work with the University of Tennessee at Knoxville Center on Deafness on follow-up for infants with failed hearing screens and audiology services. Staff from the University of Tennessee Extension collaborate with TDH staff to host an online database for tracking blood lead values and case management activities, to convene a Childhood Lead Poisoning Prevention Program Advisory Committee, and to conduct education on prevention of childhood lead poisoning. Title V staff participate on the Leadership Excellence in Neurodevelopmental Disabilities (LEND) Advisory Committee at Vanderbilt.

Family/Consumer Partnership and Leadership Programs:

WILL INSERT THIS AFTER 6/16 MEETING WITH FAMILY VOICES

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, Title V partners with multiple public and private organizations on MCH-related priorities. Recent partnerships have included:

- Tennessee Hospital Association (THA), March of Dimes, and Tennessee Initiative for Perinatal Quality Care: 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 TN, 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 Title V, 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

Tennessee MCH Needs Assessment 2015
Appendix A: Full List of Needs Assessment Team Members

Title V Leadership Team

Dr. Michael Warren, Title V/MCH Director
Jacqueline Johnson, CYSHCN Director
Julie Traylor, Needs Assessment Coordinator
Melissa Blair
Rachel Heitmann
Thea Jones
Kelly Luskin
Peggy Lewis
Loraine Lucinski
Margaret Major

Epidemiology Team

Dr. Yinmei Li
Dr. Audrey Bauer
Dr. Angela Miller
Dr. Ester Nilles
Thomas Salter
Ransom Wyse

MCH Stakeholder Group (also includes the individuals listed above)

Family Organizations

Kara Adams (Family Voices)
Donna DeStefano (Family Voices)
Adam Horn (Tennessee Voices for Children)
Belinda Hotchkiss (Family Voices)

Parent Representatives

Sara Hanai
Jeff Myrick

HRSA/MCHB Grantees

Dr. Kevin Brinkmann (TN Emergency Medical Services for Children)
Erin Hummeldorf (TN Emergency Medical Services for Children)
Dr. Marsha Spence (UT MCH Nutrition Leadership Education & Training Program)

Regional Perinatal Centers

Kitty Cashion (UT Memphis)
Cheryl Major (Vanderbilt)

Academic Partners

Cindy Chafin (Middle Tennessee State University)
Dr. Jo Edwards (Middle Tennessee State University)
Caron Peterson (Middle Tennessee State University)

Children's Hospital Alliance of Tennessee

Mary Nell Bryan
Brittany Jones

Health Care Facilities

Mary Gaston (LeBonheur Children's Hospital)

Tennessee Department of Health—Central Office

Dr. Jan BeVillie (Community Health Services)
Ashley Brooks (Child Fatality Review)
Constance Eneh (D70 Systems Integration)
Tim Gill (Media Services)
Rachel Hardaway (Primary Prevention Impact Services)
Catherine Haralson (Immunizations)
Kimberly Hinton (Community Health Services)
Lynette Hicks (Targeted Case Management)
April Kincaid (Infant Mortality)
Terry Love (Injury Prevention)
Yvette Mack (Gold Sneaker)
Angela Smith (Infant Mortality)
Laurie Stanton (Chronic Disease Prevention and Health Promotion)
Ondria Stevenson (Children's Special Services)
Kimothy Warren (Adolescent Pregnancy Prevention)
Dr. Carolyn Wester (STD/HIV)

Other State Agencies

Janet Coscarelli (Head Start)
Gail Crawford (Human Services)
Dr. Michael Cull (Children's Services)
Fay Delk (Commission on Children & Youth)
Dr. Deborah Gatlin (Children's Services)
Angela McKinney Jones (Mental Health & Substance Abuse Services)
Linda O'Neal (Commission on Children & Youth)
Lori Paisley (Coordinated School Health)
Brian Stephens (Children's Services)
Joyce Turner (Human Services)

Regional/Local Health Departments

Jamila Batts
Tina Farr

Sherri Griggs
Terry Henson
Patti Holmes
Jeanne Jowers
Diana Kreider
Danni Lambert
Valerie Lee
Tina Lester
Deborah Molder
Jackie Thompson
Alicia Verlinde
Becca Wright

Tennessee MCH Needs Assessment 2015
Appendix B: Focus Group/Community Meeting Questions

Focus Group Questions

1. Describe the health of women, children, youth and families in your community. What is good? What is bad?
2. What are the most common health problems that women, children, youth, and families face in your community?
3. What services could be provided that would improve the health of women, children, youth, and families in your community? Think about things that are missing, no longer available, or need to be improved.
4. What services are being provided that are working well for women, children, youth, and families in your community? Include the organization providing these services.
5. Think back over the past five years. Describe any new health problems that have become a concern for women, children, youth, and families in your community.

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Appendix C: Data Sources for Quantitative Analysis

- National Data Sources
 - CDC Breastfeeding Report Card
 - CDC Behavioral Risk Factor Surveillance System (BRFSS)
 - CDC Pregnancy Risk Assessment Monitoring System (PRAMS)
 - CDC Web-based Injury Statistics Query and Reporting System (WISQARS)
 - CDC Wonder – Linked Birth and Death Records 1995-2012
 - CDC YRBS
 - Census – small area insurance estimates
 - Maternal Practices in Infant Nutrition and Care (mPINC) Survey
 - MCHB Child Health USA 2013
 - Morbidity and Mortality Weekly Report
 - National Immunization Survey
 - National Immunization Survey-Teen
 - National Vital Statistics Reports
 - National Survey of Children’s Health 2012
 - National Survey of Children with Special Health Care Needs 2009
 - San Jose State University Department of Meteorology and Climate Science Heatstroke Deaths of Children in Vehicles
 - CDC United States Cancer Statistics 1999-2011
 - WHO Maternal Morbidity in 1990-2013

- State Data Sources
 - TDH Immunization Status Survey of 24 Month-Old Children in Tennessee
 - TDE Annual Statistics Report of the Department of Education
 - TDE Youth Risk Behavior Surveillance System
 - TDH Birth Statistical System
 - TDH Death Statistical System
 - TDH Health Professional Licensing Reports
 - Tennessee Bureau of Investigation TIBRS On-line Report System
 - Tennessee Family and Child Tracking System (TFACTS)
 - TDH Hospital Discharge Database System
 - TDH Lead Surveillance and Tracking System of Tennessee (LeadTRK)
 - TDH Pregnancy Risk Assessment Monitoring System (PRAMS)
 - TDH Patient Reporting, Investigating, and Surveillance Management (PRISM)
 - TDH Patient Tracking Billing Management Information System (PTBMIS)

Tennessee MCH Needs Assessment 2015
Appendix D: Prioritization Scoring Matrices

DOMAIN: MATERNAL & WOMEN’S HEALTH

Instructions: For each row under “Potential Priorities,” please write a score of 1-4 in each column under the scoring criteria.

- 4=Strongly Agree
- 3=Somewhat Agree
- 2=Somewhat Disagree
- 1=Strongly Disagree

POTENTIAL PRIORITIES	SCORING CRITERIA			
	Problem/issue has severe health consequences	Large # of individuals are affected by the problem	Addressing problem/issue is acceptable to citizens	Resources are available to address problem/issue
Preconception/Intra-Conception Care				
Early Elective Deliveries				
Primary C-Section				
Health Care Access and Utilization				
Breast and Cervical Cancer Screening				
Chronic Disease				
Mental Health				
Maternal Mortality				
Write in #1: Substance Abuse				
Write in #2:				
Write in #3:				

DOMAIN: PERINATAL & INFANT HEALTH

Instructions: For each row under “Potential Priorities,” please write a score of 1-4 in each column under the scoring criteria.

- 4=Strongly Agree
- 3=Somewhat Agree
- 2=Somewhat Disagree
- 1=Strongly Disagree

POTENTIAL PRIORITIES	SCORING CRITERIA			
	Problem/issue has severe health consequences	Large # of individuals are affected by the problem	Addressing problem/issue is acceptable to citizens	Resources are available to address problem/issue
Perinatal Regionalization				
Breastfeeding				
Infant Mortality				
Lead Screening				
Immunization				
Safe Sleep				
Write in #1: Baby Friendly Hospital				
Write in #2: Prematurity				
Write in #3:				

DOMAIN: CHILD HEALTH

Instructions: For each row under “Potential Priorities,” please write a score of 1-4 in each column under the scoring criteria.

- 4=Strongly Agree
- 3=Somewhat Agree
- 2=Somewhat Disagree
- 1=Strongly Disagree

POTENTIAL PRIORITIES	SCORING CRITERIA			
	Problem/issue has severe health consequences	Large # of individuals are affected by the problem	Addressing problem/issue is acceptable to citizens	Resources are available to address problem/issue
Obesity				
Asthma				
Developmental Screening				
Adverse Childhood Experiences (includes abuse/neglect)				
Write in #1: Mental Health				
Write in #2: Parenting Classes				
Write in #3:				

DOMAIN: ADOLESCENT HEALTH

Instructions: For each row under “Potential Priorities,” please write a score of 1-4 in each column under the scoring criteria.

- 4=Strongly Agree
- 3=Somewhat Agree
- 2=Somewhat Disagree
- 1=Strongly Disagree

POTENTIAL PRIORITIES	SCORING CRITERIA			
	Problem/issue has severe health consequences	Large # of individuals are affected by the problem	Addressing problem/issue is acceptable to citizens	Resources are available to address problem/issue
Access - Preventative Care				
Immunizations				
Obesity				
Sexual Health (including teen pregnancy & STIs)				
Education Noncompletion (Drop Out)				
Mental Health				
Tobacco				
Drug misuse/abuse				
Write in #1: Sex Edu/Access to Services				
Write in #2: Bullying				
Write in #3: Motor Vehicle Accidents				

DOMAIN: CHILDREN AND YOUTH WITH SPECIAL HEALTHCARE NEEDS

Instructions: For each row under “Potential Priorities,” please write a score of 1-4 in each column under the scoring criteria.

- 4=Strongly Agree
- 3=Somewhat Agree
- 2=Somewhat Disagree
- 1=Strongly Disagree

POTENTIAL PRIORITIES	SCORING CRITERIA			
	Problem/issue has severe health consequences	Large # of individuals are affected by the problem	Addressing problem/issue is acceptable to citizens	Resources are available to address problem/issue
Partnered Decision Making				
Medical Home				
Insurance Coverage				
Developmental Screening				
Access to Community-based Services				
Transition Services				
Autism				
Respite Care				
Write in #1: Second Generation Care				
Write in #2: Awareness/Access to Care				
Write in #3: System Navigation				

DOMAIN: CROSS-CUTTING/LIFE COURSE

Instructions: For each row under “Potential Priorities,” please write a score of 1-4 in each column under the scoring criteria.

- 4=Strongly Agree
- 3=Somewhat Agree
- 2=Somewhat Disagree
- 1=Strongly Disagree

POTENTIAL PRIORITIES	SCORING CRITERIA			
	Problem/issue has severe health consequences	Large # of individuals are affected by the problem	Addressing problem/issue is acceptable to citizens	Resources are available to address problem/issue
Asthma				
Dental Health				
Injury				
Provider Coverage				
School Nurse Availability				
Insurance				
Medical Home				
Secondhand Smoke				
Write in #1: Medicaid Expansion				
Write in #2: Bullying				
Write in #3: E-Cigarettes				

Tennessee MCH Needs Assessment 2015
Appendix E: Prioritization Meeting Evaluation Form

Prioritization Input Meeting Evaluation

1. After attending this stakeholder meeting, I have a better understanding of the Title V MCH Block Grant.
 Strongly Agree
 Somewhat Agree
 Somewhat Disagree
 Strongly Disagree

2. I feel the correct priorities were discussed in today's stakeholder meeting.
 Strongly Agree
 Somewhat Agree
 Somewhat Disagree
 Strongly Disagree

3. I feel that a broad range of issues were discussed in today's stakeholder meeting.
 Strongly Agree
 Somewhat Agree
 Somewhat Disagree
 Strongly Disagree

4. I feel the group at today's stakeholder meeting represented diverse MCH organizations/perspectives in the state.
 Strongly Agree
 Somewhat Agree
 Somewhat Disagree
 Strongly Disagree

5. I feel that I have had ample opportunity to provide input throughout this process.
 Strongly Agree
 Somewhat Agree
 Somewhat Disagree
 Strongly Disagree

6. I feel that my input was valued throughout this process.
 Strongly Agree
 Somewhat Agree
 Somewhat Disagree
 Strongly Disagree

7. I have these suggestions for improving the meeting next time. Please write them below or on the back.

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Appendix F: Free Text Comments from Prioritization Meeting Evaluation

Stakeholder Input Meeting - Evaluation Comments

- Very productive process with a large group! Well Done
- Wow! What a great meeting and wonderful way to give out a lot of information in an interesting way. Thanks so, so much ☺
- None, great job
- Thank you for the opportunity to participate
- No suggestions; appreciate this process greatly and all the hard work that has been put into the meeting
- Have participants also rank/indicate preferences among potential priorities
- Next time I recommend allowing the rates to number their top 3 or number all of the items in a rank of their priorities for each domain. The way it was done this time the questions were answered, but you don't get a sense of the person's priorities because so many of the questions were specific and weren't specifying priority.
- Prioritize each "priority issue" in each domain. This was fantastically organized and enjoyable – very impressed!
- The "somewhat agree" and "somewhat disagree" seem almost interchangeable kinda like "mostly sunny vs. partly cloudy". Or has this just been a long day! ☺
- Write-ins should be heard by all participants with the opportunity to vote. Some tables did not record the suggestions given. It would best if the large group could hear all of them. Overall, great job!
- Ability for groups to have separate meeting areas for less noise
- Highly organized – thank you. However, data was presented: 1) graphs in advance, 2) 33-page summary received today, 3) table-specific summaries, and 4) National Performance Measure packet. I read the data in advance but had difficulty keeping track of multiple data locations during the 30 minute group, which was technically a 5th (verbal) presentation of the data. Scoring – not sure that all 4 columns were necessary. It resulted in a lot of unsure, hasty responses of "3" and "4". Required subjective thought in addition to the data. 3rd column was most confusing.
- Appreciated the data printout in certain groups. Would have been better in all groups. Consistency needed across groups.
- Maybe have the presenters move next time to save on time? Great job! Very informative!
- Include more people who are not as familiar with MCH/FHW
- Health disparities, the community health systems section, should be involved next time.
- It is not often that such a diverse cross section is in the same room. It is a wonderful opportunity to network and make connections if time for that can be built in. Possibly providing a sheet with participant's contact information to make reconnecting easier.
- Bottled water at breakfast.

Tennessee MCH Needs Assessment 2015
Appendix G: Stakeholder Prioritization Rankings

Potential Priority Scores

Women's and Maternal Health

Potential Priority	Rank	Score
Chronic Disease	1	13.65
Preconception/Intra-Conception Care	2	13.56
Breast and Cervical Cancer Screening	3	13.24
Health Care Assess and Utilization	4	13.09
Substance Abuse	5	12.96
Mental Health	6	12.34
Maternal Mortality	7	12.24
Early Elective Deliveries	8	11.90
Primary C-Section	9	11.78

Perinatal and Infant Health

Potential Priority	Rank	Score
Immunization	1	14.28
Infant Mortality	2	13.97
Safe Sleep	3	13.90
Prematurity	4	13.12
Perinatal Regionalization	5	12.92
Breastfeeding	6	12.71
Lead Screening	7	12.07
Baby Friendly Hospital	8	11.68

Child Health

Potential Priority	Rank	Score
Obesity	1	13.65
Developmental Screening	2	13.12
Adverse Childhood Experiences (includes abuse/neglect)	3	13.1
Asthma	4	13.02
Mental Health	5	12.26
Parenting Classes	6	11.68

Adolescent Health

Potential Priority	Rank	Score
Obesity	1	13.82
Immunizations	2	13.36
Drug Misuse/Abuse	3	13.30
Access – Preventative Care	4	13.20
Tobacco	5	13.12
Motor Vehicle Accidents	6	12.9
Mental Health	7	12.61
Sexual Health (includes teen pregnancy and STIs)	8	12.50
Bullying	9	12.15
Education Noncompletion (Drop Out)	10	12.06
Sex Edu/Access to Services	11	12

CYSHCN

Potential Priority	Rank	Score
Developmental Screening	1	13.38
Medical Home	2	12.866
Insurance Coverage	3	12.865
Access to Community-based Services	4	12.66
Transition Services	5	12.15
Partnered Decision Making	6	12.14
Awareness/Access to Care	7	11.90
System Navigation	8	11.81
Autism	9	11.39
Respite Care	10	11.07
Second Generation Care	11	10.45

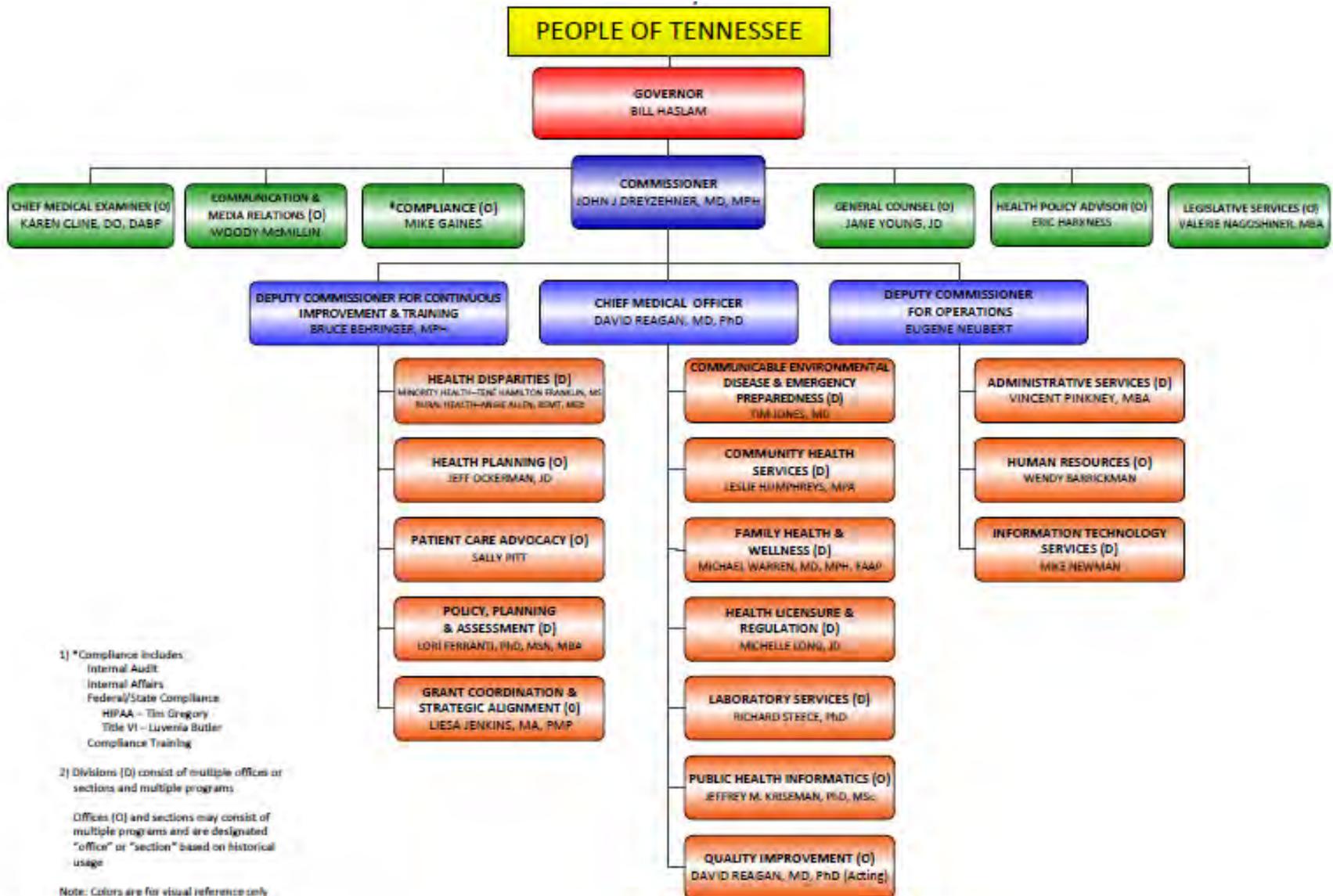
Crosscutting/Life Course

Potential Priority	Rank	Score
Injury	1	13.18
Second-hand Smoke	2	12.80
Insurance	2	12.80
Asthma	3	12.78
Provider Coverage	4	12.58
Dental Health	5	12.50
Medicaid Expansion	6	12.42
Bullying	7	12.19
Medical Home	8	12.14
School Nurse Availability	9	11.46
E-cigarettes	10	10.97

Organizational Charts (all current as of June 2015)

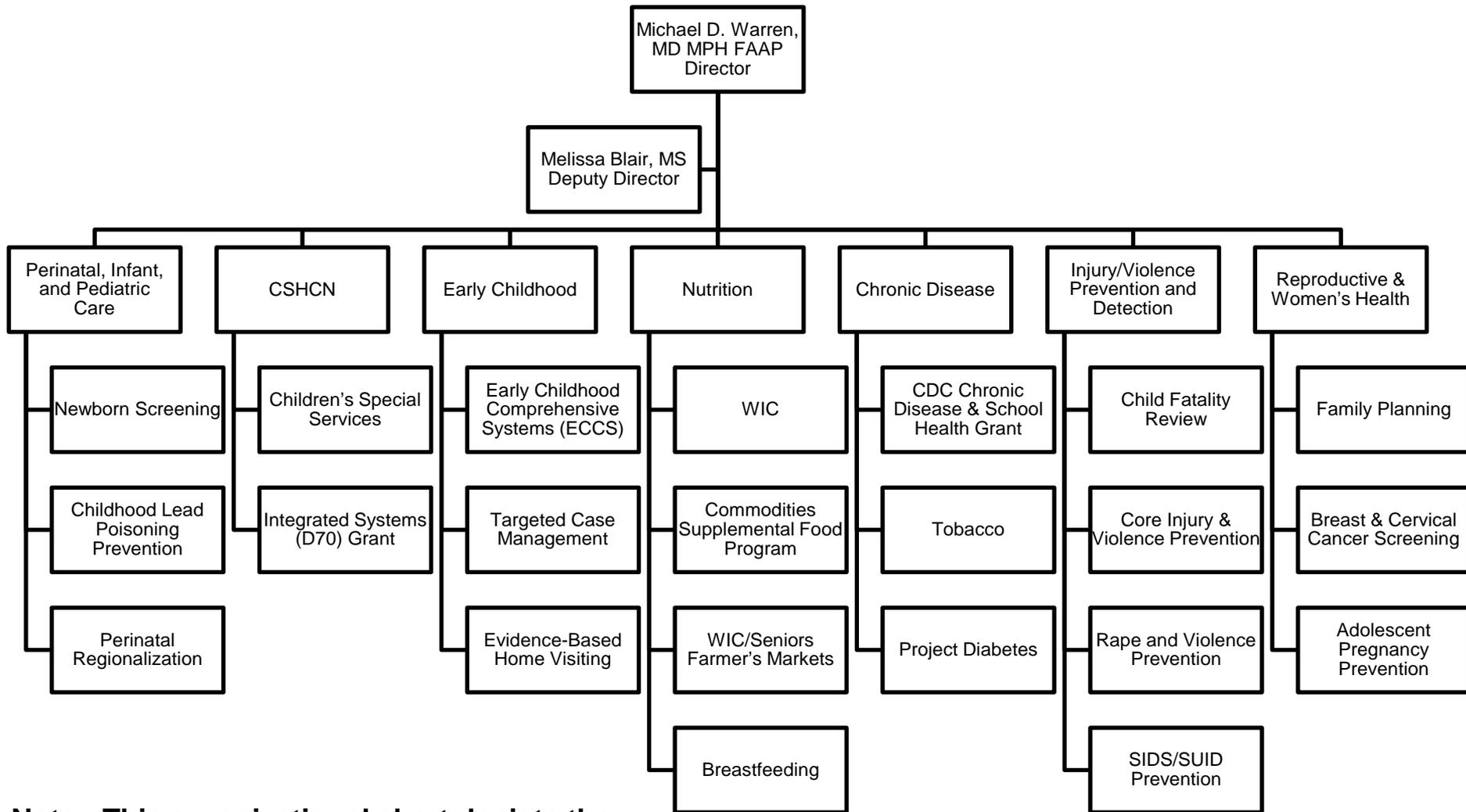
1. Tennessee Department of Health
2. Division of Family Health and Wellness

Tennessee Department of Health Organizational Chart (Current as of June 2015)



Division of Family Health and Wellness

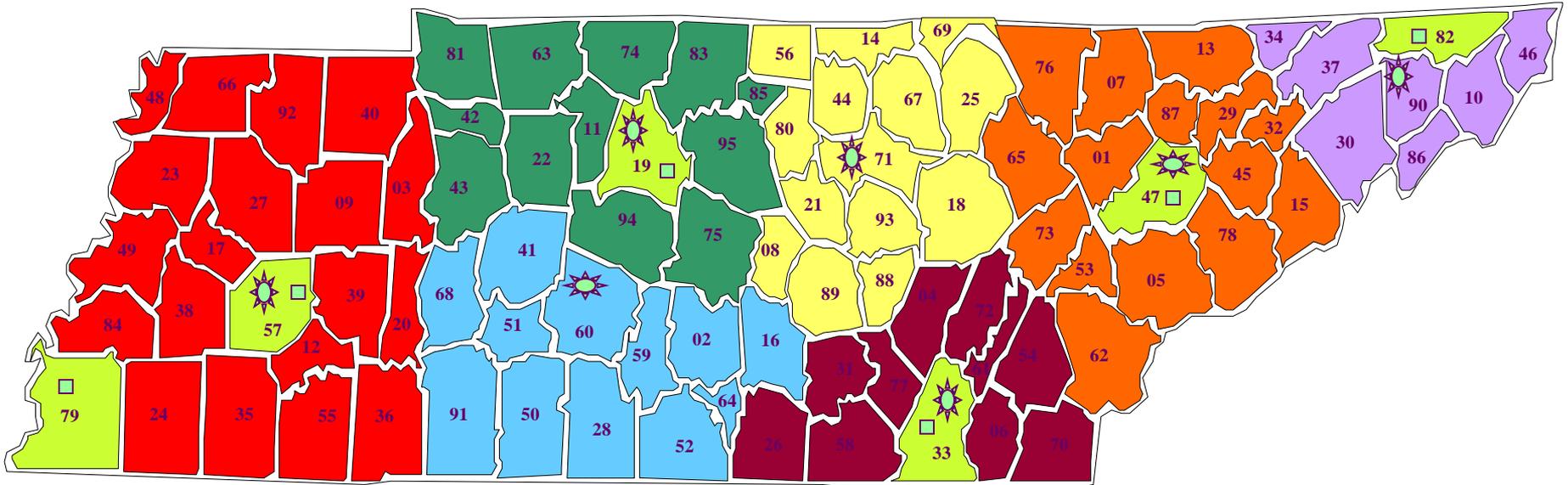
Thematic Organizational Chart (Current as of June 2015)



Note: This organizational chart depicts the various thematic areas housed in the Division of Family Health and Wellness. This does not reflect actual lines of supervision.

Tennessee MCH Needs Assessment 2015

Appendix I. TDH Regional Map



West		Mid Cumberland		South Central		Southeast		Upper Cumberland		East		North East	
#	County	#	County	#	County	#	County	#	County	#	County	#	County
3	Benton	11	Cheatham	2	Bedford	4	Bledsoe	8	Cannon	1	Anderson	10	Carter
9	Carroll	22	Dickson	16	Coffee	6	Bradley	14	Clay	5	Blount	30	Greene
12	Chester	42	Houston	28	Giles	26	Franklin	18	Cumberland	7	Campbell	34	Hancock
17	Crockett	43	Humphreys	41	Hickman	31	Grundy	21	DeKalb	13	Claiborne	37	Hawkins
20	Decatur	63	Montgomery	50	Lawrence	54	McMinn	25	Fentress	15	Cocke	46	Johnson
23	Dyer	74	Robertson	51	Lewis	58	Marion	44	Jackson	29	Grainger	86	Unicoi
24	Fayette	75	Rutherford	52	Lincoln	61	Meigs	56	Macon	32	Hamblen	90	Washington
27	Gibson	81	Stewart	59	Marshall	70	Polk	67	Overton	45	Jefferson		
35	Hardeman	83	Sumner	60	Maury	72	Rhea	69	Pickett	53	Loudon		
36	Hardin	85	Trousdale	64	Moore	77	Sequatchie	71	Putnam	62	Monroe	METROS	
38	Haywood	94	Williamson	68	Perry			80	Smith	65	Morgan	#	County
39	Henderson	95	Wilson	91	Wayne			88	Van Buren	73	Roane	19	Davidson
40	Henry							89	Warren	76	Scott	33	Hamilton
48	Lake							93	White	78	Sevier	47	Knox
49	Lauderdale									87	Union	57	Madison
55	McNairy											79	Shelby
66	Obion											82	Sullivan
84	Tipton												
92	Weakley												



Regional Offices

□ Metro Offices

Tennessee MCH Needs Assessment 2015
Appendix J. Title V-funded Position Classifications, Employee Count, and FTEs

EMPLOYEES/FTEs FUNDED BY TITLE V

LOCATION	Individual Employees	FTE
Central Office (TOTAL)	58	29.96
ADMIN ASSISTANT 1	1	0.38
ADMIN SERVICES ASSISTANT 2*	4	2.04
ADMIN SERVICES ASSISTANT 3	6	2.61
ADMIN SERVICES ASSISTANT 4	2	1.07
ADMIN SERVICES ASSISTANT 5	2	1.07
EPIDEMIOLOGIST	3	2.05
EPIDEMIOLOGIST 1	1	0.15
INFORMATION SYSTEMS ANA 4	1	0.21
NURSE PRACTITIONER	3	0.30
PHYSICIAN	1	1.00
PUBLIC HEALTH ADMINISTRATOR 1	3	1.26
PUBLIC HEALTH ADMINISTRATOR 2	1	0.98
PUBLIC HEALTH EDUCATOR 2*	4	1.70
PUBLIC HEALTH NURSING CON 1	2	0.80
PUBLIC HEALTH NURSING CON 2	3	2.03
PUBLIC HEALTH NURSING CON MGR	1	1.00
PUBLIC HEALTH PROGRAM DIR 1	4	2.95
PUBLIC HEALTH PROGRAM DIR 2	6	3.08
PUBLIC HEALTH PROGRAM DIR 3	4	3.08
REGISTERED NURSE 3	1	0.04
REGISTERED NURSE 4	5	2.15
East Regional Office (TOTAL)	16	5.84
ADMIN ASSISTANT 1	1	0.79
ADMIN SECRETARY	1	0.45
AUDIOLOGIST 2	1	0.75
PUBLIC HEALTH EDUCATOR 3	1	0.02
REGISTERED NURSE 3	3	0.89
REGISTERED NURSE 4	3	1.14
REGISTERED NURSE 5	1	0.01
SECRETARY	2	0.05
SOCIAL COUNSELOR 2*	2	1.07
SOCIAL SERVICES SPECIALIST 2*	1	0.67
Local Health Departments (TOTAL)	54	10.15

LOCATION	Individual Employees	FTE
COMMUNITY HEALTH CNCL COOR 1	2	0.14
NURSE PRACTITIONER	2	0.02
PHYSICIAN	2	0.16
PUBLIC HEALTH EDUCATOR 2*	16	0.58
PUBLIC HEALTH OFFICE ASSISTANT	2	0.00
PUBLIC HEALTH REP 2*	1	0.01
REGISTERED NURSE 2*	6	1.14
REGISTERED NURSE 3	2	0.02
REGISTERED NURSE 4	1	0.01
SOCIAL COUNSELOR 2*	15	7.24
SOCIAL WORKER 2*	5	0.85
Mid-Cumberland Regional Office (TOTAL)	3	2.16
ADMIN ASSISTANT 1	1	0.38
REGISTERED NURSE 3	1	0.95
REGISTERED NURSE 4	1	0.83
Northeast Regional Office (TOTAL)	17	2.22
ACCOUNTANT 3	1	0.01
ACCOUNTING TECHNICIAN 1	2	0.15
ADMIN SECRETARY	1	0.02
ADMIN SERVICES ASSISTANT 2*	1	0.01
ADMIN SERVICES ASSISTANT 3	1	0.02
NURSE PRACTITIONER	1	0.01
NUTRITIONIST 3	1	0.01
PHYSICIAN	1	0.01
PUBLIC HEALTH EDUCATOR 3	1	0.04
PUBLIC HEALTH PROGRAM DIR 1	1	0.09
REGISTERED NURSE 4	2	1.08
REGISTERED NURSE 5	1	0.02
SECRETARY	2	0.47
SOCIAL COUNSELOR SUPERVISOR	1	0.27
Shelby County Metro (TOTAL)	1	1.00
PUBLIC HEALTH OFFICE ASSISTANT	1	1.00
South Central Regional Office (TOTAL)	2	1.06
REGISTERED NURSE 4	2	1.06
Southeast Regional Office (TOTAL)	11	5.92
ADMIN SERVICES ASSISTANT 2*	1	1.01
COMMUNITY HEALTH CNCL COOR 1	1	0.00
PHYSICIAN	1	0.01
REGISTERED NURSE 3	5	2.83

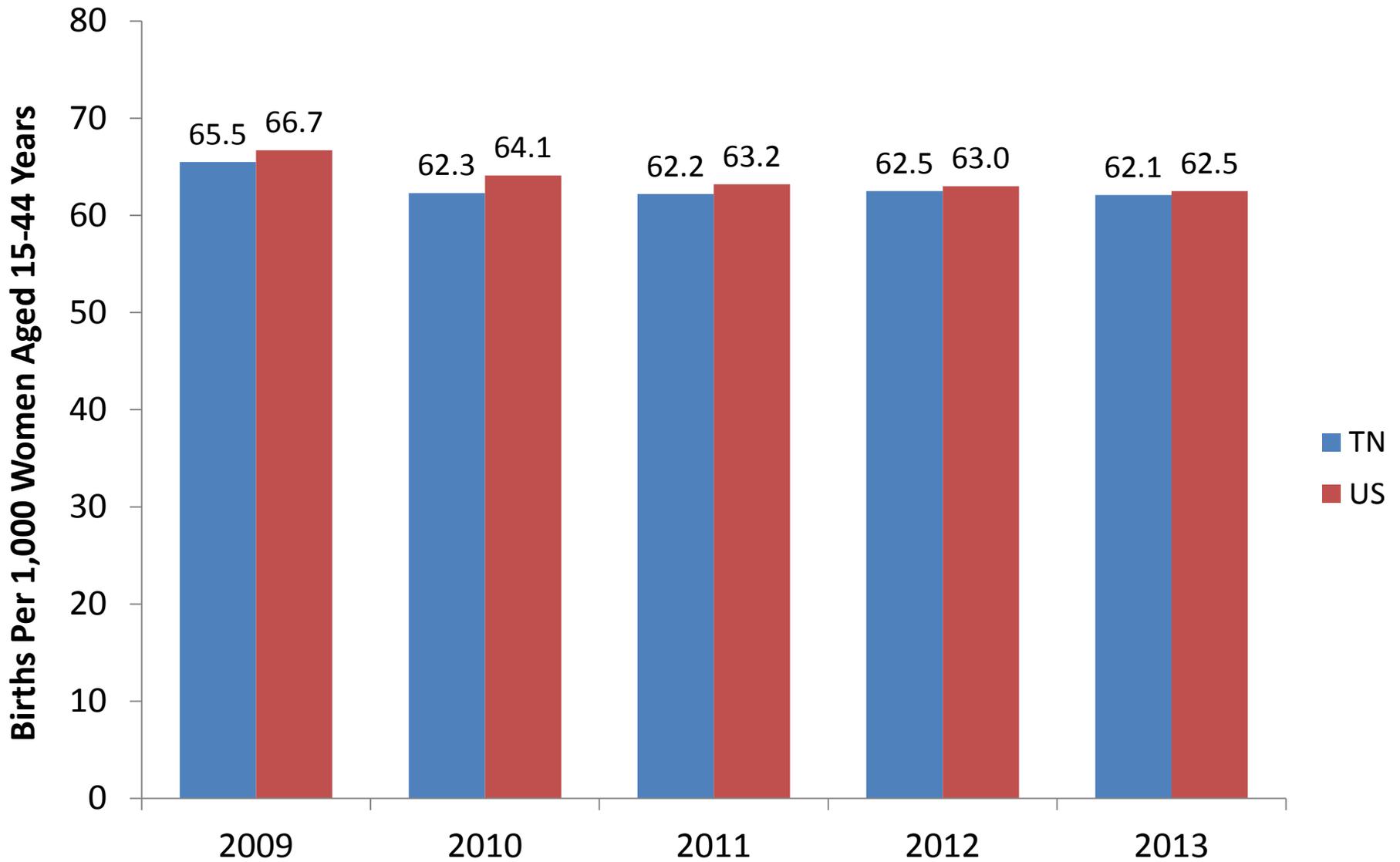
LOCATION	Individual Employees	FTE
REGISTERED NURSE 4	2	1.06
SOCIAL COUNSELOR SUPERVISOR	1	1.01
Upper Cumberland Regional Office (TOTAL)	10	3.80
ADMIN SERVICES ASSISTANT 2*	1	1.00
LICENSED PRACTICAL NURSE 2*	2	0.16
PUBLIC HEALTH EDUCATOR 3	1	0.01
PUBLIC HEALTH PROGRAM DIR 1	1	0.39
REGISTERED NURSE 3	1	0.01
REGISTERED NURSE 4	3	1.23
SOCIAL COUNSELOR 2*	1	1.00
West Regional Office (TOTAL)	15	3.47
ADMIN SERVICES ASSISTANT 4	1	0.73
NUTRITIONIST 3	2	0.02
PUBLIC HEALTH PROGRAM DIR 2	1	0.03
PUBLIC HEALTH REP 3	1	0.01
REGISTERED NURSE 2*	1	0.98
REGISTERED NURSE 3	1	1.00
REGISTERED NURSE 4	4	0.08
REGISTERED NURSE 5	1	0.00
SOCIAL COUNSELOR SUPERVISOR	2	0.57
WORD PROCESSING OPERATOR 1	1	0.06
Grand Total	187	65.60

Title V Needs Assessment

Summary of Quantitative Data

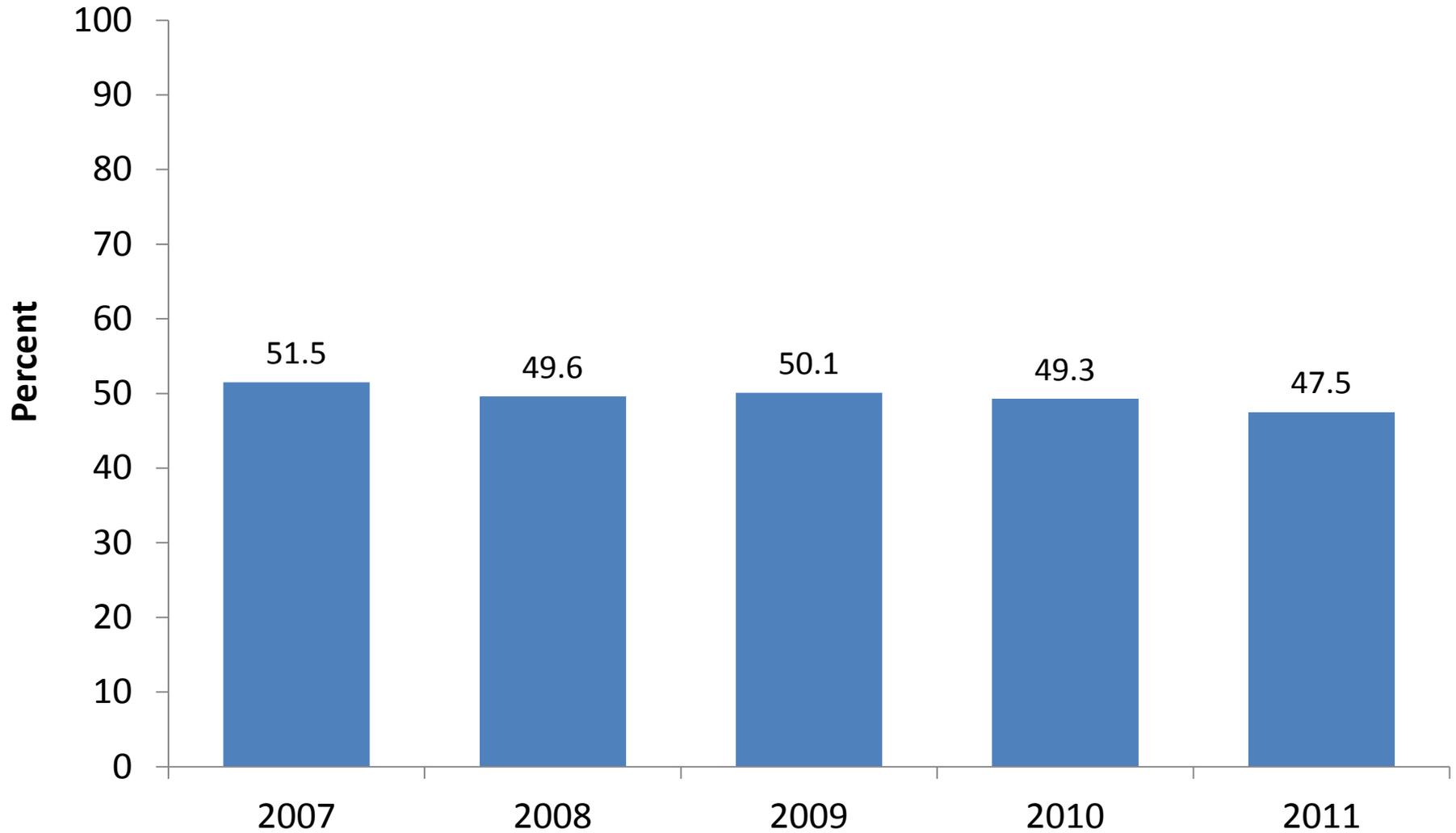
MATERNAL AND WOMEN'S HEALTH

Fertility Rate

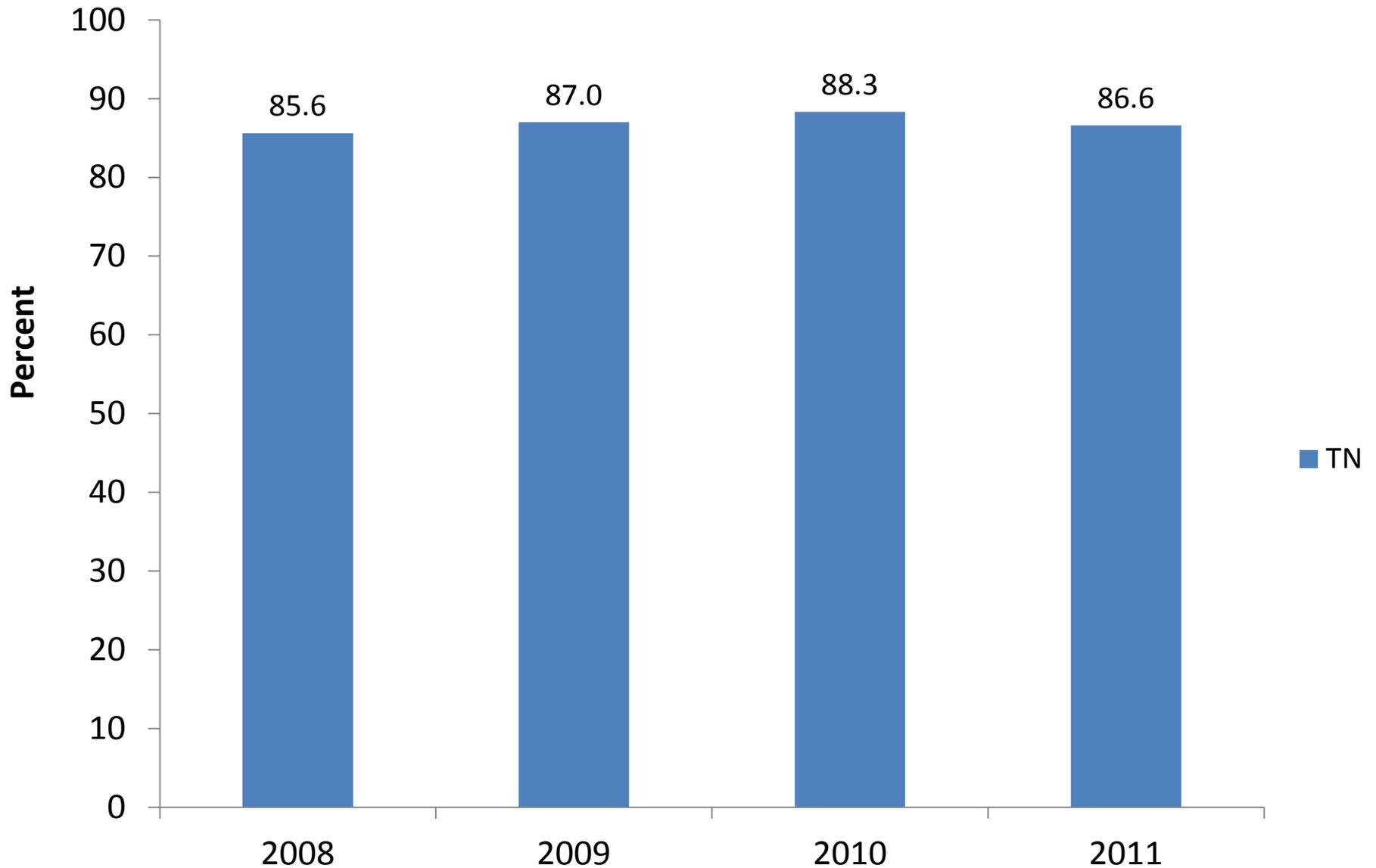


Data Source: 1) Tennessee Department of Health; Division of Policy, Planning and Assessment; Birth Statistical System.
2) Births: National vital statistics reports.

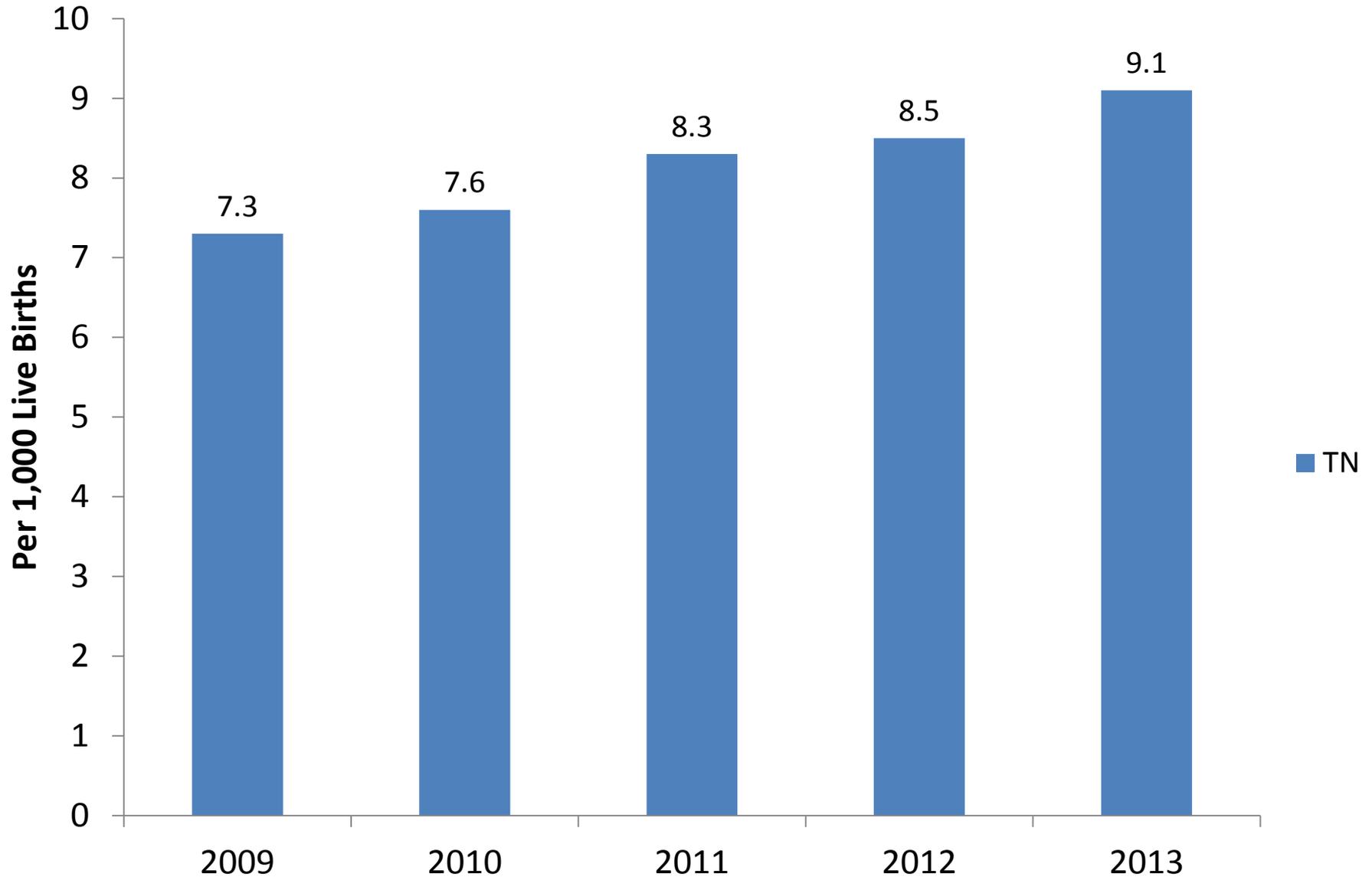
New Mothers with Unintended Pregnancies



New Mothers Using Birth Control Postpartum

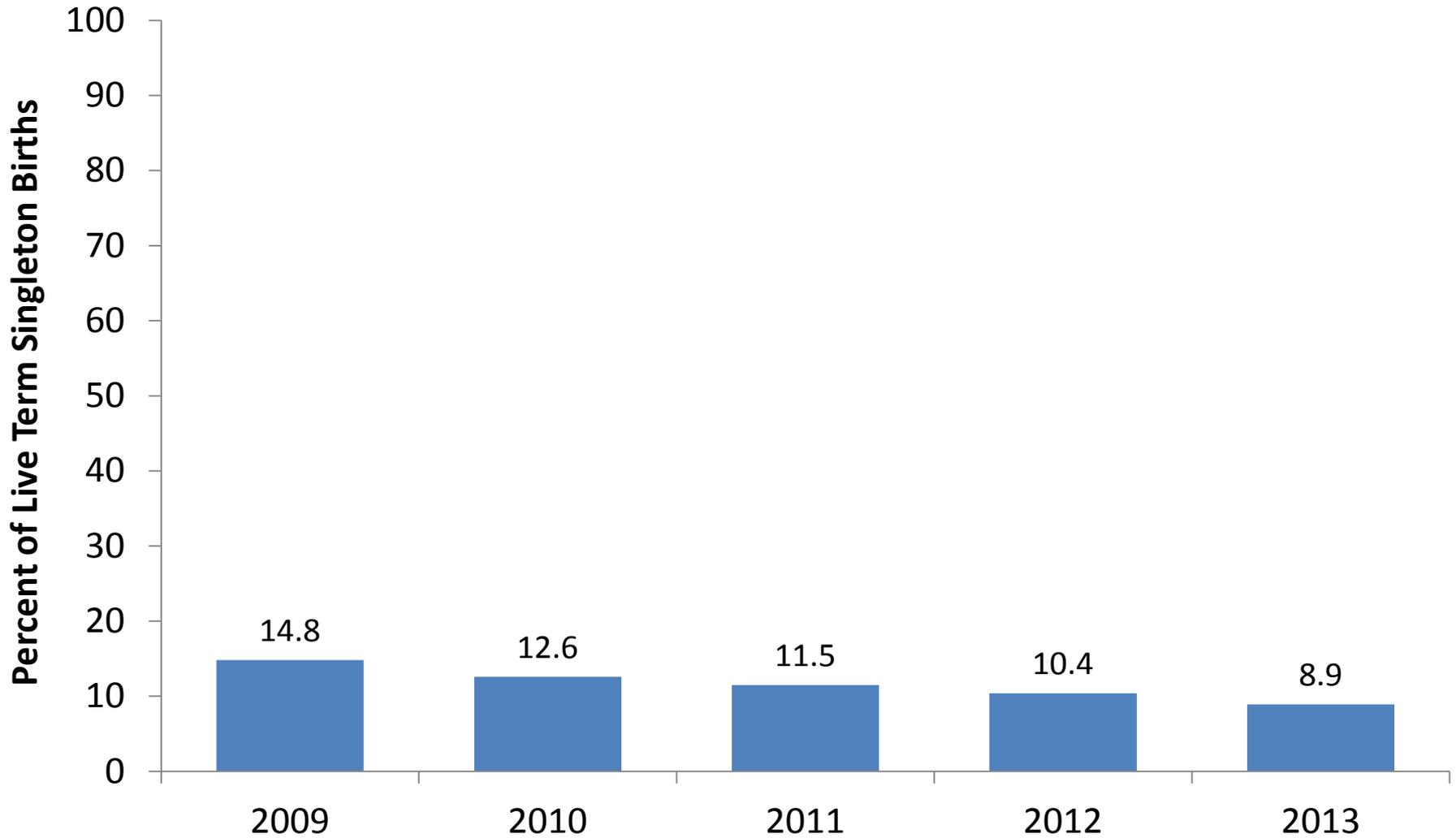


Live Births to Women Who Used Reproductive Technology

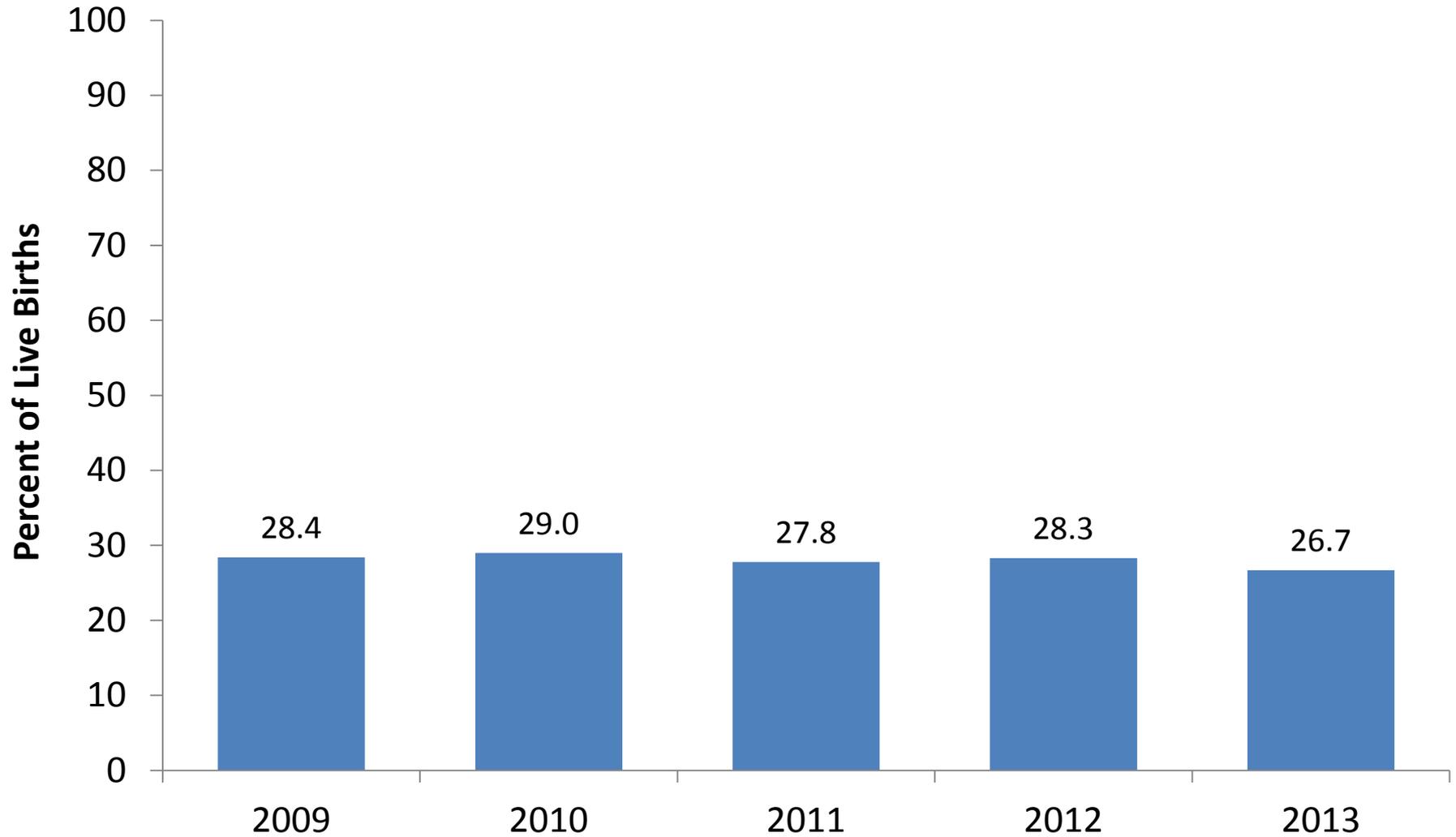


Data Source: Tennessee Department of Health; Division of Policy, Planning and Assessment; Birth Statistical System.

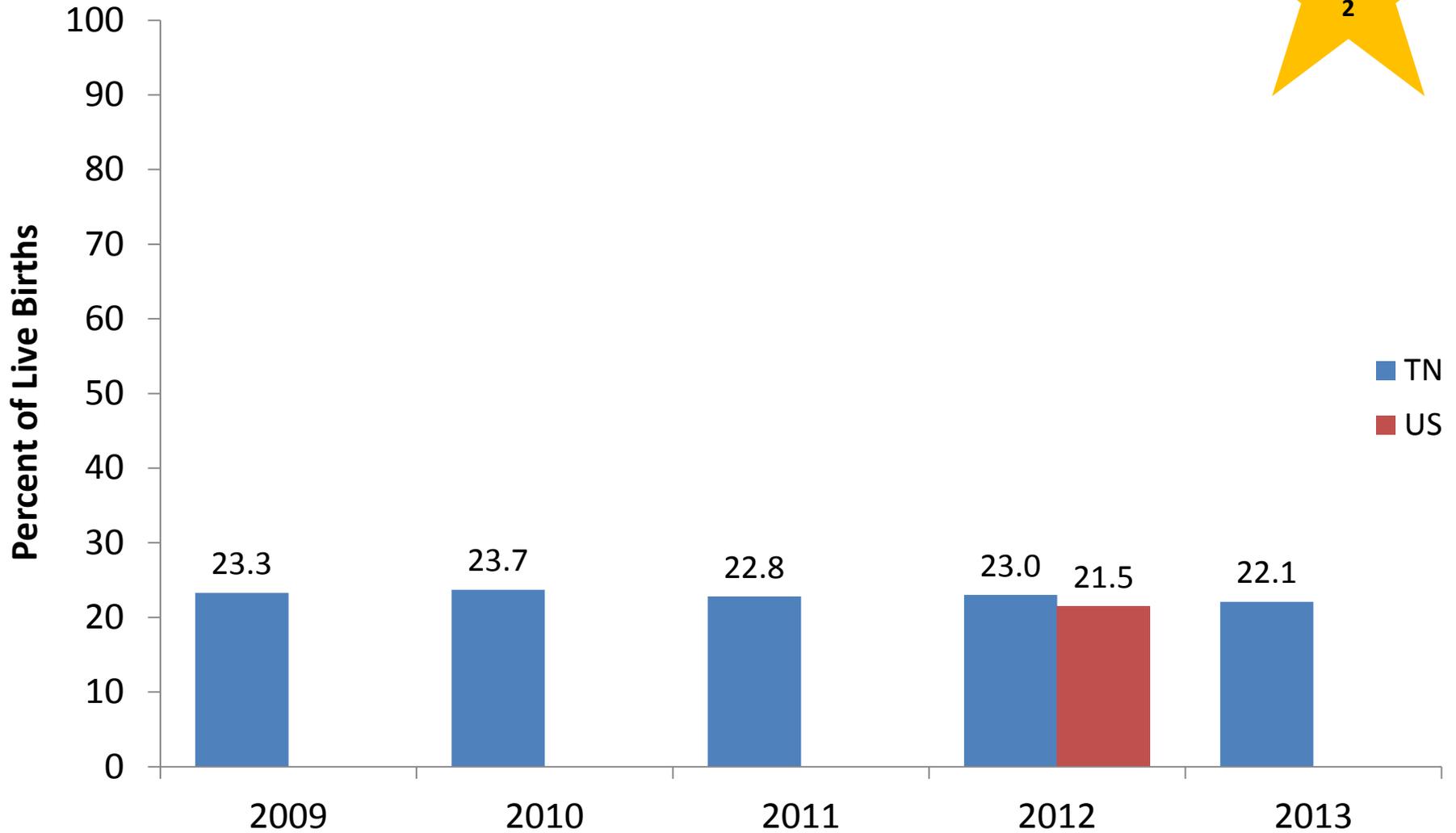
Non-Medically Indicated Early Term Singleton Births



Cesarean Deliveries Among Term, Singleton, Vertex Births to Nulliparous Women

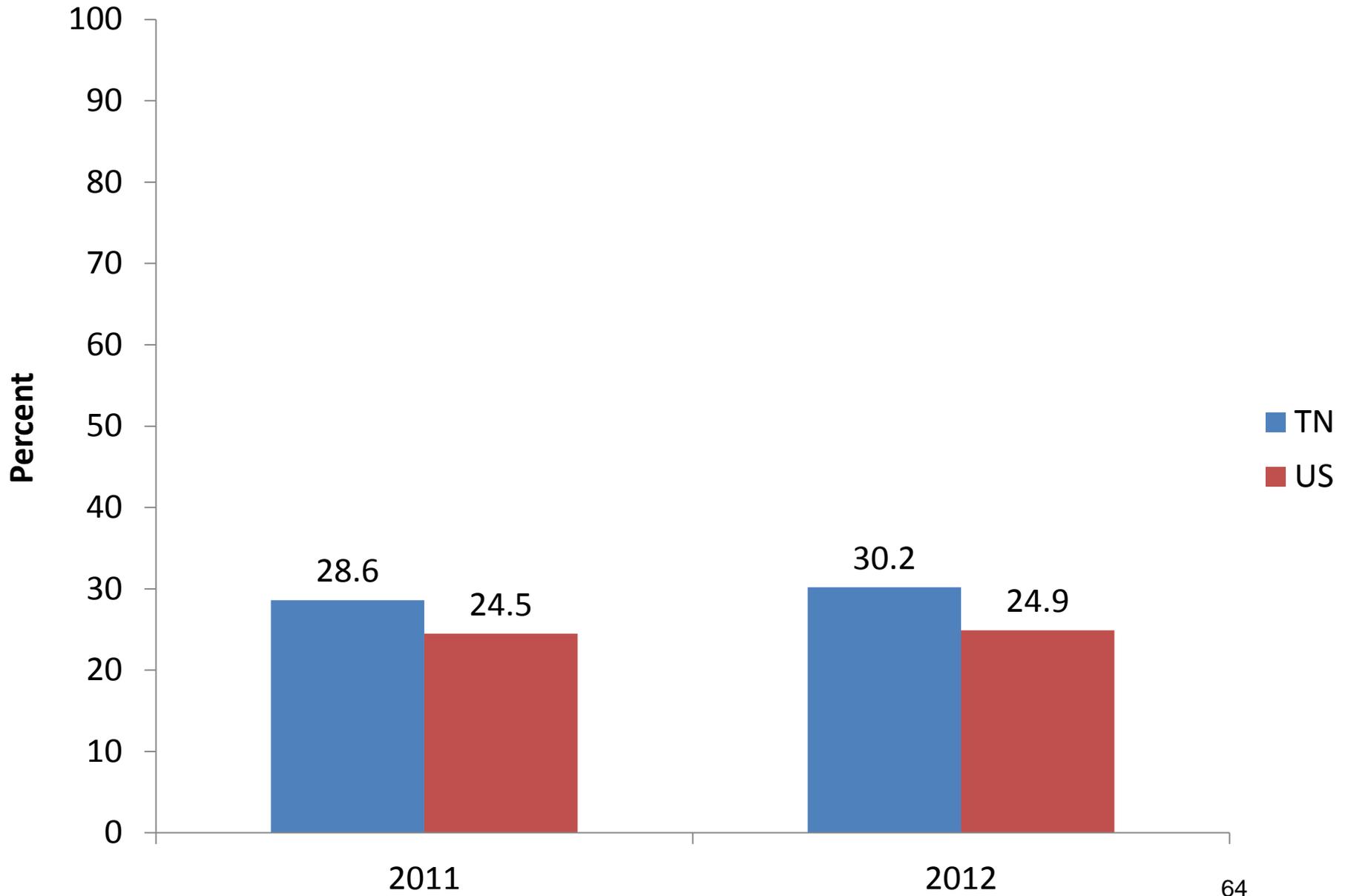


Primary Cesarean Deliveries Among Singleton Births

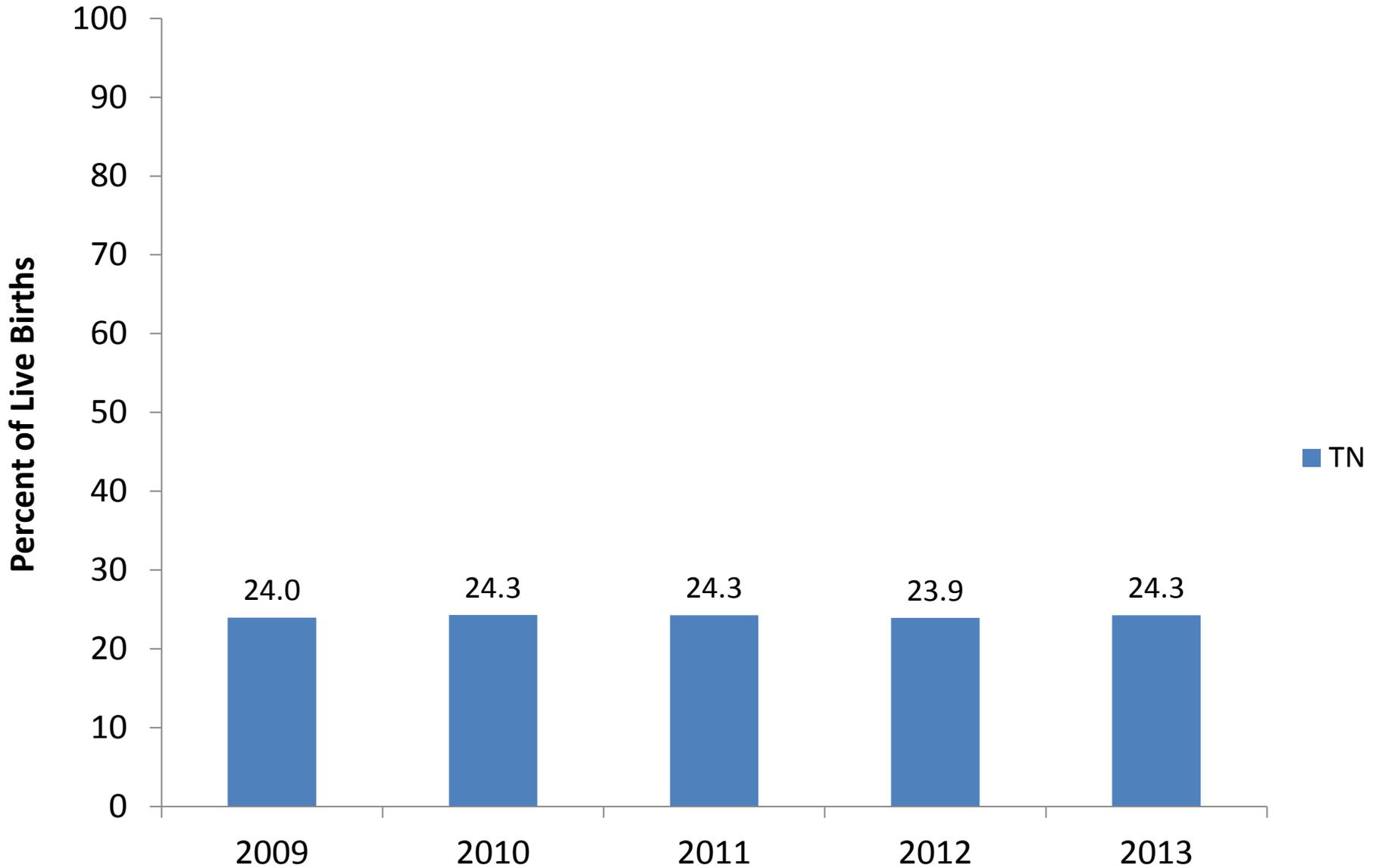


Data sources: 1) Tennessee Department of Health; Division of Policy, Planning and Assessment; Birth Statistical System. 2) Osterman MJK, Martin JA. Primary cesarean delivery rates, by state: Results from the revised birth certificate, 2006–2012. National vital statistics reports; vol 63 no 1. Hyattsville, MD: National Center for Health Statistics. 2014.

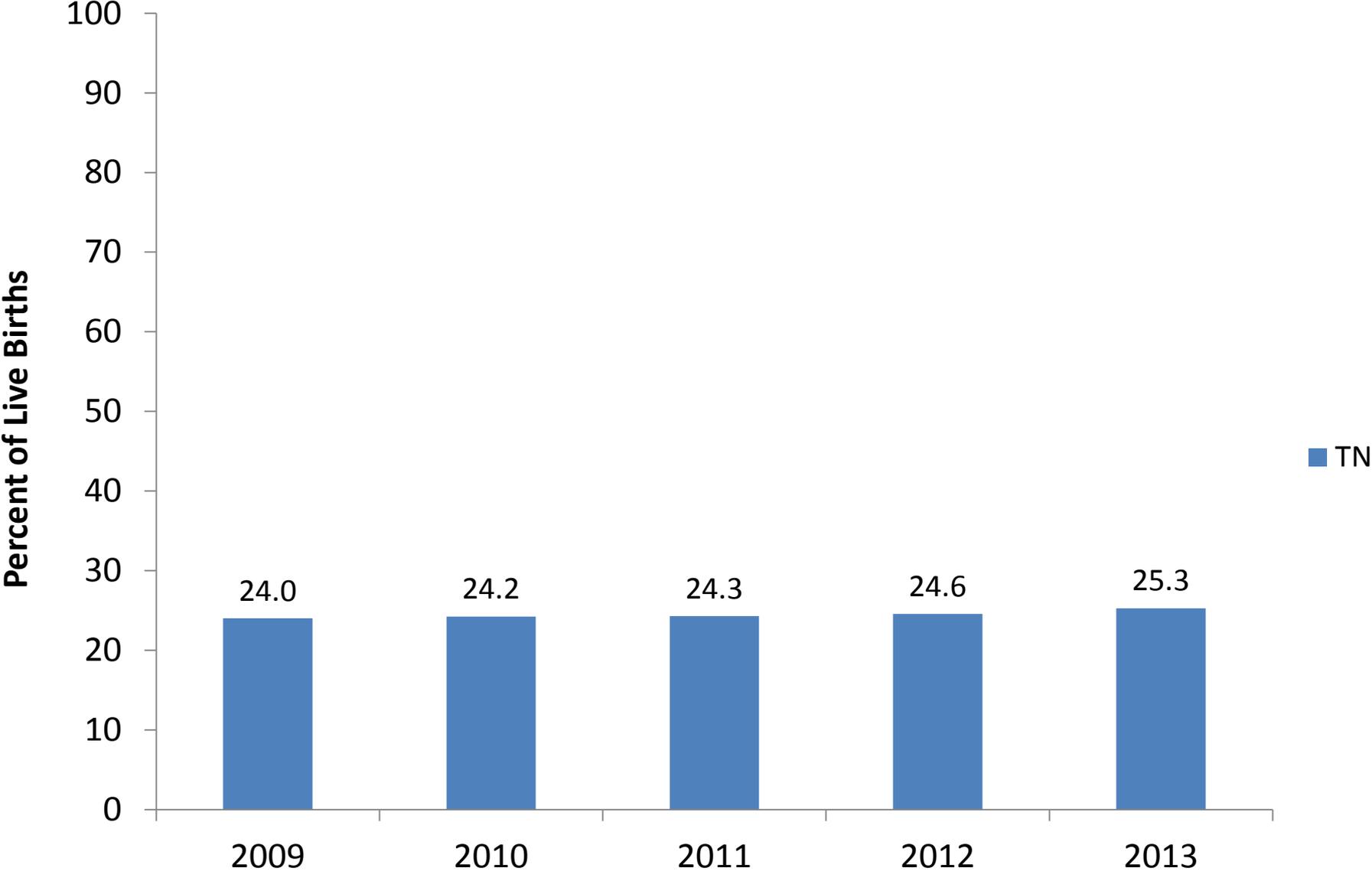
Women Aged 18-44 Years Who Are Obese (BMI >30)



Births to Women Who Were Overweight Before Pregnancy

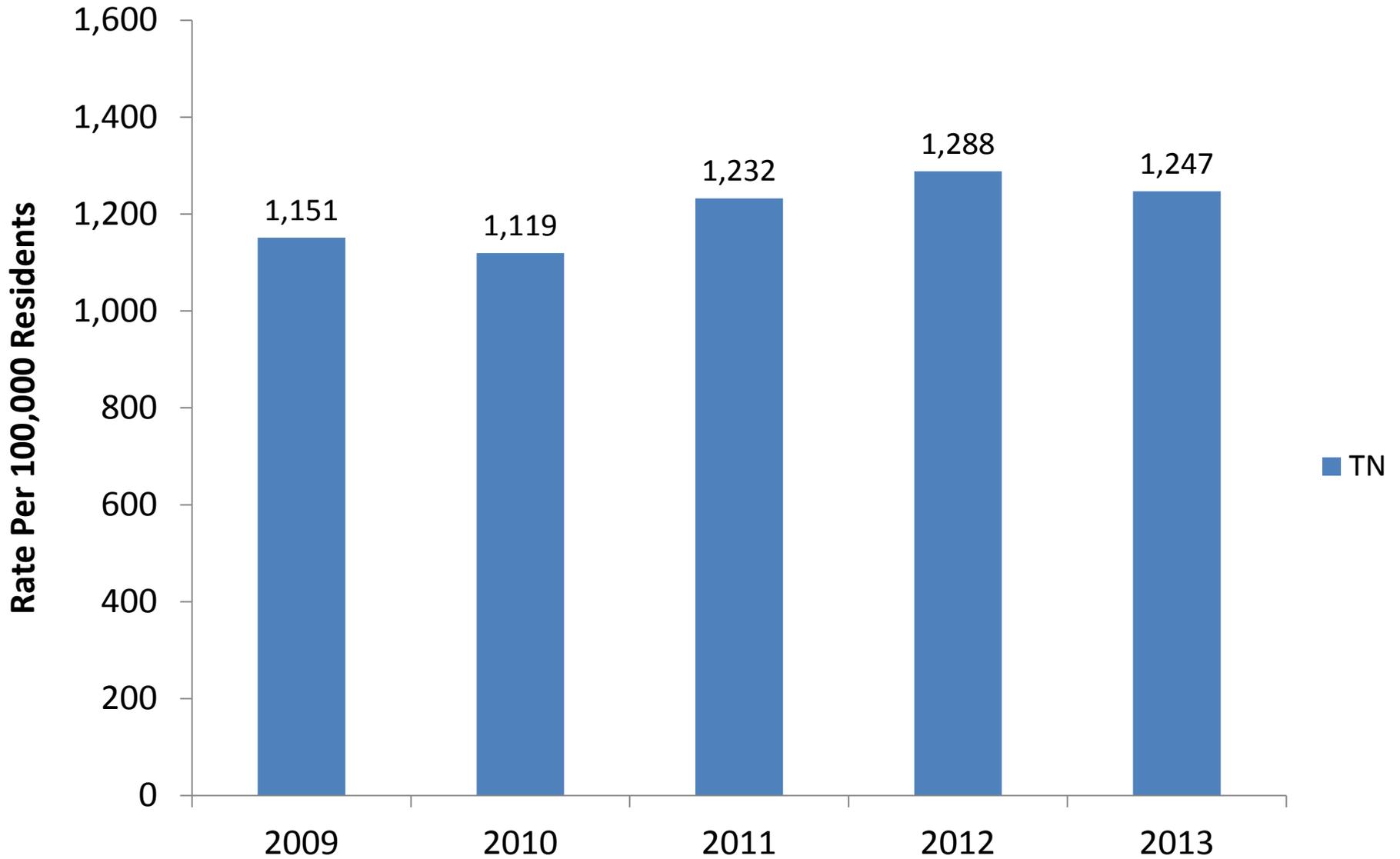


Births to Women Who Were Obese Before Pregnancy



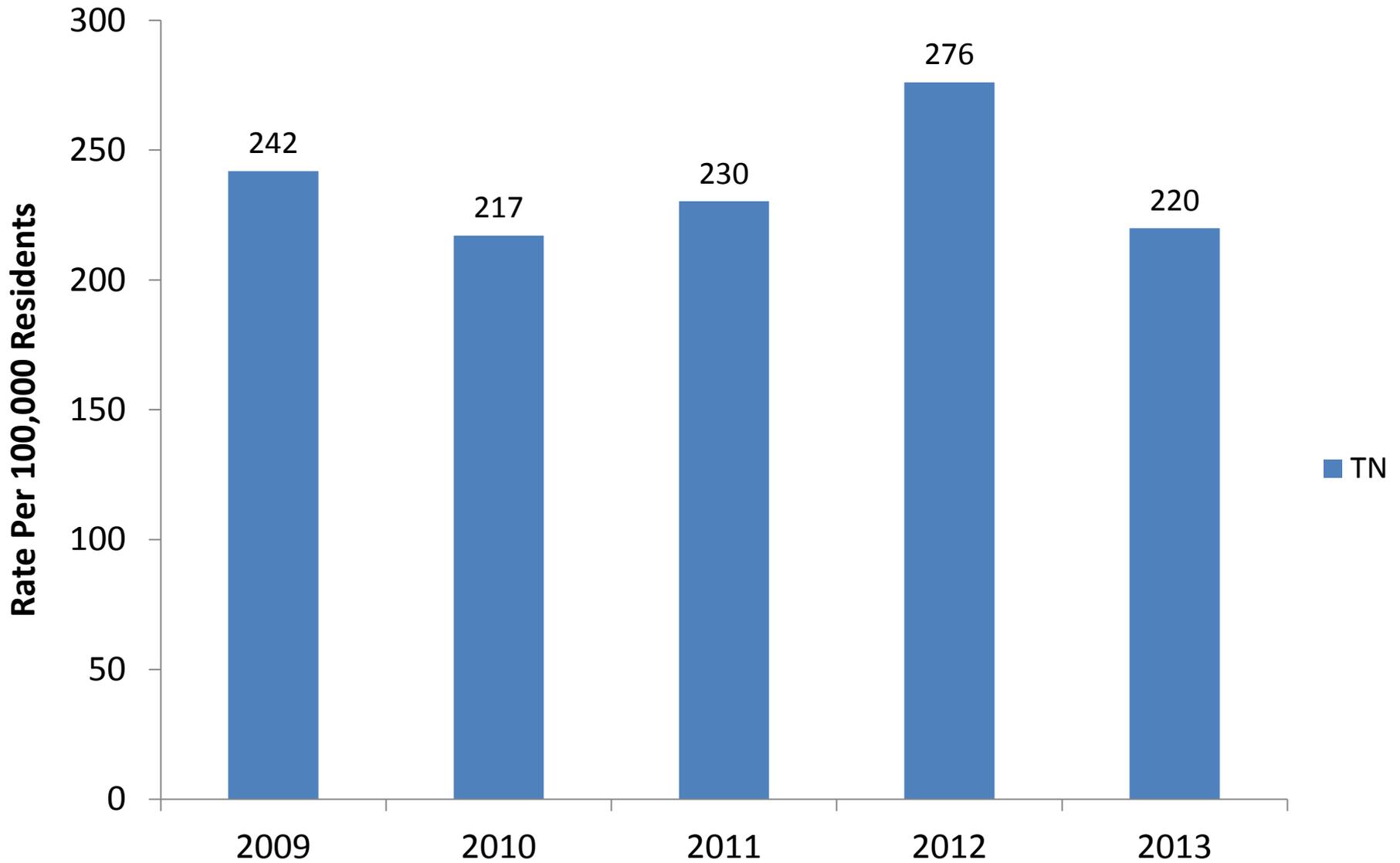
Data Source: Tennessee Department of Health; Division of Policy, Planning and Assessment; Birth Statistical System.

Chlamydia Cases Among Women Age 20-44 Years



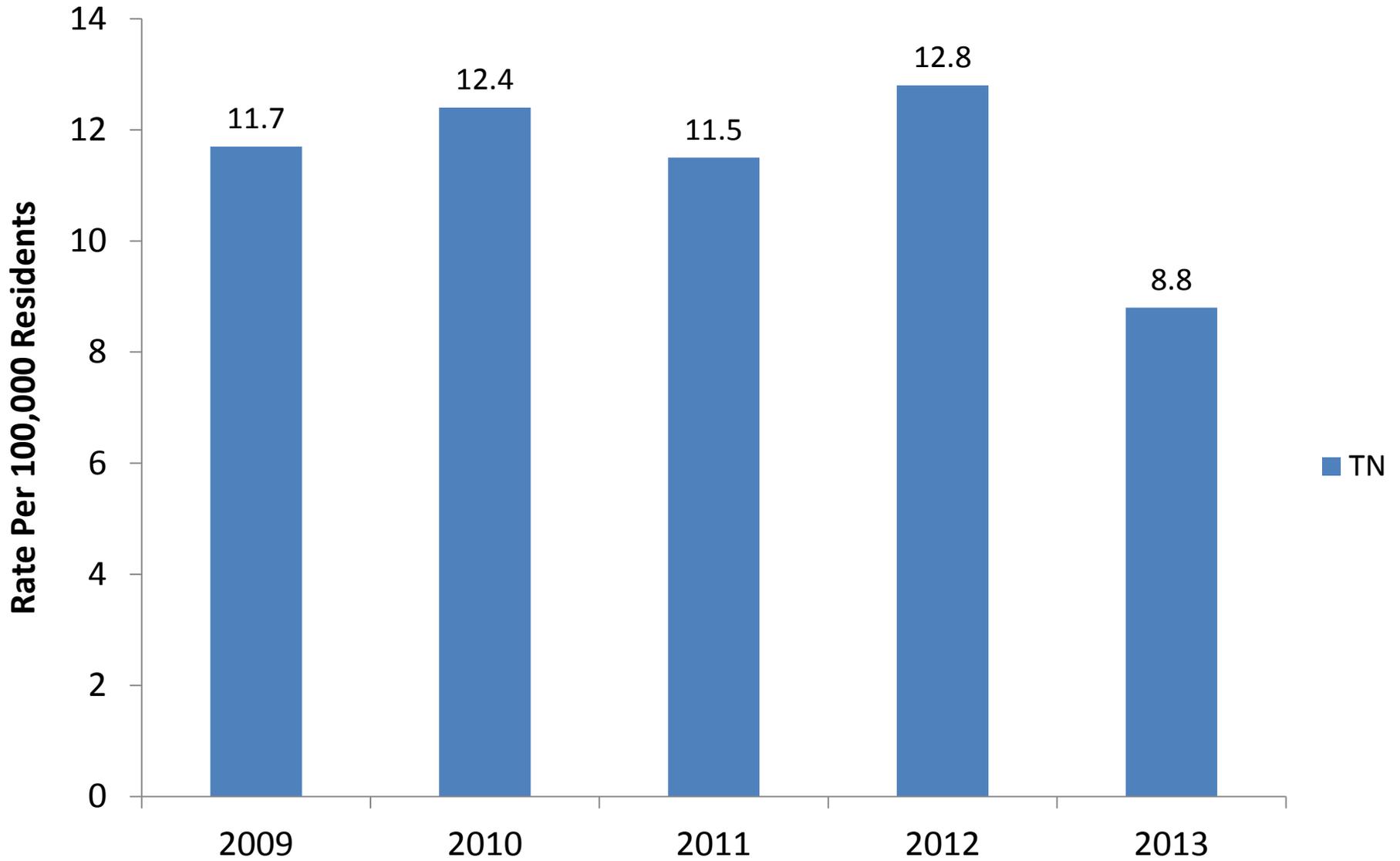
Data Source: Tennessee Department of Health; Division of Communicable and Environmental Diseases and Emergency Preparedness; PRISM.

Gonorrhea Cases Among Women Age 20-44

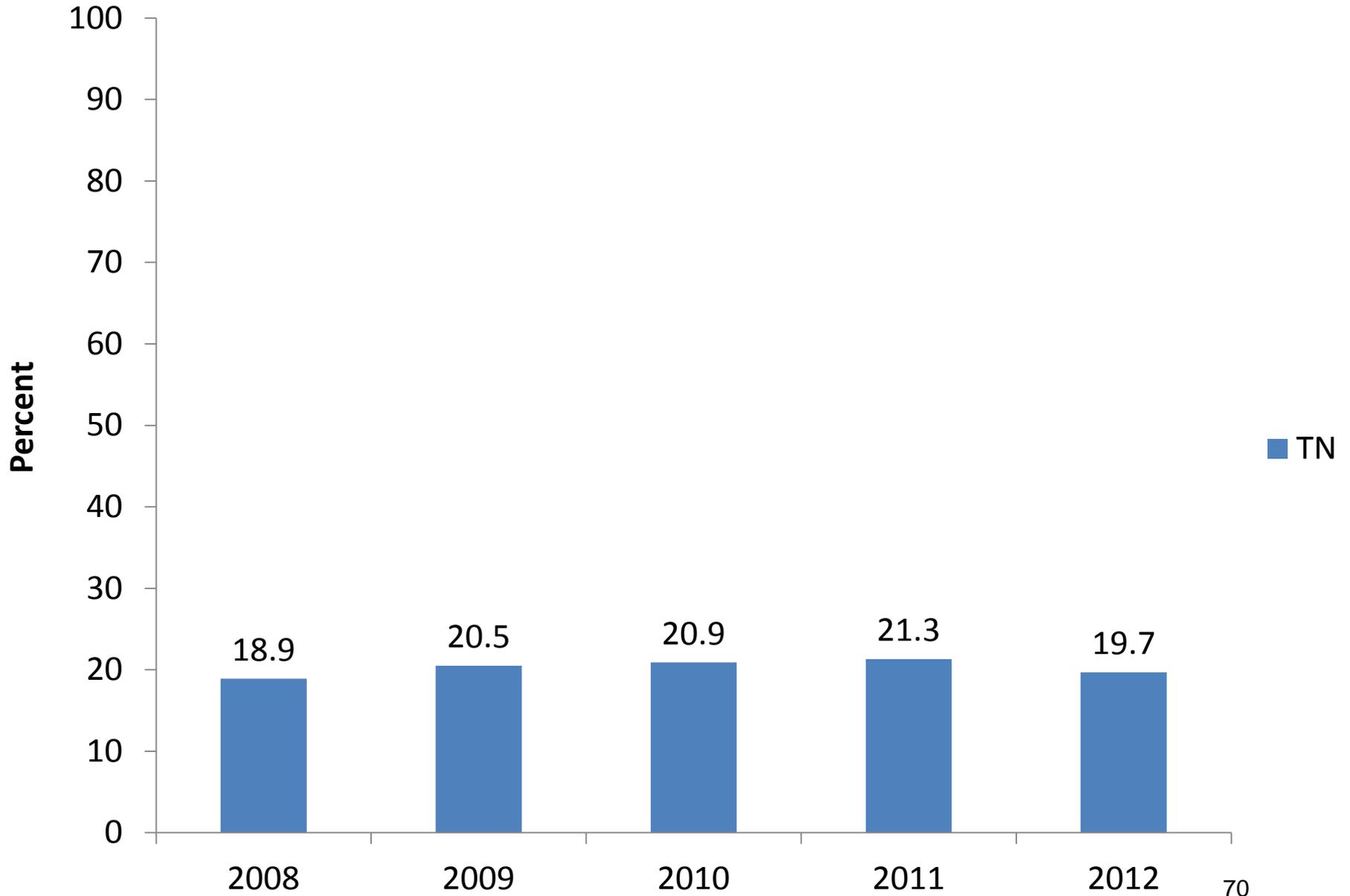


Data Source: Tennessee Department of Health; Division of Communicable and Environmental Diseases and Emergency Preparedness; PRISM.

HIV Cases Among Women Age 20-44 Years

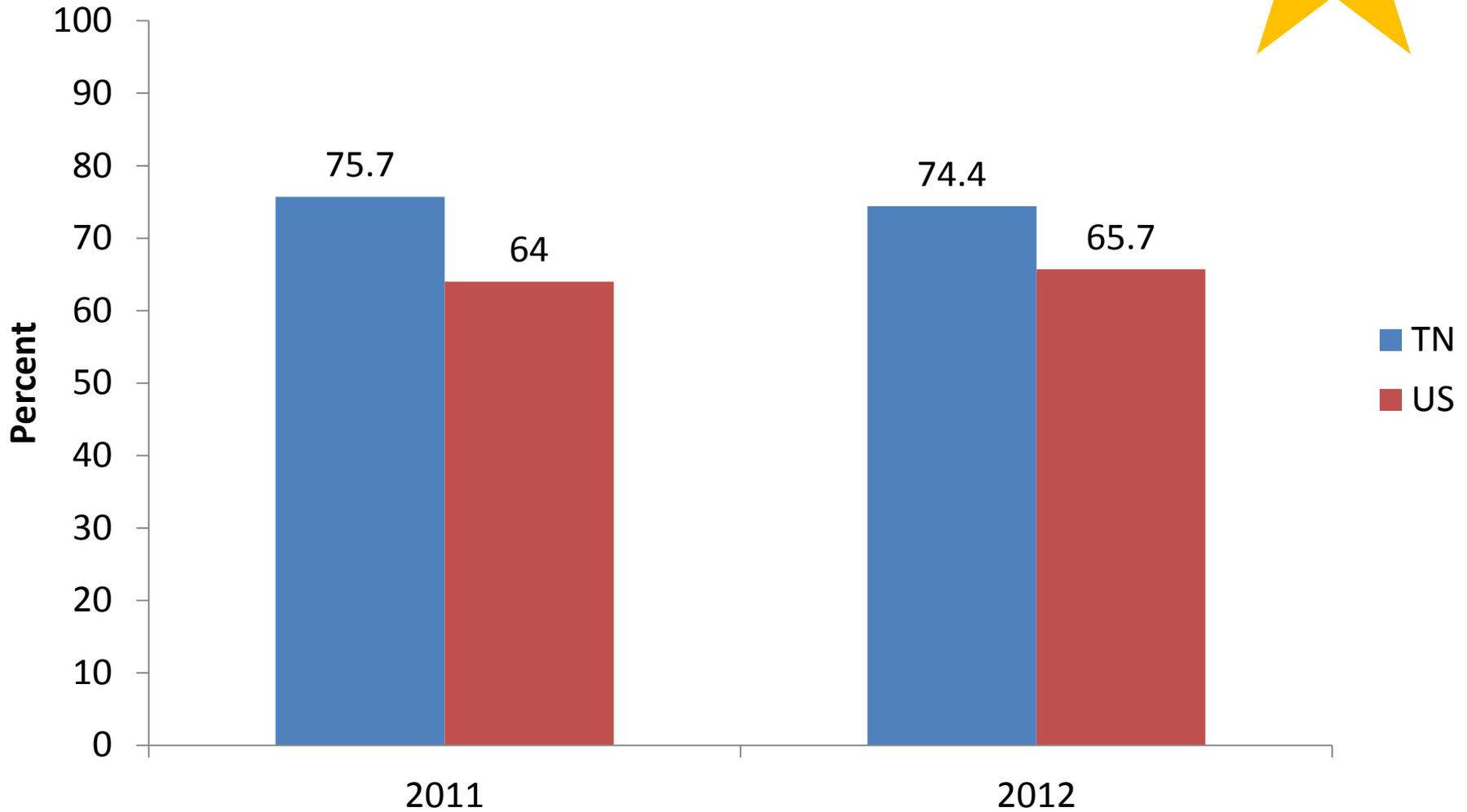


Women Age 18-40 Years without Health Insurance

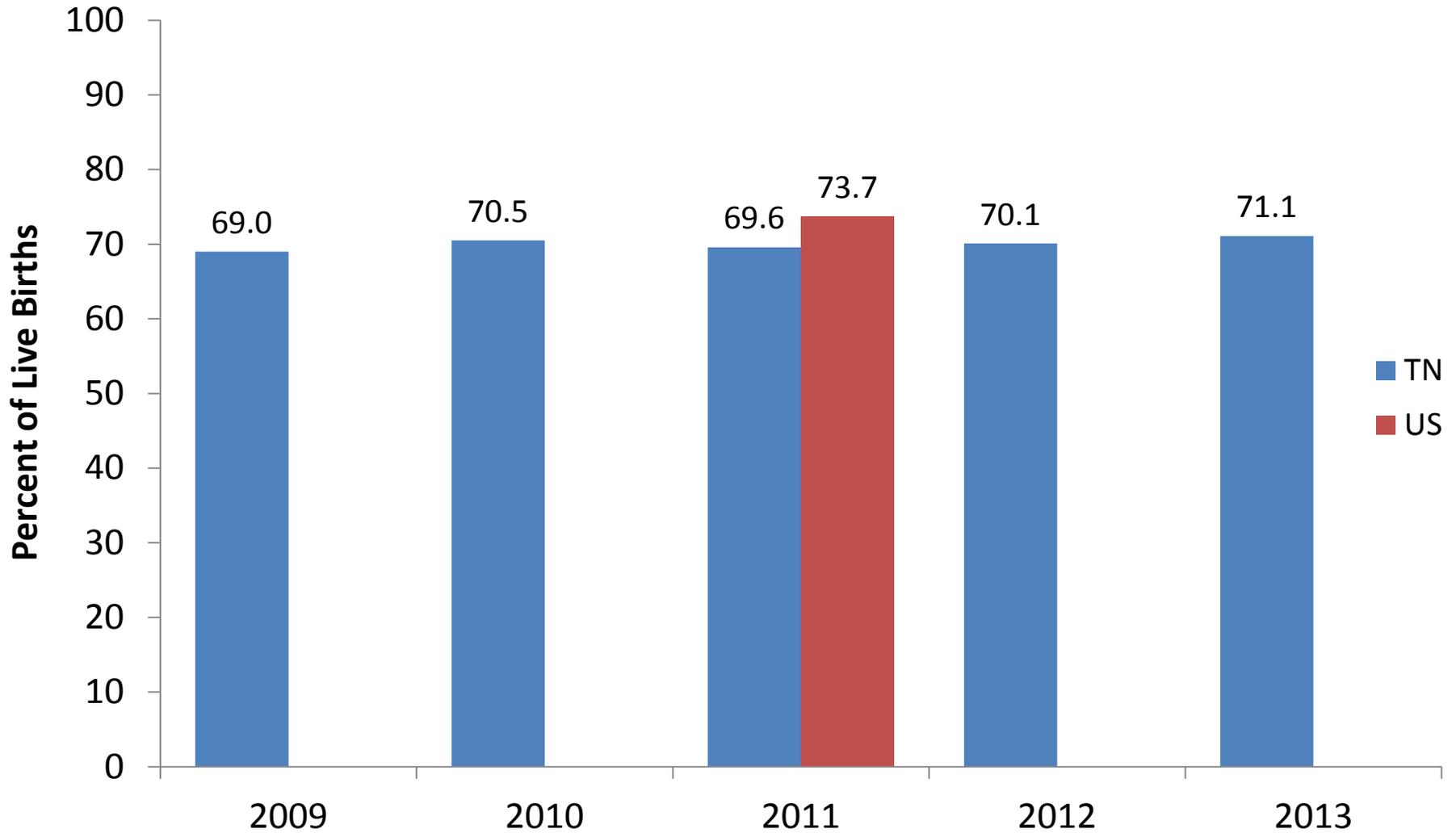


Data source: United States Census Bureau, Small Area Health Insurance Estimates.

Women Age 18-44 Years with a Preventive Care Visit in the Past 12 Months

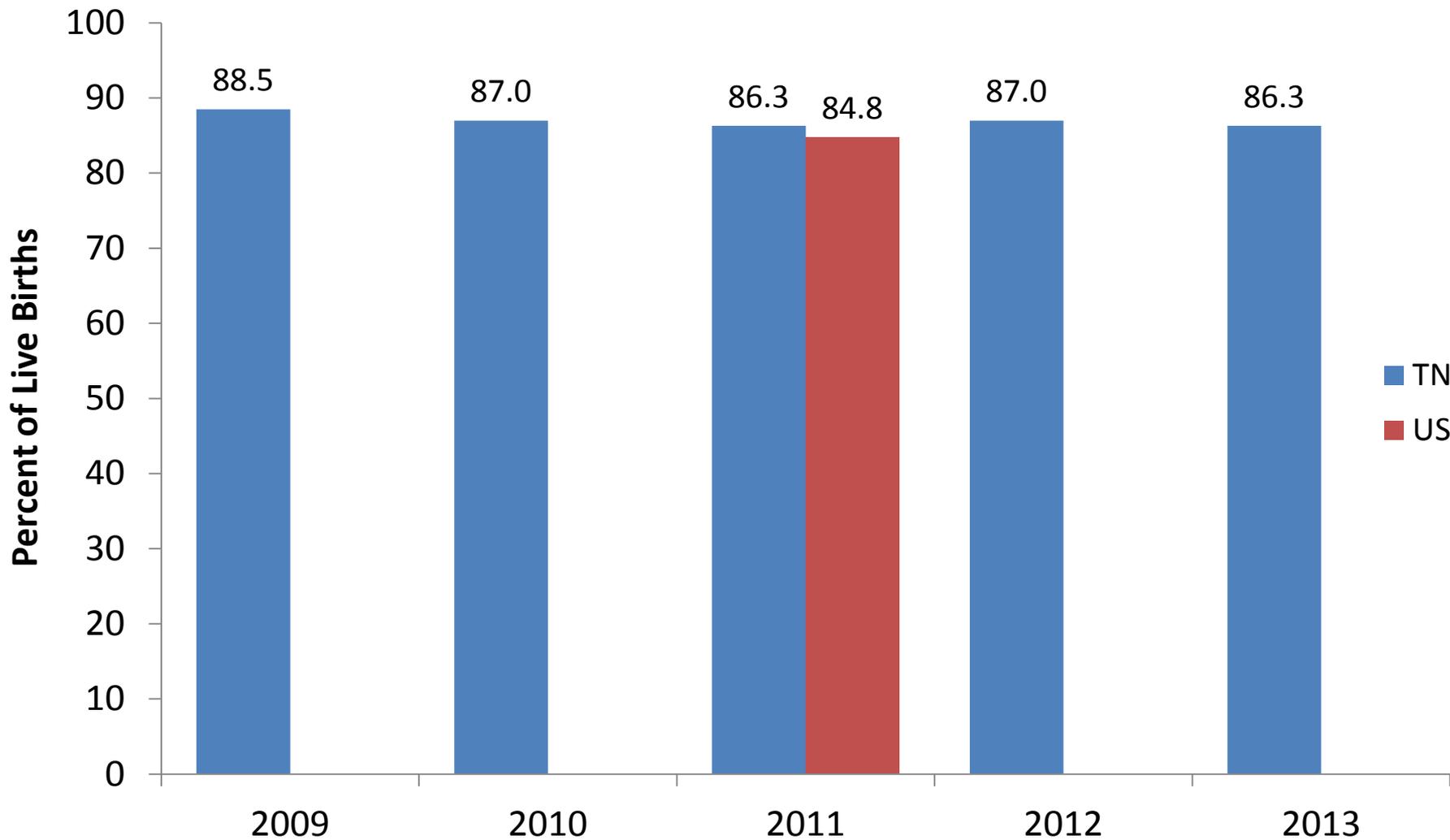


Births to Women Receiving Prenatal Care in the First Trimester



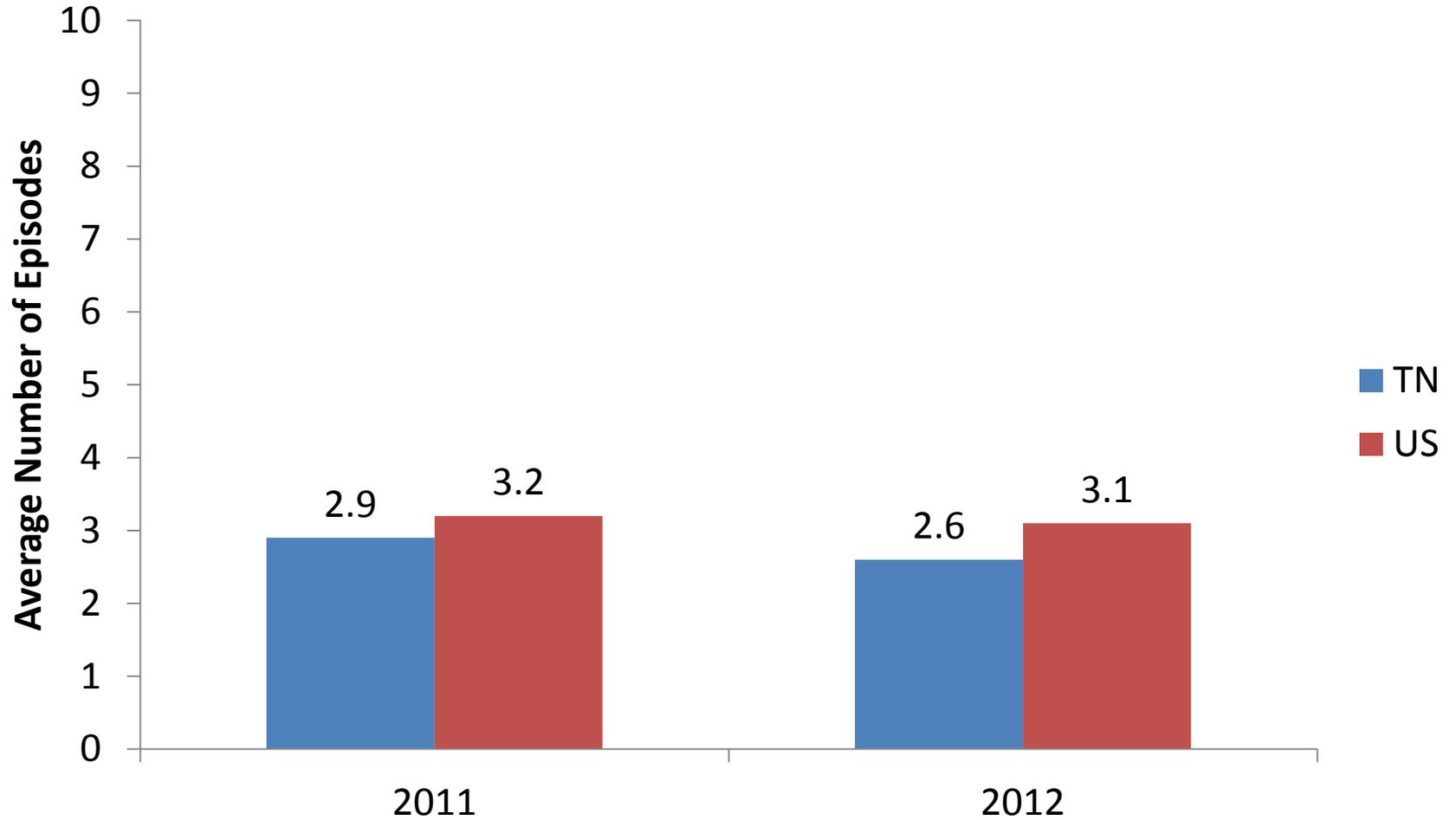
Data sources: 1) Tennessee Department of Health; Division of Policy, Planning and Assessment; Birth Statistical System. 2) U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau. Child Health USA 2013. Rockville, Maryland: U.S. Department of Health and Human Services, 2013.

Births to Women with Prenatal Visits $\geq 80\%$ on the Kotelchuck Index



Data sources: 1) Tennessee Department of Health; Division of Policy, Planning and Assessment; Birth Statistical System. 2) U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau. Child Health USA 2013. Rockville, Maryland: U.S. Department of Health and Human Services, 2013.

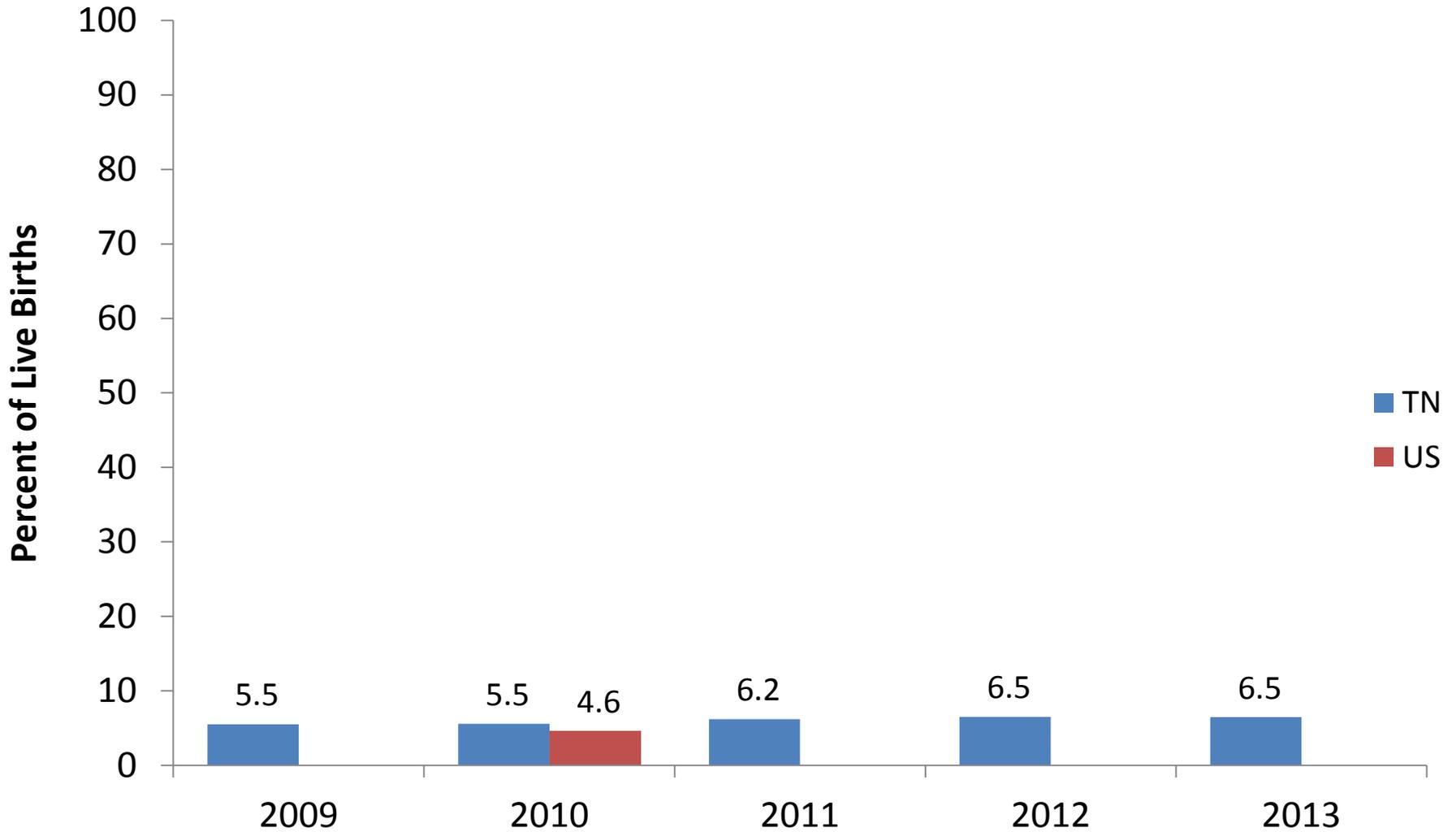
Binge Drinking* in the Last 30 Days Among Women Age 18-44 Years



*Binge Drinking is 4 or more drinks in a 2 hour period

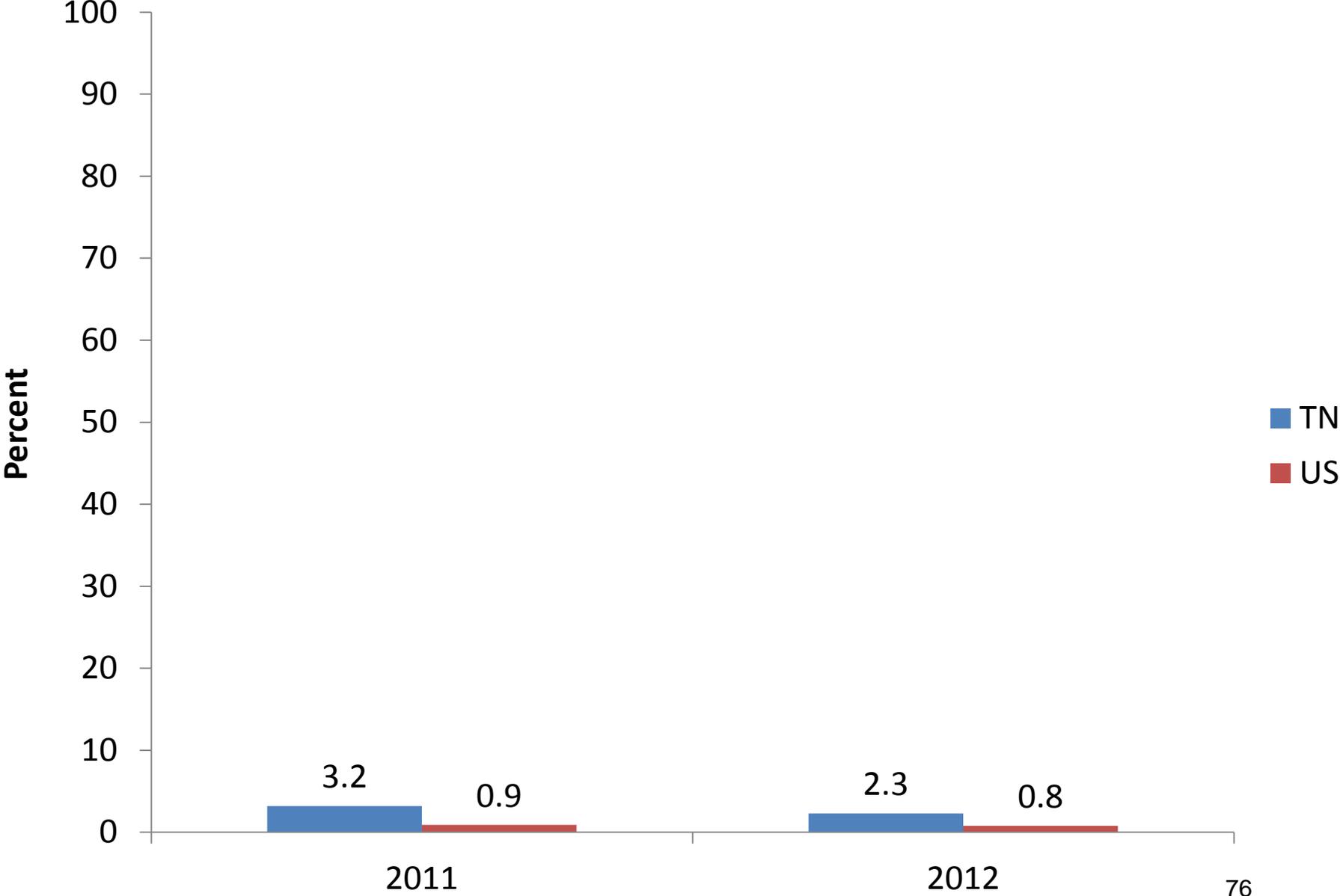
Data source: Behavioral Risk Factor Surveillance System.

Births to Women Who Had Gestational Diabetes



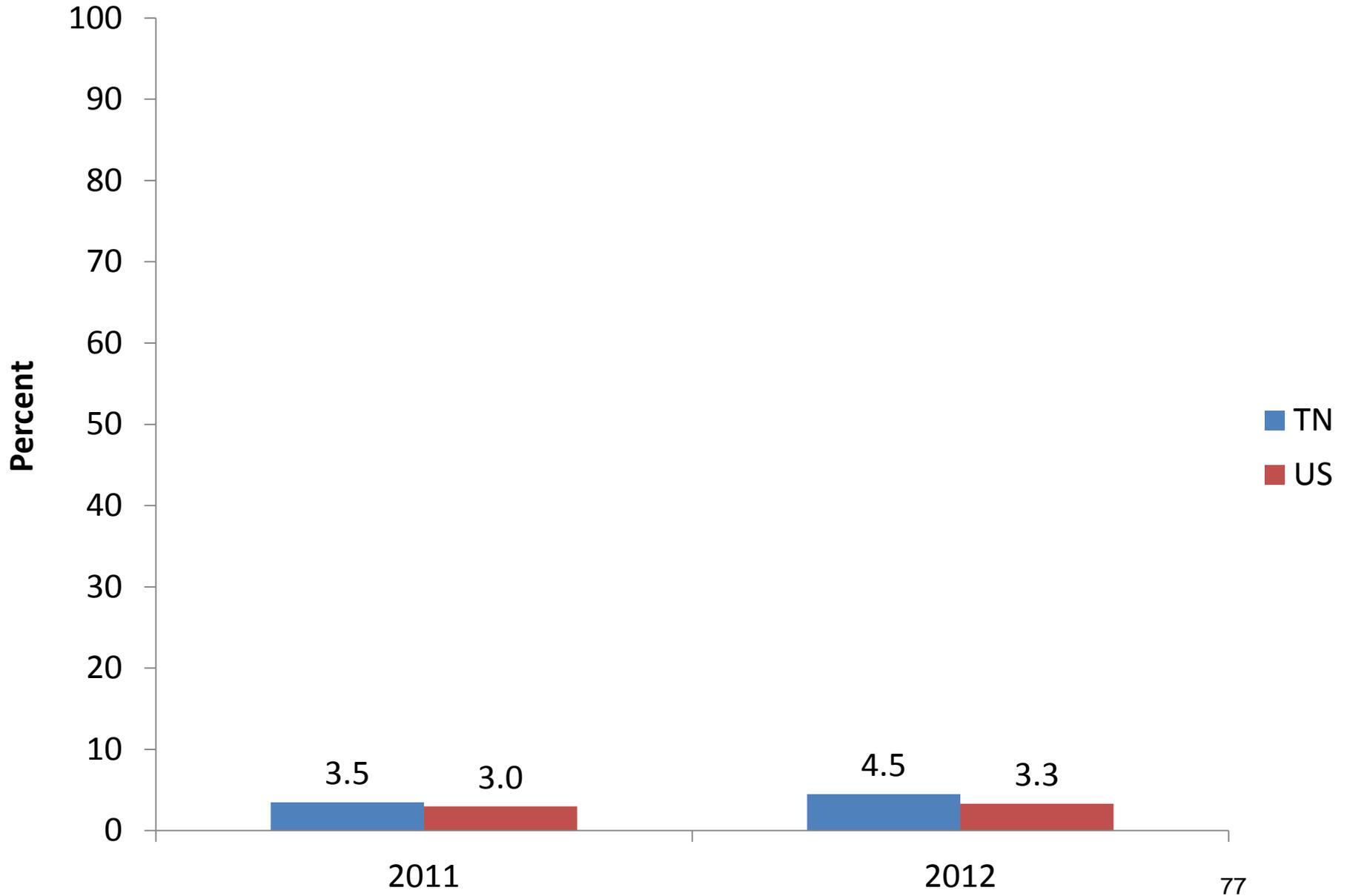
Data sources: 1) Tennessee Department of Health; Division of Policy, Planning and Assessment, Birth Statistical System. 2) U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau. Child Health USA 2013. Rockville, Maryland: U.S. Department of Health and Human Services, 2013.

Women Aged 18-44 Years With Pre-Diabetes



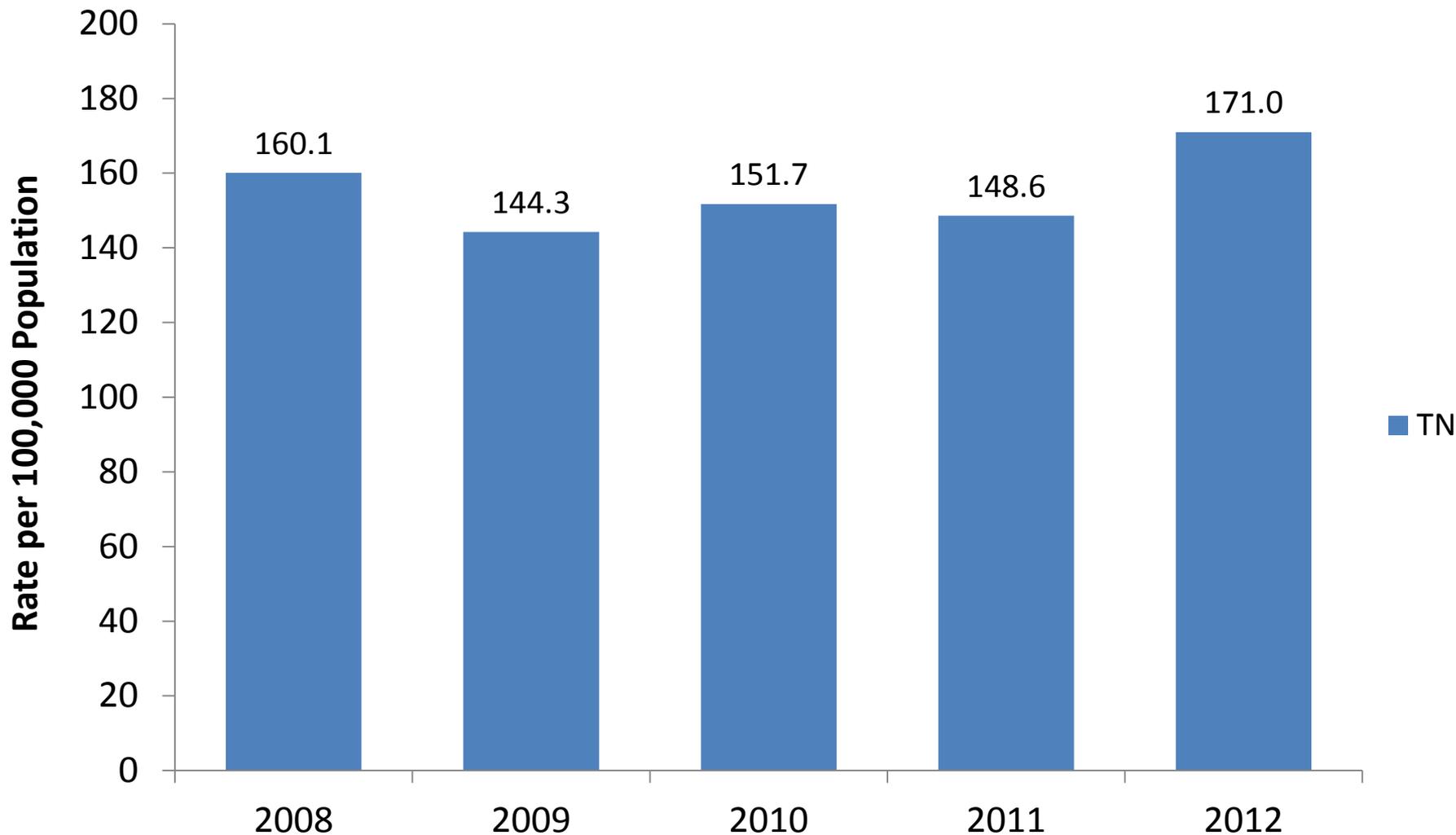
Data source: Behavioral Risk Factor Surveillance System.

Women Aged 18-44 Years with Diabetes

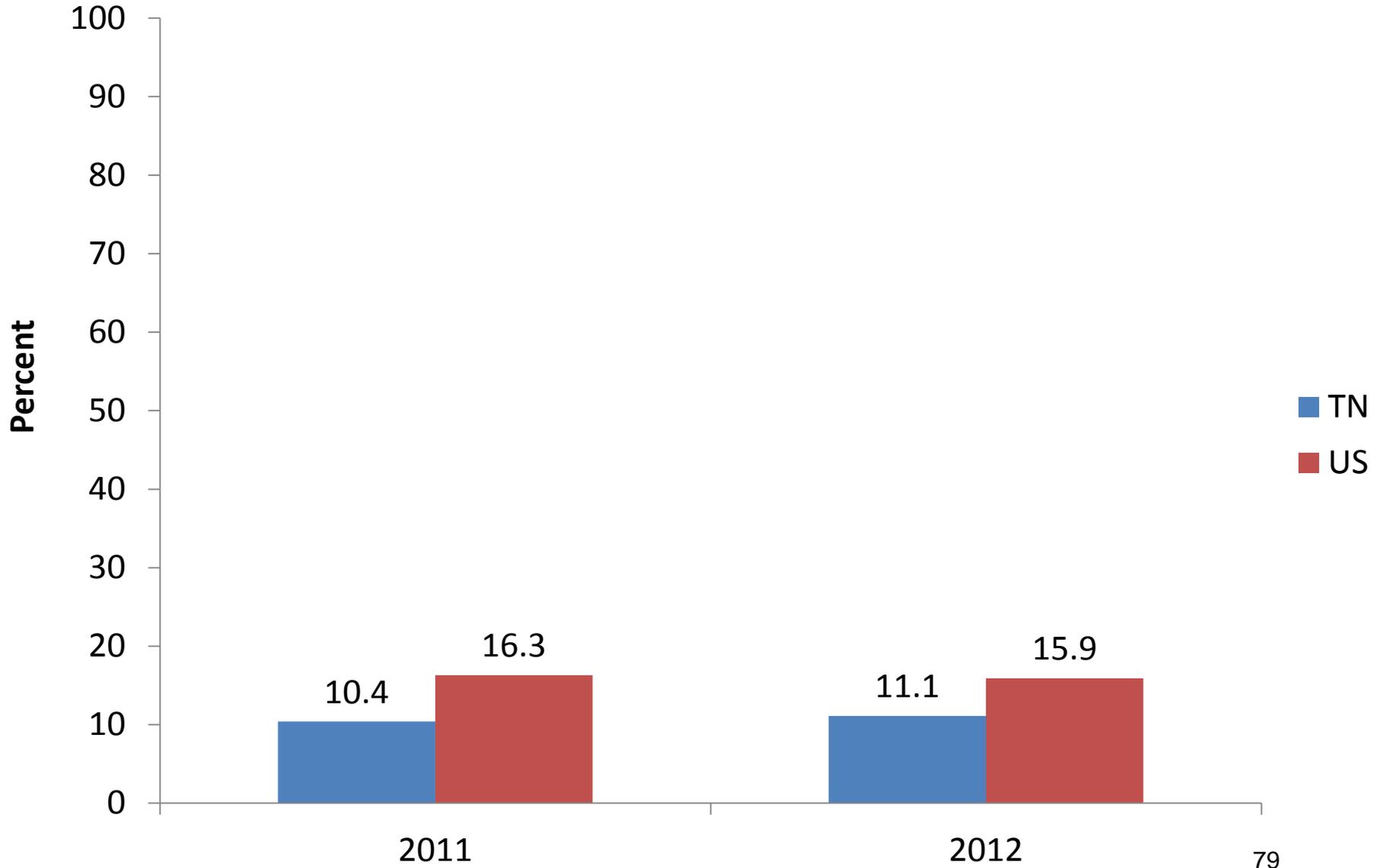


Data source: Behavioral Risk Factor Surveillance System.

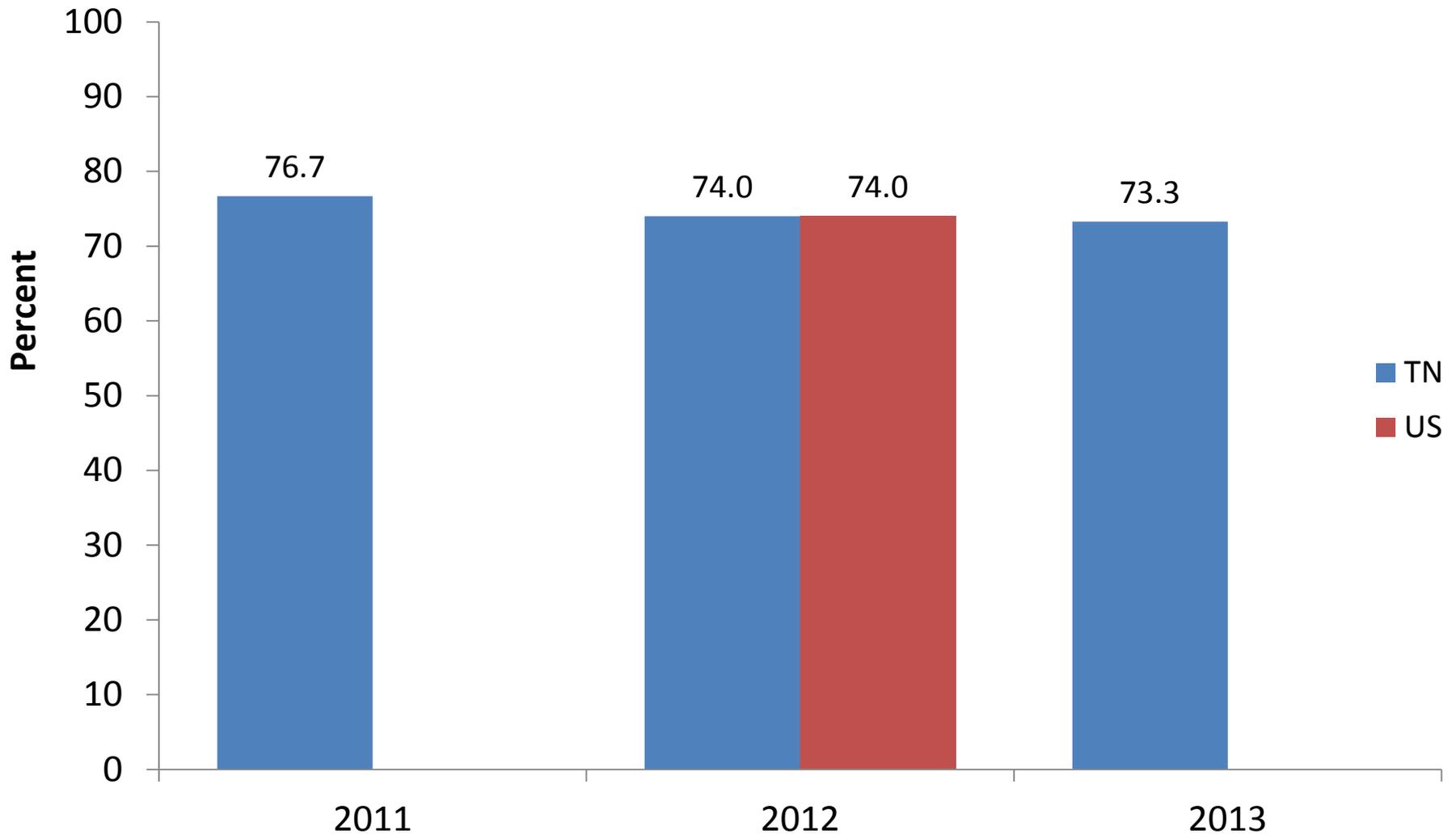
Hospitalizations for Complications of Diabetes Among Women Age 15-44 Years



Women Age 18-44 Years Who Were Ever Diagnosed with Asthma

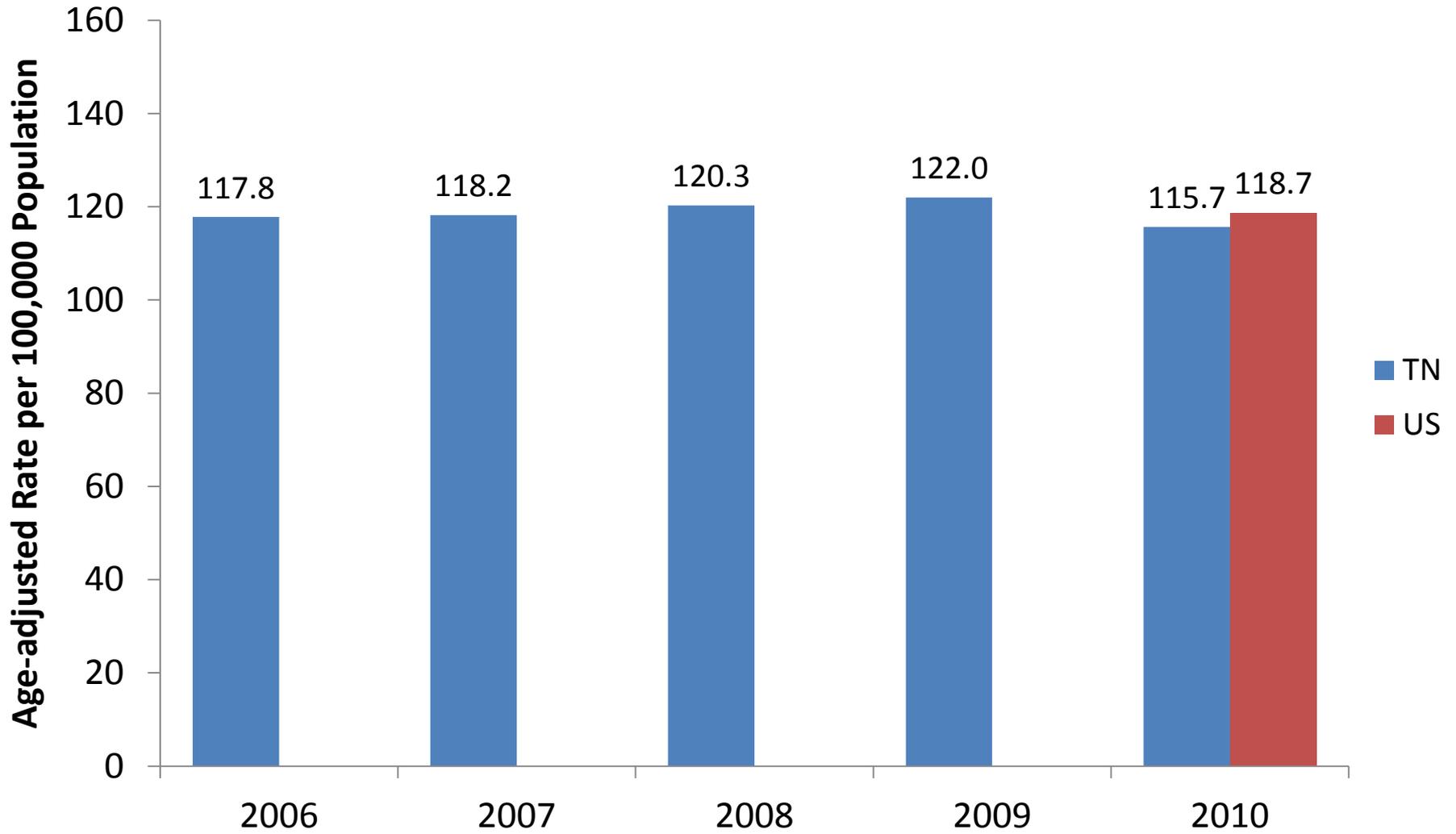


Women Age 40+ Years with a Mammogram in the Past 2 Years



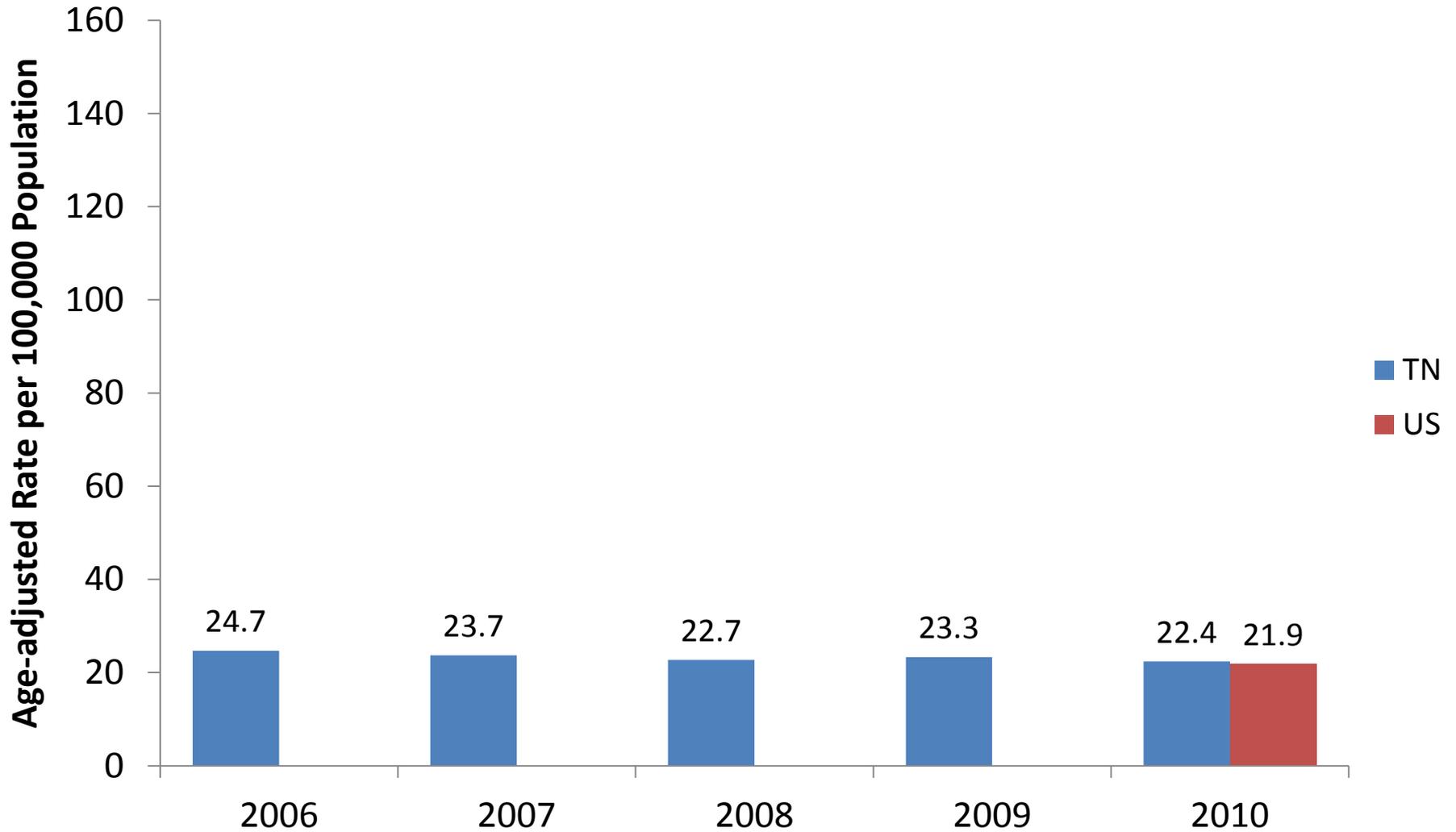
Data sources: 1) Tennessee Department of Health; Division of Policy, Planning and Assessment; Birth Statistical System. 2) Centers for Disease Control and Prevention (CDC). Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2012.

Breast Cancer Incidence



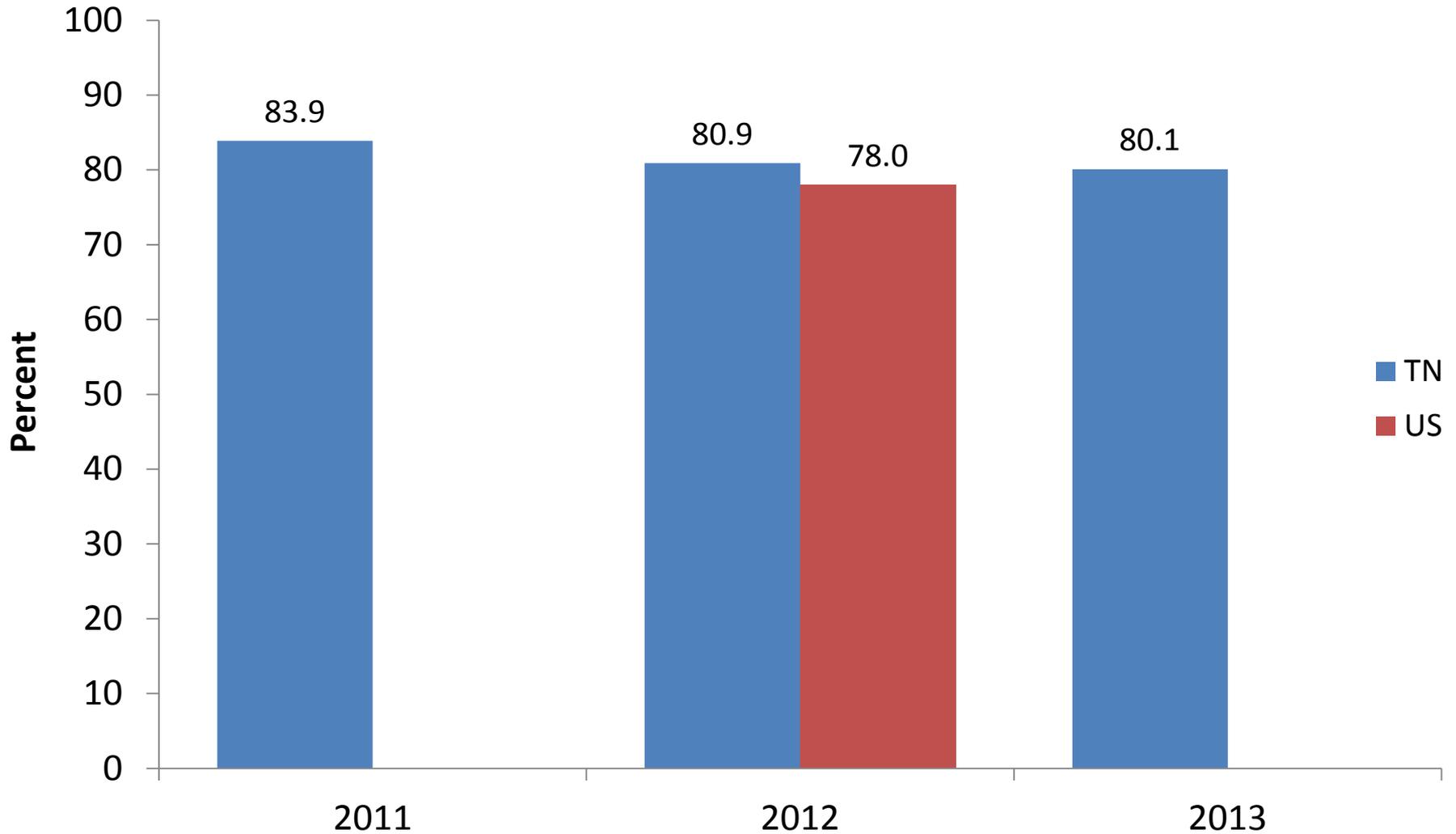
Data source: U.S. Cancer Statistics Working Group. United States Cancer Statistics: 1999–2011 Incidence and Mortality Web-based Report. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention and National Cancer Institute; 2014. Available at: www.cdc.gov/uscs.

Breast Cancer Mortality



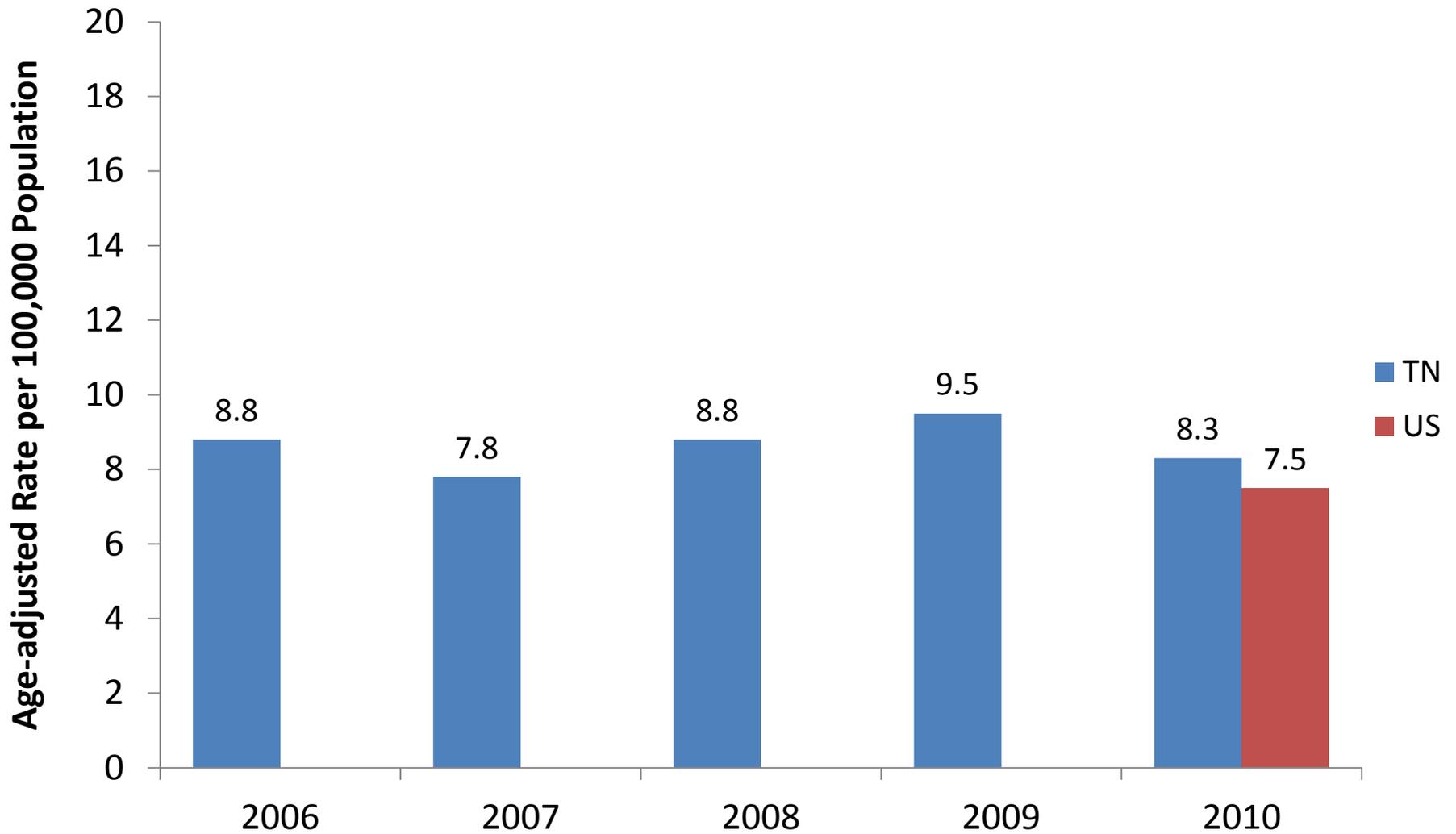
Data source: U.S. Cancer Statistics Working Group. United States Cancer Statistics: 1999–2011 Incidence and Mortality Web-based Report. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention and National Cancer Institute; 2014. Available at: www.cdc.gov/uscs.

Women Aged 18+ Years with a Pap Test in the Past 3 Years



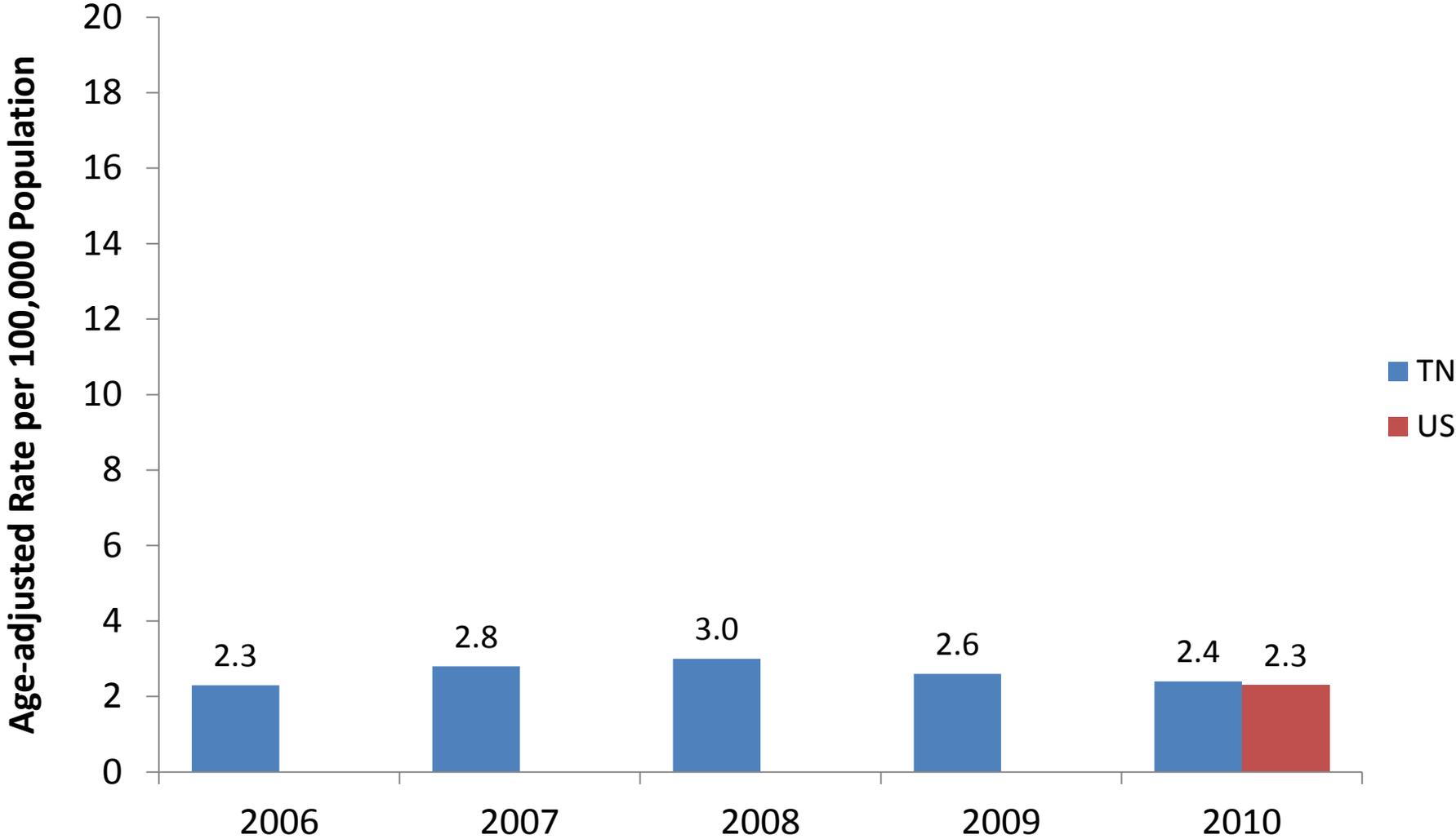
Data sources: 1) Tennessee Department of Health; Division of Policy, Planning and Assessment; Birth Statistical System. 2) Centers for Disease Control and Prevention (CDC). Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2012.

Cervical Cancer Incidence



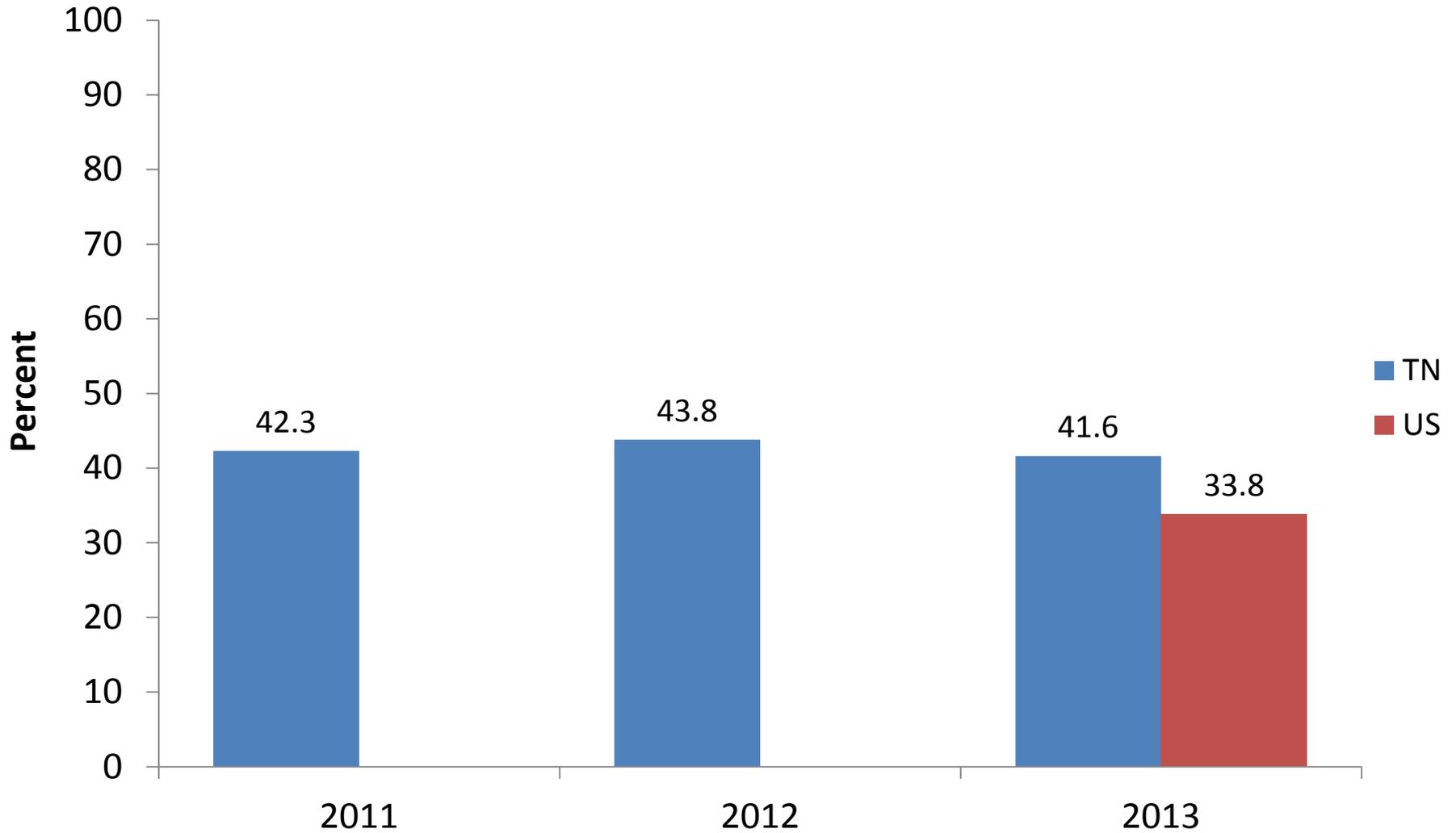
Data source: U.S. Cancer Statistics Working Group. United States Cancer Statistics: 1999–2011 Incidence and Mortality Web-based Report. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention and National Cancer Institute; 2014. Available at: www.cdc.gov/uscs.

Cervical Cancer Mortality



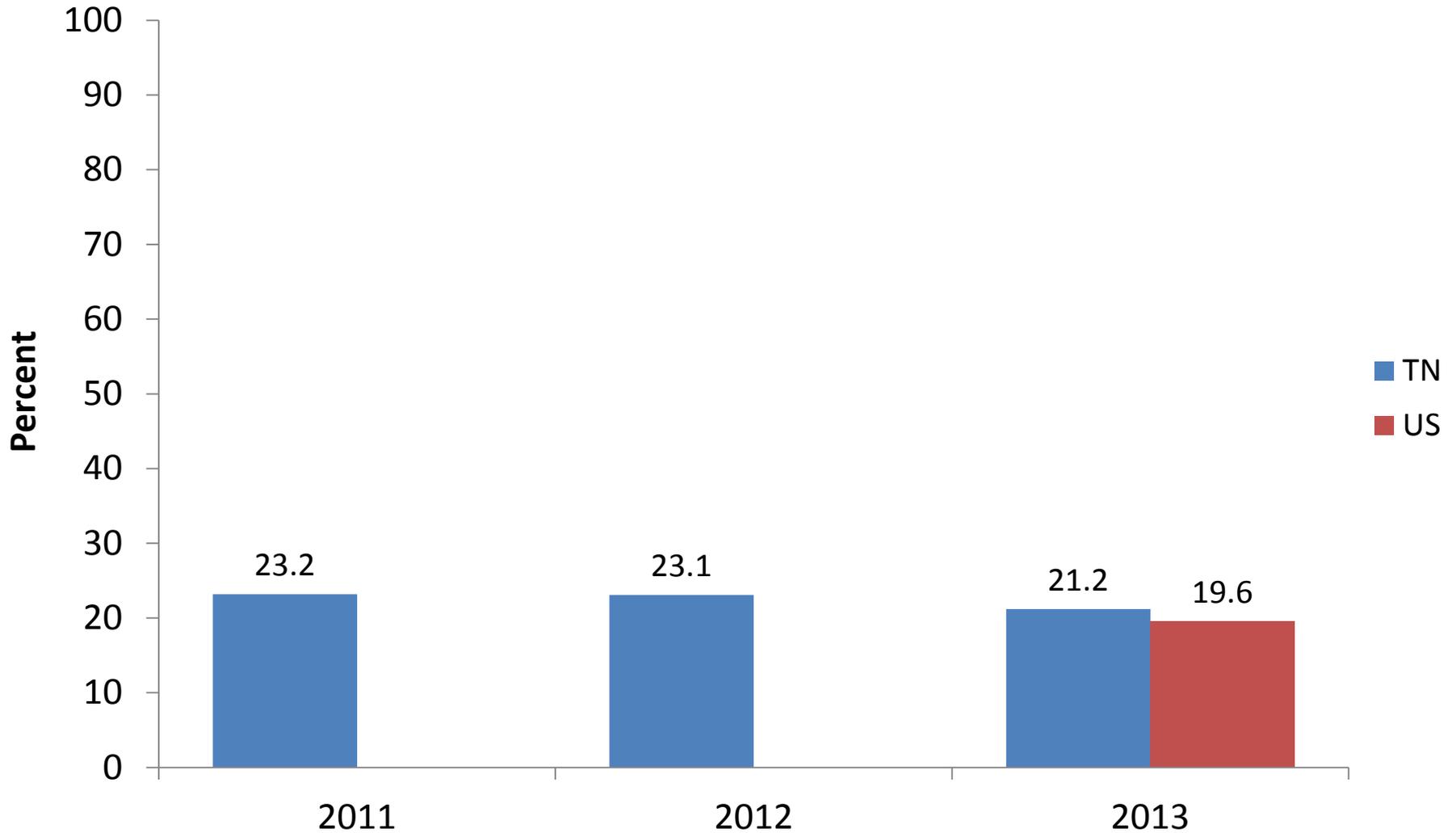
Data source: U.S. Cancer Statistics Working Group. United States Cancer Statistics: 1999–2011 Incidence and Mortality Web-based Report. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention and National Cancer Institute; 2014. Available at: www.cdc.gov/uscs.

Women Age 18+ Years Eating Fruits Less than Once per Day



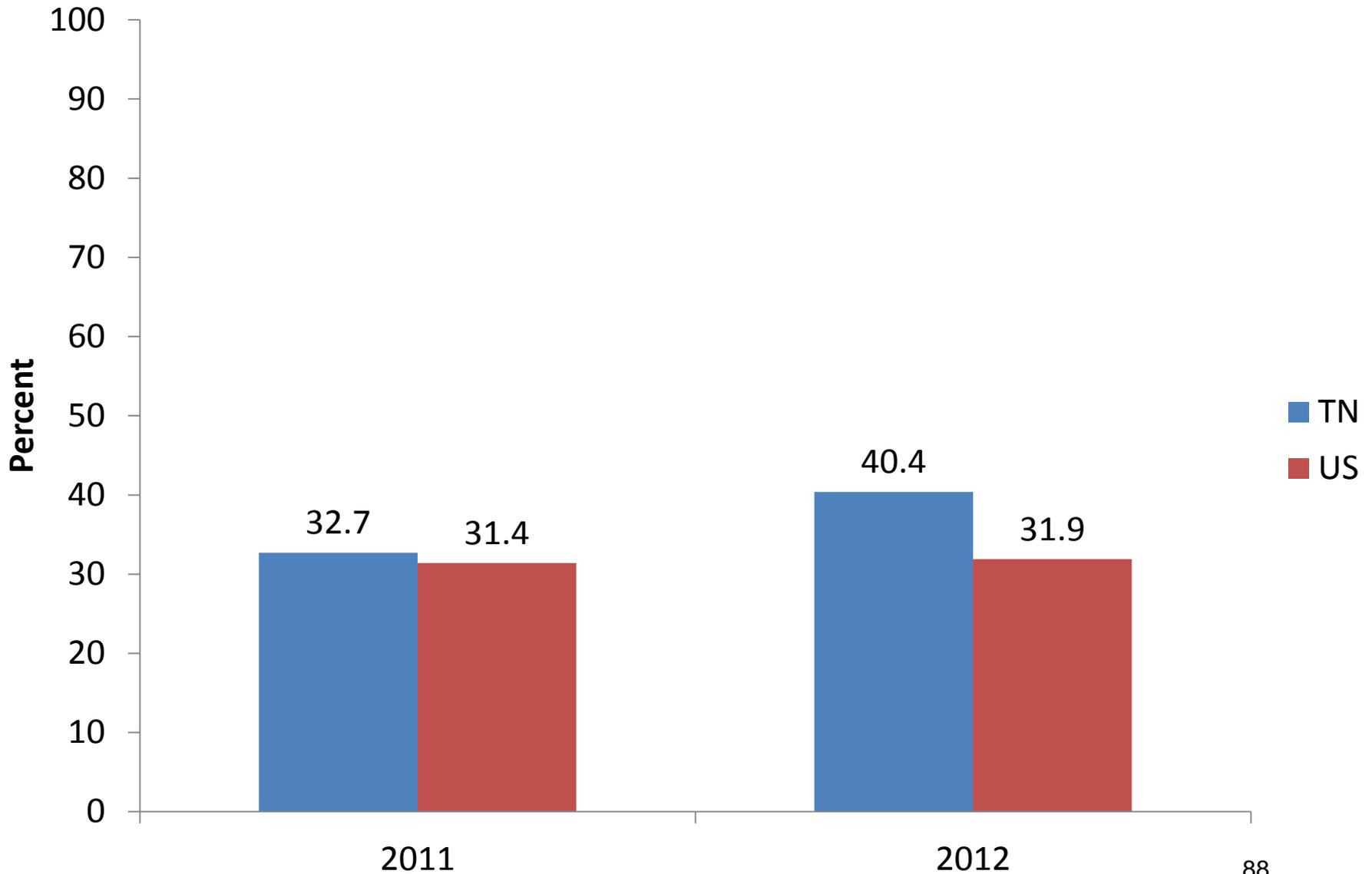
Data sources: 1) Tennessee Department of Health; Division of Policy, Planning and Assessment; Birth Statistical System. 2) Centers for Disease Control and Prevention (CDC). Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2013.

Women Age 18+ Years Eating Vegetables Less than Once per Day

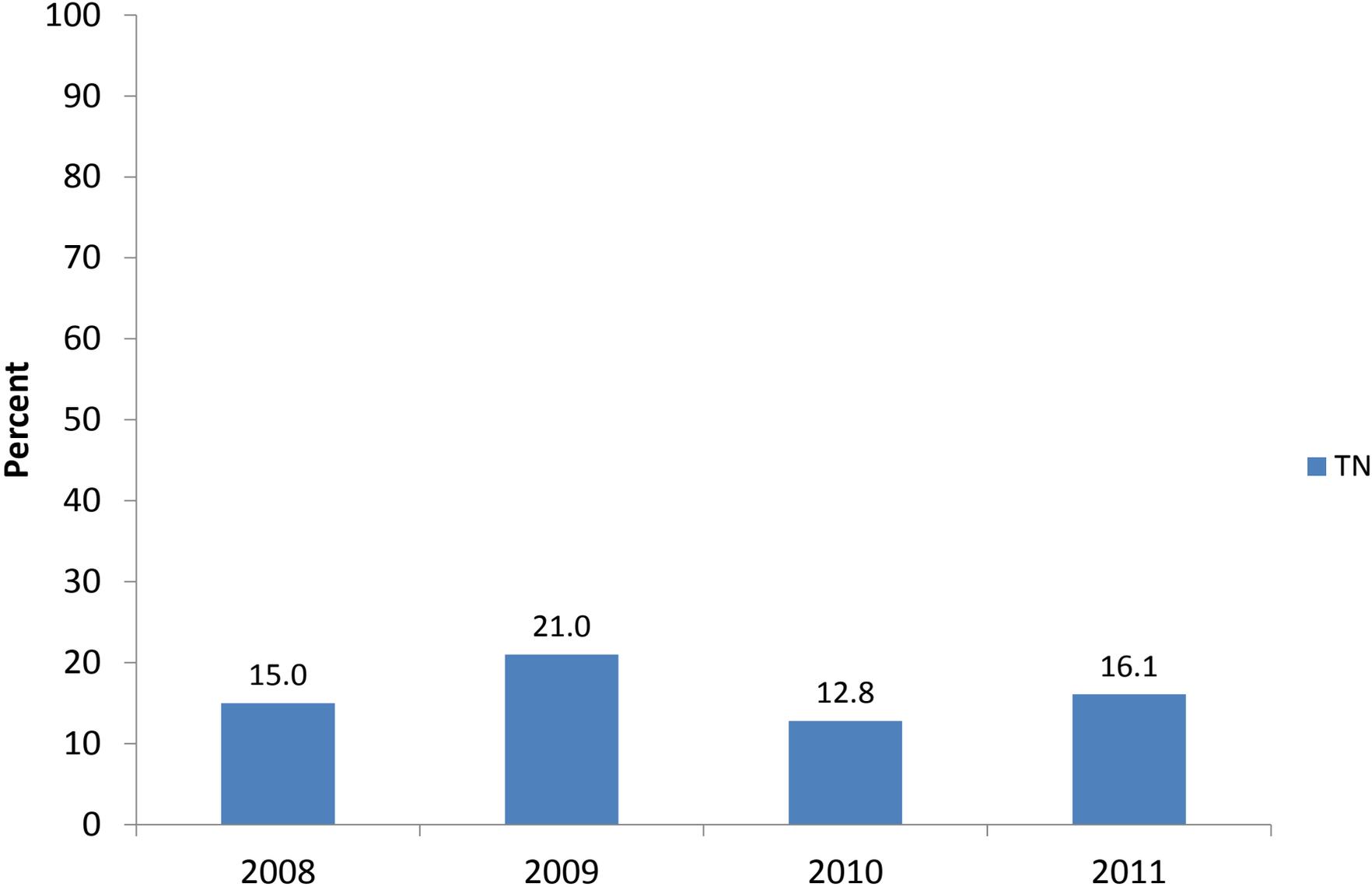


Data sources: 1) Tennessee Department of Health; Division of Policy, Planning and Assessment; Birth Statistical System. 2) Centers for Disease Control and Prevention (CDC). Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2013.

Women Aged 18-44 Years Reporting “Not Good” Mental Health for More than 14 of the Last 30 days

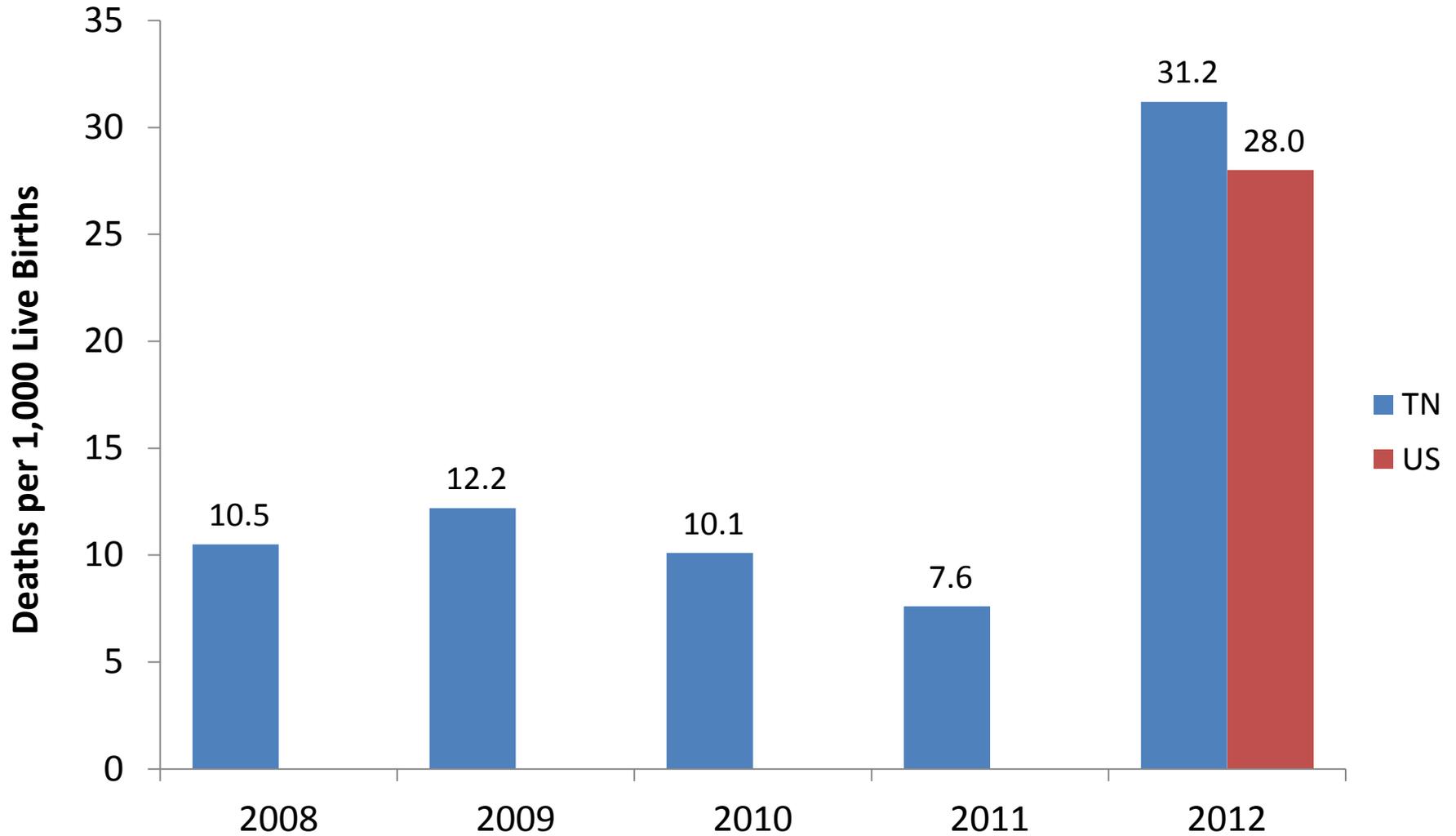


New Mothers with Postpartum Depression



Data Source: Tennessee Department of Health; Division of Policy, Planning and Assessment; TN PRAMS 2008-2011 Summary Reports.

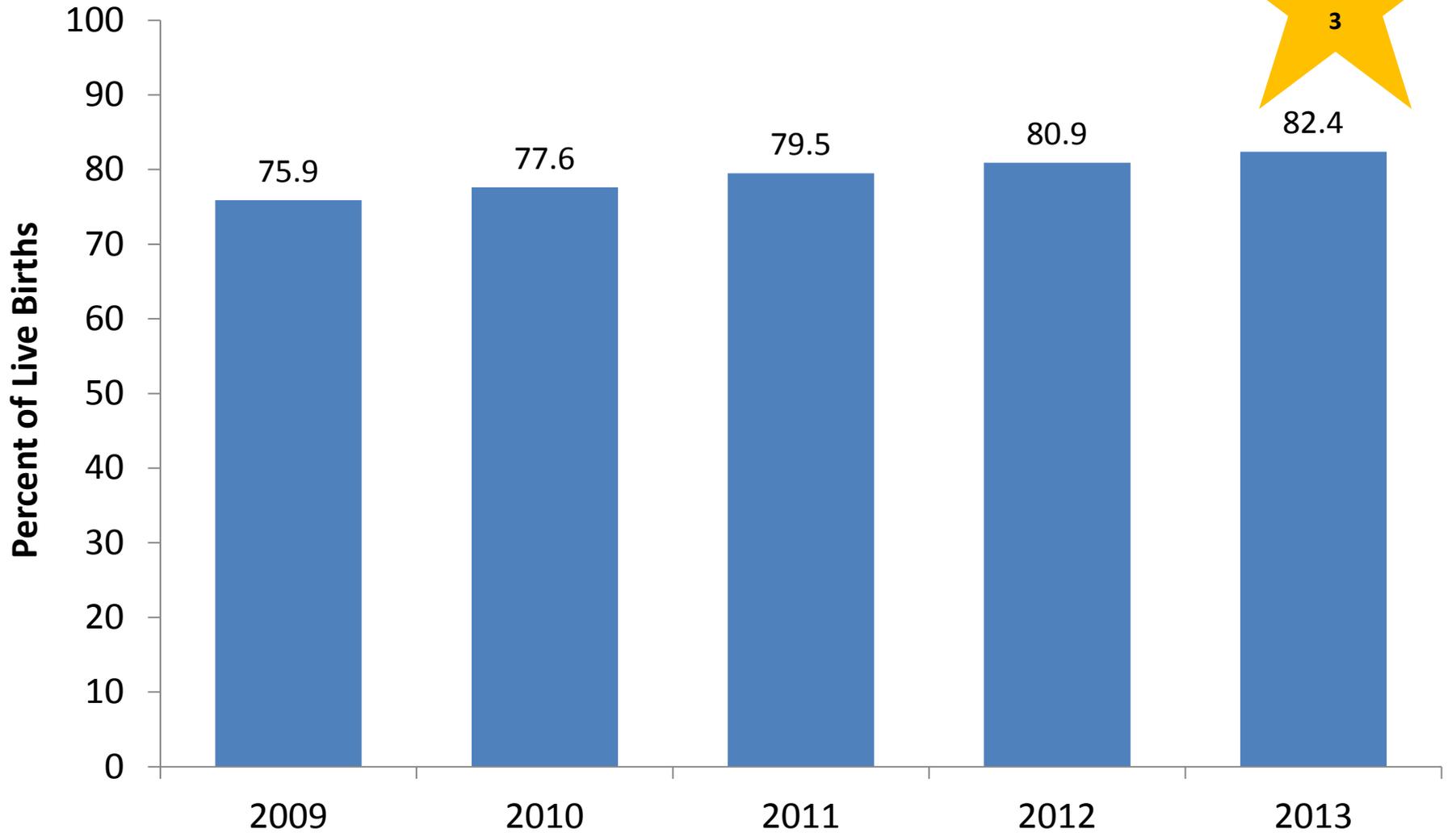
Maternal Mortality



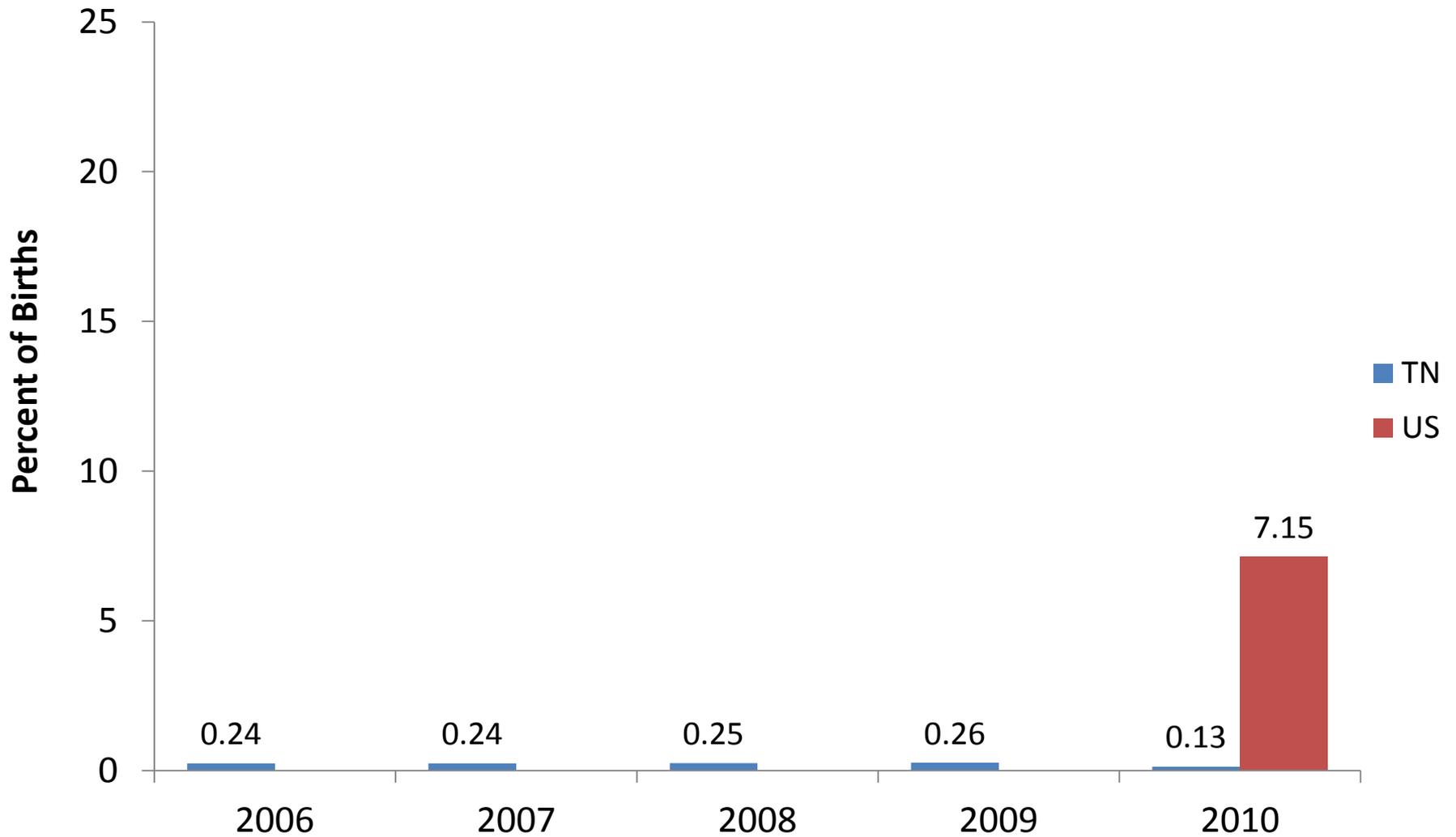
Data sources: 1) Tennessee Department of Health; Division of Policy, Planning and Assessment; Death and Birth Statistical Systems. Maternal deaths identified using underlying cause of death ICD-10 codes A34, O00-O95 and O98-O99. 2) World Health Organization, WHO, UNICEF, UNFPA, The World Bank, and UN Division Maternal Mortality Estimation Inter-Agency Group, Maternal Mortality in 1990-2013, Accessed March 2015, http://www.who.int/gho/maternal_health/countries/en/#U.

PERINATAL AND INFANT HEALTH

Very Low Birthweight Infants Born at Hospitals with Level 3 or Higher NICUs

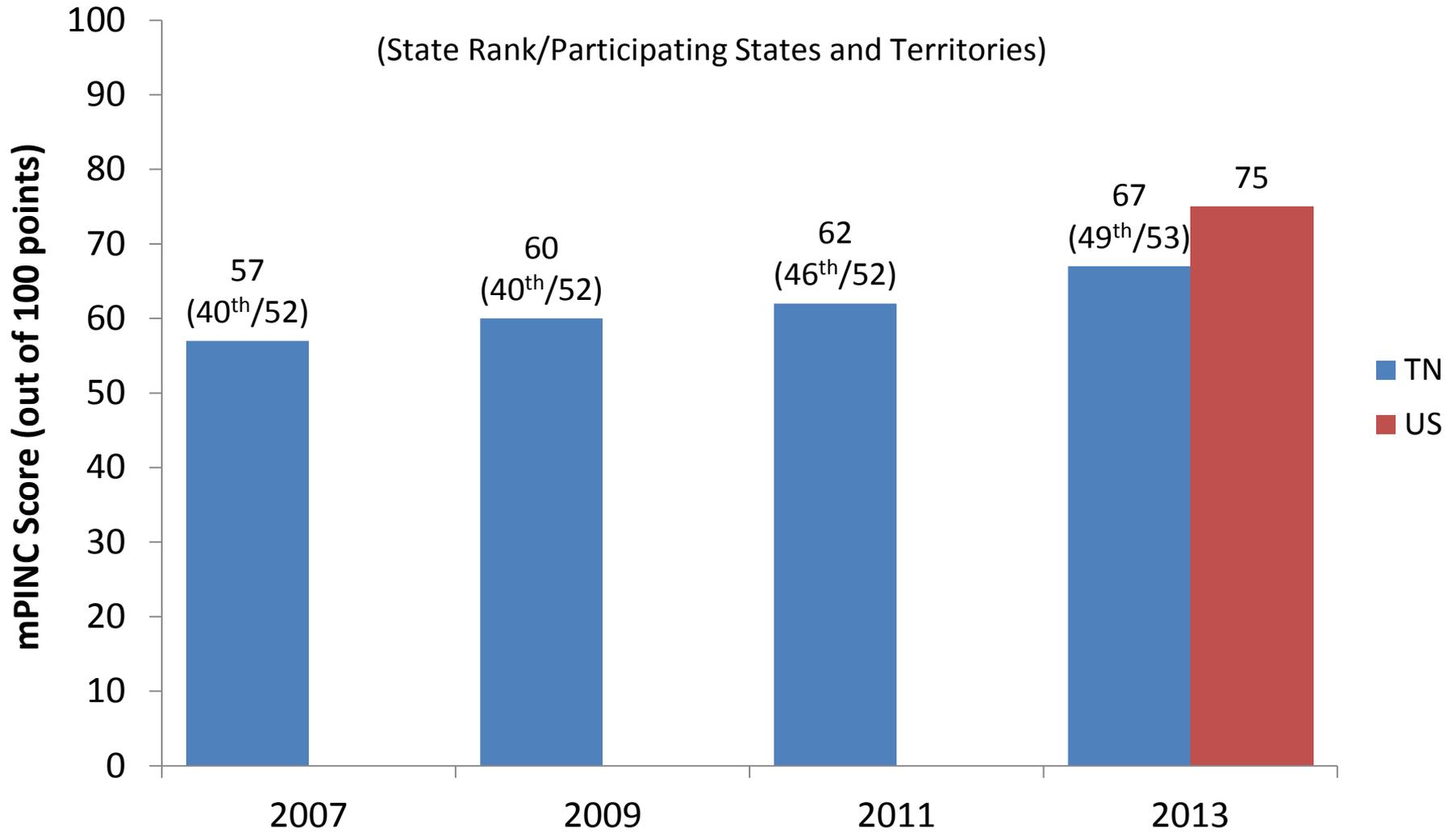


Births at Baby-Friendly Facilities



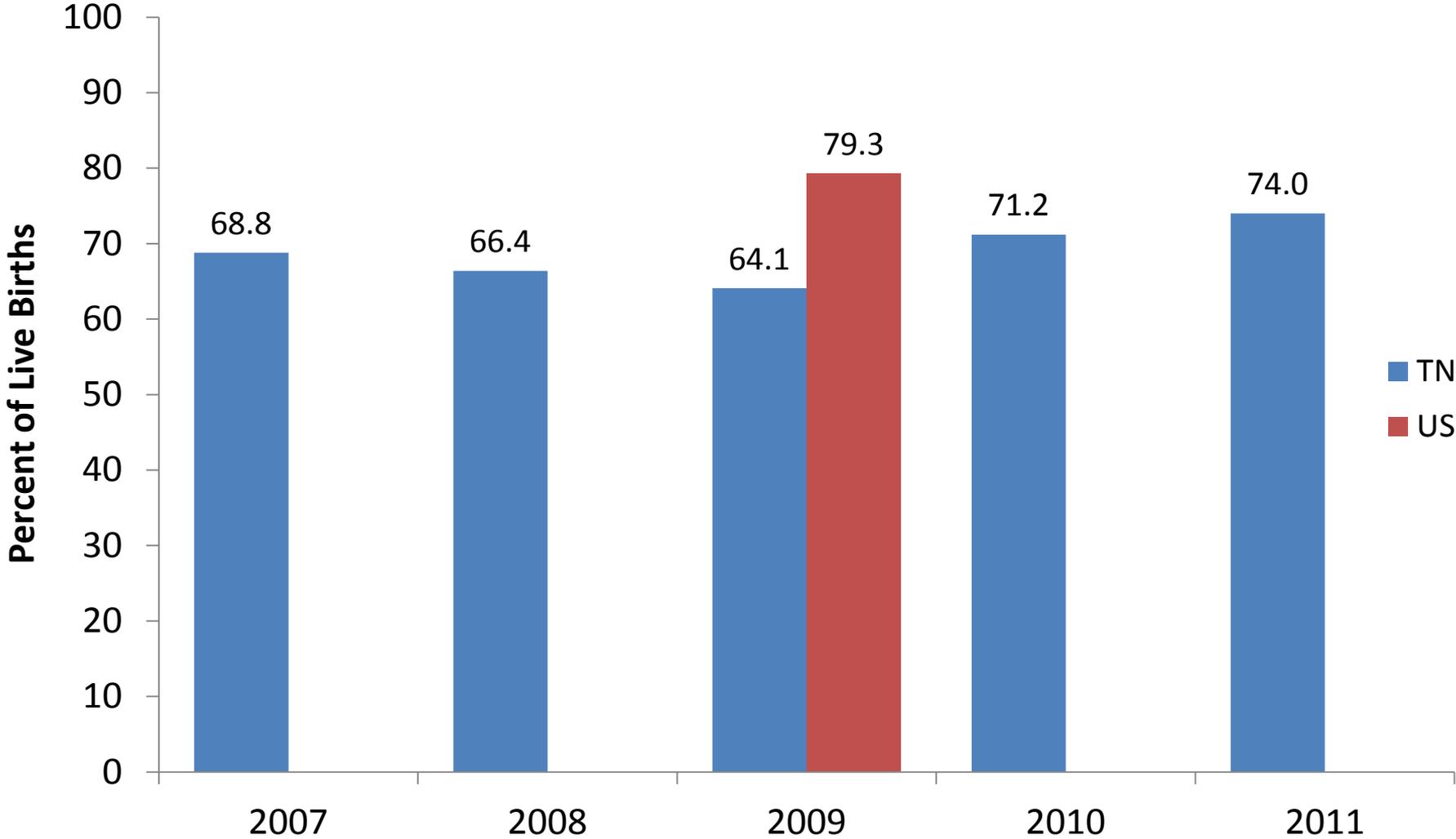
Data source: Division of Nutrition, Physical Activity, and Obesity, National Center for Chronic Disease Prevention and Health Promotion. Breastfeeding Report Card. Accessed 25 February, 2015 at <http://www.cdc.gov/breastfeeding/data/reportcard.htm>.

mPINC Breastfeeding Quality Practice Score and State Ranking*



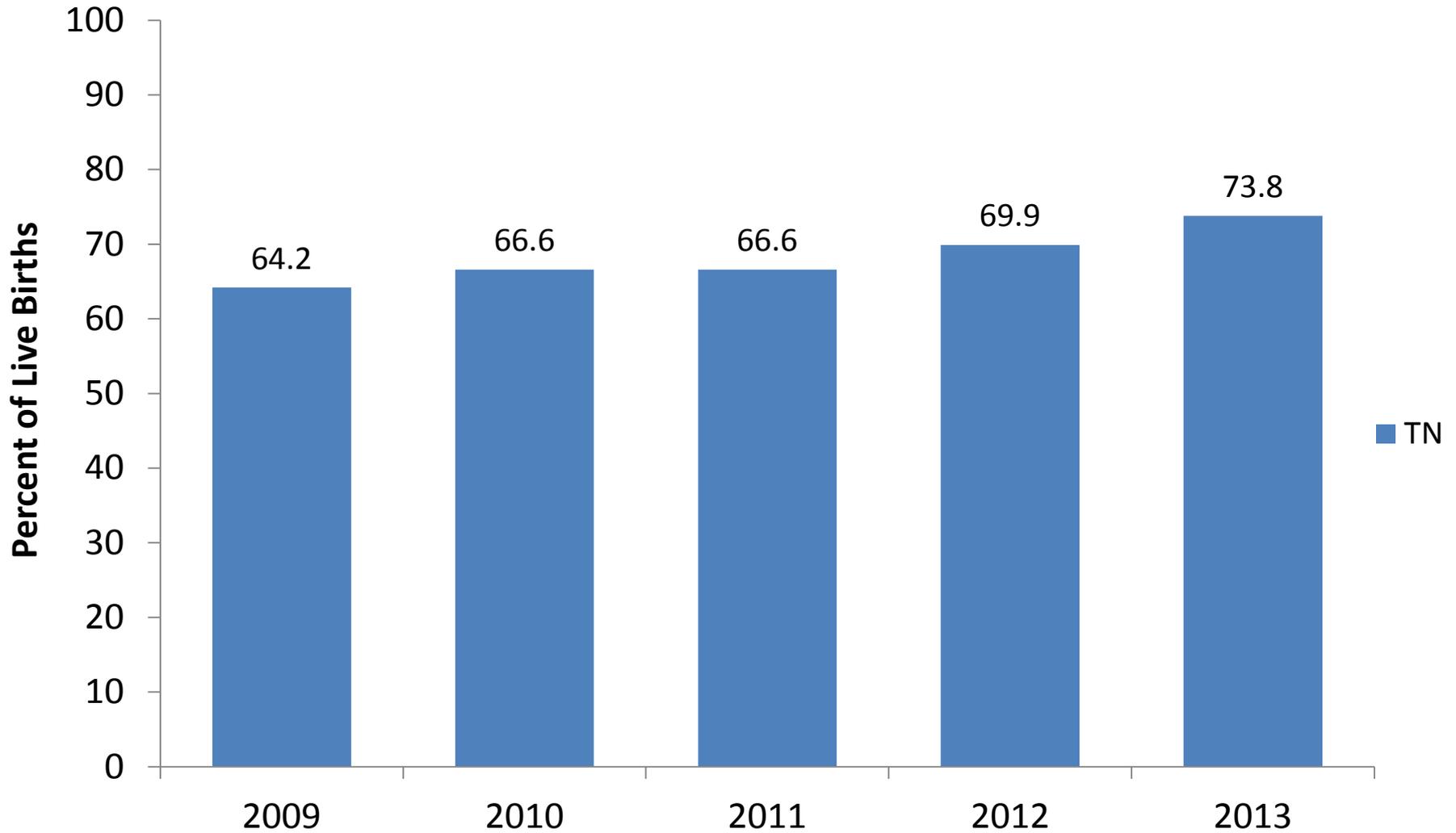
Data source: Division of Nutrition, Physical Activity, and Obesity, National Center for Chronic Disease Prevention and Health Promotion. Maternity Practices in Infant Nutrition and Care (mPINC) Survey. Accessed 25 February, 2015 at <http://www.cdc.gov/breastfeeding/data/mpinc/index.htm>. *1=highest (i.e. best) rank

Mothers Who Initiated Breastfeeding

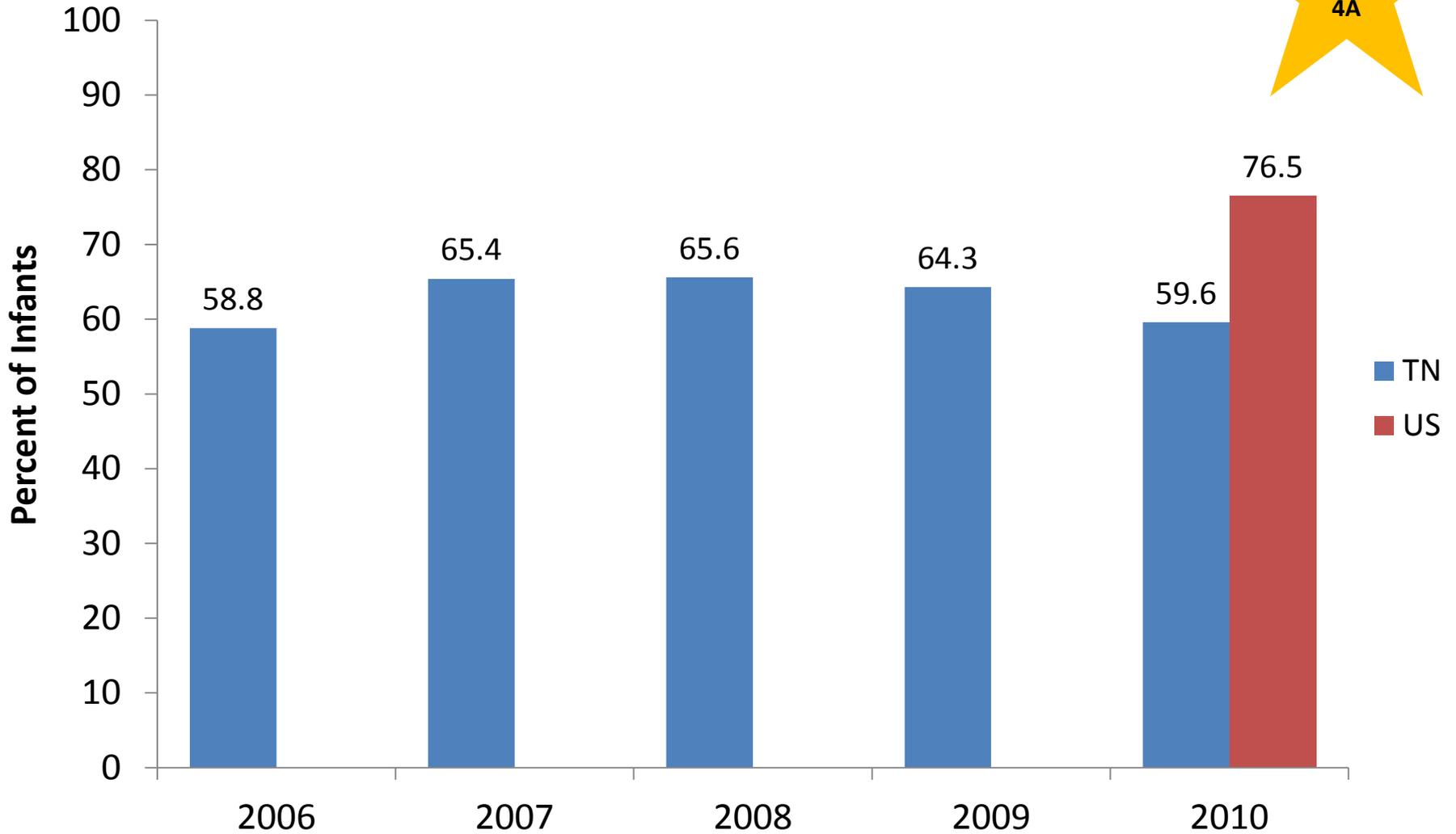


Data sources: 1) Tennessee Department of Health; Division of Policy, Planning and Assessment; Pregnancy Risk Assessment Monitoring System (PRAMS). 2) CDC PRAMS. Breastfeeding Initiation and Duration at 4 Weeks. Accessed 25 February, 2015 at <http://www.cdc.gov/prams/pdf/snapshot-report/breastfeeding.pdf>.

Infants Being Breastfed at Hospital Discharge

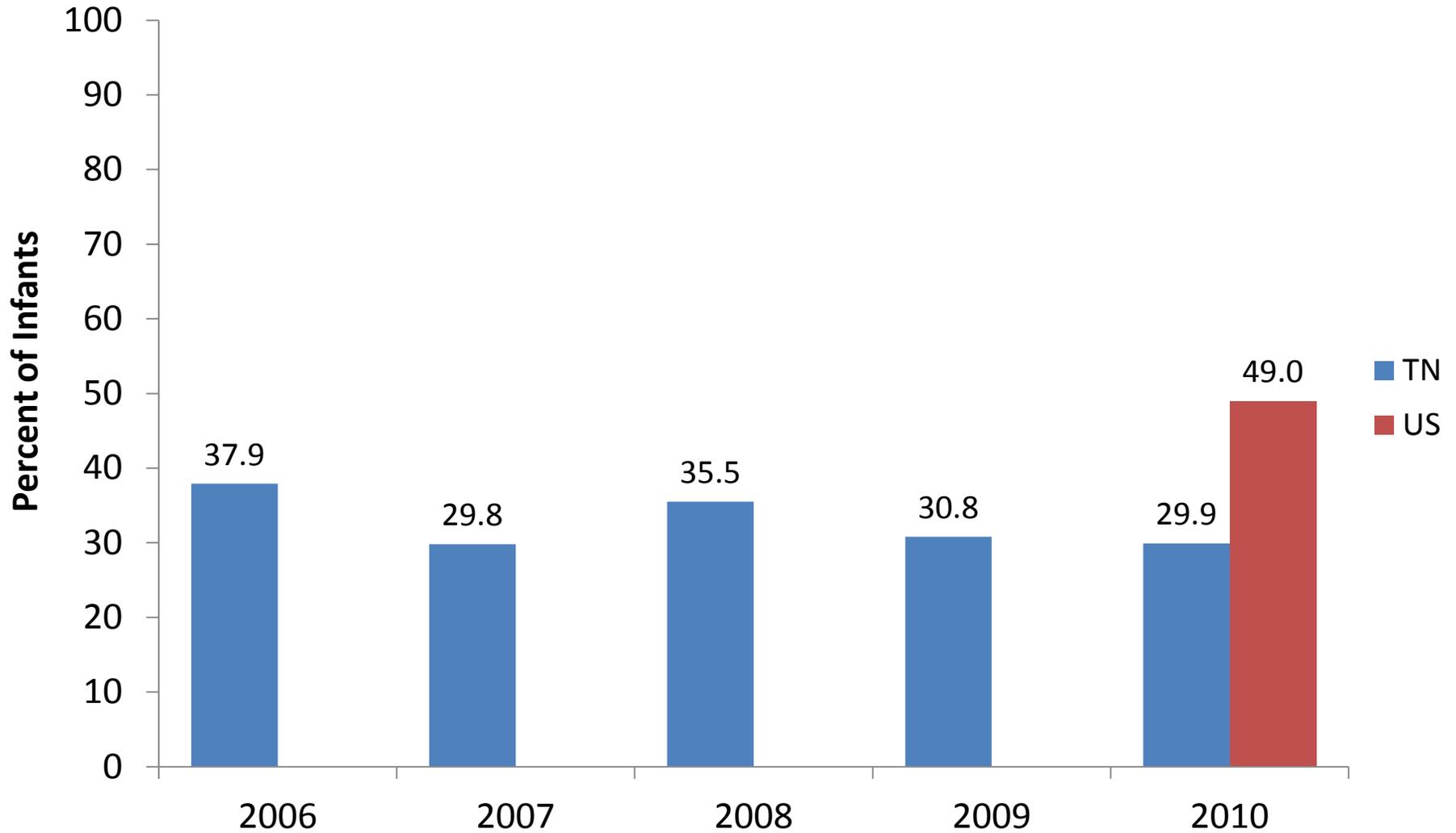


Infants Who Were Ever Breastfed



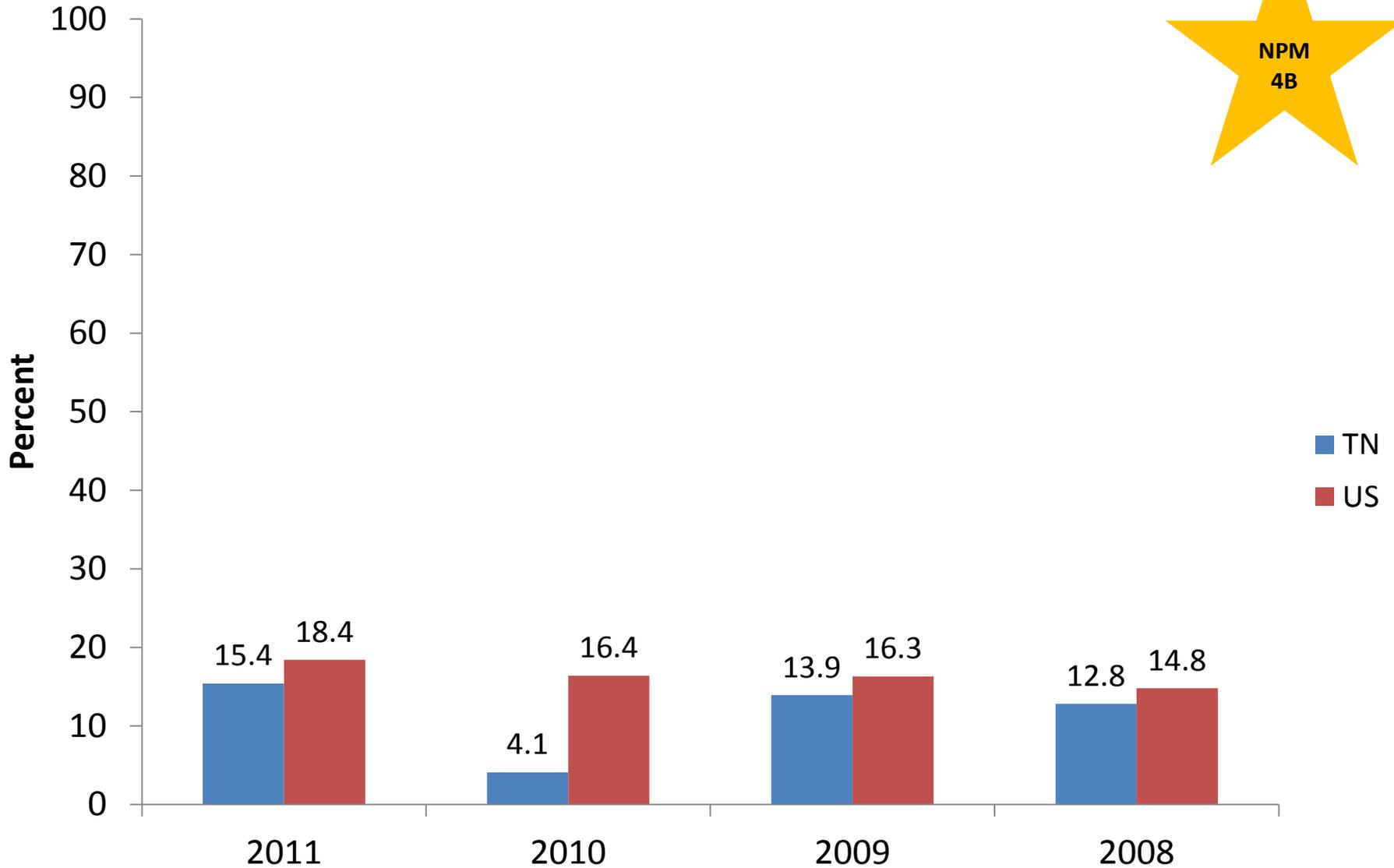
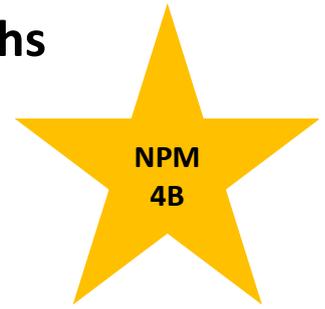
Data source: Division of Nutrition, Physical Activity, and Obesity, National Center for Chronic Disease Prevention and Health Promotion. Breastfeeding Report Card. Accessed 25 February, 2015 at <http://www.cdc.gov/breastfeeding/data/reportcard.htm>.

Infants Who Were Breastfed at 6 Months



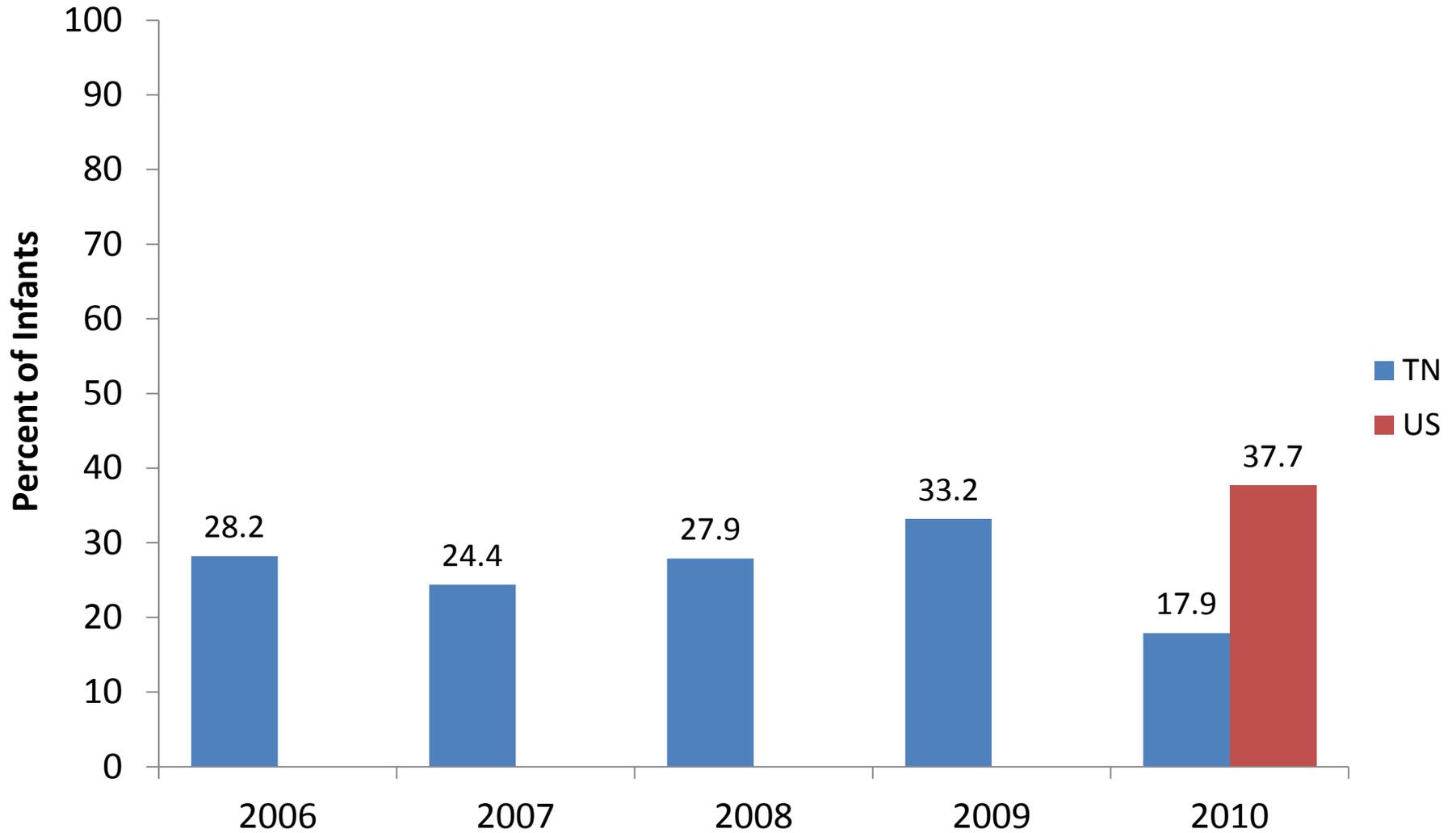
Data source: Division of Nutrition, Physical Activity, and Obesity, National Center for Chronic Disease Prevention and Health Promotion. Breastfeeding Report Card. Accessed 25 February, 2015 at <http://www.cdc.gov/breastfeeding/data/reportcard.htm>.

Percent of Infants Breastfed Exclusively Through 6 Months



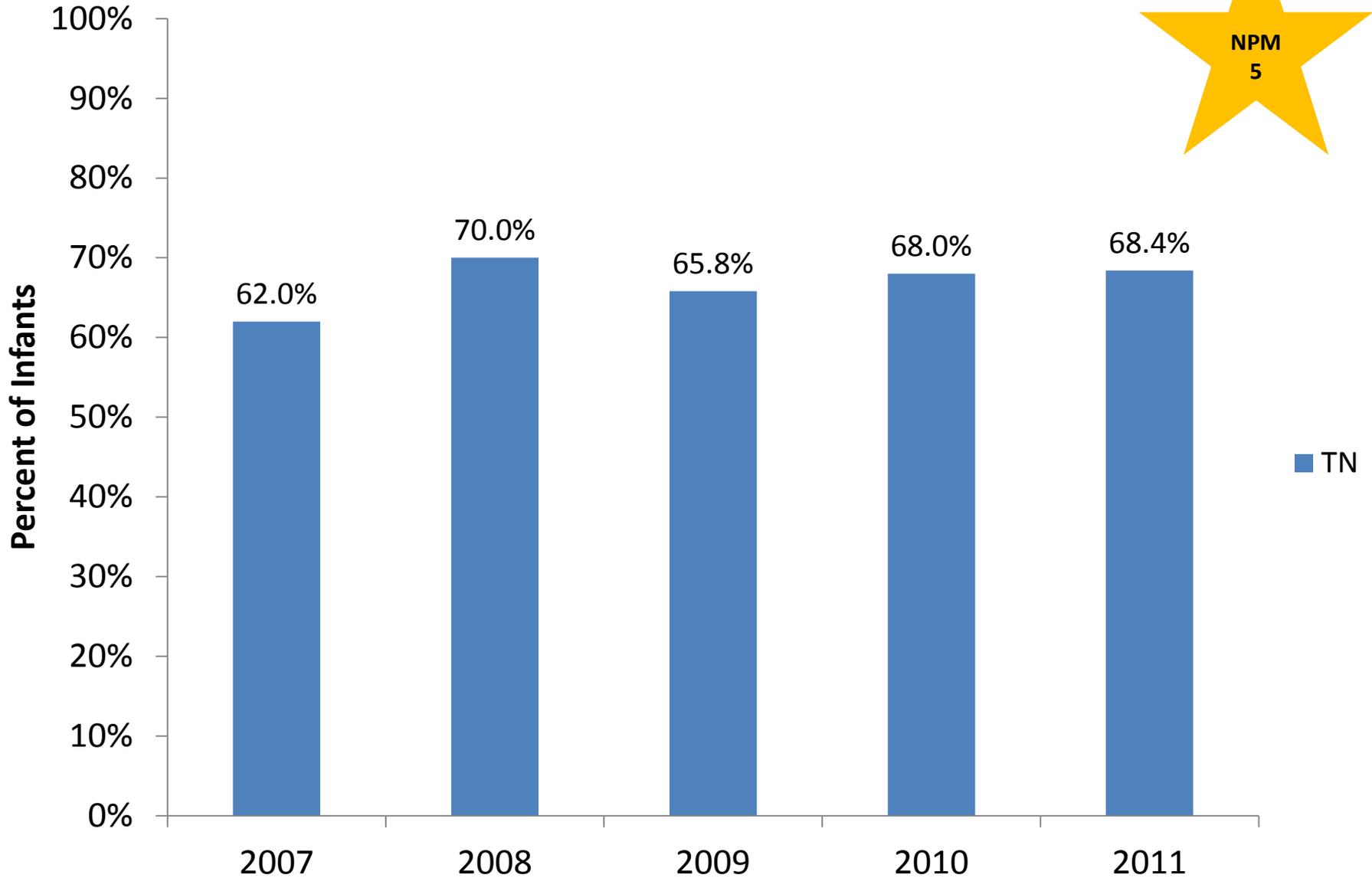
Data source: Division of Nutrition, Physical Activity, and Obesity, National Center for Chronic Disease Prevention and Health Promotion. Breastfeeding Report Card. Accessed 25 February, 2015 at <http://www.cdc.gov/breastfeeding/data/reportcard.htm>.

Infants Who Were Exclusively Breastfed through 3 Months

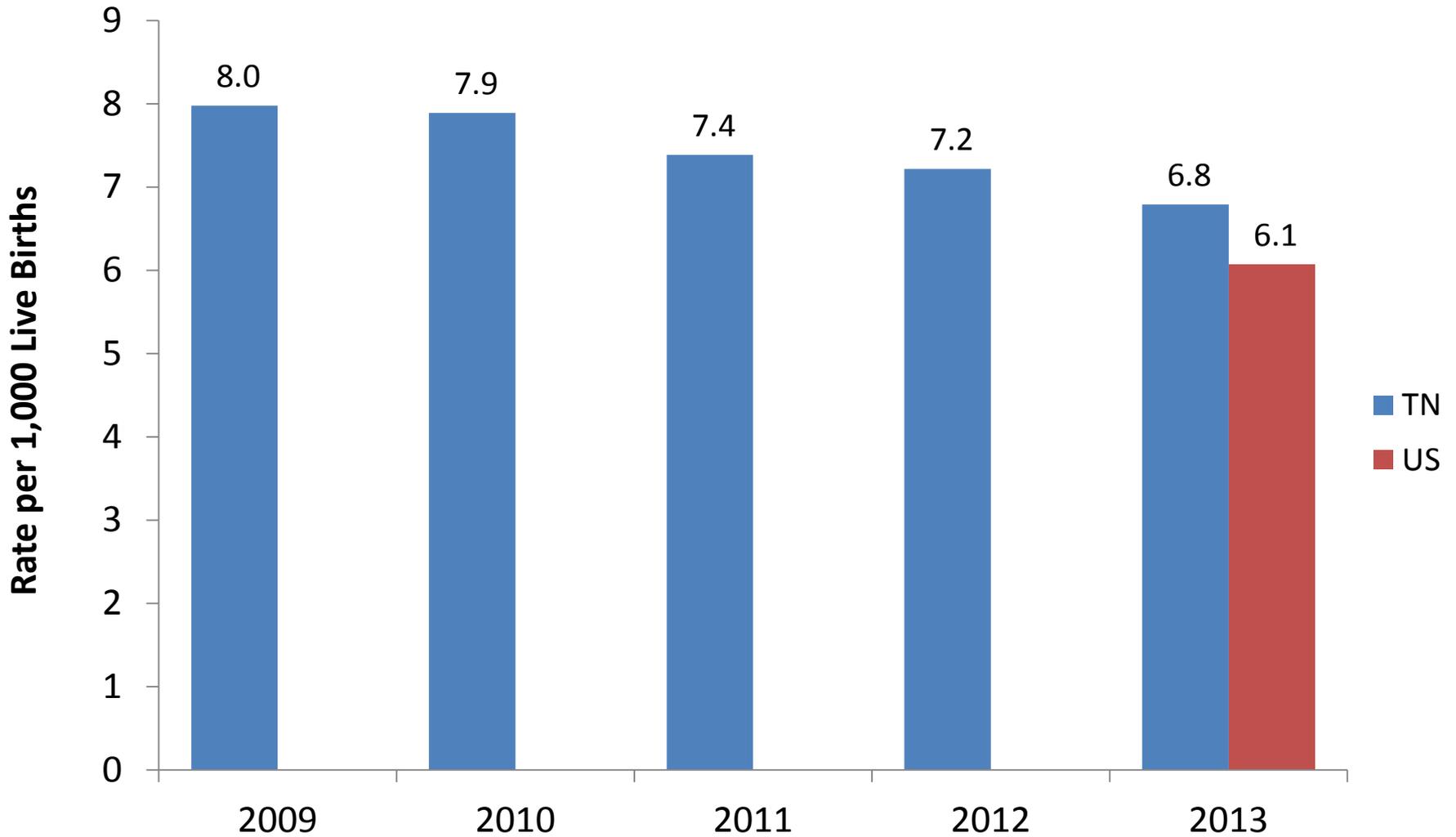


Data source: Division of Nutrition, Physical Activity, and Obesity, National Center for Chronic Disease Prevention and Health Promotion. Breastfeeding Report Card. Accessed 25 February, 2015 at <http://www.cdc.gov/breastfeeding/data/reportcard.htm>.

Infants Placed of Their Back to Sleep

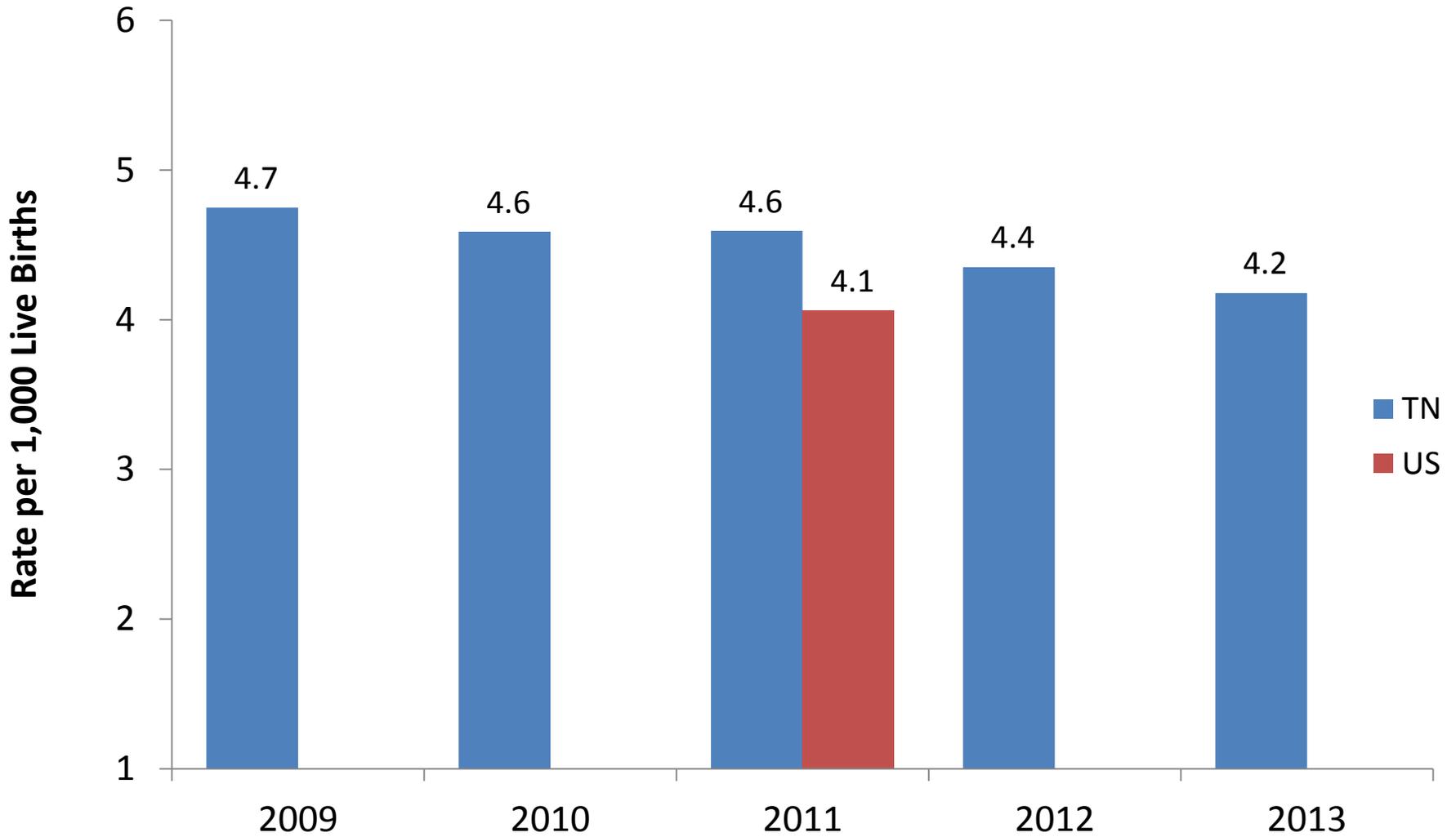


Infant Mortality



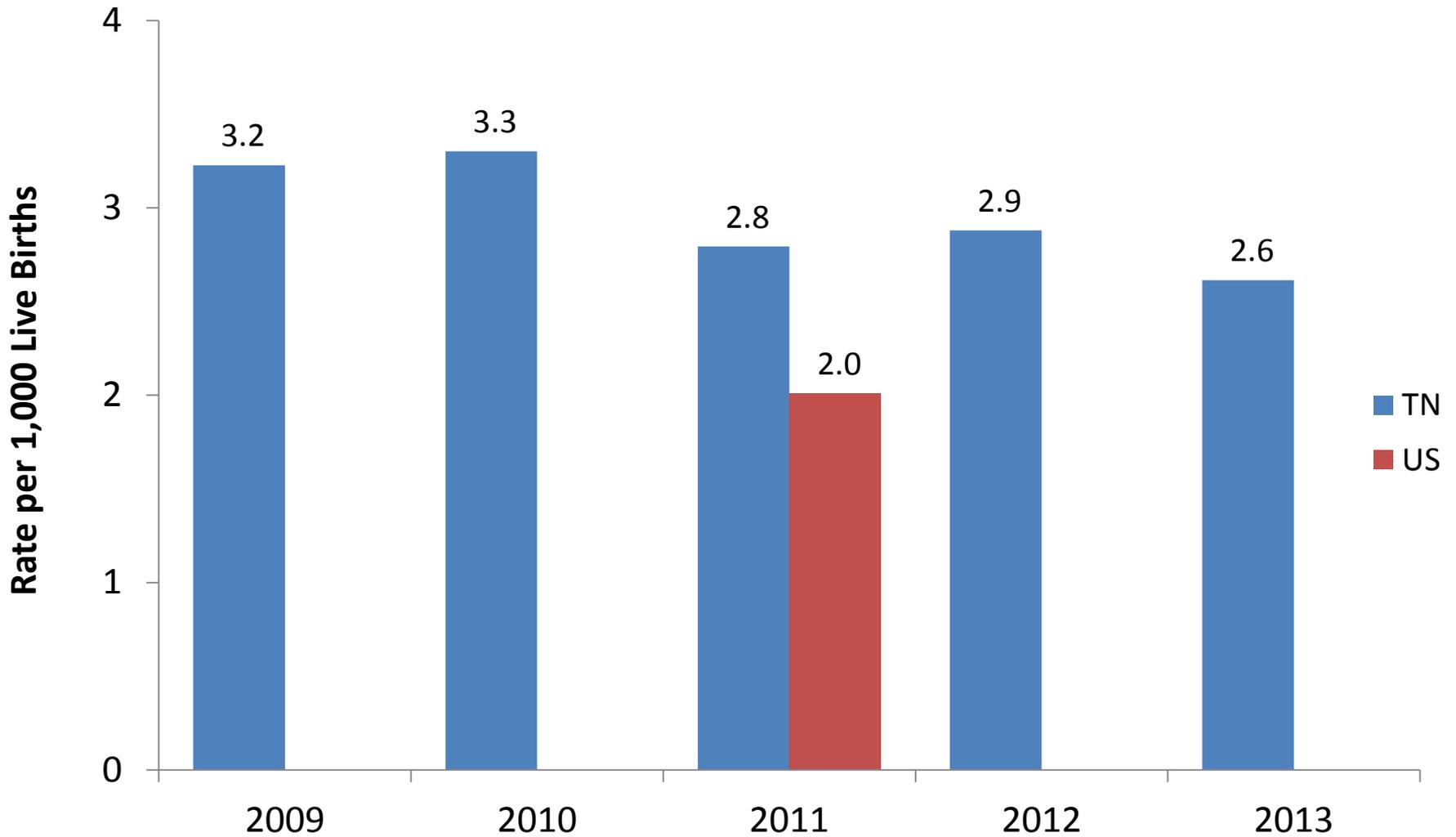
Data sources: 1) Tennessee Department of Health; Division of Policy, Planning and Assessment, Death Statistical System. 2) U.S. Department of Health and Human Services, Health Resources and Services Administration, Centers for Disease Control and Prevention. Division of Vital Statistics, Linked Birth/Infant Death Records 1995-2012 on CDC WONDER Online Database. Accessed in January, 2015.

Neonatal Mortality



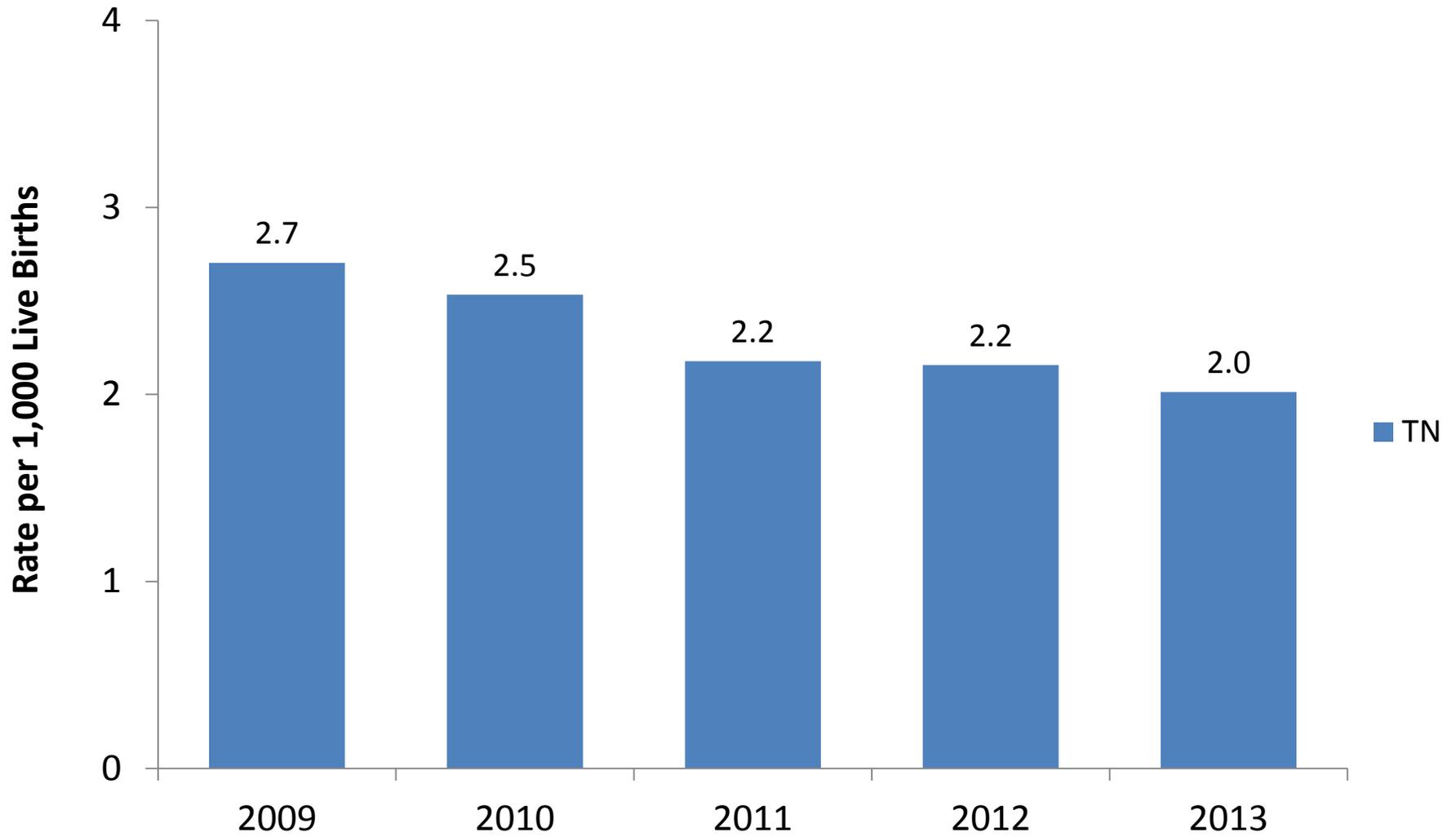
Data sources: 1) Tennessee Department of Health; Division of Policy, Planning and Assessment, Death Statistical System. 2) U.S. Department of Health and Human Services, Health Resources and Services Administration, Centers for Disease Control and Prevention. Division of Vital Statistics, Linked Birth/Infant Death Records 1995-2012 on CDC WONDER Online Database. Accessed in January, 2015.

Postneonatal Mortality

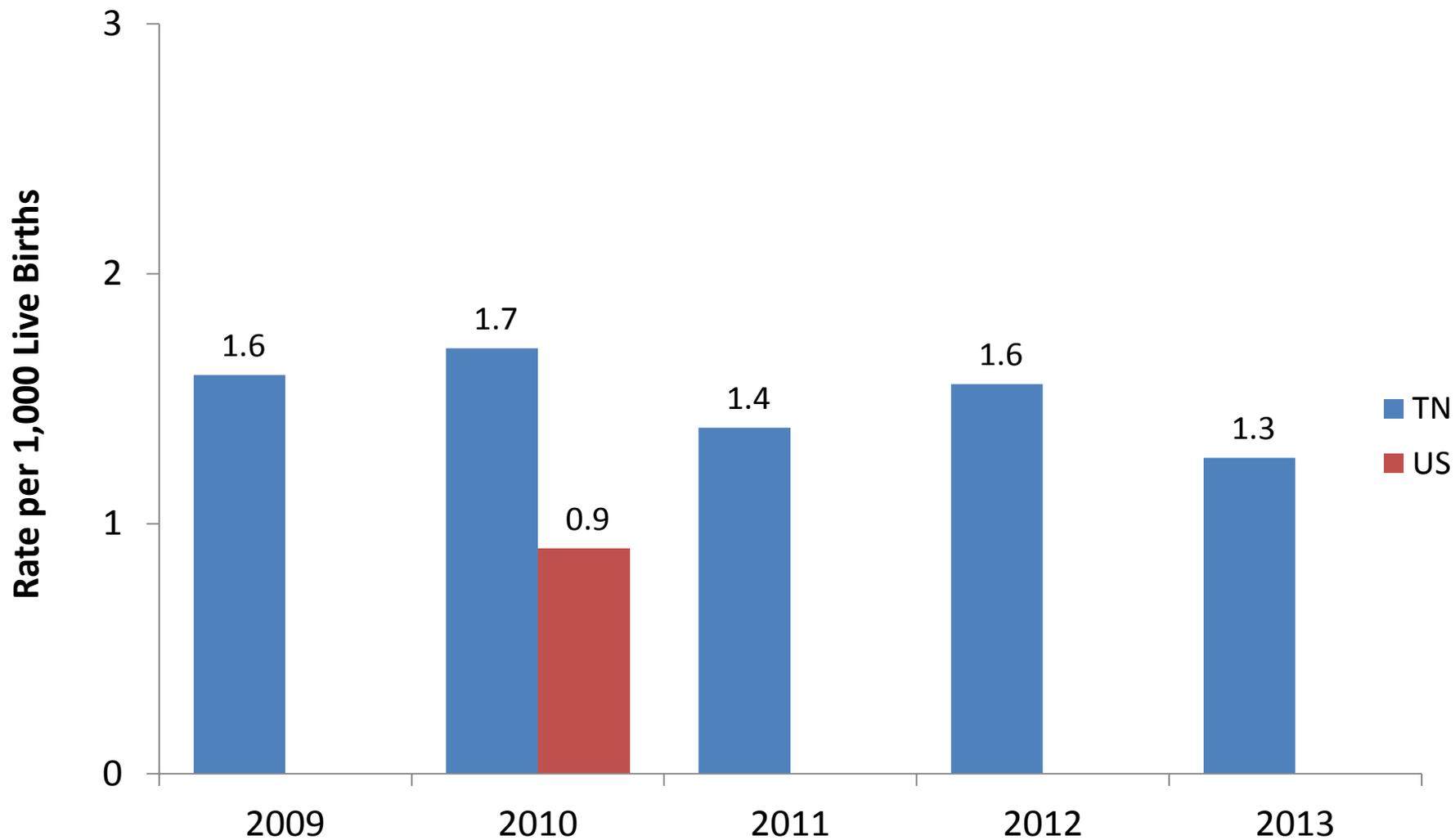


Data sources: 1) Tennessee Department of Health; Division of Policy, Planning and Assessment, Death Statistical System. 2) U.S. Department of Health and Human Services, Health Resources and Services Administration, Centers for Disease Control and Prevention. Division of Vital Statistics, Linked Birth/Infant Death Records 1995-2012 on CDC WONDER Online Database. Accessed in January, 2015.

Preterm Related Infant Deaths

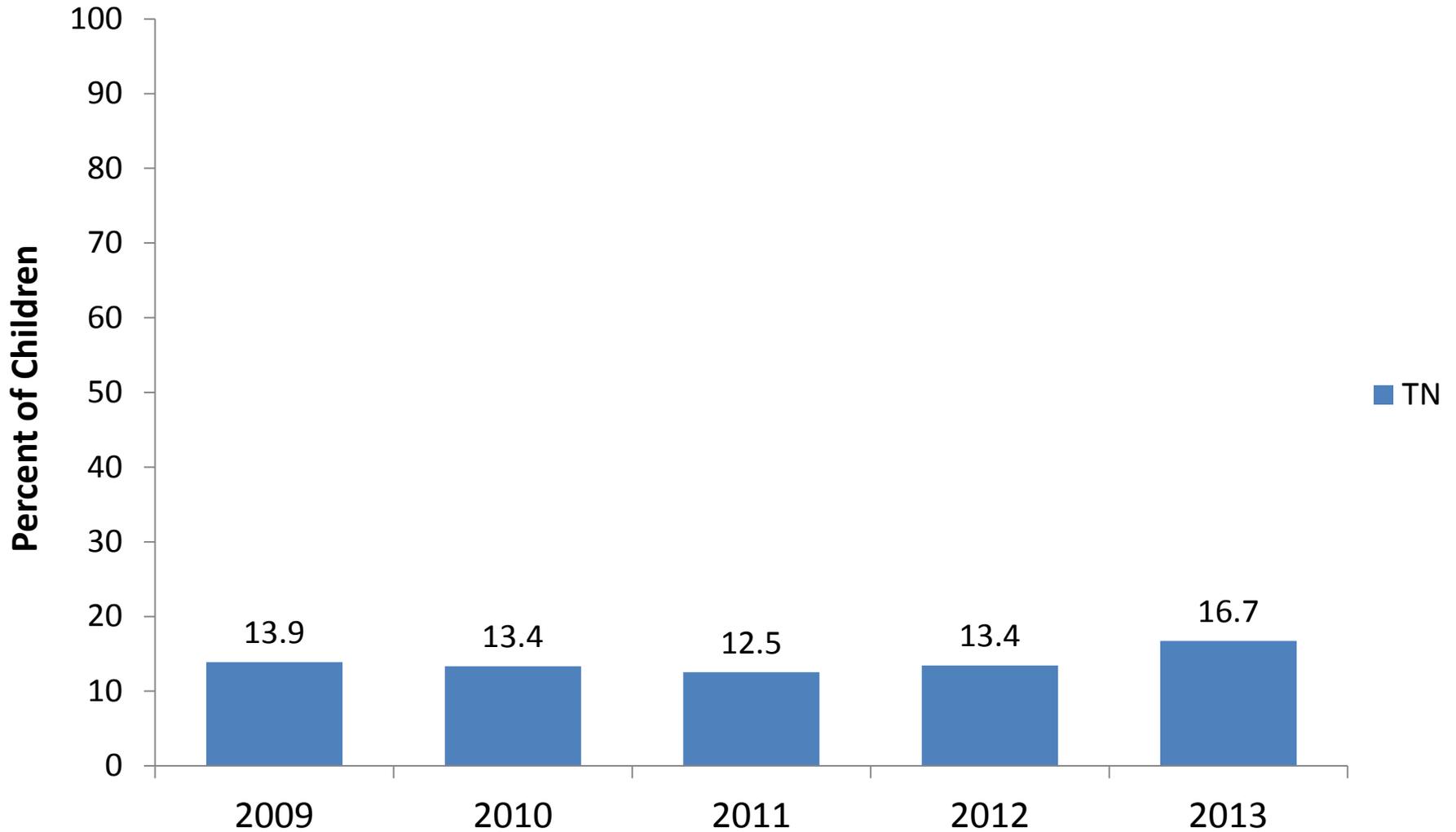


Sleep-Related SUID



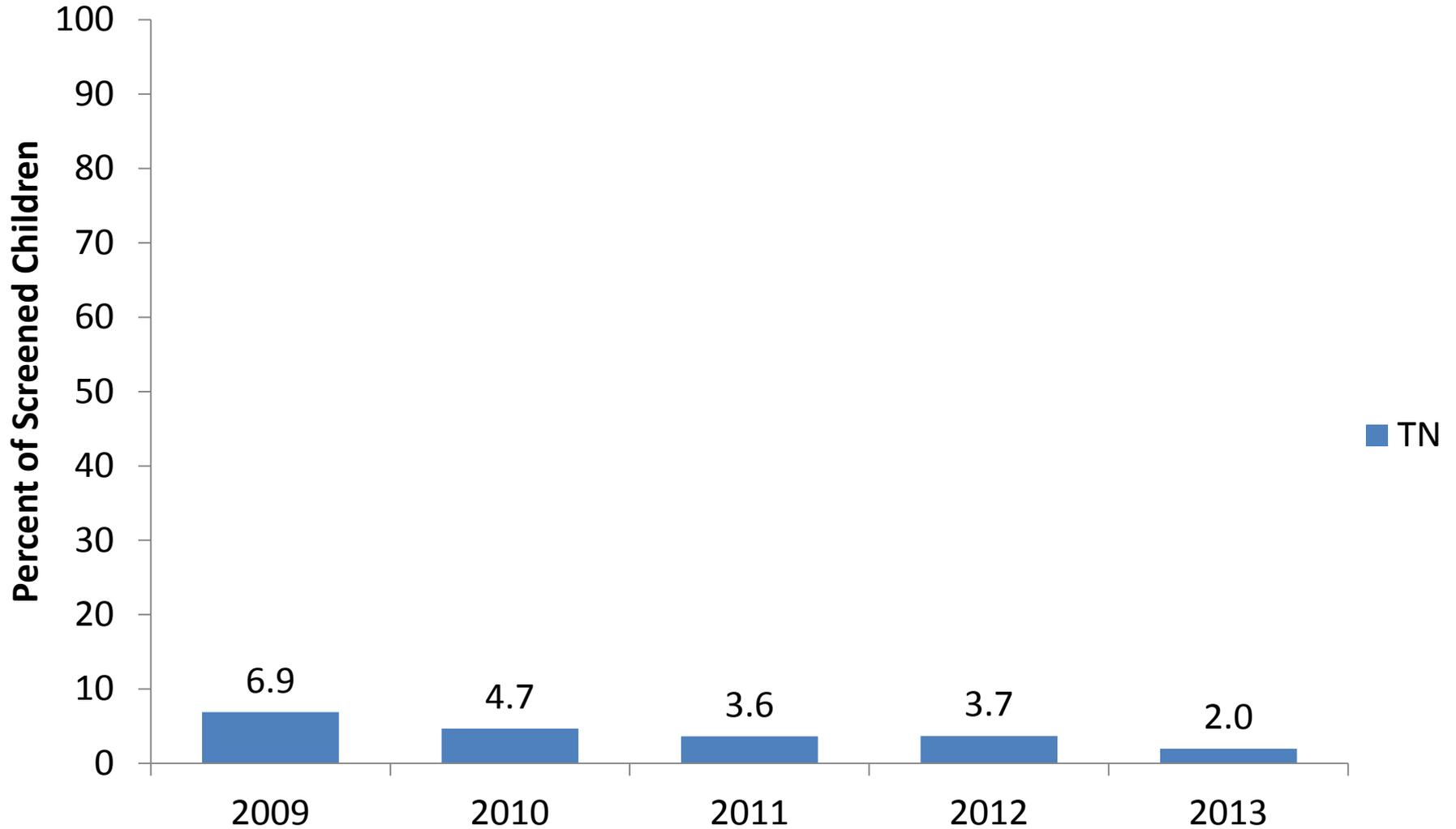
Data sources: 1) Tennessee Department of Health; Division of Policy, Planning and Assessment, Death Statistical System. 2) U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau. Child Health USA 2013. Rockville, Maryland: U.S. Department of Health and

Children Ages 0-2 Year Screened for Lead

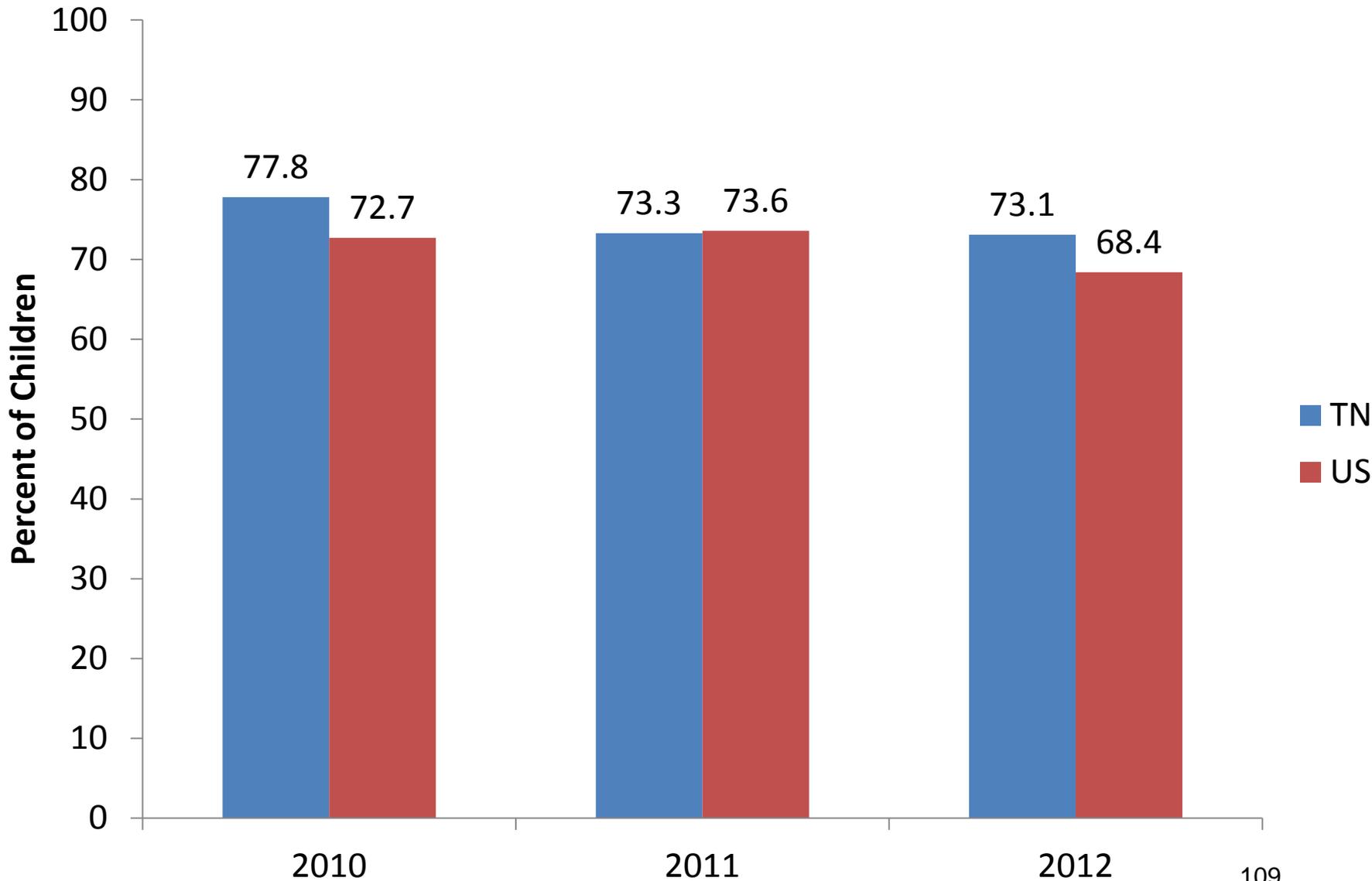


Data sources: 1) Tennessee Department of Health; Division of Family Health and Wellness, Tennessee Childhood Lead Poisoning Prevention Program, LeadTrek 2009-2013.

Percentage of Screened Children Ages 0-2 Years With Elevated Lead Levels



Percent of Children 19-35 Months With Up-to-Date Vaccinations*

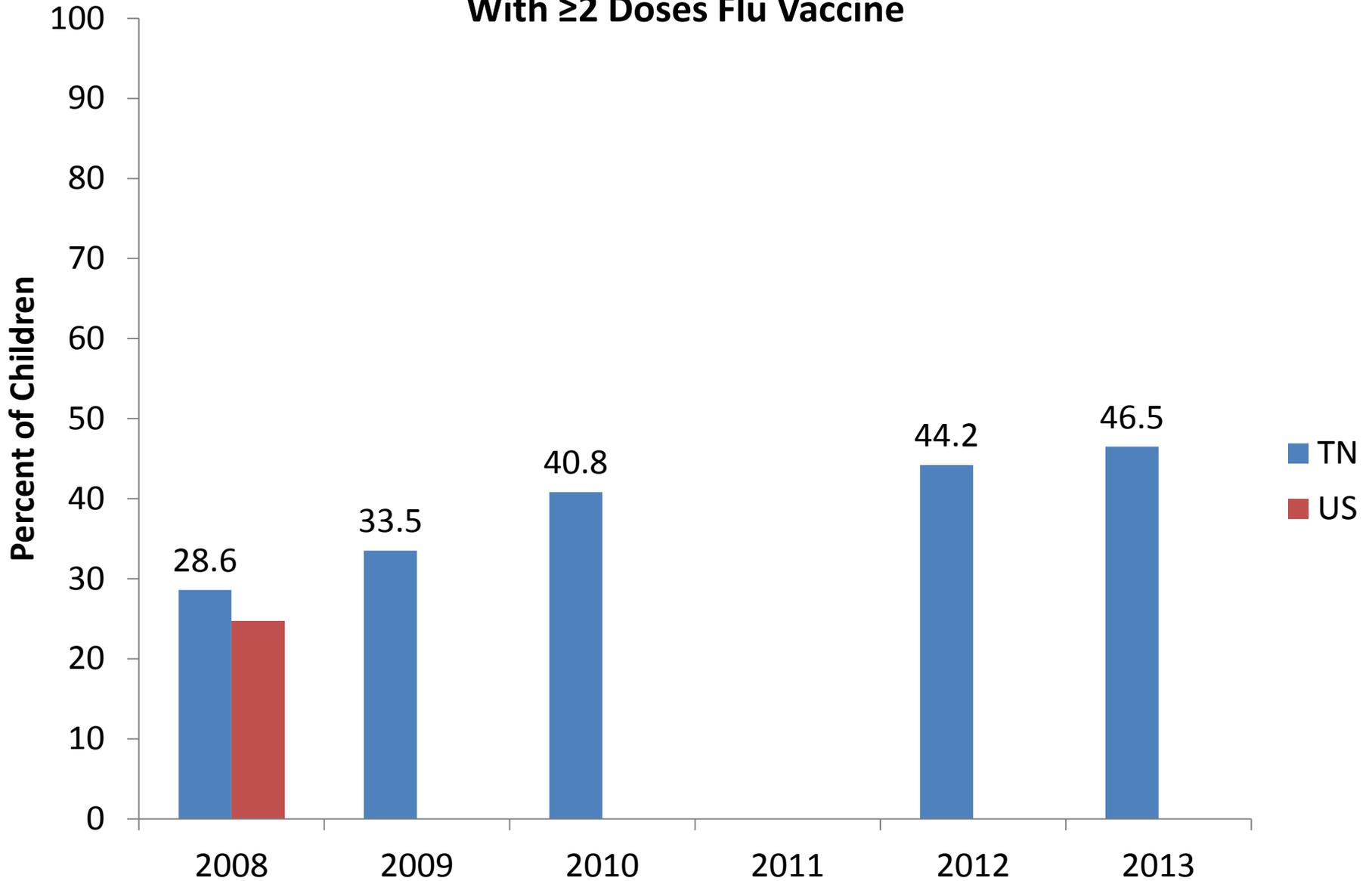


*4:3:1:3:3:1:4 Series

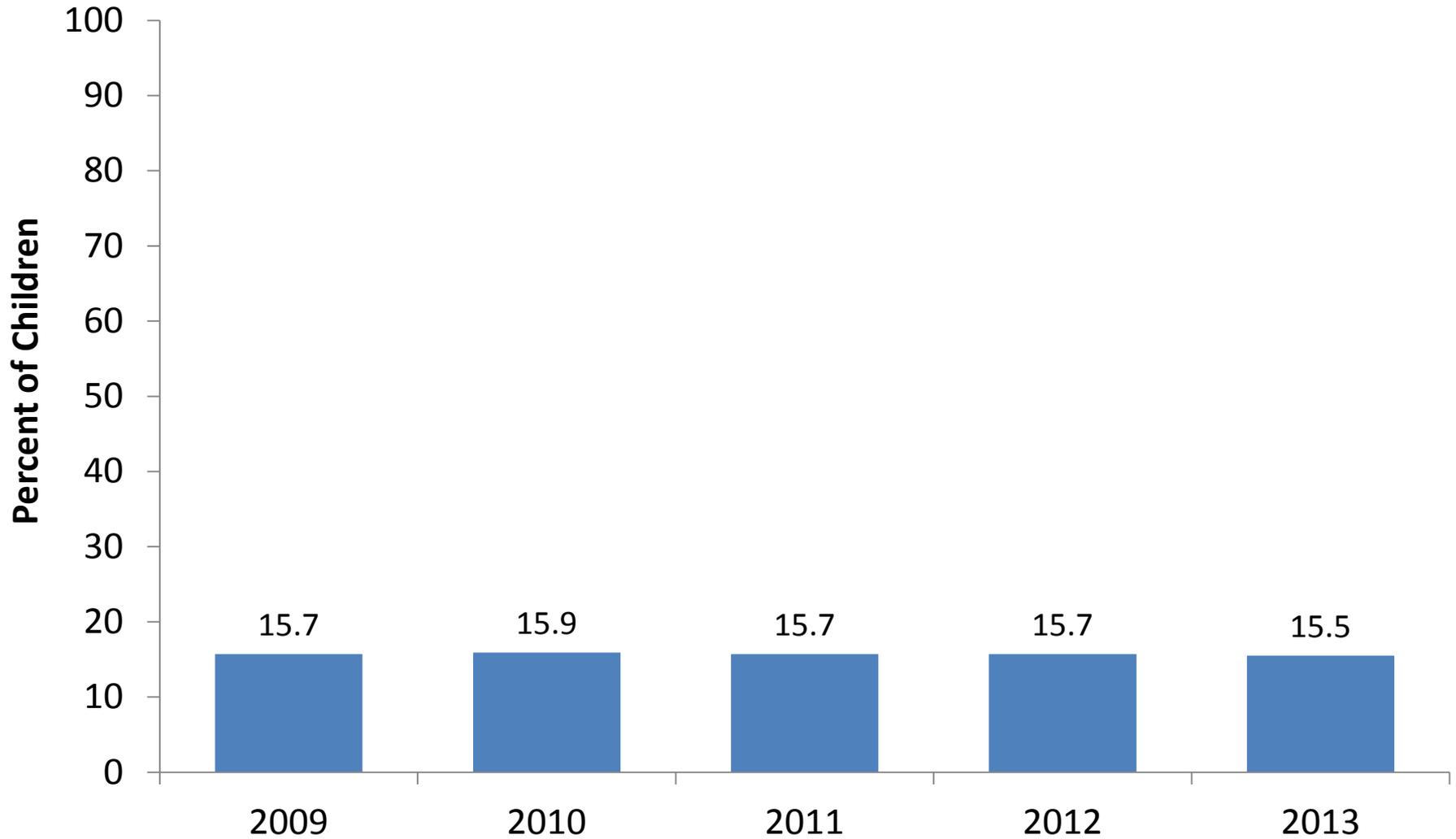
Data sources: National Immunization Survey

CHILD HEALTH

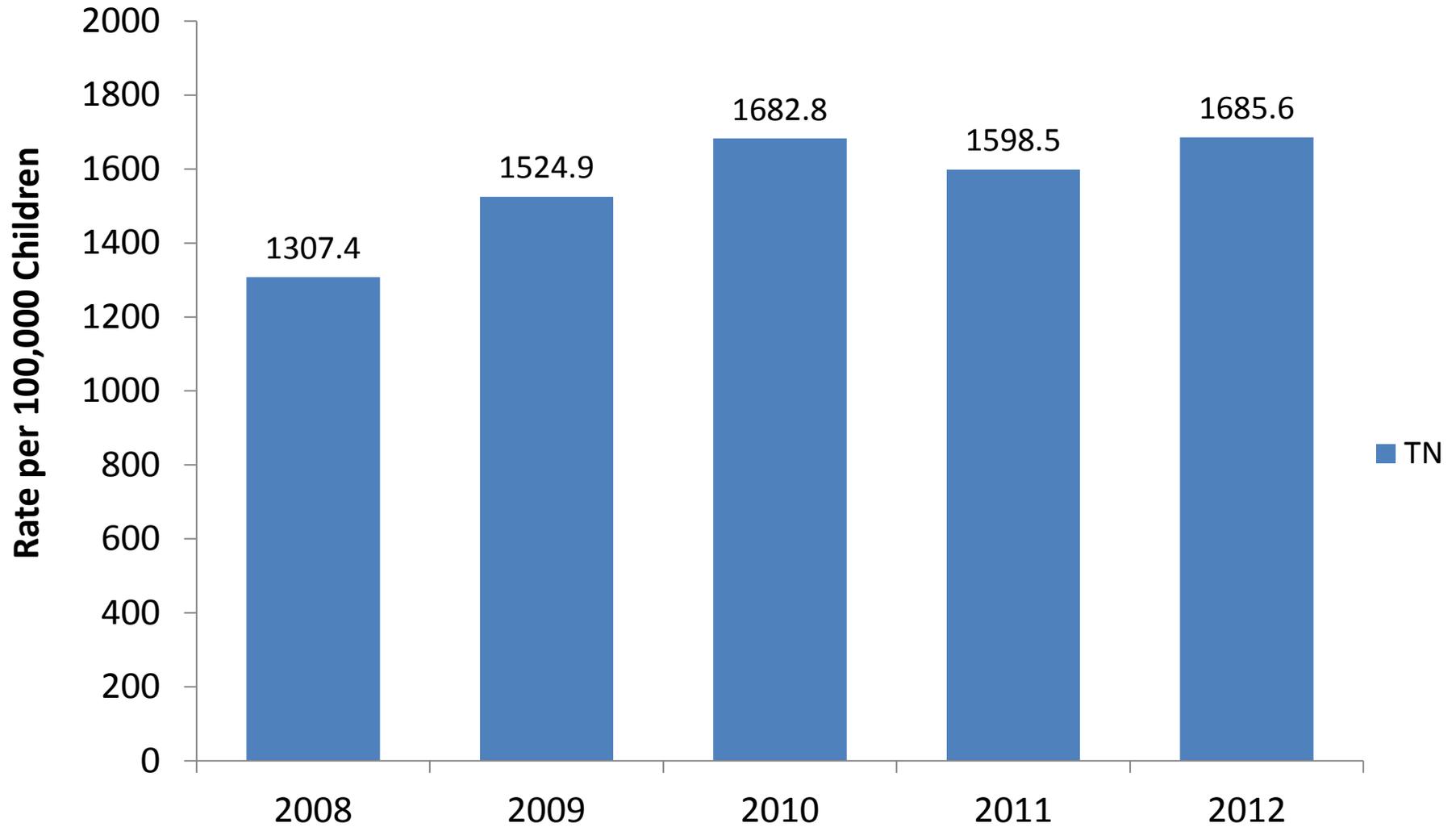
24-Month-Old Children With ≥ 2 Doses Flu Vaccine



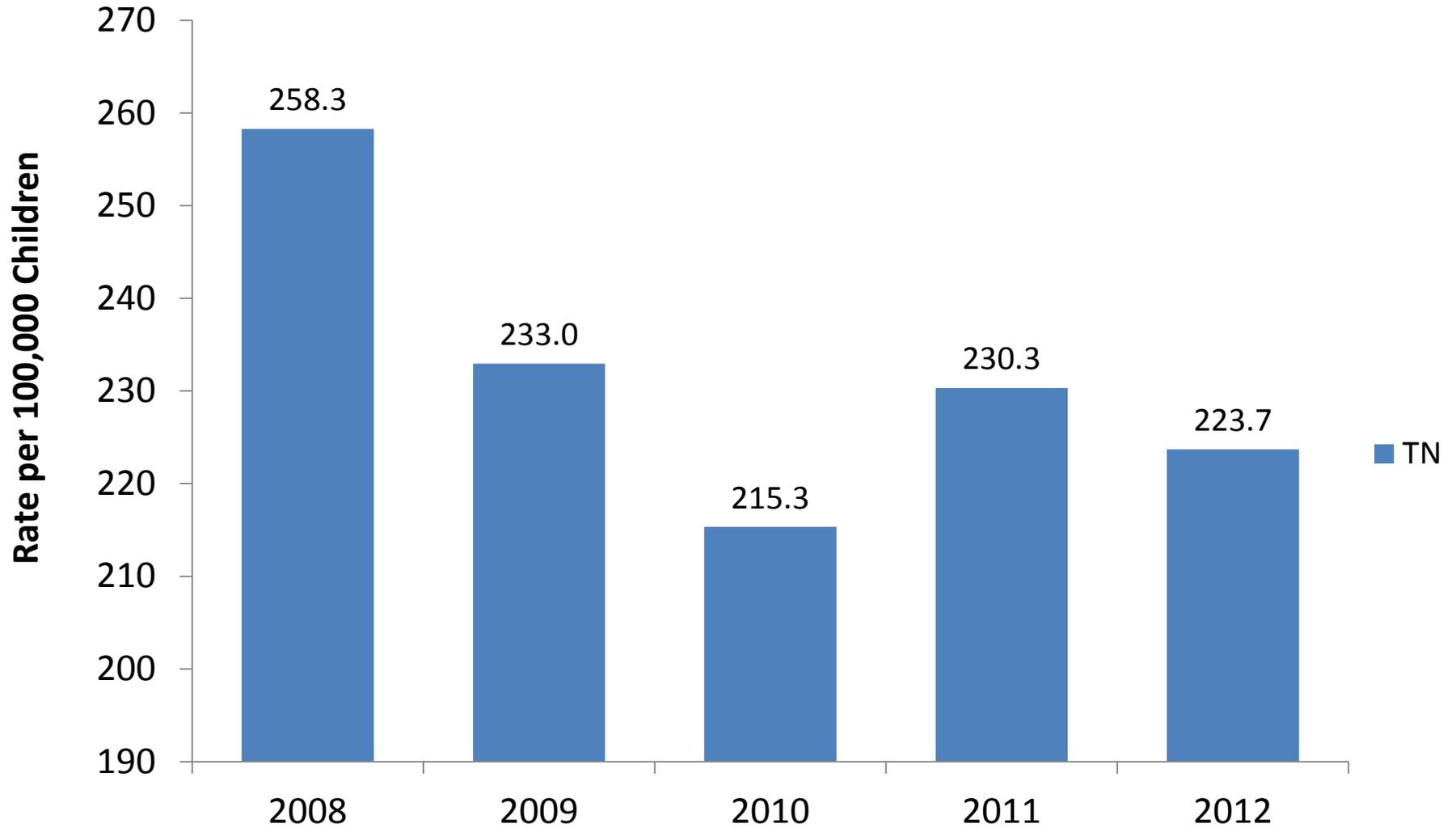
Obesity Prevalence Among WIC Children Aged 2-4 Years



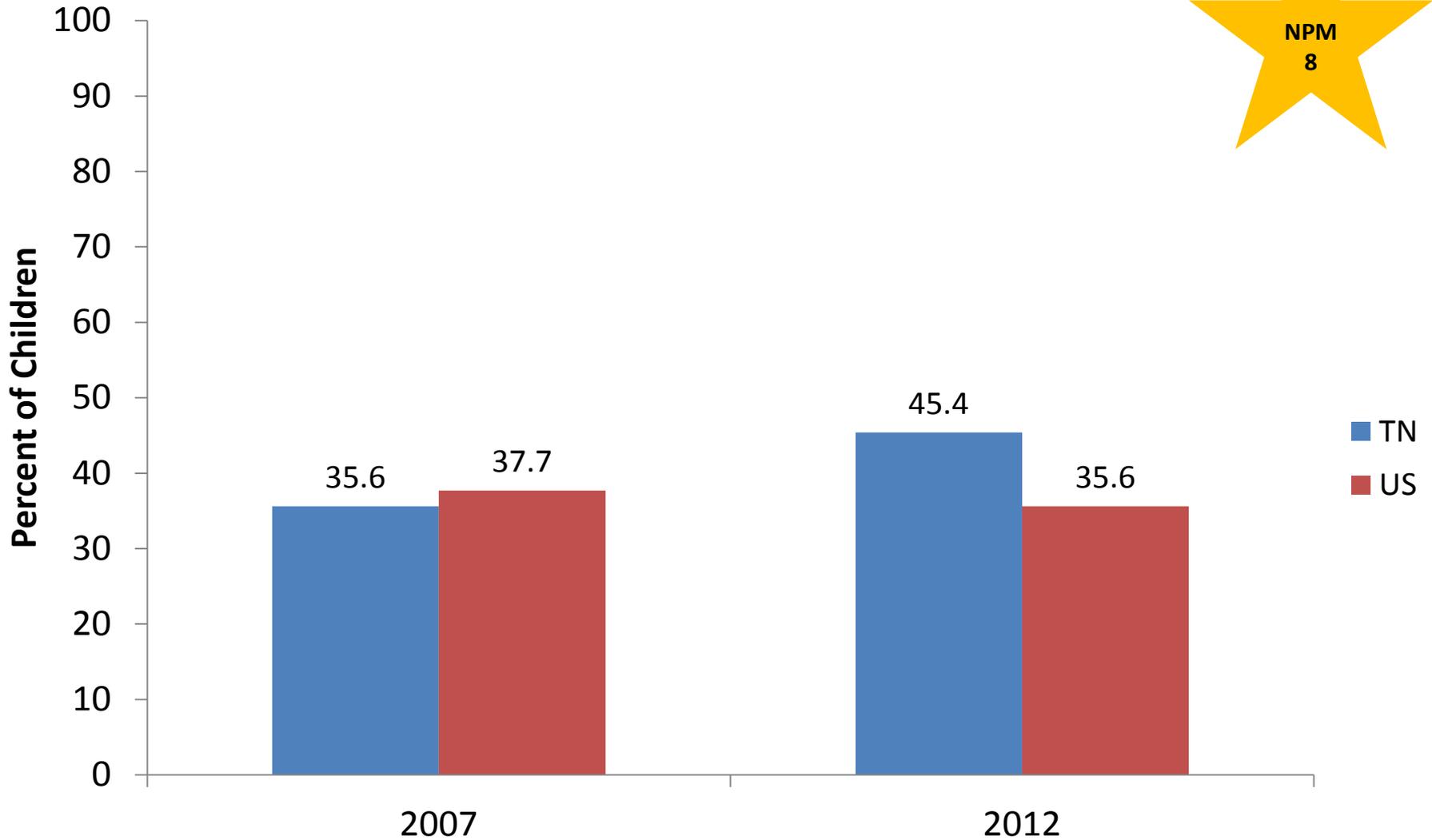
ED Visits for Asthma per 100,000 Children Ages 1-5 Years



Hospitalization for Asthma per 100,000 Children Ages 1-5 Years

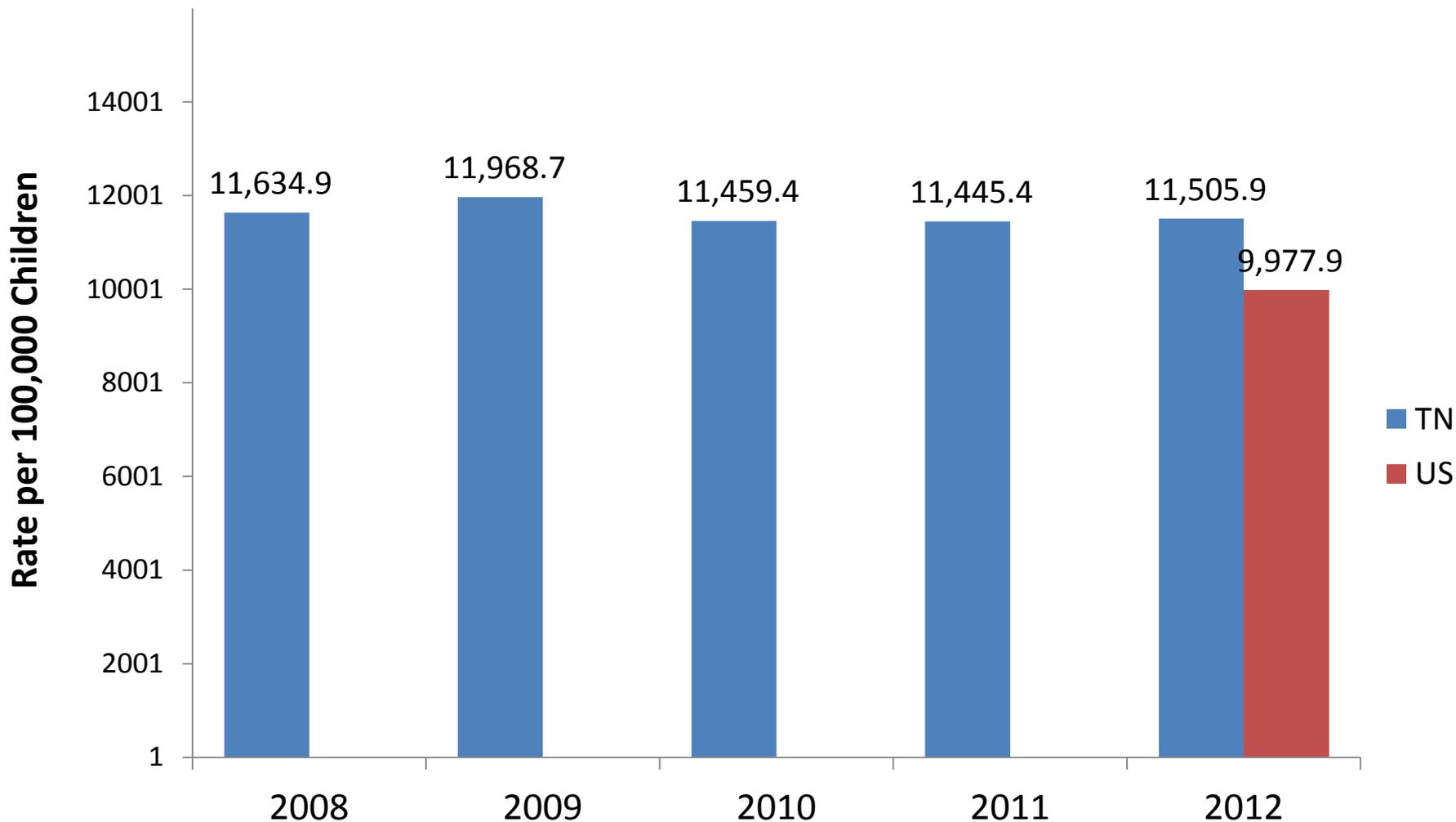


Children Age 6-11 Years Who Were Active at Least 60 Minutes per Day in the Past Week



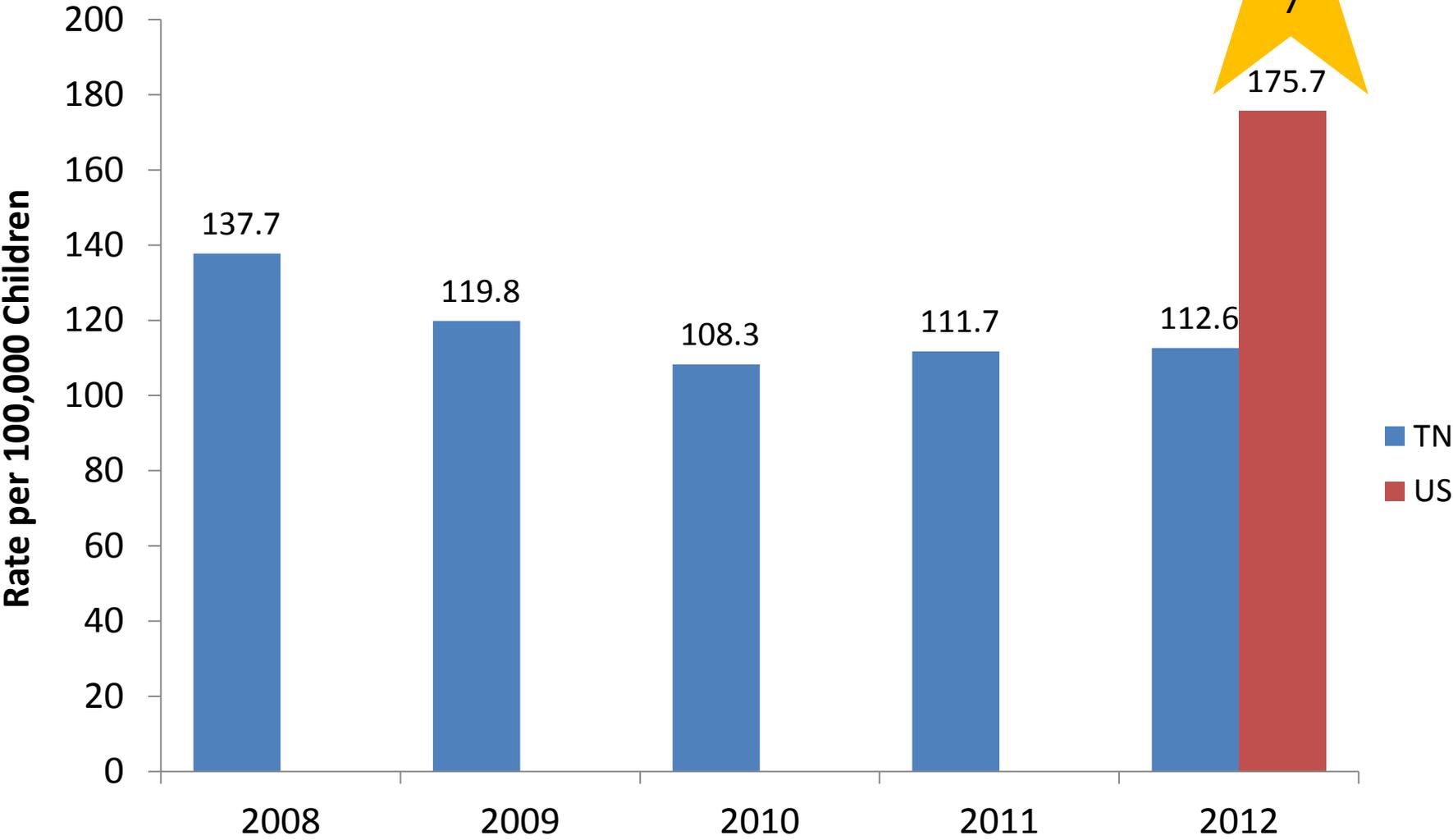
Data Source: National Survey of Children's Health. NSCH 2011/12. Data query from the Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website. Retrieved 8/1/14 from www.childhealthdata.org

Unintentional Injury ED Visits Among Children Ages 0-9 Years



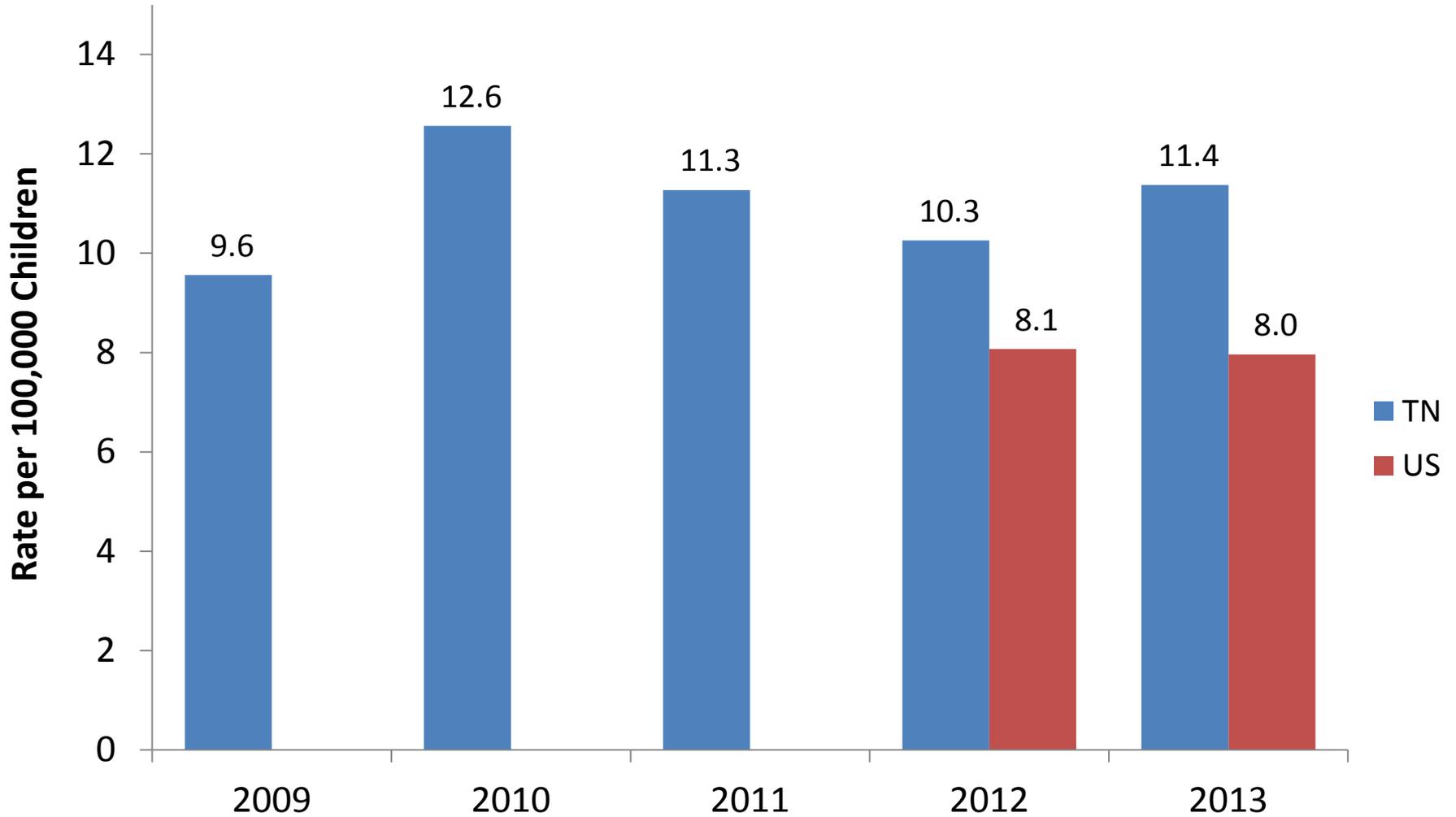
Data sources: 1) Tennessee Department of Health; Division of Policy, Planning and Assessment, Hospital Discharge Database System. 2) U.S. Department of Health and Human Services, Health Resources and Services Administration, Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Fatal Injury Report, 2008-2012, on CDC WISQARS Online Database. Accessed in January, 2015.

Unintentional Injury Hospitalizations Among Children Ages 0-9 Years



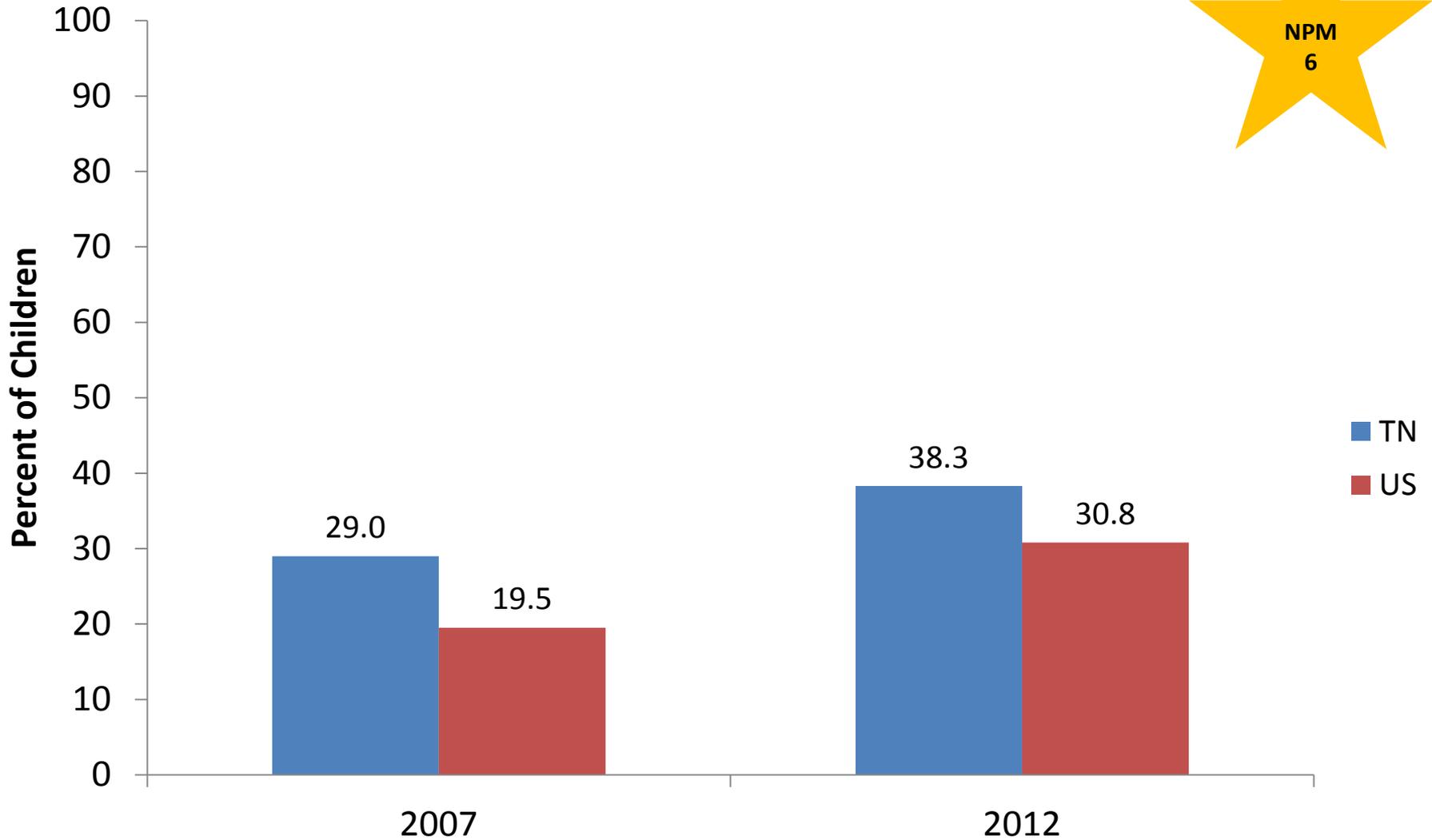
Data sources: 1) Tennessee Department of Health; Division of Policy, Planning and Assessment, Hospital Discharge Database System. 2) U.S. Department of Health and Human Services, Health Resources and Services Administration, Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Fatal Injury Report, 2008-2012, on CDC WISQARS Online Database. Accessed in January, 2015.

Unintentional Injury Deaths Among Children Ages 0-9 Years



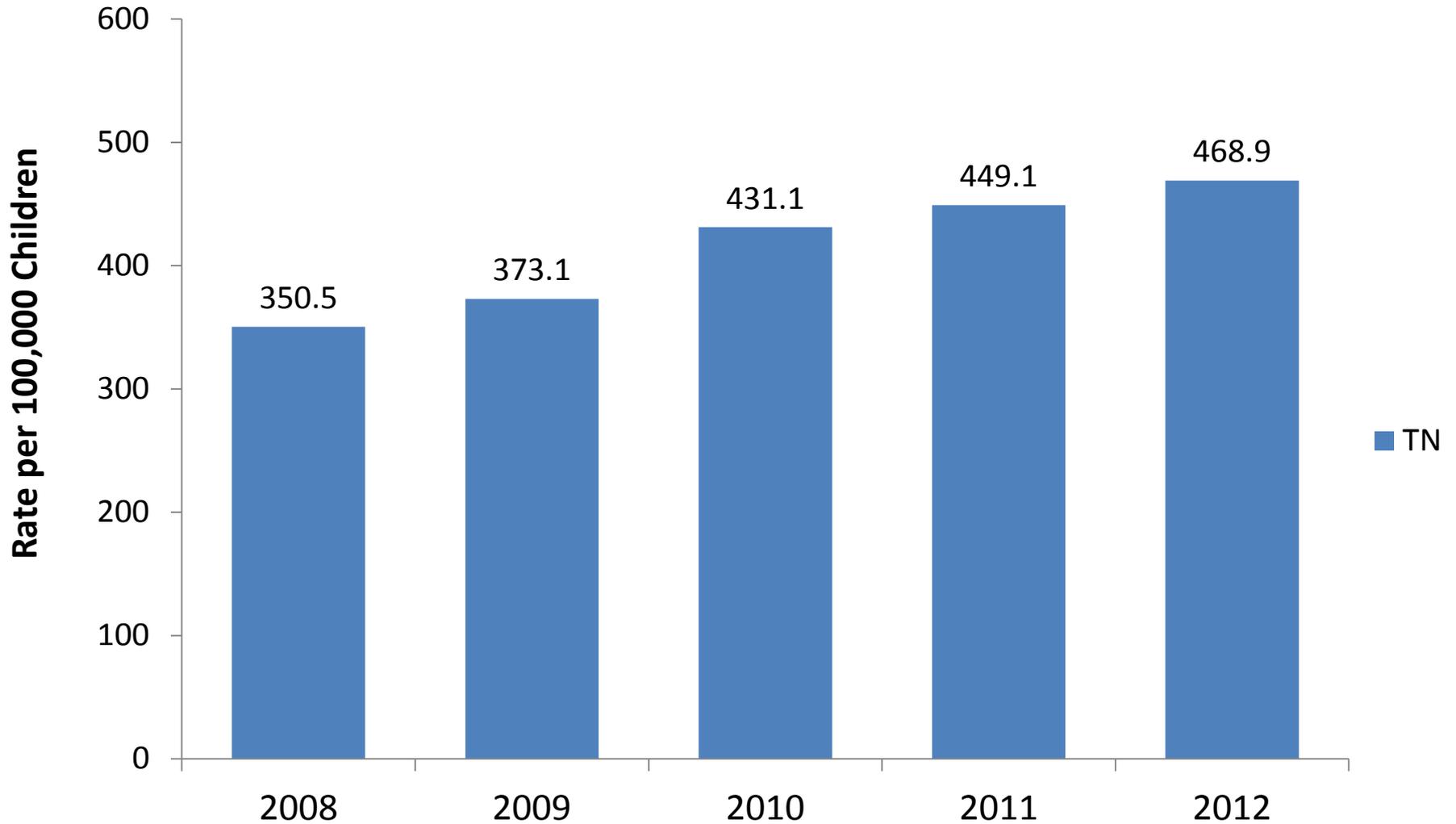
Data sources: 1) Tennessee Department of Health; Division of Policy, Planning and Assessment, Death Statistical System. 2) U.S. Department of Health and Human Services, Health Resources and Services Administration, Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Fatal Injury Report, 2009-2013, on CDC WISQARS Online Database. Accessed in January, 2015.

Children Age 10 Months to 5 Years Screened for Developmental, Behavioral, and Social Delays

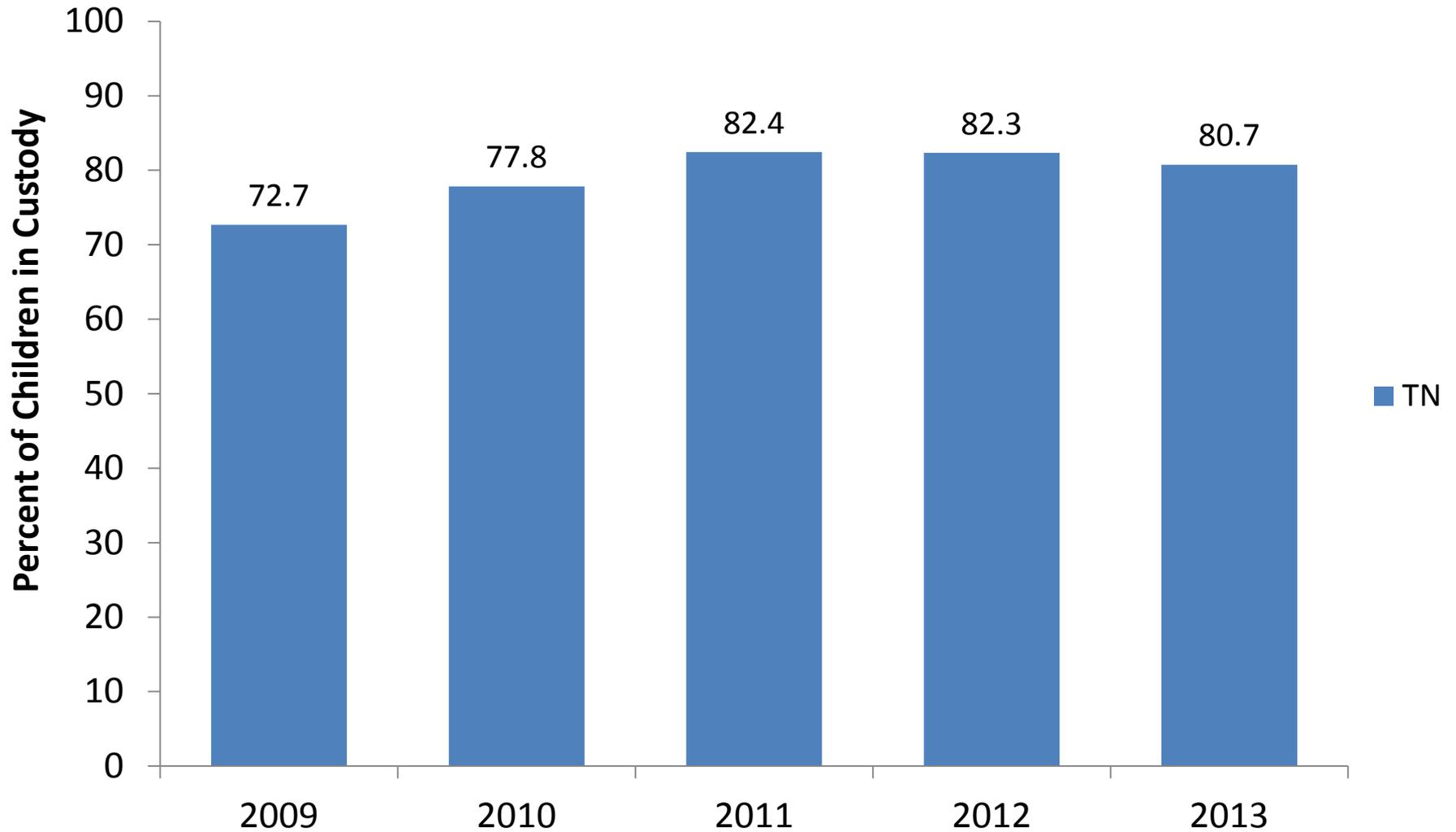


Data Source: National Survey of Children's Health. NSCH 2011/12. Data query from the Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website. Retrieved 8/1/14 from www.childhealthdata.org.

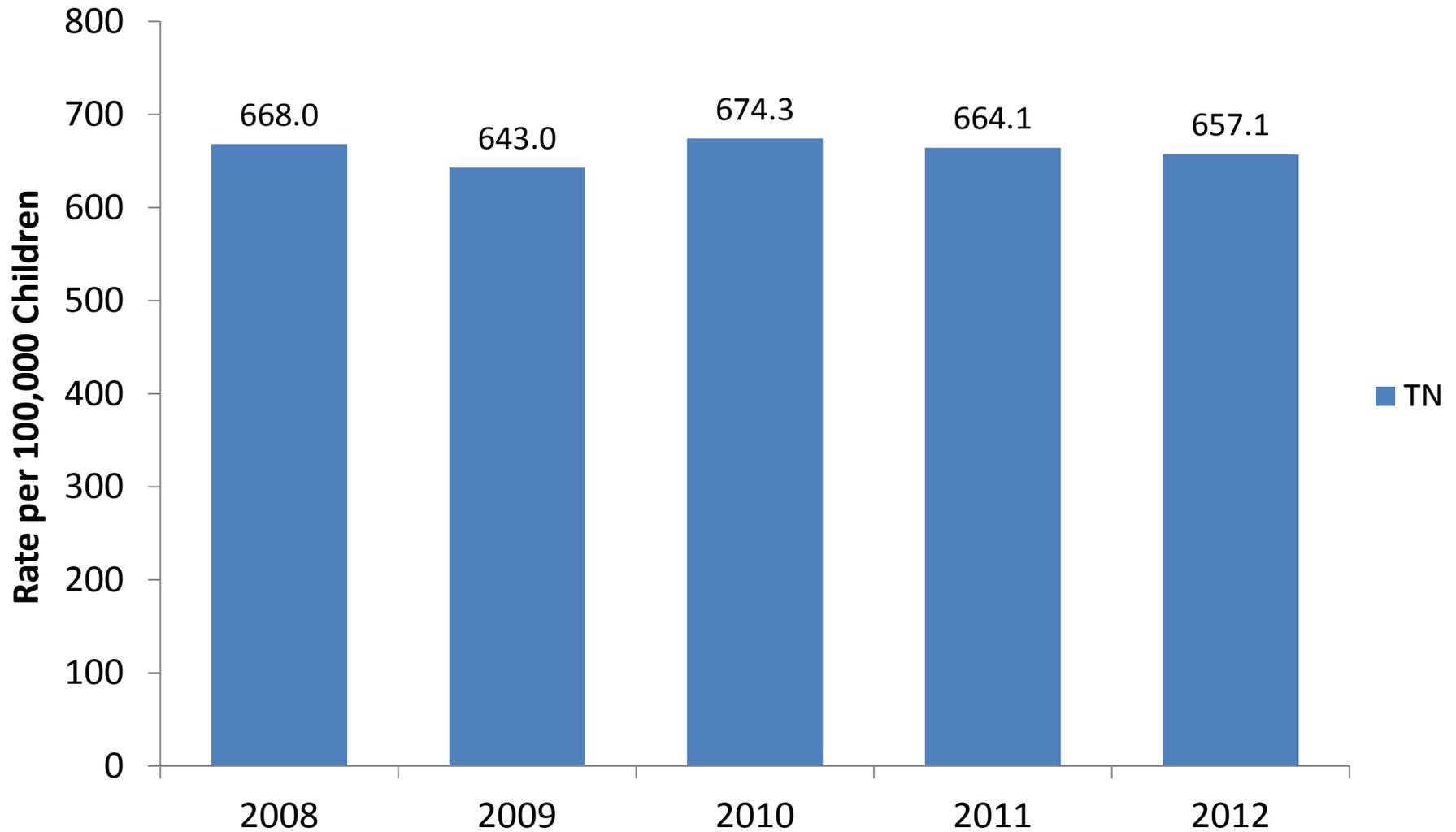
First Time Substantiated Children on Neglect Allegations per 100,000 Children Ages 0-17 Years



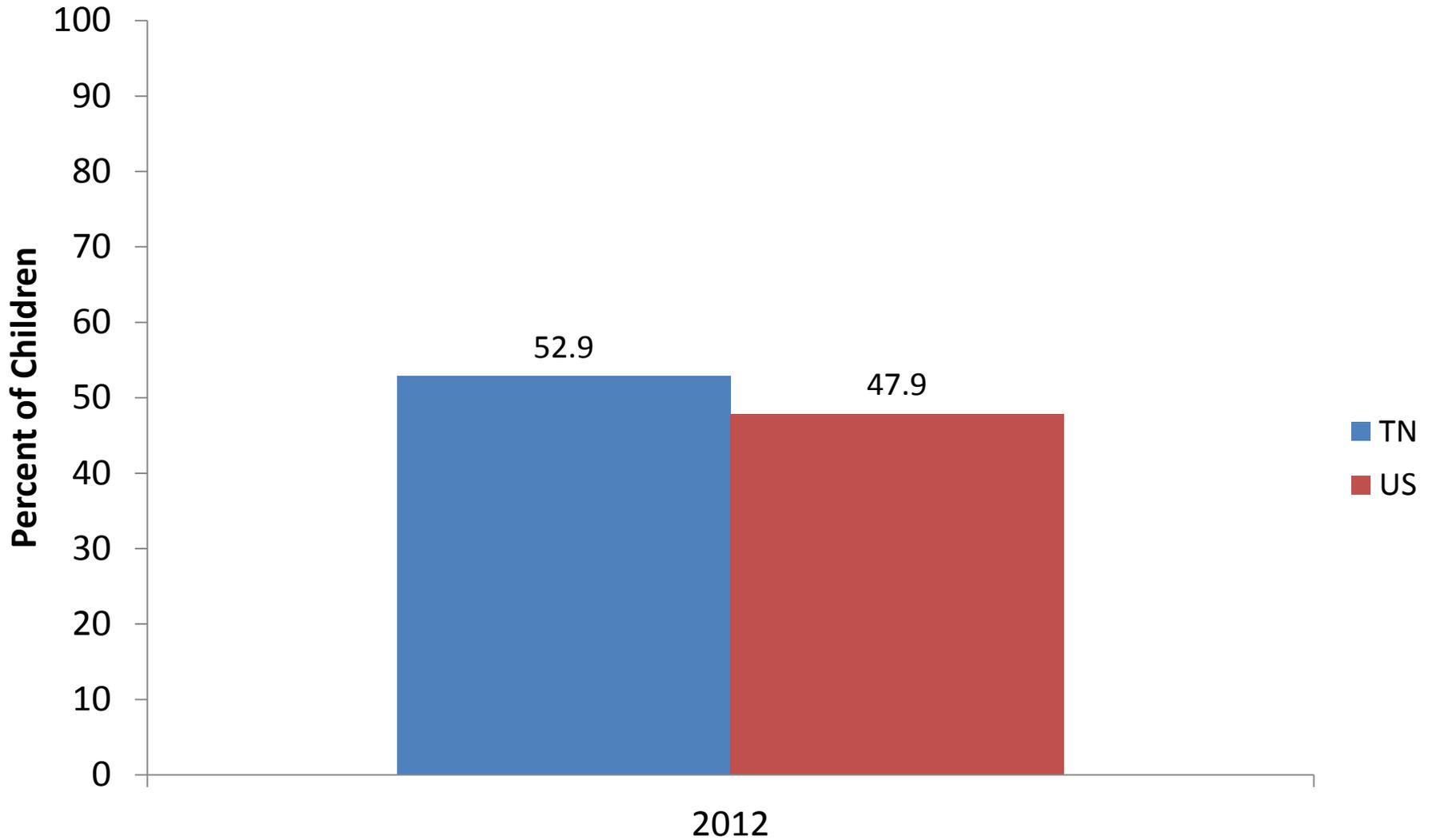
Children in Custody Due to Dependent Neglect



Children Confirmed by DCS as Victims of Maltreatment

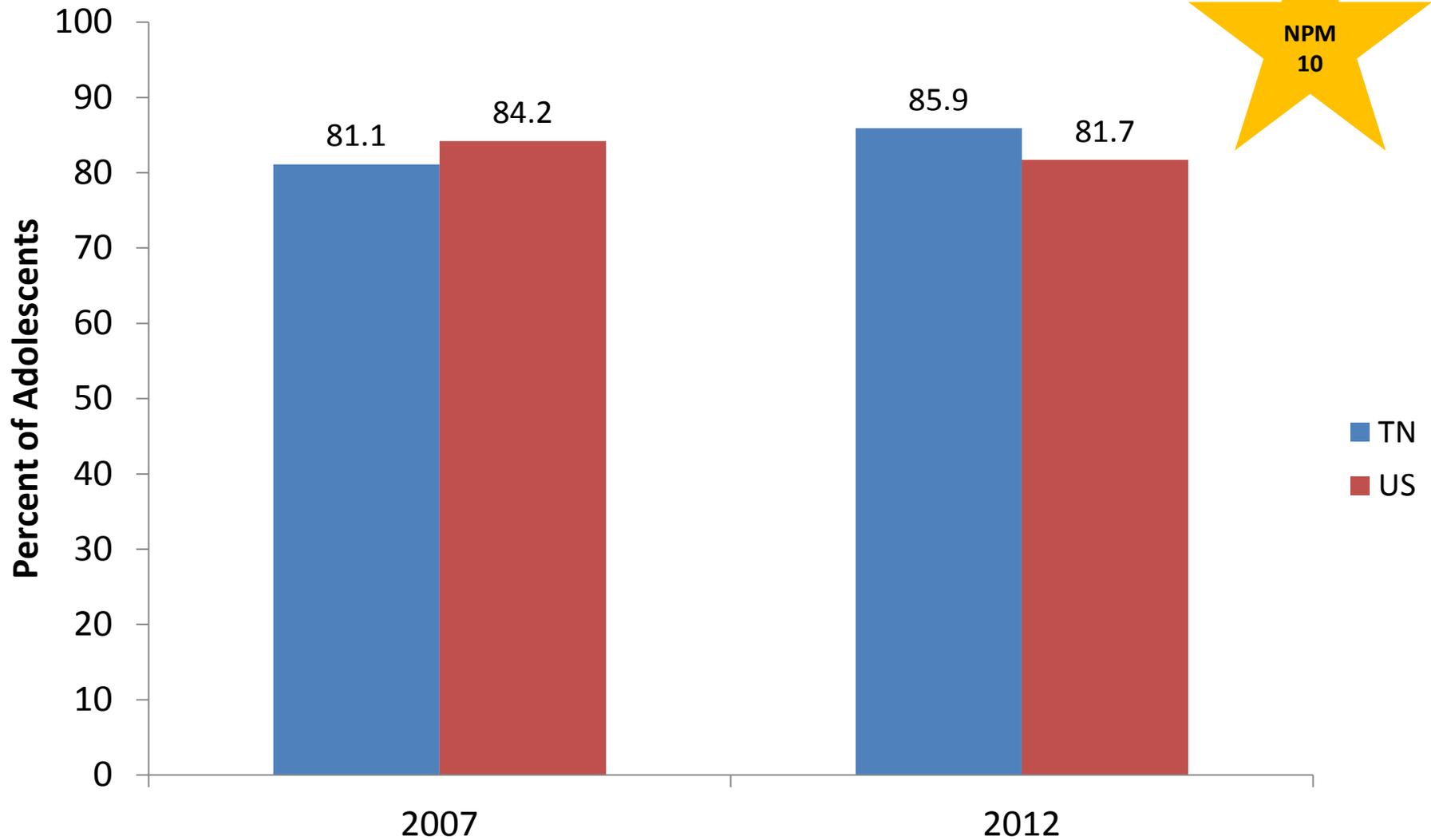


Adverse Childhood Events Prevalence Among Children and Adolescents Age 0-17 Years



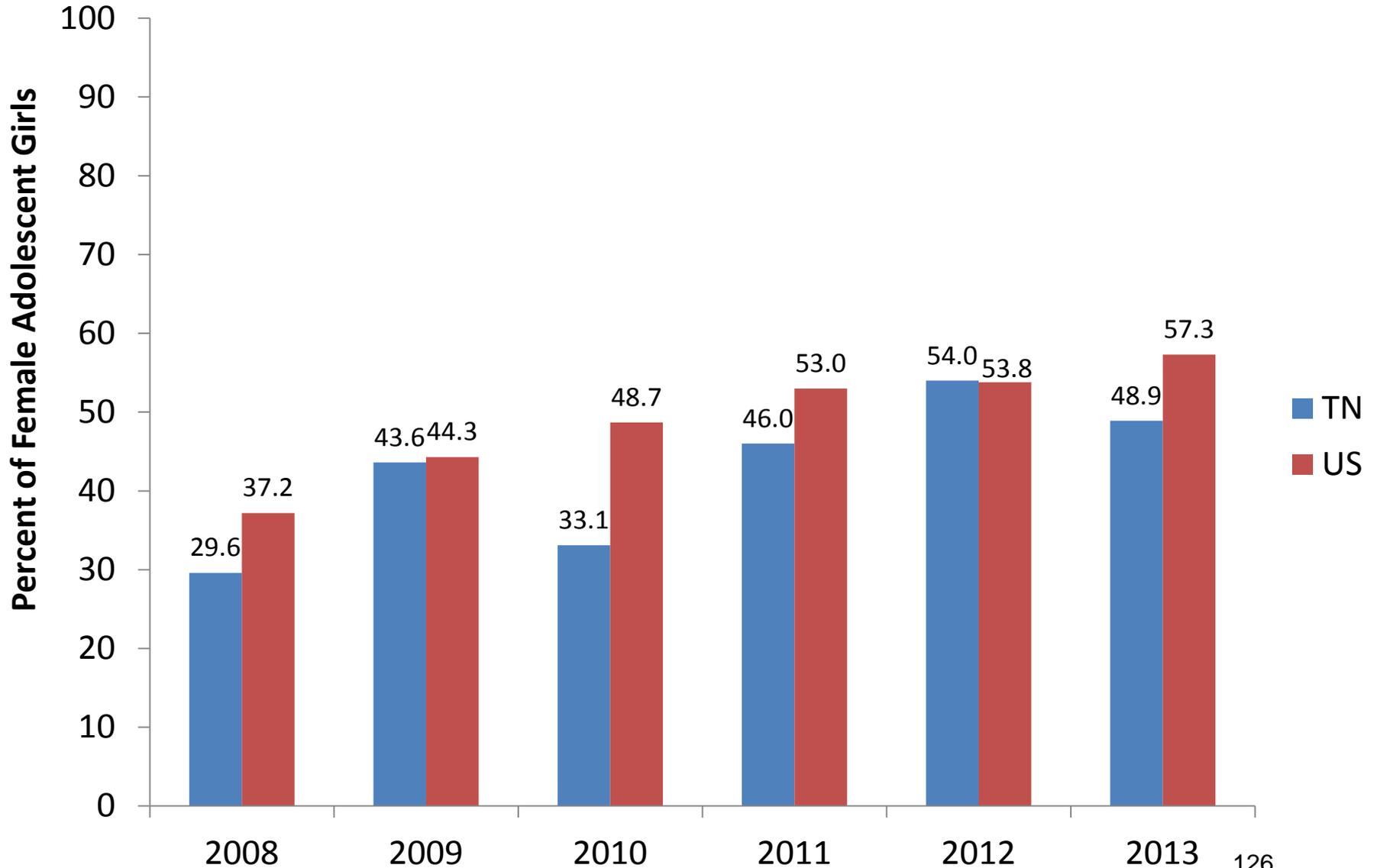
ADOLESCENT HEALTH

Adolescents Age 12-17 Years With a Preventative Medical Care Visit in the Past Year



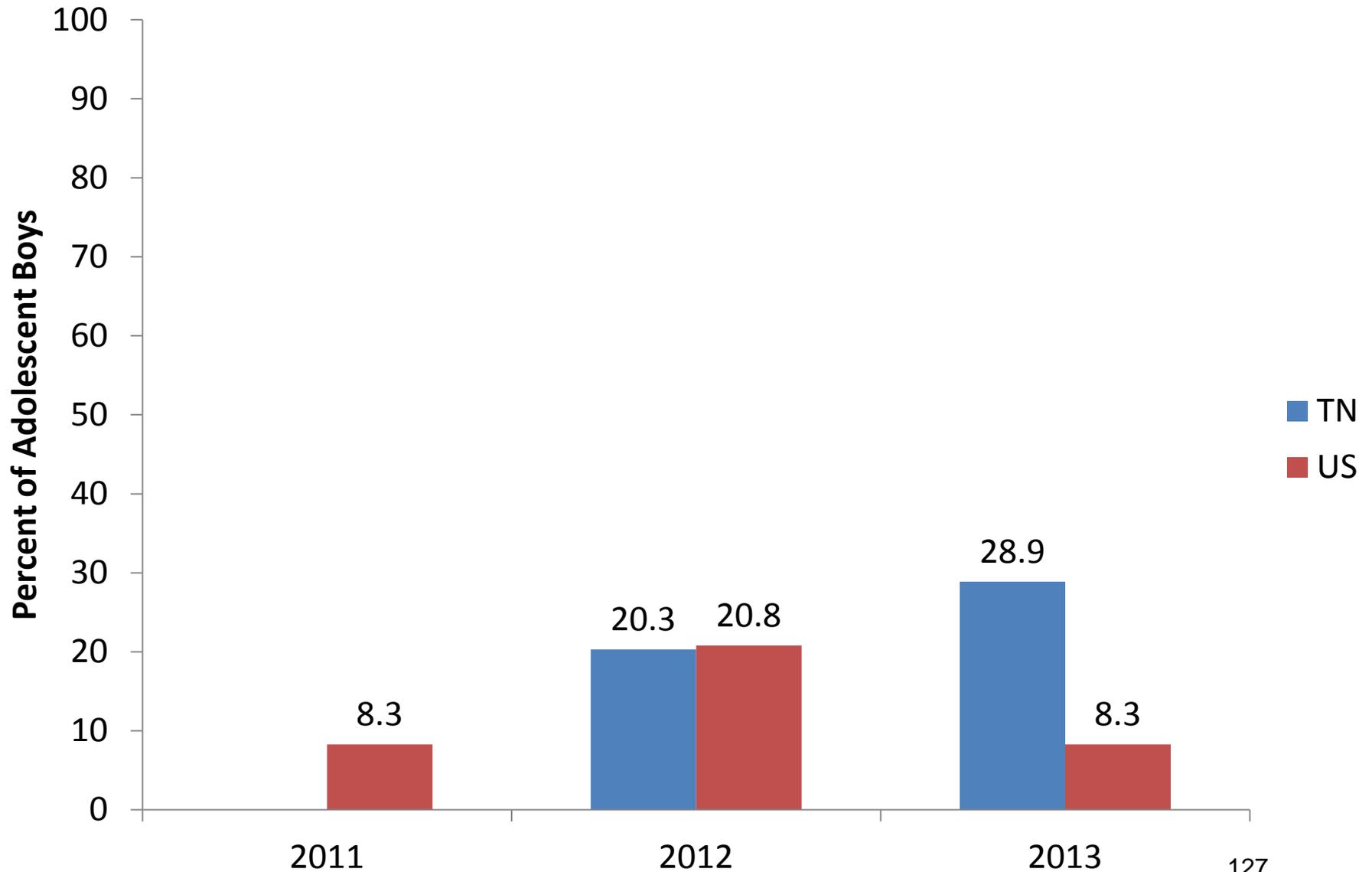
Data Source: National Survey of Children's Health. NSCH 2011/12. Data query from the Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website. Retrieved 8/1/14 from www.childhealthdata.org.

Adolescent Females Age 13-17 With ≥ 1 HPV Vaccine Dose



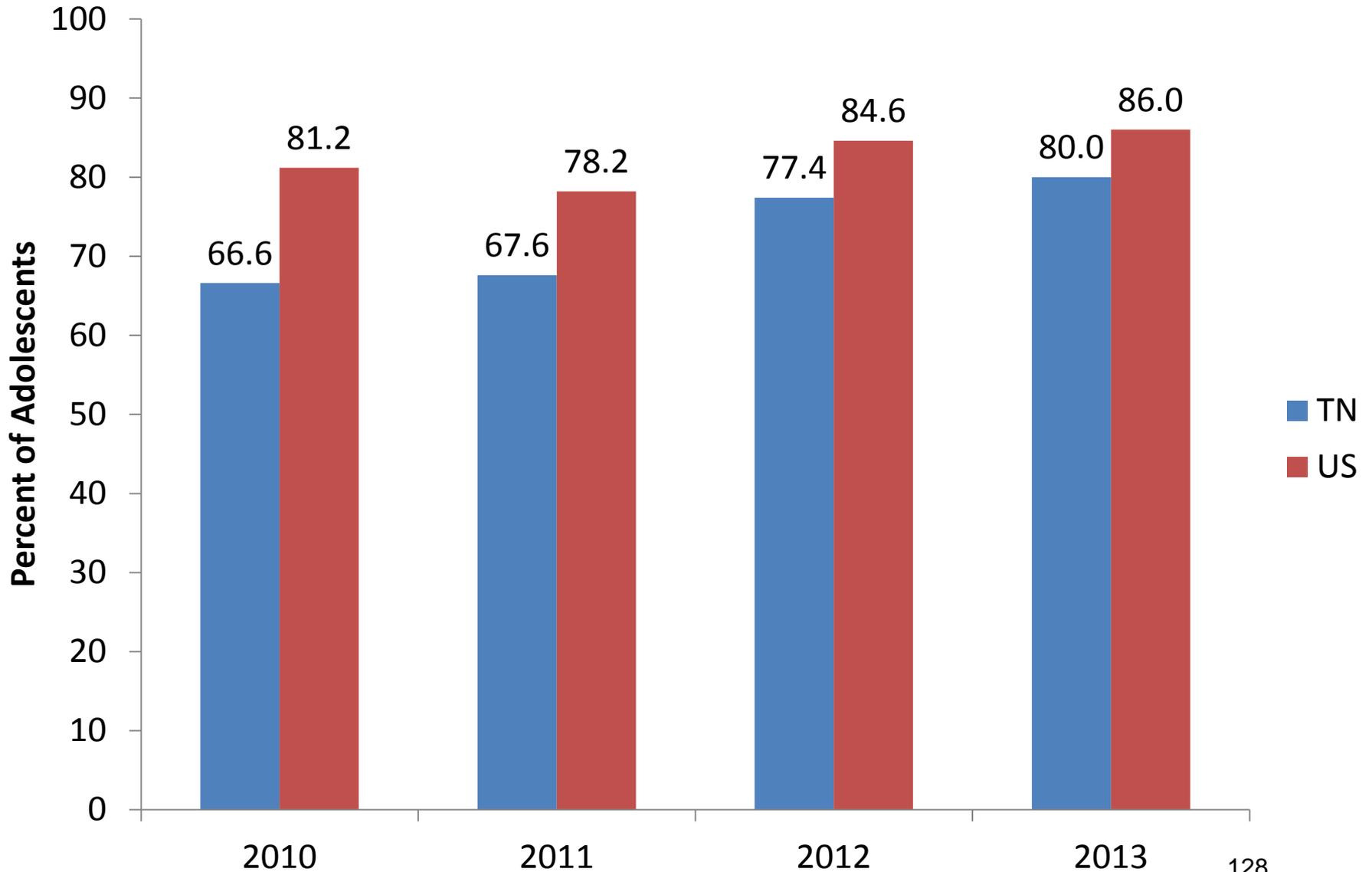
Source: 1) National Immunization Survey-Teen. 2) Elam-Evans LD, Yankey D, Jeyarajah J, et al. MMWR 2014; 63

Adolescent Males Age 13-17 With ≥ 1 HPV Vaccine Dose

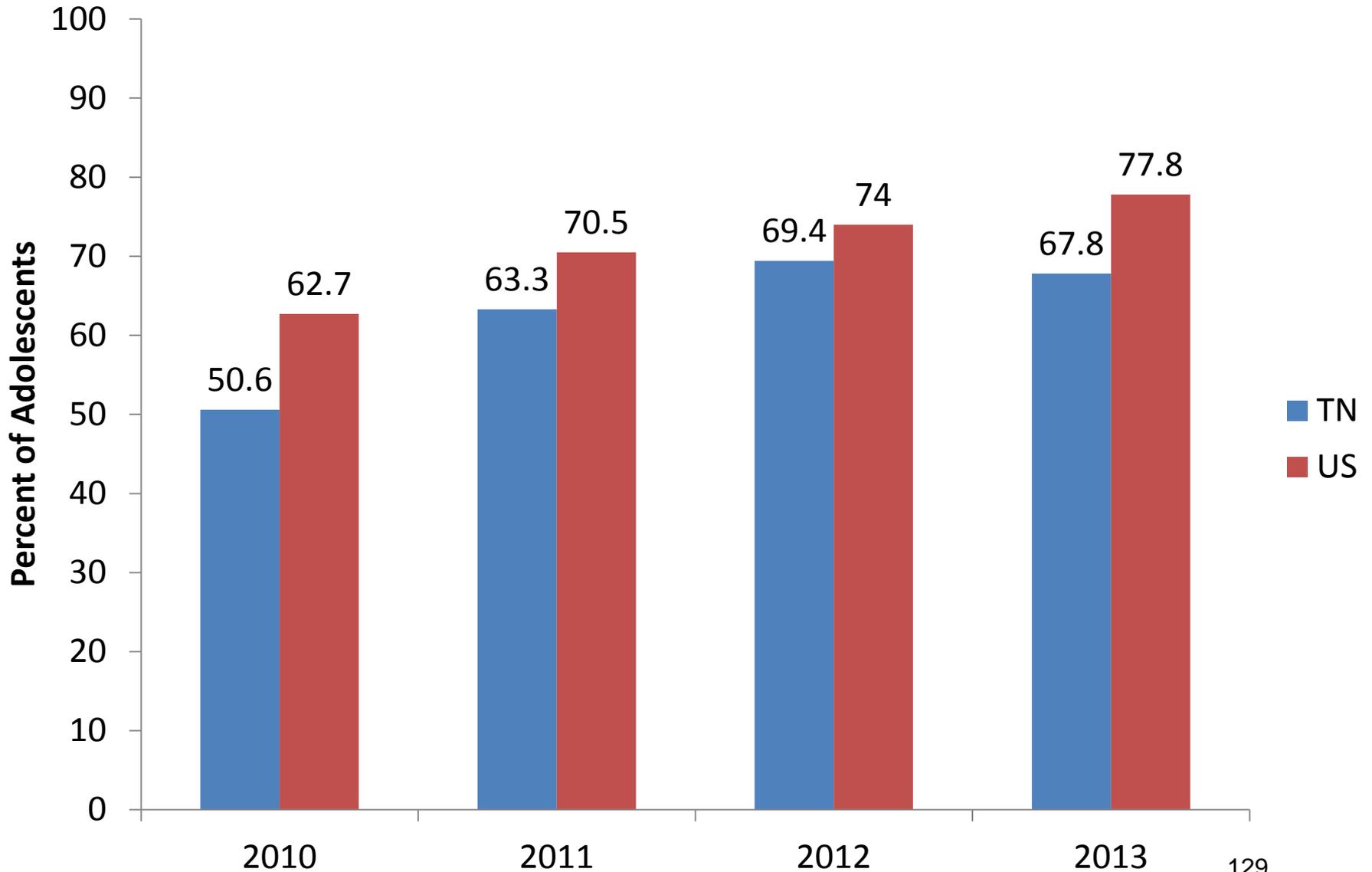


Source: 1) National Immunization Survey-Teen. 2) Elam-Evans LD, Yankey D, Jeyarajah J, et al. MMWR 2014; 63

Adolescents Age 13-15 Years With ≥ 1 Dose Tdap Vaccine

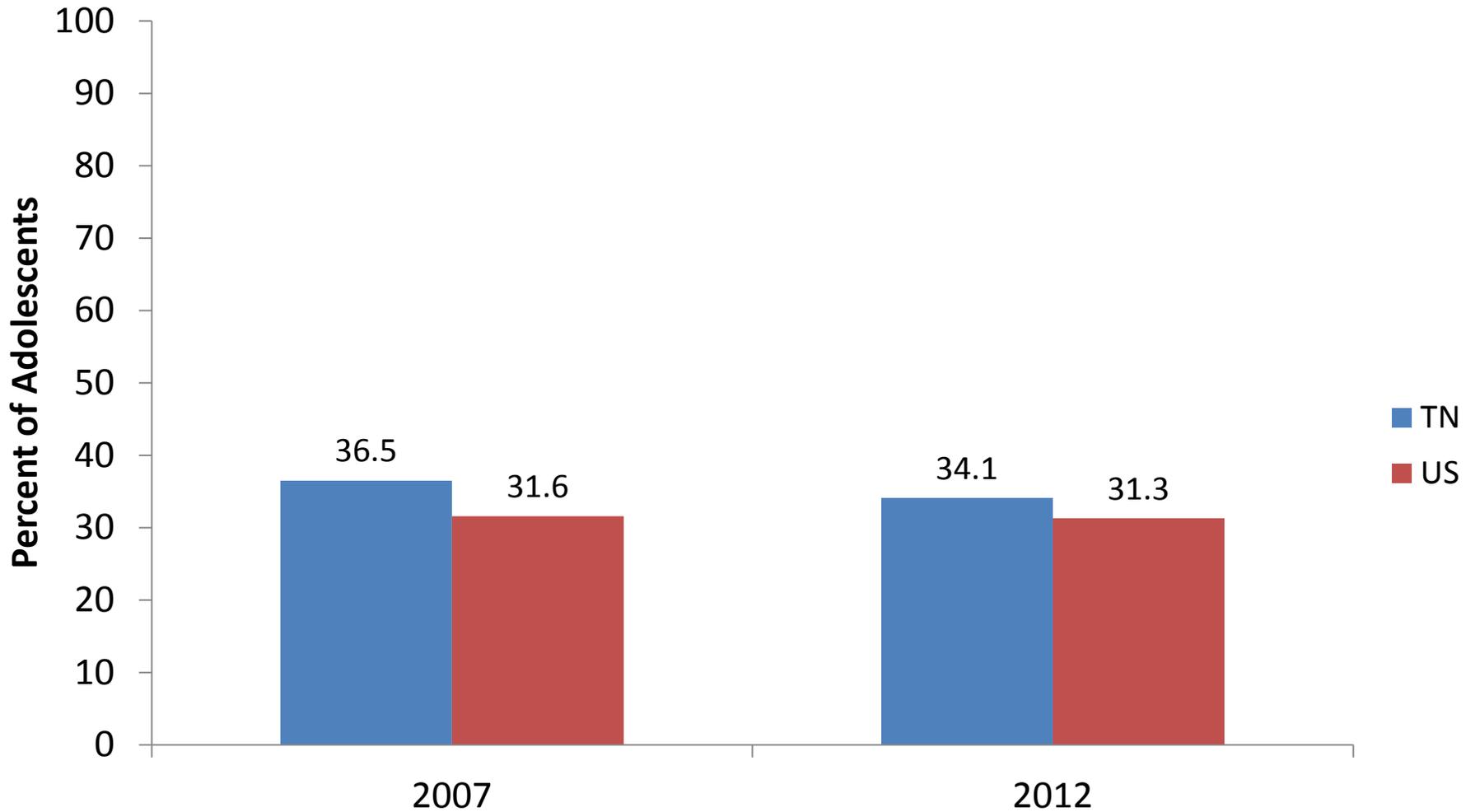


Adolescents Age 13-15 Years With ≥ 1 Dose Meningococcal Vaccine



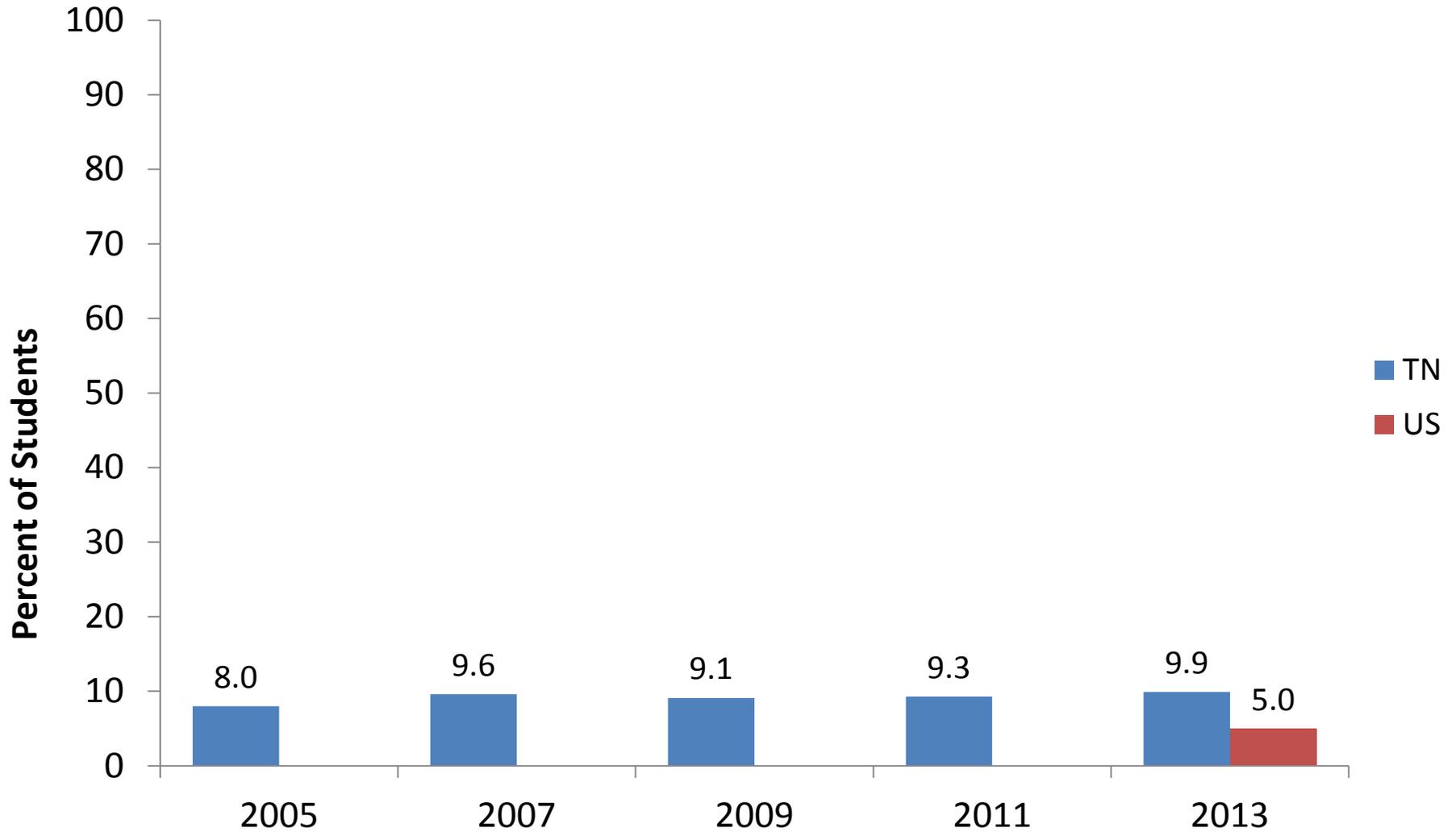
Source: 1) National Immunization Survey. 2) Elam-Evans LD, Yankey D, Jeyarajah J, et al. MMWR 2014; 63

Adolescents Age 10-17 Years Who Are Overweight or Obese (85th Percentile or Above)

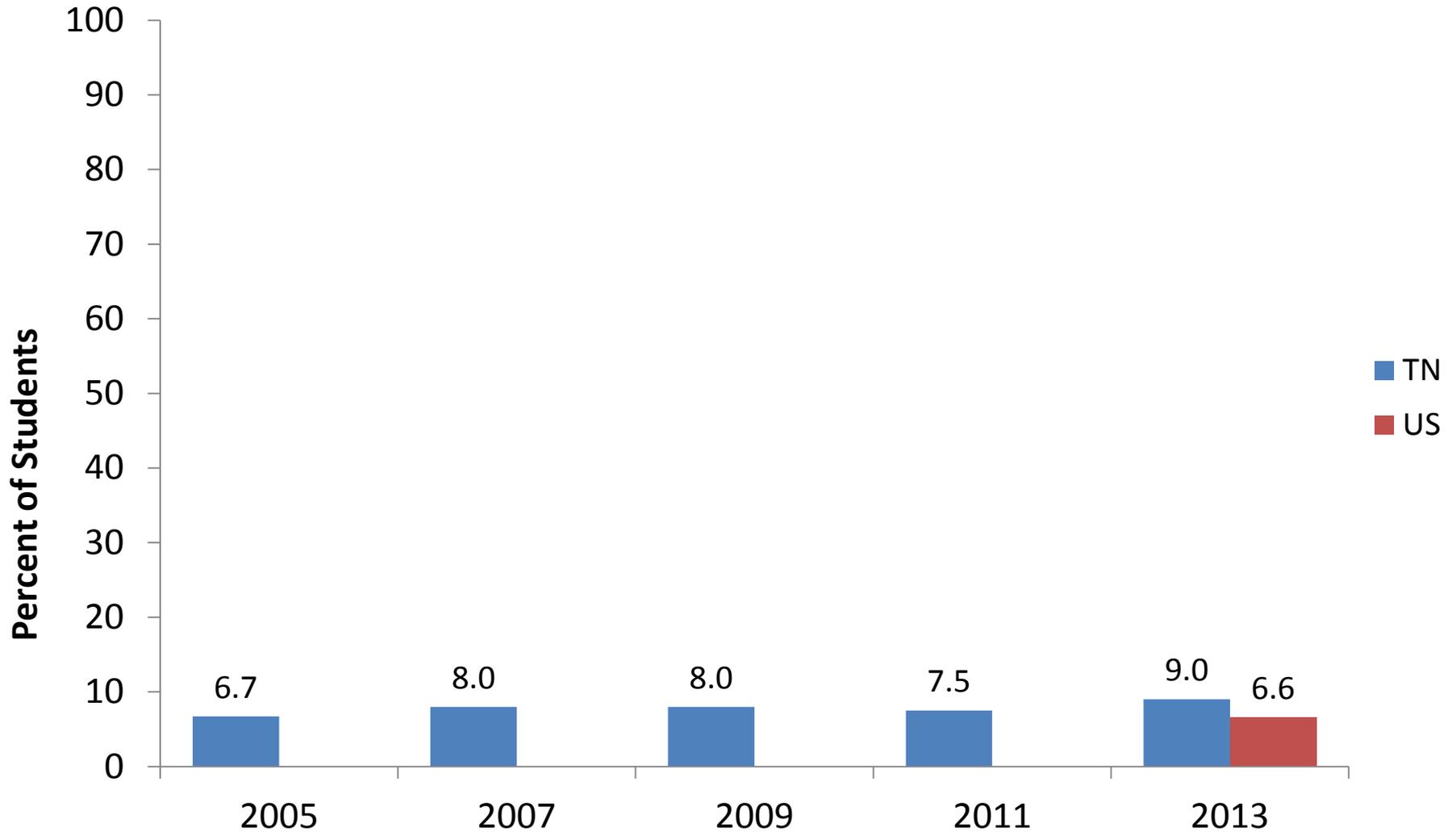


Data Source: National Survey of Children's Health. NSCH 2011/12. Data query from the Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website. Retrieved 8/1/14 from www.childhealthdata.org.

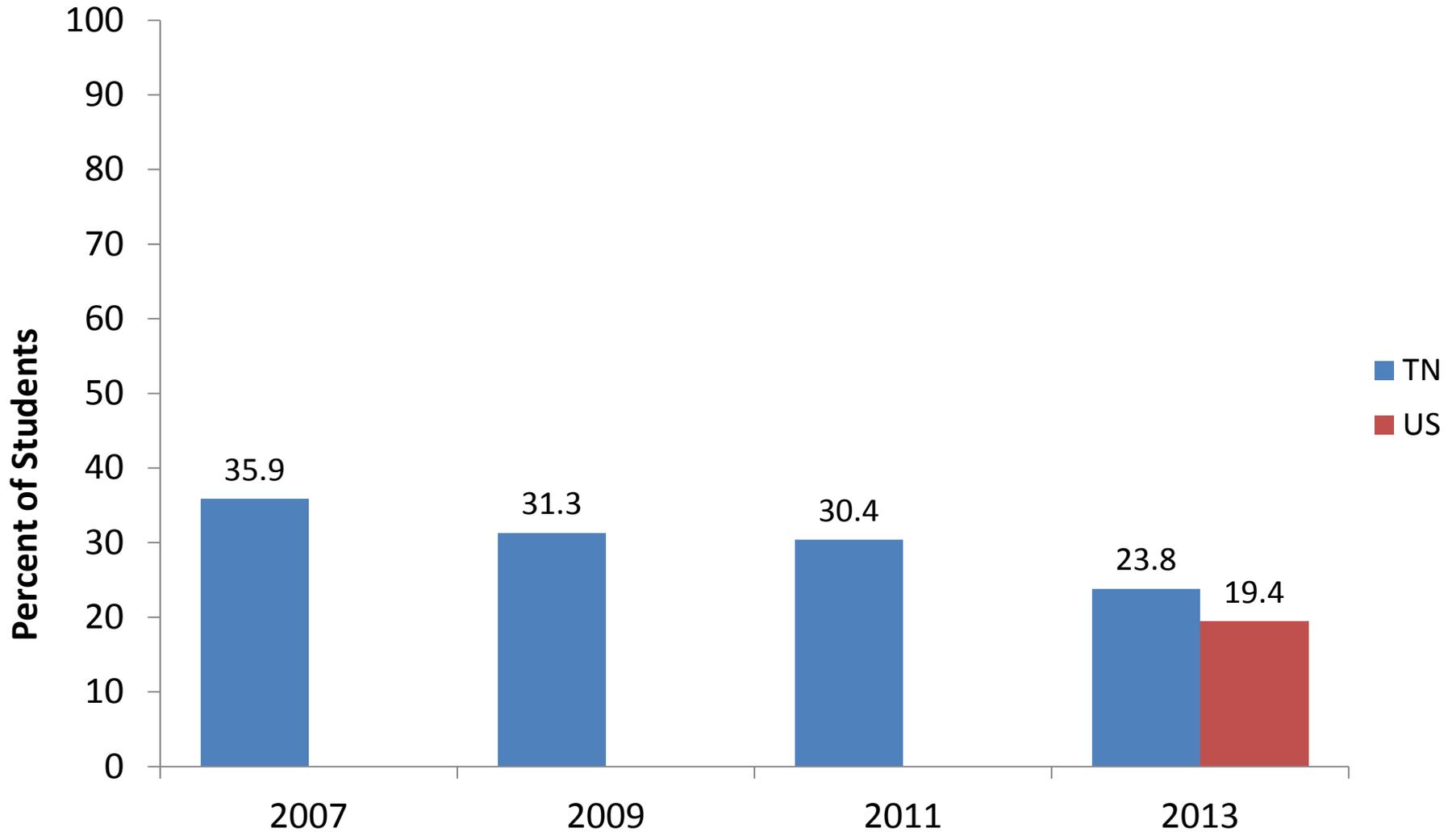
High School Students Who Did Not Eat Fruits/Juice in the past 7 Days



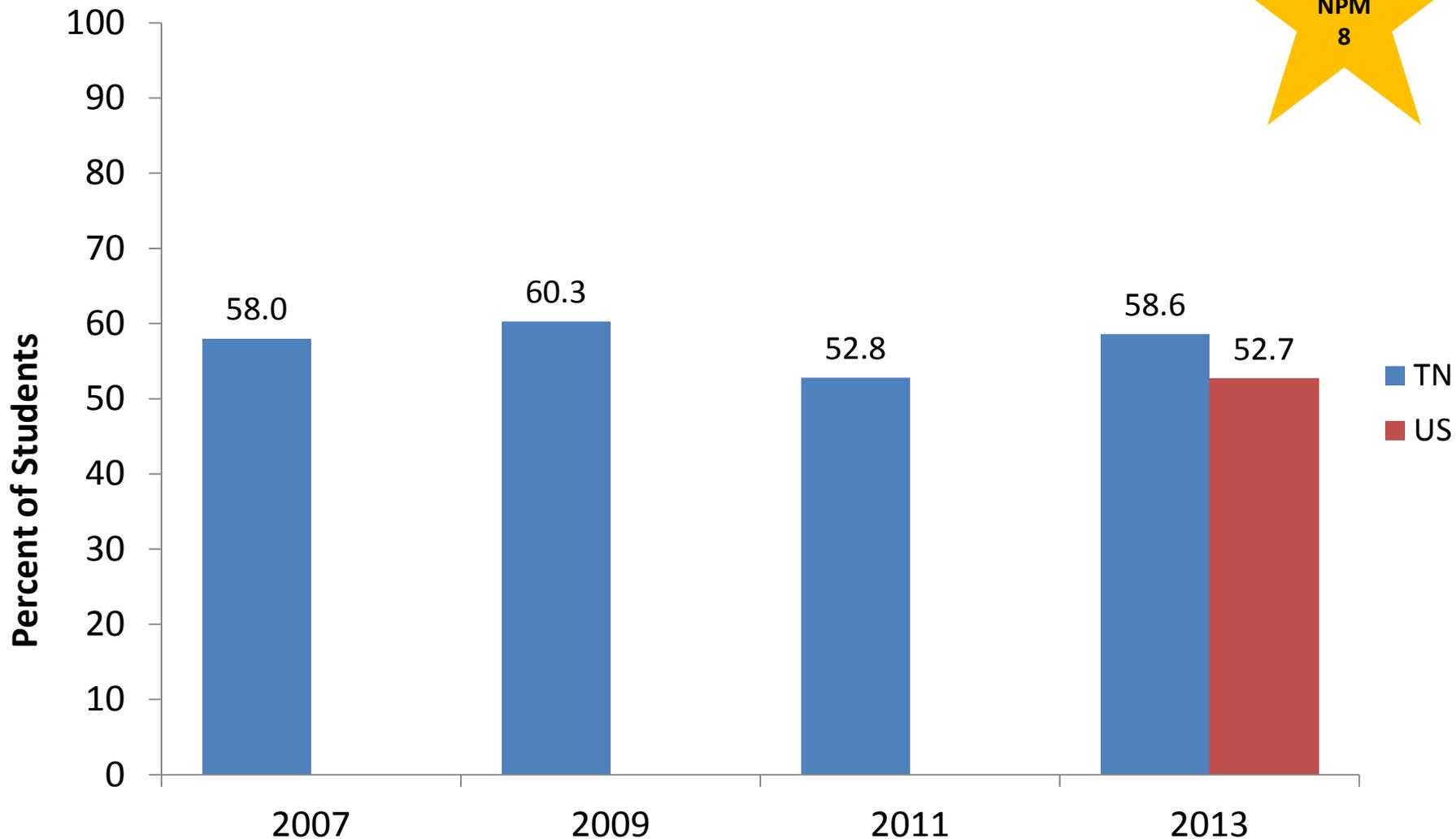
High School Students Who Did Not Eat Vegetables in the past 7 Days



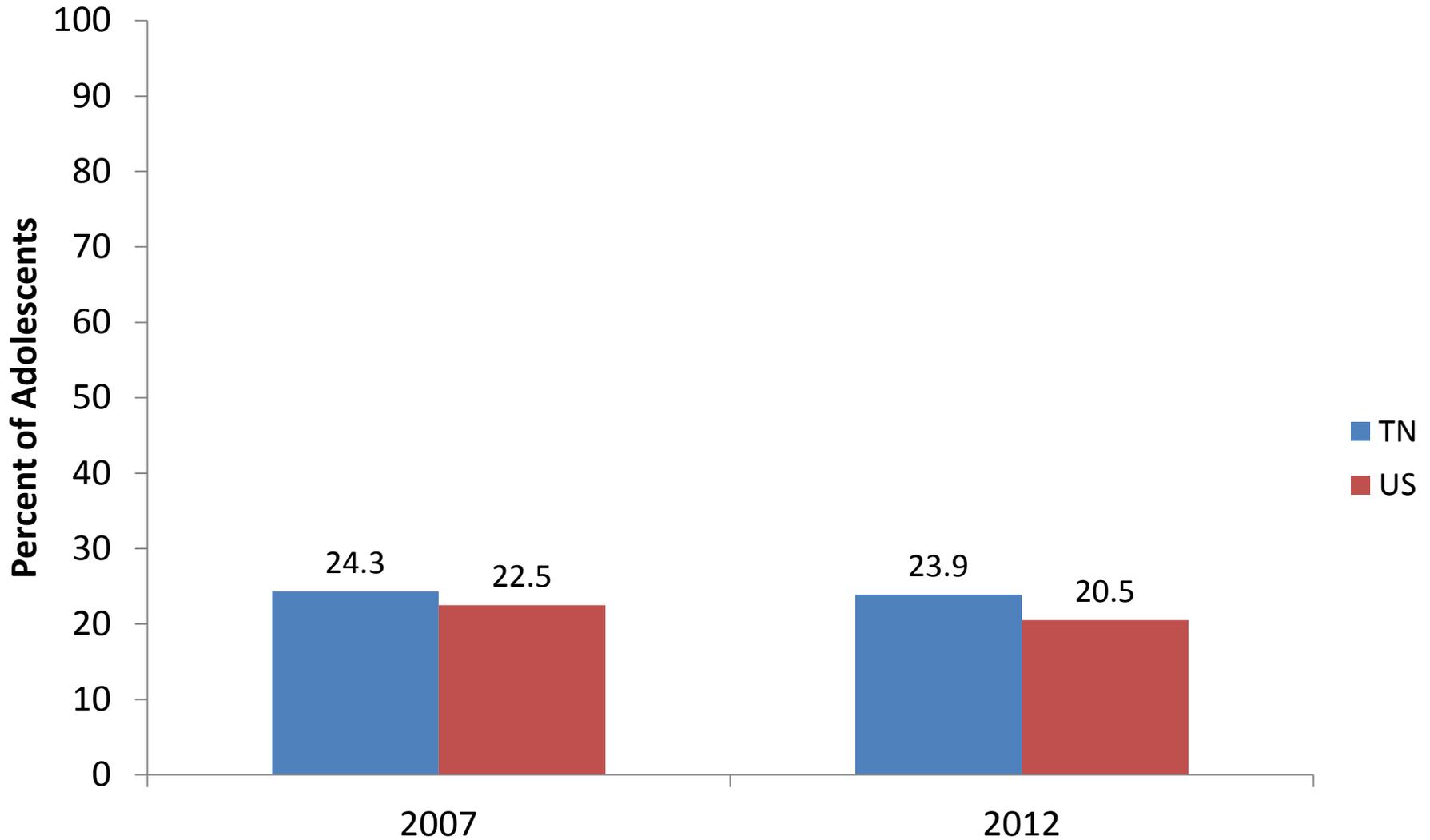
High School Students Who Drank Soda 2+ times a Day in the past 7 Days



High School Students Who Were Not Physically Active for at Least 60 Minutes/Day on 5 of the Last 7 Days

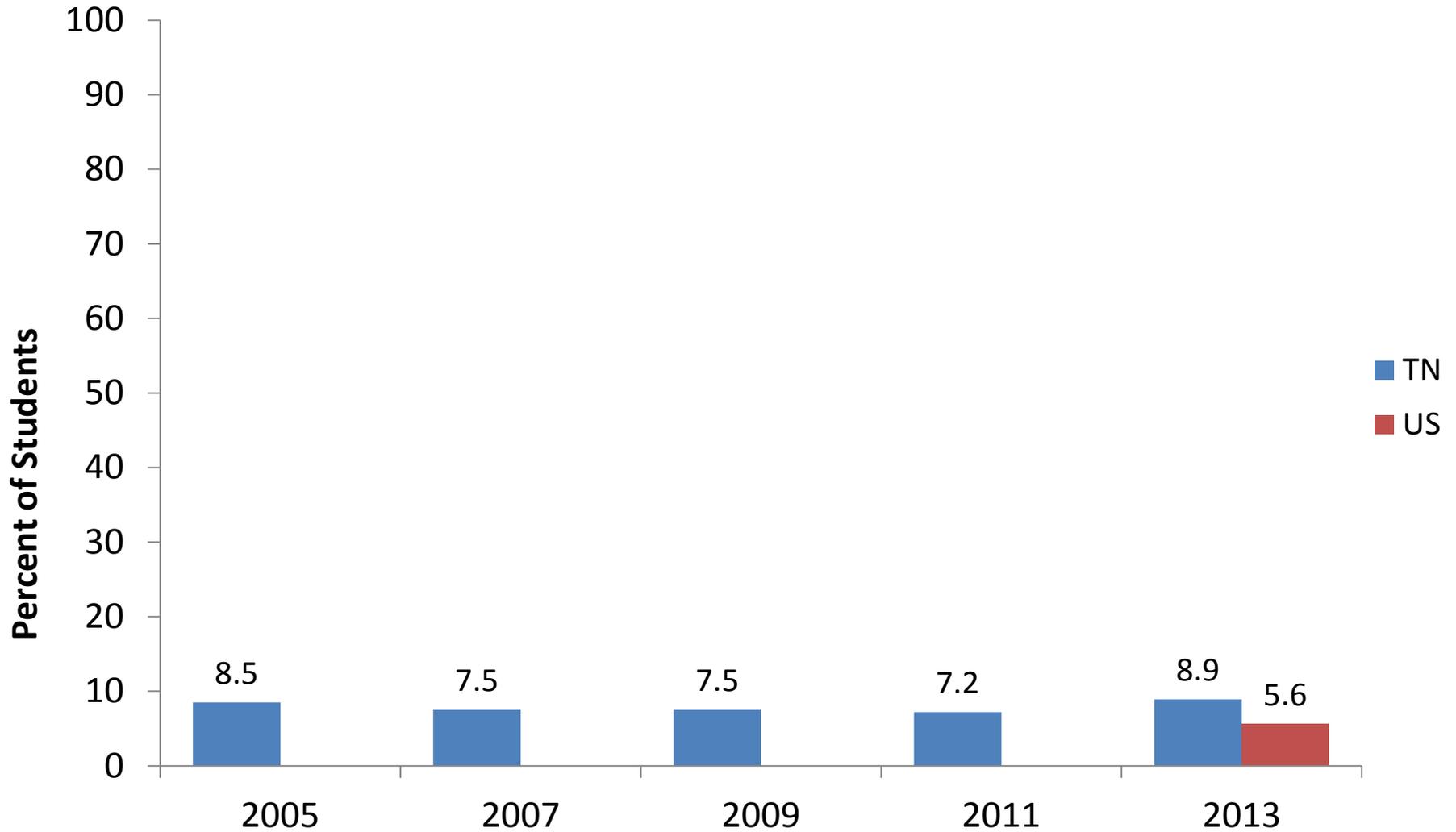


Adolescents Age 12-17 Years Who Were Active at Least 60 Minutes per Day in the Past Week



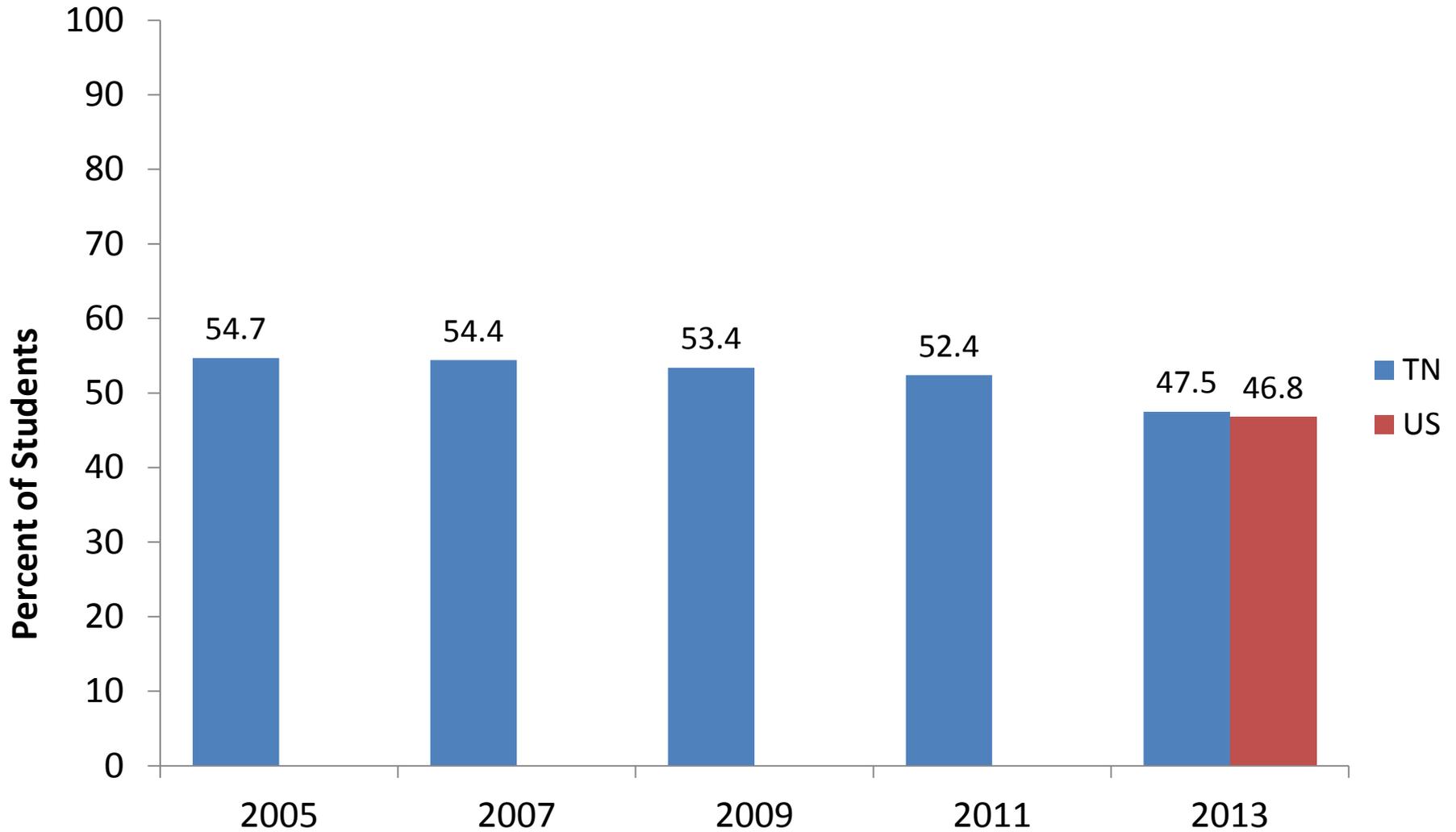
Data Source: National Survey of Children's Health. NSCH 2011/12. Data query from the Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website. Retrieved 8/1/14 from www.childhealthdata.org

High School Students Who Had Sex for the First Time before Age 13 Years

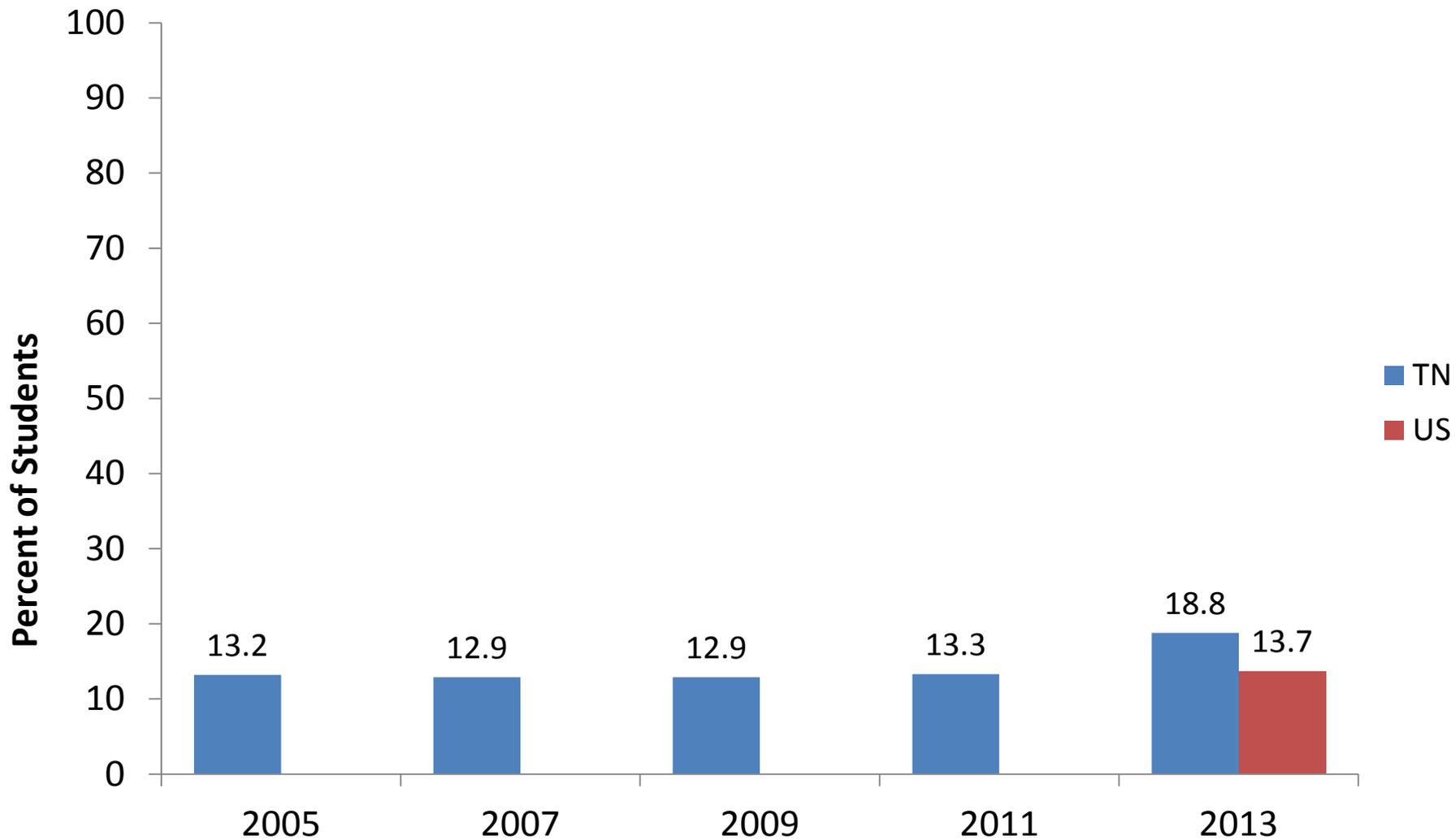


Data source: Centers for Disease Control and Prevention (CDC). 1991-2013 High School Youth Risk Behavior Survey Data. Accessed February 26, 2015 at <http://nccd.cdc.gov/youthonline/>.

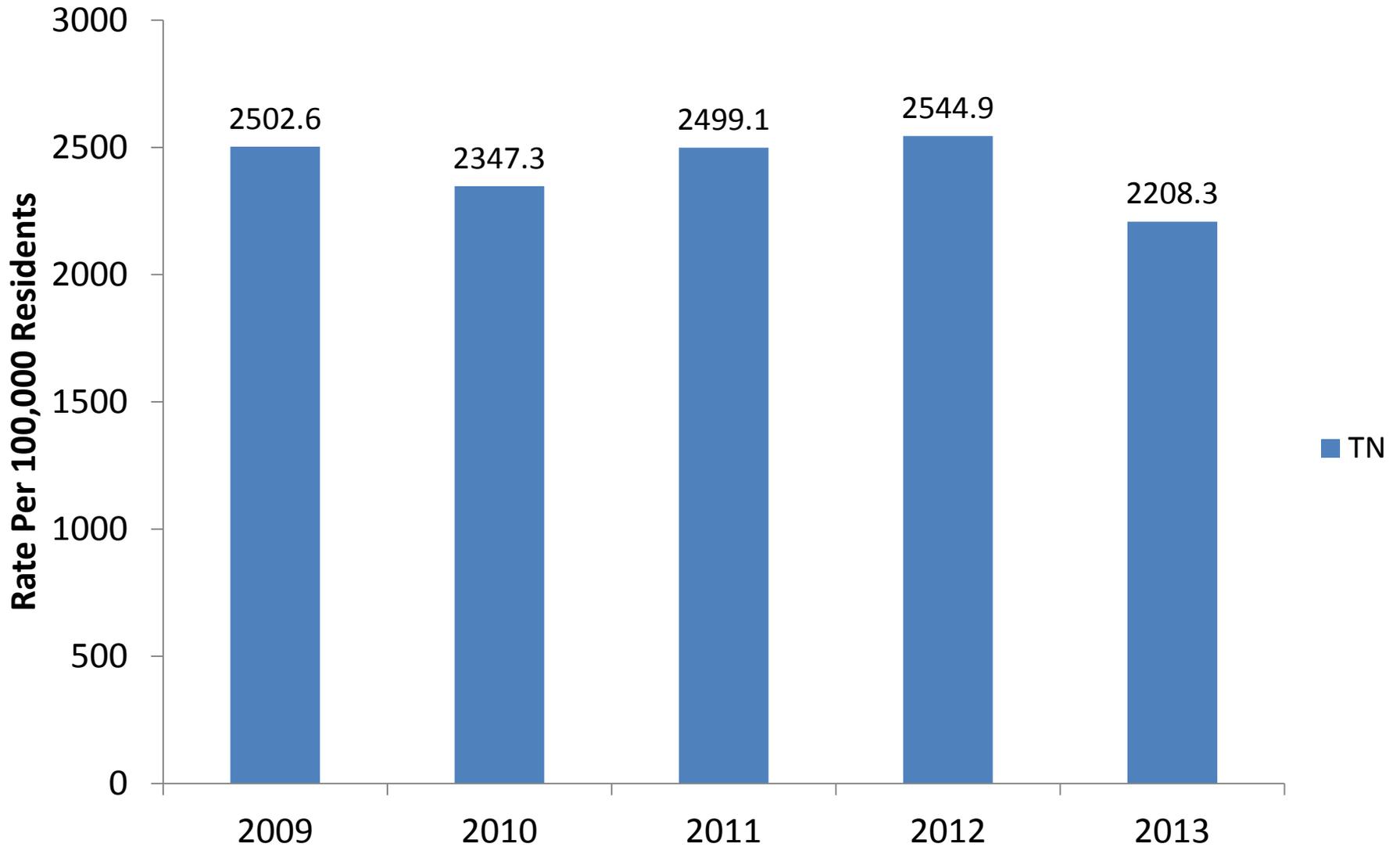
High School Students Who Have Ever Had Sex



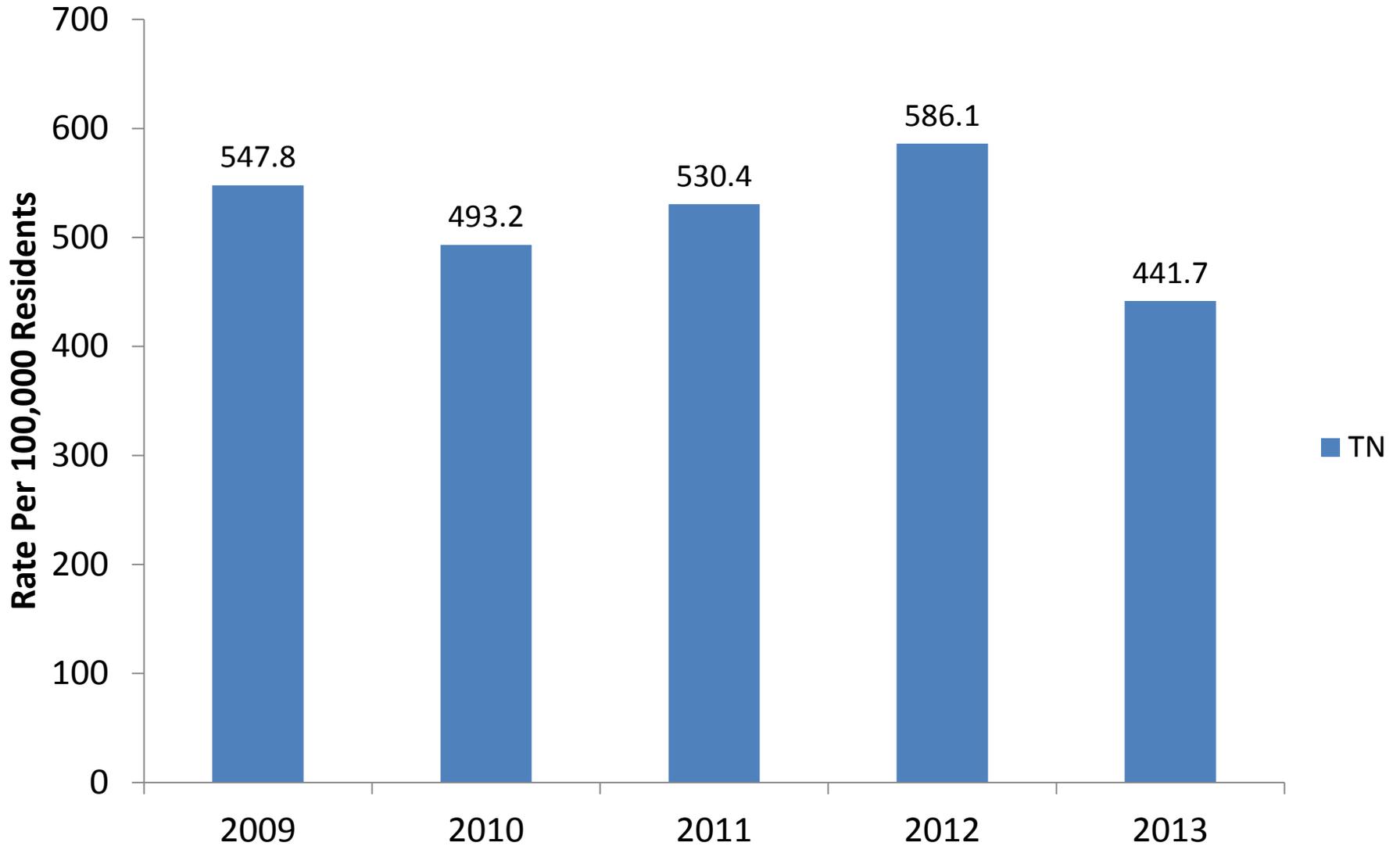
High School Students Who Did Not Use Birth Control During Last Sexual Intercourse



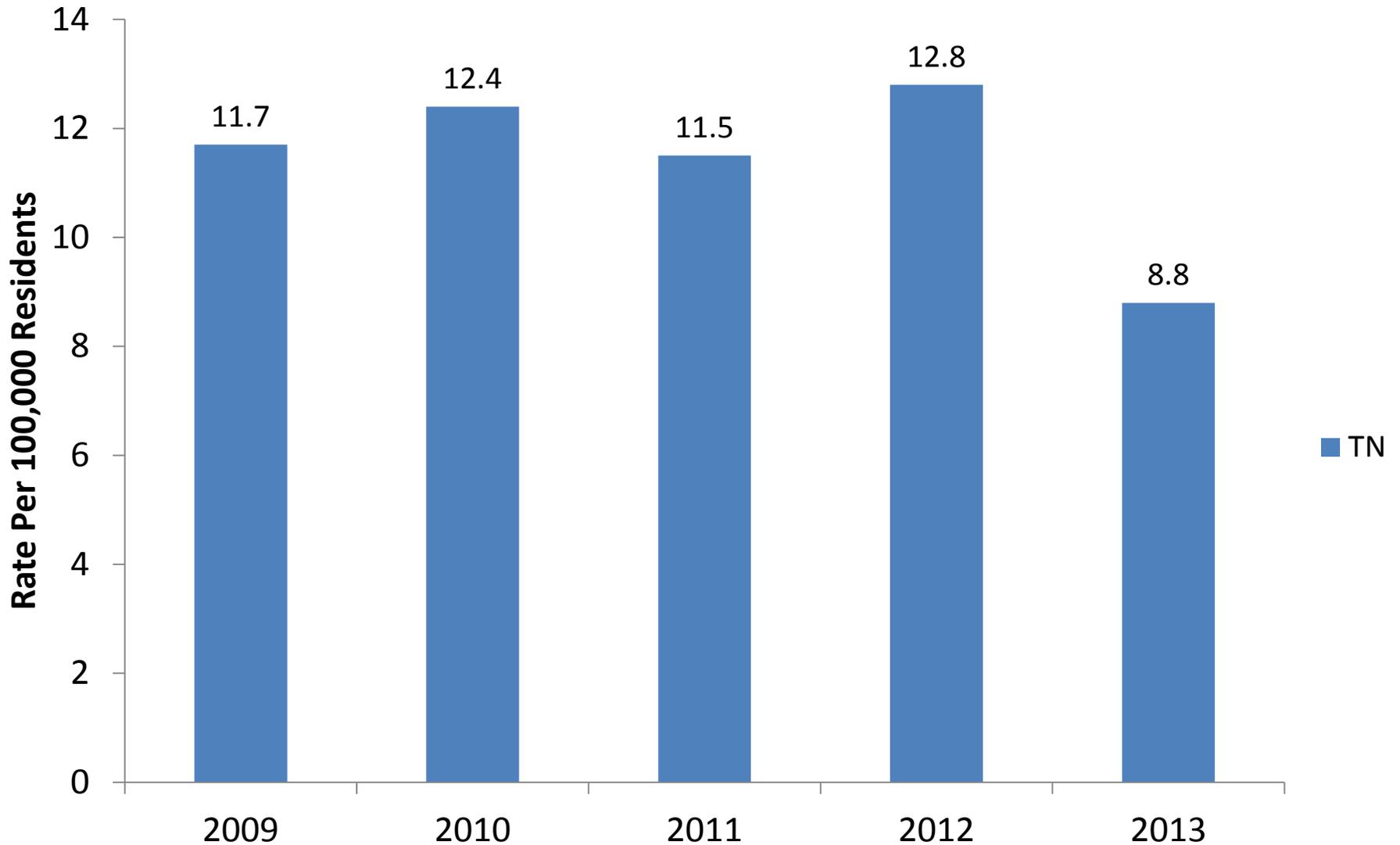
Chlamydia Cases Among Teens Age 15-19 Years



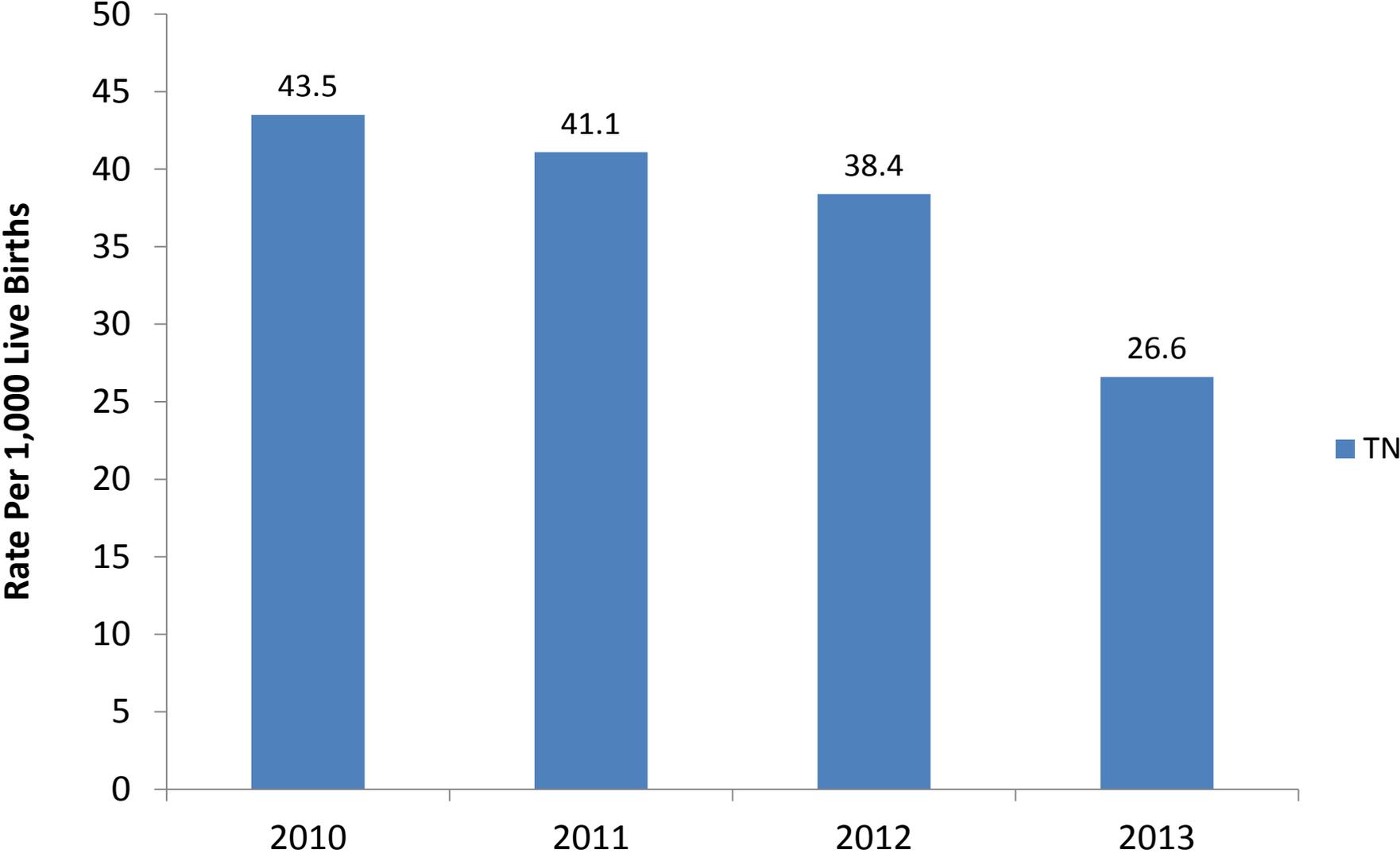
Gonorrhea Cases Among Teens Age 15-19 Years



HIV Cases Among Teens Age 15-19 Years

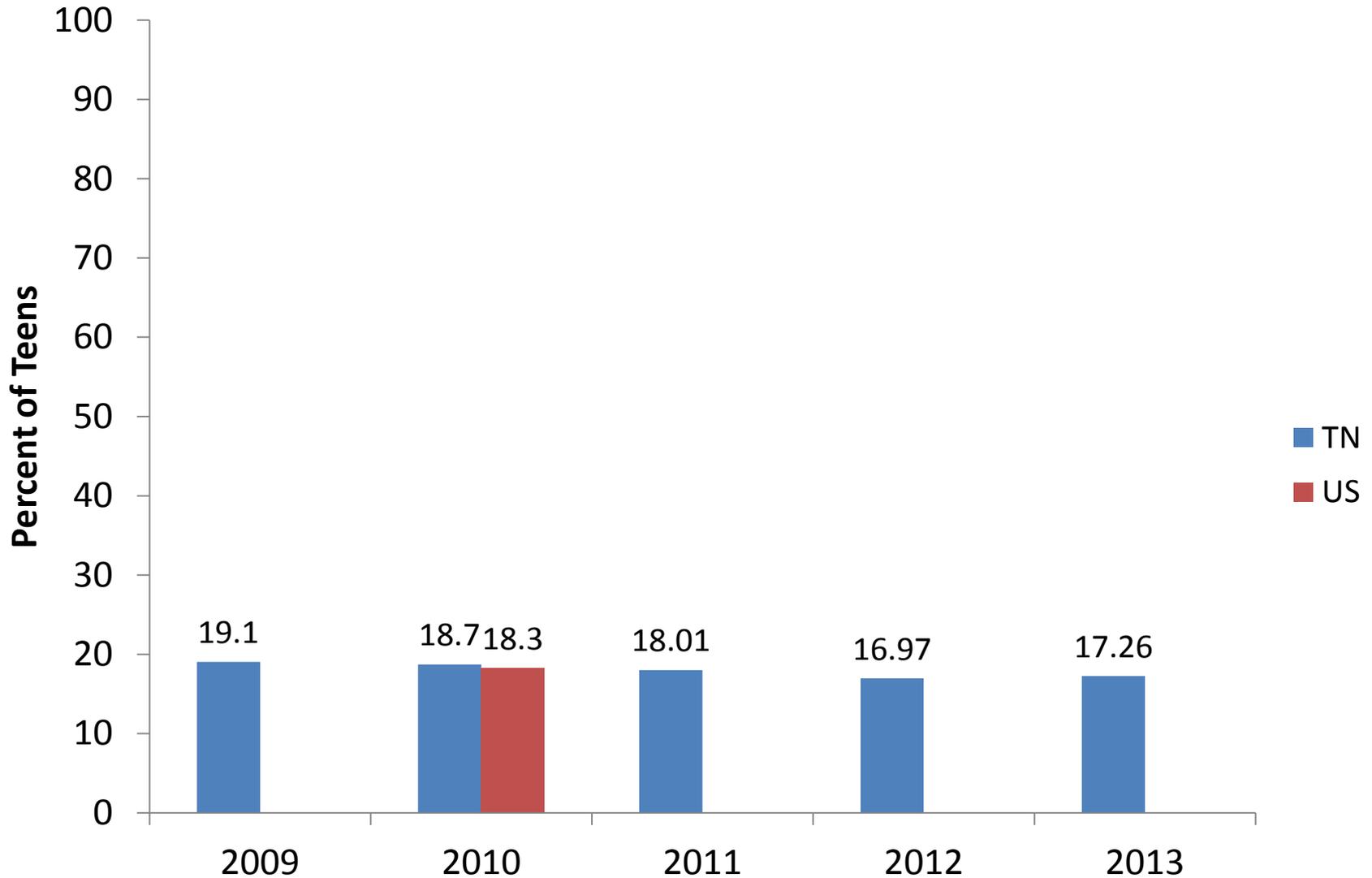


Teen Birth Rate Among Females Age 15-19 Years

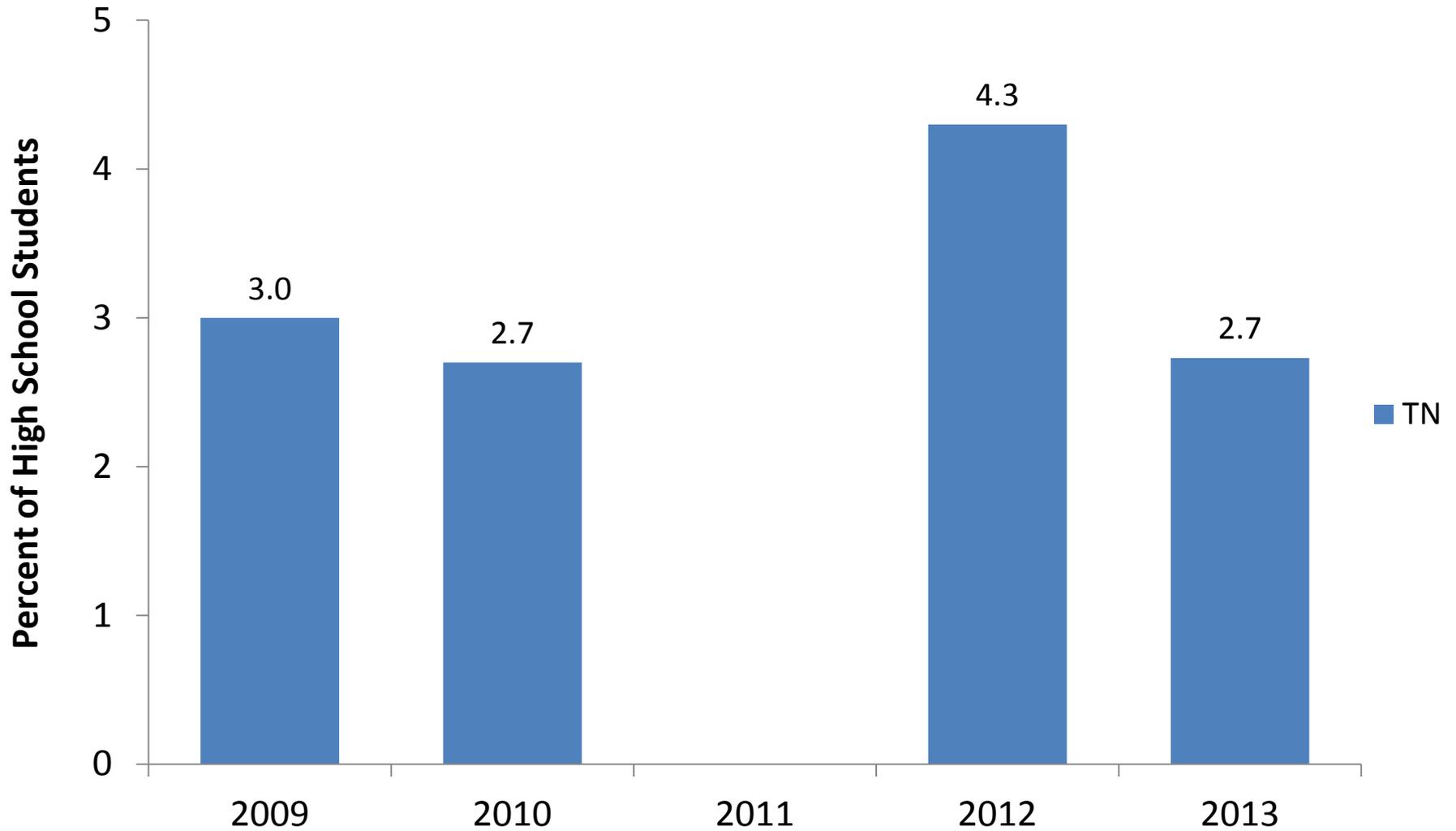


Data Source: Tennessee Department of Health; Division of Policy, Planning and Assessment; Birth Statistical System

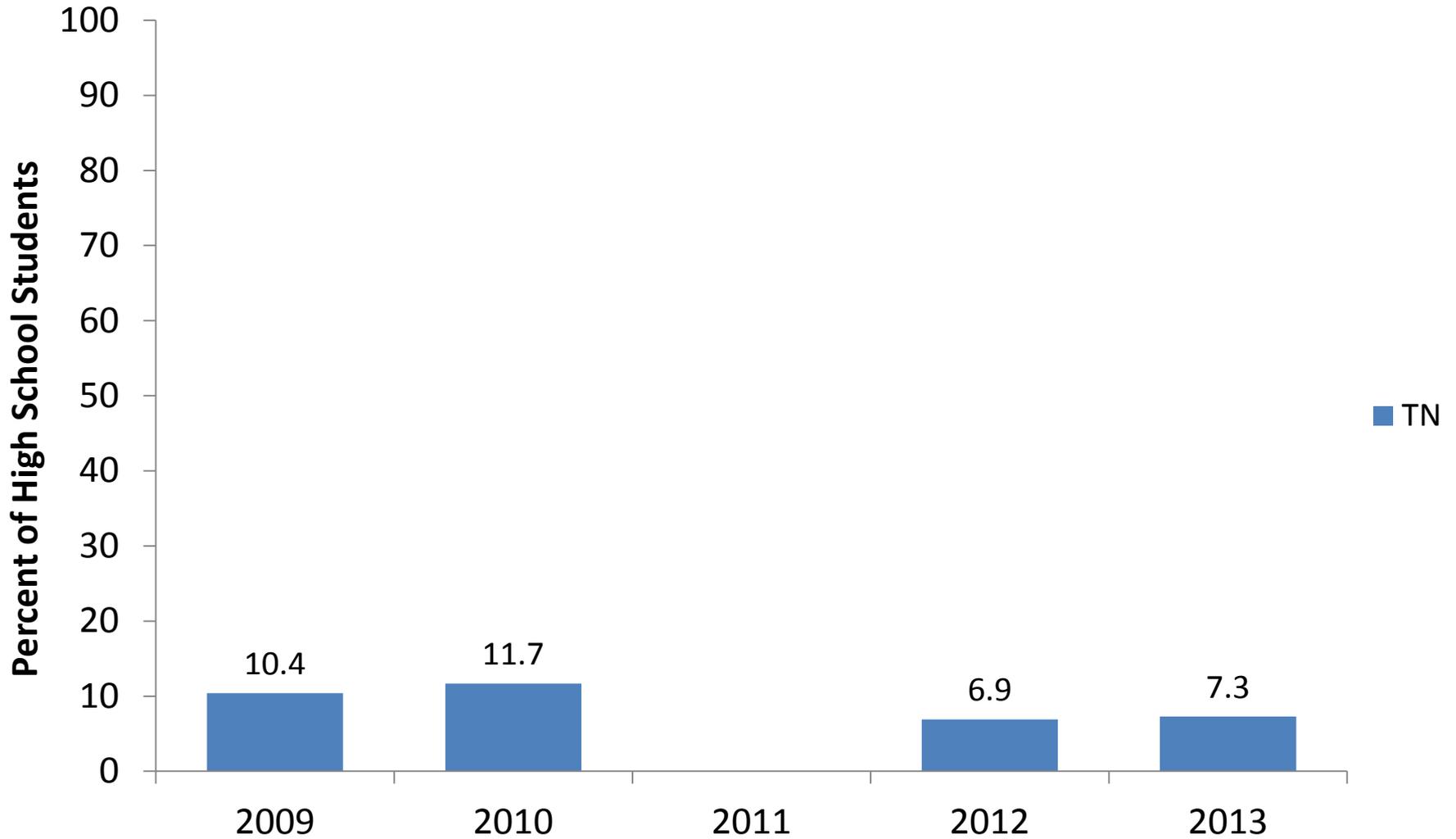
Repeat Teen Births Among Females Age 15-19 Years



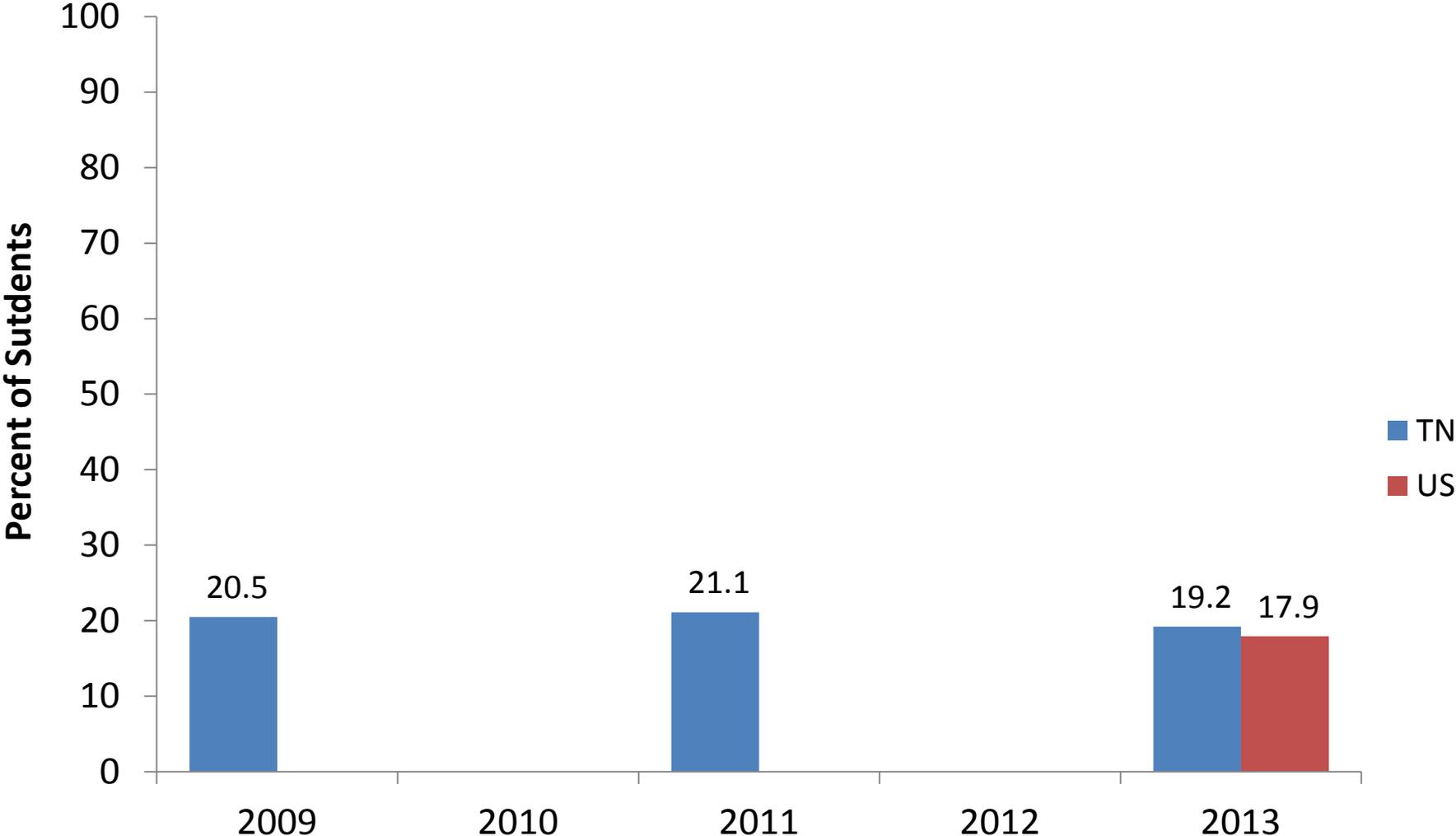
Prevalence of High School Drop Outs Within the Year



Prevalence of High School Drop Outs Before 12th Grade

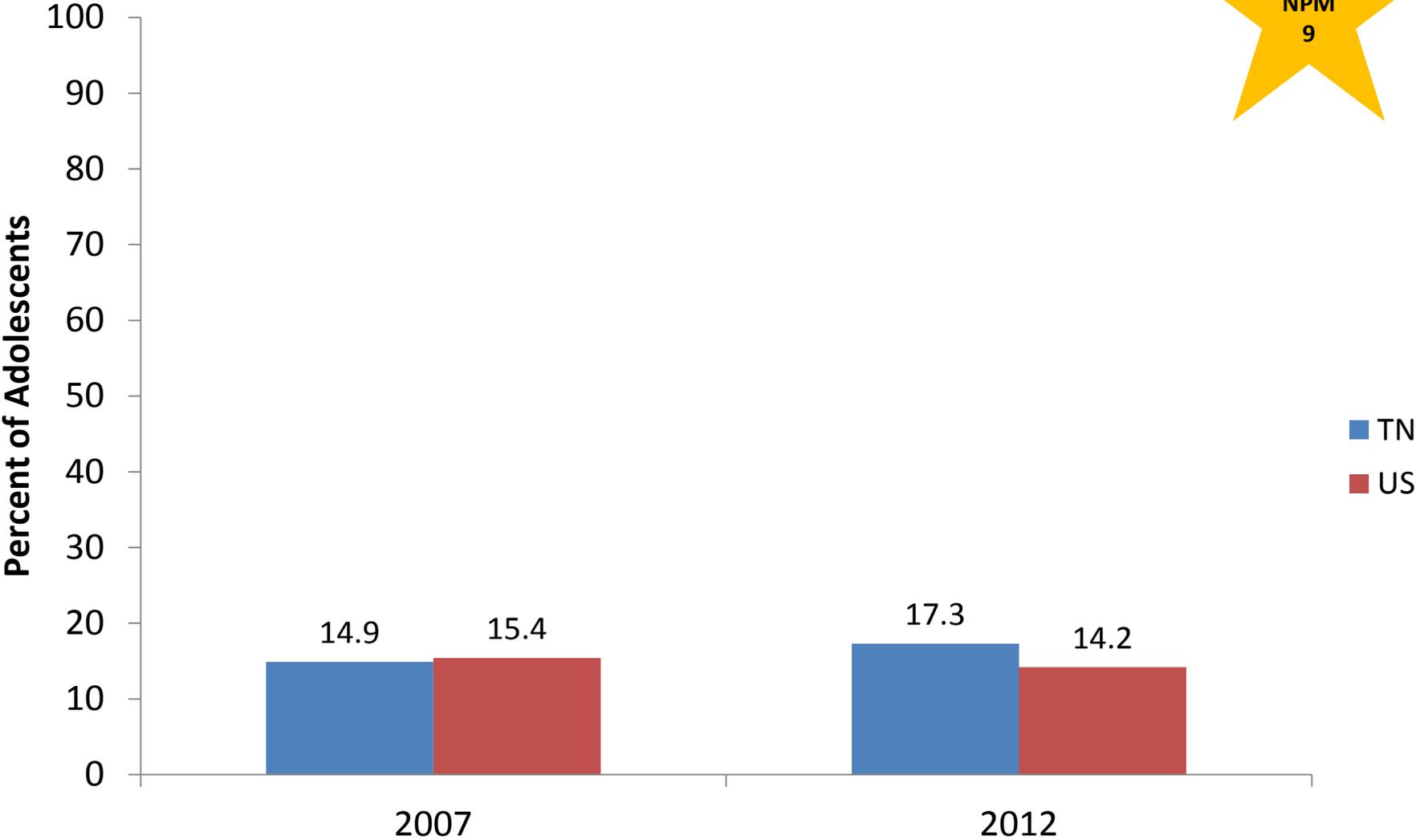


Percentage of High School Students Who Carried a Weapon on School Property



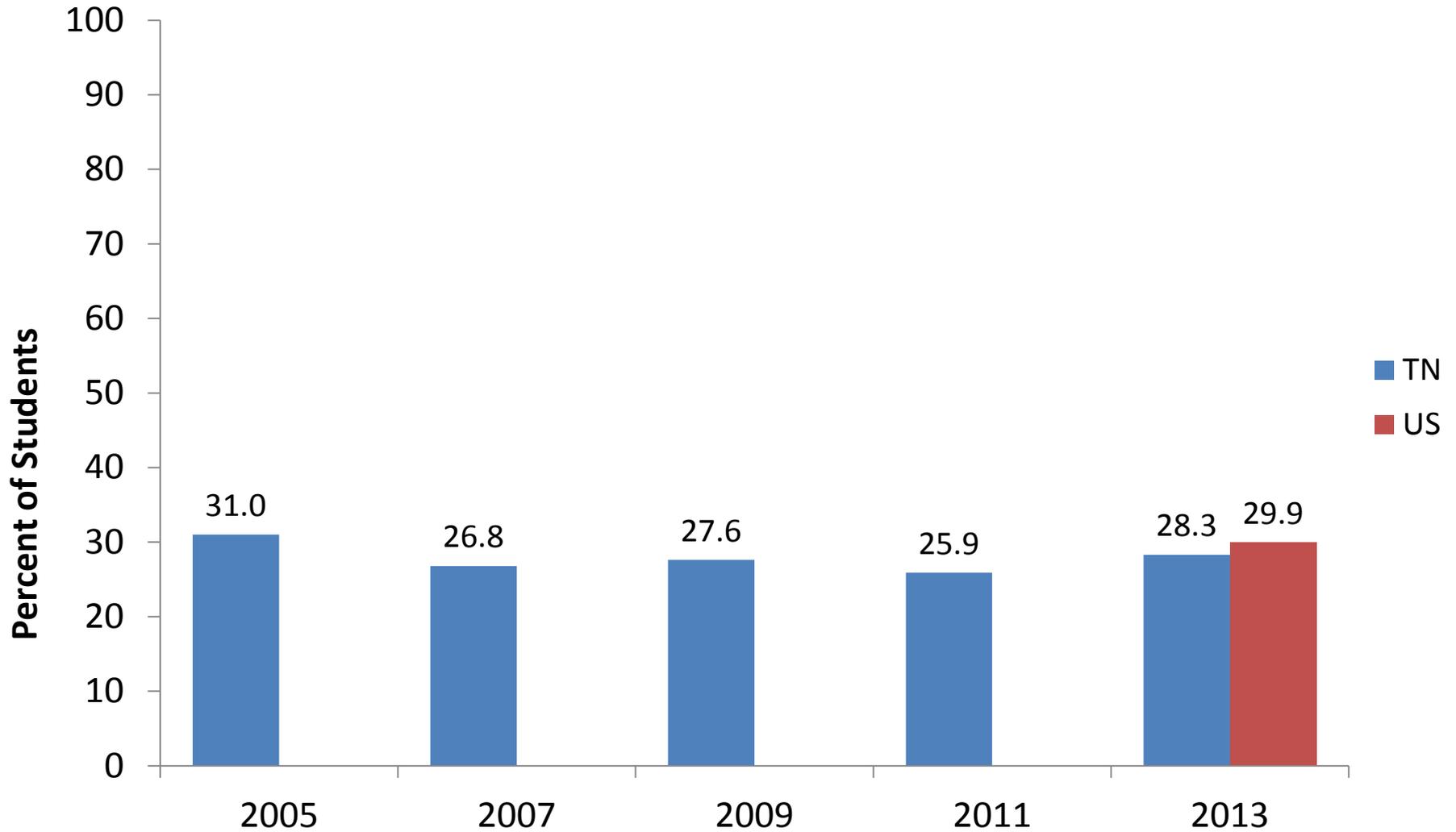
Data sources: 1) Tennessee Department of Education, Youth Risk Behavior Survey, 2009, 2011, 2013. 2) U.S. Department of Health and Human Services, Health Resources and Services Administration, Centers for Disease Control and Prevention, Youth Risk Behavior Surveillance System, 2013, on CDC YRBS Online Database. Accessed in December, 2014.

Adolescents Age 12-17 Years Who Bully Others



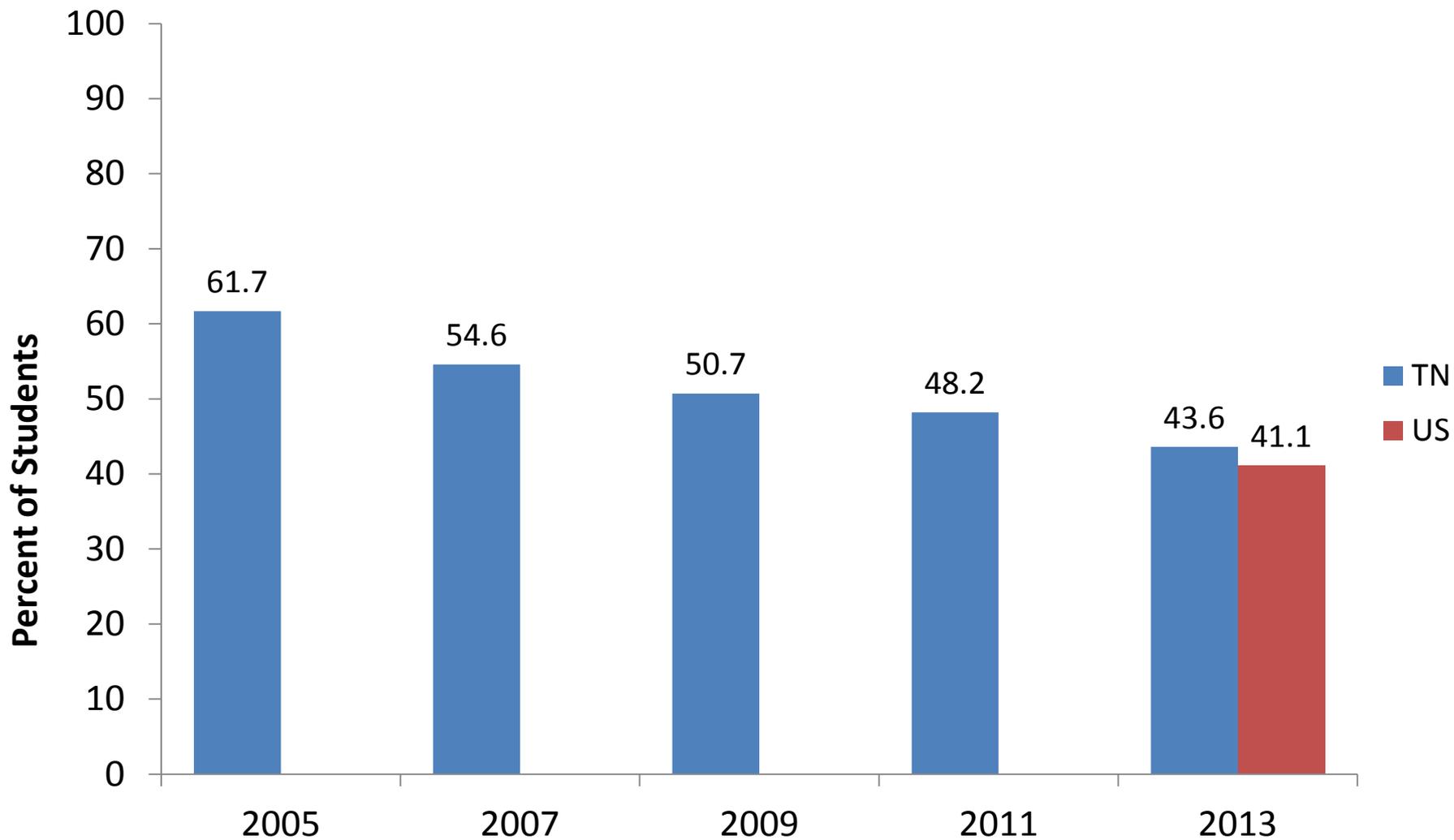
Data Source: National Survey of Children's Health. NSCH 2011/12. Data query from the Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website. Retrieved 8/1/14 from www.childhealthdata.org.

High School Students Who Were Depressed in the Past Year

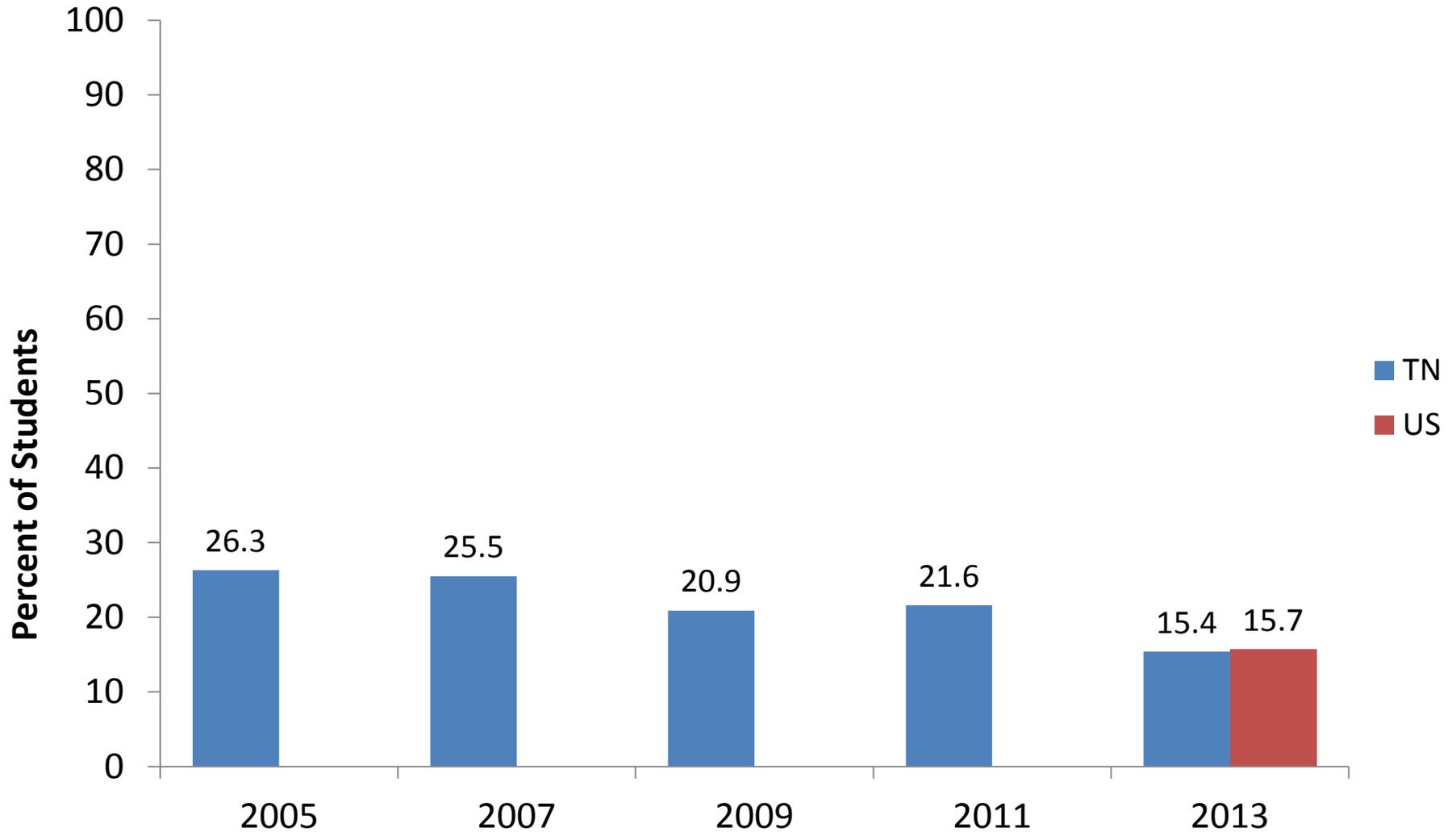


Data source: Centers for Disease Control and Prevention (CDC). 1991-2013 High School Youth Risk Behavior Survey Data. Accessed February 26, 2015 at <http://nccd.cdc.gov/youthonline/>.

High School Students Who Ever Tried Cigarette Smoking

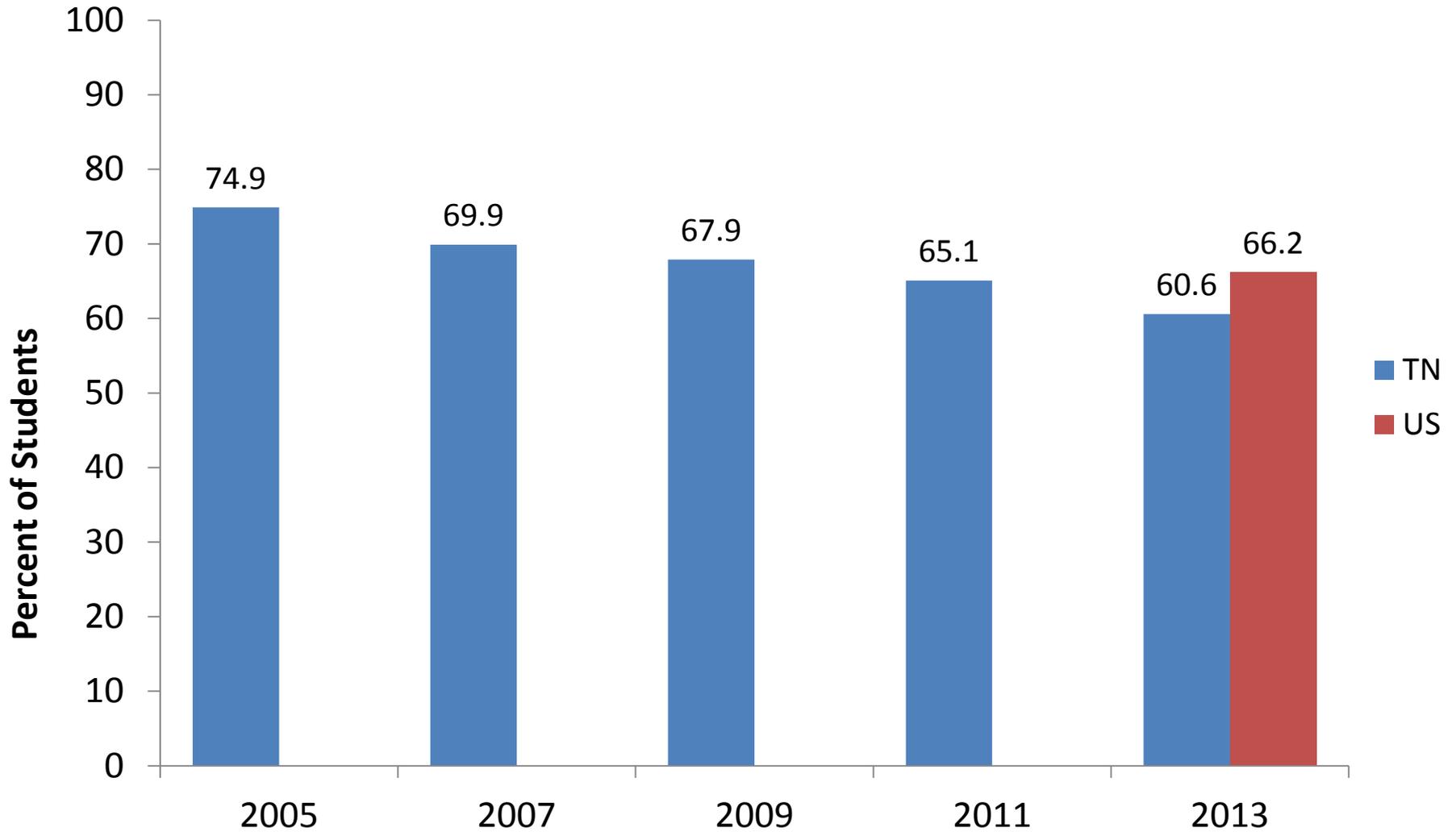


High School Students Who Currently Smoke Cigarettes

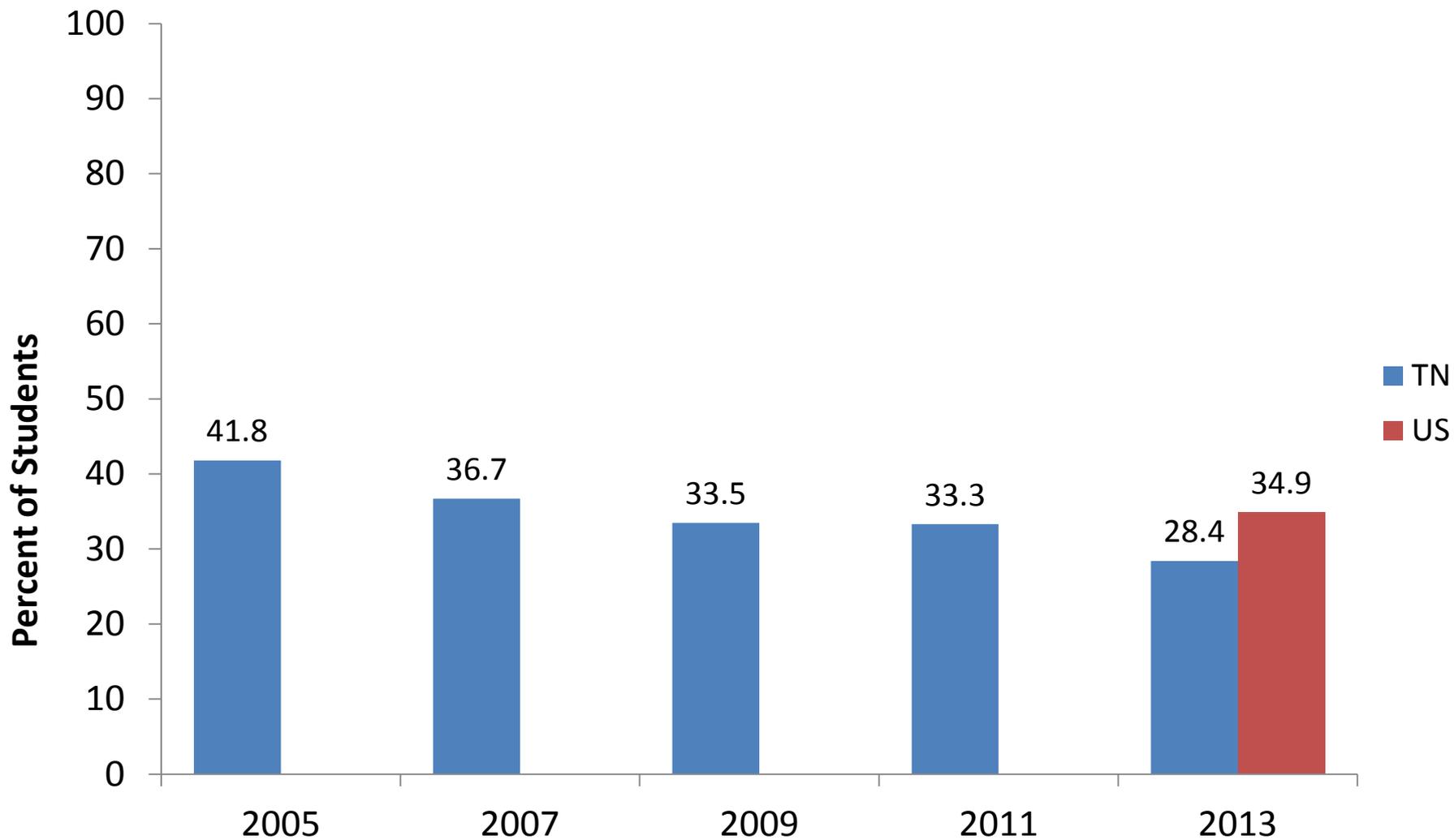


Data source: Centers for Disease Control and Prevention (CDC). 1991-2013 High School Youth Risk Behavior Survey Data. Accessed February 26, 2015 at <http://nccd.cdc.gov/youthonline/>.

High School Students Who Ever Had a Drink of Alcohol

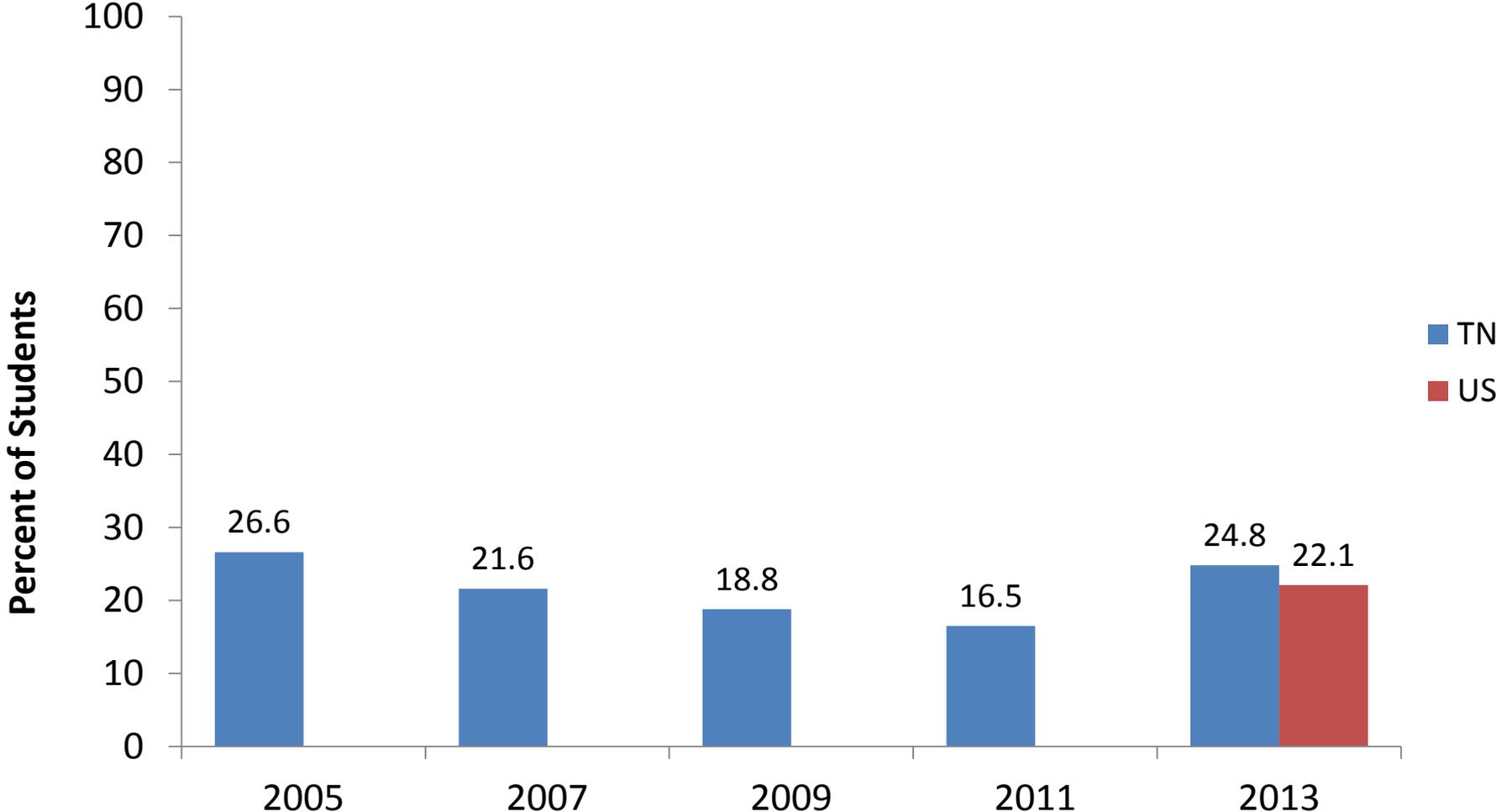


High School Students Who Currently Drink Alcohol



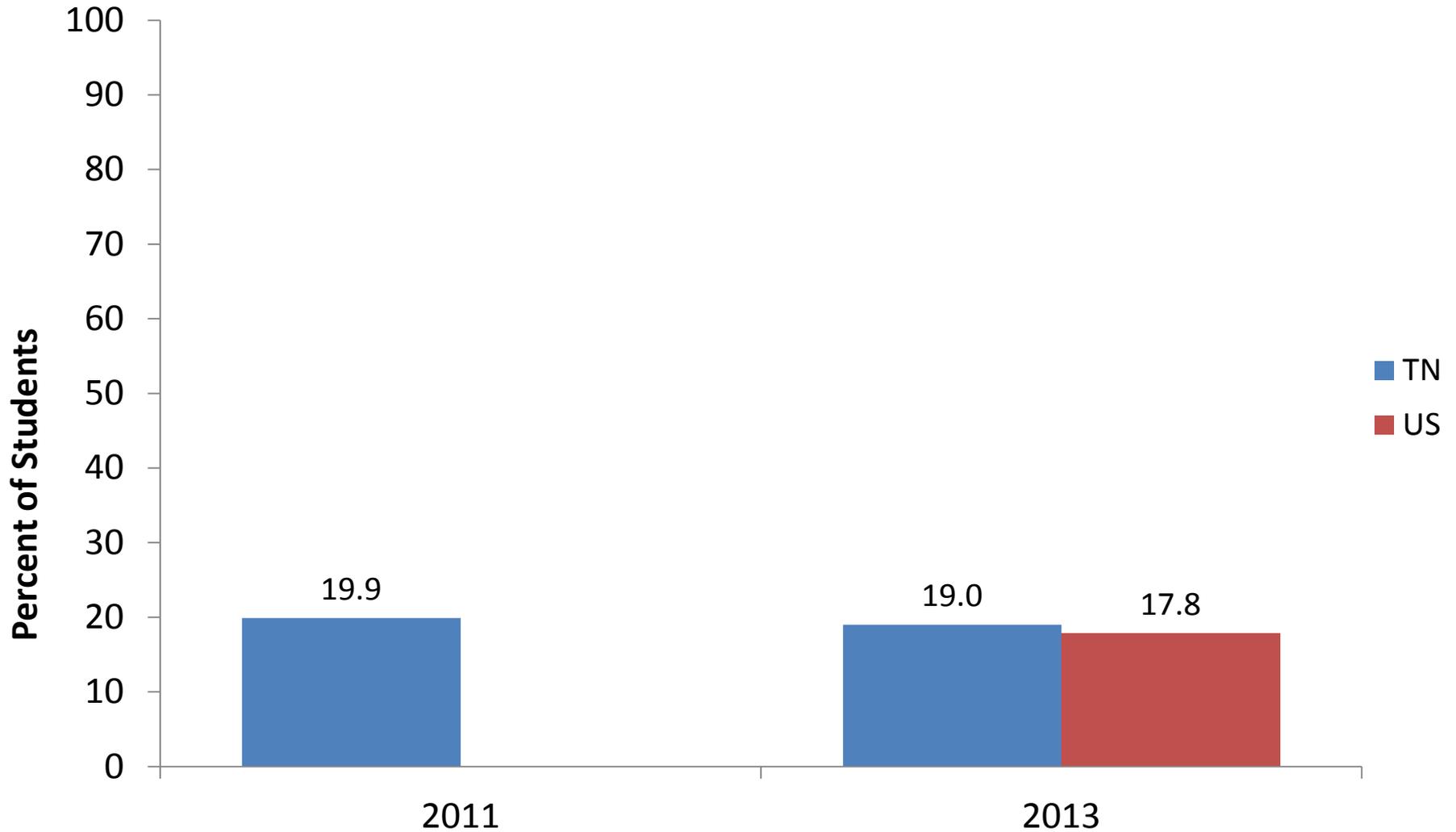
Data source: Centers for Disease Control and Prevention (CDC). 1991-2013 High School Youth Risk Behavior Survey Data. Accessed February 26, 2015 at <http://nccd.cdc.gov/youthonline/>.

High School Students Who Were Offered/Sold/Given Illegal Drugs at School in the Past Year

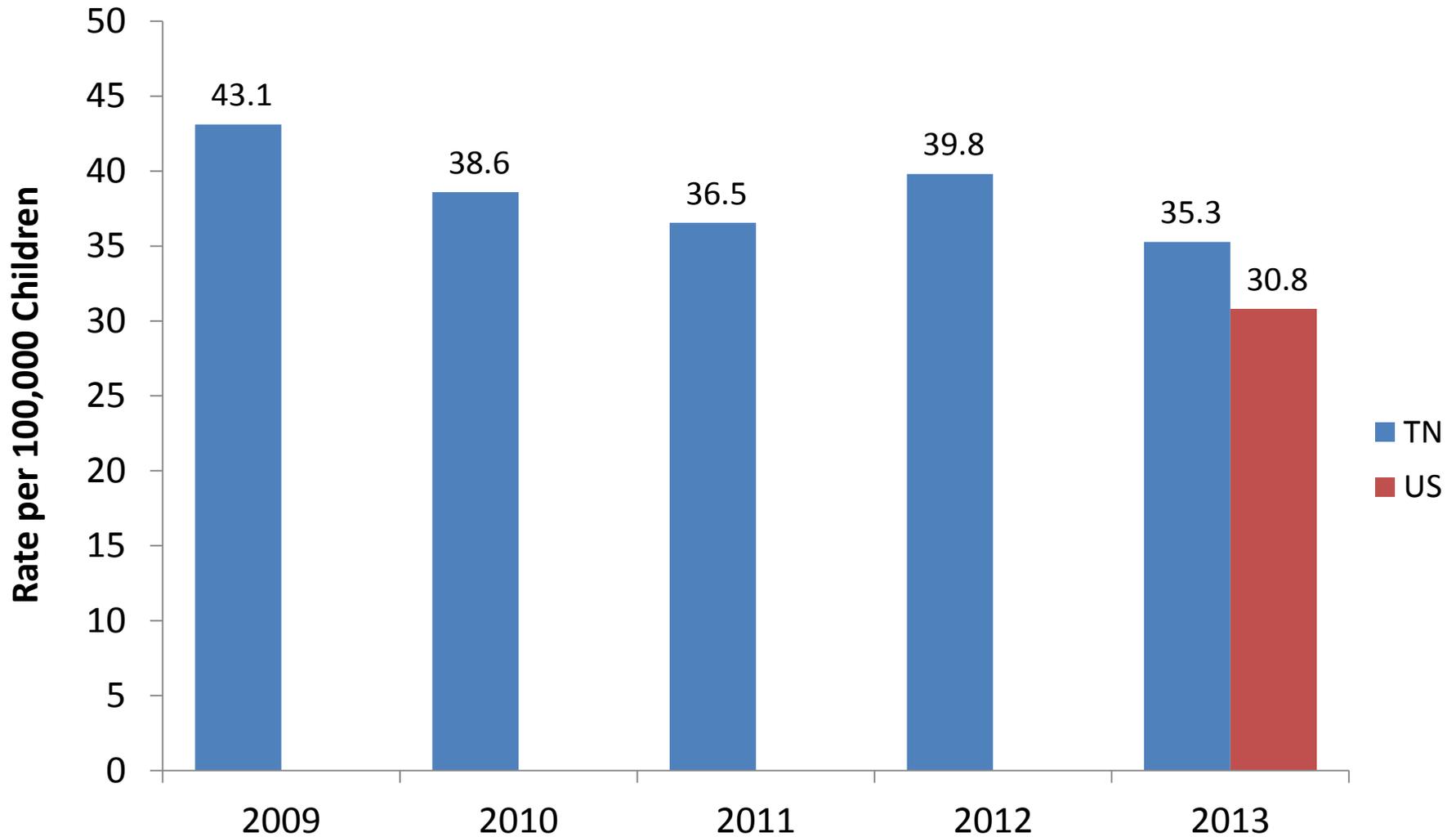


Data source: Centers for Disease Control and Prevention (CDC). 1991-2013 High School Youth Risk Behavior Survey Data. Accessed February 26, 2015 at <http://nccd.cdc.gov/youthonline/>.

High School Students Who Ever Took an Rx Drug Without a Dr.'s Prescription

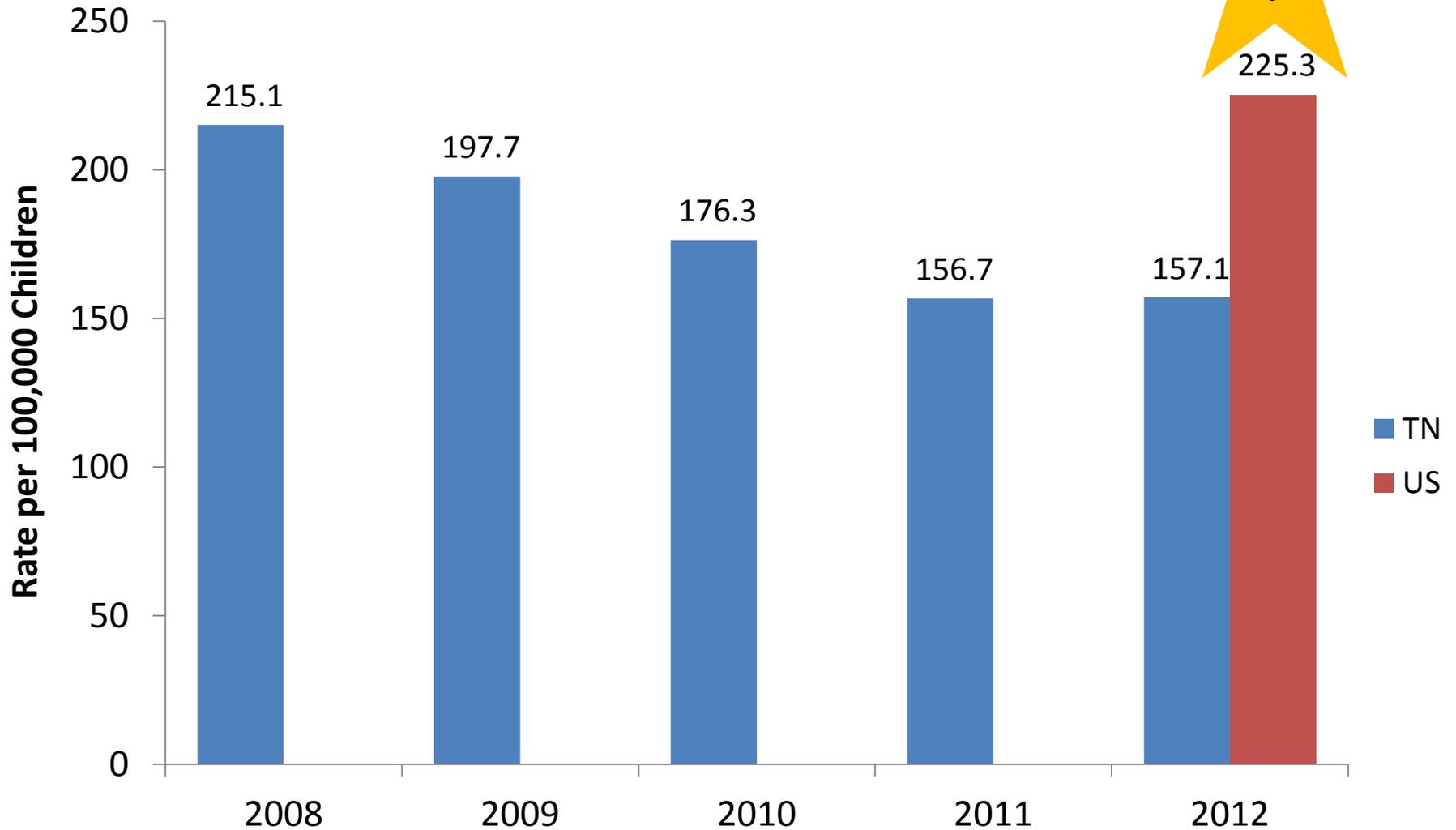


Unintentional Injury Deaths Among Adolescents Age 10-19 Years



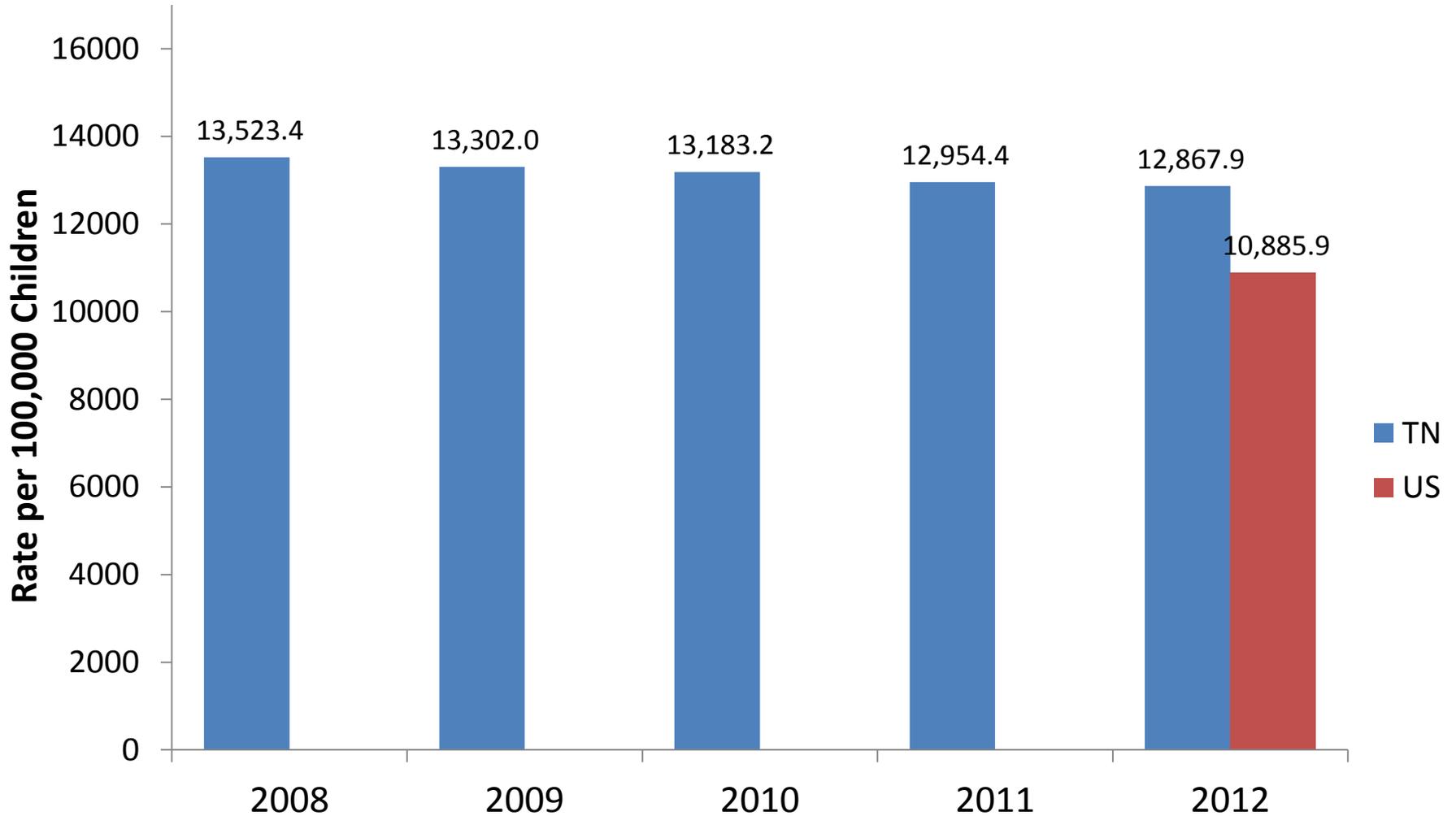
Data sources: 1) Tennessee Department of Health; Division of Policy, Planning and Assessment, Death Statistical System. 2) U.S. Department of Health and Human Services, Health Resources and Services Administration, Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Fatal Injury Report, 2009-2013, on CDC WISQARS Online Database. Accessed in January, 2015.

Unintentional Injury Hospitalizations Among Adolescents Ages 10-19 Years



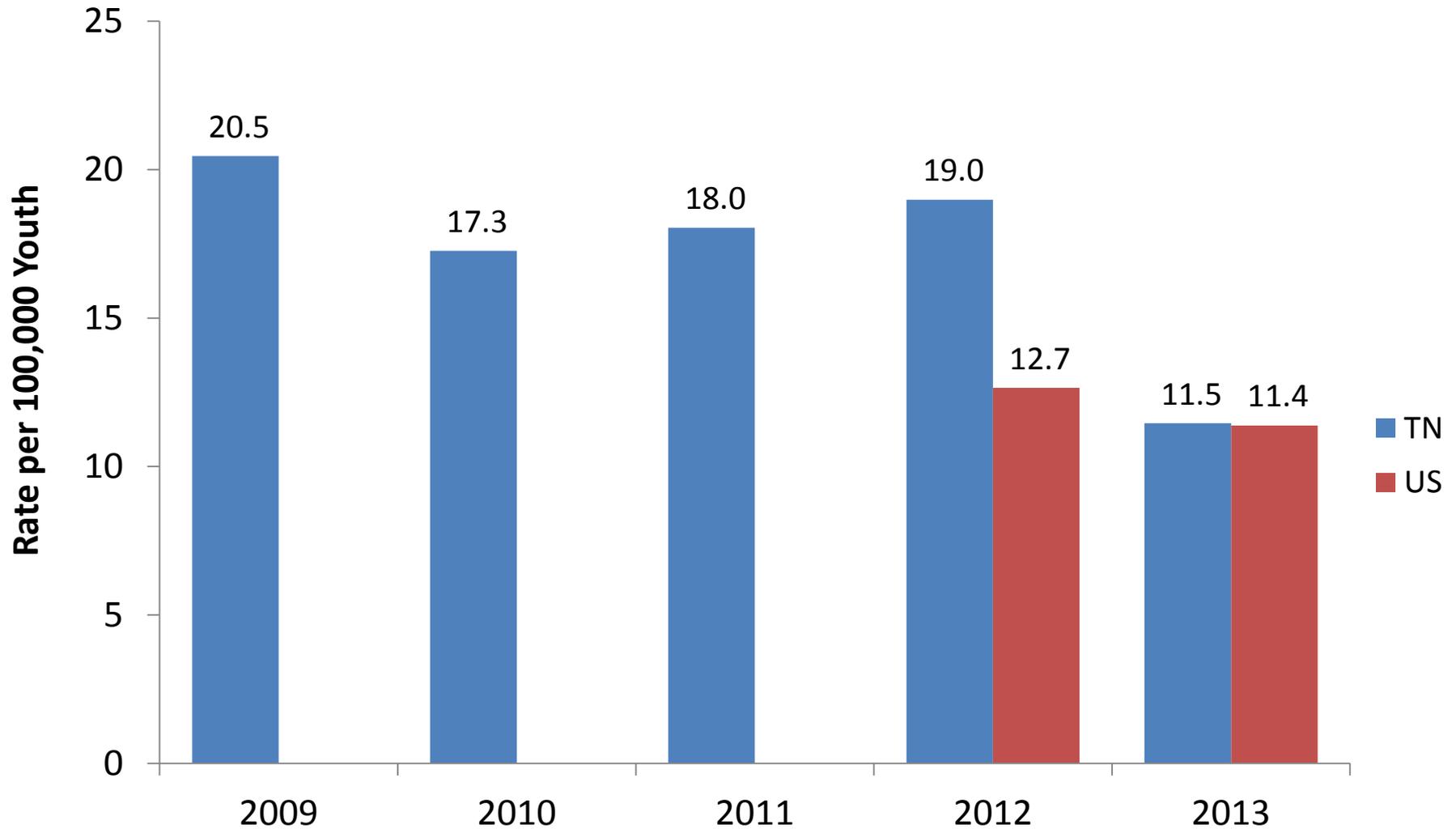
Data sources: 1) Tennessee Department of Health; Division of Policy, Planning and Assessment, Hospital Discharge Database System. 2) U.S. Department of Health and Human Services, Health Resources and Services Administration, Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Fatal Injury Report, 2008-2012, on CDC WISQARS Online Database. Accessed in January, 2015.

Unintentional Injury ED Visits Among Adolescents Age 10-19 Years



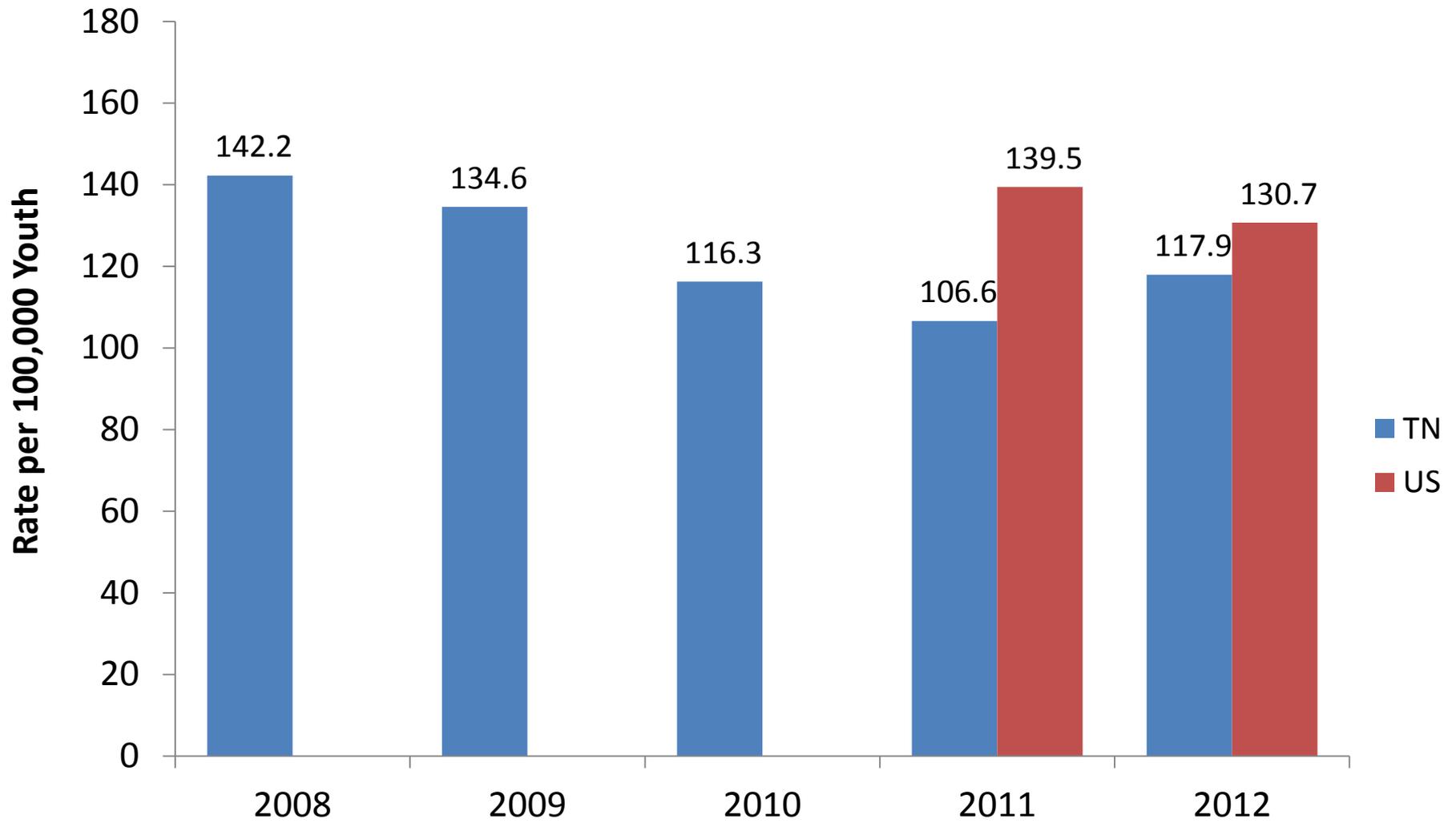
Data sources: 1) Tennessee Department of Health; Division of Policy, Planning and Assessment, Hospital Discharge Database System. 2) U.S. Department of Health and Human Services, Health Resources and Services Administration, Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Fatal Injury Report, 2008-2012, on CDC WISQARS Online Database. Accessed in January, 2015.

Motor Vehicle Related Deaths Among Adolescents Ages 15-19 Years



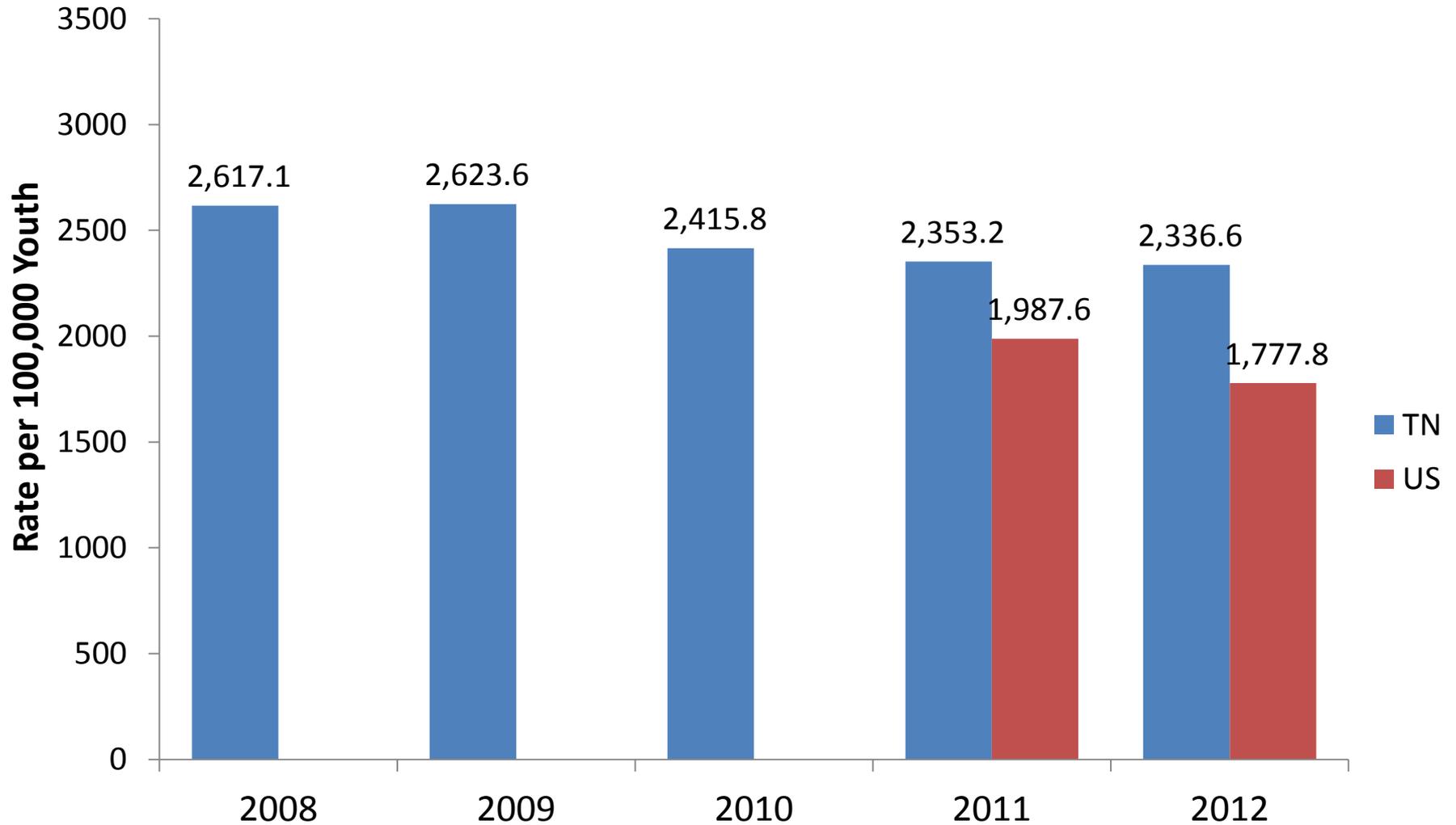
Data sources: 1) Tennessee Department of Health; Division of Policy, Planning and Assessment, Death Statistical System. 2) U.S. Department of Health and Human Services, Health Resources and Services Administration, Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Fatal Injury Report, 2009-2013, on CDC WISQARS Online Database. Accessed in January, 2015.

Motor Vehicle Related Hospitalizations Among Adolescents Age 15-19 Years



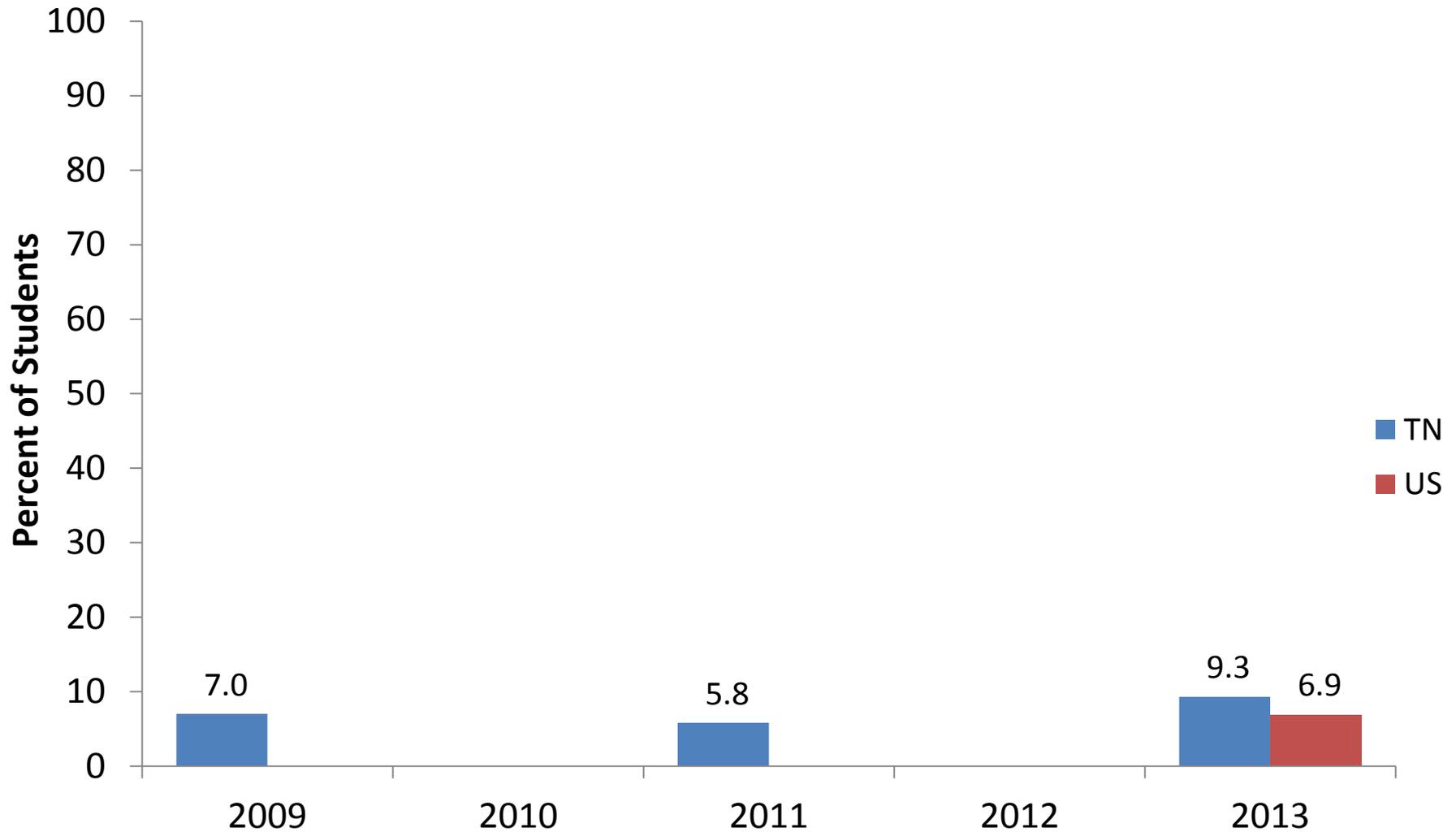
Data sources: 1) Tennessee Department of Health; Division of Policy, Planning and Assessment, Hospital Discharge Database System. 2) U.S. Department of Health and Human Services, Health Resources and Services Administration, Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Fatal Injury Report, 2008-2012, on CDC WISQARS Online Database. Accessed in January, 2015.

Motor Vehicle Related ED Visits Among Adolescents Age 15-19 Years



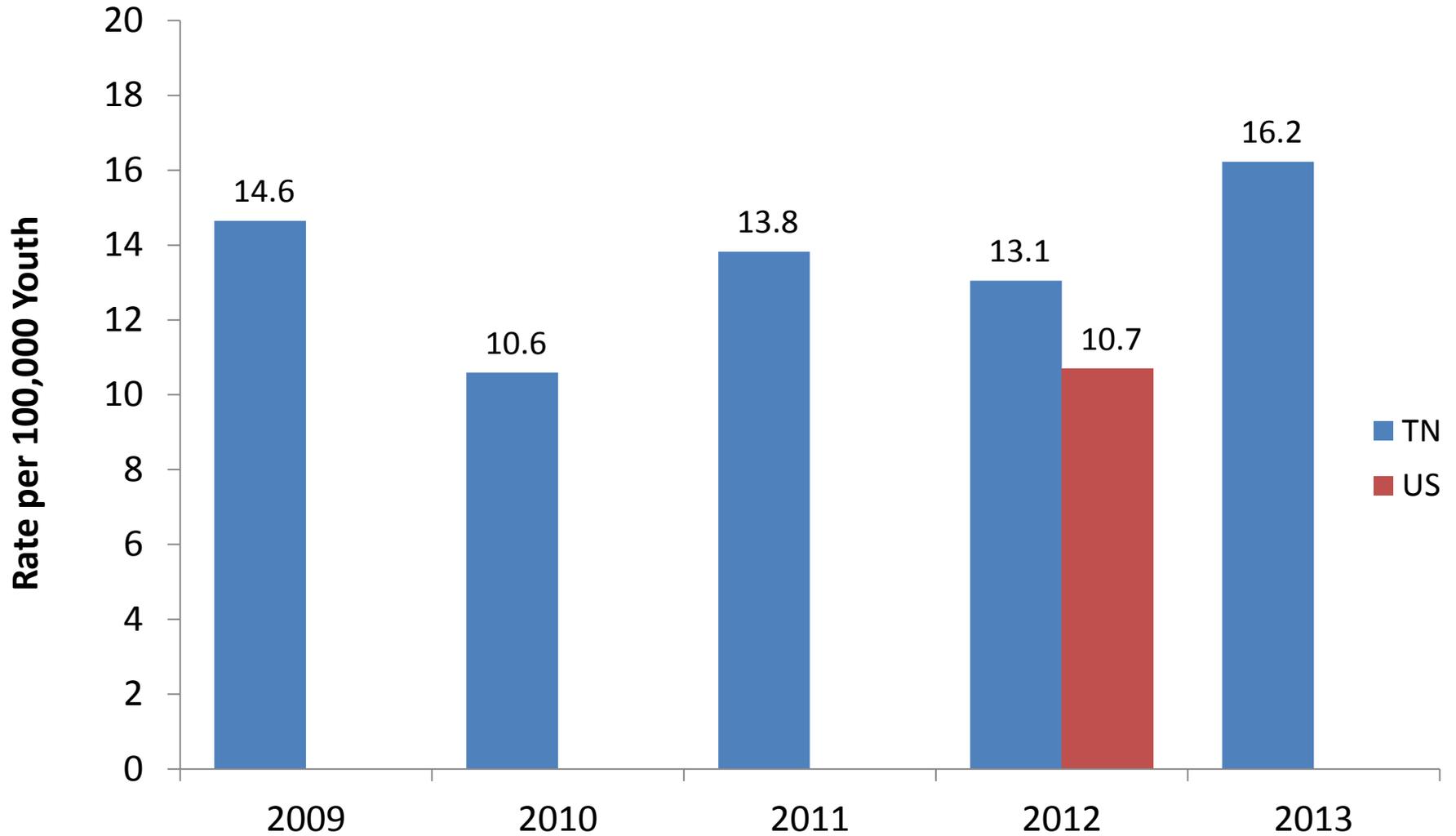
Data sources: 1) Tennessee Department of Health; Division of Policy, Planning and Assessment, Hospital Discharge Database System. 2) U.S. Department of Health and Human Services, Health Resources and Services Administration, Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Fatal Injury Report, 2008-2012, on CDC WISQARS Online Database. Accessed in January, 2015.

Percentage of High School Students Threatened or Injured With a Weapon



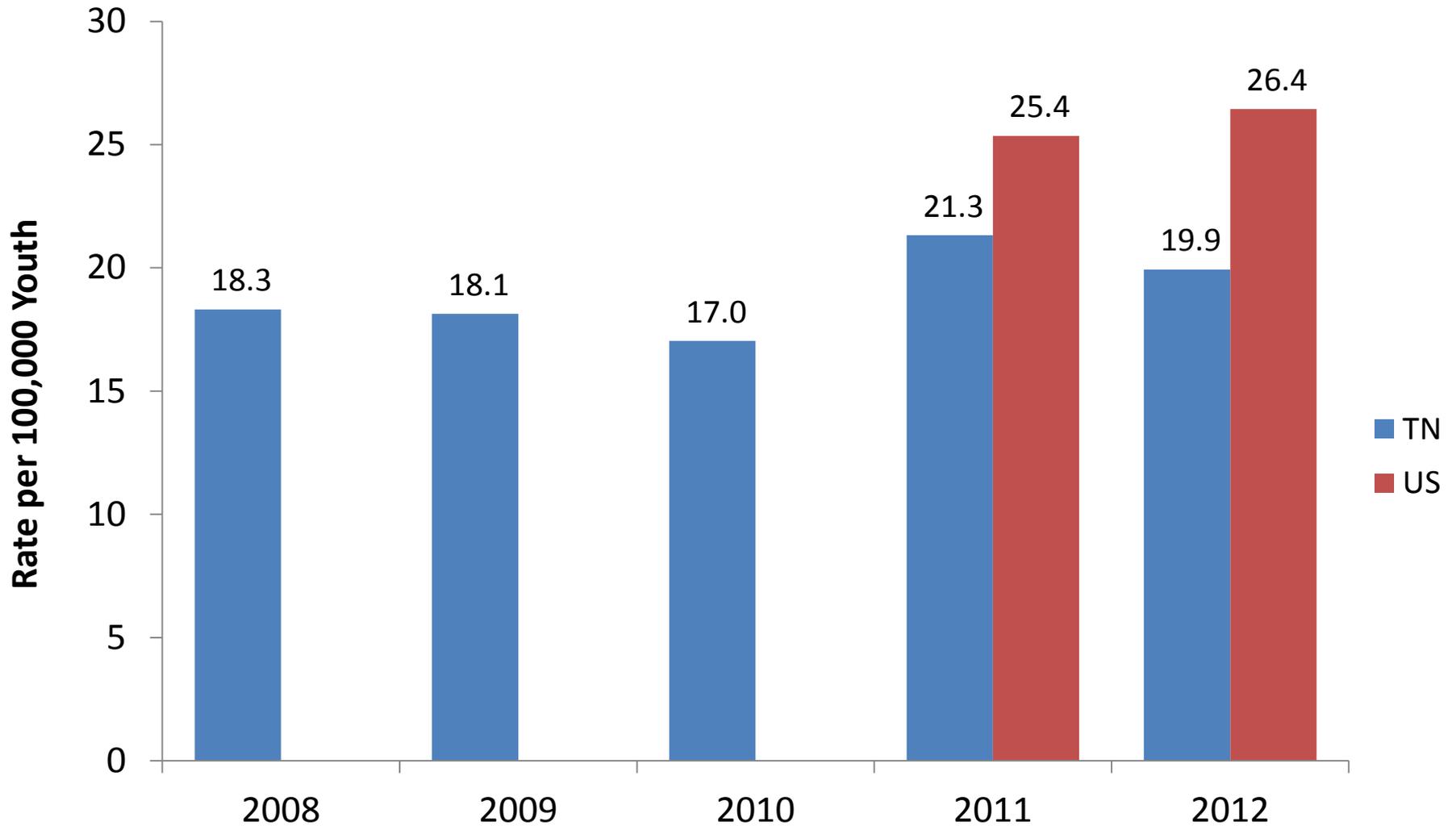
Data sources: 1) Tennessee Department of Education, Youth Risk Behavior Survey, 2009, 2011, 2013. 2) U.S. Department of Health and Human Services, Health Resources and Services Administration, Centers for Disease Control and Prevention, Youth Risk Behavior Surveillance System, 2013, on CDC YRBS Online Database. Accessed in December, 2014.

Weapon Related Injury Deaths Among Adolescents Age 15-19 Years



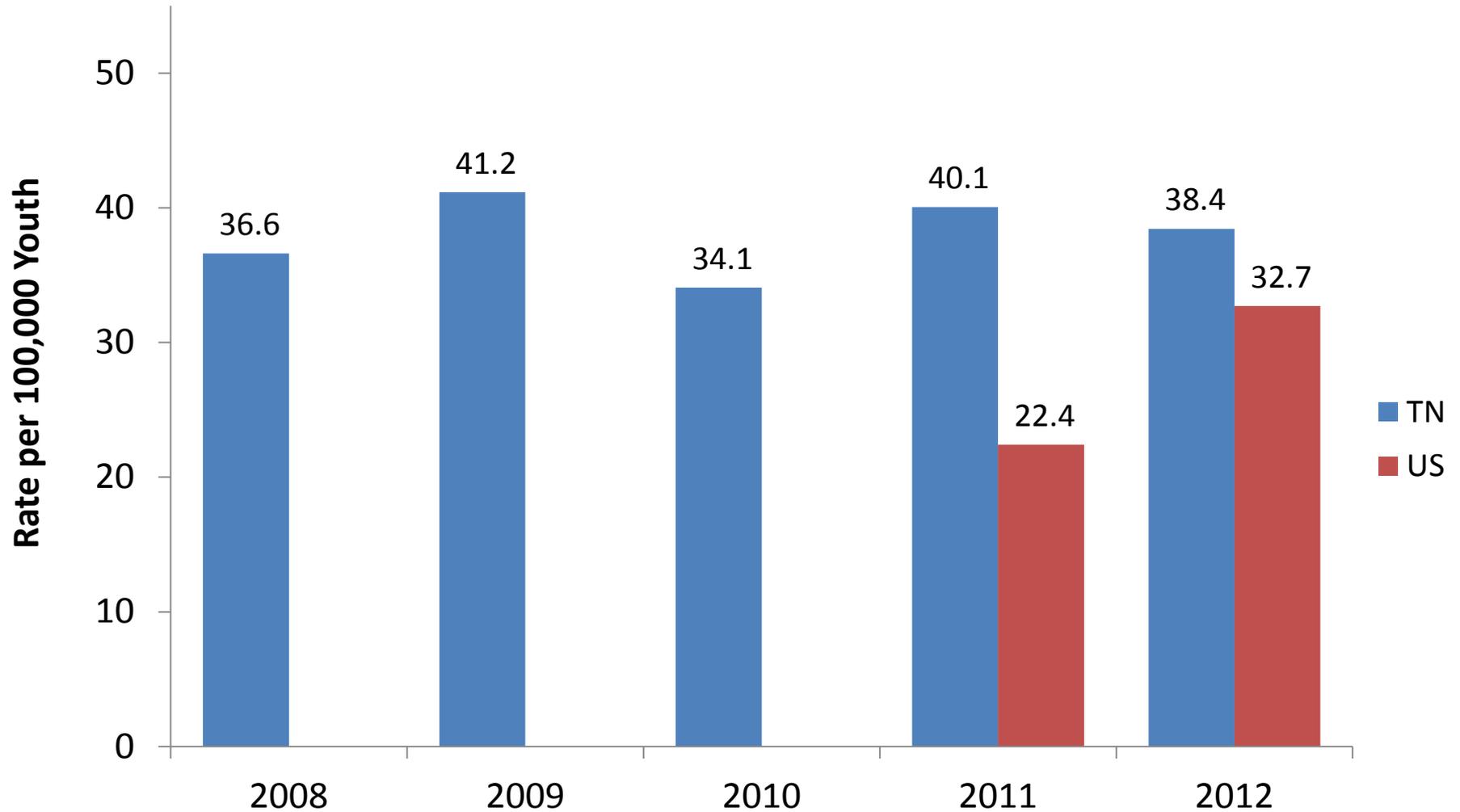
Data sources: 1) Tennessee Department of Health; Division of Policy, Planning and Assessment, Death Statistical System. 2) U.S. Department of Health and Human Services, Health Resources and Services Administration, Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Fatal Injury Report, 2009-2013, on CDC WISQARS Online Database. Accessed in January, 2015.

Weapon Related Injury Hospitalizations Among Adolescents Ages 15-19 Years



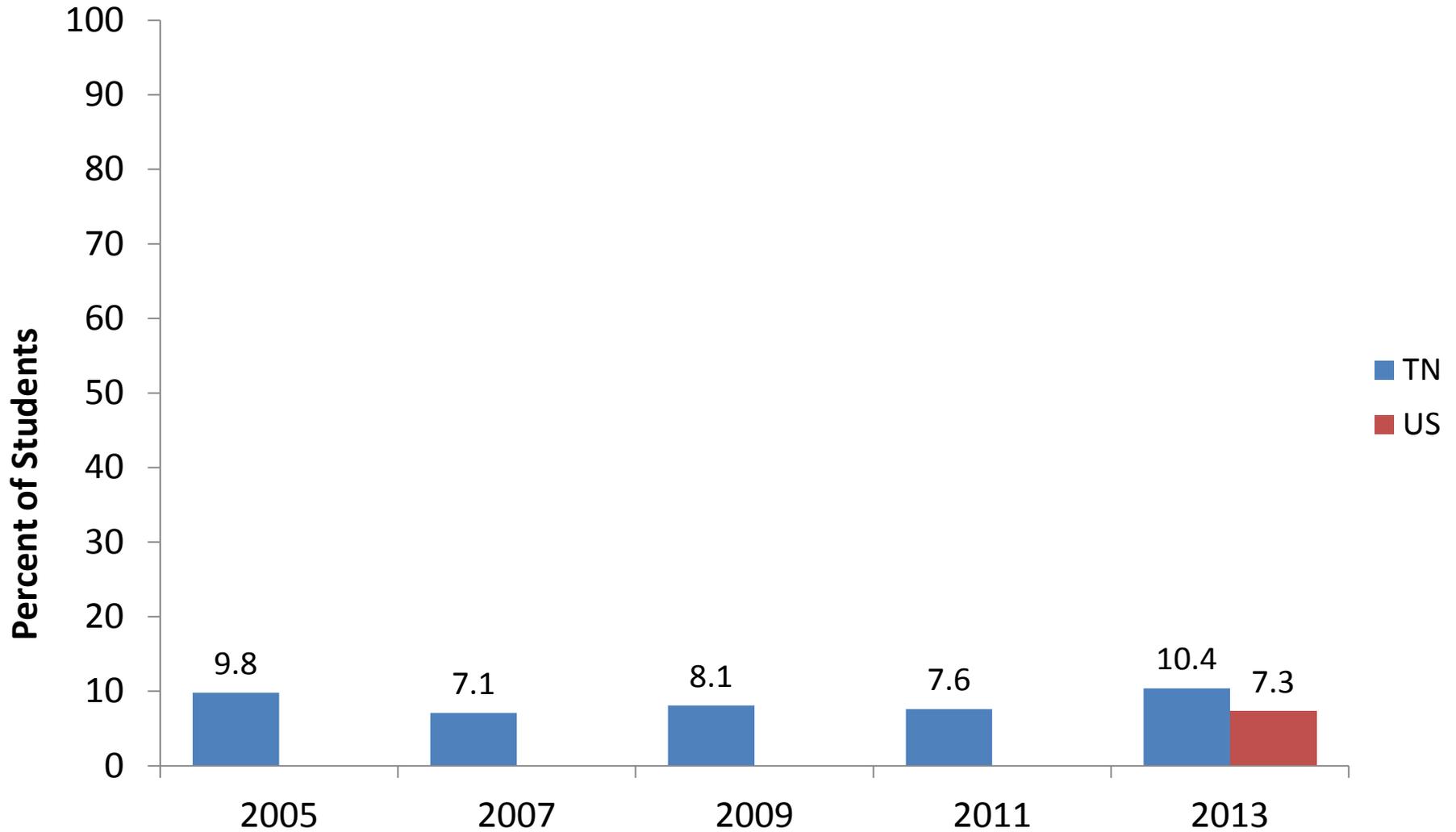
Data sources: 1) Tennessee Department of Health; Division of Policy, Planning and Assessment, Hospital Discharge Database System. 2) U.S. Department of Health and Human Services, Health Resources and Services Administration, Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Fatal Injury Report, 2008-2012, on CDC WISQARS Online Database. Accessed in January, 2015.

Weapon Related Injury ED Visits Among Adolescents Age 15-19 Years

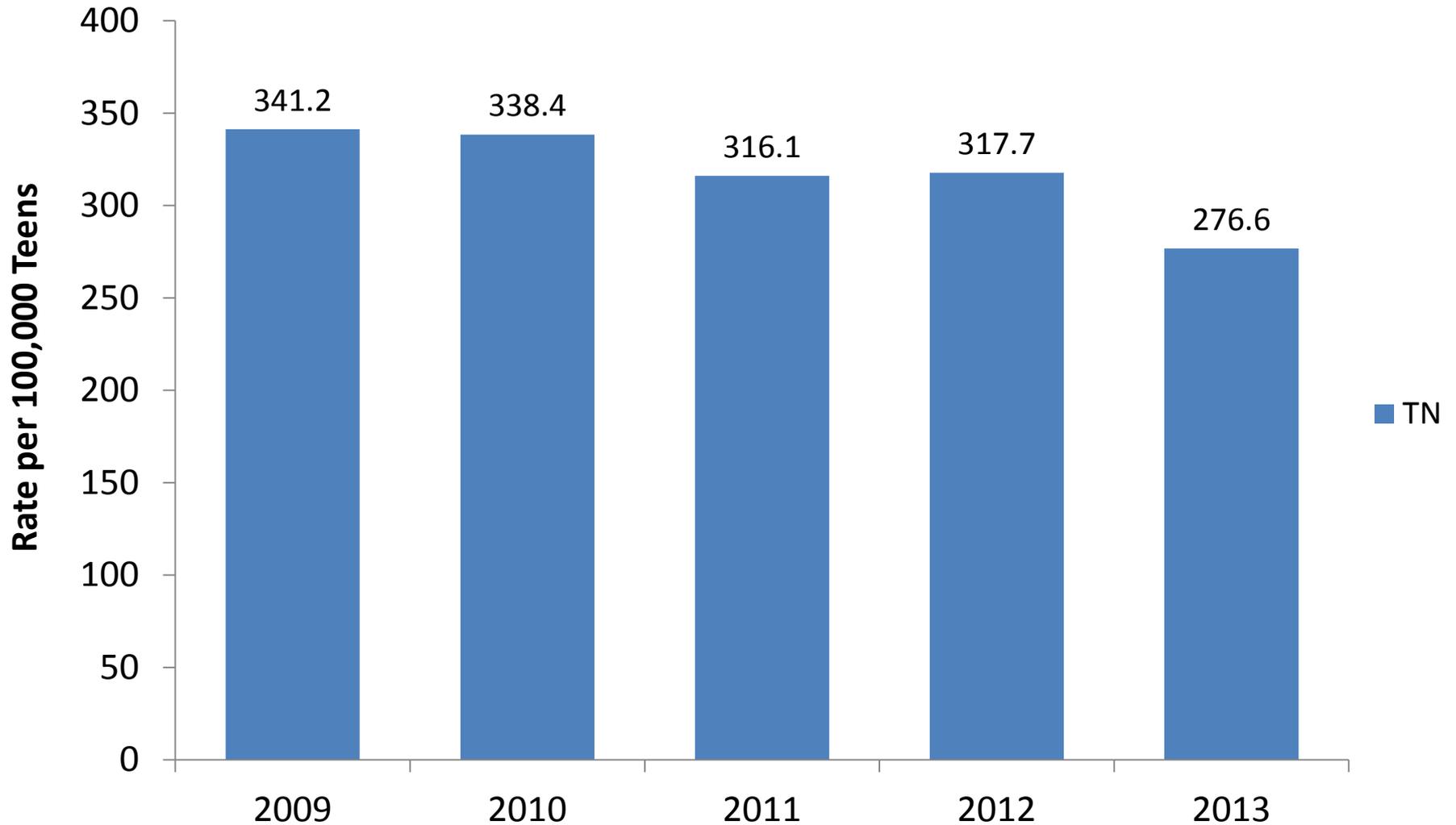


Data sources: 1) Tennessee Department of Health; Division of Policy, Planning and Assessment, Hospital Discharge Database System. 2) U.S. Department of Health and Human Services, Health Resources and Services Administration, Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Fatal Injury Report, 2008-2012, on CDC WISQARS Online Database. Accessed in January, 2015.

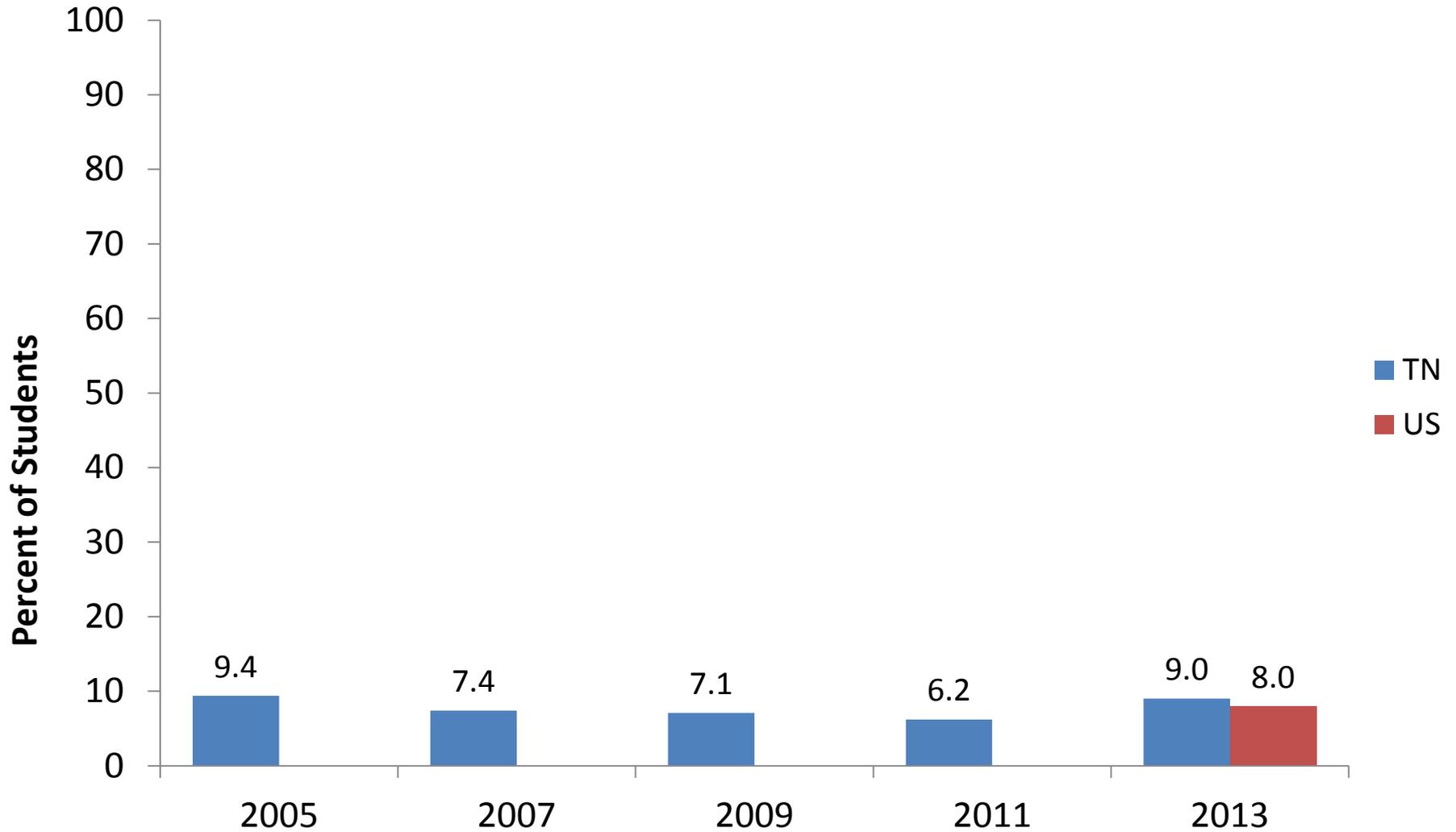
High School Students Who Were Ever Sexually Assaulted



Sexual Assault Victims per 100, 000 Adolescents Age 10-19 Years

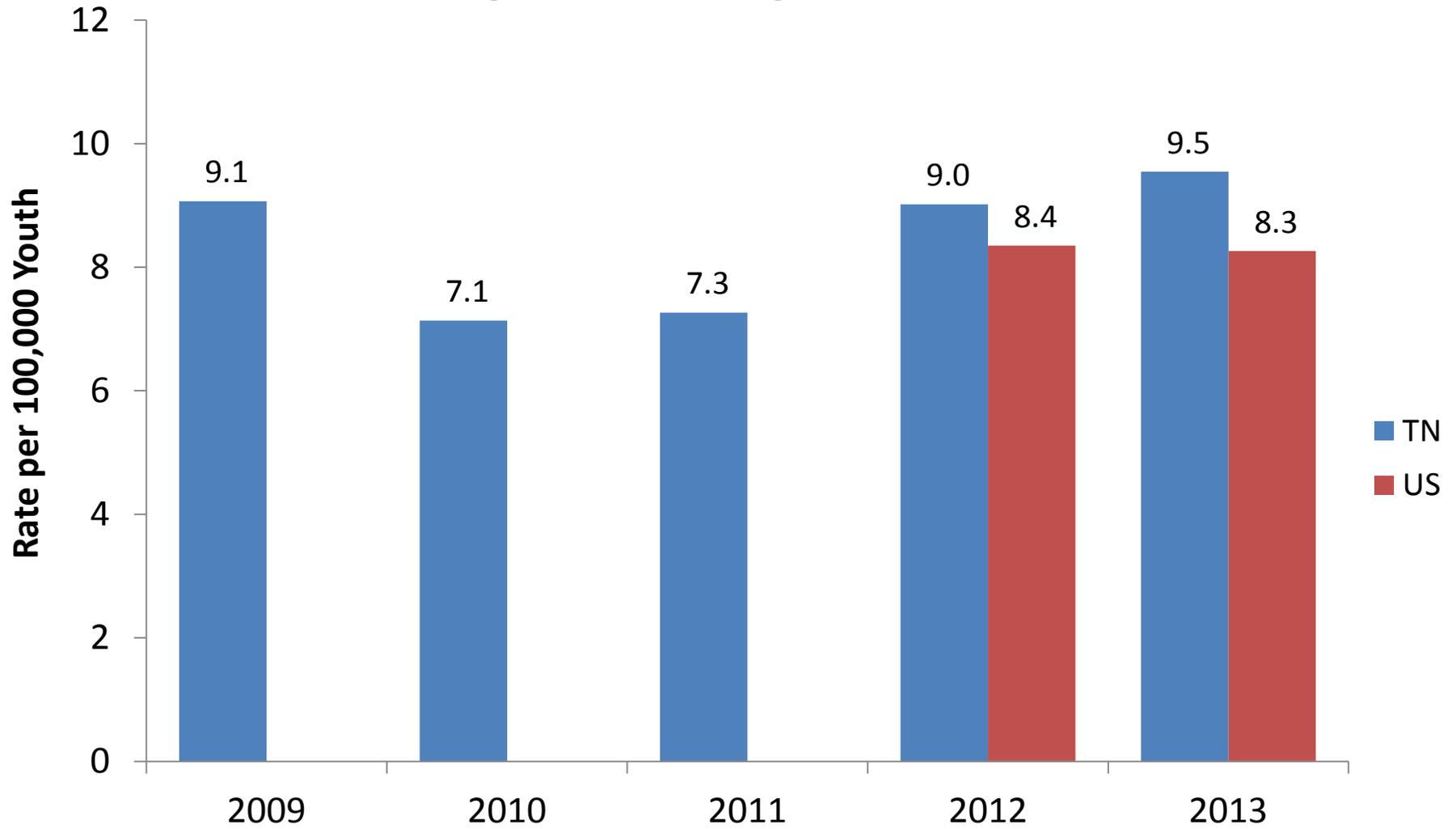


High School Students Who Attempted Suicide



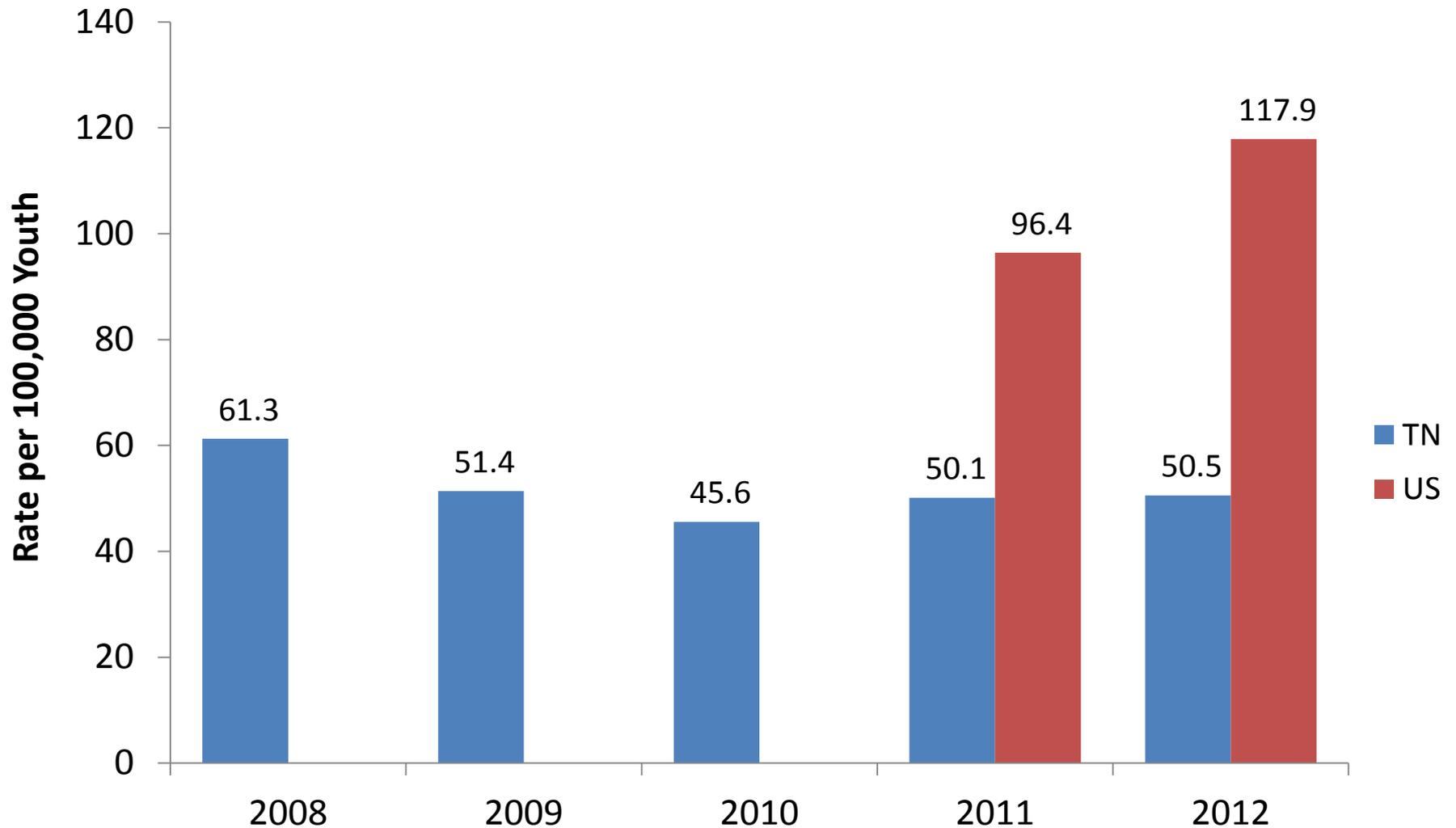
Data source: Centers for Disease Control and Prevention (CDC). 1991-2013 High School Youth Risk Behavior Survey Data. Accessed February 26, 2015 at <http://nccd.cdc.gov/youthonline/>.

Suicides Among Adolescents Age 15-19 Years



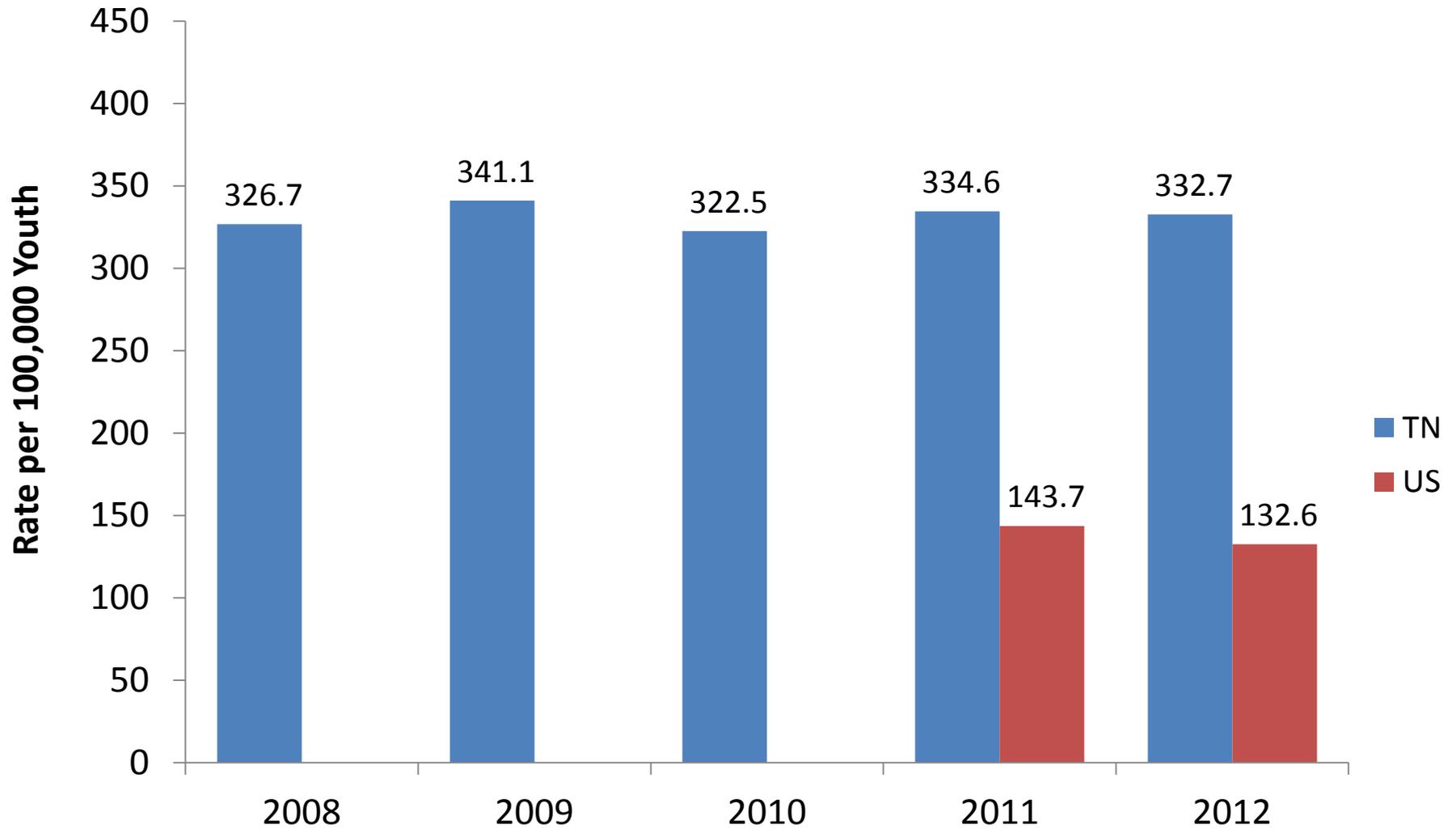
Data sources: 1) Tennessee Department of Health; Division of Policy, Planning and Assessment, Death Statistical System. 2) U.S. Department of Health and Human Services, Health Resources and Services Administration, Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Fatal Injury Report, 2009-2013, on CDC WISQARS Online Database. Accessed in January, 2015.

Suicide Attempt Hospitalizations Among Adolescents Age 15-19 Years



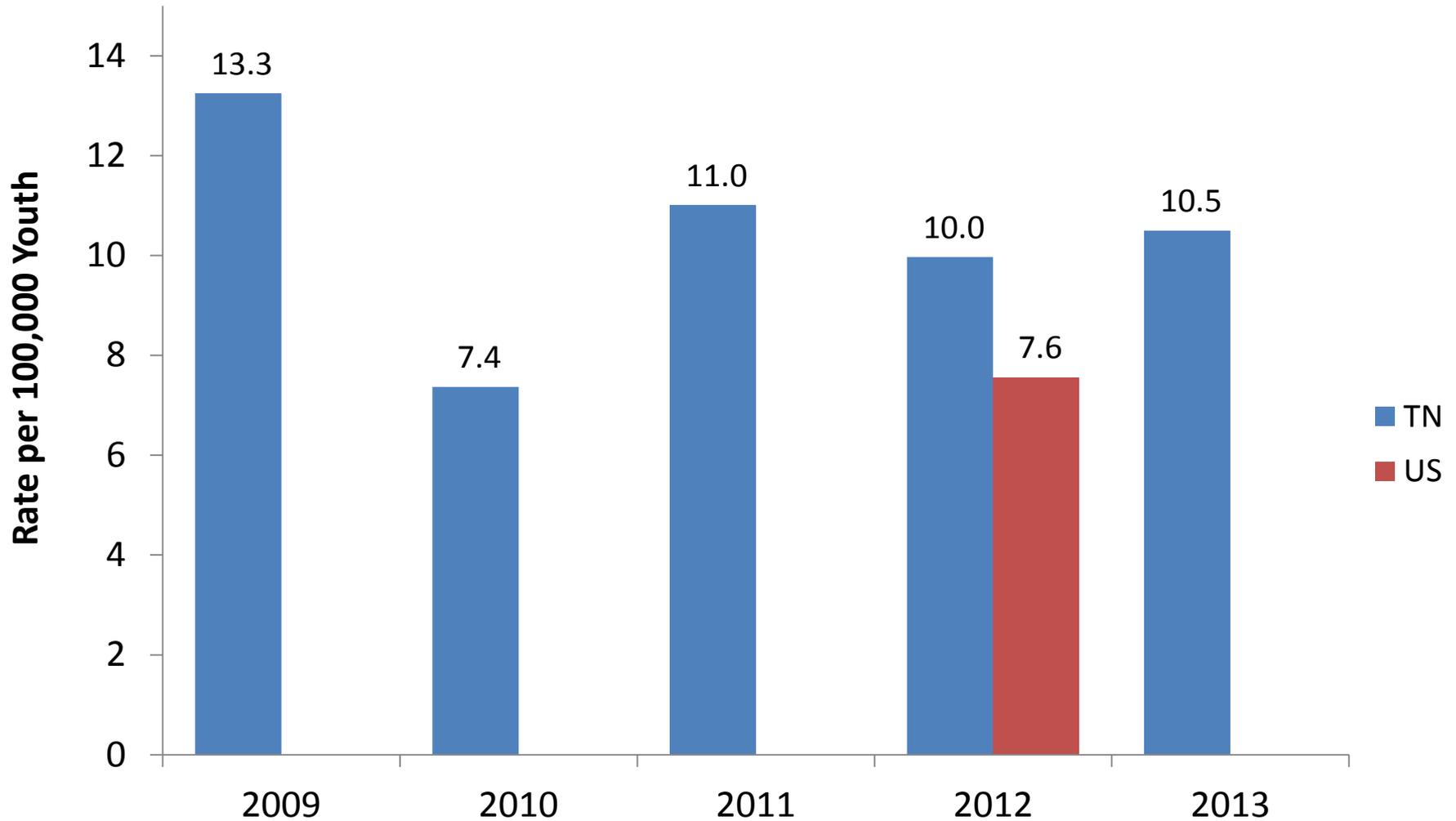
Data sources: 1) Tennessee Department of Health; Division of Policy, Planning and Assessment, Hospital Discharge Database System. 2) U.S. Department of Health and Human Services, Health Resources and Services Administration, Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Fatal Injury Report, 2008-2012, on CDC WISQARS Online Database. Accessed in January, 2015.

Suicide Attempt ED Visits Among Adolescents Age 15-19 Years



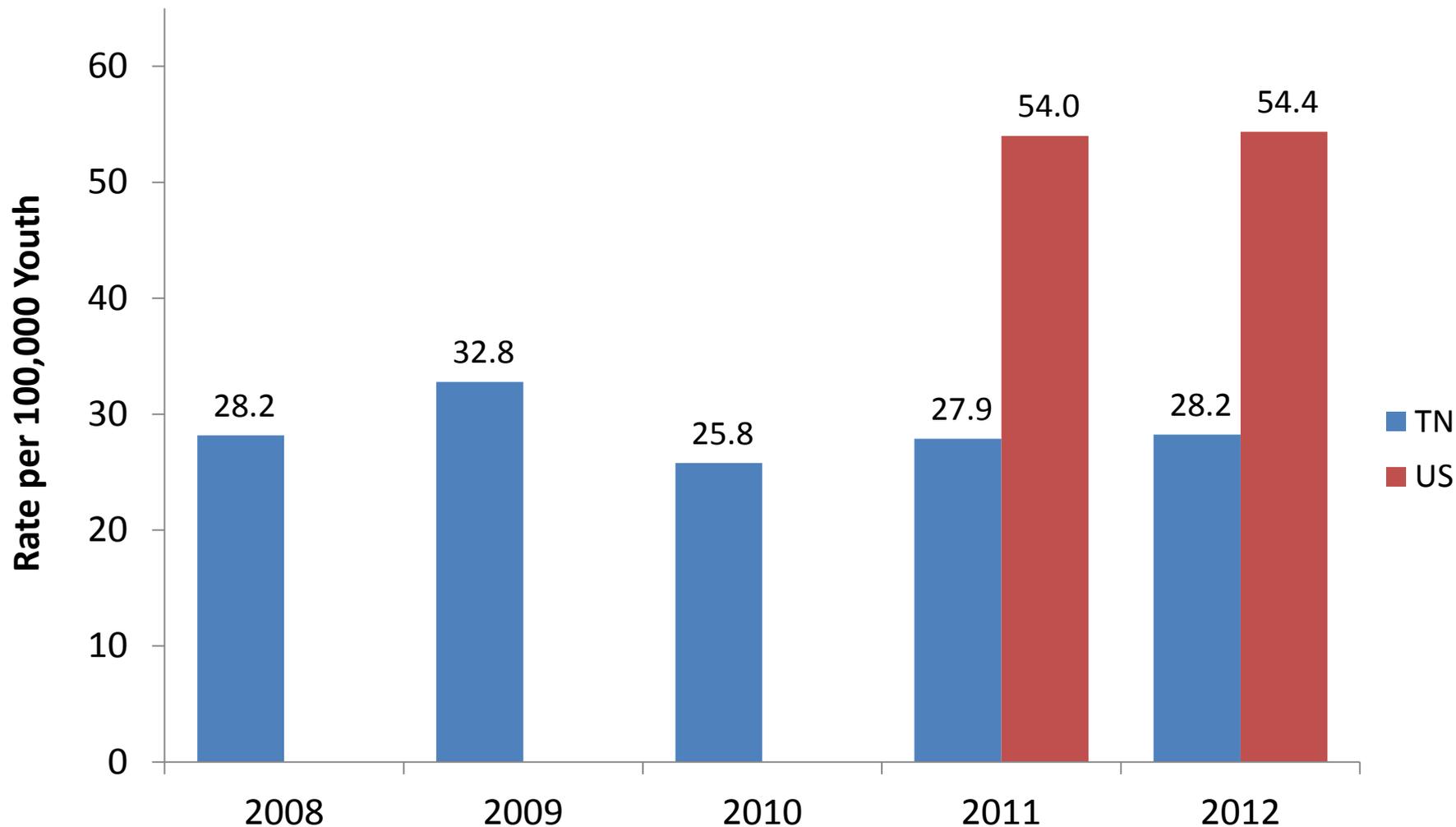
Data sources: 1) Tennessee Department of Health; Division of Policy, Planning and Assessment, Hospital Discharge Database System. 2) U.S. Department of Health and Human Services, Health Resources and Services Administration, Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Fatal Injury Report, 2008-2012, on CDC WISQARS Online Database. Accessed in January, 2015.

Homicide Related Deaths Among Adolescents Age 15-19 Years



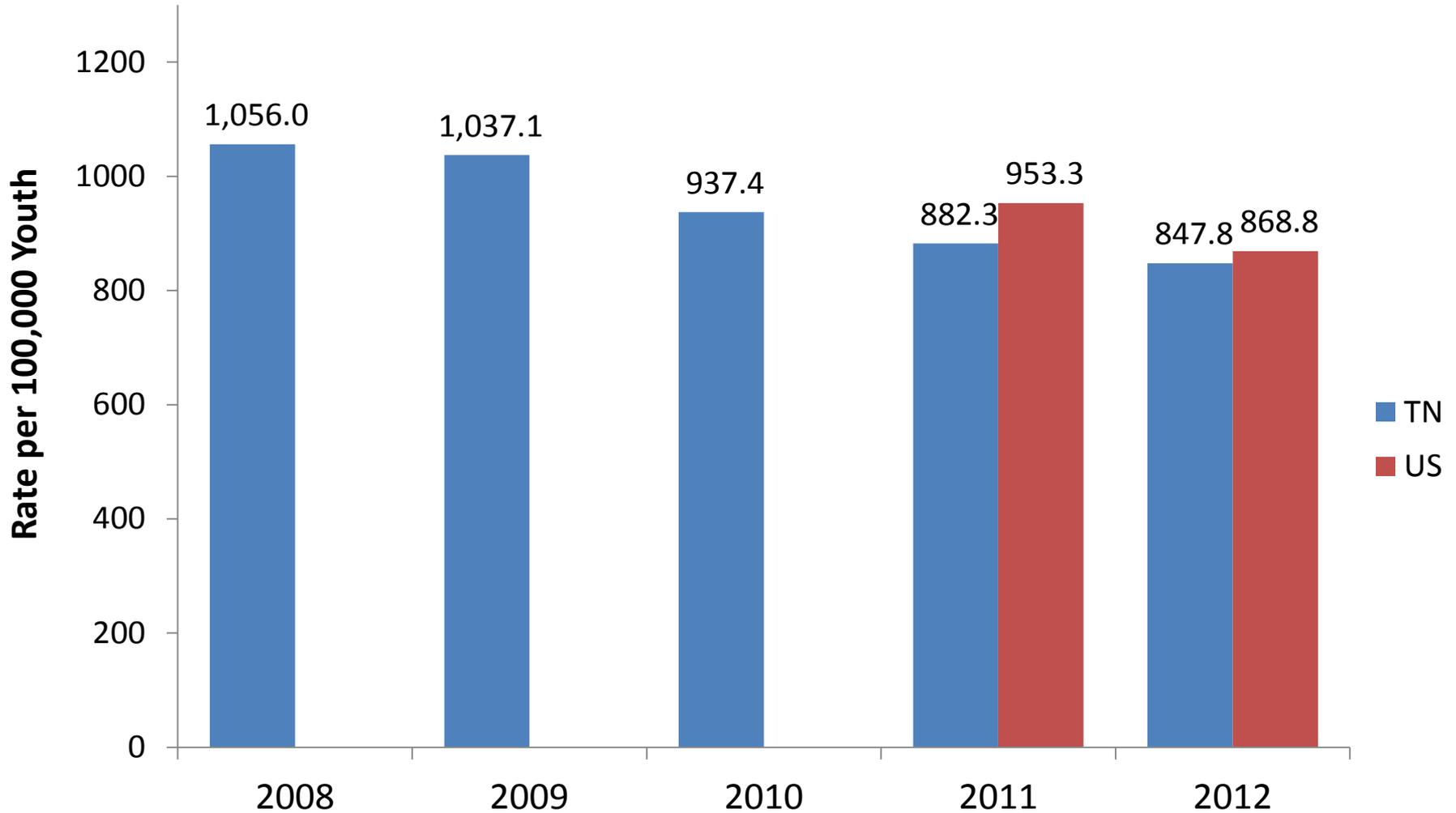
Data sources: 1) Tennessee Department of Health; Division of Policy, Planning and Assessment, Death Statistical System. 2) U.S. Department of Health and Human Services, Health Resources and Services Administration, Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Fatal Injury Report, 2009-2013, on CDC WISQARS Online Database. Accessed in January, 2015.

Homicide Related Injury Hospitalization Among Adolescents Age 15-19 Years



Data sources: 1) Tennessee Department of Health; Division of Policy, Planning and Assessment, Hospital Discharge Database System. 2) U.S. Department of Health and Human Services, Health Resources and Services Administration, Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Fatal Injury Report, 2008-2012, on CDC WISQARS Online Database. Accessed in January, 2015.

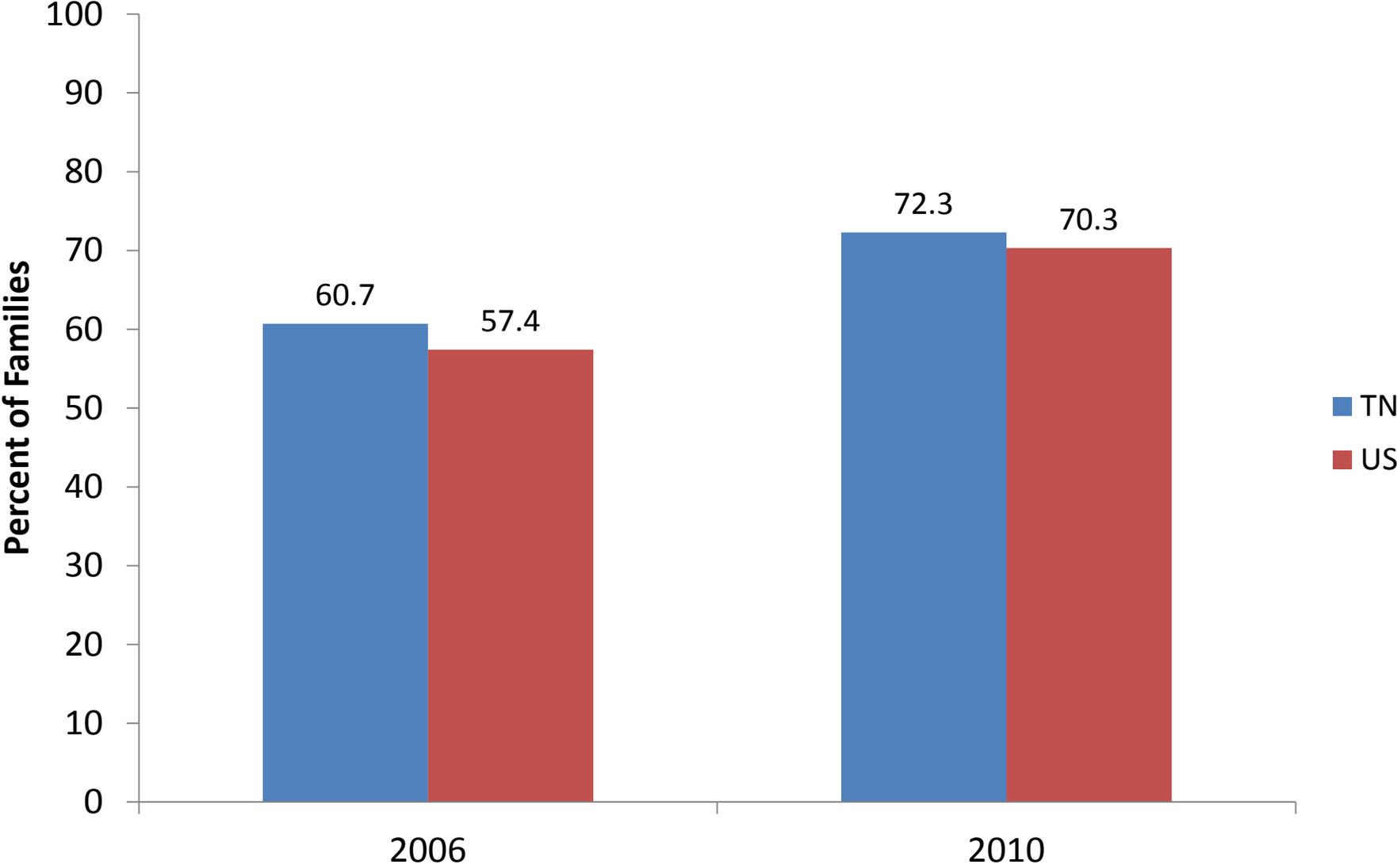
Homicide Related Injury ED Visits Among Adolescents Age 15-19 Years



Data sources: 1) Tennessee Department of Health; Division of Policy, Planning and Assessment, Hospital Discharge Database System. 2) U.S. Department of Health and Human Services, Health Resources and Services Administration, Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Fatal Injury Report, 2008-2012, on CDC WISQARS Online Database. Accessed in January, 2015.

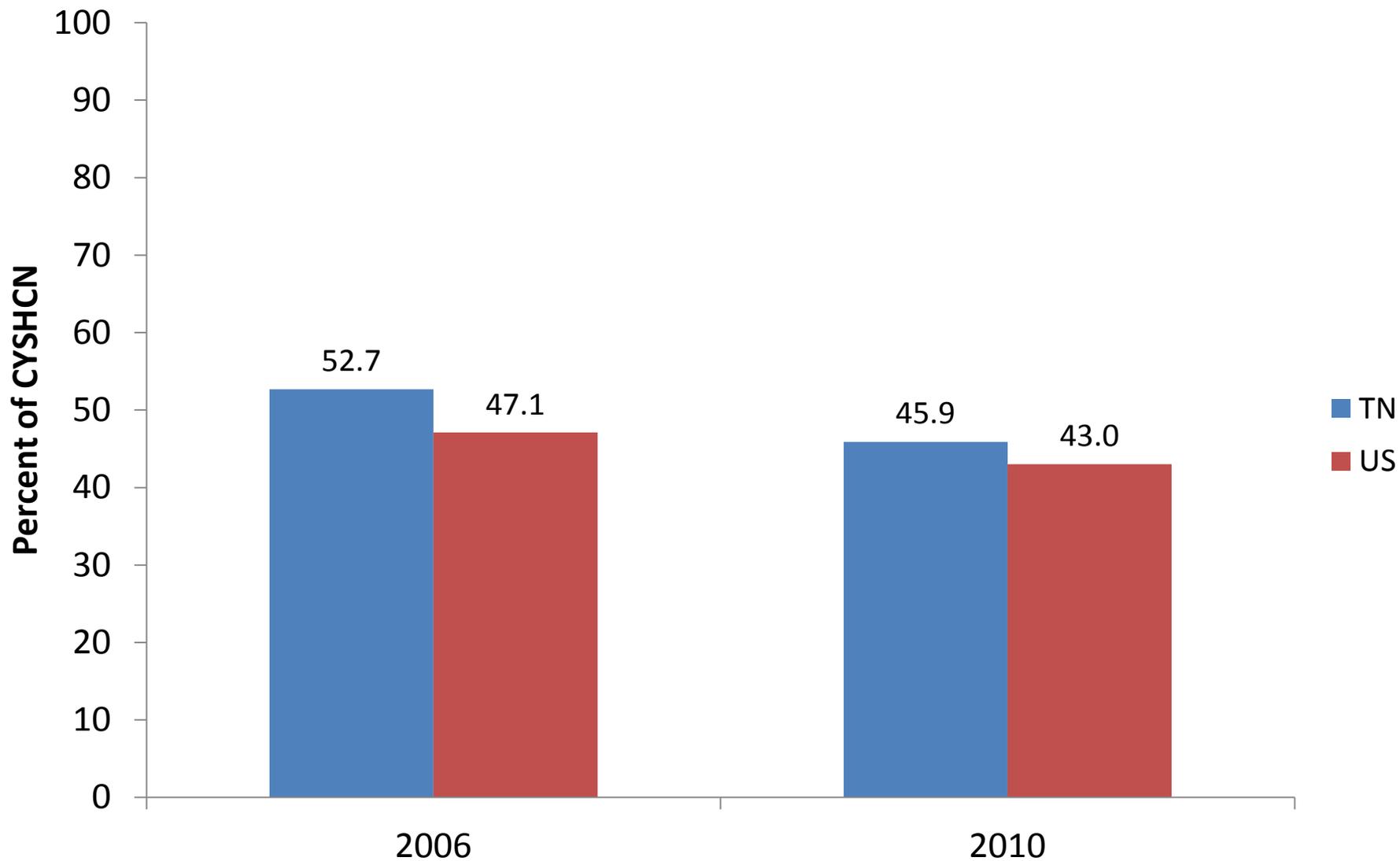
**CHILDREN AND YOUTH WITH SPECIAL
HEALTH CARE NEEDS
(CYSHCN)**

Families of CYSHCN That Partner in Decision Making

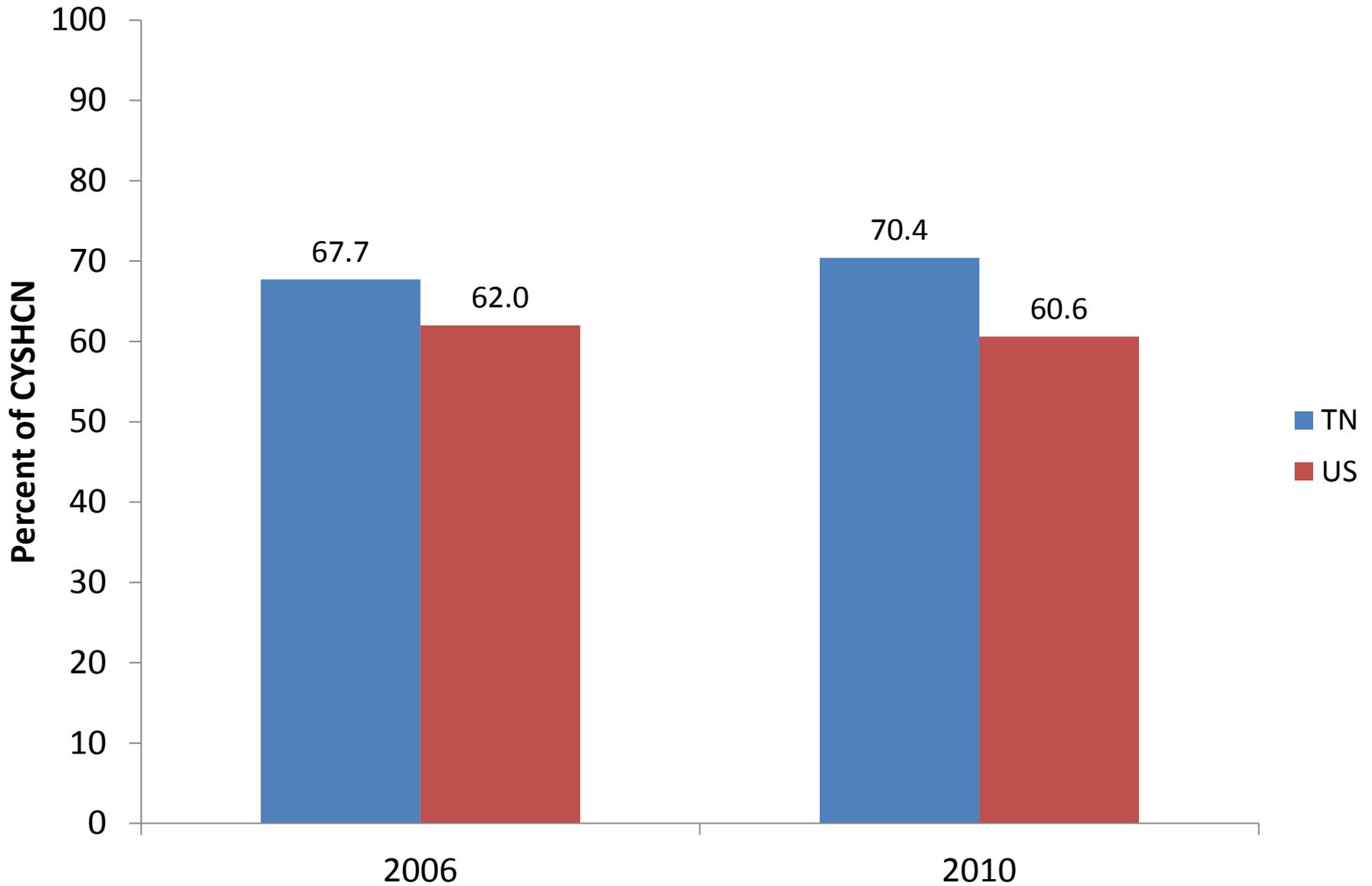


Data Source: National Survey of Children with Special Health Care Needs. NS-CSHCN 2009/10. Data query from the Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website. Retrieved [8/4/14] from <http://www.childhealthdata.org/browse/survey>

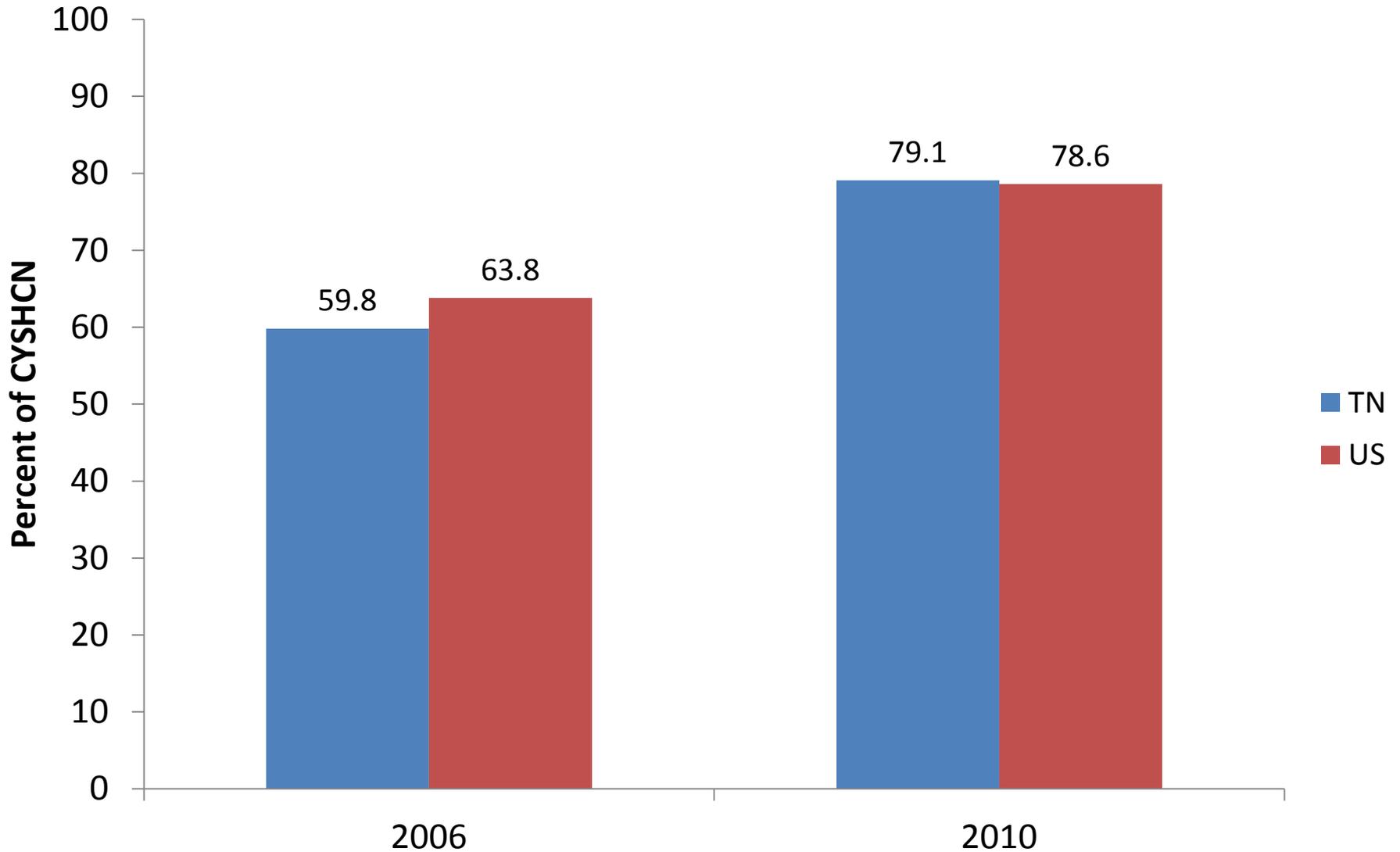
CYSHCN That Receive Coordinated, Ongoing, Comprehensive Care Within a Medical Home



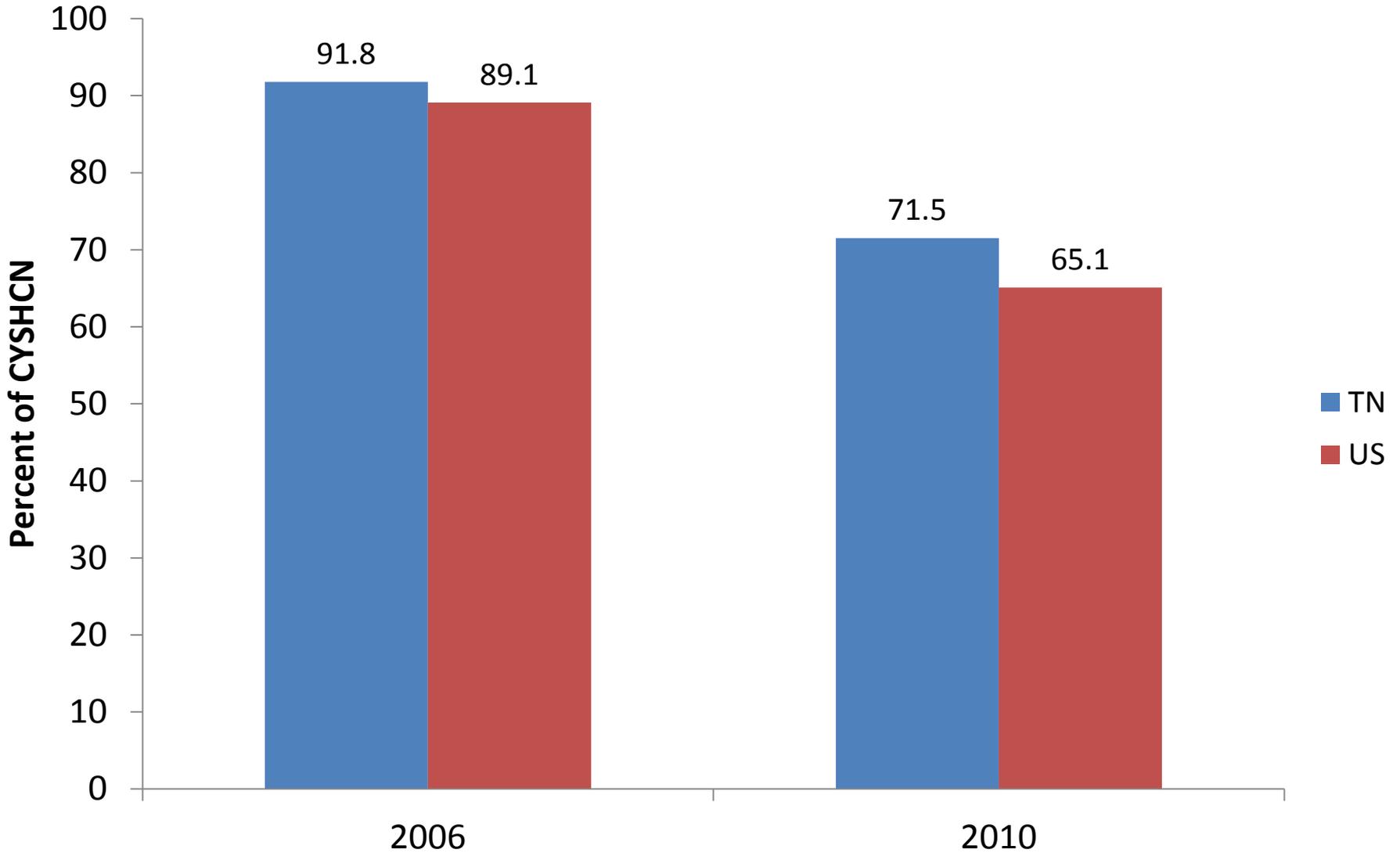
CYSHCN With Continuous and Adequate Insurance



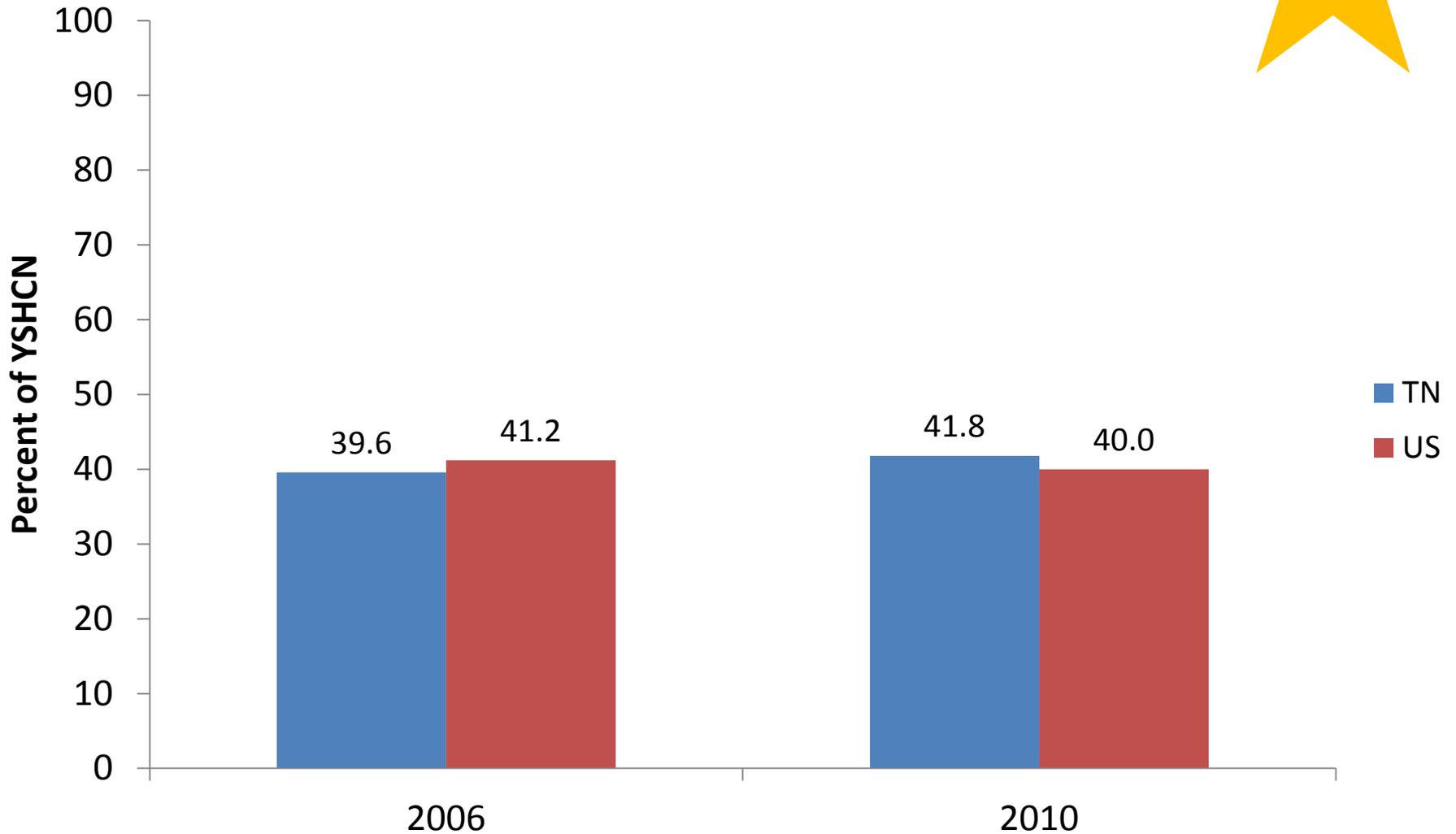
CYSHCN Screened Early and Continuously for Special Health Care Needs



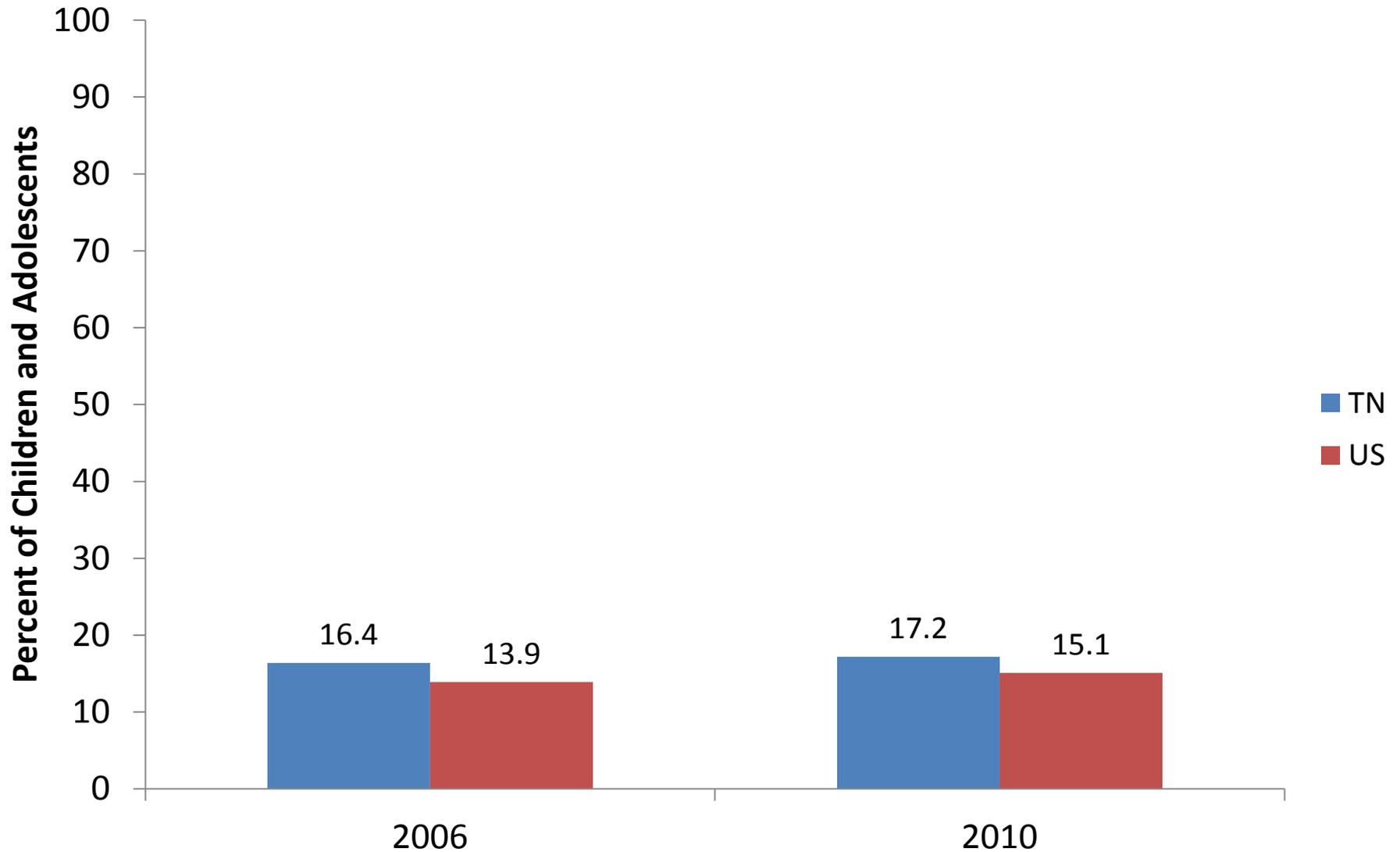
CYSHCN Who Can Easily Access Community Based Services



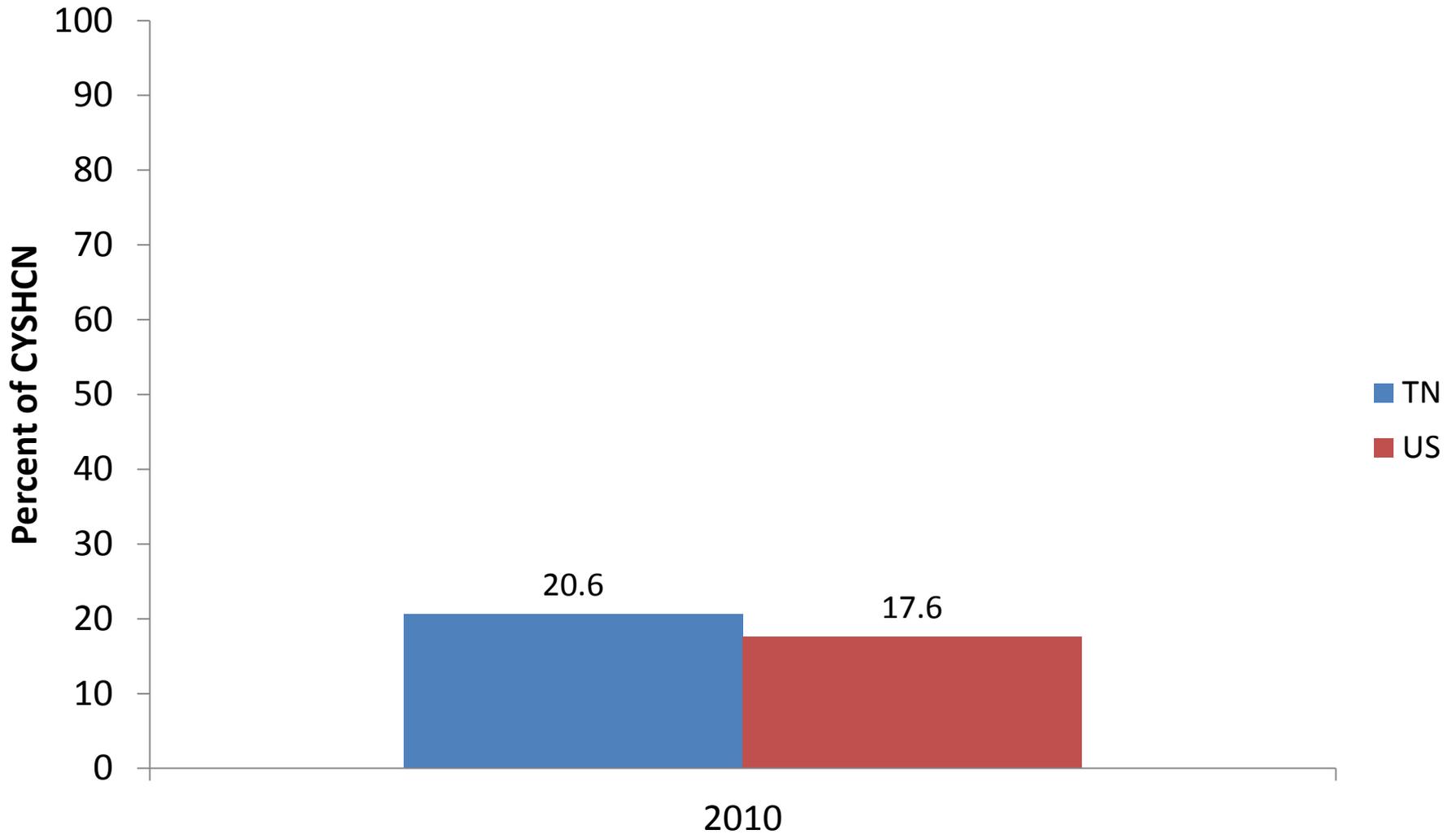
YSHCN Age 12-17 Years Who Receive Services for Transition to Adult Healthcare, Work and Independence



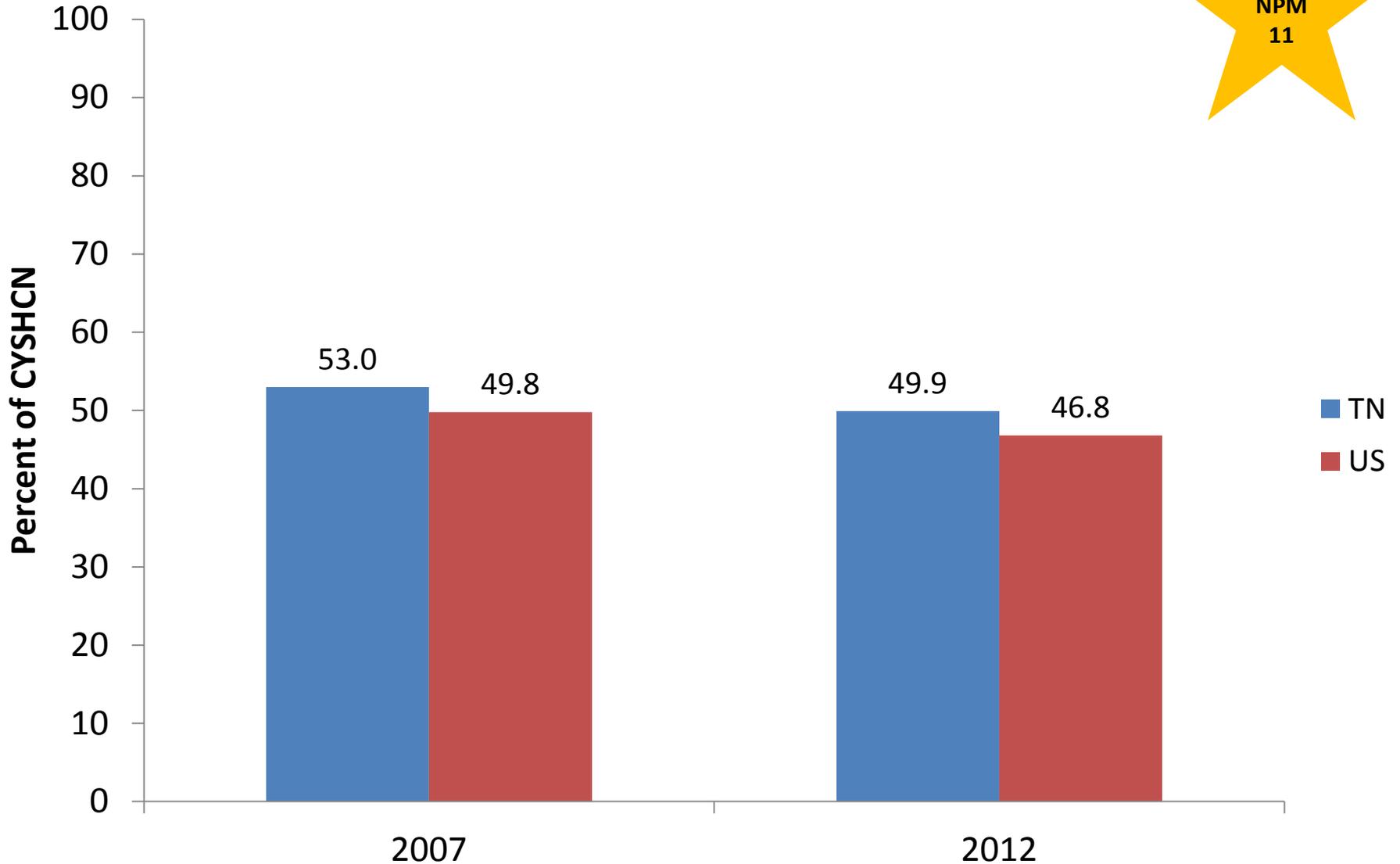
Special Health Care Need Prevalence Among Children and Adolescents Age 0-17 Years



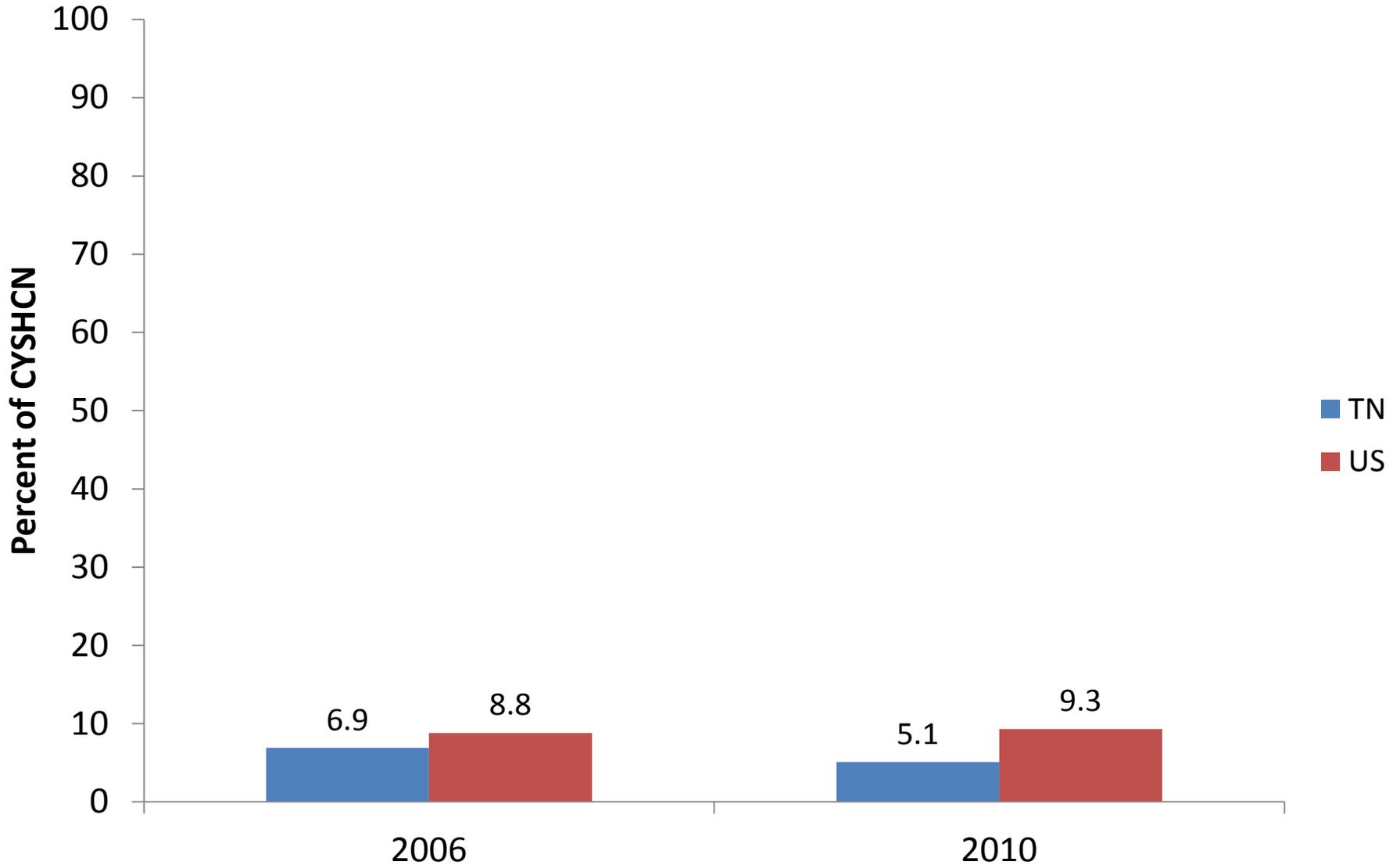
CYSHCN Age 0-17 Served by Systems of Care That Meet All Age-Relevant Core Outcomes



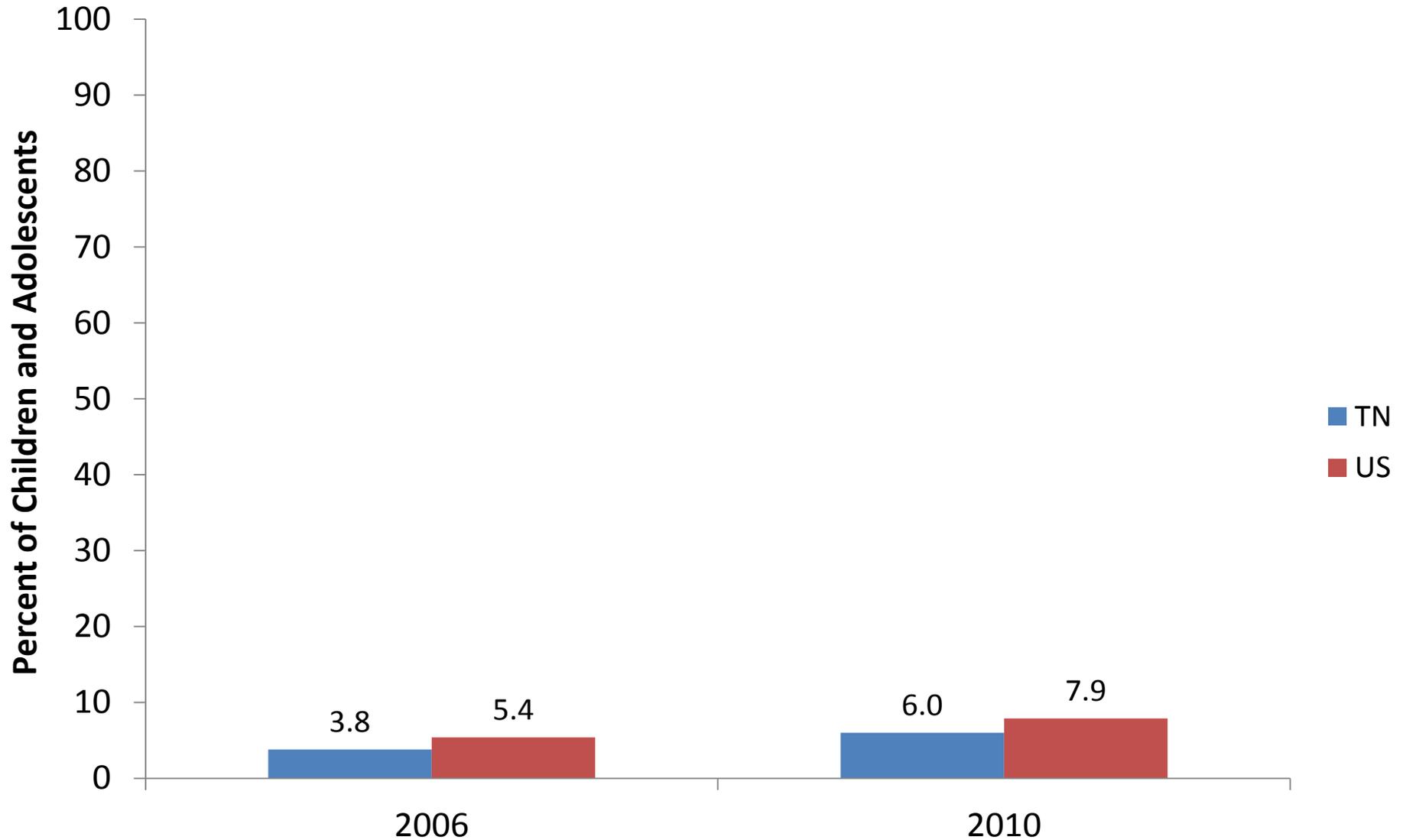
CYSHCN Age 0-17 Years Who Have a Medical Home



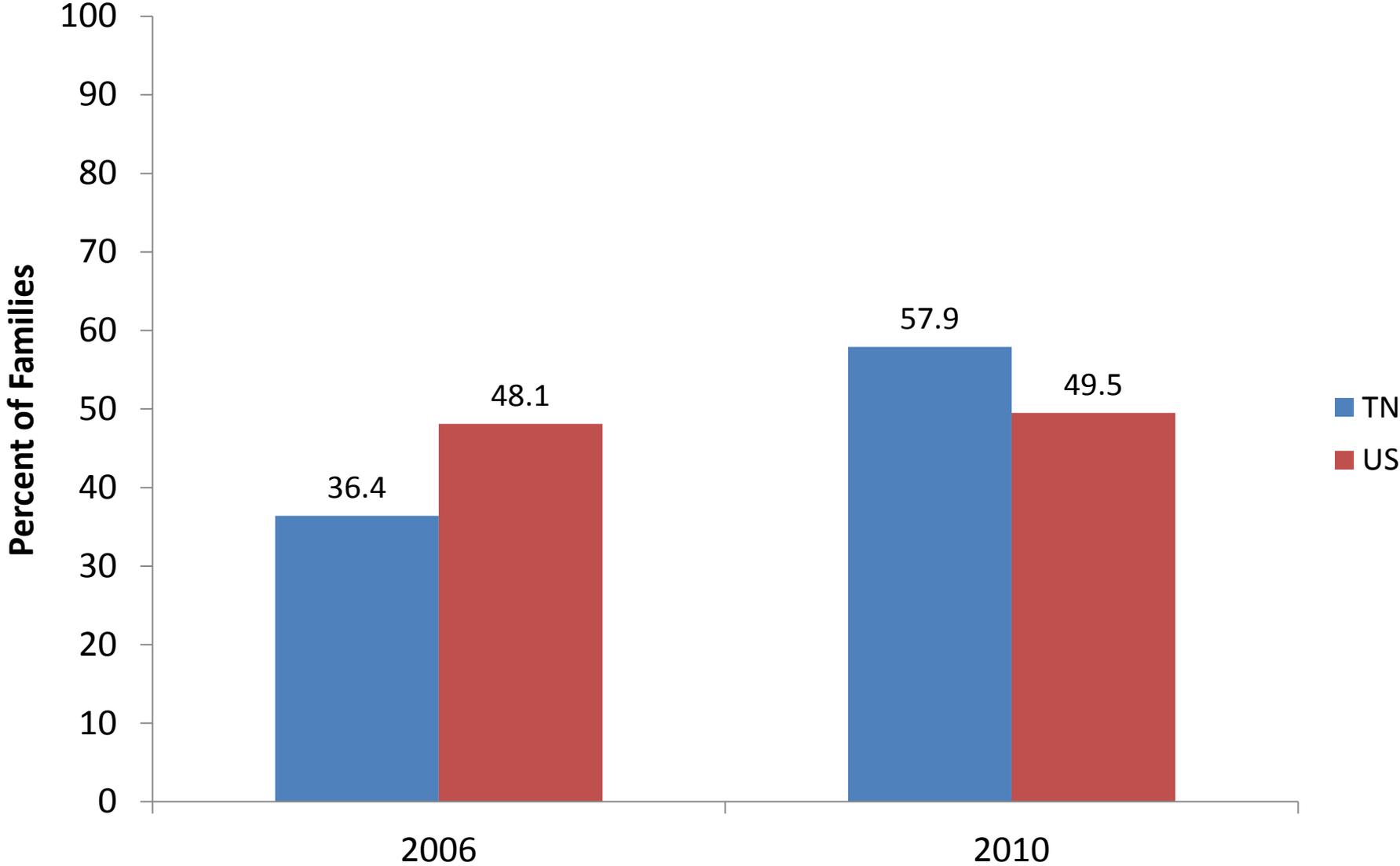
CYSHCN Age 0-17 Years Who Were Uninsured at Some Point in the Past Year



Autism Prevalence Among Children and Adolescents Age 2-17 Years



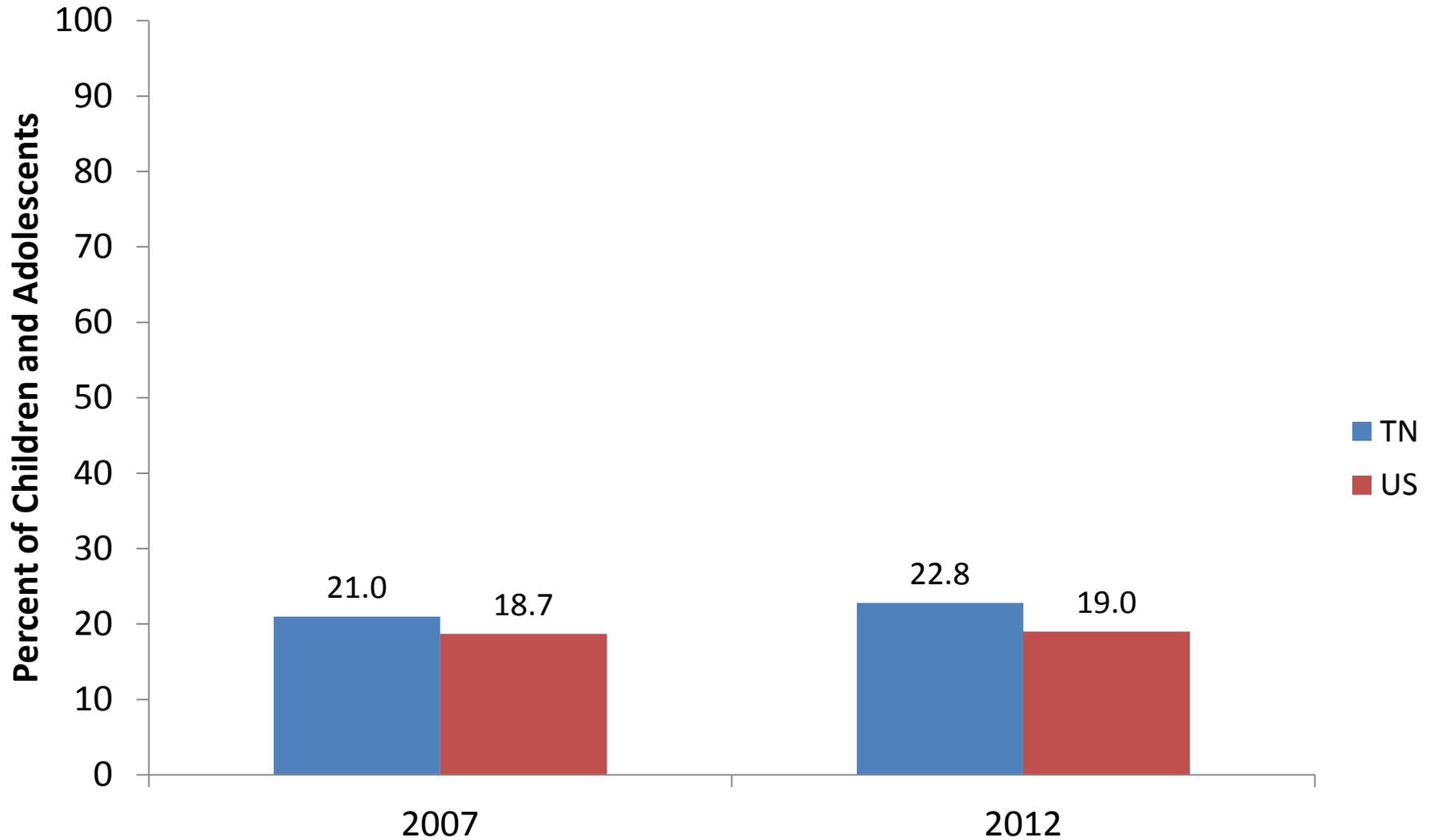
Families of CYSHCN Age 0-17 Years Who Did Not Receive All the Repite Care They Needed



Data Source: National Survey of Children with Special Health Care Needs. NS-CSHCN 2009/10. Data query from the Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website. Retrieved [8/4/14] from <http://www.childhealthdata.org/browse/survey>

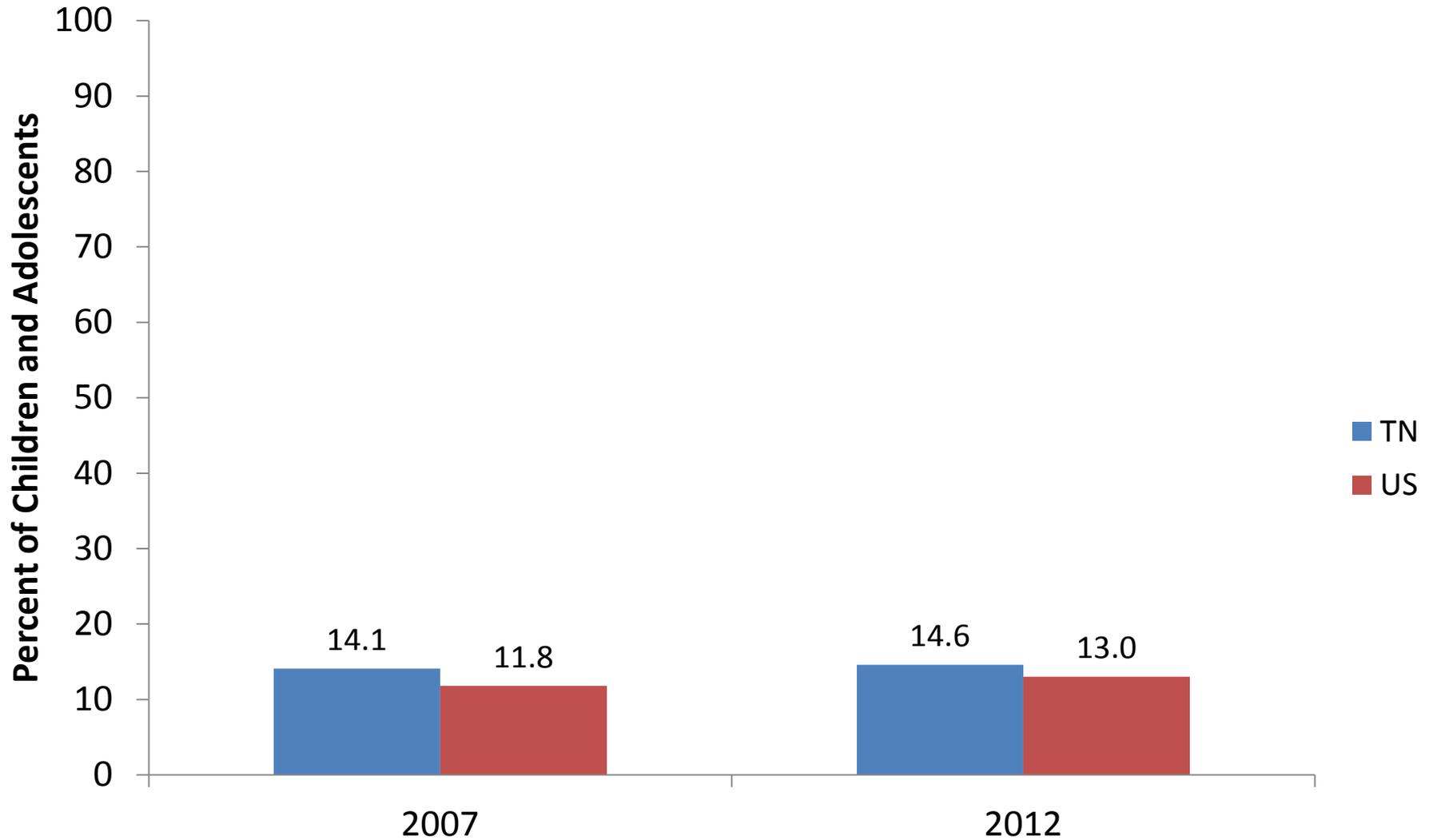
CROSSCUTTING AND LIFE COURSE

Children and Adolescents 0-17 Years Living in Mother Only Household



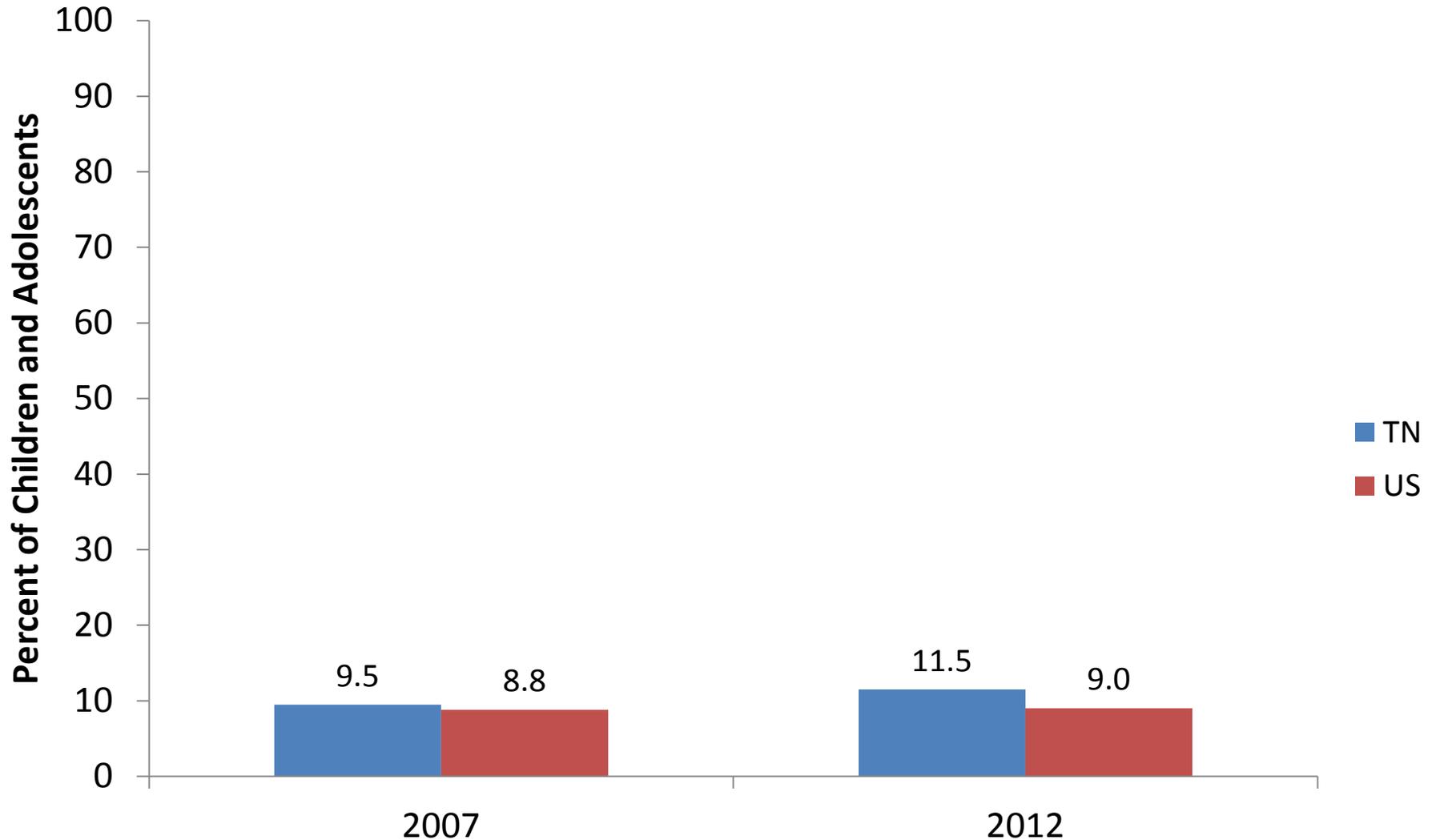
Data Source: National Survey of Children's Health. NSCH 2011/12. Data query from the Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website. Retrieved 8/1/14 from www.childhealthdata.org.

Children and Adolescents 0-17 Years Living In Poverty



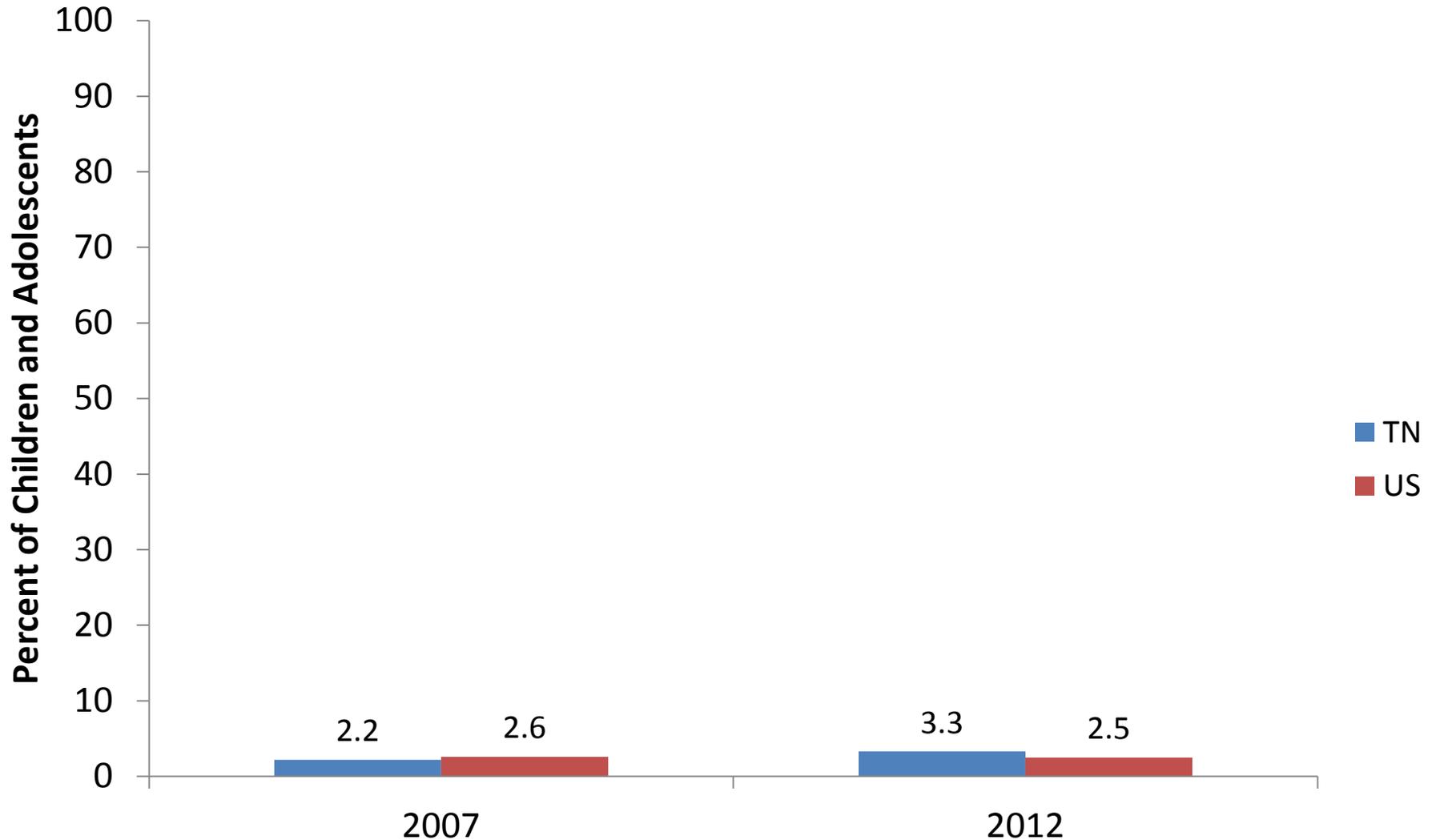
Data Source: National Survey of Children's Health. NSCH 2011/12. Data query from the Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website. Retrieved 8/1/14 from www.childhealthdata.org.

Asthma Prevalence Among Children and Adolescents 0-17 Years



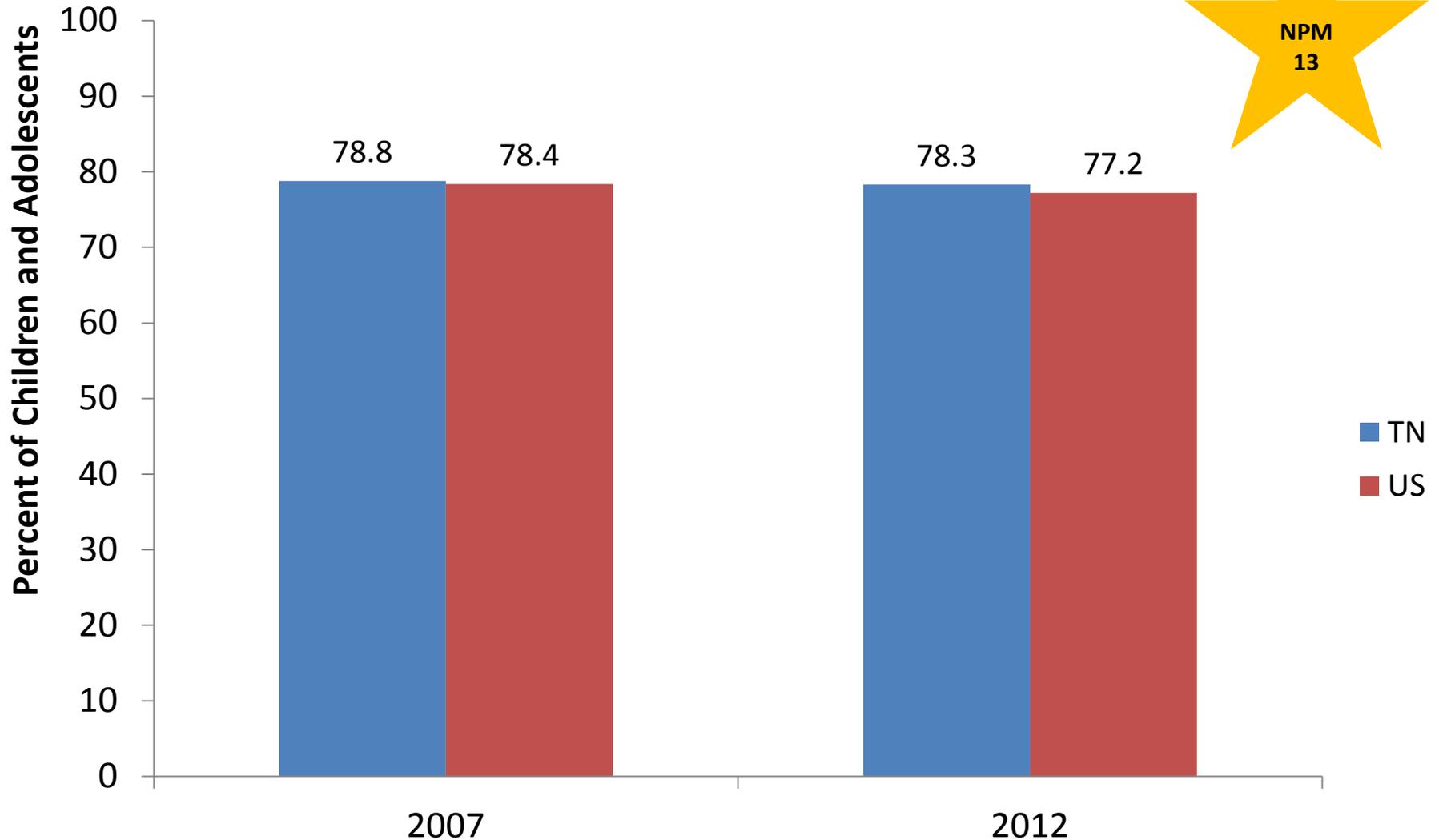
Data Source: National Survey of Children's Health. NSCH 2011/12. Data query from the Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website. Retrieved 8/1/14 from www.childhealthdata.org.

Children and Adolescents Age 0-17 Years Who Have Moderate to Severe Asthma



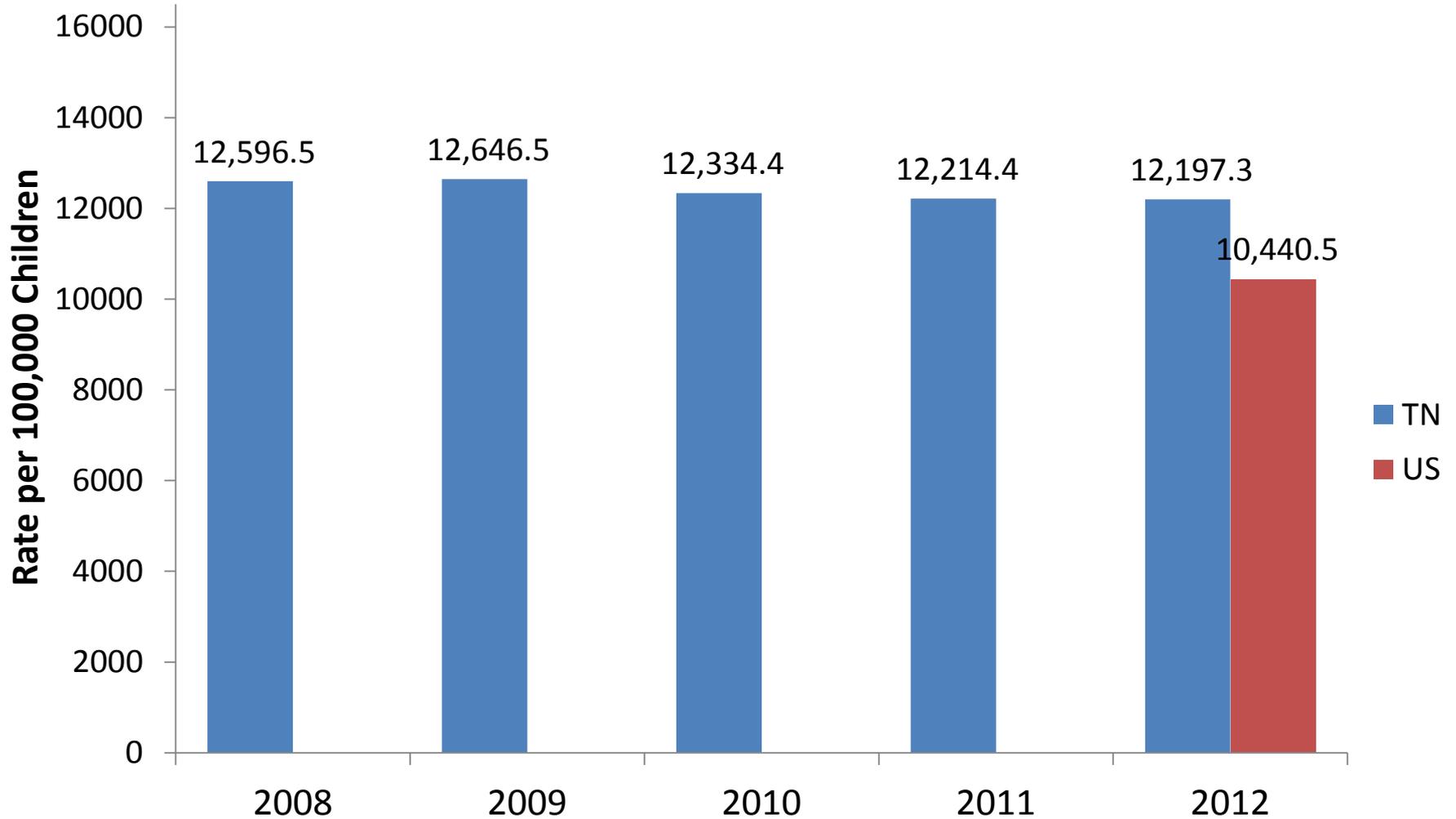
Data Source: National Survey of Children's Health. NSCH 2011/12. Data query from the Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website. Retrieved 8/1/14 from www.childhealthdata.org.

Children and Adolescents 1-17 Years Who Had a Preventative Dental Visit in the Last Year



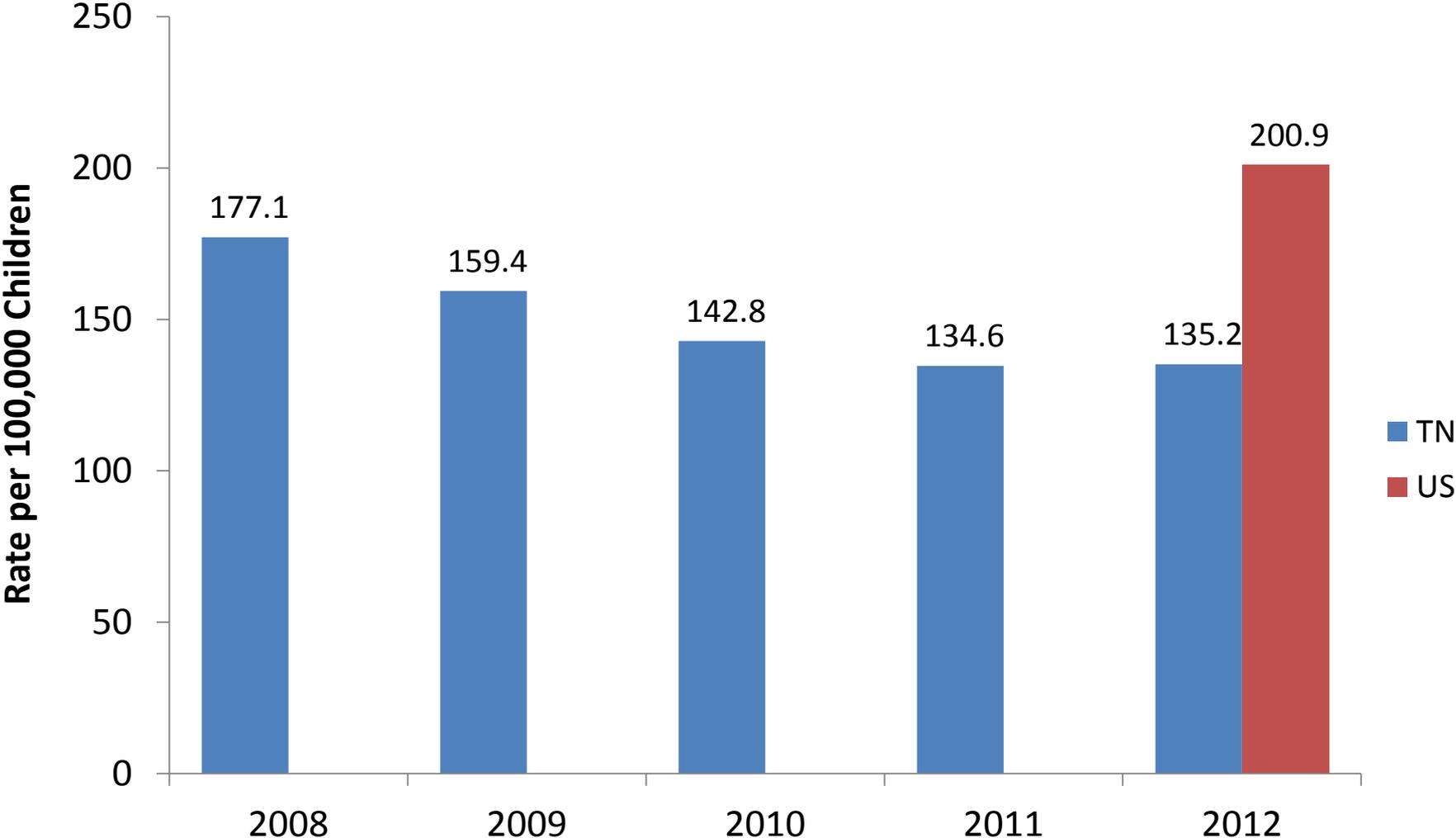
Data Source: National Survey of Children's Health. NSCH 2011/12. Data query from the Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website. Retrieved 8/1/14 from www.childhealthdata.org.

Unintentional Injury ED Visits Among Children Age 0-19 Years



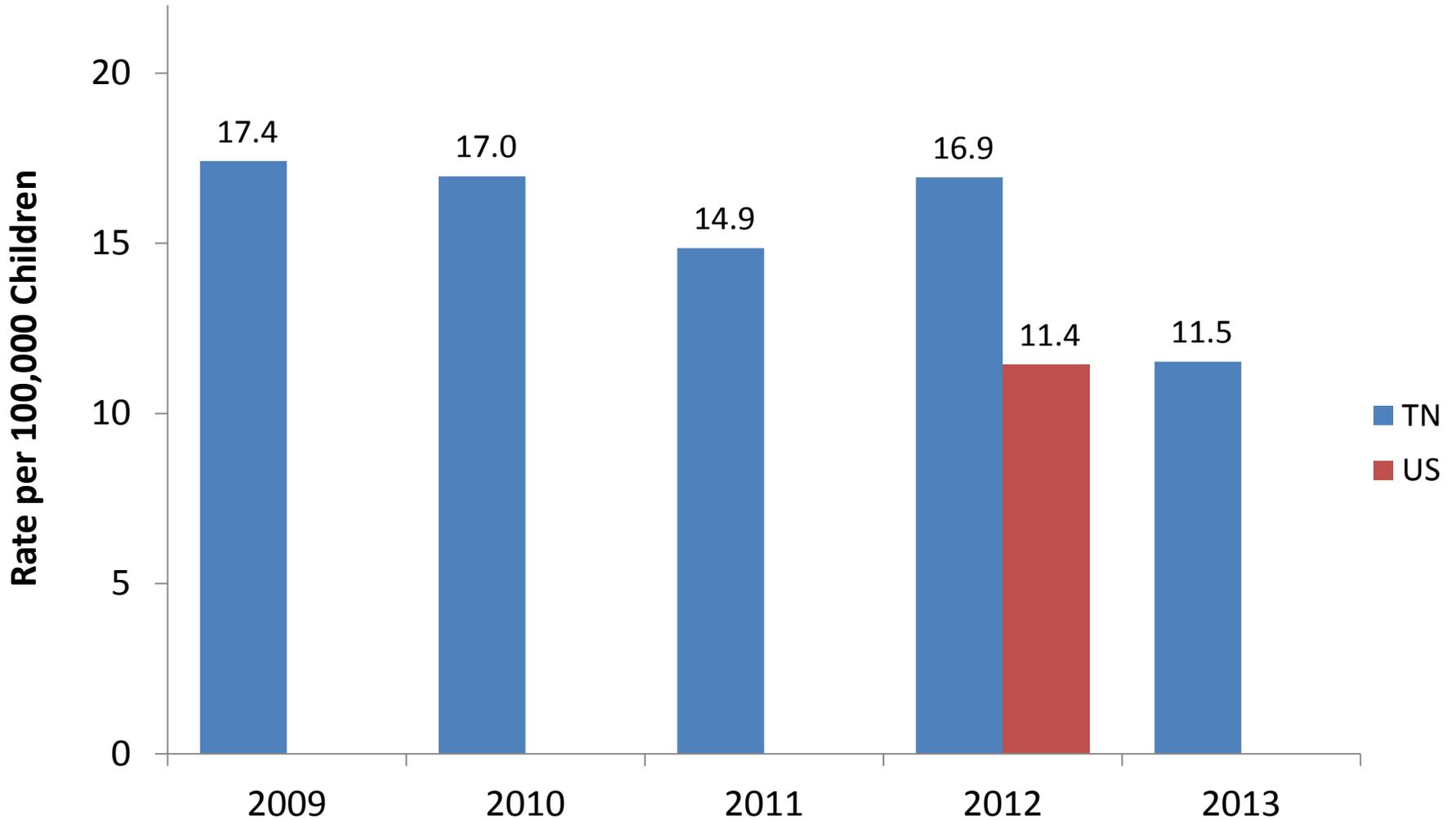
Data sources: 1) Tennessee Department of Health; Division of Policy, Planning and Assessment, Hospital Discharge Database System. 2) U.S. Department of Health and Human Services, Health Resources and Services Administration, Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Fatal Injury Report, 2008-2012, on CDC WISQARS Online Database. Accessed in January, 2015.

Unintentional Injury Hospitalizations Among Children Ages 0-19 Years



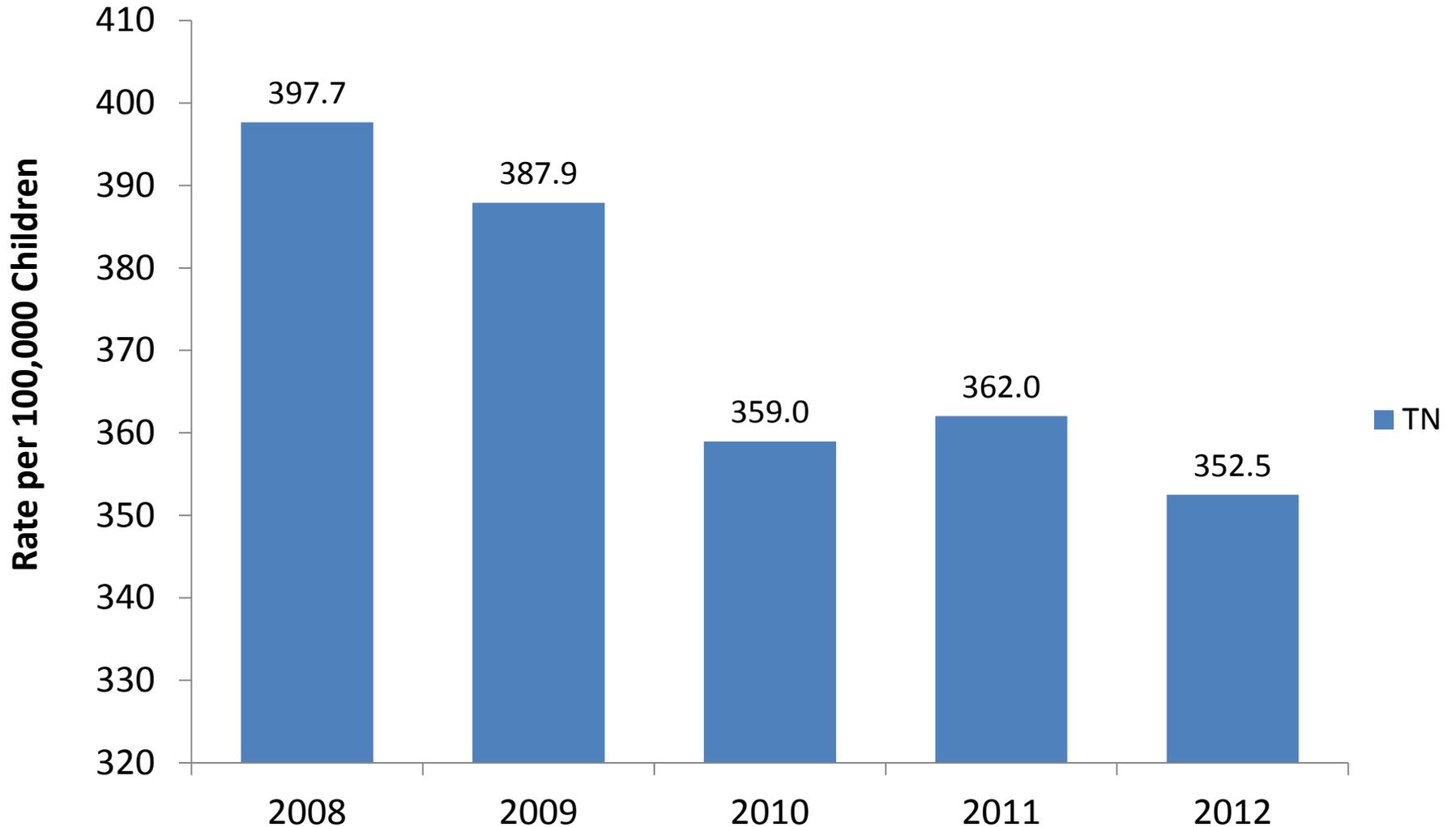
Data sources: 1) Tennessee Department of Health; Division of Policy, Planning and Assessment, Hospital Discharge Database System. 2) U.S. Department of Health and Human Services, Health Resources and Services Administration, Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Fatal Injury Report, 2008-2012, on CDC WISQARS Online Database. Accessed in January, 2015.

Unintentional Injury Deaths Among Children and Adolescents Age 0-19 Years

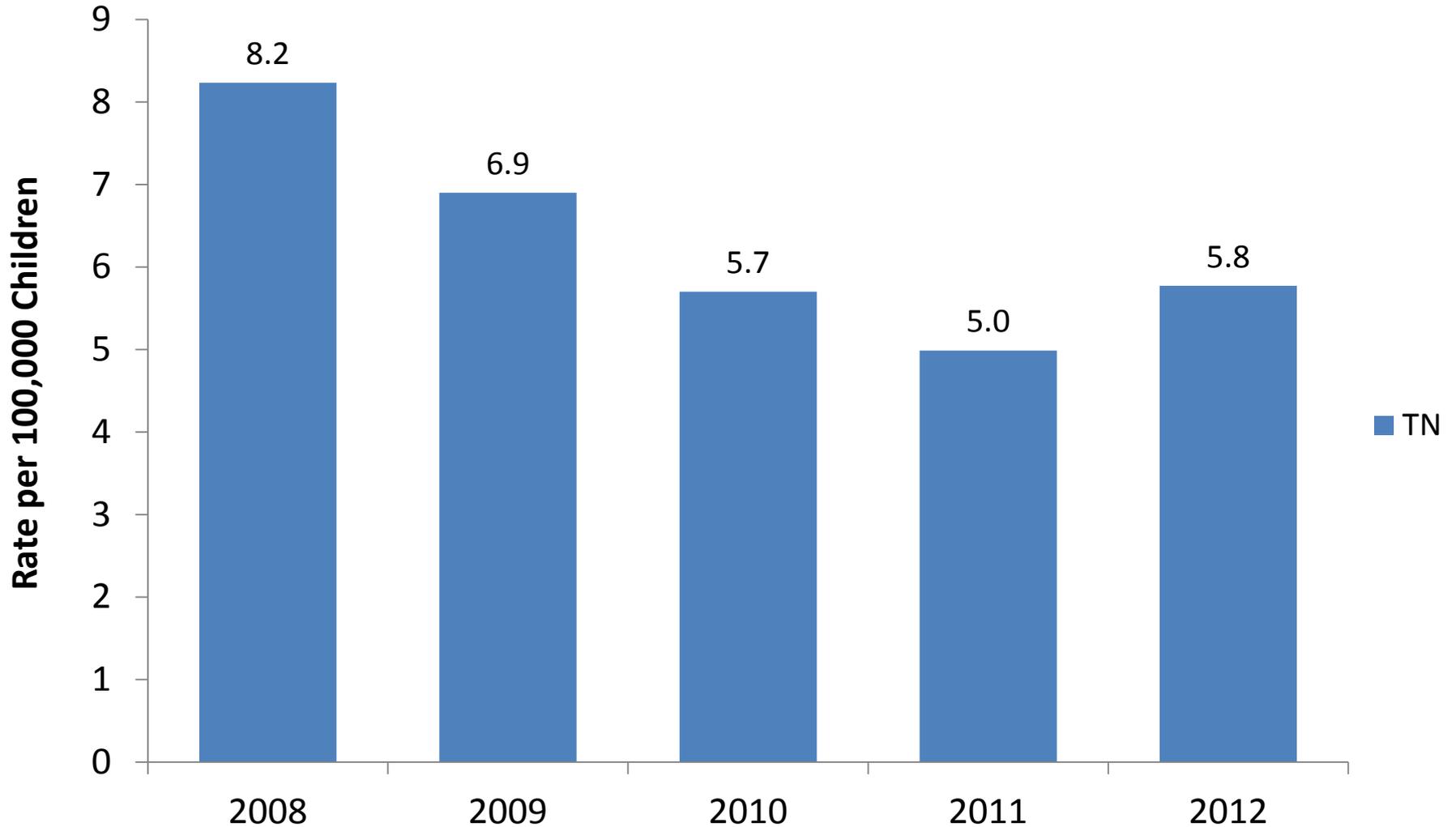


Data sources: 1) Tennessee Department of Health; Division of Policy, Planning and Assessment, Death Statistical System. 2) U.S. Department of Health and Human Services, Health Resources and Services Administration, Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Fatal Injury Report, 2009-2013, on CDC WISQARS Online Database. Accessed in January, 2015.

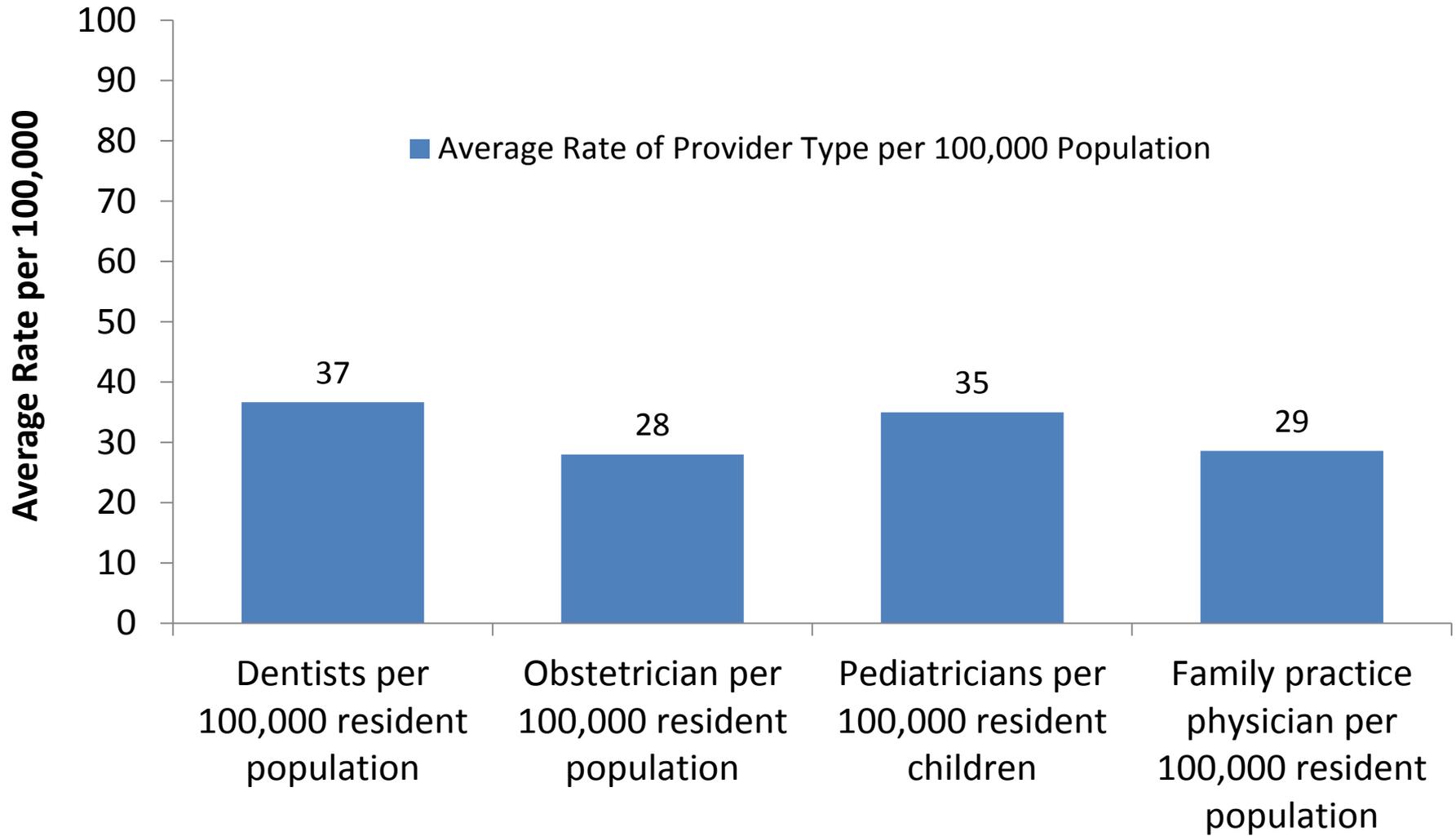
Off-Road Motor Vehicle Related ED Visits Among Children and Adolescents Age 0-19 Years



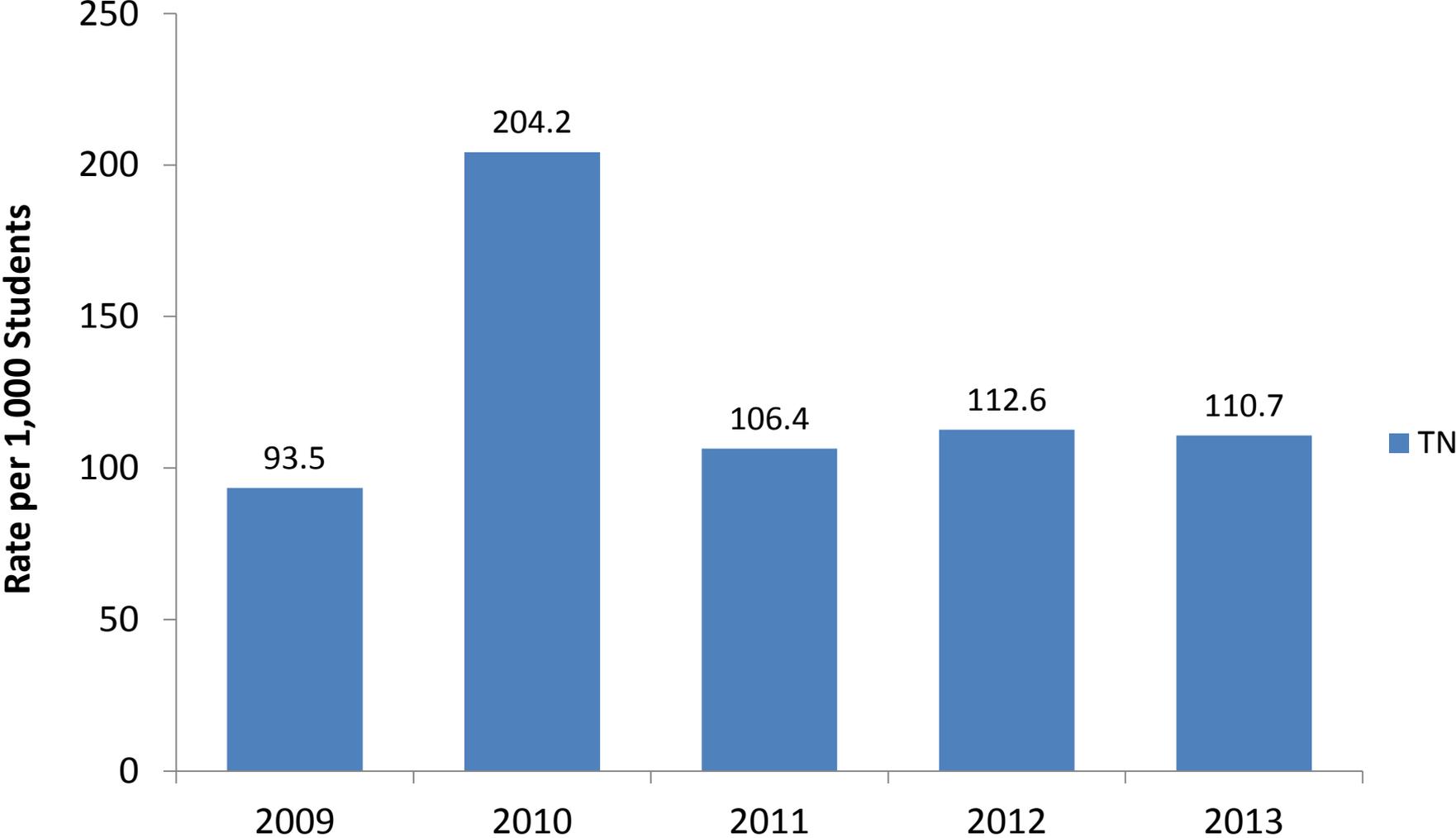
Off-Road Motor Vehicle Related Hospitalizations Among Children and Adolescents Age 0-19 Years



Accessibility of Providers in Tennessee, 2014

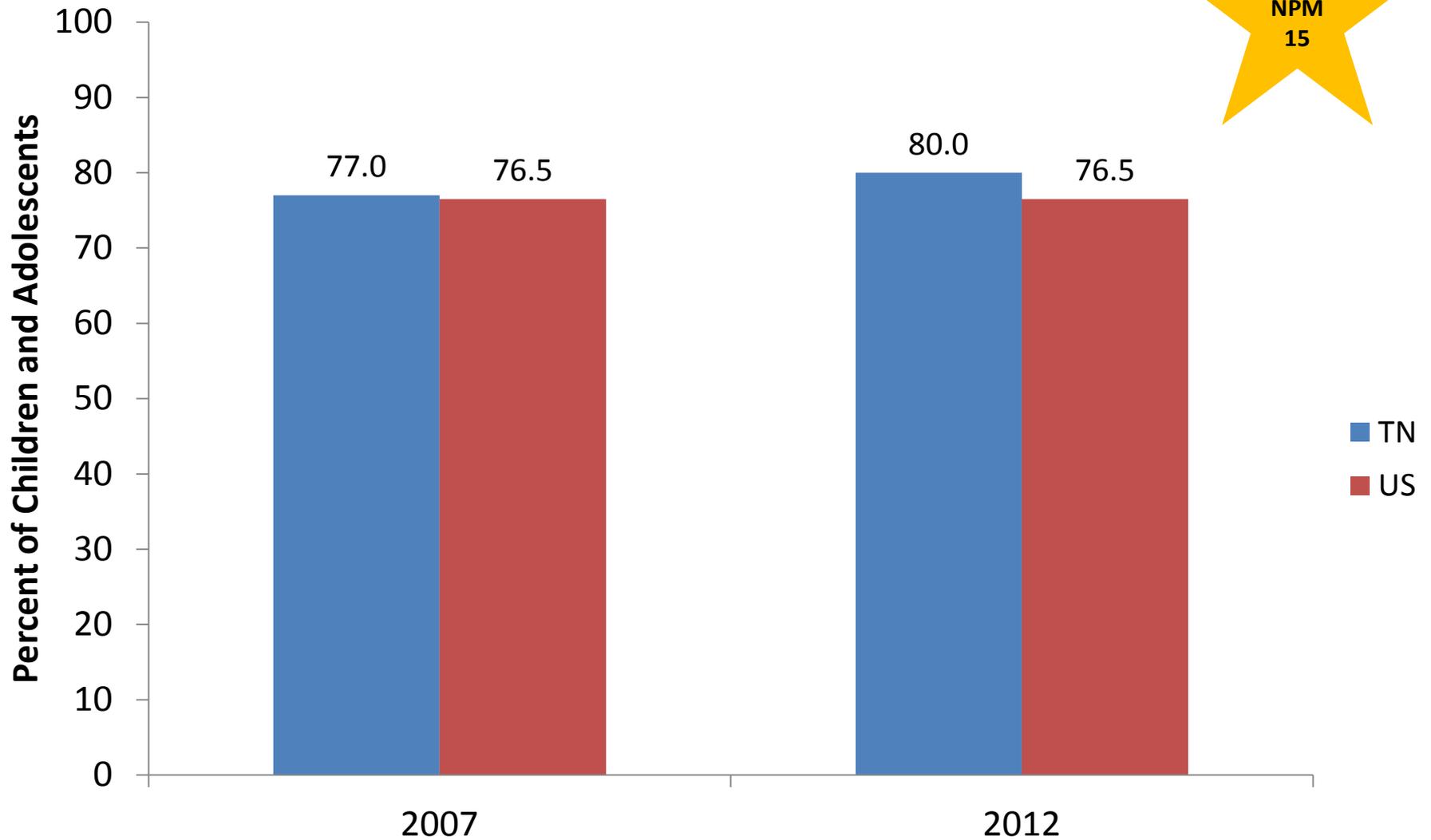


Rate of Nurses per 1,000 Students



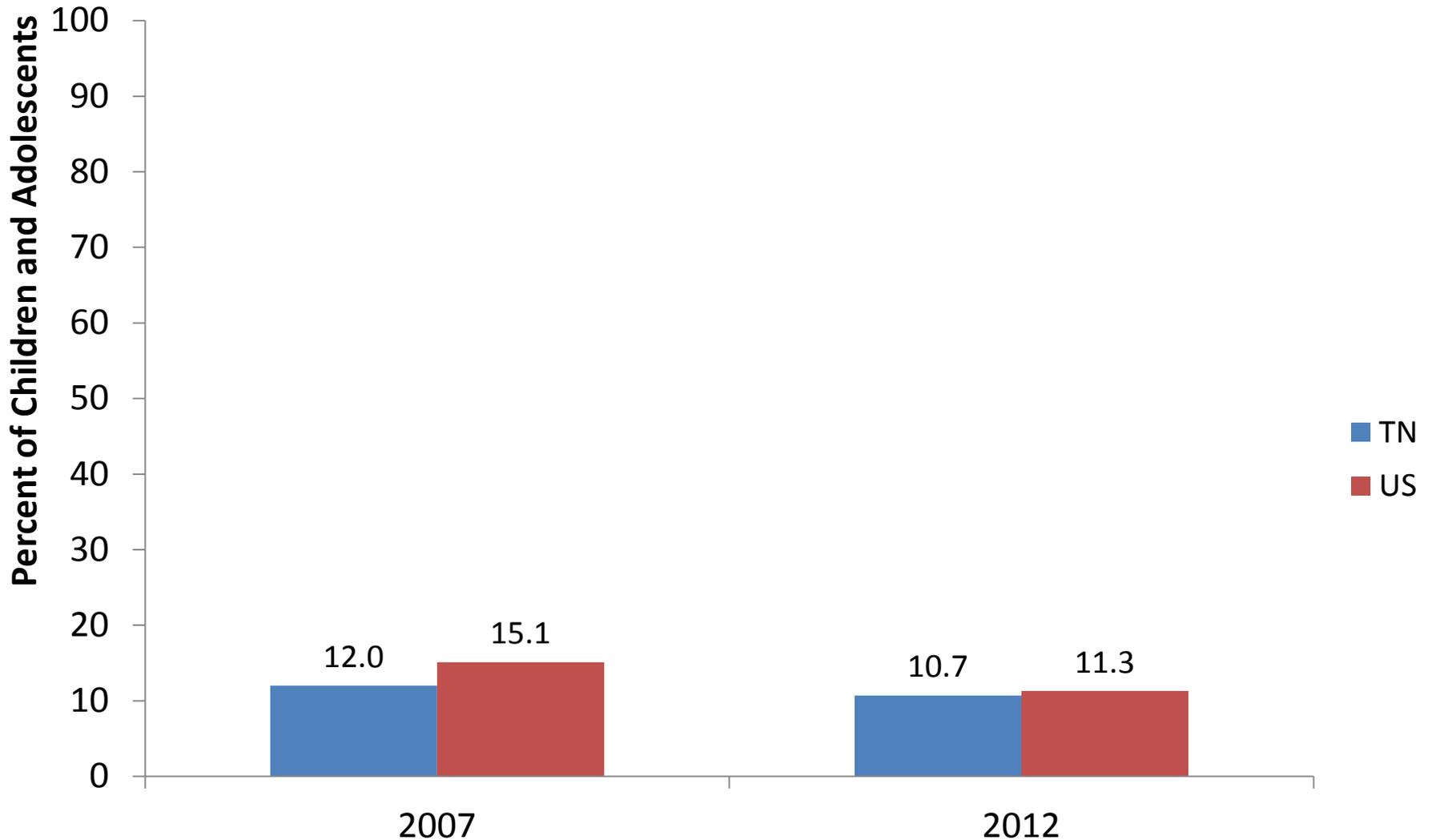
Data sources: 1) Tennessee Department of Education, Annual Statistical Report of the Department of Education, 2009-2014.

Children and Adolescents Age 0-17 Years Adequately Insured



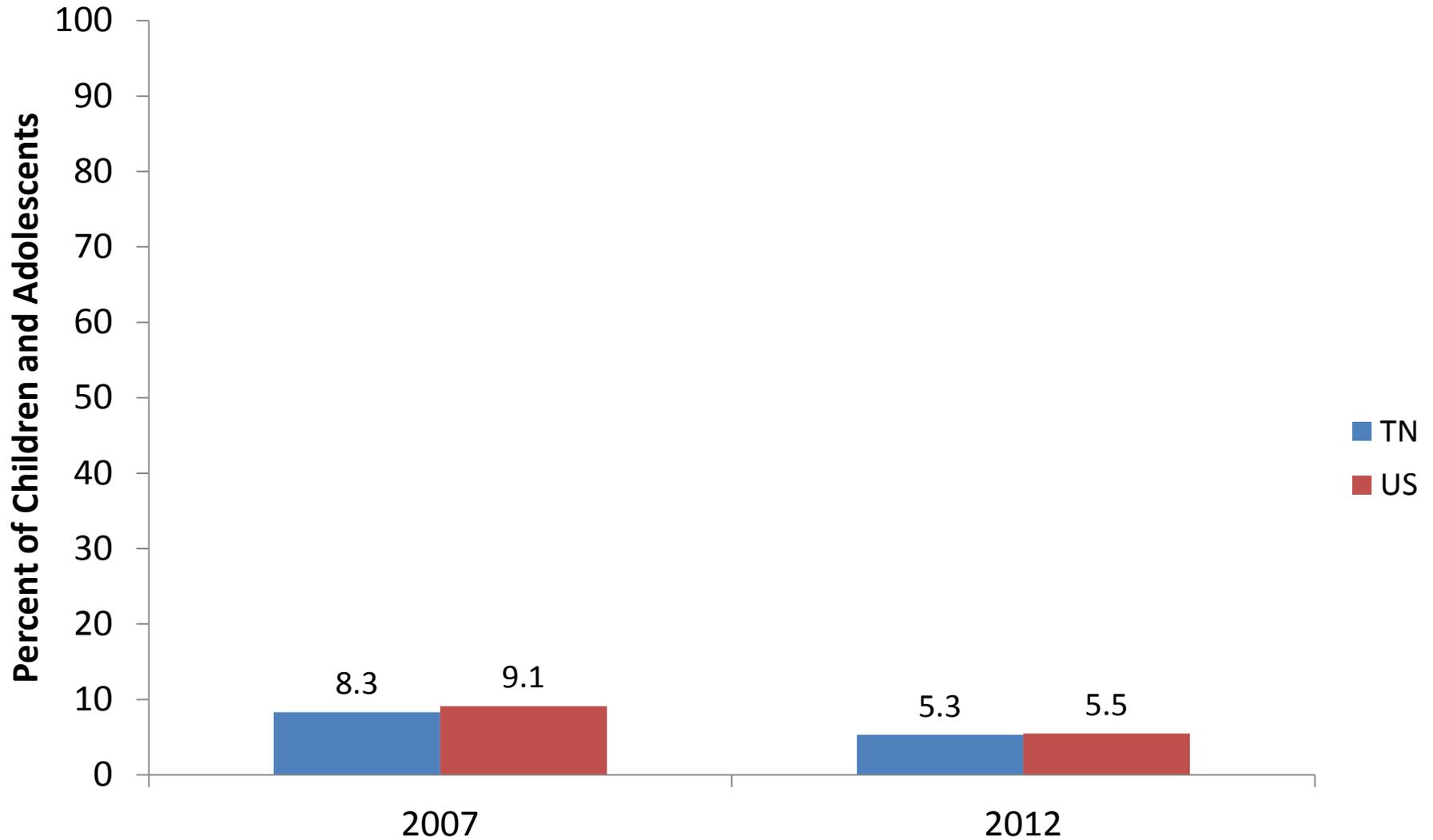
Data Source: National Survey of Children's Health. NSCH 2011/12. Data query from the Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website. Retrieved 8/1/14 from www.childhealthdata.org.

Children and Adolescents Age 0-17 Years Who Were Uninsured at Some Point in the Past Year



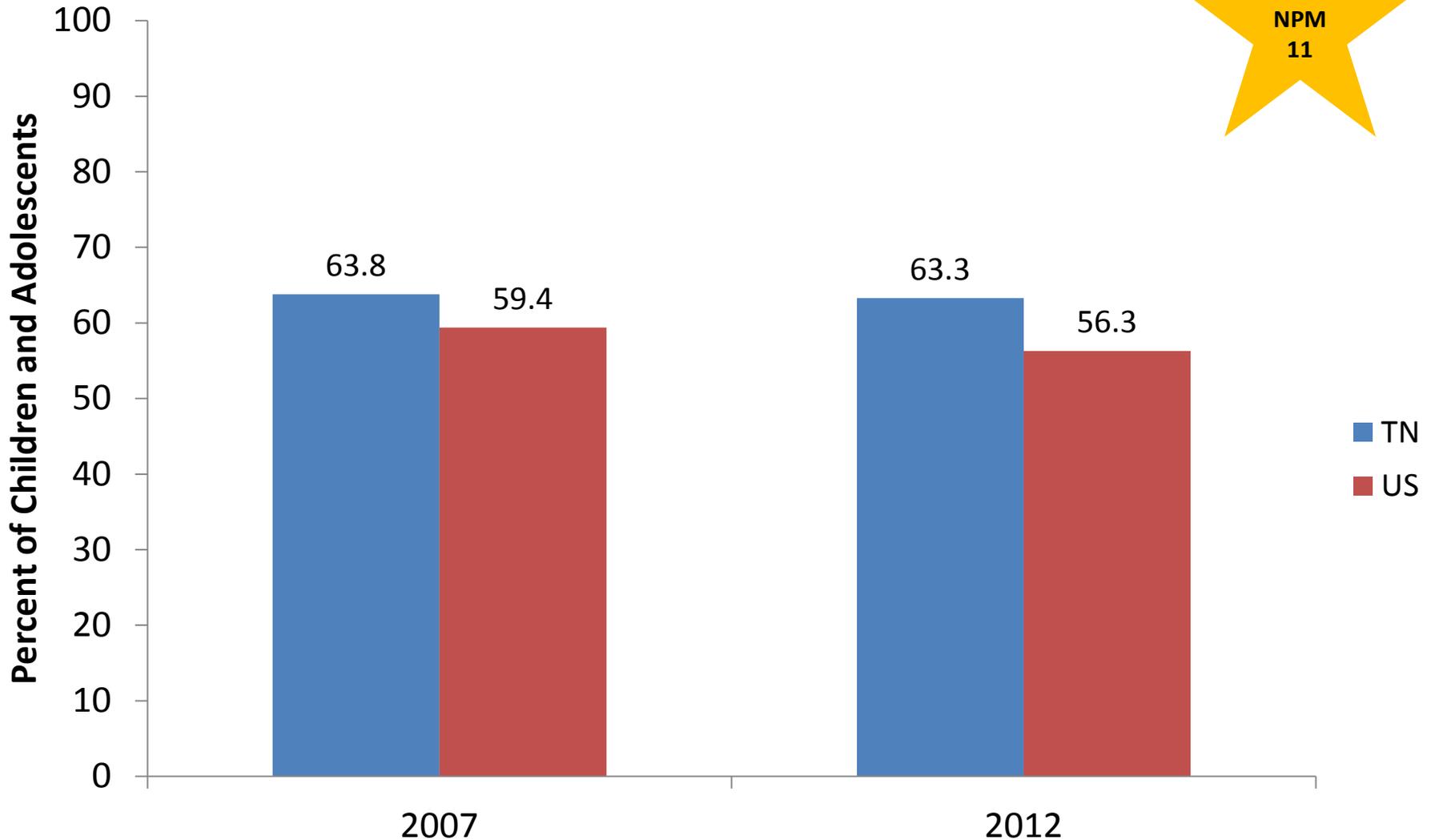
Data Source: National Survey of Children's Health. NSCH 2011/12. Data query from the Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website. Retrieved 8/1/14 from www.childhealthdata.org.

Children and Adolescents Age 0-17 Years Uninsured



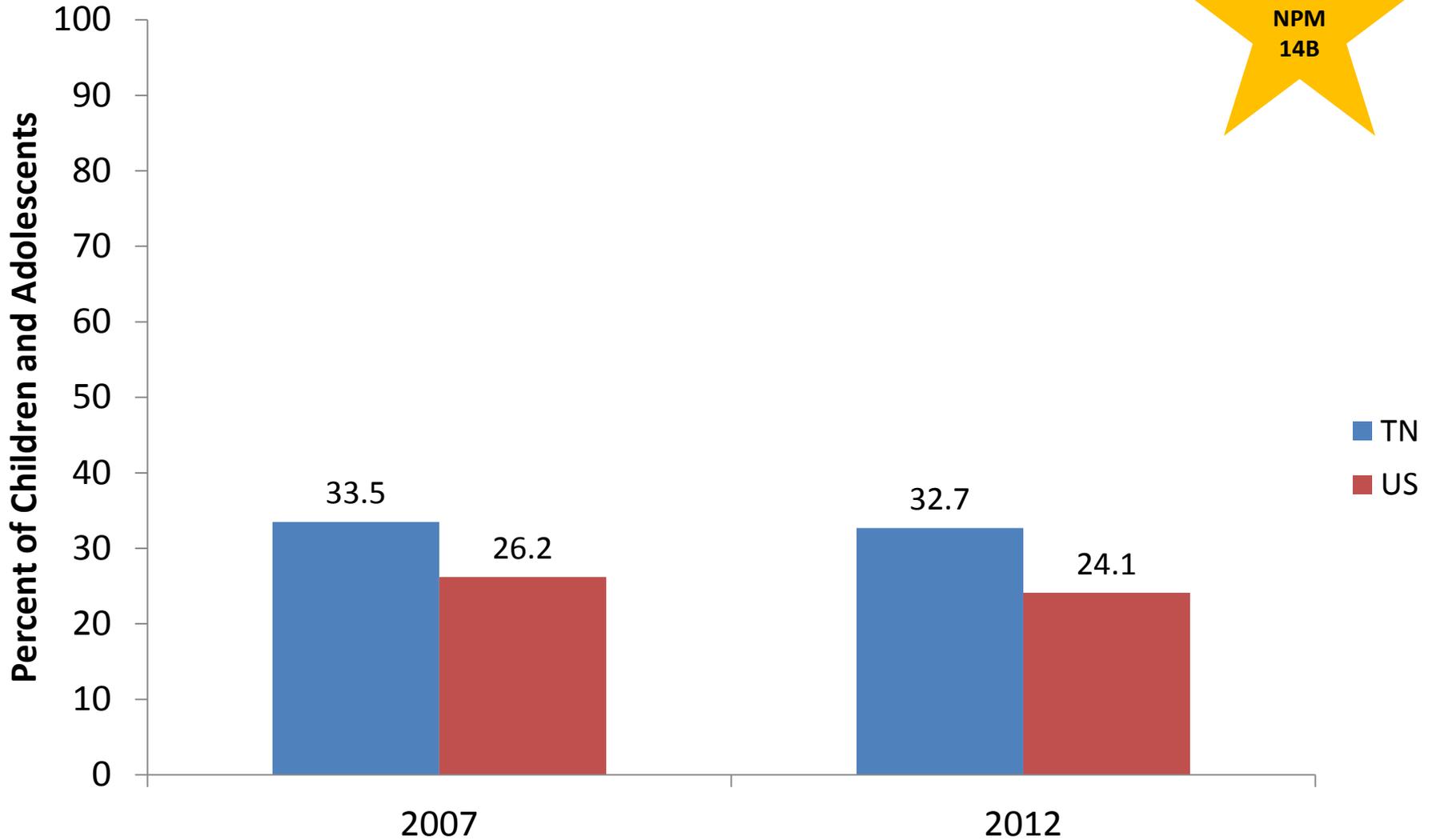
Data Source: National Survey of Children's Health. NSCH 2011/12. Data query from the Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website. Retrieved 8/1/14 from www.childhealthdata.org.

Children and Adolescents Age 0-17 Years Who Have a Medical Home



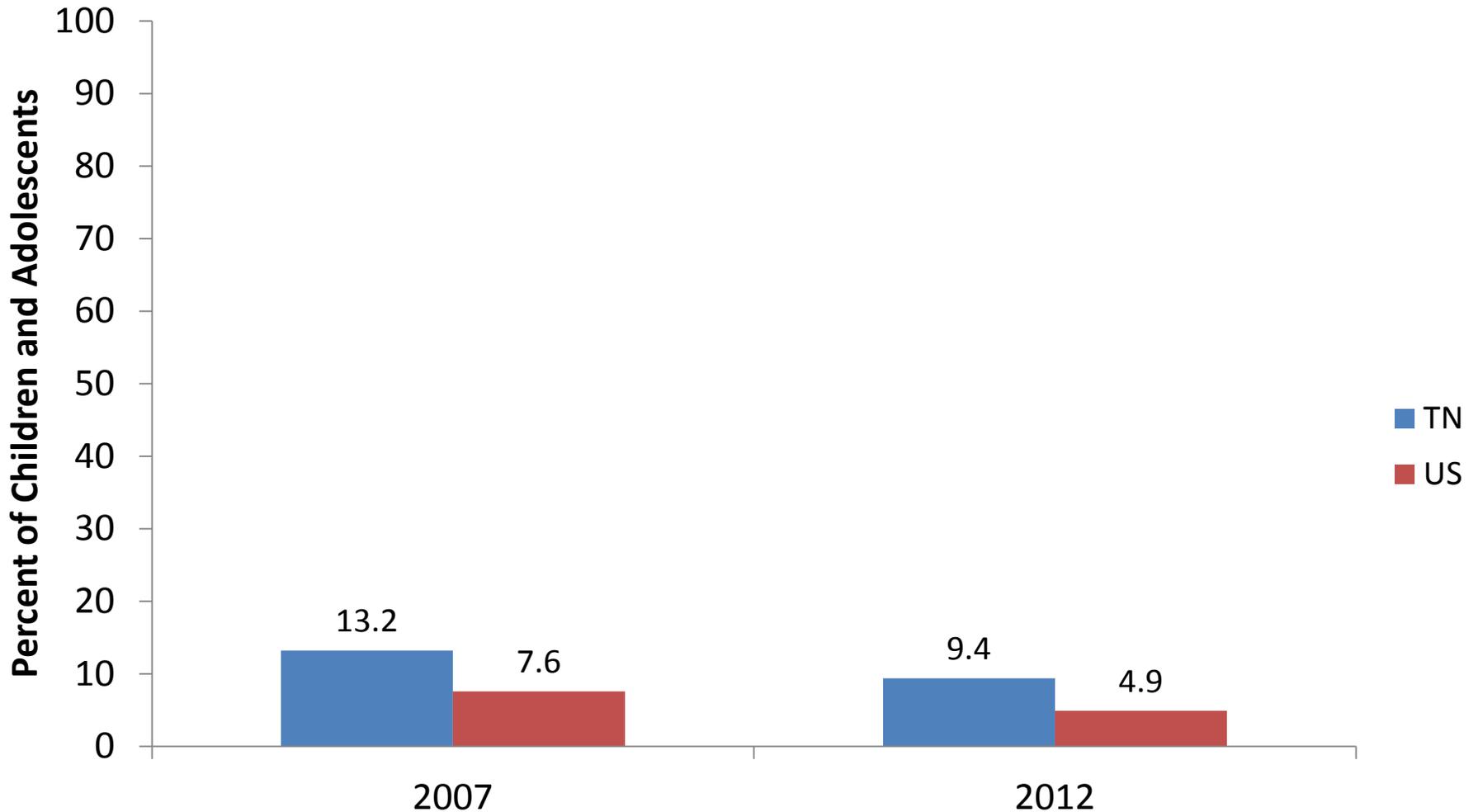
Data Source: National Survey of Children's Health. NSCH 2011/12. Data query from the Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website. Retrieved 8/1/14 from www.childhealthdata.org.

Children and Adolescents Age 0-17 Years Who Live in Households Where Someone Smokes



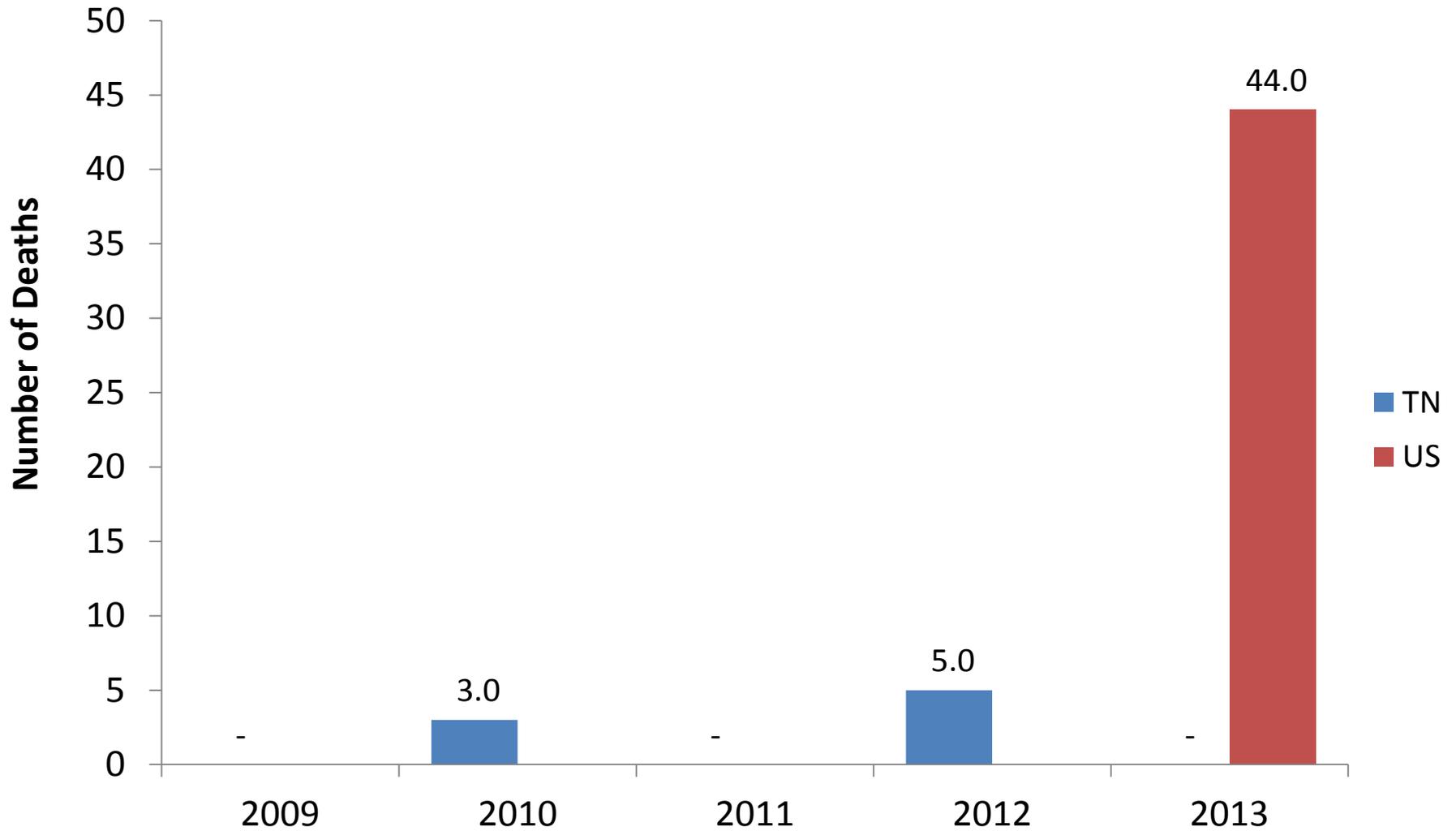
Data Source: National Survey of Children's Health. NSCH 2011/12. Data query from the Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website. Retrieved 8/1/14 from www.childhealthdata.org

Children and Adolescents Age 0-17 Who Live in a Household Where Someone Smokes Inside Their Home

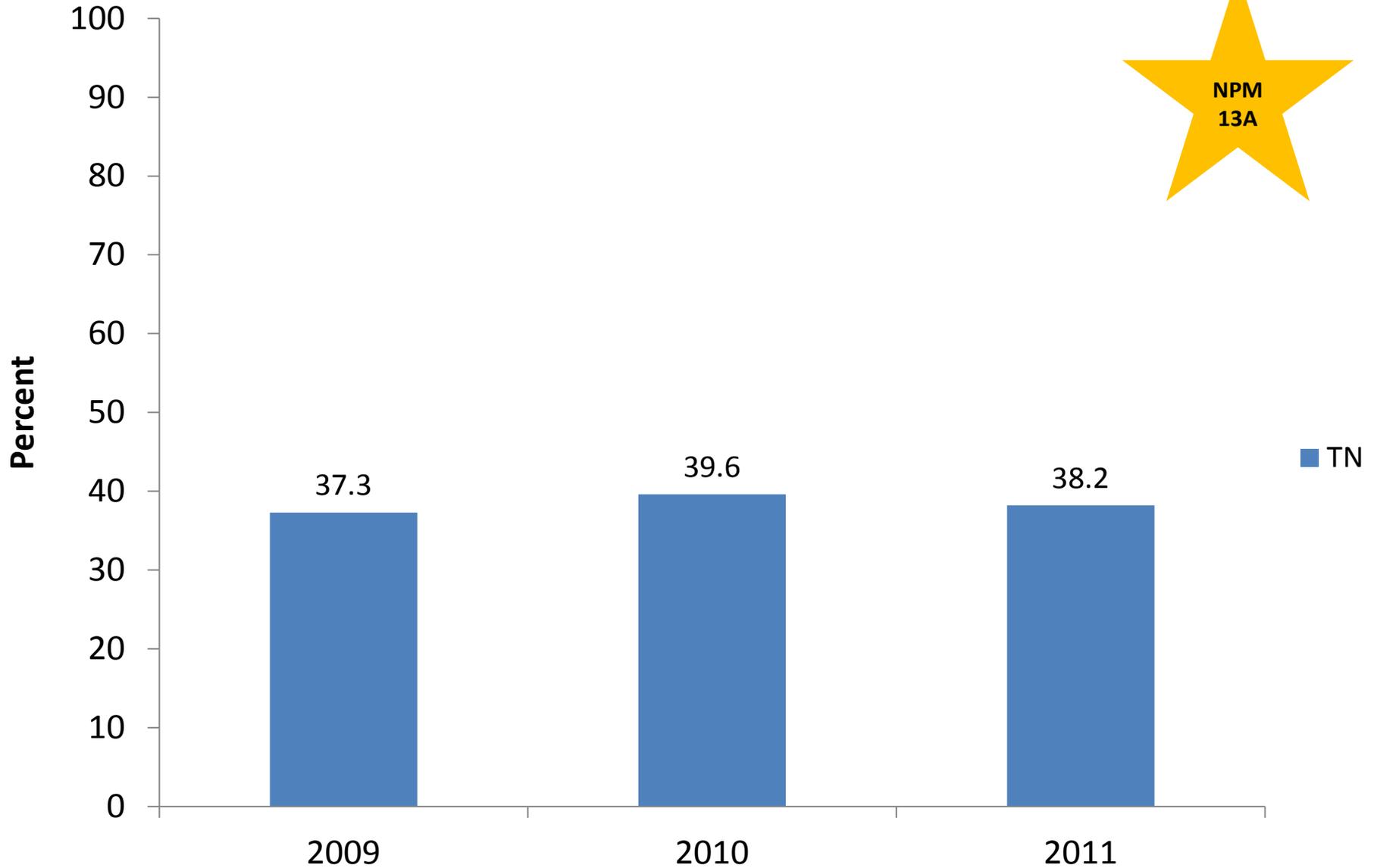


Data Source: National Survey of Children's Health. NSCH 2011/12. Data query from the Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website. Retrieved 8/1/14 from www.childhealthdata.org

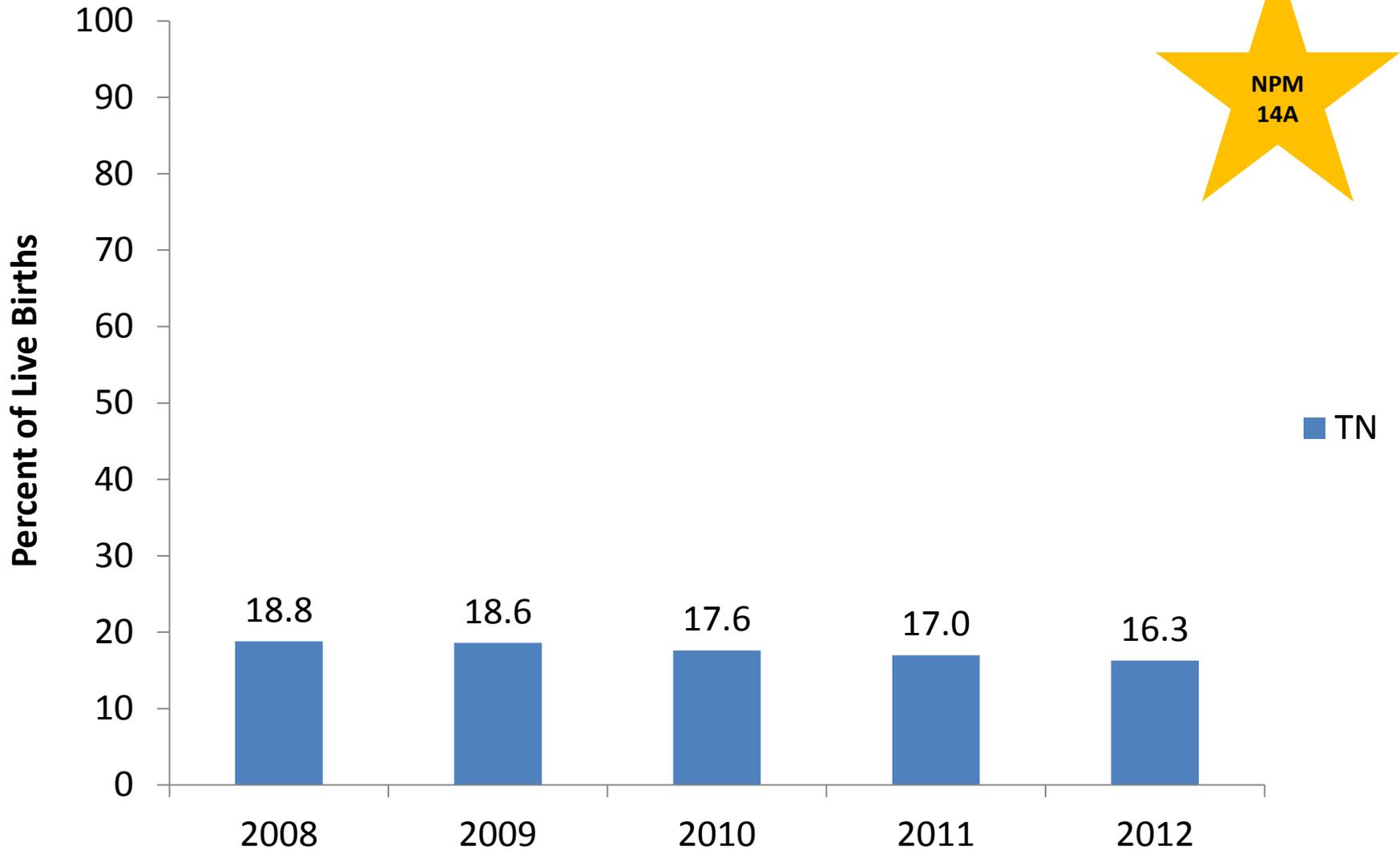
Fatalities Due to Heatstroke in Vehicles Children and Adolescents Age 0-17 Years



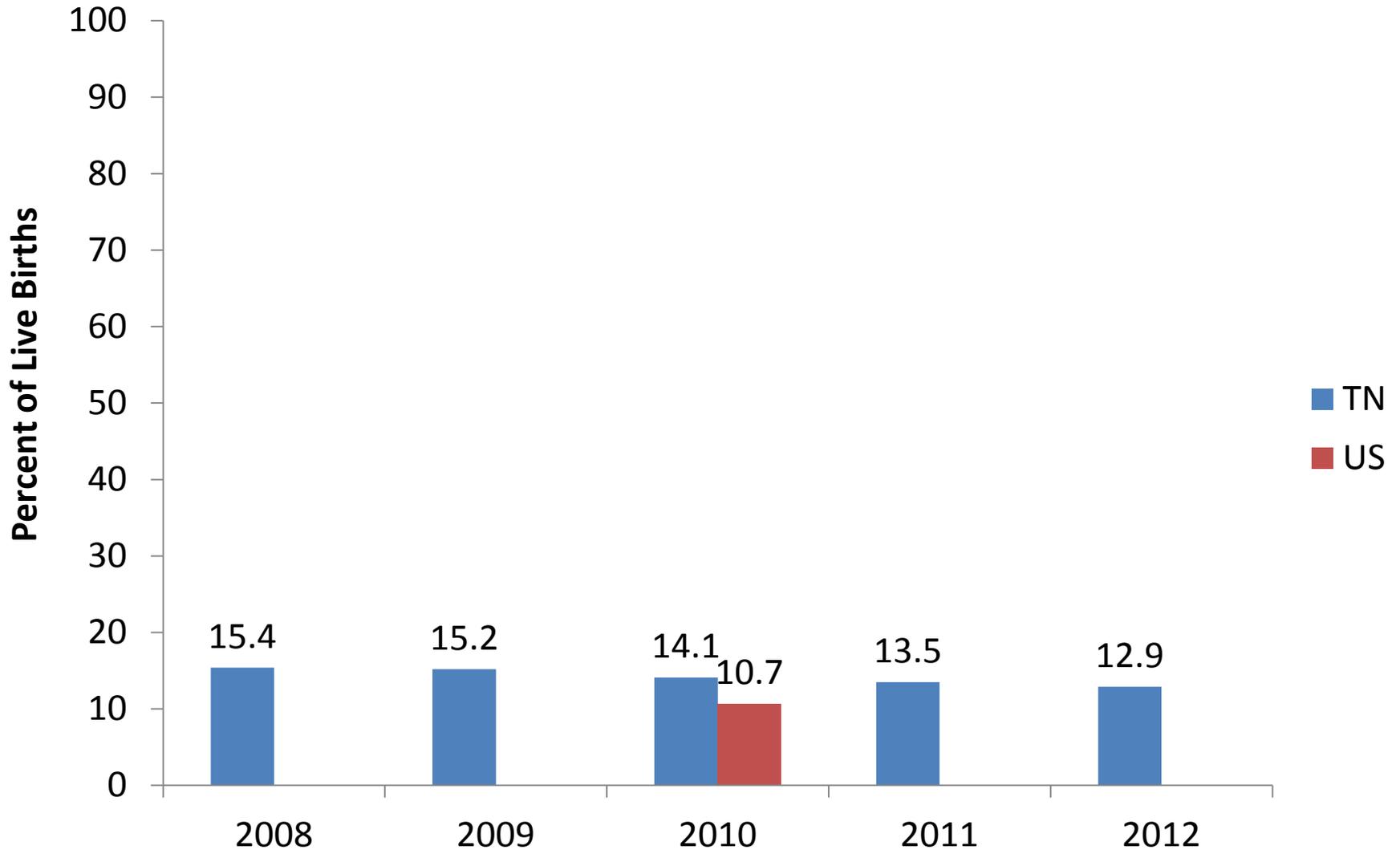
Women Who Had a Dental Visit During Pregnancy



Births to Women Who Smoking Anytime during Pregnancy



Births to Women Who Smoked During 3rd Trimester of Pregnancy



Title V Needs Assessment

Summary of Qualitative Data

Demographics

- Total Participants – 302
- Gender
 - 88% Female
 - 12% Male
- Race
 - 58% Caucasian
 - 25% African America
 - 13% Hispanic
 - 2% Other
 - 2% Missing
- Ethnicity
 - 17% Hispanic

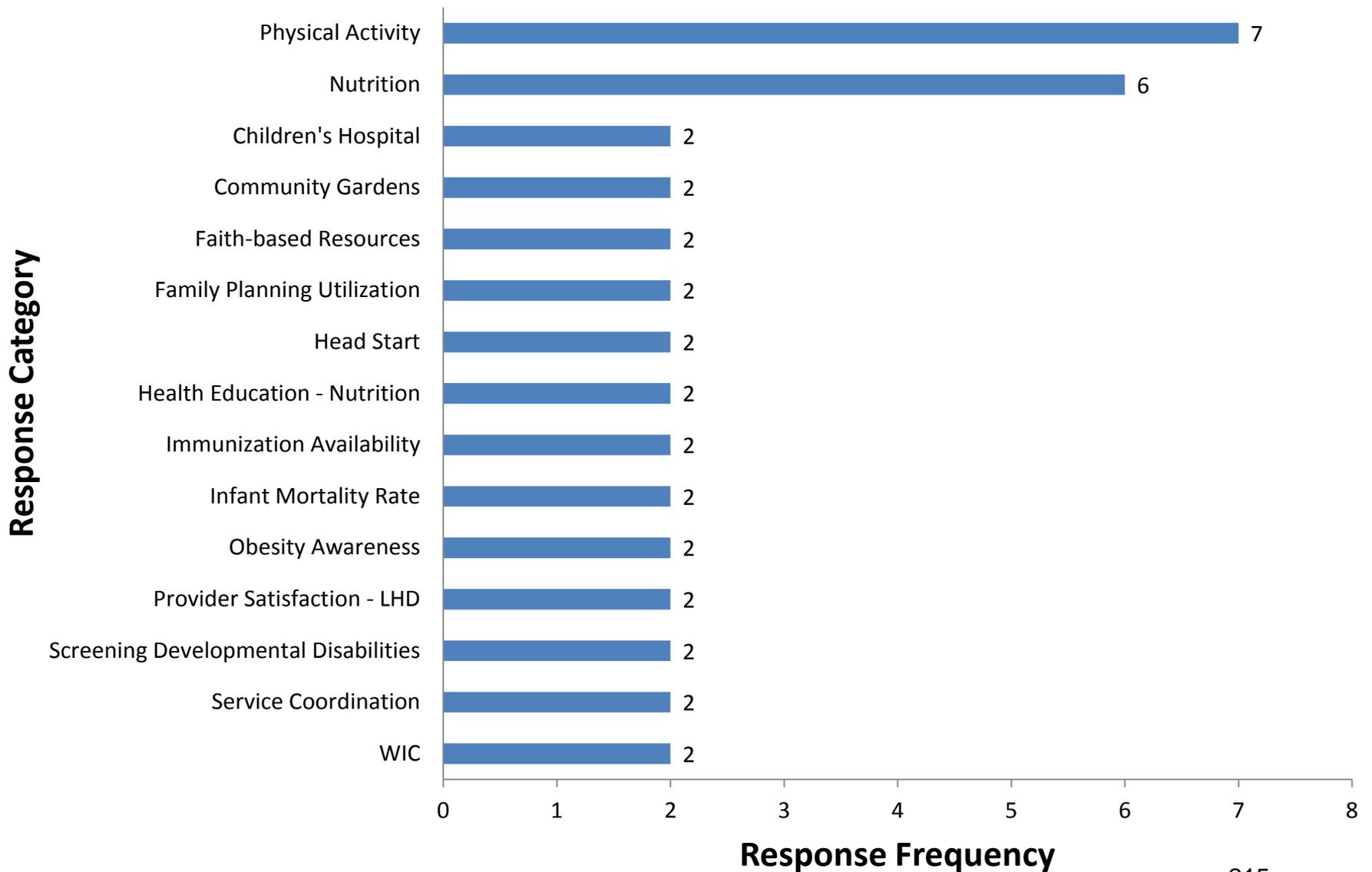
Demographics

- Average age of child
 - 10.1 years
- Average age of child (excluding those > 21)
 - 7.1 years
- Average number of children
 - 1.8 children
- Percent who have a CYSHCN
 - 21% CYSHCN

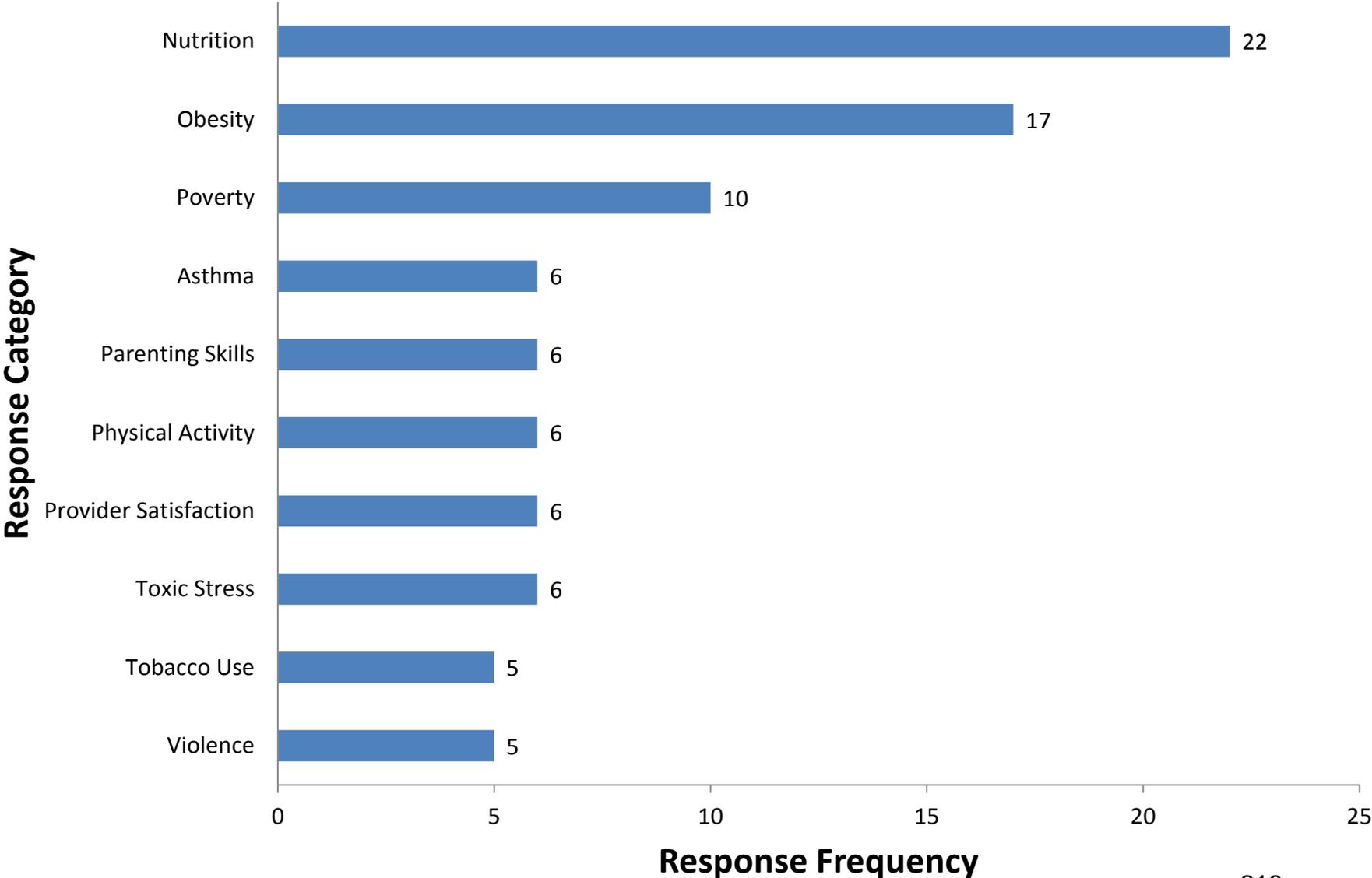
Focus Groups

- Participants received:
 - Meal
 - \$25 Dollar General Incentive Card
- Participants were asked five questions about the health of their community
 - Health needs
 - Capacity of health system to meet needs
 - Emerging Issues

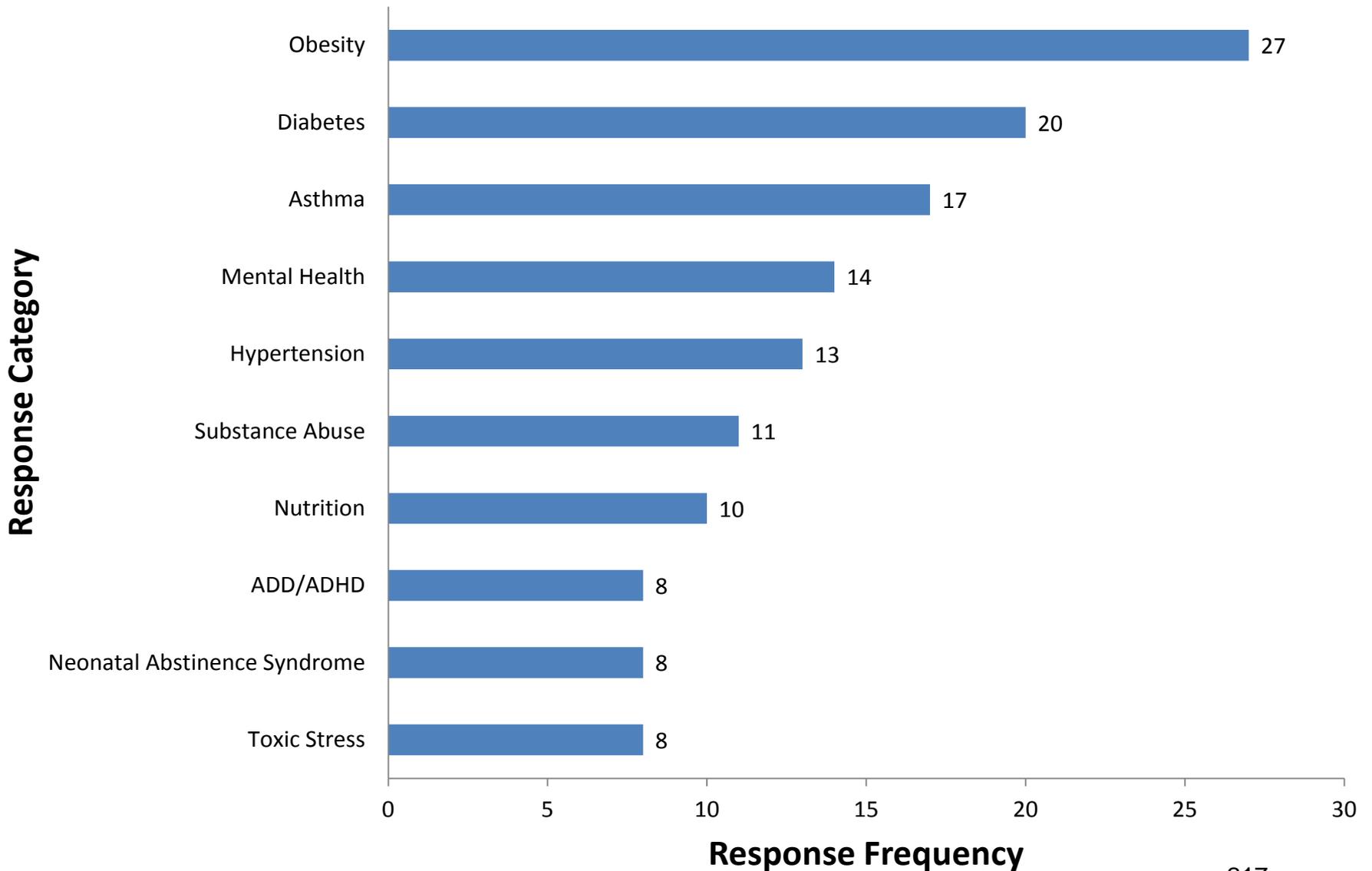
Describe the health of women, children, youth, and families in your community. What is good?



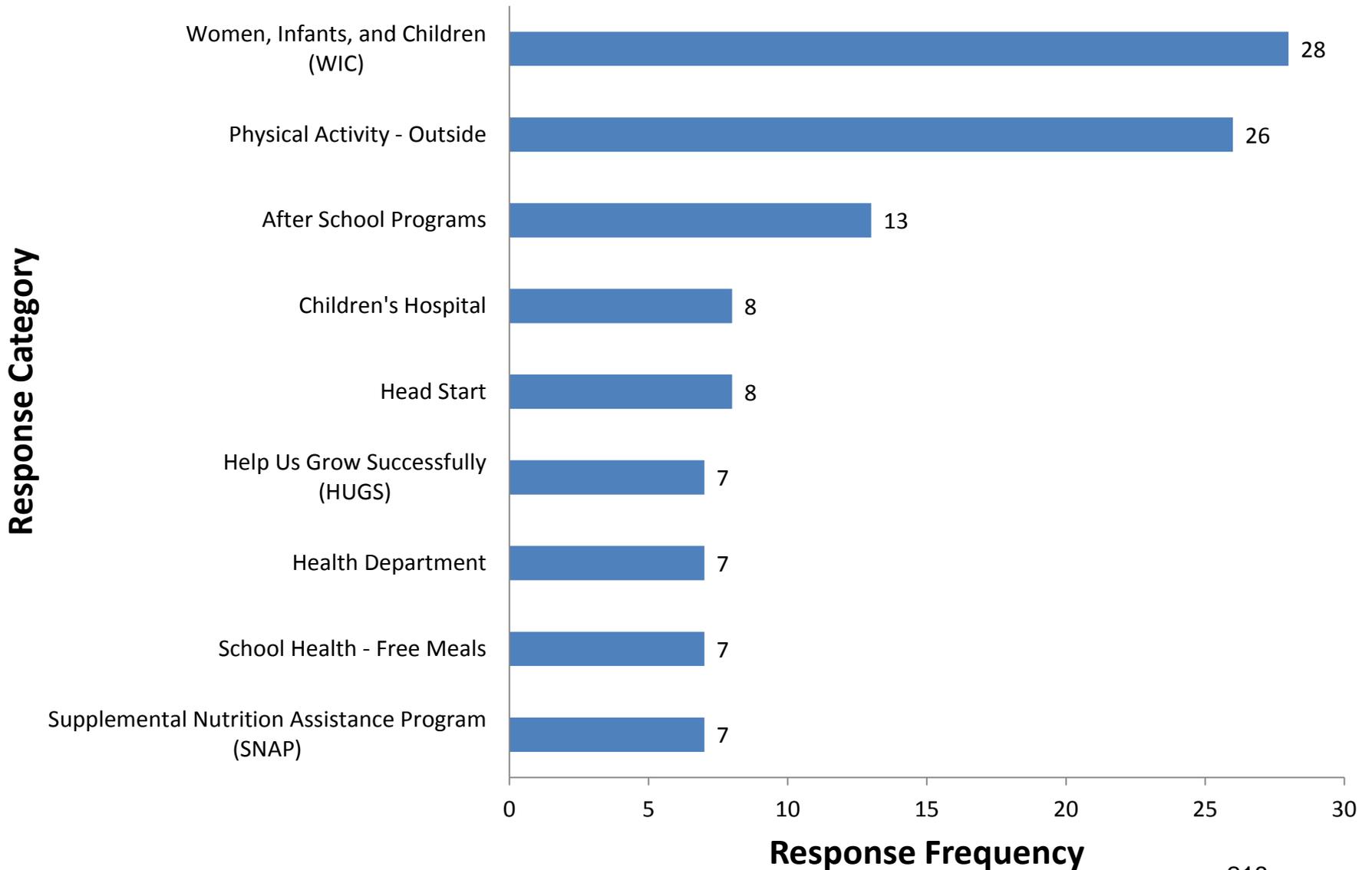
Describe the health of women, children, youth and families in your community. What is bad?



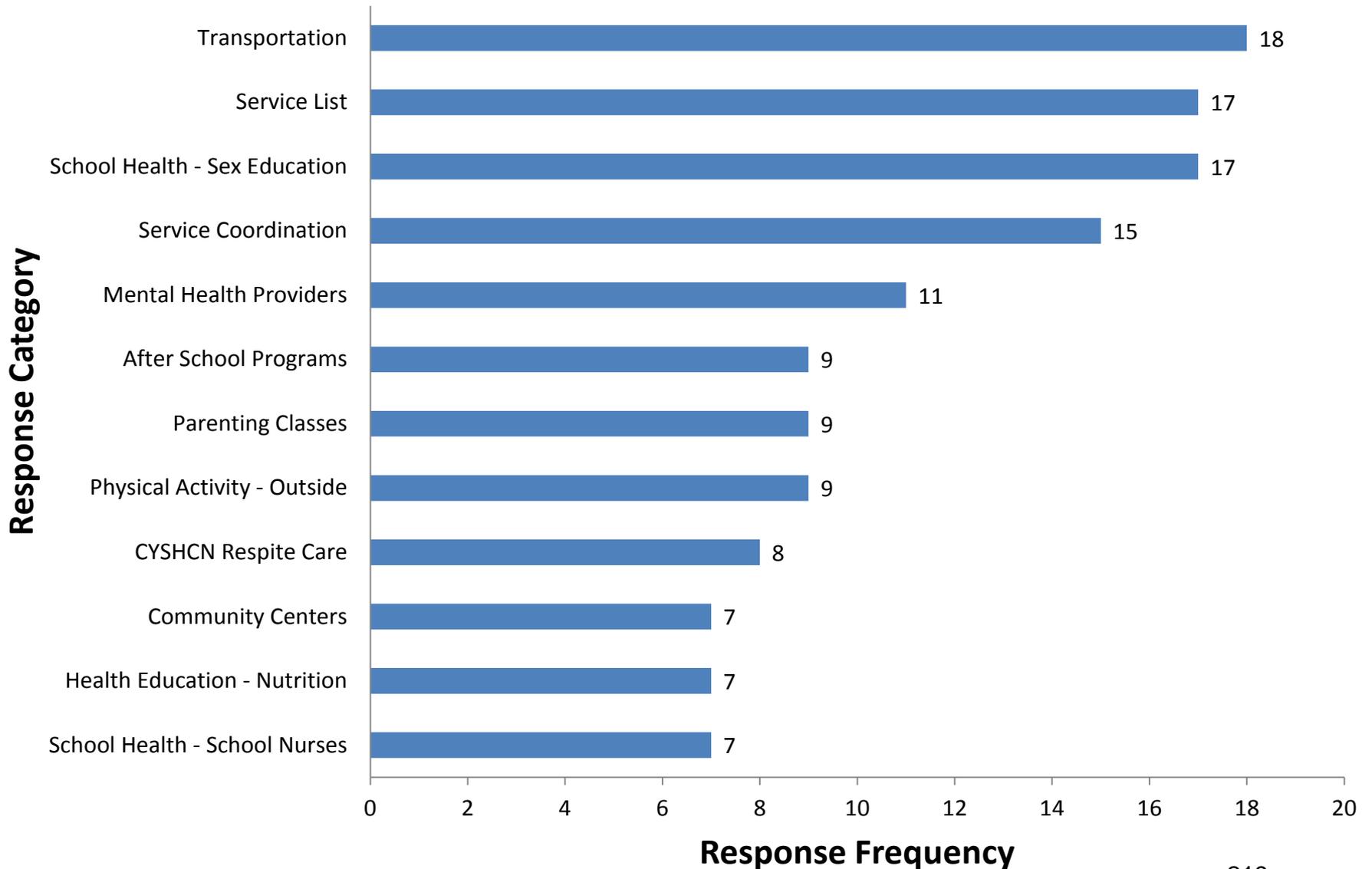
What are the most common health problems that women, children, youth, and families face in your community?



What services are being provided that are working well for women, children, youth, and families in your community?



What services could be provided that would improve the health of women, children, youth, and families in your community?



Describe any new health problems that have *recently* become a concern for women, children, youth, and families in your community.

