



State Title V Block Grant Narrative

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Sections 5.4 – 5.7, containing standard forms and detailed descriptions of national and State performance and outcome measures, are not included in this PDF. Data from these sections can be viewed in interactive formats on the Title V Information System Web site (<http://www.mchdata.net>).

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I. COMMON REQUIREMENTS FOR APPLICATION AND ANNUAL REPORT		
1.1	Letter of Transmittal	
1.2	Face Sheet	1
1.3	Table of Contents	2
1.4	Overview of the State	4
1.5	The State Title V Agency	13
1.5.1	State Agency Capacity	13
1.5.1.1	Organizational Structure	13
1.5.1.2	Program Capacity	16
1.5.1.3	Other Capacity	23
1.5.2	State Agency Coordination	25
II. REQUIREMENTS FOR THE ANNUAL REPORT [Section 506]		
2.1	Annual Expenditures	29
2.2	Annual Number of Individuals Served	29
2.3	State Summary Profile	30
2.4	Progress on Annual Performance Measures	34
2.5	Progress on Outcome Measures	66
III. REQUIREMENTS FOR APPLICATION [Section 505]		
3.1	Needs Assessment of the Maternal and Child Health Population	70
3.1.1	Needs Assessment Process	70
3.1.2	Needs Assessment Content	71
3.1.2.1	Overview of the Maternal and Child Health Population's Health Status	71
3.1.2.2	Direct Health Care Services	80
3.1.2.3	Enabling Services	80
3.1.2.4	Population-Based Services	84
3.1.2.5	Infrastructure Building Services	86
3.2	Health Status Indicators	90
3.2.1	Priority Need	90
3.3	Annual Budget and Budget Justification	90
3.3.1	Completion of the Budget Forms	91
3.3.2	Other Requirements	91
3.4	Performance Measures	93
3.4.1	National "Core" Five Year Performance Measures	93
3.4.1.1	Five Year Performance Targets	93
3.4.2	State "Negotiated" Five Year Performance Measures	93
3.4.2.1	Development of State Performance Measures	93
3.4.2.2	Discussion of State Performance Measures	96
3.4.2.3	Five Year Performance Targets	96
3.4.2.4	Review of State Performance Measures	96
3.4.3	Outcome Measures	96
IV. REQUIREMENTS FOR THE ANNUAL PLAN [Section 505 (a)(2)(A)]		
4.1	Program Activities Related to Performance Measures	97
4.2	Other Program Activities	100

4.3	Public Input	102
4.4	Technical Assistance	103
V. SUPPORTING DOCUMENTS		
5.1	Glossary	103
5.2	Assurances and Certifications	109
5.3	Other Supporting Documents	114
5.4	Core Health Status Indicator Forms	
5.5	Core Health Status Indicator Detail Sheets	
5.6	Developmental Health Status Indicator Forms	
5.7	Developmental Health Status Indicator Detail Sheets	
5.8	All Other Forms	
5.9	National "Core" Performance Measure Detail Sheets	
5.10	State "Negotiated" Performance Measure Detail Sheets	
5.11	Outcome Measure Detail Sheets	

1.4 Overview of the State

Tennessee has enjoyed remarkable prosperity, with a 4.2 % nonseasonally adjusted unemployment rate statewide, a diverse market economy, low state taxes, which attract business and industry, and environmental and cultural attributes making it a desirable place to live. At least six major interstates cut across Tennessee's boundaries, connecting the state to other hubs of prosperity. Many major corporations are now headquartered in the middle Tennessee area because of this and other quality of life indicators.

Tennessee covers 41,220 square miles of land area and is approximately 500 miles from east to west and 110 miles from north to south. The state is divided into 95 counties, each with a health department mandated by state law and located in the county seat. For departmental administrative purposes, the counties are grouped into seven rural and six metropolitan health regions.

Topographically, as well as culturally and economically, the state is divided into three grand regions. East Tennessee is a 35 county area, containing the Appalachian Mountains and bordered by Virginia, Kentucky and North Carolina. This region contains Knoxville and Chattanooga, the third and fourth largest cities, respectively. Johnson City, with a population over 50,000, is located in the extreme upper East End of the region and is the location of East Tennessee State University (ETSU) and the Quillen-Dishner School of Medicine. The ETSU Genetic Center provides on-going treatment and patient education after cases are confirmed by the Genetic Metabolic Centers. Erlanger Hospital in Chattanooga provides similar services after cases are confirmed. The University of Tennessee-Knoxville School of Medicine is one of the state's three Genetic Metabolic Centers, providing confirmatory diagnosis for suspected cases in the larger genetic region and treatment for those cases in the specific geographic area. These same medical sites also serve as the regional perinatal center sites.

Middle Tennessee encompasses 39 counties and is bordered by Kentucky, Alabama, and Georgia. The topography ranges from mountains in the east to the Tennessee River on the western edge. Nashville, the capital and second largest city, and two other cities with populations over 50,000 are located in this region: Clarksville, home to the Fort Campbell military base; and

Murfreesboro, home of Middle Tennessee State University. This region has Meharry Medical School and Vanderbilt University Medical Center providing program services. Meharry confirms all diagnoses of sickle cell anemia for suspected cases in the state and serves as the Middle Tennessee Regional Sickle Cell Center. Vanderbilt serves as the regional perinatal center and as another of the three Genetic Metabolic Centers confirming diagnoses for the larger region and providing treatment for cases in their specific catchment area.

The western part of the state has 21 counties and is bordered by the Mississippi and Tennessee Rivers and the states of Mississippi, Missouri, Kentucky and Arkansas. This area is part of the Delta, or Gulf Coastal Plain, and is very flat, rural and sparsely populated, with the exception of Memphis, the state's largest city, and Jackson (population 52,300). The University of Tennessee – Memphis Medical School is the third Genetic Metabolic Center confirming diagnoses for the West Tennessee area and providing treatment for cases in its catchment area through the Boling Center for Developmental Disabilities – an affiliate of the Medical School's Pediatric Department. This site also serves as the perinatal center for the western part of the state.

Using the latest federal census updates from the Tennessee State Data Center, the projected population for 1999 was 5,483,535. During the 1990 - 95 period, Tennessee's population growth surpassed the increase experienced during the entire decade of the 1980s and also outpaced the national average growth rate. During the 1990 - 99 period, Tennessee was the fourth fastest growing state in the South, with 1.3 percent growth.

Continuing the trend established in the mid-1980s, Middle Tennessee counties led the state's recent growth, with an average increase of 16.5% between 1990 and 1998. East Tennessee counties were next, with 6.9% growth, followed by the West Tennessee counties, which experienced a 5% net increase. Metropolitan counties (defined as those within a Metropolitan Statistical Area [MSA]) grew an average of 11.5% between 1990 and 1998.

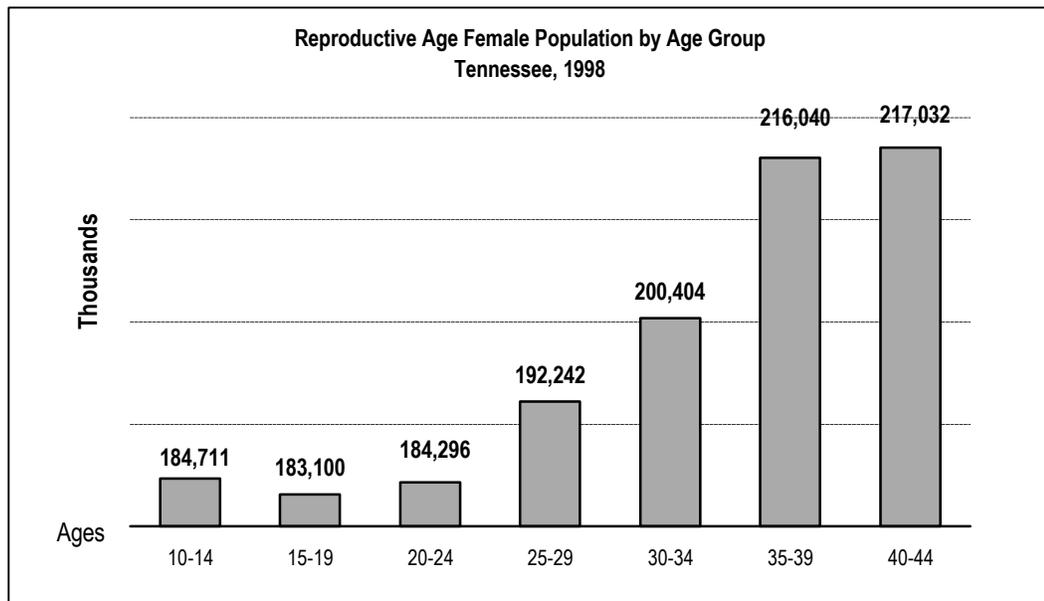
Slightly more than a quarter of all Tennesseans live in the four largest cities. Just over 68% of Tennessee's population reside in the state's seven MSAs, five of which are in the eastern two-

thirds of the state. The most sparsely populated counties are primarily in rural Middle and West Tennessee.

The distribution of Tennessee's population by race and sex has not changed significantly in the past several years: seventeen percent is black, 82% is white, and 1 percent is of other races (Graph 1). Tennessee's population is 48% male and 52% female, with 8% minority males and 9.3 % minority females.

Thirteen percent of Tennesseans are over the age of 65, and 28% are under the age of 20. Reproductive age (10-44) females make up 25% of the total population. (Graph 1).

Graph 1



Tennessee is also viewed as a prime relocation site for refugees and undocumented aliens due to the very strong economy and low unemployment rate. According to the Tennessee Office of Refugee Coordination, the state's refugee growth has remained steady at approximately 1,200 per year, while the rest of the country has decreased 10-12% in the last 2 years. There is also a significant amount of in-migration from other states due to the large number of refugees already settled here and the availability of employment. All of the refugee population is eligible for TennCare coverage for 8 months.

Tennessee's immigrant and refugee population is concentrated in the Nashville area (50-60%), in Memphis (30%) and in the rural agricultural-based counties in the southeastern and western parts of the state. Hispanics are the largest ethnic minority in Tennessee. According to the 1998 Bureau of Census population estimates, 62,223 persons, or 1.1% of all Tennesseans, identified themselves as being of Hispanic origin. The Hispanic population is most likely larger than the reported number, due to the growing population of migrant workers and undocumented residents across the state.

Tennessee has a wide variety of ethnic groups in addition to Hispanics. Southeast Asians are the second largest group (52,564), and the state is the fifth largest Kurdish resettlement site in the nation. Refugees and legal immigrants are now arriving from African, Baltic, Central Asian and Southeast Asian countries.

Current ethnocultural barriers include language, educational level, health care customs and religious restriction against medical intervention. Over 30 different languages are spoken as the primary language of the home in metro Nashville. Each major medical institution in the state has a network of locally available interpreters, and, statewide, the Tennessee Foreign Language Institute maintains a database of translators and interpreters for a wide range of linguistic needs. Other resources are available in more isolated communities, including the ATT Language Line which can be subscribed to (1-800-643-2255). Educational level and health care customs are sometimes barriers. Most medical institutions have found that parents are not resistant to treatment and therapy when the issues are appropriately explained. Religious prohibitions are also rare, but Tennessee law is clear on the obligation of care givers to bring to the attention of the Department of Children's Services any instances in which denied treatment would result in harm to the child.

NUMBERS AND ORIGINS OF REFUGEES ARRIVING IN TENNESSEE

Country	10/96-9/97	10/97-9/98	10/98-9/99
Afghanistan	0	0	0
Azerbaijan	0	0	0
Bosnia & Herzegovina	187	498	307
Burma	0	0	8
Burundi	14	0	9
Byelarus	0	4	2
Cameroon	0	7	2
Croatia	4	33	10
Cuba	45	20	26
Ethiopia	7	1	6
Gambia	0	11	0
Georgia	4	0	0
Haiti	1	0	0
Iran	56	24	30
Iraq	703	117	89
Kosovo	0	0	204
Liberia	0	12	32
Nigeria	0	14	26
Russia	8	7	0
Rwanda	13	3	1
Serbia	0	0	5
Sierra Leone	0	10	10
Sino-Lau	0	0	6
Somalia	214	133	96
Sudan	23	63	116
Togo	0	3	4
Uganda	0	0	4

Ukraine	46	30	42
Vietnam	123	227	147
Zaire	3	0	1
Total	1451	1217	1190

Source: Tennessee Office of Refugee Coordination

The confounding issues of race and poverty contribute to some of the more serious health problems and health status indicators in the state. The following is a summary of significant issues the Tennessee Department of Health (TDH) is addressing through local health department services and state health initiatives focused on women, infants and children. The original findings represented in bold type are facts taken from Tennessee Department of Health - Office of Minority Health, *Narrowing the Gap - 1997*.

- **African-American adolescents have a disproportionately higher pregnancy rate than white adolescents in all age groups** - being addressed through the state's Adolescent Pregnancy Prevention Program, the Abstinence Education Program, general health education, family planning clinics and EPSDT exams offered through the local health departments.
- **A higher number of minority women are likely to enter prenatal care after the first trimester of pregnancy** - being addressed through special outreach projects in West Tennessee where data indicate this is a significant health problem. Rural Health Initiative dollars are being used to establish these services through public-private partnerships. Local health departments are now enrolling TennCare eligible patients, and pregnancy testing and referral are available at all local health department sites.
- **The infant death rate for minorities in 1995 was two and one half times that of whites.**

- **African-American births comprise over one-fourth of the total births, but three-fourths of all infant deaths were African-American. The leading cause of African-American infant death is short gestational period and low birthweight.**
- **Neonatal mortality rates are almost three times as high for other races than they are for white infants.** Local health departments are using the HUG program for special outreach and follow-up for high-risk pregnancies and high-risk neonates. The local health department serves as a first point of contact to improve the administration of TennCare (outreach to TennCare enrollees, processing of TennCare applications, improving presumptive eligibility procedures, automatic enrollment of newborns who are eligible, reverification of those enrolled, etc.). The Healthy Start Home Visiting Program targets first time, high-risk mothers with a special emphasis on teens who are parents. Special Rural Health Initiative projects have been started in West Tennessee. The Perinatal Regionalization system is an established, effective statewide service designed to provide expert consultation about problem pregnancies and to transport the mother and baby to the next level hospital when necessary to improve the health service available to the mother and/or infant.
- **Chlamydia rates were seven times higher for African-American females than white females in 1996.** Selective screening and treatment are provided statewide through family planning and sexually transmitted disease(STD) clinics. Counties with the highest STD rates are in the western part of the state, which has a high percentage of minority residents. During CY 1999, the following tests for chlamydia and other sexually transmitted diseases were provided through family planning clinics: chlamydia – 48,347, gonorrhea – 46,066, syphilis – 8,272, and HIV – 2,886. In 1998, the positive chlamydia rate for the black population tested was 10.10% and 4.26% for the white population.
- **African-American children, more than white children, are diagnosed with elevated blood lead levels.** Tennessee Department of Health (TDH) is working in conjunction with TennCare to assure that blood lead levels are part of Early Periodic

Screening Diagnoses and Treatment (EPSDT) screening according to the periodicity schedule. The Memphis-Shelby County Health Department has an active Childhood Lead Poisoning Prevention program concentrating on inner-city neighborhoods. TDH continues to track elevated blood lead levels through the required reporting from laboratories.

- **While the statewide vaccine completion rate for 24 month old children was 80.8% in 1995, West Tennessee, where most African-Americans live had a vaccine completion rate of 76.4%.** The state Immunization Program has now established an Immunization Registry to track all children for compliance. In 1998, the statewide immunization rate for 24 month old children was 87.7% and for those living in West Tennessee where the highest concentration for Blacks are located, the immunization rate was 86.6%. This is a significant improvement from 1995.

- **African-Americans are more likely than whites to be obese, not wear seatbelts and have a sedentary lifestyle.**

- **African-Americans are more likely to be treated for diabetes and hypertension than whites.** The Health Promotion Program has active programs and coalitions to address lifestyle-related health status issues. Special initiatives are sponsored through regional health educators and other collaborating agencies.

(Facts taken from Tennessee Department of Health – Office of Minority Health, *Narrowing the Gap – 1997*).

On several other indicators of socio-economic well being, Tennessee ranks higher than national averages. Twenty - two percent of Tennessee's children live in poverty compared to 20% nationally. The overall 3 year average poverty rate of 14.5 % is lowest in history but still higher than the U.S. by 1.3%. (13.2 %)

The per capita income is more than \$4,000 less than the national per capita income (\$26,482), ranking Tennessee 34th in the U.S. By contrast, the 1998 annual average unemployment rate was 4.2%, ranking the state 21st. Jobless rates of 5% or less are considered to be full employment. County jobless rates vary from 1.7% to 13.5% in the state, with the lowest jobless rates in the Metropolitan Service Area (MSA) counties. Tennessee's annual average rate has been below the national average since 1989 indicating that while most Tennesseans are employed, salaried and hourly employees make less on average than other persons in states.

The Department of Health was one of the first departments established by state mandate. Services for women and children have always been a major part of local health department activity. By state law, there is a health department in every county; highly populated counties may have several health department sites. Title V has played an increasingly important, although often changing, role in providing services and funding for the county health department system, including services for children with special health care needs (CSHCN).

In 1994, when the state's Medicaid managed care system called TennCare was implemented, the Title V role changed once again but has not diminished in importance. Direct services in all traditional areas of public health are still provided and new roles are developing, especially in relation to outreach and follow up with patients enrolled in TennCare. Title V service providers have become more flexible and responsive to the unique needs of county residents since the managed care system is so varied across the state. Public-private partnerships are emerging to assure that health care needs are met.

The local health department is an integral part of the health care delivery system. In rural and urban counties, the local health department provides many TennCare services as a means of assuring access to care for eligible citizens. The local health department has always provided information and referral for county residents. Local health department nurses have provided screening and then enrollment for pregnant women presumptively eligible for TennCare, and most recently the local health department has been the site for enrollment of uninsured children and the site for reverification of eligibility for TennCare.

The local health departments have a positive reputation for helping people, and there is little stigma attached to seeking this service. During 1998, local health departments began assisting TennCare by re-verifying eligibility for those enrolled, a Health Care Finance Administration (HCFA) requirement for the Medicaid waiver. Local health department nurses have also been trained and are now providing assessment and referral for alcohol and drug services to treatment facilities as close to the community as possible. All these activities are in keeping with the departmental policy, articulated by the Commissioner, that local health departments should be the focal point for service for any human service need.

1.5 The State Title V Agency

1.5.1 State Agency Capacity

1.5.1.1 Organizational Structure

The Tennessee Department of Health (TDH) is a branch of state government with a Commissioner appointed by the Governor. The mission of TDH is to:

- **Promote, protect and restore the health of all Tennesseans;**
- **Prevent problems that contribute to disease, injury and disability;**
- **Promote healthy lifestyles through health education;**
- **Ensure quality health care through licensure and regulation of health professionals and health care facilities;**
- **Assure availability of services despite economic and geographic barriers.**

To accomplish this mission, TDH has developed a regional health department structure. TDH has divided the state into 13 health regions that administer services in the 95 county health departments. Seven of the regions are comprised of rural counties, and six are metropolitan counties under the jurisdiction of metropolitan governments. The counties in the rural regions are part of the state's administrative system, whereas the six metropolitan counties are part of county administrative systems. A map of Tennessee showing the regions is in section 5.3, Other Supporting Documentation. The Central Office of TDH, including Maternal and Child Health

(MCH), functions as the support, policy-making and assurance office for the public health system. The organization and structure of the MCH Section is discussed in greater detail in 1.5.1.2 of this document.

Dr. Fredia S. Wadley is the Commissioner of Public Health, and Linda Rukeyser is Commissioner of Mental Health/Mental Retardation. In addition to TennCare, long term care issues and state services for individuals with mental health and mental retardation are major topics on the Governor's policy agenda.

State statute relevant to Title V program authority is established for several programs administered by MCH. These statutes are:

TCA 68-12-101 to 112 - The Crippled Children's Act of 1934 establishes state services for children with special health care needs who meet income and diagnostic guidelines. The Act further establishes an advisory committee and directs that certain geographic requirements be met.

TCA 68-5-401-503 - The Genetics and Newborn Screening Act establishes the statewide program responsible for screening and following up with all babies born who have questionable or confirmed lab results for genetic and inborn errors in metabolism. Required screening includes phenylketonuria (PKU), hypothyroidism, hemoglobinopathies (sickle cell) and galactosemia. Congenital adrenal hyperplasia was approved by the advisory committee as a required screening in 1999.

TCA 68-142-101-109 -The Child Fatality Review Act of 1995 requires that review teams be established in each judicial district of the state and that all deaths to children under the age of 17 are reviewed. It further requires that an annual report is written and that a statewide advisory group is convened at least annually by the Commissioner to review findings and recommend policy.

TCA 71-3-151-165 - The Welfare Reform Act of 1996 requires that TDH, through the local health departments, provide home visiting services to families with young children within 30 days of termination from the program for reasons other than self-sufficiency.

TCA 37-3-703 - Establishes the Hawaii model of Healthy Start for families at risk of child abuse and neglect.

TCA 68-34-101-111 - The Family Planning Act of 1971 established the statewide family planning program, which included availability of contraceptives, eligibility for services, disposition of funds and services to minors.

Associated statutes related to maternal and child health issues are implemented by other sections of the Health Services Bureau. The Traumatic Brain Injury Program (TCA 68-55-101-402) establishes the head and spinal cord injury information system and advisory council; TCA 68-143-101-103 establishes a statewide public awareness campaign for shaken baby syndrome addressed jointly by the Departments of Health and Human Services. Tennessee was one of the first states to legislate child safety through the required use of child safety seats (TCA 55-9-602-610) which took effect in 1977. A Child Bicycle Safety Act (TCA 55-52-101-106) was passed in 1994 requiring all operators and passengers under the age of 12 riding on a state roadway to wear approved protective bicycle helmets and additional requirements for other riders. This legislation was further amended to age 16 in the 1998 state legislative session. TCA 55-8-189 declares it an offense to transport a child under 6 years old in the bed of a pickup truck on any roads of any county or state highway.

Funds that support MCH section activity include several special funding sources in addition to the MCH Block Grant. The state's award for State Systems Development Initiative (SSDI) has been used to develop the computer network and data management infrastructure. Most recently these funds have been used to support the 2000-2005 needs assessment. This has been an extended and intensive process requiring MCH involvement across sections of Health Services Administration (HSA) and across Bureaus to assure that tasks are completed and that MCH data needs are addressed. These activities are discussed elsewhere in this submittal. This funding stream has benefited not only MCH but the other sections of HSA since SSDI funds were used to

develop an integrated database on clients and services for program management called PTBMIS which is used by all Health Service Programs.

SSDI funds have also been used to upgrade the hardware and software used in the Genetic and Newborn Screening Program which is under the direction of MCH and fulfills the state mandate to screen every baby born in the state for metabolic disorders.

The section successfully competed for the Community Integrated Service System (CISS) – Health in Child Care grant. These funds have been combined with funds from the Child Care Licensing Division of the Department of Human Services and the Developmental Disabilities Council to fund Child Care Technical Resource Centers in the Department of Health Services (DHS) regions of the state. These centers provide technical assistance to licensed facilities in their geographic areas. The goal is to improve developmentally appropriate practices, address health issues in child care settings and increase inclusion of children with special needs in established child care programs. The third year of funding was just completed, and MCH field staff note an improvement in access to programs for special needs children. According to program reports, 33 children with special needs were placed (spina bifida, cerebral palsy, Downs syndrome, etc.) and 32 remain in placement at the end of the fiscal year.

The state's Abstinence Education Program is under the direction of MCH. The federal and state funds supporting this program have been used to award contracts to community based groups and to develop a media education plan for a statewide media campaign. State representatives of the statewide coalition for abstinence education and the state representative to National Coalition for Abstinence Education (NCAE) have been directly involved in program implementation. A statewide conference was held in September 1999, and the second annual conference is planned for this year.

1.5.1.2 Program Capacity

TDH is organized into five bureaus. The bureaus are Alcohol and Drug Abuse Services, Manpower and Facilities, Information Resources, Policy Planning and Assessment and Health

Services. The Bureau of Health Services is divided into Communicable and Environmental Disease Services, Patient Care Services, General Environmental Health, Health Resources Development and Regional and Local Health.

Maternal and Child Health (MCH), including Children's Special Services (CSS/CSHCN), is one of the sections contained in the Patient Care Services Division of the Bureau of Health Services. Other sections or programs contained in this Division include Nursing, Dental Services, Nutrition Services and Health Promotion/Disease Control. MCH consists of Child and Adolescent Health Services, Genetics and Newborn Screening Services, Children's Special Services and Women's Health. Organization charts for the Department, the Bureau of Health Services and Maternal and Child Health are in section 5.3, Other Supporting Documentation.

The state has local health departments in all 95 counties, established by state mandate, that carry out health related programs for women, infants and children. County local health departments operate in collaboration under the county executive and county commissioners. Metropolitan counties have boards of health, which set general policy for the metropolitan health departments. Funding for local and metropolitan health departments comes from local, state and federal government sources, third party payers and fees for services. Maternal and Child Health funds contribute to the financial base of all county health departments. Other funds supporting MCH program activities are earned on a sliding fee basis from services delivered at local health departments.

Each county has one or more health department sites delivering health services, including family planning, child health, immunizations, pregnancy testing, basic prenatal care, prevention and treatment of sexually transmitted diseases, WIC and TennCare outreach, enrollment and reverification. Other services are provided at selected sites depending upon local need and availability of resources. TDH contracts with universities, hospitals and other agencies for services such as perinatal regionalization services, genetics, children's special services, additional family planning sites, abstinence education and child care technical support services.

Preventive health services for women, infants and children are a priority of TDH and are available in all 95 county health departments regardless of insurance status. These services include communicable disease control, immunizations, health education and counseling, family planning services for specific populations, pregnancy testing and referral and STD diagnosis and treatment. EPSPT examinations for children without insurance coverage, home visiting services for families at risk and care coordination for families with CSHCN are also available.

Primary care services are provided by 16 of the 95 county health departments, which are designated as TennCare primary care providers, based on health care shortage areas. As such, they provide 24 hour coverage and referral for patients. Forty counties provide dental services. Dental services for TennCare enrollees have been increasingly problematic due to the shortage of dentists in certain areas of the state or dentists, who are TennCare providers, having closed enrollment to new patients. The Rural Health Initiatives program is addressing some of these issues by funding special dental service projects in underserved areas.

In April 1997, the state again opened TennCare enrollment to uninsured children, prior to the implementation of the federal Child Health Insurance Program (CHIP) which increased funding to states for HCFA-approved child health insurance plans under the Medicaid waiver process. Even though the state submitted a CHIP plan before December 1997, final HCFA approval was not received until September 1999. Children in TennCare up to age 19 and 200% of the Federal Poverty Level, (FPL) are now covered through CHIP.

The provision of MCH services at the local health department level has changed significantly since TennCare, the state's Medicaid managed care system was implemented in 1994. The state replaced its Medicaid program with TennCare and began a system of managed health care for citizens previously on Medicaid; enrollment was also opened to uninsurable and uninsured citizens. In 1999 after a period of closed enrollment for uninsured persons, enrollment of uninsured children was again opened. Cost-sharing responsibility under TennCare is based on the person's ability to pay. If household income is at or below the poverty level or the person is Medicaid eligible, there are no premiums, co-payments or deductibles. For those up to 200% of the poverty level, payment is on a sliding fee scale.

While certain basic health services are available at local health departments regardless of health care coverage status, others are negotiated with the managed care organizations (MCOs) based on gaps in the health care delivery system. Eight managed care organizations (MCOs) contract with the state to provide health care at established rates. The MCOs have formed networks of physicians, hospitals, clinics and other health care providers to serve the enrollees. The Bureau of Health Services has negotiated agreements with these MCOs to provide some traditional public health services without prior authorization from the MCO. Other health services can be provided to women, infants and children if individual authorization is approved. Local health department staff are increasingly involved in care coordination and case management to assure that women, infants and children enrolled in TennCare receive the services they need. Most metropolitan health departments have also negotiated contracts with MCOs operating in their geographic areas. Currently, TennCare has 1,315,894 enrolled persons. Of these, 21.3% are women of child bearing age (14-44). Enrollment figures of December indicated that 672,450 were children less than 19 years of age. TennCare provides health care coverage for 44% of the children in the state; approximately 90% of these are Medicaid eligible and the remaining 4% are uninsured or uninsurable children. TennCare covered 49% of the births in the state in 1998.

State statute defines special need children as follows: “Children shall be deemed “chronically handicapped” by any reason of physical infirmity, whether congenital or acquired, as result of accident or disease, which requires medical, surgical or dental treatment and rehabilitation, and is or may be totally or partially incapacitated for the receipt of a normal education or for self-support. This definition shall not include those children whose sole diagnosis is blindness or deafness; nor shall this definition include children who are diagnosed as psychotic.”

Services for children with special health care needs are provided through three components of the Children’s Special Services (CSS) Program, which are 1) medical services, 2) care coordination and 3) the parent support program called the Parents Encouraging Parents, (PEP), Program. The first component is for medical services and provides reimbursement for medical care, supplies, pharmaceuticals and therapies for children to age 21 years who meet medical and financial criteria. To qualify for the medical component, families of the children must have an income of 200% of poverty or less.

Medical services are provided through a network of CSS approved providers and TennCare providers. Each child is enrolled in TennCare is assigned a primary care provider (PCP) by the TennCare Managed Care Organization (MCO). The PCP serves as the medical home for the child. The CSS program assists families to identify a medical home for non-TennCare enrolled children. CSS coordinates primary and specialty care through the designated PCP and corresponding MCO network. CSS conducts various multidisciplinary clinics in the regional health offices and/or in a university hospital based clinic or other private provider setting. Comprehensive pediatric assessment clinics are only held in 4 of the 12 regions since so many CSS enrolled children are also enrolled in TennCare. Specialty clinics are established based on client need and provider participation; however, some clinics have been discontinued as children are referred to specialty providers designated by their MCO. There continues to be a shortage of some specialty providers in some of the MCO networks. Orthopedists, as a group, do not participate as TennCare MCO providers, and there are 10 special CSS orthopedic clinics offered. Out-of plan approvals for care are necessary to provide this service. Freestanding speech and hearing centers, not associated with an otolaryngologist, are not recognized as a provider by MCOs and must obtain out of plan approval to provide service to individual children.

Families with children newly eligible for Supplemental Security Income (SSI) are contacted by CSS and provided information on CSS, mental health, mental retardation, early intervention (TEIS), genetic services and other health department services that may be available to them. Forty-five percent (2287) of the 5110 CSS enrollees have SSI. This is 11% of the state total of SSI children up to age 17.

The second component of the program provides care coordination services conducted by social workers and/or public health nurses in each county. Services promote family-centered, community based, culturally sensitive, coordinated care. Care coordinators serve as a liaison for the family to medical and other providers and promote advocacy by the family for their special needs child. Care coordinators work with education, early intervention, vocational rehabilitation, mental health, human services, the justice system, Shriners' CHOICES program, Project TEACH, TennCare and Assistive Technology Centers to assure that services are timely,

appropriate and accessible. Care coordinators may attend CSS clinics, private clinics or multidisciplinary meetings with clients and their families. Care coordinators assist families and/or providers with the TennCare appeals process to challenge denied services considered “medically necessary” by the provider. Care coordination activities have been expanded to special needs children not diagnostically or financially eligible for the medical service component. These services are available to other special needs children enrolled in TennCare. This additional group of children include those identified at risk for having welfare reimbursement discontinued due to welfare reform measures (Families First) and children with conditions such as developmental delay, autism, mental retardation, etc. Care coordinators assist families in utilizing alternative funding sources and service providers or in determining location of needed services. Beginning in 1999, infants and children identified and treated at the state’s genetic centers are linked with care coordination services to assure compliance and assist with other developmentally related problems the family or child may have.

The CSS Care Coordination component is staffed through contracts with seven rural Community Services Agencies and five metropolitan counties (Nashville/Davidson, Memphis/Shelby, Knoxville/Knox, Chattanooga/Hamilton and Sullivan). The county health nurses function in a number of roles. In addition to care coordination services, staff work with other clinics, home visiting programs, Project TEACH and/or other duties as assigned. There are 5-10 care coordinators in each region or metropolitan area. The average caseload is 80-120 CSS clients. Care coordination services are provided by public health nurses, social workers or staff with a Bachelor’s Degree in a social or behavioral science. Services are specified through the scopes of service contained in the formal contracts. Care coordination supervisors work under the direction of the CSS Regional Coordinator and are housed in the CSS regional health office to assure coordination with all CSS, MCH and other health department services. Care coordinators are housed in a local county health department and may be responsible for more than one county in the rural areas.

The third component is the Parents Encouraging Parents (PEP) Program. There are no medical or financial guidelines for this program. The purpose of PEP is to provide parent to parent support by matching trained support parents with the parents of children with a disability or chronic

illness who are experiencing a time of crisis or transition, or who are seeking information. Parent consultants are themselves the parents of special needs children. The program provides training for parents, community education, outreach and group support activities. PEP staff work closely with CSS staff and families to strengthen parent-professional collaboration. During 1998-99, the program processed 1,862 referrals of families, followed-up with 2021 families and matched 367 families for support. Additionally, 12 support groups were in operations, and 125 parents were trained as support parents. There were 718 presentations to other organizations and 19,334 pieces of information were sent to parents and/or other professionals. PEP referred 1,231 parents to other organizations and referred 282 parents to CSS for additional services.

The PEP component is designed to be staffed by a 0.5 FTE social worker or public health nurse and 0.5 FTE parent consultant in each of the seven rural regions. The two large metropolitan areas of Nashville and Memphis are each staffed by one full-time social worker and one FTE parent consultant. The total PEP field staff is 6 part-time parent consultants employed out of a possible 12 and 8 out of a possible 10 social workers/nurses. Full staffing would assure additional support and service for families.

An additional focus of the CSS program has been in the promotion of the national effort for Universal Newborn Hearing Screening. In October 1996, Tennessee, along with 16 other states, began the formal survey process, coordinated by the grant awarded to the Marion Downs Center at the University of Colorado. The goal is to assist states in having 85% of infants screened at birth for hearing loss prior to discharge from the hospital.

Initial data from November 1996 indicated that nine hospitals in Tennessee were providing universal hearing screening and nine were providing screening to infants at risk for hearing loss. By March 1999, as a result of the survey and informal discussions about the efficacy of universal hearing screening, 28 hospitals representing 53% of the birth population had universal hearing screening available and 11 were providing screening to high-risk infants or to those infants in their Neonatal Intensive Care Units (NICU). Tennessee applied for but did not receive funding under the recent grant application process for systems development of the universal newborn hearing screening program.

Legislation for mandatory infant hearing screening was introduced in 1999 and 2000. The proposed legislation mandates hearing screening prior to hospital discharge and insurance coverage for this screening. In addition, it mandates collaboration between the Department of Education and the Department of Health for early intervention and follow-up of all infants with possible hearing problems. During this legislative session (2000), this bill was tabled due to concern about initial costs to small hospitals. Advocates plan to continue working with the legislature to resolve these concerns.

1.5.1.3 Other Capacity

The Maternal and Child Health section, like other sections of TDH, is organized into three levels of administration and service delivery. The Central Office, consisting of a staff of 25 professional and office support personnel, addresses strategic planning, policy development, program management, contract monitoring and data analysis functions. The seven rural regional offices are responsible for the health services offered in a specified geographic area (between 10 and 14 counties), and the metropolitan regional offices are responsible for the health services offered in each metropolitan county. A map of the regional system is contained in the Other Supporting Documentation section (5.3) of this submittal.

At both the central office and regional level, staff administer the programs mandated for women, infants and children and handle all the administrative functions including personnel management, fiscal management, systems development for the Patient Tracking Billing Management Information System (PTBMIS), outreach and coordination with other health service systems including TennCare. Staffs at the regional and local health department levels are under the supervision of the regional director and his/her staff and are not considered outstationed central office staff. This change has occurred over the last 5 years, and the final 82 positions were transferred from the central office budget to the respective regional offices on July 1, 1998. MCH staff developed MCH minimal standards of care specifying program expectations for MCH funding (see 5.3 Other Supporting Documentation).

Within central office, the Maternal and Child Health Section is organized into four primary areas of health issues under the direction of Mary Jane Dewey, MA, MPA. Ms. Dewey has over 20 years of experience serving women and children in health and health related fields in positions of increasing responsibility. She worked for TDH in the 1980s as program manager for home visiting programs funded across the state and as Assistant Director and then, Director of the Health Promotion section. Her résumé is contained in section 5.3 of this submittal.

The four areas of MCH are as follows, with brief descriptions of the identified Program Directors.

Women's Health Services – Margaret F. Major, MPA, RD, serves as Program Director and has worked in public health programs related to women and children since 1969. After 3 years of working in Brazil with international nutrition programs, she joined the Tennessee Department of Health, working in community nutrition programs, maternal and child health, family planning and women's health. Her current program responsibilities include family planning (Title X), perinatal regionalization, prenatal care, case management services for pregnant women and infants and the adolescent pregnancy prevention program.

Child and Adolescent Health Services – Deborah K. Johnson, BS, the Child and Adolescent Health Director. She has 23 years of service with the Department of Health working in a variety of capacities at all levels of health service. She has worked as a health educator in counties in the Upper Cumberland Region; she was also on the regional staff in the Mid-Cumberland Region for 9 years during which time she served as the county health director for Cheatham and Williamson counties. Since joining the Central Office staff in October of 1994, she has served as the primary project director for implementation of the Healthy Start (Hawaii model) program, the Child Fatality Review process and the TDH portion of Families First home visiting.

Children's Special Services (CSHCN) - Jacque Cundall, RNC, has served in a variety of nursing roles starting in 1971 with the Indian Health Service after graduation with a BSN degree. Her career in public health has been in both urban and rural settings in the states of Washington, Missouri, Arkansas and Tennessee with ever increasing and varied responsibility. She was named Director of the state's Children's Special Services Program in January 1996. In addition

to directing the day to day operations of that program, she has worked to develop strong relationships with other departments of state government concerning special needs children. She has developed a statewide task force for universal newborn hearing screening and is working to redesign the state program in response to the managed care system now in place. In the last year, she has worked on the TennCare EPSDT consent decree committee.

Genetics and Newborn Screening Services – Lee Fleshood, Ph.D., MPA, joined the Department in 1973 as Director of Nutrition Services. Dr. Fleshood holds degrees in chemistry, oncology and public administration. Prior to his service with the department, he served as Captain at the U.S. Army Research and Nutrition Laboratory and as Assistant Professor of Nutrition in the School of Public Health and Nutrition at Tulane University. He has been with the MCH section since 1991.

1.5.2 State Agency Coordination

The CSS program staff work closely with other TDH programs, MCH programs and other state agencies which are involved with children with special health care needs. CSS staff participates in the regional genetic clinics sponsored by the MCH Genetics Program. Staff serve as representatives on the Department of Education, Early Intervention (TEIS) Part C Interagency Coordinating Council, with members from Special Education, Head Start, Mental Health/Mental Retardation, Human Services, Vocational Rehabilitation and parents of special needs children. CSS staff across the state participate as board or committee members on the Developmental Disabilities Council and local organizations such as Family Voices. Many are members of regional and county community planning councils, March of Dimes, ARC, TEIS, TREDS (for children with dual vision/hearing disabilities), Head Start, TIPS, the Developmental Centers and many others that involve care, services or interest in children with special health care needs.

MCH and other Bureau of Health Services staff continue to play a major role in the TennCare Program. In addition to providing direct services to TennCare enrollees, staff in the local health departments are enrolling persons in TennCare on site in the clinics, are conducting outreach to TennCare clients and are re-verifying income status for the uninsured group on TennCare. The

health department staffs have become a main TennCare resource for the community providing information and assistance to citizens.

In April 1997, enrollment was opened for uninsured children; eligibility was again expanded on January 1, 1998, to include children under age 19 who have no access to insurance. With the availability of the Child Health Insurance Program (CHIP) enrollment was further expanded to children up to age 19 in families up to 200% of the federal poverty level who have access to insurance but are unable to pay the premiums. These two expansions of eligibility and the system change of enrolling eligible Tennesseans through the local health department has resulted in over 672,450 children being covered as of December 1999. This represents 44% of the child population in the State. A total of 1,315,894 persons are enrolled in TennCare.

In March 1998, a class action suit against TennCare was settled through a consent decree outlining specific target dates and activities to improve EPSDT services for all children, including those with special needs and those in state custody. The MCH Director and the Director of CSHCH participated in two different committees addressing outreach and education of providers and enrollees and recommending screening tools for hearing, vision and developmental screening. The work of these committees endorsed a public private partnership for outreach campaigns and specific tests for screening, including objective measures such as Otoacoustic Emissions (OAE) and Auditory Brainstem Response (ABR) for infant hearing screening.

The Commissioner of Health, Dr. Fredia Wadley, is serving as the chair for a special committee to address EPSDT issues for children in state custody. The committee is charged with the responsibility to design a system of care that assures all children in state custody have medical and behavioral assessments within the required time periods outlined by the consent decree. The PCP is responsible for the detailed plan of care to assure that these children then receive the necessary treatment and/or interventions as identified by the assessment process. A copy of the consent decree is contained in 5.3 Other Supporting Documentation section.

Tennessee's comprehensive welfare-to-work program, called Families First, imposes work requirements, time limits and parental responsibilities on recipients. Since the program began, the number of families (now called assistance groups) enrolled has dropped from 95,909 in 1995 to 54,762 in 1997. Families First participants who lose eligibility for any reason other than successful transition to self-sufficiency are offered a home visit by local health department staff to determine if the health or safety of the family, and the children especially, is in jeopardy. The home visit provides general health assessments of each family member and referrals to appropriate providers. The home visiting component is coordinated with the Department of Human Services (DHS). The service is concentrating on completion of successful home visits to these families since oversight groups are concerned that only 37% of those dropped from the program are home visited. Failure to follow through with agreed upon visit times, inaccurate addresses and phone numbers and families lost to follow-up are known causes for lower than expected home visiting rates. Periodically, program data are provided by region and county so that targeted improvement for completion of home visits can be emphasized. The 1999 DHS study of the visit component of the program did not reveal any significant changes to make to increase home visiting completion rates.

The Child and Adolescent Health Services Program Director is a member of the Department of Children's Services (DCS) Children's Justice Task Force representing TDH. DCS is a newly formed department of state government that is responsible for all children in state custody or at risk of state custody. Services for children who were formerly under the guardianship of DHS, because of child abuse and neglect issues, the Department of Youth Development, because of juvenile justice status or the Department of Mental Health because of mental health problems, were combined into one department. The Children's Justice Task Force meets quarterly as a multidisciplinary group to advise and consult with DCS on children's issues concerning abuse, neglect, foster care, adoption, etc. Recommendations from the group are submitted to the Commissioner for public policy consideration.

MCH is a primary participation with DHS and the Developmental Disabilities Council in implementation of the CISS – Health in Child Care Grant now in its fourth year of funding. Special funding resources were combined with CISS dollars to fund Child Care Resource

Centers in each of the DHS developmental districts of the state. Centers are now located in eight of the 10 districts with two more beginning July 1, 2000. The role of these centers is to provide technical assistance and training to the family day homes and child care center staff in their geographic area. Content of the technical assistance must concentrate on health issues, developmental appropriate practices and inclusion of children with special needs. A portion of the Preventive Health Block Grant, administered by the Health Promotion section, has also been allocated for these resource centers.

The Family Planning/Women's Health Section of MCH initiated relationships with secondary and tertiary perinatal centers in the 1980s which resulted in the state's perinatal regionalization system. The system consists of the five regional perinatal centers making high risk obstetrical and neonatal care accessible to all physicians and health care facilities across the state. This system provides a mechanism for consultation regarding high risk pregnant women and infants and a system of referral and transfer, when necessary. The system also provides an opportunity for postgraduate education in perinatal medicine for health care providers across the state.

Access to the appropriate level of high-risk care is facilitated through the agreements among delivering hospitals, physicians and the centers. During FY 1999, there were 11,930 deliveries at the centers, 4,007 NICU admissions, 1,250 newborn transports, 1,395 follow-up clinic visits and 8,578 educational hours provided to health care providers. The perinatal system is managed by a 21 member Perinatal Advisory Committee, which meets three times a year and is staffed by MCH and others from the Bureau of Health Services.

This perinatal system model is being discussed as a prototype for a medical consultation and referral network for children with special health care needs. While still in the development phase, the concept would improve routine and specialty service delivery for this particular population of children, by using the state's teaching hospitals to provide consultation to primary care providers and referral for specialty services not readily available in the community where the child lives. Ultimately, the vision for this system will include technology applications to make direct consultations about particular cases available through video conferencing. The state is completing a contract with the Memphis Medical Center and the Methodist Hospital System to

implement a video-conferencing model for health care consultation and specialty care in West Tennessee, associated with local Methodist hospital partners.

The Office of Health Access facilitates the placement of primary care practitioners in federally designated Health Resource Shortage Areas for primary care, obstetrics, pediatrics or TennCare shortage areas designated by the state. The Director of MCH serves on the departmental committee to review and decide applications for placement of these practitioners in these areas. During 1997-98, an amendment to the state law permitted regions to use all or some portions of funds for special health initiatives in their region with committee approval. The county and regional health councils develop innovative proposals to reduce service gaps and address access issues for the targeted health care services of primary care, obstetrics, pediatrics and dental care as special health initiatives.

MCH has received consultation and technical assistance from Donna Petersen, MHS, ScD, at the University of Alabama-Birmingham, regarding the block grant, defining performance objectives and working with the community diagnosis process. As a result of this consultation, the state established a contract in early 1998 with Dr. Petersen to evaluate the CSS program and advise TDH regarding future roles in relation to children with special needs. A preliminary report was delivered July 1998. Dr. Wadley and the assistant commissioner endorsed this report for Health Services. CSS is now using these recommendations as an action plan for addressing program issues. The mission, vision and goals for CSS have been rewritten; program rules are revised, submitted to the Attorney General and approved effective July 2000. Financial eligibility for CSS has been expanded to 200% of poverty. A review and status report on recommendations through Dec 1999, is contained in Section 5.3 Other Supporting Documentation.

II. REQUIREMENTS FOR THE ANNUAL REPORT

2.1 Annual Expenditures

Forms 3, 4, 5 are included in the Forms section of this submittal.

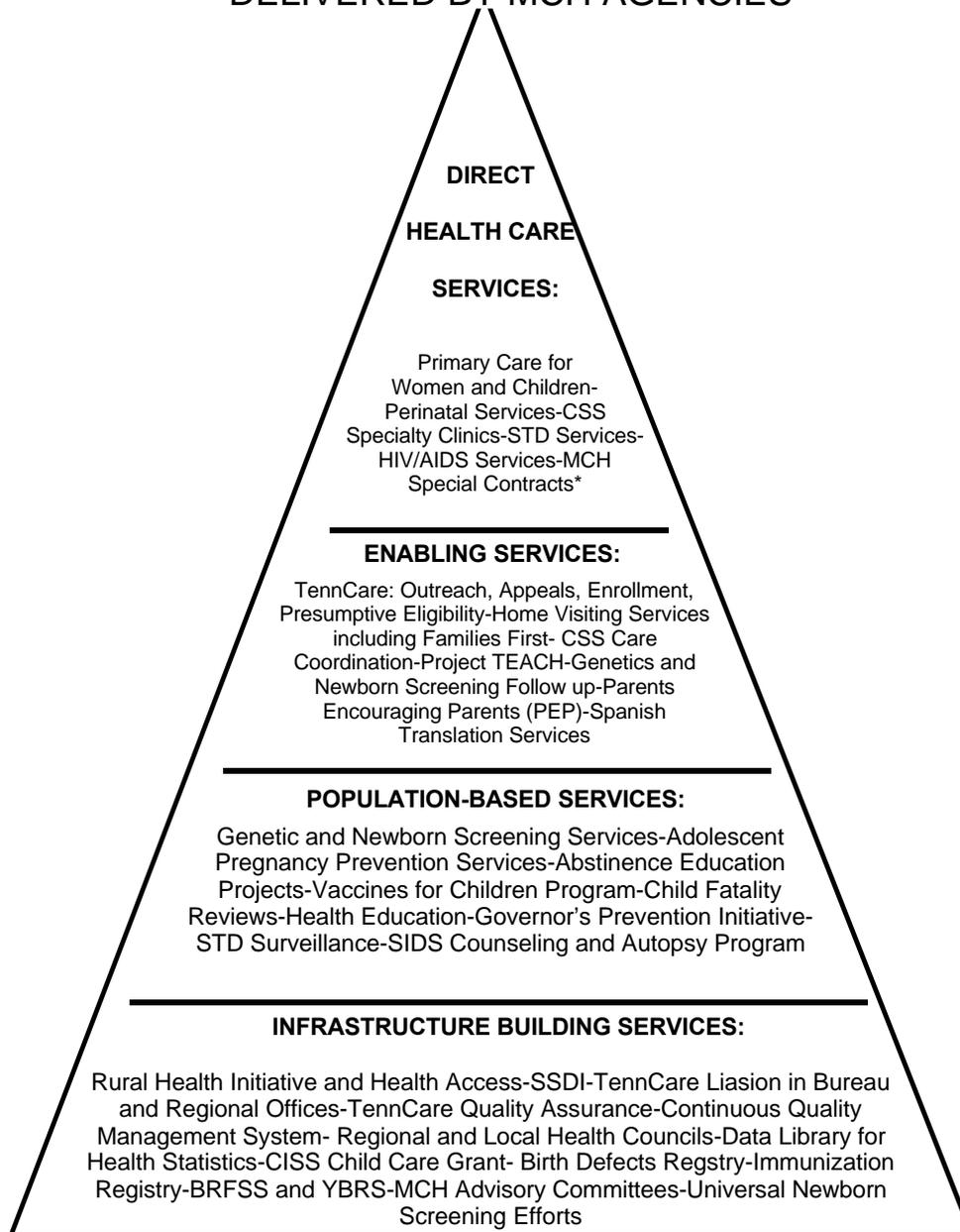
2.2 Annual Number of Individuals Served

Forms 6, 7, 8, 9 are included in the Forms section of this submittal.

2.3 State Summary Profile

Form 10 is included in the Forms section of this submittal.

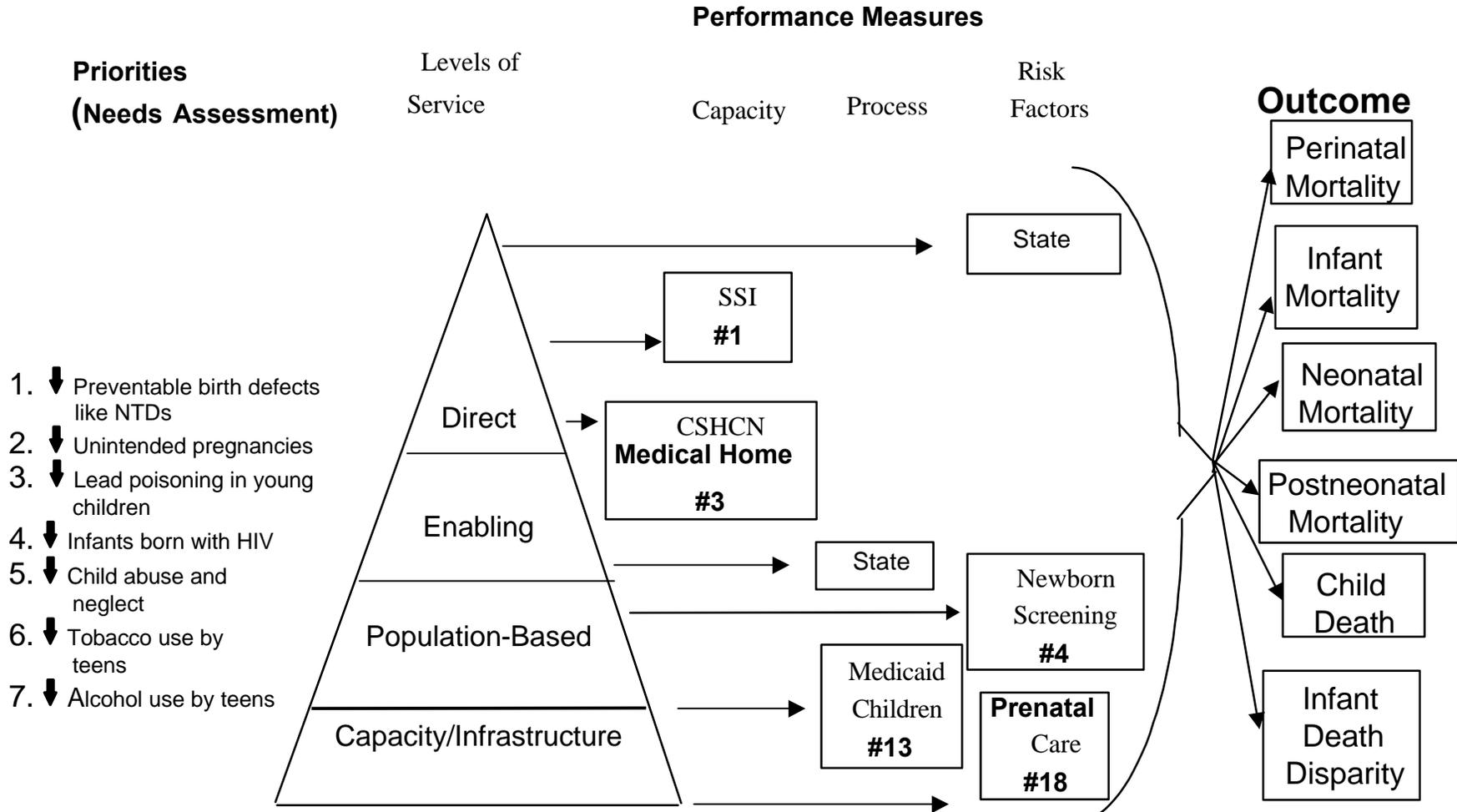
Figure 2
**CORE PUBLIC HEALTH SERVICES
 DELIVERED BY MCH AGENCIES**



*MCH Special Contracts
 Women's Wellness and Maternity Center
 Chlamydia Project with Private Providers
 East TN State University School of Medicine
 Meharry Institute for the Poor and Underserved

Figure 3

Title V Block Grant Performance Measurement System



OSCH/MCHB 4/97 *PERFORMANCE MEASURE NUMBER(Examples Only)

2.4 Progress on Annual Performance Measures

The following section addresses progress on annual performance measures reflecting those required by MCHB as a result of the 1998 changes in the federal guidance for the MCH Block Grant and those selected by the state planning process. Refer to Figure 2, Core Public Health Services Delivered by MCH Agencies, when reading the following sections.

DIRECT HEALTH CARE

Direct services, by federal definition are those services that are generally delivered on a one-on-one basis...in an office or clinic... and are considered ordinary medical care. Title V programs generally support services such as prenatal care, child health services, including immunizations, family planning and other services by operating programs or by funding local providers to provide these services.

Preventive and Primary Care for Pregnant Women, Mothers and Infants

The federal Newborns' and Mothers' Health Protection Act of 1996 states that health insurance issues may not restrict insurance coverage for any hospital length of stay to less than 48 hours for vaginal births and to less than 96 hours for cesarean section. Tennessee legislation requires follow-up care by an acknowledged provider within 48-72 hours for those mothers/infants who are discharged prior to these limits. To address this legislation, MCH and the department's Nursing Director marketed the service of public health nurses to provide home visits to TennCare MCOs resulting in a contract with TLC. TLC, one of the MCOs serving primarily the rural western part of the state, Jackson/Madison County and Memphis/Shelby County, contracted for not only postpartum but for prenatal visits as well. When the contract was first initiated, the program was so successful that TLC decided to extend the service to all of their prenatal/postpartum clients. Jackson/Madison County public health nurses provide approximately 20-25 prenatal/postpartum home visits monthly, Memphis/Shelby County provides approximately 146 visits monthly, (1,749 visits for FY 98-99) and West Tennessee Region, an area that covers 19 rural counties, provides approximately 45 visits monthly. In Memphis/Shelby County, TLC has established a high-risk perinatal disease management

committee partly in response to the home visiting program in which a public health nurse participates.

Tennessee Breast and Cervical Cancer Early Detection Program is a new statewide program in Tennessee. Prior to 1996-97, the state had a small program through the Preventive Health Block Grant. The Health Promotion Section receives program funding from CDC for payment of screening tests and limited follow-up. Although targeting women 50 years and older, some services such as colposcopy and mammograms are available for younger women who are determined to be at risk for breast and cervical cancer. Local health departments are assisting eligible females to access needed services under this program including some family planning clients. The program provides both pap smears and mammograms at 70 screening sites across the state.

Chlamydia is one of the most common, treatable, sexually transmitted infections affecting women of reproductive age in the United States today. Chlamydia causes complications related to fertility and pregnancy, including increased rates of premature delivery, premature rupture of membranes and low birth weight. Tennessee, through family planning clinics and the sexually transmitted disease (STD) clinics, is providing selective screening and treatment statewide. The state is also participating in the Region IV Chlamydia Project funded through the Centers for Disease Control and Prevention. Approximately 100,000 tests are conducted annually using state appropriations. The 1999 statewide positive rate for chlamydia was 6.57%. The majority were found in the 24 and under age group. The rate for Black population (9.43%) is twice that the rate for white population (4.1%). Federal funds are being used for data collection and analysis and for client treatment with azithromycin. The sexually transmitted diseases (STD) program provides treatment, outreach and follow-up.

Status of National Performance Measures

There are no core national performance measures for this population at this level of the pyramid.

Status of State Performance Measures #1, 6, 7

State Performance Measure #1 (SP#1) – Decrease the number of neural tube defect births by 1% after 2 years of nutrition education at the local and regional levels in a calendar year.

This measure was selected through the strategic planning process conducted in the fall of 1997 and is continued as a state performance measure based on the 1999 needs assessment. The folic acid education and supplementation activities have been very successful. The Women’s Health staff convened an internal working group to develop a Departmental plan of activities, which could be undertaken with no new funding. Staff from WIC/Nutrition, Health Promotion, TennCare, Developmental Disabilities, MCH, and Health Statistics participated in the planning and implementation.

Since that beginning a year ago, a part-time coordinator has been hired. This person coordinated the development of brochures, fact sheets and bookmarks, and designed a very elegant photographic exhibit, which has been displayed at national, state and local conferences and meetings. The Family Planning Director chairs the Folic Acid Council of the Middle Tennessee Chapter of the March of Dimes. Three regions have secured grant funding from the March of Dimes for folic acid activities involving one metropolitan and eight rural counties. Clinic protocols have been implemented requiring folic acid education for reproductive age clients, and multivitamins with folic acid were purchased for distribution to all reproductive age (non-pregnant) women seen in family planning, WIC and primary care health department clinics. The East Tennessee Region conducted a survey of 1,113 women seen in their family planning and WIC clinics and found that 28% of those surveyed knew about the benefits of folic acid and when to take it, as compared to 7% from national survey.

State Performance Measure # 6 (SP#6) - Reduce the number of HIV infected infants (status reported by year of birth) to no more than one case per year.

Through the state’s Perinatal Advisory Committee, MCH supports the work of the Ryan White Program and the efforts of the Communicable and Environmental Disease Services (CEDS) section in order to address the problem of HIV infected babies. CEDS has collected data on pediatric HIV and pediatric AIDS continuously since 1986. In November 1986, CEDS began

gathering data on the number of infants exposed during pregnancy and birth. These numbers are very fluid. That is, they change as infants who are HIV negative in 1 year, may seroconvert the next. Also, the collecting system is such that cases are sometimes reported well after the event. From 1996 to 1999, HIV infants born with perinatal exposure have ranged from 3 to 6 cases a year. The Perinatal Advisory Committee's role has been to assist in the dissemination of the most current treatment guidelines for pregnant women and newborns. The Tennessee HIV Pregnancy Screening Act (January 1, 1998) requires that all providers of prenatal care counsel pregnant women regarding HIV infection and the need for testing, test unless refused and counsel those testing positive.

State Performance Measure # 7 (SP #7) - Reduce to no more than 30% the proportion of all pregnancies that are unintended pregnancies.

This performance measure is based on a small state study conducted in 1994 and national data available on unintendedness of pregnancy. State and national data indicate that approximately 45-50% of all pregnancies are unintended. The state information from the small study (1994) indicated that 56% of those surveyed reported they had had an unintended pregnancy. More current studies regarding unintended have been completed through the CDC module on family planning, but due to the small sample size, statistics cannot be accurately extrapolated to the state as a whole. Current data report by the State is an estimate based on the number of pregnancies in 1998 and 1999. This survey is being repeated again for the year 2000.

Preventive and Primary Care for Children

The state's "Child Health Manual" was revised, approved and distributed to all local health departments in 1997. This manual is used as the guide for local health department nurses when their county office is a primary care provider (PCP) or provides basic primary care for TennCare enrolled children. Well child checks (EPSDT) for children who are uninsured are provided upon request. In these situations, staff query about eligibility for TennCare coverage and enroll children under the expanded open enrollment procedures begun in April 1997. The manual follows the American Academy of Pediatrics periodicity guidelines, which are also EPSDT

guidelines. Anticipatory guidance and basic child health issues to be discussed with the parent or caretaker are included.

Local health department staff members provide home visiting services to families with young children who have been dropped from the state's welfare to work program called Families First. The state's legislation mandated that families should be visited within 30 days of case closure to assure that basic needs were being met and that the health and safety of the children was not compromised. During these visits, nurses or social workers refer the family for needed services including the services of the health department.

Status of Performance Measures

There are no core national performance measures for this population at this level of the pyramid.

State Performance Measure #2 (SP #2) - Reduce to no more than 4% elevated blood lead levels in children 6-72 months of age who are screened.

Tennessee has had a statewide Childhood Lead Poisoning Prevention Program, funded with special Centers for Disease Control and Prevention funding, since 1993, which was discontinued in 1998. The majority of the elevated blood lead levels cases through 1998 were identified in Shelby County (Memphis). The health department in this county submitted an independent proposal to CDC that was funded and an aggressive screening, treatment and abatement program has continued. In 1998, of the 14,341 children screened, 1,492 had elevated blood lead levels which was 10.4% of those screened. Primary care physicians, following AAP and EPSDT guidelines are required to complete a lead risk assessment at each well child visit on all children 6 months to 72 months. Those with risk of exposure to lead should receive a blood lead screening. The department's office of Communicable and Environmental Disease Surveillance (CEDS) compiles lab report data on elevated blood lead levels of all children screened to confirm the need for targeted outreach and screening of children under 5.

Services for Children with Special Health Care Needs

The state's program to provide service for special needs children is one of the department's oldest programs. Initially utilized as a payment source for the medical and rehabilitation needs of a defined population, the program has been through major transition with the implementation of TennCare starting in 1994. Since most of the children enrolled in CSS are also enrolled in TennCare, staff activity to provide medical services has shifted to primarily assuring that the child receives medically necessary services from PCPs and the specialty providers in the managed care network. Staff provide care coordination services to reduce gaps and duplication of services and to advocate for other related needs of the child and family. Specialty clinics are still held in regions with documented need, and non-covered necessary services are provided.

During this same time period, TDH began upgrading and networking all local health departments into a uniform data network called the Patient Tracking Billing Management Information System (PTBMIS). The change over and inclusion of all counties, including the metropolitan counties, has taken 4 years to complete, and some system problems are still being resolved. All regions and sections of TDH will ultimately have access to program specific summary data on a quarterly and annual basis. In accomplishing this change over, some data elements which were important for program management were omitted from the system. The CSS program has worked with the information systems section to restore and/or include needed data elements to report on annual performance objectives. The Graphic Query Language (GQL) package used to provide summary reports allows Central Office, regional and local staff to monitor program activity program outcomes, CSS enrollment and services as well as access care coordinator information.

In addition, the CSS program has been using PTBMIS since 1993 to document CSS enrollment and Care Coordination Services. The system allows electronic chart documentation of patient services through the "case management" program of the PTBMIS system. By 1997-98, all regions, including the metropolitan regions, began utilizing the system. A third PTBMIS component, called "Managed Care," allows payment of bills for CSS services rendered to be initiated from the regional office. This provides a greatly improved turnaround time for vendor payments.

Status of National Performance Measures #1 and 2

Performance Measure #1 - The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.

The state's data system now collects SSI status on children enrolled in Tennessee's CSHCN program called CSS. Forty- five percent, children under 18 years old were dually enrolled in SSI.

Performance Measure #2 - The degree to which the State Children with Special Health Care Needs (CSHCN) program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to its clients.

The CSS program has always provided medical and specialty services for enrolled children. With implementation of TennCare, many medically necessary services are now covered by the MCO in which the child is enrolled. The CSS program provides services for those children whose needs have been denied and upheld through the appeals process by the MCO and TennCare including eight of the nine services indicated on the attachment to PM #2. (See Section 5.4, Form 11, PM #2). A sample study of program expenditures indicates that CSS funds for medical services are now being spent primarily on non-formulary drugs and non-covered supplies.

The CSS program established a statewide care coordination program in 1990 open to children with special needs enrolled in the CSS program. In 1997, care coordination was expanded to serve high-risk children not enrolled in the CSS program, and services were also advertised to other families who were not eligible for CSS medical services. Care coordinators are assigned to every county in the state (95); the typical caseload is 80–120 children. Care coordinators work to assure that families are aware of and access services they need including educational and social services. Annual home visits are conducted and care coordinators are frequently involved in the Individualized Education/Family Service Plan (IEP/IFSP) meeting used to establish an agreed upon plan to address the child's needs. Families are also linked with the Parents Encouraging Parents (PEP) Program. Project TEACH, a special care coordination program operating in 42 out

of a 139 school districts in the state, refers for services and determines the appropriate source of payment. Each public health region has identified one nurse to serve school systems in this capacity. Network Providers who are identified with the appropriate managed care system deliver all the services.

ENABLING SERVICES

These services, by federal definition, allow or provide for access to basic health care services and benefits including such things as transportation, translation services, outreach, respite care, case management and coordination and health education.

The enabling services provided by the state have concentrated on access to care and cultural sensitivity in the managed care environment. Staff at the local, regional and central office levels continue to invest significant amounts of time assisting TennCare enrollees with complex TennCare issues. These TennCare activities include outreach and enrollment of uninsured children, presumptively eligible pregnant women and displaced workers, assistance with the appeals process and assuring that those presumptively eligible for prenatal care are receiving needed services. Local health departments play an important role in interfacing with DHS when Medicaid eligible individuals roll off TennCare coverage. The TennCare system allows those enrolled to continue TennCare coverage as uninsured individuals if they apply for this status within certain time periods. Efforts by the local health departments to inform these individuals and process the required paperwork before the deadlines have resulted in many more families continuing TennCare coverage. In the summer of 1998, the local health departments began reverification of eligibility for TennCare to assist that Bureau in meeting HCFA requirements. Reverification involves face-to-face checks of income and insurance status and is required annually by HCFA to remain in compliance with the Medicaid waiver that established TennCare.

Many county health departments respond to the needs of Hispanic workers and families by developing innovative ways to improve communication, including hiring part time Spanish speaking employees, using volunteers and/or declaring “Spanish Day” at the clinic to assure that necessary translation services are available. Seven counties have established special family planning and/or prenatal clinics specifically for Spanish speaking clients. The MCH Section and

the Nutrition Section of the Bureau are developing or purchasing Spanish health education materials. CSS and PEP pamphlets are also available in Spanish. The Abstinence Education Program has identified Spanish pamphlets for use in the program and for distribution to interested parties. Nashville Davidson County has the highest concentration of Hispanics in the state. Additional culturally sensitive activities include special in service training sessions on Hispanic culture, working with the Hispanic population and cultural diversity training.

***Preventive and Primary Care for Pregnant Women, Mothers and Infants**

TDH and the Department of Human Services (DHS) implemented a presumptive eligibility program for pregnant women in 1989 to encourage earlier access to prenatal care. This option allows local health departments in Tennessee to grant temporary Medicaid eligibility to pregnant women with family incomes below 185% of the federal poverty level. This allows them to receive TennCare services while their formal Medicaid application is being processed by DHS. This temporary coverage is good for 45 days, allowing the woman time to complete the application to Medicaid through DHS. In November 1997, local health departments started entering TennCare application information directly into the TennCare computer system. This procedure has greatly decreased the time between enrollment and receipt of the health insurance card from the selected MCO. When Medicaid coverage for pregnancy ends at 60 days postpartum, women are offered TennCare coverage as an uninsured enrollee. Participation in TennCare can then be continued; subsequent pregnancies would be covered under TennCare for this population of women. Findings from a 1998 study of presumptive eligibility under TennCare show that fewer women are being granted presumptive eligibility under TennCare, but this may be due to enrollees already being enrolled under a different eligibility category. Almost 50% of the births in Tennessee are covered by TennCare, suggesting that women have insurance coverage before they become pregnant. TDH implemented a state specific care coordination program in 1990 to concentrate on reducing infant mortality and morbidity, including low birth weight and to optimize the growth and development of infants and young children. Project HUG (Help Us Grow) services are available to pregnant/postpartum women up to 2 years after delivery and to infants and children through 5 years of age. Initial assessments, including health, psychosocial and nutritional status, are completed and a care coordination plan is developed.

These services are available in all 95 counties. For fiscal year 1999, a total of 7,601 pregnant women and 3,426 infants were served.

Other outreach and home visiting services are offered through local health departments to address issues of prevention of child abuse and neglect in families at risk and to provide early intervention services so that children are ready for school entry. The CSS program provides home visiting on a periodic basis for special needs children enrolled in the care coordination component of the program.

In 1999, TennCare released an undated version of the special report titled “TennCare Report on Women’s Health Issues” which analyzed a wide variety of indicators including birth outcome statistics through 1998. Analysis for data from 1993-1998 compared the total population to those non-enrolled TennCare Medicaid eligible and the TennCare uninsured/uninsurables. Data from this report show that:

- 48.7% of total births were to TennCare enrollees in 1998. The number of total births has increased steadily from 1993 to 1998. (32,757 in 1993; 37,301 in 1998).
- Improvement over the time period has occurred with entry into care in the first trimester for all groups and all races.
- Percentages of preterm births have increased among the white Medicaid enrollees but decreased among the black Medicaid enrollees. (1993-1998)
- Low birth weight rates have remained consistent for all groups as well as for non-enrolled individuals.
- Infant mortality rates have decreased significantly for all groups, with much of the decrease occurring among Medicaid eligible enrollees (1993-1998).
- The median interval between deliveries has remained the same every year from 1993 to 1998 for all age groups (33 months) but the interval for Medicaid eligible enrollees has increased from 28 months to 30 months in 1998. This increase is reflected in all racial categories.

Status of National Performance Measures

There are no core national performance measures or state performance measures for this population at this level of the pyramid.

Preventive and Primary Care for Children

Tennessee has a long history of enabling services offered through the local health department or contracts for specific service needs. Special home visiting projects designed to address parent training and prevention of child abuse have been funded since the mid-seventies. The projects model and teach infant stimulation and developmentally appropriate practices, assuring that infants and young children are getting the well child care they need and that chronic or acute conditions are addressed. Children are also screened periodically and referred for other needed services to reduce the risk of serious problems, and assure that the child is ready for school.

One home-visiting program, called the Child Health and Development Project (CHAD), began with Appalachian Regional Commission funding in the early 1970s. It continues today in 41 counties. The Healthy Start program began in 1994 with the passage of state legislation to replicate the Hawaii Healthy Start model of home visiting. Contract agencies provide these services in 28 counties. A small Resource Mothers program is located in six counties of western Tennessee offering similar services using indigenous workers.

Status of National Performance Measure

There are no core national performance measures or state performance measures for this population at this level of the pyramid.

Services for Children with Special Needs

As discussed in other sections of this document, the CSS program has been in transition from providing direct medical service for eligible CSS enrolled children to a program that provides care coordination services and promotes utilization of managed care assigned PCP for medical home and specialty care. Prior to 1994, the CSS program targeted a strictly medically and financially eligible population. The transition to care coordination provides these services to a

larger targeted population of special needs children, and there are no financial requirements. The medical services component is available to serve the more limited diagnostic categories of children up to 200% of the FPL when needs are not covered by the managed care system. Ninety-two percent of the children enrolled in CSS are also enrolled in TennCare. Another 5% have some other insurance coverage bringing the total of children enrolled with some form of insurance to 99%. Care coordination services were established in 1990 as another program service. Families with special needs children may access these services whether or not they meet income guidelines for medical services. Care coordinators are nurses or social workers and are assigned in such a manner that all counties in the state are covered. The care coordination program manual describes the services a family receives and is currently under revision.

At the same time, a parent support program was developed. Named the Parents Encouraging Parents Program (PEP), this service links families with newly diagnosed infants or children to families who have an older child with similar problems. In addition to the informal network, parents are offered various seminars and discussion as a means of support and information. PEP services are available to any family who has a child with a problem; age, income or diagnosis does not restrict services.

CSS staff play an important part in assisting families and care providers with appealing denials for authorization for service from assigned MCOs. Resolution of a class action suit in the Fall of 1996 resulted in a clear and time limited appeals process that can be used when a patient's services are denied, terminated, suspended or reduced by the MCO. The appeals process contains very specific steps for requesting a review of any change in service or a request for authorization considered necessary by the PCP. It also establishes a process for review of the case information by an independent medical evaluation team at TennCare, if the request is denied a second time by the MCO. While the prior authorization process is time consuming, the roles, responsibilities and processes are clear and time limited. Staff have been successful in assisting families in appealing MCO decisions that have resulted in policy changes for approval of supplies and other items. Many of the initial problems with the prior authorization process have been reduced; problems with the definition of medical necessity and the value of habilitation services for this population must still be addressed.

Project TEACH (Together Educating And Coordinating Health) began as a pilot project in January 1995 in collaboration with Tennessee Early Intervention System (TEIS). It was intended to increase coordination of services to CSHCN and to improve the capacity of local school systems to access third party payments for approved services that were delivered in the school setting. Current indicators show that this collaborative approach has been very successful for the children served and the school system. Communication between programs has also improved. By the 1998-99 school year, eight public health nurses served 47 school systems, and several school systems have hired nurses, using the state program for training and consultation. Cost savings of \$1,150,00 have been realized by school systems through the work of Project TEACH staff from August 1998 – June 1999.

Status of National Performance Measure # 3

Performance Measure #3 - The percent of Children with Special Health Care Needs (CSHCN) in the State who have a “medical/health home”.

Tennessee has defined medical home as the health care provider or primary care physician (PCP) selected by the family or assigned by the child’s TennCare MCO or insurance company. If a CSS enrolled child does not have a PCP, the CSS program will assist the family in identifying a pediatrician, family practitioner or specialist to serve as their medical home. Certain system issues that existed prior to TennCare must still be addressed, such as assuring that well child care is provided along with the specialty care needed for chronic and acute conditions. Program data from 1999 indicate that 99% of CSS children had some form of health insurance. Of these, 92% were covered by TennCare and were affiliated with a PCP to serve as a medical home. All CSS enrolled children (100%) and other children enrolled in TennCare are considered to have a medical home.

POPULATION BASED SERVICES

These services, by federal definition, are those that are developed and available for the entire MCH population for prevention and personal health services including such things as newborn screening, immunizations, health education, injury prevention, etc.

Population based services are available to citizens of Tennessee through the activities of MCH, Nutrition, Health Promotion and Communicable and Environmental Disease Sections of the Bureau. These services target groups of people rather than one-on-one contact or education. The Abstinence Education Program is the newest program effort, using a population-based approach to reduce teen pregnancy. MCH is now responsible for the Healthy Kids Initiative which promotes community intervention models for assets building as the means of improving child health and education outcomes. See Figure 2 for other services that are population based and discussed elsewhere in this document.

Preventive and Primary Care Services for Prenatal Women, Mothers and Infants

The state's Genetics and Newborn Screening Program was established in 1968 as a result of state legislation requiring PKU screening. The legislation requires that all babies be screened for metabolic disorders prior to discharge from the birthing hospital. The program involves cooperation between birthing hospitals, the State Laboratory, the MCH Program staff, the genetics centers and primary care physicians. When an infant is identified as having a questionable specimen, the program contacts the local health department and the infant's primary care provider, if known, so that another specimen can be drawn and tested. The Genetic and Sickle Cell Centers assist in the follow-up of infants with presumptive positive results to insure rapid diagnosis and treatment.

Recent efforts in this program area have concentrated on improving the program by computerizing routine procedures and developing outcome evaluation indicators. The program is also installing an electronic birth paging system to improve the accuracy of the information submitted on the specimen collection form. A voluntary advisory committee serves to guide the program and recommend changes in tests and test procedures to the Commissioner. SSDI funds have been used to support the upgrade of hardware and software for this program.

Rural West Tennessee and Memphis (Shelby County) are now in the eighth year of the Campaign for Healthier Babies, a media and educational effort to increase the incidence of

prenatal care and improve birth outcomes. The campaign centers around a toll-free number promoted through television, radio, newspaper, mass transit ads and printed materials. Women call the number to receive a free book of information and merchandise coupons which are validated at the prenatal visits. Over 97% of pregnant women in the targeted area were reached by an average of seven media ads. Distribution of the *Happy Birthday Baby Book* began in Memphis in 1993. Five years (1993-1997) of statistics for Shelby County show that the number of women receiving no prenatal care went from 7.2% to 1.4% in the nonwhite population and from 1.9 to 1.0% in the white population. The number of prenatal care visits increased from 10.42 to 11.01% in the nonwhite population and from 11.83 to 12.25 in the white population. For 1999, 9,339 coupon books were mailed within Shelby County. This is an increase of 27% over 1998. Books are distributed in the local health departments in rural West Tennessee also.

Status of National Performance Measures #4, 6, 9

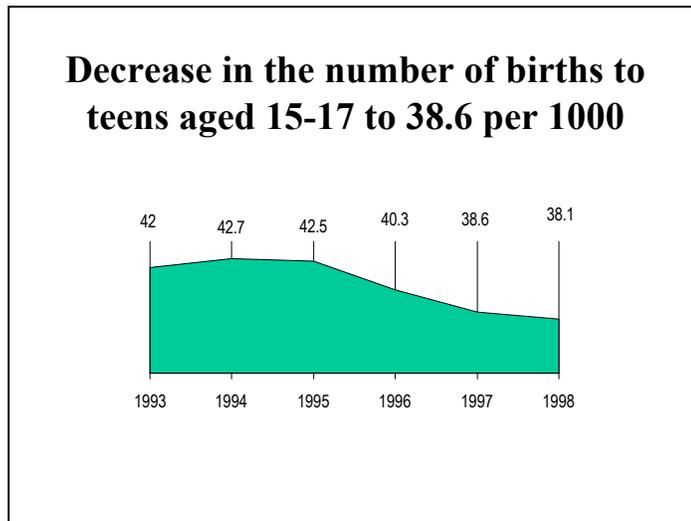
Performance Measure #4 - The percent of newborns in the state with at least one screening for each of PKU, hypothyroidism, galactosemia, hemoglobinopathies (sickle cell diseases) combined.

Performance measure #4 has been successfully met for several years due to the state law requiring testing of all infants born in the state and the quality and efficiency of the State Laboratory and the Newborn Screening program in carrying out their duties.

Performance Measure #6 - The birth rate (per 1,000) for teenagers aged 15 through 17 years.

In the 1995 application, the goal was set at 22.5/1000 for this age range. The birth rate for the 15-17 year olds was 42.5/1000 in 1995. The most recent data (1998) indicate a rate of 38.1/1000 for the 15 – 17 year old group. The state's teen birth rate has been declining over the last decade, and projections indicate that this trend will continue. The availability of reproductive health services, health education and community planning for the prevention of teen pregnancy have all contributed to this improvement. The Abstinence Education Program, which MCH implemented beginning in 1996, is contributing to reducing this rate. Activities of the Tennessee Adolescent

Pregnancy Prevention (TAPPP) and the Community Prevention Initiative Projects (CPI), which work to reduce risk and build resiliency factors in young children, are also contributing to reducing the teen birth rate.



Performance Measure #9 - Percentage of mothers that breastfeed their infants at hospital discharge.

Data on breastfeeding rates at hospital discharge are obtained from the Ross Mothers' Survey, an ongoing mail survey that has been conducted for many years. Data for 1998 for Tennessee indicate that the breastfeeding rate for all infants was 55.5%. This compares to 41.6% in 1990 and 48.6% in 1994.

Breastfeeding is widely promoted through the statewide WIC program and by other local health department staff providing services to pregnant women. All rural and metropolitan regions have breastfeeding coordinators who work with staff, clients and providers in the community. Each local health department has a breastfeeding advocate who provides services to clients. Young mothers are encouraged to breastfeed; literature is provided before delivery; and a counselor is in contact with the mother to support her efforts after delivery. Each of the 13 nutrition centers established through the WIC program statewide has a room exclusively used for breastfeeding mothers. Other health departments have set aside space for use by breastfeeding mothers. Data

from the WIC data system show that the breastfeeding rate for WIC mothers has increased over time. In 1997, the rate was 22.7, as compared to 14.9 in 1990 and 20.4 in 1993. In 1999, the rate increased to 26.8.

Preventive and Primary Care Services for Children

In May 1996, the state initiated a new approach to lowering adolescent risk factors with the formation of the Community Prevention Initiative. This community based program is targeted at decreasing youth violence, alcohol and drug use, school dropouts and teen pregnancy. All these behaviors have similar risk factors early in life. The Initiative funds projects in 49 counties of the state to provide primary intervention and risk reduction activities for youth under 13. Community planning groups are utilized to provide input to design individual strategies and services needed locally. Community agencies are awarded funding to provide the various prevention services that were identified. The University of Memphis is conducting an evaluation of the Initiative. Their reports and recommendations will be referred to the Regional Health Councils (RHC).

The state established the Adolescent Pregnancy Prevention Initiative (APPI) as a result of a state planning process in the 1980s. Originally coordinated through the Health Promotion Section of TDH, and recently moved to the MCH Section, program coordinators work in each of the regions of the state to develop coalitions to address adolescent pregnancy and parenting issues at the community level. In fiscal year 1998, the program name was changed to Tennessee Adolescent Pregnancy Prevention Program (TAPPP) to more appropriately reflect program goals and activities.

All metropolitan counties and many of the rural counties have established advisory councils. These 52 county councils consist of a cross section of individuals, agencies and organizations formed to address adolescent pregnancy and parenting issues. All councils focus on three primary efforts: (1) to promote community awareness and involvement in adolescent pregnancy and parenting issues; (2) to facilitate collaboration among various sectors of the community to

enhance and increase prevention efforts; and (3) to coordinate, improve and expand services available to pregnant and parenting adolescents.

The MCH Section applied for and received the federal award for the Abstinence Education Program, funded under Title V. The state plan includes a statewide media campaign emphasizing radio spots and print material to build parent/adult and child awareness that abstinence is a choice. The 1998-99 media campaign emphasized the parents role in talking with their children about choosing abstinence. Print material reflected the message of the radio and TV spots. Over 2,500 individuals called in for the parent information packet in the first 2 months of the campaign.

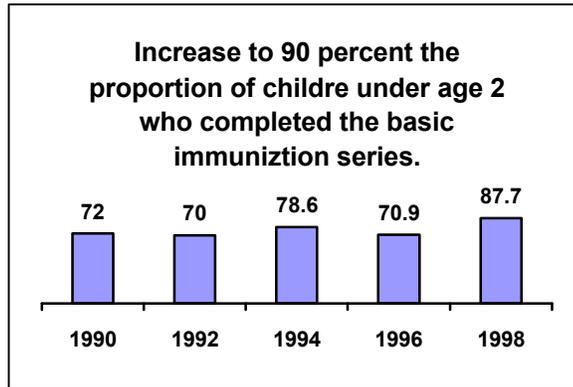
The Abstinence Education program also funds community based intervention projects that were selected from a competitive bid process. There is at least one funded project in each of the public health regions of the state. There are 18 funded projects including the Governor's Special Initiative Project, established in partnership with the National Governor's Association. The special project is located at Woods Memorial Hospital in Athens, Tennessee.

Status of National Performance Measures #5, 7, 8

Performance Measure # 5 - Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B.

The Immunization Program is administered by the state's Communicable and Environmental Disease Services Section. The Immunization Program administers the Vaccines for Children program and has recently implemented an electronic Immunization Registry. This permits PCPs to access case specific information to assure that an infant or child's shots are up to date. The baseline statewide immunization rate is 86.7%. The state is cautiously optimistic that this statewide rate can be improved. In 1998 the statewide immunization rate was 87.7%. Confounding factors are the increased problems of tracking and case finding in the current managed care environment.

The immunization rate for children enrolled in licensed child care facilities being up to date on shots is 97% as a result of a cooperative agreement between the program and the child care licensing division of the Department of Human Services.

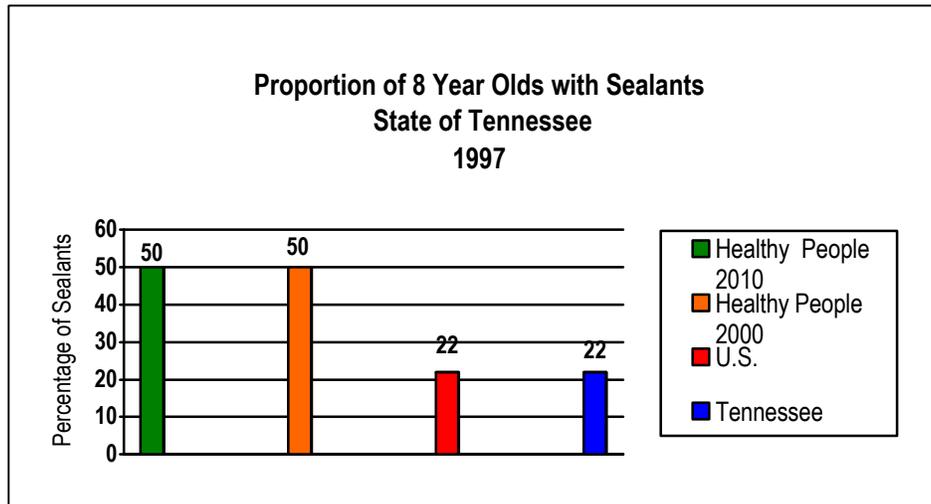


Performance Measure # 7 - Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

Dental services are required under EPSDT guidelines that are to be followed by the MCOs. There are significant shortages of dentists in MCO networks, and some areas of the state have no dental services available. To counteract this shortage, the Rural Health Initiative allows health regions to submit proposals through their Regional Health Councils to establish special dental, obstetric, pediatric and/or primary care services needed in their communities. Fifteen projects have been approved for funding under this new initiative. Many have chosen to develop mobile dental services targeting school children during the school year and providing services to others during holidays and summer.

In 1997, the state's Dental Services Division conducted an oral health survey in east Tennessee to determine caries prevalence, caries distribution by tooth morphology, dental treatment needs,

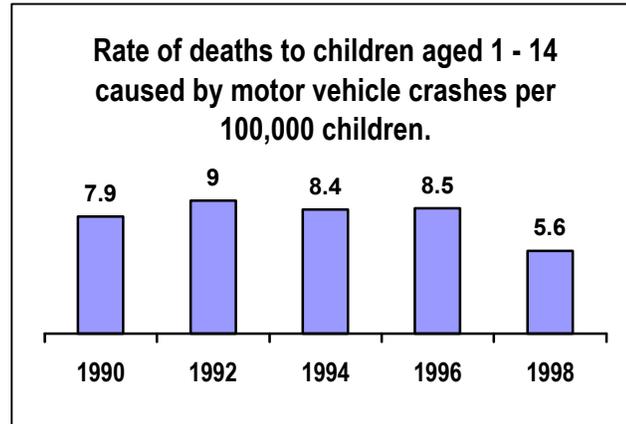
sealant prevalence and incisor trauma prevalence in children age 5-11. In all, 17,256 children were examined as part of the survey. This was the first survey of its kind conducted in Tennessee and results are published in the *Journal of the Tennessee Dental Association*. The study found that 23% of the children age 5-11 had at least one permanent tooth sealed. The proportion of children 8 years of age with sealants was 22%, less than half the Healthy People 2000 goal but about equal to the national percentage. The survey further indicates that 75% of the caries detected are concentrated in only 10% of the children examined. The challenge to the dental community in the state is to identify this disparate population and address its dental needs. The Dental Services Program will conduct a statewide survey in fall 2001 to provide statistically valid information about the oral health status of children in Tennessee.



Performance Measure #8 - The rate of death to children aged 1-14 caused by motor vehicle crashes per 100,000 children.

Tennessee began a child fatality review team system, mandated by state law, in 1996. Annual reports are published summarizing the work of these committees and statewide implications for reducing child fatalities. The state chose to use the data collection tool developed by Missouri with some modification for data collection from these team reviews.

In 1998 the rate of death for children aged 1-14 was 5.6 per 100,000 by motor vehicle crashes.



Status of State Performance Measures #3, 4, 5

State Performance Measure #3 - Reduce the percentage of high school students using tobacco (cigarettes and smokeless tobacco).

The Department, through activities of the Health Promotion section, the Alcohol and Drug Bureau and the Governor's Community Prevention Initiative, continues to address the issue of tobacco use by children and youth ages 12 and older. Despite these efforts, the data on adolescent smoking and tobacco use indicate a high use rate with little change since 1991. Tobacco use in the last 30 days is reported by 39% of the youth. State information is obtained from the 1995-97 Tennessee Alcohol, Tobacco and Other Drugs (ATOD) High School Survey.

Data are collected every 2 years. The Health Promotion section is currently conducting the Youth Tobacco Survey using the CDC designed questionnaire to collect information from 3,000 students in 62 school systems (6th through 12th graders.). This survey includes a school administrator and lead health educator survey to provide information on school policy and prevention education. Results of their survey will be available with the next submitted Block Grant.

State Performance Measure #4 - Reduce the percentage of high school students using alcohol.

Similarly to the previously reported state performance measure, alcohol use by high school students has dropped to 41% from 45% of the teens surveyed. The Governor's Community Prevention Initiative, begun in 1996, which targets children and youth at risk is expected to have a significant impact on reducing alcohol and drug use, reducing teen pregnancy and reducing youths dropping out of school in communities with funded projects. MCH will continue to monitor these and other efforts designed to change youth behavior.

State Performance Measure # 5 - Reduce the incidence of maltreatment of children younger than age 18 including physical, sexual, emotional abuse and neglect to a rate no more than 8 per 1,000.

Based on 1998 data the state's rate of substantiated child abuse and neglect cases is 8.2 per 1,000. While responsibility for preventing and intervening in child abuse cases resides in the Department of Children's Services (DCS), MCH offers a variety of intervention programs at the county level to prevent and intervene before abuse occurs. The Child Health and Development Program, funded for 41 counties by DCS, offers home visiting, parent training, infant stimulation and basic health care to families at risk or suspected of potential abuse and neglect. The Healthy Start Program (Hawaii model), located in 28 counties, offers similar services through community based agencies targeting adolescent and first time mothers. There is also a small (six counties) Resource Mothers Program located in West Tennessee. All public health staff are periodically trained on the signs, symptoms and mandatory reporting requirements for suspected child abuse.

Services for Children with Special Health Care Needs

The CSS program became interested in issues surrounding hearing impairment when staff identified that more than half of the enrolled CSS children were diagnosed with speech or hearing problems. Tennessee was one of the 17 states involved in the University of Colorado to develop statewide universal newborn hearing screening services. The survey activities required of participation in the Colorado project have increased physician and hospital interest in voluntary universal newborn hearing screening. Efforts to encourage voluntary universal hearing

screening will continue. The program anticipates that legislation mandating this will again be introduced in the next legislative session.

Status of National Performance Measures

Performance Measure # 10 - Percentage of newborns who have been screened for hearing impairment before hospital discharge.

The CSS program began collecting information from birthing hospitals and other professionals regarding newborn hearing screening in 1997. Surveys from the University of Colorado were sent to birthing hospitals, audiologists, ENTs, early intervention specialists and professionals in speech and hearing services. The Program formed a task force to address screening methods, education, legislation, assessment and early intervention. An audiologist from Memphis, who had started a universal newborn hearing program at one of the major birthing hospitals in that city, has played an integral role in the advocacy and marketing of universal newborn hearing screening. By March 1999, 28 hospitals with 54% of the birth population have universal newborn hearing screening equipment available and 11 others were screening high risk infants and those infants in Newborn Intensive Care Units (NICU). Using hospital data, 51.4 (1998) of the babies are born in hospitals which can screen for hearing problems before discharge from the hospital. Because the state doesn't have a mandate to report, the number of infants screened is unknown. Beginning in September 2000, hearing-screening results will be voluntarily reported on the Newborn Screening lab slip creating an initial surveillance system for Universal Newborn Hearing Screening. Program staff will use a letter of notification to follow up and track infants with suspected hearing loss. All those identified will be referred to TEIS, the states early intervention program.

INFRASTRUCTURE BUILDING SERVICES

These services, by federal definition, are addressed through activities aimed at developing and maintaining comprehensive health service systems that help measure and assure the quality of health services and health status for women, infants and children.

Tennessee's current infrastructure building activities concentrate on regional and county needs assessments, quality management, data and systems planning and the development or revision of standards and guidelines when necessary. An additional activity has been the development of the child care collaboration to establish child care resource centers in the development districts of the state. These centers are charged with the responsibility of providing the training and technical assistance necessary for developmental appropriate practices, inclusion of special needs children and health and safety to be practiced in licensed or registered child care centers. In all, there are 5,880 licensed and registered child care agencies in the state and 233,800 children are enrolled. During 1998-99 the six established centers have trained 2,324 staff in 1,134 childcare centers across the state. Topics covered have included 504 compliance, playground safety, emergency preparedness, food safety, CPR/First Aid, adapting materials for inclusion of special needs children, lead poisoning prevention, etc. This system has helped 33 families with special needs children to find child care placements in the past year. The diagnoses of some of these children included Downs syndrome, autism, cerebral palsy, spina bifida, language, vision and hearing impairment.

Needs assessment for health planning is now fully developed into a statewide activity through the community health councils. Each county, and in turn each region, has developed a priority list of health needs based on data; groups are now developing implementation plans and activities to address these priorities on the local level. The regional and county health councils were involved in priority setting for the MCH - 2000 Needs Assessment. Further discussion of the community development process through the health councils is contained in the needs assessment section of this document.

The Bureau has staff specifically assigned to develop and oversee the quality management (QM) structure which consists of local quality units, regional quality units and a state quality council. Regional quality teams facilitate and coordinate QM at regional and local levels. The quality units at the local level are empowered to resolve problems whenever possible in addition to streamlining existing services. The State Quality Council meets twice yearly to review reports on QM activities, including aggregated trends and recommendations from quality units and quality teams. The Director of MCH serves on the State Quality Council.

The statewide Quality Management Plan developed by the Bureau of Health Services is updated yearly. The quality management process, including record review and follow up, is conducted statewide to assure an optimum level of services for all clients. Clinic-specific patient satisfaction surveys are conducted for 1 week of every year in all rural clinics. Each county health department provides copies of the survey form to all patients served in the clinic that week. Surveys are reviewed by the county, regional and central office staff and used by Quality Management teams to plan improvements. These surveys are entered into the TDH data system and available at the regional and Central Office levels from the internet site for periodic review and evaluation of progress.

The data and systems planning functions of infrastructure building have been greatly enhanced with the availability of State Systems Development Initiative (SSDI) funds. These funds have provided the primary support for developing the statewide computer network and Patient Tracking, Billing, Management Information System (PTBMIS). This system development was finally completed in January 1998, so now MCH and other program areas can access the program data base for analysis and planning purposes. In 1999 SSDI funds were used to support the data analysis function to complete the required 5 year Needs Assessment.

Finally, MCH staff reviews program rules and manuals and updates these documents as necessary. Often the section's advisory committees are involved in guiding these revisions and approving changes before they are released to the field. This year, (1998-99), rules for the Genetics and Newborn Screening Program and the Children's Special Services Program were revised to reflect current program operation. Approval by the Attorney General's office has been received and both sets of rules will be in place by July 2000.

Preventive and Primary Care Services for Pregnant Women, Mothers and Infants

MCH and the Rural Health Initiative Program work together to address the system needs of pregnant women, mothers, infants and children. Counties are targeted as health shortage areas for obstetric, pediatric and family practice health care providers, and then the program seeks to

actively recruit personnel to serve in these areas through a cash incentive program. Maps of these rational shortage areas are contained in section 5.3, Other Supporting Documentation. A recruitment fair is held each year in conjunction with the Community Development Initiative to market available sites and provide additional information about the state, the Department and the rural health initiative. These activities directly contribute to infrastructure building of preventive and primary care services for women and children. The Director of MCH sits on the review committee for approval of physician placement and special project requests to assure that the needs for women and children are addressed.

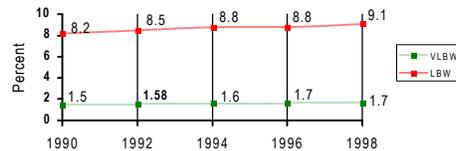
New state legislation passed in 1997 allows for the use of rural health initiative funds for community identified initiatives. The Community Initiatives Program will support projects for innovative models of health care delivery services to underserved populations or to enhance access to and utilization of existing available services. The county and regional health councils submit proposals for consideration to the state review committee. Approved proposals are funded for 3 years. The proposal process requires that the innovative models must be time limited or contain a plan for sustainability after the 3 year period. Each public health region is allocated about \$150,000 per year to use for community initiative projects and/or provider recruitment, whichever is a greater need for their area.

Status of National Performance Measures # 15, 17, 18

Performance Measure # 15 - Percent of very low birth weight live births.

Very low birth weight babies are those born weighing less than 1500 grams at birth. For the past 10 years, Tennessee's very low birth weight rate has fluctuated between 1.4 and 1.7% of the births. The actual for 1998 is 1.7% of births indicating no appreciable change in the percentage of very low birth weight babies. The percent of low birth weight babies for 1998 was 9.1%.

Reduce *low birthweight* to an incidence of no more than 7.1 percent of live births, and *very low birthweight* to an incidence of no more than 1 percent of live births.

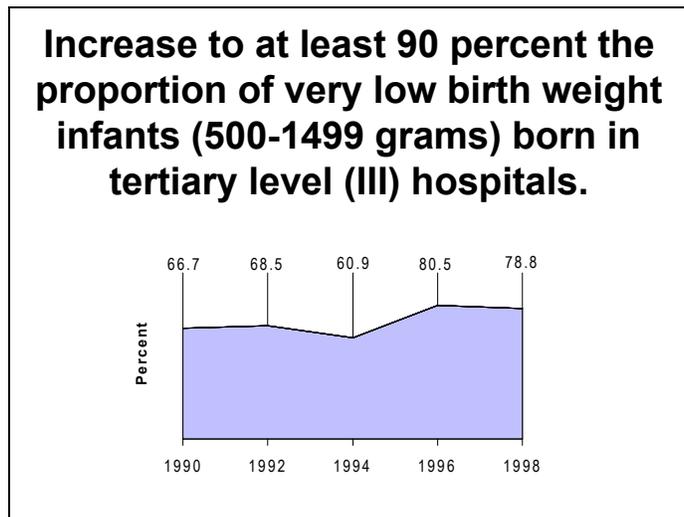


Tennessee has targeted populations at risk of adverse pregnancy outcomes for many years. Most recently efforts have focused on addressing access to care for TennCare enrollees. TennCare covers approximately half of the state’s births. A study of health statistics data comparing TennCare and non-TennCare births for 1993-1998 showed that the percentage of low birth weight deliveries was stable for the total population, as well as in the TennCare Medicaid enrollees (10.9 in 1993 before TennCare; 10.8 in 1998). Examining the data by race for the TennCare Medicaid enrollees showed that there was a slight increase in the white enrollees (8.8 in 1993; 9.0 in 1998), but for the black enrollees the percentage declined from 15.2% in 1993 to 14.3% in 1998. Thirty-four percent of the TennCare deliveries were in the nonwhite population, a higher percentage than for the population as a whole (23.5% of the total births in 1998 in the state were nonwhite). The state’s very large WIC program targets pregnant women as the highest priority; an average of 20,000 pregnant women receive WIC services monthly (13.5% of the caseload). Twenty-seven percent of the WIC caseload of pregnant women are black.

Performance Measure # 17 - Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

Data for the determination of the percentage of very low birth weight infants born in tertiary level facilities are compiled by the Health Statistics and Information Office of the Department. The definitions for determining what level of care is provided by a facility have changed over the

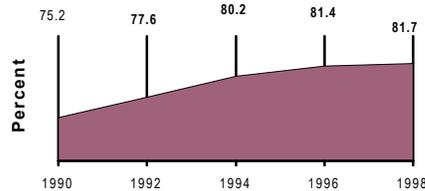
past few years. In 1999, data were collected from all Tennessee hospitals as a special perinatal supplement to the 1998 Joint Annual Report of Hospitals. This report is a joint effort between the Department of Health and the Tennessee Hospital Association. The information on the facilities by level of care is only being used for statistical analysis purposes. For future reports, the questions have been made a permanent component of the questionnaire. According to the state's vital records office, 78.8% of the very low birth weight babies born in 1998 were delivered in tertiary care centers.



Performance Measure #18 - Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

The state's 1995 objective was set to increase the percentage of pregnant women receiving prenatal care in the first trimester from 80.2 to 83%. The health statistics data for the state for 1998 indicate that 81.7% of the pregnant women received prenatal care in the first trimester.

Increase to at least 90% the proportion of all pregnant women who receive prenatal care in the first trimester of pregnancy.



Preventive and Primary Care Services for Children

In October of 1996 a court settlement called the Cluster Daniels case was resolved which gave clear and definitive guidance to TennCare, MCOs, providers and enrollees about patient rights, when they wish to appeal any decision to deny, reduce, terminate or suspend medically necessary services. Prior to this decision, neither enrollees nor PCPs had clear recourse when a request for prior authorization was denied. Within 3 months, over 1,000 local and regional health department employees were trained in the specifics of TennCare appeals. These employees actively assist families and individuals in the appeals process, when they wish to appeal a decision of medical necessity made by their MCO. While the appeals process has not corrected all problems with the system, it does represent a step for improvement of service delivery. Additional information and copies of the appeals process were included in the 1997 Block Grant submittal.

April 1997 was another milestone in the development of TennCare. Enrollment of uninsured children was again opened, with approval from HCFA, and has remained open. Over 60,000 additional uninsured children had been enrolled. A unique feature of this enrollment plan was that the application form and process were streamlined allowing local health departments to enter and verify enrollee information at the county level. This greatly improved the administrative problems of the initial TennCare enrollment and allows for emergency enrollment when

necessary. A health department “warm line” was established in the Bureau, staffed by section personnel including MCH, to assist local health department staff with problem cases, system failure and unique enrollee questions that arose. The TennCare line is now staffed by two full-time positions, one of which previously worked in the TennCare Bureau.

The state CHIP plan was submitted to HCFA in 1997 and portions of the plan were approved by September 1999. CHIP expanded eligibility up to 19 years of age and 200% of poverty. County health departments, the TennCare office and other advocacy groups are working together to assure that all eligible children are aware of and included in this health care coverage. A non-profit advocacy group, the Tennessee Health Care Coalition, has been funded through the Robert Wood Johnson Foundation-Covering Kids Program, to improve enrollment in five specific counties through innovative outreach efforts to hard to serve populations. TDH and the MCH Program are active participants in this project, and the advisory committee was formed to guide implementation. At the county level, the county health councils are serving in an advisory role. The goal is to enroll and keep eligible children enrolled in the TennCare program and to assure that they understand the benefits and receive the preventive services of the program.

Status of National Performance Measures #12, 13, 16

Performance Measure #12 - Percent of children without health insurance.

The state target for enrollment of uninsured children under the new Child Health Insurance Plan (CHIP) was estimated at 73,000; as of December 1999, an estimated 56,322 children do not have health insurance representing 4.2% of the state’s children. This estimation was developed by The University of Tennessee Center for Business and Economic Research. The percent without insurance is higher this year because of extrapolation of the number of children from the 1999 census estimate based on recent state growth.

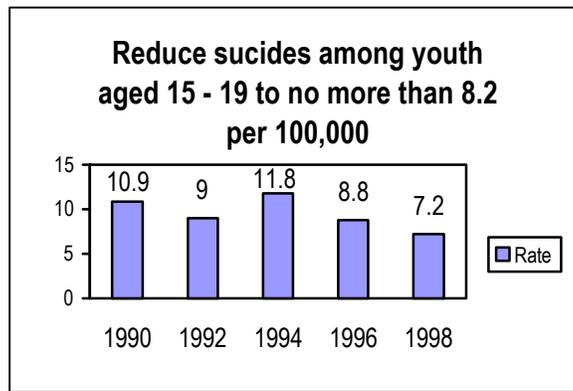
Other TennCare data and the Department of Insurance data indicate that 94% of all Tennesseans have some form of health insurance (1998), making Tennessee one of the states with the highest percentage of citizens insured. Enrollment of uninsured children will continue to be a state priority.

Performance Measure #13 - Percent of potentially Medicaid eligible children who have received a service paid by the Medicaid Program.

Since all Medicaid children are now enrolled in the state's managed care program called TennCare, MCH reviews quality assurance documents and other reports that assess the effectiveness of compliance with EPSDT guidelines to estimate Medicaid service delivery. Three different reports were summarized as part of the 2000-2005 Needs Assessment. (See 5.3 Other Supporting Documentation section for the full needs assessment report.) A survey of PCPs in managed care networks estimated that 57% of the children enrolled received a well child visit during 1998. Parents reported in a different survey, that 48% had well child visits during the year and 86% had sick child visits. While children may be being seen by PCPs, other record reviews indicate that only 25 to 29% of the children enrolled receive all components of an EPSDT exam; for children age 11-21, only 21% receive all components of an exam. In response to the consent decree, both public and private health care systems are working on improving this rate through informing parents of basic benefits, educating the PCP about the required components and conducting quality assurance record reviews. The consent decree of 1998 outlining targets to improve compliance with EPSDT standards for all children, including those in stable custody, required semi-annual reporting to the court. The narrative of the last two reports is contained in section 5.3 Other Supporting Documentation.

Performance Measure #16 - The rate (per 100,000) of suicide deaths among youths aged 15-19.

This measure would more accurately be called a health indicator than a performance measure since most states, including Tennessee, have not yet developed an effective way to screen and intervene with youth who have suicide ideation. The state's death certificate information indicates that the rate of suicide deaths in this age group is 7.2/100,000 for 1998. The suicide rate for this age group has fluctuated between 8.3 and 11.8 per 100,000 for the last 10 years.



Services for Children with Special Health Care Needs

Field staff have worked to assure that all CSS enrolled children who are eligible, are enrolled in TennCare. Then, they have further assured that the necessary medical services are approved through the MCO authorization process, or they assist the family and PCP with filing appeals. While service delivery problems still exist, and there are gaps in the service network, improvements in the delivery of care have been noted. Program efforts to identify, refer and enroll children will continue as a high priority activity. Advocacy and assistance with the appeal process will also continue. The program's medical services component has been redirected to include the provision of equipment, some therapies, durable medical goods, food supplements, pharmaceuticals, etc. that enrolled children need but are not considered medically necessary by the MCO.

Status of National Performance Measures # 11, 14

Performance Measure # 11 - Percent of Children with Special Health Care Needs (CSHCN) in the state CSHCN program with a source of insurance for primary and specialty care.

Based on TennCare and other insurance coverage information, 99.9% of the children enrolled in the CSS program have some form of health insurance. Children enrolled in CSS have been a special target group for outreach and enrollment with the expansion to 200% of poverty and up to 19 years of age.

Performance Measure #14 - The degree to which the State assures family participation in program and policy activities in the State CSHCN program.

The state assures family participation in services for special needs children through formal channels, i.e., as paid employees of the Parents Encouraging Parents Program (PEP) and through the formation of a position for a parent of a special needs child on the CSS Advisory Committee. Currently, there are 6 parents of special needs children employed out of a possible 12 positions. The state's program scores itself a 14 out of a possible 18 points on this performance measure.

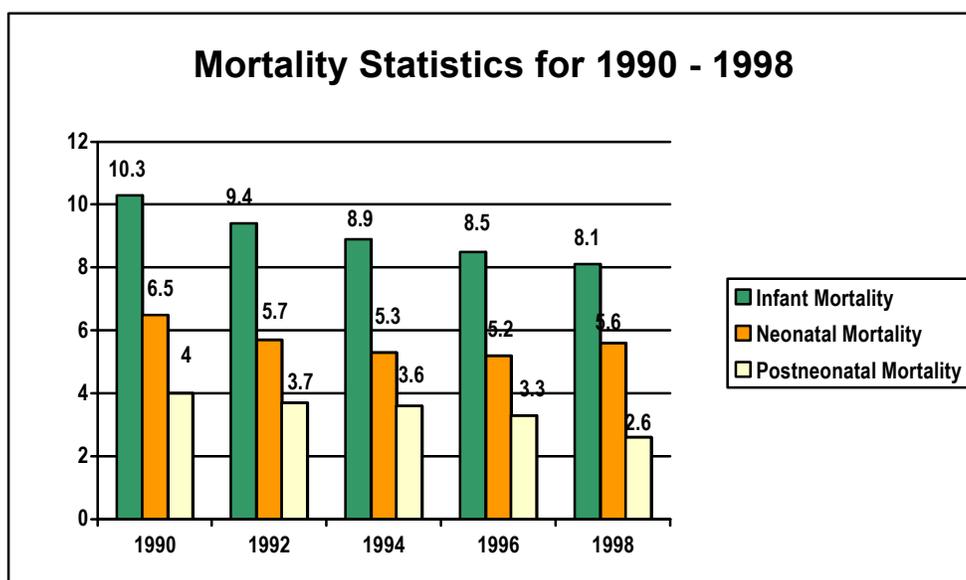
2.5 Progress on Outcome Measures

Form 12 reflecting the current status of outcome measures is contained in the Forms Section of this submittal - section 5.4.

The identified outcome measures of overall health status in Tennessee have a historic base in public health activity. As a Southern state, Tennessee has been concerned about and tracked neonatal, perinatal, post-neonatal and infant mortality rates for several decades. While there have been some improvements in these rates, they still lag behind the national average, the HP 2010 targets and the state's own goals.

National Outcome Measure # 01 - The infant mortality rate per 1,000 live births.

As defined by the guidance, the infant mortality rate is based on the number of deaths to infants from birth to 364 days of age. With the 1995 submittal, Tennessee set an objective for the infant mortality rate to decrease from 8.9 to 8.6/1,000 live births. The infant mortality rate for the baseline year of 1996 was 8.5 per 1000 live births. For 1998, it was 8.1/1000.



Efforts to improve these rates have concentrated on systems development and access to care issues. Local health departments, before TennCare, provided extensive prenatal care through local health department clinics and in cooperation with community physicians who agreed to assist with labor and delivery services at community hospitals. Concurrent with these services, the statewide perinatal system developed a system to provide referral and treatment for problem pregnancies. The goal of the local health department and perinatal system effort is to assure that pregnant women had access to the level of care they need, based on the condition of their pregnancy. Under managed care, the delivery of prenatal care has shifted from local health departments to the private sector in all but 13 counties. Services available at local health departments to improve prenatal care and pregnancy outcome include pregnancy testing, enrollment in TennCare and WIC, nutrition counseling, assistance with referrals to an OB/GYN, family planning, screening and treatment for sexually transmitted diseases. In the Memphis area, an MCO has contracted with the health department for prenatal and postpartum home visiting as a means of improving pregnancy outcome.

The disparity between the state's black and white populations with regard to infant mortality has also been tracked for many years as an indicator of overall health status. In spite of long term cooperative efforts between public and private health care agencies, the state has experienced

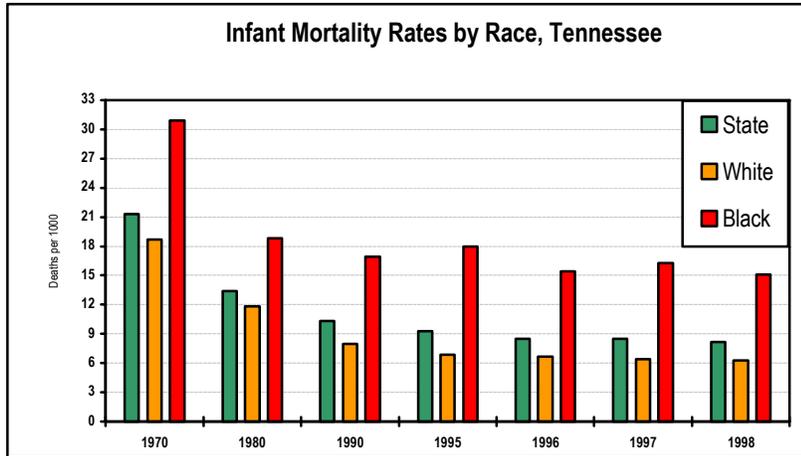
little change in this disparity. Overall, the rates for infant mortality are decreasing in the TennCare population. The last 4 years of data indicate that the gap appears to be narrowing. Additional years of data will help confirm or deny this observation.

National Outcome Measure # 02 - The ratio of black infant mortality rate to the white infant mortality rate.

MCH has consulted with TennCare regarding presumptive eligibility procedures for pregnant women resulting in an improved system. One major change has been continued coverage for pregnant women after delivery. Previously, women who were presumptively eligible were dropped from Medicaid 45 days after delivery. Without health care coverage, many did not have access to family planning services. Subsequent pregnancies would again result in Medicaid eligibility and the woman would then be re-enrolled. Now, women have the option of remaining on TennCare after delivery as an uninsured enrollee, increasing the continuity of care and entering prenatal care earlier when pregnant again.

A TennCare study on presumptive eligibility (1999) reveals a significant decrease in the number of women with presumptive eligibility, from almost 21,000 in 1993 to approximately 15,600 in 1998. This represents the number of pregnant women entering TennCare through presumptive eligibility decreased by 83% from 1993 to 1996 because women have the option of remaining on TennCare after expiration of their eligibility through Medicaid. The percentage of births covered by TennCare has remained stable during this same period.

According to TDH Office of Minority Health publication, *Narrowing the Gap 1997*, infant mortality rates for minorities were 28.8% lower in 1995 than those in 1975 but were still two and one-half times those of whites. In 1997, 42.5% of all infant deaths were minorities. This dropped to 41% in 1998. The infant mortality rates for whites and blacks were lower in 1998 than in 1997.



The Rural Health Initiative concentrates services in underserved areas and provides incentive grant awards for nurse practitioners, family practice, obstetric and pediatric physicians to establish and maintain practices in these underserved areas. For the past 2 years, funds were also made available under a request for proposal method for special community based grants addressing prenatal care health access and dental services in rural areas. The community initiatives grants have established projects in all regions of the state.

National Outcome Measure # 03 - The neonatal mortality rate per 1,000 live births.

The neonatal mortality rate is defined as the number of deaths to infants less than 28 days old. Since 1992, Tennessee’s neonatal mortality rate has fluctuated between 5.7 and 5.1/1,000 live births. In 1998 it was 5.6/1,000. See Outcome Measure # 01 above for the trend line graph and a discussion of state activities to reduce the neonatal mortality rate.

National Outcome Measure # 04 - The post-neonatal mortality rate per 1,000 births.

The post-neonatal mortality rate is defined as the number of deaths to infants 28 through 364 days of age. In 1992 the post-neonatal mortality rate in Tennessee was 3.7 per 1,000 live births. The rate has fluctuated between 3.3 and 4.0/1,000 for the past 8 years, (1989 to 1996). The post-neonatal death rate for 1998 was 2.6/1,000.

National Outcome Measure # 05 - The perinatal mortality rate.

The perinatal mortality rate is defined as perinatal deaths under 7 days and fetal deaths of greater than 20 weeks gestation per 1,000 births. Tennessee’s definition differs slightly - fetal deaths are those under 500 grams or in the absence of weight, occurring at 22 weeks gestation. This is the definition used by the Region IV Network for Data Management and Utilization Project (RNDMU). Tennessee’s actual perinatal mortality rate for 1998 was 9.2/1,000 live births. Monitoring of perinatal mortality and neonatal mortality rates for Tennessee will continue. Funding for the perinatal regionalization system, and other programs effecting perinatal outcomes is expected to continue.

PERINATAL MORTALITY RATES 1992-1998

Year	Perinatal Mortality Rate (per 1,000)
1992	9.9
1993	9.5
1994	9.2
1995	9.4
1996	9.5
1997	9.1
1998	9.2

National Outcome Measure # 06 - The child death rate per 100,000 children aged 1 –14.

The baseline year data indicate 29 deaths per 100,000 children aged 1-14. The actual death rate for the 1-14 year old range for 1998 was 24.8/100,000.

III. Requirements for the Application

3.1 Needs Assessment of Maternal and Child Health Population

3.1.1 Needs Assessment Process

The 2000-2005 needs assessment process was designed to capitalize on information already available about the health status of women and children and to convene established groups to assist in prioritizing state issues. Four independent activities were completed to develop the needs assessment. These activities were:

1. Analysis of primary health status data through the assistance of the Office of Policy, Planning and Assurance of the Department of Health.
2. Review of county and regional health council reports of their top health concerns and identification of those that relate to the women, infants and children population.
3. Review and summary of needs assessments conducted by other state organizations and advocacy groups committed to health related issues of women, children and CSHCN.
4. Citizen involvement through a statewide stakeholders meeting convened by the Commissioner and county health council meetings in nine counties across the state.

Each of these activities is discussed in the following summary.

3.1.2 Needs Assessment Content

3.1.2.1 Overview of Maternal and Child Population Health Status

Staff from the Office cited above used vital records and health statistics data to analyze health status indicators. The decision was made to match these data elements with national, state and county information because county health councils would want their specific county information contrasted with state and national data. Sources of data included: the national Annie E. Casey Foundation Kids Count data; the National Center for Health Statistics; the 1990 Census; Centers for Disease Control Disease Surveillance; the Tennessee Kids Count Report; the Tennessee Health Information Tennessee (HIT) website; Healthy People 2000; and the Department of Health Vital Records Office.

Tennessee's health status indicators that ranked higher than the U.S. as a whole included:

The percent of low birth weight babies

Teen Birth rate

Infant, neonatal and post-neonatal mortality rates

Child death rate

Teen violent death rate
Teen suicide rate
Percent of children dropping out of school
STD infection rate
Use of hallucinogens, inhalants and cigarettes by high school students.

See 5.3 Other Supporting Documentation A for the summary document developed for the stakeholders meeting which summarized the data presented and provided graphic representation of the data and trend lines.

Analysis of County Health Council Reports

As discussed previously in Block Grant submittals, the state of Tennessee has strong community participation through the county and regional health councils established in 1996. Each county meets quarterly and assists the public health system by reviewing health data and prioritizing public health priorities for their specific geographic area.

Between 1996 and 1999 these councils, under the guidance of community development staff, reviewed county and region specific data, looked at other health related issues, conducted community surveys and compiled, usually through nominal group process, an agreed upon list of priorities. When each county had completed this process, the state office responsible for their activities developed a list of top community priorities based on the frequency that each topic was identified. These top community diagnosis priorities (1999) and the number of counties listing one of these priorities are contained in the following chart.

1. Alcohol, tobacco and other drugs	82 counties
2. Teen pregnancy	70 counties
3. Cancer	63 counties
4. Heart disease	58 counties
5. Health education and wellness	47 counties
6. Access to health care	43 counties
7. High blood pressure/stroke and hypertension	37 counties

8. Violence	29 counties
9. Motor vehicle accidents	28 counties
10. Nutrition and obesity	28 counties
11. Mental health services	24 counties
12. Child abuse and neglect	22 counties
13. Dental/diabetes/elder care issues	21 counties
14. Diabetes	20 counties
15. Elderly	20 counties

Other maternal and child health issues were identified by more specific labels and not included in the prioritized list. These included maternal care (3), prenatal care (9), infant health (4) and low birthweight babies (3) counties. Related child health issues were labeled as school drop outs (3), school health (3) and child care (3).

Following this prioritization, each group developed implementation plans to begin addressing these priorities at the local level. Many county health councils have children and youth focused subcommittees that have taken a special interest in community based efforts to address these identified issues. Some financial support has been secured through local grants and/or special funding streams. The Community Prevention Initiative and the TNKIDS Initiative have made small amounts of money available through a competitive application process to fund these special local initiatives. The Community Services division of HSA-TDH, responsible for the community development process, provides technical assistance, oversight and project monitoring for these MCH related efforts.

Review of Other Needs Assessments

Many other groups conduct needs assessments on particular issues that relate to Maternal and Child Health. In all, MCH section staff reviewed 14 needs assessments on public health issues including children with special health care needs that had been conducted during the time period of 1996-99. These needs assessments fell into broad categories of: (1) Metropolitan Needs Assessments; (2) Independent Needs Assessments; (3) EPSDT related Needs Assessments; and (4) Needs Assessments of Special Populations. These needs assessments provided further

justification for the specified priorities. The summary of these needs assessments is contained in 5.3 Other Supporting Documentation.

Stakeholders and County Health Council Meetings

Stakeholder and County Health Council meetings were held between July 1999 and December 1999. The Stakeholder Meeting was convened by the Commissioner of Health with broad representation from academia including schools of medicine, advocacy groups, other state offices concerned with women and children issues including mental health, legislators, practicing physicians, nurses and health insurance representatives. The Commissioner provided an overview of health issues, and data was presented to set the stage for small group discussions about the progress and problems still present in Tennessee's health system for women and children. The fifty participants were then divided in small work groups based on the three population areas of Maternal and Child Health (Women and Infants, Children and Special Needs Children). Each group, led by a facilitator, was asked to develop a list of five to seven health needs for its particular population. The following are identified needs based on the discussions of these special focus groups.

Women's Health

1. Improve access to care for all women
2. Expand preventive care for women
3. Prevent domestic violence for women and children
4. Expand health education and wellness including pre-conceptual counseling
5. Continue to emphasize prenatal care.

Child Health

1. Assure access to quality health services including mental health, case management, social services and dental care for all children.
2. Prevent child abuse and neglect
3. Increase the availability of high quality child care.
4. Develop an integrated system for identifying and intervening with high-risk children.
5. Reduce substance abuse by mothers and children.

Children with Special Health Care Needs

1. Prevent birth defects like neural tube defects (NTD)
2. Continue prevention and intervention for conditions like lead poisoning.
3. Increase parent involvement in programs and provide support and respite care.
4. Reduce abuse and neglect for all children and CSHCN
5. Expand high quality care coordination.
6. Provide transitions to the next level of care.
7. Expand early identification intervention and treatment.

From August until November, MCH staff attended county health council meetings in nine specific counties of the state. These were selected for focus groups because of their statistical similarity while providing a perspective on health issues as viewed from small, medium and large rural counties in the three grand regions of the state. These groups were provided with a brief overview of the primary health status data including trends for at least the last 10 years. Discussion followed concerning the priorities identified for each population group by the stakeholders. Some councils added to these lists; others confirmed those that were listed as problems in their own communities. See 5.3 Other Supporting Documentation for the summaries of these county health council meetings.

At this stage the Maternal and Child Health team had almost more information, data and opinion than it could assimilated! To aid the decision-making process, the following chart was developed. Any expressed need that was a required national performance measure, such as infant mortality and low birth weight infants, was automatically assumed to be included as a need. By concentrating on subjective and objective information, MCH was able to target certain needs as state priorities and therefore, requiring a state performance measure for this next grant cycle.

The final agreed upon needs statements are:

1. Child abuse must be prevented for child health and safety and to reduce the number of children entering state custody. (HP2010 objective 19-3 and 15-33)
2. Youth health risk behaviors (obesity, smoking, alcohol and drug use) must be reduced.

(HP2010 objectives 19.3, 26.9, 27)

3. Prevent domestic violence for women and children.

(HP2010 objectives 15.34)

4. Expand health education and wellness for women including pre-conceptual counseling.

5. Continue to emphasize prenatal care. (HP2010 objectives 16.6, 16.7)

6. Prevent birth defects. (HP2010 objectives 16.16, 16.17)

The senior staff of MCH developed state specific performance measures that address these needs, or components of these needs based on current program activities and/or Initiatives of the Department.

SUMMARY OF NEEDS ASSESSMENT INFORMATION 1999 – 2000

Health Problems	State Data Higher	Required National Measure	Stakeholder Issue	County Councils Report - Focus Groups	Other N.A. Reports
Low Birth Weight Babies	+	X			
Teen Birth Rate	+	X	X	X	X
Early Prenatal Care	+	X	X	X	X
Infant Mortality		X			
NeoNatal Mortality	+	X			
Post Neonatal Mortality	+	X			
Immunizations *	+	X	*		
% w/o Health Insurance		X			
% 8 yr. olds with dental sealant		X		X	X
Child Death Rate	+	X			
Child Death Rate for MVA (1-14 years)		X		X	
Teen Suicide (15-19 years)	+	X			
Breast Feeding at Hosp. Discharge		X			
% CSHCN with Insurance		X			
% SSI and CSS enrolled		X			
Payment for Specialty & Sub-Specialty CSHCN Services.		X			
% CSHCN w/ Medical Home		X			
Family Participation in CSHCN Program		X	X		
MCD eligible children who get MCD svcs.		X			
Newborns who have hearing screening		X			
Screen for Genetic Diseases		X	* & Birth defects surveillance		

Health Problems	State Data Higher	Required National Measure	Stakeholder Issue	County Councils Report - Focus Groups	Other N.A. Reports
Ratio of Black to White Infant Mortality		X		0	
Perinatal Mortality		X			
% VLBW delivered in tertiary hospitals		X			
Tenn Violent Death Rate	+				
Child Abuse And Neglect/At Risk Youth			X CSHCN	X	X
Lifestyle and Youth issues such as Nutrition Smoking Drop-outs Alcohol & drugs	+			X	X
Violence/Domestic Violence			X	X	X
Adult Substance Abuse			X	X	X
Access To Care older women			X	X	X
High Quality Care Coordination			X	X	
Preventive Care for Women and Family Planning			X	X	X
Total EPSDT incl. Mental Health Services Provider and Parent Education Access for CSHCN to Home Health			X		X
High Quality Child Care and inclusion of CSHCN for Teachers			X		
STDs including HIV	+		*	X	
Racial Disparity	+		*	X	

LEGEND:

* = Commissioner's Priority
X= Identified Health Problem

Priority 1: Birth defects from preventable genetic causes should be prevented.

State Performance Measure: Decrease the number of neural tube defect births by 1% (per 100,000 live births) after 2 years of nutrition education and the public information campaign. (Continued)

Programs and health system activities that support this performance measure are the MCH/HP/Nutrition collaboration for the folic acid campaign; family planning services in all 95 counties of the state; WIC clinics and nutrition classes; collaboration with the state's March of Dimes program for folic acid campaign and public information; periodic press releases highlighting progress and new research; Children's Special Services program for care

coordination of those with neural tube defects; and TDH efforts to establish a birth defects registry currently piloted in Northeast Tennessee.

Priority 2: Reduce the STD infection rates, including HIV infection of infants.

State Performance Measure : Reduce the proportion of teens and young adults age 15 to 24 with Chlamydia trachomatis infections attending family planning clinics. (new)

Program and health system activities that support this performance measure are: the state's Family Planning program which provides clinics in each county of the state; the state's participation in the region IV Chlamydia Screening project; and the STD Surveillance System.

State Performance Measure : Reduce the number of HIV infected infants born to no more than one per year. (Continued)

Programs that support this performance measure are: the state's Communicable Disease Surveillance System; the HIV/AIDS program; and Ryan White program for education, intervention and prevention of HIV/AIDS.

Priority 3: Reduce child abuse and neglect in Tennessee.

State Performance Measure: Reduce the incidence of maltreatment of children younger than age 18 including physical, sexual, emotional abuse and neglect to a rate of no more than 8 per 1,000. (Continued)

Programs and health system activities that support this performance measure are: the state's mandatory reporting system; investigation and prosecution by the Department of Children's Services; community based programs for prevention education; the Child Fatality Review System; and the variety of county home visiting programs implemented by the local health department and contract agencies.

Priority 4: Reduce tobacco use in all its forms by adolescents.

State Performance Measure: Reduce the percentage of high school students using tobacco. (continued)

Programs and health system activities that support this performance measure are the state's Tobacco Control grant activities including community education campaigns, surveillance, the Youth Risk Behavior Survey information.

Priority 5: Reduce alcohol use by adolescents.

State Performance Measure : Reduce the percentage of high school students using alcohol. (Continued)

Programs and health system activities that support this performance measure are: the special programs of the Bureau of Alcohol and Drug Services; Community Prevention Initiative projects; activities of some of the county health councils; Youth Risk Behavior Survey; and other departmental surveys.

Priority 6: The state's EPSDT rates in a managed care system must improve.

State Performance Measure: Increase the percentage of children with complete EPSDT annual examinations by 3% each year. (New)

Programs and health system services that support this performance measure include: county health department activities of enrollment, reverification, outreach and follow-up of TennCare enrollees; provider and parent education activities provided by the TennCare office and the managed care organizations; and the oversight and quality assurance activities of the TennCare Bureau.

Priority 7: Women of all ages and racial groups must seek and use preventive health care services to improve their health status.

State Performance Measure: Reduce to no more than 30% the proportion of all pregnancies that are unintended pregnancies. (continued)

Pregnancy screening and patient education services are offered through all county health departments; surveillance is carried out through the addition of the special module to the Behavioral Risk Factor Survey. WIC counseling and the breastfeeding initiative managed by the Nutrition section all serve to support this performance measure.

3.1.2.2 Direct Health Care Services

This section is combined with the following section as allowed by the application guidance.

3.1.2.3 Enabling Services

Tennessee is now completing its sixth year of a statewide Medicaid managed care program called TennCare. Over 1.2 million Tennesseans are insured through this system and Dr. Robert Fox, University of Tennessee-Knoxville, special consultant to the TennCare Bureau, estimates that 94% of all Tennesseans have some form of health insurance. During 1996-97, TennCare opened enrollment once again to uninsured children living in families at 200% of poverty and up to the age of 19. Most previously uninsured children are now insured and benefits have continued for children enrolled through the former Medicaid program. Problems center on keeping the child enrolled when eligibility changes and assuring that those enrolled understand the managed care system and the benefits available to them.

Cultural sensitivity and acceptability are rapidly being addressed through direct health care and enabling services offered through local health departments. Several counties have established “Spanish” days for routine clinics for women and children. Translators are present, and health education material has been purchased to educate about certain health issues including family planning, breastfeeding, immunizations and childcare. MCH recently purchased Spanish-English health phrase books for county health departments and providers to assist with communication

issues during clinic. Several MCH pamphlets have been translated into Spanish by a recently hired bilingual staff person.

The state's welfare to work program, called Families First, has resulted in a significant decrease in the welfare roles while enrollees participation in education and employment has increased. Since 1995, those enrolled in the welfare program have decreased from 95,909 to 54,762 persons by 1997. Ninety percent attending school in 1997 and 74.4% had been employed in the last 12 months. DHS has developed new services to support participants by expanding childcare slots for 25,000 children each month and providing transportation through agreements with local transit agencies. DHS has also developed a no interest loan program to assist families in purchasing moderately priced cars for training and work.

Since the program requires responsible behavior to assure the health of children, we know that 97.7% of the children participants are current with immunizations and health checks and 90% attend school regularly. Summaries of the Families First program are contained in the Other Supporting Documentation section.

Ninety-nine percent of the children enrolled in the state's program for CSHCN have health insurance coverage for medically necessary services. Access to and approval of specialty providers and therapeutic services are of special concern for the CSHCN population. Care coordinators advocate for the services a child needs and work with the family and the primary care provider to see that the child receives them. Families often require assistance with appeals, and sometimes they need approval for an out-of-plan provider if specialists in the child's plan are no longer accepting patients or if the provider network is deficient in the specialty care needed. Staff remains concerned that the specialists affiliated with MCO plans often do not have experience with children, which may influence the quality of care he/she receives.

MCH-CSS staff coordinate referrals of children received from the Social Security Administration. Based on the diagnosis, parents of SSI eligible children are sent a brochure informing them of possible services available for their child. These include services offered by CSS, MH/MR, Tennessee Early Intervention System (TEIS) and the genetic centers. In 1999, the

number of children dually enrolled in CSS and SSI was 2,287 or 45%. When SSI eligibility changed in 1996, children with diagnoses of mental health problems experienced more disruption of service than other populations of special needs children. The number of children dually enrolled in CSS and SSI represent a 11% increase over 1998.

CSS renewed the cooperative agreement with the Department of Human Services, Division of Rehabilitation Services, for a period of 5 years, from July 1996 to June 2002. The purpose of the agreement is to outline a plan to coordinate services for individuals under the age of 21 within Tennessee who are eligible for services as defined in the laws and regulations governing the respective agencies. An additional purpose is to avoid overlap in the extension of services and provide to each agency the opportunity to refer to the other agency, those individuals who may qualify for service.

The Office of Health Access has established infrastructure/enabling projects to place certain types of health providers in federally designated Health Professional Shortage Areas, Medically Underserved Areas or TennCare shortage areas designated by the state. There are a total of 57 different counties designated as health provider shortage areas - 30 counties with primary care provider shortages, 30 with obstetric shortages and 29 with pediatric shortages (Health Access Program Plan – 1999). Maps illustrating these shortage areas are contained in section 5.3, Other Supporting Documentation. The Office of Health Access also supports the National Health Service Corps (NHSC), which assists underserved communities by bringing the services of physicians and other clinical health professionals to Health Professional Shortage Areas. Health care practitioners who are placed must agree to provide medical care to underserved Tennesseans. The Department of Health is positioned to cooperate with and assist any federal agency in its sponsoring and review of requests to waive the foreign residency requirement on behalf of primary care physicians holding J-1 visas, and who will practice in an acceptable location. The program sponsors a Medical Recruitment Fair annually to showcase targeted communities and introduce prospective health care staff to the department.

In 1997, a new component was added to the Health Access program called Community Initiatives. Regions had the flexibility to propose innovative ways to address health care needs in

their geographic areas for primary care, perinatal care or dental care. As an example, two counties in rural West Tennessee received funding to develop a pre-pregnancy program focusing on planning for parenthood starting with education and mentoring for young teens. The project employed an OB/GYN physician in a county with no specialty providers, who links to the private practice of an OB/GYN physician group in a contiguous county. The physician recently moved out-of-state. The two counties are working on a plan to improve access to obstetrical services. Two other counties in rural West Tennessee received funding to combine two medical communities in addressing a common problem and hired a nurse practitioner who is shared. Regions have the option to use the available funds for incentive grants to individual providers but must keep costs within the funds allocated for both programs combined.

Linkages and collaboration to provide services and referrals have been described extensively in other sections of this submittal. Those already covered include:

- The perinatal regionalization system;
- Families First referrals to assess the health and safety of children when a family member has been dropped from the state's TANF program called the Families First program;
- CSS program advocacy and assistance with MCOs to assure service delivery for enrolled children with special needs;
- TennCare outreach, advocacy, enrollment and assistance with the appeals process for any Tennessean needing such help;
- CISS - Health and Safety in Child Care Collaboration with the Developmental Disabilities Council and the Department of Human Services - Child Care Licensing Division.

In addition to these linkages, the Genetics and Newborn Screening Program has established a network of tertiary level providers for referral, case management and treatment of infants and children with genetic and metabolic diseases. (Maps are in 5.3 Other Supporting Documentation section.) When an infant is identified with a questionable or suspected screening test result, the Central Office staff alert the local health department and the infant's PCP, if known. These health care personnel work together to locate the baby and resample or refer immediately to one

of the designated genetic centers for further evaluation. Infants with confirmed metabolic disorders are then treated and followed by the genetic center closest to their home community. Tennessee applied for and received a grant to improve community-based networks between genetic services and CSHCN through Special Projects of Regional and National Significance (SPRANS) for 1999-2000. The program will develop uniform data sets to improve intervention and follow-up of diagnosed children and will link these children with CSS Care Coordinators in their home community.

The specialty care available for problem pregnancies and genetic/metabolic disorders has been referred to previously. Specialist care for CSS enrolled children is in transition because of the TennCare system. In some regions, the program continues to offer specialty clinics to facilitate service delivery and meet unmet needs of this population. These clinics operate in areas where the MCO networks are insufficient for the needs of the children, or when prior authorization to provide specialty service has been approved by the MCO. Clinics are held either at the regional health office, university medical centers or private physician offices as arranged by the CSS Coordinator for that region. The goal of this system is to provide services as close to home as possible and to consolidate appointments to specialty physicians as a convenience for the family.

3.1.2.4 Population-Based Services

The rapid changes in the health care delivery system in this state as a result of managed care and the changing nature of modern health problems require a shift to population-based services to change attitudes, behavior and ultimately, habits effecting health status.

Some services at this level of the pyramid are targeted at entire groups, such as the newborn screening program. Others take a population-based approach to surveillance, as in the case of persons with diagnosed STDs, and track contacts and treatment to intervene in the spread of disease. Health education activities target even broader populations in hopes that repeated messages and information will result in positive lifestyle choices to prevent morbidity and mortality as individuals age. Several sections of the Bureau of Health Services are directly

involved in the provision of all the population-based services listed. MCH has the responsibility for implementation and management of many of these.

The newest population-based intervention managed by MCH is the TNKIDS Initiative, transferred from the Commissioners Office to MCH in August 1999. This initiative links the five departments providing services to children and uses the Search Institute model for assets building to expand community investment in services for children and families. A summary of the annual report is contained in the 5.30 Other Supporting Documentation section of this submittal. MCH continues to administer the Abstinence Education Program through 18 community based projects. Tennessee proposed to fund these organizations in each of the public health regions to teach abstinence and create a community norm for abstinence before marriage with youth. A summary of these projects is contained in section 5.3 Other Supporting Documentation. This program and the Adolescent Pregnancy Prevention Program are jointly planning a yearlong media campaign for the prevention of teen pregnancy. The theme of this first year campaign stresses the importance of parent communication in teaching youth to choose abstinence before marriage. Statewide efforts concentrate on the television, cablevision and radio markets. Print material was developed for use throughout the campaign. Theatre ads are being considered. A statewide conference on character education with youth, including abstinence education, was conducted in the fall and rated outstanding by participants. A second statewide conference is planned for Fall 2000.

The Child Fatality Review Teams, established in 1996, completed the fourth year of this mandated activity. On many of the 31 review teams, the medical director from the local or regional health department office serves as the chairperson. The role of these teams is to review all deaths occurring to children under the age of 18, to increase awareness of the causes of these deaths and to recommend state policy changes to the State Health Officer and Commissioner, if indicated. The 1998 Annual Report is not yet finalized due to changes in staff responsible for data entry and report writing. Legislation for a graduated drivers license has been re-introduced in the current legislative session partly as a result of the work of child Fatality Advisory Committee and the Department of Safety.

The Genetics and Newborn Screening program informs all new parents of the need for newborn screening and assures that all babies born in Tennessee are tested for specified metabolic disorders. The program works intensively with the State Laboratory to assure accurate and timely lab results and to retest when necessary. The advisory committees, made up of the state's leading geneticists, guide the activities of the program and recommend changes to the State Health Officer. (See more detailed discussion under the Direct Service /Enabling section of this application).

The Adolescent Pregnancy Prevention Program is an outgrowth of the Tennessee State Plan to reduce teen pregnancy. The mission is threefold: to create community awareness, to solicit support from various sectors for prevention efforts and to improve and coordinate services available to pregnant and parenting adolescents. The six metropolitan and seven rural areas have a total of 52 advisory councils, consisting of a cross-section of individuals, agencies and organizations. Each has a coordinator funded by the Central Office.

3.1.2.5 Infrastructure Building Services

TDH is already promoting comprehensive systems of service through traditional and non-traditional networks. As examples, new state initiatives like the Community Prevention Initiative for Children and the CISS Health in Child Care grant are creating collaborations that are strengthening the quality of the services offered.

Starting in 1997, TDH began active development of the local health department as the primary point of contact or port of entry for Tennesseans with health or social service related problems. The rationale was that the local health department was the most inclusive in service delivery and had the best rapport and image in local communities. The continued use of the county health department as a resource is evidence of this positive rapport and image. While the services offered have changed in a managed care environment, the number of patients served has not. According to the Comptroller's Office audit report, released March 1999, the 89 rural local health departments had a total of 411,823 patient visits in 1993 and 425,192 patients were served in 1997, representing a 3% increase for six programs which had encounter data available.

Other TDH activities are also contributing to the development of the local health department as the focal point for services that a Tennessean might need. The Bureau of Alcohol and Drug Services had been part of the Department since 1991 but had not been effectively integrated into local county activity. This Bureau needed local assistance with many administrative issues to continue to develop Behavior Health Organizations (BHO) services into a user friendly and effective service for enrollees and providers. Local health department staff have been trained and are now the point of entry for any county resident who seeks intervention services because of an alcohol or drug related problem. These staff screen clients to assess the severity level of the problem and then refer to an appropriate level of care. Nationally recognized tools from American Society of Addiction Medicine (ASAM) and Substance Abuse and Mental Health Services Administration (SAMHSA) are used. As of March_1999, the county health department system was screening and referring an average of 500 persons a month for alcohol and drug related problems.

The DHS Families First program also required assistance from the local health department to assure that Families First children were receiving the immunizations required, and that those children who were in families that dropped out of the program were receiving a home visit to assure basic health needs and that safety issues were being met. The local health department is notified of families requiring visits by a DHS staffed central review committee. Staff have 30 days to contact, visit and report back to DHS regarding the health and well being of the children. To date, the public health home visiting component has achieved a 37% completion rate, exceeding the rate established in a similar program in Iowa by nine percentage points, but below the expectation of the oversight groups monitoring implementation of the Families First Program. TDH, through local health departments, is renewing efforts and emphasizing the importance of visit completion within the required time frames.

MCH staff are heavily involved in coordination efforts with other service systems concerning women and children. Coordination with TennCare, the state's Medicaid managed care program, has been discussed extensively. Coordination occurs at the central office, regional and local

levels. The following is a brief listing of some of the coordination activities in which MCH is involved.

Women's Health Coordination Activities

Osteoporosis Advisory Committee

Breast and Cervical Cancer Screening Program

March of Dimes Program Services Committee

Regional and County Health Councils

Tennessee Commission on Children and Youth

HIV/AIDS Program

Prenatal/Postpartum Home Visiting Program

STD Program

Region IV Chlamydia Project and Advisory Committee

Ryan White, Title II Statewide Coordinated Statement of Need Committee

Tennessee Folic Acid Task Force

Children's Health Services

Community Prevention Initiative for Children

Families First Implementation Team

Department of Children's Services Children's Justice Task Force

Advisory Committee for Child Care Resource Centers

Advisory Committee for Tennessee Voices for Children

TNKIDS Initiative

Children's Special Services

TN Department of Education - Tennessee Early Intervention System (TEIS) – IDEA Part C

Interdepartmental Coordinating Council (ICC)

Shriner's CHOICES Program

Directors of Speech and Hearing Programs in State Health and Welfare Agencies (DSHPSHWA)

Tennessee Family Voices

Developmental Disability Council Advisory Board

The CSS Program serves as the coordinating office for children with special needs who may be eligible for services in addition to Supplemental Security Income (SSI) through the Social Security Administration (SSA). A nurse consultant affiliated with CSS coordinates referrals of children received from the SSA. After review of the diagnosis and case information, the parent or guardian of the potentially eligible child is sent information about the possible services available to their child from other state programs. Families are referred for services offered by CSS, the Department of Mental Health/Mental Retardation, TEIS and the regional genetic centers. During 1998-99, 3,206 children with special needs were referred to these other state services.

Mental health issues with women and children are beginning to be addressed through program discussions with staff from MH/MR. The Director of MCH is serving on the Advisory Committees for both a HRSA and SAMHSA grant awarded to TDMH/MR and TN Voices for Children, a mental health advocacy group. These grants are to develop systems of care for children with serious emotional disturbance (SED).

Direct Health Care Services: Teen pregnancy, prenatal care and child health and health related issues such as parenting skills were identified as direct service needs in the 1995-96 needs assessment. Primary care services continue in 16 of the 95 health departments, because there is a recognized need based on physician shortage areas and the inadequacy of managed care provider networks to serve residents of these counties. The needs assessment process resulted in four priorities being identified for special health system effort: (1) to reduce the number of HIV positive infants; (2) reduce the proportion of young adults with STDs including chlamydia; (3) decrease unintended pregnancies; and (4) reduce birth defects like neural tube defects.

Enabling Services: As a result of TennCare and changing state demographics, TDH is already providing a number of enabling services for the target populations. The needs assessment process did not identify a priority for their level of the pyramid.

Population-based Services: The needs assessment identified three priority needs – 1) reduce teen tobacco use, 2) reduce teen alcohol use and 3) reduce child abuse and neglect.

Infrastructure Building Services: Improved EPSDT rates was identified as a priority for this level of the pyramid.

3.2 Health Status Indicators

Forms for Tennessee’s Health Status Indicators are contained in 5.4 through 5.7 Core and Developmental Health Status Indicator Forms and Detail Sheets are in the Other Supporting Documentation Section.

3.2.1. Priority Needs

The state’s identified priorities and the related outcome measures they are expected to address are listed as follows:

Priority	Outcome Measure
Reduce preventable birth defects	Neonatal, post neonatal, infant and child death rates
Reduce STD rates	Perinatal mortality
Reduce child abuse and neglect	Infant and child death rate
Reduce teen tobacco use	Not related to an outcome measure
Reduce teen alcohol use	Not related to an outcome measure
Improve the state’s EPSDT	Not related to an outcome measure
Improve the health status of women	Perinatal mortality

3.3. Annual Budget and Budget Justification

The MCH budget for FY01 remains basically the same as previous year submittals. The unobligated funds are reflected on Form 2. The required federal percentages for preventive and primary care for children (30%), children with special health care needs (30%) and administrative costs for Title V (10%) are met or exceeded. Other sources of MCH funding include the required state match and other federal grants in support of MCH activity.

3.3.1 Completion of Budget Forms

Budget Forms 2, 3, 4, 5 are completed and contained in 5.8 All Other Forms Section of this submittal.

3.3.2 Other Requirements

The state established a Maintenance of Effort (MOE) state appropriation baseline in 1989 in accordance with the requirements of the Block Grant. The Fiscal Services Section of the Bureau of Health Services developed a formula for establishing the MOE based on state expenditure data for the 15-month period from July 1, 1988 through September 30, 1989 to bring expenditures current to the end of Federal FY 1989. Then, state expenditures for July 1, 1988 through September 30, 1989 were totaled and subtracted from the 15-month expenditure amount, resulting in a 12-month total for the Federal FY of October 1, 1988/September 30, 1989.

Accrued liabilities for the state fiscal year ending June 30, 1989 were determined and subtracted from the 12-month Federal FY total. Accrued liabilities are those costs that could not be liquidated at the close of the fiscal year but represent a liability to the state for the fiscal year in which they occurred. Accrued liabilities for October 1, 1988/June 30, 1989 and July 1, 1988/September 30, 1989 were determined. Since these accrued liability liquidations are actual expenditures in the fiscal year, they were added to the funding total. Unliquidated accrued liability savings were determined from the 1988 established accrued liabilities and adjusted as expenditures. These computations resulted in the establishment of the MOE of \$13,125,024.28 in state funds for MCH. For further clarification, see past Block Grant submittals for the mathematical computation of these steps.

State law requires that all departments present a complete financial plan for the ensuing fiscal year that outlines all proposed expenditures for the administration, operation and maintenance of all programs. Procedures for completing the budget request are developed annually by the Department of Finance and Administration. The Bureau's Fiscal Services Section, with input

from the program areas, is responsible for completion of the budget documents. After being approved by the State Legislature, an operational budget work plan is developed for each program for the year.

Detailed Bureau policies and procedures have been established for local health departments, regional offices and the central office for all staff who are involved in management of funds. These include procedures on who handles money, collecting fees, depositing fees, accounts receivables, aging of accounts, charging patients, private insurance and other third party funding sources, petty cash, posting receipts, etc. All policies and procedures have been developed in accordance with state law and procedures of the Department of Finance and Administration. Computer printouts are generated for all MCH programs on expenditures and revenues, comparison to budgeted amounts and year-to-date activity. Central office staff also receive information by region and agency on fees collected from patients, TennCare collections and receipts from private insurance. Financial audits are the overall responsibility of the Office of the Comptroller of the Treasury, which is responsible for audits in all state departments and all matters related to audits. Contracting agencies are subject to audit on a regular basis.

The methodology for cost allocation has been changed with the state's shift to managed care and the multitude of integrated services being performed in the local health clinics. The Bureau of Health Services implemented a new cost allocation system, which has been approved by the Department of Health and Human Services (DHHS), based on relative value units (RVU). All relevant costs of providing a service are related to the value of one unit of service as determined through a formula which includes work involved, risk or liability and overhead expenses. This method distributes unallocated costs to program budgets based on the percentages of units of activity associated with procedures or services performed. Every procedural activity is assigned a weighted value on the basis of resources consumed or expended in performing the activity. This system more adequately reflects the resources used to perform procedures and more accurately distributes unallocated resource costs to programs. The RVU system improves the regional directors' ability to analyze and manage staff assignment, program activity and scheduling for certain health department programs. The RVU system became fully operational on July 1, 1998.

3.4 Performance Measures

3.4.1 National “Core” Five Year Performance Measures

3.4.1.1 Five Year Performance Objectives

Form 11 with the core performance measures and the required targets for five years is contained in the 5.8 All Other Forms section of this submittal. The National Core Performance Measure Detail Sheets are contained in section 5.9 of this submittal.

3.4.2 State “Negotiated” Five Year Performance Measures

The State Performance Measures and five year targets are contained in the 5.8 All Other Forms section, and identified by the required “SP” designation to distinguish them from the core performance measures. The Annual Report section of this submittal reviews the current status of these measures. The Detail Sheets are contained in section 5.10 of this submittal.

3.4.2.1 Development of State Performance Measures

State performance measures were developed through the activities discussed in Section 3.1 Needs Assessment of the Maternal and Child Health Population. State Performance Measure Detail Sheets (Form 16) are contained in section 5.10.

FIGURE 4 PERFORMANCE MEASURES SUMMARY SHEET

Core Performance Measures	Pyramid Level of Service				Type of Service		
	DHC	ES	PBS	IB	C	P	RF
1) The percent of state SSI beneficiaries less than 16 years old receiving rehabilitative services from the state Children with Special Health Care Needs (CSHCN) Program.	X				X		
2) The degree to which the state Children with Special Health Care Needs (CSHCN) Program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to its clients.	X				X		
3) The percent of Children with Special Health Care Needs (CSHCN) in the state who have a "medical/health home."		X			X		
4) Percent of newborns in the state with at least one screening for each of PKU, hypothyroidism, galactosemia, hemoglobinopathies (e.g., the sickle cell diseases) (combined).			X				X
5) Percent of children through age 2 who have completed immunizations for Measles, mumps, rubella, polio, diphtheria, tetanus, pertussis, haemophilus influenza, hepatitis B.			X				X
6) The birth rate (per 1,000) for teenagers aged 15 through 17 years.			X				X
7) Percent of third grade children who have received protective sealants on at least one permanent molar tooth.			X				X
8) The rate of deaths to children aged 1-14 caused by motor vehicle crashes per 100,000 children.			X				X
9) Percentage of mothers whom breastfeed their infants at hospital discharge.			X				X
10) Percentage of newborns who have been screened for hearing impairment before hospital discharge.			X				X
11) Percent of Children with Special Health Care Needs (CSHCN) in the state CSHCN Program with a source of insurance for primary and specialty care.				X	X		
12) Percent of children without health insurance.				X	X		
13) Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.				X		X	
14) The degree to which the state assures family participation in program and policy activities in the State CSHCN Program.				X		X	

Core Performance Measures	Pyramid Level of Service				Type of Service		
	DHC	ES	PBS	IB	C	P	RF
15) The rate (per 100,000) of suicide deaths among youths 15 - 19				X			X
16) Percent of very low birth weight live births.				X			X
17) Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.				X			X
18) Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.				X			X

Negotiated Performance Measures	Pyramid Level of Service				Type of Service		
	DHC	ES	PBS	IB	C	P	RF
1) Reduce the rate of neural tube defects by 1% after 2 years of intensive nutrition education at the local and regional levels in a calendar year.(Continued)	X					X	
2) Reduce to no more than 4% elevated blood lead levels in children 6 - 72 months of age who are screened.(Dropped)			X		X		
3) Reduce the percent of tobacco use among adolescents (Continued)			X			X	
4) Reduce the percent of alcohol use among adolescents age 12-17. (Continued)			X			X	
5) Percent of child maltreatment including physical, sexual, emotional abuse and neglect. (Continued)			X				X
6) Reduce the number of HIV infected infants to no more than one per year. (Continued)	X						X
7). Reduce to no more than 30% the proportion of all pregnancies that are unintended pregnancies. (Continued)	X					X	
8) Reduce the proportion of teens and young adults age 15-24 with "Chlamydia trachomatis" infections attending family planning clinics. (New)	X				X		
9) Increase the percentage of children with complete EPSDT annual examinations by 3 percent. (New)				X		X	

Outcome Performance Measures	Categories of Service				Type of Service	
	DHC	ES	PBS	IB	P	OC
(1) The perinatal mortality rate per 1,000 live births.	N/A	N/A	N/A	N/A		X
(2) The child death rate per 100,000 children aged 1 – 14.	N/A	N/A	N/A	N/A		X
(3) The ratio of the black infant mortality rate to						

the white infant mortality rate.	N/A	N/A	N/A	N/A		X
(4) The neonatal mortality rate per 1,000 live births.	N/A	N/A	N/A	N/A		X
(5) The post-neonatal mortality rate per 1,000 live births.	N/A	N/A	N/A	N/A		X
(6) The infant mortality rate per 1,000 live births.	N/A	N/A	N/A	N/A		X

Direct Health Care = DHC Population-Based Service = PBS Enabling Services = ES
Infrastructure Building = IB Capacity = C Process = P Outcome = OC

3.4.2.2 Discussion of State Performance Measures

The process used by MCH to discuss the MCH priority needs is described in detail in section 3.1 of this submittal. Six of the eight performance measures identified for 2000-2005 remained the same.

The required information about these measures, the priority need it relates to, and the level of the pyramid it supports are included on *Figure 4, Performance Measure Summary Sheet*. The relationship of these state performance measures to the required outcome measures is identified in the brief priority listing in section 3.2.1 of this submittal.

3.4.2.3 Five Year Performance Objectives

Form 11 has been completed for each State Performance Measure and 5 year targets have been set. See the forms section for this detail.

3.4.2.4 Review of State Performance Measures

The State understands that the state selected performance measures will be reviewed by MCHB regional and central office staff and negotiated as part of the face-to-face meeting scheduled for August in Atlanta.

3.4.3 Outcome Measures

Form 12 is contained in section 5.11 Outcome Measure Detail Sheets of this submittal.

IV. REQUIREMENTS FOR THE ANNUAL PLAN

4.1 Program Activities Related to Performance Measures

Tennessee has made every effort to directly tie the priority needs of the state and the national and state performance measures to the capacity and resource capability of MCH at the local, regional and central office levels. The direct health care services offered through the public health system are in response to identified needs and gaps in service for preventing mortality and morbidity in women, infants and children. The primary emphasis of all health department activity is to assure that women receive the preventive care they need to reduce unintended pregnancies and that when pregnant they receive early, high quality prenatal care so that babies are born healthy and remain healthy during their infancy and childhood.

The previously described Patient Tracking Billing Management Information System (PTBMIS) provides an electronic file for each patient and the services they access at the local health department. It also links all 95 counties first into their respective regional offices and then into central office so that program data are readily available for monitoring, strategic planning and fiscal management. Program data from this system help the MCH Program track success with meeting service priorities and targets for women and children. It also alerts staff when service statistics vary from the expected, permitting staff to study the impact of other related activities on MCH services. Other data sources for evaluating the health status of women and children include vital records, alcohol and drug use surveys, tobacco use surveys, Behavioral Risk Factor Surveys and information from state education and child custody programs.

Central Office staff are now moving into a role of developing collaborations and linkages with other related social services, such as education, mental health and mental retardation, to strengthen service delivery and reduce duplication for families needing a variety of services for their adult or child family members. Staff are also developing stronger relationships with the community diagnosis process, health statistics office and assessment and planning functions to establish expert assistance as applied to MCH work.

Local health departments, especially in rural areas, continue to provide direct health care services for women, infants and children. Pregnancy testing is provided on request and sexually transmitted disease screening and family planning services are available in every county. All counties operate a WIC program for those eligible, and WIC vouchers are now generated at the county level to improve service delivery to families. Individual and population-based health education about the continuing and emerging health care needs of women is readily available. Infants and children can receive immunizations and well child checks in compliance with EPSDT although most children have these completed by the assigned or selected PCP. These examinations include blood lead level screening in compliance with the Child Health Manual standards and EPSDT guidelines. Local health department staff follow-up with all children having elevated blood lead levels through periodic monitoring, environmental and household inspection and lead abatement activities with the families. When a child is enrolled in a MCO, the staff request prior authorization before providing these services or refer and assure that the child receives an EPSDT exam from the PCP.

For children with special health care needs, local nurses assist the Genetics and Newborn Screening program when an infant residing in their county needs to be retested for any one of the four required metabolic diseases. These nurses often exert extra effort to find these infants because of the potential damage that can result from the delay of confirmation and treatment. Children enrolled in the CSS program can receive basic well child care at the county health department with MCO approval, and the CSS care coordinators are based in each county to assist families with needed services.

Most enabling services also occur at the county or regional office level. These services are designed to assist individuals in seeking their own health care as informed consumers or provide the tools needed to work with their health care provider to control certain conditions, usually associated with lifestyle and chronic disease conditions. The influx of workers for the horticulture service industry, food processing and construction jobs from Spanish speaking cultures has led to innovative ways to provide translation/communication between the patient and the health care worker. The enabling services provided for TennCare outreach, enrollment

and appeals have been extensively documented in other sections of this submittal. The care coordination component and PEP Program of the CSS program provide special support and enable families to better meet their child's needs in a complex health care environment.

The public health services offered through a population-based approach are more typically initiated by regional or central office activities. Many of these listed services are mandated by state law and require surveillance and intervention when indicated to improve or restore health outcomes. Most services concentrate on infants and children with the emphasis on prevention and early intervention. The Health Promotion Section addresses many population-based services targeted for improving women's health status. These programs included osteoporosis, arthritis, diabetes, breast and cervical cancer, smoking cessation and others.

The infrastructure building level of the pyramid emphasizes systems approaches to improving health services for women, infants and children. MCH advisory committees assist the central office personnel in implementing and administering service programs for women, newborns and children with special needs. Other activities concentrate on quality improvement issues which impact all target populations or focus on a process approach, such as the TennCare liaison functions, to improve the systems and address and correct problems that significantly impact citizens. The various registries listed and resources like the data library and the resource centers, help staff of other systems improve their knowledge and information when working with individual patients or groups of people.

Program Directors for MCH assisted with targeting each performance measure. In some cases, this required working with assigned staff from Health Statistics and Vital Records. Staff also worked with other programs, such as Immunizations and WIC/Nutrition, which are under the administration of other sections in TDH, to obtain the necessary baseline or trend data needed to target the core and state performance measures. Care was taken to establish realistic but demanding objectives.

Program Directors will continue to track progress and problems with the performance measures and targets on a semi-annual basis. This will allow for discussion and modification, if necessary.

Program Directors will also be asked to compile innovative ways that health care groups within or outside the state are addressing similar performance targets. The Bureau's regional director conference calls, quarterly meetings of the regional directors, the community development staff meetings and MCH staff training and administrative meetings will be used as vehicles for discussing new or needed activities to reach objectives.

This Block Grant submittal, with an emphasis on the federal and state performance measures, will be shared with regional directors, other section chiefs, community development staff, county and regional health councils and MCH representatives from the regions. The purpose of this activity will be to build support and commitment to the performance measures and to begin discussions of new and continuing activities to help accomplish these objectives.

The Director of MCH will also work to integrate MCH performance measures and targets with the TDH strategic plan for the Governor and Healthy People 2010 Objectives.

4.2 Other Program Activities

The state's Child Fatality Review process is focusing attention and concern on the causes of death among Tennessee's infants and children. Already there has been an increase in the dialog about topics of general concern. Birth and death certificate accuracy of information is being studied by MCH and the Vital Records office. TDH has developed guidelines and is providing continuing education for health care personnel regarding the importance of accuracy in completing these forms. Vital Records and the Genetics and Newborn Screening Program are also discussing implementation of an electronic birth certificate system that will improve both the timeliness and accuracy of the information.

The MCH section operates three toll free hotlines for program and service delivery support. Two are staffed by the MCH section, and one is established with a community based agency through a state contract.

The Teen Pregnancy Information Clearinghouse is a central, toll-free telephone for professionals seeking information on teen pregnancy statistics, resource materials and services. The Family Planning Training Coordinator periodically reviews and purchases literature and other resources to keep Clearinghouse materials up to date, relevant and appropriate for the variety of topics related to teen sexuality. This line was used recently as the 1-800 number for the Abstinence Education campaign so that materials could be easily distributed to parents and other interested citizens.

The Baby Line, another separate toll-free telephone line, serves to refer callers for pregnancy testing and prenatal care within the area where they live. The goal of this service is to get women into care during the first trimester of pregnancy. Recently, Blue Care, a statewide MCO, has requested that MCH provide patient information to enrolled pregnant members whose names are provided to the Central Office. Over 40 health education materials pertinent to pregnancy are available for distribution.

Call GWEN is a statewide teen hotline contracted by MCH to Crittenton Services of Nashville. Professional staff of the agency or trained teens answers the line and respond to questions and concerns of the caller. Typically, questions concern family planning and pregnancy information, medical information and relationship issues confronting the teen caller. The agency receives about 30 calls a month. Some are from adults concerned about a teen's behavior. Factual information and referral are provided as appropriate to all callers.

TDH and MCH involvement in EPSDT services increased recently when a consent decree between TennCare representatives, the attorneys for the plaintiffs and the federal judge was signed (April 1998), averting court action. The decree outlines specific timelines and monitoring requirements for TennCare oversight of the managed care network with regard to the delivery of EPSDT services for children enrolled in their plans. The required semi-annual reports to the court indicate the progress made. The reports from July 1999 and January 2000 are contained in the Other Supporting Documentation section of this submittal.

MCH staff continue to serve on the Task Force and the work groups being established to develop implementation plans for the various requirements of the consent decree. Special care will be taken to include staff from CSS as these new activities must improve well child care and specialty care to this particular population.

The local health departments are well known as quick, convenient and helpful community-based sites for pregnancy testing and TennCare enrollment. When a woman's test is positive, the staff work immediately to enroll her in TennCare, if she is eligible, and connect her with a prenatal care provider who is taking new, TennCare prenatal patients. Other sections of this submittal contain more detailed information about presumptive eligibility and the improvement in access to care during the first trimester for eligible pregnant women. Quality assurance studies also indicate that these women are more likely to remain enrolled in TennCare, to seek preventive care and to enter care earlier for subsequent pregnancies.

4.3 Public Input

Public review and input regarding the MCH Block Grant will continue a process started with last year's submittal. Each Regional Health Council will receive a copy of the Block Grant through the regional director for review and comment. Written comments will be reviewed and included with the next Block Grant submittal. The application will be posted on the TDH web site for access by any Tennessean, and a summary is posted on the legislative Website as required by the state. Finally, MCH will continue its history of holding public meetings in concert with the WIC program regarding its role and services offered at the county level. A fact sheet about both programs is sent to over 1,500 agencies and individuals announcing the location and time of the public hearings. Comments are sought on the infant formula contract, as well as suggestions for MCH, WIC, Commodity Food Service and outreach, certification, clinic access and WIC vendor management.

The state legislature and all citizens of Tennessee will be informed of the Block Grant submittal as required by state mandate. Interested persons may contact the MCH Section for the complete copy or download the application.

4.4 Technical Assistance

MCH has taken advantage of technical assistance opportunities for systems development planning under SSDI and for consultation regarding the strategic planning session to identify MCH performance measures. Technical assistance has also been provided to establish the contract for evaluation of the CSS Program, now in process.

During 1999-2000, the section requests technical assistance for two activities:

- (1) developing standards of care for MCH services delivered at the local and regional levels;
- (2) consultation and systems development for universal newborn hearing screening.

Potential consultants and anticipated costs are reflected on the required form in the Forms section of this application.

Finally, the state would like to designate some technical assistance resources for the Region IV conference held annually in Asheville, N.C. Several MCH staff from Tennessee are on the planning committee and sponsorship of a session that meets state needs and allows for additional on-site consultation would be of benefit to the conference and to the state.

V. SUPPORTING DOCUMENTS

5.1 Glossary

Administration of Title V Funds - The amount of funds the State uses for the management of the Title V allocation. It is limited by statute to 10 percent of the Federal Title V allotment.

Assessment - (see "Needs Assessment")

Capacity - Program capacity includes delivery systems, workforce, policies, and support systems (e.g., training, research, technical assistance, and information systems) and other infrastructure needed to maintain service delivery and policy-making activities. Program capacity results measure the strength of the human and material resources necessary to meet public health obligations. As program capacity sets the stage for other activities, program capacity results are closely related to the results for process, health outcome, and risk factors. Program capacity results should answer the question, "What does the State need to achieve the results we want?"

Capacity Objectives - Objectives that describe an improvement in the ability of the program to deliver services or affect the delivery of services.

Care Coordination Services for CSHCN - Those services that promote the effective and efficient organization and utilization of resources to assure access to necessary comprehensive services for children with special health care needs and their families. *[Title V Sec. 501(b)(3)]*

Carryover (as used in Forms 2 and 3) - The unobligated balance from the previous year's MCH Block Grant Federal Allocation.

Case Management Services - For pregnant women - those services that assure access to quality prenatal, delivery and postpartum care. For infants up to age one - those services that assure access to quality preventive and primary care services. *[Title V Sec. 501(b)(4)]*

Children -A child from 1st birthday through the 21st year, who is not otherwise included in any other class of individuals.

Children With Special Health Care Needs (CSHCN) - *(For budgetary purposes)* Infants or children from birth through the 21st year with special health care needs who the State has elected to provide with services funded through Title V. CSHCN are children who have health problems requiring more than routine and basic care including children with or at risk of disabilities, chronic illnesses and conditions and health-related education and behavioral problems. *(For planning and systems development)* Those children who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type or amount beyond that required by children generally.

Children With Special Health Care Needs (CSHCN) - Constructs of a Service System

1. State Program Collaboration with Other State Agencies and Private Organizations

States establish and maintain ongoing interagency collaborative processes for the assessment of needs with respect to the development of community-based systems of services for CSHCN. State programs collaborate with other agencies and organizations in the formulation of coordinated policies, standards, data collection and analysis, financing of services, and program monitoring to assure comprehensive, coordinated services for CSHCN and their families.

2. State Support for Communities

State programs emphasize the development of community-based programs by establishing and maintaining a process for facilitating community systems building through mechanisms such as technical assistance and consultation, education and training, common data protocols, and financial resources for communities engaged in systems development, to assure that the unique needs of CSHCN are met.

3. Coordination of Health Components of Community-Based Systems

A mechanism exists in communities across the State for coordination of health services with one another. This includes coordination among providers of primary care, habilitative and rehabilitative services, other specialty medical treatment services, mental health services, and home health care.

4. Coordination of Health Services with Other Services at the Community Level

A mechanism exists in communities across the State for coordination and service integration among programs serving CSHCN, including early intervention and special education, social services, and family support services.

Classes of Individuals - Authorized persons to be served with Title V funds. See individual definitions under "Pregnant Women," "Infants," "Children with Special Health Care Needs," "Children," and "Others."

Community - A group of individuals living as a smaller social unit within the confines of a larger one due to common geographic boundaries, cultural identity, a common work environment, common interests, etc.

Community-based Care - Services provided within the context of a defined community.

Community-based Service System - An organized network of services that are grounded in a plan developed by a community and that is based upon needs assessments.

Coordination (see Care Coordination Services)

Culturally Sensitive - The recognition and understanding that different cultures may have different concepts and practices with regard to health care; the respect of those differences and the development of approaches to health care with those differences in mind.

Culturally Competent - The ability to provide services to clients that honor different cultural beliefs, interpersonal styles, attitudes and behaviors and the use of multicultural staff in the policy development, administration and provision of those services.

Deliveries - Women who received a medical care procedure associated with the delivery or expulsion of a live birth or fetal death (gestation of 20 weeks or greater).

Direct Health Services - Those services generally delivered one-on-one between a health professional and a patient in an office, clinic or emergency room which may include primary care physicians, registered dietitians, public health or visiting nurses, nurses certified for obstetric and pediatric primary care, medical social workers, nutritionists, dentists, sub-specialty physicians who serve children with special health care needs, audiologists, occupational therapists, physical therapists, speech and language therapists, specialty registered dietitians. Basic services include what most consider ordinary medical care: inpatient and outpatient medical services, allied health services, drugs, laboratory testing, x-ray services, dental care, and pharmaceutical products and services. State Title V programs support - by directly operating programs or by funding local providers - services such as prenatal care, child health including immunizations and treatment or referrals, school health and family planning. For CSHCN, these services include specialty and subspecialty care for those with HIV/AIDS, hemophilia, birth defects, chronic illness, and other conditions requiring sophisticated technology, access to highly trained specialists, or an array of services not generally available in most communities.

Enabling Services - Services that allow or provide for access to and the derivation of benefits from, the array of basic health care services and include such things as transportation, translation services, outreach, respite care, health education, family support services, purchase of health insurance, case management, coordination with Medicaid, WIC and educations. These services are especially required for the low income, disadvantaged, geographically or culturally isolated, and those with special and complicated health needs. For many of these individuals, the enabling services are essential - for without them access is not possible. Enabling services most commonly provided by agencies for CSHCN include transportation, care coordination, translation services, home visiting, and family outreach. Family support activities include parent support groups, family training workshops, advocacy, nutrition and social work.

Family-centered Care - A system or philosophy of care that incorporates the family as an integral component of the health care system.

Federal (Allocation) (as it applies specifically to the Application Face Sheet [SF 424] and Forms 2 and 3) -The monies provided to the States under the Federal Title V Block Grant in any given year.

Government Performance and Results Act (GPRA) - Federal legislation enacted in 1993 that requires Federal agencies to develop strategic plans, prepare annual plans setting performance goals, and report annually on actual performance.

Health Care System - The entirety of the agencies, services, and providers involved or potentially involved in the health care of community members and the interactions among those agencies, services and providers.

Infants - Children under one year of age not included in any other class of individuals.

Infrastructure Building Services - The services that are the base of the MCH pyramid of health services and form its foundation are activities directed at improving and maintaining the health status of all women and children by providing support for development and maintenance of comprehensive health services systems including development and maintenance of health services standards/guidelines, training, data and planning systems. Examples include needs assessment, evaluation, planning, policy development, coordination, quality assurance, standards development, monitoring, training, applied research, information systems and systems of care. In the development of systems of care it should be assured that the systems are family centered, community based and culturally competent.

Local Funding (as used in Forms 2 and 3)-Those monies deriving from local jurisdictions within the State that are used for MCH program activities.

Low Income - An individual or family with an income determined to be below the income official poverty line defined by the Office of Management and Budget and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981. [*Title V, Sec. 501 (b)(2)*]

MCH Pyramid of Health Services - (see “Types of Services”)

Measures - (see “Performance Measures”)

Needs Assessment - A study undertaken to determine the service requirements within a jurisdiction. For maternal and child health purposes, the study is aimed at determining:

- 1) What is essential in terms of the provision of health services;
- 2) What is available, and
- 3) What is missing.

Objectives - The yardsticks by which an agency can measure its efforts to accomplish a goal. (See also “Performance Objectives”)

Other Federal Funds (Forms 2 and 3) - Federal funds other than the Title V Block Grant that are under the control of the person responsible for administration of the Title V program. These may include, but are not limited to: WIC, EMSC, Healthy Start, SPRANS, AIDS monies, CISS funds, MCH targeted funds from CDC and MCH Education funds.

Others (as in Forms 4, 7, and 10) - Women of childbearing age, over age 21, and any others defined by the State and not otherwise included in any of the other listed classes of individuals.

Outcome Objectives - Objectives that describe the eventual result sought, the target date, the target population, and the desired level of achievement for the result. Outcome objectives are related to health outcome and are usually expressed in terms of morbidity and mortality.

Outcome Measure - The ultimate focus and desired result of any set of public health program activities and interventions is an improved health outcome. Morbidity and mortality statistics are

indicators of achievement of health outcome. Health outcomes results are usually longer term and tied to the ultimate program goal. Outcome measures should answer the question, “Why does the State do our program?”

Performance Indicator - The statistical or quantitative value that expresses the result of a performance objective.

Performance Measure - A narrative statement that describes a specific maternal and child health need, or requirement, that, when successfully addressed, will lead to, or will assist in leading to, a specific health outcome within a community or jurisdiction and generally within a specified time frame. (Example: “The rate of women in [State] who receive early prenatal care in 19__.” This performance measure will assist in leading to [the health outcome measure of] reducing the rate of infant mortality in the State).

Performance Measurement - The collection of data on, recording of, or tabulation of results or achievements, usually for comparing with a benchmark.

Performance Objectives - A statement of intention with which actual achievement and results can be measured and compared. Performance objective statements clearly describe what is to be achieved, when it is to be achieved, the extent of the achievement, and target populations.

Population Based Services - Preventive interventions and personal health services, developed and available for the entire MCH population of the State rather than for individuals in a one-on-one situation. Disease prevention, health promotion, and statewide outreach are major components. Common among these services are newborn screening, lead screening, immunization, Sudden Infant Death Syndrome counseling, oral health, injury prevention, nutrition and outreach/public education. These services are generally available whether the mother or child receives care in the private or public system, in a rural clinic or an HMO, and whether insured or not.

Pregnant Woman - A female from the time that she conceives to 60 days after birth, delivery, or expulsion of fetus.

Preventive Services - Activities aimed at reducing the incidence of health problems or disease prevalence in the community, or the personal risk factors for such diseases or conditions.

Primary Care - The provision of comprehensive personal health services that include health maintenance and preventive services, initial assessment of health problems, treatment of uncomplicated and diagnosed chronic health problems, and the overall management of an individual’s or family’s health care services.

Process - Process results are indicators of activities, methods, and interventions that support the achievement of outcomes (e.g., improved health status or reduction in risk factors). A focus on process results can lead to an understanding of how practices and procedures can be improved to reach successful outcomes. Process results are a mechanism for review and accountability, and as such, tend to be shorter term than results focused on health outcomes or risk factors. The utility of process results often depends on the strength of the relationship between the process and the outcome. Process results should answer the question, “Why should this process be undertaken and measured (i.e., what is its relationship to achievement of a health outcome or risk factor result)?”

Process Objectives - The objectives for activities and interventions that drive the achievement of higher-level objectives.

Program Income (as used in the Application Face Sheet [SF 424] and Forms 2 and 3) - Funds collected by State MCH agencies from sources generated by the State’s MCH program to include insurance payments, MEDICAID reimbursements, HMO payments, etc.

Risk Factor Objectives - Objectives that describe an improvement in risk factors (usually behavioral or physiological) that cause morbidity and mortality.

Risk Factors - Public health activities and programs that focus on reduction of scientifically established direct causes of, and contributors to, morbidity and mortality (i.e., risk factors) are essential steps toward achieving health outcomes. Changes in behavior or physiological conditions are the indicators of achievement of risk factor results. Results focused on risk factors tend to be intermediate term. Risk factor results should answer the question, “Why should the State address this risk factor (i.e., what health outcome will this result support)?”

State - As used in this guidance, includes the 50 States and the 9 jurisdictions of the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, the Republic of the Marshall Islands, the Federated States of Micronesia and the Republic of Belau.

State Funds (as used in Forms 2 and 3) - The State’s required matching funds (including overmatch) in any given year.

Systems Development - Activities involving the creation or enhancement of organizational infrastructures at the community level for the delivery of health services and other needed ancillary services to individuals in the community by improving the service capacity of health care service providers.

Technical Assistance (TA) - The process of providing recipients with expert assistance of specific health related or administrative services that include; systems review planning, policy options analysis, coordination coalition building/training, data system development, needs assessment, performance indicators, health care reform wrap around services, CSHCN program development/evaluation, public health managed care quality standards development, public and private interagency integration, and identification of core public health issues.

Title XIX, number of infants entitled to - The unduplicated count of infants who were eligible for the State’s Title XIX (MEDICAID) program at any time during the reporting period.

Title XIX, number of pregnant women entitled to - The number of pregnant women who delivered during the reporting period who were eligible for the State’s Title XIX (MEDICAID) program

Title V, number of deliveries to pregnant women served under - Unduplicated number of deliveries to pregnant women who were provided prenatal, delivery, or post-partum services through the Title V program during the reporting period.

Title V, number of infants enrolled under - The unduplicated count of infants provided a direct service by the State’s Title V program during the reporting period.

Total MCH Funding - All the MCH funds administered by a State MCH program which is made up of the sum of the *Federal* Title V Block Grant allocation, the *Applicant’s* funds (carryover from the previous year’s MCH Block Grant allocation - the unobligated balance), the *State* funds (the total matching funds for the Title V allocation - match and overmatch), *Local* funds (total of MCH dedicated funds from local jurisdictions within the State), *Other* Federal funds (monies other than the Title V Block Grant that are under the control of the person responsible for administration of the Title V program), and *Program Income* (those collected by State MCH agencies from insurance payments, MEDICAID, HMO’s, etc.).

Types of Services - The major kinds or levels of health care services covered under Title V activities. See individual definitions under “Infrastructure Building,” “Population Based Services,” “Enabling Services,” and “Direct Medical Services.”

5.2 Assurances and Certifications

ASSURANCES—NON-CONSTRUCTION PROGRAMS

Note: Certain of these assurances may not be applicable to your project or program. If you have any questions, please contact the Awarding Agency. Further, certain Federal assistance awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the assistance; and will establish a proper accounting system in accordance with generally accepted accounting standards or agency directives.
3. Will establish safeguards to prohibit employees from using their position for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. Sects. 4728-2763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standards for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to non-discrimination. These include but are not limited to (a) Title VI of the Civil Rights Act of 1964 (P.L. 88 Sect. 352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. Sects. 1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. Sect. 794), which prohibits discrimination on the basis of handicaps; (d) The Age Discrimination Act of 1975, as amended (42 U.S.C. Sects 6101 6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office of Treatment Act of 1972 (P.L. 92-255), as amended, relating to non-discrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to non-discrimination on the basis of alcohol abuse or alcoholism; (g) Sects. 523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. Sect. 3601 et seq.), as amended, relating to non-discrimination in the sale, rental, or financing of housing; (i) any other non-discrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other non-discrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Titles II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all

interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply with the provisions of the Hatch Act (5 U.S.C. Sects 1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. Sects. 276a to 276a-7), the Copeland Act (40 U.S.C. Sect 276c and 18 U.S.C. Sect. 874), the Contract Work Hours and Safety Standards Act (40 U.S.C. Sects. 327-333), regarding labor standards for federally assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetlands pursuant to EO 11990; (d) evaluation of flood hazards in flood plains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. Sects. 1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. 7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. Sects 1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers systems

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. Sect. 470), EO 11593 (identification and preservation of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. Sects. 469a-1 et seq.)

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. Sect. 2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by the award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. Sects. 4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

18. Will comply will all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

CERTIFICATIONS

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

By signing and submitting this proposal, the applicant, defined as the primary participant in accordance with 45 CFR Part 76, certifies to the best of its knowledge and belief that it and its principals:

- (a) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
- (b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission or fraud or criminal judgment in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
- (c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission or any of the offenses enumerated in paragraph (b) of the certification; and
- (d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause, titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion—Lower Tier Covered Transactions" in all lower tier covered transactions (i.e. transactions with sub-grantees and/or contractors) in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for applicant organization) certifies that the applicant will, or will continue to, provide a drug-free workplace in accordance with 45 CFR Part 76 by:

- (a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;
- (b) Establishing an ongoing drug-free awareness program to inform employees about-
 - (1) The dangers of drug abuse in the workplace;
 - (2) The grantee's policy of maintaining a drug-free workplace,
 - (3) Any available drug counseling, rehabilitation, and employee assistance programs; and
 - (4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
- (c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
- (d) Notifying the employee in the statement required by paragraph (a) above, that, as a condition of employment under the grant, the employee will-
 - (1) Abide by the terms of the statement; and

- (2) Notify the employer in writing of his or her conviction for violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
- (e) Notify the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
- (f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d)(2), with respect to any employee who is so convicted-
 - (1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended, or
 - (2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
- (g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Division of Grants Policy and Oversight
Office of Management and Acquisition
Department of Health and Human Services
Room 517-D
200 Independence Avenue, S.W.
Washington, D.C. 20201

3. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled “Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,” generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. The requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief that:

- (1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement,

and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18 if the services are funded by Federal programs either directly or through State or local governments by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable Federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing this certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards, which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Service strongly encourages all grant recipients to provide a smoke free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of American people.

5.3 Other Supporting Documents

See the appendix section for the following documents referenced in the narrative of this Block Grant.

- Tennessee Map with Public Health Regions
- Organizational Charts
- Minimum MCH Standard of Care
- Resume of Director
- EPSDT Consent Decree
- Maps of Physician Shortage Areas
- Needs Assessment - MCH Data
- Summary of Other Needs Assessments
- Summary of County Health Council Meetings
- Summary of Families First Program Results (TANF)
- Map of Genetics and Metabolic Screening Centers
- TnKids Annual Report
- Abstinence Education Project Summary
- EPSDT Consent Decree - Semi-Annual Reports to the Court

5.4 Core Health Status Indicator Forms

5.5 Core Health Status Indicator Detail Sheets

5.6 Developmental Health Status Indicator Forms

5.7 Developmental Health Status Indicator Detail Sheets

5.8 All Other Forms

5.9 National "Core" Performance Measure Detail Sheets

5.10 State "Negotiated" Performance Measure Detail Sheets

5.11 Outcome Measure Detail Sheets