

★ The State of
Child Health
in Tennessee ★



Access to Health Care

Access to health care is an integral part of the well-being of children and youth. Children with access to health care have reasonable assurance of obtaining the medical attention needed to maintain their physical well-being and oral health (America's Children, 2003). Child well-being is enhanced when adequate supplies of health-care professionals are available, and health coverage is provided outside government programs.

America's Health: State Health Rankings (United Health Foundation, 2004) considers 17 factors for its rankings. These include risk factors that indicate behaviors and activities related to healthiness, like poverty, and outcomes that measure morbidity and mortality. Lower values for rankings indicate the healthier states; larger ranking values reflect less healthy states.

Tennessee's overall health ranking has declined over the past three years, from 40th in 2001 to 48th in 2004; in 1990, the state's ranking was 33rd. Strengths for the state in 2004 included moderate access to prenatal care and a low rate of uninsured population, although the rate of uninsured increased from 10.8 percent in 2003 to 13.2 percent in 2004.

Problem areas are the high infant mortality rate, 9.2 deaths per 1,000 live births, and a low high school graduation rate, with only 56.7 percent of incoming ninth graders graduating within four years. Other factors contributing to the downward trend are the high prevalence of smoking, obesity and violent crime; high rate of deaths from cardiovascular disease; high rate of cancer deaths; high total mortality rate; and premature death rate. Tennessee ranks in the bottom 10 states on these seven contributing factors (United Health Foundation, 2004).

In addition, as Tennessee's population continues to grow the availability of medical doctors does not appear to be keeping pace. As of July 2004, the physician supply in Tennessee was 224.4 per 100,000, compared to 218.6 in 1997. During the same time period, Tennessee's population increased by 7.2 percent, but physician supply per 100,000 increased by only 2.7 percent.

- ★ Only 20 Tennessee counties (21.1 percent) have physician supply levels in excess of the 1965 national rate of 139 physicians per 100,000.
- ★ Lower physician supply rates are more prevalent in rural areas of the state.

Higher levels of physician supply are important because they signal better access to health care (Guagliardo et al, 2003). Adequate physician supply also factors into quality of care. Patients can be seen in a timely manner, and time lags to visit specialists will be minimal. Unfortunately, the type of insurance coverage an individual has plays a role in the adequacy of physician supply.

The Kaiser Family Foundation 2002-03 data show Tennessee tied with New York and South Carolina at 10th of the 50 states when ranked on the distribution of children ages 18 and under covered by Medicaid (2004), TennCare in Tennessee. Five of 17 Southern states topped Tennessee in this ranking.

- ★ Forty-five percent of Tennessee residents under the age of 21 years were covered by TennCare in 2003.
- ★ The number of TennCare enrollees in all age groups younger than 18 years, except children up to age 1, declined from 2002 to 2003.
- ★ Enrollees ages 2-5 years declined by 2 percent; ages 6-12 dropped by more than 5 percent; and ages 13-18 decreased

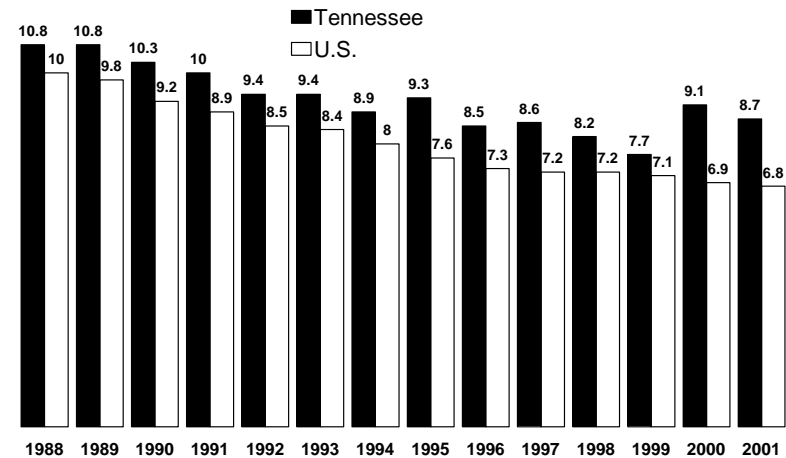
by nearly 3 percent.

- ★ The decline in enrollment for each of these categories occurred due to a change in eligibility beginning July 1, 2002, when new enrollment for children was restricted to Medicaid-only categories.
- ★ Prior to July 2002 all children under 200 percent of poverty were eligible for TennCare. After July 2002, children under 200 percent of poverty with parents who had access to insurance were no longer eligible.


Proposed changes to the TennCare program, including the plan to institute premiums and co-pays for adults on Medicaid, signals a new way of health care service delivery for low-income people in Tennessee. For children the biggest change in TennCare services is the state's new definition of "medical necessity." Medical necessity will be defined as the least costly alternative[s] for which there is adequate "clinical scientific evidence" of its safety and effectiveness, adequate to address the medical condition. The determination of what is "medically necessary" will no longer be in the hands of the child's doctor, but in the hands of the TennCare Bureau or contracted HMO. The new definition is more restrictive than any other state Medicaid program, Federal Employee Health Benefits contractor or private insurance plan (Kaiser Commission on Medicaid and the

Infant Mortality Rates (Per 1,000 Live Births)

14-Year Comparison Between Tennessee and U.S.



Source: The Annie E. Casey Foundation, National KIDS COUNT Data Book.

Uninsured, 2004). According to the Children's Defense Fund, all children in TennCare are being put at risk of losing essential health care. Additionally, some children who remain on TennCare will be impacted by their parents' loss of coverage and the adverse impact on parental health. See Appendix (page 85) for related state map. 

Infant Mortality

Infant mortality is an important indicator of health (MacDorman et al., 1994) because it is associated with a variety of health factors like maternal health, socioeconomic conditions, access to medical care, quality of medical care and public health practices (America's Children, 2003).

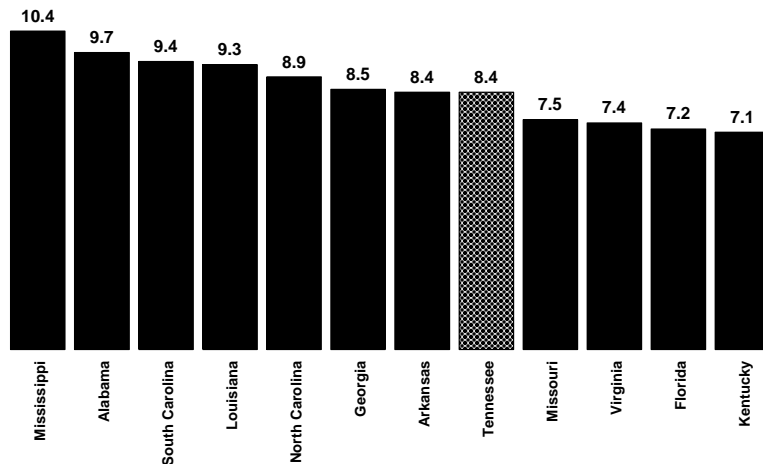
Infant mortality defines short-term outcomes of live births and serves as a predictor, giving a crude estimate of how a community or nation will thrive. Too many deaths before the age of 1 yield a poor

prognosis. Babies never have the chance to grow up, to dream dreams, or contribute to the community or nation.

The *Healthy People 2000* and *Healthy People 2010* publications incorporate several varieties of objectives related to infant mortality. For *Healthy People 2010*, the primary objective is to reduce infant deaths to 4.5 per 1,000 live births. The baseline year is 1998 with the national baseline at 7.2; Tennessee's baseline rate was 8.2, worse than the national rate.

Infant Mortality Rates per 1,000 Live Births in the Southern States

Four-Year Average 1998-2001



Source: Annie E. Casey Foundation, National KIDS COUNT Data Book

- ★ Tennessee's infant mortality rates continue to be worse than national rates.
- ★ Using a four-year average, 1998-2001, out of 12 Southern states, Tennessee ranked 5thth (NCHS, 2004).
- ★ In 2001, the state ranked 44th of 50 states in infant mortality (Annie E. Casey Foundation, 2004).
- ★ More than one third of Tennessee counties reflected infant mortality rates above the state average of 9.4 for 2002. Two of the five major counties, Shelby and Davidson, reflected above average rates.
- ★ The state's 2002 rate shows a reversion to the 1992 and 1993 levels.
- ★ In 2002, infant mortality for African-American babies (18.4 deaths per 1,000 live births) in Tennessee was two and a half times the rate for White babies (7.1 per 1,000 live births). 🌐

Births of Low Weight

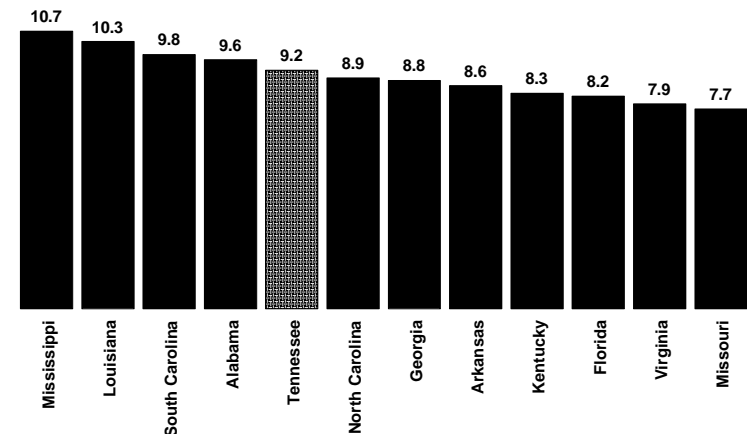
One of the preventable risk factors long associated with infant mortality is low birthweight. (Healthy People 2010, 2004). By definition, babies weighing less than 2,500 grams (5.5 pounds) at birth are designated as low weight, a definition established in 1919 by Finnish pediatrician Arvo Ylppo (Kiely et al., 1994).

Low birthweight affects almost one in every 13 babies born each year in the United States, and it is a significant factor in nearly two-thirds of all infant deaths. Babies of low birthweight are more likely than normal weight babies to have health problems during the newborn period. Many of them are cared for in intensive care nurseries during this period of their lives (March of Dimes, 2004).

Babies of low weight can be categorized as low weight (between

Percent Low Birthweight Babies in the Southern States

4-Year Average 1999-2002



Source: Annie E. Casey Foundation, National KIDS COUNT Data Book.

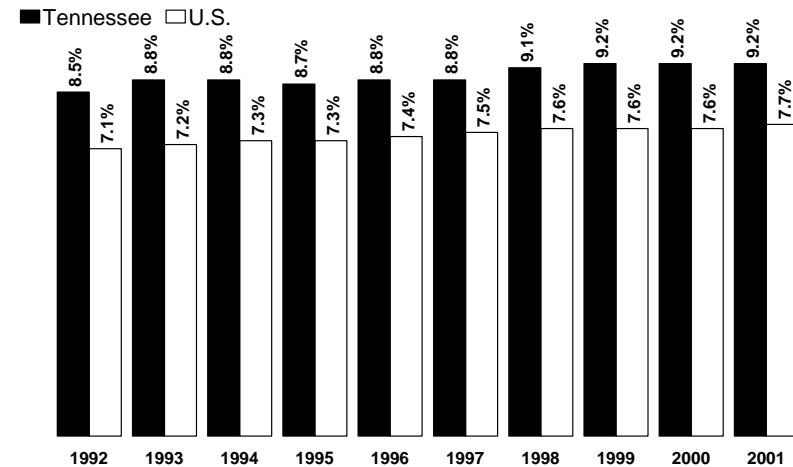
1,500 and 2,499 grams), very low weight (between 1,000 and 1,499 grams) and extremely low weight (less than 1,000 grams). Birth weight is inversely related to prolonged and more expensive hospital stays, as well as higher mortality, especially neonatal mortality (death within the first 28 days of life). This means smaller babies have longer, more costly hospital stays, and they are at greater risk of dying within the first month of life (Edwards, Conner & Soll, 2004; March of Dimes, 2004).

- ★ In 2001, Tennessee ranked 45th of 50 states in births of low weight (Annie E. Casey Foundation, 2004).
- ★ Tennessee's percent of low birthweight babies remained steady from 1999 to 2002 at 9.2 percent (Tennessee Department of Health, 2004).
- ★ The state average consistently exceeds the national average; from 1999 to 2002, the state average was 9.2 percent compared to 7.6 percent and 7.8 percent for the nation (National Center for Health Statistics, 2004).
- ★ Using four years of data (1999-2002), Tennessee ranked eighth worst when compared with 12 southern states (National Center for Health Statistics, 2004).
- ★ In 2002, nearly two thirds (62) of Tennessee counties had low birthweight percentages above the national rate of 7.8.

Percent Low-Birthweight Babies

Less Than 2,500 Grams (5.5 Pounds)

10-Year Comparison Between Tennessee and U.S.



Source: The Annie E. Casey Foundation, National KIDS COUNT Data Book.

- ★ In 2003, Tennessee's percent of low weight births showed a slight increase, 9.4 percent compared to the 9.2 percent rate the state had maintained over the last six years. Forty Tennessee counties (42.1 percent) reflect rates above the state average in 2003. All major counties exceeded the state average, except Knox with 9.3 percent.

Child Immunizations

To most people immunization is as American as apple pie. One of the greatest public health achievements in modern times, immunization has saved millions of lives. Today, the United States has the highest coverage rates of childhood vaccines and the lowest incidence of vaccine-preventable disease in its history. In fact, vaccines have been so successful that many people today have little firsthand knowledge of the diseases they prevent and their devastating effects. As a result, the public tends to take for granted

the enormous protective benefits of vaccines (Grant Makers Health, 2000).

Children are born with immunity to contagious diseases, but that natural protection is only temporary. As a result, immunizations are required to protect children from diseases that can interfere with their development and longevity (KidsHealth, 2002). Immunizations also protect the community by decreasing the spread of infectious diseases

(Adetunji et al., 2003). Recommendations call for children to receive immunizations against 11 diseases. Many are administered as combined vaccines during routine well-child check-ups in the first two years of life (Adetunji et al., 2003). The Advisory Committee on Immunization Practices (ACIP), the American Academy of Family Physicians (AAFP) and the American Academy of Pediatrics (AAP) recommend that all health-care providers adopt the Standards for Child and Adolescent Immunization Practices and that they promote the 90 percent vaccination rate of 2-year-olds, the goal of Healthy People 2010 (U.S. Department of Health and Human Services, 2000).

Tennessee's child immunization results are based on a survey of 24-month-old children across each health region. Tennessee's most recent sample includes 1,626 children born in April 2001. Prior to 2002, results focused on the extent to which 2-year-olds were receiving minimal coverage, or four doses of DTaP (Diphtheria, Tetanus, and Pertussis), three doses of



Recommended Childhood and Adolescent Immunization Schedule UNITED STATES • 2005

Vaccine ▼	Age ►	Birth	1 month	2 months	4 months	6 months	12 months	15 months	18 months	24 months	4-6 years	11-12 years	13-18 years
Hepatitis B		HepB #1					HepB #3			HepB Series			
			HepB #2										
Diphtheria, Tetanus, Pertussis				DTaP	DTaP	DTaP		DTaP			DTaP	Td	Td
<i>Haemophilus influenzae</i> type b				Hib	Hib	Hib	Hib						
Inactivated Poliovirus				IPV	IPV	IPV				IPV			
Measles, Mumps, Rubella							MMR #1			MMR#2	MMR #2		
Varicella							Varicella			Varicella			
Pneumococcal Conjugate				PCV	PCV	PCV	PCV			PCV	PPV		
Influenza							Influenza (Yearly)			Influenza (Yearly)			
----- Vaccines below this line are for selected populations -----													
Hepatitis A											Hepatitis A Series		

This schedule indicates the recommended ages for routine administration of currently licensed childhood vaccines, as of December 1, 2004, for children through age 18 years. Any dose not given at the recommended age should be given at any subsequent visit when indicated and feasible.

■ Indicates age groups that warrant special effort to administer those vaccines not previously given. Additional vaccines may be licensed and recommended during the year. Licensed combination vaccines may be used whenever any components of the combination are indicated and the vaccine's other components are not contraindicated. Providers should consult the manufacturers' package inserts for detailed recommendations. Clinically significant adverse events that follow immunization should be reported to the Vaccine Adverse Event Reporting System (VAERS). Guidance about how to obtain and complete a VAERS form can be found on the Internet: www.vaers.org or by calling 800-822-7967.

- Range of recommended ages
- Preadolescent assessment
- ▨ Only if mother HBsAg(-)
- Catch-up immunization


 DEPARTMENT OF HEALTH AND HUMAN SERVICES
 CENTERS FOR DISEASE CONTROL AND PREVENTION

 The Childhood and Adolescent Immunization Schedule is approved by:
 Advisory Committee on Immunization Practices www.cdc.gov/nip/acip
 American Academy of Pediatrics www.aap.org
 American Academy of Family Physicians www.aafp.org

More information regarding vaccine administration can be obtained from the websites above or by calling
800-CDC-INFO
 ENGLISH & ESPAÑOL
[800-232-4636]
 Keep track of your child's immunizations with the
CDC Childhood Immunization Scheduler
www.cdc.gov/nip/kidstuff/scheduler.htm

IPV (Polio), and one dose of MMR (Measles, Mumps and Rubella) describing the 4:3:1. This year's report incorporates the maximum standard that adds three doses of Hib (Influenzae), three doses of HBV (Hepatitis B), and one dose of Varicella (Chicken Pox). Therefore, the new standard is a 4:3:1:3:3:1 coverage level.

- ★ Tennessee is not close to achieving the 90 percent complete immunization coverage goal for the newer, more stringent standard. Statewide, the achieved goal was 75.1 percent and 78 percent for 2002 and 2003. The trend from 2002 to 2003 was positive, but still some distance from the goal.
- ★ The Mid-Cumberland health region came closest to meeting

- the 90 percent complete coverage goal with a rate of 89 percent, followed by Hamilton County with 87 percent.
- ★ West Tennessee and Shelby County health regions bring up the rear in goal completion with 69.3 percent and 62.4 percent, respectively. 🌐

Nurse Home Visiting Programs

Home visiting is a long-standing, well-known prevention strategy used by states and communities to improve the health and well-being of women, children and families, particularly those who are at risk. Early investments in home visiting programs have been shown to reduce costs due to foster care placements, hospitalizations and emergency room visits, unintended pregnancies and other more costly interventions (National Governors Association, 2002). Although home visiting programs for babies have long been accepted as effective in preventing child abuse and identifying physical and developmental needs, there are still many locations in Tennessee that do not offer these services.



The following Tennessee programs offer services to newborn babies and their families.

Healthy Start

Healthy Start is designed to help promote healthy beginnings for children through education, support and adequate health care. Without adequate health care, a child may be at risk of preventable, lifelong health and learning problems.

Healthy Start is an intensive home visiting program that seeks to prevent child abuse and neglect and promote family health. Families who participate must be assessed at elevated risk for child abuse or neglect to be eligible for the program. Services are provided by contract agencies funded by federal grants through the Tennessee departments of Health (DOH) and Children's Services (DCS). Tennessee Healthy Start Programs follows the national Healthy Families America program model, with families able to reach program staff 24 hours a day, seven days a week. The voluntary program targets first-time parents, beginning prenatally, continuing through the child's fifth year, and tapering off as a family's needs diminish.

During fiscal year 2004 the DOH Healthy Start Programs served 1,752 children from 1,416 families, and:

- ★ 45 percent of the mothers were less than 18 years of age;
- ★ 88 percent of mothers were unmarried;
- ★ 96 percent of the participants had an annual income less than \$10,000 per year; and
- ★ 98.5 percent of the children participating in Healthy Start programs remained at home free from abuse, neglect, and/or harm.

While Tennessee’s overall immunization rate was 81 percent during fiscal year 2004, Healthy Start participants were at 95 percent, and the percent of Healthy Start children up to date on immunizations by their second birthday was 96.3 percent.

Despite positive outcomes for children who participate in Healthy Start Programs, only 27 counties in Tennessee have these programs. The remaining 68 counties are going without this service due to limited funding, a barrier to implementing additional programs across the state.

27 Program Counties:

East: Blount, Jefferson and Loudon;

Metro: Davidson, Knox, Madison and Shelby;

Mid-Cumberland: Montgomery and Stewart;

South Central: Bedford, Coffee, Lincoln, Marshall and Moore;

Upper Cumberland: Jackson, Overton, Putnam and White;

West: Benton, Carroll, Chester, Crockett, Gibson, Henry, Lake, Obion and Weakley;

Major components of the Healthy Start Program include:

Family Needs Assessment including the following functions:

- ★ Screening of hospital records;
- ★ Assessment interview;
- ★ Referrals/follow-up.

Families are offered the following Home Visiting services:

- ★ Intensive home-based family support and education;

- ★ Creative outreach;
- ★ 24-hour availability;
- ★ Parent support/lay counseling under professional supervision;
- ★ Parent-child interaction curriculum and interventions;
- ★ Linkage with a medical home;
- ★ Referrals and advocacy;
- ★ Parent groups;
- ★ Participant levels varied with intensity of service, based on need;
- ★ Long-term follow-up to age 5;
- ★ Child development screening;
- ★ Child health tracking (well-care, immunizations).

CHAD (Child Health and Development) Program

The CHAD home visiting program is intended to prevent child abuse and neglect and promote family health. Services are provided to 22 Tennessee counties by local Department of Health personnel.

Services provided are:

- ★ Assessments;
- ★ Screenings;
- ★ Child development education;
- ★ Parenting education;
- ★ Parenting and health support.

Families receiving CHAD services must either meet a financial requirement or have had involvement with the Child Protective Services system. Families may receive services until the child turns 6 years of age, with prenatal services provided only for pregnant girls who are less than 18 years of age. In fiscal year 2004 CHAD served 1,427 children from 1,024 families in 22 Program Counties.

Northeast: Carter, Greene, Hancock, Hawkins, Johnson, Unicoi and Washington;

East: Anderson, Blount, Campbell, Claiborne, Cocke, Grainger,

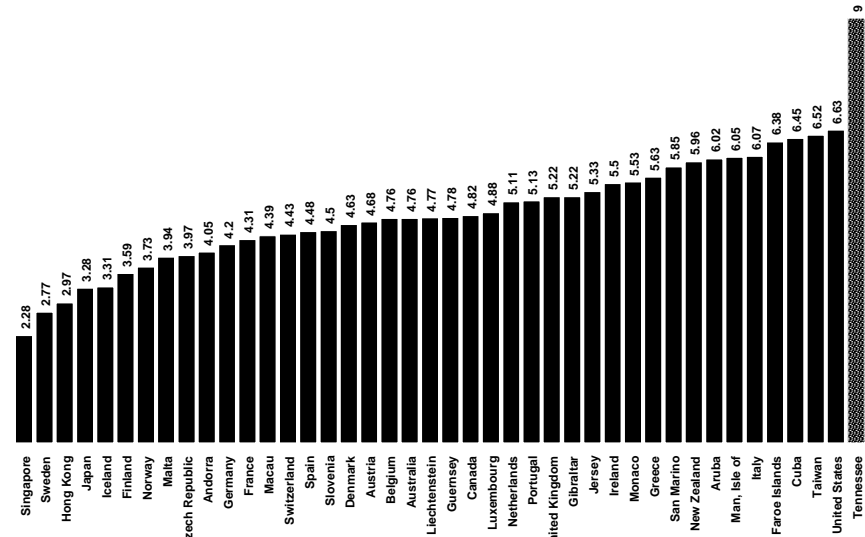
Comparison of National Infant Mortality Rates: 2004

Deaths Per 1,000 Live Births

Help Us Grow Successfully (HUGS) Program

The Help Us Grow Successfully (HUGS) Program offers home visiting and care coordination services in 74 Tennessee counties for pregnant women, postpartum women up to two years, and women who have lost a child under the age of two years and children birth through the age of five. Vital to the program are the prevention and/or intervention services offered in the home setting as it provides an opportunity to gain greater understanding of the client’s needs, constraints and supports available in the home. These services assist participants in gaining access to health care, psychosocial, educational and other necessary services to promote good health practices, improve general well-being, prevent developmental delays and reduce maternal and/or infant morbidity and mortality.

There were 36,541 visits to children during FY 2003-2004.



Source: National Center for Health Statistics. Tennessee 2002 data, Tennessee Department of Health

Nurses for Newborns Foundation

Nurses for Newborns Foundation (NFNF) is a private, not for profit organization founded in 1991 with a mission to provide a safety net for families most at risk. NFNF programs are designed to help prevent infant mortality and child abuse and neglect through home-based services that provide education, health care and positive parenting skills. The foundation offers programs that serve teen moms, moms who are mentally or physically challenged, infants who are sick and general population families who are in need. In addition to the medical component of its programs they assist families in getting connected with additional medical, social or public services they need.

In August of 2001, Nurses for Newborns began serving families in Tennessee. The program currently serves Davidson, Rutherford,

Counties currently without HUGS services:		
Mid-Cumberland Region	West TN. Region	Southeast Region
Cheatham County	Benton County	Bledsoe County
Houston County	Chester County	Franklin County
Humphreys County	Haywood County	Grundy County
Robertson County	Henry County	Marion County
Stewart County	Obion County	Meigs County
Trousdale County	Tipton County	Polk County
	Weakly County	Rhea County
		Sequatchie County

Williamson, Maury, Dickson, Hickman, Cheatham, the southern two-thirds of Sumner, Robertson, the western half of Wilson, Montgomery and Stewart counties, as well as Fort Campbell. NFNF provides home visits utilizing experienced registered nurses who do physical assessment and case management for families at risk. The programs include babies who are medically fragile, teen mothers and mothers with physical or mental disabilities. Each program collaborates with local agencies to prevent child abuse and neglect.



“fragile” include prematurity, low birthweight, Down’s syndrome, drug or alcohol exposure, cardio-respiratory abnormalities, seizure disorders, physical handicaps and more. The program begins after the infant leaves the hospital, with most infants having spent time in a neonatal intensive care unit.

- ★ The Safe Beginnings (SBG) program is open to any mother who has mental, emotional or physical challenges and can start prenatally.

- ★ The Bridge to the Future (BTF) program serves families with “medically fragile” infants, irregardless of their socioeconomic status. Some characteristics of “medically

- ★ The Teen Parent (TPT) program serves teens who will be under age 19 at the time they give birth. Services can begin during pregnancy or at birth.

Oral Health

Oral health is often overlooked. Many Americans do not have dental insurance (American Dental Education Association, 2004), despite the fact that dental disease is the “silent epidemic.” Regular visits to dental professionals reduce the likelihood of life-threatening conditions such as diabetes and low birthweight that are linked to poor oral health (Delta Dental, 2004).

- ★ The number of dentists in Tennessee increased from 1997 to 2004, but the 2004 rate per 100,000, 48.5, is well below the 2020 national goal of 52.7 (ADEA, 2004).
- ★ The federal government estimates 30-plus million Americans live in areas of “dental shortage” – where there is less than one full-time dentist for a population of four to five thousand (ADEA, 2004).

- ★ Three rural Tennessee counties had no licensed, practicing dentists as of July 2004: Grundy, Pickett and Van Buren.

The Tennessee Department of Health provides a public dental care delivery program to deliver clinical dental services to segments of the population that would not otherwise receive care. Dental facilities housed within local health departments are located in 48 of 89 rural counties and 5 of 6 metropolitan regions. Dental services are provided on a part-time or full-time basis depending on the location. Specific information on availability of services or eligibility guidelines can be obtained from the local county health department. Three mobile dental clinics located in the Mid-Cumberland, Northeast and West Tennessee Regions began operation in 2004 to provide dental services to high risk children in underserved areas.

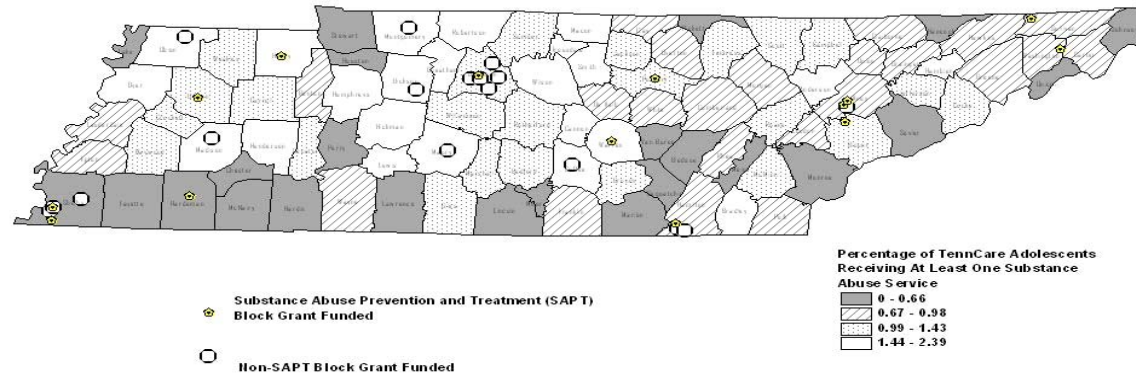
Adolescent Alcohol and Drug Use

TennCare Adolescents With Access to Substance Abuse Treatment*

Adolescent alcohol and drug treatment continues to be an area of unmet need based on the percentage of children estimated to need treatment and the lack of access to recovery services.

Tennessee administered the Youth Risk Behavior Survey (YRBS), completed by 1,940 students in 44 public high schools during the spring of 2003. The school response rate was 83 percent; student response rate was 81 percent; and the overall response rate was 67 percent with results representative of all students in grades 9-12.

Students complete a self-administered, anonymous, 87-item questionnaire designed to protect the privacy of students by allowing anonymous and voluntary participation. Local parental permission procedures are followed before survey administration. The YRBS is one component of the Youth Risk Behavior Surveillance System developed by the Centers for Disease Control and Prevention in



*Percentage of TennCare Adolescents with Substance Abuse Access - Year 2000; Adolescent Treatment Facility Data - November 22, 2004

Adolescents with Access to Substance Abuse Treatment" map shows the distribution of adolescent substance abuse treatment facilities, both public and privately funded. Sixty-two counties in Tennessee have no services for adolescents who might need services, although some of the service providers may be based out of one county and serve several surrounding counties. All of the counties having no alcohol and drug services are located in rural areas.

The overlay of hatch markings is broken into quartiles that indicate how many adolescents on TennCare received at least one substance abuse service.

collaboration with representatives from 71 state and local departments of education and health, 19 federal agencies, and national education and health organizations across the states.

The Youth Risk Behavior Surveillance System was designed to focus the nation on behaviors among youth related to the leading causes of mortality and morbidity among both youth and adults, and to assess how these risk behaviors change over time. The Youth Risk Behavior Surveillance System measures behaviors that fall into six categories:

1. Behaviors that result in unintentional injuries and violence;
2. Tobacco use;
3. Alcohol and other drug use;
4. Sexual behaviors that result in HIV infection, other sexually transmitted diseases and unintended pregnancies;
5. Dietary behaviors; and
6. Physical activity.

YRBS results in Tennessee in 2003:

- ★ 11.2 percent reported driving a car while under the influence of alcohol within the past 30 days;
- ★ 74 percent reported taking at least one drink of alcohol on one or more days of their life;
- ★ 26.2 percent reported taking their first drink of alcohol other than a few sips before age 13.

Additional information about the Youth Risk Behavior Surveillance System can be obtained from <http://www.cdc.gov/yrbss>.

According to a customized report from the George Washington University Medical Center specific to Tennessee:

- ★ 65,013 Tennessee youth have a serious alcohol problem;
- ★ 84.5 percent do not get treatment;
- ★ 54,802 youth out of 65,013 need alcohol treatment and do not get it.

Of the 65,013 young people in Tennessee with serious alcohol problems they are:

- ★ 8.5 times more likely to have serious problems with other drugs;
- ★ 7 times more likely to drink and drive;
- ★ 3.5 times more likely to be arrested;


- ★ 2 times more likely to smoke;
- ★ 1.5 times more likely to have a C+ average or lower and are likely to miss twice as much school;
- ★ 1.5 times more likely to require hospital emergency room care.

Nationally between 2002 and 2003 there was no significant change in the overall drug and alcohol use patterns. However, there were an estimated 2.6 million new marijuana users in 2002, an average of 7,000 Americans per day trying marijuana for the first time. About two thirds, 69 percent, of the new users were under age 18. The percent of youth aged 12-17 indicating that smoking marijuana once a month was a great risk increased from 32.4 percent in 2002, to 34.9 percent in 2003. There were no significant changes in the percentages of youth reporting risks associated with using cigarettes, alcohol, cocaine, heroin, and LSD. However, about 10.9 million persons aged 12 to 20 reported drinking alcohol in the month prior to the survey. (DHHS, 2003)

In 2002, of teens aged 12-17 in Tennessee:

- ★ Nearly 10 percent (9.78 percent) reported using an illicit drug within the month prior to the National Survey of Drug Use and Health (NSDUH);
- ★ 6.8 percent reported using marijuana in the month prior to the survey;
- ★ 33 percent reported that they were at great risk of using marijuana at least once per month;
- ★ 5.6 percent reported using illicit substances other than marijuana in the month prior to the survey;
- ★ 2.3 percent reported using cocaine within the past year;
- ★ 14 percent reported alcohol use in the month prior to the survey;
- ★ 39 percent reported perceptions that they were at great risk of having five or more drinks of alcohol once or twice a week;
- ★ 9 percent of reported past year dependence or abuse of illicit

- ★ drugs and or alcohol;
★ Nearly 5 percent reported needing but not receiving treatment

for illicit drug use in the past year, and 5.1 percent reporting they needed but did not receive treatment for alcohol use. 

Obesity

According to a recent study conducted by the Trust for America's Health (TFAH), Tennessee ranked ninth highest in adult obesity in the nation at 25 percent, second highest in overweight high school students at 15.2 percent, and 31st in overweight low-income children ages 2-5 at 11.3 percent. The state spent an estimated \$315 per person in 2003 on medical costs related to obesity, the sixth highest amount in the United States.

Nearly 119 million American adults, 65 percent of the population, are currently overweight or obese. Direct and indirect costs of obesity in America are more than \$117 billion per year. Since states and the federal government have a crucial role to play in fighting the obesity epidemic, TFAH conducted a study of government action and concluded that America does not have the aggressive, coordinated national and state strategies needed to address the crisis, which threatens to make the epidemic worse. 