HRSA
Health Resources & Services Administration

Title V MCH Block Grant Program

TENNESSEE

State Snapshot

FY2025 Application / FY2023 Annual Report

November 2024

Title V Federal-State Partnership - Tennessee

The Title V Maternal and Child Health Block Grant Program is a federal-state partnership with 59 states and jurisdictions to improve maternal and child health throughout the nation. This Title V Snapshot presents high-level data and the executive summary contained in the FY2025 Application / FY2023 Annual Report. For more information on MCH data, please visit the Title V Federal-State Partnership website (https://mchb.tvisdata.hrsa.gov)

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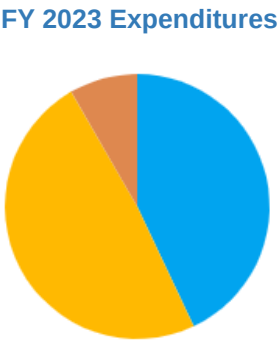
Funding by Source

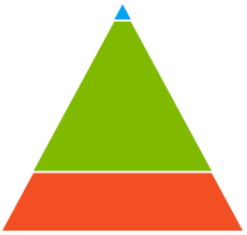
Source	FY 2023 Expenditures
Federal Allocation	$10,269,676
State MCH Funds	$11,646,690
Local MCH Funds	$0
Other Funds	$0
Program Income	$1,985,828



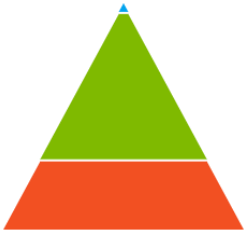
Funding by Service Level

Service Level	Federal	Non-Federal
Direct Services	$697,557	$444,149
Enabling Services	$6,907,831	$7,624,724
Public Health Services and Systems	$2,664,288	$3,577,817

FY 2023 Expenditures Federal



FY 2023 Expenditures Non-Federal



Percentage Served by Title V

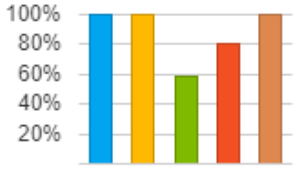
Population Served	Percentage Served	FY 2023 Expenditures
Pregnant Women	100.0%	$329,847
Infants < 1 Year	99.8%	$1,562,326
Children 1 through 21 Years	59.1%	$7,808,655
CSHCN (Subset of all infants and children)	80.9%	$4,668,101
Others *	99.9%	$6,698,993

*Others– Women and men, over age 21.

FY 2023 Expenditures

Total: $21,067,922

FY 2023 Percentage Served



The Title V legislation directs States to conduct a comprehensive, statewide maternal and child Health (MCH) needs assessment every five years. Based on the findings of the needs assessment, states select seven to ten priority needs for programmatic focus over the five-year reporting cycle. The State Priorities and Associated Measures Table below lists the national and state measures the state chose in addressing its identified priorities for the 2020 Needs Assessment reporting cycle. Beginning with the FY 2025 Application, all states are also reporting on two Universal National Performance Measures, Postpartum Visit and Medical Home.

State Priorities and Associated Measures

Priority Needs and Associated Measures	Reporting Domain(s)
Increase family planning SPMs • SPM 1: Percent of new mothers whose pregnancy was intended	Women/Maternal Health

Decrease pregnancy-associated mortality
 	
NPMs
• Percent of women, ages 18 through 44, with a preventive medical visit in the past year (Well-Woman Visit, Formerly NPM 1) - WWV
  ○ ESM WWV.1: Create pre/posttests to assesses provider knowledge of and confidence using PATH (Parenthood/Pregnancy Attitude, Timing, and How important is pregnancy prevention).
  ○ ESM WWV.2: Percent of family planning encounters that occur via telehealth
  ○ ESM WWV.3: Number of women receiving patient navigation for women's health services
  ○ ESM WWV.4: Percent of births covered by hospitals implementing data-driven, clinical recommendations
  ○ ESM WWV.5: Percent of birthing hospital providers trained reporting a change in knowledge
  ○ ESM WWV.6: Percent of non-clinical members participating in the action group
  ○ ESM WWV.7: Percent of postpartum women with positive screenings for depression (using a validated screening tool) who will receive resources/education or referrals for professional services
  ○ ESM WWV.8: Percent of recommendations with who/what/when components
 	
SPMs
• SPM 2: Percent of facilities implementing patient safety recommendations
• SPM 23: Number community level recommendations implemented
 	
SOMs
• SOM 2: Rate of pregnancy-related mortality to live births
• SOM 1: Rate of pregnancy-associated mortality to live birth
	Women/Maternal Health

Priority Needs and Associated Measures	Reporting Domain(s)
Increase breastfeeding SPMs • SPM 4: Percent of Tennessee newborns who initiated breastfeeding	Perinatal/Infant Health

Decrease infant mortality
 	
NPMs
• Percent of very low birth weight (VLBW) infants born in a hospital with a Level III + Neonatal Intensive Care Unit (NICU) (Risk-Appropriate Perinatal Care, Formerly NPM 3) - RAC
  ○ ESM RAC.1: Percent of Tennessee birthing hospitals participating in perinatal quality collaborative projects
• A) Percent of infants placed to sleep on their backs (Safe Sleep, Formerly NPM 5A) B) Percent of infants placed to sleep on a separate approved sleep surface (Safe Sleep, Formerly NPM 5B) C) Percent of infants placed to sleep without soft objects or loose bedding (Safe Sleep, Formerly NPM 5C) D) Percent of infants room-sharing with an adult during sleep (Safe Sleep) - SS
  ○ ESM SS.1: Percent of hospitals receiving national recognition or implementing approved safe sleep policy
  ○ ESM SS.2: Number of diaper bags with safe sleep educational materials distributed
 	
SPMs
• SPM 5: Percent of safe sleep diaper bag recipients who reported making a behavioral change in their infant sleep practices because of the items included in the bag
	Perinatal/Infant Health

Decrease overweight and obesity among children
 	
NPMs
• Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day (Physical Activity, Formerly NPM 8.1) - PA-Child
  ○ ESM PA-Child.1: Percent of physical education teachers receiving professional development related to 50% of PE class time spent in moderate to vigorous physical activity
  ○ ESM PA-Child.2: Percentage of TN counties in which trainings related to mental health and physical health have occurred
  ○ ESM PA-Child.3: Number of Gold Sneaker certified childcare facilities
  ○ ESM PA-Child.4: Percent of LHD primary care clinics writing HPHP prescriptions annually
  ○ ESM PA-Child.5: Number of Healthy Parks Healthy Person prescriptions written
  ○ ESM PA-Child.6: Percentage of TN counties with completed built environment projects
  ○ ESM PA-Child.7: Percent of eligible venues offering the Double Up Food Bucks Program
	Child Health

Priority Needs and Associated Measures	Reporting Domain(s)
○ ESM PA-Child.8: Percent of staff with an increase in ACEs and TIC knowledge as evidenced by post training evaluation ○ ESM PA-Child.9: Percent of families with improved protective factors score ○ ESM PA-Child.10: Percent of families enrolled in CHANT care coordination who partially or fully complete pathways identified ○ ESM PA-Child.11: Proportion of local education agencies (LEA) offered professional development on improving/maintaining moderate to vigorous physical activity in PE SPMs ● SPM 6: Percent of schools with at least 50% physical education class time spent in moderate to vigorous physical activity ● SPM 24: Rate of Double Up Food Bucks purchases per SNAP recipient SOMs ● SOM 3: Percent of public school 6th graders who are overweight or obese ● SOM 4: Percent of WIC recipients aged 2-4 years who are overweight or obese	
Increase prevention and mitigation of Adverse Childhood Experiences (ACEs) SPMs ● SPM 8: Percent of children with two or more ACEs ● SPM 9: Percent of substantiated child maltreatment cases among families served by home visiting programs	Child Health
Decrease tobacco and e-cigarette use among adolescents NPMs ● Percent of children, ages 0 through 17, who live in households where someone smokes (Smoking - Household, Formerly NPM 14.2) - SMK-Household ○ ESM SMK-Household.1: Number of tobacco-free sports teams ○ ESM SMK-Household.2: Number of social media posts promoting text-based cessation services ○ ESM SMK-Household.3: Number of anti-tobacco social media posts ○ ESM SMK-Household.4: Number of youth who attend the state anti-tobacco conference trainings ○ ESM SMK-Household.5: Number of ambassadors recruited ○ ESM SMK-Household.6: Percent of eligible women who enroll in Baby and Me Tobacco Free SPMs	Adolescent Health

Priority Needs and Associated Measures	Reporting Domain(s)
• SPM 11: Percent of high school students currently using cigarettes • SPM 12: Percent of high school students currently using e-cigarettes • SPM 13: Number of adolescents enrolled in cessation program SOMs • SOM 5: Percent of adults reporting Chronic obstructive pulmonary disease (COPD) • SOM 6: Percent of adults reporting cardiovascular disease • SOM 7: Age-adjusted mortality rate from tobacco-attributable cancers among Tennesseans aged 35+	

Increase medical homes among children with special healthcare needs
 	
NPMs
• Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH
  ○ ESM MH.1: Number of CYSHCN who receive CHANT/CSS care coordination
  ○ ESM MH.2: Percent of providers adopting medical home approach
  ○ ESM MH.3: Percent of providers reporting increased knowledge on systems of care
  ○ ESM MH.4: Number of families provided education and resources on importance of medical home access and utilization
  ○ ESM MH.5: Number of families receiving referrals to their child's primary care provider
  ○ ESM MH.6: Percent of providers who report an increase in their knowledge of available resources
  ○ ESM MH.7: Percent of families who report an increase in access and utilization of resources
  ○ ESM MH.8: Percent of CHANT families who schedule an annual visit with their child's primary care provider
  ○ ESM MH.9: Percent of CYSHCN receiving CHANT care coordination who receive medical home education
  ○ ESM MH.10: Number of teachers/school personnel trained on QPR
 	
SPMs
• SPM 14: Number of CYSHCN receiving care in a medical home
• SPM 15: Percent of providers with increased knowledge on medical home and care coordination
• SPM 16: Percent of providers reporting improved system of care for CYSCHN
• SPM 17: Percent of families who complete an annual visit with their primary care provider
	Children with Special Health Care Needs

Priority Needs and Associated Measures	Reporting Domain(s)

Improve transition from pediatric to adult care among children with special health care needs
 	
NPMs
• Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care (Transition, Formerly NPM 12) - TR
  ○ ESM TR.1: Number of transition resource kits disseminated
  ○ ESM TR.2: Number of youth with special health care needs trained as mentors
  ○ ESM TR.3: Number of parents and youth with special health care needs who receive leadership and self-advocacy training
 	
SPMs
• SPM 18: Percent of youth reporting with increased knowledge on transition resources and services
• SPM 19: Percent of YSHCN served by CHANT who complete an annual transition plan
• SPM 20: Percent of youth leaders participating in advisory councils providing resources to other youth
	Children with Special Health Care Needs

Improve mental health SPMs • SPM 21: Percent of women who reported 14+ days of poor mental health in the past month SOMs • SOM 8: Percent of pregnancy-associated deaths in which mental health conditions was a contributing factor	Cross-Cutting/Systems Building

Executive Summary

Program Overview

Tennessee's MCH/Title V Program
In the state of Tennessee, the Title V Maternal and Child Health (MCH) Services Block Grant to States is administered by the Tennessee Department of Health's Division of Family Health and Wellness (FHW). The division of 220 staff (163 state employees and 57 contract employees) is responsible for providing education, referrals, resources, services, and support to ensure the health and well-being of all Tennessee families. This division is led by a director with three deputy directors. Each of the deputies have four section chiefs who report to them and section chiefs lead teams of as small as 3 and as large as 38. These staff include program directors, clinicians, communication specialist, epidemiologists, and administrative assistants. For the two required positions for this grant the division director serves as one – MCH Director, and a public health administrator serves as the other – Children with Special Healthcare Needs (CSHCN) director. FHW is organized into two types of sections administrative and programmatic. The administrative sections include contracts and fiscal administration. The programmatic sections cover nutrition, maternal and child health, and chronic disease and health promotion. Specific sections include reproductive and women's health, perinatal/infant/pediatric care, early childhood, injury prevention and detection, children and youth with special health care needs, chronic disease and health promotion, and supplemental nutrition (including WIC). These sections implement programs that improve the health of women (including mothers), infants, children, adolescents, and their families, as well as those with special health care needs. FHW programs include topics such as family planning, maternal mortality case review, newborn screening and follow-up, WIC, breastfeeding support, infant mortality reduction initiatives, home visiting, mental health, tobacco use prevention and control, injury prevention, suicide prevention, and CSHCN. Therefore, it is the most appropriate place to administer the MCH Block Grant.

Needs Assessment
At the beginning of each five-year grant cycle, a comprehensive needs assessment is used to identify priority needs of women, mothers, infants, children, adolescents, children and youth with special health care needs, and their families; as well as determine the capacity of the health system to meet those needs. During the years between the comprehensive needs assessments, an ongoing needs assessment is conducted to identify any significant changes in needs and capacity.

FHW conducted the comprehensive needs assessment for the 2021-2025 cycle during 2019 and 2020 in conjunction with over 100 partners. Key components included:

- Quantitative analysis of key health topics
- Qualitative data collection and analysis, including focus groups, key informant interviews, and open-ended surveys
- Structured process for choosing priorities based on the data complied
- Capacity assessment of current and potential programming for each identified priority

As a part of the ongoing needs assessment, FHW hosts MCH partner meetings twice each year. These meetings are open to anyone, and effort is made to extend the invitation broadly; since the COVID-19 pandemic, meetings have been held virtually but will transition to in-person in Fall 2024. During the meetings, participants are asked to consider the progress made on performance measures during the past year, and then make recommendations for the next year's action plan based on that evaluation.

Needs and Priorities
States are required to identify at least one priority in each of the population health domains, except for the Cross-cutting/Systems Building domain which is optional. There are a total of six domains: (1) Women's and Maternal Health, (2) Perinatal and Infant Health, (3) Child Health, (4) Adolescent Health, (5) Children with Special Health Care Needs and (6) Cross-cutting/Systems Building.

As a result of the Needs Assessment, TDH identified priority needs for the MCH population for the 2021-2025 Block Grant cycle. These priorities include: (1) Increase family planning, (2) Decrease pregnancy-associated mortality, (3) Increase breastfeeding, (4) Decrease infant mortality, (5) Decrease overweight and obesity (among children), (6) Increase prevention and mitigation of Adverse Childhood Experiences (ACEs), (7) Decrease tobacco and e-cigarette use (among adolescents), (8) Increase medical homes (9) Improve transition from pediatric to adult care, (10) Health Equity, and (11) Mental Health.

Program Planning
The MCH/Title V Program is managed within the TDH's Division of FHW. This division includes sections for:

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

The breadth of content areas in FHW aligns well with the identified priorities. Therefore, each FHW section (including both program and epidemiology staff) leads a priority. Teams are responsible for developing and reporting on the action plan and corresponding measures. This is done in conjunction with the MCH Partner Group. This group was formed during the 2015 needs assessment and has met twice a year since then and grown to almost 200 participants. The group reviews the action plan, measurement progress, and suggests changes for the coming year. They also partner with the MCH/Title V Program to complete the activities outlined in the

action plan and work towards the objective for each measure. This is all done under the guidance of the MCH Title V Director who oversees all aspects of program planning.

Performance Reporting
The epidemiology staff for each priority team takes the lead on tracking and reporting on each measure. The SSDI Epidemiologist facilitates the tracking and visualization of all measures among all priority teams. This enables everyone (MCH/Title V Director, MCH Block Grant coordinator, priority teams, and MCH Partner Group) to view the overall progress made among all priorities.

Assuring Comprehensive, Coordinated, Family-Centered Services
The MCH/Title V Program assures comprehensive and coordinated services through integrated systems of care. All 95 local health departments in every Tennessee county provide core MCH services such as WIC, family planning, breast and cervical cancer screening, preventive care for children (EPSDT and immunizations), health promotion, community outreach, and the care coordination services of Community Health Access and Navigation in Tennessee (CHANT) and Children's Special Services (CSS). Local health departments also provide primary care and dental care. Rural health departments report to regional offices and to the TDH Division of Community Health Services (CHS). Metro health departments are independent and accountable to local governments but operate closely via contract with TDH. This organizational structure assures that MCH/Title V and other state and federal funds are administered comprehensively to all counties and that program fidelity is maintained via direct management or contract. Regular communication occurs with the Regional Leadership Team (metro and regional directors and CHS leadership), the Medical Leadership Team (metro and regional health officers), Nursing Leadership Team (metro and regional nursing leads), and the MCH Regional and Metro directors to assure multi-directional transmission of key information and provide opportunities for sharing of ideas. Other core MCH/Title V services such as newborn screening provide services to the entire state but are centrally located at the state lab to assure excellent communication between the lab and the FHW clinical follow-up team for lead, genetic disorders, hearing loss, and congenital heart disease (CCHD). Babies diagnosed with a hearing loss, metabolic condition, or CCHD are referred to Family Voices (FV) PEARS program for family support services, as well as referred to Children’s Special Services and Tennessee Early Intervention Services.

The MCH/Title V CYSHCN section continues to work with families to assure comprehensive coordinated family-centered services by providing education around the importance of receiving services in a patient-centered medical home and how to partner with providers in the decision-making process. The program provides the “Partnering with your Provider Booklet” statewide for distribution at community events, as well as medical providers for distribution in their practices. Staff has also collaborated with the Bureau of TennCare, the state Medicaid agency, in their Primary Care Transformation Strategy “Patient-Centered Medical Home”. There are currently over 81 participating provider organizations in over 400 locations, covering over 37% of the TennCare population.

For the MCH/Title V CYSHCN section specifically, staff include a dedicated Family/Youth Engagement and Involvement Director whose primary responsibility is to work with FV to ensure opportunities for family and youth training on patient centered medical homes, transition and policy/advocacy. MCH/Title V funds have also been used to expand the division contract with FV to provide consultation and training for all programs within FHW. In addition, several programs continue to expand their own advisory and family groups to better inform programs and services. For example, the Perinatal Advisory Committee (PAC) and Genetics Advisory Committee have always been open meetings, and recently family representatives have been sought out to attend those meetings. Furthermore, in the comprehensive redesign of the CSS, HUGS, and Community Outreach programs into the streamlined Community Health Access and Navigation in Tennessee (CHANT) program family engagement was incorporated in the design process to assure that the needs of children and families are being met appropriately.

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

For example, a multitude of local, state, and national partnerships have emerged statewide regarding the opioid crisis and prevention of neonatal abstinence syndrome (NAS). Since being added to the reportable disease list in 2013, TDH had seen annual increases in the number of cases of NAS until 2018, which marked the first decrease in the number of cases. Acute overdose was the leading cause of pregnancy-associated, but not related death in 2021. Between 2017 and 2021, 87 women died from an acute overdose from causes NOT related to pregnancy. Substance use disorder (SUD) was prevalent in most (94%) of these deaths. Fentanyl was the single most common substance, present in 68 of the 87 (78%) overdose deaths. Tennessee’s Opioid Abatement Council released its first ever community grants in 2024 which will support work in response to opioid addiction throughout Tennessee for up to three years. TDH created the Universal Postpartum Naloxone project with the goal of decreasing mortality for opioid-related overdoses by providing all postpartum women with education about opioid misuse and a family first aid kit at the time of discharge from the hospital. The contents of the first aid kit include intranasal naloxone and fentanyl test strips in addition to traditional first aid kit items like Band-Aids and a thermometer. Using a universal approach and providing education and first aid kits to all postpartum mothers at delivery discharge ensures that every family has access to naloxone at home. Not only will women who have been identified as substance users have access to the free naloxone and fentanyl test strips, but those who have not previously been identified as substance users will also have access to this potentially life-saving medication. Including test strips and naloxone in a family first aid kit normalizes the need for these items and reduces the stigma associated with their possession. Providing the education and kits is intended to increase access to naloxone, decrease stigma, improve community and family awareness of opioid-related emergencies, and decrease mortality from opioid overdose in Tennessee. The education and kits will be offered and distributed to each birthing individual at participating hospitals. There will be a total of 20,000 kits distributed (1,000 in the first year, and 7,000 and 12,000 in the second and third years, respectively). Tennessee will be using a data-driven approach to identify counties/areas that we want to pilot the project in (counties with high fatal and no-fatal overdose, maternal overdose deaths). Tennessee will also work with THA to identify and/or partner with hospitals in these areas. The response to the opioid epidemic has

been complex and growing, involving legislative action, law enforcement, regulation education, prevention messaging, and treatment.

Infant mortality reduction efforts have likewise relied extensively on partnerships. For example, DOE, DCS, EMS entities, the medical community, and the judicial system have been critical to maintaining the Child Fatality Review. Local review teams in all judicial districts serve on a volunteer basis and are essential to determining cause of death for infants and children. These data guide the priorities for the upcoming years, and the local review teams serve as bodies to disseminate information to local communities as well. Updates to the infant mortality strategic plan are currently underway. TDH is working alongside numerous partners, including Tennessee Chapter of the American Academy of Pediatrics (TNAAP), TIPQC, the PAC, academic partners such as Vanderbilt University and Children's Hospital, the Children's Hospital Alliance of Tennessee, the Tennessee Breastfeeding Coalition, Cribs for Kids, doulas, federally qualified health centers, MCH directors statewide, and community advocacy groups, to enhance existing and strategize new approaches to address areas of opportunity to improve birth outcomes and overall infant health and wellbeing.

Obesity is likewise a complex problem requiring a multi-dimensional approach and many partnerships. DOE and the Office of Coordinated School Health partner in both data collection and programming for schools across the state. Within the Chronic Disease Prevention and Health Promotion Section, the state-funded Project Diabetes initiative awards funds and technical assistance to communities for primary prevention projects to increase access to healthy food and physical activity. These projects broaden access to breastfeeding education and support, food literacy for students including gardening and cooking activities, nutrition and physical activity policy for afterschool and childcare facilities, and fresh produce for emergency food boxes at a regional food bank. Built environment improvements include a 40-mile multi-modal rails-to-trails project through an economically at-risk county, the restoration of tennis courts in another at-risk county, and ADA-accessible playgrounds in three counties. To assist healthier food choices for SNAP recipients, Project Diabetes funds four non-profits to administer the SNAP doubling program known as Double Up Food Bucks. This allows a SNAP participant to double the value of their EBT purchase at participating farmers markets and farm stores.

Academic partners have also been critical for data analysis and program implementation across the state for efforts in both obesity reduction and tobacco prevention. TDOE has closely partnered with the TDH to conduct several cohorts with 86 schools for the Tennessee Healthy Afterschool Pledge recognition. The Tennessee Healthy Afterschool Pledge is a program that recognizes out-of-school sites across the state that are committed to advancing the health and wellness of their students.

How Federal Title V Funds Complement State-Supported MCH Efforts

MCH/Title V federal funds are essential to meet state and local needs in a manner that is intentional, flexible, and accountable. States are held accountable for planning and progress in priority areas and must report how both state and federal funds are spent. A needs assessment occurs every five years and is updated annually by review of available data and input of partners. Similarly, the action plan to address the needs with available state and federal resources and a wide range of partners is revised annually. Tennessee has consistently met both maintenance of effort and state funding match requirements of the federal MCH/Title V block grant, ensuring that both funding sources are utilized for MCH needs. The flexibility of the block grant is particularly critical to meet emerging needs when obtaining needed funding from annual appropriation cycles can be significantly delayed.

Aligning MCH Block Grant funds within the Division of Family Health and Wellness allows for planning across programs to address population health priorities by leveraging both federal and state funds. This occurs for all priority areas. For example, reducing and mitigating the effect of ACEs is a priority area for Tennessee MCH/ Program since the most recent needs assessment, and activity around this topic has increased over the last 5 years. MCH/Title V state and federal funds have been used to support data collection and dissemination, workforce training of the majority of health department staff, and facilitation of multiple partnership meetings across the state. In addition, federal MIECHV (Maternal, Infant, and Early Childhood Home Visiting) and TANF (Temporary Assistance for Needy Families) funds support workforce development and support for the evidence-based home visiting (EBHV) workforce in Tennessee.

MCH Success Story

Tennessee's Title V/MCH program has worked closely with the Sexually Transmitted Infections (STI) program and the Communicable and Environmental Diseases and Emergency Preparedness Division (CEDEP) to address rapidly increasing rates of congenital syphilis (CS). TN's approach has been to develop and implement progressive, evidence-based clinical strategies, to expand our community outreach and continually monitor our impact. When TN initially recognized our CS rates mirrored those of the nation, we took action by positioning a Title V/MCH funded staff member as a leading partner in developing innovative solutions. Tennessee Health Alert Network (TNHAN) has been utilized to release timely clinical updates on CS. The first TNHAN provided timely CS case data, clinical information on screening, diagnosis and treatment, and introduced a new platform where licensed healthcare providers can request their patients' syphilis historical test results and treatment information through a REDCAP survey to expedite accurate diagnosis and treatment. For the second TNHAN, a Title V/MCH funded staff member developed new, evidence-based screen guidelines for TN. These TN specific recommendations pivoted from the established risk-based approach to a universal testing strategy. These TDH recommendations were more stringent than the national guidelines at the time of implementation (January 2024) since national guidelines were not updated until April 2024. The key changes in the TDH recommendations were the addition of universal syphilis testing at 28-32 weeks gestation, universal testing at delivery, and universal STI testing with new positive pregnancy

tests in ambulatory clinical settings. The second TNHAN, was circulated to multiple clinician associations and licensure lists in addition to direct outreach to birthing hospitals, birth centers and medical practices. To evaluate the uptake of these recommendations in hospitals, TDH conducted a survey of TN hospitals. See the Supporting Document section for more information on the survey results.

Recent initiatives to outreach to nontraditional settings include developing a pilot program for Point-of-Care (POC) syphilis testing to ensure timely screening and treatment in appropriate nontraditional settings. The local jurisdictions will deploy POC tests provided by the Medical Laboratory Board to nontraditional sites outside of the local health departments such as shelters, Syringe Services Programs, substance use treatment programs, correction facilities, and community-based care events. Additionally, TDH will utilize MCH/Title V funds and partner with the Division of Community Health Services (CHS), CEDEP, and the State Lab to purchase an additional 1,000 tests to strategically disperse to Disease Intervention Specialists in regions most impacted by high syphilis rates. Currently, Title V/MCH staff have partnered with the State Lab to create a protocol, train field staff, and collect data to inform future efforts. The draft protocol can be viewed in the Supporting Documents section. To do this work, MCH leadership has appointed the MCH Emergency Preparedness and Response Coordinator as the Outbreak Point of Contact for the Division and the CDC/CSTE Applied Epidemiology Fellow will assist with outbreak investigations and data analysis. Finally, the Women's Health Physician Consultant is instrumental in serving on the CS review board, providing community education and outreach, and created the TNHAN's that changed TN's standard practice. The CS review board, including MCH/Title V-funded staff, meet quarterly to review CS cases from each region to analyze processes, determine preventability and identify areas of improvement. Recently the review boards had standardized it process across the state with an emphasis on collaboration and sharing proven strategies. In January 2024, a statewide CS workgroup was formed to further discuss strategies and share resources. All of these initiatives are made possible by MCH/Title V funds.

Maternal and Child Health Bureau (MCHB) Discretionary Investments - Tennessee

The largest funding component (approximately 85%) of the MCH Block Grant is awarded to state health agencies based on a legislative formula. The remaining two funding components support discretionary and competitive project grants, which complement state efforts to improve the health of mothers, infants, children, including children with special needs, and their families. In addition, MCHB supports a range of other discretionary grants to help ensure that quality health care is available to the MCH population nationwide.

Provided below is a link to a web page that lists the MCHB discretionary grant programs that are located in this state/jurisdiction for Fiscal Year 2023.

List of MCHB Discretionary Grants

Please note: If you would like to view a list of more recently awarded MCHB discretionary investments, please refer to the Find Grants page that displays all HRSA awarded grants where you may filter by Maternal and Child Health.