Tennessee State Action Plan Table 2026 Application/2024 Annual Report

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
Women/Maternal Health					
Increase Access to Contraceptive Methods	Increase the percentage of women who are using a most or moderately effective method of contraception following a recent life birth from 51.5% in October 1, 2026, to 53% in September 30, 2030.	Strategy 1: Encourage clinics to offer information on or access to Long-Acting Reversible Contraception (LARC), including to postpartum women Strategy 2: Implement community-based programs that provide education and support to women seeking information on contraception methods, including postpartum women.	ESM CU.1 - Number of total providers trained on long-acting reversible contraception (LARC) insertion and removal	NPM - Postpartum Contraception Use	**Linked NOMs:** Severe Maternal Morbidity Maternal Mortality Low Birth Weight Preterm Birth Infant Mortality Neonatal Abstinence Syndrome
Improve Maternal Mental Health and Wellbeing	A) Increase the percentage of women who attend a postpartum checkup within 12 weeks after giving birth from 92.6% in FY 2026 to 93.8% in FY 2030. B) Increase the percentage of women who attended a postpartum checkup and receive recommended care components from 69.3% in FY 2026 to 75.3% in FY 2030.	Strategy 1: Educate providers on the use of standardized screening tools to identify women with postpartum depression and anxiety. Strategy 2: Support quality improvement initiatives that take a multi-component, systematic approach to increase postpartum depression and anxiety screening rates and address SUD. Strategy 3: Collaborate with home visiting programs and community-based organizations to support mothers in obtaining timely postpartum care.	***Inactive -*** *ESM PPV.1 - 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 PPV.2 - Percent of home-visiting staff trained in recognizing and providing resources/referrals for perinatal mood disorders and substance use disorder	NPM - Postpartum Visit	**Linked NOMs:** Maternal Mortality Neonatal Abstinence Syndrome Women's Health Status Postpartum Depression Postpartum Anxiety
Improve Maternal Mental Health and Wellbeing	Increase the percentage of women screened for depression and anxiety following a recent live birth from 83.7% in FY 2026 to 89.3% in	Strategy 1: Educate providers on the use of standardized screening tools to identify women with postpartum depression and anxiety. Strategy 2: Support quality improvement initiatives that take a multi-	ESM MHS.1 - Number of healthcare providers trained in using validated	NPM - Postpartum Mental Health Screening	**Linked NOMs:** Maternal Mortality Infant Mortality SUID Mortality

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	FY 2030.	component, systematic approach to increase postpartum depression and anxiety screening rates and address SUD. Strategy 3: Collaborate with home visiting programs and community-based organizations to support mothers in obtaining timely postpartum care.	screening tools for depression and anxiety		Neonatal Abstinence Syndrome Child Injury Hospitalization Women's Health Status Postpartum Depression Postpartum Anxiety
Perinatal/Infant Health					
Improve the Perinatal Regionalization System in Tennessee	Increase the percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ NICU from 84% on October 1, 2025, to 88% on September 30, 2030.	Strategy 1: Improve perinatal health outcomes through quality improvement (QI) initiatives in birthing hospitals. Strategy 2: Improve perinatal regionalization system by enhancing emergency medical services (EMS) Strategy 3: Develop or expand perinatal telehealth services targeting areas with high rates of maternal and infant morbidity and mortality to improve health outcomes.	***Inactive -*** *ESM RAC.1 - Percent of Tennessee birthing hospitals participating in perinatal quality collaborative projects* ESM RAC.2 - Number of unique patients served by perinatal telehealth pilot projects in Tennessee	NPM - Risk-Appropriate Perinatal Care	**Linked NOMs:** Stillbirth Perinatal Mortality Infant Mortality Neonatal Mortality Postneonatal Mortality Preterm-Related Mortality
Child Health					
Decrease Preventable Illness and Disease Among Children	Increase the percentage of 2-year-old children with up-to-date vaccinations from 63.5% on October 1, 2026 to 78% on September 30, 2030.	Strategy 1: Partner with the Vaccine-Preventable Diseases and Immunizations Program in the Communicable and Environmental Diseases and Emergency Preparedness (CEDEP) Program at the Department of Health (TDH) to provide a three-part training series on immunizations to evidence-based home visiting (EBHV) and CHANT staff. Strategy 2: Foster partnership with the Tennessee Department of Education (DOE) Office of School Health to increase education on preventable diseases and promote up-to-date immunizations. Strategy 3: Strengthen school-based emergency preparedness for vaccine-preventable disease outbreaks through inter-agency collaboration and exercises. Strategy 4: Collaborate with MCH Regional and Metro Directors and regional nursing staff to increase off-site vaccination opportunities, with at	ESM VAX_Child.1 - Percent of participating staff reporting increased confidence in addressing vaccine hesitancy post-training	NPM - Childhood Vaccination	**Linked NOMs:** Infant Mortality Postneonatal Mortality SUID Mortality Child Mortality Children's Health Status

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		least one event in each grand division.			
Improve Nutrition Among Families	Cross-Cutting	Cross-Cutting	ESM FS.1 - Number of individuals referred to food assistance programs through FindHelp	NPM - Food Sufficiency	**Linked NOMs:** School Readiness Children's Health Status Behavioral/Conduct Disorders Flourishing - Young Child Flourishing - Child Adolescent - CSHCN Flourishing - Child Adolescent - All Adverse Childhood Experiences
Decrease Preventable Illness and Disease Among Children	Increase the percentage of children with medical home from 49.9% on October 1, 2026 to 55% on September 30, 2030	Strategy 1: Create a 3-part immunization training for TDH EBHV Home Visitors and CHANT staff to decrease vaccine hesitancy, apply motivational interviewing strategies in vaccine conversations with families, and encourage families to receive care in a medical home.	***Inactive -*** *ESM MH.1 - Number of CYSHCN who receive CHANT/CSS care coordination* ***Inactive -*** *ESM MH.2 - Percent of providers adopting medical home approach* ***Inactive -*** *ESM MH.3 - Percent of providers reporting increased knowledge on systems of care* ***Inactive -*** *ESM MH.4 - Number of families provided education and resources on importance of medical home access and utilization* ***Inactive -*** *ESM MH.5 - Number of families receiving referrals to their child's primary care provider* ***Inactive -*** *ESM MH.6*	NPM - Medical Home	**Linked NOMs:** Children's Health Status CSHCN Systems of Care Flourishing - Young Child Flourishing - Child Adolescent - CSHCN Flourishing - Child Adolescent - All

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			- Percent of providers who report an increase in their knowledge of available resources ***Inactive -*** *ESM MH.7 - Percent of families who report an increase in access and utilization of resources* ***Inactive -*** *ESM MH.8 - Percent of CHANT families who schedule an annual visit with their child's primary care provider* ***Inactive -*** *ESM MH.9 - Percent of CYSHCN receiving CHANT care coordination who receive medical home education* ***Inactive -*** *ESM MH.10 - Number of teachers/school personnel trained on QPR* ESM MH.11 - Percentage of children with and without SHCN who are applying for health insurance ESM MH.12 - Percentage of children with and		

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			without SHCN who schedule an exam with a primary care provider		
Adolescent Health					
Improve Social and Emotional Wellbeing in Adolescents	Increase the percent of adolescents, ages 12 through 17 years, who receive needed mental health treatment or counseling from 86.6% in October 1, 2026 to 91% by September 30, 2030.	Strategy 1: Implement youth-centered mental health/social-emotional skill-building promotion to address factors that influence adolescent well-being. Strategy 2: Offer continuous training to professionals working with adolescents to enhance their ability to recognize, respond to, and manage mental health concerns using evidence-based practices. Strategy 3: Implement youth empowerment initiatives that integrate anti-nicotine education and engagement activities to promote healthy, nicotine-free lifestyles.	ESM MHT.1 - Percent increase in Tennessee Child and Adolescent Psychiatry Education and Support (TCAPES) teleconsultation call line volume	NPM - Mental Health Treatment	**Linked NOMs:** Adolescent Mortality Adolescent Suicide Adolescent Firearm Death Adolescent Injury Hospitalization Children's Health Status Adolescent Depression/Anxiety CSHCN Systems of Care Flourishing - Child Adolescent - CSHCN Flourishing - Child Adolescent - All
Children with Special Health Care Needs					
Increase Access to Quality Care for Children and Adolescents with Special Healthcare Needs	Overall Medical Home: Increase the percentage of children with and without special health care needs, ages 0-17, who have a medical home by 3% from October 1, 2026 (CYSHCN: 42.3%, Non-CYSHCN: 52.0%) to September 30, 2030 (CYSHCN: 45.3%, Non-CYSHCN: 55.0%) Personal Doctor or Nurse Sub-Component: Increase percentage of children with and without special health care needs, ages 0 through 17, who have a personal doctor or nurse by 3% from October 1, 2026 (CYSHCN: 72.1%, Non-	Strategy 1: Engage and collaborate with partners in the private sector to promote the medical home model and increase provider participation in systems of care. Strategy 2: Promote care coordination as a way to ensure all children have continuous access to high-quality, affordable, comprehensive, coordinated, and family-centered care. Strategy 3: Identify children and youth with special healthcare needs and reduce barriers that prevent their access to a medical home.	***Inactive -*** *ESM MH.1 - Number of CYSHCN who receive CHANT/CSS care coordination* ***Inactive -*** *ESM MH.2 - Percent of providers adopting medical home approach* ***Inactive -*** *ESM MH.3 - Percent of providers reporting increased knowledge on systems of care* ***Inactive -*** *ESM MH.4 - Number of families provided education*	NPM - Medical Home; Medical Home_Personal Doctor	**Linked NOMs:** Children's Health Status CSHCN Systems of Care Flourishing - Young Child Flourishing - Child Adolescent - CSHCN Flourishing - Child Adolescent - All

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	CYSHCN: 75.8%) to September 30, 2030 (CYSHCN: 75.7%, Non-CYSHCN: 79.6%)		*and resources on importance of medical home access and utilization* ***Inactive -*** *ESM MH.5 - Number of families receiving referrals to their child's primary care provider* ***Inactive -*** *ESM MH.6 - Percent of providers who report an increase in their knowledge of available resources* ***Inactive -*** *ESM MH.7 - Percent of families who report an increase in access and utilization of resources* ***Inactive -*** *ESM MH.8 - Percent of CHANT families who schedule an annual visit with their child's primary care provider* ***Inactive -*** *ESM MH.9 - Percent of CYSHCN receiving CHANT care coordination who receive medical home education* ***Inactive -*** *ESM MH.10 - Number of teachers/school personnel trained on*		

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			QPR ESM MH.11 - Percentage of children with and without SHCN who are applying for health insurance ESM MH.12 - Percentage of children with and without SHCN who schedule an exam with a primary care provider ESM MH_PDOC.1 - Percentage of children with and without SHCN who receive a referral to a primary care provider		
Increase Access to Quality Care for Children and Adolescents with Special Healthcare Needs	Increase the percentage of adolescents with special health care needs, age 12 through 17, who receive services to prepare for the transition to adult health care from 24.5% on October 1, 2026, to 29.5% on September 30, 2030.	Strategy 4: Inform and educate children and youth aged 12-17, with and without special healthcare needs, their families and program staff about new and existing resources and services for transitioning from pediatric to adult healthcare, through increased availability and visibility of transition resources.	***Inactive -*** *ESM TAHC.1 - Number of transition resource kits disseminated* ***Inactive -*** *ESM TAHC.2 - Number of youth with special health care needs trained as mentors* ***Inactive -*** *ESM TAHC.3 - Number of parents and youth with special health care needs who receive leadership and self-advocacy training* ESM TAHC.4 -	NPM - Transition To Adult Health Care	**Linked NOMs:** CSHCN Systems of Care

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			Percentage of CSS-eligible YSHCN, age 14-21, who complete a transition plan		
Cross-Cutting/Systems Building					
Improve Nutrition Among Families	Increase the percent of children, ages 0 through 11, whose households are food sufficient from 62.8% on October 1, 2026, to 65.3% on September 30, 2030.	Strategy 1: Increase access to nutritious foods by identifying families experiencing food insecurity and connecting them to food assistance programs, particularly in under resourced communities. Strategy 2: Expand Women, Infants, and Children (WIC) program to ensure that more eligible families have access to adequate nutrition Strategy 3: Launch and Support a Statewide Food Security Coordination Coalition			