Maternal and Child Health Services Title V Block Grant

Tennessee

FY 2026 Application/ FY 2024 Annual Report

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I. General Requirements

I.A. Letter of Transmittal

June 18, 2025

Grants Management Officer
Division of State and Community Health
Maternal and Child Health Bureau
Health Resources and Services Administration
5600 Fishers Lane, Room 18-31
Rockville, MD 20857

Dear Grants Management Officer,

Tennessee's Title V MCH Block Grant application and report are enclosed.

Please contact me directly if further information is needed.

Sincerely,

Elizabeth Harvey

Elizabeth Harvey, PhD, MPH
Assistant Commissioner
Title V Maternal and Child Health Director
Division of Family Health and Wellness
Tennessee Department of Health

I.B. Face Sheet

The Face Sheet (Form SF424) is submitted electronically in the HRSA Electronic Handbooks (EHBs).

I.C. Assurances and Certifications

The State certifies assurances and certifications, as specified in Appendix 2 of the 2026 Title V Application/Annual Report Guidance, are maintained on file in the States' MCH program central office, and will be able to provide them at HRSA's request.

I.D. Table of Contents

This report follows the outline of the Table of Contents provided in the *"Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms",* OMB NO: 0915-0172; Expires: December 31, 2026.

II. MCH Block Grant Workflow

Please refer to figure 3 in the "Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms", OMB NO: 0915-0172; Expires: December 31, 2026.

III. Components of the Application/Annual Report

III.A. Executive Summary

III.A.1. Program Overview

Tennessee's MCH/Title V Program

In Tennessee, the Title V Maternal and Child Health (MCH) Services Block Grant to States is administered by the Department of Health's Division of Family Health and Wellness (FHW). The division, which has 220 staff members (161 state employees and 59 contract employees), is responsible for providing education, referrals, resources, and services, supporting the mission to protect, promote, and improve the health and well-being of all people in Tennessee.

The Division is led by an Assistant Commissioner who also serves as the MCH/Title V Director and is supported by four deputy directors: Deputy Director of Operations and Supplemental Nutrition, Deputy Director of Maternal and Infant Health, Deputy Director of Child and Adolescent Health, and Deputy Medical Director. Each deputy oversees 3–4 section chiefs who manage teams ranging in size from 3 to 38 and include program directors, clinicians, communication specialists, epidemiologists, and administrative assistants. The MCH Director is also supported by the Director of Strategic Initiatives, who oversees the MCH/Title V Block Grant, Strategic Priorities, and Workforce Initiatives.

For the two required positions for this grant, the Division director serves as the MCH Director, and a public health administrator serves as the 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, whereas the programmatic sections cover nutrition, maternal and child health, and chronic disease and health promotion. Specific programmatic areas include Maternal and Infant Health, Maternal Health, Newborn Screening, Perinatal and Infant Health, Child and Adolescent Health, Children and Youth with Special Health Care Needs, Early Childhood Initiatives, Adolescent Health, Community Health, Chronic Disease and Health Promotion, Injury Prevention and Detection, Comprehensive Cancer, and Supplemental Nutrition and Operations, which includes WIC and related support programs.

These sections implement programs that improve the health of women (including mothers), infants, children, adolescents, and their families, as well as those with special healthcare 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, health promotion and education, physical activity and nutrition initiatives for adults and children/adolescents, injury prevention, suicide prevention, and CSHCN. These efforts closely align with the Presidential Commission to Make America Healthy Again (MAHA) priorities by focusing on prevention, supporting healthier lifestyles, reducing the burden of chronic health conditions, and improving access to essential services for families. Through these coordinated efforts, FHW continues to promote long-term health and wellness across the lifespan; therefore, it is the most appropriate place to administer the MCH Block Grant.

Program Framework Overview

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

- Maternal 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
- Strategic Initiatives (including Adolescent Health)

Members of FHW sections are a part of the domains that address the selected MCH priorities. Each domain had a domain lead and an epidemiology lead, and they addressed the domain priorities. Domain teams were 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 over 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.

The 2020 Needs Assessment used the Public Health Planning Cycle from the federal guidance for the framework of the assessment. The steps were (1) engage partners, (2) assess needs and identify desired outcomes and mandates, (3) examine strengths and capacity, (4) select priorities, (5) set performance objectives, (6) develop an action plan, (7) seek and allocate resources, (8) monitor progress for impact on outcomes, and (9) report back to partners. Additionally, TDH used stages from the Needs Assessment in Public Health: A Practical Guide for Students and Professionals book to supplement the framework from the federal guidance. These stages included (1) start-up planning, (2) operational planning, (3) data, (4) needs analysis, (5) program and policy development, and (6) resource allocation.

The framework for the Year 5 MCH/Title V Needs Assessment was 9 steps: (1) engage partners, (2) assess & identify needs, (3) examine strengths and capacity, (4) select priorities, (5) set performance measures, (6) develop an action plan, (7) seek and allocate resources, (8) monitor progress, (9) report back to partners. While using this framework, the bulk of the Needs Assessment consisted of three main parts: the quantitative portion, the qualitative portion, and the capacity assessment. Results from the quantitative and qualitative portions were presented to the MCH Partner Group at an in-person meeting and a virtual meeting. MCH Partners voted on priorities and indicated which priorities they would be interested in partnering with. These selections were then reviewed by FHW staff and leadership at the capacity assessment, which was an in-person meeting in December 2024. FHW staff and leadership determined the MCH/Title V priorities for the next five years, and domain and priority leads were selected. Additionally, lead clinical and epidemiology staff were also selected, and domain leads identified teams for their priority. These teams included both internal and external partners, and priority leads created action plans using MCH Evidence Center guidance. The MCH/Title V Block Grant Coordinator used Asana, an online project management software, to organize action plans and reports, and also to inform domains when and how to complete these plans and reports.

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.

Summary of Needs Assessment Findings

2020 Five-Year 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, 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 compiled; and capacity assessment of current and potential programming for each identified priority.

FHW hosts MCH partner meetings twice each year in the spring and fall. These meetings are open to anyone, and efforts are made to extend the invitation broadly by offering both in-person and virtual meetings. During the meetings, participants are asked to consider the progress made on performance measures during the past year and make recommendations for the next year's action plan based on that evaluation.

Identified MCH Priorities and Five-Year State Action Plan

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. Each selected priority was paired with relevant National Performance Measures (NPMs) and State Performance Measures (SPMs) to guide tailored, data-driven strategies aimed at improving health outcomes and ensuring everyone achieves their full health potential across the state.

As a result of the Needs Assessment, TDH identified priority needs for the MCH population for the 2021-2025 Block Grant cycle. The identified priority areas are as follows: Increase Family Planning (SPM 1); Decrease Pregnancy-Associated Mortality (NPM 1, SPM 2, SPM 4, SPM 23); Increase Breastfeeding (SPM 4); Decrease Infant Mortality (NPM 3, NPM 5A, NPM 5B, NPM 5C, NPM 14A, SPM 5); Decrease Overweight and Obesity Among Children (NPM 8.1, SPM 6, SPM 24); Increase Prevention and Mitigation of Adverse Childhood Experiences (SPM 8, SPM 9, SPM 10); Decrease Tobacco and E-cigarette Use Among Adolescents (NPM 14.2, SPM 11-13); Increase Access to Medical Homes (NPM 11, SPMs 14–17); Improve Transition from Pediatric to Adult Care (NPM 12, SPMs 18–20); and Improve Mental Health (SPM 21-22). Each priority plan was designed to promote fair access and support the best possible health outcomes for all populations.

Role in Supporting Comprehensive 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 (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 ensure 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 the 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 ensure 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 advancing dignity, fairness, and well-being. 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 families are integrated as representatives. Furthermore, in the comprehensive redesign of the CSS, HUGS, and Community Outreach programs into the streamlined CHANT program, family engagement was incorporated in the design process to ensure that the needs of children and families are being met appropriately.

Assuring MCH Populations Achieve Their Full Health Potential

FHW is committed to ensuring that all MCH populations have the opportunity to achieve their full health potential. This commitment is rooted in a system of care that prioritizes access, quality, and responsiveness for all communities. Tennessee’s approach is anchored in multisector partnerships, robust public health infrastructure, and continuous engagement with families, communities, and individuals.

Further, the state integrates family and community perspectives throughout all stages of program design, implementation, and evaluation. This includes dedicated advisory groups across population domains, the integration of parent and youth voices in strategic planning, and collaboration with family-led organizations such as Family Voices of Tennessee. Whether through statewide advisory councils, parent focus groups, or youth advisory boards, these efforts ensure that those most impacted by health policies and programs are guiding them. Programs like the Maternal Health Innovation initiative, Breastfeeding Peer Counseling, and CHANT provide community-embedded services that uplift identified priorities as a central component of care.

By centering its MCH/Title V efforts on high-quality services, shared decision-making, and community-driven strategies, Tennessee continues to enhance its capacity to meet the evolving needs of MCH populations and improve health outcomes for families statewide.

III.A.2. How Federal Title V Funds Complement State-Supported MCH Efforts

Tennessee’s Maternal and Child Health (MCH)/Title V program has long demonstrated the critical role of federal funds in supporting the state’s overall MCH efforts, fostering a strong federal-state partnership aimed at improving the health and well-being of the MCH population. Federal MCH/Title V Block Grant funds, approximately $12 million annually, are essential to meeting Tennessee's MCH priorities. These funds are complemented by an additional $13 million in state funds, which meet the maintenance of effort and match requirements. This funding is allocated across central, regional, and local health department staff and programs, supporting a comprehensive approach to MCH issues throughout the state.

The flexibility of MCH/Title V funding allows Tennessee to align resources and strategies to address the unique needs of the MCH population. The Tennessee MCH program utilizes both federal and state funds to support a wide range of initiatives aimed at improving MCH outcomes. One example is the use of MCH/Title V funding to support the School Health Nurse Consultant position within the Department of Education. This role is responsible for coordinating, supporting, and evaluating school health services in Tennessee, ensuring compliance with state and federal laws while promoting high-quality care for school-age children. In addition, the School Health Nurse Consultant is partnering on multiple MCH priorities to improve school-based outbreak readiness, increase education on preventable diseases through vaccinations and provide peer-to-peer mental health promotion trainings to youth within schools and community and faith-based settings. This position also provides technical assistance and consultation to school administrators, school nurses, health care providers, and others regarding delivering quality health care in Tennessee schools.

Tennessee’s MCH/Title V program exemplifies the power of the federal-state partnership, with MCH/Title V funds playing a pivotal role in supporting the state’s MCH priorities, enhancing local health infrastructure, and fostering collaboration across a broad array of partners. Through thoughtful planning, flexible funding, and strategic partnerships, the MCH/Title V program continues to contribute to the overall health and well-being of Tennessee’s MCH population. For example, reducing and mitigating the effects of Adverse Childhood Experiences (ACEs) is currently a priority area for the Tennessee MCH/ Program, 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.

III.A.3. MCH Success Story

Enhancing Care Coordination Through the FindHelp Closed-Loop Referral System (CLRS)

Context & Need for Innovation: Several Maternal and Child Health (MCH) programs in Tennessee, including Community Health Access and Navigation in Tennessee (CHANT), Evidence-Based Home Visting (EBHV), and others, serve as critical navigation systems, helping families connect to essential medical and social services. However, traditional referral methods relied on paper-based processes and standalone databases, limiting efficiency, follow-up, and coordination across agencies. Recognizing the need for innovation, FHW sought to improve care coordination through a digital Closed-Loop Referral System (CLRS). TennCare, Tennessee's Medicaid agency, supported this initiative and encouraged FHW to pilot FindHelp, a CLRS referral platform designed to track service delivery, improve access, and integrate community-based resources.

The FindHelp Pilot: From July to September 2024, TDH piloted FindHelp within the CHANT program, focusing on enhancing care coordination and streamlining referrals. The pilot took place in seven counties (one urban, six rural) and involved 16 Care Coordinators (CCs), who integrated FindHelp into their daily workflows to locate services and track referral outcomes.

Key Results:

- 825 searches & 190 referrals were made, ensuring families were connected to needed services.
- 30% of referrals were successfully closed-loop, meaning providers confirmed service delivery.
- 49% of CCs discovered new community resources they had not previously used, expanding access to services such as housing, food, and mental health support.
- Ease of use: 4.4/5 rating. A CC noted: *"FindHelp makes tracking my patients and referrals much easier without needing to switch between platforms."*

Statewide Expansion & Long-Term Vision: The pilot's success demonstrated FindHelp's potential to transform care coordination, leading TDH's Executive Leadership to formally partner with TennCare. Recognizing the value of this innovation, TennCare agreed to absorb the platform's cost, ensuring its integration into statewide public health programs. As of this year, FindHelp is being implemented in CHANT, EBHV, and the Viral Hepatitis Program, with 40,000 weekly searches from 11,000 users statewide. This expansion will enhance care coordination across MCH programs, improving access for families facing health-related social needs, including food insecurity and housing instability.

The long-term vision is to establish a coordinated, statewide care system with a "no wrong door" policy, ensuring families can seamlessly access services regardless of where they enter the system. This approach will integrate key partners—including community-based organizations, government agencies, healthcare providers, and schools—into a unified network that efficiently identifies, refers, and supports individuals in need. By ensuring access to critical services, this system will streamline navigation and enhance support for families. Ultimately, FHW aims to integrate all programs into FindHelp, creating a centralized, technology-driven infrastructure to serve communities across Tennessee.

III.B. Overview of the State

III.B.1. State Description

Demographics, Geography, Economy, and Urbanization

Tennessee spans approximately 500 miles east to west, 110 miles north to south, and is bordered by eight other states. To drive across the state, from Memphis to Pigeon Forge would take about eight hours, without traffic. The state, comprised of 95 counties, is geographically, politically, and constitutionally divided into three Grand Divisions: East, Middle, and West. East Tennessee, comprised of 35 counties, is characterized by the Blue Ridge mountains and rugged terrain. This region includes Knoxville and Chattanooga (the 3rd and 4th largest cities in the state) as well as the "Tri-Cities" of Bristol, Johnson City, and Kingsport, located in the northeastern part of the state near the borders to Virginia and North Carolina. Middle Tennessee consists of 39 counties, has the largest land area, and is characterized by rolling hills and fertile stream valleys. Middle Tennessee is the least densely populated of the three Grand Divisions yet houses the state's capital and largest city. West Tennessee, bordered by the Mississippi River on the west and the Tennessee River on the east, contains 21 counties. This region has the smallest land area and is the least populous of the three Grand Divisions, yet it contains the second most populous city in the state – Memphis. Outside of Greater Memphis, the region is mostly agricultural.

In 2024, Tennessee's population was estimated to be 7.2 million. Compared to the United States, Tennessee has a smaller foreign-born and non-native English-speaking population. The state fares better than the nation in terms of unemployment, home ownership, and high school graduates. However, the state sees slightly worse rates of poverty and uninsurance. The tables below compare Tennessee to the US on different demographic characteristics based on the most recent 2024 Census data estimates.[1]

Race and Hispanic Origin	Tennessee (%)	United States (%)
White alone	78.4	75.3
Black or African American alone	16.5	13.7
Two or more races	2.3	3.1
Asian alone	2.1	6.4
American Indian and Alaska Native alone	0.6	1.3
Native Hawaiian and Other Pacific Islander alone	0.1	0.3
Hispanic or Latino	7.5	19.5

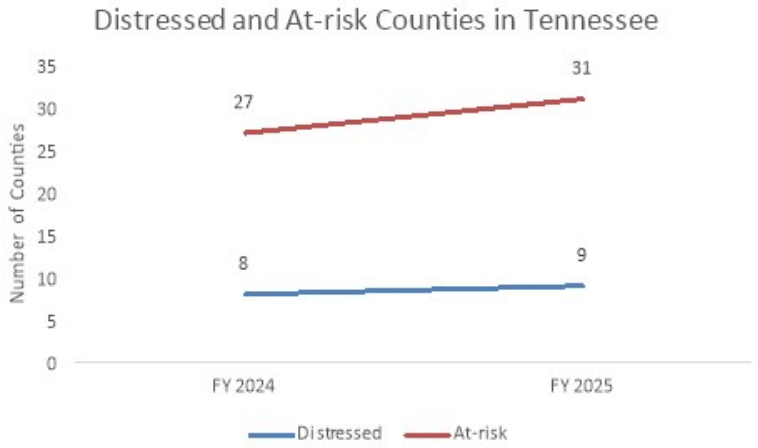
Ethnicity	Tennessee (%)	United States (%)
Hispanic	7.5	19.5
Non-Hispanic	94.5	80.5

Nativity and Language	Tennessee (%)	United States (%)
Foreign born	5.9	13.9
Language other than English spoken at home	8.3	22.0

Socioeconomic Factors	Tennessee (%)	United States (%)
High school graduates or higher	89.6	89.4
Total employment percent change, 2021-2022*	5.3	5.8
Homeownership rate, 2019-2023	67.0	65.0
Persons in poverty	14.0	11.1
Without Health Coverage	11.1	9.5

**Employment percent change is computed by subtracting the previous year's employment figure from the current year employment figure; this result is then divided by the previous year's employment figure to obtain the percentage change.*

Distressed counties rank among the 10 percent most economically distressed counties in the nation. Each year, the Appalachian Regional Commission (ARC) prepares an index of county economic status for every county in the United States. Economic status designations are identified through a composite measure of each county's three-year average unemployment rate, per capita market income, and poverty rate. Based on these indicators, each county is then categorized as distressed, at-risk, transitional, competitive, or attainment. As of State FY 2025, there were 9 distressed and 31 at-risk counties in Tennessee, representing an increase of 1 distressed and 4 at-risk counties from State FY 2024.[2]



Population Characteristics

In Tennessee, there are almost 1.4 million women of reproductive age (15-44), comprising 20% of the state's total population in 2023.[3] The number of live births in 2023 was 82,035, translating to a fertility rate of 58.2 per 1,000 women aged 15-44. There are 1.5 million children under the age of 18 in Tennessee, and it is estimated that 326,868 are children with special health care needs, making up approximately 21% of Tennessee's child population. This compares to 21% of the nation[4]. Through efforts to advance emergency preparedness, Tennessee used AMCHP's "Public Health Emergency Preparedness and Response Checklist for Maternal and Infant Health" to calculate estimates of the number of pregnant women (S2-A2), as well as infants and children <5 years statewide, by region, and by county. Using the Centers for Disease Control and Prevention's "Estimating the Number of Pregnant Women in a Geographic Area: A Reproductive Health Tool," there are an estimated 62,532 pregnant women in Tennessee at a given point in time, with county ranges between 31 and 10,288. There are 81,188 infants in Tennessee, with county ranges between 47 and 12,674. There are 407,366 children under 5 years old in Tennessee, with county ranges between 218 and 64,464.

Health Status of Tennessee's MCH Population

According to the 2024 Annual Report for America's Health Rankings, Tennessee continues to rank 44th in the nation for overall health.[5] Historically, Tennessee has ranked in the bottom ten states for this overall measure.[6] The state ranks poorly on several key MCH, chronic disease, and conditions that influence health outcomes. From 2023 to 2024, the following indicators worsened, remained unchanged, or improved.

Worsened:

- Uninsured **41st**
  - Previously 40th
- Teen births **45th**
  - Previously 44th

- Preventable hospitalizations **31st**
  - Previously 28th
- Income Inequality **29th**
  - Previously 23rd

Unchanged:
- Drug deaths **49th**
- Mental distress **46th**
- Fruit and vegetable consumption **30th**
- Dental Care Providers (Number per 100,000) **45th**
- Mental Health Providers (Number per 100,000) **45th**

Improved:
- Smoking **47th**
  - Previously 48th
- Childhood Immunizations **35th**
  - Previously 41st
- Multiple chronic conditions **47th**
  - Previously 48th
- Physical distress **45th**
  - Previously 47th
- Physical inactivity **33rd**
  - Previously 44th
- Obesity **40th**
  - Previously 46th
- Adverse Childhood Experiences **35th**
  - Previously 44th
- Excessive Drinking **10th**
  - Previously 11th
- Public Health Funding (Dollars per person) **20th**
  - Previously 25th
- Severe Housing Problems (% of occupied housing units) **18th**
  - Previously 19th

According to the Health of Women and Children Report, a sub-report of America's Health Rankings Report, Tennessee ranked 43rd overall in 2024.[7] Compared to 2023, the overall health ranking of women in Tennessee declined in 2024, decreasing two rankings from 41st to 43rd.[8] Strengths noted included a low prevalence of illicit drug use among adolescents, a low prevalence of public-school students experiencing homelessness, and a high prevalence of developmental screenings. The report identified challenges such as a high mortality rate among women ages 20-44, a high prevalence of multiple chronic conditions among women, and a high prevalence of frequent mental distress among women.

The 2024 report also highlighted the following changes in maternal and child health indicators:
- 37% reduction in the percentage of cigarette smoking during pregnancy between 2019 and 2022
- 33% increase in the rate of injury deaths among women ages 20-44 between 2016-2018 and 2020-2022
- 13% increase in child mortality among children ages 1-19 between 2017-2019 and 2020-2022
- 17% decrease in poverty among women ages 18-44 between 2018 and 2022

Tennessee's Strengths and Challenges

State Systems of Care for Medically Underserved Communities

As of May 2025, Tennessee is home to 15 Critical Access Hospitals strategically designated to preserve access to primary and emergency health services in rural areas. These hospitals are situated in counties with less healthy populations, which exhibit higher rates of obesity, diabetes, preventable hospitalizations, cardiovascular deaths, and cancer deaths compared to state and national benchmarks. Moreover, these rural counties have fewer physicians and a higher proportion of residents living in poverty, along with a significant Medicaid population. These hospitals have 25 beds or fewer and are located more than 35 miles from the nearest hospital.

As of March 2024, 93 of Tennessee's 95 counties are federally designated as either whole or partial-county Health Professional Shortage Areas (HPSAs) for primary care, based on either the low-income population or geography. This has increased from March 2024, when 90 counties were designated as such. Additionally, 86 of the state's counties are designated as federal Dental HPSAs, and 93 counties are designated as federal Mental Health HPSAs.

Federally Qualified Health Centers (FQHCs) offer comprehensive preventive and primary care services in at risk urban and rural areas. By both mission and law, FQHCs provide care to all patients who walk through their doors, regardless of their insurance status or ability to pay. There are 30 Federally Qualified Health Center (FQHC) organizations in Tennessee, with approximately 175 satellite sites across the state. The 30 FQHCs in Tennessee have sites in 68 of the state's 95 counties. The Tennessee Primary Care Association (TPCA) is the membership association for FQHCs across Tennessee. TPCA provides training, support, leadership, and empowerment for health centers. FQHCs are struggling to retain a qualified workforce, as it has become increasingly difficult to recruit medical, dental, and behavioral health providers.[9]

Community and Faith-Based (CFB) clinics provide affordable healthcare to reduce emergency room visits and hospital costs. They support Tennesseans by offering a medical home and continuous care. Services include preventive care, primary and specialty medical care, oral health, mental health, substance abuse treatment, vision care, diagnostics, and pharmaceuticals, available for free or at a low cost. The Tennessee Charitable Care Network (TCCN) is a statewide association representing CFB organizations and clinics. It includes 42 member organizations, 53 locations, and a growing number of mobile clinics, providing healthcare in 64 of Tennessee's 95 counties.

During FY2024, a total of 56 Local Health Departments (LHDs) provided primary care services, while 33 of these departments offered dental care services. Out of these clinics, 16 primary care clinics and seven dental clinics are designated as FQHCs. These 16 LHDs, recognized as FQHCs, received funding from the Uninsured Adult Healthcare Safety Net Program, collectively delivering 26,537 medical encounters to 11,909 unduplicated, uninsured patients aged 19 to 64 years. In comparison, the 40 non-FQHC LHD clinics facilitated 50,034 medical service encounters for 23,126 unduplicated patients.

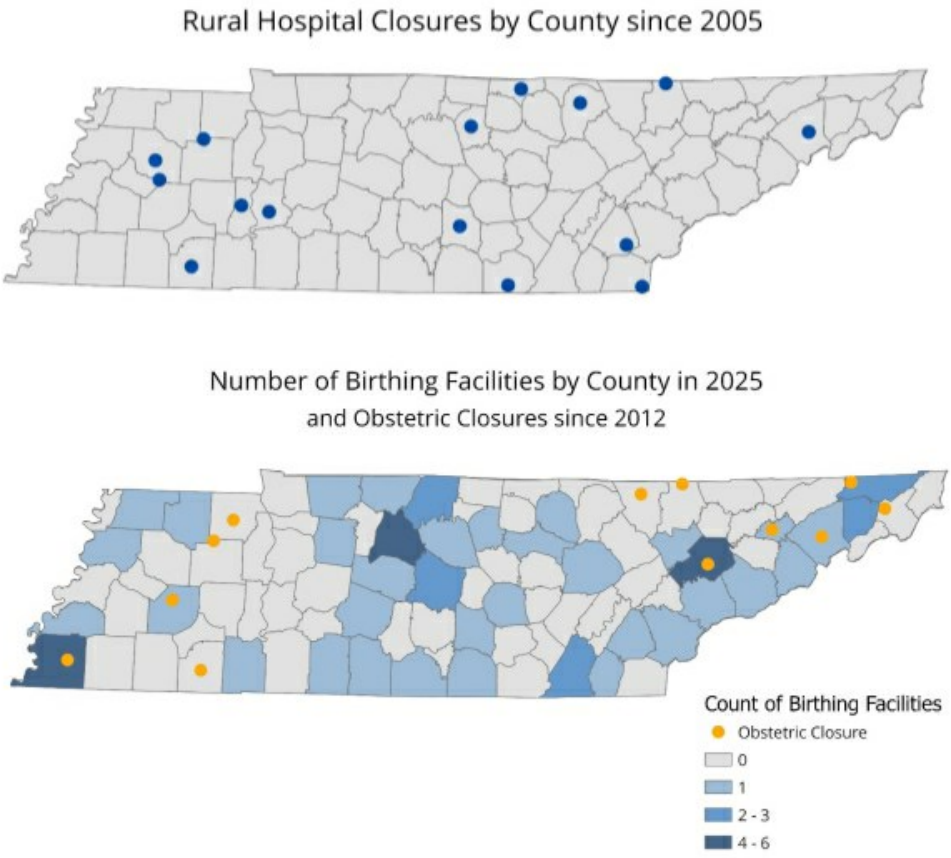
The distribution of primary care providers varies across the state. A map with health resource shortage areas for obstetrics and pediatrics can be found in the Supporting Documents section. As of January 2023, TDH Division of Health Licensure and Regulation[10]:

Specialty	Actively Licensed Physicians (Total= 7734)
Obstetrics and Gynecology	1242
Family Medicine/General Practice	3123
Pediatrics (includes subspecialities and Med/Peds)	3205

The most pressing primary care workforce shortages in Tennessee are in the field of obstetrics. Nearly a third of

Tennessee counties are a maternity care desert, with 18 Tennessee rational service areas (can be one or more counties together) having zero obstetric providers. According to FY24 Female Population of Childbearing Age to Obstetric Provider Ratio Table, among the 95 Tennessee counties, thirty-six (37.9%) have no obstetric providers, nine have patient: obstetric provider ratios greater than 100,000:1, 34 have patient: obstetric provider ratios between 10,000:1 and 100,000:1, and 16 have ratios less than 5,000:1.

Since 2005, Tennessee has had 15 rural hospital closures and ranks second in the nation for the most hospital closures.[11] Nearly a quarter of rural Tennessee counties lack a hospital. Additionally, 45 percent of hospitals have unsustainable financial metrics, putting them at an increased risk of closure, up from 23 percent of hospitals in 2019.[12] Further, Tennessee had 57 birthing hospitals and two birth centers (a total of 59 birthing facilities) in FY2025 (see figure below), down from 68 in 2016.[13] Since 2012, there have been 12 obstetric closures, including three full hospital closures, five obstetric facility closures, and four obstetric department mergers; of these 12 closures, five have occurred in rural counties. Of the 95 Tennessee counties, 57 (60%) do not have a birthing facility.[14]



In 2024, 59 Tennessee birthing facilities participated in the Centers for Disease Control and Prevention's Levels of Care Assessment tool (CDC LOCATe^{SM}). The Tennessee Department of Health had previously implemented LOCATe^{SM} in 2018, but several updates have been made to the survey tool since Tennessee birthing facilities initially participated. The most notable changes to LOCATe^{SM} reflect the 2019 American College of Obstetricians and Gynecologists/Society for Maternal-Fetal Medicine publication on Maternal Levels of Care. LOCATe^{SM} was electronically administered through REDCap. The CDC analyzed data, and letters with LOCATe^{SM} results were sent to birthing facilities. LOCATe^{SM} assessments revealed that Tennessee has 26 facilities below level II, 26 at level II, 6 at level III, and 1 at level IV for neonatal care. For maternal care, there are 18 facilities below level I, 28 at level I, 10 at level II, 2 at level III, and 1 at level IV. Notably, Tennessee had a 100% response rate, with all 59 birthing facilities successfully participating in LOCATe^{SM}.

The Tennessee Department of Health (TDH) coordinates the Tennessee Regional Perinatal Centers, comprising five regional centers across the state. These centers ensure a robust statewide infrastructure for high-risk obstetric and infant care, offering 24/7 direct clinical care and consultation, education for community hospitals and providers, and technical assistance to state agencies. In FY 2024, perinatal center staff performed 122,978 obstetrical consultations (outpatient), 6,518 NICU follow-up clinic visits, and 1,310 neonatal transports to or from the Regional Centers. Additionally, they provided 9,051.5 hours of education throughout the state. The Perinatal Advisory Committee (PAC) is addressing the lack of prenatal care in the state's rural communities and the role that Emergency Medical Services (EMS) providers play in transport and care. A PAC member has been working with the EMS Board toward updating their standards for personnel to require Neonatal Resuscitation training and certification (NRP) and to require that all emergency vehicles carry appropriate equipment for serving the tiniest babies. All Regional Perinatal Centers provide NRP training, but the cost of certification and recertification has been a barrier. The Department has purchased the electronic training materials for use by all trainers and trainees in the regional centers and also purchased small amounts of certification exams for this past year and the upcoming year for use by the Centers with their EMS providers.

TDH works closely with TennCare, the state of Tennessee's Medicaid program that provides health care for approximately 1.5 million Tennesseans and operates with an annual budget of approximately $18.6 billion. TennCare members are primarily low-income pregnant women, children, and individuals who are elderly or have a disability. TennCare covers approximately 20 percent of the state's population, 50 percent of the state's births, and 50 percent of the state's children.[15] TennCare is a critical and valuable partner in serving Tennessee's MCH population.

Children's Special Services (CSS) is Tennessee's state MCH/Title V program for Children and Youth with Special Health Care Needs (CYSHCN). Founded in 1919 and governed by state code, CSS acts as a payor of last resort and provides care coordination for families. It aims to fill critical gaps in services through broad family and partner engagement, particularly in pediatric to adult transition and patient-centered medical homes. The CSS program offers coverage for comprehensive medical care and non-medical resources for children with physical disabilities and special health care needs from birth to 21 years, with participation requiring specific diagnostic and financial eligibility criteria. CSS consists of two main components: medical services, which include reimbursement for physician visits, hospitalizations, medical supplies, pharmaceuticals, durable medical equipment, and therapies for eligible children, and care coordination, which assists families in coordinating primary and specialty care through designated primary care physicians and managed care organizations. Care coordinators help families access educational, medical, social, transportation, support, and empowerment services. CSS operates in all 95 counties through local and metropolitan health departments.

While CSS is core to CYSHCN services in Tennessee, CYSHCN priorities for this medically underserved area extend beyond the program to include broad family and partner engagement, particularly in pediatric to adult transition and patient-centered medical home, as determined by the state needs assessment. CYSHCN staff have also coordinated some efforts at behavioral health integration. However, this has primarily occurred within healthcare delivery facilities, particularly FQHCs and safety net mental health centers. The Family and Youth Engagement program has also partnered with other state entities and with the local EMS, fire, and police department personnel to ensure families can self-identify a child with special health care needs in their vehicle or the home.

Roles, Responsibilities, and Targeted Interests of the State Health Agency

The Tennessee Department of Health's Division of Family Health and Wellness is committed to advancing maternal and child health outcomes. The Division provides leadership, direction, and accountability in meeting the needs of Tennessee's mothers, infants, and children, including children and youth with special healthcare needs, and their families. The Division utilizes a multifaceted approach that includes oversight, legislative analysis, and interagency collaboration. Tennessee's MCH/Title V Program ensures compliance with federal regulations, manages MCH/Title V funds, and conducts the five-year needs assessment that establishes priorities and the direction for programming. This is all facilitated while engaging community and partner input through public meetings and advisory committees.

Additionally, the placement of Tennessee's MCH/Title V Program in the Division of Family Health and Wellness ensures alignment with MCH-related programs to bolster the program and offer well rounded, supportive services for MCH populations and their families. One significant way this is achieved is through actively monitoring and reviewing legislative proposals. Staff contribute to the development of policy briefs and impact statements, helping lawmakers understand how proposed legislation may affect maternal and child health services statewide.

Tennessee's MCH/Title V Program plays a pivotal role in shaping, coordinating, and evaluating maternal and child health services across the state. This strategic direction, informed by data and grounded in community voices, ensures that MCH/Title V services are efficient, effective, and promote positive health outcomes for the populations it serves.

State Statutes and Other Regulations Impacting MCH/Title V

Numerous state laws and regulations impact the operation of MCH/Title V program services in Tennessee. Many of the laws provide TDH authority to operate programs such as family planning, CSS, evidence-based home visiting, fetal infant mortality review (FIMR), child fatality review (CFR), maternal mortality review, or teen pregnancy prevention. Child fatality review and, more recently, maternal mortality review legislation provides funding and legal authority to enhance data collection to inform action.

Some state laws mandate specific activities or services related to the MCH population. For example, laws mandate that infants receive screening for metabolic/genetic conditions, critical congenital heart disease, and congenital hearing loss. Others mandate coverage for services such as hearing screening or hearing aids.

Other laws provide basic protections for the MCH population. These include Tennessee's child passenger restraint law (which was the first such law passed in the nation), as well as laws that require prophylactic eye antibiotics for infants, prohibit female genital mutilation, require schools to test for lead in water, and prohibit smoking in most public places.

Several laws establish committees that advise TDH on specific programs or services. These include the Children's Special Services Advisory Committee (services for children and youth with special health care needs), Perinatal Advisory Committee (perinatal regionalization), the Genetics Advisory Committee (newborn screening and follow-up), and the Traumatic Brain Injury Advisory Committee.

In addition to laws passed by the General Assembly, many programs and services related to the MCH population operate under rules and regulations promulgated by the TDH and approved by the Attorney General, Secretary of State, and Government Operations Committee of the General Assembly. Often these rules contain more detailed information on program operations than the law that established a particular program or service. Examples include rules related to newborn screening, operation of the CSS program, and operation of the child safety fund (funding from child safety seat violations used to fund the purchase of additional child safety seats for distribution in local communities).

Several new MCH-related laws were passed during the 2024 legislative session:

Genetic Advisory Committee

Public Chapter 28 (HB0247/SB0069) extends the genetic advisory committee to June 30, 2029.

Perinatal Advisory Committee

Public Chapter 29 (HB0257/SB0079) extends the perinatal advisory committee to June 30, 2029.

Traumatic Brain Injury Advisory Council

Public Chapter 41 (HB0284/SB0106) extends the traumatic brain injury advisory council to June 30, 2029.

Maternal Health Screening

Public Chapter 46 (HB0111/SB1283) amends current law regarding blood testing during pregnancy to enhance maternal and infant health protections. The updated law now requires testing at three specific points during pregnancy: the first prenatal visit (or within 10 days of that visit), between 28 and 32 weeks of gestation, and at the time of delivery. At the first visit, healthcare providers must test for syphilis, hepatitis B, hepatitis C, and verify rubella immunity—three of which (hepatitis B, hepatitis C, and rubella immunity) are newly added requirements. Later in pregnancy, between 28 and 32 weeks, and again at delivery, testing for syphilis is required. These changes are intended to support early identification and treatment of infections that can significantly impact the health of both the mother and the baby.

Children's Special Services Advisory Committee

Public Chapter 48 (HB0227/SB0049) extends the advisory committee for children's special services to June 30, 2029.

Hormonal Contraceptives

Public Chapter 68 (HB0693/SB0569) makes certain changes to the practice of pharmacy, including removing the present prohibition on requiring a patient to pay an administrative fee for pharmacist-provided hormonal contraceptives when the patient is insured or covered and receives a pharmacy benefit that covers the cost of the hormonal contraceptives.

Bereavement Leave

Public Chapter 74 (HB1312/SB1285) expands bereavement leave of certain state officers and employees to grant (i) three days paid leave in the event of the death of siblings, grandparents, grandchildren, foster parents, or parents-in-law; (ii) five days paid leave in the event of the death of parents or stepparents; and (iii) 10 days paid leave in the event of the death of a spouse, child(ren), or stepchild(ren).

Adoption Records

Public Chapter 79 (HB0102/SB1267) changes the age at which certain adoption records must be made available to certain adopted persons from 21 to 18.

Personal Responsibility Plan

Public Chapter 81 (HB0107/SB1287) removes the requirement that a parent or caretaker enter a personal responsibility plan that requires a child to attend school and receive immunizations and health checks; removes certain requirements for a parent or caretaker regarding personal responsibility plans; removes a 20 percent reduction in temporary assistance payments for failure to comply with certain personal responsibility plan requirements.

Urgent Maternal Warning Signs

Public Chapter 99 (HB0572/SB0575) requires all hospitals and birthing centers to provide information on post-birth warning signs, including symptoms and resources, to a mother and, if possible, to the mother's caregiver or at least one of the mother's family members prior to discharge following a birth; requires the department to provide all hospitals and birthing centers with information on post-birth warning signs, including symptoms and resources, and

to have the information available on the department's website.

Tobacco Products

Public Chapter 118 (HB0821/SB0707) specifies that a prospective purchaser of tobacco, smoking hemp, vapor products, or smokeless nicotine products must produce proof of age prior to the sale being made; increases from 30 to 50 years the apparent age above which a seller is not required to demand presentation of proof of age.

Type I and II Diabetes

Public Chapter 172 (HB0515/SB0680) requires an LEA and public charter school that provides parents or guardians of K-12 students with information on immunizations, infectious diseases, medications, or other school health issues to include information about Type 1 and Type 2 diabetes published by the department of education; directs the department, in cooperation with the department of health, to publish and make available to LEAs and public charter schools for free on its website certain information about Type 1 and Type 2 diabetes.

Critical Hospital Access

Public Chapter 196 (HB0843/SB1198) declares Perry County Community Hospital in Linden and Decatur County General Hospital in Parsons to be necessary providers for the purpose of critical access hospital designation eligibility in accordance with Section 1820 of the Social Security Act.

Tennessee Physician Workforce

Public Chapter 213 (HB0510/SB0554) requires the Department of Health to contact qualified medical organizations in Tennessee and request information on challenges, opportunities, and solutions related to physician workforce sustainability, including burnout, policy needs, training, access to care, and national trends.

Abortion

Public Chapter 217 (HB0990/SB1004) creates definitions for "inevitable abortion" and "serious risk of substantial and irreversible impairment of a major bodily function" providing more clarity to physicians in determining when a condition could qualify for an abortion to be performed that is not considered criminal.

Fertility Treatment and Contraceptive Protection Act

Public Chapter 247 (HB0533/SB0449) outlines protections for fertility treatment and contraception including that (i) an individual has a right to engage in activities associated with fertility treatment and contraception; (ii) the laws of this state do not prohibit an activity associated with fertility treatment or contraception; and (iii) the laws of this state clearly and unambiguously acknowledge the right of an individual to perform, and the right of an individual to receive or use, fertility treatment and contraceptives in this state.

Maternal Mental Health

Public Chapter 261 (HB09609SB0849) requires the department to collaborate with an organization in this state to create or identify a continuing education program to provide healthcare professionals with information or training relative to maternal mental health disorders.

Medical Ethics Defense Act

Public Chapter 266 (HB1044/SB0955) grants healthcare providers the legal right to decline to participate in or fund

any healthcare procedure, treatment, or service that violates their conscience.

Physical Activity/Recess

Public Chapter 306 (HB0085/SB0158) increases elementary school students' physical activity time from 130 minutes per full school week to 40 minutes per day, totaling 200 minutes per full school week. Additionally, a student may not be withheld from participating in physical activity as a form of punishment.

Vapor Products

Public Chapter 324 (HB0968/SB0763) requires the department of revenue to maintain a directory on its website that lists all vapor products certified as authorized to be sold in this state; levies a privilege tax of seven cents per milliliter of consumable material contained in a closed-system vapor product; levies a privilege tax at the rate of 10 percent of the wholesale cost price on vapor products.

Rescue Inhaler

Public Chapter 346 (HB0760/SB0817) authorizes a healthcare practitioner to prescribe and a pharmacist to dispense a prescribed, bronchodilator rescue inhaler to an authorized entity to be administered to a person believed to be experiencing asthma symptoms or respiratory distress in an emergency situation, under a standing protocol from the healthcare practitioner; encourages schools in LEAs and public charter schools to keep bronchodilator rescue inhalers to be administered to students believed to be having asthma symptoms or in respiratory distress in an emergency situation.

Families' Rights and Responsibilities Act Enforcement Reporting Act

Public Chapter 347 (HB0826/SB0895) outlines parental consent regarding medical treatment and video or voice recording of children on school property, as well as absences from school due to religious holidays.

Adoption Simplification Act

Public Chapter 386 (HB1180/SB1005) allows petitioners to include all children in one adoption or termination of parental rights petition if the petitioners are seeking to adopt more than one child at the same time and the children are siblings who share at least one biological parent, unless the court issues a written order finding that it is in the best interest of the children that separate petitions be filed; specifies that the clerk of court shall charge only one filing fee for such a petition.

Adoption Streamlining Act

Public Chapter 390 (HB1355/SB1052) specifies that a biological father or alleged biological father who makes token financial support to or for the benefit of a child or the child's mother during the pregnancy or when the mother had physical custody of the child is not a putative father; makes various other changes regarding final orders of adoption. Adds to the list of persons a healthcare provider can get informed consent from before vaccinating a minor to include biological, legal, adoptive parent, potential adoptive parent or individual granted medical decision-making authority over a child under state law.

Kinship Foster Placement

Public Chapter 393 (HB1356/SB1116) allows the Department of Children's Services to access sealed adoption records for the purposes of kinship foster placement.

Childhood Hunger

Public Chapter 397 (HB1357/SB1239) creates the Tennessee task force to end childhood hunger with the purpose of developing an action plan for ending childhood hunger. The task force shall recommend a strategic action plan to guide the administration and general assembly.

Red Dye 40

HB0134/SB0476 requires LEAs and public charter schools to prohibit food or beverage items that contain Red 40 to be sold, offered for sale, or provided to students on school property unless the food or beverage item is sold to the student as part of a school fundraising event.

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III.B.2. State Title V Program

III.B.2.a. Purpose and Design

Partnership and Leadership Roles in Accomplishing Goals and Mission

The purpose of the MCH/Title V Program is to broadly support and improve the health of women, infants, children, adolescents, and families in Tennessee. This is done by identifying priority needs and working with partners to leverage program capacity to meet those needs, which ultimately improves health outcomes. Tennessee's MCH/Title V Program works to convene MCH partners at least twice a year, so that all programs serving these populations can be strategically aligned statewide. This strategic alignment is imperative for utilizing resources efficiently and ensuring the greatest impact.

The MCH/Title V Director is building systems and communication strategies to ensure collaboration in addressing MCH Priorities. Since starting in her role in September 2023, she meets monthly with the Director of Strategic Initiatives, the Director of the Division of Health Disparities, and the Director of the Office of Primary Prevention. She has successfully partnered with the Office of Strategic Initiatives to utilize Public Health Emergency Preparedness (PHEP) and Public Health Infrastructure Grant (PHIG) to support the MCH workforce. She meets on a regular basis with counterparts at the Department of Mental Health and Substance Abuse Services and the Department of Education to build relationships, share information, and align strategy, which will continue on a monthly basis. Additionally, she meets monthly with the Deputy Chief Medical Officer at TennCare and with the Executive Director of the Tennessee Initiative for Perinatal Quality Care and quarterly with the Tennessee Chapter of the American Academy of Pediatrics. She holds quarterly meetings with regional and metro counterparts to coordinate MCH programming and highlight successes. Similar to previous years, she also holds bi-annual opportunities for all

MCHB grantees to come together to share progress and success on grants and identify areas to decrease duplication of effort and increase collective impact.

Recently, the MCH/Title V Director has been cultivating relationships with philanthropy organizations throughout the state to explore public-private partnerships to advance Tennessee's first-ever Maternal Health Strategic Plan, published in January 2025. This effort is sustained statewide through the AimHiTN organization, in a new Action Team, with the goal to establish and strengthen public-private partnerships to collaboratively improve maternal health outcomes. Action steps identified by this team include: 1) Support the awareness and implementation of the TDH Maternal Health Strategic Plan; 2) Develop a mechanism for aligning philanthropic and public funding to streamline the goals of the TDH Maternal Health Strategic Plan; 3) Identify opportunities for coordinated initiatives by maintaining awareness of the goals and progress of other action teams; 4) Identify strategic priorities for selected policy initiatives; and 5) Increase education and awareness efforts in the philanthropic community across Tennessee.

The MCH/Title V CYSHCN Section continues to strategically align with partners vital to the accomplishment of established goals and priorities for the families and children served. Collaboration with the Tennessee Family Voices Program has considerably increased the Team’s ability to provide training and leadership to youth, parents, guardians, and family members on the Six Core Indicators indicative of a well-functioning system of care. This allows the CYSHCN team to further the mission of ensuring that all families participate in the decision-making process of the child’s health care and that they are included in processes that create decisions about their transition to adulthood and independence.

Framework and Approach to Addressing the MCH Priorities

The MCH Block grant works within a life course framework, operationalized by the population health domains below. Through these domains, the MCH population is subdivided into time periods that represent important stages in life. States are required to choose at least one priority within each domain, ensuring that priorities are spread across the life course.

Population Health Domains:
- Women/Maternal Health
- Perinatal/Infant Health
- Child Health
- Adolescent Health
- Children with Special Health Care Needs (CYSHCN)
- Cross-Cutting/Systems Building

Utilizing information gathered through the comprehensive needs assessment, the Tennessee MCH/Title V program identifies priority areas and then assembles teams to work on each area. FHW senior leaders, along with their program/epidemiology staff, are entrusted to oversee at least one priority. The teams they create are responsible for developing action plans, implementing the plans, reporting on progress, and measuring success. All of this is done in collaboration with MCH partners at multiple touchpoints throughout the year. In addition to FHW senior leadership and program/epidemiology staff, the MCH/Title V core team’s Emergency Preparedness and Response Coordinator, Adolescent Health Lead, and the Director of Quality Improvement lead one priority while the SSDI Epidemiologist supports a priority team with strategies, activities, and measures. The MCH Block Grant Coordinator and SSDI Project Coordinator provide administrative coordination and oversight for programs and initiatives focused on improving health outcomes for all. This new organization infrastructure has strengthened expertise and support for the Division to better inform MCH/Title V priorities and activities.

MCH/Title V Program: Ensuring Access to Quality Health Care for Families and Communities

Implementation of the CYSHCN Blueprint for Change

The CYSHCN team participated in trainings on the *Blueprint for Change* to ensure families have adequate access to care. The team Epidemiologist helped to determine what the state is doing within the 4 domains of the *Blueprint for Change* and the Six Core Indicators. The team held a series of meetings to study the most current data and use the *Blueprint* as a starting point for identifying the work that is currently being done, and to develop future activities and priorities. Ten potential health indicators were identified during the team's discussion:

1. Families as Partners
2. Adequate Insurance
3. Early and Continuous Screening
4. Medical Home
5. Access to Community-Based Services
6. Transition to Adulthood
7. Health Information Technology
8. Access to Care
9. Health outcomes in CYSHCN Services and Supports
10. Quality of Life for CYSHCN Children

The identification of these potential health indicators directly aligns with the four domains: assurance, quality of life, access to service, and financing. Identification of possible qualitative questions/topics for focus groups was also an outcome during the team meetings. After identifying the potential health indicators, the team was also able to decide on community partners for the domain. Utilizing the *Blueprint* has been a great asset to the needs assessment process and continued care coordination for Tennessee's children and youth with special healthcare needs.

A major success of utilizing the *Blueprint* was the development of a comprehensive work plan that highlighted the efforts underway within the team and how they align with the *Blueprint's* key areas and strategies. The team held a meeting to evaluate the work already completed and to identify areas where the *Blueprint's* strategies had not yet been fully met. In this process, the team also examined the initiatives being carried out by other sections of the Division, focusing on collaboration and coordination efforts to prevent the duplication of services and maximize resources. Once the work plan was developed, the section chief shared it with a broader audience during the AMCHP Partners meeting in October and the MCH Partner meeting in November. During these discussions, the team, along with the partners, realized that a significant portion of the *Blueprint's* goals and strategies were already being addressed by partners outside of the CYSHCN team. This insight opened up new avenues for collaboration and partnership across various areas, enabling the team to leverage existing work and strengthen collective efforts. By working together, additional opportunities were identified, such as partnering with Evidence Based Home Visiting Program to complete the access to care strategy that addresses interoperability across service sectors, due to them working on a similar strategy. Another opportunity that was identified was to utilize the partnership with TNAAP, Family Physicians group, and other entities to develop and provide trainings around trauma-informed care for Care Coordinators. These opportunities were identified to meet the expectations of the *Blueprint's* four key areas and its forty strategies, ensuring that progress continues in a more integrated and efficient manner.

III.B.2.b. Organizational Structure

Organizational Structure and Placement of the State Health Agency and Title V MCH and CSHCN Programs

Tennessee's Maternal and Child Health (MCH) initiatives are overseen by the Tennessee Department of Health (TDH), the state's cabinet-level public health agency. TDH's mission is to protect, promote, and improve the health and wellbeing of all people in Tennessee. The Department operates based on core values of service, excellence, trust, and compassion. TDH's strategic plan focuses on eight goals, all of which align closely with Tennessee's MCH priorities. In addition, the State Health Plan (2024-2026) is a key document outlining Tennessee's health priorities, which are grouped into four main areas: a healthy start, a healthy life, a healthy environment, and a healthy system of care. This plan includes eight priorities that directly support MCH, including Maternal and Infant Health, Nutrition Security, Chronic Conditions, and Workforce Development.

Within TDH, the Division of Family Health and Wellness (FHW) manages Tennessee's MCH/Title V programs. The Division's purpose is to provide high quality resources and availability of care to Tennessee families through developing a skilled workforce and fostering community partnerships. This Division manages the Department's portfolio of programs and initiatives related to Maternal and Child Health, Chronic Disease Prevention and Health Promotion, Injury Prevention and Detection, and Supplemental Nutrition. FHW is responsible for the programmatic implementation of core public health services at the populational level (newborn screening) and within local health departments (i.e., family planning, breast and cervical cancer screening, care coordination and navigation, Children's Special Services, and WIC) in addition to health promotion activities (tobacco prevention, lead prevention and case follow up, etc.) as well as management of programs external to the department such as Evidence Based Home Visiting and expanding systems capacity for priorities spanning from perinatal care to diabetes prevention programs.

The Community Health Services (CHS) Strategic Plan aligns closely with both Tennessee's State Health Plan and the MCH/Title V Block Grant. FHW actively seeks to provide direct services and enhance partnerships with local health departments, community organizations, and the broader population. This collaborative approach ensures that all people in Tennessee have the knowledge, ability, and access to primary health planning and prevention services.

Continuous evaluation is a cornerstone of TDH's MCH/Title V programs, ensuring that quality is prioritized, and services remain available. The Department works to incorporate feedback from community partners and health professionals into programming. Additionally, through its commitment to building a workforce representative of all communities, the Division is equipped with the skills and knowledge to address the complex needs of Tennessee's MCH population.

Overall, Tennessee's MCH/Title V initiatives are strategically aligned with state health priorities to improve the health and wellbeing of women, children, and families, reflecting a life-course approach to public health.

State Health Agency's Responsibility for Administration of Programs Funded by Title V MCH Block Grant

The Tennessee Department of Health (TDH) is responsible for the administration and supervision of programs funded through the Maternal and Child Health (MCH) Block Grant, in accordance with Section 509(b) of the MCH/Title V program. The MCH Block Grant provides federal funds, complemented by a state match, to support a wide range of services aimed at improving the health and well-being of women, children, and families across Tennessee. TDH ensures these funds are effectively allocated to programs that address critical health issues, including maternal and infant health, chronic conditions, developmental disabilities, and special healthcare needs. Below is a list of programs funded by the Title V MCH Block Grant, detailing their purposes and the ways in which they contribute to meeting the health needs of Tennessee’s population.

Primary Care – Child Health

A significant portion of Tennessee's federal MCH dollars is directed toward the RVU (Relative Value Unit) program, a method used by the Centers for Medicare and Medicaid Services (CMS). This program provides financial support for a variety of services for children to access care in all 95 local health departments, including physical exams and preventive care; immunizations and vaccine administration; screenings, counseling, and educational services; specialized health assessments (e.g., various laboratory work); nutritional and behavioral interventions; telehealth services; dental care services; interpreter services; and special health visits and home visiting. The RVU model ultimately supports the broad range of services that contribute to the overall health of all communities, ensuring that they receive necessary screenings, vaccinations, and health interventions.

Breast and Cervical Cancer Program

Tennessee's Breast and Cervical Screening Program contracts with each Tennessee metro (Hamilton County, Knox County, Madison County, Metro Nashville, Shelby County, and Sullivan County) to implement Women's Health Navigators (WHN) to support women through their recommended services. WHNs aim to identify and address barriers to care and improve access to services for women, such as wellness exams, cancer screenings, and family planning.

Breast and Cervical DPA

The Delegated Purchase Authority (DPA) provides direct services to eligible individuals for breast and cervical cancer screening and diagnostic services. An eligible individual is someone who is uninsured or underinsured, low-income, and meets the clinical qualifications for breast or cervical cancer screening or diagnostic procedures.

Community Health Access and Navigation in Tennessee (CHANT)

The CHANT program offers voluntary care comprehensive care coordination services through Local Health Departments for eligible families and children. It provides screenings, assessments, and connects families to available resources. Additionally, it assists with reimbursements for medical services, co-pays, deductibles, and co-insurance for pregnant and postpartum adolescents and women, all children less than five (5) years of age, TennCare eligible kids up to 21 years of age, and children and youth with special healthcare needs up to 21 years of age.

Tennessee Disability Coalition (Family Voices)

Family Voices maintains programs that provide support for families of children and youth with special healthcare needs, continuously assessing differences in health outcomes and providing ongoing consultation and support to the MCH/Title V Block Grant. The contracted partner organization maintains the Tennessee Parent-to-Parent (P2P) program which connects families of children and youth with special health care needs to peer support and education. This includes outreach, training, and individualized support through a network of trained volunteer support parents. Moreover, the Coalition receives referrals from the Tennessee Birth Defects Surveillance System and provides assistance to families by connecting them to resources and services.

Tennessee Council on Developmental Disabilities

This multi-agency contract funds activities that provide statewide information and referral services for individuals with disabilities, their families, and service providers. Key objectives include expanding a comprehensive database of

disability services and community resources, operating a toll-free helpline staffed by navigators, and providing information and assistance to medically underserved individuals and families across Tennessee.

Child Fatality Review and Prevention DSI/SIDS Training

In collaboration with Middle Tennessee State University (MTSU), this program focuses on increasing knowledge of SUID by training first responders through death scene investigation and educating professionals on SUID/SIDS. MTSU leads train-the-trainer initiatives across the state, including two in-person death scene investigation annual trainings, developing and maintaining training videos and booklets, developing and updating a Bereavement Support Services booklet, and maintaining and updating the online DSI training module. MTSU maintains a tracking system of where materials are distributed and how they are used, and they ensure that the project website stays updated. MTSU also works with TDH's Child Fatality Review (CFR) Program on two annual training conferences, one focused on safe sleep and SUID and one for child fatality review. Lastly, through this contract, MTSU pays for up to three medical examiners (as approved by the State Medical Examiner) to attend a pediatric forensic conference so they can stay abreast of information pertaining to infant death scene investigations.

Childhood Lead Poisoning

The Tennessee Department of Environment and Conservation conducts environmental investigations for children with elevated blood lead levels. Local health departments, such as Hamilton County and Shelby County, provide case management and community outreach for lead poisoning prevention. Additionally, the University of Tennessee maintains a database for blood lead test results to be reported to the state, as required by the reportable disease matrix including maintenance, upgrades, and training; support to providers and laboratories regarding blood lead test reporting; and quarterly data cleaning and submission to the Centers for Disease Control and Prevention.

Children's Special Services (CSS)

This program provides reimbursement for medical services for CSS enrollees. These services align with the goals and objectives of the CSS program and comply with federal MCH/Title V requirements. The program focuses on improving access to high-quality health services, including rehabilitative care, and offers family-centered, community-based, coordinated care systems for children and youth with special healthcare needs (CYSHCN).

Genetics Screening Program/Newborn Screening Follow-Up

Various contracted partners, including East Tennessee Children's Hospital, Erlanger Health, the University of Tennessee's Health Science Center, East Tennessee State University, and Vanderbilt University Medical Center, provide genetic, endocrine, and hemoglobinopathy follow-up services for newborn screening. These services ensure diagnostic testing and treatment for newborns with screen-positive results, with specific catchment areas across Tennessee (i.e., Knoxville, Chattanooga, Memphis, Johnson City, and Nashville).

Genetics/Sickle Cell Program

The Genetics/Sickle Cell Program contracts with Meharry Medical College and St. Jude’s Children’s Research Hospital to provide hemoglobinopathy services for newborn screening follow-up, including diagnostic testing and treatment. Meharry Medical College follows up with all newborns in the Nashville area and surrounding counties who test positive for hemoglobinopathy or possible traits. Additionally, Meharry performs confirmatory testing for all babies across the state of Tennessee who are suspected of having hemoglobinopathy disease or traits. Similarly, St. Jude’s Children’s Research Hospital provides follow-up services for newborns in the Memphis area and surrounding counties who test positive for hemoglobinopathy or possible traits, ensuring timely diagnostic testing and treatment.

Poison Control Center

The Tennessee Poison Center provides free, confidential poison information and treatment recommendations to Tennessee residents. It serves as a vital resource for preventing and managing poison-related incidents across the state.

State School Health Nurse Consultant

Through a partnership with the Tennessee Department of Education, the School Health Nurse Consultant is responsible for coordinating, supporting, and evaluating school health services in Tennessee, ensuring compliance with state and federal laws while promoting high-quality care for school-age children.

Family Planning

The Family Planning Services Program plays a crucial role in providing affordable contraception, preventive care, and essential health screenings, which help reduce the risk of unintended pregnancies, maternal and infant complications, and untreated health conditions. By offering these services, the program supports medically

underserved populations, including low-income and rural communities, and helps address existing preventable differences in health outcomes. The program also helps prevent the need for more costly emergency care and Medicaid coverage by promoting proactive health management, while ensuring that community clinics can continue to operate and provide these vital services.

III.B.3. Health Care Delivery System

III.B.3.a. System of Care for Mothers, Children, and Families

System of Care for Mothers, Children, and Families in Tennessee

1. Population Served

Tennessee's system of care for mothers, children, and families is designed to address the various needs of its population, with a particular focus on medically underserved communities. The state's public health infrastructure encompasses a wide range of programs and initiatives aimed at improving maternal and child health outcomes. However preventable differences in health outcomes and challenges in maternal health and child well-being persist. These persistent challenges are reflected in Tennessee's high maternal mortality rate, highlighting the critical need for ongoing improvements in maternal and child health to strengthen healthcare services and enhance coordination among partners.

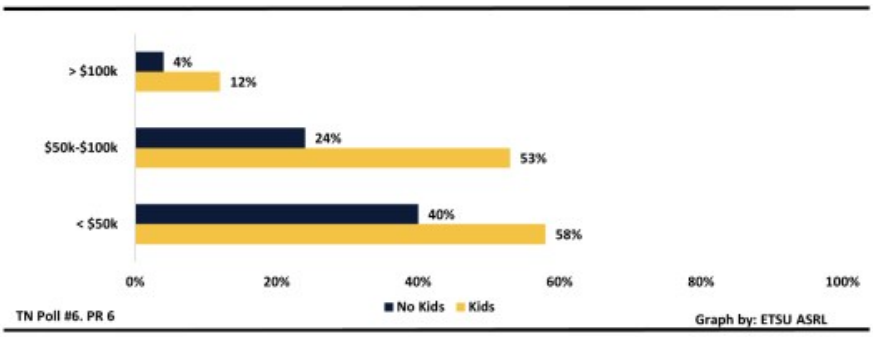
Tennessee has approximately 1.4 million women of reproductive age (15-44), representing about 20% of the state's total population in 2023. The number of live births in 2023 was 82,035, translating to a fertility rate of 58.2 per 1,000 women aged 15-44. Additionally, there are an estimated 62,532 pregnant women at any given time, with county-level estimates ranging between 31 and 10,288[1]. These fertility rates provide a glimpse into the state's reproductive health trends and highlight the importance of tailored maternal health services to address the unique challenges faced by Tennessee communities.

Tennessee’s infant population includes approximately 81,188 infants, with county-level variations between 47 and 12,674. Additionally, 407,366 children under the age of five reside in the state, forming a crucial demographic requiring comprehensive health and developmental services. Further, the percentage of children under 18 with special healthcare needs is estimated at 21% of Tennessee’s total child population, slightly above the national average of 20%[2].

Despite Tennessee’s robust healthcare efforts, challenges remain, particularly in maternal and child health. The state’s preterm birth rate of 11.3% in 2023 surpasses the national average, highlighting a pressing need for enhanced prenatal care and preventive measures. Furthermore, the pregnancy-related maternal mortality rate is 81 per 100,000 live births for those with TennCare, nearly three times higher than that of individuals with private insurance[3].

Further, Tennessee’s child poverty rate remains alarmingly high, with 17.6% of children living in poverty as of 2022[4]. In 2024, nearly half of Tennesseans (48%) struggled to afford enough food, with 29% experiencing this challenge "sometimes" and 19% "often". Additionally, those in Middle Tennessee, faced severe food insecurity, with 44% reducing meal sizes, 47% eating less than they feel they should, and 39% going hungry because they simply can't afford enough food for their families[7]. Over the past 12 months in 2024, 58% of Tennessee families with children earning $50,000 or less, and 53% of those earning between $50,000 and $100,000, have had to reduce meal sizes or skip meals due to financial hardship[5]:

Percent of those who responded "yes" to the following statement: "In the last 12 months, did you or other adults in your household ever cut the size of your meals or skip meals because there wasn't enough money for food?" By income level and children status.



These rates, along with the accompanying graphs, indicate a significant portion of the population is not only struggling to make their food last but also lacks the financial resources to secure more, highlighting a critical issue of food insecurity in the state. Poverty and food insecurity are key factors that are deeply interconnected with chronic health conditions, poor nutrition, and diminished quality of life, particularly among children. The intersection of child poverty and food insecurity is concerning, as these conditions often result in poor health outcomes, limited access to healthcare, and challenges in educational attainment.

Moreover, Tennessee continues to rank 44th in the nation for overall health status, facing persistent challenges related to chronic disease, mental health, and access to care. Additionally, the state has ranked 35th in food insecurity, 38th in low birth weight and 45th in premature death[6]. The state has ranked poorly across several critical MCH, chronic disease, and community health conditions that influence health outcomes. According to the 2024 HRSA Overview of State report, rankings for the following indicators have shown varying trends when compared to 2022—some have declined, others remained stable, while several demonstrated measurable improvements over the two-year period[7]:

Unchanged or declined (2022 – 2024):

- Teen births (44th to 45th)
- Childhood immunizations (33rd to 35th)
- Premature death (44th to 45th)

Improved (2022 – 2024):

- Food insecurity (35th to 27th)
- Adverse Childhood Experiences (44th to 35th)
- Low birthweight (36th to 34th)

Addressing these rankings requires comprehensive efforts to improve healthcare access, address community health factors that influence health outcomes and enhance services for both mothers and children.

2. Health Services Infrastructure and Human Resources

The state’s healthcare infrastructure includes a network of birthing hospitals, children's hospitals, federally qualified health centers (FQHCs), and rural health clinics. Tennessee has 57 birthing facilities and two birth centers as of 2024, a decline from 68 in 2016. Since 2012, there have been 11 obstetric unit closures, which include three complete hospital shutdowns. Additionally, there have been seven obstetric facility closures; of these, seven occurred in rural counties; resulting in 57 of Tennessee’s 95 counties (60%) lacking a birthing facility[8].

Tennessee is home to 15 Critical Access Hospitals, designated to preserve access to primary and emergency health services in rural areas. These hospitals are located in counties with higher rates of obesity, diabetes, preventable hospitalizations, cardiovascular deaths, and cancer deaths compared to state and national benchmarks.

Since 2005, Tennessee has experienced a concerning trend of 16 hospital closures, making it the second-highest state in the nation for hospital closures[9]. In rural areas, many counties are without a hospital, and 18 of the remaining hospitals are at risk of closure[10].

As of March 2024, 90 counties are federally designated as Health Professional Shortage Areas (HPSAs) in primary care, mental health services, or dental care.

Specialty	Actively Licensed Physicians (Total= 9868)
Obstetrics and Gynecology	1,132
Family Medicine/General Practice	2,811
Pediatrics (includes subspecialities and Med/Peds)	1,977

Healthcare workforce shortages intensify the challenges surrounding maternal health. As of January 2025, Tennessee had 9,868 primary care licensed physicians, including 1,132 obstetricians and gynecologists and 1,977 pediatricians[11]. Despite this, 32.6% of counties lack obstetric providers[12].

Tennessee's Federally Qualified Health Centers (FQHCs) also play a vital role in addressing healthcare access challenges. Tennessee's Healthcare Safety Net provides primary care, behavioral health and dental care to uninsured adults in 93 of 95 counties. Services are delivered through 56 Local Health Department clinics (16 designated as Federally Qualified Health Centers), 118 non-LHD FQHCs, and 44 Community/Faith-Based clinics for primary care, as well as 45 LHD clinics (6 FQHCs), 20 non-LHD FQHCs, and 20 Community/Faith-Based clinics for dental care. Additionally, 30 FQHCs receive state support to provide primary care in areas with high numbers of uninsured or underinsured individuals, serving 68 of Tennessee's 95 counties[13].

A key aspect of the MCH/Title V program is its dedication to supporting medically underserved communities, especially those that are low-income, live in rural areas, or are uninsured or underinsured. In addition to providing essential healthcare services such as primary care, vaccinations, mental health services, and dental care, the program also focuses on outreach initiatives to help families navigate the healthcare system. This includes case management services that assist families in connecting with providers, scheduling appointments, and securing support for transportation or childcare[14].

The impact of the MCH/MCH/Title V program is wide-reaching, tackling a range of critical health issues. MCH/Title V ensures pregnant women have access to high-quality prenatal care by funding regular checkups, screenings, counseling, and medical interventions aimed at preventing complications such as gestational diabetes, preeclampsia, and preterm birth[15]. The program also emphasizes postpartum care, encouraging follow-up appointments and addressing mental health concerns like postpartum depression[16].

Programs funded through the MCH Block Grant play a crucial role in addressing these gaps. The MCH/Title V workforce supporting these efforts includes 224 state staff, 68 contract staff, and 1,412 CHS staff, totaling 1,983 personnel dedicated to maternal and child health services across Tennessee[18]. This workforce provides comprehensive primary care and preventive services to women, mothers, infants, children aged 1-21, and children

with special health care needs across the state.

3. Key Strategies and Opportunities for Strengthening the System

Tennessee is implementing key strategies to strengthen the care system and better meet the needs of mothers, children—including adolescents—and families. This includes both the system's strengths and the gaps that still need to be addressed.

The State Strategic Health Plan (2024-2027) outlines priorities across surrounding the mission and values of the Tennessee Department of Health, which strives to protect, promote, and improve the health and well-being of all Tennesseans. Guided by core values of service, excellence, trust, and compassion, TDH addresses the state's complex health challenges through a strategic plan focused on the overarching vision of Healthy People, Healthy Communities, Healthy Tennessee[17]. A few goals established within the strategic plan include implementing primary prevention initiatives, increasing access to quality care and services while improving safety, improving internal processes to increase efficiency along with many others. The first goal surrounding primary prevention focuses on implementing the following strategy:

- "By 2027, ensure all children in Tennessee have a strong start to life through positive experiences and family support"[17].
    1. Use Evidence-based Home Visiting (EBHV) program data from Local Implementing Agencies (LIAs) to identify opportunities for continuous quality improvement.
    2. Increase the number of counties reporting 95% fully immunized childhood vaccine coverage for students entering kindergarten by administering the Vaccines for Children (VFC) program.

Additionally, the State Strategic Plan includes a goal that increases access to quality care by implementing the following strategy:

- "By 2027, expand the capacity of primary care providers to coordinate with specialty service providers for consults, referrals, and delivery of integrated services to ensure access to specialty care and care coordination services for rural, underinsured, and uninsured Tennesseans"[17].
    1. Promote utilization of Project Access, to connect the uninsured to primary care safety net clinics that serve patients based upon their ability to pay
    2. Increase utilization of e-consults to expand capacity to access to care.

TDH is making strategic investments to advance these goals. For example, in the Success Story, FHW's partnership with TennCare highlights work to enhance social needs screening and referral within TDH programs.

Another example of strengthening Tennessee's system of care is the Department of Health's Healthcare Resiliency Program (HRP), funded through the American Rescue Plan (ARP), which Congress passed in March 2022. Of the $3.9 billion in total ARP funds awarded to Tennessee, $250 million was allocated to TDH for healthcare modernization and transformation efforts. HRP funding was approved as part of the Tennessee Resiliency Plan, developed by the state's Financial Stimulus Accountability Group. The response to the federal HRP opportunity was significant—TDH received over $440 million in funding requests. To expand support, Governor Lee proposed an additional $50 million in his FY2025 budget for Practice Transformation and Extension projects, prioritizing Tennessee's 89 rural counties. The Rural HRP aims to improve access to care in rural communities through investments in school health, social service linkages, co-located and wraparound services, mobile medical units, and other critical resources.

In addition, the MCH/Title V program is a vital component of Tennessee's maternal and child healthcare system, playing a crucial role in improving access to quality services, reducing maternal and infant mortality, and promoting overall health. By offering comprehensive care MCH/Title V aligns with both federal and state priorities. This integrated approach aims to strengthen and create a more resilient maternal and child healthcare system that fosters engagement across all populations and communities. MCH/Title V-funded programs play a crucial role in strengthening the healthcare system by expanding services in multiple areas. Some examples are:

- **Maternal Health Strategic Plan:** The Maternal Mortality Review Committee (MMRC), coordinated by this program, plays a vital role in reducing maternal deaths and improving outcomes for medically underserved populations. Through data analysis and evidence-based recommendations, the MMRC identifies critical areas for improvement within the state's healthcare system that contribute to adverse maternal outcomes. Building on these efforts, the Maternal Health Strategic Plan (2025-2030), released in January 2025, provides a comprehensive framework for enhancing maternal health. The plan outlines key initiatives to address health-

related social needs, expand access to comprehensive care, and ensure that healthcare providers deliver high-quality care[18].

- **Telehealth Services** The implementation of telehealth services has also played a crucial role in reducing barriers to care, particularly in remote and medically underserved areas, by facilitating timely access to prenatal and postnatal consultations. Recognizing the importance of telehealth in improving healthcare availability, Tennessee has prioritized digital solutions to bridge gaps in care, particularly in remote and medically underserved areas. The expansion of telehealth services has facilitated stronger connections between patients and providers, reducing delays in accessing critical prenatal and postnatal services[19]. One example of this efforts is the **Tennessee Child and Adolescent Psychiatry Education and Support (TCAPES)** an initiative aimed at addressing the behavioral health needs of children and adolescents across the state by integrating mental health care into pediatric primary care settings. The program seeks to alleviate the growing shortage of mental health providers and expand access to timely, high-quality mental health services for youth. TCAPES offers free, same-day telephone consultations between pediatric primary care providers and child and adolescent psychiatrists, ensuring immediate and available mental health support. Additionally, the program provides training and resources to primary care physicians, enhancing their ability to screen, diagnose, and manage behavioral health conditions. By equipping providers with the necessary skills, TCAPES increases the healthcare system's capacity to effectively address the mental health needs of children and adolescents. This integration of mental health services into primary care is especially beneficial for rural and medically underserved communities, where access to specialized care is often limited. Ultimately, TCAPES strengthens Tennessee's healthcare system by improving mental health access, supporting primary care providers, and addressing the state's shortage of mental health professionals[19]. Another example of new telehealth services under development is the **Perinatal Telehealth Services** being implemented in west Tennessee and east Tennessee through two three-year contracts to provide telehealth services to high-risk pregnant women. The TN Strong Families Perinatal Telehealth Investment has awarded a three-year grant to High Risk Obstetrical Consultants and Regional One Health at $3M each for a total funding of $6M. The purpose of the Perinatal Telehealth program is to develop or expand perinatal telehealth services in Tennessee focusing on areas with high rates of maternal and infant mortality and morbidity to improve health outcomes. High Risk Obstetrical Consultants located in Knoxville will expand perinatal telehealth services in East Tennessee and Regional One Health located in Memphis will expand perinatal telehealth services in Tennessee counties North and West of Shelby County through a mobile healthcare unit. Both programs plan to start telehealth visits in April 2025.
- **Breast and Cervical Cancer Program**: The mission of this program is to reduce preventable disease, disability, and early death caused by breast and cervical cancers. Early detection, along with prompt follow-up and treatment, plays a critical role in lowering the risks of illness and mortality. The program provides a comprehensive range of services, including clinical breast examinations, screening mammograms, Pap and HPV testing, and professional medical consultations. By supporting uninsured and underinsured women in all 95 counties, with early detection and treatment, the program aims to reduce cancer mortality through preventive screenings and interventions. Additionally, navigation services are available to help individuals overcome barriers to accessing timely and quality care. In 2023, the program provided over 5,700 cervical services, over 14,600 breast services, and diagnosed 164 breast cancer patients through routine breast screenings. These numbers reflect an 18% increase in women served from 2022, underscoring the significant progress in efforts to reduce cancer-related mortality[20].

Breast and Cervical Cancer Program	Impact on Tennesseans (2023)
Total women served	16,714
Breast services provided	14,600
Cervical services provided	5,700
Breast cancer diagnosis	164
Cervical cancer diagnosis	157

- **Women, Infants, and Children (WIC) Program**: This program is committed to improving the health of income eligible pregnant women, new mothers, infants, and young children up to age five, aiming to improve their overall health and nutrition; eligibility is based on income, and nutritional risk factors, with participants receiving nutritious foods, personalized counseling, and community health referrals to promote healthy eating and lifestyle choices. Further, WIC provides essential services, including education, supplemental healthy foods, breastfeeding support, and healthcare referrals, all aimed at enhancing maternal and child health outcomes. In Tennessee, WIC serves over 157,000 eligible residents each month, actively addressing nutritional challenges and the concerning rates of maternal health issues across 121 county health

departments, clinics, and hospital sites[21]. Program participation has increased 14% from February 2024 to February 2025, in part due to operationalization of a data linkage with TennCare to inform prioritized outreach to pregnant women. Additionally, the WIC breast feeding peer counseling program serves 43,501 women by offering mother to mother breastfeeding support and education[22]. The WIC Farmers Market serves 4,098 participants, providing them with supplemental fresh fruits and vegetables[22].

Finally, Tennessee has also championed the integration of community health workers into maternal and child health programs, fostering partnerships with local organizations to provide better quality care. These initiatives emphasize the importance of building trust within communities to improve health outcomes and ensure that all families receive the support they need. By aligning these efforts with federal and state priorities, Tennessee aims to create a more resilient and comprehensive maternal and child healthcare system across all populations.

In summary, Tennessee is committed to strengthening its care system to meet the needs of mothers and children, particularly those facing financial or social challenges. By ensuring access to essential services, resources, and support, the state plays a vital role in improving maternal and child health outcomes. Through ongoing efforts to provide high-quality care, these programs not only enhance family well-being today but also lay the foundation for a healthier, more prosperous future for communities across Tennessee.

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III.B.3.b. System of Services for CSHCN

Overview of the State System of Services for CSHCN

Tennessee's system of care for Children and Youth with Special Healthcare Needs (CYSHCN) is structured to

provide comprehensive, family-centered, and coordinated services to ensure the well-being of children with chronic conditions, disabilities, and other special healthcare needs. The system is supported by a collaboration of state agencies, healthcare providers, and community organizations. The primary entities involved include the Tennessee Department of Health (TDH), TennCare (Medicaid), local health departments, and other state and nonprofit organizations dedicated to serving CYSHCN, including our partnership with Family Voices of Tennessee. Services range from referral and follow-up, medical reimbursement, and collaboration with early intervention, educational support, and family assistance programs, including support (mentoring) groups, care coordination, and empowerment services that help families navigate the healthcare and social service systems. These programs aim to reduce the burden on families by providing necessary resources and connections to community-based organizations that offer specialized services for CYSHCN. Through the partnership with Family Voices, the organization is able to provide one-to-one support, resources, information, and training to families across the state who are raising children with disabilities, chronic illnesses, and special healthcare needs at no cost.

Strengths and Gaps in the System for CSHCN

Strengths include, but are not limited to, various care coordination models, including CHANT (Community Health Access and Navigation in Tennessee), which helps families navigate complex healthcare and support systems. CHANT is available in every health department across the state, and the program has served 34,198 unique families across Tennessee between SFY19 and SFY24. Strong collaborations exist between state agencies, hospitals, schools, and empowerment groups to support CYSHCN and their families. Programs such as TennCare and the Title V Maternal and Child Health Block Grant provide critical financial assistance and support services. The expansion of telemedicine has improved access to specialty care, particularly in rural and medically underserved areas.

Another strength is the strong referral networks within TDH and across other agencies. For example, infants diagnosed with Neonatal Abstinence/Withdrawal Syndrome (NAS/NOWS) are automatically eligible for the TDH Children's Special Services Program and Tennessee Early Intervention System (TEIS), based in the Department of Disability and Aging. The CHANT program also makes referrals to TEIS, medical providers, and other services as identified through screeners and family needs. Another example of the strong referral networks within TDH and across other agencies is with the Newborn Screening Program. All infants diagnosed with confirmed disease from the screening panel, all children up to age three diagnosed with hearing loss, and all infants diagnosed with confirmed CCHD are referred to TEIS, Children's Special Services, and Family Voices.

Another notable strength is The Youth Advisory Council which was created through the collaboration with Family Voices of Tennessee and provides an opportunity for youth and young adults ages 14 to 24 and have special healthcare needs to advise on activities, programs, policies and resources affecting the health, wellbeing, and successful transition of youth across Tennessee. Currently, the council has 8 members. The Family Advisory Council is comprised of 15 parents/guardians of youth with special healthcare needs representing the three grand regions in Tennessee. This council brings an opportunity for experienced parents/guardians to participate and assist the TDH to better understand the perspective of their family's needs in program development, policy development, and resources that affect the health and well-being of youth with special healthcare needs and their caretakers.

TN MCH/Title V can reach all families with newborns through the Child Health Call Center. The Welcome Baby algorithm for infant mortality risk prediction is stratified, and calls are made to each family to offer enrollment into either CHANT or EBHV.

Gaps experienced by CYSCHN are related to a lack of pediatric specialists, as many rural areas in Tennessee lack access to specialists who can provide comprehensive care for CYSHCN. Families often struggle to find easily available and comprehensive information regarding available services and care coordination. Limited resources and inadequate transition planning create barriers for youth with special healthcare needs moving into adult systems of care and independence. Last but not least, children in rural and low-income communities face significant challenges in accessing quality healthcare services.

Core Outcomes for a Well-Functioning System of Care for CSHCN

There are six core outcomes of a well-functioning system of care for CYSHCN including the following:

1. Partners in Decision-Making
2. Medical Home
3. Adequate Health Insurance
4. Early and Continuous Screening
5. Ease of Community-Based Service Use
6. Transition to Adulthood (age 12-17 years only)

CYSHCN have a better experience when they are included as active participants in and kept at the center of their care. However, data from the National Survey of Children's Health (NSCH) (2022-2023) revealed that 14.0% of CSHCN aged 0-17 in Tennessee sometimes or never felt partnered when they made decisions about their care.

It is a primary goal to increase access to health services for CYSHCN. An essential component of making health services more attainable is the availability of insurance coverage that is available, affordable, comprehensive, and continuous. The NSCH showed that between 2017 and 2023, only 62.43% of CSHCN aged 0-17 in Tennessee on average had adequate and continuous insurance. However, coverage increased 7.3% between 2019 (61.6%) and 2022 (66.1%), overlapping with the start of the CHANT program. The CHANT program includes a Health Insurance Pathway that focuses on providing care coordinator support to increase the number of children who have health insurance. Further, NSCH 2022-2023 results reported that 41.8% had public health insurance, 45.0% had private insurance, and 9.3% had a combination of public and private insurance.

A medical home provides comprehensive primary care for CYSHCN and serves as the medium in which partnerships between care systems, CYSHCN, and their families grow and thrive. The NSCH reported that, between 2017-2023, 48.2% of CSHCN aged 0-17 in Tennessee on average had a medical home. Data from the 2021-2022 survey found that nearly one-third of Hispanic (38.0%) and Black, non-Hispanic (32.0%), and just under one-half of Other, non-Hispanic (44.6%) CSHCN aged 0-17 in Tennessee had a medical home. On average, only 34.8% of CSHCN in Tennessee with an FPL of 0-99% had a medical home (NSCH 2017-2023).

Early and continuous screening is necessary to identify health changes or acute conditions that develop in CYSHCN. Two indicators often used are the frequency of preventive medical and dental visits over a 12-month timeframe. The NSCH reported that between 2019-2023, 87.4% of CSHCN aged 0-17 in Tennessee on average had one or more preventive medical visits. In the same timeframe, 81.4% of CSHCN in Tennessee on average had one or more preventive dental visits. Despite efforts from the Tennessee Department of Health, such as the School Based Dental Prevention Program (SBDPP) which helps provide dental services to Title 1 eligible schools, access to preventive dental visits through plans with DentaQuest (TennCare dental benefits), and CHANT assistance with dental referrals and scheduling, CSCHN reporting that they had one or more preventive dental visits decreased 6.29% between 2017 (85.8%) and 2022 (80.4%).

Lastly, a smooth transition process between pediatric and adult health care is especially important for CYSHCN. Between 2017-2023, 22.57% of CSHCN aged 0-17 in Tennessee on average received transition services. Notably, there was a 16.7% increase in the number of CSHCN who received transition services between 2019 (22.10%) and 2022 (25.80%). This increase co-occurred with the CHANT Transition Pathway, as a part of the Children's Special Services (CSS) program and focuses on developing transition plans with CYSHCN aged 14-21.

Capacity of the System to Address the Needs of Low-Income and Medically Underserved CSHCN

Tennessee has taken steps to improve services for medically underserved and at risk CYSHCN through initiatives such as working to expand telehealth services and increase access to specialty care for children in remote areas, tailoring outreach and support to ensure that services are available for all communities. The Children's Special Services Program is also working to ensure that families with the greatest need receive assistance and is currently

piloting an increase in the financial eligibility criteria, raising the federal poverty level threshold from 225% to 250% to expand access to services for more families. The system has also increased efforts to recruit and retain pediatric specialists, and care coordinators are continuously trained to assist families in locating providers in areas where shortages have been identified. CHANT has continued to grow and expand, and with the incorporation of FindHelp, has expanded its ability to identify resources, make referrals, and receive closed-loop feedback as gaps in service delivery are identified and mitigated. TDH is also developing a “No Wrong Door” approach for incoming referrals to the Child Health Call Center, which was initiated by the Tennessee Early Connect program, which began with a MIECHV Innovation Grant. Coordination between the Call Center, CHANT, and Evidence-Based Home Visiting implementing agencies allows referrals to flow efficiently between agencies to ensure that families are connected to services as capacity at individual programs fluctuates.

An emerging CHANT innovation is the use of the FindHelp Closed-Loop Referral System (CLRS). To improve access and move beyond paper-based referrals, CHANT partnered with TennCare in 2024 to pilot FindHelp, a digital platform that tracks referral outcomes and connects families with community resources. From July to September, the CHANT program piloted the system in seven counties, generating 825 service searches and 190 referrals, 30% of which were successfully closed loop. Nearly half of Care Coordinators also identified new community resources, expanding support for housing, food, and mental health services.

The CHANT program is actively working to improve maternal and infant health outcomes through a pilot initiative called the "Mother-Infant Welcome Home Kit." This project provides enhanced care coordination and incentive items for participating mothers and infants. Designed to engage pregnant women as early as the first trimester, the program includes at least one in-home visit per trimester and a minimum of two follow-up visits within the first month after birth. Families may remain enrolled in the project for up to 12 months postpartum. Participants will receive educational materials covering breastfeeding, WIC, safe sleep, Count the Kicks, maternal urgent warning signs, and family planning. Based on individual needs, families will also be connected to relevant resources and referrals. In alignment with Bright Futures recommendations, the Ages & Stages Questionnaires (ASQ and ASQ:SE) will be administered to support early identification of developmental concerns and ensure timely follow-up.

Public Health Infrastructure Supporting CSHCN Needs

The public health infrastructure in Tennessee plays a crucial role in supporting CYSHCN through the Title V Maternal and Child Health Block Grant by providing funding for medical, early intervention, and family support programs. Local health departments serve as key access points for screenings, referrals, resources, and navigation of services. TDH supports and collaborates with school-based early intervention services and supports the early identification and treatment of CYSHCN. Programs also use data collection and surveillance to track health outcomes, and service access and utilization to improve planning and policy development.

The Role of the MCH/Title V Program in Serving CSHCN

The MCH/Title V Program is a cornerstone of Tennessee’s efforts to support CYSHCN and their families. It funds essential services such as care coordination, medical assistance, and resources and referrals for families. MCH/Title V also supports family engagement initiatives to involve caregivers in policymaking and service design. To ensure that CYSHCN receive necessary services through Medicaid and payor sources, MCH/Title V collaborates with TennCare to ensure that families are connected to insurance and providers. MCH/Title V also provides training and workforce development to enhance the capacity of healthcare providers working with CYSHCN and uses data to drive improvements in care delivery and service gap identification.
In addition, the CYSHCN section also has two advisory committees, the Children’s Special Services Advisory Committee and the Birth Defects Advisory Committee. Both engaged in the ongoing review, planning, and guidance of programs and policies that impact children and youth with special health care needs. These committees play a critical role in strengthening infrastructure by informing service delivery improvements, promoting cross-sector collaboration, and ensuring that the voices of clinical experts, families, and community partners are reflected in decision-making.

Tennessee has made significant progress in developing a well-functioning system of care for CYSHCN. However, gaps remain in access to specialized care, family support, and care transition. Strengthening partnerships between public health agencies, healthcare providers, and community organizations is essential to ensuring access to services for all CYSHCN. By continuing to invest in infrastructure, workforce development, and family-centered care, Tennessee can enhance outcomes for children and youth with special healthcare needs across the state.

III.B.3.c. Relationship with Medicaid

This section outlines Tennessee's coordinated efforts between the MCH/Title V and Medicaid programs to improve maternal and child health. It highlights program integration, healthcare financing, policy innovations, joint decision-making, and progress on Medicaid Core Set measures.

TDH Efforts for Outreach and Enrollment

TDH has implemented a range of strategies to help clients access public and marketplace insurance across the state. In all 89 rural counties, at least two options are available for Medicaid and Affordable Care Act (ACA) enrollment assistance. 1) Clinic management staff provide both verbal and written guidance and determine presumptive eligibility for Medicaid coverage for pregnant women and individuals diagnosed with breast or cervical cancer. 2) Through CHANT, staff screen families for insurance coverage and help those uninsured, or unaware of their assigned MCO or PCP, apply for TennCare/Medicaid and connect to care. Families with children with special health care needs receive assistance enrolling in all available coverage options, including TennCare/Medicaid, CHIP, and Marketplace plans via Healthcare.gov.

TDH's Medicaid Redetermination Project, launched in February 2024, has made rapid progress in ensuring continuous coverage. Healthcare Connect Navigators (HCCNs) use monthly TennCare redetermination lists to conduct tailored outreach to pregnant and postpartum women. Between March 2024 and March 2025, HCCNs contacted 6,420 individuals; 943 received enrollment support for prenatal Presumptive Eligibility, CoverKids, or full TennCare. For those found ineligible, 1,570 were referred to additional resources such as CHANT, SNAP, and WIC.

Healthcare Financing

TennCare services are offered through managed care entities. Medical, behavioral, and Long-Term Services and Supports are covered by "at-risk" Managed Care Organizations (MCOs). All of TennCare's MCOs have recently been ranked among the top 100 Medicaid health plans in the country. The care provided by TennCare's MCOs is assessed annually by the National Committee for Quality Assurance (NCQA) as part of the state's accreditation process.[1] In addition to the MCOs, there is a Pharmacy Benefits Manager for coverage of prescription drugs and a Dental Benefits Manager for coverage of services to children under age 21.

Policy Waivers and State Plan Amendments

TennCare III Demonstration Amendment
Since 2022, Tennessee's Medicaid and MCH/Title V agencies have pursued a multi-year, multi-faceted strategy to strengthen Medicaid support for pregnant women, mothers, children, and families. Key milestones include:

- **2022**: Initiated 12 months of continuous postpartum coverage under the state's 1115 demonstration waiver.
- **2023**: Amended the State Plan to add lactation support and 12-month continuous coverage for children enrolled in Medicaid.
- **2024**:
    - Increased income eligibility for pregnant women (from 195% to 250% FPL) and for parents/caretakers (to 100% FPL).
    - Amended the 1115 waiver to provide up to 100 diapers per month for children under age 2 in Medicaid/CHIP, effective August 7.
    - Added comprehensive dental benefits for pregnant and postpartum members, covering cleanings,

fillings, root canals, dentures, and other services during pregnancy and 12 months postpartum.
    - Approved reimbursement for lay health educators (health coaches) delivering team-based care services under TennCare.
- **2025 (Ongoing)**:
    - **Eligibility & Services**: Submitted amendments to extend Medicaid coverage to children adopted from state custody without adoption assistance.
    - **Diaper Benefit Implementation**: As of March 2025, 47,273 unique members have accessed the diaper benefit. Diapers have been distributed in 90 of 95 counties through over 400 pharmacies, reaching approximately 49% of the eligible population.
    - **Home Blood Pressure Cuff Coverage**: In May 2025, TennCare began covering home BP cuffs for pregnant and postpartum members.

MCH Title V/Title XIX Joint Policy Making

The MCH/Title V Director meets monthly with the Title XIX Chief Medical Officer to coordinate efforts and address shared challenges. In addition to these leadership meetings, regular joint workgroups focus on CHANT and Presumptive Eligibility (PE). Over the past year, these collaborations have resulted in formal contracts outlining the health department's role in care coordination for families, including those with CSHCN, immunization outreach, data sharing, and expanded support for PE and care coordination for pregnant women.

A key innovation emerging from this partnership is the implementation of the FindHelp Closed-Loop Referral System (CLRS) within Tennessee's MCH programs. To replace fragmented, paper-based referrals, TDH partnered with TennCare in 2024 to pilot FindHelp, a digital platform that enhances service access, tracks referral outcomes, and connects families to community resources. Between July and September 2024, CHANT piloted the system in seven counties, generating 190 referrals, with 30% successfully closed loop. Additionally, 49% of care coordinators identified new community resources, broadening access to critical supports like housing, food, and mental health services. Building on this success, the MCH/Title V Director and Title XIX Chief Medical Officer committed to statewide expansion. FindHelp is now being integrated into core programs such as CHANT and Evidence-Based Home Visiting (EBHV).

In addition, Women's Health Navigator (WHN) contracts were established in the Metropolitan Health Departments to seamlessly coordinate activities between Family Planning, Presumptive Eligibility, and Breast and Cervical Cancer Screening. The WHN contracts have since expanded to promote holistic navigation efforts among CHANT and Evidence-Based Home Visiting (EBHV). Additionally, health technology will be expanded to track more navigation efforts to evaluate the scope of support for maternal and child health.

TDH has ensured the ongoing training of Public Health Office Assistants and Supervisors on assisting with TennCare Applications. These individuals are in every county health department, both rural and metro. A full TennCare application can take up to 45 days. Programs such as Presumptive Prenatal TennCare and Presumptive Breast and Cervical Cancer TennCare give immediate, temporary Medicaid coverage to qualifying pregnant women and individuals who receive breast or cervical cancer diagnoses, including certain precancerous conditions. This partnership has assisted with streamlining the TennCare enrollment process and ensuring some of Tennessee's Underserved areas and communities can access more timely care.

The Tennessee Early Connect (TEC) project, funded by the MIECHV Innovation Grant, surpassed outreach goals by reaching over 6,700 newly pregnant families and facilitating 1,348 referrals to Evidence-Based Home Visiting (EBHV) services. TEC integrated cross-agency data, strengthened referral systems, and partnered with TennCare to use presumptive eligibility data for early engagement. Early results show improved prenatal engagement and increased enrollments, especially where language and capacity needs were addressed.

The WIC program partnered with TennCare to connect eligible pregnant women and their families to nutrition support, launching a pilot in August 2024 across 10 regions. The pilot enrolled 1,292 women and 1,192 infants and

children, leading to a statewide expansion. WIC now uses monthly TennCare data to identify and reach more families, certifying 2,641 women and 2,291 infants and children since the initiative began.

Medicaid Maternal Health Measures

The Tennessee MCH/Title V works closely with the Tennessee Department of Health and TennCare to address the Medicaid Core Set Measures by creating access and entry points. TennCare's rates for Measurement Year 2023 in maternal metrics are as follows:

Measure Name		MY2023 Rate
Live Births Weighing Less Than 2,500 Grams (LBW-CH)		10.9%
Well-Child Visits in the First 30 Months of Life (W30-CH)		
	First 15 Months	66.60%
	15-30 Months	70.80%
Prenatal and Postpartum Care (PPC)		
Postpartum Care	Child – Under Age 21*	67.40%
	Adult – Age 21 and Older	70.57%
Timeliness of Prenatal Care	Child – Under Age 21	69.49%
	Adult – Age 21 and Older*	68.16%
Contraceptive Care – Postpartum Women (CCP)		
Most effective 3 days postpartum	Child – Ages 15 to 20	6.34%
	Adult – Ages 21 to 44	11.83%
Most effective 90 days postpartum	Child – Ages 15 to 20	51.41%
	Adult – Ages 21 to 44	45.95%
LARC 3 days postpartum	Child – Ages 15 to 20	2.75%
	Adult – Ages 21 to 44	2.51%
LARC 90 days postpartum	Child – Ages 15 to 20	20.10%
	Adult – Ages 21 to 44	17.01%
Contraceptive Care – All Women (CCW)		
Most Effective Method	Child – Ages 15 to 20	26.83%
	Adult – Ages 21 to 44	20.37%
LARC	Child – Ages 15 to 20	3.88%
	Adult – Ages 21 to 44	4.32%
Low-Risk Cesarean Delivery (LRCD-CH)		24.3%

*New submeasure MY2023

TennCare's first goal of improving the health and wellness of mothers and infants includes the above core set measures and rates.

[1] https://www.tn.gov/tenncare/information-statistics/annual-reports.html

III.B.4. MCH Emergency Planning and Preparedness

MCH Considerations in the State Emergency Operations Plan (Along with Other State Plans)

State Emergency Operations Plan

The State has an Emergency Operations Plan (EOP) that outlines the department's all-hazards approach to managing events and emergencies that may exceed their day-to-day response capabilities. The EOP aligns with state and federal emergency management documents and principles, and TDH's Emergency Preparedness (EP) team maintains and provides access to the current EOP base plan, annexes, and appendices.

The plan considers the needs of pregnant women, infants, and children, including those with special health care needs. Specifically, the plan pre-identifies populations that have access and functional needs resources and determines resource gaps while identifying related contingency options. The EOP also includes a plan to monitor the health and medical needs of medically underserved populations within the community and implement response actions to address them. This includes developing protocols to provide timely and effective medical care to MCH populations, coordinating with healthcare providers to ensure that MCH patients receive the care they need, and ensuring that emergency response personnel have the training and resources necessary to address the unique

needs of the MCH populations.

An MCH-specific annex was authored by the MCH EPR Coordinator in late-2023 to supplement the disability-functional and access needs annex, which gives more in-depth information on specific MCH populations, specifically children and youth with special healthcare needs along with children with medical complexities. This annex has also been converted and added to the state's plan standardization process so that regions across the state can also adopt this annex at their level in addition to assisting them with meeting Project Public Health Ready (PPHR) requirements.

An infant shelter feeding plan, started in early 2024, has been completed and added to the mass care plan. The MCH EPR Coordinator has worked with regional MCH directors, WIC coordinators, and nutritionists to develop a plan that can be used to demonstrate how public health can support mass care. This plan will also be added to the state mass care plan when it has been completed and gone through the review process.

To ensure the EOP remains current and effective, each component is reviewed and updated at least once every two years. This review process reflects changes in procedures and capabilities, as well as the identification of deficiencies that require corrective action.

The MCH EPR coordinator is also working to standardize the communication process for food and product recalls. This is taking place by working with the state's foodborne and endemic diseases program along with injury prevention to ensure that MCH populations are included in all forms of recalls and with through the proper channels.

Incident Command System Structure (ICS)

The ICS is dependent upon the specific incident. For example, in the past during COVID-19, the Deputy Commissioner who oversees the Division of Family Health and Wellness (FHW) was a part of the Mission Coordination Group, which oversaw the Direction & Coordination Officers. During COVID, the MCH Epidemiology Assignees co-led the enhanced pregnancy surveillance group, which was under the Operations Surveillance and Response Team and Investigations group. For monkeypox, the CDC/CSTE Applied Epidemiology Fellow was on the Data Support team.

While the MCH role is ever-changing in the ICS structure, there is a functional and access needs support coordinator that has been designated in our state's emergency operations plan. Maternal and child health populations would fall under the responsibility of this designated ICS piece, and this position has been activated this past year in the state's full-scale exercise called Fight Flu. There are different ways that this coordinator can be folded into the ICS structure based on the needs of the evolving threat. Some of the state's regional emergency response coordinators have also integrated this position into their structures and regional operation centers.

Critical Gaps Identified and Addressed

Capacity for MCH EPR Activities

MCH/Title V Leadership identified a gap in MCH EPR based on state reporting from AMCHP's Public Health Emergency Preparedness and Response Checklist for Maternal and Infant Health as well as early experiences in COVID-19 pandemic response. Through the CDC Foundation, TDH was able to hire an MCH EPR coordinator in March 2022, and is now funded by the MCH block grant. The role of this position is to coordinate MCH/Title V EPR efforts with internal and external partners to prioritize emergency preparedness, response, and recovery efforts among the Tennessee MCH population.

Coordination with Public Health Programs

The MCH EPR Coordinator position holds formal quarterly meetings with the EP Program in addition to more frequent meetings in between including Emergency Response Coordinator (ERC) calls, Communicable and Environmental Diseases and Emergency Preparedness Division (CEDEP) Surveillance Calls, and EP Team Huddle bi-monthly meetings. Additionally, the MCH EPR Coordinator also holds quarterly calls with the Office of Strategic Initiatives in the Tennessee Department of Health. These meetings are used to collaborate, strategize, and operationalize preparedness efforts to effectively meet the needs of the people we serve, which includes MCH populations. In 2024, the MCH EPR Coordinator began networking with other states, including Utah and Colorado, to foster relationships aimed at increasing comprehensiveness. The MCH EPR Coordinator meets with EMS-C when there are MCH-related projects to collaborate on. Additionally, the Coordinator worked with AMCHP to pilot training programs and support an emergency preparedness learning collaborative set to launch in 2025.

The MCH EPR Coordinator also regularly meets with the Tennessee Emergency Management Agency. The MCH EPR Coordinator also assists in leading the Functional and Access Needs Support (FANS) Resiliency Workgroup that the state emergency management agency has to assist in the state hazard mitigation planning process. This group created and deployed a survey to local emergency management and found that at least half of the respondents needed more educational resources and wanted to prioritize MCH populations more in their emergency responses. Through the FANS Resiliency Workgroup, two major projects have been started, and the MCH EPR Coordinator assists in leading those as well. Those projects include a tabletop-in-a-box project and a make a plan checklist project currently being reviewed by TEMA that should go live in quarter three of 2025.

The tabletop-in-a-box project is a concept of developing ready-made materials specific to access and functional needs populations that can be used in tabletop exercises. These tools include sample objectives, discussion questions for public health, emergency management, healthcare, along with injects that include children and youth with special healthcare needs, pregnant mothers, blind/low vision, and deaf/hard of hearing. The components of the tabletop-in-a-box can be modular and added to tabletop exercises that already exist, so that preparedness is being embraced at all different levels of emergency preparedness. The make-a-plan checklist, created through the CMIST Framework, are specific identified populations that may need special assistance or considerations during an emergency or disaster. These are being created for emergency management at all levels.

The MCH EPR coordinator also co-leads a functional access needs support group with an Emergency Response Coordinator (ERC) within the EP Program. This group consists of subject matter experts, representatives from the Tennessee Council on Developmental Disabilities, the Down Syndrome Association of Tennessee, human resources, individuals that serve deaf or hard of hearing, the Executive Director of the Statewide Independent Living Council of Tennessee, and many others. This group has completed a tips document that is a quick hit guide to inform the general public on best practices to assist individuals that may have an access/functional need during an emergency. This document includes sections on autism spectrum disorder, children, pregnant mothers, older adults, mobility impairments, chemical sensitivities, and more.

This work group is currently working on an assistive communication project. This project is being created to use as an alternative way for individuals to communicate if the traditional way is not the most effective. For example, the group is creating images to create storyboards that could assist individuals in understanding the process that individuals have to go through in the event of a community reception center opening during a radiological event, and they plan on adding more images to this resource for it to be used in points of dispensing, sheltering events, etc. This group is also currently working on building a FANS trailer that can be deployed during disasters with different items needed to support individuals with access and functional needs.

Hurricane Helene Response

Northeast and East Tennessee were devastated by Hurricane Helene in October 2024. Through program staff and coordination with other departments, MCH populations were prioritized in the emergency response and recovery. Several examples highlight these coordination efforts:

- WIC provided critical support post-hurricane by automatically issuing benefits to those with scheduled appointments and conducting virtual re-certifications. The WIC Shopper App was utilized for push notifications, and additional resources were allocated to the WIC Hotline to assist families. Staff also assessed WIC and MCH needs in shelters using the infant shelter feeding guide to ensure proper support.
- Safe sleep efforts were supported through the ordering and dispatching of 310 Pack ’N Plays and 600 cotton and fleece sleep sacks.
- The newborn screening program’s continuity efforts ensured there were no delays or missing specimens despite hospital diversions or infant transfers. Courier services were confirmed to have uninterrupted access to all facilities.
- CSS issued a 90-day emergency application process and communicated that to all field staff. Regional office teams conducted priority outreach to families needing DME, prescriptions, and formula to ensure all critical medical needs were met.
- MCH EPR played a role in emergency response also by connecting shelters with the TN Mental Health Strike Team, assisting the Council on Developmental and Intellectual Disabilities with AAC resources, and collaborating with Chronic Disease Health Promotion to provide physical activity items in the Disaster Resource Center. To evaluate the response, the MCH EPR Coordinator is synthesizing information from program staff to conduct an after-action report to inform future emergency responses.

American Academy of Pediatrics Enhancing Systems of Care Project

This project, co-led by TDH and parents at the Tennessee Chapter of Family Voices, focused on gaps in discharge

planning for emergency preparedness specifically for children sent home with electricity-dependent medical equipment. Focus groups and interviews with families and NICU hospital staff highlighted key gaps, including a lack of emergency preparedness education and coordination with utility companies.

In Phase 2 of this project, the team secured resources to improve emergency planning during hospital discharges, forming the Tennessee Systems of Care Taskforce to engage parents and youth in the process. Monthly meetings and quarterly reports to the AAP guided this work. The project resulted in the distribution of 40 car adapters for durable medical equipment and 150 medical ID cards to two participating children's hospitals. While the adapters were highly valued, barriers with the medical ID cards, such as keeping information updated, were identified.

Children and Youth with Special Health Care Needs EPR Decal & Toolkits

The Emergency Alert Decals and Magnets were created to notify first responders of a child with special health care needs in a home or vehicle. All 11,000 decals and magnets ordered were distributed by July 2022 through local health departments, first responders, hospitals, and community organizations. Due to ongoing demand, TDH is exploring funding for additional decals.

The Emergency Toolkits were designed to assist families in disasters, particularly after recent tornadoes and floods. Each backpack contains essential items, including masks, hand sanitizer, a first aid kit, a flashlight, and a resource checklist. All 10,000 toolkits were distributed through partnerships with regional health departments, schools, hospitals, and community organizations. Efforts are underway to integrate the checklist with the related AAP project to streamline resources for families.

III.C. Needs Assessment

III.C.1. Five-Year Needs Assessment Summary and Annual Updates

III.C.1.a. Process Description

Overview of Five-Year Needs Assessment Activities

The Five-Year Needs Assessment was conducted in 2024 to inform the priority selection for the next five years. The Needs Assessment was made up of three parts: a quantitative portion, a qualitative portion, and a capacity assessment. Quantitative and qualitative data collection methods included a community survey, data analyses of key health topics within each domain, and focus groups. These results were analyzed and presented to TDH MCH partners during the 2024 Fall Partner meetings to obtain partner feedback and have partners vote on the priorities they thought were most important within each domain. These results were then brought to the capacity assessment, where FHW leadership determined the priorities for the next five years based on the partner input, internal, and external resources.

Quantitative
The Tennessee Community Health Survey was a REDCap survey created in both English and Spanish to understand current MCH needs across the state. Each domain was included, and respondents were asked to select the domain areas for input. Branching logic within the survey allowed respondents to only see questions pertaining to the domain they selected, which kept the survey length relational to the quantity of domains selected. Questions were not required, and all responses were anonymous to encourage Tennesseans to complete the survey. FHW staff worked with regional and metro staff to distribute the survey via email and sent the survey to over 750 Tennessee partners. Although primarily distributed via email, the survey could also be completed via a mobile device. Flyers with the survey QR code were created in English and Spanish to promote the survey, and the number of respondents in regions across the state was shared periodically with regional directors to increase promotional efforts. The survey was for anyone who lived in Tennessee and was 18 years old or older.

Results of the survey were analyzed using SAS. There was a total of 1,103 responses to the survey, representing 86 out of 95 total counties (90.5%) in TN. Top health concerns included mental health, chronic conditions before and after pregnancy, child and adolescent overweight and obesity, cost of care, and negative social media and bullying. Additional concerns included a lack of or limited social support and poverty, difficulty affording medical care, food insecurity, affordable childcare, and transportation.

Another quantitative portion of the needs assessment was the data one-pagers. FHW epidemiologists created data one-pagers highlighting the most important health topics within their domain. These were created in Canva, and epidemiologists used a variety of sources to create visual summaries of each health topic. Numerous analyses were conducted, such as trend analysis, geographic analysis, and analysis by specific sub-groups of the population to highlight these key health priorities.

Health Topics per Domain:

- Women & Maternal Health
    - Pregnancy Intent
    - Healthcare Access
    - Postpartum Care
    - Severe Maternal Morbidity
    - Intimate Partner Violence
    - Obstetric Closures
    - Pregnancy-Related Deaths
    - Substance Use
    - Postpartum Depression

    - Sexually Transmitted Infections

- Perinatal & Infant Health
    - Sleep-Related Infant Deaths
    - Fetal Deaths
    - Premature Births
    - Low Birthweight
    - Breastfeeding
    - Birth Defects
    - Prenatal Smoking
    - Uptake of Recommended Vaccines in Pregnancy

- Child Health
    - Developmental Screening
    - Physical Activity
    - Preventive Dental Visit
    - Firearm-Related Deaths
    - Drowning-Related Deaths
    - Poison-Related Deaths
    - Child Immunization
    - Adverse Childhood Experiences
    - Lead Poisoning
    - Obesity
    - Food Insecurity

- Adolescent Health
    - Tobacco/Vaping
    - Mental Health
    - Suicide
    - Adolescent Births
    - Physical Activity
    - Firearm-Related Deaths
    - Sexual Violence
    - Sexually Transmitted Infections
    - Adolescent Mortality
    - Nutrition

- CYSHCN
    - Families as Partners
    - Adequate Insurance
    - Early and Continuous Screening
    - Medical Home
    - Access to Community-Based or Specialty Services
    - Transition to Adulthood
    - Access to Care
    - CYSHCN Access
    - Quality of Life

Data sources included:

- America's Health Rankings
- Centers for Disease Control and Prevention (CDC)
    - PRAMS; PMSS; NCHHSTP AtlasPlus; Births; WONDER; Youth Risk Behavior Survey; WISQARS;

Division of Nutrition, Physical Activity, and Obesity, National Center for Chronic Disease Prevention and Health Promotion

- Child Health Poll 2024. Vanderbilt Center for Child Health Policy
- Health Resources and Services Administration (HRSA)
  - National Survey of Children's Health
- March of Dimes
- National Institute on Minority Health and Disparities. Food Accessibility, Insecurity and Health Outcomes
- Tennessee Bureau of Investigation (TBI), Tennessee Incident Based Reporting System (TIBRS)
- Tennessee Department of Health
  - Birth Defects Registry 2016-2020
  - Community Health Access and Navigation (CHANT) Screening Assessment
  - Child Fatality Review Database System, 2018-2022
  - Childhood Lead Poisoning Surveillance Dashboard
  - Division of Vital Records & Statistics
    - Birth Statistical System, Death Statistical System
  - Hospital Discharge Data System; Division of Policy, Planning and Assessment
  - Immunizations Coverage Rates Dashboards
  - Lead Screening Data: LeadTRK
  - Maternal Mortality Review Program, 2023 Maternal Mortality Report
  - NAS Surveillance System, Neonatal Abstinence Syndrome Surveillance Annual Report 2022

Sources can be found listed at the bottom of each data one-pager. The data one-pagers were shared at the 2024 Fall Partner Meetings via a PowerPoint presentation and a data packet to provide additional information to partners before they voted on priorities. The data packet will be available on the TDH website.

Qualitative

The qualitative portion was completed by conducting 18 focus groups across the state on topics within the following health domains: women & maternal health, perinatal & infant health, child health, adolescent health, and children and youth with special healthcare needs (CYSHCN). Also, additional focus groups were conducted virtually on the topics of MCH Emergency Preparedness and Access to Care for all communities, including those medically underserved. The virtual option allowed statewide recruitment of participants. Focus groups were conducted from July through October 2024 by coordinating with central office staff, regions, and metros. Partnerships with regional and metro health departments across the state were imperative for the success of the focus groups. Central office staff coordinated with each region and metro across the state to set up a focus group in their area via Microsoft Teams meetings. Regional and metro staff were able to pick which focus group topics they wanted to have for their own communities. These meetings were also used to determine which questions would be included for each focus group topic. Domains and the topics for the focus groups included:

In-person focus groups:

- Women/Maternal: Syphilis and Prenatal Care Barriers for Pregnant Women
- Women/Maternal: Postpartum Depression
- Perinatal/Infant: Sleep-related Deaths (SIDS)
- Perinatal/Infant: Safe Sleep
- Perinatal/Infant: Breastfeeding
- Child: Preventive Dental Care/Screenings
- Child: Firearm Related Fatalities
- Child: Physical Activity/Obesity
- CYSHCN: Access to Community-Based Services
- CYSHCN: Access to Education and Resources
- CYSHCN: Addressing Medical Complexities within School Systems
- CYSHCN: Access to Care

Virtual focus groups:

- Perinatal/Infant: Prenatal Care and Birthing Experiences Among the Black Community

- Cross-Cutting: MCH Emergency Preparedness and Response
- Cross-Cutting: Access to Care Among the Hispanic Community
- Adolescent: Social Connectedness, Social Media, Mental Health, and Transition to Adulthood

The Maternal Health Innovation (MHI) program also conducted focus groups across the state on topics related to Women & Maternal health. In an effort to deduplicate focus groups and avoid taxing community resources, FHW staff worked with the staff involved with the MHI program to avoid conducting focus groups on the same topics (Women & Maternal Health) in the same locations. The MHI focus group results were included in the overall Fall Partner meeting presentations.

FHW staff also conducted a virtual training for regional and metro staff and created focus group guides with a script for facilitators to follow. The goal for each focus group was to have one facilitator, two note takers, and someone to write major themes and quotes on a flip chart or shared screen. The majority of focus groups were conducted in person, but virtual focus groups remained an option for those that could not physically meet in person and for topics that recruited participants from across the state. A parental consent form was created for the two adolescent focus groups to allow for individuals under 18 to participate. All questions were provided ahead of time to parents and participants for parental/guardian consent. A total of 93 Tennesseans participated in the focus groups.

Central office staff relied heavily on partnerships with regional and metro directors and staff for focus group locations and recruitment. To encourage participation from community members, incentives and food were provided to participants. Incentives included a tumbler, a canvas tote bag, and a charging pack while food depended on the location of the focus group and the time of day. Central office staff drove to each in- person focus group to bring incentives and food. Regional and metro staff also included materials on local resources in the bags for participants to take with them. Consent forms for participation were created and obtained prior to the focus groups. Focus groups were not recorded to respect participants' anonymity, so analyses relied on the note takers and the quality of notes taken.

After all focus groups are conducted, the notes from the note takers were compiled and analyzed using Dedoose, a qualitative analysis software. Notes were coded to identify overarching themes and major takeaways for each topic. The focus groups' top themes, challenges and successes were combined into a one paged data brief for each health topic. Select quotes were also included to provide an insight into what participants shared. These focus group data briefs were included in the data packet.

2024 Fall Partner Meeting Series

Results from the quantitative and qualitative portions of the needs assessment were presented to MCH partners during two meetings. The first meeting was an all-day, in person meeting just outside of Nashville, centrally located. Partners were invited to attend, and breakfast and lunch were provided. A virtual meeting was also held after work hours to provide additional individuals and family partners the opportunity to participate in priority selection if they were not able to attend the in-person meeting. The 2024 Fall Partner in-person meeting had a total of 106 partners attend. More would have attended, but the location of the meeting had to cap attendees due to the size of the rooms available. The 2024 Fall Partner virtual after-hours meeting had a total of 53 participants, made up of 45 central office/Regional/Metro staff, 2 family members, and 6 professional partners. During these meetings, TDH staff presented the quantitative and qualitative data findings, as well as current interventions for each domain. The data packet was shared with partners for both meetings to allow partners to reference how top health topics were chosen. MCH Partners then determined what they believed to be the most important health topics for each domain via matrices that were created in REDCap. The matrices asked partners to score each health topic within a domain according to the Hanlon method. This method required partners to rate the size and seriousness of the health problem and the effectiveness of interventions on a scale of 0 to 10, with 0 being the least and 10 being the greatest. This method is particularly useful when trying to determine health priorities. After voting, the top health topics were then reviewed during a capacity assessment for TDH FHW leadership to decide on the priorities.

Capacity Assessment

A capacity assessment was conducted for FHW leadership and staff to determine the MCH/Title V priorities for the next five years. FHW staff worked with UNC Workforce Development Center to plan and facilitate an in-person meeting in December 2024. During the all-day capacity assessment, FHW assessed TN's organizational capacity by discussing past successes and challenges in addressing potential health needs and current support from partners, funding, and available staff to support the work. FHW analyzed the top-ranked priorities and existing resources for each domain and discussed what FHW staff want to achieve in the next five years. Through these discussions, FHW staff selected our final priorities.

Once confirmed, domain and priority leads were selected, along with lead clinical and epidemiology staff to ensure accountability. Domain leads then identified teams for the priority, including both internal and external partners. Priority leads led the creation of action plans, using guidance from the MCH Evidence Center. Asana, an online project management software, was used to inform domains when and how to report their data action plans.

2025 Spring Partner Meeting
A Spring 2025 TDH MCH Partner Meeting was held virtually April 9, 2025 to inform partners of the MCH/Title V Priorities for the next five years and gather comments and feedback. During this meeting, partners are made aware of the data packet from the Needs Assessment and the plan for it to become publicly available to Tennesseans.

Approaches for Soliciting Feedback and Conducting Ongoing Monitoring

Needs Assessment Survey and Focus Groups
The Community Health Survey for TN distributed via REDCap and focus groups were a great way to solicit feedback and input from communities. The survey produced 1,015 responses from Tennesseans and there were 93 participants in the 18 focus groups. FHW staff worked with regions and metros, community health councils, maternal health innovation team, and more to recruit participants for focus groups. Regions and metros were also included in focus group question development to ensure they could provide feedback.

The Maternal Health Innovation (MHI) program also conducted focus groups in 2024 across the state on topics related to Women & Maternal health. In an effort to deduplicate focus groups and avoid taxing community resources, FHW staff worked with the staff involved with the MHI program to avoid conducting similar focus groups in the same areas. The MHI focus group results were included in the presentation to partners at the 2024 Fall Partner meetings.

MCH Partner Meetings
The Fall and Spring Partner Meetings were also effective ways to engage partners when determining the MCH/Title V priorities for the next five years. The 2024 Spring Partner meeting took place virtually after hours and had a total of 163 participants. The 2024 Fall Partner in-person meeting had a total of 64 central office/regional/ metro staff, 1 family member, and 41 professional partners. The 2024 Fall Partner virtual after-hours meeting had a total of 53 participants, made up of 45 central office/Regional/Metro staff, 2 family members, and 6 professional partners.

Key Informant Interviews and Ongoing Focus Groups
Plans for ongoing key informant interviews and focus groups for 2025 are currently in progress. So far, topics include home births in Tennessee and adolescent health. For adolescent health, there is a plan to partner with the Tennessee Teen Institute, a teen conference that is expected to host 525 attendees in June 2025, to hold adolescent focus groups. These focus groups will highlight the selected MCHBG adolescent priorities and maintain relevancy with the population. Further, the focus groups will allow FHW teams to evaluate MCHBG strategies and activities to make sure it is reflective of the needs of Tennessee adolescents.

Advisory Councils, Committees and other Partner Meetings
FHW staff continue to lead and participate in numerous advisory councils and committees, including:

- TDH Data Advisory Council
- Traumatic Brain Injury Advisory Council

- Genetic Advisory Committee
- Perinatal Advisory Committee
- Doula Services Advisory Committee
- Children's Special Services Advisory Committee
- TCAPES Advisory Committee
- Young Child Wellness Council
- Birth Defects Advisory Committee

Engagement of Families, Caregivers, and Partners

Families were invited and encouraged to engage throughout multiple steps of the needs assessment process. The REDCap survey, focus groups, fall and spring partner meetings were all separate instances where TDH reached out to hear from the community. Out of total survey respondents, 73% indicated they had a child or children, demonstrating success with outreach to hear from parents and caregivers. After hours meetings and virtual focus groups were provided to hear from families and caregivers who wanted to participate but couldn't travel or attend in person. Great effort was made to encourage families and caregivers to attend, and to invite them to virtual after-hours meetings in order to meet families where they were. Recruitment for adolescent focus groups was challenging, but TDH staff ensured their voices were heard by working with adolescent groups like the Youth Advisory Council to find a date and time that would work for them. Challenges included creating a consent form to send to parents after getting it approved by TDH's Office of General Counsel and navigating schedules to find a date and time that would work. Finding a time to meet was a priority to ensure adolescent focus groups could be held, even if it meant pushing back the original Needs Assessment timeline.

While planning and facilitating these events, participants were also asked if any special accommodations were needed (e.g., materials in braille, an ASL interpreter, large print font, etc.) to ensure all participants could provide input and feedback. This question was included in the registration survey for the meetings, with an automatic alert set up to notify FHW staff if someone indicated they needed special accommodations. The alert sent an email notification, and FHW staff would follow up with the individual one-on-one to make sure they had everything they needed to attend and participate.

During the Fall and Spring Partner Meetings, when voting on priorities, partners were also asked if they would be interested in partnering with TDH on the health topics and priorities they voted on. This provided a list of partners for domains to reach out to when conducting their action plans. There were 28 participants willing to partner for action for CYSHCN, 23 for Child Health, 15 for Adolescent Health, 36 for Women & Maternal Health, and 28 for Perinatal & Infant Health. Priority was given to partners and families to attend the in-person Fall Partner meeting before allowing additional TDH staff. For those who couldn't attend in person, TDH held a virtual MCH Fall Partner meeting at an after-hours time to ensure families and caregivers could attend a time outside of work and school hours. FHW staff reached out to families and partners who weren't able to attend the in-person meeting to make sure they were invited to the virtual option. For the virtual after-hours meeting, a condensed presentation of top health issues and current interventions was presented, and a data packet was sent out ahead of time as a resource for attendees to review before the meeting.

The data packet was created compiling the quantitative data one-pagers and the focus group data into a 65-page packet detailing the top health concerns identified from the needs assessment process. FHW staff worked with the TDH communications team to ensure the layout, visuals, and language throughout the data packet were engaging and appropriate for a variety of audiences. This data packet will be publicly available to Tennesseans via the TDH website and distributed to regions and metros to share with community members and focus group participants.

Summary of Ongoing Performance Monitoring and Assessment

TDH will continue engaging with communities across Tennessee to evaluate the impact of action plans for the newly determined priorities. Plans to continue focus groups, distribute surveys, and host key informant interviews during the

next five years are in progress. Action reports for the action plans developed by FHW staff will also provide insight into action plan impacts and effectiveness. MCH/Title V staff will meet with internal partner groups to touch base every two months and continue hosting Spring and Fall Partner meetings.

Each quarter, MCHB Grantees meet virtually to touch base and provide updates on their grants and activities. They share successes and challenges with FHW central office staff and establish connections with all attendees. Central office staff also meets with regional and metro MCH directors quarterly. These meetings provide an opportunity to share updates across the state and hear about new resources, emerging issues, challenges, and successes. This protected time ensures that regional and metro staff can be heard, and meetings have taken place both virtually and in person. Both the MCHB Grantee and MCH Directors meetings will serve as avenues to evaluate the performance and impact of Needs Assessment activities.

III.C.1.b. Findings

III.C.1.b.i. MCH Population Health and Wellbeing

Summary of the Strengths and Needs of the State's MCH Population

Pregnant Women, Mothers, and Infants
In 2022, there were 100 maternal deaths in Tennessee, occurring during pregnancy or within one year after childbirth. Among these, 45 deaths were classified as pregnancy-related. The number and rate of pregnancy-related deaths more than doubled from 2019 to 2021, followed by a 15% decrease in 2022. The percentage of pregnancy-associated deaths that were deemed pregnancy-related by the Maternal Mortality Review Committee has increased. Pregnancy-related deaths accounted for 30% of all pregnancy-associated deaths between 2017-2019 versus 43% between 2020-2022. This increase was due in part to COVID-19, which can cause more severe disease during pregnancy. There were 24 pregnancy-related deaths due to COVID-19, only two of which occurred in 2022. In 2022, 76% of pregnancy-related deaths were considered preventable.

From 2012 to 2021, the fetal mortality rate in Tennessee decreased by 18% (or 1.4 fetal deaths per 1,000 live births and fetal deaths). Over these 10 years, there was an average of 567 fetal deaths annually. Almost half (46%) of public health regions in Tennessee had a fetal mortality rate above the Healthy People 2030 Target of 5.7 fetal deaths per 1,000 live births. Nearly half of all fetal deaths were due to an unspecified cause. The top three identified causes were placenta, cord, and membrane complications, maternal complications, and maternal conditions unrelated to pregnancy. Pregnant women with pre-pregnancy diabetes or hypertension, obesity, maternal infections, previous pregnancy loss, or preterm birth experienced higher rates of fetal death.

Children
The 2024 Vanderbilt Child Health Poll aimed to gather insights on child well-being and parents' concerns on various topics in TN, including education, food security, insurance status, and mental health. In late 2024, a representative sample of over 1,000 parents in the state were surveyed on topics including education, food security, insurance status, and mental health.

In 2024, nearly half (47%) of TN children had public health insurance (TennCare or CoverKids), which was the same percentage as those with private insurance (47%), marking an increase from previous years. About 6% of parents reported that their child was uninsured, a small increase compared to previous years. Additionally, approximately 40% of parents in TN reported occasionally sending their child to health care visits without a parent or guardian present. Among those parents, one in three said their child faced difficulties accessing care, with a larger proportion of Black parents (39%) reporting challenges.

Nearly half (48%) of TN parents indicated they were unlikely to vaccinate their child against seasonal influenza in the winter of 2024-2025. The primary reasons cited for this reluctance included concerns about the vaccine's safety and fears that the vaccine could cause illness. Similarly, about 30% of parents expressed skepticism about having their child complete the human papillomavirus (HPV) vaccine series.

The poll also found that 40% of parents in Tennessee reported unmet needs for food, utilities, or housing over the past year. Access to healthy food was the most prevalent issue, affecting 39% of families, followed by utility concerns at 17% and unstable housing at 13%. One in five parents reported facing multiple unmet needs.

Since the poll began in 2021, food insecurity has risen from 32% to between 39% and 41% in recent years. Black and Hispanic families continue to experience higher rates of food insecurity, with 43% of Black families affected compared to 37% of white families.

Children and Youth with Special Healthcare Needs
According to the 2021-2022 National Survey of Children's Health, 78.9% of children and youth with special healthcare needs (CYSHCN) have a personal doctor or nurse, 85.2% have a usual source for sick care, and 85.7% have family-centered care. Nearly half (49.3%) of CYSHCN have a medical home, while a quarter (25.8%) received services to prepare them for transition to adult healthcare. Further, 19.1% of CYSHCN receive care in a well-functioning system, 53% aged 12–17 years old are bullied, and 34.5% are flourishing.

National Outcome and Performance Measures
There are 8 Outcome and Performance Measures with significant **improvement** in TN since baseline reported in the Application/Annual Report Year: 2025/2023 Federally Available Document:

- Early term birth decreased from 11.1% in 2018 to 11.0% in 2022 (NOM-6)
- Neonatal abstinence syndrome decreased from 16.2 per 1,000 birth hospitalizations in 2017 Q1-3 to 9.8 in 2021 (NOM-11)
- Tooth decay/cavities among children 1-17 years decreased from 13.3% in 2017-2018 to 13.2% in 2021-2022 (NOM-14)
- HPV vaccination increased from 62.3% among adolescents 13-17 in 2018 to 74.1% in 2022 (NOM 22.3)
- Teen births decreased from 25.3 per 1,000 among 15-19-year-olds in 2018 to 21.0 per 1,000 in 2022 (NOM-23)
- Low-risk cesarean delivery decreased from 26.4% in 2018 to 26.3% in 2022 (NPM-2)
- Developmental screening among children ages 9 through 35 months increased from 42.7% in 2017-2018 to 42.8% in 2021-2022 (NPM-6)
- Child injury hospitalization among children 0 through 9 years decreased from 122.6 per 100,000 in 2017 Q1-3 to 121.4 in 2021 (NPM-7.1)
- Transition to adult care among CYSHCN aged 12-17 increased from 16.6% in 2017-2018 to 25.8% in 2021-2022 (NPM-12)
- Smoking in pregnancy decreased from 12.2% in 2018 to 7.3% in 2022 (NPM-14.1)

There are 9 MCH/Title V Outcome and Performance Measures with significant **worsening** since baseline:

- Adolescent mortality among 10-19-year-olds increased from 44.9 per 100,000 in 2018 to 52.4 per 100,000 in 2022 (NOM-16.1)
- Adolescent motor vehicle death among 15-19-year-olds increased from 15.1 per 100,000 in 2014-2016 to 21.2 in 2020-2022 (NOM 16.2)
- Flu vaccination among children 6 months to 17 years decreased from 62.1% in 2018-2019 to 50.7% in 2022-2023 (NOM-22.2)
- Tdap vaccination decreased from 90.7% among adolescents 13-17 in 2018 to 90.6% in 2022 (NOM 22.4)
- Meningitis vaccination decreased from 85.2% among adolescents 13-17 in 2018 to 82.9% in 2022 (NOM-22.5)
- Adolescent injury hospitalization among children 10 through 19 years increased from 220.7 per 100,000 in 2017 Q1-3 to 232.5 in 2021 (NPM-7.2)
- Adolescent physical activity among children 12 through 17 years decreased from 16.8% in 2017-2018 to 14.9% in 2021-2022 (NPM-8.2)

State Successes, Challenges, and Gaps by MCH Health Domain

2025 Needs Assessment – Quantitative and Qualitative Results

The 2024 Tennessee (TN) Community Health Survey aimed to determine the priority health successes, challenges, and community health factors in the MCH population and each population domain. A total of 1,015 TN residents responded to the survey. This sample represented 86 out of 95 counties in TN, with the greatest representation from Shelby County, Knox County, Davidson County, Hamilton County, and Williamson County. Survey respondents were predominantly non-Hispanic White (76.8%), followed by non-Hispanic Black respondents (17.1%) and Hispanic respondents (4.8%). Survey respondents were also predominantly female (87.4%). Most survey respondents were ages 45-54, making up 26.5%. Respondents aged 35-44 accounted for 24.6%, those aged 25-34 made up 18.5%, respondents aged 55-64 represented 17.6%, and 9.2% were 65 or older.

Survey respondents highlighted several health successes in the overall MCH population, including (1) supportive communities, non-profits, and faith-based organizations (63.6%), (2) availability of parks and recreational facilities (54.0%), (3) safe and quality schools (43.6%), (4) safe neighborhoods (36.2%), and (5) employment opportunities (33.2%). Survey respondents identified health challenges and gaps, including several services that are needed for the MCH population like (1) healthcare providers (70.7%), (2) primary care clinics (49.0%), (3) mental health services (47.8%), (4) pharmacies (41.0%), and (5) hospitals (40.6%). Additionally, respondents specified the types of providers that are most in demand, including primary care physicians (83.6%), OB/GYNs (52.7%), and pediatricians (43.0%). Respondents also expressed a preference for receiving health information primarily through social media, healthcare providers, the Internet, television, and radio. Moreover, survey respondents indicated their leading environmental health concerns were poor air quality (50.8%), pollution (47.7%), and natural disasters (45.0%).

Children and Youth with Special Healthcare Needs Domain

Among the Children and Youth with Special Healthcare Needs (CYSHCN) domain, access to quality care emerged as a priority. The top health challenges and gaps include (1) the ability to get the proper treatment (53.1%), (2) difficulties affording medical care (i.e., limited or lack of insurance coverage) (50.2%), (3) reliable transportation to medical appointments (45.0%), (4) ability to get therapy for medical needs (44.5%), and (5) early and ongoing screening (43.5%). Most of the same barriers fell within the top five across races and ethnicities, except Hispanic respondents included a lack of healthcare providers, Black respondents included the ability to get medications, and Black and Asian respondents included the lack of availability of caregivers. The top community health factors impacting CYSHCN include (1) limited or lack of social support (63.5%), (2) poverty (55.5%), (3) planning for transition to adulthood (52.6%), (4) isolation (44.5%), and (5) bullying (37.9%).

To understand access to resources, care, and needs within the school system, parents of CYSHCN, healthcare providers, and community organizations participated in a focus group. Challenges include insufficient access to knowledgeable providers and difficulties traveling to specialty medical practitioners. Language barriers often hinder effective communication, necessitating the use of translation services. A concern exists regarding potential association with the Department of Children's Services. Further, participants noted limited insurance coverage, or the lack of it altogether, further complicates access to services, and CYSHCN frequently encounter prolonged waiting periods for appointments. Moreover, there is a pressing need for additional trained personnel to CYSHCN in clinical and educational settings. Lastly, the increased financial burden for developmentally appropriate equipment presents another obstacle for families seeking proper care for their children. Successes for CYSHCN include the ability to find understanding and knowledgeable providers and transportation services offered by hospitals and clinics.

Women/Maternal Health Domain

In the Women and Maternal Health domain, maternal mental health, substance use disorder, and family planning emerged as priorities. The top health challenges and gaps identified include (1) mental health (79.9%), (2) chronic diseases (73.6%), (3) breast and cervical cancer (63.0%), (4) reproductive system issues (such as PCOS) (50.7%), and (5) unhealthy relationships (49.3%). These health challenges were similar across races and ethnicities. However, Black and multi-racial respondents included death during pregnancy, delivery, or shortly after as one of their top five health challenges. Among American Indian/Alaskan Native respondents, alcohol use, drug use, and vaccination were highlighted as top health challenges. The top community health factors identified are (1) difficulties in affording medical care (61.9%), (2) poverty (53.6%), (3) lack of social support (49.6%), (4) housing insecurity (42.6%), and (5)

food sufficiency (35.0%).

To understand prenatal care and birthing experiences for Black mothers, a focus group was conducted with Black moms in Tennessee. Participants shared several challenges, including providers not believing their reported pain levels, pregnancy complications, a lack of education and information about doula services, and limited prenatal and postpartum care. Respondents noted successes such as support and person-centered engagement from doulas, midwifery care, and social support. Additional focus groups and community listening sessions were conducted through the Maternal Health Innovation grant with over 200 participants from across TN. Participants noted challenges such as access to care (geographic, transportation, and insurance barriers), workforce and provider shortages (OB/GYNs, midwives, doulas, mental health services, etc.), financial challenges (employment, parental leave, childcare), and trust (stigma, policies, psychological safety).

Perinatal/Infant Health Domain

In the Perinatal/Infant Health domain, strengthened perinatal regionalization emerged as a priority. The top health challenges and gaps faced by women during the prenatal and postpartum periods are (1) conditions during pregnancy, such as preeclampsia (73.2%), (2) mental health issues (65.4%), (3) access to medical care before becoming pregnant (63.1%), (4) postpartum care (62.4%), and (5) smoking and alcohol cessation (61.4%). These health challenges were consistent across different races and ethnicities. However, Hispanic respondents identified access to family planning as a top health challenge, while multi-racial respondents highlighted chronic diseases and pregnancy-related deaths as a top health challenge. Respondents also reported health challenges and gaps during pregnancy, including (1) difficulties affording medical care (61.1%), (2) access to childcare (58.7%), (3) access to transportation (54.9%), (4) access to mental health specialists (52.2%), and (5) access to prenatal care (45.4%). The community health factors during pregnancy include (1) poverty (67.0%), (2) lack of social support (66.7%), (3) access to transportation (56.4%), (4) food sufficiency (50.2%), and (5) housing insecurity.

The top health challenges and gaps faced by infants include (1) premature birth (57.5%), (2) breastfeeding difficulties (43.9%), (3) complications during labor and delivery (37.4%), (4) sudden infant death syndrome (29.9%), and (5) low birth weight (26.5%). The top barriers to optimal health contributing to these challenges are (1) difficulties affording or accessing childcare (73.8%), (2) lack of social support (65.3%), (3) financial challenges in affording medical care (50.0%), (4) limited access to lactation support (41.5%), and (5) inadequate access to diapers (40.8%).

To understand safe sleep practices, breastfeeding initiation, prenatal care, and syphilis, focus groups were conducted with parents, nurses, and public health practitioners. Participants identified several challenges, including a need for education on these topics, access to healthcare, lack of social support, long travel times to clinics, and challenges related to breastfeeding. Successes include home visiting programs that support families, access to community-based pregnancy support resources, follow-ups from WIC (Women, Infants, and Children), the use of doulas for education and support, lactation consultants, and strong social support networks.

Child Health Domain

In the Child Health domain, childhood vaccination emerged as a top priority. The top health challenges identified include (1) mental health issues (54.9%), (2) overweight and obesity (54.6%), (3) adverse childhood experiences (52.1%), (4) lack of healthy food choices (43.3%), and (5) excessive screen time (39.5%). These challenges are consistent across different races and ethnicities; however, Black respondents specifically highlighted developmental disabilities (such as autism), while Hispanic respondents noted a lack of exercise as one of the top five health challenges. The top community health factors impacting children are (1) poverty (66.8%), (2) bullying (52.1%), (3) food sufficiency (51.5%), (4) negative influences from social media (46.9%), and (5) exposure to violence (44.1%).

Focus groups were conducted with parents, family members, and public health practitioners to understand dental health, firearm security, and food sufficiency. Participants revealed several challenges, including high expenses (in all areas), issues with TennCare, a shortage of dental services, limited access to fresh and quality foods, and long distances to grocery stores. Participants noted successes, including mobile dental clinics in Title I schools, firearm security and storage, and school-based breakfast, lunch, or summer meal programs.

Adolescent Health Domain

Social and emotional well-being emerged as a priority in the Adolescent Health domain. The top health challenges include (1) mental health issues (77.4%), (2) smoking and vaping (57.2%), (3) overweight and obesity (56.8%), (4) teen pregnancy (50.7%), and (5) sexually transmitted infections (42.5%). These challenges are consistently reported across different races and ethnicities, although Hispanic respondents specifically cited a lack of exercise and healthy food choices as additional concerns. The top community health factors identified are (1) negative social media influence (63.4%), (2) bullying (61.6%), (3) poverty (56.5%), (4) negative peer influences (48.6%), and (5) a lack of social support (47.6%).

Focus groups, including adolescents from statewide youth groups, were conducted to understand social connectedness, social media, mental health, and transition to adulthood. Participants highlighted several challenges, including a lack of appropriate places for adolescents to spend time with friends, the negative impacts of social media, changes that occur during the transition from adolescence to adulthood, insufficient support and mentorship during this transition, and various mental health conditions. On a positive note, participants mentioned social opportunities available through school settings, resources for transition provided by the Youth Advisory Council, and the importance of reliable adults in adolescents' lives.

Health Issues Stratified by Population Characteristics

To address health issues for all people, state successes, challenges, and gaps are stratified by race and ethnicity. Among Black survey respondents, the top health successes include (1) supportive communities, non-profits, and faith-based organizations (64.3%), (2) availability of parks and recreational facilities (42.7%), (3) safe and quality schools (30.1%), (4) employment opportunities (27.3%), and (5) safe neighborhoods (25.2%). The most used health services include (1) providers (midwives, OB/GYNs, primary care doctors, etc.) (71.8%), (2) urgent care (48.1%) and primary care clinics (48.1%), (3) pharmacies (62.2%), (4) hospitals (34.0%), and (5) mental health (28.2%).

Among Hispanic survey respondents, the top health successes include (1) safe and quality schools (37.5%), (2) supportive communities, non-profits, and faith-based organizations (32.5%) and availability of parks and recreational facilities (32.5%), (3) employment opportunities (30.0%), (4) safe neighborhoods (25.0%) and affordable and quality grocery stores (25.0%), and (5) affordable and quality housing (20.0%). The most used health services include (1) primary care clinics (52.8%), (2) providers (midwives, OB/GYNs, primary care doctors, etc.) (47.2%) and pharmacies (47.2%), (3) urgent care (41.7%), (4) hospitals (30.6%), and (5) mental health (13.9%).

To understand access to healthcare for at-risk groups in TN, a statewide focus group was conducted with Hispanic Tennesseans. The top overall health challenges include a lack of health insurance, expensive medical costs, language barriers, lack of varied food options (for example, in WIC), lack of support from healthcare providers, low wages, and lack of time for healthcare visits. The availability of translation services offered in health departments and clinics was noted as a success.

TN conducted a focus group concentrating on Natural Disasters and Preparedness. Participants identified several health challenges at-risk populations face in accessing care during emergencies, including the need for special accommodations, improved communication, and additional staffing. They also pointed out that essential items, such as baby formula, are often unavailable during emergencies and that there is a lack of understanding concerning the specific needs of different at-risk groups. Participants highlighted several successes: special communication accommodations have been established for medically underserved populations, including tools like UbiDuo, American Sign Language interpreters, and language lines. Additionally, training sessions (such as tabletop exercises and planning annexes) include considerations for at-risk populations, mobility trailers have been utilized effectively, and partnerships have been formed with schools, children, adolescents, and families to enhance support.

Analysis of Current MCH Block Grant Efforts

Areas of Success

The MCH/Title V program made significant efforts to identify successful strategies for addressing MCH needs in TN. The Community Health Survey included participation from residents across most of the state, ensuring comprehensive representation in geographic regions, races and ethnicities, and age groups. This comprehensive survey uncovered the unique strengths and successes that flourish within TN communities. Moreover, our focus groups allowed the Tennessee Department of Health (TDH) to connect with Tennesseans face-to-face, providing invaluable insights into the health topics and needs that resonate most deeply in their communities. The use of focus groups also enhanced the quantitative data with qualitative insights. These efforts allowed us to share our findings with MCH partners, strengthen our relationships with partners across the state, and hear directly from Tennesseans. The MCH/Title V Program will continue its comprehensive needs assessment yearly to assess the needs of TN's MCH population accurately.

Areas for New or Enhanced Strategies

The Community Health Survey and focus groups documented several health challenges and gaps in TN. Below are areas for new or enhanced strategies identified through the Needs Assessment.

Access to Healthy Foods

According to the 2024 Vanderbilt Child Health Poll, 39% of TN families reported that they were unable to access healthy foods in 2024. Almost half (45%) of parents in the state surveyed said they used a nutrition assistance program, like WIC (for women, infants, and children), SNAP (food assistance), or a local community program. More parents in East Tennessee (50%) and West Tennessee (52%) reported using these programs compared to Middle Tennessee, where only 38% participated. When asked about a statewide policy to provide free, healthy meals for all children during school, 85% of parents supported the idea, with 74% strongly supporting it. Only 11% were unsure or had no opinion, and just 6% opposed the idea.

Child Immunizations

In the 2023-2024 school year, the immunization coverage rate for children enrolled in kindergarten in TN was 92.8% (a decline by 0.5% from 2022-2023). This marks the third consecutive year of a decrease in the coverage rate for kindergarten-required immunizations. In TN public schools, enrolled kindergartners had a higher immunization coverage rate (93.0%) for all required vaccines than those enrolled in private schools (90.2%). While immunization coverage among kindergartners remains relatively high, TN has been below the statewide goal of 95% coverage for the past three school years.

Child Homicide Deaths

In 2022, 65 TN children died of homicide, a rate of 4.3 deaths per 100,000 children: the third-highest number and rate over the past five years. Between 2018 and 2022, the rate of homicide among TN children increased by 16.2%. TN consistently is above the national rate of 3.3 per 100,000 from 2022. Firearms were used in 78% of homicide deaths among children. Additionally, there was a higher burden of homicide among Black children, males, and children 15-17 years of age. Local review teams described 100% of homicide deaths as probably preventable. TN has identified prevention opportunities such as strengthening gun safety standards in schools and developing and supporting community initiatives that provide mentorship, after-school programs, and safe recreational activities for children. Further prevention opportunities include the Be SMART Program to promote gun safety and secure firearm storage to reduce the risk of fatalities among children, conflict resolution training programs for at-risk youth and their families to reduce violence and promote safer communities, and public awareness around adverse childhood experiences and the impact upon the risk of intentional injury.

Mental Health

Mental health continues to be a critical issue in TN. According to the 2024 Vanderbilt Child Health poll, reveal that social media, online activity, and teen mental health are the top concerns for parents regarding their children. Aside from these issues, parents expressed worries about bullying, gun violence, and the quality of schools. There are notable differences in concerns by race and ethnicity among parents. White parents shared concerns similar to the overall trends in the state. In contrast, Black parents reported greater worries about fair opportunities in life and belonging for everyone (29%), gun violence (29%), and bullying (25%). Hispanic parents were particularly focused on

gun violence (43%), teen substance use (37%), and housing access (30%).

The 2023 TN Youth Risk Behavior Survey results support this, as they found 42.7% of high school students felt sad or helpless almost every day for at least 2 weeks in a row; this represents a significant increase from 2019 (37.5%). Additionally, suicide rates have been increasing since 2011. In 2023, 24.1% of high school students seriously considered suicide, a 1.3%-point increase from 2022.

Electronic Vapor Products

In the 2023 TN Youth Risk Behavior Survey, 39.3% of high school students reported ever using an electronic vapor product, including e-cigarettes, vapes, vape pens, e-cigars, e-hookahs, hookah pens, and mods (such as JUUL, SMOKE, Suorin, Vuse, and blu). While there has been no change in trend after controlling for sex, race/ethnicity, and grade since 2015 (41.6%), the outcomes associated with electronic vapor products in adolescents remain a high concern.

Drug Overdoses and Deaths

According to the TN Hospital Discharge Data System, drug overdose mortality and morbidity rates have decreased for the first time since the state began monitoring overdose data in 2013. The age-adjusted rate for all drug overdose deaths was 56 per 100,000 residents in 2022, and it declined to 52.8 per 100,000 in 2023, marking a 5.5% decrease from the previous year. Although opioid overdose deaths have also declined, they remain high, falling from 45.5 per 100,000 residents in 2022 to 43.5 per 100,000 in 2023. Further, there are over seven nonfatal overdose discharges for every overdose death. In 2023, there were 25,779 drug overdose hospital discharges among residents, with 6,745 (26.2%) being inpatient stays and 19,034 (73.8%) outpatient visits. The highest outpatient overdose rates were among males, those aged 25-44 years, and Black Tennesseans, while the inpatient rates were highest among males, individuals aged 35-44 years, and Black Tennesseans.

Home Births

In 2024 provisional birth data, 2.03% of all births were home births (N=1,665), a slight decline from 2023, when home births comprised 2.17% of all births. This is the first time TN has seen a decline in home births since 2017. However, in 2023 and 2024, home birth rates exceeded 2.0% for the first time in over two decades. Planned home births increased to 1.95% of all births in 2023 but dropped to 1.82% in 2024. Home births also increased among urban and rural Tennesseans. Home births increased from 2.04% of all births among rural Tennesseans in 2020 to 2.81% in 2024. Among urban Tennesseans, home births increased from 1.30% of all births to 1.83% in 2024.

To ensure that newborn screening is conducted promptly for home births, Tennessee has added features to the Newborn Dried Blood Spot Screening Dashboard (tn.gov) specifically for tracking screenings related to home births. Additionally, the state is enhancing its perinatal regionalization guidelines to include standards for neonatal resuscitation training and the required personnel and equipment. Finally, the Tennessee Department of Health has funding for three years of perinatal telehealth projects across the state to develop or expand telehealth services in designated geographic areas.

III.C.1.b.ii. Title V Program Capacity

III.C.1.b.ii.a. Impact of Organizational Structure

Impact of Organizational Structure

Summary of Organizational Placement

Tennessee's MCH/Title V program is strategically located within the Division of Family Health and Wellness (FHW), part of the Population Health branch of the Tennessee Department of Health. FHW encompasses a variety of programs including supplemental nutrition programs; workforce development; child health and injury prevention programming (including CYSHCN and early childhood initiatives such as evidence-based home visiting); perinatal, infant, and pediatric care programs (e.g., newborn screening, lead and poison prevention); chronic disease and health promotion; and reproductive and women's health. Given its programmatic approach spanning the life course, it is an ideal home for the Maternal and Child Health Block Grant. Organizational charts outlining the programs and departments within the Division and State can be found in the Supporting Documents section.

Strengths

The placement of Tennessee's MCH/Title V program within the Division of Family Health and Wellness (FHW) aligns directly with its mission to improve the health and well-being of mothers, children, and families. FHW's broad portfolio of programs provides a holistic and intentional approach to MCH by leveraging existing resources and coordinating efforts to address the needs of Tennessee's MCH population. With MCH-related programs housed within the same Division, the MCH/Title V program is interwoven into the Division's broader programmatic areas ensuring all stages of life are considered. This placement eliminates the need for the MCH/Title V program to work across multiple divisions, facilitating more efficient service delivery and coordination. Additionally, the dual role of the MCH Title V Director as the Assistant Commissioner for FHW which further ensures that MCH/Title V programs are consistently considered across the Division. With this structure, MCH/Title V has become the central, driving force for programming in the Division.

Opportunities

A significant opportunity exists for increasing collaboration with Community Health Services (CHS), particularly given that CHS utilizes approximately $8 million of the $12 million in federal funding allocated to Tennessee's MCH/Title V program through the RVU system in local health departments. Tennessee's legislative mandate to have a local health department in all 95 counties presents a unique opportunity to leverage existing resources to increase the efficiency of MCH programs. Tennessee's MCH/Title V program considered CHS' strategic plan along with partner feedback and organizational capacity when defining priorities for the next five years to create a pathway for increased buy-in and evaluation efforts and eliminate programmatic silos.

Regular monthly meetings with the Office of Strategic Initiatives (OSI) provide a platform for MCH/Title V alignment with broader state health priorities. OSI serves as the direct link to the Commissioner's Office and the State Health Plan. Additionally, OSI oversees all county health councils, which conduct County Health Assessments (CHAs) every 3 years and develop Community Health Improvement Plans (CHIPs). These local planning efforts provide insight into community-specific needs and priorities and create additional opportunities for the integration of MCH/Title V work at the local level. This connection ensures that MCH issues are considered and included in policy and statewide priorities that further enhance the reach and visibility of Tennessee's MCH/Title V program.

The MCH Emergency Preparedness and Response Coordinator facilitates monthly meetings with Communicable and Environmental Diseases and Emergency Preparedness (CEDEP) to ensure engagement of MCH populations in emergency preparedness. This cross-agency partnership has resulted in an annex for MCH populations in the State Emergency Operations Plan, tabletop projects, tailored documents for population needs, and broad participation in disaster relief efforts.

A stronger partnership with TennCare, Tennessee's Medicaid program, is another key opportunity to enhance the reach and impact of MCH initiatives. Currently, Tennessee's MCH/Title V program maintains four interagency agreements with TennCare including TennCare Services and Coordination, Fetal and Infant Mortality Reduction, TennCare Presumptive Eligibility, and Perinatal Regionalization. Efforts are currently underway to develop a broader, more comprehensive interagency agreement that includes enhanced data sharing between TennCare and the MCH/Title V program. This expansion would facilitate more intentional, data-informed programming and strengthen the alignment of services for shared populations.

Challenges

While many MCH-related programs are housed within FHW, several important partners and programs, including TennCare and CHS, are located outside the Division. This structure can sometimes create silos that require intentional coordination. Current efforts to strengthen interdivisional communication and collaboration include monthly cross divisional meetings with enhancing opportunities for joint programming. Additionally, processes such as establishing or updating interagency agreements often require multiple levels of review, which can extend timelines for implementing initiatives like data-sharing agreements.

An important consideration for Tennessee's MCH/Title V program is that a significant portion of federal funding is allocated to CHS via the RVU system for local health department Direct and Enabling Services, which is not administered by the Division of Family and Wellness and MCH/Title V. The current RVU system allows broad reach across the state to ensure access to both primary and dental care, and there is increased MCH/Title V effort to ensure alignment with priorities for our MCH population. Current meetings are ongoing between FHW and CHS to optimize funding for direct services with the strategic goal of ensuring population-based services and infrastructure that align with MCH/Title V priorities.

Impact on Addressing Needs Assessment Findings

The current organizational structure for Tennessee's MCH/Title V program has provided numerous opportunities to act on key findings from the Five-Year Needs Assessment. For example, each region and metro health department in the state has an MCH Director who was instrumental in planning focus groups across the state. Their connections within their respective communities helped establish the necessary trust for open and meaningful dialogue during these sessions. Additionally, various programs in the Division maintain advisory councils and partnership listservs. These networks have been essential in promoting the Tennessee Community Health Survey and securing participation in focus groups across the state. By actively engaging local partners, Tennessee's MCH/Title V program grounded its needs assessment process with real community insight. In return, partners were delivered a comprehensive data packet with synthesized data findings. This reciprocal process not only closed the feedback loop but also created a tool that can be used to inform decision making and amplify impact. Beyond the Five-Year Needs Assessment, these partnerships are leveraged to solicit input on program planning which allows the MCH/Title V program to remain responsive to community-identified needs and ensure partner voices are woven throughout the decision-making process.

III.C.1.b.ii.b. Impact of Agency Capacity

Title V's Capacity Across the Five Population Health Domains

After the completion of the 2025 needs assessment, FHW leadership discussed the rankings of top health concerns within each domain. They then reviewed what it means to be a priority, and identified existing programs to lead program efforts, available internal staff, and funding sources. Highlights from the assessment are listed below, such as top health concerns, existing programs and internal staff, by domain. These are all in addition to specific domain personnel already identified, current partners, and existing programs.

Women & Maternal Health
Top health concerns were family planning, postpartum care components, and mental health. Current programs considered were the maternal health taskforce, maternal health strategic plan, severe maternal morbidity report, doula pilot program, women's health navigators, and opioid abatement funding for postpartum naloxone. Internal staff available included perinatal workforce.

Perinatal & Infant Health
Top health concerns were access to prenatal care, breastfeeding/safe sleep, and perinatal regionalization. Existing programs included breastfeeding hotline, perinatal regionalization, FIMR, and CDC LOCATe. Internal staff available were the perinatal program and safe sleep supplies.

Child Health
Top health concerns included food security, childhood vaccination, and overweight/obesity. Existing programs identified were FindHelp, WIC, TennCare, EBHV, CEDEP Vaccine Outreach, Department of Education Coordinated School Health, CHS. Internal staff that could be available were FindHelp team, WIC staff, school health nurse consultant, clinical staff, CHS, training health educator staff.

Adolescent Health
Top health concerns were mental health/suicide, tobacco/e-cigarette use, and sexual health. Existing programs identified were TNSTRONG, TCAPES, and the SPARK curriculum. Internal staff available were the tobacco team, the priority lead, growing adolescent health team, and the school health nurse contract.

CYSHCN
Top health concerns were provider education, medical home, access to insurance. Existing programs included family voices and TNAAP. Internal staff available were the CYSHCN team, the priority lead, the Family and Youth Engagement team, Family and Youth Advisory members, clinical leadership support and school health nurse contract.

Capacity to Promote and Protect the Health of All Mothers and Children

The Maternal and Child Health (MCH) and Children with Special Health Care Needs (CSHCN) programs in Tennessee have taken extensive, multi-step actions to ensure a statewide system of services that embodies comprehensive, community-based, and family-centered care. These steps were strategically aligned with the 2025 Five-Year Needs Assessment and guided by continuous collaboration with community stakeholders, families, and partners.

Comprehensive and Collaborative Needs Assessment Process
Tennessee Department of Health (TDH) and Family Health and Wellness (FHW) prioritized broad engagement during every stage of the 2024 Five-Year Needs Assessment. This process ensured that voices from communities, families, and professional partners were central to identifying statewide priorities.

- Community and Partner Engagement: TDH collaborated with regional and metro health departments, central office staff, and community councils to facilitate 18 statewide focus groups and a community health survey. Additional focus groups were hosted virtually to include medically underserved communities, ensuring statewide representation and broad participation.
- Usability and Multilingual Tools: The Community Health Survey was available in both English and Spanish and available via mobile devices. Flyers and QR codes were disseminated across regions, and participation was encouraged through regional outreach.
- Incentives and Local Support: Participants were offered tangible incentives (e.g., tote bags, tumblers, and food), and local resources were included to foster trust and community engagement.

Comprehensive Data Collection and Analysis
FHW conducted a three-part Needs Assessment: quantitative, qualitative, and capacity-focused.

- Quantitative Analysis: A REDCap survey yielded 1,103 responses from 86 of 95 counties. It highlighted key concerns and FHW epidemiologists further created data one-pagers with in-depth analyses using tools like SAS and Canva.
- Qualitative Analysis: Focus groups addressed specific MCH domain with additional attention to emergency preparedness and care access. These sessions were designed to foster candid discussions while preserving participant anonymity.

Data-Informed Priority Selection with Family and Partner Input
TDH and FHW ensured that partners and families actively shaped the state's public health priorities:
- Partner Meetings: In Fall 2024, FHW hosted in-person and virtual partner meetings, where data findings were presented and participants voted on priority domains. The meetings had strong participation across sectors, including professionals, regional staff, and family members.
- Capacity Assessment: In December 2024, FHW staff met to align stakeholder priorities with available resources, organizational capacity, and strategic goals. Final priorities were selected with facilitation from the UNC Workforce Development Center.

Sustained Communication and Accountability Structures
To maintain a responsive and transparent system, TDH and FHW committed to ongoing communication and evaluation.
- Ongoing Partner Engagement: Fall and Spring Partner Meetings are scheduled annually to foster continued collaboration. These are hosted in-person or virtually to accommodate participation.
- Action Planning and Oversight: Once priorities were finalized, FHW assigned domain and priority leads, including epidemiologists and clinical staff. Using project management software like Asana, these teams developed data-informed action plans based on guidance from the MCH Evidence Center.
- Future Engagement: Key informant interviews and new focus groups are planned for 2025, including a collaboration with the Tennessee Teen Institute to engage youth directly in adolescent health strategy

development.

Through a comprehensive and participatory approach, Tennessee's MCH and CSHCN programs have built a statewide system that reflects the principles of comprehensive, community-based, and family-centered care. By valuing transparency, broad participation, and evidence-based planning, TDH ensures that health services align with the true needs of Tennesseans, both now and in the years to come.

Collaboration with Other Entities to Support Health Services Delivery

The Fall Partner meetings provided partners the opportunity to weigh in on what they believed were the most important health concerns within each domain based on the Needs Assessment results. When scoring each topic using the Hanlon Method, partners were also asked if they would like to partner with TDH on any of the activities related to the health topic. Partners were both internal and external, and varied from health institutions to universities to community programs. The list of partners who indicated they would like to partner on top health concerns are listed below by domain:

Women & Maternal Health

- Centerstone
- Consilience Group
- Erlanger Health
- Family Cornerstones
- Family Voices of Tennessee
- Knox County Health Department
- Migrant Education Program of Tennessee
- NailEd It Empowerment
- Nashville Metro Public Health Department
- Northeast Regional Office
- Papillon Center for FASD
- Prenatal-to-3 Policy Impact Center
- Safe Sleep
- Shelby County Health Department
- TDMHSAS
- TIPQC
- Tennessee Doulas Association
- Tennessee Hospital Association
- Tennessee Poison Center
- Tennessee State University
- UT MCH Nutrition Leadership Training Program
- Vanderbilt University Medical Center
- West Tennessee Healthcare

Perinatal & Infant Health

- Centerstone
- Consilience Group
- Erlanger Health
- Family Voices of Tennessee
- Knox County Health Department
- NailED It Empowerment
- Nashville Metro Public Health Department
- Northeast Regional Office
- Papillon Center for FASD

- Safe Sleep
- Shelby County Health Department
- TIPQC
- Tennessee Doulas Association
- Tennessee Poison Center
- Tennessee State University
- Vanderbilt University Medical Center
- UT MCH Nutrition Training Program
- West Tennessee Healthcare

Child Health

- Centerstone
- Consilience Group
- Family Voices of TN
- Knox County Health Department
- Migrant Education Program of Tennessee
- Nashville Metro Public Health Department
- Papillon Center for FASD
- Shelby County Health Department
- Tennessee American Academy-Pediatrics
- Tennessee Department of Education
- Tennessee Poison Center
- Tennessee State University
- UT MCH Nutrition Leadership Training Program
- Vanderbilt University Medical Center

Adolescent Health

- Consilience Group
- Knox County Health Department
- NailEd It Empowerment
- Nashville Metro Public Health Department
- Northeast Regional Office
- Papillon Center for FASD
- Safe Sleep
- Shelby County Health Department
- Tennessee Department of Education
- Tennessee Poison Center
- UT MCH Nutrition Leadership Training Program

CYSHCN

- Centerstone
- Consilience Group
- Erlanger Health
- Family Voices of Tennessee
- Knox County Health Department
- Le Bonheur Children's Hospital
- Migrant Education Program of Tennessee
- Northeast Regional Office
- Papillon Center for FSD
- Parent Advocate

- Prenatal-to-3 Policy Impact Center
- Safe Sleep
- Shelby County Health Department
- TDMHSAS
- Tennessee Poison Center
- Tennessee State University
- Tennessee Department of Education
- UT Health Science Center
- UT MCH Nutrition Leadership Training Program
- Vanderbilt University Medical Center
- West Tennessee Healthcare

These partners were those that attended the Fall Partner meetings and checked off that they would like to partner with TDH, but there are more partners that TDH works with that could provide additional capacity for serving MCH/Title V populations in TN.

Capacity to Serve Children with Special Health Care Needs (CSHCN)

In Tennessee, there is a strong emphasis on family and youth engagement for the state's Title V Maternal and Child Health (MCH) efforts to support Children and Youth with Special Health Care Needs (CYSHCN), ensuring that services are informed by those with experience. The CSS Advisory Committee includes family representation for plan development and CYSHCN-related policy discussions. Families also play a vital role in staff training and professional development for Community Health Access and Navigation in Tennessee (CHANT), reinforcing partnerships between care coordinators and the communities they serve.

The state's most recent Needs Assessment highlighted top health concerns for CYSHCN and their families, including provider education, access to a medical home, and insurance coverage. Tennessee's response leverages a broad network of programs and partners, such as:

Core Programs Supporting CYSHCN:

- Children's Special Services (CSS)
- Family and Youth Engagement and Involvement
- Birth Defects Program
- Community Health Access and Navigation in Tennessee (CHANT) ()
- Newborn Screening (Metabolic and Hearing), and Lead Testing
- Evidence-Based Home Visiting (EBHV)
- Traumatic Brain Injury Services
- Neonatal Abstinence Syndrome

Key Partners:

- Family Voices and Brain Links (FV Sister Program)
- TennCare, TCCY, DDA, TDOE, TNAAP, YCWC, CCMH, LEND, TPCA, TAFP
- Office of Minority Health and Disparity Elimination
- Disability Pathfinder
- TN Council on Developmental Disabilities
- Transition TN
- Siskin Children's Institute
- Hospital Advisory Groups
- Council on Developmental Disabilities

Additional internal support includes clinical leadership, as well as contracted school health nurses who help bridge

the gap between medical and educational systems. Specifically related to the health topic of CYSHCN having access to a medical home, leadership identified the CHANT program for additional capacity to assist connecting children in need to a medical home through care coordination provided on the Medical Home Pathway. There are also plans to connect and collaborate with partners in the private sector to strengthen provider participation in systems of care and make the medical home model more widely available to all children. Together, these efforts represent a coordinated, family-driven approach to improving systems of care for Tennessee's children and youth with special health care needs.

III.C.1.b.ii.c. Title V Workforce Capacity and Workforce Development

Capacity of MCH/Title V Workforce to Address Priorities

Family Health and Wellness (FHW) leadership held an all-day capacity assessment in Fall 2024 to respond to the Needs Assessment findings and determine the next health priorities. The MCHB funded National Maternal and Child Health Workforce Development Center at the University of North Carolina helped facilitate the capacity assessment and led discussions. The day started with a recap of what had already been done:

- Identified key health topics for each domain
- Asked partners (214 attended) for feedback on topics
- Conducted community survey (>1,000 respondents)
- Analyzed quantitative data on key health topics
- Identified gaps in quantitative data or areas where quantitative data was inconclusive
- Filled in gaps with qualitative data (18 focus groups with 93 participants)
- Presented the community survey, quantitative, and qualitative data to partners (117 attended) and gathered their input on potential priorities through scoring matrix

Each domain then reviewed the key findings (top health concerns, challenges and successes, and the partner rankings of health topics) and assessed their expertise and resources. FHW leadership then reviewed what a priority is, implementation support, and fairness in resources to help define what the next priorities should be. This was done by considering multiple factors such as a domain's current topic rankings, existing programs, internal staff available, and funding.

Once final priorities were confirmed, FHW selected staff leads for domains and priorities, as well as clinical and epidemiology support. Teams were further built out by adding additional internal and external partners who work on similar or complementary topics. Using the MCHB funded MCH Evidence Center, priority leads for each domain led the creation of action plans for their priorities.

Strengths and Needs of the MCH/Title V Workforce

Every year, FHW conducts an employee engagement survey which is led by the SSDI Project Coordinator and analyzed SSDI Epidemiologist. The 2024 survey had an 88% response rate.

From the survey, it was clear that within FHW communication has improved overall but there is still room for improvement. Staff identified improved communication from top to bottom and increased collaboration between programs. They appreciated more transparency through monthly division wide virtual meetings. Staff can also sign up for lunch meetings where they can connect directly with the FHW/Title V Director. Staff suggestions for improvement included keeping up with FHW growth, improving leadership culture, and streamlining contracts and procurement processes. While FHW offered staff with opportunities for professional development, staff have still mentioned a need for position stability and advancement opportunities. Overall, there were noted improvements in workplace culture. However, FHW staff still want teambuilding within the division. The results from the psychological safety questions also made it clear that there was room for improvement. A psychological safety training took place in June 2025 to encourage teams to reflect and improve psychological safety throughout the division. In Fall 2024, based on the survey results, FHW senior leadership committed to several key actions:

- Coordinate supervisor development opportunities

- Promote and provide team building resources for training within sections
- Implement trauma-informed practices
- Develop FHW recognition plan
- Opportunities for informal in-person connection

Skillset and Composition of MCH/Title V Staff to Address Priorities

At the state level, a total of 55.0 Full-Time Equivalents (FTEs) are dedicated to MCH/Title V activities. This includes:

- 30.95 FTEs from the FHW Division
- 24.05 FTEs from the Community Health Services (CHS) section

These state-level staff expertise spans strategic planning, program management, data analysis, clinical oversight, and quality improvement.

At the local level, an additional 84.0 FTEs are supported through MCH/Title V funding to implement MCH activities directly in communities across the state. These staff serve as the frontline public health workforce and are experienced in healthcare, administrative, and community services roles.

In total, 139.0 FTEs across the state are funded through MCH/Title V and state-level investments to support maternal and child health programs, providing a strong infrastructure to meet the goals of the Title V MCH Block Grant and respond to the needs of women, children, and families in our state.

Impact of Planned/Implemented Organizational Changes on Workforce Capacity

Over the last year the FHW Division Director has outlined an organizational realignment plan with the goal of more logically and evenly distributing programs across the division. This required creating a new deputy director position and adopting a life course based organizational structure (grouping programs that address the same life stage together). This has provided much needed relief to programs such as maternal health which has double in the last 3 years and outgrew its support structure. The creation of two new sections was also required including Maternal Health and Cancer Control Programs.

Family Members, Youth, and Adolescent Representatives

Family members and parents, including CYSHCN and families, play an active role in TN's MCH/Title V programming, all on a volunteer basis.

- Michelle Gross serves as TN's **Family Delegate** and brings her unique perspective as a parent of a child with special health care needs. As a Family Delegate, she partners with state agencies, advocates for programs that impact CYSHCN and their families, shares her knowledge and experiences to help shape effective and family-centered programming, and develops leadership skills to enact positive change in TN.
- Darivon Badee serves as the **Youth Leader** in TN and helps guide and influence policies, programs, and awareness efforts to reduce stigmas, improve mental health, and support transitions to adulthood.
- The **Tennessee Adolescent Advisory Board** ensures youth voices shape MCH programs by providing feedback that makes initiatives more relevant and impactful. Members also build skills like public speaking, teamwork, and leadership, empowering them to drive positive change in their communities.
- The **Youth Advisory Council** was created through the collaboration with Family Voices of Tennessee and provides an opportunity for youth and young adults ages 14 to 24 and have special healthcare needs to advise on activities, programs, policies and resources affecting the health, wellbeing, and successful transition of youth across TN.

Recruitment and Retention of Qualified Staff

In 2023 FHW hired a full-time staff member to lead the recruitment, onboarding, and offboarding of all FHW staff. The Specialist assists hiring managers in deciding what knowledge and skills are needed to support their work and helps them create clear job postings, ensuring postings are placed where the most qualified applicants will see them. This support has consistently received a rating of 4.7 out of 5 among new hires and hiring managers.

FHW retention efforts focus first on hiring the right people, then providing competitive compensation, recognizing staff effort and accomplishment, promoting from within when possible, and allowing flexible schedules and work locations.

The Tennessee Department of Human Resources uses a Pay for Performance (P4P) system to reward full-time employees based on annual performance reviews. In 2024, staff earned salary increases between 3.5-7% and bonuses between 2.5-4.5% based on their performance scores. Contractors are also provided an annual pay increase opportunity of up to 5% based on contract scope performance.

To support retention, FHW recognizes staff for service milestones every five years through an annual ceremony. Staff reaching 10, 15, or 20 years are honored with a supervisor's speech, while those with over 20 years receive a peer video tribute. In 2024, the Division Director introduced the Values in Action awards, celebrating employees nominated by peers for Service, Trust, Compassion, and Excellence.

Over the past two years, significant effort has been dedicated to providing staff with professional development opportunities aimed at enhancing their skills and positioning them as competitive candidates for promotion. This includes hiring an Engagement and Development Specialist who has procured, promoted, and provided technical, management, and leadership trainings.

Assessment of Training and Professional Development Needs

Based on the annual staff survey results training topics were identified for 2025. This included psychological safety training for the entire division as well as topics specifically for supervisors including:

- How to provide clear performance expectations
- How to provide space for professional development and advancement conversations
- How to provide meaningful performance feedback

All FHW supervisors are invited to attend the monthly skill building session to learn best practices on topics identified by the annual staff engagement survey as well as leadership requests. Topics covered in the Supervisor Skill Sessions have included:

- Effective Onboarding
- Balancing Empathy and Accountability
- Transition Planning
- Optimizing Your 1-on-1 Meetings
- Engaging Teams in a Virtual Environment
- Setting Clear Expectations
- How to Support Staff Training and Development
- Position Funding Transparency
- How to Advocate for Your Staff and Communicate Their Impact Effectively
- How to Address Performance Concerns
- How to Make the Most of Feedback"

TDH has also used CDC's Public Health Infrastructure Grant (PHIG) funds to contract with the University of Tennessee's Naifeh Center for Effective Leadership to provide live virtual trainings. They are offered bi-monthly and cover a myriad of topics for entry level, mid-level and advance level leaders. The Center provides certificate programs in the areas of management and supervision, mentoring, and leadership development. These trainings have included:

- Turning Conflict into Opportunities
- Strengths Based Leadership
- Plowing a New Row
- The Art of Great Communication
- Time Management and Organizational Efficiency
- Executive Agility
- When Stress Comes to Work
- Generational Appreciation
- Clifton Strengths Based Leadership
- Ploughing a New Row
- Turning Conflict into Opportunity
- Defining Your Legacy
- Bridge the Gap: Enhancing Top-Down Communication
- Managing Change
- Effective Communication
- Striving for Balance
- Avoiding the Gray: Ethics in the Workplace

FHW staff are also encouraged to apply for state sponsors leadership and management training cohort programs. The 2024 FHW staff cohort application results are below:
These yearlong training programs include day-long and/or week-long conferences that cover various leadership competencies. Some programs include group and one-on-one professional coaching.

- Lead TN: 8 applied; 0 accepted
- TN Government Management Institute: 5 applied; 1 accepted
- Accelerated Leadership Institute (ALI): 1 applied; 1 accepted
- Tennessee Administrator's Professional (TAP) conference: 9 applied; 9 selected
- TDH Commissioner's Leadership Academy program: 6 applied; 5 accepted

Staff are also encouraged to apply to external 2024 cohort training programs including:

- AMCHP Leadership Lab: 3 applied; 3 accepted
- CityMatCH Epi Training Course: 4 applied; 3 accepted
- Tennessee Government Management institute (TGMI): 3 applied

Since these cohort-based programs have limited capacity, staff are encouraged to utilize LinkedIn Learning (subscription is covered for all staff) and CDC's TRAIN Learning Management System for asynchronous learning that covers many topics, including business, technology, creative skills, public health, health care, behavioral health, preparedness, and other public health and health care topics.

Engagement of MCH/Title V Workforce in Training Next Generation

FHW seeks to strengthen the MCH pipeline by connecting with interns and fellows early in their careers. As a result, the Division seeks out qualified candidates from different fellowship and internship programs including:

- CDC/CSTE Applied Epidemiology Fellowship: Carissa Rodriguez, MSPH, matched with the TDH FHW and started her Fellowship in August 2023 and concluded it by January of 2025, when she transitioned to the SSDI Epidemiologist role. FHW applied for another fellow to start summer of 2025.
- TDH Public Health Executive Fellows: FHW matched with 2 fellows starting in June 2022 to increase communications capacity and support MCH/Title V implementation efforts. Krista Cole began her Fellowship in Fall 2023 and has continued to support the division throughout 2024 and 2025. FHW applied for another fellow to start in Fall 2025.
- TDH Interns: FHW continues to host interns from various universities for workforce support. Division sections with interns include CYSHCN, Perinatal, Infant and Pediatric Care, Reproductive and Women's Health, and Injury Prevention and Detection. Since 2024, 24 interns have been hosted. Interns worked on multiple projects

and efforts across the division.

The MCH/Title V Director provides a lecture to students each year to show a pathway from academic organizations to health departments while serving as an internship site. The TDH Academic Health Department provides opportunities for students, faculty, and academic institutions to partner with the TDH. The AHD centrally manages student experiences including internships, fellowships, medical residencies, and collaborative projects. The goal of the AHD is to engage students, educators, and new graduates in meaningful practice to protect and improve the health and well-being of people in TN.

Key Partnership that Enhanced Capacity to Meet Goals

In August 2023, TDH welcomed a CSTE Applied Epidemiology Fellow who significantly expanded the division's capacity. The fellow's primary focus was reimplementing CDC's LOCATe tool to assess maternal and neonatal care capabilities statewide and engage partners in advancing risk-appropriate perinatal care. She also analyzed data from the GIFTS prenatal smoking cessation program, assessing enrollment, completion, and outcomes. Another major project involved examining trends and outcomes of out-of-hospital births, which have more than doubled in TN over the past decade, offering insights into perinatal regionalization. The fellow also contributed to the Five-Year Needs Assessment through focus groups, data analysis, and narrative development, and supported the creation of action plans and measures.

III.C.1.b.ii.d. State Systems Development Initiative (SSDI)

The SSDI grant complements the MCH Block grant by setting aside funds for MCH data infrastructure. This ensures staff have opportunities for continued development of MCH assessment and analytic skillsets. Staff are then able to leverage this capacity to make data-informed decisions, particularly for program planning. This, in turn, facilitates the creation and continuity of effective data-driven programs, ultimately leading to health improvements in the MCH population. The program has built epidemiologist capacity to collect and analyze data, including detailed quarterly reports to identify the demographic of individuals currently being served by the program stratified by clinic/location. This information has been used to inform programmatic efforts including creating appropriate materials, promoting health education efforts in areas of need, and supporting clinics in screening uptakes. These efforts have resulted in assuring optimal health for all. Additionally, WIC's Enrolled Not Participating report identifies WIC enrollees that are not participating in the program. WIC staff utilize the report to contact participants and offer to complete their nutrition education over the phone or schedule an appointment. The report has been utilized to increase program participation since its creation in 2018. From FFY 2020 to FFY 2024, non-participation among WIC enrollees decreased 29.3%.

Supporting Data Needs

The SSDI grant supports direct, consistent, electronic, and timely access to data by coordinating with the Division of Vital Records and Statistics (VRS), Division of Population Health Assessment (PHA) and Office of Informatics and Analytics (OIA) within TDH. The SSDI Project Coordinator and MCH/Title V Director maintain the data sharing relationship between these divisions. This relationship enables FHW epidemiologists to have access to many datasets, including provisional data. As data sharing issues arise, they are discussed and resolved in a way that addresses the needs and concerns of all divisions.

FHW epidemiologists have direct, consistent, electronic access to these data:

- Vital Records Birth
- Vital Records Death
- Vital Records Birth-Death Linked
- Vital Records Fetal Death
- Youth Risk Behavior Surveillance System (YRBSS)
- Behavioral Risk Factor Surveillance System (BRFSS)
- Pregnancy Risk Assessment Monitoring System (PRAMS)

- Hospital Discharge
- Population Estimation
- Electronic Surveillance System for the Early Notification of Community-Based Epidemics (ESSENCE)

The FHW epidemiologists have direct consistent, electronic, timely access to the following FHW datasets:

- Patient Tracking and Billing Management Information System (direct care in LHDs)
- Women, Infants, and Children (WIC)
- Newborn Bloodspot Screening
- Newborn Hearing Screening
- Newborn Screening for Critical Congenital Heart Disease
- Evidence-Based Home Visiting
- Healthy Start (Tennessee specific program)
- Tobacco Quitline
- Growing Inside, Free of Tobacco and Smoking (GIFTS)
- Neonatal Abstinence Syndrome Surveillance
- Child Fatality Review
- Maternal Mortality Review
- Traumatic Brain Injury Registry
- Tennessee Birth Defects Registry
- Children's Special Services (MCH/Title V CSHCN program)
- Childhood Lead Screening
- CHANT
- Breast and Cervical Cancer Screening (BCS)

If FHW epidemiologists outside of these programs need to access this data, they can access it by coordinating with the epidemiologist for that program.

Current Dataset Linkages:

- The Division of Vital Records and Statistics houses all vital record data - which includes birth statistical system, death statistical system, Induced Termination of Pregnancy (ITOP), and fetal death statistical system. With the addition of the Integrated Data System (IDS), and soon SPARK, data linkages can be provided on an ad hoc basis when requests are submitted.
- The epidemiologist within FHW's Supplemental Nutrition section uses TennCare data to identify pregnant women who qualify for WIC, compares PRAMS cohort data with TDH data to update contact information monthly, and looked at the 24- month cohort from VPDIP to identify WIC participants annually.
- The epidemiologist within the Injury Prevention section links TBI data with death certificate data monthly to identify and remove any non-survivor patients from their survivor list.
- The epidemiologist within the Injury Prevention section links death and birth data for routine identification of child deaths for the Child Fatality Review program.
- The epidemiologist in the Maternal Mortality Review program within the Reproductive and Women's Health section links death, birth, hospital discharge data, and fetal death data for routine identification of pregnancy-associated deaths.
- The epidemiologist within the Newborn Screening (NBS) program section links the newborn screening data to the birth certificate data weekly for multiple reasons: 1) to identify infants who were not screened so that they can be followed up with to complete screening, 2) to determine screening rates, and 3) to identify infants at high risk for mortality for outreach staff to intervene.
- The epidemiologist with the NBS program links the death data with newborn screening data so case managers can update the death information, and cancel any pending follow up actions and also alert other programs to whom infants were referred with confirmed diseases for early intervention.
- The epidemiologist within the Tennessee Birth Defects Surveillance System program links hospital discharge data with birth certificate data to match identified birth defect cases with the birth record as well as death and

fetal death data.

- The epidemiologist within the Chronic Disease Prevention and Health Promotion section links prenatal smoking cessation program Growing Inside, Free of Tobacco and Smoking (GIFTS) data to birth data annually to assess birth outcomes.
- The epidemiologist with Reproductive & Women's Health section links birth data with Hospital Discharge Data through the TDH Integrated Data System (IDS) to produce the Severe Maternal Morbidity report in 2025.

By ensuring access to MCH data, FHW epidemiologists are able to analyze and present information which programs can then use to make data informed decisions. Access to MCH data allows for population assessment, program development, and progress monitoring of the MCH Block grant Action Plans. At the beginning of each grant cycle FHW epidemiologists and program staff complete a needs assessment which provides data analysis on the MCH population. FHW staff and other partners use these data to select priorities for the upcoming grant cycle. Once the priorities are chosen, an action plan is developed (i.e. program development) to impact each priority. Lastly, FHW epidemiologists assist in developing process and outcome measures to measure the impact of the Action Plans on the health of the MCH population. Progress is monitored on each measure by FHW staff and other internal and external partners at the bi-annual public MCH partner meetings. Based on measurement performance and collective feedback received at the bi-annual meetings, FHW staff revise the Action Plans as needed to improve health impact.

The SSDI grant also supports key MCH data priority needs. For example, the SSDI Project Coordinator has supported the building of the birth defects surveillance system for the state. This includes how birth defect data is collected, transferred, and stored within the system by uploading and matching birth defects cases to existing NBS cases. In 2022, remote electronic health records access was obtained from seven hospital systems, allowing the birth defects and maternal mortality review teams to access medical records more securely, quicker, and in an electronic format. The birth defects surveillance team also have access to the clinical viewer in etHIN, covering an additional four hospitals in East Tennessee. SSDI is also supports obtaining access to admission discharge transfer payer claims data for quicker case identification compared to current hospital discharge data used. Through current enhanced surveillance efforts within the TNBDSS, the average time from birth to case identification has decreased from 477 days in 2018 to 100 days in 2024, as of March 2025. As more 2024 cases are identified, the average days from birth to case identification will increase for that year. Additional cases may also be identified once eCR data starts being received in 2025, and eCR reporting overall will improve timeliness for case identification.

Starting in 2021, the SSDI Coordinator initiated involvement in the integration of birth data into the Integrated Data System (IDS) at TDH. This system already includes death data, hospital discharge, and controlled substance monitoring database data. The addition of birth data allows for FHW epidemiologists to better understand topics longitudinally, such as infant and maternal risk factors and outcomes among pregnant women who use opioids. The integration of birth data has enabled epidemiologists in the Maternal Health section to analyze severe maternal morbidity (SMM) for the first time in Tennessee. This analysis is a critical step toward developing a comprehensive SMM report for the state, which offers detailed information on trends, leading indicators and complications, preventable differences in health outcomes, and other risk factors affecting maternal health. Furthermore, SMM analysis provides baseline data for various patient safety bundles within the Alliance for Innovation on Maternal Health (AIM) program. This data equips AIM with essential insights and evidence-based recommendations to improve initiatives that support best practices to making birth safer and improving maternal health outcomes. The SMM in Tennessee 2018-2022 report was released in April 2025 and is publicly available online.

CDC LOCATe

Risk-appropriate care is a strategy to improve maternal and infant health outcomes by providing appropriate care to pregnant women and newborns in facilities that align with their health needs. However, the definitions and monitoring of levels of care vary widely among states. For this reason, CDC developed the CDC Levels of Care Assessment Tool (LOCATe) to assist states with assessing facility levels of maternal and neonatal care using guidelines that align with professional physician associations. In Tennessee, the LOCATe tool was reimplemented in 2024 after updates were made since its initial use in 2018. The most notable changes to LOCATe reflect the 2019 American College of

Obstetricians and Gynecologists/Society for Maternal-Fetal Medicine publication on Maternal Levels of Care. For this reason, TDH reimplemented LOCATe in 2024. TDH administered LOCATe to 59 Tennessee birthing facilities. Before reimplementation, TDH worked with perinatal outreach coordinators to identify survey representatives from each facility. During this time, TDH contacted the CDC to meet with LOCATe staff and obtain the current survey tool and other resources. Once we identified survey representatives, we invited facilities to participate in the assessment. LOCATe was then electronically administered through REDCap over six months, with reminders sent to improve response rates. The CDC analyzed LOCATe data, and results were discussed with facilities to reconcile any discrepancies. After revisions, results were sent back to CDC for final analysis, and letters with LOCATe results were sent to birthing facilities. Successful implementation was driven by building relationships with facilities and state partners to foster support and participation. Collaborating with organizations like the Tennessee Initiative for Perinatal Quality Care and the Tennessee Hospital Association encouraged the use of LOCATe. The SSDI Epidemiologist serves as a subject matter expert for the division regarding LOCATe.

TDH Data Portal Project
In the past, the Tennessee Department of Health (TDH) did not have a full service, single location for publicly available data and data products. Partners, internal and external to TDH, seeking data would have to know what data they were looking for and where to look for it. Additionally, there was no catalog of all existing publicly available data and data products making maintenance, standardization, and governance extremely variable, distributed, and inefficient. This project aims to explore and implement a dynamic, public-facing TDH data portal to enhance data usability and availability, data quality, and data governance. This data portal serves as a one-stop shop for publicly available TDH data and associated data products leveraging a variety of visualization techniques, as well as links to existing data and data product pages currently available, via self-service features and data request functionality. Currently, seven TDH divisions and offices are participating.

1. Division of Communicable and Environmental Diseases and Emergency Preparedness (CEDEP)
    - Vaccine-Preventable Disease Immunizations Program (VPDIP) (CEDEP)
    - Environmental Epidemiology Program (CEDEP)
    - HSVH/Syndemic Coordination (CEDEP)
2. Division of Family Health and Wellness (FHW)
    - Tennessee Cancer Coalition (TC2) (FHW)
    - MCH/Title V Program (FHW)
    - Newborn Screening (FHW)
    - TN CLPPP (FHW)
3. Division of Population Health Assessment (PHA)
    - Office of the Cancer Registry (TCR) (PHA)
    - Office of Healthcare Statistics (PHA)
        - Hospital Discharge Data System (HDDS) (Healthcare Statistics -PHA)
    - Office of Population Health Surveillance (PHS) (PHA)
        - Pregnancy Risk Assessment Monitoring Survey (PRAMS) (PHS-PHA)
4. Office of Health Planning
5. Office of Informatics and Analytics (OIA)
6. Office of Primary Prevention
7. Office of Vital Records and Statistics (VRS)

The SSDI Coordinator leads the TDH Data Portal work for FHW and will work with FHW Epidemiologists and Data Portal support staff to add publicly available data. Over 20 data products are currently in the portal, and more products will be added each year. The total number of views for all FHW data in 2023 was 150, which jumped to 2,705 views in 2024 and already has 951 views in 2025 as of June, demonstrating the public's interest in FHW data products.

SPARK: TDH Data Lake – Secure Platform for Analytics, Research and Knowledge (SPARK)
In an effort to combat data silos and increase access to timely TDH data, the Office of Informatics and Analytics is working to create a data lake, referred to as SPARK (Secure Platform for Analytics, Research and Knowledge)

which will compile all internal TDH data into one place. SPARK will also include integrated data sets and a standardization process to enable data linkage. FHW epidemiologists will be able to request the data needed, and can use statistical software like SAS to conduct analyses. The current plan is to phase out the IDS and eventually replace it with SPARK. This project is currently in the beginning phases, but SPARK is up and running and the SSDI Project Coordinator will provide support by attending meetings to discuss next steps and provide input and documentation review as needed.

Transition from PTBMIS to Juno
The state EHR system, PTBMIS, is planned to sunset by March 2026 and be replaced with a new system, Juno. Multiple sections in FHW use data from PTBMIS for programs and will need to procure additional data systems or ensure that the new EHR system can provide the same variables (i.e., GIFTS, CHANT and Children's Special Services (CSS), patient enrollment data for Reproductive and Women's Health section). The SSDI Project Coordinator is supporting FHW staff to identify data needs and work towards a seamless transition.

Tableau Dashboards
Over the last few years, a portion of the SSDI grant has been used to provide licenses for the data visualization software, Tableau, which provides epidemiologists with the tools to create dashboards. The department has five live Tableau dashboards, which are listed below, and an additional Child Fatality Review dashboard that is currently in development.

Tableau Dashboards
- Newborn Dried Blood Spot Screening Dashboard
- Newborn Hearing Screening and Follow-Up
- Tennessee Birth Defects Surveillance System
- Tennessee Childhood Lead Poisoning Surveillance Dashboard
- Perinatal Health Indicator Dashboard

Training
FHW epidemiologists also receive additional training opportunities for SAS, SQL, R and ArcGIS funded through the CDC Crisis Response Cooperative Agreement. From March 2024 through March 2025, there were a total of 41 FHW staff who enrolled in a training: 15 for ArcGIS courses, 4 for SQL courses, 1 for R Studio, and 21 for SAS courses. These trainings provided skill development for epidemiologists to support their teams and use in their current work. SSDI also provided three FHW epidemiologists with ArcGIS Business Analyst Pro licenses and training passes to conduct drive time analyses for different health topics. These include home births across the state, tobacco use, and birth defects surveillance. These analyses will assist in identifying locations of need for programs and interventions.

Epidemiology Successes & Challenges Meeting
Epidemiologists throughout FHW attend a meeting every other month where they are encouraged to share recent successes and challenges in their work. It is also a time to announce upcoming trainings, conferences, and abstract opportunities and encourage epidemiologists to participate. This meeting also allows for guest speakers to attend and speak on relevant topics to FHW, and for fellow epidemiologists to share best practices and data governance strategies. One of the projects shared during this meeting was the data portal project where epidemiologists can submit their data products so that they can be published on the Data Portal Website. A data suppression code was also shared within the division because this was a main concern for many staff. The SSDI Epidemiologist will be putting together a standard operating procedure document for using SAS to read in data files for other epidemiologists throughout the division. Technical trainings shared during the meeting included SQL, Tableau, R, and ArcGIS allowing for further professional development. This meeting has been successful and will continue through 2025.

Conferences
Over the last year, a portion of the SSDI grant has been used to support opportunities for FHW epidemiologists and

staff to attend various conferences virtually and in person, including pre-conference trainings. The SSDI grant also enabled three epidemiologists to travel to a CityMatCH training. A list of conferences and the Epi training is below. An asterisk at the end of the conference name signifies conferences where FHW staff presented:

- Association of Maternal and Child Health Programs (AMCHP) Annual Conference*
- CityMatCH Leadership and MCH Epidemiology Conference*
    - *FHW staff attended pre-conference trainings*
- CityMatCH Epidemiology Training
- Council of State and Territorial Epidemiologists (CSTE) Annual Conference*
- 2024 Preparedness Summit*
- Access & Functional Needs Conference
- Tennessee Public Health Association Annual Conference*
    - *SSDI Project Coordinator and FHW staff hosted pre-conference session*

Centralized Referral System
A working group was created made up of FHW leadership and the SSDI Project Coordinator for a Centralized Referral System. This system would be an online platform where an individual or family would fill out their information, and a list of eligible services from FHW and other TN Departments would appear. Currently this is still in the discussion and planning phase, and the group is working to identify partners and partners to help develop next steps.

Additional Data Systems
In addition to Tableau and SAS, the SSDI Project Coordinator procured new data systems to support FHW staff. These systems include Asana, Dedoose, and CLEAR. Asana is a project management platform, which staff can use to help monitor workload and prioritize tasks, as well as manage the MCH/Title V grant projects and application process in a more organized way. In two months (August and September 2024), Asana estimated 55.4 hours were saved by individuals using the project management platform. Dedoose is a system for qualitative analysis, specifically for the results from the MCH/Title V Needs Assessment focus groups. Notes from each of the focus groups was uploaded and coded. Staff identified key themes, successes, and challenges from the coded notes and created data briefs for each focus group topic. These data briefs were part of the data packet and were presented to MCH partners at the Fall MCH Partner Meeting to help determine the MCH/Title V priorities for the next grant cycle. CLEAR is an investigative software, which will support FHW programs with outreach.

TennCare Data Access
The SSDI Project Coordinator has begun supporting FHW in an effort to establish a streamlined and standardized approach to accessing TennCare data. Currently, epidemiologists have different types of access. SSDI will provide support by collecting information from sections and programs on how access to TennCare data will improve program outcomes and draft an interagency use agreement with data sharing guidelines.

Memorandum of Understanding (MOU) with Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS)
The Office of Crisis Services and Suicide Prevention (OCSSP) within the Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS) partners with the Tennessee Department of Health's (TDH) Division of Family Health and Wellness's (FHW) Suicide Prevention Program to access suicide death records from the Office of Vital Statistics from 2022 onward. The OCSSP contracts with twelve crisis service providers across the state to deliver a range of crisis services, including mobile crisis teams, Walk-In Centers (WICs) with 23-hour observation, and Crisis Stabilization Units (CSUs), which offer short-term stabilization for up to 120 hours, with an optional 72-hour respite extension to prepare for safe discharge, for clients experiencing a mental health emergency . All crisis providers enter data on all services provided into the state-managed Crisis Management System (CMS) database.

By utilizing suicide death data provided by TDH on a quarterly basis, the OCSSP has developed reports in CMS that cross-reference suicide death data to determine if any person who died by suicide had prior crisis service contact. These reports can be filtered by year of death and provider agency. The reports include information on services received, hospitalization outcomes, and admission locations. They also show the number and percentage of

individuals who died by suicide and had contact with crisis services within 30 days, 90 days, six months, or one year prior to death.
This analysis helps the TDMHSAS identify gaps in follow-up care, timing, and coordination across systems when someone accesses crisis services across Tennessee. Individualized reports are shared with each crisis service provider agency to support in-depth case studies of clients who received crisis services and later died by suicide, helping uncover barriers to accessing proper treatment and care. The collaboration between OCSSP and TDH promotes continuous quality improvement across Tennessee's crisis care continuum, ensuring timely and effective intervention for individuals experiencing mental health emergencies.

FHW Employee Engagement Survey
Every year, FHW conducts an employee engagement survey. The 2024 survey had an 88% response rate. Key results from the 2024 survey included successes and identified opportunities for improvement:

- 89% of respondents reported being satisfied/extremely satisfied with employment at FHW– a 1% decrease from 2023 (90%)
    - Relative percentage difference: 1.1%
    - Absolute percentage difference: 1.1%
- 9 out of 10 respondents agreed/strongly agreed the mission of TDH makes their job feel important (90%) and their fellow staff members are committed to quality work (94%)
- 87% of respondents agreed/strongly agreed someone at work encourages their development – a 7% increase from 2023 (80%)
    - Relative percentage difference: 8.75%
    - Absolute percentage difference: 8.4%
- 83% of respondents agreed/strongly agreed they've been provided feedback about their progress in the last six months – a 1% decrease from 2023 (84%)
    - Relative percentage difference: 1.2%
    - Absolute percentage difference:1.2%
- Only 49% of respondents agreed/strongly agreed they have a best friend at work – only 33% of contractors reported having a best friend at work, compared to 53% of state employees

This past year, a new psychological safety section was added to the survey. The seven questions asked respondents to rate statements on a scale of 1 to 5, with 1 being strongly disagree and 5 being strongly agree. Results showed:

- 7 in 10 respondents feel people can bring up problems at work
- 56% of respondents feel safe to take a risk
- A quarter of respondents agree that it is difficult to ask others for help, with 21% of contractors and 28% of state employees agreeing it is difficult
- 20% of respondents feel that someone would deliberately undermine their efforts
- 8 in 10 respondents feel their skills and talents are valued and utilized
- Nearly 2 in 10 respondents feel their mistakes are often held against them
- 20% of respondents feel people don't accept others for being different

The survey findings identified opportunities to enhance workforce culture.

III.C.1.b.ii.e. Other Data Capacity

State Partnership and Collaboration in Implementing National Surveys

Pregnancy Risk Assessment Monitoring System (PRAMS)
The MCH/Title V Program and SSDI staff met with PRAMS staff for data to action meetings throughout the year. TN PRAMS has linked to hospital discharge data since 2017 through 2020 for both maternal and infant records for the multistate study on severe maternal morbidity and pregnancy-related hypertension that is currently underway, with analyses and a manuscript in progress, "*Multi-jurisdiction Linkage of PRAMS and Hospital Discharge Data: Methods, Key Challenges, and Practical Applications*."

Behavioral Risk Factor Surveillance System (BRFSS)
Several FHW epidemiologists participate in the TN BRFSS Stakeholders Group to share experiences related to using BRFSS data. Through submission of justifications and a voting process, participants also provide input into selecting optional modules and state-added questions for the annual TN BRFSS questionnaire. BRFSS optional and core modules include a wide range of topic areas, and these modules provide programs with unique opportunities to explore data that would otherwise be unavailable. Data from BRFSS are used to inform the MCH/Title V Needs Assessment and other program efforts. FHW epidemiologists use the following variables from the core, optional, and state-added sections:

Core
- Demographics
- Chronic Health Conditions
- Alcohol Consumption (Binge drinking and Heavy alcohol consumption)
- Health Care Access (Insurance, Personal doctor, Routine checkup)
- Hypertension Awareness (High blood pressure, Taking medicine)
- Cholesterol Awareness (Cholesterol checked, High cholesterol, Taking medicine)
- Colorectal Cancer Screening
- Disability (Deaf, Blind, Difficulty Concentrating/Walking/Dressing)
- Exercise
- Falls
- Lung Cancer Screening (Smoking age, Number of cigarettes/day, CT or CAT scan)
- Tobacco Use (Cigarettes, Smokeless, E-cigs)
- Health Status (General Health Status)
- Health Days (Quality of physical health and mental health)
- Breast and Cervical Cancer Screening (Mammogram, PAP, HPV test, Hysterectomy)
- Fruits and Vegetables

Optional
- Adverse Childhood Experiences
- Diabetes (Type, Taking insulin, Eye exam, Management)
- Family Planning
- Industry and Occupation (Type of work, Business/industry)
- Pre-Diabetes
- Sexual Orientation and sex (only asked in 2018 and 2019)
- Community health factors, policies, and conditions that influence health outcomes
- Tobacco Cessation
- Other Tobacco Use (Menthol cigarettes/e-cigarettes, Heated tobacco)

State Added
- Positive Child Experiences

Youth Risk Behavior Surveillance System (YRBSS)
YRBS data is also used to inform programs in the division of FHW. The Tobacco Program uses YRBS results to monitor student health behaviors, identify emerging issues, and inform program practice. For example, the program tracks trends of youth vaping by grade level and sex. Each of these data points provide valuable information on when programs should be implemented and which groups face the highest burden of use. YRBS is administered by Tennessee Department of Education's (TDE) Office of Coordinated School Health. The Tobacco Program section has maintained a close working relationship with TDE and CSH to access Tennessee's YRBS data and have also collaborated on potentially (re)adding questions to the survey.

Tennessee Public Schools: A Summary of Student Body Mass Index Data
Each year, a standardized spreadsheet is sent to school health coordinators in Tennessee to collect student health

data, including height, weight, age, and sex, from selected grades (K, 2nd, 4th, 6th, 8th, and high school). This data allows for the calculation of BMI and includes other health indicators useful for school nurses in referring students to care. The compiled data is analyzed alongside enrollment figures to determine representativeness (defined as 50% or more of students assessed) and to identify trends in BMI, overweight, and obesity rates by year, district, county, sex, and grade. The report highlights statistically significant differences and identifies the five districts and counties with the highest and lowest rates of overweight and obesity, excluding those with low participation. The Decrease Overweight & Obesity priority from the 2020-2025 MCH Block Grant cycle has historically used the BMI report findings to inform their work and measure effectiveness of programming.

Advances in Availability/Usability of State MCH Data Information Systems

Decreases in Hospital Discharge Data Reporting Lag
Prior to 2022, TDH Maternal Mortality Program was unable to use hospital discharge dataset (HDDS) to inform case identification efforts for pregnancy-associated mortality due to the lag time of access to the provisional data set. In 2022, the MMR program incorporated HDDS into the regular process for case identification of 2021 pregnancy-associated deaths. An additional 32 cases that were not captured in prior case identification were discovered; and 14 of these cases were verified true pregnancy-associated deaths. Of all 14 verified HDDS cases, 4 of them were pregnancy-related deaths with cardiovascular disease, COVID-19, and substance use disorders as the cause of death. Most (79%) of the pregnancy associated deaths identified by HDDS were deemed preventable. These efforts were highlighted as a success story in the 2023 Annual Report. The 2024 Annual Report also included a call out to the criteria change, noting the HDDS was added as a data source and contributed to an increase in the number of identified pregnancy-associated deaths.

WIC and TennCare Data Linkage Pilot Project
A new pilot project began in Fall 2024 to identify families on TennCare who are not also enrolled in WIC. FHW receives a list from TennCare of all pregnant women who enrolled the previous month. This list is compared to the WIC participant list to identify who is also not enrolled in WIC. The list of WIC eligible, unenrolled individuals is sent to their local WIC office so that WIC staff can contact them to offer services. As of March 2025, 2,238 women from the lists have enrolled in WIC, along with their 1,238 infants and 652 children.

Tennessee Early Connect (TEC)
The Tennessee Early Connect (TEC) leverages state-level data and technology-driven innovations to improve access to and enrollment in Maternal Infant and Early Childhood Home Visitation (MIECHV)-funded home visitation and related supportive services for pregnant women with complex social and health-related needs in Tennessee. TEC built relationships with state agencies and referral partners (i.e., TennCare Presumptive Eligibility and the Department of Human Services) to identify pregnant women for referral to EBHV programs and to establish a formal referral process. The program also incorporated the TDH Call Center and new statewide EBHV case management system into the referral process. As of September 30, 2024, the TDH Call Center has made outreach calls to over 6,713 newly pregnant Tennessee families.

Collection and Tracking of Real-Time Data

ESSENCE
TDH is applying syndromic surveillance to MCH/Title V-related issues. Currently, the Suicide Prevention Program (SPP), which aligns with the MCH/Title V cross-cutting Mental Health priority, uses ESSENCE to track suicide attempts and suicidal ideation among children aged 5 and older that result in emergency department utilization. TDH disseminates regional alerts when data are significantly higher than expected to partner organizations, including the TDOE, to address potential clustering of cases through programmatic activities. In an effort to increase knowledge of suicide prevalence and programming among internal and external partners, the SPP has begun developing quarterly ESSENCE data briefs to be shared with TDH executive leadership as well as partners at the TDOE, TDMHSAS, and the TDDA. Quarterly briefs include trends in suicidal behavior stratified by age group and region. They also provide an overview of the most prevalent risk factors for each age group. MCH/Title V also uses ESSENCE to

understand sexual violence and intimate partner violence among women of reproductive age to inform the MCH/Title V priority of decreasing pregnancy-associated deaths. Following a Spring 2024 ESSENCE alert highlighting increased youth suicidality in Robertson County, partners quickly mobilized to schedule Youth Mental Health First Aid trainings. Held on April 6 and May 10, 2024, the sessions aimed to build local capacity for early identification and intervention. The trainings focused on equipping adults who regularly interact with youth to recognize warning signs and respond effectively during moments of crisis.

Neonatal Abstinence Surveillance
The NAS Surveillance Program issues monthly and annual reports used to inform partner and program activities. The program is working to make data reporting easier for hospitals by allowing them to report data as a CSV and transport the file to TDH via SFTP setup as opposed to the current REDCap survey process. FHW staff are also in early stages of discussing the implementation of eCR for NAS, and plan to pilot with a several hospitals where they have EMR access to cross-check the reporting with medical records to ensure all the information needed is being reported.

Welcome Baby Program
This is TDH's outreach program designed to support families with newborns by providing timely information and connecting them to community services. The program employs an algorithm utilizing provisional birth data to stratify infants into three categories based on their risk of infant mortality. The CHANT Call Center uses the risk categories to prioritize calling families to inform them of the CHANT program and extend an invitation to enroll in the program. While families of the highest risk infants are called first, it is the intent that all families receive a phone call.

The program also utilizes a mobile app to share available resources and services throughout the state. Between August 1, 2023 and March 25, 2025, there have been 1,409 visits to the app and 1,211 unique visitors. The top 5 most visited pages were:

1. Child Care
2. TennCare Kids
3. PRAMS
4. Imagination Library
5. Other Resources

Creation of Data Review Boards

Data Advisory Council (DAC)
The DAC focuses on dissemination, discussion, implementation support, and recommendation for data projects or initiatives throughout TDH. DAC meetings are held monthly and are attended by FHW Leadership and the SSDI Project Coordinator. Use cases for 2024 include: input for legal framework for data sharing, input for Data Portal expansion, and input for Data Lake prioritization. The SSDI Project Coordinator shares information from these meetings with the epidemiologists throughout the division.

Sharing Data with Partners
TDH has published reports, dashboards, and infographics on MCH/Title V-related activities that inform the MCH population. In recent years, reports have focused data visualization. A variety of products are listed below. To highlight one, the Tennessee Birth Defects Surveillance System dashboard, which is updated yearly and currently displays data from 2016-2021. This dashboard provides an overview of all defects by maternal resident county and viewers can select specific birth defects and year ranges. Site visitors can also view additional details, such as social and economic factors and maternal health factors related to birth defects.

Dashboards:

- PRAMS Dashboard
- Newborn Dried Blood Spot Screening Dashboard
- Tennessee Childhood Lead Poisoning Surveillance Dashboard

- Perinatal Health Indicator Dashboard
- Newborn Hearing Screening and Follow-Up
- Tennessee Birth Defects Surveillance System

Reports:
- Tennessee Birth Defects Data Report 2017-2021
- Positive Childhood Experiences among Tennesseans in 2021
- Tennessee NAS Annual Report 2022
- Suicide Prevention Annual Report 2025
- Maternal Mortality in Tennessee 2024 Report
- 2024 Child Fatality Annual Report
- Provider Recommendation and Safe Sleep Practices, PRAMS 2016-2020
- Severe Maternal Morbidity in Tennessee 2018-2022
- Traumatic Brain Injury Report (2024)
- Diabetes Action Report (2024)
- Fetal Death Report (2024)
- Home Visiting Report (FY2024)
- Neonatal Abstinence Syndrome Report 2022 (Published 2024)

Infographics and Fact Sheets:
- Tennessee Early Hearing Detection and Intervention Provider Infographic
- 2024 TN Child Lead Poisoning Prevention (CLPPP) Infographic
- Preterm Births in Tennessee Infographic (2021)
- Perinatal Regionalization Fact Sheets

Advances in Information Technology

Public Health Infrastructure Grant (PHIG) Funded Data Systems
CHANT was awarded PHIG funding to acquire a new data system. A Request for Applications (RFA) detailing system requirements has been drafted, and internal approvals to receive bids are expected to be complete Summer 2025.

In May 2025, PHIG awarded funding for the TBI Data Modernization Project, which runs from December 1, 2024 through November 30, 2025. Activities include an analysis of TBI Registry and Hospital Discharge data, the development of interactive dashboards, and the creation of data infographics to enhance real-time usability and visualization.

WIC Shopper App Notifications
In 2023, the TN WIC program began utilizing push notifications through the WIC Shopper App as an additional method of communicating with participants. Push notifications have been used to alert participants about food recalls, advertise events, report clinic closures, remind participants to get recertified, and share various programmatic updates.

Electronic Access of Newborn Screening Results
As of January 1, 2025, the TDH Laboratory began requiring providers to access normal newborn screening results through the Secure Remote Viewer (SRV) system, replacing mailed paper results to promote electronic access. NBS Follow-up staff are assisting with provider enrollment, and 89% of birthing hospitals are now using the portal. Efforts are ongoing to transition the remaining hospitals and physicians, though follow-up procedures for abnormal results remain unchanged to ensure patient safety.

Key Challenges

A key challenge faced when trying to improve the use of MCH data is funding to build data infrastructure. The SSDI grant is helpful in this area, but it is small amount of money when it comes to data projects. It costs money to hire staff with the skills and expertise to build and analyze MCH information systems, not to mention the systems themselves. Another challenge is sharing the data with the public. Data suppression guidance limits what can be shared based on data governance and protection of privacy, and data that will be shared needs to be reviewed and assessed by a scoring system to receive approval to be published.

III.C.1.b.iii. Title V Program Partnerships, Collaboration, and Coordination

The Tennessee Department of Health (TDH) Division of Family Health and Wellness (FHW) partners with federal, state, and local organizations—both public and private—to strengthen the Title V Maternal and Child Health (MCH) program. The examples below show how partner input and cross-sector coordination guide program decisions, enhance services, and expand MCH/Title V's impact statewide, reflecting a shared goal of improving care and outcomes for Tennessee families.

Partnerships and Engagement

Maternal Child Health (MCH) Partner Meetings
External partner meetings were held in November 2024 and April 2025, led by priority and epidemiology leads. Three Fall Partner Meetings also gathered input from a variety of partners. The MCH Regional Director Meeting included 26 participants, the in-person Fall Partner Meeting hosted 106, and a follow-up virtual session engaged 53, reaching a total of 185 partners. These meetings aimed to unite partners focused on improving health outcomes for pregnant and postpartum women, infants, children, and adolescents, while exploring ways to build and strengthen partnerships statewide.

The in-person Fall Partner Meeting brought together a wider range of partners—from state agencies to nonprofits—to review data from the Five-Year Needs Assessment and inform future MCH priorities. In spring, the meetings shifted to engaging partners with MCH priority teams, offering program updates, collecting feedback on proposed Action Plans, and identifying support opportunities for upcoming strategies.

Two virtual sessions were held: one on Child, Adolescent, and CYSHCN domains, and another on Women/Maternal, Perinatal/Infant, and Cross-Cutting domains. A total of 208 participants joined and shared insights on key priorities, their roles, and gaps to address moving forward.[1]

MCHB Grantee Meetings
Tennessee's MCH/Title V Program hosts biannual meetings with MCHB grantees statewide to foster collaboration, gather feedback, and align program efforts with grantee work. These meetings allow grantees to engage with relevant MCH priority teams, provide input to ensure planned efforts meet community needs, and identify areas for partnership. On average, 21 MCHB grantees attend regularly. The program also seeks to strengthen collective impact by aligning with grantees on Five-Year Needs Assessment priorities. In addition to these sessions, MCHB grantees participate in broader MCH Partner Meetings, where they share insights, resources, and collaborate to advance MCH/Title V goals.

Family Voices Contract
TDH partners with Family Voices of Tennessee (FVTN) to engage families of Children and Youth with Special Health Care Needs (CYSHCN), supporting efforts like the Youth Advisory Committee (YAC). In this period, TDH and FVTN co-presented at the AMCHP conference, emphasizing the value of partnerships between Family-Led Organizations and MCH/Title V agencies in promoting youth and family engagement.

With TDH support, FVTN's peer support program matched over 50 CYSHCN families with trained parent mentors who provided emotional and practical guidance. TDH also worked with FVTN and the LEND program to strengthen the YAC. While several members graduated and moved on, a new chairperson was elected and is receiving mentorship from FVTN and TDH. The YAC now includes 28 members—eight of whom serve as mentors—focusing on empowerment, communication, and leadership development. Members received training on legislative

engagement and led the planning of the annual Youth and Family Conference, themed “Advocating for U(s).” They also took part in Disability Day on the Hill and continue connecting with peers through virtual platforms.

The CYSHCN program advances integrated care systems through partnerships with agencies such as TEIS, EBHV, the Council on Developmental Disabilities, TennCare, and others. It supports care coordination via the CHANT program and strengthens quality through collaborations with TNAAP and statewide initiatives.

To enhance family engagement, the program launched the CYSHCN Family Council, currently composed of one father and four mothers of youth with special needs. Meeting monthly, the council addresses system barriers, receives updates, and develops shared goals. Members created a mission statement focused on broad participation and engagement across populations and communities and are drafting by-laws to guide future work.

Partnering to Expand Capacity

Children’s Special Services (CSS)
MCH/Title V funding supports both care coordination and reimbursement for a range of direct medical services, including inpatient and outpatient hospitalizations, physician visits, laboratory testing, medications, medical supplies, durable medical equipment, and various therapies. These services are available to children with a chronic physical diagnosis whose family income is at or below 225% of the federal poverty level.

Since October 2024, CSS has spent $2.19 million in claims to support active program participants. Statewide, 4,640 individuals have received medical payment assistance along with essential care coordination services.[2] The program continues to collaborate with and receive referrals from a variety of partners, including TennCare, KidCentralTN, hospitals, the Department of Children’s Services, local health departments, and numerous other organizations across the state.

Breast and Cervical Cancer Screening
MCH/Title V funding supports screening and diagnostic services for uninsured or underinsured women with incomes at or below 250% of the federal poverty level.[3] This funding also supports the work of Women’s Health Navigators (WHN) in metro health departments, helping ensure women in Tennessee access direct services in a timely manner. The WHN provide crucial support in navigating the healthcare system. This funding complements other federal resources, such as those from the CDC, as well as dedicated state appropriations.

Family Planning
MCH/Title V funding supplements state appropriations, insurance reimbursements, and patient billing collections. Since April 2023, the Family Planning program has been funded exclusively by the State and MCH/Title V and the majority of this funding supports the delivery of direct family planning services within rural health departments. It also funds staff salaries, clinic supplies, and clinical services in all six metropolitan health departments.[4]

Additionally, through a collaborative partnership, the program supports the provision of family planning services and provider training at the University of Tennessee at Martin, serving communities in West Tennessee.

Early Periodic Screening, Diagnosis and Treatment (EPSDT)
MCH/Title V funding supports Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) visits for uninsured children at Local Health Departments (LHDs). Additionally, children seen at WIC, immunization clinics, or adolescents in family planning clinics are offered EPSDT services by a Nurse Practitioner or Medical Doctor, if requested by the family, in collaboration with TennCare. This effort aims to increase screening rates across the state, though parents are encouraged to establish a pediatrician or medical home for their child. In calendar year 2023, TDH provided 1,903 TennCare EPSDT visits statewide. TennCare, TDH, and the MCOs share data to specific counties and improve adherence to the AAP periodicity schedule. In calendar year 2024, LHDs completed a total of 1,454 EPSDT screenings, with numbers varying by region. The breakdown by region is as follows: Northeast – 160, Southeast – 2, West – 250, Upper Cumberland – 194, Mid Cumberland – 488, East – 378, and South Central – 22. In CY 2024, the number of EPSDT visits varied across sub-regions, ranging from 1 to 133 per location. To improve

coordination, TDH is strengthening efforts to link EPSDT visits to medical homes through CHANT pathways.[5]

Tennessee Strong Families
The Governor's FY24 budget includes substantial investments in maternal and child health as part of a multi-pronged strategy to address the factors contributing to infant and maternal mortality. Key allocations include $2.3 million for strengthening perinatal telehealth infrastructure; $2 million to support regional perinatal centers and enhance EMS training; $1.3 million to expand the CHANT program, enabling broader care coordination and increased outreach through community health workers; and $1 million in non-recurring funds to launch a doula pilot program.[6]

The CHANT program in addition to expanding the workforce has also used the funding as a means for continued tailored outreach for families. The focus for year one of the funding was on safe sleep and pregnant and postpartum women. The program has launched an initiative that will provide maternal and newborn supply kits and educational material to CHANT participants. CHANT is also collaborating on the Infant Mortality Strategic Plan and will assist in creating promotional material aimed at recruiting families and increasing maternal and infant health and well being.

Throughout this year work, started on creating and obtaining approval to award perinatal telehealth funding to expand or develop up to four pilot projects in areas of the state with limited access to high-risk maternal health/perinatal care. A request for information was completed and work for a competitive award is ongoing to establish this new system for the new projects. The new director for perinatal telehealth started in June 2024. Also, the new epidemiologist started in January 2025.

The TN Strong Families Perinatal Telehealth Investment has awarded a three-year grant to High Risk Obstetrical Consultants and Regional One Health at $3M each for a total funding of $6M. The purpose of the Perinatal Telehealth program is to develop or expand perinatal telehealth services in Tennessee focusing on areas with high rates of maternal and infant mortality and morbidity to improve health outcomes. High Risk Obstetrical Consultants located in Knoxville is expanding perinatal telehealth services in East Tennessee and began telehealth visits in April. Regional One Health located in Memphis will expand perinatal telehealth services in Tennessee counties North and West of Shelby County through a mobile healthcare unit. The purchase, outfitting and build of the mobile unit will take up to a year with an anticipated rollout in 2026. During the interim, Regional One Health will expand their in-office telehealth visits starting in July. Two positions, Director of Perinatal Telehealth and Epidemiologist, were funded through this grant and are currently working.

Doula Services & Pilot Project
In 2023, Tennessee enacted Public Chapter No. 424, establishing the Doula Services Advisory Committee to create core competencies, propose Medicaid reimbursement plans, and explore incentive-based programs for doula services. This marks the state's initial step to integrate doula services into Medicaid, ensuring broader availability and sustainable funding. Tennessee allocated $1 million to six organizations to offer free doula support to Medicaid-eligible women during pregnancy and postpartum across 29 counties. The Doula Services for Tennessee report was published in March 2025.[7] To date, the program has reached nearly 250 families. This innovative pilot program addresses financial barriers, offering prenatal, labor, and postpartum visits until June 2025, prioritizing high-risk populations in Tennessee. Data collected through the doula program captures key evaluation metrics related to both workforce and client outcomes. These data support ongoing monitoring of service reach, quality, and impact on maternal health outcomes across pilot locations.[8]

Maternal Health Innovation
In 2022, Tennessee was awarded the HRSA Maternal Health Innovation grant—a five-year, $5 million initiative—to support community and clinical programs aimed at improving maternal health outcomes. Through the Maternal Health Innovation Program (MHI), the state has continued to strengthen the Maternal Health Task Force (MHTF), which now includes nearly 300 members from across all regions of Tennessee. This geographically broad and multidisciplinary group includes midwives, doulas, substance use disorder specialists, mental health professionals, hospitals, academic institutions, TennCare, and community-based organizations. A key responsibility of the MHTF is to develop Tennessee's maternal health strategic plan[9]. A draft of the plan was completed in 2024, with public

release anticipated in January 2025. Further, the MHI program awarded funding to three community-based maternal health projects in Tennessee to be implemented from July 1, 2024, through September 30, 2025. The selected organizations are Nurses for Newborns, Servolution Health Services, and Tennessee Initiative for Perinatal Quality Care (TIPQC). These projects collectively aim to provide comprehensive care, education, and resources to improve maternal health outcomes across Tennessee. Additionally, in 2025 Centerstone was awarded $154,000 to provide education and training to maternal healthcare workers to address workforce wellbeing and care coordination.[10]

In addition, the MHI program has reached a significant milestone towards drafting Tennessee's first Severe Maternal Morbidity (SMM) report. This comprehensive report, released in 2025, integrates data from the Maternal Mortality Review (MMR) report, providing information about pregnancy-related and associated deaths and risk factors related to maternal mortality and morbidity (see Footnote 10). Some key findings included that, "hemorrhagic diagnoses and procedures were the most common category of SMM, accounting for one-third of morbidities" and "between 2018 and 2022, there were 189 pregnancy-related deaths and 2,795 deliveries with one or more SMM. This means that for every death, 15 deliveries experienced SMM events."[11]

Evidence-Based Home Visiting (EBHV)
TDH provides oversight to 18 local implementing agencies (LIAs) in Tennessee to deliver EBHV services to all 95 counties in the state. EBHV in Tennessee is funded by a combination of federal and state funding including federal MIECHV (Maternal, Infant, and Early Childhood Home Visiting), TANF (Temporary Assistance for Needy Families), and two (2) state appropriations. Funding for EBHV totaled $44,928,944 in SFY24. In SFY24, 3,663 families received EBHV services. This was an increase of 445 families served from SFY23. Four (4) EBHV models are delivered in Tennessee: Healthy Families America (HFA), Parents As Teachers (PAT), Nurse Family Partnership (NFP), and Maternal Infant Health Outreach Worker (MIHOW). TDH also partners with AIMHiTN (the Association of Infant Mental Health in Tennessee) to administer the Infant Mental Health Endorsement system and Infant and Early Childhood Mental Health Consultation (IECMHC) for the EBHV state system. EBHV partnered with Be SMART to provide firearm safe storage training to EBHV home visitors to increase comfort having safe firearm storage conversations with EBHV enrolled families. The Be SMART training is now included in the EBHV annual training plan and will be provided twice each year. Further, two (2) members of the Early Childhood Initiatives team in FHW are being trained as Be SMART trainers to ensure availability of trainings and sustainability. TANF funds are also currently used to sustain the Count the Kicks and Breastfeeding Hotline programs within FHW.

Tennessee Pediatric Mental Health Care Access Program
The Tennessee Child and Adolescent Psychiatry Education and Support (TCAPES) is Tennessee's Pediatric Mental Health Care Access (PMHCA) program. The program is funded through Health Resources and Services Administration (HRSA) and has been awarded over $2.5 million over a 5-year project period. TCAPES initially launched in the spring of 2024 in West Tennessee and expanded to Middle Tennessee in the summer of 2024. TCAPES supports the integration of mental health care into pediatric primary care and offers several free services for primary care providers who care for pediatric patients (under 21 years old) in Tennessee. These services include same-day phone consultations provided by a licensed mental health professional and a team of child and adolescent psychiatrists. Additionally, TCAPES offers behavioral health training—in partnership with the Tennessee Chapter of the American Academy of Pediatrics—to help primary care providers increase their knowledge and confidence in managing the behavioral health needs of their patients. The program also provides assistance with finding community behavioral health resources and services.[12]

Since launching in the spring of 2023, TCAPES has trained 171 providers and received 109 consultation calls. Over 77% of the providers who have called have been pediatricians, and among those who have called, over 50% have also participated in the TCAPES training. Over 70% of providers sought assistance with medication management, while over 30% requested assistance with identifying local mental health resources for their patients. The primary symptoms or diagnosis of their patients included anxiety (39%), depression (38%), disruptive behavior/impulse control (29%), ADHD (22%), autism (19%), and suicidality (12%). A total of 18 providers have called the consult line at least twice (see Footnote 12).

Juul Settlement Funds
In 2023, 40% of Tennessee high school students reported using an electronic vapor product at least once, with 22% reporting use within the past 30 days. To tackle the youth vaping and emerging tobacco product epidemic in Tennessee, the Department of Health has proposed a comprehensive, multi-pronged approach with funding provided by the Tennessee Attorney General's Office with JUUL Settlement dollars. The Tobacco Control Program will receive $1.6 million annually for five years to implement and expand current programs for youth, parents, community partners, teachers, and schools starting July 2025. Recognizing that effective prevention and cessation require a systems-level approach, the proposal includes supporting policy development for both schools and retailers. Funding will expand existing efforts and introduce new training, programs, grants, surveillance, and analysis initiatives.[13]

Count the Kicks
Fetal deaths account for nearly half of all fetal and infant deaths in Tennessee each year. In response, the TDH partnered with Healthy Birth Day, Inc. in September 2024 to launch *Count the Kicks* (countthekicks.org), a statewide stillbirth prevention campaign. Count the Kicks is an evidence-based initiative that empowers expectant parents to monitor their baby's movements during the third trimester—a proven method to help prevent stillbirths. The campaign features a free mobile app that enables parents to track fetal movement patterns and recognize any changes. If a decrease in movement is detected, parents are encouraged to seek medical attention, potentially saving lives. By December 2024, the initiative had made significant strides in outreach and engagement across Tennessee. It reached 1,092 new app users, generated 20,171 website visits from Tennesseans, and distributed 102,130 pieces of Count the Kicks marketing and educational materials statewide. Additionally, 274 orders were fulfilled for organizations and facilities actively promoting the resource.[14]

Looking ahead to federal fiscal year 2026, the Tennessee Department of Health (TDH) plans to further expand its outreach by installing seven billboards in counties with high fetal death rates and hosting six webinars to educate maternal health professionals on stillbirth prevention and the importance of tracking fetal movement (see Footnote 14).

NBS Long-Term Follow-up
The Newborn Screening Long-Term Follow-Up program provides support to families whose babies have been diagnosed with a confirmed condition identified through the newborn screening panel. As part of this outreach, a Genetic Counselor (GC) contacts families to offer genetic counseling tailored to the child's diagnosis and to inform them about available services.

The GC also reviews referrals made by the newborn screening program to agencies such as Tennessee Early Intervention, Children's Special Services, and Family Voices, while discussing other relevant services that may benefit the family. Program staff work collaboratively with families to identify and address any gaps in healthcare related to the child's condition. This genetic counselor position is funded through the HRSA Propel Grant.

Adolescent Pregnancy Prevention Program: SPARK
Tennessee has seen a continued decline in teen pregnancy and birth rates. While these trends are encouraging, the state's teen birth rate remains higher than the national average, and variabilities in outcomes persist. The SPARK Program, funded by the federal Sexual Risk Avoidance Education (SRAE) grant, supports four metro health departments in providing education, resources, and support to individuals aged 10 to 19. The program educates youth about the economic, social, and societal consequences of sex, while emphasizing the importance of the success sequence. Designed to reduce teen pregnancy and STI rates, it promotes community and family involvement, advocates strategies to prevent unintended pregnancies, and raises awareness of available services. Additionally, the SPARK program supports youth-serving agencies by organizing community resource events, offering workshops for parents, and promoting adolescent health campaigns.[15]

The SRAE also supports the TDH's statewide anti-human trafficking campaign, The Red Sand Project. Each year, the department collaborates with local health departments, businesses, and agencies to host Red Sand events. This interactive initiative brings communities together to raise awareness about human trafficking in Tennessee. During

the events, community members, leaders, coworkers, and families participate in a symbolic demonstration by pouring red sand into the cracks of the sidewalk, representing the gaps in society where individuals may fall victim to trafficking. These events offer communities an opportunity to learn more about human trafficking and its impact across the state.

In addition, the Tennessee Adolescent Advisory Board (TAAB)was created in FY25 through the SRAE grant to gather feedback from youth aged 14 to 19 on adolescent programs and initiatives (see Footnote 15). The TAAB meets monthly, and the first meeting took place in May 2025. The board provides young people in Tennessee with the opportunity to grow positively while offering valuable feedback to help the TDH reach more youth through its various initiatives aimed at supporting them.

Emergency Medical Services (EMS) Neonatal Resuscitation (NRP)
Staff at the five Regional Perinatal Centers are offering the NRP to EMS and ED providers within their respective perinatal regions. Federal workforce development funding has been allocated to purchase a limited number of NRP certification exams for use by the perinatal regions during FY 25. In the first six months of SFY 25, the five centers have trained 1,175 EMTs and medics.[16]

Maternal Mental Health and Substance Use Disorder
In 2023, Tennessee Department of Health was awarded a 5-year, $3.75 million grant from HRSA to address maternal mental health and substance use disorder. The program aims to expand and increase healthcare providers' capacity to screen, assess, treat, and refer pregnant and postpartum women for maternal mental health and substance use disorders.

Now in its second year of funding, TDH has made significant investments to advances these goals. A baseline needs assessment is underway to identify gaps in training, treatment, and services for perinatal professionals and pregnant/postpartum women in Tennessee. Recruitment efforts are also underway to expand the https://findhelpnow.org/tn platform to include mental health providers who serve pregnant/postpartum women. Finally, TDH will soon release a competitive application to select the entity responsible for developing the state's multicomponent perinatal psychiatric access program.[17]

Conclusion
The Tennessee Department of Health's Family Health and Wellness Division, through the Title V Maternal and Child Health program, continues to advance its mission of improving health outcomes for mothers, children, and families across the state. From enhancing family engagement and integrated care to strengthening maternal health infrastructure and launching innovative pilots, these coordinated efforts underscore the department's commitment to quality and availability. As Tennessee moves forward, and as funding changes are projected to be proposed, we continue to look forward to our future collaborations ensuring that every child and family has the opportunity to thrive.

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[1] Tennessee Department of Health. (2025). Internal MCH Partner Meetings data.
[2] Tennessee Department of Health. (2025). Internal CSS data.
[3] Tennessee Department of Health. (2025). Internal Breast and Cervical Cancer Screening data.
[4] Tennessee Department of Health. (2025). Internal Family Planning data.
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[14] Tennessee Department of Health. (2025). Internal Count the Kicks data.
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[17] Tennessee Department of Health. (2025). Internal Maternal Mental Health and Substance Use Disorder data.

III.C.1.b.iv. Family and Community Partnerships

The Tennessee Department of Health's Division of Family Health and Wellness (FHW) prioritizes ongoing partnerships with families, individuals, and family-led organizations as part of its MCH/Title V Action Plan. Committed to collaboration, quality, and shared decision-making, FHW involves partners through advisory committees, planning, quality improvement, training, materials, and outreach, ensuring community voices inform programs and policies.

Below are examples of how family partnerships are integrated across domains:

Women's/Maternal Health

Tennessee Breast and Cervical Screening Program (TBCSP)
Aligned with the Healthy People 2030 core objectives for the nation, the TBCSP focuses on addressing the national cancer burden.

TBCSP collaborates with families to guide program planning and implementation, including the development of marketing and educational materials. The program is currently conducting a qualitative review of the patient experience to refine its priorities and activities. Additionally, TBCSP is intensifying efforts to increase outreach and education in communities through tailored initiatives. One such initiative involves partnering with MPH students to pilot a project in the South-Central Region, aimed at enhancing outreach in local communities through the PinkLink program. The TBCSP is also advancing the FAITH train-the-trainer initiative, which connects with congregational leaders to further extend its reach.

In FY23, the TBCSP program saw an 18% increase in the number of women served compared to FY22, with 16,714 women benefiting. Additionally, 51 men received breast services through the program during the same period. In FY24, nearly 400 TBCSP vendors provided services across Tennessee, and the program served a total of 15,595 unique patients—approximately the same as in FY23.[1]

Maternal Health Innovation (MHI)
This program advances maternal health in Tennessee through strong community and family-centered partnerships. In 2024, efforts focused on addressing preventable differences in care and experience across communities. The Maternal Health Initiative (MHI) established a Maternal Health Advisory Group to lead the creation of Tennessee's first Maternal Health Strategic Plan, published in January 2025. This plan emphasizes improved data and surveillance, along with innovative, community-based approaches to care delivery.

MHI's work is guided by recommendations from a Maternal Mortality Review Committee (MMRC) and relies on collaboration to drive change. A key element is the Maternal Health Task Force (MHTF), a statewide, multidisciplinary group of 253 members—including midwives, doulas, mental health providers, hospitals, academic institutions, TennCare, and experienced individuals—that meets quarterly to guide strategy and ensure community voices shape maternal health efforts.

In 2024, MHI also received funding to support Medicaid unwinding. Through this initiative, Healthcare Connect Navigators—based in trusted local organizations—helped 6,420 women, particularly those pregnant or postpartum, navigate redetermination and connect to CHANT, SNAP, WIC, and other services, strengthening care access and support at the community level.

Perinatal and Infant Health

Tennessee Birth Defects Surveillance Program
The Tennessee Birth Defects Surveillance System (TNBDSS), established under Tennessee Code Annotated (TCA) §68-5-506, is a statewide program that tracks children with birth defects It provides data on the incidence,

prevalence, and trends of birth defects, while also informing the public and partners about risk factors and prevention efforts. Additionally, the system offers families of children with birth defects information on available supportive services in Tennessee and, when appropriate, provides referrals to these services.[2]

Further, the TNBDSS ensures parent representation on the Birth Defects Registry Advisory Committee by including parents of children with a birth defect. In addition, the program goes beyond compliance by actively partnering with Family Voices to identify and elevate parent perspectives while the Advisory Committee meetings serve as a platform to showcase the program's latest data, trends, and initiatives, while engaging members in meaningful dialogue to guide strategic direction and enhance impact.

Breastfeeding Peer Counselor Program (BFPC)

Tennessee's Breastfeeding Peer Counselor (BFPC) program exemplifies community-led support by selecting counselors directly from the WIC population to serve as trusted advocates for breastfeeding families. These counselors provide critical education, encouragement, and family-centered support to WIC participants during both the prenatal and postpartum periods. Currently, 46 BFPCs serve families across 32 counties, expanding access to breastfeeding support statewide.

The BFPC program not only empowers families but also elevates the voices of counselors themselves. Through an open-door policy with Region/Metro BF Coordinators and the State BFPC Program Manager, peer counselors offer ongoing feedback that directly shapes program development and strategic planning. Additionally, monthly State calls provide a structured opportunity for BFPCs to contribute ideas, ensuring that those closest to the work help guide its continuous improvement.[3]

Newborn Hearing Follow-Up Program

The Tennessee Newborn Hearing Screening and Follow-Up Program—also known as the Early Hearing Detection and Intervention (EHDI) Program—ensures that all infants born in Tennessee receive a hearing screening before hospital discharge or by one month of age. In addition to early screening, the program guarantees that every family of a child diagnosed with hearing loss has access to dedicated parent support services.

Through the Newborn Hearing Follow-Up grant, TDH partners with the Tennessee Disability Coalition to operate the Family Voices Parent Empowerment Access Resources and Support (FV PEARS) program. Every infant identified with hearing loss is referred to FV PEARS, which offers direct, personalized support to families of children with any degree of hearing loss. At the heart of this initiative are Parent Guides—part-time team members with experience raising children with hearing loss—who provide empathetic guidance on available services and communication options.

Parents are not just recipients of services—they are leaders in shaping them. A quarter of the Newborn Hearing Follow-Up Program Advisory Committee is composed of parents, and the FV PEARS Program Coordinator, herself a parent of a child who is deaf or hard of hearing, plays an active role in monthly planning meetings. With input from parents and professionals, the program developed and disseminated educational materials for all birthing facilities in Tennessee through the state's newborn screening booklet. To further foster connection and shared learning, the program also launched a Parent-Professional Collaborative and Learning Community, creating an ongoing platform for families to engage with professionals and each other in the shared goal of supporting Tennessee's youngest children with hearing loss.[4]

Newborn Screening and Follow-Up Program

The Tennessee Newborn Screening Program, established in 1968, screens for over 70 conditions using dried blood spots, along with screenings for Critical Congenital Heart Disease (CCHD) and congenital hearing loss—providing a comprehensive early detection approach.

Program oversight is provided by the Genetics Advisory Committee (GAC), formed by state legislation in 1985. This multidisciplinary group includes medical specialists, regional genetics and sickle cell center representatives, at-large

members, a parent representative, and the state's chief medical officer or designee. The GAC meets at least three times annually to advise TDH on screening operations, condition incorporation, and follow-up improvements.

Family experience is central to quality improvement efforts. This year, a parent focus group was launched, including families of children with both normal and abnormal results, to inform engagement strategies and program enhancements.

In addition, this program also launched a long-term follow-up initiative to track children diagnosed through screening until age 10. This effort identifies care gaps, strengthens service connections, and collects data on outcomes, positioning Tennessee as a leader in lifelong support for children with inherited conditions.[5]

Perinatal Regionalization Program

The Perinatal Regionalization Program is a cornerstone of Tennessee's strategy to improve birth outcomes and reduce infant mortality. Established in the early 1970s, the program was created to ensure timely, specialized care for pregnant women and newborns facing life-threatening conditions. It operates through five regional perinatal centers strategically located across the state, creating a statewide infrastructure for high-risk perinatal care. These centers serve as hubs of expertise, providing advanced clinical services, coordinating patient transport, and offering real-time consultation and referral pathways for healthcare providers. Tennessee's regionalization model has played a central role in the state's sustained efforts to lower infant mortality and ensure access to high-risk obstetric and neonatal care.

The Perinatal Advisory Committee (PAC) provides expert oversight and strategic direction to the program. Composed of 21 members—including perinatal center directors, medical and nursing professionals, hospital administrators, and family representatives—the PAC advises the Tennessee Department of Health on program operations and broader maternal and infant health issues. By integrating clinical expertise with identified priorities, the PAC ensures that Tennessee's perinatal system remains responsive, community-informed, and committed to improving outcomes for all families.[6]

Child Health

Tennessee Comprehensive Cancer Control Program (TCCCP)

Comprehensive cancer control is a strategic approach aimed at preventing or reducing the impact of cancer within communities. It brings together state and local health departments, community organizations, researchers, healthcare providers, policymakers, cancer survivors and their families, and many others to collaboratively identify and address cancer-related concerns in their communities.[7]

The TCCCP Program has two key family/youth quality improvement initiatives to inform its efforts. In partnership with Ballad Health, the program works to enhance and expand a multidisciplinary palliative care team to improve the quality of life for children newly diagnosed with cancer at the St. Jude Affiliate Clinic and Niswonger Children's Hospital. This pediatric palliative care team delivers essential care for patients nearing the end of life, as well as for their caregivers. Through this collaboration, TCCCP and Ballad Health are developing palliative care guides and creating training resources for clinics interested in establishing their own palliative care programs.
Additionally, TCCCP partners with the Cumberland Pediatric Foundation (CPF) to establish and maintain a Quality Improvement Team focused on increasing HPV immunization rates. This initiative includes provider education, patient education, the use of an immunization registry, provider prompts, reminder/recall systems, and standing orders.

Evidence-Based Home Visiting Program

Evidence-Based Home Visiting (EBHV) programs are a proven early intervention strategy that improves the health and well-being of both children and parents. Research shows that children from families enrolled in EBHV programs experience measurable gains in health, development, and school readiness.

These voluntary programs support families by enhancing parenting skills, strengthening family functioning, connecting

participants with essential social services, promoting early learning, and helping parents build safe, nurturing environments. Equally important, EBHV programs foster self-sufficiency and long-term resilience. The Tennessee Department of Health oversees EBHV services in all 95 counties through contracts with local community-based organizations and public health departments, ensuring access to support statewide.

Recognizing the importance of family voice in shaping effective programs, the Early Childhood Initiatives team has worked to establish a statewide EBHV Parent Advisory Council (PAC). And to strengthen this work, the department embedded the development of the EBHV PAC into an ancillary contract with the Association of Infant Mental Health in Tennessee (AIMHiTN). Through its regional staff, AIMHiTN leads localized community engagement, offering an ideal platform for identifying and uplifting parent leaders. Additionally, a parent representative now serves on the Tennessee Young Child Wellness Council (TNYCWC), further integrating family voice into statewide early childhood systems planning.[8]

Tennessee Child and Adolescent Psychiatry Education and Support Program

The Tennessee Child and Adolescent Psychiatry and Enhanced Services (TCAPES) program is a statewide effort to integrate mental health care into pediatric primary care in response to growing behavioral health needs and a shortage of mental health providers. TCAPES empowers primary care providers to serve as front-line responders in promoting mental wellness for children and adolescents.

The program offers psychiatry consultations to enrolled pediatric Primary Care Providers (PCPs), strengthens collaboration between PCPs and behavioral health professionals, and provides training on screening and managing common behavioral health conditions. It also connects providers to local behavioral health resources, focusing on reducing access gaps across Tennessee communities.

A key element of TCAPES is its multidisciplinary advisory committee, which includes pediatricians, psychiatrists, psychologists, youth advocates, researchers, and representatives from TennCare and TDMHSAS—many of whom are also parents or work directly with youth. Their input ensures the program remains grounded in the identified priorities and community needs while supporting provider engagement and long-term sustainability.

While youth participation on the advisory committee remains a goal, TCAPES has incorporated family partnership strategies into provider training, emphasizing shared decision-making and family involvement in care planning to promote usable, high-quality, family-centered mental health services.[9]

Supplemental Nutrition Program for Women, Infants, and Children (WIC)

The Tennessee Women, Infants, and Children (WIC) Program is a federally funded initiative that provides supplemental food assistance, nutrition education, breastfeeding support, and referrals to health and community-based services. Serving income-eligible pregnant, postpartum, and breastfeeding women, as well as infants and children up to age five, WIC has been proven to prevent and improve nutrition-related health outcomes.

WIC services are delivered through a robust network of 126 county health departments, stand-alone clinics, and hospital-based sites across the state, reaching approximately 150,000 participants each month. To qualify, individuals must be Tennessee residents who meet income guidelines and are determined to be at nutritional or medical risk.

Family engagement is central to the TN WIC Program’s approach. Participants and their families play a key role in shaping program improvements—from updating the WIC Approved Product List (APL) via the WIC Shopper app, to providing direct input on food package variety and availability. These updates ensure that families can purchase eligible foods more easily and receive options that reflect their preferences and needs.

In addition, TN WIC regularly consults with Regional Leadership to ensure that participant feedback informs both

program operations and policy development. New policies and guidance documents are created with this input and reviewed by Regional Leadership before implementation, reinforcing WIC's commitment to being responsive, family-centered, and community-informed.[10]

Adolescent Health

Rape Prevention and Education (RPE) Program

The Rape Prevention and Education (RPE) program works to prevent sexual violence among youth by fostering strong community partnerships and implementing evidence-based strategies at both the community and societal levels. The program engages local partners through quarterly meetings of the RPE Community Advisory Board, where members collaboratively review the state action plan, identify emerging issues affecting youth, and advance prevention strategies.

RPE-supported interventions include Green Dot for Communities, Shifting Boundaries, Benefits Kitchen, and Tennessee scholarship programs—each designed to shift norms, strengthen protective factors, and promote safer environments for youth. These initiatives are implemented in collaboration with local health departments and community-based partners across the state.

In addition to program delivery, the RPE program invests in building community capacity by offering training to residents, service providers, and youth-serving professionals on effective sexual violence prevention practices.

Tennessee Stop Tobacco and Revolutionize Our New Generation (TNSTRONG) Program

TNSTRONG is a youth-led, statewide movement dedicated to raising awareness about the dangers of tobacco and combating the tobacco industry's influence on Tennessee's youth TNSTRONG Ambassadors are a group of youth aged 13-19 who have committed to a two-year program focused on advocating for nicotine prevention and cessation within their communities. For the 2024-2025 fiscal year, there are 30 active Ambassadors. Additionally, an alumni program has been established for those who have completed their two-year commitment but wish to continue their empowerment work. In the 2024-2025 fiscal year, there are 13 alumni ambassadors. Both the active Ambassadors and alumni play a crucial role in supporting the Tobacco Use, Prevention, and Control program, helping to advance its goals in various ways.

TNSTRONG Ambassadors lead and support a range of nicotine prevention and cessation efforts. Their journey begins with a two-day training for students and chaperones, where alumni share experiences. Ambassadors help organize the annual TNSTRONG Summit, uniting over 500 youth and chaperones statewide. They also promote Nicotine Free Teams (NFTs), which have had wide school participation, such as at Gatlinburg-Pittman High. Working with Public Health Educators and Prevention Coalitions, they deliver school programs and support marketing by designing materials, writing press releases, and recruiting peers. Ambassadors also advocate for stronger tobacco-free policies through presentations to school boards and local governments, and they provide ongoing feedback to strengthen programs in their communities.

Adolescent Pregnancy Prevention Program: SPARK

The Tennessee Department of Health's SPARK Program provides federal and state funding to health departments and community organizations to deliver education and resources promoting abstinence and sexual risk avoidance for youth ages 10–19, all within a Positive Youth Development (PYD) framework.

SPARK works through metro health departments, leveraging their trusted presence to deliver community-based prevention education for all communities. The program's curriculum emphasizes PYD-based sexual risk avoidance, while also building awareness and engagement through local partnerships and services.

To ensure youth perspectives shape statewide adolescent health strategies, a new Adolescent Advisory Board is being established by the Adolescent Health Lead. This board will help align programs with the real challenges young

Tennesseans face.
SPARK's broader goals include reducing teen pregnancy, strengthening community involvement, and supporting pregnant and parenting teens. The program offers tailored resources and interactive learning for teens, parents, and educators, while also improving coordination of services for young families to promote healthier outcomes statewide. [11]

Traumatic Brain Injury Program

The Tennessee Traumatic Brain Injury (TBI) Program, established by the General Assembly, supports individuals with brain injuries and their families and caregivers. Recognizing that TBI impacts not just the individual but entire families and communities, the program promotes collaboration across a wide network of partners.
Key initiatives include the governor-appointed TBI Advisory Council, a comprehensive quinquennial TBI Needs Assessment, educational resource development, and regular support groups. The TBI Advisory Council—comprised of survivors, family members, caregivers, state agency representatives, and a physician—guides policy, operations, and program improvement based on community feedback and evolving needs.
The program also partners with Monroe Carell Jr. Children's Hospital at Vanderbilt to raise awareness of TBI services and expand youth enrollment in the TBI Service Coordination Program. Additional outreach includes the TBI Annual Conference, which brings together survivors, caregivers, and professionals to share knowledge and best practices.

To provide ongoing support, the program contracts with seven organizations to host monthly virtual and in-person support groups for individuals with TBI and their families—ensuring connection, care, and community engagement statewide.

Across Domains Initiatives

Family Voices of Tennessee (FVTN)

During the 2024 Needs Assessment, the TDH collaborated with FVTN and other organizations to host focus groups with families as part of the five-year MCH/Title V Needs Assessment. TDH intentionally provided multiple opportunities for participation, holding meetings during regular working hours, as well as in the evenings and on weekends, to accommodate youth and family members. FVTN also played a significant role in other aspects of the block grant development process. For example, the FVTN Director, along with the CYSHCN Director, co-chaired the Spring 2019 MCH Stakeholder Meeting breakout for CYSHCN, where key MCH partners contributed input on selecting priority areas and national performance measures for the current five-year grant cycle. TDH continues to receive broad representation, support, and participation from families at the MCH Stakeholder Meetings, now called MCH Partner Meetings, which are organized up to three times a year to address the priority areas identified through the Needs Assessment.[12] In addition, FVTN assists with the Parent-to-Parent mentoring program. This program ensures parents are matched with mentors, helping to build their skills and capacity to become active, engaged partners in their child's health.

Children and Youth with Special Health Care Needs (CYSHCN)/Children Special Services

Family and youth engagement is central to Tennessee's MCH/Title V CYSHCN Program, Children's Special Services (CSS). The CSS Advisory Committee includes a parent representative from Middle Tennessee who contributes valuable insights to discussions on both program operations and broader CYSHCN issues. Families also participate in statewide professional development for Community Health Access and Navigation in Tennessee (CHANT) staff, helping strengthen the connection between care teams and those they serve.

In addition, parents play a leading role in planning the annual professional development conference. At the most recent event, a Family Voices staff member moderated a parent panel that shared how the program has supported their families and provided guidance to care coordinators on reducing barriers and fostering partnership. A similar panel, featuring both care coordinators and families, is planned for August 2025 to explore effective engagement

strategies for CYSHCN.

Further, in 2018, CYSHCN staff launched a statewide youth workgroup to support youth with special health care needs ages 14–24. The group includes representatives from multiple state departments and local agencies, such as Education, Health, TennCare, Mental Health and Substance Abuse Services, Vocational Rehabilitation, and Family Voices of Tennessee. Initially focused on recruitment and retention, the group—now called the Family and Youth Engagement Workgroup—has evolved into a collaborative space to share updates, coordinate projects, and advise on engagement practices. It meets monthly alongside the Youth and Family Advisory Councils and currently includes over 30 active members.

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[2] Tennessee Department of Health. (n.d.). About Tennessee Birth Defects Surveillance System. About Tennessee Birth Defects Surveillance System
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[5] Tennessee Department of Health. (n.d.). Newborn Screening. https://www.tn.gov/health/health-program-areas/fhw/newborn-screening.html
[6] Tennessee Department of Health. (n.d.). About Perinatal Regionalization. https://www.tn.gov/health/health-program-areas/fhw/perinatal-regionalization-program/about-perinatal-regionalization.html
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[11] Tennessee Department of Health. (n.d.). About the SPARK Program https://www.tn.gov/health/health-program-areas/fhw/tappp/about-program.html
[12] Tennessee Department of Health. (2025). Internal Title V/MCH Block Grant Program data.

III.C.1.c. Identifying Priority Needs and Linking to Performance Measures

Methodology for Ranking and Selecting Priority Needs

The MCH/Title V partners ranked the broad set of identified needs from the Needs Assessment using the Hanlon Method, a systematic approach for prioritizing public health issues. To facilitate this, scoring matrices were developed using REDCap, and surveys specific to each population domain were distributed to partners during the Fall Partner Meetings. Each survey listed the key health topics relevant to that domain, and partners rated each topic based on three criteria: the size of the health problem, its seriousness, and the effectiveness of current interventions. Scores were assigned on a scale from 0 to 10, where 0 represented the lowest priority and 10 the highest. Once each health problem's criteria were ranked, the priority score was calculated by multiplying the effectiveness of the intervention by the sum of the size of the health problem and the product of the seriousness times two. The seriousness is multiplied by two because it is weighted as being twice as important as the size of the health problem. The Hanlon Method's structured scoring system enabled an objective comparison of needs, helping to identify the most critical areas of focus. The results were then ordered by their calculated value and were reviewed by TDH FHW leadership to guide the selection of final priorities.

The final priority selection process included a capacity assessment conducted through collaboration between FHW leadership, staff, and the UNC Workforce Development Center. In December 2024, an in-person meeting was held to evaluate Tennessee's organizational capacity to address the identified needs. This assessment involved reflecting on past successes and challenges, as well as reviewing current partnerships, available funding, and staffing resources. For each population domain, FHW leadership and staff considered the top-ranked priorities from partner input alongside existing resources and strategic goals for the upcoming five-year cycle. This comprehensive review ensured that the final priorities were representative of partner input and aligned with Tennessee's capacity to effectively implement programs and interventions.

Emerging Issues and Needs Not Included in the Final Priorities

While breastfeeding initiation, access to prenatal care in rural areas, tobacco and e-cigarette use, suicide among

teens, insurance coverage for CYSHCN, pregnancy-related deaths, and physical activity among children remain important health concerns, these needs were not selected as standalone priorities for the upcoming five-year cycle due to the capacity assessment. Instead, they are incorporated within broader priority areas as strategies to ensure a more focused and effective approach.

For example, breastfeeding promotion is integrated into the broader maternal and infant health efforts, supporting healthy pregnancies and newborn outcomes. Access to prenatal care in rural areas aligns with initiatives to strengthen the State's perinatal regionalization system. Tobacco and e-cigarette use prevention are addressed as components of adolescent health strategies focused on improving social and emotional well-being. Suicide prevention among teens is incorporated within the adolescent mental health priority, which emphasizes increasing access to mental health treatment. Insurance coverage for CYSHCN is part of the priority to increase access to quality care for this population, ensuring comprehensive medical home services and coordinated care. Pregnancy-related deaths are addressed through maternal mental health initiatives and improved perinatal care systems that focus on comprehensive risk-appropriate care. Physical activity, a key factor in overall child health and development, is incorporated within the broader priority of improving nutrition and food sufficiency among children, which encompasses healthy lifestyle promotion.

By embedding these important areas as strategies and activities within broader priorities, Tennessee aims to leverage resources effectively and address interconnected health issues comprehensively.

Factors Influencing Changes in Priority Needs

The state's priority needs for maternal and child health have evolved from the 2021–2025 cycle to the upcoming 2026–2030 cycle, reflecting changing health challenges and community needs. While priorities such as family planning and adolescent well-being remain consistent, new areas of focus have been added in response to updated data and feedback. Increased attention to maternal mental health highlights the importance of addressing postpartum depression and access to screening. The incorporation of access to quality care for CYSHCN, preventable diseases among children, and access to nutrition reflects efforts to support overall health and well-being. These adjustments demonstrate Tennessee's commitment to addressing the evolving needs of mothers, children, and families across the state.

Linking Priority Needs to National and State Performance Measures

Women and Maternal Health
The priority need among the women and maternal health domain to increase access to contraceptive methods supports the NPM Postpartum Contraception Use (Percent of women using a most or moderately effective contraceptive following a recent live birth). By expanding access to a broad range of family planning options—including peer support, community programs, education, and contraceptive methods—the state can support postpartum women in making informed decisions that align with their goals. These initiatives enhance the availability, education, and support necessary for postpartum women to utilize effective contraception, ultimately supporting improved maternal and infant health outcomes across Tennessee.

Another priority need among this domain is to improve maternal mental health and wellbeing. This supports the NPM Postpartum Visit (A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth; and B) Percent of women who attended a postpartum checkup and received recommended care components). Improving maternal mental health begins with ensuring postpartum women attend their follow-up visits, where critical screening and support for mental health concerns such as postpartum depression can be provided. By increasing attendance at these visits, more women have the opportunity to receive timely assessment, counseling, and referrals for mental health services. Furthermore, this enhances the quality and comprehensiveness of care during postpartum visits, including routine mental health screenings and appropriate interventions.

Perinatal and Infant Health

The priority need among the perinatal and infant health domain to improve the perinatal regionalization system in Tennessee supports the NPM Risk Appropriate Care (Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)). Strengthening the perinatal regionalization system ensures that high-risk pregnancies and VLBW infants are identified early and directed to facilities equipped with the necessary specialized care. This improves outcomes by increasing the likelihood that VLBW infants receive appropriate, timely care in Level III+ NICUs, reducing complications and mortality. Efforts such as standardized facility assessments, telehealth consultations, and enhanced emergency response support this goal and align with federal priorities to provide risk-appropriate care.

Child Health

The priority need among the child health domain to decrease preventable illness and disease among children supports the NPM Childhood Vaccination (Percent of children who have completed the combined 7-vaccine series (4:3:1:3*:3:1:4) by age 24 months). Ensuring children receive the full series of vaccines on time reduces the incidence of vaccine-preventable illnesses and supports broader community immunity. By focusing on increasing vaccination rates, the State aims to protect children from serious preventable diseases, reduce outbreaks, and improve overall child health outcomes. Efforts to enhance education, access, and delivery help ensure that more children complete the full vaccine series on time, aligning with the goal of reducing preventable illness through effective immunization programs.

The priority need to decrease preventable illness and disease among children also supports the NPM Medical Home (Percent of children with and without special health care needs, ages 0 through 17, who have a medical home). A medical home is essential for ensuring children receive preventive services. By increasing access to medical homes, families are more likely to engage consistently with healthcare providers, improving early disease prevention. This ongoing relationship fosters better health management, helping to reduce preventable illnesses and improve overall child health outcomes.

Adolescent Health

The priority need among the adolescent health domain is to improve social and emotional well-being. This supports the NPM Mental Health Treatment (Percent of adolescents, ages 12 through 17, who receive needed mental health treatment or counseling). By focusing on enhancing social and emotional well-being, the State aims to increase awareness, access, and utilization of mental health services among adolescents. This includes identifying mental health needs early and connecting youth with appropriate counseling and treatment resources. Strengthening these supports helps improve overall adolescent mental health outcomes and aligns with the goal of ensuring that adolescents receive timely and effective mental health care.

Children and Youth with Special Health Care Needs (CYSHCN)

The priority need among the CYSHCN domain is to increase access to quality care. This supports the NPM Medical Home (Percent of children with and without special health care needs, ages 0 through 17, who have a medical home). A medical home provides coordinated, comprehensive, and family-centered care that is essential for addressing the complex health needs of CYSHCN. By increasing access to medical homes, CYSHCN receive timely, continuous, and tailored care that improves health outcomes, reduces care fragmentation, and enhances overall quality of life. This measure helps drive improvements by promoting the delivery of effective care for this population.

Cross-Cutting Initiatives

Improving nutrition among children is a priority across all domains, which supports the NPM Food Sufficiency (Percent of children, ages 0 through 11, whose households were food sufficient in the past year). Adequate nutrition supports healthy pregnancies and positive birth outcomes, reduces the risk of preventable illnesses in children, and promotes healthy growth and development throughout childhood and adolescence. For CYSHCN, proper nutrition can be critical in managing health conditions and improving overall well-being. By focusing on food sufficiency, the State addresses a key factor that influences many health outcomes, making it a priority across all MCH population domains.

Partner Involvement in the Needs Ranking and Selection Process

Partners were actively engaged throughout the Needs Assessment and priority-setting process. The Tennessee Community Health Survey was widely distributed to over 750 partners and residents across the state, including regional and metro health staff, via email. To further broaden outreach, FHW staff also distributed flyers containing QR codes for the survey. Through this community engagement, there were over 1,000 responses to the Tennessee Community Health Survey.

In addition to the survey, focus groups were held statewide, offered both in-person and virtually, to accommodate varying preferences and access needs. To maximize participation, FHW and regional/metro staff scheduled meetings outside typical work hours and ensured virtual attendance options were available, allowing families and community members greater opportunity to contribute.

Partners were also actively involved in ranking and selecting priorities subsequent to the Fall Partner Meetings. Again, to maximize engagement and ensure flexibility for partners, meetings were offered both during and after work hours, and virtually. This approach ensured that a broad range of perspectives—especially those of families and constituent-led organizations—were integrated into the final decision-making, strengthening the alignment of Tennessee's MCH priorities with community needs.

III.D. Financial Narrative

	2022		2023	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$11,800,000	$9,240,412	$11,800,000	$10,269,676
State Funds	$12,100,000	$11,609,659	$11,500,000	$11,646,690
Local Funds	$0	$0	$0	$0
Other Funds	$0	$0	$0	$0
Program Funds	$1,200,000	$1,959,439	$1,800,000	$1,985,828
SubTotal	$25,100,000	$22,809,510	$25,100,000	$23,902,194
Other Federal Funds	$153,475,117	$143,600,957	$171,947,087	$145,117,348
Total	$178,575,117	$166,410,467	$197,047,087	$169,019,542

	2024		2025	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$11,800,000	$8,272,326	$12,300,800	
State Funds	$11,700,000	$11,161,305	$11,700,000	
Local Funds	$0	$0	$0	
Other Funds	$0	$0	$0	
Program Funds	$2,000,000	$1,964,649	$2,000,000	
SubTotal	$25,500,000	$21,398,280	$26,000,800	
Other Federal Funds	$161,977,795	$175,433,013	$163,339,930	
Total	$187,477,795	$196,831,293	$189,340,730	

	2026	
	Budgeted	Expended
Federal Allocation	$12,600,000	
State Funds	$11,700,000	
Local Funds	$0	
Other Funds	$0	
Program Funds	$2,000,000	
SubTotal	$26,300,000	
Other Federal Funds	$191,807,056	
Total	$218,107,056	

III.D.1. Expenditures

The Division of Administrative Services within TDH is responsible for all fiscal management. Division staff uses Edison which is the State of Tennessee's Enterprise Resource Planning (ERP) system for budgeting, collection of revenues and distribution of expenditures. Computer generated cumulative expenditure and receipt plan analysis, transaction listings and spending/receipt plans are available statewide on-line for all MCH programs. This information can be accessed by both central and regional office staff. Financial audits are the responsibility of the Comptroller's Office. All departments, offices and programs within state government are subject to frequent audits. Contract agencies are also audited frequently. MCH program staff provide site visits and program monitoring at contract agencies in order to assure compliance with the contract's scope of services. Fiscal monitoring of contract agencies is the responsibility of TDH's Internal Audit staff.

Federal MCH/Title V, state and other federal funds were expended in FY 2024 to support MCH programming throughout the state. The outcomes discussed in the state action plan and other sections of the application could not have been achieved without the federal MCH/Title V funding. The MCH/Title V FY 2024 expenditures, both federal and non-federal, align with Tennessee’s MCH priority needs resulting from the 2020 Needs Assessment, as identified in Form 9.

The expenditures for FY 2024 are presented in Form 2, Form 3a, and Form 3b of the application. The current indirect cost rate agreement can be found in the Supporting Documents section.

The Tennessee MCH/Title V Program met all legislative requirements regarding the spending of grant funds. This includes a maintenance of effort in the amount of $13,125,024 set by the state in 1989. This figure is based on the amount the state was spending on maternal and child health programs in 1989. The state is required to continue to contribute at least this amount to the program in order to receive this federal grant. The state is on track to meet the maintenance of effort amount for the FY 2024 award. The state is also required to match the federal dollars. For every four federal dollars the state receives, the state must contribute three dollars. As of May 2025, Tennessee has used $8,272,326 of the FY 2024 federal allocation, therefore the required match on that amount is $6,204,245. Tennessee has expended $13,125,954 of state MCH funds, which meets the required state match. As specified in Section 504(d) and Section 505(a)(3), by the end of the fiscal year September 30, 2025 at least 30% of federal grant funds will be spent on preventive and primary care for children, 30% on children with special health care needs, and no more than 10% on administrative cost. Tennessee will meet these thresholds for the FY 2024 award (Form 2, Annual Report Expended, Lines 1A-C):

- Line 1A, Preventive and Primary Care for Children – $3,027,724 (36.6%)
- Line 1B, Children with Special Health Care Needs – $2,651,757 (32.06%)
- Line 1C, Administrative Costs – $669,711 (8.1%)

In Form 2, Annual Report Expended, Lines 1, 1B, 1C, and 9 were flagged as greater or less than 10% of the Annual Report Budgeted due to the following reason:

- The federal allocation is unknown when the budget is originally submitted with the application. Therefore, the budget is created based on an estimate. In FY2024 the estimate was higher than the actual allocation. Due to this many budget categories had to be adjusted, including this line item.

As illustrated in Form 2, Annual Report Expended, Line 9, improvements to maternal and child health were also supported by a variety of other federal funds in FY 2024, including Women, Infants and Children (WIC), State Systems Development Initiative (SSDI), Maternal, Infant, and Childhood Home Visiting Program (MIECHV), and Tobacco Control Programs, among others.

Each year, the Tennessee MCH/Title V Program completes an assessment of expenditures by the types of individuals served as reflected in Form 3a. In Form 3a, Annual Report Expended, MCH/Title V FY 2024 Block Grant

federal expenditures totaled $7,674,300 excluding administrative costs, and included services provided to Pregnant Women ($31,503), Infants <1 year ($701,329), Children 1 through 21 years ($3,027,724), CSHCN ($2,651,757) and All Others ($1,261,757). MCH/Title V FY 2024 state expenditures totaled $11,161,305 excluding administrative costs, and included services provided Pregnant Women ($77,002), Infants < 1 year ($330,467), Children 1 through 21 years ($4,061,492), CSHCN ($614,093), and All Others ($6,078,251).

FY 2024 total expenditures for the federal-state MCH/Title V Block Grant Partnership was $18,835,605 excluding administrative costs. The FY 2024 federal award and state match MCH/Title V Program dollars supported programs across the health domains as illustrated below. Some of the programs span multiple domains, and therefore are repeated among the domains.

Federal Funds				
Women's/Maternal	Perinatal/Infant	Child Health	Adolescent Health	CSHCN
Breast and Cervical Cancer Screening Program Family Planning Program Primary Care Women's Health Services (local health department)	Child Fatality Review and Prevention Program Genetics/Sickle Cell Centers Newborn Screening Follow Up Primary Care Child Health Services (local health department)	Child Fatality Review and Prevention Program Lead Poisoning Prevention Program Primary Care Child Health Services (local health department)	Child Fatality Review and Prevention Program Family Planning Program Lead Poisoning Prevention Program Primary Care Child Health Services (local health department)	Children's Special Services (Tennessee's MCH/Title V CSHCN Program) Genetics/Sickle Cell Centers Lead Poisoning Prevention Program Newborn Screening Follow Up

State Match Funds				
Women's/Maternal	Perinatal/Infant	Child Health	Adolescent Health	CSHCN
Breast and Cervical Cancer Screening Program Family Planning Program Primary Care Women's Health Services (local health department)	Child Fatality Review and Prevention Program Genetics/ Sickle Cell Centers Newborn Hearing Follow Up Primary Care Child Health Services (local health department)	Child Fatality Review and Prevention Program Child Health and Development Program Lead Poisoning Prevention Program Primary Care Child Health Services (local health department)	Child Fatality Review and Prevention Program Adolescent Pregnancy Prevention Lead Poisoning Prevention Program Primary Care Child Health Services (local health department)	Children's Special Services (Tennessee's MCH/Title V CSHCN Program) Genetics/ Sickle Cell Centers Lead Poisoning Prevention Program Newborn Hearing Follow Up

MCH/Title V expenditures are also assessed types of services. In Form 3b, Annual Report Expended, FY 2024

MCH/Title V Block Grant federal expenditures totaled $8,272,326 for MCH services. MCH/Title V FY 2024 federal expenditures for Direct Services totaled $502,621, which included Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants Up to Age One ($34,902), Preventive and Primary Care Services for Children ($54,127), and Services for CSHCN ($413,592). MCH/Title V FY 2024 federal expenditures for Enabling Services totaled $5,750,381 and Public Health and Systems totaled $2,019,324. State expenditures for FY 2024 totaled $11,161,305 for MCH services. MCH/Title V FY 2024 state expenditures for Direct Services totaled $1,647,347, which included Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants Up to Age One ($1,419,840), Preventive and Primary Care Services for Children ($0) and Services for CSHCN ($227,507). FY 2024 state expenditures for Enabling Services totaled $6,309,177 and Public Health Services and Systems totaled $3,204,781.

Estimates of the reach of the MCH/Title V program in terms of population served is listed on Form 5a and 5b. As reflected in Form 5a, the estimated total count of individuals served via Direct, and Enabling Services was 818,491. As reported on Form 5b, Tennessee’s MCH/Title V program has the widest reach among Pregnant Women (100%), Infants < 1 Year of Age (100%), and Others (99.8%) categories through the work of the perinatal centers, newborn screening, and suicide prevention efforts respectively. Approximately 63.7% of all Children 1 through 21 Years of Age were reached and 64.3% of CSHCN. Tennessee’s MCH/Title V program continues to build partnerships and explore ways to heighten awareness of programs to expand its reach.
The Title V programs across Tennessee utilize funding to support a variety of initiatives aimed at promoting engaging families and expanding the reach of critical services. Programs such as newborn screening and Children's Special Services (CSS) ensure follow-up care and financial assistance for families, regardless of their ability to pay, by contracting services and providing direct referrals. Training efforts—such as those through the Tennessee Department of Health's partnership with MTSU—enhance statewide capacity to respond effectively to infant deaths through education and consistent investigation practices. Family engagement is supported through partnerships with organizations like Family Voices and the development of educational materials, while some programs indirectly support families by ensuring high-quality data and prevention-focused actions. Efforts to expand reach include increasing income eligibility thresholds, creating outreach materials, and using surveillance data to drive service improvements. Despite these strengths, programs face ongoing challenges including limited access to in-person training, political and legal shifts, staff shortages, healthcare access gaps, and reduced federal funding in key areas such as lead poisoning prevention.

Tennessee supports MCH/Title V regulations to use MCH Block Grant funds as a payer of last resort. It also should be noted that none of the services paid by the grant were reimbursable by other agencies (namely Medicaid) or providers. This is assured through eligibility determination processes for programs such as CSS as well as regular communication with TennCare regarding the reimbursement services of the MCOs. Any unobligated balance noted in the report will be used to support program activities through the end of FY2025.

III.D.2. Budget

Tennessee state law requires all departments to submit a complete financial plan and base budget request for the ensuing fiscal year that outlines proposed expenditures for the administration, operation, and maintenance of programs. Budget guidelines are prepared annually by the Department of Finance and Administration. The Department's Budget Management Office, in cooperation with all programs, is responsible for the preparation of the budget documents. The base budget request becomes law after it is approved by the General Assembly and signed by the Governor. A work program budget is then developed for each program.

TDH uses a cost allocation system for the local health departments. Costs are allocated using two specific methods, the direct cost allocation method and the resource based relative value method (RBRVS). The direct cost allocation method is used when costs can be directly allocated to one or more programs. Any cost can be directly allocated when coded correctly on the appropriate accounting document. Direct cost allocation is used primarily for costs that arise from administrative support staff in the Department's central and regional offices and for selected contract expenditures. The RBRVS cost allocation method is used to allocate costs which cannot be directly allocated to one or more programs. These costs arise from the delivery of direct health or patient care services in local health departments. RBRVS adds weighted encounter activities using relative value units and allocates costs based on the percentage of activity for each program. RBRVS is a federally approved cost allocation method for TDH. RBRVS is linked at the service delivery level to AS/400 computers at the regional and central offices.

Program encounter data are entered at local health departments for direct patient care services using Current Procedural Terminology (CPT) codes and program codes. Relative value units assigned to each procedure code allow a proportionate amount of cost to be associated with each procedure. RBRVS provides quarterly cost allocation reports to central and regional office staff. These reports are used to monitor and manage expenditures, determine cost for services provided, and allocate resources as needed.

The MCH/Title V FY2025 budget estimates, both federal and non-federal, align with Tennessee's seven MCH priority needs selected from the 2024 Needs Assessment, as identified in Form 9. Staff funded through the Title V/MCH Block Grant will coordinate efforts to address the priority needs through the strategies below.

1. **Increase access to contraceptive methods** – Evidence-based or informed activities will be implemented to (a) Encourage clinics to offer information on or access to Long-Acting Reversible Contraception (LARC), including to postpartum women; and (b) Implement community-based programs that provide education and support to women seeking information on contraception methods, including postpartum women

2. **Improve maternal mental health and wellbeing** – Evidence-based or informed activities will be implemented to (a) Educate providers on the use of standardized screening tools to identify women with postpartum depression and anxiety; (b) Support quality improvement initiatives that take a multi-component, systematic approach to increase postpartum depression and anxiety screening rates and address SUD; and (c) Collaborate with home visiting programs and community-based organizations to support mothers in obtaining timely postpartum care.

3. **Improve the perinatal regionalization system in Tennessee** – Evidence-based or informed activities will be implemented to (a) Improve perinatal health outcomes through quality improvement (QI) initiatives in birthing hospitals; (b) Improve perinatal regionalization system by enhancing emergency medical services (EMS); and (c) Develop or expand perinatal telehealth services targeting areas with high rates of maternal and infant morbidity and mortality to improve health outcomes

4. **Decrease preventable illness and disease among children** – Evidence-based or informed activities will be implemented to (a) 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; (b) 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; (c) Strengthen school-based emergency preparedness for vaccine-preventable disease outbreaks through inter-agency collaboration and exercises; and (d) Collaborate with MCH Regional and Metro Directors and regional nursing staff to increase off-site vaccination opportunities, with at least one event in each grand division.

5. **Improve social and emotional wellbeing in adolescents** – Evidence-based or informed activities will be implemented to (a) Implement youth-centered mental health/social-emotional skill-building promotion to address factors that influence adolescent wellbeing; (b) 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; and (c) Implement youth empowerment initiatives that integrate anti-tobacco education and engagement activities to promote healthy, tobacco-free lifestyles.

6. **Increase access to quality care for children and youth with special healthcare needs** – Evidence-based or informed activities will be implemented to (a) Engage and collaborate with partners in the private sector to promote the medical home model and increase provider participation in systems of care; (b) Promote care coordination as a way to ensure all children have continuous access to high-quality, affordable, comprehensive, coordinated, and family-centered care; (c) Identify children and youth with special healthcare needs and reduce barriers that prevent their access to a medical home; and (d) 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.

7. **Improve nutrition among families** – Evidence-based or informed activities will be implemented to (a) Increase access to nutritious foods by identifying families experiencing food insecurity and connecting them to food assistance programs, particularly in under resourced communities; (b) Expand Women, Infants, and Children (WIC) program to ensure that more eligible families have access to adequate nutrition; and (c) Launch and support a statewide food security coordination coalition.

Form 2, Form 3a, and Form 3b have been completed in accordance with the guidance. Tennessee is requesting a federal funding amount for FY 2026 that is level with the FY 2024 request, $12,600,000. The current indirect cost rate agreement can be found in the Supporting Documents section.

Tennessee's planned budget for FY 2026 is in full compliance with the federally mandated 30% - 30% - 10% threshold requirements as specified in Section 504(d) and Section 505(a)(3), (Form 2, Application Budgeted, Lines 1A-C):

- Line 1A, Preventive and Primary Care for Children – $4,410,000 (34%)
- Line 1B, Children with Special Health Care Needs – $4,158,000 (32%)
- Line 1C, Title V Administrative Costs – $1,260,000 (10%)

The maintenance of effort requirement for maternal and child health programs in Tennessee was established in 1989. This requirement specifies that the state must, at minimum, continue to fund Tennessee MCH program efforts using state funds at the level it was in 1989. At that time Tennessee calculated its maintenance of effort to be $13,125,024.28. This calculation was based on an analysis of 15 months of expenditures for the program, adjusted for differences between the state and federal fiscal years, as well as adjustments for accrued liabilities. The state is also required to match every four federal dollars received with three state dollars. Tennessee fully utilizes Maternal and Child Health Block Grant funding within the 24-month allowable timeframe and meets all targeted maintenance and match requirements set forth in the grant regulations (Form 2, Application Budgeted, Line 7). TDH monitors its maintenance of effort and state match annually and has met requirements in all reporting years.

The Tennessee MCH/Title V Program is not proposing major changes to the reported budget for this year. Apart from Form 2, Application Budgeted, Line 9, which includes other federal funds that were recently added to the MCH/Title V Program portfolio, the budget will mirror that of the FY 2025 budget. Federal dollars are used to extend the reach

of state dollars and support some of the efforts and outcomes discussed in the state action plan and elsewhere in the application. The MCH/Title V director leverages other federal dollars from the programs listed below which are under the director's control.

Other Federal Grants

- Birth Defects and Developmental Disabilities
- Commodity Supplemental Food Program (CSFP)
- Comprehensive Suicide Prevention
- Diabetes Prevention and Control
- Early Hearing Detection and Intervention (EHDI) State Programs (CDC)
- Early Hearing Detection and Intervention (EHDI) State Programs (HRSA)
- Injury Prevention and Control
- Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants
- National Breast and Cervical Cancer Early Detection Program (NBCCEDP)
- National Cardiovascular Health Program
- National Comprehensive Cancer Control Program (NCCCP)
- Partnership Programs to Reduce Maternal Deaths due to Violence
- Preventing Maternal Deaths: Supporting Maternal Mortality Review Committees
- Pediatric Mental Health Care Access Program
- Perinatal Substance Exposure: Surveillance and Prevention
- Preventive Health and Health Services Block Grant
- Rape Prevention and Education (RPE) Program
- State Sexual Risk Avoidance Education Program
- State and Local Healthy Homes and Childhood Lead Poisoning Prevention Programs (CLPPPs)
- State Maternal Health Innovation Program
- State Systems Development Initiative (SSDI)
- Sudden Death in the Young (SDY) Registry
- The Loving Support Peer Counseling Program (Breastfeeding)
- Tobacco Control Programs
- Traumatic Brain Injury
- Treatment for Maternal Depression and Related Behavioral Disorders
- WIC Technology for a Better WIC Experience
- WIC Modernization
- WISEWOMAN Program
- Women, Infants, and Children (WIC)

*Denote grants added since last year.

All programs of the TDH must be free from unjust or unfair treatment. TDH’s policy is as follows: Title VI of the Civil Rights Act of 1964 requires that federally assisted programs be free of unjust or unfair treatment. In accordance with Federal civil rights laws, the Tennessee Department of Health does not tolerate harassment and unjust or unfair treatment based upon any protected class including race, color, national origin, sex, age, disability or reprisal or retaliation, in any program or activity conducted or funded by TDH. Such harassment and unjust or unfair treatment constitute misconduct which undermines the integrity of the employment relationship and is subject to disciplinary action, up to and including dismissal.

In Form 3a, Application Budgeted, the FY 2026 federal Title V Block Grant planned budget totals $11,340,000 excluding administrative costs, and the planned state budget totals $11,700,000 excluding administrative costs. The FY 2025 planned budget for the federal-state Title V Block Grant Partnership is $23,040,000 excluding administrative costs.

Budgeted amounts outlined in Form 3b support Tennessee’s intention to spend the majority of its anticipated FY 2026 Title V federal and state funding on enabling and public health services and systems. Tennessee supports Title

V regulations to use MCH Block Grant funds as a payer of last resort. The amounts budgeted for direct services are estimates of costs not reimbursable by other agencies (namely Medicaid) or providers.

III.E. Five-Year State Action Plan

III.E.1. Five-Year State Action Plan Table

State: Tennessee

Please click the links below to download a PDF of the Entry View or Legal Size Paper View of the State Action Plan Table.

State Action Plan Table - Entry View

State Action Plan Table - Legal Size Paper View

III.E.2. State Action Plan Narrative Overview (Optional)

The MCH/Title V Program is the cornerstone grant within the Division of Family Health and Wellness (FHW) in the Tennessee Department of Health. The purpose of this particular program is to broadly support and improve the health of the maternal and child population in Tennessee. This is done by identifying priority needs and working with partners to leverage program capacity to meet those needs, which ultimately improves health outcomes for women, infants, children, and families across the state. Tennessee's MCH/Title V Program works to convene MCH partners at least twice a year, so all programs serving these populations can be better aligned statewide. This strategic alignment is imperative for stewarding fiscal resources efficiently and assuring the greatest impact.

The MCH Block grant works within a life course framework, operationalized by the population health domains below. Through these domains, the MCH population is subdivided into time periods that represent important stages in life. States are required to choose at least one priority within each domain, ensuring that priorities are spread across the life course.

Population Health Domains:

- Women/Maternal Health
- Perinatal/Infant Health
- Child Health
- Adolescent Health
- Children with Special Health Care Needs (CYSHCN)
- Cross-Cutting/Systems Building

Utilizing information gathered through the comprehensive needs assessment, the Tennessee MCH/Title V program identifies priority areas and then assembles teams to work on each area. The new structure for priorities and action planning involves a clear division of roles across all levels of leadership. Each priority is assigned a domain lead, a priority lead, program staff, an epidemiologist, and a clinician. Domain leads, serving as section chiefs in FHW, are responsible for selecting the program staff who will implement the strategies in the action plan. They play a key role in identifying and facilitating partnerships between different sections and programs to ensure effective collaboration. Additionally, domain leads are accountable for overseeing the development of the final plan and report. They serve as the primary representatives of all domain-related activities during partner meetings, ensuring that the domain's work is well-represented and integrated into broader discussions. Priority leads are responsible for leading the creation of action plans, ensuring the strategies are evidence-based. They coordinate closely with program staff to ensure the successful completion of activities, ensuring that each priority is effectively advanced and aligned with the overall objectives. Program staff are responsible for implementing the evidence-based strategies outlined in the action plan and reporting updates to the priority lead. The priority's epidemiologist identifies metrics related to the strategies; supports the priority lead by identifying evidence-based strategies; ensures alignment between strategies, activities, and measures; and leads the team by setting reasonable objectives. Finally, each team is assigned a clinician to plan, implement, and report on the clinical portions of the action plan.

Together, teams are responsible for developing action plans, creating logic models (included in supporting documents), implementing the plans, reporting on progress, and measuring success. Additionally, priority teams work closely with partners at various points throughout the year, incorporating their feedback into the plans and fostering ongoing partnerships. Currently, teams identify partners in the action plan, define their level of involvement, and hold regular meetings to drive the strategy forward.

This year's State Action Plan Narrative includes reports for the fourth year of activities in the current 2021-2025 cycle (October 2023 – September 2024) as well as plans for the first year of the new 2026-2030 cycle (October 2025 – September 2026).

Priorities for the current cycle include the following:

1. Increase Family Planning (Women/Maternal Health)

2. Decrease Pregnancy-Associated Mortality (Women/Maternal Health)
3. Increase Breastfeeding (Perinatal/Infant Health)
4. Decrease Infant Mortality (Perinatal/Infant Health)
5. Decrease Overweight and Obesity Among Children (Child Health)
6. Increase Prevention and Mitigation of Adverse Childhood Experiences (Child Health)
7. Decrease Tobacco and E-Cigarette Use (Adolescent Health)
8. Increase Medical Homes Among Children with Special Health Care Needs (CYSHCN)
9. Improve Transition from Pediatric to Adult Care Among Children with Special Health Care Needs (CYSHCN)
10. Improve Mental Health (Cross-Cutting/Systems Building)

In the annual report for these priorities, teams provide an overview of how MCH/Title V funding supports the administration of the priority and/or strategies, updates on performance data, accomplishments and challenges for strategies and activities, and updates on other programs supported by MCH/Title V funds.

Priorities for the new cycle include the following:

1. Increase Access to Contraceptive Methods (Women/Maternal Health)
2. Improve Maternal Mental Health and Wellbeing (Women/Maternal Health)
3. Improve the Perinatal Regionalization System in Tennessee (Perinatal/Infant Health)
4. Decrease Preventable Illness and Disease Among Children (Child Health)
5. Improve Social and Emotional Wellbeing in Adolescents (Adolescent Health)
6. Increase Access to Quality Care for Children and Adolescents with Special Healthcare Needs (CYSHCN)
7. Improve Nutrition Among Families (Cross-Cutting/Systems Building)

In the annual plan for these priorities, teams provide SMART objectives for NPMs and SPMs, evidence-based strategies and activities, planned partnerships, and programs supported by or connected to MCH/Title V funding.

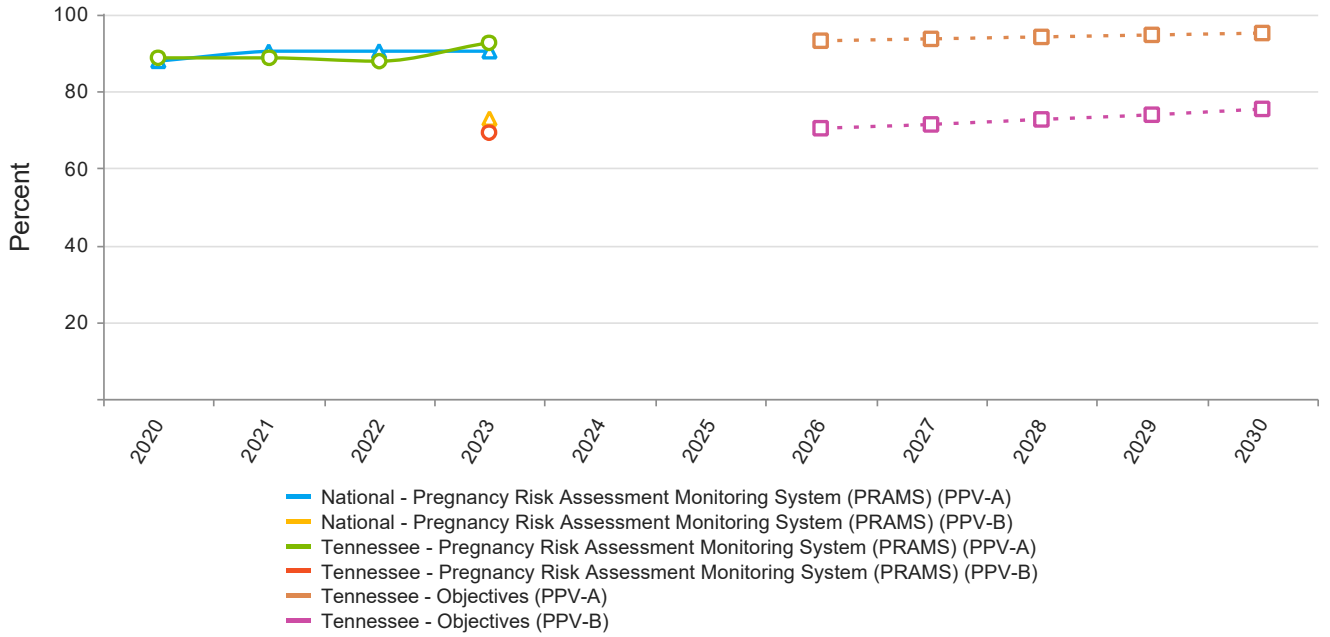
III.E.3 State Action Plan Narrative by Domain

If a Priority Population is selected for an NPM, then this section will display only the data associated with the Priority Population in the charts, data tables, and field notes. Additional NPM data are available in the Form 10 appendix.

Women/Maternal Health

National Performance Measures

NPM - A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth B) Percent of women who attended a postpartum checkup and received recommended care components - PPV
Indicators and Annual Objectives



NPM - A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth - PPV

Federally Available Data		
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)		
	2023	**2024**
Annual Objective		
Annual Indicator	88.7	92.6
Numerator	69,327	72,765
Denominator	78,187	78,597
Data Source	PRAMS	PRAMS
Data Source Year	2021	2023

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	93.0	93.5	94.0	94.5	95.0

NPM - B) Percent of women who attended a postpartum checkup and received recommended care components - PPV

Federally Available Data		
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)		
	2023	**2024**
Annual Objective		
Annual Indicator	78.3	69.3
Numerator	53,264	49,673
Denominator	67,995	71,690
Data Source	PRAMS	PRAMS
Data Source Year	2021	2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	70.3	71.3	72.6	73.8	75.3

Evidence-Based or –Informed Strategy Measures

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

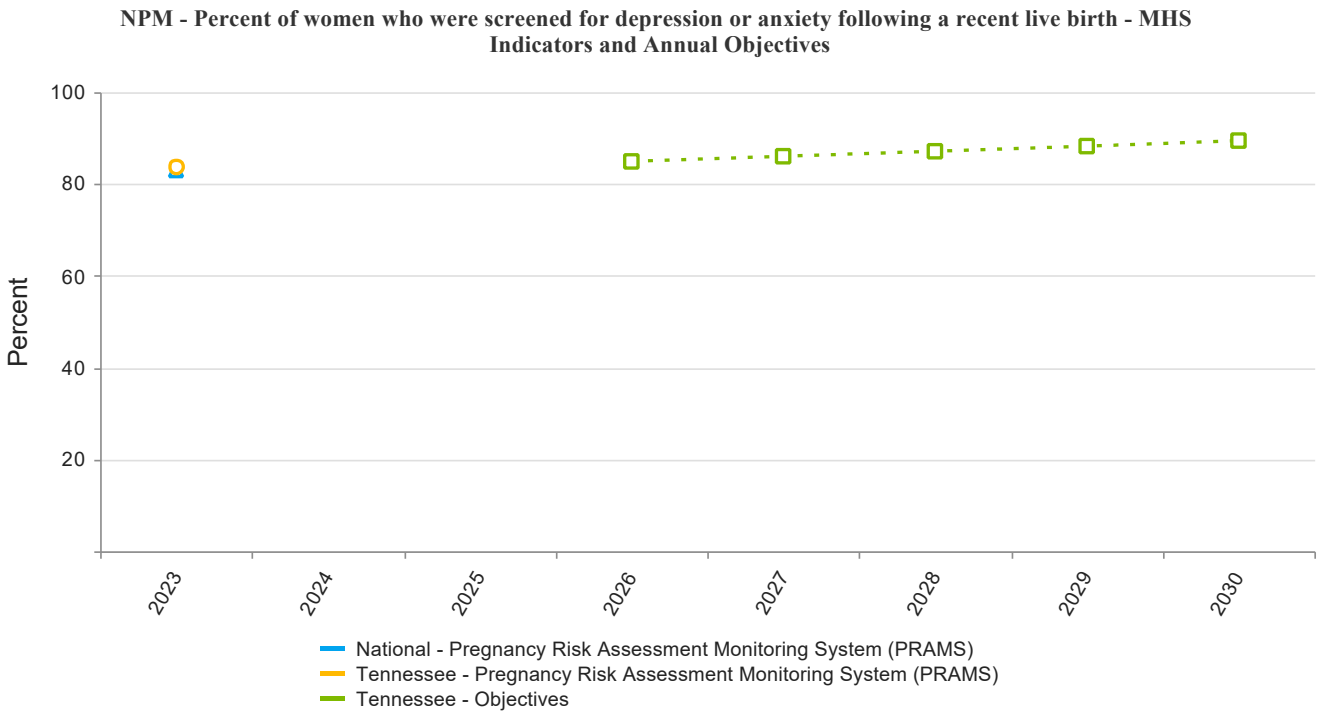
Measure Status:	Inactive - Completed	
State Provided Data		
	2023	**2024**
Annual Objective		
Annual Indicator	100	69.5
Numerator		
Denominator		
Data Source	EBHV	EBHV
Data Source Year	2023	2024
Provisional or Final ?	Final	Final

ESM PPV.2 - Percent of home-visiting staff trained in recognizing and providing resources/referrals for perinatal mood disorders and substance use disorder

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	50.0	60.0	70.0	80.0	90.0



Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2024
Annual Objective	
Annual Indicator	83.7
Numerator	64,785
Denominator	77,395
Data Source	PRAMS
Data Source Year	2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	84.8	85.9	87.0	88.1	89.3

Evidence-Based or –Informed Strategy Measures

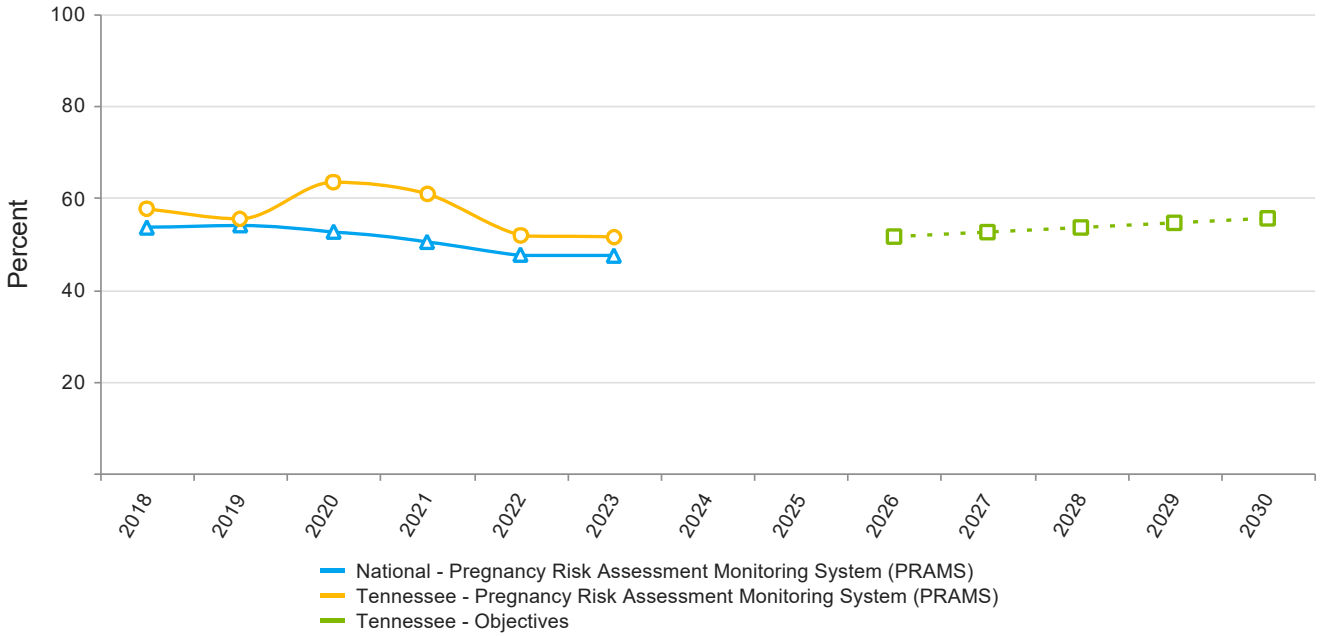
ESM MHS.1 - Number of healthcare providers trained in using validated screening tools for depression and anxiety

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	60.0	60.0	60.0	60.0	60.0

NPM - Percent of women who are using a most or moderately effective contraceptive following a recent live birth - CU Indicators and Annual Objectives



Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2024
Annual Objective	
Annual Indicator	51.5
Numerator	38,617
Denominator	74,930
Data Source	PRAMS
Data Source Year	2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	51.5	52.5	53.5	54.5	55.5

Evidence-Based or –Informed Strategy Measures

ESM CU.1 - Number of total providers trained on long-acting reversible contraception (LARC) insertion and removal

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	0.0	20.0	25.0	30.0	35.0

State Action Plan Table

State Action Plan Table (Tennessee) - Women/Maternal Health - Entry 1	
Priority Need	
Increase Access to Contraceptive Methods	
NPM	
NPM - Postpartum Contraception Use	
Five-Year Objectives	
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.	
Strategies	
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.	
ESMs	**Status**
ESM CU.1 - Number of total providers trained on long-acting reversible contraception (LARC) insertion and removal	Active
NOMs	
Severe Maternal Morbidity	
Maternal Mortality	
Low Birth Weight	
Preterm Birth	
Infant Mortality	
Neonatal Abstinence Syndrome	

State Action Plan Table (Tennessee) - Women/Maternal Health - Entry 2

Priority Need

Improve Maternal Mental Health and Wellbeing

NPM

NPM - Postpartum Visit

Five-Year Objectives

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.

Strategies

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.

ESMs	Status
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	Inactive
ESM PPV.2 - Percent of home-visiting staff trained in recognizing and providing resources/referrals for perinatal mood disorders and substance use disorder	Active

NOMs

Maternal Mortality

Neonatal Abstinence Syndrome

Women's Health Status

Postpartum Depression

Postpartum Anxiety

State Action Plan Table (Tennessee) - Women/Maternal Health - Entry 3

Priority Need

Improve Maternal Mental Health and Wellbeing

NPM

NPM - Postpartum Mental Health Screening

Five-Year Objectives

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 FY 2030.

Strategies

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.

ESMs	Status
ESM MHS.1 - Number of healthcare providers trained in using validated screening tools for depression and anxiety	Active

NOMs

Maternal Mortality

Infant Mortality

SUID Mortality

Neonatal Abstinence Syndrome

Child Injury Hospitalization

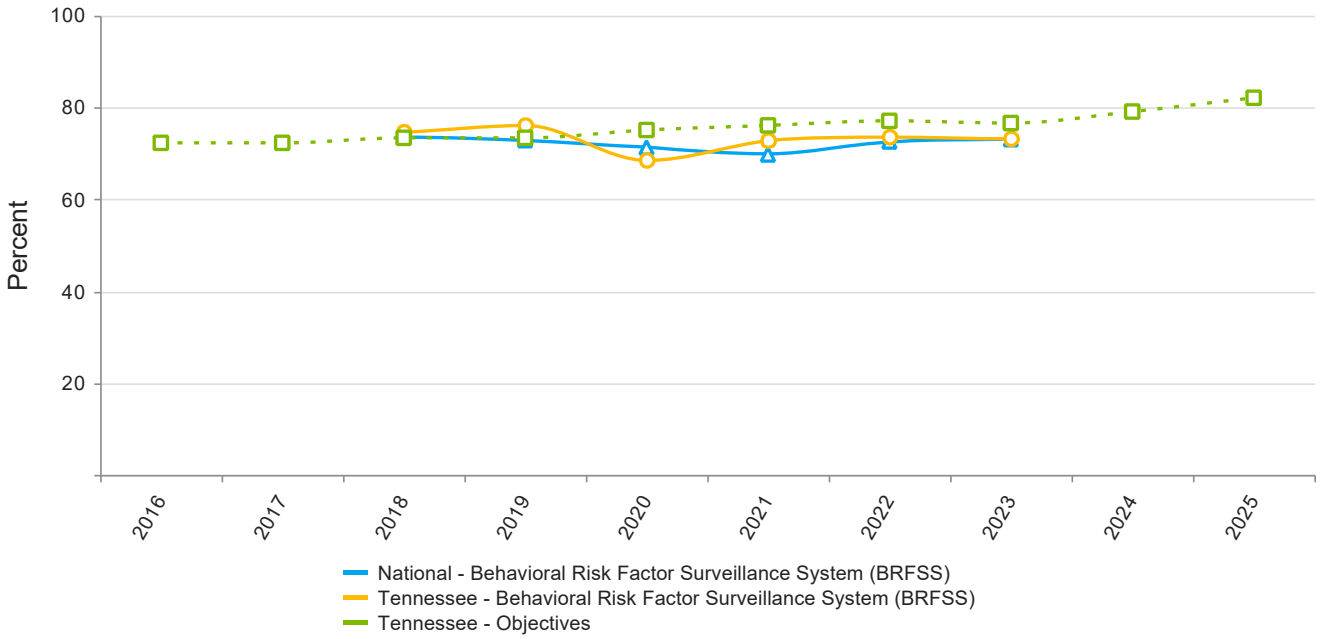
Women's Health Status

Postpartum Depression

Postpartum Anxiety

2021-2025: National Performance Measures

2021-2025: NPM - Percent of women, ages 18 through 44, with a preventive medical visit in the past year - WWV Indicators



Federally Available Data					
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	75	76	77	76.5	79
Annual Indicator	76.0	68.3	72.6	73.4	73.1
Numerator	897,415	808,894	868,079	890,338	900,914
Denominator	1,180,193	1,185,003	1,195,830	1,213,611	1,232,189
Data Source	BRFSS	BRFSS	BRFSS	BRFSS	BRFSS
Data Source Year	2019	2020	2021	2022	2023

2021-2025: Evidence-Based or –Informed Strategy Measures

2021-2025: ESM WWV.2 - Percent of family planning encounters that occur via telehealth

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective			0.4	0.8	1.6
Annual Indicator		0.3	1.2	1.6	1
Numerator					
Denominator					
Data Source		PTBMIS	PTBMIS	PTBMIS	PTBMIS
Data Source Year		2021	2022	2023	2024
Provisional or Final ?		Final	Final	Final	Final

2021-2025: ESM WWV.3 - Number of women receiving patient navigation for women's health services

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective			250		
Annual Indicator		0	0	900	2,729
Numerator					
Denominator					
Data Source		REDCap	REDCap	PTBMIS	PTBMIS
Data Source Year		2021	2022	2023	2024
Provisional or Final ?		Final	Final	Final	Final

2021-2025: ESM WWV.4 - Percent of births covered by hospitals implementing data-driven, clinical recommendations

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective			65	75	85
Annual Indicator		55	55	81	88
Numerator					
Denominator					
Data Source		NVSS	NVSS	NVSS	Birth certificate data
Data Source Year		2020	2021	2022	2024
Provisional or Final ?		Final	Final	Final	Final

2021-2025: ESM WWV.8 - Percent of recommendations with who/what/when components

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		75	79	84	89
Annual Indicator		24	71	68	90
Numerator					
Denominator					
Data Source		ERASE MM APR Report	ERASE MM APR Report	ERASE MM APR Report	ERASE MM APR Report
Data Source Year		2021	2022	2023	2024
Provisional or Final ?		Final	Final	Final	Final

2021-2025: SPM 1 - Percent of new mothers whose pregnancy was intended

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	62	62	63	63	65
Annual Indicator	50	50	50	52	55
Numerator					
Denominator					
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2016-2018	2020	2020	2021	2022
Provisional or Final ?	Final	Final	Final	Final	Final

2021-2025: SPM 2 - Percent of facilities implementing patient safety recommendations

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		12.5	63	66	91
Annual Indicator	54	25	44	88	58
Numerator					
Denominator					
Data Source	MMR Annual Performance Review Report	MMR Annual Performance Review Report	MMR Annual Performance Review Report	MMR Annual Performance Review Report	Performance Progress and Measuring Report
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Final	Final	Final	Final	Final

2021-2025: SPM 23 - Number community level recommendations implemented

Measure Status:				Active	
State Provided Data					

	2022	2023	2024
Annual Objective			15
Annual Indicator	18	13	13
Numerator			
Denominator			
Data Source	MMR Annual Performance Review Report	MMR Annual Performance Review Report	MMR Annual Performance Review Report
Data Source Year	2022	2023	2024
Provisional or Final ?	Final	Final	Final

2021-2025: State Outcome Measures

2021-2025: SOM 1 - Rate of pregnancy-associated mortality to live birth

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		95.6	93.2	90.9	89.5
Annual Indicator	78.3	124.5	164	164	122
Numerator					
Denominator					
Data Source	MMRIA and birth records	MMRIA and birth records	MMRIA and birth records	MMRIA and birth records	MMRIA and birth records
Data Source Year	CY 2019	CY 2020	CY 2021	CY 2021	CY2022
Provisional or Final ?	Final	Final	Final	Final	Final

2021-2025: SOM 2 - Rate of pregnancy-related mortality to live births

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		25.6	23.5	22	21.8
Annual Indicator	28.6	58.5	64.9	64.9	55
Numerator					
Denominator					
Data Source	MMRIA and birth records	MMRIA and birth records	MMRIA and birth records	MMRIA and birth records	MMRIA and birth records
Data Source Year	CY 2019	CY 2020	CY 2021	CY 2021	CY2022
Provisional or Final ?	Final	Final	Final	Final	Final

Priority: Increase Access to Family Planning Services

MCH/Title V Funding: The family planning priority team is administratively led by the Reproductive and Women's Health section within the Division of Family Health and Wellness of TDH. The Reproductive and Women's Health (RWH) section includes family planning, presumptive eligibility, breast and cervical cancer (BCC) early detection, adolescent pregnancy prevention and sexual risk avoidance education, as well as the rape prevention program. The family planning program efforts are partially funded by MCH/Title V funds. Additionally, the RWH Section Chief and Breast and Cervical Cancer program director are partially funded by MCH/Title V, and the BCC Administrative Assistant 2 is fully funded by MCH/Title V.

Interpretation of Performance Data on selected NPMs, SPMs, and SOMs:

SPM 1: Percent of new mothers whose pregnancy was intended
Baseline for SPM1 was 50% based on a three-year average for calendar years 2016-2018. The objective for grant year 1 was to maintain this measure at 50% and then increase it to 51% in grant years 2 and 3 and to 53% in grant year 4. Grant year 4 performance was based on 2022 PRAMS data, during which time the percent of new mothers whose pregnancy was intended was 55%. Although this exceeded the objective for year 4, compared to baseline the difference was not statistically significant. PRAMS data are not yet available for calendar year 2023 or 2024.

The percentage of new mothers reporting that their pregnancy was intended has remained relatively stable from grant year 1 to grant year 4. Several factors may have contributed to this trend, including the impact of the COVID-19 pandemic, changes in state laws affecting reproductive healthcare access, and shifts in funding sources for publicly funded family planning services.

Accomplishments and Challenges (based on the FY2024 Action Plan):

Strategy 1: Increase access to Family Planning Services through Telehealth

Supporting Evidence for Strategy 1: TDH seeks to ensure that communities and individuals residing in rural and urban areas, and individuals with disabilities can reap the benefits of telehealth by assuring that all people achieve their full health potential. Some barriers can include taking time off work, transportation, childcare, and confidentiality. Telehealth has the potential to help clients overcome these barriers and improve access to care.

Activity 1a: Identify three (3) key partners to help promote Family Planning Telehealth services through the dissemination of, but not exclusive of, flyers, posters, social media posts, and radio interviews.

Report 1a: During this reporting period, the Family Planning program (FP) collaborated with the Community Health Services Division (CHS) to transition the FP Telehealth program. In addition to overseeing and operationalizing all clinical services within the health department and the primary care telehealth program, CHS now directly oversees family planning services offered via telehealth. Throughout the transition, Family Planning Telehealth has continued to be promoted through Tennessee's Department of Health (TDH) public-facing website, which includes online referrals, updated FP Telehealth-specific flyers, multiple TDH social media posts, and communication with external partners. Transitioning family planning telehealth services to CHS will enhance efficiency and improve patient outcomes. Also, by consolidating resources and expertise, patients will receive a more cohesive approach to care. The staff will benefit from more streamlined processes, better technology integration, reduced duplication of efforts, and shared best practices. Although the total number of family planning encounters declined in 2023 following the loss of Title X funding, telehealth encounters continued to increase

slightly, reaching 994 that year. In 2024, both overall and telehealth encounters saw a decrease. This pattern suggests that telehealth may have played a role in sustaining access to services during a period of reduced funding, though further data would be needed to determine its full impact at the population level.

Activity 1b: Create statewide or regional partnerships with A Step Ahead Foundation (ASAF) Affiliates to reduce barriers for clients.

Report 1b: The Tennessee Department of Health was not able to formalize a statewide or regional partnership with A Step Ahead Foundation (ASAF) Affiliates during this reporting period. However, TDH continues to work closely with ASAF organizations to support patients in accessing long-acting reversible contraception (LARC) and other reproductive health services. ASAF Affiliates regularly assist clients by helping to reduce barriers to care. Additionally, TDH has engaged ASAF leadership through meetings and collaboration on statewide maternal and reproductive health initiatives, strengthening ongoing efforts to align resources and support services for Tennesseans.

Activity 1c: Partner with at least one (1) library in each grand region to provide designated space for telehealth appointments.

Report 1c: The Family Planning program continues efforts to expand telehealth access by partnering with libraries across Tennessee. In October 2024, program staff presented to the Tennessee State Library Association (TSLA), highlighting the goal of reducing mistimed, unintended, and teen pregnancies and emphasizing telehealth as a means to increase availability of contraceptives and preventive health services. While securing sustainable funding for soundproof pods or room modifications remains a challenge, progress is underway in the Upper Cumberland region. The Putnam County Library recently received grant funding to establish a dedicated telehealth room for individuals without computer access. Discussions are ongoing regarding room features, including soundproofing, technology setup, and equipment needs.

Activity 1d: Provide quarterly satisfaction survey summary data to key partners to show success and encourage participation and referral to Family Planning telehealth.

Report 1d: TDH convened a statewide patient satisfaction workgroup and developed an updated patient satisfaction survey to capture feedback from both in-person and telehealth visits. The updated tool will be utilized in all health departments within the 89 rural Tennessee counties and is expected to be implemented on July 1, 2025. The survey will be distributed via text message and include questions on clinic location, overall experience (friendliness, timeliness), cost, ease of scheduling, services provided, and the patient's understanding of information received based on provider type. Results will be summarized monthly through an internal dashboard. All negative responses will be immediately addressed by the Health Department's County Director.

Activity 1e: Continue telehealth expansion, focusing on counties serving less than 21% of eligible clients

Report 1e: Oversight of all direct clinical services for Family Planning have been transferred to CHS, including telehealth. This transition will create a more robust telehealth service that effectively meets community needs. At this time, telehealth expansion is occurring in all counties, not just those serving less than 21% of eligible clients. In 2023, 994 individuals were provided family planning telehealth services. That number decreased to 749 in 2024. However, overall family planning numbers declined, and the percentage of these visits being telehealth remained around 2%.

Baseline for **ESM WWV.2** was 0.2% based on federal fiscal year 2020. The objective for grant year 1 was to maintain this percentage at 0.2% and then to increase it to 0.4% in grant year 2 0.8% in grant year 3 and 1.6% in grant year 4. The actual percentages for grant years 2 and 3 were 1.2% and 1.6%, respectively, which exceeded the objectives. However, the percentage decreased to 1.0% in grant year 4. Although the statewide goal for the year wasn't met, county-level percentages ranged from 0% to 24%, with 34 out of 95 counties (over one-third) exceeding the goal.

Challenges Issues Related to Implementation of Strategy 1: The transition of all family planning clinical services to a new division significantly impacted the timeline for expanding telehealth-specific activities. Much of the team's capacity this year was focused on ensuring a smooth and successful transfer of services to the Community Health Services (CHS) division. While the transition was completed successfully, promotion of telehealth specific to family planning was limited, as CHS integrated telehealth messaging more broadly across primary care, family planning, and other clinical services.

Strategy 2: Increase access to women's health services by addressing and eliminating barriers to care through client navigation.

Supporting Evidence for Strategy 2: Many challenges related to fair access and achieving optimal health outcomes surround women's health, obstetrics, and gynecology. Client navigation can support efforts to address barriers to care and help to reduce these preventable differences in health outcomes.

Activity 2a: Provide navigation services according to identified scope while identifying and addressing differences in care.

Report 2a: From October 1, 2023-September 30, 2024, the Women's Health Navigators (WHNs) provided navigation services according to the identified scope. Additional partnerships were built with CHANT and EBHV to support access to services and navigation support.

Grant years 1 and 2 were used to establish funding for women's health navigators and implement contracts for these services**.** The objective was zero (0) in grant year 1 and 250 in grant year 2 for **ESM WWV.3**. Unfortunately, contracts did not go into effect until August 2022 and grantees did not have enough time to start providing navigation services before the end of the grant year (i.e., the number of women receiving navigation services in grant year 2 was zero (0)). Navigation services began in grant year 3 and exceeded expectations in both grant years 3 and 4. In year 3, approximately 900 women were navigated (compared to the objective of 250), and in year 4, at least 2,729 women were navigated (compared to the objective of 900). Navigators work directly with clients to address challenges such as transportation, scheduling, insurance enrollment, and language needs, helping to connect them with resources and support to ensure timely and fair and effective care.

Activity 2b: Collaborate with at least four (4) new internal and/or external partners to assist with resource gathering and ensure the continuation of care.

Report 2b: During the project period, partnerships were developed with CHANT, EBHV, the Health Care Connect Navigators (HCCN), and several local justice systems. This enhanced the services and resources available to patients and identified a population in significant need of support through the healthcare system.

There were two new interagency partnerships established in grant year 4, one with the

Tennessee Department of Human Services and the other with the Tennessee Department of Corrections (TDOC) **(ESM: number of new or diverse partnerships**).

The partnership with the TDOC has helped address challenges related to breastfeeding and mother–child bonding among incarcerated mothers. One key advancement has been advocating for the incorporation of infants under three months of age in TDOC's weekend visitation program, allowing for critical early bonding opportunities. Additionally, the program is actively working with TennCare to explore options for covering breast pump supplies through the infant's insurance, as these supplies are not currently provided to breastfeeding mothers while incarcerated. Also, TDH was invited to participate in reentry fairs held within the correctional facilities. These events are valuable opportunities to share information and resources (including contraception education) with incarcerated individuals preparing for their transition back into the community.

Activity 2c: Promote the navigation program by developing marketing materials that are appropriate for communities with varied needs and backgrounds.

Report 2c: Throughout the reporting period, Women's Health Navigators (WHNs) were encouraged to develop materials tailored to the unique needs of the communities they serve. Central Office is providing ongoing support to WHNs, including offering templates, guidance, and technical assistance to ensure consistency and quality while still allowing for local customization.

Activity 2d: Perform at least four (4) outreach events to identify community members needing services and initiate navigation.

Report 2d: Over 166 outreach events were conducted from October 1, 2023-September 30, 2024, in the WHN service areas. The events included community events, small and large group education, and one-on-one education. The most successful outreach events were community events and large group education sessions. Their success can be linked to several key factors, including the commitment and active involvement of community partners, the usability of the event, some of which were held in the evenings, and the opportunity for meaningful engagement with the attendees. 43 of the events resulted in participants being navigated or connected to a variety of services.

Challenges Issues Related to Implementation of Strategy 2: Data collection remained a challenge during the reporting period. In January 2024, the new data system from the Tennessee Breast and Cervical Screening Program (TBCSP) was launched to support navigation data collection and continues to be refined for more effective use. Key data priorities include tracking referrals to services such as Family Planning and Presumptive Eligibility, collecting basic demographic information, identifying barriers and how they are addressed, and documenting clients' primary medical homes. To support these efforts, the Central Office is promoting the use of FindHelp as a tool for both connecting clients to social services and documenting navigation activities.

Strategy 3: Establish connections with community leaders to build partner relationships and strengthen long-standing collaborations

Supporting Evidence for Strategy 3: Engaging community members in problem-solving solutions to issues that affect them is one of the fundamental principles of public health. The most effective way to achieve public health goals, especially eliminating preventable differences in health statuses, is to actively engage those experiencing the problems in every aspect of addressing them. Community engagement means involving community members in all activities—from identifying the relevant issues and deciding how to

address them to evaluating and sharing the results with the community.

Community engagement is a strong value and fundamental practice of public. We have a list of things that we would like to collect. Among the priority areas are basic program navigation (e.g., referred to FP, PE, etc.), but also basic demographic, barriers identified, how barriers were addressed, and primary medical home. We are consistently highlighting FindHelp as a social service resource to the WHNs and will incorporate the use of it into collecting information about activities performed during navigation health. The importance of engaging the community is grounded in the belief that the public has a right to participate. The public health community believes that by using our "collective intelligence" and working together, we will more accurately identify problems and develop more elegant and effective solutions. We also believe that conflict will be minimized if people have had a chance to "buy into" the process.

Community engagement is a vital part of conducting a community health assessment and a community health improvement plan, both required components of the Local Public Health Assessment and Planning cycle.

Activity 3a: Establish partnerships with at least one (1) college or university health clinic to provide direct family planning services.

Report 3a: TDH continues to partner with the University of Tennessee Martin (UTM) student health services to provide family planning services to its students. The UTM Director of Student Health is assessing and recruiting other UT schools for an additional partnership discussion.

Activity 3b: At the 3rd quarter Information and Education (I&E) Committee meeting, request nomination of new members that encourages expression of a variety of experiences of family planning clients in Tennessee.

Report 3b: This activity was not completed due to the loss of Title X funding in Tennessee, which previously supported the operations and membership recruitment efforts of the Information and Education (I&E) Committee. In response, efforts were readjusted to engage partners and continue advancing family planning priorities through alternative strategies and collaborations outside of Title X.

Activity 3c: Work with TennCare and MCOs to identify at least one (1) area of collaboration to increase family planning services

Report 3c: TDH hired two (2) Health Care Connect navigators to assist with navigating women undergoing Medicaid Redetermination, including the loss of coverage after pregnancy or one (1) year postpartum. This includes navigating to family planning services in the health department as well as other health-related social needs. Between March and September of 2024, seven individuals were navigated to family planning services (including A Step Ahead). In addition, women were navigated to a broad range of services to meet their health and social needs:

- Supplemental Nutrition Program for Women, Infants, and Children (WIC): 614
- Community Health Access and Navigation (CHANT): 410
- Supplemental Nutrition Assistance Program (SNAP): 167
- Primary Care: 59
- Department of Human Services: 46
- Housing: 11
- Family Planning: 6
- Evidence Based Home Visiting (EBHV): 5
- Breast and Cervical Cancer Screening (BCS): 2

- Find Help Now: 2
- A Step Ahead: 1
- GIFTS: 1

Activity 3d: Promote family planning services in TDH and partner newsletters and presentations at key community and partner conferences and meetings

Report 3d: Family Planning was discussed during multiple presentations with partners, including Title V Needs Assessment, Department of Human Services (DHS), Community Baby Showers, and TSLA. The importance of family planning services has also been highlighted in Tennessee's first Maternal Health Strategic Plan. The plan highlights the importance of increasing availability of integrated reproductive and primary care services, particularly before pregnancy, to reduce adverse outcomes. It also emphasizes addressing differences in health outcomes by engaging all populations and ensuring responsive, high-quality, and coordinated care. Expanding access to LARCs, both in general and immediately postpartum, is identified as a strategy to reduce unintended pregnancies and improve birth spacing.

Activity 3e: Establish partnerships with at least one (1) organization operating a mobile health unit, including but not limited to Ballad Health, Project Rural Recovery and Knox County HD.

Report 3e: TDH continues to partner with Knox County Health Department to provide family planning services through the Knox County Women's Mobile Health Unit. Most recently, the bus was used to provide family planning services to those impacted by Hurricane Helene. Over 20 patients were seen on the unit, and services varied from Women's Health to vaccines and some wound care. Throughout the reporting period, it has also been used alongside the UT Mobile Mammography bus to provide more comprehensive reproductive health services in a centralized location.

Challenges Issues Related to Implementation of Strategy 3: Limited staffing and programmatic changes affected the ability to pursue partnerships with universities, libraries, other community spaces, and non-traditional partners during this period. Additionally, Knox County reported difficulty with staffing the Women's Mobile Health Unit that impacted the ability to serve more patients.

Update on Other Women/Maternal Health Programs Supported by MCH/Title V:

Breast and Cervical Cancer: From October 1, 2023, to September 30, 2024, MCH funds assisted in funding salaries for regional TBCSP coordinators and local HD staff, TBCSP services, which include wellness exams, cervical cancer screenings, and clinic support. During this reporting period, TBCSP served 16,528 unique patients, representing an increase of 377 women served when compared to the previous program year.

Family Planning Clinics: During the project period, MCH assisted in funding salaries for Family Planning Central Office, Regional, and Local Health Department staff. Additionally, MCH assisted in funding direct family planning services in the local health departments. Services included family planning-specific office visits and procedures, contraception provided on-site, and referrals for family planning services outside of the health department when applicable.

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3. McKenney, K. M., Martinez, N. G., & Yee, L. M. (2018). Patient navigation across the spectrum of women's health care in the United States. *American journal of obstetrics and gynecology*, *218*(3), 280–286. https://doi.org/10.1016/j.ajog.2017.08.009

4. Polinski JM, Barker T, Gagliano N, Sussman A, Brennan TA, Shrank WH. Patients' Satisfaction with and Preference for Telehealth Visits. J Gen Intern Med. 2016;31(3):269-275. doi:10.1007/s11606-015-3489-x

Priority: Decrease Pregnancy-Associated Mortality

MCH/Title V Funding: The pregnancy-associated mortality priority team is administratively led by the Injury Prevention and Detection section within the Division of Family Health and Wellness of TDH. The Injury Prevention and Detection section includes SIDS/SUID prevention, fetal and infant mortality reduction, child fatality review, core violence and injury, traumatic brain injury, suicide prevention, and the maternal mental health and substance use disorders programs. The maternal mortality reduction efforts are funded by state and other federal funds. While MCH/Title V does not directly fund these activities, it does fund staff who support maternal mortality reduction efforts, including the Section Chief and the program's administrative assistant. Both the Co-Chairs of the Maternal Mortality Review Committee are funded by MCH/Title V.

Interpretation of Performance Data on selected NPMs, SPMs, and SOMs:

Well-Woman Visit NPM: Percent of women, ages 18 through 44, with a preventive medical visit in the past year

The percentage of women ages 18-44 with a preventive medical visit in the past year was 73.8% according to 2023 TN Behavioral Risk Factor Surveillance System (BRFSS) data. This was 6.6% lower than the objective established for FY2024 of 79.0%, and similar to the percentage for the previous year of 73.4%. Looking back to previous years, at the start of this five-year cycle, the FY2020 baseline percentage of women ages 18-44 with a preventive medical visit in the past year was 76.0%, based on 2019 BRFSS data. The percentage dropped in the following year to 68.3%, but has risen slightly each year since (72.6% in FY2022, 73.4% in FY2023, 73.8% in FY2024). This drop and subsequent rebound may be due to the COVID-19 pandemic, which disrupted all routine healthcare in 2020 and 2021.

SPM 2: Percent of facilities implementing patient safety recommendations

In FY2024, 58% of facilities were implementing patient safety recommendations. This was 36% lower than the FY2024 objective of 91%. This decrease may be due to initiatives from the previous year coming to an end as well as infant QI initiatives in last year's data. During this reporting period, Tennessee Hospital Association (THA) continued to support 20 non-birthing hospitals to improve the identification, assessment, and treatment of pregnant and postpartum women in emergency departments through the Maternal Mortality Reduction project. In 2023-2024, Tennessee Initiative Perinatal Quality Care (TIPQC) continued to develop and implement improvement projects to support the work of local hospital teams to decrease preventable maternal deaths. During FY2024, The Promotion of Safe Vaginal Delivery Project, which has 35 participating hospitals, moved into sustainment in September of 2024. TIPQC also hosted 4 Spinning Babies workshops across the state as part of this project, reaching a variety of providers from more than 50 organizations. The TeamBirth project, which kicked off in November of 2023 with five hospital teams, uses structured huddles and a shared planning board, to enhance communication among the care team as well as with the patient, empowering everyone to reach decisions together. The aim of this project is to promote respectful care for mothers and their support persons and to prevent adverse outcomes due to provider miscommunication. TIPQC also launched the Best For All project in spring of 2024 in four pilot hospitals, adding another 5 hospitals by the fall. This project uses a learning collaborative and a patient satisfaction survey to identify areas of improvement, integrate best practices into discharge teaching, and ultimately promote respectful care for all patients. In FY2024, TIPQC also wrapped up AWHONN POST-BIRTH Warning Signs Education program and toolkit distribution. Through this initiative, they trained a total of 283 providers among 40 hospitals and distributed education toolkits and discharge magnets to all participating hospitals.

SPM 4: Increase in knowledge utilizing the danger assessment

The Prevention of Violent Maternal Deaths (PMVD) Program saw on average a 40% increase in knowledge in pre-

and post-test scores among Danger Assessment trainees. This surpassed the objective set for FY2024 of 20%. There were 79 Danger Assessment training participants in FY2024.

This is a new measure for FY2024, and therefore there is no previous data for comparison to assess progress. The Danger Assessment tool is a nationally recognized and validated instrument, and the training is conducted by the tool's creator, Dr. Jacquelyn Campell. PMVD partners with TN Voices to host the training twice a year, with the goal of training care providers, care coordination staff, and domestic violence advocates in assessing for the risk of serious injury or death among women experiencing domestic violence.

SPM 23: Number of community level recommendations implemented

In FY2024, 13 community-level recommendations were implemented from the Maternal Mortality Review Report. This is the same as the performance for FY2023 but fell short of the FY2024 target of 15. TDH has worked to address the 2023 Maternal Mortality Review Committee recommendations. These were distributed to the Maternal Health Task Force, THA, and TIPQC and uploaded to the Maternal Mortality Review website. In FY2024, TDH:

- Continued its partnership with Comcast Creative to broadcast the PSAs on maternal homicide and mental health/suicide. The PSAs were broadcast on various platforms in the fall of 2024 across multiple target areas, with the homicide PSAs primarily in the Shelby County area and the mental health PSAs primarily in the East/Knox County area. There were a total of 6,102,774 impressions, or views, during this media campaign.
- Funded two community-based organizations to implement the MMRC's recommendations.
    - Nurses for Newborns with a focus on increasing screenings for postpartum depression and substance use disorders, improving access to support resources, and boosting attendance at postnatal checkups. Through home visits by registered nurses, NFN offers comprehensive care coordination and 24/7 on-call nursing support for mothers throughout pregnancy and the postpartum period.
    - Servolution Health Services will provide comprehensive health services to all women, through their *EmpowHer* initiative. The program involves meeting with patients and their substance-using family members to emphasize the importance of recovery for all and to connect them with resources for creating a sober living environment. The project will screen all pregnant and postpartum women for domestic violence and substance use, ensure outpatient treatment access for pregnant women, and provide essential education and resources.
    - TIPQC's Severe Maternal Hypertension project had a sustainment huddle in in 2024, that provided funding for AWHONN's POST BIRTH Warning Signs Education Program and National Preeclampsia Foundation blood pressure cuff kits to 750 at-risk patients across 25 hospitals.

      In previous years, the Maternal Health Task Force was polled to see if they were implementing any community-level recommendations and may explain why the numbers were higher.

SOM 1: Rate of pregnancy-associated mortality to live births

The MMR team reviews deaths on a calendar year basis. During this reporting period, the team completed the review of maternal deaths that occurred in 2022. These data showed the rate of pregnancy-associated mortality was 122 deaths per 100,000 live births. Although this was higher than the FY2024 target of 89.5 deaths per 100,000 live births, this was a 26% decrease from FY2023.

Several factors contributed to the increase in FY2022 including the COVID-19 pandemic, overdose deaths, and improvements in identifying pregnancy-associated deaths. Waning effects of the pandemic, a slight reduction in overdose deaths, and potentially increased access to Naloxone may have contributed to the decrease seen in FY2024.

SOM 2: Rate of pregnancy-related mortality to live births

The rate of pregnancy-related mortality was 55 deaths per 100,000 live births for FY2024, reflecting 2022 deaths. This is substantially higher than the established objective of 21.8, but this objective has not been revised since Year 1. This rate shows a 15% decrease in pregnancy-related mortality from FY2023.

This increase was due in part to COVID-19, which can cause more severe disease during pregnancy in deaths occurring in 2021. There were 24 pregnancy-related deaths from 2020-2022 due to COVID-19, only two of which occurred in 2022.

Accomplishments and Challenges (based on FY2024 Action Plan):

Strategy 1: Increase surveillance of maternal deaths

Supporting Evidence for Strategy 1: There is moderate evidence to suggest maternal mortality review provides comprehensive information on causes of death, preventability, contributing factors, and leads to actions improving maternal deaths.

Activity 1a: Identify pregnancy-associated deaths and facilitate state Maternal Mortality Review Committee meetings.

Report 1a: TDH continues to improve its process for linking birth and death certificates, as well as linking hospital discharge data to death certificates. By adding these data sources, and increasing their collaboration with Vital Records and Statistics, the Maternal Mortality Review Program has improved its ability to identify pregnancy-associated deaths. The MMRC meets quarterly to review all pregnancy-associated deaths, determine pregnancy-relatedness, preventability, and identify contributing factors that surround each death.

TDH was granted the authority to conduct informant interviews. The informant interview will consist of conversations with family members who have lost a loved one, providing insight to help understand the circumstances surrounding the death. This will provide more information to the MMRC to determine if the death is pregnancy-related. Currently, the MMR Program lacks the capacity to implement informant interviews due to the demands of case abstraction. The Program is working to identify funding to start implementation of informant interviews.

In 2024, TDH expanded its internal and full review teams. The internal team now includes representation from the Maternal Deaths Due to Violence Program, the Family Planning Program, Suicide Prevention Program, and the Overdose Response Coordination Office. The full review team has been further strengthened with the addition of a cardiologist, mental health care provider, psychiatrist, two certified nurse midwives, and an obstetric hospital-based educator. These additions enhance the expertise available for committee decision-making and determinations. Additionally, four community-based organizations were appointed to the Maternal Mortality Review Committee to broaden membership and increase both representation and subject matter expertise. These include a Doula, Certified Professional Midwife, the Director of Primary Prevention and Government Relations from the Metro Drug Coalition, and a member of Delta Sigma Theta Sorority who is an OB hospitalist by profession.

Activity 1b: Through the Maternal Mortality Review Committee, determine the relatedness of all deaths to pregnancy, contributing factors, cause(s) of death, and preventability of all deaths. For each pregnancy-related death determine personal characteristics. For each pregnancy-related

death, the MMRC will determine the cause as specified by the Pregnancy Mortality Surveillance System.

Report 1b: The Maternal Mortality Review Committee completed their 2022 death reviews in August 2024. In the 2024 report, TDH expanded the number of factors assessed to include leading causes by racial and age groups and pregnancy-related mortality rate by marital status, in addition to PRMR by educational attainment, age, insurance, urban/rural residence, and state geography, which were analyzed in the 2024 report as well as in previous years.

Activity 1c: Develop and disseminate recommendations to prevent pregnancy-associated deaths quarterly and annually.

Report 1c: The MMRC reviews deaths quarterly and develops actionable recommendations to prevent future deaths. These recommendations are put in the legislatively mandated annual report which is disseminated throughout our partners and the state of TN. The 2023 annual report was distributed to the MMRC, Maternal Health Task Force, TIPQC, and THA. It was also uploaded to the MMR website, where it was downloaded over 700 times in FY2024. A PowerPoint on the key findings and recommendations was presented to the Maternal Health Advisory Committee, Maternal Health Task Force, and the Lentz Health Department. Dr. Tobi Amosun spoke on TIPQC's podcast, Healthy Mom Healthy Baby Tennessee, on the 2023 Maternal Mortality Review Committee findings – this episode had 138 listens. Dr. Alvarado, presented at TIPQC's annual conference and reported on MMR key findings and recommendations.

The percentage of recommendations with who/what/when components (**ESM WWV.8)** were 90% for FY2024, a 32% increase from FY2023. This percentage also surpassed the FY2024 target of 89%. These numbers have improved due to working with the Maternal Mortality Review Committee members to develop more clear, specific, and actionable recommendations.

Challenges Issues Related to Implementation of Strategy 1: Staff capacity and delays in accessing medical records led to challenges in completing case abstractions in a timely manner. Additionally, the increased number of pregnancy-associated deaths resulted in an increase in time commitment from the MMRC to complete all the reviews.

Strategy 2: Increase evidence-based education at hospitals on topics identified by the Maternal Mortality Review Committee (MMRC).

Supporting Evidence for Strategy 2: There is moderate evidence to suggest that provider education, such as continued medical educational opportunities is effective.

Activity 2a: Contract with Tennessee Hospital Association (THA) and Tennessee Initiative for Perinatal Quality Care (TIPQC) to provide training to birthing and non-birthing hospitals on top causes leading to maternal death as identified by the MMRC.

Report 2a: THA enhanced their efforts to address healthcare differences in health outcomes, by organizing in-person subconscious inclinations or preferences training sessions sponsored by the March of Dimes, and open to all hospitals. In 2023-2024, TIPQC continued to develop high-quality improvement projects to support the work of local hospital teams, to decrease preventable maternal and neonatal morbidity and mortality across Tennessee.

The Best for All Learning Collaborative, involving eleven participating hospitals, focuses on delivering respectful patient care, consistently screening for community health factors that influence health outcomes with timely referrals, and improving overall patient care.

Team Birth is a collaborative initiative between TIPQC and Ariadne Labs aimed at fostering open communication among patients, their support networks, and clinicians throughout the birthing process. In 2023, five hospitals joined this initiative.

TIPQC launched the ACOG AIM Cardiac Conditions in Obstetric Care Quality Improvement Bundle across six participating hospitals. This initiative aims to reduce severe maternal morbidity and pregnancy-related deaths associated with cardiac conditions, which accounted for more than 1 in 5 pregnancy-related deaths between 2020-2022.

Hypertensive disorders of pregnancy accounted for nearly one-third of cardiovascular deaths. To address these conditions, the Severe Maternal Hypertension project had a sustainment huddle that provided funding for AWHONN's POST BIRTH Warning Signs Education Program as well as the distribution of National Preeclampsia Foundation blood pressure cuff kits to 750 at-risk patients across 25 hospitals.

TIPQC also launched the Promotion of Safe Vaginal Delivery Project in 2022 with 6 hospitals, which were joined by an additional 29 hospitals in spring of 2023. This project aimed to reduce the number of unnecessary cesareans due to the increased risk of hemorrhage and infection as well as longer recovery time associated with c-section deliveries.

In FY2024, 88% of births in TN took place in hospitals implementing data-driven, clinical recommendations (**ESM WWV.4**). This is a 9% increase from FY2023, and is 3.5% higher than objective of 85%.

Activity 2b: Provide funding and technical assistance to TIPQC to increase infrastructure for hospital participation in the AIM bundles.

Report 2b: TIPQC received additional grant funding from the MMR and MHI programs to facilitate the distribution of blood pressure cuffs to hospitals to be given to women who are high risk. In 2024, TIPQC launched the ACOG AIM Cardiac Conditions in Obstetric Are Quality Improvement Bundle across six participating hospitals. To provide technical assistance to TIPQC, the Title V Director, the Associate Medical Director of Women's Health, the FHW Maternal and Infant Health Deputy Director, and the Section Chief for Perinatal, Infant, and Pediatric Care meet monthly with the executive director of TIPQC. Additionally, the Title V Director and the Associate Medical Director of Women's Health are active members on the TIPQC Oversight Committee.

Challenges Issues Related to Implementation of Strategy 2: TIPQC had internal challenges with staff vacancies, and understanding the funding expenditure of their contract.

Strategy 3: Increase access to services through community agency involvement to improve maternal health outcomes.

Supporting Evidence for Strategy 3: There is moderate evidence to suggest that expanded insurance coverage is effective.

Activity 3a: Increase the number of women applying for presumptive eligibility by implementing an outreach plan and collaborating with community partners to reach communities at risk for poor health outcomes and who are medically underserved.

Report 3a: In FY24 the MHI program hired 2 Health Care Connect Navigators to assist with reducing the number of pregnant and postpartum women who lost Medicaid coverage due to the Medicaid unwinding. The MHI program partnered with TennCare to receive a monthly list of members due to lose coverage. Members are proactively reached out to and provided navigation assistance. Nearly 6,500 women and their families were navigated. Over 1,500 were reenrolled into TennCare, 507 were referred to CHANT, 684 were enrolled in WIC, and many others were referred to local community and social resources. Also in FY24, the PE program was able to secure a contract with the Johnson City Community Clinic to do presumptive eligibility applications. This allowed 18 pregnant women to apply for TennCare at the clinic giving them immediate access to Medicaid insurance without the burden of having to go to the local health department.

Activity 3b: Convene a multi-disciplinary maternal health task force a minimum of quarterly and ensure broad representation. Utilize the maternal health task force members to finalize the maternal health strategic plan with strategies to address preventable differences in health outcomes and implement recommendations.

Report 3b: The Maternal Health Task Force (MHTF) met quarterly during FY24. The MHTF has a multi-disciplinary membership of over 300 members. Membership includes community members and leaders, legislators, physicians, nurses, doulas, academics, TennCare, and more. There are members from each of the grand divisions (East, West, and Middle) as well as rural and metropolitan areas. Topics covered during the MHTF meetings included a review of the 2023 Maternal Mortality Report, focus group data, and Severe Maternal Morbidity data. TSU and Meharry both presented on their maternal health research as Maternal and Child Health Bureau grantees.

The maternal health strategic plan was completed and submitted to HRSA as part of the MHI grant requirement at the end of this reporting period. HRSA had no recommendations or comments for the plan. ETSU had been contracted to do a baseline assessment and focus groups statewide.

Community grants were awarded to 3 grantees, all members of the MHTF, to implement recommendations by the MMRC in the 2023 MMR report. TIPQC was awarded grant funding to purchase blood pressure cuffs as part of a quality improvement project educating hospitals and doulas on maternal hypertension and early warning signs. Nurses for Newborns (NFN) is providing evidence-based home visiting services to pregnant and postpartum women who have complex needs. During this time period, NFN served 33 new moms and babies and provided 25 with screening for postpartum depression. Servolution Health Services is working to provide medically accurate maternal health information and education through classes held at their clinic as well as with pregnant and postpartum women who are incarcerated in Claiborne County. During this time period, Servolution has held 11 recovery coaching sessions, provided education and referrals for 100 individuals, provided 23 depression screenings, and provided 30 new moms with Lovie Dovie bags that include resource guides.

Activity 3c: Provide training on the danger assessment to community agencies and healthcare providers with a focus on the area of the state with the highest rate of pregnancy-associated deaths due

to homicide.

Report 3c: The Prevention of Maternal Deaths due to Violence program partnered with TN Voices to provide Domestic Violence training and two Danger Assessment (DA) trainings in 2025, one in Shelby County and the other in Davidson County. These trainings are designed for healthcare providers, domestic violence advocates, criminal justice professionals, community health workers, CHANT coordinators, evidence-based home visitors, doulas and other members of the community. Dr. Jacquelyn Campbell's training is a nationally recognized instrument used to measure a person's risk of experiencing life-threatening violence or homicide by a partner. Between 2017 and 2021 there were 76 violent maternal deaths with 64% of them classified as preventable. Notably, 48% of these maternal homicide deaths occurred in Shelby County and in 2021 40% were killed by an intimate partner. The DA training was offered in multiple regions, including East TN (Hamblen County), West TN (Shelby County) and Middle TN (Davidson County) with the highest attendance being in Shelby County. The DA tool is instrumental in helping providers and others assess the level of danger faced by someone who's in an abusive relationship, aiding in the identification of Intimate Partner Violence (IPV) cases in patients and facilitating connections to available resources. Ultimately the goal is to reduce maternal homicide by effectively addressing and intervening in cases of IPV. The PVMD program has delivered comprehensive Domestic Violence training to staff across priority programs such as CHANT and EBHV, with approximately 103 CHANT staff and an estimated 260 EBHV staff participating in efforts to enhance awareness, response, and support for individuals affected by domestic violence. The program continues to expand these efforts by promoting awareness of available and upcoming trainings including both Danger Assessment and Domestic Violence across the State, in hopes to train as many people as possible to achieve said goal.

In FY2024, there were 79 participants between the two Danger Assessment trainings held (**ESM: number of individuals trained on utilizing the danger assessment**). The training involved representatives from a range of organizations, including health departments, family justice centers, and victim support services. Roles included domestic violence advocates, health care providers, program coordinators, and specialists in areas like home visiting, peer recovery, and disease intervention. Participants worked across various sectors such as healthcare, legal services, and victim support, with a focus on supporting victims of domestic violence, crime, and drug-endangered children. This surpassed the objective of 40 trainees, which was the minimum number of participants required by the contract with TN Voices. This is the first year for this measure, so there is no previous data for comparison.

Activity 3d: Develop a media campaign to create maternal health awareness and highlight resources for maternal health complications. Media campaign will focus on areas of the state with the greatest rates in pregnancy-associated mortality.

Report 3d: The Maternal Mortality Review Program, the Maternal Health Innovation, and Prevention of Maternal Deaths due to Violence Programs partnered with Comcast Media Productions to broadcast PSAs on Maternal Mental Health and SUD to help raise awareness in the community. These PSAs aired on traditional TV from 9/21 to 9/30 and on streaming TV from 9/21 to 11/01, achieving a total of 6,103,774 impressions. Priority counties for the homicide campaign include Shelby, Madison, Haywood, Humphreys, Carroll, Dyer, Lake, Obion, Decatur, and Davidson. Priority counties for the suicide campaign include Knox, Anderson, Blount, Sevier, Sullivan, Roane, Morgan, Cocke, Monroe, and Davidson. In addition, a total of 21 social media posts were shared across

Facebook, Instagram, and X, generating the following impressions: Facebook had 54,337, Instagram had 4,995, and X had 21,124.

Activity 3e: Promote the use of telehealth for family planning visits.

Report 3e: Baseline for **ESM WWV.2** was 0.2% based on federal fiscal year 2020. The objective for grant year 1 was to maintain this percentage at 0.2% and then to increase it to 0.4% in grant year 2 0.8% in grant year 3 and 1.6% in grant year 4. The actual percentages for grant years 2 and 3 were 1.2% and 1.6%, respectively, which exceeded the objectives. However, the percentage decreased to 1.0% in grant year 4. Although the statewide goal for the year was not met, county-level percentages ranged from 0% to 24%, with 34 out of 95 counties (over one-third) exceeding the goal. Administrative changes in the Family Planning program as well as changes in how the data were captured may have contributed to the decrease observed in ESM WWV.2 in FY2024.

During this reporting period, the Family Planning program (FP) collaborated with the Community Health Services Division (CHS) to transition the FP Telehealth program. Throughout the transition, Family Planning Telehealth has continued being promoted through Tennessee's Department of Health (TDH) public-facing website, which includes online referrals, updated FP Telehealth-specific flyers, multiple TDH social media posts, and communication with external partners.

Challenges Issues Related to Implementation of Strategy 3: TennCare's privacy and security policies limited opportunities to expand the PE program beyond the Tennessee Department of Health (TDH) and local health departments. While direct expansion was not possible, TDH is moving forward with plans to strengthen access by connecting community partners and healthcare clinics to metro health departments, where staff will be able to assist clients with PE applications by phone.
The Maternal Health Strategic Plan (MHSP) was finalized late in the reporting period. Clear timelines and responsibilities for implementing MHSP recommendations should be established during the next reporting period. Recruiting healthcare providers for training in the use of danger assessments proved challenging, likely due to competing priorities and resource constraints. However, participation from community agencies and domestic violence advocates was robust. Contract delays significantly affected the timely broadcasting of public service announcements (PSAs), reducing their impact.
The significant change surrounding the transition of all FP Telehealth to a different division stalled activities for 3e this year.

Update on Other Women/Maternal Health Programs Supported by MCH/Title V:

Maternal Mortality Review Program: The Maternal Mortality Review Program has continued its strong partnership and collaboration with Tennessee Hospital Association and Tennessee Initiative Perinatal Quality Care in addressing pregnancy-related deaths. TDH is currently developing a severe maternal morbidity report that will provide key insights into trends, leading SMM causes, unfair and/or preventable differences in health outcomes, and other contributing risk factors, aiming to guide prevention efforts. TDH released its first Maternal Health Strategic Plan in January 2025 that outlines goals, strategies, and objectives to enhance maternal health across Tennessee by building on current partnerships and strengths while addressing existing challenges and gaps.

Regional Perinatal Centers: During this period, the five Perinatal Centers reported 122,978 outpatient consultation visits with health care providers and provided 9,050.50 hours of high-risk education for health care professionals, increasing their expertise of perinatal health topics. The Perinatal Program also secured supplemental funding for the Neonatal Resuscitation Program (NRP) eBook and certification exams for statewide use by the Centers with training EMS providers. To further address high rates of maternal infant mortality and morbidity, TDH awarded a total of $6 million to two organizations, High Risk Obstetrical Consultants and Regional One Health to provide perinatal

telehealth services to high-risk pregnant women.

Perinatal Advisory Committee: For federal fiscal year 2024, the Tennessee Perinatal Advisory Committee (PAC) made progress in enhancing maternal and neonatal health outcomes. The committee convened three times, fostering collaborations among health care providers, hospitals, and community organizations to strengthen the statewide perinatal care network. During these meetings, the PAC addressed crucial topics, including updates on TennCare, Perinatal Vital Statistics, vaccine recommendations for pregnancy, NRP training for EMS staff, newborn screening birth data, legislative updates, drug shortages, Perinatal Telehealth, and neonatal abstinence syndrome. The committee also approved the publication of the 8th edition of the social work manual. In addition, a workgroup reviewed and updated the Guidelines for Equipment, Supplies, and Training for EMS and Emergency Department Personnel. Prior to December 1, 2025, the initiation of neonatal intensive care units was administered by the HFC Certificate of Need (CON) Program. Since 1978, the Perinatal Advisory Committee (PAC) has maintained Guidelines for regionalization, which include levels of neonatal care. Hospitals self-designate their facility's care level based on published PAC regionalization guidelines. In 2024, the Tennessee General Assembly removed the CON program and tasked the Health Facilities Commission (HFC) with developing licensure quality standards to ensure the health, safety, and welfare of Tennessee NICU patients. Beginning December 1, 2025, NICU Licensure will replace the CON program. HFC assembled the NICU Technical Advisory Group (TAG) of experts to develop quality regulations for incorporation into the licensure process. Four members of the PAC (include the Co-chair of the PAC) participated in the NICU TAG to develop quality regulations. The NICU TAG's recommendations include that the NICU's level of care be verified every three years by an in-person survey team according to the Tennessee Perinatal Care System Guidelines for Regionalization, Hospital Care Levels, Staffing and Facilities (Ninth Edition).

Maternal Mental Health and Substance Use Disorder grant: The Maternal Mental Health and Substance Use Disorder (MMHSUD) grant has worked to secure contracts for the training of healthcare providers on MMHSUD, the expansion of FindHelpnowTN, and the teleconsultation line. During this time period, the program also begun recruiting for a social work position that will train EBHV and CHANT staff on MMHSUD and available screening tools and best practices.

Doula Services Advisory Committee: The Doula Services Advisory Committee (DSAC) met monthly during FY24. In 2023 the DSAC was tasked by the Legislature to create core competencies and standards for doula services, propose multiple options for a Medicaid reimbursement plan, including rates and fee schedules, propose incentive-based programs such as fee waivers, examine outcomes, findings, and reports from existing doula-related pilot programs, produce a report to the Legislature within 18 months of the first meeting. The DSAC released the report to the Legislature in March 2025.

Priority: Increase Access to Contraceptive Methods

Objective for Postpartum Contraception Use: 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.

Evidence-Based or Informed Strategy Measure (ESM): Number of providers trained on long-acting reversible contraception (LARC) insertion and removal

The following strategies and activities are planned for October 1, 2025, to September 30, 2026:

Strategy 1: Encourage clinics to offer information on or access to Long-Acting Reversible Contraception (LARC), including to postpartum women

Supporting Evidence for Strategy 1: Long-acting reversible contraceptives (LARCs) include intrauterine devices (IUDs) and implants that can prevent pregnancy for 3 to 10 years and can be removed at a woman's discretion. LARCs are over 99% effective, a higher effectiveness rate than other birth control options[1]. LARCs can be used safely by teens and women regardless of whether they have previously given birth[2]. Despite very few medical contraindications to LARC use[3], a variety of barriers at the patient, provider, and systems level have limited access to and uptake of LARCs. LARCs can be made available through broad-based efforts to decrease patient costs such as ensuring that LARCs are available at low or no cost through Title X family planning sites and other sources of care, and ACA provisions requiring full coverage of birth control options. Efforts to increase access to LARCs can include provision of comprehensive contraceptive counseling on the full range of birth control options (including LARC) for all interested patients, provider training on LARC insertion and removal, and consistent availability of LARCs at local hospitals and clinics. Availability of LARCs could also be improved by elimination of medically unnecessary steps between request and insertion, including two visit protocols and STI testing prior to the day of insertion[4].[4] LARCs can be inserted and removed by many types of clinicians in a range of clinical settings, including primary care and nontraditional locations such as school-based health center or mobile van settings[5].

Activity 1a: Distribute a contraceptive counseling toolkit designed for healthcare providers to support client-centered counseling and streamline the process for offering long-acting reversible contraception (LARC) methods. The toolkit will include guidance on delivering contraceptive counseling through telehealth, especially as an alternative option for women in rural and medically underserved areas. Promotion of the toolkit will include provider webinars, in-person trainings, and Medical Leadership Team (MLT) sessions to ensure broad awareness and effective implementation.

Activity 1b: Provide LARC insertion and removal provider training.

Activity 1c: Promote awareness of LARCs through social media and community outreach to increase understanding and reduce misconceptions about these methods.

Activity 1d: Promote the importance of including LARCs as part of birthing facilities' standard postpartum care package.

Activity 1e: Work with insurance providers to provide full coverage for immediate postpartum LARC placement.

Planned Partnerships:

- **Partnership/Shared Leadership:** TDH Community Health Services, Tennessee Initiative for Perinatal

Quality Care (TIPQC), TennCare and Managed Care Organizations, and Rural and Metro health departments
- **Involvement:** TDH Maternal Health Innovation, TDH Presumptive Eligibility, TDH Community Health Access and Navigation in Tennessee (CHANT), TDH Evidence-based Home Visiting (EBHV), TDH Office of Minority Health and Disparities Elimination, TDH Office of Communication, Tennessee Primary Care Association (TPCA), Tennessee Charitable Care Network (TCCN), and Tennessee Rural Health Association
- **Consultation:** TDH Maternal Mortality Review (MMR)

Strategy 2: Implement community-based programs that provide education and support to women seeking information on contraception methods, including postpartum women.

Supporting Evidence for Strategy 2: Peer-support and community programs utilize the relationships and connections within the community and across social circles to provide education and resources to those who may not be reachable by traditional outreach methods. These types of programs may be delivered during pregnancy and the postpartum period or limited to the postpartum period. Evidence shows that peer-support initiatives delivered in group settings, especially those that are delivered across the perinatal period, are effective in delivering effective postpartum contraception education, and increasing uptake in the use of more/most effective postpartum contraception methods[6] [7] [8].

Activity 2a: Collaborate on the integration of women's health services and community support resources into Community Compass to ensure a sustainable, up-to-date referral tool for navigators and community health workers.

Activity 2b: Increase the number of women navigated to family planning health services through Evidence-Based Home Visiting (EBHV), Community Health Access and Navigation in Tennessee (CHANT), Women, Infant, and Children (WIC), and Women's Health Navigators (WHNs).

Activity 2c: Apply data-driven QI methods such as workflow improvements, staff training, or patient navigation enhancements to directly improve service delivery and access to family planning.

Activity 2d: Strengthen relationships with the Tennessee Primary Care Association (TPCA) and Federally Qualified Health Centers (FQHCs) to implement provider training and outreach initiatives focused on contraceptive counseling, with special emphasis on improving access for postpartum women in medically underserved areas.

Planned Partnerships:
- **Partnership/Shared Leadership:** TDH Breast and Cervical Cancer Program, TDH Presumptive Eligibility, TDH Evidence-based Home Visiting, TDH CHANT Program, TDH Women, Infant, and Children (WIC), TDH Community Health Services, Rural and Metro health departments, TDH Office of Quality Improvement, FQHCs/rural health clinics, Tennessee Primary Care Association (TPCA), Tennessee Charitable Care Network (TCCN)
- **Involvement:** TDH Maternal Health Innovation, TDH Maternal Mortality Review (MMR), TDH Office of Minority Health and Disparities Elimination, Title X Grantees, Colleges and Universities, Faith-based communities, Tennessee Public Health Association, Tennessee Rural Health Association, A Step Ahead Foundation, TennCare & MCOs
- **Consultation:** Tennessee Initiative for Perinatal Quality Care (TIPQC), TDH STI/HIV Program, TDH Tennessee Adolescent Pregnancy Prevention Program,
Association of Maternal and Child Health Programs, Association of State and Territorial Health Officials

Family Planning Health Programs Supported by MCH/Title V:
- ***Breast and Cervical Cancer (TBCSP):*** MCH funds assist with funding salaries for regional TBCSP

coordinators and local HD staff, TBCSP services, which include wellness exams and cervical cancer screenings, and clinic support.

- ***Family Planning Clinics:*** MCH funds assist with funding salaries for Family Planning Central Office, Regional, and Local Health Department staff. Additionally, MCH assists in funding direct family planning services in the local health departments. Services include family planning-specific office visits and procedures, contraception provided on-site, and referrals for family planning services outside of the health department when applicable.
- ***Evidence-Based Home Visiting (EBHV)****:* MCH funds assist with funding salaries for EBHV staff. Home visitors complete screening and referral for intimate partner violence (IPV), depression, and developmental delays. Also, home visitors educate on healthy home, safe sleep practices, breastfeeding, smoking cessation, and immunizations.

Family Planning Health Programs Connected but Not Funded by MCH/Title V:

- Presumptive Eligibility (PE)
- Maternal Health Innovation (MHI)
- Maternal Mortality Review (MMR)
- Community Health Access and Navigation in Tennessee (CHANT)
- Sexually Transmitted Infections (STI)
- Adolescent Pregnancy Prevention (APP)

Contextual Factors:

- Available funding
- National Program Guidelines and Policies
- Political Environment
- Socioeconomic Factors
- Competing telehealth programs with other organizations
- Willingness of partners to work with programs

Assumptions:

- State funding will be secure throughout the program period
- Partnerships will be established and maintained with a broad group of community leaders
- Continuation of essential health services
- Continued support of increased access to care
- Staff with the necessary skills and abilities can be recruited, hired, and retained

Priority: Improve Maternal Mental Health and Wellbeing

Objective for Postpartum Visit: 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.

Evidence-Based or Informed Strategy Measure (ESM): Percent of home-visiting staff trained in recognizing and providing resources/referrals for perinatal mood and anxiety disorders and substance use disorder

Objective for Postpartum Mental Health Screening: 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 FY 2030.

Evidence-Based or Informed Strategy Measure (ESM): Number of healthcare providers trained in using validated screening tools for depression and anxiety

The following strategies and activities are planned for October 1, 2025, to September 30, 2026:

Strategy 1: Educate providers on the use of standardized screening tools to identify women with postpartum depression and anxiety.

Supporting Evidence for Strategy 1: Provider training interventions such as slide presentations, educational sessions, video training, and other training modalities seek to improve the knowledge and skills of providers around the signs, symptoms, screening protocols and treatment options for postpartum depression and anxiety. Research supports that increasing provider knowledge and comfort level around postpartum depression and anxiety screening improves screening and referral rates. Findings also indicate that trainings that address the values of providers' clients have a positive impact on health outcomes[9] [10].

Activity 1a: Conduct statewide webinars and in-person training, offering continuing education credits for OB/GYNs, midwives, pediatricians, and primary care clinicians on administering validated screening tools (EPDS, PHQ-9, GAD-7, 4Ps Plus, etc.).

Activity 1b: Establish a peer-to-peer teleconsultation service for maternal health providers, offering real-time access to MMHSUD specialists. Ensure successful implementation by developing and disseminating training, outreach, and promotional materials to raise awareness and encourage utilization of the service across the maternal health workforce.

Activity 1c: Provide targeted technical assistance for integrating postpartum mental health screening into pediatric settings (e.g., well-baby visits), including practical implementation strategies and resources to support clinicians in applying screening tools and referral pathways effectively.

Planned Partnerships:

- **Consultation/Involvement:** OB/GYN practices, pediatric clinics, midwifery associations, Doulas
- **Partnership/Shared Leadership:** TIPQC, TPCA, THA, TNAAP, HRSA-supported MCH programs, Medicaid Managed Care Organizations (MCOs), Behavioral Health Providers, Regional Health Departments

Strategy 2: Support quality improvement initiatives that take a multi-component, systematic approach to increase postpartum depression and anxiety screening rates and address SUD.

Supporting Evidence for Strategy 2: Hospitals that support quality improvement (QI) initiatives that enact standardized screening protocols and referral pathways, staff and patient engagement, and use a multi-component, systematic approach to encourage postpartum depression and anxiety screening are likely to increase screening and referral rates. Research supports that QI initiatives that utilize a standardized postpartum depression and anxiety screening tool have been shown to be effective in increasing screening rates. QI initiatives have also been studied in specialized populations such as incarcerated women and have shown to have positive outcomes in increasing screening rates[11] [12] [13].

Activity 2a: Implement the Postpartum Naloxone Project in birthing facilities to support routine distribution at discharge, while also promoting widespread access to naloxone through expanded education, training, and community-based distribution efforts.

Activity 2b: Coordinate with TIPQC to expand the maternal mental health focus within existing initiatives, such as hemorrhage, hypertension, or SUD AIM bundles, addressing the intersection of physical and behavioral health.

Activity 2c: Collaborate with TIPQC to expand education and training for healthcare providers on the identification, treatment, and management of substance use disorder (SUD) and opioid use disorder (OUD) among pregnant and postpartum women.

Activity 2d: Increase the number and availability of maternal mental health and substance use disorder (MMHSUD) resources listed on FindHelpNowTN.org and promote the platform by providing training, technical assistance, and materials to hospital staff involved in postpartum discharge planning.

Planned Partnerships:

- **Consultation:** TIPQC, Hospital Quality Improvement Teams, PQC4ME, Harm-Reduction organizations
- **Partnership/Shared Leadership:** HRSA-supported State MCH programs, Behavioral Health Agencies, THA, Tennessee Tech University/iCube, Opioid Response and Coordination Office

Strategy 3: Collaborate with home visiting programs and community-based organizations to support mothers in obtaining timely postpartum care.

Supporting Evidence for Strategy 3: Home visiting programs. (HVPs)—whether staffed by nurses, midwives, or community health workers—can decrease access barriers and increase the likelihood that new mothers will receive postpartum care. Trained HVP professionals and paraprofessionals can screen for maternal conditions, help postpartum participants make and attend medical appointments, and provide access to community services. However, not all HPVs focus on maternal healthcare and some do not meet the U.S. Department of Health and Human Services' criteria as an evidence-based service delivery model. Programs that meet the federal guidelines and include postpartum care as a performance measure are likely to increase the rate of postpartum visit attendance[14] [15] [16] [17] [18] [19] [20] [21].

Activity 3a: Support the expansion of peer support groups for perinatal mental health and SUD recovery by partnering with existing organizations to promote, elevate, and connect these groups through the Maternal Health Task Force.

Activity 3b: Collaborate with community-based organizations to provide wraparound services (transportation, childcare, housing supports) to address barriers that impact postpartum care attendance and treatment engagement, including but not limited to the Medicaid transportation benefit.

Activity 3c: Train home visiting and CHANT staff on postpartum care, identifying signs and symptoms of perinatal mood disorders (PMADs) and SUD, and on using validated

screening tools.

Planned Partnerships:

- **Consultation/Involvement:** Local Evidence-Based Home Visiting (EBHV) Programs [Nurse-Family Partnership (NFP), Healthy Families TN (HFT), Parents as Teachers (PAT), and Maternal Infant Health Outreach Worker (MIHOW)]
- **Partnership/Shared Leadership:** Community-based Organizations, TennCare, Peer Recovery Networks, Behavioral Health Agencies, Faith-Based Organizations, HRSA-funded Healthy Start Programs

Women/Maternal Health Programs Supported by MCH/Title V:

- Family Planning
- Evidence-Based Home Visiting Programs

Women/Maternal Health Programs Connected but Not Funded by MCH/Title V:

- Maternal Health Innovation
- Maternal Mental Health and Substance Use Disorder
- Prevention of Violent Maternal Deaths

Contextual Factors:

- Persistent stigma surrounding maternal mental health and substance use may reduce screening uptake and follow-through on referrals.
- Behavioral health workforce shortages limit service availability, particularly in rural and medically underserved areas.
- Community health factors that influence health outcomes (transportation barriers, childcare needs, housing instability) affect service engagement and postpartum care participation.
- Existing supportive initiatives from HRSA MCHB, including funding for Perinatal and Infant Mental Health programs, can be leveraged for alignment and sustainability.
- Competing initiatives and varying hospital system priorities may influence the adoption of quality improvement efforts.
- Variability in provider engagement and health system readiness for behavioral health integration impacts the consistency of implementation.

Assumptions:

- Providers will be willing to implement screening tools and participate in teleconsultation and training opportunities.
- TIPQC and hospital systems will collaborate on quality improvement activities, including the AIM Perinatal Mental Health Bundle.
- Funding from HRSA MCHB, HRSA MMHSUD, and state programs will continue to support maternal mental health and SUD services.
- Staff with the necessary expertise in maternal mental health and peer recovery support will be available and adequately trained.
- Participants in home visiting and peer support programs will engage with services when barriers (e.g., transportation, stigma) are addressed.
- Cross-sector partnerships (healthcare, behavioral health, community services) will facilitate timely and effective referrals and follow-up care.
- Integration of FindHelpTN.org into referral processes will enhance service navigation and resource access for providers and families.

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Perinatal/Infant Health

National Performance Measures

NPM - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III + Neonatal Intensive Care Unit (NICU) - RAC
Indicators and Annual Objectives

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data					
	2020	2021	2022	2023	2024
Annual Objective		85	85.5	86	86.5
Annual Indicator	84.5	80	82	83	84
Numerator					
Denominator					
Data Source	Birth Statistical System	Birth Statistical System	Birth Statistical System	Birth Statistical System	Birth Statistical System
Data Source Year	CY 2019	CY 2020	CY 2021	CY 2022	CY 2023
Provisional or Final ?	Final	Final	Final	Provisional	Final

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	85.0	85.8	86.6	87.3	88.1

Evidence-Based or –Informed Strategy Measures

ESM RAC.1 - Percent of Tennessee birthing hospitals participating in perinatal quality collaborative projects

Measure Status:	Inactive - Completed				
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		33	33	33	33
Annual Indicator	41	43.3	36.2	68	72.4
Numerator					
Denominator					
Data Source	TIPQC	TIPQC	TIPQC	TIPQC	TIPQC
Data Source Year	2020	2021	2022	2023	2024
Provisional or Final ?	Final	Final	Final	Final	Final

ESM RAC.2 - Number of unique patients served by perinatal telehealth pilot projects in Tennessee

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	500.0	750.0	1,000.0	1,000.0	1,000.0

State Action Plan Table

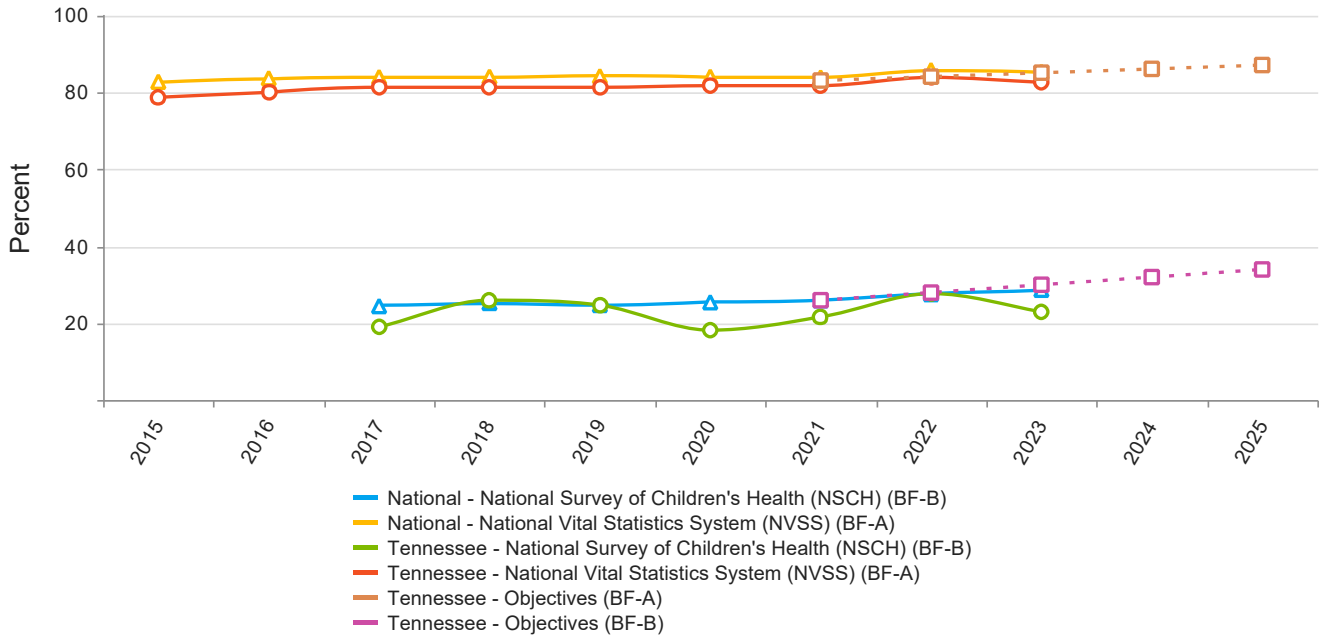
State Action Plan Table (Tennessee) - Perinatal/Infant Health - Entry 1
Priority Need
Improve the Perinatal Regionalization System in Tennessee
NPM
NPM - Risk-Appropriate Perinatal Care
Five-Year Objectives
Increase the percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ NICU from 84% on October 1, 2025, to 88% on September 30, 2030.
Strategies
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.

ESMs	Status
ESM RAC.1 - Percent of Tennessee birthing hospitals participating in perinatal quality collaborative projects	Inactive
ESM RAC.2 - Number of unique patients served by perinatal telehealth pilot projects in Tennessee	Active

NOMs
Stillbirth
Perinatal Mortality
Infant Mortality
Neonatal Mortality
Postneonatal Mortality
Preterm-Related Mortality

2021-2025: National Performance Measures

2021-2025: NPM - A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months - BF Indicators



2021-2025: NPM - A) Percent of infants who are ever breastfed - BF

Federally Available Data		
Data Source: National Vital Statistics System (NVSS)		
	2023	**2024**
Annual Objective	85	86
Annual Indicator	83.9	82.7
Numerator	67,385	67,009
Denominator	80,338	81,027
Data Source	NVSS	NVSS
Data Source Year	2022	2023

2021-2025: NPM - B) Percent of infants breastfed exclusively through 6 months - BF

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH)		
	2023	**2024**
Annual Objective	30	32
Annual Indicator	27.8	23.1
Numerator	48,856	42,995
Denominator	175,921	185,817
Data Source	NSCH	NSCH
Data Source Year	2021_2022	2022_2023

2021-2025: Evidence-Based or –Informed Strategy Measures

2021-2025: ESM BF.1 - Number of credentialed lactation professionals within WIC

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		166	176	186	196
Annual Indicator	156	148	159	147	142
Numerator					
Denominator					
Data Source	WIC Monitoring Reports	WIC Monitoring Reports	WIC Monitoring Reports	WIC Monitoring Reports	WIC Monitoring Reports
Data Source Year	2020	2021	2022	2023	2024
Provisional or Final ?	Final	Final	Final	Final	Final

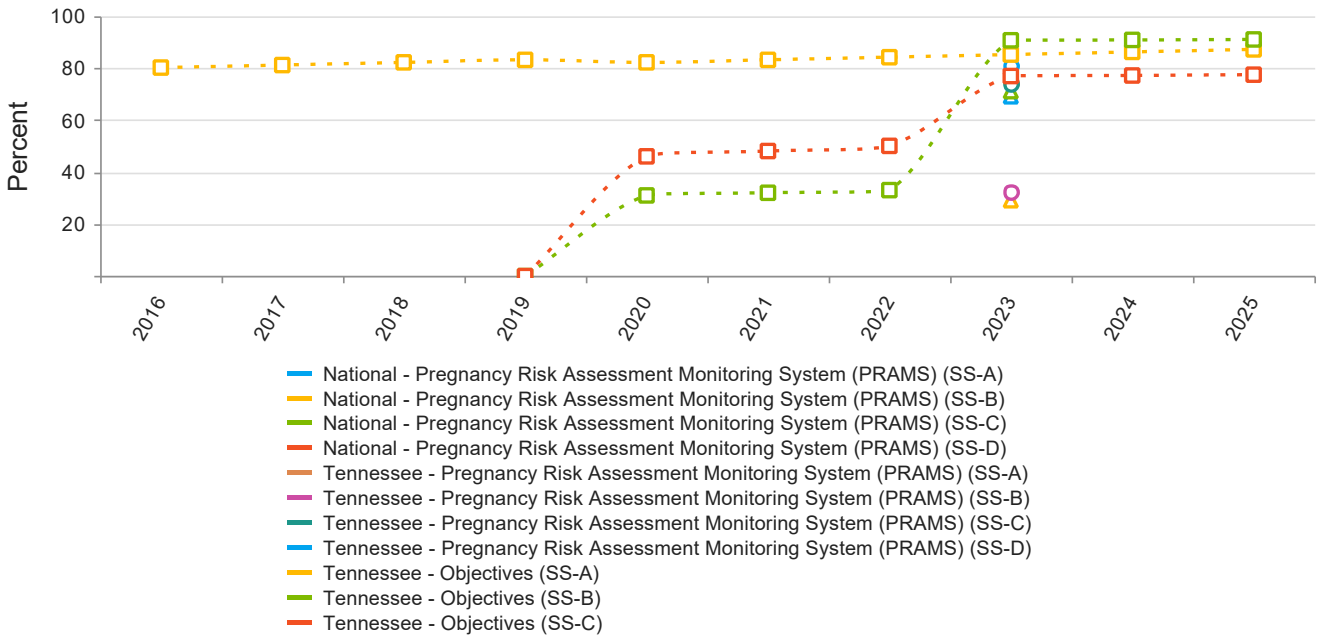
2021-2025: ESM BF.2 - Percent of Breastfeeding Welcomed Here (BFWH)-designated businesses with ideal workplace lactation policies

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		0	0	0	0
Annual Indicator		0	38	0	0
Numerator					
Denominator					
Data Source		BFWH Tracking Spreadsheet	BFWH Tracking Spreadsheet	N/A	N/A
Data Source Year		2021	2022	N/A	N/A
Provisional or Final ?		Final	Final	Final	Final

2021-2025: ESM BF.3 - Recognition process implemented for Breastfeeding Welcomed Here (BFWH)-designated businesses

Measure Status:				**Active**	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		Yes	Yes	Yes	Yes
Annual Indicator		No	No	No	No
Numerator					
Denominator					
Data Source		BFWH Tracking Spreadsheet	BFWH Tracking Spreadsheet	BFWH Tracking Spreadsheet	BFWH Tracking Spreadsheet
Data Source Year		2021	2022	2023	2024
Provisional or Final ?		Final	Final	Final	Final

2021-2025: NPM - A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding D) Percent of infants room-sharing with an adult during sleep - SS
Indicators



2021-2025: NPM - A) Percent of infants placed to sleep on their backs - SS

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	82	83	84	85	86
Annual Indicator	79.4	78.4	79.1	79.1	74.1
Numerator	59,805	58,480	60,875	60,875	55,518
Denominator	75,369	74,548	76,934	76,934	74,938
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2019	2020	2021	2021	2023

2021-2025: NPM - B) Percent of infants placed to sleep on a separate approved sleep surface - SS

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	31	32	33	90.5	90.6
Annual Indicator	37.9	40.1	39.4	39.4	32.3
Numerator	27,572	29,031	28,955	28,955	24,569
Denominator	72,769	72,337	73,461	73,461	76,007
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2019	2020	2021	2021	2023

State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		32	33	90.5	90.6
Annual Indicator	92	89.5	79.2	79.2	
Numerator					
Denominator					
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	
Data Source Year	2019	2020	2021	2021	
Provisional or Final ?	Final	Final	Final	Final	

2021-2025: NPM - C) Percent of infants placed to sleep without soft objects or loose bedding - SS

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	46	48	50	76.8	77
Annual Indicator	44.8	50.2	53.3	53.3	73.6
Numerator	32,496	36,072	39,426	39,426	55,764
Denominator	72,533	71,863	73,951	73,951	75,770
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2019	2020	2021	2021	2023

State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		48	50	76.8	77
Annual Indicator	76.7	80	52.9	52.9	
Numerator					
Denominator					
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	
Data Source Year	2019	2020	2021	2021	
Provisional or Final ?	Final	Final	Final	Final	

2021-2025: NPM - D) Percent of infants room-sharing with an adult during sleep - SS

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2024
Annual Objective	
Annual Indicator	80.6
Numerator	62,910
Denominator	78,036
Data Source	PRAMS
Data Source Year	2023

2021-2025: Evidence-Based or –Informed Strategy Measures

2021-2025: ESM SS.1 - Percent of hospitals receiving national recognition or implementing approved safe sleep policy

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		100	100	100	100
Annual Indicator		100	100	100	100
Numerator					
Denominator					
Data Source		TDH	TDH	TDH	TDH
Data Source Year		2021	2022	2023	2024
Provisional or Final ?		Final	Final	Final	Final

2021-2025: ESM SS.2 - Number of diaper bags with safe sleep educational materials distributed

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		663	676	690	704
Annual Indicator	1,636	1,928	1,932	1,011	1,200
Numerator					
Denominator					
Data Source	TDH	TDH	TDH	TDH	TDH
Data Source Year	2020	2021	2022	2023	2024
Provisional or Final ?	Final	Final	Final	Final	Final

2021-2025: State Performance Measures

2021-2025: SPM 4 - Percent of Tennessee newborns who initiated breastfeeding

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	80.7	81.2	81.7	82.2	83.8
Annual Indicator	80.6	81.2	81.1	83.3	82.2
Numerator					
Denominator					
Data Source	TDH PHA - Birth Statistical System	TDH PHA - Birth Statistical System	TDH PHA - Birth Statistical System	TDH PHA - Birth Statistical System	TDH PHA - Birth Statistical System
Data Source Year	CY2019	CY2020	CY2021	CY 2022	CY 2023
Provisional or Final ?	Final	Final	Final	Final	Final

2021-2025: 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

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective			47	50	52
Annual Indicator		45	44	30	26
Numerator					
Denominator					
Data Source		TDH EBHV and CHANT	TDH EBHV and CHANT	TDH EBHV and CHANT	TDH CHANT
Data Source Year		2021	2022	2023	2024
Provisional or Final ?		Final	Final	Final	Final

Priority: Increase Breastfeeding

MCH/Title V Funding: The breastfeeding priority team is administratively led by the Supplemental Nutrition section within the Division of Family Health and Wellness of the TDH. The Supplemental Nutrition section includes WIC, commodity supplemental food program, seniors' farmers market, and breastfeeding. Most of the breastfeeding initiation activities are funded by other federal grants and Tennessee's 24-hour breastfeeding hotline is partially funded by MCH/Title V. Additionally, the Deputy Director for the section is fully funded by MCH/Title V.

Interpretation of Performance Data on selected NPMs, SPMs, and SOMs:

SPM 4: Percent of Tennessee newborns who initiated breastfeeding.
Breastfeeding initiation among Tennessee newborns decreased from 83.3% in 2022 (Year 3) to 82.2% in 2023 (Year 4). This rate did not meet the fiscal year objective of an initiation rate of 83.8%.

Breastfeeding initiation rates in Tennessee decreased between Year 3 and Year 4 despite several targeted health policy and community-based interventions. In Year 3, rates may have been elevated due to the formula recall and resulting formula shortage. Tennessee's efforts to support breastfeeding mothers through local WIC offices and healthcare provider training, which focus on access to lactation support, have not fully offset the barriers affecting certain populations, leading to a decline in breastfeeding rates.

Although updates to workplace policies, including the Federal PUMP Act, aim to improve breastfeeding accommodations, many mothers still face challenges in initiating and continuing breastfeeding while balancing work responsibilities. As workplace support for breastfeeding improves with the implementation of the PUMP Act, mothers may be more confident in initiating breastfeeding knowing they will be able to continue when they return to work. Another improvement in lactation care in Tennessee is the implementation of TennCare covering lactation services for mothers. WIC staff across the state were educated on the details of the TennCare Lactation benefit at both the 2024 Tennessee Breastfeeding Symposium in June and WIC Field Staff in August of 2024.

Accomplishments and Challenges (based on FY2024 Action Plan):

Strategy 1: Cultivate a community of professional lactation support through education and training opportunities across health care disciplines

Supporting Evidence for Strategy 1: HCP from medically underserved areas and communities are more likely to care for patients from similar backgrounds, and a strong sense of group belonging has been shown to enhance task-related outcomes [1,2]

While physicians feel they received adequate education on lactation, patients report they do not receive sufficient information from their PCP. However, additional skill targeted education with HCPs is shown to improve knowledge, attitudes, and confidence related to lactation support.[3, 4] Increased breastfeeding rates for practices have also been documented.[5]

Increased presence of lactation counselors and other supports are shown to increase breastfeeding duration through the first year of life.[6,7] Staff training in advanced lactation provides community-wide lactation counseling through the local health departments and increases the access to lactation support across the state. Increased referral and use of the hotline are an added layer of access, especially in those areas with little access to lactation professionals.[8]

Activity 1a: Advertise the 20-hour lactation curriculum to health care providers that serve in communities with low breastfeeding engagement. Advertisement efforts will be prioritized for birthing hospital delivery staff at hospitals identified as serving a large non-Hispanic African American delivery

population.

Report 1a: The WIC population has a lower breastfeeding rate than the non-WIC population. Therefore, the first cohort of seven providers successfully completed this training by September 2024. TDH has a current partnership with the Philadelphia Department of Health to send TN providers to complete this 20-hour lactation curriculum at no cost to Tennessee. HCPs from various hospitals across the state have been invited to participate in this training. A new cohort will begin for Year 5.

Activity 1b: Provide advanced lactation training to WIC public health nutritionists and nursing staff within local health departments, focusing on rural areas with limited community breastfeeding support professionals.

Report 1b: The number of credentialed lactation professionals within WIC decreased from 147 in Year 3 to 142 in Year 4 (**ESM BF.1**). This number did not meet the fiscal year objective of 196 credentialed lactation professionals within WIC.

Several factors may have contributed to not meeting the Year 4 objective. (1) Vacant positions limited availability for existing staff to complete trainings for certification and recertification. (2) Existing online training continued to be challenging for staff to be successful due to technical barriers. (3) Limited in-person course offerings of an in-person CLS training in Tennessee.

During Year 4, 30 WIC credentialed lactation professionals renewed their certifications. State employees who obtain CLC or CLS certifications by passing the examination for certification may be eligible for a 5% increase in salary.

Activity 1c: Re-establish connection between birthing hospitals and Tennessee Breastfeeding Hotline services to ensure lactation support at discharge. Additional outreach to re-establish a connection with the hotline will be planned for birthing hospitals identified as serving a large non-Hispanic African American delivery population.

Report 1c: The vendor for the TN Breastfeeding Hotline, Pacify, attended, and participated in events across Tennessee in Year 4. They attended the annual TIPQC meeting and the Spring Tennessee Breastfeeding Coalition meeting in March 2024. They presented at the 2024 Tennessee Breastfeeding Symposium, an event supported by the Tennessee Breastfeeding Coalition and the Office of Minority Health in the Division of Health Disparities Elimination. Tennessee has begun collaborating with Pacify on the implementation of the Pacify app, which will allow families across the state to connect to a Lactation Consultant at any time via video call or text messages.

Activity 1d: Engage at least four birthing hospitals to conduct a needs assessment in order to gather information on their training needs, barriers, perceived dignity of staff, and healthcare workers perceptions of doulas

Report 1d: Tennessee has six doula pilot sites and two of them are with birthing hospitals: West Tennessee Healthcare Jackson-Madison County General Hospital (JMCGH) and Vanderbilt University Medical Center (VUMC). The pilot ended June 2025 and breastfeeding data and qualitative workforce data will be analyzed in FY26.

Challenges Issues Related to Implementation of Strategy 1: Challenges related to implementing Strategy 1 include limited staffing, lack of in-person training opportunities, and technical barriers to completing online trainings.

Strategy 2: Re-enforce lactation policies that positively influence breastfeeding practices in the workplace

Supporting Evidence for Strategy 2: Within the community, partnerships are vital to create system and environmental change.[9, 10] **"**Effective workplace breastfeeding interventions activate three mechanisms: 1) awareness of the intervention, 2) changes in workplace culture, manager/supervisor support, co-worker support and physical environments, and 3) provision of time.**"** [11] By systematically evaluating and addressing the barriers to workplace accommodations TDH will improve workplace support in areas with low access to supports[12, 13] and promote those businesses with best practices[10].

Activity 2a: Assess workplace lactation policies for businesses with BFWH designation

Report 2a: The number of Breastfeeding Welcomed Here (BFWH)- designated businesses with ideal workplace lactation policies was not assessed in Year 4. During Year 3, the PUMP Act was passed which mandates employers to provide nursing employees with reasonable break times and private, comfortable spaces for expressing breast milk, ensuring a more accommodating workplace. With the passing of the PUMP Act, lactation policies that were formerly considered ideal in our survey tool are now mandated policies. The survey tool must be updated to reflect the new mandatory and ideal workplace lactation policies.

Activity 2b: Acknowledge BFWH-designated businesses that have established lactation workplace policies for employees

Report 2b: The BFWH website lists 1,281 businesses that continue to be recognized:

- Demonstrate their support for breastfeeding;
- Make a commitment through a pledge;
- Display the BFWH window decal visibly.

This decal helps moms identify public locations where they can breastfeed comfortably and encourages the perception that breastfeeding is normal, accepted, and welcomed. By taking the "Breastfeeding Welcomed Here" pledge businesses agree to provide an environment where breastfeeding mothers are able to sit anywhere and enjoy a welcoming attitude from staff, management, and other patrons while breastfeeding.

The number of Breastfeeding Welcomed Here (BFWH)- designated businesses with ideal workplace lactation policies (**ESM BF.2**) was not assessed in Year 4.

Activity 2c: Promote Breastfeeding Welcomed Here (BFWH) designation in rural areas and among businesses

Report 2c: A recognition process for BFWH-designated businesses was not implemented in Year 4 (**ESM BF.3**).

A recognition process for Breastfeeding Welcomed Here (BFWH)-designated businesses was not implemented in Year 4.

Activity 2d: Create marketing and education materials for Tennessee workplaces that reflect new workplace lactation policies put into place by the PUMP Act

Report 2d: The Department of Labor provides materials regarding the new PUMP Act workplace

lactation policies for TN workplaces (**ESM Materials regarding new PUMP Act workplace lactation policies created for TN workplaces**).

Challenges Issues Related to Implementation of Strategy 2: During Year 4, limited staffing was a challenge to move strategies forward.

Update on Other Perinatal/Infant Health Programs Supported by MCH/Title V:

Breastfeeding Hotline: The Tennessee Breastfeeding Hotline, staffed by International Board-Certified Lactation Consultants (IBCLC), is available to nursing mothers and partners, their families, expectant mothers, and health care providers seeking breastfeeding support and information. The Tennessee Breastfeeding Hotline operates 7 days a week, 24 hours a day. WIC offices and birthing hospitals provide hotline palm cards and magnets to families. Individuals are welcome to call the Tennessee Breastfeeding Hotline anytime they need support, regardless of language barriers. Interpretative services available directly include Spanish, French, Arabic, and Mandarin. The Tennessee Breastfeeding Hotline provides accurate, up-to-date information for common breastfeeding issues. Call volume to the Tennessee Breastfeeding Hotline decreased from 4,191 calls in Year 3 to 3,786 calls in Year 4. The decrease in call volume from Year 3 to Year 4 was due to the formula shortage in Year 3.

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Priority: Decrease Infant Mortality

MCH/Title V Funding: The infant mortality priority team is administratively led by the Perinatal, Infant, and Pediatric Care section within the Division of Family Health and Wellness of TDH. The Perinatal, Infant, and Pediatric Care section includes newborn screening (NBS), childhood lead poisoning prevention, and perinatal regionalization. Infant mortality reduction efforts are funded by state and other federal funds. While MCH/Title V does not directly fund the infant mortality reduction activities highlighted in the annual report, funds are used to partially support programs within this section, including newborn screening and childhood lead poisoning. The MCH/Title V block grant fully funds the Section Chief, the perinatal regionalization program director, the hearing program director, and two administrative assistants, and it also partially funds three NBS administrative assistants in the Perinatal, Infant, and Pediatric Care section.

Interpretation of Performance Data on selected NPMs, SPMs, and SOMs:

Safe Sleep NPM 5A: Percent of infants placed to sleep on their backs
In FY2024, 95.0% of all infants in Tennessee were placed to sleep on their backs. This measure is 15.0% points higher than FY2023's (80.0%) value and more than the projected objective for FY2024 (86.0%). It should be noted that data reported for Years 1-3 were collected using the PRAMS Phase 8 questionnaire. With the implementation of the Phase 9 questionnaire in 2023, PRAMS introduced slight changes to both the phrasing of the question and the available response options. The change in the percentage could be partially due to the modifications made to the survey questionnaire.
The increase in the percentage of infants placed to sleep on their backs from 80% in 2022 to 95% in 2023 may be attributed to several factors. Enhanced public awareness campaigns, including PSAs, social media outreach, and community-based messaging, have likely reinforced safe sleep recommendations. The expanded distribution of safe sleep resources, such as sleep sacks, portable cribs, and educational materials through partnerships like the Safe Sleep Collaborative, may have also contributed to this improvement. Increased engagement with healthcare providers, hospitals, and home visiting programs has helped ensure consistent and frequent safe sleep messaging at key intervention points, such as prenatal visits and hospital discharge. Additionally, the transition from the Phase 8 to Phase 9 PRAMS questionnaire may have influenced how responses were collected or interpreted, impacting the reported percentage. Localized initiatives, including community baby showers and targeted interventions in high-risk areas, as well as the integration of safe sleep education into maternal and child health programs, have further reinforced safe sleep practices among parents and caregivers. While the increase is promising, further analysis is needed to determine whether this reflects a true behavior change or is influenced by differences in data collection methodology.

Safe Sleep NPM 5B: Percent of infants placed to sleep on a separate approved sleep surface
The proportion of infants that slept on approved surface (i.e., crib, bassinet, or Pack & Play) in FY2024 was 93.9%, the highest value in 4 years. In comparison to the prior year, the FY2024 value is 2.7% points higher than the FY2023 (91.2%) value and 3.3% points higher than the FY2024 objective of 90.6%. It should be noted that data reported for Years 1-3 were collected using the PRAMS Phase 8 questionnaire. With the implementation of the Phase 9 questionnaire in 2023, PRAMS introduced slight changes to both the phrasing of the question and the available response options. The change in the percentage could be partially due to the modifications made to the survey questionnaire.

The increase in the percentage of infants placed to sleep on a separate approved sleep surface from 91% in 2022 to 94% in 2023 may be attributed to ongoing safe sleep education efforts and increased access to resources. Targeted outreach through healthcare providers, home visiting programs, and hospital discharge education has reinforced the importance of using a safe sleep environment. The distribution of portable cribs through programs like the Safe Sleep Collaborative has likely helped families who may not have had access to a separate approved sleep surface. Additionally, public awareness campaigns, including social media messaging, community baby showers, and partnerships with maternal and child health programs, have played a role in promoting safe sleep environments. While the increase is encouraging, continued monitoring is necessary to assess whether this trend reflects sustained

behavior change or potential shifts in data collection methods. Additionally, the transition from the Phase 8 to Phase 9 PRAMS questionnaire may have influenced how responses were collected or interpreted, impacting the reported percentage.

Safe Sleep NPM 5C: Percent of infants placed to sleep without soft objects or loose bedding
In FY2024 92.5% of infants were placed to sleep without soft objects or loose bedding. This increased 4.2% points compared to FY2023 (88.3%). The FY2024 percentage was 15.5% points higher than the FY2024 objective of 77.0%. It should be noted that data reported for Years 1-3 were collected using the PRAMS Phase 8 questionnaire. With the implementation of the Phase 9 questionnaire in 2023, PRAMS introduced slight changes to both the phrasing of the question and the available response options. The change in the percentage could be partially due to the modifications made to the survey questionnaire.

The increase in the percentage of infants placed to sleep without soft objects or loose bedding from 88% in 2022 to 93% in 2023 may be attributed to ongoing safe sleep education efforts and increased awareness among caregivers. Programs promoting safe sleep practices, including hospital-based education at birth, home visiting programs, and community outreach, have reinforced the risks associated with soft objects and loose bedding in the sleep environment. Additionally, statewide campaigns using social media, educational materials, and direct engagement with families have helped clarify safe sleep recommendations. The distribution of safe sleep resources, such as educational brochures and sleep sacks, may have also contributed to behavior change. While this increase is encouraging, continued efforts are necessary to sustain this progress and ensure consistent messaging reaches all caregivers. While the increase is encouraging, continued monitoring is necessary to assess whether this trend reflects sustained behavior change or potential shifts in data collection methods. Additionally, the transition from the Phase 8 to Phase 9 PRAMS questionnaire may have influenced how responses were collected or interpreted, impacting the reported percentage.

Risk-Appropriate Perinatal Care NPM: Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)
The percent has changed little from the previous year (83%), although there was a slight decline to 82%. The State will continue with perinatal regionalization efforts and quality improvement initiatives with hospitals to reach the target.

It is possible that the decline in percent can be contributed to the number of prenatal care deserts in rural counties in Tennessee. Access to care remains a significant problem for families.

Accomplishments and Challenges (based on the FY2024 Action Plan):

Strategy 1: Reduce infant sleep-related deaths, with outreach focused on regions with the highest infant mortality rates and numbers and the highest reported number of sleep-related deaths.

Supporting Evidence for Strategy 1: There is emerging evidence to suggest hospitals implementing a safe sleep policy will reduce sleep-related deaths. There is also emerging evidence to suggest educating caregivers will change their behavior.

Activity 1a: Increase the percent of birthing hospitals recognized as a National Cribs for Kids certified hospital or with an approved safe sleep policy that aligns with the AAP Safe Sleep Recommendations.

Report 1a: During this reporting cycle, Tennessee achieved several key milestones in advancing safe sleep practices statewide. A significant accomplishment was the strategic transition from Best for Babies initiative to aligning with the National Cribs for Kids Certification program. This shift underscored the state's commitment to standardized, evidence-based approaches to safe sleep practices and set the stage for long-term

improvements.

To support this transition, the Infant Mortality team conducted a comprehensive assessment of Tennessee birthing hospitals, identifying those already certified through the Cribs for Kids program. This foundational work aims to inform the future development of a Tennessee-specific safe sleep toolkit, which will provide hospitals with resources to achieve certification and sustain safe sleep practices. Additionally, the team plans to implement a safe sleep and knowledge-based survey for birthing hospitals to better understand their needs and inform targeted support.

The state has also set an ambitious goal of achieving 80% hospital certification through the Cribs for Kids program. By strengthening partnerships with healthcare providers and hospital networks, Tennessee is establishing a strong foundation to enhance hospital participation in safe sleep initiatives and achieve long-term goals in reducing infant mortality.

In FY24, the percentage of Tennessee hospitals receiving national recognition through the Cribs for Kids Certification or implementing an approved safe sleep policy (**ESM SS.1**) decreased by 5%, going from 40% in FY23 to 38% in FY24.

This decrease can be attributed to several factors. During this reporting cycle, Tennessee transitioned from the Best for Babies initiatives to align more closely with the National Cribs for Kids Certification program. While this strategic shift established a foundation for standardized safe sleep practices, it temporarily disrupted hospital participation as the state focused on identifying certified hospitals and developing a Tennessee-specific plan to support future certification efforts. This plan includes working closely with the Tennessee Hospital Association (THA), developing and implementing a survey to evaluate hospital safe sleep practices and knowledge, and developing and implementing a toolkit.

Additionally, the National Cribs for Kids program introduced more stringent criteria and updated requirements which may have introduced new or more rigorous requirements, making it challenging for some hospitals to qualify or maintain their certification. Resource constraints, such as staffing shortages and limited funding, further hindered some hospitals from meeting or sustaining certification requirements.

Despite this short-term decline, the Infant Mortality team has focused on long-term improvements, setting an ambitious goal of achieving an 80% hospital national recognition rate. The development of a Tennessee-specific toolkit and promotion strategy aims to increase hospital participation and address existing barriers. These efforts, coupled with a commitment to aligning with national standards, are expected to drive substantial progress in meeting and exceeding the ESM target in future years.

Activity 1b: Improve infant caregiver safe sleep behaviors through the education provided by the safe sleep diaper bag project in Evidence Based Home Visiting Programs and care coordination (CHANT) programs.

Report 1b: During this reporting cycle, several key accomplishments were made in advancing safe sleep education through the distribution of diaper bags containing educational materials. The program distributed 1,200 diaper bags, far surpassing the target of 704. This increase reflects a significant expansion in outreach efforts, indicating strengthened distribution channels and enhanced partnerships across the state. Compared to the

previous year's distribution of 1,011 bags, this surge in numbers demonstrates the growing success of the program. Since this activity has consistently surpassed its target, the goal has been increased by 105 bags, bringing the new target for the Year 5 to 1,696.

The increase in diaper bag distribution also highlights the program's effective outreach and engagement with CHANT and EBHV. These collaborations have ensured that more families received vital safe sleep education, fostering greater awareness of safe sleep practices.

Data collection methods also shifted during this reporting cycle, with CHANT being the sole program collecting information on behavioral changes in safe sleep practices. As a result, 26% of recipients reported improvements in their infant's sleep practices, a slight decrease from 30% in the previous year. While this reduction in reported behavior changes is noteworthy, it is important to recognize that this data reflects a smaller, focused sample due to change in reporting methodology.

Additionally, during this reporting cycle, the program has been researching more effective and engaging items to add to the diaper bags in order to enhance the promotion of safe sleep in Tennessee. Potential additions include better quality onesies with safe sleep messaging that are more likely to be used and retained by families, data-driven educational materials tailored to specific communities and risk factors, and visually engaging safe sleep materials. The goal is to incorporate these new items into the diaper bags by the next reporting cycle, further improving their reach and effectiveness in promoting safe sleep practices. Despite the decrease in reported behavioral changes, the overall success in distributing educational materials demonstrates the program's ongoing commitment to promoting safe sleep practices and reducing infant mortality. The program's ability to exceed its distribution goals provides a solid foundation for further growth, ensuring continued expansion and impact in future cycles. Through continued collaboration and a focused effort on reaching more families, the initiative remains poised to strengthen its impact on safe sleep education across Tennessee.

In FY24, 1,200 diaper bags containing safe sleep educational materials (**ESM SS.2**) were distributed, reflecting a 19% increase from the 1,011 bags distributed in FY23. This total exceeded the target of 704 by 496 bags, or 70.5%. This increase in diaper bag distribution demonstrates enhanced program outreach and engagement, likely supported by improved distribution processes or expanded partnerships.

Despite this success, the percentage of recipients reporting a behavioral change in their infant safe sleep practices, based on data from CHANT, decreased slightly from 30% in the last reporting cycle to 26% during this reporting cycle. This decline is primarily attributed to changes in data collection methods. During this reporting period, only CHANT (Community Health Access and Navigation in Tennessee) program collected data on behavioral changes as the Evidence-Based Home Visiting (EBHV) program ceased reporting on this measure due to the adoption of a new reporting system. EBHV home visitors provide families with evidence-based information on safe sleep recommendations throughout services, beginning in pregnancy and adjusting guidance as the child grows. Some home visitors may use dolls or visual flip charts to demonstrate safe sleep setups. They also connect families with resources such as cribs or pack-n-plays when needed. Additionally, home visitors observe the family's current sleep environment, discuss challenges they may face in following safe sleep guidelines, and

explore realistic solutions that support safe sleep practices.

EBHV data indicates that 1,271 of 2,300 children aged 12 months or less were reported to be practicing safe sleep at home. These children were consistently placed to sleep on their backs, without bed-sharing, and without soft bedding.

While diaper bag distribution has clearly exceeded expectations, the decline in reported behavioral changes highlights the need for consistent and comprehensive data collection across all participating programs. Addressing these limitations and expanding efforts to measure the effectiveness of safe sleep educational materials will be crucial to sustaining and building on the program's success in future reporting cycles.

Activity 1c: Identify and engage new community partners with trusted ties to areas with high infant mortality.

Report 1c: In February 2024, the Tennessee Department of Health launched the Safe Sleep Collaborative, a key initiative aimed at fostering multidisciplinary collaboration to address sleep-related infant deaths in disproportionately impacted communities. The Collaborative's mission is to bring together state agencies, community partners, and hospitals to enhance existing efforts and develop new initiatives focused on Sudden Unexpected Infant Death (SUID) prevention. Through these efforts, the Collaborative seeks to disseminate safe sleep education and materials, support community needs assessments and provide strategic feedback on a Safe Sleep Strategic Plan, which will be implemented following the completion of the community needs assessment.

During this reporting period, the Safe Sleep Collaborative convened twice, providing a platform for robust discussions and connections among key stakeholders. While the Safe Sleep Needs Assessment Contract could not be finalized within the reporting cycle, plans are in place to execute this contract during the next cycle to further guide prevention efforts.

The TDH Fetal and Infant Mortality Program successfully identified and engaged 27 new community partners across Tennessee, strengthening ties with trusted organizations serving communities with high infant mortality. This includes two partners in the West Region, three in Shelby County, three in Davidson County, seven in the East Region, and four in the Mid-Cumberland Region. Additionally, eight statewide organizations with broad-reaching services were engaged to amplify safe sleep messaging and resources. These accomplishments reflect a significant step forward in building a collaborative network to support disproportionately impacted communities and advance SUID prevention across Tennessee.

The Tennessee Department of Health Safe Sleep Collaborative partners participated in over 50 events during this reporting period. These events included baby showers, health fairs, and other community outreach initiatives, providing opportunities to distribute safe sleep materials and engage directly with communities. These activities demonstrated a strong commitment to increasing awareness and education about safe sleep practices in disproportionately impacted areas in Tennessee.

Activity 1d: Broadcast public service announcements.

Report 1d: From December 12, 2023, to March 31, 2024, the Safe Sleep PSA campaign strategically targeted high-indexing SUID zip codes across Tennessee. The campaign focused on reaching new parents with messaging to address differences in health

outcomes and promote safe sleep practices. By emphasizing communities at the highest risk, the campaign aimed to reduce infant mortality outcomes.

The campaign leveraged both traditional and streaming media to maximize reach and engagement. It delivered an impressive 6.7 million (6,749,893) impressions, including 4.6 million (4,609,376) impressions through traditional TV, achieving a 63% reach of the target audience with an average frequence of 4.5. Additionally, 2.1 million (2,140,517) impressions were delivered via streaming platforms, demonstrating a strong multi-channel approach to reaching broad audiences.

Engagement metrics from streaming platforms underscored the campaign's impact, with 16,802 hours spent interacting with safe sleep videos. Notably, 93% of video impressions were viewed in full, indicating a strong audience connection to the content. Streaming impressions were primarily delivered via Connected TV (62%), ensuring the message was seen in high-quality, premium content environments popular among target demographics.

Placement in premium content such as Investigation Discovery, HGTV, Paramount+ (Sports and Entertainment), and Tubi TV further ensured the campaign reached a wide yet relevant audience.

The campaign's success was supported by a partnership with Comcast, which provided robust delivery across traditional and streaming TV platforms. Comcast detailed reporting allowed for precise measurement of the campaign's reach and effectiveness, demonstrating the value of collaboration in achieving public health goals.

Challenges Issues Related to Implementation of Strategy 1: One key challenge in implementing this strategy was the temporary decline in percentage of hospitals achieving Cribs for Kids Certification, which dropped from 40% in 2023 to 38% in 2024. This was due to the transition from the Best for Babies initiatives to a more rigorous alignment with the Cribs for Kids program, which introduced updated requirements and disrupted hospital participation. Additionally, resource constraints such as staffing shortages and limited funding impacted some hospitals' ability to qualify or maintain certification. Another challenge was the change in data collection methods for evaluating the impact of diaper bags containing safe sleep educational materials. During this reporting cycle, only the CHANT program collected data on behavioral changes in infant sleep practices, as the EBHV program transitioned to a new reporting system and ceased reporting on this measure. This shift reduced the number of data sources, resulting in slight decline in the percentage of recipients reporting behavioral changes, from 30% in the previous cycle to 26% in this reporting cycle. Furthermore, while the Safe Sleep Collaborative convened to foster multidisciplinary collaboration, delays in finalizing Safe Sleep Needs Assessment Contract hindered progress. Despite these challenges, the program continued to strengthen partnerships, distribute educational materials, and develop tools to support future growth and long-term impact.

Strategy 2: Improve perinatal health outcomes through quality improvement and regionalization efforts.

Supporting Evidence for Strategy 2: A 2017 review of three online databases (Johns Hopkins University) showed moderate evidence for continuing education of hospital providers plus state guidelines/policy. Tennessee Initiative for Perinatal Quality Care (TIPQC) projects educate hospital providers. Tennessee has had regionalization guidelines in place for decades for all levels of perinatal care and for both obstetrics and neonatal care.

Activity 2a: Support quality improvement collaborative projects for hospitals regarding care for high risk maternal and/or neonatal patients.

Report 2a: During the period from October 1, 2023, to September 30, 2024, TIPQC engaged 42 hospitals in significant maternal, infant, and neonatal initiatives. The Tennessee Tiniest Babies projects have shown an initial 15% reduction in infant mortality for level III and IV NICUs caring for these tiniest babies. Statewide c-sections have also been reduced due to the Promotion of Safe Vaginal Deliveries project. TIPQC also conducted workshops and webinars for over 200 health care professionals, partnering with the American Academy of Pediatrics, Spinning Babies, and March of Dimes. Community outreach programs increased participation in health screenings and educational sessions by 25% through local partnerships. Throughout these initiatives, TIPQC collaborated with various partners, including hospitals, the Tennessee Department of Health, AWHONN, and local health care providers, fostering a strong network aimed at improving maternal and infant health across Tennessee. TIPQC continued to expand its educational outreach, launching numerous podcasts and webinars, which reached a wide audience of health care professionals.

Key initiatives included:

- Promotion of Vaginal Delivery: Enhanced labor practices across 36 hospitals and trained staff on AWHONN POST BIRTH Warning Signs.
- TeamBirth Initiative: Launched with 5 hospitals to improve communication during labor.
- Cardiac Conditions in OB Care (CCOC): 3 hospitals piloted this project, and it is now being spread statewide to address cardiovascular disease in pregnancy and includes screening, identification, and a referral network across the state.
- Intraventricular Hemorrhage (IVH) Project: Involved 12 hospitals in collaborative learning for IVH prevention.
- Chronic Lung Disease (CLD) Project: 10 hospitals participating in the reduction of CLD and BPD.
- Lactation Workforce Training: Trained lactation consultants and nursing staff, benefiting over 200 professionals.

The number of participating hospitals (**ESM RAC.1**) increased from the previous year. However, it should be noted that the quality improvement projects vary from year to year; hospital participation is voluntary and dependent upon the topics being offered.

Challenges Issues Related to Implementation of Strategy 2: During the reporting year, TIPQC did not note any major challenges. However, if additional funding could be found, expansion of the projects and reach could be addressed.

Strategy 3: Reduce infant deaths due to prematurity and low birthweight by reducing infant exposure to tobacco.

Supporting Evidence for Strategy 3: The United States Preventive Services Task Force recommends providing behavioral interventions for cessation to pregnant women who use tobacco.

Activity 3a: Support tobacco cessation among women of childbearing age or individuals living with an infant < 1 year by providing nicotine replacement therapy (NRT) to individuals through the Tennessee Tobacco QuitLine.

Report 3a: In FFY 2024, GIFTS began including the Tennessee Tobacco QuitLine as an additional supportive resource to help pregnant women quit.

In FFY 2024, Tennessee's Tobacco QuitLine enrolled 295 women of childbearing age and individuals living with an infant under 1 year. This represents a slight decrease from FFY 2023 (n=323).

Activity 3b: Promote enrollment in the State's evidence-based pregnancy smoking cessation program to reduce smoking during pregnancy.

Report 3b: In FFY 2024, pop-up banners were created for display in every local health department to promote GIFTS. Additionally, rack cards were developed for dissemination in the community and among potential referring providers.

In FFY 2024, the Tobacco Control Program transitioned its prenatal smoking cessation program to a new vendor and program. During this period, the program enrolled approximately 12.7% of eligible women in Tennessee's prenatal smoking cessation program (**ESM SMK-Household.6**). This represents a relative decline from FFY 2023 (14.6%). This is likely due to limited enrollment and referrals as new processes had to be established with the transition to a new vendor & program.

Challenges Issues Related to Implementation of Strategy 3:
Challenges associated with this strategy include delays in promoting the GIFTS program following extensive revisions to the GIFTS program processes & protocols.

Update on Other Perinatal/Infant Health Programs Supported by MCH/Title V:

Child Fatality Review/SIDS Training: During this reporting cycle, significant progress was made within the Child Fatality Review program through the hiring of a Program Director 3 position, in April 2024, funded by the Maternal and Child Health Block Grant (MCHGB). This new role oversees both the Child Fatality Review Program and the Fetal and Infant Mortality Review Program, enhancing coordination and leadership across these critical initiatives. Additionally, guidance was provided to the program directors to support Strategy 1 activities within the Infant Mortality program, including efforts to strengthen program strategies and align activities with statewide goals. These collaborative efforts have ensured the programs remain focused on identifying and addressing the underlying causes of child fatalities and improving infant health outcomes across Tennessee. MTSU conducted extensive activities under its contract with TDH for Death Scene Investigation (DSI) and Sudden Unexpected Infant Death (SUID) initiatives. Training materials, including updated trainer and trainee guides, CDC SUIDI guidelines, and bereavement support resources, were reproduced and disseminated at lives sessions, local trainings, and through an online project website. Two live DSI trainings were held for first responders, engaging 109 participants and distributing 54 reenactment dolls. Additionally, two virtual train-the-trainer sessions were conducted, with 72 participants completing the training. MTSU facilitated online training opportunities for first responders year-round, with 341 individuals completing courses, and supported 38 local training sessions by providing materials and CEUs. In collaboration with TDH, MTSU hosted virtual Safe Sleep and Child Fatality conferences in May 2024, drawing over 140 participants. The program maintained an updated project website, ensuring access to training resources, schedules, and materials, further supporting education and prevention efforts.

NAS Surveillance: MCH/Title V funds partially support salaries for the NAS Surveillance staff. In 2023 the program was awarded a 4-year CDC grant to expand NAS surveillance capacity by incorporating additional data sources and medical records abstraction. The NAS Surveillance Program also aims to improve care coordination for infants and pregnant and postpartum women affected by substance use by utilizing its case management system and partnering with existing navigation programs.

Newborn Screening (Genetics and Hemoglobinopathies): The Newborn Screening program maintained a 99% screening rate for all infants born in Tennessee. The program created new parent education materials about newborn screening to be distributed by birthing facilities. The materials are available in English, Spanish, and Arabic. All

infants with a screen positive were referred to the regional genetic, endocrine, or hemoglobinopathy centers for diagnostic testing and treatment. All infants with a confirmed diagnosis of metabolic/genetic disorder, hearing loss, and CCHD are referred to Tennessee Early Intervention System (TEIS), Children's Special Services (CSS), and Family Voices PEARS for support services. Infants with confirmed metabolic/genetic disorders are also eligible for the Newborn Screening Long-term Follow-up program which began in January 2024 to follow children with confirmed disease up to age 10 for outcome data and support service enrollment.

Newborn Hearing Screening: The Newborn Hearing Follow-Up program maintained a 97% screening rate for all infants born in Tennessee that completed a newborn hearing screening before one (1) month of age. Infants who did not pass the newborn hearing screening were referred for a diagnostic evaluation, to be completed before three (3) months of age. All Infants who received a confirmed hearing loss diagnosis were referred to Tennessee Early Intervention System for early intervention services by six (6) months of age. In addition, all infants with a confirmed hearing loss were referred to Tennessee Disability Coalition, Family Voices PEARS, for enrollment in family support services.

Perinatal Regionalization: For federal fiscal year 2024, the Tennessee Perinatal Advisory Committee (PAC) made progress in enhancing maternal and neonatal health outcomes. The committee convened three times, fostering collaborations among health care providers, hospitals, and community organizations to strengthen the statewide perinatal care network. During these meetings, the PAC addressed crucial topics, including updates on TennCare, Perinatal Vital Statistics, vaccine recommendations for pregnancy, NRP training for EMS staff, newborn screening birth data, legislative updates, drug shortages, Perinatal Telehealth, and neonatal abstinence syndrome. The committee also approved the publication of the 8th edition of the social work manual. In addition, a workgroup reviewed and updated the Guidelines for Equipment, Supplies, and Training for EMS and Emergency Department Personnel. During this period, the five Perinatal Centers reported 122,978 outpatient consultation visits with health care providers and provided 9,050.5 hours of high-risk education for health care professionals, increasing their expertise of perinatal health topics. The Perinatal Program also secured supplemental funding for the Neonatal Resuscitation Program (NRP) eBook and certification exams for statewide use by the Centers with training EMS providers.

Tennessee Birth Defects Surveillance System: The MCH/Title V funds continued to support the Tennessee Birth Defects Surveillance System during the October 1, 2023 – September 30, 2024, timeframe in two ways. First, Title V funding supports the ongoing maintenance of the Program's internet case management system. This system links Birth Defects to the Newborn Screening and Neonatal Abstinence Syndrome programs to ensure programmatic alignment. Second, MCH/Title V funding also supplements salaries for the Birth Defects Program Director and Administrative Services Assistant.

Priority: Improve the Perinatal Regionalization System in Tennessee

Objective for Risk-Appropriate Perinatal Care: 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.

Evidence-Based or Informed Strategy Measure (ESM): Number of unique patients served by the perinatal telehealth pilot projects in Tennessee

The following strategies and activities are planned for October 1, 2025 to September 30, 2026:

Strategy 1: Improve perinatal health outcomes through quality improvement (QI) initiatives in birthing hospitals.

Supporting Evidence for Strategy 1: Implementing QI collaborative initiatives in birthing hospitals is an evidence-based approach to improve maternal and neonatal outcomes[1]. Tennessee is well-positioned to leverage this strategy to increase the percent of VLBW infants born in a hospital with a Level III+ NICU through the state's initiative for perinatal quality collaboratives (i.e., Tennessee Initiative for Perinatal Quality Care, TIPQC). TIPQC has engaged birthing hospitals since 2008 to drive improvements in perinatal care through data-driven QI initiatives[2]. Such QI collaboratives have been credited with improving birth outcomes for preterm infants in other states like California[3], and has the potential to improve birth outcomes for VLBW infants in Tennessee.

As of March 2025, nine evidence-based strategies have been identified to provide risk appropriate perinatal care for high-risk mothers and VLBW infants[4]. These strategies aim to increase the percentage of very low birth weight (VLBW) infants born in hospitals with a Level III+ Neonatal Intensive Care Unit (NICU). The evidence supporting these strategies is drawn from MCH Evidence Toolkits[5], indicating their effectiveness in advancing the National Performance Measure (NPM) by addressing the specific needs and challenges associated with VLBW infants and ensuring access to high-quality NICU care.

Activity 1a: Contract with TIPQC to implement quality improvement collaborative projects in hospitals to improve care for high risk maternal and neonatal patients.

Planned Partnerships: TIPQC is the state's perinatal quality improvement collaborative and has success in creating and implementing quality improvement projects with birthing hospitals across the state. TIPQC works in collaboration with the Perinatal Advisory Committee as well as the Regional Perinatal Centers and regularly provide update on QI initiatives at the Perinatal Advisory Committee Meeting.

Strategy 2: Improve perinatal regionalization system by enhancing emergency medical services (EMS)

Supporting Evidence for Strategy 2: Members of the Tennessee Perinatal Advisory Committee have been discussing concerns regarding the lack of access to obstetric services, especially in the rural counties, for Tennessee women. Currently, 54 out of 95 counties lack obstetric providers, and 27% of women in the state have no birthing hospital within a 30-minute radius, significantly higher than the national average of 9.7%[6]. In the United States, approximately 62,000 out-of-hospital births occur annually, and about 10% of newborns require assistance to breathe at birth[7]. EMS providers play a critical role for pregnant women in Tennessee, especially in rural areas. Tennessee has 19,000 EMS providers who potentially could provide services to high-risk infant and pregnant women. Currently, EMS standards do not require EMS providers to be trained or certified in Neonatal Resuscitation (NRP) or emergency vehicles to carry appropriately sized equipment necessary to care for very low birth weight infants. A quality improvement initiative in Southeast Texas demonstrated that formal NRP training for EMS significantly improved providers' confidence and competence in neonatal resuscitation and safe transport[8]. This finding suggests that NRP training for EMS providers and

safe transport is an effective strategy to improve newborn outcomes, ensuring that even when a VLBW infant is born during transportation, they receive appropriate care until they reach a Level III+ NICU.

Discussions and planning are ongoing with staff at the five Regional Perinatal Centers and with the EMS Board to address NRP training needs for the 19,000 EMS providers in Tennessee, and to request that the equipment standards for the emergency vehicles be updated to include those items necessary to care for a very low birth weight baby. Changing these standards will take some time for approval if the decision is made for the Board to move on these recommendations. All five Regional Perinatal Centers currently provide training on NRP for any health care providers in their region including EMS and emergency department staff; however, even though trainees are encouraged to take the certification exam, there is no funding to support this work, and many do not follow through. In addition, recertification is required every two years. Perinatal Cetner staff have identified the cost of the exam as a barrier to certification. Access to the training materials has been recently made available using one-time only workforce development federal funds to the Department for a two-year subscription to the eBook which can be accessed by all trainees statewide. However, the Department will need ongoing funding to continue to purchase the subscription.

EMS has faced a significant cultural shift over the years including an overall reduction in healthcare workforce, increased EMS requirements for training and education, as well as the heightened need and demand has led to a decline in volunteerism. This cultural shift has rural EMS agencies struggling to find trained staff and to retain them[9]. Additionally, the role of EMS professionals has expanded considerably, and they are now an integral part of the overall rural patient's healthcare needs. Therefore, the training and collaboration with educational institutions and the rural hospitals is vital to sustaining the rural EMS workforce and in improving risk appropriate perinatal care[10].

Activity 2a: Increase the number of Emergency Medical Services (EMS) providers receiving Neonatal Resuscitation (NRP) training, prioritizing rural areas and areas without local obstetric providers, through collaboration with the Regional Perinatal Centers and the EMS Board.

Activity 2b: Collaborate with local community colleges on workforce strategies and solutions that include training and education related to transport guidelines for high-risk pregnancy in the curriculum.

Activity 2c: Facilitate meetings with Tennessee Hospital Association (THA) and Tennessee Office of Rural Health (TORH) to explore activities to support education and training to EMS and emergency department (ED) staff at non-birthing rural hospitals on emergent maternal and perinatal care.

Planned Partnerships: The Tennessee Department of Health (TDH) works in collaboration with the five Regional Perinatal Centers to address training needs and provides limited workforce development funds for the certification examinations.

Strategy 3: Develop or expand perinatal telehealth services targeting areas with high rates of maternal and infant morbidity and mortality to improve health outcomes.

Supporting Evidence for Strategy 3: Current evidence shows that programs that integrate telehealth have consistently seen more high-risk babies delivered at high-level NICUs and corresponding decrease in neonatal or infant mortality and morbidity. One study of telehealth effect on VLBW deliveries in Arkansas showed that telehealth significantly decreased the rate of VLBW neonates delivered in hospitals without NICUs (from 13% to 7% in less than one year of telehealth interventions) and was associated with decreased infant mortality across the state[11]. Another study showed that a high-risk pregnancy telehealth program in Arkansas achieved a 0.5% reduction in 60-day infant mortality by increasing the proportion of low-birth-weight

infants delivered at a Level III hospital (from 38% to 42%;[12]). Findings from these studies validate decades of research showing that VLBW infants have better chances of survival when born at high-level NICUs.

By developing and expanding perinatal telehealth services in areas of high maternal and infant mortality, health systems in Tennessee can replicate the successes identified in other states, including identifying high-risk pregnancies earlier, coordinating timely transfers to Level III+ NICUs, and ultimately improving VLBW infant outcomes.

Activity 3a: Establish and expand perinatal telehealth pilot programs for high-risk obstetrical care in medically underserved areas or areas with high rates of maternal and infant morbidity and mortality.

Activity 3b: Create a system for data collection, monitoring and evaluation of the perinatal telehealth pilot programs.

Activity 3c: Share lessons learned, challenges, and successes from perinatal telehealth implementation at the Perinatal Advisory Committee (PAC) meeting and/or other state or national meetings as the program progresses and data become available.

Planned Partnerships: During 2025 fiscal year (FY25), the State allocated new funding through TN Strong Families to invest in Perinatal Telehealth. TDH has awarded a three-year grant to High Risk Obstetrical Consultants and Regional One Health at $3 million each for a total funding of $6 million. The purpose of the Perinatal Telehealth program is to develop or expand perinatal telehealth services in Tennessee targeting areas with high rates of maternal and infant mortality and morbidity to improve health outcomes. High Risk Obstetrical Consultants located in Knoxville will expand perinatal telehealth services in East Tennessee and Regional One Health located in Memphis will expand perinatal telehealth services in Tennessee counties North and West of Shelby County through a mobile healthcare unit and will begin seeing patients in April.

Contextual Factors:

- TIPQC has a long-standing history of creating, promoting and implementing quality improvement projects with Tennessee birthing hospitals.
- TIPQC projects only work with birthing hospitals and their health care providers and only reach indirectly into the community health care providers.
- Participation in quality improvement projects is not required and availability of resources can be a barrier.
- The perinatal telehealth program is new and limited to certain regions so statewide outcomes will be difficult to achieve.
- Changes to EMS requirements require a multi-collaborative approach and may take several years to accomplish.
- Training and education to EMS and ED staff at non-birthing hospitals requires hospital acceptance and willingness to support.
- Socioeconomic factors such as poverty and lack of health insurance coverage can influence the proportion of VLBW infants born in a hospital with a Level III+ NICU. Patients facing financial strain or lack of insurance may delay or avoid prenatal care, making it harder to get them into appropriate facilities in time.
- Social norms such as skepticism in adoption of perinatal telehealth for patients not accustomed to virtual or remote care may influence health outcomes for high-risk pregnant women and VLBW newborns.

Assumptions:

- Partnership with TIPQC, Regional Perinatal Centers, education systems, and the EMS Board can effectively address problems and foster relationships that we cannot.
- TIPQC's past experiences with QI projects show ability to succeed.
- Perinatal collaborative projects across the country continue to show improvement in birth outcomes.
- State funding has been annually allocated for the perinatal telehealth program and pilot projects will show successes and address barriers for future implementation.

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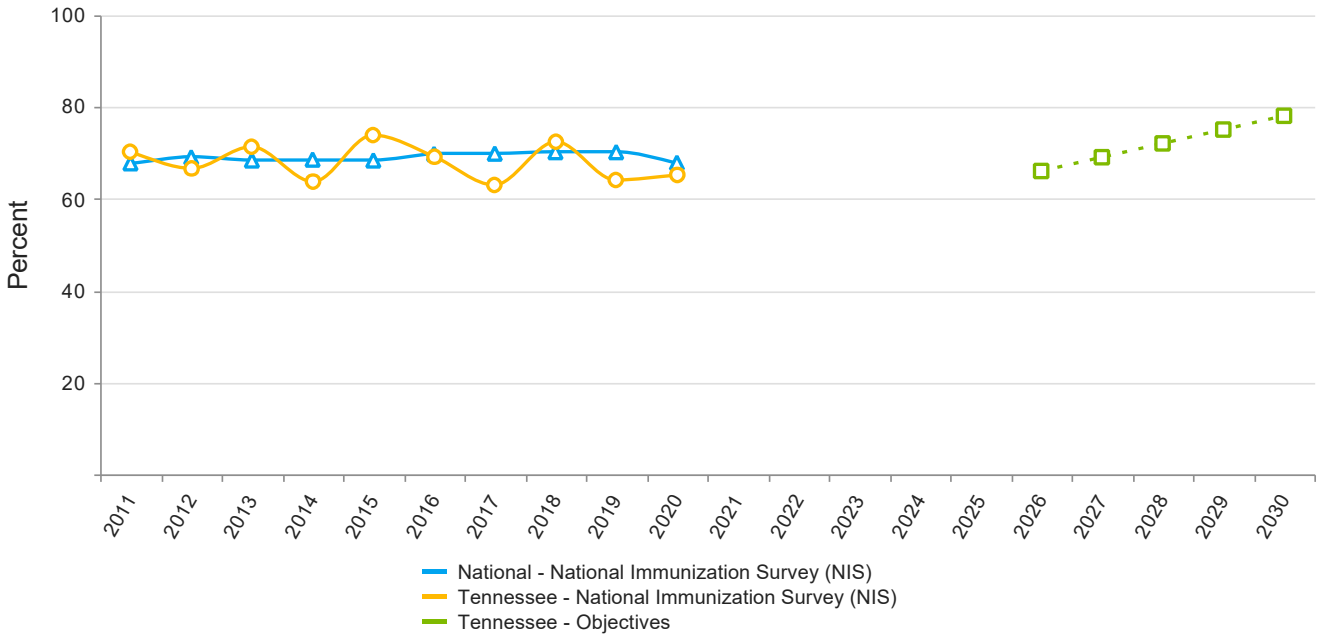
[12] PSNet (2020). Statewide Telehealth Program Enhances Access to Care, Improves Outcomes for High-Risk Pregnancies in Rural Area. Retrieved March 19, 2025, from https://psnet.ahrq.gov/innovation/statewide-telehealth-program-enhances-access-care-improves-outcomes-high-risk#:~:text=resulted%20in%20fewer%20medical%20complications%2C,The%20women%20in%20this%20program.

Child Health

National Performance Measures

NPM - Percent of children who have completed the combined 7-vaccine series (4:3:1:3*:3:1:4) by age 24 months - VAX_Child
Indicators and Annual Objectives



Federally Available Data	
Data Source: National Immunization Survey (NIS)	
	2024
Annual Objective	
Annual Indicator	65.3
Numerator	54,000
Denominator	82,000
Data Source	NIS
Data Source Year	2020

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	66.0	69.0	72.0	75.0	78.0

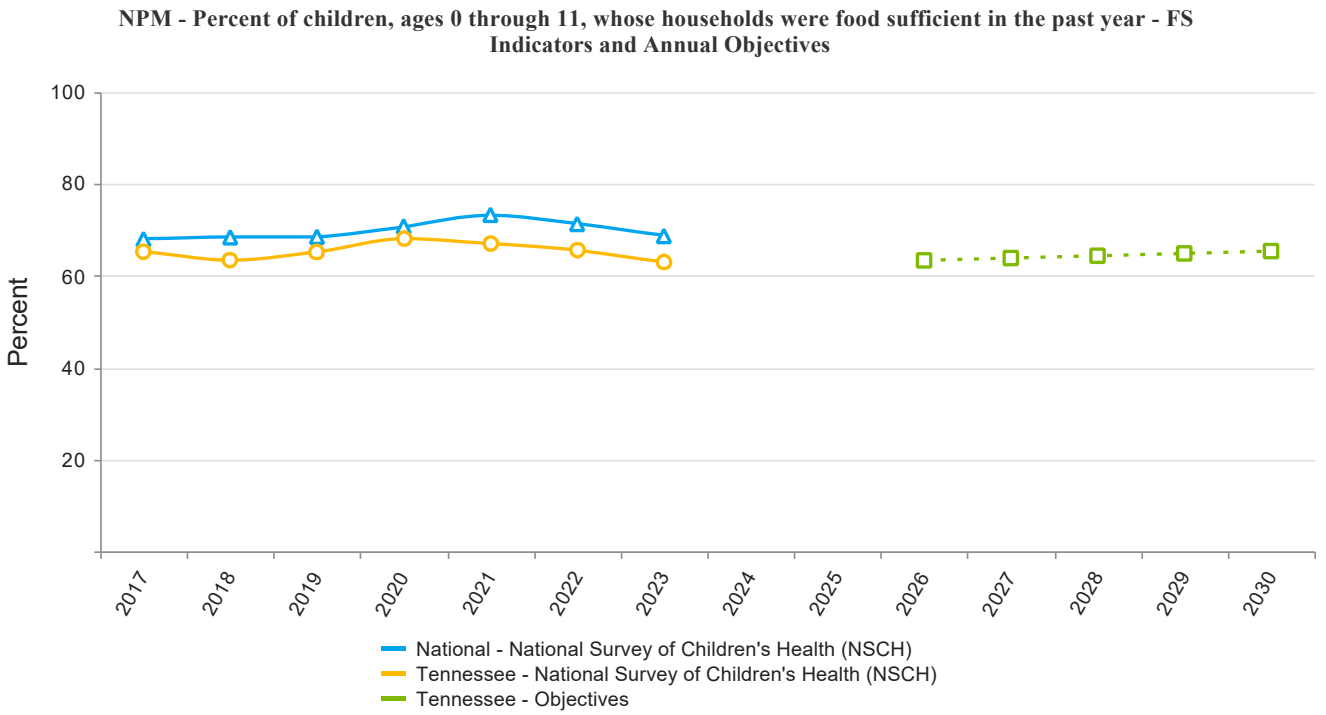
Evidence-Based or –Informed Strategy Measures

ESM VAX_Child.1 - Percent of participating staff reporting increased confidence in addressing vaccine hesitancy post-training

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	63.0	68.2	71.1	74.0	78.0



Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2024
Annual Objective	
Annual Indicator	62.8
Numerator	605,985
Denominator	964,449
Data Source	NSCH
Data Source Year	2022_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	63.3	63.8	64.3	64.8	65.3

Evidence-Based or –Informed Strategy Measures

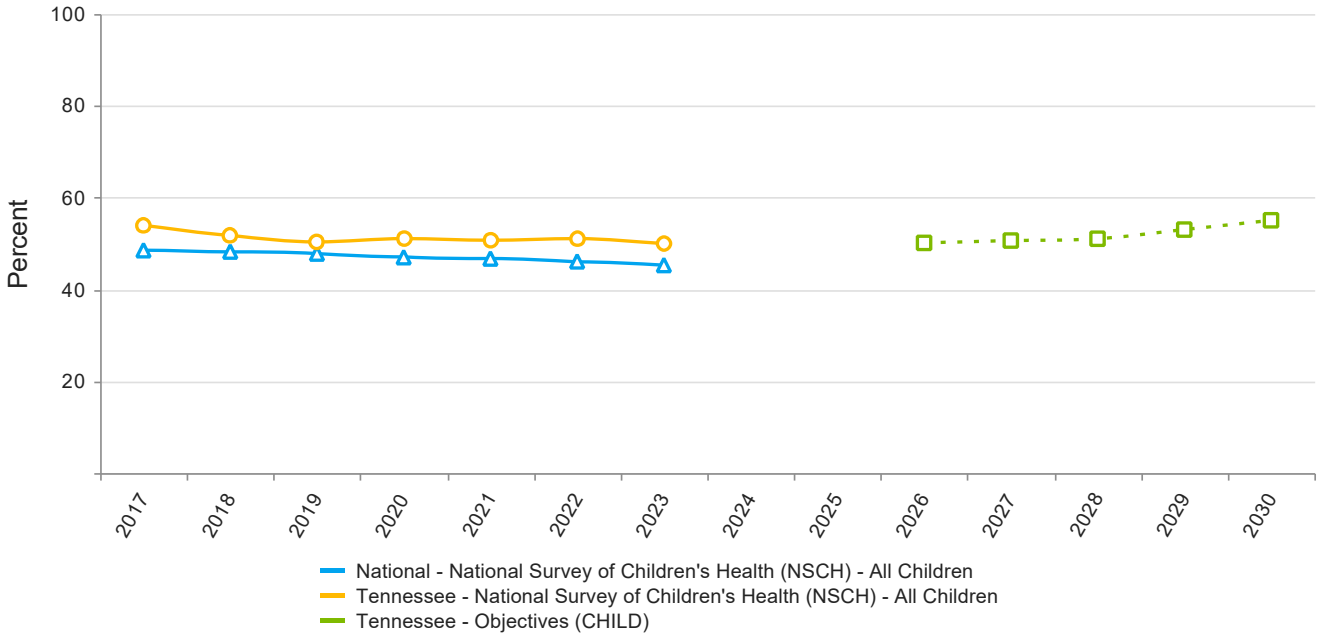
ESM FS.1 - Number of individuals referred to food assistance programs through FindHelp

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	25,000.0	27,500.0	30,000.0	32,500.0	35,000.0

NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - MH Indicators and Annual Objectives



NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - MH - Child Health - All Children

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH) - All Children		
	2023	**2024**
Annual Objective		
Annual Indicator	50.9	49.9
Numerator	771,791	764,731
Denominator	1,517,526	1,532,836
Data Source	NSCH-All Children	NSCH-All Children
Data Source Year	2021_2022	2022_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	50.1	50.6	51.0	53.0	55.0

Evidence-Based or –Informed Strategy Measures

ESM MH.1 - Number of CYSHCN who receive CHANT/CSS care coordination

Measure Status:	Inactive - Completed				
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		2,500	3,000	3,500	4,500
Annual Indicator		4,885	4,930	4,560	4,702
Numerator					
Denominator					
Data Source		PTBMIS	PTBMIS	PTBMIS	PTBMIS
Data Source Year		2021	2022	2023	2024
Provisional or Final ?		Final	Final	Final	Final

ESM MH.2 - Percent of providers adopting medical home approach

Measure Status:	Inactive - Completed				
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective			40	55	65
Annual Indicator			0	0	0
Numerator					
Denominator					
Data Source			N/A	N/A	N/A
Data Source Year			N/A	N/A	N/A
Provisional or Final ?			Final	Final	Final

ESM MH.3 - Percent of providers reporting increased knowledge on systems of care

Measure Status:	Inactive - Completed				
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective			20	30	40
Annual Indicator			0	0	0
Numerator					
Denominator					
Data Source			N/A	N/A	N/A
Data Source Year			N/A	N/A	N/A
Provisional or Final ?			Final	Final	Final

ESM MH.4 - Number of families provided education and resources on importance of medical home access and utilization

Measure Status:	Inactive - Completed				
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective					
Annual Indicator	1,383	1,424	1,749	1,527	1,824
Numerator					
Denominator					
Data Source	CHANT	CHANT	CHANT	CHANT	CHANT
Data Source Year	2020	2021	2022	2023	2024
Provisional or Final ?	Final	Final	Final	Final	Final

ESM MH.5 - Number of families receiving referrals to their child's primary care provider

Measure Status:	Inactive - Completed				
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		375	400	425	450
Annual Indicator	222	216	272	233	338
Numerator					
Denominator					
Data Source	CHANT	CHANT	CHANT	CHANT	CHANT
Data Source Year	2020	2021	2022	2023	2024
Provisional or Final ?	Final	Final	Final	Final	Final

ESM MH.6 - Percent of providers who report an increase in their knowledge of available resources

Measure Status:	Inactive - Completed				
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective			25	50	75
Annual Indicator			0	0	0
Numerator					
Denominator					
Data Source			N/A	N/A	N/A
Data Source Year			N/A	N/A	N/A
Provisional or Final ?			Final	Final	Final

ESM MH.7 - Percent of families who report an increase in access and utilization of resources

Measure Status:	Inactive - Completed				
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective			35	40	50
Annual Indicator			0	0	0
Numerator					
Denominator					
Data Source			N/A	N/A	N/A
Data Source Year			N/A	N/A	N/A
Provisional or Final ?			Final	Final	Final

ESM MH.8 - Percent of CHANT families who schedule an annual visit with their child's primary care provider

Measure Status:	Inactive - Completed				
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		25	35	45	55
Annual Indicator		3.2	16	13.9	16.5
Numerator					
Denominator					
Data Source		CHANT	CHANT	CHANT	CHANT
Data Source Year		2021	2022	2023	2024
Provisional or Final ?		Final	Final	Final	Final

ESM MH.9 - Percent of CYSHCN receiving CHANT care coordination who receive medical home education

Measure Status:	Inactive - Completed				
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective			75	85	20
Annual Indicator		5.4	16.2	10.9	16.9
Numerator					
Denominator					
Data Source		CHANT	CHANT	CHANT	CHANT
Data Source Year		2021	2022	2023	2024
Provisional or Final ?		Final	Final	Final	Final

ESM MH.10 - Number of teachers/school personnel trained on QPR

Measure Status:	Inactive - Completed	
State Provided Data		
	2023	**2024**
Annual Objective		
Annual Indicator	2,111	
Numerator		
Denominator		
Data Source	TDH	
Data Source Year	2023	
Provisional or Final ?	Final	

ESM MH.11 - Percentage of children with and without SHCN who are applying for health insurance

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	21.0	23.0	25.0	27.0	29.0

ESM MH.12 - Percentage of children with and without SHCN who schedule an exam with a primary care provider

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	39.0	42.0	45.0	48.0	51.0

State Action Plan Table

State Action Plan Table (Tennessee) - Child Health - Entry 1	
Priority Need	
Decrease Preventable Illness and Disease Among Children	
NPM	
NPM - Childhood Vaccination	
Five-Year Objectives	
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.	
Strategies	
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 least one event in each grand division.	
ESMs	**Status**
ESM VAX_Child.1 - Percent of participating staff reporting increased confidence in addressing vaccine hesitancy post-training	Active
NOMs	
Infant Mortality	
Postneonatal Mortality	
SUID Mortality	
Child Mortality	
Children's Health Status	

State Action Plan Table (Tennessee) - Child Health - Entry 2	
Priority Need	
Improve Nutrition Among Families	
NPM	
NPM - Food Sufficiency	
Five-Year Objectives	
Cross-Cutting	
Strategies	
Cross-Cutting	
ESMs	Status
ESM FS.1 - Number of individuals referred to food assistance programs through FindHelp	Active
NOMs	
School Readiness	
Children's Health Status	
Behavioral/Conduct Disorders	
Flourishing - Young Child	
Flourishing - Child Adolescent - CSHCN	
Flourishing - Child Adolescent - All	
Adverse Childhood Experiences	

State Action Plan Table (Tennessee) - Child Health - Entry 3

Priority Need

Decrease Preventable Illness and Disease Among Children

NPM

NPM - Medical Home

Five-Year Objectives

Increase the percentage of children with medical home from 49.9% on October 1, 2026 to 55% on September 30, 2030

Strategies

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.

ESMs	Status
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 - 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	Inactive
ESM MH.11 - Percentage of children with and without SHCN who are applying for health insurance	Active
ESM MH.12 - Percentage of children with and without SHCN who schedule an exam with a primary care provider	Active

NOMs

Children's Health Status

CSHCN Systems of Care

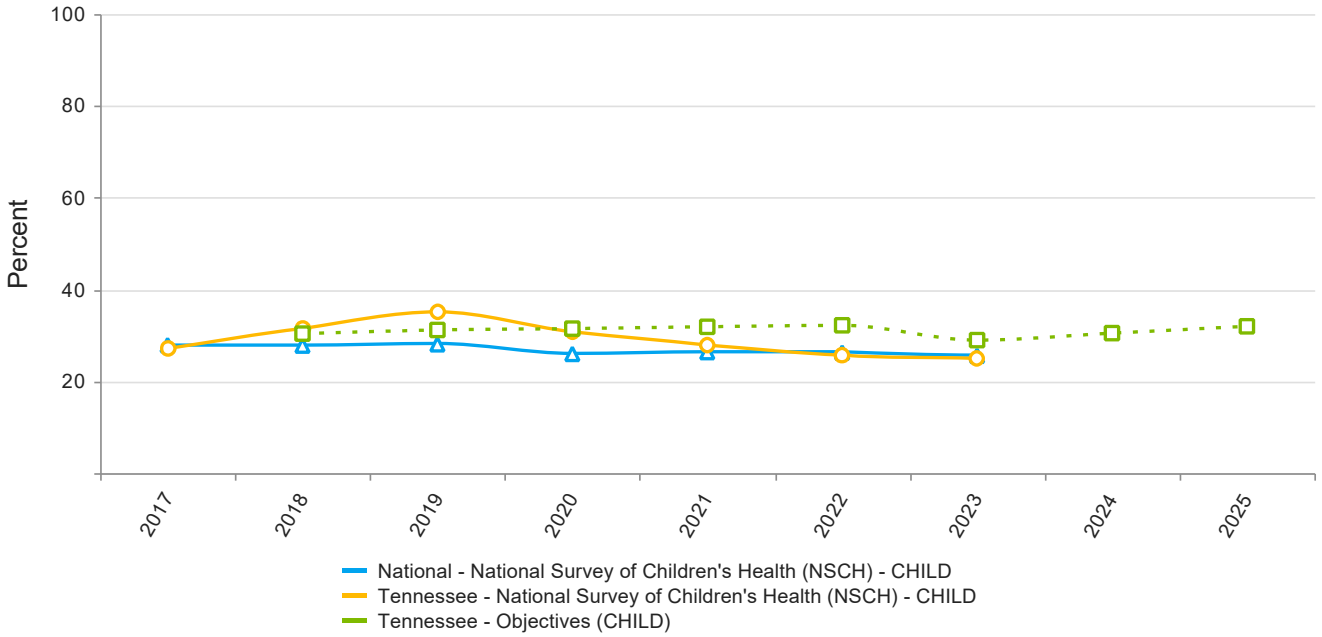
Flourishing - Young Child

Flourishing - Child Adolescent - CSHCN

Flourishing - Child Adolescent - All

2021-2025: National Performance Measures

2021-2025: NPM - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day - PA-Child Indicators



Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CHILD					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	31.5	31.9	32.2	29	30.5
Annual Indicator	35.2	30.6	27.7	25.6	25.1
Numerator	176,434	148,444	137,097	128,251	127,194
Denominator	500,965	485,754	495,348	501,349	506,739
Data Source	NSCH-CHILD	NSCH-CHILD	NSCH-CHILD	NSCH-CHILD	NSCH-CHILD
Data Source Year	2018_2019	2019_2020	2020_2021	2021_2022	2022_2023

2021-2025: Evidence-Based or –Informed Strategy Measures

2021-2025: ESM PA-Child.2 - Percentage of TN counties in which trainings related to mental health and physical health have occurred

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective			10	20	30
Annual Indicator			5.3	63.2	0
Numerator					
Denominator					
Data Source			TDH/CDHP Tracking Database	TDH/CDHP Tracking Database	N/A
Data Source Year			2022	2023	N/A
Provisional or Final ?			Final	Final	Final

2021-2025: ESM PA-Child.4 - Percent of LHD primary care clinics writing HPHP prescriptions annually

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective			25	40	60
Annual Indicator			57.1	44.6	19.6
Numerator					
Denominator					
Data Source			TDH	TDH	TDH
Data Source Year			2022	2023	2024
Provisional or Final ?			Final	Final	Final

2021-2025: ESM PA-Child.5 - Number of Healthy Parks Healthy Person prescriptions written

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		125	400	550	225
Annual Indicator	0	195	289	166	175
Numerator					
Denominator					
Data Source	TDEC HPHP Rx portal	TDEC HPHP Rx portal	TDEC HPHP Rx portal	TDEC HPHP Rx portal	TDEC HPHP Rx portal
Data Source Year	2020	2021	2022	2023	2024
Provisional or Final ?	Final	Final	Final	Final	Final

2021-2025: ESM PA-Child.6 - Percentage of TN counties with completed built environment projects

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		20	30	40	68
Annual Indicator		0	54	60	65
Numerator					
Denominator					
Data Source		OPP and Project Diabetes tracking databases	OPP and Project Diabetes tracking databases	OPP and Project Diabetes tracking databases	OPP and Project Diabetes tracking databases
Data Source Year		2021	2022	2023	2024
Provisional or Final ?		Final	Final	Final	Final

2021-2025: ESM PA-Child.7 - Percent of eligible venues offering the Double Up Food Bucks Program

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		35	45	55	94.5
Annual Indicator		0	76.2	88.9	90.5
Numerator					
Denominator					
Data Source		Nourish Knoxville tracking database	Nourish Knoxville tracking database	Nourish Knoxville tracking database	Nourish Knoxville tracking database
Data Source Year		2021	2022	2023	2024
Provisional or Final ?		Final	Final	Final	Final

2021-2025: ESM PA-Child.9 - Percent of families with improved protective factors score

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		50	52	54	56
Annual Indicator		49.9	50	47	48
Numerator					
Denominator					
Data Source		EBHV	EBHV	EBHV	EBHV
Data Source Year		2021	2022	2023	2024
Provisional or Final ?		Final	Final	Final	Final

2021-2025: ESM PA-Child.10 - Percent of families enrolled in CHANT care coordination who partially or fully complete pathways identified

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		41	42	43	47
Annual Indicator		42.6	45.2	46.1	46
Numerator					
Denominator					
Data Source		CHANT	CHANT	CHANT	CHANT
Data Source Year		2021	2022	2023	2024
Provisional or Final ?		Final	Final	Final	Final

2021-2025: ESM PA-Child.11 - Proportion of local education agencies (LEA) offered professional development on improving/maintaining moderate to vigorous physical activity in PE

Measure Status:		Active
State Provided Data		
	2023	**2024**
Annual Objective		
Annual Indicator	38.2	56.5
Numerator		
Denominator		
Data Source	TDE District Application Survey	TDE District Application Survey
Data Source Year	2023	2024
Provisional or Final ?	Final	Final

2021-2025: SPM 6 - Percent of schools with at least 50% physical education class time spent in moderate to vigorous physical activity

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		10	20	90.7	89
Annual Indicator		0	90.2	86.7	90.1
Numerator					
Denominator					
Data Source		N/A	2022 QPE Survey	2023 QPE Survey	2024 QPE Survey
Data Source Year		N/A	2022	2023	2024
Provisional or Final ?		Final	Final	Final	Final

2021-2025: SPM 8 - Percent of children with two or more ACEs

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	23	22.5	22	21.6	21.2
Annual Indicator	20.1	21.5	21.5	21.3	20.4
Numerator					
Denominator					
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2018	2020	2020	2021	2022
Provisional or Final ?	Final	Final	Final	Final	Final

2021-2025: SPM 9 - Percent of substantiated child maltreatment cases among families served by home visiting programs

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**

Annual Objective		0.3	3.3	3.2	2.2
Annual Indicator	4.2	1.5	3.2	2.4	1
Numerator					
Denominator					
Data Source	EBHV	EBHV	EBHV	EBHV	EBHV
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Final	Final	Final	Final	Final

2021-2025: SPM 24 - Rate of Double Up Food Bucks purchases per SNAP recipient

Measure Status:			**Active**
State Provided Data			
	2022	**2023**	**2024**
Annual Objective			32.6
Annual Indicator	18	50.9	39.1
Numerator			
Denominator			
Data Source	Nourish Knoxville tracking database and DHS SNAP d	Nourish Knoxville tracking database and DHS SNAP d	Nourish Knoxville database and DHS SNAP database
Data Source Year	2022	2023	2024
Provisional or Final ?	Final	Final	Final

2021-2025: State Outcome Measures

2021-2025: SOM 3 - Percent of public school 6th graders who are overweight or obese

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		43.3	44.8	47	46.5
Annual Indicator	43.6	45	47.4	45.6	0
Numerator					
Denominator					
Data Source	CSH BMI Report	CSH BMI Report	CSH BMI Report	CSH BMI Report	NA
Data Source Year	2017-2018	2019-2020	2021-2022	2022-2023	NA
Provisional or Final ?	Final	Final	Final	Final	Provisional

2021-2025: SOM 4 - Percent of WIC recipients aged 2-4 years who are overweight or obese

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective			31	27.5	26.5
Annual Indicator	31.2	32	28.7	28.7	27.7
Numerator					
Denominator					
Data Source	WIC	WIC	WIC	WIC	WIC
Data Source Year	CY 2020	CY 2021	CY 2022	CY 2022	CY2023
Provisional or Final ?	Final	Final	Final	Final	Final

Priority: Decrease Overweight and Obesity Among Children

MCH/Title V Funding: The children overweight and obesity reduction priority team is administratively led by the Chronic Disease Prevention and Health Promotion (CDPHP) section within the Division of Family Health and Wellness of TDH. The CDPHP section includes chronic disease, school health, tobacco prevention and control, diabetes and cardiovascular disease prevention and management, Project Diabetes (built environment and nutrition initiatives), the Preventive Health and Health Services block grant (PHHSBG), school health and wellness, and the Rape Prevention Education program. The section also housed the Gold Sneaker initiative, which is now retired due to state policy integration (See Strategy 2 below). In addition, CDPHP and MCH/Title V funding support other child health initiatives through a partnership with the Tennessee Poison Center (TPC). The childhood overweight and obesity reduction efforts are mostly funded by state and other federal funds; however, MCH/Title V funds are used to fund state school health nurse consultant position. Additionally, the Deputy Medical Director who provides leadership to this section is fully funded by MCH/Title V.

Interpretation of Performance Data on selected NPMs, SPMs, and SOMs:

Physical Activity NPM: Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

The Year 4 percentage of TN children ages 6-11 who are physically active for at least 60 minutes every day was 25.10% based on combined 2022-2023 data from the National Survey of Children's Health (NSCH). Although not statistically significant, this rate was a half-point increase (i.e., lower risk) compared to 2022 data and the first yearly increase during the 5-year cycle. Nonetheless, the 2022-2023 figure fell short of the Year 4 target by nearly one percentage point. There is still much progress to be made for the state to exceed the baseline value of 31.50% in Year 1. Despite the NSCH being the definitive source for MCH national performance and outcome measures, the state sample size is small even after combining years of data. Therefore, the confidence interval around percentages is fairly broad and the sensitivity for determining statistical significance is low for all but the most substantial differences in percentages.

Although the data do not show an improvement in the NPM, the partnership between TDH and the Tennessee Department of Education (TDOE) continues to be integral in providing professional development opportunities for school staff and public health educators. Trainings focused on Focused Fitness, Healthy Students Stronger Learners Community of Practice (CoP), Out of School Time (OST), and incorporating physical activities during class time.

SPM 6: Percent of schools with at least 50% physical education class time spent in moderate to vigorous physical activity

This is the third year of data collection and monitoring for this performance measure, as the question was added to the TDOE annual Quality Physical Education (QPE) survey in 2022. The Year 4 (2024) value of 90.91% exceeded the target of 89.00%. With such relatively high percentages overall, there would appear to be some year-over-year variability in this measure. Such variability is inevitable as the person completing the survey for each school may differ from year to year. Nonetheless, the Year 3 to Year 4 increase of over four percentage points is very encouraging and suggests that efforts to offer training to more Local Education Agencies (LEAs) related to moderate to vigorous physical activity in PE classes has had a positive impact. This result is the first annual increase in the measure during the current MCH cycle.

The strong partnership with TDOE contributed to the increase in the high rates observed for SPM 6. The Overweight and Obesity Among Children priority team facilitated several meetings with the TDOE Physical Activity/Physical Education State Coordinator to discuss program activities, collaborative efforts, professional development opportunities, performance measures, data collection, and survey revisions to support the MCHBG strategies and activities. The ability to incorporate relevant questions into the QPE, as well as the TDOE Annual Application (formerly the District Application survey) related to the work being conducted in the school, has been instrumental in measuring and reporting progress.

SPM 24: Rate of Double Up Food Bucks purchases per SNAP recipient
This is the third year of data collection and monitoring for this performance measure. The actual value of 39.05 Double Up Food Bucks (DUFB) transactions per 1000 SNAP recipients in 2024 exceeded the target of 32.58. However, we had to revise the Year 3 rate of 25.58 to 50.88 due to an error in the total number of SNAP recipients in counties of interest. Consequently, the Year 3 to Year 4 rate actually declined by over 23%. It is possible that changes in the program, including one new county (Sevier) and a second contractor (Appalachian Resource Conservation) in East Tennessee, may have slowed the growth of the program overall. Updated SNAP numbers for Year 2 were not available for revising that year's rate, which limits the program's ability to determine trends. Overall, there still remains much room for improvement, as the latest rate represents just 1,492 DUFB transactions among 38,212 SNAP recipients. The team has revised the 2025 target based on the above revisions and actual DUFB rates.

There were ongoing issues with the SNAP EBT machines in the Northeast region that persisted for several months, likely leading to a decrease in participation.

SOM 3: Percent of public-school 6th graders who are overweight or obese
The data source for this outcome measure is the TDOE Coordinated School Health Weight Status (BMI) report. The report highlights data from annual direct measurements of height and weight among public school students statewide. Rates of overweight or obesity had been climbing steadily over the past few years, although no data were available for the 2020-2021 academic year due to widespread school closings from COVID-19. However, the data from the 2022-2023 report showed a statistically significant decline from 47.40% in the previous year to 45.60%. This annual decrease is encouraging, although more years of data will be necessary to detect any lasting change in trends, especially for this outcome measure. Nonetheless, it is noteworthy that the 2022-23 overweight or obesity percentage is still significantly higher than the 43.64% baseline in 2017-2018.

The decline in 6th graders who are overweight or obese could be signaling that the negative impact of the pandemic is beginning to wane.

SOM 4: Percent of WIC recipients aged 2-4 years who are overweight or obese
The source for this outcome measure is the TN WIC program database. There is usually a lag time of one year between the MCH fiscal year and the most recent, complete WIC data. Therefore, the latest data are from CY2023, as the WIC program has not yet completed data collection for height and weight in CY2024.

In 2023, the risk of overweight or obesity in TN WIC recipients ages 2-4 decreased slightly to 27.70% from 28.70% in 2022. This was the second straight year of declines, which suggests that values continue to return slowly to pre-COVID levels (i.e., 25.5% in 2019). During the pandemic, the WIC program waived the requirement for in-person height and weight measurements, which could have greatly impacted the results for that period. Limited opportunities for physical activity outside the home and other COVID related restrictions might have been a factor as well. The WIC requirement for in-person measurements has been reinstated. However, considering that the 2023 value fell short of the target by over a percentage point, at least one more year of data will be necessary to identify a definitive declining trend in overweight or obesity.

The moderate decrease in overweight or obesity in TN WIC recipients ages 2-4 could be attributed to the promotion of the WIC Shopper App and the implementation of the WIC EBT card. WIC participants were able to obtain the EBT cards virtually and utilize the app to identify WIC locations to purchase healthy food and find healthy recipes.

Accomplishments and Challenges (based on the FY2024 Action Plan):

Strategy 1: Support school-based efforts to promote physical activity and good nutrition

Supporting Evidence for Strategy 1: Physical Activity: Enhanced School-Based Physical Education (ESBPE) and Out of School Time (OST) Academic Programs: ESBPE involves changing the curriculum and

course work for K-12 students to increase the amount of time they spend engaged in moderate- or vigorous-intensity physical activity during physical education classes. OST academic achievement is linked with long-term health.

Source: The Community Guide https://www.thecommunityguide.org/findings/physical-activity-enhanced-school-based-physical-education
https://www.thecommunityguide.org/biblio/out-school-time-academic-programs-are-recommended-improve-academic-achievement-and-health.html

Activity 1a: Collaborate with TDOE to develop and implement strategies to provide professional development to physical education teachers pertaining to engaging students in moderate-to-vigorous physical activity 50% or more of physical education class time.

Report 1a: During the reporting period, we partnered with TDOE, the Alliance for a Healthier Generation, and On Point in support of the Statewide School Health Advisory Council (SHAC) to advance health education, mental health education, and physical education. The SHAC health education subcommittee created a comprehensive resource list that encompasses materials related to physical education, health services, mental health, and substance abuse prevention. These resources, which can be accessed via the Healthier Generation and the Tennessee Department of Education websites, are available to teachers, school staff, coordinated school health (CSH) coordinators, and public health educators. TDOE provides monthly virtual training sessions through the Healthy Students, Stronger Learners Tennessee Community of Practice (CoP) for CSH coordinators and health educators. These training sessions covered various topics, including Physical Education and Physical Activity, Health Services, and Health Education.

Additionally, we collaborated with TDOE by providing professional development for school health coordinators and health educators to maintain partnerships between TDOE and TDH. This partnership provided the opportunity to develop action plans that increase physical activity in a classroom setting as well as before and after school care.

This is only the second year of data collection for **ESM PA-Child.11** as TDOE added the question to the District Application in 2023. Nonetheless, **the proportion of LEAs in 2024 offered professional development related to physical activity in physical education classes** was 56.46%. This value exceeded the target of 41.00%. The increase undoubtedly reflects enhanced efforts by TDOE, TDH, and other partners to emphasize the importance of this topic via various training opportunities and other resources. It must also be noted that the indicator refers to being “offered” professional development in contrast to receiving training or implementing strategies to increase moderate to vigorous physical activity.

Activity 1b: Collaborate with TDOE to provide statewide trainings for educators in school and community-based after school programs, in identified priority counties, to increase enrollment in the TN Healthy After-school Pledge Out of School Time (OST) program to support student health and academic achievement.

Report 1b: During this reporting period, we partnered with TDOE to offer professional learning opportunities that emphasized mental health as part of the Tennessee Healthy Afterschool Pledge, which advocates for nutrition education, physical activity, and fostering safe and supportive environments for students.

Twenty-seven sites successfully completed the pledge assessment, 15 sites developed an action plan related to the pledge, and 14 sites concluded with the evaluation process of the Tennessee Healthy Afterschool Pledge.

This is the first year of data collection for **ESM percentage of counties or local education agencies receiving professional development in TN Healthy After-School Pledge Out of School Time programs.** Therefore, the value of 2.74% constitutes a baseline for the proportion of LEAs statewide (n=146) that received professional development in the TN Healthy After-School Pledge OST program. This value represents the 4 LEAs in Tennessee in which 14 sites completed the TNHASP closing and evaluation. Overall, 27 sites completed TNHASP assessments, and 15 sites completed a TNHASP action plan. Although off to good start, the program still has much to accomplish to expand After-school Pledge OST to most LEAs statewide. TDH and TDOE will enhance their efforts to increase the number of site-specific trainings significantly in Year 5 (2025).

Challenges Issues Related to Implementation of Strategy 1: During the reporting period, we saw the need for evaluation of the Tennessee Healthy Afterschool Pledge program. This caused a pause in the program for restructuring. The program was transitioned to the Tennessee Department of Education's Office of Coordinated School Health (TDOE CSH). At the time of the transition, TDOE CSH indicated plans to continue the initiative and conduct program evaluations. In support of these efforts, an evaluation framework and tools were developed and submitted to CSH. However, the initiative was not continued under their leadership, and therefore, the planned evaluations were not implemented. We will discuss new ways to implement physical activity in the classroom.

Strategy 2: Promote nutrition and physical activity professional development opportunities for Early Childhood Education (ECE) and licensed childcare centers

Supporting Evidence for Strategy 2: Center-based early childhood education programs (ECE) aim to improve educational outcomes that are associated with long-term health as well as social- and health-related outcomes. Economic evidence indicates there is a positive return on investment in early childhood education. The benefits from students' future earnings gains alone exceed program costs.

Source: The Community Guide:
https://www.thecommunityguide.org/news/community-preventive-services-task-force-recommends-early-childhood-education-programs.html

Activity 2a: Through targeted promotion, increase the number of ECE staff, local health educators, physical education teachers, and childcare providers trained in Physical Activity Learning Sessions (PALS) in priority areas.

Report 2a: Throughout the reporting period, our collaboration with Nemours persisted in providing PALS trainings and ongoing education, Mini PALS sessions, for ECE staff, facilitated through our partnership with the TN Childcare Resource and Referral centers. PALS is an evidence-informed training program designed for early care and education (ECE) trainers and technical assistants. The PALS workshops explore best practices for promoting physical activity in ECE settings and address providers' challenges in supporting active play. The program covers eight key areas: Policies, Providers, Daily Activities, Type of Activities, Duration, Training, and Families. The training consists of several sessions. Session 1 introduces the program and the Self-Assessment process. Session 2 covers brain development and the benefits of physical activity. The following sessions focus on gross motor development, fundamental movement skills, physical literacy, and social and emotional development. Additional topics include physical

activity in indoor spaces, the roles of staff and providers regarding physical activity, and components like goal planning, action plans, action steps, and daycare policies.

During the reported period, 333 staff members were trained, and 215 of the trainings were unduplicated trainees.

This was the first year of data collection and reporting for **ESM: Percentage of trained PALS childcare centers among all DHS licensed facilities.** Therefore, the Year 4 value of 5.03% (i.e.,118 of 2348 DHS licensed childcare centers receiving PALS training) will serve as a baseline moving forward. While 118 is a solid number and reflects the concerted efforts of TDH and Nemours, there is still considerable room for additional progress.

During this first year, we have seen a steady increase in trained facilities due to the continuing professional development trainings that Nemours recently added. Our continued partnership with Nemours has shown the importance of professional development in childcare facilities.

Activity 2b: Through targeted promotion, increase the number of free evidence-based professional development TrainTN and TN Professional Archive of Learning (TNPAL) modules and/or trainings completed by ECE staff and childcare professionals in priority areas.

Report 2b: During the reporting period, we have seen an increase in unduplicated trainings by ECE staff and childcare professionals in priority areas. We have 118 trained facilities, (118 of 2348 DHS licensed childcare centers receiving PALS training) 333 staff members were trained, and 215 of the trainings were unduplicated trainees. Our partnership with Childcare Resource and Referral Centers and Signal Centers Inc. has been so successful that our Nemours partners have offered mini-series physical activity training for continuing education and shared materials with ECE staff.

Activity 2c: Utilize GIS mapping to identify priority counties with areas of food insecurity and food deserts as well as ECEs that are not currently participating in the Child and Adult Care Food Program (CACFP) in those locations.

Report 2c: Due to staff changes at DHS, we cannot provide outcomes for the GIS mapping project. However, to raise awareness of food security programs, TDH recommended adding 716 programs in the FindHelp platform between 05/01/24 and 05/01/25. Of these, 163 were added to the platform, and 133 were claimed by Tennessee organizations. To date, there are 771 food related programs in FindHelp.

Activity 2d: Work with Department of Human Services (DHS) and CACFP sponsoring organizations to identify at least one (1) community-based organization or facility in each priority county as champions to raise awareness of early childhood obesity, nutrition, and gaps in existing resources. The ultimate goal would be to increase participation in the CACFP. Community organizations could include ECEs that are current CACFP participants.

Utilize the identified community-based organizations to 1) disseminate CACFP promotional materials through one-on-one contact or via hand off to other community-based agencies to at least thirty (30) early childcare facilities across the priority counties; and 2) arrange for at least ten (10) of these facilities to begin the process of becoming a CACFP participant.
There has been a modification in the process for obtaining data, due to internal changes from the organizations.

Report 2d: Our strong partnerships with Nemours and CCR&R have demonstrated significant success in outreach through the PALS program. These collaborations present an opportunity to further leverage these relationships to promote CACFP to a broader network of early childcare agencies.

Not counting 2023 baseline data, this is the first year of data collection for **ESM: Percentage of CACFP childcare centers among all DHS licensed facilities**. The Year 4 (2024) value of 53.66% for licensed childcare centers statewide participating in the CACFP fell short of the target value of 60.00% and was over two points lower than the previous year's value of 56.05%. This decline resulted from a decrease of 46 CACFP facilities statewide and a slight increase in the total number of DHS licensed centers. Much room for improvement remains to expand the number of CACFP sites substantially across the state. During Year 5, DHS and TDH will collaborate in planning and implementing strategies that will promote the CACFP and facilitate the application process for facilities.

Challenges Issues Related to Implementation of Strategy 2: Due to staff changes at TDHS, it made it challenging to obtain information for this Strategy.

Strategy 3: Partner with healthcare providers to promote physical activity counseling during well-child visits

Supporting Evidence for Strategy 3: Physical Activity: Family-Based Interventions. Family-based interventions combine activities to build family support with health education to increase physical activity among children.

Source: The Community Guide https://www.thecommunityguide.org/findings/physical-activity-family-based-interventions

Activity 3a: Increase the number of LHD primary care clinics that provide the Healthy Parks Healthy Person (HPHP) park prescription to increase family-based outdoor physical activity.

Report 3a: During the reporting period, 48 LHDs provided Healthy Parks Healthy People (HPHP) park prescriptions. We delivered Healthy Parks Healthy People (HPHP) toolkits (HPHP) Rx pads, brochures, posters, trail signs) to nine LHD primary care clinics.

The percentage of LHD primary care clinics writing HPHP prescriptions (**ESM PA-Child.4**) in Year 4 was 19.64%, which was 40 points below the target. However, the target had been erroneously based on data that included non-primary care LHD clinics. Nonetheless, the Year 4 percentage represents the third consecutive year of steady declines in this measure. During this period, the HPHP organization went through a transition where their primary focus switched to promoting HPHP scripts in non-LHD medical practices. As staff turned over at LHDs, fewer providers were familiar with the HPHP script program. HPHP plans to resume and enhance efforts to promote LHD participation in the program in the future.

This was the first year of data collection for the modified measure (**ESM PA-Child.5 (m) – Number of HPHP prescriptions written by LHDs and other medical practices)**. Unfortunately, implementation of the HPHP PaRx electronic portal has been delayed, which means that no data exist for HPHP scripts written by non-LHD providers. The Year 4 value was 175 LHD only scripts, representing a slight increase over Year 3. However,

the number fell short of the target of 275. That target was based on an anticipated influx of non-LHD scripts. The PaRx portal is scheduled to be operational soon, and the Year 5 target has been adjusted to include HPHP scripts from all types of medical providers.

Activity 3b: Partner with professional medical associations, including TN Medical Association (TMA), TN Primary Care Association (TPCA), TN Section of American College of Obstetricians and Gynecologists (ACOG), and Tennessee Academy of Family Physicians (TAFP) to promote the use of the HPHP park prescription program and free mobile app to increase outdoor physical activity.

Report 3b: During the reporting period we were unable to partner with any of the three medical associations listed above during the time frame. However, we are planning these collaborations in the future.

The Healthy Parks Healthy Person organization presented Healthy Parks Healthy People (HPHP) at the International SHIFT Summit in Bend, Oregon. There were approximately 150 people in attendance from across the US and abroad, including medical professionals and researchers in the health and wellness field. Healthy Parks Healthy People HPHP was the winner of the SHIFT (now ActivEnviro) award in 2022. The SHIFT Award honors organizations, initiatives, and individuals from around the U.S. helping advance and promote access to nature and the health benefits of time spent outside.

November 2023, the Healthy Parks Healthy Person organization presented to Leadership Middle Tennessee as part of their 2-day session on public health with 50 people in attendance.

The Healthy Parks Healthy Person organization presented Healthy Parks Healthy Person to the medical residents and fellows at the UT Memphis Health Science Center. There were approximately 50 people in attendance.
The Healthy Parks Healthy Person organization presented to the TN Cancer Coalition. There were approximately 45 attendees.

During the reporting period approximately 20 public health educators were in attendance at the TDH Mid-Cumberland regional meeting where the Healthy Parks Healthy Person organization presented.

HPHP is a member of the Rural Health Association of TN (RHAT). This partnership allows our resources and materials to be shared in their newsletters that are shared across the state.

HPHP resources are regularly listed in the TDH Office of Primary Prevention newsletters, and an article on HPHP was featured in the May 2024 newsletter.

Challenges Issues Related to Implementation of Strategy 3: During the reporting period, the HPHP program indicated that the decline in annual prescriptions was most likely the result of less reliance on LHDs as the main partners among medical providers. The barrier presented has been partnering with physicians and clinics in the private medical field has been difficult, the physicians are busy and sometimes unavailable to learn a new system. However, HPHP could benefit from personal introductions or contacts within these organizations.

Strategy 4: Promote policy, systems, and environmental change (PSE) strategies to increase physical activity and promote access to healthy food and beverages

Supporting Evidence for Strategy 4: Physical Activity: Creating or Improving Places for Physical Activity. In these types of interventions, worksites, coalitions, agencies, and communities work together to change local environments to create opportunities for physical activity. Changes can include creating or improving walking trails, building exercise facilities, or providing access to existing facilities.

Source: The Community Guide https://www.thecommunityguide.org/biblio/recommendations-increase-physical-activity-communities.html

Activity 4a: Partner with a minimum of 4 Regional Healthy Development Coordinators (HDCs) to increase the number of communities, especially in priority geographic areas, participating in Active Living Workshop (ALW) trainings to implement community design changes that improve walkability and green spaces.

Report 4a: During the reporting period, in partnership with the TDH Office of Primary Prevention (OPP) and Regional Healthy Development Coordinators, eight (8) Active Living Workshops (ALW) were successfully conducted across the West, South Central, Southeast, East, and Upper Cumberland regions, engaging a total of one hundred seventy-eight (178) participants. An ALW is considered to have taken place when the following three components are fulfilled: performing a walk audit, conducting a community input prioritization activity, and preparing a follow-up report with actionable next steps authored by the HDC. Five (5) communities completed the ALWs and received funding of $3,500, which facilitated the implementation of various initiatives, including painting crosswalks, stenciling playground designs, installing bike racks, purchasing flower boxes, set up pedestrian safety signage, and hiring a muralist. These initiatives were identified by community members as key factors that would enhance walkability and bikeability. Many rural communities in Tennessee face limited financial resources for walkability-related improvements, making it remarkable to witness the significant impact achieved with a relatively modest amount of funding.

OPP established a standardized process for conducting ALWs, procuring tactical urbanism supplies, and disbursing seed money. To optimize the program's administration and minimize paperwork burden, job aids and templates were developed for the Healthy Development Coordinators (HDCs). OPP also collaborated with the procurement team to identify an efficient method for distributing small seed money grants, ensuring that application requirements were proportionate to the funding amount while maintaining accountability for the use of federal funds. Insights and lessons learned from the workshops were shared during monthly calls.

This was the third year of data collection for **ESM PA-Child.6**. **The cumulative percentage of counties with completed built environment projects** for Year 4 rose to 65.26%, which fell three points short of the 68.42% target. These values translated to 62 counties statewide instead of the projected 65 counties. The trend still represents a steady increase over the three-year period. Due to the set schedule and number of grantees per program cycle, the number of completed Project Diabetes projects and counties has remained relatively static. Most of the growth in the indicator for Year 4 has come from TDH Office of Primary Prevention built environment projects. The Year 5 target was adjusted accordingly. The efforts of the HDCs in conducting ALWs generated increased community interest in participating in future workshops.

Activity 4b: Collaborate with a minimum of 4 non-profits in priority communities to increase access to fresh fruit and vegetables for SNAP recipients through the Double Up Food Bucks (DUFB) program.

Report 4b: TDH partnered with Nourish Knoxville, Chattanooga Food Center, Nashville Farmers Market, and Appalachian Resource Conservation to execute the DUFB program, which made a significant impact across 12 counties. Nourish Knoxville, a nonprofit organization supported by TDH's Project Diabetes to implement DUFB in eight counties, actively participated in various meetings and events, including health council meetings, Knoxville-Knox County Food Policy discussions, tabling events at housing sites managed by Knoxville's Community Development Corporation, and Tennessee Well Child Collaborative meetings. Additionally, Nourish Knoxville oversees the website doubleuptn.org, which provides a comprehensive list of all DUFB locations in Tennessee.

Each of the four nonprofits has developed additional initiatives aimed at boosting fruit and vegetable consumption. Notable programs include Farmacy Fit and Nourish Moves, which offer pedometers to farmers market patrons, rewarding their steps with vouchers for fresh produce. There are also Build It Up and Nourish Kids initiatives designed to expose children to fresh fruits and vegetables, equipping them with vouchers to select produce for home use. Furthermore, Chattanooga Food Center offers cooking classes for local community members.

In collaboration with organizations across the state, TDH also prepared and submitted an application for GusNIP funding aimed at expanding the DUFB initiative statewide. Although the funding was not awarded, the application reviewers commended the proposal for its strong organization and the broad input from various partners, acknowledging TDH's extensive experience and readiness for this initiative.

This was the third year of data collection for **ESM PA-Child.7**. The Year 4 **percentage of eligible venues offering the Double Up Food Bucks Program (DUFB)** was 90.48%, falling shy of the 94.5% target. Although there has been a year-over-year increase during the entire period, the rate of increase slowed substantially in the past year. The Year 4 value represented data from Nourish Knoxville and Appalachian Resource Conservation and covered the same counties (with the addition of Sevier County) as in previous years. Adding a new contractor and new county may have contributed to the lower rate of increase in eligible venues participating in the DUFB program. The Year 5 target was adjusted accordingly.

Challenges Issues Related to Implementation of Strategy 4: More funding is needed to expand the DUFB program to additional counties within the state. TDH plans to apply for GusNip funding again in 2025.

Update on Other Child Health Programs Supported by MCH/Title V:

Poison Control Center: During the reporting period, the Tennessee Poison Center (TPC) provided program materials, as requested, and distributed over 105,776 pieces of literature statewide, including brochures, fact sheets, and stickers. The TPC staff gave presentations and lectures to 3, 096 Tennessee residents including 1,491 adults, 785 children, and 820 healthcare professionals. Additionally, TPC sent 25 different Question of the Week topics that reached more than 3,231 healthcare professionals each month. TPC received 51, 571 calls to the Tennessee Poison Center Hotline from individuals who have been exposed to poison agents. TPC staff provided appropriate medical follow-up to 100% of individuals calling the Tennessee Poison Hotline who have been exposed to poison agents. TPC is estimated to save $32.8 million in prevented emergency department and hospitalization costs in SFY 2025.

Priority: Increase Prevention and Mitigation of Adverse Childhood Experiences (ACEs)

MCH/Title V Funding: The prevention and mitigation of ACEs team is administratively led by the Early Childhood Initiatives section within the Division of Family Health and Wellness of TDH. The Early Childhood Initiatives section includes evidence-based home visiting, ACEs reduction, and early childhood comprehensive systems. ACEs prevention efforts are funded by state and other federal funds. While MCH/Title V does not directly fund the activities highlighted in the annual report, it does fully fund the Deputy Director of Child Health who provides leadership to this section.

Interpretation of Performance Data on selected NPMs, SPMs, and SOMs:

SPM 8: Percent of children with two or more ACEs.
The percentage of children reported with two or more Adverse Childhood Experiences (ACEs) in Tennessee declined from 21.4% in the NSCH FY2021/2022 survey to 20.1% in FY2022/2023, a notable improvement from the 23.3% baseline in FY2018/2019 and below the target of 21.2%. This reduction may reflect expanded public health interventions, increased adoption of trauma-informed practices, and economic support programs such as TANF. However, direct attribution to specific programmatic activities remains difficult given the nature of national survey data.

EBHV and CHANT have continued to be implemented in all 95 counties across Tennessee. TDH began providing warm referrals to EBHV local implementing agencies (LIAs) during FFY24 through partnership with the TDH TennCare presumptive eligibility program with the goal of increasing prenatal referrals to EBHV services for improved outcomes.

SPM 9: Percent of substantiated child maltreatment cases among families served by home visiting programs
Since 2020, the percentage of substantiated maltreatment cases has generally declined, despite periodic fluctuations. The baseline rate was 4.2%, decreasing to 1.5%, rising to 3.2% in 2022, and then falling to 1% in FY 2024, according to data from DCS. This most recent figure falls below the target of 2.2%. Potential contributing factors include post-pandemic recovery and improved socioeconomic conditions. While some external factors remain beyond the control of the EBHV program, home visitors continue to provide critical support to families, promoting resilience. Notably, 63% of primary caregivers reported improved resilience at program exit or after one year, compared to 30.3% at enrollment. However, caution is warranted in interpreting the decline in substantiated cases, as reporting backlogs at DCS may also influence these figures.

It is not known if this decrease is a result of EBHV or CHANT programs.

SPM 10: Percent of caregivers who experience intimate partner violence and do not receive professional support services among families served by home visiting.
This measure was retired last year.

SOM 2: Percent of adults reporting COPD
Based on BRFSS data, there was a decrease in the percent of adults reporting COPD from 11.6 in FY23 to 10.2 in FY24. This decrease, however, is not statistically significant. This stagnation is likely because of a relatively slow decline in Tennessee's adult smoking rate due to a myriad of factors including inadequate tobacco control policies, decreased quit attempts, and aggressive marketing tactics by the tobacco industry.

Accomplishments and Challenges (based on the FY2024 Action Plan):

Strategy 1: Increase knowledge of ACEs, PCEs (Positive Childhood Experiences), and practice of Trauma Informed Care (TIC).

Supporting Evidence for Strategy 1: The variety of sectors can make a difference in preventing ACEs by impacting the various contexts and underlying risks that contribute to violence and adversity and by supporting safe, stable, nurturing relationships and environments for all children while taking a trauma informed approach to prevent ACEs[1].

Activity 1a: Continue to make available online ACEs and TIC trainings for TDH staff, including those in the CHANT and EBHV programs. Through this training TDH staff and CHANT and EBHV programs will be able to integrate trauma informed practices into their work with families, mitigating the impact of ACEs.

Report 1a: ACEs and TIC online trainings are available for TDH staff to complete. During FFY24 the EBHV workforce development director distributed a free training to the EBHV workforce titled ACES in Bilingual Communities from the Aces Aware Learning Center to introduce participants to how Adverse Childhood Experience (ACE) screening is being used alongside other assessment measures as part of the intake process in a community mental health program that serves English- and Spanish-speaking patients. It is unknown how many participated. Also, the Early Childhood Initiatives section was in the planning stages to add Trauma-Based Relational Intervention (TBRI) trainings for the EBHV workforce. TBRI training is a program designed to equip individuals with the skills and knowledge to effectively support children and families impacted by trauma. It focuses on building strong, trusting relationships through connecting, empowering, and correcting principles.

ESM PA-Child.8 was retired due to a lack of data last year.

Activity 1b: Provide ACEs and TIC refresher trainings for child fatality review teams as part of their ongoing training. This training will provide information and insight to teams on the impact of ACEs and trauma and assist in understanding the impact on community health factors that influence health outcomes.

Report 1b: The ACEs and TIC online training is still available. TDH staff and EBHV LIAs are ACEs informed to provide TIC. TDH has begun providing education on the impact of Positive Childhood Experiences (PCEs). In May 2024, local Child Fatality Review teams received training on ACEs and psychological safety in the workplace and death review meetings. A total of 76[] attendees representing all 34 local CFR teams participated in the training.

Challenges Issues Related to Implementation of Strategy 1: The assumption is that trained staff will practice trauma informed care following training. Families may choose not to participate in EBHV or CHANT when referred.

Strategy 2: Ensure a strong start for children by promoting a healthy parent-child attachment through implementation of home visiting programs throughout the 95 counties of Tennessee.

Supporting Evidence for Strategy 2: Effective home visiting models have demonstrated many benefits for children and parents. Early childhood home visitation can prevent ACEs by providing information, caregiver support, and training about child health, development, and care to families in their homes to build a safe, stable, nurturing and supportive home environment. Children participating in a home visiting program have better cognitive and language development, better academic achievement, fewer behavioral problems, lower rates of substance use, and fewer arrests, convictions, and parole violations by age 19. Home visiting is associated with better pregnancy outcomes, improved parenting practices, reductions in the use of welfare and other government assistance, greater employment, lower rates of substance use, and reduced exposure to intimate partner violence[2].

Activity 2a: Teach positive parenting skills through home visitation in partnership with local EBHV implementing agencies. This will include encouraging social-emotional learning and parent-child relationship.

Report 2a: EBHV services are available in all 95 Tennessee counties. During SFY24, families were served in 94 of 95 counties. TDH partners with 18 local implementing agencies (LIAs) to deliver 4 EBHV models. More than one (1) EBHV model is now available in 22 of the 95 counties. Several LIAs began delivering a second EBHV model, further increasing access to EBHV services and increasing family choice of an EBHV program. EBHV home visitors provide education to mothers and caregivers on effective parenting practices and assess parent-child interactions using CHEERs—a validated observational tool administered during home visits. In FY 2024, 75% of primary caregivers (2,074 out of 2,776) received a CHEERs observation. Additionally, based on the Protective Factors Survey, 63% of primary caregivers reported improved resiliency at program exit or after one year of participation, a significant increase from 30.3% at enrollment.

Activity 2b: Provide health education through EBHV home visiting programs in counties throughout Tennessee. Communicating the importance of children having a medical home to parents promotes high quality and effective integrated care.

Report 2b: EBHV home visitors educate enrolled caregivers on the importance of breastfeeding, vaccines, safe sleep practices, and a creating a safe home environment to prevent injury.

Data from the EBHV reflects the program's efforts. During FY2024, 87.7% (441/503) of EBHV participating children were up to date with 2-year-old immunizations. This was slightly above the statewide immunization average of 77.7% in SFY2023. Similarly, 1271 of 2300 children aged 12 months or less were reported to be practicing safe sleep at home. These were children who were reported to always be placed to sleep on their backs, without bed-sharing, and did not use soft bedding. During this same period, 122 of 440 children (13%) were breastfed at 6 months of age.

Activity 2c: Provide supportive care and additional services to families and children through EBHV home visitation. By connecting families with concrete services and knowledge of parenting and child development improve protective factors which mitigate or prevent ACEs.

Report 2c: EBHV home visitors complete the Ages and Stages Questionnaire (ASQ) to ascertain possible developmental issues of the index child and make referrals as needed. EBHV home visitors also screen enrolled families for Intimate Partner Violence (IPV) and make referrals as needed. EBHV home visitors also complete the Edinburgh Postpartum Depression Screening (EPDS) with enrolled caregivers and referral the caregiver for mental health services when needed.

During FY 2024, 85% of the 2,350 children (2,007 out of 2,335) were screened for developmental delays. Of those screened, 115 children showed signs of developmental delays, and 92.2% were referred for appropriate services. Among the 106 children referred, 42.5% successfully received the services they needed. While home visitors make every effort to ensure all children are screened and referred, when necessary, the decision to pursue services ultimately lies with the family. Additionally, barriers such as cost and limited access to services continue to pose significant challenges. The outcome of this data has been worsening overall instead of improving. However, during

FY24, there was a 1 percent point increase from FY23, from 47% to 48% for **ESM PA-Child.9**.

Challenges Issues Related to Implementation of Strategy 2: While EBHV home visitors may provide a referral, a family may choose not to follow through. Additionally, although a referral is made a provider may not have availability within a reasonable timeframe (e.g., EBHV enrolled caregiver screens positive for depression. Home visitor refers caregiver for mental health services, and an appointment with a mental health provider is not available for months or there is no mental health provider in the county of residence). Further, in the example of breastfeeding, the majority of EBHV enrolled families are enrolled postnatally when it is too late to initiate breastfeeding.

Strategy 3: Intervene to lessen immediate and long-term harms by linking families to health and social services.

Supporting Evidence for Strategy 3: Traumatic events in childhood can be emotionally painful or distressing and can have effects that persist for years. Factors such as the nature, frequency and seriousness of the traumatic event, prior history of trauma, and available family and community supports can shape a child's response to trauma. Creating and sustaining safe, stable, nurturing relationships and environments for all children and families can prevent ACEs and help all children reach their full health and life potential[3].

Activity 3a: Screen and assess families for enrollment in CHANT to identify health and social needs that have long term impact on families and children. By identifying the families' immediate needs, priority services can be provided to families.

Report 3a: Data shows that from FY23 to FY24 there was an increase in the percentage of families enrolled in CHANT Care Coordination who partially or fully complete pathways identified (**ESM PA-Child.10**). The increase shows movement from 43% to 47% from year to year. This increase may be related to an increase in training opportunities provided to CHANT staff during this time frame- increasing their knowledge on how to successfully engage families. CHANT has focused some of the staff trainings on motivational interviewing and relationship development. There has also been an increased focus on the efficacy of home visiting in assisting the relationship development with the families served in CHANT. Both of these have supported staff in working to develop strong, trusting relationships with the families they serve.

CHANT completes a comprehensive screening and assessment on all individuals referred to CHANT services. This process allows families to self-identify areas of need (Pathways) for family-guided care. CHANT Care Coordinators create a plan of action with the family. During Year 4 CHANT 7,521 families were screened and served. In Year 3, there was a 20% increase in the number of families served compared to Year 3.

Activity 3b: Provide referrals to families for identified health care and social service needs. Identifying which of the sixteen pathways of care families have identified as needs increase the protective factors within a family by providing concrete services at the time identified.

Report 3b: Referrals are made based on needs identified by the family. Care Coordinators (CCs) identify resources within the families' community and make referrals as needed. External partners include but are not limited to PCPs, Dental Services, Behavioral Health Services, TEIS (Tennessee Early Intervention Services), School systems, the Department of Human Services (DHS), food banks, utility assistance programs, family planning, etc.

The Tennessee Department of Health (TDH) conducted a CHANT–FindHelp pilot in

seven counties—Hamilton (metro region), and the Mid-Cumberland counties of Dickson, Trousdale, Williamson, Wilson, Stewart, and Houston—to evaluate the feasibility and effectiveness of implementing a Closed Loop Referral System (CLRS) within public health programs. A CLRS is a coordinated system that not only facilitates referrals to community-based services but also ensures that those referrals are completed and confirmed by the receiving organization, thereby "closing the loop." This approach helps public health staff track whether families actually access the services they are referred to, improving accountability and client outcomes. The pilot, which ran from July 1, 2024, to September 30, 2024, aimed to integrate FindHelp, a social service referral platform, into the Community Health Access and Navigation in Tennessee (CHANT) workflow. A total of 190 referrals were initiated through FindHelp during the pilot period, of which 56 were confirmed as closed loop—meaning the service provider acknowledged the referral and indicated whether the client received the service.

Based on promising early results and lessons learned, TDH is now expanding the use of FindHelp across additional Family Health and Wellness (FHW) programs in alignment with TennCare's existing branded FindHelp platform, TN Community Compass, which could streamline referral coordination across agencies and improve service delivery for Medicaid-enrolled families and other at-risk populations.

Activity 3c: Assist families in navigating the healthcare and social services system through the CHANT care-coordination model. Aiding in navigating any of the sixteen pathways, including obtaining a medical home or an EPSDT, is solution focused as barriers and other obstacles are addressed. Through this, family resiliency is increased as a strategy to eliminate and mitigate ACEs the family might have experienced.

Report 3c: The CHANT program continued to serve families during this Year 4 period. CCs address barriers the family may have in achieving CHANT Pathway goals. Barriers identified included: transportation, lack of support, financial issues, knowledge of resources.

Data shows that from FY23 to FY24, the percentage of families enrolled in CHANT Care Coordination who partially or fully complete pathways identified was similar, hovering around 46% (**ESM PA-Child.10**). Overall, 15% more CHANT pathways were started in FY24, and 7% more pathways were completed.

Challenges Issues Related to Implementation of Strategy 3: Challenges include shifting available resources. There have been noted issues with a lack of dental providers across the state. The lack of affordable housing resources and long wait lists for these options in some areas make it difficult to identify and refer families to needed resources. CHANT staff provide education on resources even when they are not able to satisfy the referral need.

Update on Other Child Health Programs Supported by MCH/Title V:
The MCH block grant does not directly support implementation of EBHV programs in Tennessee; however, TDH administrative staff FTEs funded by MCH block grant provide support to the Early Childhood Initiatives (ECI) section in the Division of Family Health and Wellness (FHW).

[1] Centers for Disease Control and Prevention (2019). Preventing Adverse Childhood Experiences: Leveraging the Best Available Evidence. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. https://www.cdc.gov/violenceprevention/pdf/preventingACES.pdf

[2] Centers for Disease Control and Prevention (2019). Preventing Adverse Childhood Experiences: Leveraging the Best Available Evidence. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. https://www.cdc.gov/violenceprevention/pdf/preventingACES.pdf

[3] Centers for Disease Control and Prevention (2019). Preventing Adverse Childhood Experiences: Leveraging the Best Available Evidence. Atlanta, GA:

National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.
https://www.cdc.gov/violenceprevention/pdf/preventingACES.pdf

Priority: Decrease Preventable Illness and Disease Among Children

Objective for Childhood Vaccinations: 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.

Evidence-Based or Informed Strategy Measure (ESM): Percent of participating staff reporting increased confidence in addressing vaccine hesitancy post-training

Objective for Medical Home: Increase the percentage of children with medical home from 49.9% on October 1, 2026 to 55% on September 30, 2030.

The following strategies and activities are planned for October 1, 2025 to September 30, 2026:

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.

Supporting Evidence for Strategy 1: Motivational interviewing (MI) is a patient-centered communication technique shown to be effective in addressing vaccine hesitancy by helping healthcare professionals explore parental concerns, build trust, and support informed decisions. Training in MI techniques—such as reflective listening and affirming autonomy—along with integrating MI into routine care and offering ongoing resources, can enhance vaccine conversations. Public health initiatives, including those by the CDC and state health departments, have developed MI-based training programs to support this approach[1].

Activity 1a: 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.

Activity 1b: Train the evidence-based home visiting (EBHV) and CHANT workforces with the 3-part immunization training series to increase confidence in conversations around vaccines with enrolled parents.

Activity 1c: Create and conduct pre- and 3-month post-tests following the 3-part immunization training series to evaluate training effectiveness among EBHV home visitors and CHANT Care Coordinators.

Activity 1d: Standardize the 3-part immunization training series and upload it to the Tennessee TRAIN Learning Management System to support broader access and long-term sustainability of immunization education tools.

Planned Partnerships: Vaccine-Preventable Diseases and Immunizations Program within the Communicable and Environmental Diseases and Emergency Preparedness Program at the Department of Health to support training efforts, provide expertise, and enhance immunization messaging strategies.

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.

Supporting Evidence for Strategy 2: Collaboration between public health and schools/educators refers to a joint effort to improve student health and well-being, leveraging the trusted relationships educators have with

families. This collaboration is advantageous because schools can reach a large portion of the population, particularly children, and educators can act as trusted messengers for public health initiatives. Public health approaches to this collaboration often involve multifaceted strategies like providing educators with vaccine education and communication resources, hosting vaccination clinics at schools, and developing outreach programs for families. Peer-reviewed research suggests that collaborative approaches are effective in increasing vaccination uptake, especially when they address vaccine-related questions through open communication. [2],[3],[4].

Activity 2a: Provide the Department of Education Office of School Health with guidance on effective vaccine recommendation language and motivational interviewing strategies to help address vaccine hesitancy in school communities.

Activity 2b: Distribute immunization education resources developed for school nurses to additional school-based partners to support consistent and coordinated messaging.

Activity 2c: Conduct focus groups or listening sessions with parents/caregivers to assess confidence in vaccine-related decision-making and tailor future educational outreach based on community feedback.

Strategy 3: Strengthen school-based emergency preparedness for vaccine-preventable disease outbreaks through inter-agency collaboration and exercises.

Supporting Evidence for Strategy 3: Strengthening school-based emergency preparedness for vaccine-preventable disease outbreaks can be achieved through inter-agency collaboration, such as partnerships between public health departments, schools, and emergency management agencies. Joint preparedness exercises and coordinated response plans have been shown to improve outbreak readiness and ensure rapid, effective interventions during public health emergencies[5],[6]. Furthermore, providing school nurses with training and resources enhances their ability to participate effectively in emergency planning, immunization efforts, and early outbreak detection. Equipped with proper tools and knowledge, school nurses can serve as frontline responders, helping to identify vaccine-preventable disease threats and coordinate timely interventions[7],[8].

Activity 3a: Coordinate with the Department of Education, TDH Emergency Preparedness Program, and County Health Councils/Office of Strategic Initiatives to plan and implement a tabletop exercise focused on pediatric vaccine-preventable disease outbreaks. The exercise will engage school nurses, local public health officials, and emergency response teams to test response strategies and improve inter-agency collaboration.

Activity 3b: Build and strengthen relationships with the Department of Education and school nurses to support emergency preparedness activities. Encourage school nurse participation in County Health Councils to create communication pathways for coordinated outbreak response.

Activity 3c: Provide school nurses with training and resources to support their role in emergency planning related to immunization and outbreak detection.

Strategy 4: Collaborate with MCH Regional and Metro Directors and regional nursing staff to increase off-site vaccination opportunities, with at least one event in each grand division

Supporting Evidence for Strategy 4: Off-site vaccination clinics expand access for families who may face transportation or scheduling barriers. Coordinating through MCH Regional and Metro Directors, along with regional nursing staff, ensures that efforts are locally informed, strategically located, and supported by clinical

personnel familiar with community needs. Targeting at least one event in each Grand Division helps ensure a broader, statewide impact.

Activity 4a: Coordinate with MCH Regional and Metro Directors and regional nursing staff to plan and implement at least one off-site vaccination event in each grand division (East, Middle, and West Tennessee), prioritizing areas with access challenges or low immunization coverage.

Activity 4b: Collaborate with local health departments, schools, and community-based organizations to support clinic logistics, promote events, and ensure broad outreach to families.

Planned Partnerships: MCH Regional and Metro Directors for planning and coordination. Regional nursing staff for on-site clinical support and planning input. Local Health Departments and community organizations for implementation and outreach.

Child Health Programs Supported by MCH/Title V:

- CHANT

Child Health Programs Connected but Not Funded by MCH/Title V:

- Evidence Based Home Visiting (EBHV)
- TDH Emergency Preparedness Program
- Tennessee Department of Education (DOE) Office of School Health
- Vaccine-Preventable Diseases and Immunizations Program
- TDH County Health Councils/Office of Strategic Initiatives

Contextual Factors:

- Other state and federal early childhood home visiting programs may have their own immunization promotion strategies that could either complement or compete with this initiative. Private pediatric practices and healthcare providers may deliver different messaging around vaccinations, affecting parental decision-making. Pediatric providers often do not have time to use additional vaccine communication strategies such as motivational interviewing.
- Families participating in EBHV programs may experience financial instability, housing insecurity, or transportation barriers, making access to vaccination sites challenging.
- Language barriers among families in EBHV programs or school communities may hinder effective communication around immunization benefits.
- Some families may lack a consistent healthcare provider, relying instead on sporadic emergency department visits where vaccine follow-up is inconsistent.
- Parents involved in EBHV programs may be more open to vaccine education due to established trust with home visitors, but they may still face external pressures from family members or cultural beliefs discouraging vaccination.
- Misinformation about vaccines may create additional resistance in both home visiting, clinical settings, and school-based settings.
- Parents may be more receptive to vaccine education from trusted sources, such as home visitors, school nurses, or peer groups, rather than government agencies.
- Cultural attitudes toward childhood vaccinations vary across different communities and may require tailored outreach efforts.
- Parents who have negative experiences with the healthcare system (e.g., poor health outcomes, medical distrust) may be more resistant to public health messaging about vaccines.
- Social networks and community leaders can either reinforce vaccine confidence or spread misinformation that reduces uptake.
- Legislative changes related to vaccine exemptions may impact school-based immunization rates, potentially making it harder to enforce vaccine requirements.

- Policies that support or limit funding for EBHV programs may affect the availability of home visits as a means of delivering immunization education.
- Changes in Medicaid reimbursement policies may impact families' ability to access regular well-child visits where vaccinations are administered.
- Time constraints for home visitors—vaccination discussions may need to compete with other urgent concerns (e.g., food security, housing instability).
- Limited availability of free or low-cost vaccines in some communities, making it harder for families in EBHV programs to follow through on immunization schedules.
- Distrust in government or public health institutions, particularly in communities with low vaccination rates.
- Established relationships between home visitors and families—this trust can be leveraged to provide accurate vaccine information.
- Partnerships with community organizations and faith-based groups to reinforce vaccine messaging in trusted spaces.
- Collaboration between home visiting programs and pediatric providers, ensuring consistent messaging around immunization.

Assumptions: Assumptions are that EBHV and CHANT home visitors will attend and complete Motivational Interviewing Training when offered and apply learning during home visits. EBHV and CHANT home visitors will have effective conversations with families as a result of Motivational Interviewing Training and that families will be responsive to those conversations and so adhere to recommended vaccination schedule guidelines. Tennessee Departments of Health (TDH) and Education (TDOE) Office of School Health will create an effective partnership that guides implementation of immunization education in the School Health program. School Nurses hold effective conversations with parents and students on the importance of vaccinations. Funding for School Nurses will continue. Assumption that increased education will result in individual behavior change.

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[1] Gagneur, 2020; CDC, 2021; NYSDOH, 2022; Centers for Disease Control and Prevention (CDC). (2021). Motivational Interviewing for Health Care Professionals: Talking With Parents About Vaccines

[2] Ways Schools Can Support Routine Vaccination Catch-Up Among School-Aged Children: Public Health Foundation.

[3] Phillips, T. B., Wells, N. M., Brown, A. H., Tralins, J. R., & Bonter, D. N. (2023). Nature and well-being: The association of nature engagement and well-being during the SARS-CoV-2 pandemic. People and Nature, 5(2), 607-620.

[4] Bajaj et al., 2020; CDC, 2019- Partnering with Schools to Increase Vaccination Coverage.

[5] Nelson C, Lurie N, Wasserman J, Zakowski S. Conceptualizing and defining public health emergency preparedness. Am J Public Health. 2007;97 Suppl 1(Suppl 1):S9-11. doi:10.2105/AJPH.2007.114496

[6] Rebmann T, Elliott MB, Artman D, VanNatta M, Wakefield M. Impact of an Education Intervention on Missouri K-12 School Disaster and Biological Event Preparedness. J Sch Health. 2016;86(11):794-802. doi:10.1111/josh.12435

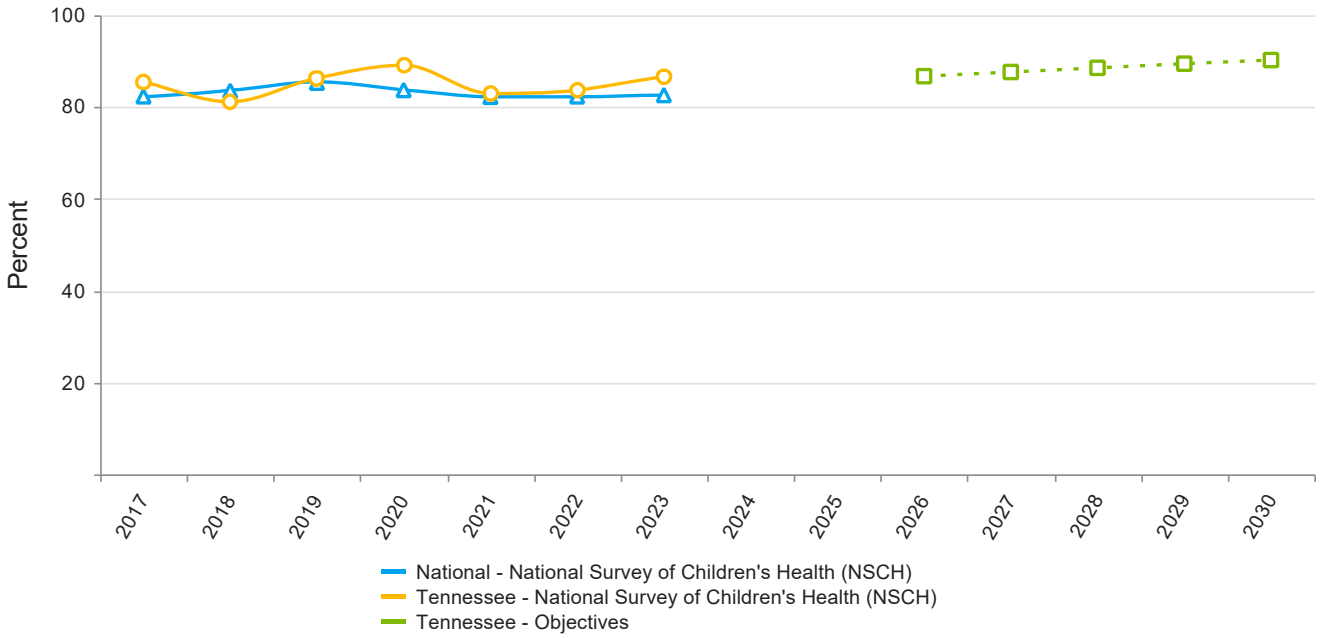
[7] Maughan et al., 2018; NASN, 2021- National Association of School Nurses (NASN).

[8] Maughan ED, Cowell J, Engelke MK, et al. The vital role of school nurses in ensuring the health of our nation's youth. Nurs Outlook. 2018;66(1):94-96. doi:10.1016/j.outlook.2017.11.002

Adolescent Health

National Performance Measures

NPM - Percent of adolescents, ages 12 through 17, who receive needed mental health treatment or counseling - MHT Indicators and Annual Objectives



Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2024
Annual Objective	
Annual Indicator	86.6
Numerator	93,079
Denominator	107,437
Data Source	NSCH
Data Source Year	2022_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	86.6	87.5	88.4	89.3	90.1

Evidence-Based or –Informed Strategy Measures

ESM MHT.1 - Percent increase in Tennessee Child and Adolescent Psychiatry Education and Support (TCAPES) teleconsultation call line volume

Measure Status:	Active

Baseline data was not available/provided.

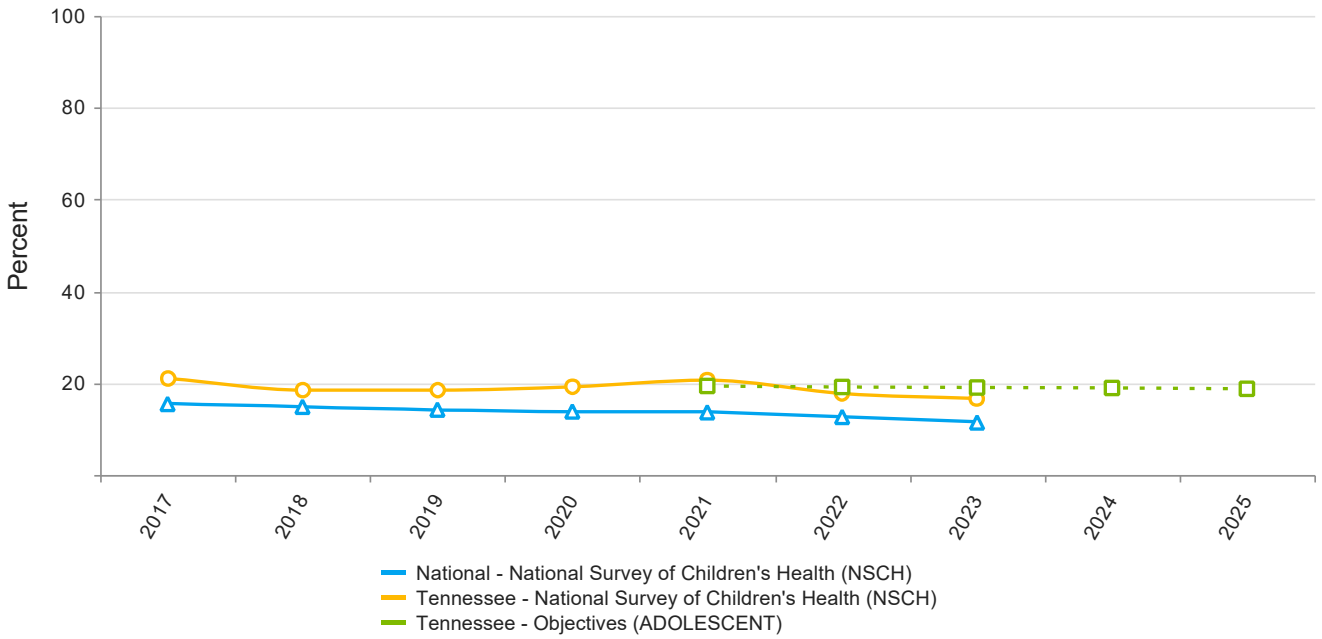
Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	33.0	25.0	20.0	17.0	14.0

State Action Plan Table

State Action Plan Table (Tennessee) - Adolescent Health - Entry 1	
Priority Need	
Improve Social and Emotional Wellbeing in Adolescents	
NPM	
NPM - Mental Health Treatment	
Five-Year Objectives	
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.	
Strategies	
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.	
ESMs	**Status**
ESM MHT.1 - Percent increase in Tennessee Child and Adolescent Psychiatry Education and Support (TCAPES) teleconsultation call line volume	Active
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	

2021-2025: National Performance Measures

2021-2025: NPM - Percent of children, ages 0 through 17, who live in households where someone smokes - SMK-Household Indicators



2021-2025: 2021-2025: NPM - Percent of children, ages 0 through 17, who live in households where someone smokes - SMK-Household - Adolescent Health

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		19.4	19.2	19.1	19
Annual Indicator	18.6	19.5	20.8	17.9	16.6
Numerator	271,871	286,194	303,920	262,342	247,449
Denominator	1,464,986	1,464,685	1,458,803	1,466,841	1,491,195
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2018_2019	2019_2020	2020_2021	2021_2022	2022_2023

2021-2025: Evidence-Based or –Informed Strategy Measures

2021-2025: ESM SMK-Household.1 - Number of tobacco-free sports teams

Measure Status:				**Active**	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective					250
Annual Indicator	77	88	145	213	309
Numerator					
Denominator					
Data Source	Tobacco-free Sports Teams Database	Tobacco-free Sports Teams Database	Tobacco-free Sports Teams Database	Tobacco-free Sports Teams Database	Tobacco-free Sports Teams Database
Data Source Year	CY 2020	CY 2021	CY 2022	CY 2023	CY 2024
Provisional or Final ?	Final	Final	Final	Final	Final

2021-2025: ESM SMK-Household.2 - Number of social media posts promoting text-based cessation services

Measure Status:				**Active**	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective				12	24
Annual Indicator	0	9	33	12	25
Numerator					
Denominator					
Data Source	TDH Office of Communications	TDH Office of Communications	TDH Office of Communications	TDH Office of Communications	TDH Office of Communications
Data Source Year	2020	2021	2022	2023	2024
Provisional or Final ?	Final	Final	Final	Final	Final

2021-2025: ESM SMK-Household.3 - Number of anti-tobacco social media posts

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective					550
Annual Indicator	8	27	281	496	105
Numerator					
Denominator					
Data Source	TDH Office of Communications	TDH Office of Communications	TDH Office of Communications	TDH Office of Communications	TDH Office of Communications
Data Source Year	2020	2021	2022	2023	2024
Provisional or Final ?	Final	Final	Final	Final	Final

2021-2025: ESM SMK-Household.4 - Number of youth who attend the state anti-tobacco conference trainings

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		75	300	300	350
Annual Indicator	0	0	238	259	317
Numerator					
Denominator					
Data Source	TNSTRONG Registration	TNSTRONG Registration	TNSTRONG Registration	TNSTRONG Registration	TNSTRONG Registration
Data Source Year	2020	2021	2022	2023	2024
Provisional or Final ?	Final	Final	Final	Final	Final

2021-2025: ESM SMK-Household.5 - Number of ambassadors recruited

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		26	26	26	26
Annual Indicator	23	18	20	20	26
Numerator					
Denominator					
Data Source	TNSTRONG Ambassador Registration	TNSTRONG Ambassador Registration	TNSTRONG Ambassador Registration	TNSTRONG Ambassador Registration	TNSTRONG Ambassador Registration
Data Source Year	2020	2021	2022	2023	2024
Provisional or Final ?	Final	Final	Final	Final	Final

2021-2025: ESM SMK-Household.6 - Percent of eligible women who enroll in Baby and Me Tobacco Free

Measure Status:			Active
State Provided Data			
	2022	**2023**	**2024**
Annual Objective			14.7
Annual Indicator	13.9	14.6	12.7
Numerator			
Denominator			
Data Source	TDH Tobacco Program	TDH Tobacco Program	TDH Tobacco Program
Data Source Year	2022	2023	2024
Provisional or Final ?	Final	Final	Final

2021-2025: SPM 11 - Percent of high school students currently using cigarettes

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		6.4	5.8	5.3	4.8
Annual Indicator	7.1	0	4.9	0	5.4
Numerator					
Denominator					
Data Source	2019	N/A	2021	N/A	2023
Data Source Year	YRBS	N/A	YRBS	N/A	YRBS
Provisional or Final ?	Final	Final	Final	Final	Final

2021-2025: SPM 12 - Percent of high school students currently using e-cigarettes

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		18	17.9	17.8	17.8
Annual Indicator	22.1	0	19	0	21.6
Numerator					
Denominator					
Data Source	YRBS	N/A	YRBS	N/A	2023
Data Source Year	2019	N/A	2021	N/A	YRBS
Provisional or Final ?	Final	Final	Final	Final	Final

2021-2025: SPM 13 - Number of adolescents enrolled in cessation program

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**

State Provided Data					
	2020	2021	2022	2023	2024
Annual Objective		0	20	50	100
Annual Indicator	7	22	16	30	30
Numerator					
Denominator					
Data Source	QuitLine and NOT Program (ALA)	QuitLine and NOT Program (ALA)	QuitLine only	QuitLine and NOT Program (ALA)	QuitLine and NOT Program (ALA)
Data Source Year	CY 2020	CY 2021	CY 2022	CY 2023	CY 2024
Provisional or Final ?	Final	Final	Final	Final	Final

2021-2025: SOM 5 - Percent of adults reporting Chronic obstructive pulmonary disease (COPD)

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		9.3	9.2	9.6	9.6
Annual Indicator	9.7	9.5	10.4	11.6	10.2
Numerator					
Denominator					
Data Source	BRFSS	BRFSS	BRFSS	BRFSS	BRFSS
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Final	Final	Final	Final	Final

2021-2025: SOM 6 - Percent of adults reporting cardiovascular disease

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		5.3	5.3	5.3	5.2
Annual Indicator	4.9	5.1	5.2	5.8	5.1
Numerator					
Denominator					
Data Source	BRFSS	BRFSS	BRFSS	BRFSS	BRFSS
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Final	Final	Final	Final	Final

2021-2025: SOM 7 - Age-adjusted mortality rate from tobacco-attributable cancers among Tennesseans aged 35+

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**

State Provided Data					
	2020	2021	2022	2023	2024
Annual Objective		176.4	171.4	166.4	161.3
Annual Indicator	190.8	188	188.3	181.5	186.6
Numerator					
Denominator					
Data Source	CDC WONDER	CDC WONDER	CDC WONDER	CDC Wonder	CDC Wonder
Data Source Year	CY 2019	CY 2020	CY 2021	CY 2022	CY 2023
Provisional or Final ?	Final	Final	Final	Final	Final

Priority: Decrease Tobacco and E-cigarette Use Among Adolescents

MCH/Title V Funding: The tobacco and e-cigarette priority team is administratively led by the Chronic Disease Prevention and Health Promotion section within the Division of Family Health and Wellness of TDH. The Chronic Disease Prevention and Health Promotion section includes chronic disease and school health, tobacco prevention and control, diabetes prevention, preventive health and health services block grant, and poison control. The tobacco prevention and control efforts are funded by state and other federal funds. While MCH/Title V does not directly fund the activities highlighted in the annual report, it does fund the Deputy Medical Director who provides leadership to this section and fiscal support services provided by an accounting tech and public health administrator.

Interpretation of Performance Data on selected NPMs, SPMs, and SOMs:

Smoking NPM: Percent of children, ages 0 through 17, who live in households where someone smokes
The 2022-2023 combined survey years of the National Survey of Children's Health found that 16.6% of Tennessee children aged 0-17 live in households where someone smokes. This represents a non-statistically significant decrease from 17.9% in the 2021-2022 combined-year survey results. The rate of children who live in households where someone smokes may have not decreased as the proportion of adults in their childbearing years in Tennessee who smoke did not change significantly between 2022 and 2023 (18–24-year-old adults: 6.6% in 2022 to 6.8% in 2023; 25-34-year-old adults: 18.1% in 2022 to 14.3% in 2023).

SPM 11: Percent of high school students currently using cigarettes
In 2023, Tennessee's Youth Risk Behavior Survey results showed the rate of decrease of current smoking among Tennessee high school students may be slowing. The percentage of high school students in Tennessee who reported current smoking did not change significantly between 2021 (4.9%) and 2023 (5.4%). These findings may be a result of continued youth vaping which is known to increase the likelihood youth will transition to combustible tobacco products three- to four-fold compared to youth who do not vape.

SPM 12: Percent of high school students currently using e-cigarettes
In 2023, Tennessee's Youth Risk Behavior Survey results showed no change in the rate of e-cigarette use among Tennessee high school students. The percentage of high school students in Tennessee who reported current e-cigarette use did not change significantly between 2021 (19.0%) and 2023 (21.6%). The continued high rate of e-cigarette use among Tennessee youth is likely due to a myriad of reasons including a lack of evidence-based state policies to reduce youth use of e-cigarette products, aggressive marketing tactics by the tobacco industry targeting youth, and a lack of widespread cessation support services available to youth in the state.

SPM 13: Number of adolescents enrolled in cessation program
The number of adolescents enrolled in Tennessee's QuitLine program decreased from 15 in CY 2023 to 10 in CY 2024 as of October 31, 2024. The small and relatively unchanged number of adolescents who enrolled in Tennessee's Tobacco QuitLine program may indicate the program may not appeal to adolescents' preferred modalities for receiving cessation support (i.e., phone counseling instead of texting), and as a result of limitations on program promotion to Tennessee youth. The number of adolescents enrolled in the N-O-T youth cessation program is 20 as of October 2024. This number has likely remained the same due to limited integration of cessation programming in Tennessee schools over the past year.

SOM 5: Percent of adults reporting Chronic obstructive pulmonary disease (COPD)
The percentage of adult Tennesseans with COPD decreased between 2022 (11.6%) and 2023 (10.2%). This decrease, however, was not statistically significant. This stagnation is likely because of a relatively slow decline in Tennessee's adult smoking rate due to a myriad of factors including inadequate tobacco control policies and because COPD cannot be reversed after onset of the disease.

SOM 6: Percent of adults reporting cardiovascular disease

The percentage of adults reporting cardiovascular disease decreased slightly between 2022 (5.8%) and 2023 (5.1%). This decrease, however, was not statistically significant.

This is likely a result of the relatively slow decline in Tennessee's adult smoking rate due to a myriad of factors including inadequate tobacco control policies.

SOM 7: Age-adjusted mortality rate from tobacco-attributable cancers among Tennesseans aged 35+
Data for FFY2024 (CDC WONDER CY2023) is not yet available. In CY 2022, the age-adjusted mortality rate from tobacco-attributable cancers among Tennesseans aged 35+ was 181.5, which was effectively unchanged from CY 2021 (188.3). Stagnation in tobacco-attributable cancer mortality rates is due to the continued trend of high rates of tobacco use among Tennessee adults (19.7% in 2021) and exceptionally low screening rates for lung cancer (13.0% in 2023) in the state.

Accomplishments and Challenges (based on the FY2024 Action Plan):

Strategy 1: Engage youth to increase tobacco prevention and anti-tobacco engagement strategies to shift social norms around tobacco use in communities.

Supporting Evidence for Strategy 1: The tobacco epidemic will not end without preventing initiation among young people; it is critical that programs engage youth in tobacco control efforts. Youth can be powerful allies to help communicate the impact of tobacco use on young people, implement effective tobacco control strategies, and shift social norms around tobacco use in their communities[1].

Activity 1a: Promote nicotine-free teams and increase the number of teams taking the pledge to be nicotine-free.

Report 1a: The cumulative number of tobacco-free sports teams increased from 213 in SFY 2023 to 309 in SFY 2024 (**ESM SMK-Household.1**). This translates to 1,480 students who have taken the pledge to be tobacco free in SFY 2024. This increase is due in part to continued, effective promotion of the incentive-based program by field and program staff, and by expanding the scope of teams and clubs that are allowed to sign the pledge. A growing partnership with the Department of Education has allowed for opportunities to promote the program including during the Coordinated School Health Institute in February 2024, attended by Coordinated School Health staff, school nurses, and health educators. Nicotine-Free Teams was also promoted to physical education teachers during a virtual professional development session in June 2024. In August 2024, incentives for Health Occupation Students of America (HOSA) clubs were offered when students pledge to be nicotine-free. During this reporting period, three HOSA clubs have taken the pledge. This has increased program participation with other academic clubs in schools including Beta clubs and other youth councils.

Activity 1b: Host annual TNSTRONG Youth Summit to engage and educate adolescents and adolescent leaders on the dangers of using tobacco products, and tobacco control interventions.

Report 1b: The increase from 259 in FFY 2023 with representation in 37 counties to 317 in FFY 2024 in 49 counties was due to the promotional efforts from local staff and community partners (**ESM SMK-Household.4**). In addition to the increase in number of attendees, The TNSTRONG Youth conference was held in Chattanooga, TN in July 2024. New partnerships formed in preparation for and during the conference included one with the Roane County Prevention Coalition, whose director brought youth to attend and presented during a breakout session. Another new partnership was formed with Students Taking a Right Stand (STARS) Nashville when a representative attended and

presented during a breakout session. During the Summit a highlight video was recorded including interviews from attendees to use for future promotion of the Summit.

Activity 1c: Promote anti-tobacco messaging via social media.

Report 1c: The number of anti-tobacco social media posts declined from FFY2023 (n=496) to FFY2024 (n=105) (**ESM SMK-Household.3**). The Health Communications Specialist position was vacant for a portion of FFY2024, which resulted in the decline. Post frequency resumed to near normal levels once the position was refilled.

Activity 1d: Provide TA to K-12 school districts without comprehensive policies including model policy templates, resources on cessation programming, and alternative disciplinary procedures.

Report 1d: Program maintained a youth and staff Policy Committee that was established in a previous reporting period to provide technical assistance for the counties without a comprehensive tobacco policy. During this time period, local staff provided seven training opportunities for school staff statewide during professional development sessions in June 2024. The Policy Committee completed an annual review and update to the K-12 School Policy Toolkit. During this reporting period, the Tobacco Program has maintained representation on the School Health Advisory Council (SHAC). During the SHAC meeting report out, 49 counties identified that strengthening the Tobacco-Free Schools Policy was a top priority.

Challenges Issues Related to Implementation of Strategy 1: No challenges to report for this strategy.

Strategy 2: Engage partner organizations and utilize social media to increase the reach and impact of tobacco cessation programs among youth.

Supporting Evidence for Strategy 2: Close to 95 percent of smokers try their first cigarette before the age of 21. Nicotine is highly addictive and can harm brain development in youth. People who start using tobacco at an early age are more likely to develop an addiction than those who start at a later age, and kids who use vapor products are more likely to go on to smoke cigarettes[2].

Activity 2a: Promote youth cessation programs via social media.

Report 2a: The number of social media posts promoting text-based cessation services decreased from FFY2023 (n=90) to FFY2024 (n=25) (**ESM SMK-Household.2**). The Health Communications Specialist position was vacant for a portion of FFY2024, which resulted in the decline. Post frequency resumed to near normal levels once the position was refilled.

The number of TNSTRONG ambassadors recruited (**ESM SMK-Household.5**) increased from 20 in CY 2023 to 26 in CY 2024. This increase is likely due to the development and deployment of a recruitment video in schools, through partner organizations, and in local communities across the state; and promotion of the Ambassador application and opportunity at the TNSTRONG summit.

Activity 2b: Partner with TN AAP to educate adolescent health care providers and public health professionals on youth cessation, especially regarding prescribing NRT to adolescents.

Report 2b: A staff training in November 2023 was held and a pediatrician from Vanderbilt University was invited to share best practice for youth cessation and prescribing NRT. A total of

approximately 30 staff were trained. This training equipped staff with tools to engage health care providers, esp. Pediatricians, in their communities who may provide NRT to youth who use tobacco products. Between May 2023 and April 2024, 5 counties worked with school clinics and 5 counties worked with primary care providers on best practices and cessation resources for youth.

Challenges Issues Related to Implementation of Strategy 2: Connecting and partnering with healthcare providers willing to provide youth cessation and prescribing trainings for other healthcare providers.

Update on Other Adolescent Health Programs Supported by MCH/Title V:

Battle of the Belt: Battle of the Belt TN is an evidence-based program for Tennessee high schools designed to reduce motor vehicle injuries and fatalities by increasing seat belt use. Schools improve seat belt use by conducting a student-led educational program and three unannounced seat belt checks with faculty advisor support. Schools can document and showcase educational programs, seat belt use increase, and/or maintaining a high seat belt use rate and share with students, faculty, parents, and community partners. A total of eight school districts registered to compete in the Battle of the Belt TN Program during the 2022-2023 school year. Six hundred thirty-eight (638) seatbelt observations were made during the program and the overall observed seatbelt use increased by 8% for the winning school, Science High School in Johnson City, TN. This is the second year for Science High School to win the competition.

Checkpoints: The goal of the Checkpoints Parent and Teen Driving Program is to reduce teen crashes and violations received by first-time teen drivers by establishing a parent-teen driving agreement to manage known new teen driving risks. During the 2022-2023 school year, a total of 12 schools and organizations conducted the Checkpoints program in Williamson, Dyer, and Hamilton Counties, serving a total of 3,461 individuals. The groups conducted the evidence-based Checkpoints™ program, completing over 1,800 parent-teen driving agreements to address teen driving risks. Williamson County provided the program virtually to parents and teens with success. TDH also partnered with the Michigan Injury Prevention Center to market the online version of the Tennessee Checkpoints Program at https://youngdriverparenting.org/home-2/welcome-to-checkpoints-tennessee/.

[1] CDC Best Practice User Guide: Youth Engagement in Tobacco Prevention and Control, 2019
[2] American Lung Association. 2020.Helping Teens Quit: Teen Tobacco Cessation and Education Resources. https://www.lung.org/quit-smoking/helping-teens-quit

Priority: Improve Social and Emotional Wellbeing in Adolescents

Objective for Mental Health Treatment: 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.

Evidence-Based or Informed Strategy Measure (ESM): Percent of increase in Tennessee Child and Adolescent Psychiatry Education and Support (TCAPES) teleconsultation call line volume

The following strategies and activities are planned for October 1, 2025 to September 30, 2026:

Strategy 1: Implement youth-centered mental health/social-emotional skill-building promotion to address factors that influence adolescent well-being.

Supporting Evidence for Strategy 1: Holistic and community-based approaches embed comprehensive mental health promotion initiatives within environments that are available and familiar to adolescents, such as schools, youth centers, and faith-based organizations to improve access, engagement, and effectiveness. These approaches extend beyond traditional clinical services by delivering mental health care that addresses the interconnected social, cultural, environmental, and widespread factors impacting adolescents' mental health and well-being. This is achieved by collaborating with community partners to identify priorities, overcome barriers, and implement multifaceted and responsive mental health interventions for adolescents. Holistic and community-based approaches often incorporate peer support, skill-building, recreational activities, and collaboration across sectors like education, social services, and healthcare. Evidence suggests that well-implemented, community-driven programs effectively improve mental health outcomes for adolescents by fostering emotional resilience, promoting positive health outcomes, increasing service availability, and providing comprehensive care tailored to the unique needs within their local contexts[1],[2].

Activity 1a: Support schools and sports organizations in actively strengthening adherence to injury prevention protocols and promoting adolescent social-emotional wellbeing through adoption of the Safe Stars Coaches Code of Conduct.

Activity 1b: Explore funding and sustainability opportunities to implement the Wait Until 8th Campaign, or a comparable initiative.

Activity 1c: Provide peer-to-peer mental health promotion trainings (e.g. Sources of Strength, QPR, Youth Mental Health First Aid, etc.) to youth within school, community, and faith-based settings.

Activity 1d: Conduct a continuous needs assessment (i.e., focus groups, key informant interviews, etc.) to incorporate adolescent voices by partnering with adolescents from Tennessee Adolescent Advisory Board (TAAB), Youth Advisory Council (YAC), TNSTRONG Ambassadors, and other adolescent groups to ensure incorporation and alignment with activities outlined within this plan.

Planned Partnerships: Schools; Community Sports Leagues; TDH Office of Communication; Youth-Serving Community-Based Organizations; Faith-Based Organizations; County Health Councils

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.

Supporting Evidence for Strategy 2: Training and supporting healthcare providers to identify and address adolescent mental health concerns is a key strategy for improving access to care and early intervention. This approach equips professionals with the knowledge and skills to recognize signs of mental health issues, conduct screenings and assessments, make appropriate referrals, and deliver evidence-based interventions. Training often covers topics such as common mental health conditions, different cultures, motivational interviewing, and collaborative care models. Additionally, providing ongoing consultation, supervision, and access to mental health specialists can support healthcare providers in managing complex cases and ensure appropriate care coordination. Evidence suggests that training programs can significantly improve healthcare providers' abilities to accurately identify mental health problems, increase their confidence in managing these issues, and lead to improved mental health outcomes for youth, especially when integrated with mental health specialist support[3].

Activity 2a: Continue and expand the peer-to-peer teleconsultation service available to pediatric providers, offering real-time access to psychiatric specialists.

Activity 2b: Offer education and training for healthcare providers on the identification, treatment, and management of adolescent behavioral health conditions.

Activity 2c: Provide mental health promotion trainings (e.g., Sources of Strength, Youth Mental Health First Aid, QPR, Living Works, etc.) to adults within school, community- and faith-based settings, including adults who work who support youth.

Activity 2e: Promote FindHelpNowTN.org as a centralized referral source for pediatric mental health and substance use disorder treatment services by offering technical assistance and materials to healthcare providers and other professionals who support adolescents.

Activity 2f: Create a dashboard of suicide behavior and risk factors across demographics using the ESSENCE syndromic surveillance system to help guide state and local suicide prevention efforts.

Planned Partnerships: TN Department of Mental Health and Substance Abuse Services (TNDMHSAS); TN Department of Education; University of Tennessee Le Bonheur Pediatric Specialists (ULPS); County Health Councils; Le Bonheur Children's Hospital Emergency Department; TDH Health Disparities Advisory Committee; Tennessee Commission on Children and Youth (TCCY); Young Child Wellness Council (YCWC); Regional and Metro Health Departments; TN Chapter of the American Academy of Pediatrics (TNAAP); Pediatric Providers, Mental Health Providers, and Hospitals; Families and Youth Self-Advocates; Faith-Based Organization; Schools; Children's Safety Network, Child Safety Learning Collaborative – Suicide and Self Harm Prevention; Children and Youth with Special Health Care Needs (CYSHCN); Family Voices of Tennessee; TN Voices; Tennessee Suicide Prevention Network (TSPN); Suicide Prevention Advisory Council

Strategy 3: Implement youth empowerment initiatives that integrate anti-nicotine education and engagement activities to promote healthy, nicotine-free lifestyles.

Supporting Evidence for Strategy 3: The tobacco epidemic will not end without preventing initiation among young people; it is critical that programs engage youth in tobacco control efforts. Youth can be powerful allies to help communicate the impact of tobacco use on young people, implement effective tobacco control strategies, and shift social norms around tobacco use in their communities[4],[5],[6].

Activity 3a: Create a TNSRONG Ambassador collegiate/alumni group to continue to work with and support program goals and objectives, with a focus on increasing outreach to 18–24-year-olds.

Activity 3b: Promote nicotine-free teams and increase the number of teams taking the pledge to be nicotine-free.

Activity 3c: Support TNSTRONG Ambassadors in leading peer-to-peer conference sessions on tobacco education and promoting nicotine-free lifestyles at the annual Tennessee Teen Institute.

Planned Partnerships: School Districts; Anti-Drug Coalitions; County Health Councils; Tennessee Teen Institute

Adolescent Health Programs Supported by MCH/Title V:

- Child Fatality Review
- Coordinated School Health (School Health Nurse Consultant – 1.0 FTE)
- Children and Youth with Special Health Care Needs (CYSHCN)

Adolescent Health Programs Connected but Not Funded by MCH/Title V:

- Adolescent Pregnancy Prevention (SPARK)
- Core Injury Prevention
- Health Promotion
- Overdose Prevention and Response
- Rape Prevention Education
- Suicide Prevention
- Tennessee Child and Adolescent Psychiatry Education and Support (TCAPES)
- Tobacco Control and Prevention
- Traumatic Brain Injury

Contextual Factors:

- Persistent stigma surrounding mental health and substance use may reduce follow-through on referrals
- Behavioral health workforce shortages limit service availability, particularly in rural and medically underserved areas.
- Community health factors (transportation barriers, insurance, etc.) affect service engagement and participation
- Existing supportive initiatives from HRSA MCHB, including funding for the Maternal Mental Health and Substance Use Disorders program, can be leveraged for alignment and sustainability.
- Competing or supporting initiatives sponsored by other agencies
- Socioeconomic factors of the target audience

Assumptions:

- Funding from HRSA MCHB, HRSA PMHCA, CDC CSP, CDC NTCP, CDC OD2A and state programs will continue to support pediatric mental health, substance use disorders, and tobacco and e-cigarette cessation efforts.
- Staff with the necessary expertise will be available and adequately trained.
- Adolescents and professionals will be motivated to attend education and training sessions, and the information received will be adopted and used as intended.
- Providers will access the teleconsultation service.
- Partnerships or coalitions can effectively address problems or reach into areas we cannot.
- Cross-sector partnerships (healthcare, behavioral health, community services) will facilitate timely and effective referrals and follow-up care.
- Integration of FindHelpTN.org into referral processes will enhance service navigation and resource access for providers and families.

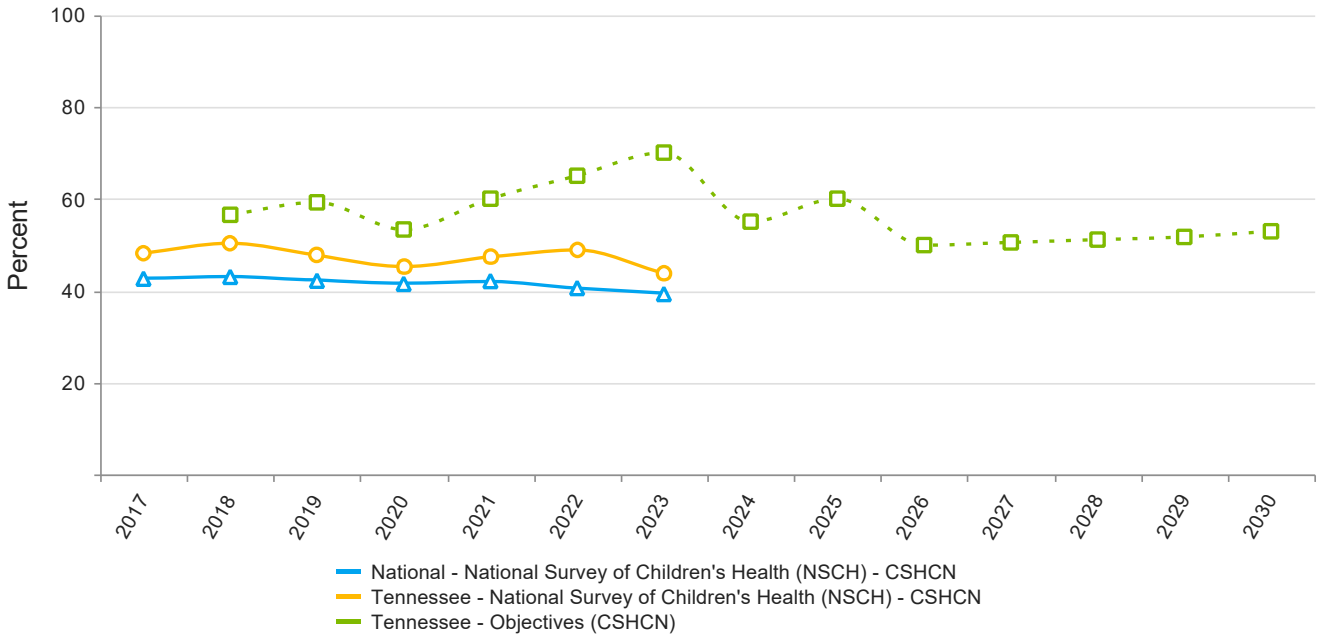
[1] Casañas, R., Castellvi, P., Gil, J.J. et al. The effectiveness of a “EspaiJove.net”- a school-based intervention programme in increasing mental health knowledge, help seeking and reducing stigma attitudes in the adolescent population: a cluster randomised controlled trial. BMC Public Health 22, 2425 (2022).

[2] Hart LM, Morgan AJ, Rossetto A, Kelly CM, Gregg K, Gross M, Johnson C, Jorm AF. teen Mental Health First Aid: 12-month outcomes from a cluster crossover randomized controlled trial evaluation of a universal program to help adolescents better support peers with a mental health problem. BMC Public Health. 2022; 22(1):1159.
[3] Haddad, M., Pinfold, V., Ford, T., Walsh, B., & Tylee, A. (2018). The effect of a training programme on school nurses' knowledge, attitudes, and depression recognition skills: The QUEST cluster randomised controlled trial. International Journal of Nursing Studies, 83, 1-10.
[4] CDC Best Practice User Guide: Youth Engagement in Tobacco Prevention and Control, 2019
[5] King, J. L., Reboussin, B. A., Spangler, J., Cornacchione Ross, J., & Sutfin, E. L. (2018). Tobacco product use and mental health status among young adults. Addictive behaviors, 77, 67–72.
[6] Oğuz Emre, Kadriye Özyazıcı, Ayşegül Keskinkılıç, Zekeriya Arslan, (2024). The role of adolescents' mental health and well-being in predicting their smoking status. Archives of Psychiatric Nursing, Volume 51, 2024, Pages 137-142, ISSN 0883-9417.

Children with Special Health Care Needs

National Performance Measures

NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - MH Indicators and Annual Objectives



NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - MH - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	53.3	60	65	70	55
Annual Indicator	48.5	46.5	49.3	49.3	43.7
Numerator	157,666	155,739	157,779	157,276	180,127
Denominator	325,137	334,628	320,158	319,309	412,011
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2018_2019	2019_2020	2020_2021	2021_2022	2022_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	49.9	50.5	51.1	51.7	52.9

Evidence-Based or –Informed Strategy Measures

ESM MH.1 - Number of CYSHCN who receive CHANT/CSS care coordination

Measure Status:	Inactive - Completed				
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		2,500	3,000	3,500	4,500
Annual Indicator		4,885	4,930	4,560	4,702
Numerator					
Denominator					
Data Source		PTBMIS	PTBMIS	PTBMIS	PTBMIS
Data Source Year		2021	2022	2023	2024
Provisional or Final ?		Final	Final	Final	Final

ESM MH.2 - Percent of providers adopting medical home approach

Measure Status:	Inactive - Completed				
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective			40	55	65
Annual Indicator			0	0	0
Numerator					
Denominator					
Data Source			N/A	N/A	N/A
Data Source Year			N/A	N/A	N/A
Provisional or Final ?			Final	Final	Final

ESM MH.3 - Percent of providers reporting increased knowledge on systems of care

Measure Status:	Inactive - Completed				
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective			20	30	40
Annual Indicator			0	0	0
Numerator					
Denominator					
Data Source			N/A	N/A	N/A
Data Source Year			N/A	N/A	N/A
Provisional or Final ?			Final	Final	Final

ESM MH.4 - Number of families provided education and resources on importance of medical home access and utilization

Measure Status:	Inactive - Completed				
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective					
Annual Indicator	1,383	1,424	1,749	1,527	1,824
Numerator					
Denominator					
Data Source	CHANT	CHANT	CHANT	CHANT	CHANT
Data Source Year	2020	2021	2022	2023	2024
Provisional or Final ?	Final	Final	Final	Final	Final

ESM MH.5 - Number of families receiving referrals to their child's primary care provider

Measure Status:	Inactive - Completed				
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		375	400	425	450
Annual Indicator	222	216	272	233	338
Numerator					
Denominator					
Data Source	CHANT	CHANT	CHANT	CHANT	CHANT
Data Source Year	2020	2021	2022	2023	2024
Provisional or Final ?	Final	Final	Final	Final	Final

ESM MH.6 - Percent of providers who report an increase in their knowledge of available resources

Measure Status:	Inactive - Completed				
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective			25	50	75
Annual Indicator			0	0	0
Numerator					
Denominator					
Data Source			N/A	N/A	N/A
Data Source Year			N/A	N/A	N/A
Provisional or Final ?			Final	Final	Final

ESM MH.7 - Percent of families who report an increase in access and utilization of resources

Measure Status:	Inactive - Completed				
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective			35	40	50
Annual Indicator			0	0	0
Numerator					
Denominator					
Data Source			N/A	N/A	N/A
Data Source Year			N/A	N/A	N/A
Provisional or Final ?			Final	Final	Final

ESM MH.8 - Percent of CHANT families who schedule an annual visit with their child's primary care provider

Measure Status:	Inactive - Completed				
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		25	35	45	55
Annual Indicator		3.2	16	13.9	16.5
Numerator					
Denominator					
Data Source		CHANT	CHANT	CHANT	CHANT
Data Source Year		2021	2022	2023	2024
Provisional or Final ?		Final	Final	Final	Final

ESM MH.9 - Percent of CYSHCN receiving CHANT care coordination who receive medical home education

Measure Status:	Inactive - Completed				
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective			75	85	20
Annual Indicator		5.4	16.2	10.9	16.9
Numerator					
Denominator					
Data Source		CHANT	CHANT	CHANT	CHANT
Data Source Year		2021	2022	2023	2024
Provisional or Final ?		Final	Final	Final	Final

ESM MH.10 - Number of teachers/school personnel trained on QPR

Measure Status:	Inactive - Completed	
State Provided Data		
	2023	**2024**
Annual Objective		
Annual Indicator	2,111	
Numerator		
Denominator		
Data Source	TDH	
Data Source Year	2023	
Provisional or Final ?	Final	

ESM MH.11 - Percentage of children with and without SHCN who are applying for health insurance

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	21.0	23.0	25.0	27.0	29.0

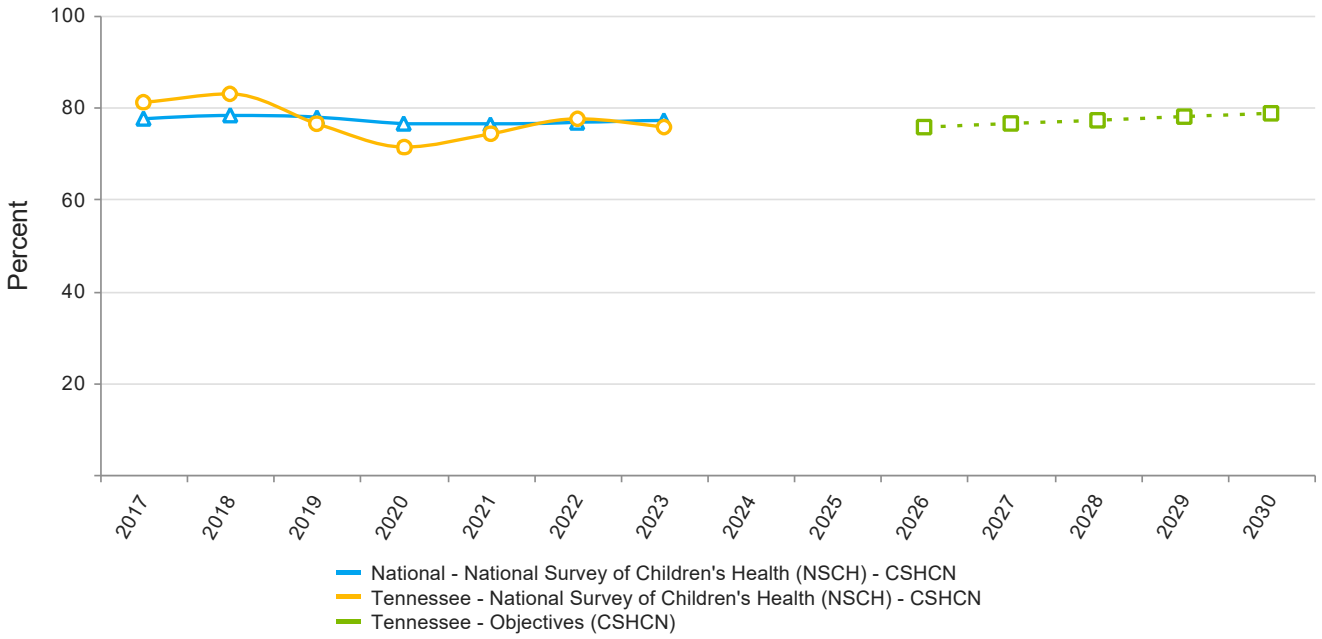
ESM MH.12 - Percentage of children with and without SHCN who schedule an exam with a primary care provider

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	39.0	42.0	45.0	48.0	51.0

NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a personal doctor or nurse - MH_PDOC
Indicators and Annual Objectives



NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a personal doctor or nurse - MH_PDOC - Children with Special Health Care Needs

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - CSHCN	
	2024
Annual Objective	
Annual Indicator	75.6
Numerator	310,326
Denominator	410,234
Data Source	NSCH-CSHCN
Data Source Year	2022_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	75.6	76.4	77.1	77.9	78.6

Evidence-Based or –Informed Strategy Measures

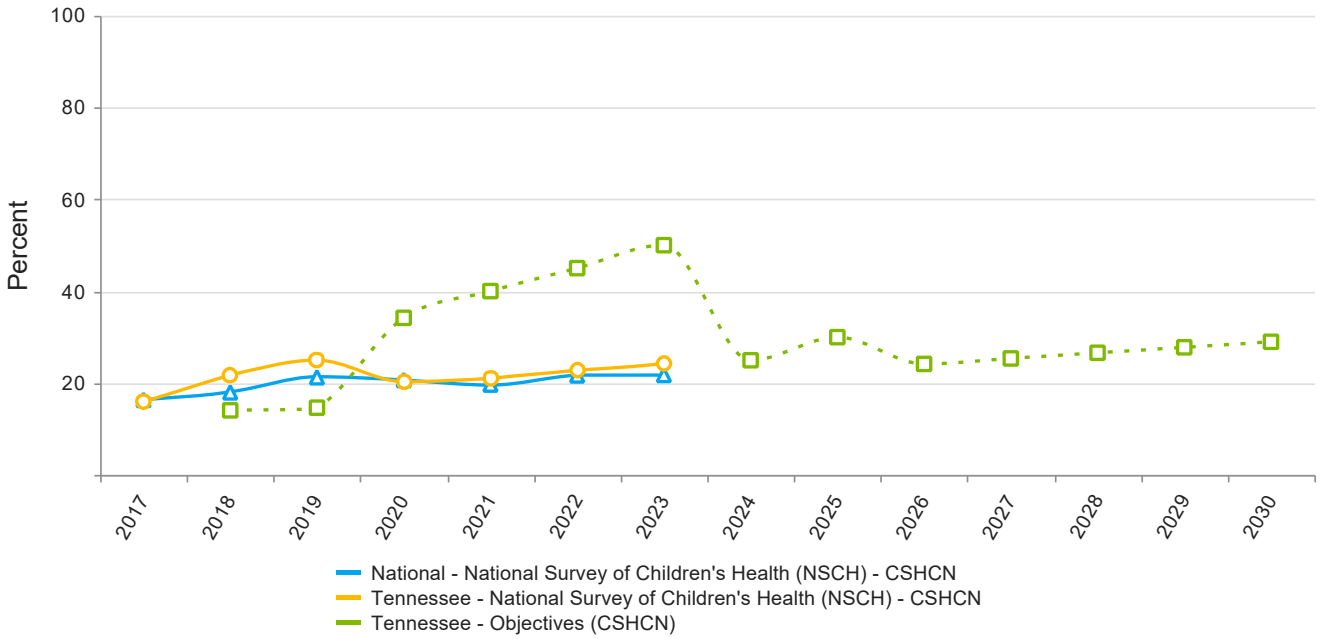
ESM MH_PDOC.1 - Percentage of children with and without SHCN who receive a referral to a primary care provider

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	94.0	95.0	96.0	97.0	98.0

NPM - 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 - TAHC
Indicators and Annual Objectives



NPM - 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 - TAHC - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	34.2	40	45	50	25
Annual Indicator	22.2	22.1	24.2	25.8	24.2
Numerator	30,583	30,634	37,238	39,988	43,593
Denominator	137,839	138,824	153,684	155,239	180,045
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2018_2019	2019_2020	2020_2021	2021_2022	2022_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	24.2	25.4	26.6	27.8	29.0

Evidence-Based or –Informed Strategy Measures

ESM TAHC.1 - Number of transition resource kits disseminated

Measure Status:	Inactive - Not continuing this ESM in the 2026-2030 cycle				
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		150	300	600	1,200
Annual Indicator	0	100	366	552	785
Numerator					
Denominator					
Data Source	CYSHCN	CYSHCN	CYSHCN Program Data	CYSHCN Program Data	CYSHCN Program Data
Data Source Year	2020	2021	2022	2023	2024
Provisional or Final ?	Final	Final	Final	Final	Final

ESM TAHC.2 - Number of youth with special health care needs trained as mentors

Measure Status:	Inactive - Not continuing this ESM in the 2026-2030 cycle				
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		25	35	45	55
Annual Indicator	0	5	6	47	53
Numerator					
Denominator					
Data Source	CYSHCN Program Data	CYSHCN Program Data	CYSHCN Program Data	CYSHCN Program Data	CYSHCN Program Data
Data Source Year	2020	2021	2022	2023	2024
Provisional or Final ?	Final	Final	Final	Final	Final

ESM TAHC.3 - Number of parents and youth with special health care needs who receive leadership and self-advocacy training

Measure Status:	Inactive - Not continuing this ESM in the 2026-2030 cycle				
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		50	75	100	450
Annual Indicator	71	150	475	475	465
Numerator					
Denominator					
Data Source	CYSHCN Program Data	CYSHCN Program Data	CYSHCN Program Data	CYSHCN Program Data	CYSHCN Program Data
Data Source Year	2020	2021	2022	2023	2024
Provisional or Final ?	Final	Final	Final	Final	Final

ESM TAHC.4 - Percentage of CSS-eligible YSHCN, age 14-21, who complete a transition plan

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	92.0	93.0	94.0	95.0	96.0

State Action Plan Table

State Action Plan Table (Tennessee) - Children with Special Health Care Needs - Entry 1

Priority Need

Increase Access to Quality Care for Children and Adolescents with Special Healthcare Needs

NPM

NPM - Medical Home; Medical Home_Personal Doctor

Five-Year Objectives

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-CYSHCN: 75.8%) to September 30, 2030 (CYSHCN: 75.7%, Non-CYSHCN: 79.6%)

Strategies

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.

ESMs	Status
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 - 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	Inactive
ESM MH.11 - Percentage of children with and without SHCN who are applying for health insurance	Active
ESM MH.12 - Percentage of children with and without SHCN who schedule an exam with a primary care provider	Active
ESM MH_PDOC.1 - Percentage of children with and without SHCN who receive a referral to a primary care provider	Active

NOMs
Children's Health Status
CSHCN Systems of Care
Flourishing - Young Child
Flourishing - Child Adolescent - CSHCN
Flourishing - Child Adolescent - All

State Action Plan Table (Tennessee) - Children with Special Health Care Needs - Entry 2

Priority Need

Increase Access to Quality Care for Children and Adolescents with Special Healthcare Needs

NPM

NPM - Transition To Adult Health Care

Five-Year Objectives

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.

Strategies

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.

ESMs	Status
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	Inactive
ESM TAHC.4 - Percentage of CSS-eligible YSHCN, age 14-21, who complete a transition plan	Active

NOMs

CSHCN Systems of Care

2021-2025: State Performance Measures

2021-2025: SPM 14 - Number of CYSHCN receiving care in a medical home

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		800	850		2,300
Annual Indicator	2,194	2,196	2,100	2,140	2,895
Numerator					
Denominator					
Data Source	PTBMIS	PTBMIS	PTBMIS	PTBMIS	PTBMIS
Data Source Year	2020	2021	2022	2023	2024
Provisional or Final ?	Final	Final	Final	Final	Final

2021-2025: SPM 15 - Percent of providers with increased knowledge on medical home and care coordination

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		25	35	50	65
Annual Indicator		0	0	0	0
Numerator					
Denominator					
Data Source		N/A	CYSHCN Program Data	CYSHCN Program Data	CYSHCN Program Data
Data Source Year		N/A	2022	2023	2024
Provisional or Final ?		Final	Final	Final	Final

2021-2025: SPM 16 - Percent of providers reporting improved system of care for CYSCHN

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**

Annual Objective			35	50	65
Annual Indicator			0	0	0
Numerator					
Denominator					
Data Source			CYSHCN Program Data	CYSHCN Program Data	CYSHCN Program Data
Data Source Year			2022	2023	2024
Provisional or Final ?			Final	Final	Final

2021-2025: SPM 17 - Percent of families who complete an annual visit with their primary care provider

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective			10	12.5	15
Annual Indicator		7.5	7.4	7.3	14
Numerator					
Denominator					
Data Source		CHANT	CHANT	CHANT	CHANT
Data Source Year		2021	2022	2023	2024
Provisional or Final ?		Final	Final	Final	Final

2021-2025: SPM 18 - Percent of youth reporting with increased knowledge on transition resources and services

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective			100	100	100
Annual Indicator		100	100	100	100
Numerator					
Denominator					
Data Source		CYSHCN	YAC	YAC	YAC
Data Source Year		2021	2022	2023	2024
Provisional or Final ?		Final	Final	Final	Final

2021-2025: SPM 19 - Percent of YSHCN served by CHANT who complete an annual transition plan

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**

State Provided Data					
	2020	2021	2022	2023	2024
Annual Objective			75	80	85
Annual Indicator		72	72	72.5	74.1
Numerator					
Denominator					
Data Source		PTBMIS	PTBMIS (CSS)	PTBMIS (CSS)	PTBMIS (CSS)
Data Source Year		2021	2022	2023	2024
Provisional or Final ?		Final	Final	Final	Final

2021-2025: SPM 20 - Percent of youth leaders participating in advisory councils providing resources to other youth

Measure Status:				Active	
State Provided Data					
	2020	2021	2022	2023	2024
Annual Objective			30	30	30
Annual Indicator		26.3	35.3	28.6	29.1
Numerator					
Denominator					
Data Source		CYSHCN	CYSHCN	CYSHCN	CYSHCN
Data Source Year		2021	2022	2023	2024
Provisional or Final ?		Final	Final	Final	Final

Priority: Increase CYSHCN Medical Home Access and Utilization

MCH/Title V Funding: MCH Title V funds the CYSHCN activities and initiatives in the State of Tennessee. Funds are also used to cover positions in the central office, local, regional, urban and metro health departments who provide services to CYSHCN. These funds also provide support for contractual agreements with Family Voices and for the Council on Developmental Disabilities.

Interpretation of Performance Data on selected NPMs, SPMs, and SOMs:

Medical Home NPM: Percent of children with and without special health care needs 0-17 who have a medical home
49.65% of TN children 0-17 had a medical home in 2022 per NSCH data, the most recent single-year data available. This indicator has been stable in the last three years, and while less than the 2024 goal set for CYSHCN of 55%, this metric continues to be significantly higher than the national average of 43.1%.

The stability of this NPM can be attributed to the Community Health Access and Navigation in Tennessee (CHANT) program continuing to promote access and utilization of a medical home. The program identifies families that are not currently receiving services in a medical home and assists with identification of provider and with scheduling appointments for annual visits. Follow-up is conducted to ensure that families keep their appointments and needed referrals with specialty providers are received.

SPM 14: Number of CYSHCN receiving care in a medical home
During State Fiscal Year (July 1, 2023 - June 30, 2024), 2,895 of children participating in the Children's Special Services (CSS) program reported having seen their primary providers for an annual exam, a proxy indicator for medical home. This accounts for 61.56% of the CSS population. This number has been consistent in recent years and is above the goal of 2,300 for 2024.

This increase over the previous reporting cycle can be attributed to the CSS program's re-training of all care coordinators and the requirement that all families referred to the CHANT program are screened using the CSHCN Screener. This screener helps to identify those families that have children and youth who may qualify for the CSS program and is a precursor to CSS eligibility determination.

SPM 15: Percent of providers with increased knowledge on medical home and care coordination
There is no data available for SPM 15 at this time.

Activities related to this SPM will be conducted during the Spring and Fall of 2025.

SPM 16: Percent of providers reporting improved system of care for CYSHCN
There is no data available for SPM 16 at this time.

Activities related to this SPM will be conducted during the Spring and Fall of 2025.

SPM 17: Percent of families who complete an annual visit with their primary care provider
13.96% of CHANT families served completed an annual exam visit with their primary care provider during FY 2024.

Previously, SPM 17 percentage was calculated as the number of families who completed a primary care visit out of the number of families who triggered the Medical Home Pathway at the time of screening and assessment. However, triggering a pathway does not necessarily mean that the family initiates the pathway or enrolls in CHANT. The new methodology calculates the percentage as the number of families who completed a primary care visit out of the number of families who enrolled in CHANT and triggered the Medical Home pathway. The team changed the methodology because it was theorized that the previous methodology did not consider families who were not

enrolled and served in CHANT. If the family did not enroll in the program, there was no way to determine if the primary care visit was completed. The team has also determined that many of the families that trigger the pathway may not necessarily need an appointment but might have triggered the pathway for another reason (e.g., seek care by going to the emergency room).

Accomplishments and Challenges (based on the FY2024 Action Plan):

Strategy 1: Create a shared vision for integrating and improving CYSHCN system of care.

Supporting Evidence for Strategy 1: Creating an effective system of care for children and youth with special health care needs (CYSHCN) is one of the most challenging and pressing roles for state health leaders. In the United States, 9.4 million children, or almost 13 percent, have special health care needs. A major challenge for families of CYSHCN is accessing an often-fragmented system of care." Models-of-Care-for-CYSHCN.pdf (amchp.org). The National Survey of Children's Health reports in the 2020-2021 combined survey that only 49.3% of Tennessee children with special health care needs report receiving care that meets the medical home criteria of coordinated, ongoing, comprehensive care within a medical home.

Activity 1a: Meet with the TennCare PCMH Coordinator and Chief Quality Officer to discuss the concerns of primary care providers in caring for CYSHCN, namely, care coordination and primary care reimbursement. Determine how TennCare is currently handling these areas and if updates can be made within the PCMH program/broader scope of TennCare.

Report 1a: During this reporting period, the CYSHCN team met with the TennCare (Medicaid) Patient Centered Medical Home (PCMH) coordinator and Chief Medical Officer. One of the requirements for the PCMH program is that all participating practices be National Committee for Quality Assurance (NCQA) certified. There are currently 82 pediatric providers who have received NCQA recognition as gold practices. With the NCQA certification, practices are required to provide care coordination, and TennCare reimburses for primary care visits and care coordination according to their standard billing practices. TennCare expressed a desire to focus on rural areas that are not currently involved in the PCMH program. TennCare publishes a monthly newsletter geared towards the 82 approved PCMH practices, which is also available on their website to the state Medicaid provider network. In an effort to meet the concerns of rural providers, the CYSHCN team developed an article to be shared with the providers.

The article emphasized the importance of Patient-Centered Medical Homes for Children and Youth with Special Health Care Needs (CYSHCN) and highlighted the TennCare PCMH program and the upcoming application period for new practices to become a part of the PCMH cohort and receive the NCQA certification. The article was published in the TennCare Provider Insider Newsletter for the June and July issues, and analytics showed that it received 470 unique clicks.

Activity 1b: Sponsor a learning collaborative to help improve service coordination and CYSHCN linkage for medically underserved communities to providers and community-based services.

Report 1b: The CYSHCN Team has not sponsored a learning collaborative at the time of this report, and there is no data available to measure **ESM MH3**. However, the team has developed a model to sponsor a medical home learning collaborative for execution in the summer and fall of 2025. This collaborative will be hosted to increase access to medical homes and to create a provider, patient, family, and network that will improve service coordination. Four networking events will be hosted, one in each region across the state, three in person and one virtually, that will provide a comfortable, safe setting for families,

providers, internal and external partners the opportunity to learn about the importance of a medical home.

To create opportunities to link CYSHCN populations to providers and community-based services, the CSS program collaborated with the Department's Health Disparities Advisory Group about how the CSS program can assist Children and Youth with Special Health Care Needs (CYSHCN), particularly those living in rural or suburban areas and those facing socioeconomic challenges. During this discussion, the team addressed several unique populations and answered questions regarding access to the CSS and Community Health Access and Navigation in Tennessee (CHANT) online referral form. The team met with the Vanderbilt Family Advisory group to discuss participants who do not have health insurance. This meeting helped identify useful resources the team could provide for the children that Vanderbilt serves. This alliance collaborates with the Tennessee Department of Health (TDH) Office of Faith-Based Community Engagement. This provided an opportunity for linkages to services for families that may not be aware of these programs or otherwise engage with the Department of Health.

Activity 1c: Promote access to high-quality health care through hosting a Statewide Medical Home Conference.

Report 1c: The team is currently planning a series of statewide networking and educational events to promote the importance of medical homes in 2025. As part of this effort, a medical home learning collaborative will be launched in the summer and fall of 2025, aimed at increasing access to medical homes and fostering a network among providers, patients, and families to improve service coordination. Four regional networking events will be held, with three in-person and one virtual, to provide a supportive environment for families, providers, and partners to learn about the value of medical homes.

In addition to these plans, the team holds quarterly meetings with Managed Care Organizations (MCOs) to discuss outreach efforts for all populations and is actively involved in the Well Child Collaborative, which focuses on TennCare initiatives to improve Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) rates for medically underserved communities. The team also participates in the Tennessee Primary Care Association webinars to stay informed on improving access to care.

Activity 1d: Identify and provide data information on medical home to non-Medicaid providers seeking to implement a medical home approach to care.

Report 1d: To address medical home differences in care, the team engaged non-Medicaid providers by making information on the medical home approach easily available. In doing so, the team provides medical home resources, which are available on the Tennessee Birth Defects Surveillance System (TNBDSS) providers' website. The website reaches all providers across the state, including non-Medicaid providers. From this website, providers can download the Medical Home Toolkit, which includes valuable resources for both TennCare and non-TennCare providers. Between October 1, 2023 and September 30, 2024, there were 64 page views and 39 unique visitors to the website.

The team has also developed a medical home resource information sheet that is included in all faxes sent to pediatric providers for birth defects diagnosis verification and service referral information. This ensures that both TennCare and non-TennCare providers have access to the support they need to help families with medical home

development.

There is no data available to analyze progress towards achieving **ESM MH.2 (Percent of providers adopting medical home approach).** The team will report data during FY 2025 following the learning collaborative.

Activity 1e: CYSHCN, in conjunction with Family Voices, will investigate the current needs for broadband access in the most medically underserved regions of Tennessee, as identified by CSS data.

Report 1e: A meeting was held with Family Voices (FV) to discuss strategies for engaging families in the most at-risk regions. The team, along with FV, explored broadband services to identify areas that lack access to this important resource. The team created a Family Resource Guide that shares information on how telehealth improves a child's health, how their child can participate in a telehealth visit and how to prepare your child for a telehealth visit. A Tennessee Broadband Resource Guide was also created for people with disabilities and their families that shares low-cost or free broadband services that are available across the state of Tennessee with eligibility criteria and how to access the services. Both of those resource guides can be found via these links: Broadband - Family Voices of Tennessee and Telehealth - Family Voices of Tennessee. Also, TNBDSS provides data analysis on access to care at both the county and regional levels, which can be utilized to investigate broadband access in Tennessee.

Challenges and Issues Related to Implementation of Strategy 1: Challenges for this strategy continue to be related to the implementation of a learning collaborative for medical providers. The program has performed well in providing information and learning opportunities to the CHANT team, community partners, and families. The program will continue working with identified partners to ensure completion of this strategy during the ensuing year. The partnership with the TennCare PCHM team has led to additional opportunities to share information on the importance of medical home access and utilization, and will continue during the learning collaborative scheduled for 2025.

Strategy 2: Inform and educate families and providers to promote systems change.

Supporting Evidence for Strategy 2: All children should receive comprehensive coordinated care in a medical home environment that is a collaboration between the family and the provider and provides medical care and support, care coordination, and resources. This strategy will increase the knowledge of families and providers and promote systems change. The National Survey of Children's Health reports in the 2020-2021 combined survey that only 49.3% of Tennessee children with special health care needs report receiving care that meets the medical home criteria of coordinated, ongoing, comprehensive care within a medical home.

Activity 2a: Prioritize families and providers by geographic location and promote medical home implementation through education, training, and resources.

Report 2a: During this reporting cycle, the team developed and updated resources that promote medical home implementation. The Transition Resource Guide has been uploaded to the website to facilitate broader collaboration with partners. Additionally, a Care Coordination Resource Guide has been created to assist Care Coordinators across the state with service referrals, ensuring they have the necessary resources to support their clients effectively. The Partnering with Your Doctor booklet has also been updated during this reporting period, with revisions sent to the leadership team for approval, aiming for completion in year 5 of the grant cycle. A Medical Home webpage has been established on the CYSHCN and TNBDSS websites, allowing providers and families the ability to access and download essential Medical Home resources. The team also encourages

Care Coordinators to prioritize referrals to PCMH/NCQA providers for families who lack a medical home by sharing links to the PCMH-approved providers. Planning for the 2025 CYSHCN Medical Home Learning Collaborative is currently in development. This collaborative will focus on networking opportunities for providers and families, emphasizing the importance of medical homes. The plan includes hosting four events—three in-person and one virtual—to foster engagement and learning in a comfortable and safe environment.

The FY 24 target for **ESM MH.4 (Number of families provided education and resources on the importance of medical home access and utilization)** was 1,500. The number of families actually provided education and resources was 1,824, which far exceeded the target for FY2024. This data has continued to increase over the grant cycle, and targets were increased for FY 24 and 25. This increase can be attributed to the continuous training of CHANT care coordinators and updated resources available for families and staff.

Activity 2b: Identify and provide resources and referrals to providers on dental home, behavioral/mental health care coordination, respite care, and family engagement practices.

Report 2b: Ongoing collaboration with Family Voices of TN, Department of Disability and Aging and Disability Pathfinder highlights a strong commitment to supporting families and individuals with disabilities.

As part of the birth defects enhanced surveillance initiative, TNBDSS has been proactive in sending information about supportive services to pediatric providers, including resources with information about the services that CHANT, CSS, Tennessee Early Intervention Services, and Family Voices provide. As of September 30, 2024, TNBDSS has distributed 1,369 information sheets to pediatric providers across Tennessee. Additionally, TNBDSS makes referrals upon request from pediatricians and parents, with 28 service referrals sent on behalf of families to date. To further promote available services, TNBDSS provided public-facing flyers at key events, including the Tennessee State Pediatric Conference on August 17 and the Cumberland Pediatric Foundation's Open House held on September 25.

CHANT addresses this need through the dental home and behavioral health pathways. The dental home pathway supports families in identifying dental homes, the importance of dental preventive care, and ongoing dental services.
The behavioral health pathway assists families in identifying and/or becoming engaged with behavioral health providers in their counties. CHANT Care Coordinators provide education, referral, and/or resource assistance to families who identify a need for dental or behavioral health services.

In FFY24, 41.19% of children under 21 who enrolled in CHANT needed dental assistance. 32% more children needed dental assistance in FFY24 compared to FFY23, and CYSHCN had a higher increase (40%) than non-CYSHCN (15% increase).

About half (54.76%) of children in need of a Dental Home who enrolled in CHANT started the Dental Home Pathway. Broken down, about three-quarters (78.63%) of children without special health care needs and nearly a quarter (21.37%) of CYSHCN who needed it started the pathway. Although the total number starting the pathway increased, 5% fewer children who needed to start the pathway compared to FFY23 (54.76% in FFY24 vs. 60.10% in FFY23). About 20% of children who started the Dental

Home pathway scheduled a dental exam.

In FFY24, 1.63% of children under 21 who enrolled in CHANT needed assistance on the Behavioral Health Pathway. Out of those children, 56.48% did not have special health care needs, and 43.52% were CYSHCN. Compared to FFY23, 5% fewer children needed behavioral health assistance overall, but there were differences between children with and without special health care needs: 12% more CYSHCN but 16% fewer non-CYSHCN needed behavioral health assistance in FFY24.

Further, 63.73% of children started the Behavioral Health Pathway in FFY24: 52.03% of those who started did not have special health care needs, and 47.9% were CYSHCN. More than half (56.67%) of children who received services on the pathway were CYSHCN, and 43.33% of children without special health care needs received services. In FFY24, 16% more CYSHCN confirmed that they received services compared to FFY23.

The CHANT team is equipped to provide data on service recipients enrolled in CHANT on the Dental and Behavioral Health pathways. This data, which is collected through the RedCap platform, plays a vital role in identifying resources needed for each pathway of care. Once the resources are identified, they are available in the SharePoint drive for all CHANT staff to utilize. These resources are organized by region/county and are updated every six months. Additionally, the CHANT collaborative subcommittee, which focuses on identifying community partners and improving access to resources, works to enhance the tools available for care coordinators serving enrolled families.

Activity 2c: Provide coordinated care to CHANT-enrolled CYSHCN families that results in identifying a medical home and assistance with scheduling appointments for annual EPSDT/WCC visits.

Report 2c: During FY 2024, 4,702 (**ESM MH. 1**) children received CSS care coordination services, which was a 3% increase over FY 2023. This increase can be attributed to the continuation of CHANT-enrolled families receiving care coordination and assistance in scheduling annual appointments with their primary care providers. During this reporting period, 83.77% of all children served in CHANT reported having a medical provider, a proxy for an identified medical home, at the time of the screening and assessment. 87.21% of CYSHCN who were eligible for CSS in FY2024 reported having an identified medical home at the time of the screening and assessment. 41.0% of CYSHCN who needed a medical home started the Medical Home Pathway in FFY24, which was similar to FFY23 (44.1%). About half (52.9%) of CYSHCN who started the Medical Home Pathway confirmed that they completed an annual medical exam, which was about 13% less than FFY23 (65.8%).

Care Coordinators are encouraged to utilize PCMH/NCQA Centers as the primary resource for families lacking an identified medical home, providing them with links to approved providers within the medical home pathway. By providing this resource, families are empowered to choose a medical home based on state and national certification and the education provided.

During this reporting cycle, the team met with the CSS medical service leads to emphasize the importance of completing the child health section of the CSS pathway, particularly regarding EPSDT visits and ensuring appropriate follow-up for participants who have not had their annual appointment. This topic was also addressed at the Annual Professional Development Conference held on August 20th, underscoring the

commitment to improving health outcomes for children.

Activity 2d: Partner with local Managed Care Organizations (MCOs) to provide education/outreach to CHANT-enrolled CYSHCN families residing in rural and metro areas with the lowest EPSDT/WCC completion rates on the importance of having a medical home and the resources available within their communities.

Report 2d: CHANT's partnership with Managed Care Organizations (MCOs) has fostered valuable education/outreach efforts. The team has been proactive in holding quarterly meetings with the MCOs, ensuring effective communication and collaboration. Each month, MCOs receive a list of CHANT outreach events and send the team information about their upcoming events, facilitating a two-way flow of information. During this reporting cycle, MCO representatives also attended the CHANT CHAT, providing Care Coordinators with insights into their specific TennCare programs and addressing questions from CHANT staff. MCOs also participated in quarterly CHANT meetings, where they engaged with Care Coordinators to discuss their specific programs and the services offered. Most CHANT Care Coordinators attended this meeting virtually, highlighting the commitment to ongoing communication and collaboration among all parties involved.

During this reporting period, CHANT continued to focus on the ten counties with the lowest EPSDT screening rates. Those counties were Decatur, Haywood, Henry, Houston, Giles, Lake, Pickett, Chester, Wayne and Carol. The program partnered with the MCOs and other community- based organizations to host outreach activities designed to promote and increase the number of children receiving an annual primary care examination and immunizations.

Families received education, resources, and referrals on the importance of EPSDT and Well-Child Check-ups. Families are assisted with scheduling annual visits, and follow-up is conducted to ensure that appointments are kept. The collaboration with the MCOs has provided additional resources for families and has increased compliance with EPSDT and Well Child Check-ups.

Challenges and Issues Related to Implementation of Strategy 2: Overall, the program continues to make progress on Strategy 2. The program continues to review the measures and make adjustments based on their ability to meet and exceed the targets.

Strategy 3: Identify and disseminate resources on medical home best practices in Tennessee to inform and educate families and providers on care-coordination benefits.

Supporting Evidence for Strategy 3: Care coordination can be critical for linking families and CYSHCN to needed medical, developmental, behavioral, educational, and social services, and for providing community-based resources and emotional support. works. The National Care Coordination Standards for CYSHCN indicates "Care coordination for CYSHCN is based on the premise that all children and families should have an equal opportunity to attain their full health potential, and no barriers should exist to prevent children and their families from achieving this potential and that care coordination should address the full range of social, behavioral, environmental, and health care needs of CYSHCN." (https://www.nashp.org/national-care-coordination-standards-for-children-and-youth-with-special-health-care-needs/#toggle-id-2) The National Survey of Children's Health reported in the 2020-2021 combined survey results that 23.5% of CYSHCN in Tennessee did not receive needed care coordination.

Activity 3a: Create and disseminate a medical home toolkit to families and providers.

Report 3a: During this reporting cycle, the Medical Home webpage received updates that included information on enhancing the resources available to providers and families. This webpage can be accessed through the CYSHCN and TNBDSS sites, allowing users to find and download essential Medical Home resources. Between October 1, 2023 and September 30, 2024, there were 64 page views and 39 unique visitors to the Medical Home website.

Currently, TNBDSS is collaborating with FHW Communications to finalize approval for a Medical Home information sheet. As of October 2024, this sheet has been included in all faxes sent to pediatric providers for birth defects diagnosis verification and service referral information. It features resources for providers that accept TennCare, as well as additional resources for those that do not, ensuring comprehensive support for families navigating their medical home options. To date, approximately 1600 letters have been sent out.

The CYSHCN section continues to update and promote the medical home toolkit at https://www.tn.gov/health/health-program-areas/fhw/cyshcn-section/medical-home/mh-toolkit.html

Activity 3b: Create and disseminate a care coordination toolkit to healthcare providers and CHANT care coordinators.

Report 3b: The CYSHCN team is actively engaged in regular meetings and collaborative opportunities that provide opportunities to develop care coordination tools that can be utilized for all populations. A key initiative has been the development of a Care Coordinators Resource Guide, designed to provide essential resource information for Care Coordinators across the state. This guide aims to assist in making service referrals and was presented at the CSS Advisory Committee meeting, where feedback from providers and parent advocates was solicited. The guide will be disseminated during the next reporting period.

The CYSHCN team continues to facilitate bi-monthly strategic topic calls, during which the team continues to identify and share new resources for CSS families.

Between October 1, 2023 and September 30, 2024, there were 4 CSS Strategic Topic Calls ranging from 122-163 attendees. Topic themes are as follows:

Program & Family Engagement:

- Youth Engagement Workshop Assistance
- Upcoming CSS Advisory Committee / CSS Advisory Committee Recruitment
- Incentives
- CSS Emergency Plan
- Autism Webinar Presentation (Vanderbilt Kennedy Center)
- CSS Care Coordination Toolkit
- Effective Communication (Human Resources)

Training, Process Improvement, and Site Support:

- CSS Training Takeaways
- Nurses CSS LEAN Meeting
- August Training
- Upcoming Site Visits

- Upcoming Medical Services Lead Meeting
- Maxim Presentation/Partnership for Referrals

Data, Tools, and Evaluation:
- Redcap Numbers Needed
- Billing Spreadsheet
- Expenditure Update / Expenditures
- Cases Transferred

Vendor and Contract Management:
- Vendor Updates
- Vendor Authorization Importance (Cornerstone)
- New Food and Formula Vendor
- Special Food and Supplies Vendor Update
- Metro Contract Renewals Due

Policy, Operations, and Administrative Updates (recurring or system-wide):
- Field Updates (noted in every session)
- Policy and Rules Overview
- Bill Keying Errors
- MSL Audit Requirements
- Central Office Communication
- Tentative Conference Dates

This ongoing effort ensures that families are kept informed about available support. Care coordination remains a priority during CSS's training sessions, involving the entire team rather than focusing on individual members. This approach fosters a collaborative environment and strengthens the overall effectiveness of care coordination efforts.

There is no data available for **ESM MH.6 (Percent of providers who report an increase in their knowledge of available resources)**.

Activity 3c: Promote the medical home and provide care coordination and medical home referrals to families receiving services through the Children's Special Services Program.

Report 3c: The Annual Professional Development training took place in August 2024 with the theme "Removing Barriers and Strengthening Families." During this conference, several sessions were held providing updates on the importance of care coordination for the entire CHANT/CSS team. This year's conference included more than 200 attendees, with presentations from family representatives on what they experience on a day-to-day basis when seeking care and navigating the system for their CYSHCN. The evaluations indicated that 42 individuals thought that the conference was a good conference, while 69 individuals indicated that it was a good conference. 87 individuals indicated that the speakers were effective and 37 indicated that the speakers were very effective. Suggestions were care coordinators wanted to hear more success stories from families, wanted less data and numbers presented, wanted shorter sessions and wanted more self care presentations. One person even suggested moving the conference to another state. The feedback from the conference was good and items will be taken into account as we plan the conference for 2025. The CSS team also facilitates bi-monthly strategic topic calls, allowing the team to continually identify and share new resources with CSS families. Care coordination remains a priority during individualized training sessions, which involve the entire team rather than focusing solely on individual members. This

collective approach strengthens the effectiveness of care coordination efforts across the board, ensuring that ongoing training is provided to all staff and that families enrolled in the CSS program receive referrals to medical homes.

To further efforts for medical home access, the CSS team created an informational poster at the request of a local med-peds program. This poster will be disseminated statewide at local hospitals and partners such as Meharry Medical Center and other clinics.

The team also completed training with TEIS on medical home referrals, and the CSS team updated the CSS professional one-pager during this reporting period.

Activity 3d: Provide education and resources to Children's Special Services authorized vendors.

Report 3d: Several resource materials have been ordered for dissemination, including the CSS information poster created for local hospitals and partners. The team ordered 6,900 copies for distribution across the state. The CSS professional infographic was developed for providers, containing information that will help them decide if their patients should be referred to the CSS program. The team ordered 15,000 copies, which were all distributed to the metros and regions across the state for team leads and care coordinators to distribute during outreach events and educational programming events. Additionally, the Partnering with Your Doctor booklet has been reviewed and updated to reflect current practices and resources for families to understand the importance of a medical home. The Vendor Enrollment Manual has also been updated and disseminated during this grant year, further supporting efforts to enhance communication and resource sharing among providers. This manual is distributed via email with new vendor packets and renewal notices. The CSS Hands brochure is an informational brochure that care coordinators distribute to families that provides information about the CSS program. The team ordered 17,000 copies for distribution. Additionally, the CSS participant booklet is for families who enroll in the CSS program. It contains more in-depth information about the program, including resources and contact information for other metros and regions. The team ordered 8,000 copies. These resources are aimed at providing essential and current information to CSS-authorized vendors.

Challenges and Issues Related to Implementation of Strategy 3: Challenges related to the implementation of Strategy 3 continue to be around the learning collaborative for providers and families. The program has made significant strides towards creating a model learning collaborative and resources for FY 2025.

Strategy 4: Inform CHANT families about the benefits of medical home and care coordination.

Supporting Evidence for Strategy 4: Access to a pediatric medical home is associated with increased quality of care, improved health outcomes, and decreased unmet medical needs for children and youth, including children and youth with special health care needs. Research shows that access to and utilization of a pediatric medical home is associated with the following:
Increased provision of preventive services for children, including - Increased likelihood of having anticipatory guidance provided; Increased likelihood of being seen by a primary care clinician within the last year; Increased rates of childhood immunizations; Increased rates of well-child visits; Increased likelihood to have had height, weight, and blood pressure checked; Decreased amount of outpatient sick visits; Decreased rate of inappropriate use of antibiotics; and Improved health outcomes and health status (https://medicalhomeinfo.aap.org/overview/Pages/Evidence.aspx) The National Survey of Children's Health reports in the 2020-2021 combined survey only 49.3% of Tennessee children with special health care needs report receiving care that meets the medical home criteria of coordinated, ongoing, and comprehensive care

within a medical home.

Activity 4a: Provide education and resources on the importance of care in the medical home.

Report 4a: When new clients enroll in the CHANT medical home pathway, they receive essential information about available resources. Staff members are required to provide resources and referrals, ensuring that education and support are available even if clients choose not to pursue the pathway. Several resources were updated or developed during this reporting period, including updates to the Partnering with Your Doctor booklet, which has been completed and is awaiting approval for dissemination.

Several key messages are emphasized to CHANT families, including the importance of maintaining the same medical doctor, as this is crucial for child health outcomes; having a consistent provider fosters familiarity, enabling the provider to identify health issues early through routine check-ups. Other messages conveyed reinforce the importance that regular check-ups play in maintaining health, and families are reminded to keep all appointments, including follow-ups. Families receive this information even if they do not enroll in the medical home pathway. CHANT staff also encourages Care Coordinators to prioritize PCMH Qualified Centers as the first resource for families without an identified medical home, providing links to approved providers in the medical home pathway.

The team is in the planning stages for a statewide medical home collaborative event aimed at promoting the importance of medical homes for the summer and fall of 2025.

According to **ESM MH.9 (Percent of CYSHCN receiving CHANT care coordination who receive medical home education),** 16.86% of CYSHCN receiving CHANT care coordination receive medical home education. This percentage is lower than the target of 20% for FY2024. The data has continued to be lower than the target for the past four reporting periods; however, many families enrolled in the CSS program indicate their children 87.21% are already receiving care in a medical home and therefore may not require additional education. The program has continued to make resources available and provide opportunities for care coordinators to share medical home messages as families access the program. 97% (163) of CYSHCN who needed a primary care provider were referred, which was similar to the percentage referred in FFY23 (98%, 149).

Activity 4b: Increase family referrals to primary care providers by promoting the use of the CHANT electronic referral form to families, MCOs, and providers that will allow families, particularly families in locations with poor health outcomes, to gain access to coordinated care services, resulting in an identified medical home.

Report 4b: The team is actively promoting the Referral QR code, which is featured on flyers being distributed at outreach events across the state. These flyers help raise awareness about CHANT's services. In FFY24, 1,010 Community Outreach events were held, which was a 21% (n=837) increase compared to FFY23. There were 105,466 attendees in FFY24 (76,280 in FFY23). As a result of outreach efforts, the number of triaged community outreach referrals between FFY23 (311) and FFY24 (536) almost doubled. Additionally, quarterly meetings with the MCOs are held to ensure they are informed about CHANT outreach events, with monthly updates shared between both parties.

TNBDSS has provided public-facing flyers detailing available supportive services at the Tennessee State Pediatric Conference and the Cumberland Pediatric Foundation's

Open House. They also send information on supportive services to pediatric providers involved in the birth defects enhanced surveillance initiative. This includes highlighting resources like CHANT, CSS, Tennessee Early Intervention Services, and Family Voices. As of September 30, 2024, TNBDSS has distributed 1,369 information sheets to providers through the diagnosis verification process and has made 28 service referrals on behalf of families upon request.

The team has actively engaged with various regional health staff and partners to enhance the implementation of transition and medical home initiatives through the CSS Family Services plan. A meeting was held with Vanderbilt to address the needs of participants without health insurance and to identify useful resources for the children they serve. Discussions with Tennessee Early Intervention Services (TEIS) focused on individuals currently receiving care and the partnership between CSS service recipients and their participants. Outreach coaching was provided by the CYSHCN team during visits to Jackson-Madison County where discussions were held on referrals, vendors, and providers. The team met with Sullivan County to talk about referrals and held a meeting with the Shelby County CSS team and several pharmacies, including Le Bonheur Outpatient Pharmacy, Medicine Shoppe, Boatwright Pharmacy, and CashSaver Pharmacy, to discuss continuity of care through vendor contracts for CSS participants.

There is no data available for **ESM MH.7 (Percent of families who report an increase in access and utilization of resources**). Activities related to this ESM that would measure whether families report an increase in access and utilization of medical homes have not been conducted; therefore, the program is unable to provide data for FY2024. This data will be available during FY 2025.

Activity 4c: Increase the number of families who schedule appointments with their primary care provider.

Report 4c: CSS participants are routinely asked whether they have a primary provider, as maintaining an annual visit with their provider is a requirement for continued enrollment in the program. This ensures that participants receive consistent and comprehensive care, reinforcing the value of regular health check-ups. During this reporting period, a total of 13.96% (*n*=630) kept their appointments with primary care providers out of 4,513 enrolled families who triggered and initiated the medical home pathway.

The target for **ESM MH.5 (Number of families receiving referrals to their child's primary care provider)** for FY2024 was 450. The actual number was 338, which was an increase over the past four reporting periods. While this number remains significantly lower than the target, many families report they already have an identified primary care provider and participate in regular scheduled appointments. The improvement can be attributed to the continued training of care coordinators and the availability of resources for families and providers on the importance of access and utilization of a medical home.

During this reporting period, **ESM MH.8 (Percent of CHANT families who schedule an annual visit with their child's primary care provider)** was 16.50%, which was significantly less than the target for FY2024 (55%). The percentage may be low because the denominator includes all children who triggered the pathway; however, not all children go on to enroll in CHANT. Additionally, early projected targets for ESM MH.8 were based on data from the National Survey of Children's Health (NSCH). NSCH uses more stringent criteria to define a medical home, resulting in higher percentages of estimated need. Reported annual percentages for this ESM have remained relatively steady over the grant cycle. 97% or more children and their families who started the Medical Home

Pathway received education about the importance of keeping a medical home and primary prevention (99.3%) or received assistance identifying a medical provider if they needed one (97.82%). However, after receiving providers and/or insurance resources, families may decline additional care coordinator assistance (e.g., help with scheduling an appointment) and choose to continue steps on their own.

Challenges and Issues Related to Implementation of Strategy 4: The team has experienced success in identifying resources and assisting families with accessing those resources and scheduling appointments. Challenges associated with Strategy 4 may be attributed to the ability to determine if those families who actually reported their child had a medical home may have participated in an annual primary care appointment prior to the screening and assessment. The measures for this strategy do not necessarily correspond to the actual data that is collected on the pathways.

Update on Other CYSHCN (Medical Home) Programs Supported by MCH/Title V:

MCH Title V funds support the CHANT program statewide, providing funds for staff salaries and benefits, outreach efforts, and data system infrastructure. The CSS program is also supported by MCH/Title V funds for children and youth with special health care needs. The funds are used to reimburse providers for medical services and are coordination. Development and dissemination of medical home educational material is also supported by MCH Title V funds. The CYSHCN program also utilizes MCH Title V funds to support partnerships with family and youth-serving agencies such as Family Voices of Tennessee and the Department's Youth and Family Advisory Committees.

Tennessee Birth Defects Surveillance System: The MCH/Title V funds continued to support the Tennessee Birth Defects Surveillance System during the October 1, 2023 – September 30, 2024, timeframe in two ways. First, Title V funding supports the ongoing maintenance of the Program's internet case management system. This system links Birth Defects to the Newborn Screening and Neonatal Abstinence Syndrome programs to ensure programmatic alignment. Second, MCH/Title V funding also supplements salaries for the Birth Defects Program Director and Administrative Services Assistant.

Priority: Improve Transition from Pediatric to Adult Care Among Children with Special Health Care Needs

MCH/Title V Funding: Title V MCH Block Grant along with the state-required match funds 100% of the CYSHCN transition initiatives. This includes the Family and Youth Engagement Director and the Youth Coordinator position in the Title V CYSHCN program. These funds also cover contractual agreements with Tennessee Family Voices which covers a parent mentor program, peer-to-peer mentor position, Youth Advisory Council, leadership and self-empowerment training, and the annual youth conference. The second contractual agreement is a combined agreement with four other state agencies and the Tennessee Council on Developmental Disabilities – Vanderbilt Kennedy Center (Pathfinder) to provide resources and referrals for families of children and youth with special health needs. One FTE is included in this agreement to screen and refer families to the TN CYSHCN program and other needed services and resources.

Interpretation of Performance Data on selected NPMs, SPMs, and SOMs:

Transition NPM 12: 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
Based on 2022 data from the NSCH, 22.0% of TN children with and without a special healthcare need received services to prepare for the transition to adult health care, although this is a slight dip from 2020-2021 data, Tennessee continues to be slightly higher than the national average of 19.8%.

The Family and Youth Engagement and Involvement program experienced a loss in the director position, which caused some unraveling of the actual Youth Advisory leadership and also resulted in the newly formed Family Advisory Council shifting. The Family Voices leadership assisted during this time in recruiting new family members and helping to guide the reformation of that group while the Youth Coordinator continued to facilitate the Youth Advisory group. At the time of this report, a new director has been hired, and the program is moving forward with all goals.

The other challenge of this strategy is based on the fact that our national data is based on all children 0-17, and the program only has access to those who are served either through our Children's Special Services (CSS) program or through the Youth Advisory Council and the Youth Engagement Workgroup. Program leaders continue to serve on all available boards and committees that serve transition-aged youth; however, moving the needle continues to be a slow process.

SPM 18: Percent of youth reporting with increased knowledge on transition resources and services
During the 2024 Youth Advisory Conference, 100% of the youth participating (approximately 30 youth) indicated increased knowledge on transition resources and services. This data has not changed due to a continued focus on all YAC members and participants receiving information throughout the year and at the conference. Youth Advisory Council members continue to review and refine the Transition Tool kit and share it with their peers at school and other youth-led initiatives. The Youth and Family Engagement team also published the Transition Resource Guide and made it available on the website.

SPM 19: Percent of YSHCN served by CHANT and YAC who complete an annual transition plan
During FY 2024, 74.1% of youth participating in the CSS program completed their annual transition plan. This was an increase over the 72.5% from FY 2023, although lower than the targeted 85%.

This increase can be attributed to the CHANT team continuing to work with families participating in the CSS program to ensure that youth aged 14 and older receive an annual transition plan. Care coordinators continue to receive training on how to conduct transition planning, and the recently developed tool kit was made available to all staff https://www.tn.gov/content/dam/tn/health/program-areas/CYSHCN%20Resource%20Guide.pdf.

SPM 20: Percent of youth leaders participating in advisory councils providing resources to other youth
During FY 2024, 29.1% of youth leaders who participated in advisory councils provided resources to other youth.

This was more than the 28.6% of the previous reporting period, but slightly less than the 30% target.

This can be attributed to the fact that the Youth Advisory Council remained the same for FY 2024 and did not increase the number of mentors during this time frame. The Council has dedicated several meetings to mentor training for the newer council members, aimed at creating additional opportunities for youth to move up into leadership positions.

Accomplishments and Challenges (based on the FY2024 Action Plan):

Strategy 1: Inform, educate, and link YSHCN, families, and providers to available transition resources and services, and how to access those services.

Supporting Evidence for Strategy: All youth with special health care needs should receive services necessary to make transitions to adult health care work and independence. As youth age, transition from parent-supervised patient-controlled care to independent patient-centered care is vital for growth and development. The National Child Health 2020-2021 combined survey indicates that 75.8% of children and youth with special health care needs aged 12-17 in Tennessee did not receive the services necessary for transition to adult health care. https://www.childhealthdata.org/browse/survey/results?q=9428&r=44&g=1000.

Activity 1a: Provide available resources by age and appropriate geographic location for YSHCN and families – inclusive, but not limited to, medical home, dental home, behavioral/mental health services, and transition.

Report 1a: The CYSHCN team is actively providing and frequently updating field staff resource guides, including information on services for youth that are age-appropriate or require alternative payor sources. Collaborations with Family Voices, Disability Pathways, and Transition TN help ensure these resources are effectively distributed. The Community Health Access and Navigation in Tennessee Program (CHANT) also contributes valuable resources to support families and Care Coordinators statewide. A key initiative has been the development of a Care Coordinators Resource Guide aimed at equipping Care Coordinators across the state with essential information for making service referrals. This guide was presented to the Children's Special Services (CSS) Advisory Committee for input and recommendations. The guide has been approved and sent to the communications department for approval and issuance of the promulgation statement. Once completed, it will be ready to go on the website and distributed to the care coordinators. Additionally, resources were provided by the Department of Mental Health and Substance Abuse Services during a training for the Youth Advisory Council. The Young Adult Leadership Council was also in attendance. The Youth Advisory Council's annual conference focused on a variety of relevant topics; several of the presentations and resources were distributed at the Conference.

The CYSHCN contract with Family Voices includes deliverables focusing on medical home and transition strategies for youth. To meet the requirements of the contract, Family Voices held a medical home series with sessions entitled "What is a Medical Home" in April (Webinar – 10 attendees; online views-18), "How to Make Every Home a Medical Home" in May (Webinar – 8 attendees; online views- 4), and "How to Find a Medical Home" in June (Webinar – 3 attendees; online views- 7). They have also launched a new series called "Make it Make Sense," which includes webinars and tip sheets designed to educate families on available benefit programs in clear, family-focused language. The topics presented during the "Make itMake Sense" series covered the following areas: Family Support Program, Katie Beckett, ECF Choices, and TennCare, and are stand-alone webinars.

- **Family Support Program**
  - Webinar attendees: 14
  - Resource views: 778
  - Link clicks (downloads of material): 10
- **Katie Beckett**
  - Webinar attendees: 70 (parents)
  - In-person attendees: 50 (professionals trained at Family & Children's Services, Nashville)
  - Online views: 71
  - Resource views: 6.8k
  - Link clicks (downloads): 56
- **ECF Choices**
  - Webinar attendees: 18
  - Online views: 14
  - Resource views: 1.3k
  - Link clicks (downloads): 18
- **TennCare**
  - Webinar attendees: 35
  - Online views: 19
  - Resource views: 1.4k
  - Link clicks (downloads): 6

Family Voices (FV) social media data shows for the period January 2025-March 2025:

- 155.5k views of FV resources (increase by 278%)
- 27.5k people reached (increase by 141%)

More information can be found on their website: [Family Voices TN Resources].

Activity 1b: Develop and disseminate a state-wide YSHCNs transition resource kit, including resources for medically underserved populations.

Report 1b: With input from the Youth Advisory Council, a Transition Resource Guide was developed and is available on the State of Tennessee website. The guide provides resources for youth, families, and providers and includes links for local, state, and national websites. During this reporting period, the Youth and Family Engagement and Involvement section of the website was updated to provide a more interactive platform. There are videos of previous conferences, meetings, and training. The site also houses the transition planning guide developed for use at the 2021 conference. Families and youth are encouraged to download the transition plan and complete or update it annually. Resources developed and identified are aimed at youth in transition, beginning at age 14 and continuing until the youth no longer needs the resources (i.e., graduation from high school, college enrollment, employment, etc.). All resources are shared with participants and their families to ensure they have the necessary information during this critical period.

As a part of the contractual agreement with Family Voices, a partnership with the ARC of Tennessee has been formed to create a "Transition to Adulthood" resource guide. This guide will cover essential topics, including medical history, social security, and other relevant resources for transition-aged youth. Additionally, Family Voices is in the process of updating the web-based resource entitled "Dude, Where is My Transition Plan" which will create a broader outreach to transition-age youth. These initiatives reflect a strong commitment to supporting young individuals as they navigate the transition to adulthood.

During FY 2024, a total of 785 resource kits were distributed to partners such as Family

Voices, YAC, and the State Work Group. This is a significant increase from last year of 552, though still short of the goal of 1,200.

The department was able to track website traffic to the youth transition page on the Department of Health website. Between October 1, 2023, and September 30, 2024, there were 85 page views and 33 unique visitors to this uniform resource locator (URL).

Activity 1c: Develop appropriate training for family and youth on all aspects of medical transition.

Report 1c: The CYSHCN team continues to develop and refine transition-related resources. The team developed a Transition Resource Guide during the previous reporting period and has provided that guide to all CHANT care coordinators, partner agencies, and the Youth Advisory Council. The CHANT annual professional conference included sessions on care coordination and transition and provided presentations from Family Leaders on the importance of working with families and providers to ensure transition opportunities are discussed and planned for youth with special health care needs.

The CYSHCN leadership, in conjunction with Ballad Health, planned a transition camp for summer 2024 specifically designed to cover medical home transition. That camp was cancelled due to low registration numbers. The team continued to work with the Youth Advisory Council, partner agencies, and Family Voices to ensure several transition break-out sessions were planned and facilitated at the annual Youth Conference.

Activity 1d: Develop training on all aspects of medical transition for partners and providers across Tennessee.

Report 1d: In conjunction with the Ballad Health Pediatric Care Navigation team, a training was developed and held entitled “Let’s Talk Medical Home.” Additionally, the partnership with Family Voices has led to a collaboration with Le Bonheur Hospital to host a webinar on “Transition to Adult Healthcare”. There were eight (8) attendees at the live webinar, and to date, there have been nine (9) views on the YouTube video. The webinar was recorded and made available on the Tennessee Family Voices website for ongoing education.

The CYSHCN team continues to partner with youth-serving agencies to develop and provide transition-related resources for all providers, families, and transition-aged youth.

Activity 1e: Review the CSS charts of participants residing in urban and rural locations who have complete and incomplete transition plans to identify indications of barriers or facilitators.

Report 1e: During FY 2024, there were a total of 51 participants aged 14 and older enrolled in the CSS program. The program director has audited all of the charts and identified several barriers that hindered the participants from completing their annual plans. Those barriers included a lack of resources, transportation challenges, and staff retention issues. In response to some of these challenges, the team developed a Care Coordination Resource guide that will be used in conjunction with the Transition Resource guide to assist families and youth with developing sustainable transition plans. Training is also being planned and conducted on a regular scheduled basis to provide additional resources for care coordinators. Transition components will also be included in the medical home learning collaborative and will provide additional information to families and providers.

Challenges and Issues Related to Implementation of Strategy 1: Challenges related to the implementation of

Strategy 1 are related to this strategy being based on all transition aged youth, however the initiatives are limited to the numbers of youth that are served through the CSS program, the Youth Advisory Council and the partner agencies. Other challenges included are those that are related to staffing issues. Each time the program experiences a change in staff, youth and family participation decrease.

Strategy 2: Promote successful transition through educational opportunities and self-empowerment training.

Supporting Evidence for Strategy: Youth and parents who receive leadership training can provide mentoring and peer-to-peer support to other parents and youth with special health care needs. Trained parents and YSHCN are better equipped to become self-advocates and participate in the decision-making process and policy development. The National Child Health 2020-2021 combined survey indicates that 75.8% of children and youth with special health care needs aged 12-17 in Tennessee did not receive the services necessary for transition to adult health care. https://www.childhealthdata.org/browse/survey/results?q=9428&r=44&g=1000

Activity 2a: Recruit and retain YAC council members, ensuring makeup reflects the state's population. Increase membership by 20% through strategic, targeted recruitment.

Report 2a: The team is currently in the process of securing final approval for an updated flyer and website to enhance outreach efforts. The Youth Advisory Council (YAC) has been enlisted in reaching the goal of engaging 20% more participants. This includes creating a new YAC flyer, continuing the quarterly newsletter, and a template for the YAC application. The YAC will also have its own dedicated website to host all the new resources. Additionally, approval has been received for the transition resource guide QR code.

As of September 2023, the YAC had a total of 28 members and 8 mentors. This total remained the same for FY 2024, and while slightly below the 30% target, it nearly reached the goal at 29.10%, which was impressive. The team provided updated flyers that were shared with local health providers and at a conference, as well as distributed to special education teachers throughout the state. New recruits discovered the flyer in offices and on the website, prompting them to contact the team for membership applications. During FY 2024, four new members completed the application process and have shown interest in joining the YAC.

Additionally, the Tennessee Department of Health, LEND trainees, and Family Voices of Tennessee hosted a YAC ice cream social for approximately 30 participants. This event provided a valuable opportunity for existing YAC members to connect and served as a recruitment opportunity, resulting in the addition of one new YAC member.

Activity 2b: Train YAC members to mentor other YSHCN in leadership and self-empowerment skills.

Report 2b: The team is currently collaborating with LEND trainees on establishing peer-to-peer mentorships. Meetings have been scheduled for the Chair to mentor new members stepping into leadership positions, during which they will review by-laws and share lessons learned from their experiences in leadership roles.

Molly Anderson, Director of Peer Support and Self-Advocate at Family Voices of Tennessee, led a training at the 5th Annual Youth Conference, which saw an impressive attendance of approximately 80 participants. This training provided participants with essential skills.

Additionally, Family Voices of Tennessee, in partnership with Empower TN, is working on a series of resource sheets aimed at supporting youth with special healthcare needs (YSHCN) as they transition to adult healthcare. These resources will help ensure a smoother transition process for young individuals moving into adulthood.

During FY 2024 the team continued to make progress towards achieving the **ESM TR.2 (Number of YSHCN trained as mentors).** The target for FY2024 was 55 and there were 53 trained at the YAC conference and virtually as mentors. While 2 less than the target, this was six more than last year and a significant increase over the previous reporting periods.

Activity 2c: Provide learning opportunities (leadership training – ex., Peer-to-Peer support program, talking to legislators, taking control of your healthcare) for youth and families across Tennessee.

Report 2c: The LEND trainees' major project focuses on developing a peer-to-peer support program. The Department of Children's Services (DCS) has established a new Young Adult Leadership Council (YALC), and there are plans to collaborate and partner with them in the upcoming grant year. Meanwhile, members of the Family and Youth Engagement Workgroup are working on individual objectives, and the team is actively learning more to share valuable information with others.

Through the contractual agreement with Family Voices of Tennessee, leadership and financial support for five families and CYSHN representatives were provided for attendance at the 2024 Disability Day on the Hill. This event allowed them to engage with their legislators and participate in public policy promotion. Family Voices also participated in a Special Education Community Conversation, where they discussed the transition to adulthood with families across the state. Additionally, the Family Voices of Tennessee Director presented at the Chattanooga Autism Conference, covering financial support options available to children and youth with special healthcare needs (CYSHN) and their families.

During FY 2024, over 100 youth and 365 families received leadership and self-empowerment training. This was a slight increase over FY 2023 reported numbers and remained above the goal of. This increase can be attributed to the continued partnership and collaboration with other agencies to provide training opportunities and the training provided during the YAC conference and bi-monthly meetings.

Challenges and Issues Related to Implementation of Strategy 2: Overall the program continues to experience success towards implementation of Strategy 2.

Update on Other CYSHCN (Transition) Programs Supported by MCH/Title V:

Family and Youth Engagement Program: MCH Title V funds are used to support the Family and Youth Engagement program through salaries for a program director and a dedicated youth coordinator. The program is also supported by providing training opportunities for the staff to ensure leadership of the youth initiatives.

Family Voices: Family Voices is supported by MCH Title V funds through a contractual agreement that provides for salaries and benefits for dedicated staff to provide training and empowerment opportunities, to attend conferences, and provide education to other agencies. This funding also supports the Parent2Parent mentoring program and activities related to identifying and mitigating barriers and challenges for CYSHC participation in virtual health care visits.

Tennessee Disability Pathfinders: MCH Title V funds continue to support the Tennessee Disability Pathfinders through a contractual agreement. Pathfinders provides a robust electronic resource and referral platform that can be accessed by all families and is essential for families of CYSHCN to identify needed resources. This funding supports dedicated staff persons who ensure referrals are made to the CHANT and CSS program.

Youth Advisory Council: The Youth Advisory Council is supported by MCH Title V funding, which supports the activities of the council, including the annual conference, speakers, transition resources, and outreach activities. The MCH Title V funds also support the Council by providing opportunities for training and participation in conferences and mentoring opportunities. Funds are also used to provide specific assistance to individuals and professional fees and grants, for example, stipends for speaking engagements, travel, and interpreters as necessary for full participation in meetings, conferences, and training opportunities.

Priority: Increase Access to Quality Care for Children and Youth with Special Healthcare Needs

Objective for Universal 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%).

Evidence-Based or Informed Strategy Measure (ESM): Percentage of children with and without SHCN who are applying for health insurance.

Evidence-Based or Informed Strategy Measure (ESM): Percentage of children with and without SHCN who schedule an exam with a primary care provider.

Objective for 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-CYSHCN: 75.8%) to September 30, 2030 (CYSHCN: 75.7%, Non-CYSHCN: 79.6%).

Evidence-Based or Informed Strategy Measure (ESM): Percentage of children with and without SHCN who receive a referral to a primary care provider.

Objective for Transition to Adult Health Care: 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.

Evidence-Based or Informed Strategy Measure (ESM): Percentage of CSS-eligible YSHCN, age 14-21, who complete a transition plan.

The following strategies and activities are planned for October 1, 2025, to September 30, 2026:

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.

Supporting Evidence for Strategy 1: The American Academy of Pediatrics describes a medical home as possessing seven qualities: accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and responsive[1]. A medical home is more than a primary care provider, or the extension to a wraparound service, or a physical location. It involves the formation of partnerships between the family, community resources, and providers. The National Survey of Children's Health (NSCH) reported that in 2022-2023, only 42.3% of children in Tennessee had a medical home[2]. Connecting these children to a medical home relies on informed providers and community partner and agencies who are committed to participating in a system of care. There are currently 430 patient-centered medical homes (PCMHs) in Tennessee that are recognized by the National Committee for Quality Assurance, many of which are part of the PCMH care delivery model for TennCare, Tennessee's Medicaid program[3] [4]. However, PCMH-focused organizations tend to cluster around metro areas, and expanding knowledge about and capacity for medical homes into rural areas is needed.

Strengthening systems of care promotes effective care coordination, reduces duplication of services, improves access to medical homes, and ensures families are supported by insurance coverage that facilitates timely and appropriate care. A high-functioning system is foundational to achieving whole-child, whole-family health, and is essential for reducing negative health outcomes and meeting the complex needs of CSHCN across Tennessee.

Medical complexity, along with sociodemographic factors that affect them, impacts CSHCN care experience

within health systems and beyond. In 2022-2023 NSCH survey years, 3.9% more CSHCN (6.7%) did not feel they lived in a safe neighborhood compared to children without special health care needs (2.8%) and 4% more CSCHN with more complex health needs did not live in a safe neighborhood (7.7%) compared to those with less complex needs (3.7%)[5]. This calls for a critical need to expand partnerships not only within immediate health services, but extending to wraparound services, community supports, and any groups who may interact with CSHCN and lack awareness or understanding of their complex needs and associated medical, developmental, or behavioral symptoms.

Activity 1a: Continue the facilitation of a statewide Medical Home Learning Collaborative for families and providers to gain education and increased understanding and knowledge of the importance of a medical home.

Activity 1b: Facilitate connections between public health programs and external partners (e.g., Family Voices) to strengthen service availability and support systems for CYSHCN and families through meetings and networking opportunities.

Activity 1c: Collaborate with statewide and community-based organizations to better support families with accessing medical insurance and related support services.

Activity 1d: Increase the variety of agencies involved in growing, promoting, and participating in Family Advisory and Youth Advisory Councils, by engaging new agencies.

Planned Partnerships: The CYSHCN Team currently partners and plans to continue partnering with TNAAP, TN Chapter of Family Physicians, Federally Qualified Health Care Centers, local health departments, Family Voices, the State of TN child-serving agencies, i.e., Department of Disability and Aging, TN Council on Developmental Disability, Tennessee Commission on Children and Youth, Tennessee Council on Children's Mental Health, the Department of Mental Health and Substance Abuse Services, and the local hospital family advisory groups.

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.

Supporting Evidence for Strategy 2: Families who do not receive care in a well-functioning system often face fragmented care, delayed diagnoses, inconsistent treatment plans, and financial strain—barriers that disproportionately impact CSHCN and contribute to poorer health outcomes. Data from the National Survey of Children's Health from 2022-2023 showed that only 18.5% of children and only 15.4% of CSHCN in Tennessee between 0-17 years received care within a well-functioning system, defined as one that provides coordinated, comprehensive, family-centered care across providers and services[6]. This significant gap underscores the urgent need for robust systems of care that ensure all children and families have informed, high-quality, and seamless access to affordable health insurance coverage and a medical home with a participating primary care provider where children have access to preventive exams and coordinated care.

Health insurance is critical for gaining access to a well-functioning system and for establishing service with a primary care provider. The 2022-2023 National Survey of Children's Health indicated that 69.5% of children aged 0-17 in Tennessee had adequate and continuous insurance[7]. In the same reporting years, 63.5% of children and youth with special health care needs and 71.1% of children without stated that they had adequate and continuous insurance. The CHANT program provides care coordination to children under 21 and their families, and a part of that is assistance with health insurance applications. Between Fiscal Year 2019-2024, 73.1% of children who received assistance with a health insurance application successfully obtained health insurance[8].

A well-functioning system includes a primary care provider who can help children keep up with preventive exams. According to the 2022-2023 National Survey of Children's Health, 27.1% of children in Tennessee did not have a personal doctor or nurse[9]. Specifically, 24.2% of CSHN and 27.9% of children without special

health care needs lacked a personal doctor or nurse. In the same year, 19% of children in Tennessee did not have an annual preventive care visit; nearly 10% more children without special healthcare needs (21%) went without an annual preventive care visit compared to CYSHCN (11.2%)[10].

There is evidence that shows that the provision of care coordination can improve health outcomes for children and youth with special health care needs[11]. Care coordination is essential for connecting families and CYSHCN to necessary medical, developmental, behavioral, educational, and social services, as well as providing community resources, understanding the importance of a medical home and emotional support. Despite this, the National Survey of Children's Health reported that in the 2022-2023 survey year, about one-quarter (26.7%) of children ages 0-17 did not receive needed care coordination[12].

Programs like CHANT that provide assistance removing barriers to access (e.g., navigating health insurance applications, providing transportation for medical visits) are suited well for impact. Data from the CHANT program supports care coordination as part of a successful strategy to connect children in need of care to a medical home. These data showed that, on average, 19% of children under 21 who were determined to need a medical home between Fiscal Years 2020-2024 also needed assistance scheduling an appointment with a provider[8]. With the help of a care coordinator, about 83% of children with and without special health care needs who received scheduling assistance successfully completed an exam with a provider[8].

Activity 2a: Through all local health departments, provide assistance applying to health insurance for children navigating the CHANT Health Insurance Pathway.

Activity 2b: Provide referrals to primary care providers at patient-centered medical homes for children in need of a provider who are enrolled on the CHANT Medical Home Pathway.

Activity 2c: Assist CHANT-enrolled children on the Medical Home pathway with scheduling PCP appointments and assist in removing barriers to attending the PCP appointment.

Planned Partnerships: The CYSHCN Team currently partners and plans to continue partnering with TNAAP, TN Chapter of Family Physicians, Federally Qualified Health Care Centers, local health departments, Family Voices, the State of TN child-serving agencies, i.e., Department of Disability and Aging, TN Council on Developmental Disability, Tennessee Commission on Children and Youth, Tennessee Council on Children's Mental Health, the Department of Mental Health and Substance Abuse Services, and the local hospital family advisory groups.

Strategy 3: Identify children and youth with special healthcare needs and reduce barriers that prevent their access to a medical home.

Supporting Evidence for Strategy 3: Obtaining and maintaining a medical home is critical for children receiving their care from a well-functioning system. However, for children in need, gaps exist between children with and without special health care needs. Between 2017-2023, on average, 3.6% fewer CYSHCN (average: 16.8%) in Tennessee received care in a well-functioning system compared to children without special health care needs (average: 20.43%)[13]. Additionally, 3.4% fewer CYSHCN (average: 48.2%) had a medical home compared to children without special health care needs (average: 51.6%)[14]. In the same time frame, CYSHCN were less likely to be insured - 9.5% more CYSHCN on average lacked adequate or continuous insurance compared to children without special health care needs[15]. Data from the National Survey of Children's Health showed that in the 2022-2023 survey year, nearly one-quarter (24.2%) of CYSHCN did not have a personal doctor or nurse and 11.2% did not have an annual preventive visit with a provider[9 10].

Care coordination at its core provides all children and families an opportunity to seek healthcare or commit to healthy behavior through the reduction of barriers and the facilitation of referrals and assistance[11]. The National Survey of Children's Health reported in the 2022-2023 survey results that 41.6% of CYSHCN in

Tennessee did not receive effective care coordination[16]. As mentioned in Strategy 2, the CHANT program has the capacity to connect children in need to a medical home through care coordination provided on the Medical Home Pathway. The program enrolls children with and without special health care needs, and similar strategies can be used for CYSHCN.

Activity 3a: Conduct targeted recruitment activities (e.g., community outreach, provider offices, newborn screening list) to identify CYSHCN and offer care coordination through CHANT.

Activity 3b: Through all local health departments, provide assistance applying to health insurance for CYSHCN navigating the CHANT Health Insurance Pathway.

Activity 3c: Provide referrals to primary care providers at patient-centered medical homes for CYSHCN in need of a provider who are enrolled on the CHANT Medical Home Pathway.

Activity 3d: Assist CHANT-enrolled CYSHCN on the Medical Home pathway with scheduling PCP appointments and assist in removing barriers to attending the PCP appointment.

Planned Partnerships: The CYSHCN Team currently partners and plans to continue partnering with TNAAP, TN Chapter of Family Physicians, Federally Qualified Health Care Centers, local health departments, Family Voices, the State of TN child-serving agencies, i.e., Department of Disability and Aging, TN Council on Developmental Disability, Tennessee Commission on Children and Youth, Tennessee Council on Children's Mental Health, the Department of Mental Health and Substance Abuse Services, and the local hospital family advisory groups

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.

Supporting Evidence for Strategy 4: All youth with special health care needs should receive the services required to facilitate a successful transition to adult health care and independence. As they grow older, transitioning from parent-managed, patient-controlled care to independent, patient-centered care is crucial for their growth and development. The 2022-2023 National Child Health survey indicates that 75.5% children and youth with special health care needs aged 12-17 in Tennessee did not receive the services necessary for transition to adult health care[17].

Activity 4a: Provide ongoing annual training on the importance of transition plans and identify gaps for CHANT/CSS care coordinators and medical service leads.

Activity 4b: Promote and distribute educational resources and support services for navigating the transition to adult healthcare to youth, families, providers statewide.

Activity 4c: Develop a transition passport card that details the steps for transition into adult care and establish an electronic health history summary form to help facilitate the transition handoff to adult healthcare.

Activity 4d: Schedule and hold meetings with Department of Education special education leadership and/or Coordinated School Health to discuss the transition process and provide transition resources for distribution.

Activity 4e: Through the Youth Advisory Council (YAC), develop a media campaign targeting CYSHCN that will help initiate the transition discussion to be shared in schools,

community centers, libraries, and public spaces where youth congregate.

Activity 4f: Empower YAC members, through a train-the-trainer model, to educate peers on transitioning to adult healthcare.

Activity 4g: Complete an annual transition plan with CYSHCN actively enrolled in CSS who are between 14-21 years old.

Planned Partnerships: CYSHCN will also continue our collaborative efforts and partnering with Family Voices, Tennessee American Academy of Pediatrics, Tennessee Primary Care Association, Tennessee Academy of Family Physicians, State Transition Work Group, Vocational Rehabilitation, Transition TN, the Youth Advisory Committee, Department of Disability and Aging, Ballad Health, Tennessee Board of Regents, and the Tennessee Council on Developmental Disabilities (Pathfinders).

CYSHCN Health Programs Supported by MCH/Title V:

- Reproductive and Women's Health
- Perinatal, Infant, and Pediatric Care (including Newborn Screening)
- Childhood Lead Poisoning Program
- Injury Prevention and Detection
- Chronic Disease Prevention and Health Promotion

CYSHCN Health Programs Connected but Not Funded by MCH/Title V:

- Neonatal Abstinence Program
- Evidence Based Home Visiting
- Communicable Disease Program
- Supplemental Nutrition (including WIC)
- Early Childhood Programs

Contextual Factors: For many years, Tennessee has experienced a drastic decline in the number of rural hospitals. With the closing of the hospitals, this also caused many providers to relocate their practices, which created barriers to access and care for families, especially families with special health care needs, as many areas lack pediatric and specialty providers. Rural transportation is also a major issue (to urban areas). Some families do not have access to insurance and are not eligible for Medicaid. Other barriers include finding adult providers who accept Medicaid, a lack of Medicaid expansion in Tennessee, or limited access to the internet or broadband service.

Additionally, there are many challenges for Youth with Special Health Care Needs (YSHCN) who attempt to make a successful and efficient transition to adult health care. These challenges may include age limits on pediatric service, a lack of experienced adult providers who work with youth with complex health conditions, and limited financing options for care, especially as YSCHN face the loss of their Medicaid coverage and are not able to afford or are not eligible for private insurance.

Assumptions: The status of health care for Children and Youth with Special Health Care Needs (CYSHCN) will improve through coordinated, family-centered approaches that expand access to high-quality services and support lifelong health and well-being. Efforts will focus on increasing the number of CYSHCN who receive care through a well-functioning medical home and strengthening family and youth capacity to access and use community-based resources. To achieve this, families and youth will be empowered with timely, available information, delivered through updated, user-friendly electronic resources and providers and community partners will deepen their knowledge of medical homes, transition planning, and local supports. Youth leadership opportunities and continuity of care throughout adulthood will be prioritized to ensure long-term success and independence. Professionals will be motivated and supported to participate in learning opportunities, and agencies will focus on recruiting, hiring, and retaining staff with the skills and abilities needed to serve CYSHCN effectively. Strong partnerships and coalitions will be leveraged to address complex challenges and reach communities that might otherwise remain medically

underserved; ensuring that every CYSHCN has the opportunity to achieve their highest quality-of-life potential.

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[1] American Academy of Pediatrics (2025). *What is a medical home?*
[2] Child and Adolescent Health Measurement Initiative. 2022-2023 National Survey of Children's Health (NSCH) data query. NPM: Percent of children ages 0 through 17, who have a medical home. Data Resource Center for Child and Adolescent Health supported by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB).
[3] National Committee for Quality Assurance. (2025). *Health care practices*.
[4] Division of TennCare (n.d.). *Patient-centered medical homes (PCMH)*.
[5] Child and Adolescent Health Measurement Initiative. 2022-2023 National Survey of Children's Health (NSCH) data query. Indicator 7.2: Does this child live in a safe neighborhood?
[6] Child and Adolescent Health Measurement Initiative. *2022-2023 National Survey of Children's Health (NSCH) data query.* Indicator 4.17: Does this child receive care in a well-functioning system? Data Resource Center for Child and Adolescent Health supported by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB).
[7] Child and Adolescent Health Measurement Initiative. *2022-2023 National Survey of Children's Health (NSCH) data query. Standardized Measure: Percent of children, ages 0 through 17, who are continuously and adequately insured.* Data Resource Center for Child and Adolescent Health supported by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB).
[8] REDCap. (2024). *CHANT Care Coordination* [dataset]. Data from 10/21/2024.
[9] Child and Adolescent Health Measurement Initiative. *2022-2023 National Survey of Children's Health (NSCH) data query. Indicator 4.12a: Do you have one or more persons you think of as this child's personal doctor or nurse?* Data Resource Center for Child and Adolescent Health supported by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB).
[10] Child and Adolescent Health Measurement Initiative. *2022-2023 National Survey of Children's Health (NSCH) data query. Indicator 4.1a: During the past 12 months, how many times did this child visit a doctor, nurse, or other health care professional to receive a preventive check-up? (A preventive check-up is when this child was not sick or injured, such as an annual or sports physical, or well-child visit)* Data Resource Center for Child and Adolescent Health supported by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB).
[11] National Academy for State Health Policy (2020). *National care coordination standards for children and youth with special health care needs.*
[12] Child and Adolescent Health Measurement Initiative. *2022-2023 National Survey of Children's Health (NSCH) data query. NPM: Percent of children, ages 0 through 17, who receive needed care coordination.* Data Resource Center for Child and Adolescent Health supported by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB).

[13] Child and Adolescent Health Measurement Initiative. *2017-2018 National Survey of Children's Health (NSCH) data query. Indicator 4.17: Does this child receive care in a well-functioning system?* Data Resource Center for Child and Adolescent Health supported by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB).
[14] Child and Adolescent Health Measurement Initiative. *2017-2018 National Survey of Children's Health (NSCH) data query. NPM 11: Percent of children with special health care needs, ages 0 through 17, who have a medical home.* Data Resource Center for Child and Adolescent Health supported by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB).
[15] Child and Adolescent Health Measurement Initiative. *2017-2018 National Survey of Children's Health (NSCH) data query. NPM* 15*: Percent of children, ages 0 through 17, who are continuously and adequately insured.* Data Resource Center for Child and Adolescent Health supported by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB).
[16] Child and Adolescent Health Measurement Initiative. *2022-2023 National Survey of Children's Health (NSCH) data query. NPM: Percent of children with special health care needs, ages 0 through 17, who receive needed care coordination.* Data Resource Center for Child and Adolescent Health supported by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB).
[17] Child and Adolescent Health Measurement Initiative. *2022-2023 National Survey of Children's Health (NSCH) data query. NPM: Percent of adolescents with special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care.* Data Resource Center for Child and Adolescent Health supported by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB).

Cross-Cutting/Systems Building

State Action Plan Table

State Action Plan Table (Tennessee) - Cross-Cutting/Systems Building - Entry 1
Priority Need
Improve Nutrition Among Families
Five-Year Objectives
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.
Strategies
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

2021-2025: State Performance Measures

2021-2025: SPM 21 - Percent of women who reported 14+ days of poor mental health in the past month

Measure Status:				**Active**	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective			18.2	17.8	17.4
Annual Indicator			25.3	35.9	30.2
Numerator					
Denominator					
Data Source			BRFSS	BRFSS	BRFSS
Data Source Year			2021	2022	2023
Provisional or Final ?			Final	Final	Final

2021-2025: State Outcome Measures

2021-2025: SOM 8 - Percent of pregnancy-associated deaths in which mental health conditions was a contributing factor

Measure Status:	**Inactive - No longer reviewing pregnancy-associated deaths, specifically motor vehicle crashes, if they're determined not to be pregnancy-related**				
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective			25	18	16
Annual Indicator			23	35	37
Numerator					
Denominator					
Data Source			Maternal Mortality Review	Maternal Mortality Review	Maternal Mortality Review
Data Source Year			2017-2020	2021	2022
Provisional or Final ?			Final	Final	Final

Priority: Improve Mental Health

MCH/Title V Funding: The mental health priority team is administratively led by the Associate Medical Director of Pediatrics within the Division of Family Health and Wellness of TDH. The Associate Medical Director provides leadership for the NAS surveillance and pediatric mental health programs and serves as a pediatric consultant for the division and department. The mental health improvement efforts are funded by federal funds. While MCH/Title V does not directly fund the activities highlighted in the annual report, it does fully fund staff who support mental health improvement efforts, including the Deputy Medical Director who provides leadership for this area as well as the Associate Medical Director.

Interpretation of Performance Data on selected NPMs, SPMs, and SOMs:

SPM 21: Percent of women who reported 14+ days of poor mental health in the past month
From 2022 to 2023, there was a 5.7% decrease of women who reported 14+ days of poor mental health in the past month [Data source: TN BRFSS].

After worsening from 2021 to 2022, there was improvement in this SPM from 2022 to 2023. This improvement is encouraging and suggests increased awareness and access to mental health treatment. However, there continues to be a need to address the stigma associated with seeking mental health care and develop specific strategies that support women's mental health.

SPM 22: percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling.
In 2023, 82.8% of adolescents aged 12-17 with a mental or behavioral condition received treatment or counseling. This reflects strong engagement in services among youth with identified needs, particularly in the adolescent population. By comparison, in 2022, 51.8% of children aged 3-17 received treatment or counseling. While this broader age range includes both younger children and adolescents, it may reflect lower identification rates, fewer referrals, or additional barriers to accessing services among younger age groups. The improvement of mental health services highlights the need for continued investment in early screening, referral systems, and age-appropriate mental health supports. [Data source: NSCH]

SOM 8: Percent of pregnancy-associated deaths in which mental health conditions was a contributing factor
In 2022, the proportion of pregnancy-associated deaths in which mental health conditions alone were a contributing factor increased from 31% to 37%. That same year, 49% of pregnancy-associated deaths were related to either mental health conditions *or* substance use disorder. The increase in pregnancy-associated deaths may be linked to several contributing factors. Many pregnant and postpartum women face limited access to timely and adequate mental health care, especially in rural or poor areas. Persistent stigma surrounding mental health can also deter individuals from seeking needed support. Substance use disorders, which often co-occur with untreated mental health conditions, continue to be a major driver of maternal deaths, especially amid ongoing opioid-related challenges. Additionally, socioeconomic stressors such as financial hardship, housing instability, and lack of social support can worsen mental health during the perinatal period. Lastly, improvements in the identification and documentation of mental health-related causes may have led to more accurate reporting, contributing to the observed increase. [Data source: TN MMR]

Accomplishments and Challenges (based on the FY2024 Action Plan):

Strategy 1: Use evidence-based screening tools to screen pregnant and postpartum women for perinatal mood and anxiety disorders and refer to mental health resources, if indicated.

Supporting Evidence for Strategy 1: The US Preventive Services Task Force (USPSTF), American

College of Obstetricians and Gynecologists (ACOG), and other women's health organizations recommend that pregnant and postpartum women be assessed for risk of depression so that they can receive intervention before symptoms arise.

Activity 1a: Conduct mental health screenings among women enrolled in Community Health Access and Navigation in TN (CHANT) and Evidence Based Home Visiting (EBHV).

Report 1a: As part of the CHANT comprehensive screening and assessment, each member of the family unit is screened for mental/behavioral health needs. In addition, the head of the household, if postpartum, is screened for depression using the Edinburgh Postnatal Depression Scale (EPDS). Positive screens trigger the Pregnancy/Postpartum Pathway of Care, and an action step on this pathway is to provide perinatal depression education.

EBHV is a relationship-based program that is strengths-based, and family-centered. The EBHV models are equipped to work with families who may have experienced trauma, intimate partner violence, poor mental health, or substance abuse diagnoses. As part of the EBHV services, home visitors screen for maternal depression using the EPDS.

Activity 1b: Connect women with mental health needs identified through screening to resources

Report 1b: Among EBHV participants, 69.5% of primary caregivers with positive screens for perinatal depression were referred to mental health services or resources (**ESM PPV.1**). Within the CHANT program, 26.51% of postpartum women with positive screens received resources.

The differences in the percent of women with positive screens who were connected to resources can be explained by differences between the EBHV and CHANT programs and when the EPDS is administered. For the EBHV programs a caregiver participating in the EBHV program is screened for depression using the EPDS tool (which is at least 10-item questionnaire) either within 3 months of delivery if enrolled prenatally, or within 3 months of enrollment if enrolled postnatally. This is done once per each EBHV participant. Anybody with a positive score is then referred for depression services- each person can decline referral or take it up and follow-up for services at their own discretion during their time with the EBHV. EBHV services are relationship-based and designed to improve long-term outcomes for families. The focus on building a trusted relationship between the home visitor and caregiver could have led to the high percent of women identified with mental health needs who are referred to services.

The percentage of postpartum women with positive screenings for depression who received resources/education or referrals for professional services decreased for the EBHV program from FY2023 to FY2024 by 30.5% and decreased for the CHANT program from FY2023 to FY2024 by 4%.
For EBHV, some models do not require EPDS, which has led to a shift of most agencies not following up on the EPDS screening. For CHANT, women complete a depression screen at the time of the CHANT Screen & Assessment. However, those women may not choose to enroll in the Postpartum pathway, which is where these women would receive education or referrals in the CHANT program. Out of the 215 who were screened and were depressed, 137 women went on to enroll in the CHANT program and 79 women enrolled on the postnatal pathway. Compared to FY2023, this is about 40 fewer depressed women enrolling in CHANT (n=176) and starting the Postnatal Pathway (n=124). There was a steady decline in postpartum referrals enrolling in CHANT in the

first half of FY2024.

Challenges and Issues Related to Implementation of Strategy 1: The primary challenge related to implementing this strategy in the EBHV program is the smaller number of women who are screened in comparison to the CHANT program. CHANT has a broader reach; however, caregivers have not enrolled in services or established a relationship with a care coordinator at the time that they are screened. Caregivers may decline services between the time that they are identified and provided resources.

Strategy 2: Support Le Bonheur Children's Hospital Emergency Department's (ED) implementation of universal suicide risk screening in the ED

Supporting Evidence for Strategy 2: The 2022 American Academy of Pediatrics/Bright Futures Recommendations for Preventive Pediatric Care recommends screening for suicide risk for all youth ages 12 and above. For youth ages 8-11, it is recommended to screen when clinically indicated.

Activity 2a: Train ED staff on suicide risk assessment.

Report 2a: Between October 1, 2023-September 30, 2024, the TCAPES (TN Child and Adolescent Psychiatry Education and Support) program partnered with the Le Bonheur Children's Hospital Emergency Department (ED) to implement universal suicide screening and follow-up suicide assessment for those at risk. The aim of the project was to implement a validated suicide screening tool and screen 95% of eligible patients who present to the Le Bonheur Children's Hospital ED by June 2025. The Le Bonheur Children's ED formed an interdisciplinary taskforce, updated their suicide policy and embedded the suicide screening tool (PHQ-9) into their electronic health record. All ED staff received training on the suicide screening tool prior to launching the new initiative. Team members were also sponsored to attend various trainings related to suicide assessment and care including A.S.I.S.T., mental health first aid, peer support training, and conferences

Data for FY2023 was unavailable because **ESM: % of ED staff trained** was new for FY2024. However, the actual performance percentage of ED staff trained exceeded the objective of 25% by reaching 100% This was due to the requirement for all staff to receive training on suicide screening tools as part of their electronic training from the education department. Furthermore, 100% of eligible patients have been screened since the suicide screening tool was implemented in November 2023.

Activity 2b: Provide guidance on the development of behavioral health care plans while patients are in the ED awaiting an inpatient bed or transfer to another facility.

Report 2b: TCAPES supports 0.5 FTE of an ED behavioral health social worker. The social worker is responsible for the assessment, care, and safety planning for patients experiencing depression or suicidal thoughts/attempt. The social worker has also strengthened relationships with community partners to connect patients to care. This project has reduced the length of stay for behavioral and mental health patients in the ED from 14 hours in January 2023 to 5 hours in January 2024.

Activity 2c: Improve the follow-up of children with mental health concerns after ED discharge.

Report 2c: The Le Bonheur Children's ED developed a safety planning tool modeled from the Stanley Brown safety planning tool. This tool is utilized by the behavioral health social worker for safety planning. The SW has also been able to connect with the majority of families post-discharge to ensure that patients receive the planned follow-up, such as an

appointment with their PCP, and medications, if prescribed.

Challenges and Issues Related to Implementation of Strategy 2: While the social worker is able to reach the majority of patients discharged with a safety plan, some families are unable to be reached post-discharge. There has also been a delay in developing a warm hand-off (including introduction to TCAPES and the consult line) from the ED to the patient's PCP. Le Bonheur plans to include information on TCAPES in discharge summaries sent to PCPs; however, this activity has been delayed due to the launching of a new electronic health record.

Strategy 3: Launch the Pediatric Mental Health Care Access Program in West TN

Activity 3a: Establish a regional pediatric mental health team, to include onboarding of new staff, establishing an Advisory Committee, and supporting youth and family engagement through on-going feedback.

Report 3a: Between October 1, 2023-September 30, 2024, the TCAPES team and its partners hired and onboarded new staff, including an Epidemiologist and a Communications Specialist. TCAPES launched a new toll-free psychiatry consultation number, which will support the growth of the consultation line. The program requests input from stakeholders and partners on an ongoing basis through meetings and surveys. TCAPES also established an Advisory Committee, which has met four times in this reporting cycle. Recommendations from the committee members include obtaining feedback from providers who have benefitted from the consultation line and training, onboarding a family support specialist who can follow up patients post-consultation, and collaborating with other health providers who see pediatric patients, such as dentists, to help create awareness about program offerings.

Activity 3b: Pilot a phone-based consultation service with PCPs in Shelby County. As part of the pilot, the team plans to focus efforts on the most socio-demographically at risk populations.

Report 3b: TCAPES initially launched its psychiatry consultation service in Shelby County to serve the western region of the state and has since expanded to Middle Tennessee. The partners supporting the consultation line include Methodist Le Bonheur Community Outreach (MLCO), the University of Tennessee - Le Bonheur Psychiatric Specialist (ULPS) and the Allied Behavioral Health Solution (ABHS).

The number of consultations for FY2023 was unavailable because **ESM: Number of consultation/year** was a new measure for FY2024. In FY2024, the actual performance of consultations was 49 with the objective to meet 60 consultations (81%).

Activity 3c: Offer training on the early identification and management of children with behavioral health conditions to PCPs in West TN. The training is evidence-based and will cover the principles of providing trauma-informed care that is family-centered.

Report 3c: TCAPES provides training on the integration of mental health care into pediatric primary care through a partnership with the Tennessee Chapter of the American Academy of Pediatrics (TNAAP). TCAPES launched 4 in-person and 3 virtual BeHiP (Behavioral Health in Pediatrics) training opportunities and 10 virtual ECHO sessions from April 2023 to November 2024. To date, there have been 70 attendees for BeHiP training and 171 attendees for the ECHO sessions. In-person trainings have now expanded to Middle Tennessee. Trainings are available to all pediatric providers in Tennessee and offer Continuing Medical Education (CME) credit.

Challenges and Issues Related to Implementation of Strategy 3: Provider recruitment and engagement, specifically regarding use of the psychiatry consultation line, has been a challenge for TCAPES. TCAPES has learned successful recruitment strategies from other pediatric mental health care access programs. TCAPES also onboarded a Communication Specialist, who is implementing a marketing plan. Provider recruitment for trainings has also been a challenge. Although there has been increasing attendance for the ECHO sessions, attendance for the comprehensive, 3.5-hour in-person training continues to be a challenge. Attendance at these training sessions was low despite continued promotion of the training on organizational social media pages, at conferences, and through the distribution of program brochures and fliers.

Update on Other Mental Health Programs Supported by MCH/Title V:

Suicide Prevention Program: During FY2023, TDH's funded partner, the Tennessee Suicide Prevention Network (TSPN), provided suicide prevention training to more than 7,000 teachers/school staff, far exceeding our yearly goal of 100. TDH-sponsored suicide prevention trainings include Question, Persuade, Refer (QPR) and Applied Suicide Intervention Skills Training (ASIST). TDH staff has worked with TSPN to further enhance their internal data collection and management system to ensure that all data pertaining to trainings conducted was accurately captured from TSPN regional staff and volunteers. Through our partnership with TSPN, QPR and ASIST trainings are offered to school staff across all regions of Tennessee, with a specific focus on rural counties.

Priority: Improve Nutrition Among Families

Objective for Food Sufficiency: 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.

Evidence-Based or Informed Strategy Measure (ESM): Number of individuals referred to food assistance programs through FindHelp

The following strategies and activities are planned for October 1, 2025 to September 30, 2026:

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.

Supporting Evidence for Strategy 1: Increasing access to nutritious foods involves making healthy food options more readily available and affordable, particularly in communities with limited access to grocery stores, fresh produce, or food assistance.

This approach is central to strengthening food sufficiency and promoting child health and development. Just as critical as expanding availability is the ability to identify families experiencing food sufficiency and refer them to appropriate resources—without timely and accurate connections, even well-resourced programs may go underutilized, and families may remain unsupported.

In Tennessee, food insufficiency remains alarmingly high. The 2024 Vanderbilt Child Health Poll found that over 40% of families with children reported experiencing food insufficiency, with 71% adjusting their food spending due to increased costs[1]. Food insufficiency directly affects children's well-being by limiting access to adequate, quality food and introducing chronic stress and anxiety around food availability. These conditions are associated with developmental delays in early childhood and behavioral challenges in school-age children[2]. National research shows food sufficiency contributes to increased school absenteeism, lower academic performance, and higher rates of emotional distress[3],[4].

Evidence-based interventions have demonstrated success in addressing food sufficiency. For example, supermarket “double-dollar” incentive programs have significantly increased purchases of fruits and vegetables among low-income families with children[5]. Similarly, additional produce vouchers for pregnant WIC clients have improved food security and diet quality, particularly in historically medically underserved populations[6].

Recent policy and technology-based innovations offer further promise. NCCARE360, North Carolina’s statewide coordinated care network, links individuals with identified social needs—including food sufficiency—to community resources via a digital platform that supports real-time referrals and closed-loop follow-up. This system has been integrated into the state’s Medicaid transformation strategy and has enabled more systematic screening for food sufficiency across healthcare settings, resulting in improved support for families and better health outcomes[7],[8].

Following this model, Tennessee has launched a similar Closed-Loop Referral System (CLRS) via the FindHelp platform. With more than 42,000 weekly searches and food-related needs accounting for nearly 25% of referrals, the platform shows strong potential to serve as the backbone of a coordinated food security care system[9] (9). As multiple sectors—including healthcare, education, social services, and community-based organizations—express growing interest, Tennessee is uniquely positioned to integrate and scale this infrastructure statewide.

A coordinated system would strengthen the identification, referral, and support of families experiencing food insufficiency, ensuring that services are available, streamlined, and sustainable. By learning from peer states like North Carolina and building on its own statewide tools, Tennessee can develop a long-term, data-driven solution that reduces food insufficiency and supports healthier futures for children and families.

Activity 1a: Leverage and expand Tennessee's statewide referral infrastructure by onboarding additional healthcare providers, community-based organizations (CBOs), schools, and public programs into the Closed-Loop Referral System (CLRS), FindHelp online platform. Promote platform use through specific outreach, training, and technical assistance. Prioritize seamless integration of CHANT, EBHV and, eventually, other Title V programs to enhance family referrals for food assistance.

Activity 1b: Partner with the Uninsured Adult Healthcare Safety Net Program (SORH) to support primary care providers, FQHCs, and Local Health Departments (LHDs) in embedding routine food security screening into clinical care. Provide tailored technical assistance, staff training, and implementation resources. Enhance referral effectiveness by promoting the use of FindHelp, a centralized and up-to-date resource platform for connecting patients to food assistance programs. Strengthen LHDs as referral hubs by streamlining workflows, investing in technology infrastructure, and fostering partnerships with local food systems. Participation will be incentivized through the Quality Improvement Incentive Program (QIIP), which offers funding for a range of innovations. This initiative will prioritize support for providers who choose to implement food security screening and referral activities.

Planned Partnerships:

- TennCare – Partnership/Shared Leadership: Collaborate on referral alignment and service integration.
- THD Office of Rural Health/Uninsured Adult Healthcare Safety Net Program (SORH) – Infrastructure & Provider Support: Provide program infrastructure and funding mechanisms to support implementation of food security screening and referral activities in safety net clinics.
- Local Health Departments (LHDs) – Involvement: Serve as frontline screening and referral hubs using standardized tools.
- Community-Based Organizations and Food Banks (e.g., Second Harvest, Mid-South Food Bank, Chattanooga Area Food Bank, Centro Hispano, Knoxville Academy of Medicine Foundation) – Involvement/Consultation: Deliver direct food assistance and onboard into FindHelp.
- Faith-Based Organizations – Consultation/Involvement: Mobilize existing food pantries and outreach channels through the Division of Health Disparities Elimination.
- Department of Education – Involvement: Support screening and referrals through schools and student wellness programs.
- FindHelp – Partnership: Maintain and enhance the Closed-Loop Referral System (CLRS).

Strategy 2: Expand Women, Infants, and Children (WIC) program to ensure that more eligible families have access to adequate nutrition

Supporting Evidence for Strategy 2: Expanding nutrition assistance programs involves increasing outreach efforts, streamlining enrollment processes, and advocating for additional funding to reach more eligible individuals and families[10]. Proven programs like the Supplemental Nutrition Assistance Program (SNAP) and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) have been shown to effectively reduce food insufficiency, particularly among children, by providing essential resources to purchase nutritious food[10]. A public health approach to implementing nutrition assistance programs emphasizes collaboration between government agencies, community organizations, state and local health departments, and healthcare providers to address enrollment barriers and ensure program availability[10]. Examples include partnering with healthcare providers to screen patients for eligibility, utilizing community

health workers to dispel misconceptions and simplify the application process, and advocating for policy changes that streamline program enrollment and increase benefit levels[10, [11]]. Peer-reviewed research demonstrates these approaches to expanding nutritional assistance programs have demonstrably increased program participation rates, improved dietary intake among families experiencing economic challenges, and reduced overall food insufficiency within communities[10, 11]. (1,2) Evidence of the impact of these data partnerships is seen in Tennessee's WIC-TennCare initiative, which began as a pilot in 2024. By sharing lists of eligible prenatal clients, the partnership led to the enrollment of over 2,400 women and children in just the first phase. This success prompted a statewide expansion, demonstrating how coordinated data efforts can effectively increase access to essential nutrition support[12].

Activity 2a: As federal funding allows, increase the percentage of TennCare recipients who enroll in WIC by continuing data-sharing agreements with TennCare to identify and outreach to pregnant women and children who are eligible but not currently participating in WIC.

Activity 2b: Boost awareness and usage of the WIC Shopper App among eligible families to help them fully utilize their WIC food packages. The app allows users to scan items in real time to verify WIC eligibility, improving the shopping experience, reducing confusion at checkout, and making it easier to select and access WIC-approved foods.

Activity 2c: As federal funding allows, collaborate with Dollar General to significantly increase the number of WIC-authorized vendor locations across Tennessee, with a focus on rural and medically underserved areas where grocery access is limited. This activity will involve onboarding processes for new vendor locations, providing technical assistance to ensure compliance with WIC guidelines, and a joint effort to inform eligible families.

Planned Partnerships:

- TennCare – *Partnership/Shared Leadership*: Share data on eligible prenatal clients to support proactive WIC outreach.
- WIC Clinics and Local Agencies – *Shared Leadership*: Implement streamlined application tools, digital supports (WIC Shopper App), and enhanced client communications.
- Dollar General Stores – *Partnership*: Collaborate to onboard retail locations as approved WIC vendors and support operational implementation, compliance training, and outreach to communities.

Strategy 3: Launch and Support a Statewide Food Security Coordination Coalition

Supporting Evidence for Strategy 3: Efforts to address food insufficiency are often fragmented across sectors, creating duplication, inefficiencies, and missed opportunities for impact. A statewide food security coordination coalition can serve as a foundation for aligning partners, policies, and practices to maximize collective effectiveness. Peer states such as North Carolina and California have shown that structured coalitions—especially those linked to platforms like FindHelp or NCCARE360—can significantly improve coordination, support data-informed decision-making, and strengthen overall system performance[7,8].

In Tennessee, the Office of Primary Prevention has already begun laying the groundwork for this coalition by bringing together public agencies, nonprofit organizations, and key partners to advance a shared food security agenda. With growing interagency momentum and clear infrastructure opportunities through platforms like FindHelp, Tennessee has a timely opportunity to formalize this coordination and transform individual efforts into a unified, statewide system.

Activity 3a: Strengthen the Tennessee Food Security Coordination Coalition by convening representatives from TDH divisions, TennCare, DHS (SNAP), the Department of Education, food banks, community-based organizations (CBOs), and faith-based partners. The coalition will meet regularly to align strategies, share data insights, build

shared accountability structures, and eventually co-develop policy recommendations. It will use FindHelp data to monitor referral trends and identify service gaps across geographic and demographic groups.

Planned Partnerships:

- Office of Primary Prevention – *Partnership*: Lead the formation of a statewide coalition focused on food security.
- TennCare – *Partnership*: Support integrated referral pathways and policy alignment
- FindHelp – *Partnership*: Provide data infrastructure and analytics for coalition planning
- Department of Human Services (DHS) – *Involvement*: Link SNAP data and outreach strategies
- Department of Education – *Involvement*: Engage school-based food programs and wellness policies
- Local Health Departments – *Involvement*: Serve as community-based implementation partners
- Community-Based Organizations and Food Banks – *Involvement/Consultation*: Share ground-level insights and deliver direct food support
- Faith-Based Organizations – *Involvement*: Mobilize trusted community channels

Contextual Factors:

Tennessee continues to face persistently high rates of food insufficiency, particularly among families with children. The 2023 Vanderbilt Child Health Poll found that over 40% of Tennessee families with children reported experiencing food insufficiency, with 71% adjusting their food spending habits due to rising costs[13]. (1) The National Survey of Children's Health reported that 16% of families nationwide struggled to cover basic needs such as food and housing in 2022. Within Tennessee, regional differences are stark: food insufficiency affects 50% of families in West Tennessee, 43% in East Tennessee, and 34% in Middle Tennessee. The 2024 *State of Health in Tennessee* report noted that 17.9% of households with children in the state were food insecure in 2022, close to the national average of 18.5%[14]. Further, a statewide poll by East Tennessee State University found that 24% of Tennesseans had gone hungry in the past 12 months due to financial constraints—with parents more than twice as likely to report food insufficiency[15].

Internal program data confirms these patterns, underscoring the need for targeted food security policies and interventions that account for local context and structural barriers.

Food sufficiency is influenced by various socioeconomic and environmental conditions that impact implementation and outcomes. Income and employment status are key drivers—limited or unstable income increases the likelihood of food insufficiency, especially in households with children and in areas where unemployment is high. Access to full-service grocery stores remains limited in many low-income communities, especially in rural and historically medically underserved urban areas. Physical barriers such as lack of transportation, inadequate public transit, and long distances to food retailers further restrict families' ability to obtain healthy, affordable food. These structural limitations can hinder the effectiveness of even the most well-resourced food programs unless accompanied by robust screening, referral, and outreach systems.

Variability in digital literacy, internet access, and local staffing capacity can limit the uptake of technology-driven solutions. Additionally, existing nonprofit and faith-based food initiatives, while valuable, may operate independently and without coordination, making system-level alignment more complex. Mistrust of government systems and stigma around receiving food assistance may further reduce participation in some communities. Local health departments, while critical partners, may face workforce shortages or other competing demands that affect their ability to consistently serve as referral hubs.

Contextual barriers also include social norms, misinformation, and perceived stigma around public assistance programs. Despite WIC’s strong evidence base, many eligible families remain unenrolled. Even when digital tools like the WIC Shopper App or online applications are available, their effectiveness is influenced by families’ access to technology and trust in the system. Provider capacity is another consideration, health providers lack the time or tools to screen for WIC eligibility or make direct referrals during routine care.

Despite potential challenges (listed in the assumptions section), both strategies are supported by a strong foundation of existing programs, pilot successes (e.g., the WIC-TennCare data-sharing initiative), and an increasing willingness among partners to coordinate efforts for greater collective impact.

Assumptions:

- Partnerships between government agencies, healthcare providers, schools, and community-based organizations can effectively coordinate efforts and streamline referrals to food assistance resources.
- Community-based organizations and local health departments will be willing and able to integrate into the Closed-Loop Referral System (CLRS) via FindHelp and adopt standardized referral practices.
- Partners will remain engaged in the statewide food security coalition, contributing time, data, and shared decision-making toward system-wide coordination.
- Local health departments will have the staff capacity and infrastructure to implement universal food sufficiency screening and act as referral hubs.
- Sharing data across agencies and systems will be feasible, secure, and compliant with privacy regulations.
- The FindHelp platform will remain available, reliable, and scalable to meet growing demand across regions.
- Families experiencing food insufficiency will accept referrals and follow through when connected with services.
- Increased identification and referral will lead to measurable improvements in access to nutritious foods and reductions in food sufficiency over time.
- Data-sharing between TennCare and WIC will continue and expand, allowing for timely identification and proactive outreach to eligible families.
- Simplifying the WIC application process and promoting tools like the WIC Shopper App will increase enrollment and retention among eligible clients.
- Eligible individuals and families will trust the system and be willing to enroll
- Federal funding and policy support for WIC will remain stable or increase throughout the project period.
- Increasing WIC participation will reduce food sufficiency and improve nutrition outcomes for women, infants, and children, consistent with decades of research and best practices.

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III.F. Public Input

Tennessee's MCH/Title V Program offers multiple mechanisms for continuous engagement for the public to provide feedback on the annual application/report. The first is through participating in partner meetings that are held twice each year. These meetings are open to the public, with special effort being made to reach out to those serving the MCH population as well as parents (including parents of CYSHCN, foster parents, and grandparents) and adolescents. During the meetings, participants evaluate the progress made on action plan measures. At the Fall meeting, that evaluation is utilized to identify partnership opportunities between the Tennessee MCH/Title V Program and the other organizations that will help to achieve measurable progress. At the Spring meeting, the information is used to develop the action plan for the coming year. Both meetings have an average of 200 partners in attendance. Since the pandemic, both of these meetings have been held virtually; however, Tennessee's MCH/Title V program transitioned to having the Fall Partner Meeting in person. Virtual meetings have increased attendance by approximately 50 participants and have allowed people who do not live close, or are not able to travel to Nashville, to attend. Tennessee's MCH/Title V Program is very intentional with multifaceted outreach efforts for partner meetings. The Program maintains a robust listserv with over 700 subscribers, ensuring broad dissemination of meeting invitations and related materials. During 2024, 393 partners attended the Fall and Spring MCH Partner Meetings. In addition, the Program works closely with the Family Health and Wellness' (FHW) Senior Leadership Team to engage partners across the state and encourage them to extend invitations through their own networks. This approach helps reach Tennessee's most at-risk populations.

The second opportunity to provide feedback is through membership or public participation in advisory committees. The division convenes multiple advisory committees commissioned by Tennessee statute including Genetics Advisory Committee (focused on newborn screening), Traumatic Brain Injury Advisory Council (focused on providing guidance to TBI program staff), Perinatal Advisory Committee (focused on perinatal health and the regionalization system), Doula Services Advisory Committee (focused on doula care and Medicaid reimbursement), and Children's Special Services Advisory Committee. Committee members are appointed by the Department of Health Commissioner or the Governor and provide topic-specific expertise to the respective committees. Furthermore, these meetings are subject to the State's Open Meetings Law and are open for attendance by members of the general public. The MCH/Title V director and program staff are in regular communication with committee members, members of the public, and members of the General Assembly on topic areas of interest to those committees. For each advisory committee meeting subject to the open meetings law, the agenda sets aside a specific time for public comments related to the committee's purpose. In addition to these long-standing committees, the MCH/Title V CYSHCN program established a youth advisory committee in 2017, and sections of the Division operate advisory committees for grants such as the Preventive Health and Health Services Block Grant, the Birth Defects Surveillance Program (Birth Defects Registry Advisory Committee), Suicide Prevention Advisory Group, and the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program (Home Visiting Leadership Alliance and the Young Child Wellness Council).

Regional MCH Directors are convened via conference call every quarter. On each call, the MCH/Title V Director focuses on information that increases understanding and collaborative efforts between programs, as well as updates that affect all MCH programs. Additionally, Central Office program staff regularly visit each of the Department's 13 regions/metros to individually meet with frontline program staff. The visits are separate from required monitoring visits and are aimed to provide opportunities for Central Office staff to see firsthand the unique needs of Tennessee communities and to understand how state-level staff can best support frontline staff.

Each year the application/report is uploaded to the state website where it is available to all. Contact details for the MCH/Title V Director are included, allowing the public to submit comments year-round.

III.G. Technical Assistance

MCH Capacity Building in Central Appalachia

People in Appalachia have worse health and health outcomes than those living in the rest of the United States, including rates of obesity and diabetes[1]. Infants born to women in Appalachia have worse birth outcomes, as measured by rates of preterm birth, low birthweight, and infant mortality than those born to women in the rest of the United States. These adverse outcomes are associated with higher levels of teen childbearing, lower educational attainment, and less timely or no prenatal care. Additionally, there are persistent economic differences in the region, as the Appalachian counties of these states reflected higher poverty rates compared with the rest of the United States.

In March 2025, MCH/Title V Directors and key program staff representing Central Appalachia came together for a half-day meeting to develop a multi-state approach to address maternal and child health (MCH) outcomes in Appalachian communities. The team reviewed data and discussed opportunities for collaboration and impact. One key opportunity proposed was a 2-day summit to promote MCH successes and challenges paired with workforce trainings led by Appalachian local health department staff and community partners. Additional partners for outreach include East Tennessee State University, Appalachian Regional Commission, hospital associations (Ballad Health), and payors. This technical assistance request includes an ask for funding to support the planning and execution of a 2-day summit for building MCH capacity in Central Appalachia. Additional asks include coordination with CDC to provide Appalachian-specific PRAMS and pregnancy-related mortality trends.

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IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - IV. Title V-Medicaid IAA MOU.pdf

V. Supporting Documents

The following supporting documents have been provided to supplement the narrative discussion.

Supporting Document #01 - V. A. TN Dept. of Health FY24 Rate Agreement 05282025.pdf

Supporting Document #02 - V. B. Logic Models Report and Application Years.pdf

Supporting Document #03 - V. C. Glossary of Terms.pdf

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - Org Charts.pdf

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Tennessee

	FY 26 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 12,600,000	
A. Preventive and Primary Care for Children	$ 4,410,000	(35%)
B. Children with Special Health Care Needs	$ 4,158,000	(33%)
C. Title V Administrative Costs	$ 1,260,000	(10%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 9,828,000	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 11,700,000	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 2,000,000	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 13,700,000	
A. Your State's FY 1989 Maintenance of Effort Amount $ 13,125,024		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 26,300,000	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS(Subtotal of all funds under item 9)	$ 191,807,056	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 218,107,056	

OTHER FEDERAL FUNDS	FY 26 Application Budgeted
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Sexual Risk Avoidance Education (SRAE)	$ 1,246,018
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Birth Defects and Developmental Disabilities	$ 350,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Colorectal Cancer Control Program (CRCCP)	$ 0
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 169,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Injury Prevention and Control	$ 400,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Breast and Cervical Cancer Early Detection Program (NBCCEDP)	$ 4,224,678
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Comprehensive Cancer Control Program (NCCCP)	$ 495,320
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventing Maternal Deaths: Supporting Maternal Mortality Review Committees	$ 595,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventive Health and Health Services Block Grant	$ 2,886,135
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	$ 850,096
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State and Local Healthy Homes and Childhood Lead Poisoning Prevention Programs (CLPPPs)	$ 468,678
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Sudden Unexpected Infant Death (SUID) Case Registry Program	$ 285,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Tobacco Control Programs	$ 1,664,198
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > WISEWOMAN Program	$ 628,791
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 258,959

OTHER FEDERAL FUNDS	FY 26 Application Budgeted
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	$ 11,744,394
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Pediatric Mental Health Care Access Program	$ 952,324
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Maternal Health Innovation Program	$ 1,816,308
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 100,000
US Department of Agriculture (USDA) > Food and Nutrition Services > Commodity Supplemental Food Program (CSFP)	$ 849,938
US Department of Agriculture (USDA) > Food and Nutrition Services > The Loving Support Peer Counseling Program (Breastfeeding)	$ 1,796,183
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 152,583,994
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Screening and Treatment for Maternal Depression and Related Behavioral Disorders Program	$ 750,000
Department of Health and Human Services (DHHS) > Administration for Community Living (ACL) > Traumatic Brain Injury	$ 200,179
US Department of Agriculture (USDA) > Food and Nutrition Services > WIC - Technology	$ 350,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > TN Diabetes Prevention and Control	$ 1,200,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Tennessee Cardiovascular Health Program	$ 1,172,233
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Comprehensive Suicide Prevention	$ 1,038,147
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Perinatal Substance Exposure: Surveillance and Prevention	$ 1,029,765
US Department of Agriculture (USDA) > Food and Nutrition Services > WIC - Modernization	$ 1,277,562
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Partnership Programs to Reduce Maternal Deaths due to Violence	$ 424,156

	FY 24 Annual Report Budgeted		FY 24 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 11,800,000 (FY 24 Federal Award: $ 12,546,108)		$ 8,272,326	
A. Preventive and Primary Care for Children	$ 3,868,100	(32.8%)	$ 3,027,724	(36.6%)
B. Children with Special Health Care Needs	$ 3,658,000	(31%)	$ 2,651,757	(32%)
C. Title V Administrative Costs	$ 1,180,000	(10%)	$ 669,711	(8.1%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 8,706,100		$ 6,349,192	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 11,700,000		$ 11,161,305	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0		$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0		$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 2,000,000		$ 1,964,649	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 13,700,000		$ 13,125,954	
A. Your State's FY 1989 Maintenance of Effort Amount $ 13,125,024				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 25,500,000		$ 21,398,280	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.				
10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9)	$ 161,977,795		$ 175,433,013	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 187,477,795		$ 196,831,293	

OTHER FEDERAL FUNDS	FY 24 Annual Report Budgeted	FY 24 Annual Report Expended
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 160,000	$ 154,908
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Injury Prevention and Control	$ 400,000	$ 356,455
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Breast and Cervical Cancer Early Detection Program (NBCCEDP)	$ 3,742,004	$ 3,810,190
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Birth Defects and Developmental Disabilities	$ 349,214	$ 336,123
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Comprehensive Cancer Control Program (NCCCP)	$ 363,722	$ 333,977
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventing Maternal Deaths: Supporting Maternal Mortality Review Committees	$ 450,000	$ 672,282
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventive Health and Health Services Block Grant	$ 2,511,471	$ 2,511,471
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	$ 734,550	$ 610,695
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State and Local Healthy Homes and Childhood Lead Poisoning Prevention Programs (CLPPPs)	$ 350,000	$ 458,631
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Sudden Death in the Young (SDY) Registry	$ 212,281	$ 181,376
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Tobacco Control Programs	$ 1,664,198	$ 1,965,713
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > WISEWOMAN Program	$ 650,000	$ 68,459

OTHER FEDERAL FUNDS	FY 24 Annual Report Budgeted	FY 24 Annual Report Expended
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 235,000	$ 223,402
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	$ 9,929,648	$ 9,151,150
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) American Rescue Plan (ARP)	$ 1,100,000	$ 1,230,071
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Innovation Grants	$ 1,000,000	$ 1,481,153
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Pediatric Mental Health Care Access Program	$ 445,000	$ 601,046
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Maternal Health Innovation Program	$ 1,000,000	$ 1,137,679
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 100,000	$ 100,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Traumatic Brain Injury	$ 200,179	$ 213,131
US Department of Agriculture (USDA) > Food and Nutrition Services > Commodity Supplemental Food Program (CSFP)	$ 899,745	$ 823,789
US Department of Agriculture (USDA) > Food and Nutrition Services > The Loving Support Peer Counseling Program (Breastfeeding)	$ 1,714,101	$ 1,714,101
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 129,861,928	$ 144,029,445
US Department of Agriculture (USDA) > Food and Nutrition Services > WIC Technology for a Better WIC Experience	$ 349,521	$ 202,104

OTHER FEDERAL FUNDS	FY 24 Annual Report Budgeted	FY 24 Annual Report Expended
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Comprehensive Suicide Prevention	$ 883,000	$ 1,224,370
Department of Health and Human Services (DHHS) > Other > Partnership Programs to Reduce Maternal Deaths Due to Violence	$ 300,000	$ 277,060
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Diabetes Prevention and Control	$ 1,200,000	$ 852,276
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Cardiovascular Health Program	$ 1,172,233	$ 711,956

Form Notes for Form 2:

None

Field Level Notes for Form 2:

None

Data Alerts:

- The value in Line 1, Federal Allocation, Annual Report Expended is greater or less than 10% of the Annual Report Budgeted. Please correct or add a field level note indicating the reason for the discrepancy.
- The value in Line 1A, Preventive And Primary Care Expended, Annual Report Expended is greater or less than 10% of the Annual Report Budgeted. Please correct or add a field level note indicating the reason for the discrepancy.
- The value in Line 1B, Children with Special Health Care Needs, Annual Report Expended is greater or less than 10% of the Annual Report Budgeted. Please correct or add a field level note indicating the reason for the discrepancy.
- The value in Line 1C, Title V Administrative Costs, Annual Report Expended is greater or less than 10% of the Annual Report Budgeted. Please add a field level note indicating the reason for the discrepancy.

Form 3a
Budget and Expenditure Details by Types of Individuals Served

State: Tennessee

I. TYPES OF INDIVIDUALS SERVED

IA. Federal MCH Block Grant	FY 26 Application Budgeted	FY 24 Annual Report Expended
1. Pregnant Women	$ 48,558	$ 31,503
2. Infants < 1 year	$ 977,127	$ 701,329
3. Children 1 through 21 Years	$ 4,410,000	$ 3,027,724
4. CSHCN	$ 4,158,000	$ 2,651,757
5. All Others	$ 1,746,315	$ 1,190,302
Federal Total of Individuals Served	$ 11,340,000	$ 7,602,615

IB. Non-Federal MCH Block Grant	FY 26 Application Budgeted	FY 24 Annual Report Expended
1. Pregnant Women	$ 80,718	$ 77,002
2. Infants < 1 year	$ 346,417	$ 330,467
3. Children 1 through 21 Years	$ 4,257,518	$ 4,061,492
4. CSHCN	$ 643,732	$ 614,093
5. All Others	$ 6,371,615	$ 6,078,251
Non-Federal Total of Individuals Served	$ 11,700,000	$ 11,161,305
Federal State MCH Block Grant Partnership Total	$ 23,040,000	$ 18,763,920

Form Notes for Form 3a:

None

Field Level Notes for Form 3a:

None

Data Alerts: None

Form 3b
Budget and Expenditure Details by Types of Services

State: Tennessee

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY 26 Application Budgeted	FY 24 Annual Report Expended
1. Direct Services	$ 689,011	$ 502,621
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 47,844	$ 34,902
B. Preventive and Primary Care Services for Children	$ 74,199	$ 54,127
C. Services for CSHCN	$ 566,968	$ 413,592
2. Enabling Services	$ 7,882,827	$ 5,750,381
3. Public Health Services and Systems	$ 4,028,162	$ 2,019,324
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 58,664
Physician/Office Services		$ 91,517
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 154,263
Dental Care (Does Not Include Orthodontic Services)		$ 14,862
Durable Medical Equipment and Supplies		$ 75,867
Laboratory Services		$ 28,111
Other		
CSS Food		$ 79,337
Direct Services Line 4 Expended Total		$ 502,621
Federal Total	$ 12,600,000	$ 8,272,326

IIB. Non-Federal MCH Block Grant	FY 26 Application Budgeted	FY 24 Annual Report Expended
1. Direct Services	$ 1,726,856	$ 1,647,347
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 1,467,827	$ 1,419,840
B. Preventive and Primary Care Services for Children	$ 17,269	$ 0
C. Services for CSHCN	$ 241,760	$ 227,507
2. Enabling Services	$ 6,613,686	$ 6,309,177
3. Public Health Services and Systems	$ 3,359,458	$ 3,204,781
4. Select the types of Non-Federally-supported "Direct Services", as reported in II.B.1. Provide the total amount of Non-Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 1,353,919
Physician/Office Services		$ 47,845
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 107,467
Dental Care (Does Not Include Orthodontic Services)		$ 872
Durable Medical Equipment and Supplies		$ 18,706
Laboratory Services		$ 93,391
Other		
CSS Food		$ 25,147
Direct Services Line 4 Expended Total		$ 1,647,347
Non-Federal Total	$ 11,700,000	$ 11,161,305

Form Notes for Form 3b:

None

Field Level Notes for Form 3b:

None

Form 4
Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated

State: Tennessee

Total Births by Occurrence: 89,673 **Data Source Year: 2024**

1. Core RUSP Conditions

Program Name	(A) Aggregate Total Number Receiving at Least One Valid Screen	(B) Aggregate Total Number of Out-of-Range Results	(C) Aggregate Total Number Confirmed Cases	(D) Aggregate Total Number Referred for Treatment
Core RUSP Conditions	89,153 (99.4%)	2,156	247	246 (99.6%)

Program Name(s)				
3-Hydroxy-3-Methyglutaric Aciduria	3-Methylcrotonyl-Coa Carboxylase Deficiency	Argininosuccinic Aciduria	Biotinidase Deficiency	Carnitine Uptake Defect/Carnitine Transport Defect
Citrullinemia, Type I	Classic Galactosemia	Classic Phenylketonuria	Congenital Adrenal Hyperplasia	Cystic Fibrosis
Glutaric Acidemia Type I	Glycogen Storage Disease Type II (Pompe)	Holocarboxylase Synthase Deficiency	Homocystinuria	Isovaleric Acidemia
Long-Chain L-3 Hydroxyacyl-Coa Dehydrogenase Deficiency	Maple Syrup Urine Disease	Medium-Chain Acyl-Coa Dehydrogenase Deficiency	Methylmalonic Acidemia (Cobalamin Disorders)	Methylmalonic Acidemia (Methylmalonyl-Coa Mutase)
Primary Congenital Hypothyroidism	Propionic Acidemia	S, ßeta-Thalassemia	S,C Disease	S,S Disease (Sickle Cell Anemia)
Severe Combined Immunodeficiences	Spinal Muscular Atrophy Due To Homozygous Deletion Of Exon 7 In SMN1	ß-Ketothiolase Deficiency	Trifunctional Protein Deficiency	Tyrosinemia, Type I
Very Long-Chain Acyl-Coa Dehydrogenase Deficiency	X-Linked Adrenoleukodystrophy			

2. Other Newborn Screening Tests

Program Name	(A) Total Number Receiving at Least One Screen	(B) Total Number Presumptive Positive Screens	(C) Total Number Confirmed Cases	(D) Total Number Referred for Treatment
2-Methyl-3-hydroxybutyric aciduria	89,153 (99.4%)	37	0	0 (0%)
2-Methylbutyrylglycinuria	89,153 (99.4%)	37	0	0 (0%)
3-Methylglutaconic aciduria	89,153 (99.4%)	37	0	0 (0%)
Argininemia	89,153 (99.4%)	0	0	0 (0%)
Biopterin defect in cofactor biosynthesis	89,153 (99.4%)	5	4	4 (100.0%)
Biopterin defect in cofactor regeneration	89,153 (99.4%)	5	4	4 (100.0%)
Carnitine acylcarnitine translocase deficiency	89,153 (99.4%)	9	0	0 (0%)
Methylmalonic acidemia with homocystinuria	89,153 (99.4%)	25	2	2 (100.0%)
Citrullinemia, type II	89,153 (99.4%)	5	1	1 (100.0%)
Carnitine palmitoyltransferase type I deficiency	89,153 (99.4%)	4	0	0 (0%)
Carnitine palmitoyltransferase type II deficiency	89,153 (99.4%)	9	0	0 (0%)
2,4 Dienoyl-CoA reductase deficiency	89,153 (99.4%)	4	0	0 (0%)
Glutaric acidemia type II	89,153 (99.4%)	36	0	0 (0%)
Galactoepimerase deficiency	89,153 (99.4%)	58	0	0 (0%)
Galactokinase deficiency	89,153 (99.4%)	58	0	0 (0%)
Benign hyperphenylalaninemia	89,153 (99.4%)	5	4	4 (100.0%)

Program Name	(A) Total Number Receiving at Least One Screen	(B) Total Number Presumptive Positive Screens	(C) Total Number Confirmed Cases	(D) Total Number Referred for Treatment
Isobutyrylglycinuria	89,153 (99.4%)	36	0	0 (0%)
Medium/short-chain L-3-hydroxyacl-CoA dehydrogenase deficiency	89,153 (99.4%)	30	0	0 (0%)
Malonic acidemia	89,153 (99.4%)	30	0	0 (0%)
Hypermethioninemia	89,153 (99.4%)	1	0	0 (0%)
Short-chain acyl-CoA dehydrogenase deficiency	89,153 (99.4%)	36	2	2 (100.0%)
Tyrosinemia, type II	89,153 (99.4%)	33	0	0 (0%)
Tyrosinemia, type III	89,153 (99.4%)	33	0	0 (0%)
Various other hemoglobinopathies	89,153 (99.4%)	51	7	7 (100.0%)
T-Cell related lymphocyte deficiencies	89,153 (99.4%)	114	7	7 (100.0%)

3. Screening Programs for Older Children & Women

None

4. Long-Term Follow-Up

Tennessee's Newborn Screening Follow-Up Program has a case management section which provides short-term follow up to monitor all cases with abnormal tests through to diagnostic testing and treatment initiation. The State contracts with tertiary specialty centers to assure follow-up and diagnostic testing for all infants with abnormal bloodspot screens. The centers are required, by contract, to report the results (whether disease was confirmed) back to the State, and for cases in which disease was confirmed, the center reports the date on which treatment was started or counseling was performed with the family. In 2024, the State began building a long-term follow-up program to monitor confirmed diagnosed infants beyond notification of diagnosis and treatment initiation by the contracted tertiary specialty center and this work will begin later in 2025.

Form Notes for Form 4:

None

Field Level Notes for Form 4:

1.	**Field Name:**	**Core RUSP Conditions - Total Number Referred For Treatment**
	Fiscal Year:	**2024**
	Column Name:	**Core RUSP Conditions**
	Field Note: Spinal Muscular Atrophy confirmed disease is higher than presumed positives and referred for treatment because we had a false negative that was identified by a tertiary center	

Data Alerts: None

Form 5
Count of Individuals Served by Title V & Total Percentage of Populations Served by Title V

State: Tennessee

Annual Report Year 2024

Form 5a – Count of Individuals Served by Title V
(Direct & Enabling Services Only)

		Primary Source of Coverage				
Types Of Individuals Served	(A) Title V Total Served	(B) Title XIX %	(C) Title XXI %	(D) Private / Other %	(E) None %	(F) Unknown %
1. Pregnant Women	17,177	46.0	0.0	51.0	3.0	0.0
2. Infants < 1 Year of Age	38,232	46.0	0.0	51.0	3.0	0.0
3. Children 1 through 21 Years of Age	330,134	39.0	0.0	54.0	7.0	0.0
3a. Children with Special Health Care Needs 0 through 21 years of age^	75,109	51.0	0.0	45.0	4.0	0.0
4. Others	302,019	13.0	0.0	76.0	11.0	0.0
Total	687,562					

Form 5b – Total Percentage of Populations Served by Title V
(Direct, Enabling, and Public Health Services and Systems)

Populations Served by Title V	Reference Data	Used Reference Data?	Denominator	Total % Served	Form 5b Count (Calculated)	Form 5a Count
1. Pregnant Women	83,021	Yes	83,021	100.0	83,021	17,177
2. Infants < 1 Year of Age	88,387	Yes	88,387	99.6	88,033	38,232
3. Children 1 through 21 Years of Age	1,837,640	Yes	1,837,640	63.7	1,170,577	330,134
3a. Children with Special Health Care Needs 0 through 21 years of age^	516,372	Yes	516,372	62.8	324,282	75,109
4. Others	5,206,890	Yes	5,206,890	99.8	5,196,476	302,019

^Represents a subset of all infants and children.

Form Notes for Form 5:

In response to the feedback received from federal reviews of this grant in the past, the Tennessee MCH/Title V Program has adjusted the counting method used for this form to more accurately reflect the populations served. To calculate the Title V Total Served, a list of programs supporting each population was created and ordered from largest to smallest population served. To deduplicate and account for a person being supported by more than one program, the calculations below were applied to the ordered program list.

50% of Tennessee resident births are to women receiving Medicaid at delivery
40% of Tennessee resident births are to women receiving WIC during pregnancy
60% of Tennessee resident births covered by Medicaid are to women who received WIC during pregnancy
23% of the state's population is covered by Medicaid
50% of Tennessee resident births are covered by Medicaid
53% of Tennessee children are covered by Medicaid
21.1% of Tennessee children (ages 0-17) have at least one special healthcare need

Field Level Notes for Form 5a:

1.	**Field Name:**	**Pregnant Women Total Served**
	Fiscal Year:	**2024**
	Field Note:	The count of pregnant women includes women's health services in Local Health Departments (9,314), Community Health Services: Primary Care (5,472), pregnant women served by Community Health Access and Navigation in Tennessee (CHANT) (1,953), pregnant women enrolled in Growing Inside Free of Tobacco and Smoke (GIFTS) (420), and pregnant women served by the Tobacco Quitline (18).
2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2024**
	Field Note:	The count of infants includes Community Health Services: Primary Care (29,933), infants served by Community Health Access and Navigation in Tennessee (CHANT) (4,038), infants served by Poison Control (2,362), infants served by Genetics (1,539), and the Child Safety Fund (360).
3.	**Field Name:**	**Children 1 through 21 Years of Age**
	Fiscal Year:	**2024**
	Field Note:	This count includes children's health services in Local Health Departments (302,571), children served by Poison Control (12,863), Family Planning (5,661), children served by Community Health Access and Navigation in Tennessee (CHANT) (4,396), Family Planning (5,661), Rape Prevention Education services (3,305), Child Safety Fund (738), children receiving Tobacco Prevention services (317), children receiving Breast and Cervical Cancer services (208), Traumatic Brain Injury (46), and children receiving services from the Tobacco Quitline (27).
4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age**
	Fiscal Year:	**2024**
	Field Note:	This count includes the assumption that 21.3% of children in Tennessee have a special healthcare need. It was calculated by applying that assumption to the number of children who received health services in Local Health Departments (70,318). This count also includes Children's Special Services (4,697), the Youth Advisory Council Conference attendees (80), and CYSHCN receiving services from CHANT.
5.	**Field Name:**	**Others**
	Fiscal Year:	**2024**
	Field Note:	This count includes health services in Local Health Departments (187,944), Family Planning services (21,212), Poison Control services (16,811), Breast and Cervical Cancer services (13,236), Traumatic Brain Injury services (10,334), Genetics services (9,563), Farmer's Market (8,185), individuals receiving services from Community Health Access and Navigation in Tennessee (CHANT) (6,134), individuals receiving services from the Tobacco Quitline (2,043), Rape Prevention education (609), TN Strong Families Doula Pilot Project (65), Family Planning sterilizations (53), WISEWOMAN (46), and Sexual Risk Avoidance Education (7).

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women Total % Served**
	Fiscal Year:	**2024**

Field Note:
The Tennessee Title V program and partners serve 100% of pregnancies and deliveries through the state's perinatal centers by developing and maintaining a system of risk-appropriate perinatal care designations and transfer protocols. In addition to the programs and service numbers included in Form 5a and listed in the notes on that form, other related efforts include: Project Diabetes grantees (6,234), outreach and education provided at the five perinatal centers (2,570), the Maternal Health Innovation Grant (266), and the Maternal Mortality Review Committee (20).

A new pilot project began to identify families on TennCare who are not also enrolled in WIC. FHW receives a list from TennCare of all pregnant women who enrolled the previous month. This list is compared to the WIC participant list to identify who is also not enrolled in WIC. The list of WIC-eligible, unenrolled individuals is sent to their local WIC office so that WIC staff can contact them to offer services. Through this effort, 2,238 women from the lists enrolled in WIC.

2.	**Field Name:**	**Infants Less Than One Year Total % Served**
	Fiscal Year:	**2024**

Field Note:
The Tennessee Title V program serves 99.6% of newborns through a newborn screening before hospital discharge (see https://www.tn.gov/content/tn/health/health-program-areas/fhw/newborn-screening/newborn-hearing-screening-dashboard.html), excluding infants who passed away, refused screening, or were referred for evaluation before screening took place. In addition to the programs and service numbers included in Form 5a and listed in the notes to that form, other related efforts for this age group include: Newborn Screeborn Screening/Early Hearing and Detection (89,622), Infant Mortality Reduction (83,021), education and outreach provided at the five perinatal centers regionalization (4,918), Child Fatality Review (446), education and outreach through the Injury Surveillance and Prevention program, Sudden Death in Young Registry (137), Traumatic Brain Injury Registry (132), the Maternal Health Innovation Grant (102), Project Diabetes grantees (98), and the Fetal and Infant Mortality Review Committee (66).

A new pilot project began to identify families on TennCare who are not also enrolled in WIC. FHW receives a list from TennCare of all pregnant women who enrolled the previous month. This list is compared to the WIC participant list to identify those who are not enrolled in WIC. The list of WIC-eligible, unenrolled individuals is sent to their local WIC office so that WIC staff can contact them to offer services. Through this effort, 1,238 infants from the lists were enrolled in WIC.

3.	**Field Name:**	**Children 1 through 21 Years of Age Total % Served**
	Fiscal Year:	**2024**

Field Note:
In addition to the multiple programs and service numbers included in Form 5a and listed in the notes to that form, other related public health services and systems for this population include: Suicide Prevention (1,082,161), Childhood Lead Poisoning (87,257), and Traumatic Brain Injury Registry (1,673). Other services and outreach include programs such as Injury Surveillance and Prevention, Health Promotion, Project Diabetes, Rape Prevention education, Pediatric Mental Health Care Access, Sudden Death in Young Registry, and Pregnancy Prevention.

A new pilot project began to identify families on TennCare who are not also enrolled in WIC. FHW receives a list from TennCare of all pregnant women who enrolled the previous month. This list is compared to the WIC participant list to identify those who are not enrolled in WIC. The list of WIC-eligible, unenrolled individuals is sent to their local WIC office so that WIC staff can contact them to offer services. Through this effort, 652 children from the lists were enrolled in WIC.

The count for the Suicide Prevention Program represents unduplicated children ages 10-21 only. In an effort to account for estimated duplication, programs listed above without a count are not included in the calculation used to come up with the Total % Served for this population due to the assumption that they could be counted in the other programs. However, the percentage may still be an overestimation.

4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age Total % Served**
	Fiscal Year:	**2024**

Field Note:
In addition to the programs and service numbers included in Form 5a and listed in the notes to that form, this population is calculated by assuming 21.3% of children in Tennessee have a special healthcare need. This population also includes education and outreach efforts, including: Infant Mortality Reduction, Newborn Hearing Follow-up, Newborn Dried Blood Spot Screening Follow-up, Birth Defects, Childhood Lead Poisoning, and Pediatric Mental Health Care Access. At this time, de-duplication between programs is not possible; however, in an effort to account for estimated duplication, programs listed are not included in the calculation used to come up with the Total % Served for this population. The percentage may still be an overestimation.

5.	**Field Name:**	**Others Total % Served**
	Fiscal Year:	**2024**

Field Note:
The Suicide Prevention Program expanded syndromic surveillance to include individuals greater than or equal to 22 years. Expanded estimate includes ages 22 - 65+. In addition to the programs and service numbers included in Form 5a and listed in the notes to that form, this population includes education and outreach efforts including: TBI BRAIN grant, Shaken Baby Syndrome, Traumatic Brain Inuurty Registry, Health Promotion workforce development, Maternal Health Innovation Grant, Project Diabetes, Preventing Maternal Deaths Grant, Tobacco Quitline, Injury Surveillance and Prevention, Child Fatality Review, Maternal Deaths from Violence Grant, Traumatic Brain Injury workforce development, Maternal Mortality Review Committee, Rape Prevention program workforce development, and Pregnancy Prevention.

In an effort to account for estimated duplication, programs listed above without a count are not included in the calculation used to come up with the Total % Served for this population due to the assumption that they could be counted in the other programs. However, the percentage may still be an overestimation.

Data Alerts:

1.	Reported percentage for Others on Form 5b is greater than or equal to 50%. The Others denominator includes both women and men ages 22 and over. Please double check and justify with a field note.

Form 6
Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: Tennessee

Annual Report Year 2024

I. Unduplicated Count by Race/Ethnicity

	(A) Total	(B) Non-Hispanic White	(C) Non-Hispanic Black or African American	(D) Hispanic	(E) Non-Hispanic American Indian or Native Alaskan	(F) Non-Hispanic Asian	(G) Non-Hispanic Native Hawaiian or Other Pacific Islander	(H) Non-Hispanic Multiple Race	(I) Other & Unknown
1. Total Deliveries in State	88,387	56,885	15,029	12,178	110	1,885	98	1,724	478
Title V Served	88,030	56,657	14,968	12,129	109	1,877	97	1,717	476
Eligible for Title XIX	42,539	33,098	4,788	2,479	50	1,295	15	675	139
2. Total Infants in State	83,021	52,717	14,303	11,858	104	1,799	85	1,624	531
Title V Served	88,030	56,657	14,968	12,129	109	1,877	97	1,717	476
Eligible for Title XIX	39,676	30,723	4,491	2,382	48	1,243	14	638	137

Form Notes for Form 6:

Final 2023 TN Birth Certificate data was used to complete Form 6.

Field Level Notes for Form 6:

1.	**Field Name:**	**1. Total Deliveries in State**
	Fiscal Year:	**2024**
	Column Name:	**Total**
	Field Note: The total number of deliveries in the state includes infants born in Tennessee, residents or non-residents, with a valid birth certificate.	
2.	**Field Name:**	**1. Title V Served**
	Fiscal Year:	**2024**
	Column Name:	**Total**
	Field Note: The total number of deliveries in the state served by Title V includes infants born in Tennessee, residents or non-residents, with a valid birth certificate. All infants born in TN are required to have a hearing screening. In 2023, 99.6% of infants were screened, excluding infants who passed away, the family refused screening, or the infant was referred for evaluation before the screening took place. Screened Rate = (# Screened / (# Births - # Exclusions)) * 100	
3.	**Field Name:**	**1. Eligible for Title XIX**
	Fiscal Year:	**2024**
	Column Name:	**Total**
	Field Note: The total number of deliveries in the state eligible for Title XIX includes infants born in Tennessee, residents or non-residents, who had a valid birth certificate, and who had Medicaid/TennCare as their payment source on the birth certificate.	
4.	**Field Name:**	**2. Total Infants in State**
	Fiscal Year:	**2024**
	Column Name:	**Total**
	Field Note: The total number of infants in the state includes in-state and out-of-state births to moms residing in Tennessee who have a valid birth certificate.	
5.	**Field Name:**	**2. Title V Served**
	Fiscal Year:	**2024**
	Column Name:	**Total**

	Field Note: The total number of deliveries in the state served by Title V includes infants born in Tennessee, residents or non-residents, with a valid birth certificate. All infants born in TN are required to have a hearing screening. In 2023, 99.6% of infants were screened, excluding infants who passed away, the family refused screening, or the infant was referred for evaluation before the screening took place. Screened Rate = (# Screened / (# Births - # Exclusions)) * 100	
6.	**Field Name:**	**2. Eligible for Title XIX**
	Fiscal Year:	**2024**
	Column Name:	**Total**
	Field Note: The total number of infants in the state eligible for Title XIX includes in-state and out-of-state births to moms residing in Tennessee, who had a valid birth certificate, and who had Medicaid/TennCare listed as their payment source on the birth certificate.	

Form 7
Title V Program Workforce

State: Tennessee

Form 7 Entry Page

A. Title V Program Workforce FTEs	
Title V Funded Positions	
1. Total Number of FTEs	139
1a. Total Number of FTEs (State Level)	55
1b. Total Number of FTEs (Local Level)	84
2. Total Number of MCH Epidemiology FTEs (subset of A. 1)	2
3. Total Number of FTEs eliminated in the past 12 months	0
4. Total Number of Current Vacant FTEs	3
4a. Total Number of Vacant MCH Epidemiology FTEs	0
5. Total Number of FTEs onboarded in the past 12 months	11
B. Training Needs (Optional)	
No training needs were reported by the state.	

Form Notes for Form 7:

None

Field Level Notes for Form 7:

None

Form 8
State MCH and CSHCN Directors Contact Information

State: Tennessee

1. Title V Maternal and Child Health (MCH) Director	
Name	Elizabeth Harvey
Title	Assistant Commissioner, Title V Maternal and Child Health Director
Address 1	710 James Robertson Parkway
Address 2	
City/State/Zip	Nashville / TN / 37243
Telephone	(615) 917-9608
Extension	
Email	elizabeth.harvey@tn.gov

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Jacqueline Johnson
Title	Section Chief, Title V Children and Youth with Special Health Care Needs Director
Address 1	710 James Robertson Parkway
Address 2	
City/State/Zip	Nashville / TN / 37243
Telephone	(615) 741-0361
Extension	
Email	jacqueline.johnson@tn.gov

3. State Family Leader (Optional)	
Name	Michelle Gross
Title	Family Delegate
Address 1	710 James Robertson Parkway
Address 2	
City/State/Zip	Nashville / TN / 37243
Telephone	(423) 431-9598
Extension	
Email	Mlgross0207@gmail.com

4. State Youth Leader (Optional)	
Name	Darivon Badee
Title	Youth Advisory Council, Chair
Address 1	710 James Robertson Parkway
Address 2	
City/State/Zip	Nashville / TN / 37243
Telephone	(615) 708-3212
Extension	
Email	Badeedarivon4@gmail.com

5. SSDI Project Director	
Name	Julie Traylor
Title	SSDI Project Director
Address 1	710 James Robertson Parkway
Address 2	
City/State/Zip	Nashville / TN / 37243
Telephone	(615) 532-7476
Extension	
Email	julie.traylor@tn.gov

6. State MCH Toll-Free Telephone Line	
State MCH Toll-Free “Hotline” Telephone Number	(615) 741-7353

Form Notes for Form 8:

None

Form 9
List of Priority Needs – Needs Assessment Year

State: Tennessee

Application Year 2026

No.	Priority Need	Priority Need Type (New, Revised or Continued Priority Need for this five-year reporting period)
1.	Increase Access to Contraceptive Methods	Continued
2.	Decrease Preventable Illness and Disease Among Children	New
3.	Improve Social and Emotional Wellbeing in Adolescents	Revised
4.	Improve Nutrition Among Families	New
5.	Improve Maternal Mental Health and Wellbeing	New
6.	Increase Access to Quality Care for Children and Adolescents with Special Healthcare Needs	Continued
7.	Improve the Perinatal Regionalization System in Tennessee	Revised

Form Notes for Form 9:

None

Field Level Notes for Form 9:

None

Form 10
National Outcome Measures (NOMs)

State: Tennessee

Form Notes for Form 10 NPMs, NOMs, SPMs, SOMs, and ESMs.

Our ESM calculates the percentage change in call volume from year to year. Therefore, the percent increases will decrease over time as the number of calls increases.

NOM - Rate of severe maternal morbidity per 10,000 delivery hospitalizations - SMM

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	88.0	3.4	693	78,718
2021	96.8	3.5	754	77,862
2020	88.6	3.5	662	74,693
2019	73.1	3.2	536	73,285
2018	79.4	3.4	562	70,742
2017	79.7	3.4	558	70,014
2016	73.8	3.4	480	65,006
2015	90.8	4.4	439	48,340
2014	90.9	3.8	587	64,567
2013	106.2	4.0	709	66,787
2012	96.1	3.8	635	66,091
2011	89.5	3.6	627	70,040
2010	82.2	3.5	572	69,591
2009	76.6	3.3	556	72,589
2008	76.1	3.2	570	74,884

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM SMM - Notes:

None

Data Alerts: None

NOM - Maternal mortality rate per 100,000 live births - MM

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2023	42.1	3.2	171	406,142
2018_2022	41.1	3.2	166	403,872
2017_2021	40.2	3.2	162	402,623
2016_2020	31.6	2.8	127	401,713
2015_2019	26.4	2.6	107	404,709
2014_2018	24.9	2.5	101	405,861

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM MM - Notes:

None

Data Alerts: None

NOM - Teen birth rate, ages 15 through 19, per 1,000 females - TB

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2023	20.4	0.3	4,547	222,849
2022	21.0	0.3	4,502	214,582
2021	21.5	0.3	4,613	214,193
2020	23.3	0.3	4,826	207,490
2019	23.7	0.3	4,918	207,809
2018	25.3	0.4	5,258	207,756
2017	26.6	0.4	5,516	207,240
2016	28.0	0.4	5,766	206,065
2015	30.6	0.4	6,267	204,782
2014	33.2	0.4	6,756	203,551
2013	34.8	0.4	7,105	204,285
2012	38.4	0.4	7,910	205,905
2011	40.8	0.4	8,497	208,285
2010	43.5	0.5	9,254	212,929
2009	48.4	0.5	10,378	214,436

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM TB - Notes:

None

Data Alerts: None

NOM - Percent of low birth weight deliveries (<2,500 grams) - LBW

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2023	9.1 %	0.1 %	7,526	82,987
2022	9.0 %	0.1 %	7,367	82,229
2021	9.3 %	0.1 %	7,595	81,683
2020	8.9 %	0.1 %	7,002	78,653
2019	9.2 %	0.1 %	7,356	80,283
2018	9.3 %	0.1 %	7,471	80,473
2017	9.2 %	0.1 %	7,409	80,813
2016	9.3 %	0.1 %	7,431	80,084
2015	9.2 %	0.1 %	7,460	81,384
2014	9.0 %	0.1 %	7,297	81,441
2013	9.1 %	0.1 %	7,307	79,962
2012	9.2 %	0.1 %	7,377	80,318
2011	9.0 %	0.1 %	7,176	79,554
2010	9.0 %	0.1 %	7,179	79,451
2009	9.2 %	0.1 %	7,539	82,172

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM LBW - Notes:

None

Data Alerts: None

NOM - Percent of preterm births (<37 weeks gestation) - PTB

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2023	11.3 %	0.1 %	9,408	82,972
2022	11.0 %	0.1 %	9,078	82,213
2021	11.3 %	0.1 %	9,218	81,658
2020	10.9 %	0.1 %	8,594	78,642
2019	11.2 %	0.1 %	8,993	80,340
2018	11.1 %	0.1 %	8,911	80,541
2017	11.1 %	0.1 %	8,962	80,847
2016	11.3 %	0.1 %	9,085	80,340
2015	11.0 %	0.1 %	8,959	81,538
2014	10.8 %	0.1 %	8,780	81,497
2013	11.1 %	0.1 %	8,826	79,691
2012	11.2 %	0.1 %	8,961	79,807
2011	11.1 %	0.1 %	8,729	78,903
2010	11.4 %	0.1 %	8,988	78,936
2009	11.3 %	0.1 %	9,231	81,518

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM PTB - Notes:

None

Data Alerts: None

NOM - Stillbirth rate per 1,000 live births plus fetal deaths - SB

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	6.5	0.3	538	82,803
2021	6.5	0.3	537	82,254
2020	6.6	0.3	520	79,209
2019	6.2	0.3	498	80,948
2018	7.2	0.3	586	81,337
2017	6.8	0.3	553	81,569
2016	7.3	0.3	592	81,399
2015	7.2	0.3	593	82,278
2014	7.1	0.3	581	82,183
2013	7.1	0.3	569	80,561
2012	7.8	0.3	633	81,004
2011	7.4	0.3	593	80,181
2010	5.7	0.3	453	79,948
2009	4.6	0.2	376	82,587

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM SB - Notes:

None

Data Alerts: None

NOM - Perinatal mortality rate per 1,000 live births plus fetal deaths - PNM

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	5.8	0.3	477	82,539
2021	5.7	0.3	469	81,990
2020	6.0	0.3	476	78,930
2019	6.7	0.3	537	80,689
2018	6.8	0.3	555	81,028
2017	6.8	0.3	549	81,276
2016	6.8	0.3	555	81,107
2015	6.4	0.3	521	81,958
2014	6.8	0.3	554	81,875
2013	7.0	0.3	558	80,281
2012	7.2	0.3	582	80,674
2011	7.4	0.3	595	79,909
2010	6.6	0.3	524	79,743
2009	6.8	0.3	561	82,469

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM PNM - Notes:

None

Data Alerts: None

NOM - Infant mortality rate per 1,000 live births - IM

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	6.6	0.3	544	82,265
2021	6.2	0.3	505	81,717
2020	6.4	0.3	502	78,689
2019	7.0	0.3	560	80,450
2018	6.9	0.3	556	80,751
2017	7.3	0.3	591	81,016
2016	7.4	0.3	594	80,807
2015	7.0	0.3	568	81,685
2014	6.9	0.3	561	81,602
2013	6.8	0.3	544	79,992
2012	7.2	0.3	582	80,371
2011	7.4	0.3	592	79,588
2010	7.9	0.3	626	79,495
2009	8.0	0.3	657	82,211

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM IM - Notes:

None

Data Alerts: None

NOM - Neonatal mortality rate per 1,000 live births - IM-Neonatal

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	3.5	0.2	290	82,265
2021	3.2	0.2	262	81,717
2020	3.9	0.2	305	78,689
2019	4.5	0.2	364	80,450
2018	4.5	0.2	361	80,751
2017	4.6	0.2	372	81,016
2016	4.2	0.2	343	80,807
2015	4.1	0.2	335	81,685
2014	4.3	0.2	349	81,602
2013	4.2	0.2	333	79,992
2012	4.3	0.2	349	80,371
2011	4.6	0.2	365	79,588
2010	4.6	0.2	368	79,495
2009	4.8	0.2	396	82,211

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM IM-Neonatal - Notes:

None

Data Alerts: None

NOM - Post neonatal mortality rate per 1,000 live births - IM-Postneonatal

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	3.1	0.2	254	82,265
2021	3.0	0.2	243	81,717
2020	2.5	0.2	197	78,689
2019	2.4	0.2	196	80,450
2018	2.4	0.2	195	80,751
2017	2.7	0.2	219	81,016
2016	3.1	0.2	251	80,807
2015	2.9	0.2	233	81,685
2014	2.6	0.2	212	81,602
2013	2.6	0.2	211	79,992
2012	2.9	0.2	233	80,371
2011	2.9	0.2	227	79,588
2010	3.2	0.2	258	79,495
2009	3.2	0.2	261	82,211

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM IM-Postneonatal - Notes:

None

Data Alerts: None

NOM - Preterm-related mortality rate per 100,000 live births - IM-Preterm Related

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	150.7	13.6	124	82,265
2021	140.7	13.1	115	81,717
2020	207.1	16.2	163	78,689
2019	264.8	18.2	213	80,450
2018	216.7	16.4	175	80,751
2017	201.2	15.8	163	81,016
2016	211.6	16.2	171	80,807
2015	189.8	15.3	155	81,685
2014	230.4	16.8	188	81,602
2013	193.8	15.6	155	79,992
2012	209.0	16.1	168	80,371
2011	214.9	16.5	171	79,588
2010	245.3	17.6	195	79,495
2009	255.4	17.7	210	82,211

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM IM-Preterm Related - Notes:

None

Data Alerts: None

NOM - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births - IM-SUID

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	182.3	14.9	150	82,265
2021	172.5	14.5	141	81,717
2020	143.6	13.5	113	78,689
2019	125.5	12.5	101	80,450
2018	153.6	13.8	124	80,751
2017	149.4	13.6	121	81,016
2016	153.5	13.8	124	80,807
2015	153.0	13.7	125	81,685
2014	111.5	11.7	91	81,602
2013	123.8	12.5	99	79,992
2012	164.2	14.3	132	80,371
2011	154.5	14.0	123	79,588
2010	171.1	14.7	136	79,495
2009	153.3	13.7	126	82,211

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM IM-SUID - Notes:

None

Data Alerts: None

NOM - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations - NAS

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	8.1	0.3	614	75,503
2021	9.8	0.4	734	74,797
2020	9.6	0.4	694	72,133
2019	10.9	0.4	779	71,219
2018	14.6	0.5	995	68,376
2017	16.2	0.5	1,099	67,827
2016	18.0	0.5	1,134	63,143
2015	16.9	0.6	793	46,904
2014	15.3	0.5	959	62,637
2013	12.5	0.4	815	65,309
2012	8.9	0.4	584	65,480
2011	6.0	0.3	414	69,570
2010	5.4	0.3	375	69,409
2009	4.3	0.2	311	72,741
2008	3.0	0.2	225	75,307

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM NAS - Notes:

None

Data Alerts: None

NOM - Percent of children meeting the criteria developed for school readiness - SR

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022_2023	70.0 %	2.5 %	180,744	258,346

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM SR - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year - TDC

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022_2023	11.5 %	0.8 %	168,263	1,462,815
2021_2022	13.2 %	1.0 %	189,644	1,439,770
2020_2021	12.8 %	1.2 %	181,570	1,413,251
2019_2020	11.8 %	1.3 %	167,399	1,416,243
2018_2019	13.3 %	1.4 %	185,999	1,400,474
2017_2018	13.3 %	1.6 %	182,528	1,375,531
2016_2017	10.3 %	1.4 %	143,791	1,390,099

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM TDC - Notes:

None

Data Alerts: None

NOM - Child Mortality rate, ages 1 through 9, per 100,000 - CM

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2023	29.9	2.0	228	762,312
2022	22.3	1.7	166	745,277
2021	21.8	1.7	163	748,023
2020	19.5	1.6	145	743,703
2019	20.7	1.7	154	742,209
2018	22.3	1.7	165	739,940
2017	23.3	1.8	173	741,775
2016	23.2	1.8	172	741,404
2015	18.3	1.6	135	739,432
2014	20.6	1.7	152	738,611
2013	21.1	1.7	156	738,334
2012	22.4	1.7	166	739,838
2011	20.0	1.7	147	736,697
2010	22.0	1.7	163	740,978
2009	20.0	1.7	148	738,731

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM CM - Notes:

None

Data Alerts: None

NOM - Adolescent mortality rate ages 10 through 19, per 100,000 - AM

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2023	51.3	2.4	461	898,616
2022	52.4	2.4	460	878,455
2021	54.9	2.5	485	883,615
2020	48.0	2.4	410	854,258
2019	42.0	2.2	359	855,582
2018	44.9	2.3	384	855,439
2017	43.5	2.3	370	850,432
2016	39.9	2.2	336	842,341
2015	39.8	2.2	335	840,920
2014	36.7	2.1	309	841,738
2013	35.5	2.1	299	841,885
2012	40.3	2.2	340	844,247
2011	37.1	2.1	315	848,300
2010	38.2	2.1	327	856,127
2009	42.4	2.2	363	855,924

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM AM - Notes:

None

Data Alerts: None

NOM - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000 - AM-Motor Vehicle

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021-2023	20.9	1.3	279	1,334,754
2020_2022	21.2	1.3	276	1,300,738
2019_2021	20.6	1.3	264	1,284,599
2018_2020	18.1	1.2	230	1,272,469
2017_2019	15.9	1.1	203	1,274,577
2016_2018	15.3	1.1	195	1,272,255
2015_2017	15.5	1.1	197	1,267,849
2014_2016	15.1	1.1	191	1,262,485
2013_2015	14.1	1.1	177	1,259,614
2012_2014	15.5	1.1	195	1,260,128
2011_2013	16.9	1.2	214	1,267,375
2010_2012	18.9	1.2	243	1,285,474
2009_2011	19.2	1.2	250	1,302,264
2008_2010	21.7	1.3	285	1,312,853
2007_2009	28.1	1.5	368	1,307,973

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM AM-Motor Vehicle - Notes:

None

Data Alerts: None

NOM - Adolescent suicide rate, ages 10 through 19 per 100,000 - AM-Suicide

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2023	7.4	0.5	196	2,660,686
2020_2022	7.0	0.5	184	2,616,328
2019_2021	6.8	0.5	176	2,593,455
2018_2020	6.6	0.5	169	2,565,279
2017_2019	7.4	0.5	190	2,561,453
2016_2018	7.9	0.6	202	2,548,212
2015_2017	7.7	0.6	195	2,533,693
2014_2016	6.8	0.5	172	2,524,999
2013_2015	6.1	0.5	154	2,524,543
2012_2014	5.6	0.5	142	2,527,870
2011_2013	4.9	0.4	123	2,534,432
2010_2012	4.4	0.4	112	2,548,674
2009_2011	4.5	0.4	115	2,560,351

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM AM-Suicide - Notes:

None

Data Alerts: None

NOM - Adolescent firearm mortality rate, ages 10 through 19 per 100,000 - AM-Firearm

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2023	15.8	0.8	421	2,660,686
2020_2022	14.9	0.8	389	2,616,328
2019_2021	13.2	0.7	343	2,593,455
2018_2020	13.3	0.7	340	2,565,279
2017_2019	13.7	0.7	351	2,561,453
2016_2018	13.6	0.7	346	2,548,212
2015_2017	11.8	0.7	299	2,533,693
2014_2016	9.6	0.6	243	2,524,999
2013_2015	9.0	0.6	226	2,524,543
2012_2014	8.1	0.6	204	2,527,870
2011_2013	7.9	0.6	199	2,534,432
2010_2012	7.2	0.5	184	2,548,674
2009_2011	7.5	0.5	192	2,560,351
2008_2010	7.7	0.6	197	2,565,317
2007_2009	7.7	0.6	196	2,556,163

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM AM-Firearm - Notes:

None

Data Alerts: None

NOM - Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9 - IH-Child

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	106.2	3.6	878	826,737
2021	121.4	3.8	1,001	824,694
2020	127.5	3.9	1,050	823,594
2019	127.4	3.9	1,047	821,984
2018	118.8	3.8	973	818,914
2017	122.6	3.9	1,009	822,681
2016	100.1	3.5	823	822,424
2015	109.3	4.2	672	614,986
2014	91.2	3.3	746	818,117
2013	93.4	3.4	764	817,630
2012	88.8	3.3	727	818,814
2011	127.2	4.0	1,038	816,255
2010	120.7	3.8	990	819,994
2009	132.9	4.0	1,088	818,847
2008	158.7	4.4	1,297	817,112

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM IH-Child - Notes:

None

Data Alerts: None

NOM - Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19 - IH-Adolescent

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	221.4	5.0	1,945	878,455
2021	232.5	5.1	2,054	883,615
2020	233.1	5.2	1,991	854,258
2019	222.2	5.1	1,901	855,582
2018	213.9	5.0	1,830	855,439
2017	220.7	5.1	1,877	850,432
2016	206.3	5.0	1,738	842,341
2015	191.2	5.5	1,206	630,690
2014	179.5	4.6	1,511	841,738
2013	187.9	4.7	1,582	841,885
2012	187.7	4.7	1,585	844,247
2011	209.1	5.0	1,774	848,300
2010	215.7	5.0	1,847	856,127
2009	245.5	5.4	2,101	855,924
2008	275.5	5.7	2,351	853,266

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM IH-Adolescent - Notes:

None

Data Alerts: None

NOM - Percent of women, ages 18 through 44, in excellent or very good health - WHS

Data Source: Behavioral Risk Factor Surveillance System (BRFSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2023	47.3 %	2.2 %	597,931	1,262,853
2022	51.3 %	2.2 %	631,335	1,231,643
2021	58.3 %	2.1 %	714,820	1,225,191
2020	64.0 %	2.3 %	774,197	1,208,934
2019	57.0 %	2.1 %	682,274	1,197,239
2018	52.3 %	2.4 %	618,293	1,182,746
2017	56.0 %	2.2 %	661,234	1,180,673
2017	56.0 %	2.2 %	661,234	1,180,673
2016	58.1 %	2.3 %	679,926	1,171,163
2015	53.5 %	2.4 %	623,418	1,164,719
2014	52.6 %	2.4 %	608,115	1,157,160
2013	56.4 %	2.1 %	650,026	1,153,511
2012	55.8 %	1.9 %	638,744	1,143,936

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

NOM WHS - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 0 through 17, in excellent or very good health - CHS

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022_2023	90.1 %	0.8 %	1,377,039	1,528,621
2021_2022	89.4 %	1.0 %	1,358,315	1,519,778
2020_2021	89.7 %	1.1 %	1,351,102	1,505,868
2019_2020	88.8 %	1.3 %	1,333,574	1,501,583
2018_2019	87.8 %	1.3 %	1,315,929	1,499,546
2017_2018	89.2 %	1.3 %	1,334,026	1,495,494
2016_2017	89.8 %	1.3 %	1,336,307	1,488,374

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM CHS - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 2 through 4, and adolescents, ages 6 through 17, who are obese (BMI at or above the 95th percentile) - OBS

Data Source: WIC

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	14.6 %	0.2 %	4,376	30,061
2018	15.2 %	0.2 %	6,693	44,025
2016	14.6 %	0.2 %	7,457	51,157
2014	14.9 %	0.2 %	8,083	54,429
2012	15.3 %	0.2 %	8,130	53,033
2010	16.0 %	0.2 %	9,126	57,153
2008	14.7 %	0.2 %	7,596	51,616

Legends:

Indicator has a denominator <20 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022_2023	19.9 %	1.3 %	197,740	993,734
2021_2022	21.2 %	1.5 %	206,746	973,357
2020_2021	22.6 %	1.8 %	216,653	959,549
2019_2020	21.9 %	2.0 %	210,231	959,395
2018_2019	20.4 %	2.0 %	193,249	947,580
2017_2018	17.3 %	2.1 %	162,264	936,662
2016_2017	17.3 %	2.0 %	159,693	920,423

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM OBS - Notes:

None

Data Alerts: None

NOM - Percent of women who experience postpartum depressive symptoms - PPD

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2023	12.5 %	1.9 %	9,770	77,940
2022	17.1 %	2.6 %	13,454	78,628
2021	13.0 %	1.6 %	10,082	77,580
2020	15.3 %	2.0 %	11,403	74,330
2019	15.5 %	2.1 %	11,792	75,888
2015	15.4 %	1.6 %	12,063	78,110
2014	13.6 %	1.6 %	10,620	78,096
2013	18.1 %	1.8 %	13,695	75,835
2012	17.2 %	1.6 %	13,157	76,677

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

NOM PPD - Notes:

None

Data Alerts: None

NOM - Percent of women who experience postpartum anxiety symptoms - PPA

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2023	18.1 %	2.2 %	14,053	77,531

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

NOM PPA - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 6 through 11, who have a behavioral or conduct disRecordOrder - BCD

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022_2023	9.7 %	1.4 %	49,680	509,774
2021_2022	8.8 %	1.3 %	44,339	505,053
2020_2021	7.8 %	1.6 %	39,006	502,363
2019_2020	7.8 %	2.0 %	39,347	501,551
2018_2019	10.8 %	2.4 %	54,036	500,986
2017_2018	10.9 %	2.3 %	54,175	499,181
2016_2017	10.0 %	2.1 %	49,882	497,326

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM BCD - Notes:

None

Data Alerts: None

NOM - Percent of adolescents, ages 12 through 17, who have depression or anxiety - ADA

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022_2023	19.1 %	1.7 %	103,390	542,214
2021_2022	17.7 %	1.7 %	94,144	530,534
2020_2021	14.7 %	1.8 %	75,600	516,033
2019_2020	13.2 %	1.8 %	67,525	513,400
2018_2019	14.4 %	2.2 %	74,462	516,604
2017_2018	16.2 %	2.7 %	83,530	516,237
2016_2017	13.6 %	2.4 %	69,756	511,301

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM ADA - Notes:

None

Data Alerts: None

NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system - SOC

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022_2023	16.1 %	1.7 %	66,278	412,011
2021_2022	18.2 %	2.1 %	71,979	395,641
2020_2021	16.6 %	2.4 %	62,146	375,118
2019_2020	18.0 %	2.7 %	77,021	428,232
2018_2019	17.6 %	2.6 %	78,768	447,757
2017_2018	14.4 %	2.3 %	56,384	390,467
2016_2017	17.0 %	2.6 %	62,863	370,543

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM SOC - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 6 months through 5, who are flourishing - FL-YC

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022_2023	81.8 %	1.8 %	360,029	439,972
2021_2022	80.9 %	2.1 %	355,310	438,932
2020_2021	82.4 %	2.6 %	365,125	442,949
2019_2020	84.5 %	2.8 %	384,590	455,135
2018_2019	87.7 %	2.5 %	390,658	445,427

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM FL-YC - Notes:

None

Data Alerts: None

NOM - Percent of children with and without special health care needs, ages 6 through 17, who are flourishing - FL-CA

Data Source: National Survey of Children's Health (NSCH)-CSHCN

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022_2023	38.9 %	2.6 %	130,660	336,290
2021_2022	36.4 %	2.8 %	117,278	322,194
2020_2021	44.3 %	3.5 %	140,058	316,378
2019_2020	49.9 %	3.7 %	173,252	347,119
2018_2019	51.8 %	3.7 %	186,534	359,856

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM FL-CA - Notes:

None

Data Alerts: None

NOM - Percent of children with and without special health care needs, ages 6 through 17, who are flourishing - FL-Child Adolescent

Data Source: National Survey of Children's Health (NSCH)-All Children

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022_2023	61.3 %	1.6 %	640,653	1,044,732
2021_2022	58.0 %	1.7 %	594,177	1,024,661
2020_2021	58.3 %	2.0 %	587,692	1,008,862
2019_2020	64.1 %	2.1 %	648,370	1,012,228
2018_2019	67.2 %	2.2 %	684,897	1,018,436

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM FL-Child Adolescent - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 0 through 17, who have experienced 2 or more Adverse Childhood Experiences - ACE

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022_2023	20.1 %	1.2 %	301,591	1,499,592
2021_2022	21.4 %	1.2 %	316,588	1,477,254
2020_2021	21.3 %	1.5 %	311,962	1,465,299
2019_2020	21.0 %	1.6 %	306,164	1,459,943
2018_2019	20.9 %	1.6 %	304,673	1,456,747
2017_2018	22.0 %	1.8 %	324,313	1,473,448
2016_2017	23.7 %	1.8 %	350,728	1,477,908

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM ACE - Notes:

None

Data Alerts: None

Form 10
National Performance Measures (NPMs)

State: Tennessee

NPM - A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth - PPV

Federally Available Data		
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)		
	2023	**2024**
Annual Objective		
Annual Indicator	88.7	92.6
Numerator	69,327	72,765
Denominator	78,187	78,597
Data Source	PRAMS	PRAMS
Data Source Year	2021	2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	93.0	93.5	94.0	94.5	95.0

Field Level Notes for Form 10 NPMs:

None

NPM - B) Percent of women who attended a postpartum checkup and received recommended care components - PPV

Federally Available Data		
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)		
	2023	**2024**
Annual Objective		
Annual Indicator	78.3	69.3
Numerator	53,264	49,673
Denominator	67,995	71,690
Data Source	PRAMS	PRAMS
Data Source Year	2021	2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	70.3	71.3	72.6	73.8	75.3

Field Level Notes for Form 10 NPMs:

None

NPM - Percent of women who were screened for depression or anxiety following a recent live birth - MHS

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2024
Annual Objective	
Annual Indicator	83.7
Numerator	64,785
Denominator	77,395
Data Source	PRAMS
Data Source Year	2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	84.8	85.9	87.0	88.1	89.3

Field Level Notes for Form 10 NPMs:

None

NPM - Percent of women who are using a most or moderately effective contraceptive following a recent live birth - CU

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2024
Annual Objective	
Annual Indicator	51.5
Numerator	38,617
Denominator	74,930
Data Source	PRAMS
Data Source Year	2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	51.5	52.5	53.5	54.5	55.5

Field Level Notes for Form 10 NPMs:

None

NPM - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III + Neonatal Intensive Care Unit (NICU) - RAC

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data					
	2020	2021	2022	2023	2024
Annual Objective		85	85.5	86	86.5
Annual Indicator	84.5	80	82	83	84
Numerator					
Denominator					
Data Source	Birth Statistical System	Birth Statistical System	Birth Statistical System	Birth Statistical System	Birth Statistical System
Data Source Year	CY 2019	CY 2020	CY 2021	CY 2022	CY 2023
Provisional or Final ?	Final	Final	Final	Provisional	Final

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	85.0	85.8	86.6	87.3	88.1

Field Level Notes for Form 10 NPMs:

None

NPM - Percent of children who have completed the combined 7-vaccine series (4:3:1:3*:3:1:4) by age 24 months - VAX_Child

Federally Available Data	
Data Source: National Immunization Survey (NIS)	
	2024
Annual Objective	
Annual Indicator	65.3
Numerator	54,000
Denominator	82,000
Data Source	NIS
Data Source Year	2020

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	66.0	69.0	72.0	75.0	78.0

Field Level Notes for Form 10 NPMs:

None

NPM - Percent of children, ages 0 through 11, whose households were food sufficient in the past year - FS

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2024
Annual Objective	
Annual Indicator	62.8
Numerator	605,985
Denominator	964,449
Data Source	NSCH
Data Source Year	2022_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	63.3	63.8	64.3	64.8	65.3

Field Level Notes for Form 10 NPMs:

None

NPM - Percent of adolescents, ages 12 through 17, who receive needed mental health treatment or counseling - MHT

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2024
Annual Objective	
Annual Indicator	86.6
Numerator	93,079
Denominator	107,437
Data Source	NSCH
Data Source Year	2022_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	86.6	87.5	88.4	89.3	90.1

Field Level Notes for Form 10 NPMs:

None

NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - MH - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	53.3	60	65	70	55
Annual Indicator	48.5	46.5	49.3	49.3	43.7
Numerator	157,666	155,739	157,779	157,276	180,127
Denominator	325,137	334,628	320,158	319,309	412,011
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2018_2019	2019_2020	2020_2021	2021_2022	2022_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	49.9	50.5	51.1	51.7	52.9

Field Level Notes for Form 10 NPMs:

None

NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - MH - Child Health - All Children

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH) - All Children		
	2023	**2024**
Annual Objective		
Annual Indicator	50.9	49.9
Numerator	771,791	764,731
Denominator	1,517,526	1,532,836
Data Source	NSCH-All Children	NSCH-All Children
Data Source Year	2021_2022	2022_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	50.1	50.6	51.0	53.0	55.0

Field Level Notes for Form 10 NPMs:

None

NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a personal doctor or nurse - MH_PDOC - Children with Special Health Care Needs

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - CSHCN	
	2024
Annual Objective	
Annual Indicator	75.6
Numerator	310,326
Denominator	410,234
Data Source	NSCH-CSHCN
Data Source Year	2022_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	75.6	76.4	77.1	77.9	78.6

Field Level Notes for Form 10 NPMs:

None

NPM - 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 - TAHC - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	34.2	40	45	50	25
Annual Indicator	22.2	22.1	24.2	25.8	24.2
Numerator	30,583	30,634	37,238	39,988	43,593
Denominator	137,839	138,824	153,684	155,239	180,045
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2018_2019	2019_2020	2020_2021	2021_2022	2022_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	24.2	25.4	26.6	27.8	29.0

Field Level Notes for Form 10 NPMs:

None

Form 10
National Performance Measures (NPMs) (2021-2025 Needs Assessment Cycle)

State: Tennessee

2021-2025: NPM - A) Percent of infants who are ever breastfed - BF

Federally Available Data		
Data Source: National Vital Statistics System (NVSS)		
	2023	**2024**
Annual Objective	85	86
Annual Indicator	83.9	82.7
Numerator	67,385	67,009
Denominator	80,338	81,027
Data Source	NVSS	NVSS
Data Source Year	2022	2023

Field Level Notes for Form 10 NPMs:

None

2021-2025: NPM - B) Percent of infants breastfed exclusively through 6 months - BF

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH)		
	2023	**2024**
Annual Objective	30	32
Annual Indicator	27.8	23.1
Numerator	48,856	42,995
Denominator	175,921	185,817
Data Source	NSCH	NSCH
Data Source Year	2021_2022	2022_2023

Field Level Notes for Form 10 NPMs:

None

2021-2025: NPM - A) Percent of infants placed to sleep on their backs - SS

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	82	83	84	85	86
Annual Indicator	79.4	78.4	79.1	79.1	74.1
Numerator	59,805	58,480	60,875	60,875	55,518
Denominator	75,369	74,548	76,934	76,934	74,938
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2019	2020	2021	2021	2023

Field Level Notes for Form 10 NPMs:

None

2021-2025: NPM - B) Percent of infants placed to sleep on a separate approved sleep surface - SS

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	31	32	33	90.5	90.6
Annual Indicator	37.9	40.1	39.4	39.4	32.3
Numerator	27,572	29,031	28,955	28,955	24,569
Denominator	72,769	72,337	73,461	73,461	76,007
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2019	2020	2021	2021	2023

State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		32	33	90.5	90.6
Annual Indicator	92	89.5	79.2	79.2	
Numerator					
Denominator					
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	
Data Source Year	2019	2020	2021	2021	
Provisional or Final ?	Final	Final	Final	Final	

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**

Field Note:
2022 PRAMS data has not been released

2021-2025: NPM - C) Percent of infants placed to sleep without soft objects or loose bedding - SS

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	46	48	50	76.8	77
Annual Indicator	44.8	50.2	53.3	53.3	73.6
Numerator	32,496	36,072	39,426	39,426	55,764
Denominator	72,533	71,863	73,951	73,951	75,770
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2019	2020	2021	2021	2023

State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		48	50	76.8	77
Annual Indicator	76.7	80	52.9	52.9	
Numerator					
Denominator					
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	
Data Source Year	2019	2020	2021	2021	
Provisional or Final ?	Final	Final	Final	Final	

Field Level Notes for Form 10 NPMs:

None

2021-2025: NPM - D) Percent of infants room-sharing with an adult during sleep - SS

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2024
Annual Objective	
Annual Indicator	80.6
Numerator	62,910
Denominator	78,036
Data Source	PRAMS
Data Source Year	2023

Field Level Notes for Form 10 NPMs:

None

2021-2025: NPM - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day - PA-Child

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CHILD					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	31.5	31.9	32.2	29	30.5
Annual Indicator	35.2	30.6	27.7	25.6	25.1
Numerator	176,434	148,444	137,097	128,251	127,194
Denominator	500,965	485,754	495,348	501,349	506,739
Data Source	NSCH-CHILD	NSCH-CHILD	NSCH-CHILD	NSCH-CHILD	NSCH-CHILD
Data Source Year	2018_2019	2019_2020	2020_2021	2021_2022	2022_2023

Field Level Notes for Form 10 NPMs:

None

2021-2025: NPM - Percent of women, ages 18 through 44, with a preventive medical visit in the past year - WWV

Federally Available Data					
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	75	76	77	76.5	79
Annual Indicator	76.0	68.3	72.6	73.4	73.1
Numerator	897,415	808,894	868,079	890,338	900,914
Denominator	1,180,193	1,185,003	1,195,830	1,213,611	1,232,189
Data Source	BRFSS	BRFSS	BRFSS	BRFSS	BRFSS
Data Source Year	2019	2020	2021	2022	2023

Field Level Notes for Form 10 NPMs:

None

2021-2025: NPM - Percent of children, ages 0 through 17, who live in households where someone smokes - SMK-Household - Adolescent Health

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		19.4	19.2	19.1	19
Annual Indicator	18.6	19.5	20.8	17.9	16.6
Numerator	271,871	286,194	303,920	262,342	247,449
Denominator	1,464,986	1,464,685	1,458,803	1,466,841	1,491,195
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2018_2019	2019_2020	2020_2021	2021_2022	2022_2023

Field Level Notes for Form 10 NPMs:

None

Form 10
State Performance Measures (SPMs)

State: Tennessee

Form 10
State Performance Measures (SPMs) (2021-2025 Needs Assessment Cycle)

2021-2025: SPM 1 - Percent of new mothers whose pregnancy was intended

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	62	62	63	63	65
Annual Indicator	50	50	50	52	55
Numerator					
Denominator					
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2016-2018	2020	2020	2021	2022
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: baseline = 3-year average	
2.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: 2021 performance data based on 2020 PRAMS data; compared to baseline and previous year, difference is not statistically significant	
3.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: 2022 performance data based on 2020 PRAMS data; compared to baseline and previous year, difference is not statistically significant (2021 PRAMS data not yet available)	
4.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: 2023 performance based on 2021 PRAMS data; compared to the previous year, difference is not statistically significant (2022 PRAMS data is not yet available)	
5.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**
	Field Note: 2024 performance based on 2022 PRAMS data; compared to the previous year, difference is not statistically significant	

2021-2025: SPM 2 - Percent of facilities implementing patient safety recommendations

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		12.5	63	66	91
Annual Indicator	54	25	44	88	58
Numerator					
Denominator					
Data Source	MMR Annual Performance Review Report	MMR Annual Performance Review Report	MMR Annual Performance Review Report	MMR Annual Performance Review Report	Performance Progress and Measuring Report
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 SPMs:

None

2021-2025: SPM 4 - Percent of Tennessee newborns who initiated breastfeeding

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	80.7	81.2	81.7	82.2	83.8
Annual Indicator	80.6	81.2	81.1	83.3	82.2
Numerator					
Denominator					
Data Source	TDH PHA - Birth Statistical System	TDH PHA - Birth Statistical System	TDH PHA - Birth Statistical System	TDH PHA - Birth Statistical System	TDH PHA - Birth Statistical System
Data Source Year	CY2019	CY2020	CY2021	CY 2022	CY 2023
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 SPMs:

None

2021-2025: 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

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective			47	50	52
Annual Indicator		45	44	30	26
Numerator					
Denominator					
Data Source		TDH EBHV and CHANT	TDH EBHV and CHANT	TDH EBHV and CHANT	TDH CHANT
Data Source Year		2021	2022	2023	2024
Provisional or Final ?		Final	Final	Final	Final

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Data is unavailable for 2020.	
2.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: For SPM 5, the annual objective in 2021 should have been 45%.	
3.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: For SPM 5, the annual objective in 2022 should have been 47%.	
4.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: For EBHV: 133 of 499 For CHANT: 160 of 572	
5.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**
	Field Note: FY24 For CHANT: 154 of 597	

2021-2025: SPM 6 - Percent of schools with at least 50% physical education class time spent in moderate to vigorous physical activity

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		10	20	90.7	89
Annual Indicator		0	90.2	86.7	90.1
Numerator					
Denominator					
Data Source		N/A	2022 QPE Survey	2023 QPE Survey	2024 QPE Survey
Data Source Year		N/A	2022	2023	2024
Provisional or Final ?		Final	Final	Final	Final

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: The state did not track progress on SPM 6 until Year 2; annual indicator will be provided in next year's application.	
2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: 2022 QPE Survey. This is the baseline value. Targets for 2023-25 have been revised.	
3.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: 2023 QPE Survey. Based on 958 of 1105 schools reporting. 2024-25 targets have been revised.	
4.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**
	Field Note: 2024 QPE Survey. Based on 910 of 1001 schools reporting. Revised 2025 target.	

2021-2025: SPM 8 - Percent of children with two or more ACEs

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	23	22.5	22	21.6	21.2
Annual Indicator	20.1	21.5	21.5	21.3	20.4
Numerator					
Denominator					
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2018	2020	2020	2021	2022
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: There was a decreases by 3.2% in FY 2020 from baseline (23.3%). Data for FY 2021 have not been released yet by NSCH. FY2020/2021 data reported.	
2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: FY2020/2021 data was reported since NSCS has not released the FY2021/2022 data.	
3.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: FY2020/2021 data was reported since NSCH has not released the FY2021/2022 data.	
4.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**
	Field Note: There was a decrease from 21.3% to 20.4% based on NSCH survey data for 2022-2023.	

2021-2025: SPM 9 - Percent of substantiated child maltreatment cases among families served by home visiting programs

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		0.3	3.3	3.2	2.2
Annual Indicator	4.2	1.5	3.2	2.4	1
Numerator					
Denominator					
Data Source	EBHV	EBHV	EBHV	EBHV	EBHV
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Baseline	
2.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: For SPM 9, the annual objective for 2021 should have been 3.3%.	
3.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Increased from last year.	
4.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: There was a decrease from 21.3% to 20.4% based on NSCH survey data for 2022-2023.	
5.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**
	Field Note: There was a decrease from 2.35% to 1%.	

2021-2025: SPM 11 - Percent of high school students currently using cigarettes

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		6.4	5.8	5.3	4.8
Annual Indicator	7.1	0	4.9	0	5.4
Numerator					
Denominator					
Data Source	2019	N/A	2021	N/A	2023
Data Source Year	YRBS	N/A	YRBS	N/A	YRBS
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Baseline	
2.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: For SPM 11, the state is unable to provide an annual indicator for 2021 as YRBS is only released in odd number years.	
3.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: For SPM 11, the state is unable to provide an annual indicator for 2023 as YRBS is only released in odd number years.	

2021-2025: SPM 12 - Percent of high school students currently using e-cigarettes

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		18	17.9	17.8	17.8
Annual Indicator	22.1	0	19	0	21.6
Numerator					
Denominator					
Data Source	YRBS	N/A	YRBS	N/A	2023
Data Source Year	2019	N/A	2021	N/A	YRBS
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Basline	
2.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: For SPM 12, the state is unable to provide an annual indicator for 2021 as YRBS is only released in odd number years.	
3.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: For SPM 12, the state is unable to provide an annual indicator for 2023 as YRBS is only released in odd number years.	

2021-2025: SPM 13 - Number of adolescents enrolled in cessation program

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		0	20	50	100
Annual Indicator	7	22	16	30	30
Numerator					
Denominator					
Data Source	QuitLine and NOT Program (ALA)	QuitLine and NOT Program (ALA)	QuitLine only	QuitLine and NOT Program (ALA)	QuitLine and NOT Program (ALA)
Data Source Year	CY 2020	CY 2021	CY 2022	CY 2023	CY 2024
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: QuitLine & NOT - NOT enrollment only includes May-Dec 2023	
2.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**
	Field Note: QuitLine & Not on Tobacco (NOT) American Lung Association (ALA) youth enrollment as of Oct 2024	

2021-2025: SPM 14 - Number of CYSHCN receiving care in a medical home

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		800	850		2,300
Annual Indicator	2,194	2,196	2,100	2,140	2,895
Numerator					
Denominator					
Data Source	PTBMIS	PTBMIS	PTBMIS	PTBMIS	PTBMIS
Data Source Year	2020	2021	2022	2023	2024
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 SPMs:

None

2021-2025: SPM 15 - Percent of providers with increased knowledge on medical home and care coordination

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		25	35	50	65
Annual Indicator		0	0	0	0
Numerator					
Denominator					
Data Source		N/A	CYSHCN Program Data	CYSHCN Program Data	CYSHCN Program Data
Data Source Year		N/A	2022	2023	2024
Provisional or Final ?		Final	Final	Final	Final

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: No data to report at this time. Provider training and survey are planned for Year 3.	
2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: No data to report at this time. Provider training and survey are planned for Year 3. Data source will be from the program once the surveys are conducted an analyzed.	
3.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: No data to report at this time. Provider training and survey are planned for Year 3. Data source will be from the program once the surveys are conducted an analyzed.	
4.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**
	Field Note: No data to report at this time.	

2021-2025: SPM 16 - Percent of providers reporting improved system of care for CYSCHN

Measure Status:			Active		
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective			35	50	65
Annual Indicator			0	0	0
Numerator					
Denominator					
Data Source			CYSHCN Program Data	CYSHCN Program Data	CYSHCN Program Data
Data Source Year			2022	2023	2024
Provisional or Final ?			Final	Final	Final

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: No data to report at this time. Provider training and survey are planned for Year 3.	
2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: No data to report at this time. Provider training and survey are planned for Year 3. Data source will be from the program once the surveys are conducted an analyzed.	
3.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: No data to report at this time. Provider training and survey are planned for Year 3. Data source will be from the program once the surveys are conducted an analyzed.	
4.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**
	Field Note: No data to report at this time.	

2021-2025: SPM 17 - Percent of families who complete an annual visit with their primary care provider

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective			10	12.5	15
Annual Indicator		7.5	7.4	7.3	14
Numerator					
Denominator					
Data Source		CHANT	CHANT	CHANT	CHANT
Data Source Year		2021	2022	2023	2024
Provisional or Final ?		Final	Final	Final	Final

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Baseline	

2021-2025: SPM 18 - Percent of youth reporting with increased knowledge on transition resources and services

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective			100	100	100
Annual Indicator		100	100	100	100
Numerator					
Denominator					
Data Source		CYSHCN	YAC	YAC	YAC
Data Source Year		2021	2022	2023	2024
Provisional or Final ?		Final	Final	Final	Final

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Baseline	
2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Data from YAC Conference and YAC members who create annual transition plan.	
3.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: Data from YAC Conference and YAC members who create annual transiiton plan	
4.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**
	Field Note: Data from YAC Conference and YAC members who create annual transiiton plan	

2021-2025: SPM 19 - Percent of YSHCN served by CHANT who complete an annual transition plan

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective			75	80	85
Annual Indicator		72	72	72.5	74.1
Numerator					
Denominator					
Data Source		PTBMIS	PTBMIS (CSS)	PTBMIS (CSS)	PTBMIS (CSS)
Data Source Year		2021	2022	2023	2024
Provisional or Final ?		Final	Final	Final	Final

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Baseline	

2021-2025: SPM 20 - Percent of youth leaders participating in advisory councils providing resources to other youth

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective			30	30	30
Annual Indicator		26.3	35.3	28.6	29.1
Numerator					
Denominator					
Data Source		CYSHCN	CYSHCN	CYSHCN	CYSHCN
Data Source Year		2021	2022	2023	2024
Provisional or Final ?		Final	Final	Final	Final

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Baseline	
2.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: Program Data - YAC 28 Members, 8 Mentors	
3.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**
	Field Note: Program Data - YAC 28 Members, 8 Mentors	

2021-2025: SPM 21 - Percent of women who reported 14+ days of poor mental health in the past month

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective			18.2	17.8	17.4
Annual Indicator			25.3	35.9	30.2
Numerator					
Denominator					
Data Source			BRFSS	BRFSS	BRFSS
Data Source Year			2021	2022	2023
Provisional or Final ?			Final	Final	Final

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

Field Note:
The state did not track progress on SPM 21 until Year 2; annual indicator will be provided in next year's application.

2021-2025: SPM 23 - Number community level recommendations implemented

Measure Status:			**Active**
State Provided Data			
	2022	**2023**	**2024**
Annual Objective			15
Annual Indicator	18	13	13
Numerator			
Denominator			
Data Source	MMR Annual Performance Review Report	MMR Annual Performance Review Report	MMR Annual Performance Review Report
Data Source Year	2022	2023	2024
Provisional or Final ?	Final	Final	Final

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Data Source: 2022 MMR Annual Performance Review Report - poll of MHTF	
2.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: Data Source: 2023 MMR Annual Performance Review Report	
3.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**
	Field Note: Data Source: 2024 MMR Annual Performance Review Report	

2021-2025: SPM 24 - Rate of Double Up Food Bucks purchases per SNAP recipient

Measure Status:			Active
State Provided Data			
	2022	**2023**	**2024**
Annual Objective			32.6
Annual Indicator	18	50.9	39.1
Numerator			
Denominator			
Data Source	Nourish Knoxville tracking database and DHS SNAP d	Nourish Knoxville tracking database and DHS SNAP d	Nourish Knoxville database and DHS SNAP database
Data Source Year	2022	2023	2024
Provisional or Final ?	Final	Final	Final

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: 18.03 is the baseline value. Targets for 2023-25 have been set. Represents 1454 DUFB purchases among 80636 SNAP recipients. Rate per 1000 recipients.	
2.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: This is a revised Year 3 value, as we identified an error in the number of SNAP recipients in counties of interest. The 2038 DUFB purchases remains the same, but the number of SNAP recipients in Knox, Anderson, Unicoi, Union, Greene, and Washington Counties is now 40054 (changed from 79659). The rate is still # of DUFB purchases per 1000 SNAP recipients.	
3.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**
	Field Note: 1,492 DUFB purchases among 38212 SNAP recipients in Knox, Anderson, Union, Unicoi, Washington, Greene, and Sevier Counties. Rate per 1000 recipients. Revised 2025 target.	

Form 10
State Outcome Measures (SOMs)

State: Tennessee

Form 10
State Outcome Measures (SOMs) (2021-2025 Needs Assessment Cycle)

2021-2025: SOM 1 - Rate of pregnancy-associated mortality to live birth

Measure Status:				**Active**	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		95.6	93.2	90.9	89.5
Annual Indicator	78.3	124.5	164	164	122
Numerator					
Denominator					
Data Source	MMRIA and birth records	MMRIA and birth records	MMRIA and birth records	MMRIA and birth records	MMRIA and birth records
Data Source Year	CY 2019	CY 2020	CY 2021	CY 2021	CY2022
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 SOMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Baseline	
2.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: 2022 Maternal deaths have not been entirely reviewed	
3.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**
	Field Note: Rates calculated from 2022 MMRIA and birth records	

2021-2025: SOM 2 - Rate of pregnancy-related mortality to live births

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		25.6	23.5	22	21.8
Annual Indicator	28.6	58.5	64.9	64.9	55
Numerator					
Denominator					
Data Source	MMRIA and birth records	MMRIA and birth records	MMRIA and birth records	MMRIA and birth records	MMRIA and birth records
Data Source Year	CY 2019	CY 2020	CY 2021	CY 2021	CY2022
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 SOMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Baseline	
2.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: For SOM 2, the annual objective for 2021 should have been 24.2.	
3.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: 2022 Maternal deaths have not been entirely reviewed	
4.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**
	Field Note: Rates calculated from 2022 MMRIA and birth records	

2021-2025: SOM 3 - Percent of public school 6th graders who are overweight or obese

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		43.3	44.8	47	46.5
Annual Indicator	43.6	45	47.4	45.6	0
Numerator					
Denominator					
Data Source	CSH BMI Report	CSH BMI Report	CSH BMI Report	CSH BMI Report	NA
Data Source Year	2017-2018	2019-2020	2021-2022	2022-2023	NA
Provisional or Final ?	Final	Final	Final	Final	Provisional

Field Level Notes for Form 10 SOMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Baseline	
2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: 2020-21 report never got released due to COVID. 2021-22 report has not yet been released. However, we were able to get the 2021-22 data from TDE and TDH. This is a statistically significant increase from 2019-20.	
3.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: We didn't have 2022-23 data as of mid-March 2024. 2022-23 TDH/TDE_CSH BMI Report. CI 45.1 - 46.0. Statistically significant decrease from 2021-2022. Revised 2024-25 targets.	
4.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**
	Field Note: Data for the 2023-2024 BMI report will not be available until at least July 2025.	

2021-2025: SOM 4 - Percent of WIC recipients aged 2-4 years who are overweight or obese

Measure Status:				**Active**	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective			31	27.5	26.5
Annual Indicator	31.2	32	28.7	28.7	27.7
Numerator					
Denominator					
Data Source	WIC	WIC	WIC	WIC	WIC
Data Source Year	CY 2020	CY 2021	CY 2022	CY 2022	CY2023
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 SOMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Baseline	
2.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: For SOM 4, the annual objective should have been 30.2%	
3.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: CY2022 WIC Data. WIC data are usually based on the previous CY.	
4.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**
	Field Note: CY2023 WIC Data. WIC data are usually based on the previous CY.	

2021-2025: SOM 5 - Percent of adults reporting Chronic obstructive pulmonary disease (COPD)

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		9.3	9.2	9.6	9.6
Annual Indicator	9.7	9.5	10.4	11.6	10.2
Numerator					
Denominator					
Data Source	BRFSS	BRFSS	BRFSS	BRFSS	BRFSS
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 SOMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Baseline	
2.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: objective should be 9.7%	
3.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: objective should be 9.6%	

2021-2025: SOM 6 - Percent of adults reporting cardiovascular disease

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		5.3	5.3	5.3	5.2
Annual Indicator	4.9	5.1	5.2	5.8	5.1
Numerator					
Denominator					
Data Source	BRFSS	BRFSS	BRFSS	BRFSS	BRFSS
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 SOMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Baseline	

2021-2025: SOM 7 - Age-adjusted mortality rate from tobacco-attributable cancers among Tennesseans aged 35+

Measure Status:				**Active**	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		176.4	171.4	166.4	161.3
Annual Indicator	190.8	188	188.3	181.5	186.6
Numerator					
Denominator					
Data Source	CDC WONDER	CDC WONDER	CDC WONDER	CDC Wonder	CDC Wonder
Data Source Year	CY 2019	CY 2020	CY 2021	CY 2022	CY 2023
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 SOMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Baseline	

2021-2025: SOM 8 - Percent of pregnancy-associated deaths in which mental health conditions was a contributing factor

Measure Status:	Inactive - No longer reviewing pregnancy-associated deaths, specifically motor vehicle crashes, if they're determined not to be pregnancy-related

State Provided Data					
	2020	2021	2022	2023	2024
Annual Objective			25	18	16
Annual Indicator			23	35	37
Numerator					
Denominator					
Data Source			Maternal Mortality Review	Maternal Mortality Review	Maternal Mortality Review
Data Source Year			2017-2020	2021	2022
Provisional or Final ?			Final	Final	Final

Field Level Notes for Form 10 SOMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: The state did not track progress on SOM 8 until Year 2; annual indicator will be provided in next year's application.	
2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Annual objective should be 20%	
3.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**
	Field Note: This ESM is actually measuring the percentage of mental health conditions other than substance use disorder that were a contributing factor. We are no longer doing a thorough review of some pregnancy-associated deaths, specifically motor vehicle crashes, if they're determined not to be pregnancy-related, so we are discontinuing this measure since our data will be incomplete.	

Form 10
Evidence-Based or –Informed Strategy Measures (ESMs)

State: Tennessee

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

Measure Status:	Inactive - Completed	
State Provided Data		
	2023	**2024**
Annual Objective		
Annual Indicator	100	69.5
Numerator		
Denominator		
Data Source	EBHV	EBHV
Data Source Year	2023	2024
Provisional or Final ?	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: Objective for 2023 should have been 97	
2.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**
	Field Note: Objective should have been 98	

ESM PPV.2 - Percent of home-visiting staff trained in recognizing and providing resources/referrals for perinatal mood disorders and substance use disorder

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	50.0	60.0	70.0	80.0	90.0

Field Level Notes for Form 10 ESMs:

None

ESM MHS.1 - Number of healthcare providers trained in using validated screening tools for depression and anxiety

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	60.0	60.0	60.0	60.0	60.0

Field Level Notes for Form 10 ESMs:

None

ESM CU.1 - Number of total providers trained on long-acting reversible contraception (LARC) insertion and removal

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	0.0	20.0	25.0	30.0	35.0

Field Level Notes for Form 10 ESMs:

None

ESM RAC.1 - Percent of Tennessee birthing hospitals participating in perinatal quality collaborative projects

Measure Status:	Inactive - Completed				
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		33	33	33	33
Annual Indicator	41	43.3	36.2	68	72.4
Numerator					
Denominator					
Data Source	TIPQC	TIPQC	TIPQC	TIPQC	TIPQC
Data Source Year	2020	2021	2022	2023	2024
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: 21 birthing hospitals out of 58 birthing hospitals in TN	
2.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: 39 of 57 birthing hospitals participated in at least ONE TIPQC project. This measure does not include the 4 children's hospital that participated in the project. See https://tipqc.org/ and look up hospitals with under specific projects.	
3.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**
	Field Note: 42 birth hospital out of 58 birth hospital in TN participated in at least ONE TIPQC project.	

ESM RAC.2 - Number of unique patients served by perinatal telehealth pilot projects in Tennessee

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	500.0	750.0	1,000.0	1,000.0	1,000.0

Field Level Notes for Form 10 ESMs:

None

ESM VAX_Child.1 - Percent of participating staff reporting increased confidence in addressing vaccine hesitancy post-training

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	63.0	68.2	71.1	74.0	78.0

Field Level Notes for Form 10 ESMs:

None

ESM FS.1 - Number of individuals referred to food assistance programs through FindHelp

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	25,000.0	27,500.0	30,000.0	32,500.0	35,000.0

Field Level Notes for Form 10 ESMs:

None

ESM MHT.1 - Percent increase in Tennessee Child and Adolescent Psychiatry Education and Support (TCAPES) teleconsultation call line volume

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	33.0	25.0	20.0	17.0	14.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**
	Field Note: 44 calls in 2024 to 60 calls in 2025	
2.	**Field Name:**	**2026**
	Column Name:	**Annual Objective**
	Field Note: 60 calls to 80 calls	
3.	**Field Name:**	**2027**
	Column Name:	**Annual Objective**
	Field Note: 80 calls to 100 calls	
4.	**Field Name:**	**2028**
	Column Name:	**Annual Objective**
	Field Note: 100 calls to 120 calls	
5.	**Field Name:**	**2029**
	Column Name:	**Annual Objective**
	Field Note: 120 calls to 140 calls	
6.	**Field Name:**	**2030**
	Column Name:	**Annual Objective**
	Field Note: 140 calls to 160 calls	

ESM MH.1 - Number of CYSHCN who receive CHANT/CSS care coordination

Measure Status:	Inactive - Completed				
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		2,500	3,000	3,500	4,500
Annual Indicator		4,885	4,930	4,560	4,702
Numerator					
Denominator					
Data Source		PTBMIS	PTBMIS	PTBMIS	PTBMIS
Data Source Year		2021	2022	2023	2024
Provisional or Final ?		Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

ESM MH.2 - Percent of providers adopting medical home approach

Measure Status:	Inactive - Completed				
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective			40	55	65
Annual Indicator			0	0	0
Numerator					
Denominator					
Data Source			N/A	N/A	N/A
Data Source Year			N/A	N/A	N/A
Provisional or Final ?			Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: No data to report at this time. Training and survey are expected to occur in Year 3.	
2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: No data at this time - training and survey are to be conducted, expected to happen in Year 3. Data source will be from the program once the surveys are conducted an analyzed	
3.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: No data at this time - training and survey are to be conducted, expected to happen in Year 3. Data source will be from the program once the surveys are conducted an analyzed.	
4.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**
	Field Note: No data at this time - data to be collected at one timepoint for FY25 at training	

ESM MH.3 - Percent of providers reporting increased knowledge on systems of care

Measure Status:	Inactive - Completed				
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective			20	30	40
Annual Indicator			0	0	0
Numerator					
Denominator					
Data Source			N/A	N/A	N/A
Data Source Year			N/A	N/A	N/A
Provisional or Final ?			Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: No data to report at this time. Training and survey are expected to occur in Year 3.	
2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: No data at this time - training and survey are to be conducted, expected to happen in Year 3. Data source will be from the program once the surveys are conducted an analyzed.	
3.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: No data at this time - training and survey are to be conducted, expected to happen in Year 3. Data source will be from the program once the surveys are conducted an analyzed.	
4.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**
	Field Note: No data at this time - data to be collected at one timepoint for FY25 at training	

ESM MH.4 - Number of families provided education and resources on importance of medical home access and utilization

Measure Status:	Inactive - Completed				
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective					
Annual Indicator	1,383	1,424	1,749	1,527	1,824
Numerator					
Denominator					
Data Source	CHANT	CHANT	CHANT	CHANT	CHANT
Data Source Year	2020	2021	2022	2023	2024
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: annual objective should be 600	
2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: annual objective should be 700	

ESM MH.5 - Number of families receiving referrals to their child's primary care provider

Measure Status:	Inactive - Completed				
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		375	400	425	450
Annual Indicator	222	216	272	233	338
Numerator					
Denominator					
Data Source	CHANT	CHANT	CHANT	CHANT	CHANT
Data Source Year	2020	2021	2022	2023	2024
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

ESM MH.6 - Percent of providers who report an increase in their knowledge of available resources

Measure Status:	Inactive - Completed				
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective			25	50	75
Annual Indicator			0	0	0
Numerator					
Denominator					
Data Source			N/A	N/A	N/A
Data Source Year			N/A	N/A	N/A
Provisional or Final ?			Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: No data to report at this time. Training and survey are expected to occur in Year 3.	
2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: No data at this time - training and survey are to be conducted, expected to happen in Year 3. Data source will be from the program once the surveys are conducted an analyzed.	
3.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: No data at this time - training and survey are to be conducted, expected to happen in Year 3. Data source will be from the program once the surveys are conducted an analyzed.	
4.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**
	Field Note: No data at this time - data to be collected at one timepoint for FY25 at training	

ESM MH.7 - Percent of families who report an increase in access and utilization of resources

Measure Status:	Inactive - Completed				
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective			35	40	50
Annual Indicator			0	0	0
Numerator					
Denominator					
Data Source			N/A	N/A	N/A
Data Source Year			N/A	N/A	N/A
Provisional or Final ?			Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: No data to report at this time. Training and survey are expected to occur in Year 3.	
2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: No data at this time - training and survey are to be conducted, expected to happen in Year 3. Data source will be from the program once the surveys are conducted an analyzed.	
3.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: No data at this time - training and survey are to be conducted, expected to happen in Year 3. Data source will be from the program once the surveys are conducted an analyzed.	
4.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**
	Field Note: No data at this time	

ESM MH.8 - Percent of CHANT families who schedule an annual visit with their child's primary care provider

Measure Status:	Inactive - Completed				
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		25	35	45	55
Annual Indicator		3.2	16	13.9	16.5
Numerator					
Denominator					
Data Source		CHANT	CHANT	CHANT	CHANT
Data Source Year		2021	2022	2023	2024
Provisional or Final ?		Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

ESM MH.9 - Percent of CYSHCN receiving CHANT care coordination who receive medical home education

Measure Status:	Inactive - Completed

State Provided Data					
	2020	2021	2022	2023	2024
Annual Objective			75	85	20
Annual Indicator		5.4	16.2	10.9	16.9
Numerator					
Denominator					
Data Source		CHANT	CHANT	CHANT	CHANT
Data Source Year		2021	2022	2023	2024
Provisional or Final ?		Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: 2870 eligible for CYSHCN received CHANT/CSS care coordination during FY. Of these, none marked already having a medical home, 555 are on medical home pathway, and 90 received education.	
2.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: 2744 eligible for CYSHCN received CHANT/CSS care coordination. 67 received education, 611 medical home pathway	
3.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**
	Field Note: 2711 families with CSS-eligible children received CHANT/CSS care coordination. 118 received education, 700 medical home pathway. Note. Many CYSHCN already have a medical home when they enroll, and this may not always be needed.	

ESM MH.10 - Number of teachers/school personnel trained on QPR

Measure Status:	Inactive - Completed	
State Provided Data		
	2023	**2024**
Annual Objective		
Annual Indicator	2,111	
Numerator		
Denominator		
Data Source	TDH	
Data Source Year	2023	
Provisional or Final ?	Final	

Field Level Notes for Form 10 ESMs:

None

ESM MH.11 - Percentage of children with and without SHCN who are applying for health insurance

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	21.0	23.0	25.0	27.0	29.0

Field Level Notes for Form 10 ESMs:

None

ESM MH.12 - Percentage of children with and without SHCN who schedule an exam with a primary care provider

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	39.0	42.0	45.0	48.0	51.0

Field Level Notes for Form 10 ESMs:

None

ESM MH_PDOC.1 - Percentage of children with and without SHCN who receive a referral to a primary care provider

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	94.0	95.0	96.0	97.0	98.0

Field Level Notes for Form 10 ESMs:

None

ESM TAHC.1 - Number of transition resource kits disseminated

Measure Status:	Inactive - Not continuing this ESM in the 2026-2030 cycle

State Provided Data					
	2020	2021	2022	2023	2024
Annual Objective		150	300	600	1,200
Annual Indicator	0	100	366	552	785
Numerator					
Denominator					
Data Source	CYSHCN	CYSHCN	CYSHCN Program Data	CYSHCN Program Data	CYSHCN Program Data
Data Source Year	2020	2021	2022	2023	2024
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: No kits disseminated due to COVID.	
2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Data source FV and Program data for YAC and Attendees at YAC Conference, and training offered by FV	
3.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: Pre-Ets, AMCHP Exchange, and YAC, FV	
4.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**
	Field Note: FV, YAC, State WorkGroup - just crated new tool kit that will be housed on line	

ESM TAHC.2 - Number of youth with special health care needs trained as mentors

Measure Status:	Inactive - Not continuing this ESM in the 2026-2030 cycle

State Provided Data					
	2020	2021	2022	2023	2024
Annual Objective		25	35	45	55
Annual Indicator	0	5	6	47	53
Numerator					
Denominator					
Data Source	CYSHCN Program Data	CYSHCN Program Data	CYSHCN Program Data	CYSHCN Program Data	CYSHCN Program Data
Data Source Year	2020	2021	2022	2023	2024
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: No mentors trained due to COVID.	
2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Program data. Number of YAC Members.	
3.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: Program Data # of YSHCN trained at Oasis Center annual mentorship training (total 101 youth attendees)	
4.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**
	Field Note: Program Data # of YSHCN trained at YAC Conference and virtually	

ESM TAHC.3 - Number of parents and youth with special health care needs who receive leadership and self-advocacy training

Measure Status:	Inactive - Not continuing this ESM in the 2026-2030 cycle

State Provided Data					
	2020	2021	2022	2023	2024
Annual Objective		50	75	100	450
Annual Indicator	71	150	475	475	465
Numerator					
Denominator					
Data Source	CYSHCN Program Data	CYSHCN Program Data	CYSHCN Program Data	CYSHCN Program Data	CYSHCN Program Data
Data Source Year	2020	2021	2022	2023	2024
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: 60 youth and 415 parents received leadership and self-advocacy training in Year 1.	
2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: 60 youth, 415 parents	
3.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: 114 youth, 361 families	
4.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**
	Field Note: 100 youth, 365 Families	

ESM TAHC.4 - Percentage of CSS-eligible YSHCN, age 14-21, who complete a transition plan

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	92.0	93.0	94.0	95.0	96.0

Field Level Notes for Form 10 ESMs:

None

Form 10
Evidence-Based or -Informed Strategy Measures (ESMs) (2021-2025 Needs Assessment Cycle)

2021-2025: ESM BF.1 - Number of credentialed lactation professionals within WIC

Measure Status:				**Active**	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		166	176	186	196
Annual Indicator	156	148	159	147	142
Numerator					
Denominator					
Data Source	WIC Monitoring Reports	WIC Monitoring Reports	WIC Monitoring Reports	WIC Monitoring Reports	WIC Monitoring Reports
Data Source Year	2020	2021	2022	2023	2024
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:
None

2021-2025: ESM BF.2 - Percent of Breastfeeding Welcomed Here (BFWH)-designated businesses with ideal workplace lactation policies

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		0	0	0	0
Annual Indicator		0	38	0	0
Numerator					
Denominator					
Data Source		BFWH Tracking Spreadsheet	BFWH Tracking Spreadsheet	N/A	N/A
Data Source Year		2021	2022	N/A	N/A
Provisional or Final ?		Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Survey will be implemented in Year 3.	
2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Results are from the survey pilot which was limited to Knox County BFWH businesses. 21 businesses completed the survey.	
3.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: Not assessed during FFY 2023	
4.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**
	Field Note: Not assessed during FFY 2024	

2021-2025: ESM BF.3 - Recognition process implemented for Breastfeeding Welcomed Here (BFWH)-designated businesses

Measure Status:				**Active**	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		Yes	Yes	Yes	Yes
Annual Indicator		No	No	No	No
Numerator					
Denominator					
Data Source		BFWH Tracking Spreadsheet	BFWH Tracking Spreadsheet	BFWH Tracking Spreadsheet	BFWH Tracking Spreadsheet
Data Source Year		2021	2022	2023	2024
Provisional or Final ?		Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Survey will be implemented in Year 3.	
2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Survey results indicated BFWH businesses were not interested or not sure about a tiered recognition system, so new recognition ideas are being explored	
3.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: Recognition ideas are still being explored	
4.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**
	Field Note: Recognition process was not created in Year 4	

2021-2025: ESM SS.1 - Percent of hospitals receiving national recognition or implementing approved safe sleep policy

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		100	100	100	100
Annual Indicator		100	100	100	100
Numerator					
Denominator					
Data Source		TDH	TDH	TDH	TDH
Data Source Year		2021	2022	2023	2024
Provisional or Final ?		Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: 50% of birthing hospitals have received national recognition; 100% have implemented an approved safe sleep policy.	
2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: 50% of birthing hospitals have received national recognition; 100% have implemented an approved safe sleep policy.	
3.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: 40% recognition, 100% have a policy	
4.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**
	Field Note: 38% recognition, 100% have a policy	

2021-2025: ESM SS.2 - Number of diaper bags with safe sleep educational materials distributed

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		663	676	690	704
Annual Indicator	1,636	1,928	1,932	1,011	1,200
Numerator					
Denominator					
Data Source	TDH	TDH	TDH	TDH	TDH
Data Source Year	2020	2021	2022	2023	2024
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**

Field Note:
603 diaperbags distributed by EBHV and 597 diaperbags distributed by CHANT programs

2021-2025: ESM PA-Child.2 - Percentage of TN counties in which trainings related to mental health and physical health have occurred

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective			10	20	30
Annual Indicator			5.3	63.2	0
Numerator					
Denominator					
Data Source			TDH/CDHP Tracking Database	TDH/CDHP Tracking Database	N/A
Data Source Year			2022	2023	N/A
Provisional or Final ?			Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: The state did not track progress on ESM 8.1.2 until Year 2; annual indicator will be provided in next year's applicaiton.	
2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Five counties received MAM training, including Cannon, Hawkins, Sumner, Carroll, and Wilson. Targets for 2023-25 have been revised.	
3.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: Sixty of 95 counties have received training cumulatively. Also represents 78 of 136 school districts responding to the District Application (57.4%). No targets revised. ESM retired.	
4.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**
	Field Note: This measure needs to be inactivated as of FY23.	

2021-2025: ESM PA-Child.4 - Percent of LHD primary care clinics writing HPHP prescriptions annually

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective			25	40	60
Annual Indicator			57.1	44.6	19.6
Numerator					
Denominator					
Data Source			TDH	TDH	TDH
Data Source Year			2022	2023	2024
Provisional or Final ?			Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: The state did not track progress on ESM 8.1.4 until Year 2; annual indicator will be provided in next year's applicaiton.	
2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Based on 32 out of 56 clinics writing scripts. Revised targets for 2023-25.	
3.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: Based on 25 out of 56 clinics writing scripts. Revised targets for 2024-25 to reflect year over year decrease.	
4.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**
	Field Note: Based on 11 out of 56 clinics writing scripts.	

2021-2025: ESM PA-Child.5 - Number of Healthy Parks Healthy Person prescriptions written

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		125	400	550	225
Annual Indicator	0	195	289	166	175
Numerator					
Denominator					
Data Source	TDEC HPHP Rx portal	TDEC HPHP Rx portal	TDEC HPHP Rx portal	TDEC HPHP Rx portal	TDEC HPHP Rx portal
Data Source Year	2020	2021	2022	2023	2024
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Objectives are cumulative.	
2.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: Revised targets for 2024-25 to reflect year over year decrease as well as the modification to include scripts from non-LHD sources.	
3.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**
	Field Note: This value represents just the number of HPHP scripts written by LHDs. Stacey Levine (HPHP) stated that there would be no data on non-LHD scripts until their PaRx portal is up and running.	

2021-2025: ESM PA-Child.6 - Percentage of TN counties with completed built environment projects

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		20	30	40	68
Annual Indicator		0	54	60	65
Numerator					
Denominator					
Data Source		OPP and Project Diabetes tracking databases	OPP and Project Diabetes tracking databases	OPP and Project Diabetes tracking databases	OPP and Project Diabetes tracking databases
Data Source Year		2021	2022	2023	2024
Provisional or Final ?		Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: The state did not track progress on ESM 8.1.6 until Year 2; annual indicator will be provided in next year's application.	
2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Based on 57 counties. The original count of 91 counties for 2022 was inaccurate due to a confusion over the dates. The revised number is 51 and the percentage is 53.68. Targets for 2024 and 2025 have been revised.	
3.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**
	Field Note: Based on 62 non-duplicated counties with a completed OPP or PD built environment project.	

2021-2025: ESM PA-Child.7 - Percent of eligible venues offering the Double Up Food Bucks Program

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		35	45	55	94.5
Annual Indicator		0	76.2	88.9	90.5
Numerator					
Denominator					
Data Source		Nourish Knoxville tracking database	Nourish Knoxville tracking database	Nourish Knoxville tracking database	Nourish Knoxville tracking database
Data Source Year		2021	2022	2023	2024
Provisional or Final ?		Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: The state did not track progress on ESM 8.1.7 until Year 2; annual indicator will be provided in next year's applicaiton.	
2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Based on 16 of 21 eligible venues.	
3.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: Based on 16 of 18 eligible venues. Revised targets for 2024-25.	
4.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**
	Field Note: Based on 19 of 21 eligible venues	

2021-2025: ESM PA-Child.9 - Percent of families with improved protective factors score

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		50	52	54	56
Annual Indicator		49.9	50	47	48
Numerator					
Denominator					
Data Source		EBHV	EBHV	EBHV	EBHV
Data Source Year		2021	2022	2023	2024
Provisional or Final ?		Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Data unavailable for 2020.	

2021-2025: ESM PA-Child.10 - Percent of families enrolled in CHANT care coordination who partially or fully complete pathways identified

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		41	42	43	47
Annual Indicator		42.6	45.2	46.1	46
Numerator					
Denominator					
Data Source		CHANT	CHANT	CHANT	CHANT
Data Source Year		2021	2022	2023	2024
Provisional or Final ?		Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

2021-2025: ESM PA-Child.11 - Proportion of local education agencies (LEA) offered professional development on improving/maintaining moderate to vigorous physical activity in PE

Measure Status:	Active

State Provided Data		
	2023	2024
Annual Objective		
Annual Indicator	38.2	56.5
Numerator		
Denominator		
Data Source	TDE District Application Survey	TDE District Application Survey
Data Source Year	2023	2024
Provisional or Final ?	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: There were no baseline data prior to 2023. A question was added to the 2023 TDE District Application. Difficult to set meaningful target for 2023. 2024-25 targets set.	
2.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**
	Field Note: 2024 Annual Report (formerly the District Application). Based on 83 out of 147 LEAs reporting that they had been offered professional development. Objective should have been 71	

2021-2025: ESM WWV.2 - Percent of family planning encounters that occur via telehealth

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective			0.4	0.8	1.6
Annual Indicator		0.3	1.2	1.6	1
Numerator					
Denominator					
Data Source		PTBMIS	PTBMIS	PTBMIS	PTBMIS
Data Source Year		2021	2022	2023	2024
Provisional or Final ?		Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

Field Note:
For ESM 1.2, the annual objective for 2021 should have been 0.2%.

2021-2025: ESM WWV.3 - Number of women receiving patient navigation for women's health services

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective			250		
Annual Indicator		0	0	900	2,729
Numerator					
Denominator					
Data Source		REDCap	REDCap	PTBMIS	PTBMIS
Data Source Year		2021	2022	2023	2024
Provisional or Final ?		Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

Field Note:
Year 1 was used to establish funding for women's health navigators, so the objective for number of women navigated was zero. Services are expected to begin in July 2022.

2021-2025: ESM WWV.4 - Percent of births covered by hospitals implementing data-driven, clinical recommendations

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective			65	75	85
Annual Indicator		55	55	81	88
Numerator					
Denominator					
Data Source		NVSS	NVSS	NVSS	Birth certificate data
Data Source Year		2020	2021	2022	2024
Provisional or Final ?		Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Baseline	
2.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**
	Field Note: Births in FY2024 at facilities divided by total births in TN in FY2024	

2021-2025: ESM WWV.8 - Percent of recommendations with who/what/when components

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		75	79	84	89
Annual Indicator		24	71	68	90
Numerator					
Denominator					
Data Source		ERASE MM APR Report	ERASE MM APR Report	ERASE MM APR Report	ERASE MM APR Report
Data Source Year		2021	2022	2023	2024
Provisional or Final ?		Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Data Source: 2021 ERASE MM APR Report; 14/59 recs (data reflects 2018 deaths)	
2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Data source: 2022 ERASE MM APR Report; 44/62 recs (data reflects 2019 deaths)	
3.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: Data source: 2023 ERASE MM APR Report; 122/179 recs (data reflects 2020 deaths)	
4.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**
	Field Note: Data source: 2024 ERASE MM APR Report; 79/88 recs (data reflects 2021 deaths)	

2021-2025: ESM SMK-Household.1 - Number of tobacco-free sports teams

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective					250
Annual Indicator	77	88	145	213	309
Numerator					
Denominator					
Data Source	Tobacco-free Sports Teams Database	Tobacco-free Sports Teams Database	Tobacco-free Sports Teams Database	Tobacco-free Sports Teams Database	Tobacco-free Sports Teams Database
Data Source Year	CY 2020	CY 2021	CY 2022	CY 2023	CY 2024
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Objective is cumulative	
2.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Objective is cumulative	
3.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Objective is cumulative & should be 81	
4.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: Objective is cumulative and should be 83	
5.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**
	Field Note: Objective and indicator are cumulative	

2021-2025: ESM SMK-Household.2 - Number of social media posts promoting text-based cessation services

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective				12	24
Annual Indicator	0	9	33	12	25
Numerator					
Denominator					
Data Source	TDH Office of Communications	TDH Office of Communications	TDH Office of Communications	TDH Office of Communications	TDH Office of Communications
Data Source Year	2020	2021	2022	2023	2024
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: objective should be 6	
2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: objective should be 12	

2021-2025: ESM SMK-Household.3 - Number of anti-tobacco social media posts

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective					550
Annual Indicator	8	27	281	496	105
Numerator					
Denominator					
Data Source	TDH Office of Communications	TDH Office of Communications	TDH Office of Communications	TDH Office of Communications	TDH Office of Communications
Data Source Year	2020	2021	2022	2023	2024
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: 94 unique posts duplicated across three social media platforms	
2.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: The objective should have been 12. 165 unique posts duplicated across 3 platforms.	
3.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**
	Field Note: 52 unique posts across 3 different platforms	

2021-2025: ESM SMK-Household.4 - Number of youth who attend the state anti-tobacco conference trainings

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		75	300	300	350
Annual Indicator	0	0	238	259	317
Numerator					
Denominator					
Data Source	TNSTRONG Registration	TNSTRONG Registration	TNSTRONG Registration	TNSTRONG Registration	TNSTRONG Registration
Data Source Year	2020	2021	2022	2023	2024
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: No conference held due to COVID.	
2.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: No conference held in Year 1 due to COVID.	
3.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: In person - Chattanooga - June 2022	
4.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: In person - Chattanooga - June 2023	
5.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**
	Field Note: In person - Chattanooga - July 2024	

2021-2025: ESM SMK-Household.5 - Number of ambassadors recruited

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		26	26	26	26
Annual Indicator	23	18	20	20	26
Numerator					
Denominator					
Data Source	TNSTRONG Ambassador Registration	TNSTRONG Ambassador Registration	TNSTRONG Ambassador Registration	TNSTRONG Ambassador Registration	TNSTRONG Ambassador Registration
Data Source Year	2020	2021	2022	2023	2024
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: 20 recruited; 31 total serving	

2021-2025: ESM SMK-Household.6 - Percent of eligible women who enroll in Baby and Me Tobacco Free

Measure Status:			**Active**
State Provided Data			
	2022	**2023**	**2024**
Annual Objective			14.7
Annual Indicator	13.9	14.6	12.7
Numerator			
Denominator			
Data Source	TDH Tobacco Program	TDH Tobacco Program	TDH Tobacco Program
Data Source Year	2022	2023	2024
Provisional or Final ?	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: FY 2022 annual objective should be 14.1%	
2.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: Objective should be 14.4. Baby & Me Tobacco Free has been renamed to prenatal tobacco cessation program.	

Form 10
State Performance Measure (SPM) Detail Sheets

State: Tennessee

No State Performance Measures were created by the State.

Form 10
State Outcome Measure (SOM) Detail Sheets

State: Tennessee

No State Outcome Measures were created by the State.

Form 10
Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets

State: Tennessee

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
NPM – A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth B) Percent of women who attended a postpartum checkup and received recommended care components - PPV

Measure Status:	Inactive - Completed
Goal:	To identify women with signs and symptoms of postpartum depression and connect affected women to resources.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of postpartum women with positive screening for depression who receive resources/education or referrals for professional services **Denominator:** Number of postpartum women with positive screening for depression
Data Sources and Data Issues:	Community Health Access and Navigation in TN (CHANT) and Evidence Based Home Visiting (EBHV) REDCap projects
Evidence-based/informed strategy:	1. the evidence-based/informed strategy that the ESM measures; Percentage of postpartum women with positive screening for depression 2. where you accessed the evidence on this strategy; The US Preventive Services Task Force (USPSTF)1, the American College of Obstetricians and Gynecologists (ACOG)2, and the American Academy of Pediatrics (AAP)3 recommend screening all postpartum women for depression. Screening is recommended because postnatal depression is serious, under-recognized, and treatable. Standardized screening tools are available, and the most commonly used instrument is the Edinburgh Postnatal Depression Scale (EPDS), which can be completed in less than 5 minutes. Screening should be implemented with follow-up procedures for diagnosis and treatment in place. 3. a description of how this strategy influences the NPM. Screening postpartum women for depression may lead to increased referrals for care, which could increase the percent of women, ages 18 through 44, with a preventive medical visit in the past year.
Significance:	The US Preventive Services Task Force (USPSTF), American College of Obstetricians and Gynecologists (ACOG)2, and other women's health organizations recommend that pregnant and postpartum women be assessed for risk of depression. Screening should be implemented with follow-up procedures for diagnosis and treatment in place. This data will be obtained from REDCap. Postpartum women will be identified from the data field "Have you had a baby in the past two months?" Postpartum women who were screened for depression will be identified from the Edinburgh Postnatal Depression Scale (EPDS) field. Women with positive screenings will be identified from the EPDS score data field.

ESM PPV.2 - Percent of home-visiting staff trained in recognizing and providing resources/referrals for perinatal mood disorders and substance use disorder
NPM – A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth B) Percent of women who attended a postpartum checkup and received recommended care components - PPV

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Enhance the capacity of home-visiting staff to recognize postpartum depression and anxiety and substance use disorder and to provide resources and/or referrals to women who need them.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of home-visiting staff trained in recognizing and providing resources/referrals for perinatal mood disorders and substance use disorder</td></tr>
<tr><td>Denominator:</td><td>Total number of home-visiting field staff</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data will come from the Tennessee Department of Health (TDH) Evidence-Based Home-Visiting Program and their grantees. TDH programs will work together to identify or provide training for home-visiting staff and track training attendance among staff.</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>The ESM measures the strategy: Collaborate with home visiting programs and community-based organizations to support mothers in obtaining timely postpartum care. Home visiting programs. (HVPs)—whether staffed by nurses, midwives, or community health workers—can decrease access barriers and increase the likelihood that new mothers will receive postpartum care. Trained HVP professionals and paraprofessionals can screen for maternal conditions, help postpartum participants make and attend medical appointments, and provide access to community services. However, not all HPVs focus on maternal healthcare and some do not meet the U.S. Department of Health and Human Services' criteria as an evidence-based service delivery model. Programs that meet the federal guidelines and include postpartum care as a performance measure are likely to increase the rate of postpartum visit attendance.</td></tr>
<tr><td>Significance:</td><td>Tennessee has home-visiting staff in all of its 95 counties. There is moderate evidence that home-visiting programs can support women's access to postpartum care by reducing barriers. Additionally, home-visiting staff, who generally serve more at risk families, are in a unique position to help mothers with mental health conditions to access care. Their presence in the home provides an opportunity to build deeper rapport, garner more trust, and get a broader view of the mother. Training home-visiting staff in recognizing mental health conditions can help their clients get connected to care.</td></tr>
</table>

ESM MHS.1 - Number of healthcare providers trained in using validated screening tools for depression and anxiety
NPM – Percent of women who were screened for depression or anxiety following a recent live birth - MHS

Measure Status:	Active
Goal:	Increase the number of healthcare providers trained in and utilizing validated screening tools for depression and anxiety in postpartum women.
Definition:	**Unit Type:** Count **Unit Number:** 1,000 **Numerator:** Number of healthcare providers trained in using validated screening tools for depression and anxiety **Denominator:**
Data Sources and Data Issues:	Data will come from TDH programs or contracted partners that host webinars or in-person trainings. Training hosts will track attendance. Programs that may host trainings include the Prevention of Violent Maternal Deaths Program and the Maternal Mental Health and Substance Use Disorder Program. Grantees that may host trainings include Tennessee Initiative for Perinatal Quality Care and Tennessee Voices.
Evidence-based/informed strategy:	The ESM supports the strategy: Educate providers on the use of standardized screening tools to identify women with postpartum depression and anxiety. Provider training interventions such as slide presentations, educational sessions, video training, and other training modalities seek to improve the knowledge and skills of providers around the signs, symptoms, screening protocols and treatment options for postpartum depression and anxiety. Research supports that increasing provider knowledge and comfort level around postpartum depression and anxiety screening improves screening and referral rates. Findings also indicate that trainings that address the values of providers' clients have a positive impact on health outcomes.
Significance:	The aim of the strategy associated with this ESM is to train providers in using mental health screening tools, especially providers who are likely to care for pregnant and postpartum women. Mental health conditions, including substance use disorder, were the leading cause of pregnancy-related death in Tennessee between 2020-2022. There is emerging evidence that increasing provider knowledge and comfort level around postpartum mood disorders leads to increased screening and referral. This strategy works toward screening all women for postpartum depression, which aligns with ACOG Patient Screening Guidelines.

ESM CU.1 - Number of total providers trained on long-acting reversible contraception (LARC) insertion and removal
NPM – Percent of women who are using a most or moderately effective contraceptive following a recent live birth - CU

Measure Status:	Active
Goal:	Increase the total number of providers able to do LARC insertion and removal.
Definition:	**Unit Type:** Count **Unit Number:** 1,000 **Numerator:** Number of total providers trained on long-acting reversible contraception (LARC) insertion and removal **Denominator:**
Data Sources and Data Issues:	Tennessee Department of Health Family Health and Wellness program data. This data includes the number of providers previously trained and the number of providers newly trained.
Evidence-based/informed strategy:	The ESM measures strategy: Long-Acting Reversible Contraception (LARC) Information and Access - Encourage clinics to offer information on or access to LARCs, including to postpartum women. Long-acting reversible contraceptives (LARCs) include intrauterine devices (IUDs) and implants that can prevent pregnancy for 3 to 10 years and can be removed at a woman's discretion. LARCs are over 99% effective, a higher effectiveness rate than other birth control options. LARCs can be used safely by teens and women regardless of whether they have previously given birth. Despite very few medical contraindications to LARC use, a variety of barriers at the patient, provider, and systems level have limited access to and uptake of LARCs. LARCs can be made available through broad-based efforts to decrease patient costs such as ensuring that LARCs are available at low or no cost through Title X family planning sites and other sources of care, and ACA provisions requiring full coverage of birth control options. Efforts to increase access to LARCs can include provision of comprehensive contraceptive counseling on the full range of birth control options (including LARC) for all interested patients, provider training on LARC insertion and removal, and consistent availability of LARCs at local hospitals and clinics. Availability of LARCs could also be improved by elimination of medically unnecessary steps between request and insertion, including two visit protocols and STI testing prior to the day of insertion. LARCs can be inserted and removed by many types of clinicians in a range of clinical settings, including primary care and nontraditional locations such as school-based health centers or mobile van settings.
Significance:	Long-acting reversible contraceptives (LARCs) include intrauterine devices (IUDs) and implants that can prevent pregnancy for 3 to 10 years and can be removed at a woman's discretion. LARCs are over 99% effective, with a higher effectiveness rate than other birth control options. LARCs can be used safely by teens and women regardless of whether they have previously given birth. Despite very few medical contraindications to LARC use, a variety of barriers at the patient, provider, and systems level have limited access to and uptake of LARCs. LARCs can be made available through broad-based efforts to decrease patient costs, such as ensuring that LARCs are available at low or no cost through Title X family planning sites and other sources of care and ACA provisions requiring full coverage of birth control options. Efforts to increase access to LARCs can include the provision of comprehensive contraceptive counseling on the full range of birth control options (including LARC) for all interested patients, provider training on LARC insertion and removal, and consistent availability of LARCs at local hospitals and clinics. Availability of LARCs could also

be improved by eliminating medically unnecessary steps between request and insertion, including two-visit protocols and STI testing before the day of insertion. LARCs can be inserted and removed by many types of clinicians in various clinical settings, including primary care and nontraditional locations such as school-based health centers or mobile van settings.

ESM RAC.1 - Percent of Tennessee birthing hospitals participating in perinatal quality collaborative projects
NPM – Percent of very low birth weight (VLBW) infants born in a hospital with a Level III + Neonatal Intensive Care Unit (NICU) - RAC

Measure Status:	Inactive - Completed
Goal:	To increase percent of Tennessee birthing hospitals participating in perinatal quality collaborative projects
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of Tennessee birthing hospitals participating in perinatal quality collaborative projects **Denominator:** Number of Tennessee birthing hospitals
Data Sources and Data Issues:	Family Health and Wellness tracking tool
Significance:	The Tennessee Initiative for Perinatal Quality Care seeks to improve health outcomes for mothers and infants by implementing data-driven provider- and community-based performance improvement initiatives. Current projects being implemented include initiatives targeted to neonatal abstinence syndrome, opioid use disorder, sleep-related infant death, and several maternal hypertension. More Tennessee birthing hospitals participating in these projects will ensure that the best evidence-based clinical practices are being allied to pressing public health facing mothers and infants. Ultimately, a higher percentage of birthing hospitals with these initiatives in place will lead to improved infant health outcomes and reduced disparities in access and treatment.

ESM RAC.2 - Number of unique patients served by perinatal telehealth pilot projects in Tennessee
NPM – Percent of very low birth weight (VLBW) infants born in a hospital with a Level III + Neonatal Intensive Care Unit (NICU) - RAC

Measure Status:	Active
Goal:	Increase the number of unique patients served by perinatal telehealth pilot projects in Tennessee.
Definition:	**Unit Type:** Count **Unit Number:** 1,000 **Numerator:** Number of unique patients served by the perinatal telehealth pilot projects in Tennessee **Denominator:**
Data Sources and Data Issues:	Tennessee Department of Health Family Health and Wellness program data
Evidence-based/informed strategy:	The ESM supports the strategy: Improve perinatal health outcomes through quality improvement (QI) initiatives in birthing hospitals. Implementing QI collaborative initiatives in birthing hospitals is an evidence-based approach to improve maternal and neonatal outcomes. Tennessee is well-positioned to leverage this strategy to increase the percentage of VLBW infants born in a hospital with a Level III+ NICU through the state's initiative for perinatal quality collaboratives (i.e., Tennessee Initiative for Perinatal Quality Care, TIPQC). TIPQC has engaged birthing hospitals since 2008 to drive improvements in perinatal care through data-driven QI initiatives. Such QI collaboratives have been credited with improving birth outcomes for preterm infants in other states like California and have the potential to improve birth outcomes for VLBW infants in Tennessee. As of March 2025, nine evidence-based strategies have been identified to provide risk-appropriate perinatal care for high-risk mothers and VLBW infants. These strategies aim to increase the percentage of very low birth weight (VLBW) infants born in hospitals with a Level III+ Neonatal Intensive Care Unit (NICU). The evidence supporting these strategies is drawn from MCH Evidence Toolkits, indicating their effectiveness in advancing the NPM by addressing the specific needs and challenges associated with VLBW infants and ensuring access to high-quality NICU care.
Significance:	Current evidence shows that programs that integrate telehealth have consistently seen more high-risk babies delivered at high-level NICUs and a corresponding decrease in neonatal or infant mortality and morbidity. One study of telehealth's effect on VLBW deliveries in Arkansas showed that telehealth significantly decreased the rate of VLBW neonates delivered in hospitals without NICUs (from 13% to 7% in less than one year of telehealth interventions) and was associated with decreased infant mortality across the state (Kim et al., 2013). Another study showed that a high-risk pregnancy telehealth program in Arkansas achieved a 0.5% reduction in 60-day infant mortality by increasing the proportion of low-birth-weight infants delivered at a Level III hospital (from 38% to 42%; PSNet, 2020). By increasing the number of unique patients served through telehealth in Tennessee, health systems in Tennessee can replicate the successes identified in other states, including identifying high-risk pregnancies earlier, coordinating timely transfers to Level III+ NICUs, and ultimately improving VLBW infant outcomes.

ESM VAX_Child.1 - Percent of participating staff reporting increased confidence in addressing vaccine hesitancy post-training
NPM – Percent of children who have completed the combined 7-vaccine series (4:3:1:3*:3:1:4) by age 24 months - VAX_Child

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To increase the percentage of EBHV/CHANT staff reporting increased addressing of vaccine hesitancy post-training.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of EBHV/CHANT staff reporting increased addressing vaccine hesitancy post-training</td></tr>
<tr><td>Denominator:</td><td>Total number of EBHV/CHANT staff undertaking training</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>EBHV/CHANT through CEDEP collaborative training.

Limitations: Measuring increased confidence following training on vaccine hesitancy for children has limitations, including the challenge of capturing long-term changes in attitudes, as immediate post-training assessments may not reflect sustained confidence. Additionally, self-reported confidence may be influenced by social desirability preferences, and training effectiveness might not translate into real-world application or increased vaccination rates among hesitant parents.</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>The ESM measures the strategy: 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. Motivational interviewing (MI) is a patient-centered communication technique shown to be effective in addressing vaccine hesitancy by helping healthcare professionals explore parental concerns, build trust, and support informed decisions. Training in MI techniques—such as reflective listening and affirming autonomy—along with integrating MI into routine care and offering ongoing resources, can enhance vaccine conversations. Public health initiatives, including those by the CDC and state health departments, have developed MI-based training programs to support this approach.</td></tr>
<tr><td>Significance:</td><td>Training staff to address child vaccination hesitancy is crucial for building trust with hesitant parents and improving vaccine uptake. Well-trained staff can effectively communicate the benefits of vaccination, address misconceptions, and provide evidence-based information in a responsive manner. This training equips healthcare providers and community workers with the skills to navigate difficult conversations, increase parental confidence in vaccines, and reduce barriers to immunization. Ultimately, these efforts contribute to higher vaccination rates, improved public health outcomes, and protection against preventable diseases for children. Motivational interviewing (MI) is a patient-centered communication technique shown to be effective in addressing vaccine hesitancy by helping healthcare professionals explore parental concerns, build trust, and support informed decisions. Training in MI techniques—such as reflective listening and affirming autonomy—along with integrating MI into routine care and offering ongoing resources, can enhance vaccine conversations. Public health initiatives, including those by the CDC and state health departments, have developed MI-based training programs to support this approach.</td></tr>
</table>

ESM FS.1 - Number of individuals referred to food assistance programs through FindHelp
NPM – Percent of children, ages 0 through 11, whose households were food sufficient in the past year - FS

Measure Status:	Active
Goal:	To ensure continuous access to food assistance by expanding referrals through a coordinated care network.
Definition:	**Unit Type:** Count **Unit Number:** 40,000 **Numerator:** Number of individuals referred to food assistance programs through FindHelp **Denominator:**
Data Sources and Data Issues:	Tennessee's MCH/Title V staff will use the FindHelp platform to track the number of individuals referred to food assistance programs. There are no data issues.
Evidence-based/informed strategy:	The ESM measures the strategy: Increase access to nutritious foods by identifying families experiencing food insecurity and connecting them to food assistance programs, particularly in under-resourced communities. Increasing access to nutritious foods involves making healthy food options more readily available and affordable, particularly in communities with limited access to grocery stores, fresh produce, or food assistance. This approach is central to strengthening food sufficiency and promoting child health and development. Just as critical as expanding availability is the ability to identify families experiencing food sufficiency and refer them to appropriate resources, without timely and accurate connections, even well-resourced programs may go underutilized, and families may remain unsupported. Evidence-based interventions have demonstrated success in addressing food sufficiency. For example, supermarket “double-dollar” incentive programs have significantly increased purchases of fruits and vegetables among low-income families with children. Similarly, additional produce vouchers for pregnant WIC clients have improved food security and diet quality, particularly in historically medically underserved populations. A coordinated system would strengthen the identification, referral, and support of families experiencing food insufficiency, ensuring that services are available, streamlined, and sustainable.
Significance:	Tennessee has launched a Closed-Loop Referral System (CLRS) via the FindHelp platform. As multiple sectors—including healthcare, education, social services, and community-based organizations—express growing interest, Tennessee is positioned to integrate and scale this infrastructure statewide. A coordinated care network can link individuals with identified social needs—including food security—to community resources via a digital platform that supports real-time referrals and closed-loop follow-up. A coordinated system will strengthen the identification, referral, and support of families experiencing food insufficiency, ensuring that services are available, streamlined, and sustainable.

ESM MHT.1 - Percent increase in Tennessee Child and Adolescent Psychiatry Education and Support (TCAPES) teleconsultation call line volume
NPM – Percent of adolescents, ages 12 through 17, who receive needed mental health treatment or counseling - MHT

Measure Status:	Active
Goal:	Increase the number of calls to the teleconsultation line for the Tennessee Child and Adolescent Psychiatry Education and Support (TCAPES) program.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of calls in the previous year minus the number of calls in the current year **Denominator:** Number of calls in the previous year
Data Sources and Data Issues:	As part of the HRSA's Pediatric Mental Health Care Access (PMHCA) Program initiative, the TCAPES team will monitor the number of consultations providers initiate. This will be tracked through the TCAPES REDCap database management system to support ongoing evaluation, identify emerging needs, and improve access to pediatric mental health care.
Evidence-based/informed strategy:	The ESM measures the strategy: Implement youth-centered mental health/social-emotional skill-building promotion to address factors that influence adolescent well-being. Holistic and community-based approaches embed comprehensive mental health promotion initiatives within environments that are available and familiar to adolescents, such as schools, youth centers, and faith-based organizations, to improve access, engagement, and effectiveness. These approaches extend beyond traditional clinical services by delivering mental health care that addresses the interconnected social, cultural, environmental, and widespread factors impacting adolescents' mental health and well-being. This is achieved by collaborating with community partners to identify priorities, overcome barriers, and implement multifaceted and tailored mental health interventions for adolescents. Holistic and community-based approaches often incorporate peer support, skill-building, recreational activities, and collaboration across sectors like education, social services, and healthcare. Evidence suggests that well-implemented, community-driven programs effectively improve mental health outcomes for adolescents by fostering emotional resilience, promoting positive health outcomes, increasing service availability, and providing comprehensive care tailored to the unique needs within their local contexts.
Significance:	This measure is significant because it reflects the extent to which pediatric providers seek support for mental health care, highlighting both the demand for resources and the proactive steps to address adolescent mental health needs. By tracking consultation calls, we gain insight into how often providers engage with mental health support services, which can inform gaps in care, training needs, and system responsiveness to improve adolescent health outcomes.

ESM MH.1 - Number of CYSHCN who receive CHANT/CSS care coordination
NPM – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - MH

Measure Status:	Inactive - Completed
Goal:	To increase the number of children and youth with special health care needs receiving CHANT/CSS care coordination.
Definition:	**Unit Type:** Count **Unit Number:** 5,000 **Numerator:** Number of CYSHCN receiving CHANT/CSS care coordination **Denominator:**
Data Sources and Data Issues:	CYSHCN MCH/Title V Program data and PTBMIS
Significance:	It is important to ensure the children with special healthcare needs served by the Tennessee Children's Special Services program receive care coordination services to assist in system navigation.

ESM MH.2 - Percent of providers adopting medical home approach
NPM – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - MH

Measure Status:	Inactive - Completed
Goal:	To increase the percentage of providers adopting medical home approach in their practice
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of providers reporting adoption of the medical home approach **Denominator:** Number of providers participating in the medical home collaborative
Data Sources and Data Issues:	Program will host learning collaborative for providers, families and community members. Pre and Post assessments will be administered to determine providers who report adopting medical home approach.
Evidence-based/informed strategy:	Create a shared vision for integrating and improving CYSHCN system of care.
Significance:	By increasing the number of providers who adopt a medical home approach in their practices, this will also increase the number of children who receive care in a medical home.

ESM MH.3 - Percent of providers reporting increased knowledge on systems of care
NPM – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - MH

Measure Status:	Inactive - Completed
Goal:	To increase the percentage of providers reporting an increase in knowledge on systems of care.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of providers reporting increased knowledge on systems of care **Denominator:** Number of providers participating in the medical home collaborative
Data Sources and Data Issues:	Create a shared vision for integrating and improving CYSHCN system of care.
Evidence-based/informed strategy:	Program will host learning collaborative for providers, families and community members. Pre and Post assessments will be administered to determine providers who report increased knowledge.
Significance:	By increasing providers' knowledge on systems of care will increase the number of children who receive coordinated, comprehensive care in a medical home.

ESM MH.4 - Number of families provided education and resources on importance of medical home access and utilization
NPM – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - MH

Measure Status:	Inactive - Completed
Goal:	To increase the number of families who receive education and resources on the importance of coordinated and comprehensive care in the medical home.
Definition:	**Unit Type:** Count **Unit Number:** 2,000 **Numerator:** Number of families provided education and resources **Denominator:**
Data Sources and Data Issues:	Data Sources: CHANT program data and Call Center data; Limitations: Retrieving data from separate data systems
Evidence-based/informed strategy:	Number of families provided education and resources on importance of medical home access and utilization
Significance:	It is important to ensure that children and families receive annual medical exams and preventive care in an assigned medical home setting. Providing education and knowledge on the importance of care in the medical home will be significant in increasing actual utilization of the medical home.

ESM MH.5 - Number of families receiving referrals to their child's primary care provider
NPM – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - MH

Measure Status:	Inactive - Completed
Goal:	To increase the number of families referred to their child's primary care provider.
Definition:	**Unit Type:** Count **Unit Number:** 500 **Numerator:** Number of referrals to the primary care providers **Denominator:**
Data Sources and Data Issues:	CHANT program data and Call Center data
Significance:	It is important to ensure that children and families receive annual medical exams and preventive care in an assigned medical home setting. Identifying and providing referrals to the primary care provider will be significant in increasing actual utilization of the medical home.

ESM MH.6 - Percent of providers who report an increase in their knowledge of available resources
NPM – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - MH

Measure Status:	Inactive - Completed
Goal:	To increase the percentage of providers reporting increased resource referrals for CYSHCN.
Definition:	<table><tr><td>**Unit Type:**</td><td>Percentage</td></tr><tr><td>**Unit Number:**</td><td>100</td></tr><tr><td>**Numerator:**</td><td>Number of providers who report an increase in the number of referrals provided</td></tr><tr><td>**Denominator:**</td><td>Number of providers receiving educational material on available resources for children and youth with special health care needs</td></tr></table>
Data Sources and Data Issues:	Program will distribute resource information to providers. A pre-post questionnaire will be used to determine if increase in referrals occur based on resources provided.
Evidence-based/informed strategy:	Inform and educate families and providers to promote systems change.
Significance:	It is important that providers receive information on available resources and make referrals for CYSHCN by doing so, access and utilization of the medical home will increase and additional opportunities for systems change with the potential of increasing knowledge of providers and families of CYSHCN

ESM MH.7 - Percent of families who report an increase in access and utilization of resources
NPM – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - MH

Measure Status:	Inactive - Completed
Goal:	To increase the percentage of families who reporting increased access and utilization of CYSHCN.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of families who report an increase in access and utilization of resources **Denominator:** Number of families receiving list of available resources
Data Sources and Data Issues:	Program will distribute resource information to families. A pre-post questionnaire will be used to determine if increase in access and utilizations occur based on resources provided.
Evidence-based/informed strategy:	Inform and educate families and providers to promote systems change.v
Significance:	It is important that families receive information on available resources. Care for CYSHCN involves multiple stakeholders, including primary and specialty care providers as well as non-medical service providers. For CYSHCN to thrive, partnership between care providers and families is critical that resources are made available for as many needs as possible including health and community based. By doing so medical home access and utilization will increase.

ESM MH.8 - Percent of CHANT families who schedule an annual visit with their child's primary care provider
NPM – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - MH

Measure Status:	Inactive - Completed
Goal:	To increase the percent families who schedule their child's primary care appointment.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of CHANT families who schedule appointments **Denominator:** Number of CHANT families referred to primary care provider
Data Sources and Data Issues:	CHANT program data and Call Center data
Significance:	It is important to ensure that children and families receive annual medical exams and preventive care in an assigned medical home setting. Assisting families to schedule appointments will be significant in increasing actual utilization of the medical home.

ESM MH.9 - Percent of CYSHCN receiving CHANT care coordination who receive medical home education
NPM – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - MH

Measure Status:	Inactive - Completed
Goal:	To increase the percent of children and youth with special health care needs receiving CHANT care coordination who receive medical home education.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of CYSHCN receiving CHANT care coordination who receive medical home education **Denominator:** Number of CYSHCN receiving CHANT care coordination
Data Sources and Data Issues:	Data source: PTBMIS and REDCap Limitations: Families may reject CSS services because they do not want to go through the CHANT screening and assessment
Evidence-based/informed strategy:	Increase the number of CYSHCN who have access to patient and family-centered care coordination.
Significance:	It is important to ensure the children with special healthcare needs served by the Tennessee Children's Special Services program receive medical home education to increase access and utilization and ensure positive health outcomes.

ESM MH.10 - Number of teachers/school personnel trained on QPR
NPM – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - MH

Measure Status:	Inactive - Completed
Goal:	To increase the number of teachers and school personnel trained in Question, Persuade, Refer (QPR) Gatekeeper Training
Definition:	**Unit Type:** Count **Unit Number:** 3,000 **Numerator:** Number of teachers/school personnel trained on QPR **Denominator:**
Data Sources and Data Issues:	TN Suicide Prevention Program records
Evidence-based/informed strategy:	1) the evidence-based/informed strategy that the ESM measures; The number (or count) of teachers and school personnel trained in Question, Persuade, Refer (QPR) Gatekeeper Training. 2) where you accessed the evidence on this strategy; Evidence accessed to support this strategy included the 2021 National Survey of Children's Health (NSCH) survey data and Mental Health and Mental Disorders (MHMD) Objective 03. 3) a description of how this strategy influences the NPM. Research and data have shown that QPR training is effective in increasing the likelihood of an intervention at school2. In this case, a child in need of mental health treatment or counseling. With an increase in teacher/school personnel knowledge and skills through the QPR training, this will increase awareness which will lead to more children receiving treatment. As a result, the number of children having difficulty receiving mental health treatment will decrease.
Significance:	According to the 2021 National Survey of Children's Health (NSCH), approximately 58.7% of children aged 3-17 have some difficulty in receiving mental health treatment or counseling.1 Evidence suggests that school-based gatekeeper training is effective in improving participants' knowledge, skills, self-efficacy and likelihood to intervene.2 Question, Persuade, Refer (QPR) Gatekeeper Training is designed to teach participants how to recognize the warning signs of someone who may be contemplating suicide and question them about whether or not they are suicidal; how to offer hope to an individual experiencing a suicidal crisis and persuade them to get help; and how to refer an individual having a suicidal crisis for help in order to save their life.

ESM MH.11 - Percentage of children with and without SHCN who are applying for health insurance
NPM – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - MH

Measure Status:	Active
Goal:	Increase the percentage of children with and without SCHN who are applying for health insurance in CHANT by 2% annually
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of children under 21 who applied for health insurance on the Health Insurance Pathway within the FFY **Denominator:** Number of children under 21 who started the Health Insurance Pathway within the FFY
Data Sources and Data Issues:	Data will come from the CHANT REDCap
Evidence-based/informed strategy:	Strategy: The ESM measures strategy, Dedicated Care Coordinators, uses dedicated care coordinators to develop relationships with families to increase timely attendance of well-child visits and respond to the needs of families. Research shows that designating a care coordinator with protected time to make outreach calls and identify patient needs are effective strategies for improving connections to the medical home. The care coordinator can identify and coordinate care with patients through establishing early relationships by making “welcome calls” to families which include congratulating them on the baby, welcoming them to the practice, reminding them of their appointments, and acting as the point-of-contact for caregiver’s concerns. The care coordinator can also serve as a critical component in connecting and referring families to needed services for community organizations outside of the provider’s office.[1] Alternatively, the care coordinator role can also be part of a home visiting program. (see strategies for Strengthening Service Coordination Between Home Visitors and Pediatric Primary Care Providers). Evidence: Strategies with this rating typically trend positive and have good potential to work. They often have a growing body of recent, but limited research that documents effects. However, further study is needed to confirm effects, determine which types of health behaviors and conditions these interventions address, and gauge effectiveness across different population groups. The CHANT program provides dedicated care coordination, which is used to assist families enrolled with learning about options for health insurance and submitting applications. Source: MCH Evidence https://www.mchevidence.org/tools/strategies/details.php?medical-home-overall-02
Significance:	The 2022-2023 National Survey of Children’s Health indicated that 69.5% of children aged 0-17 in Tennessee had adequate and continuous insurance. In the same reporting years, 63.5% of children and youth with special health care needs and 71.1% of children without stated that they had adequate and continuous insurance (1). The CHANT program provides

care coordination to children under 21 and their families, and a part of that is assistance with health insurance applications. Between SFY19-SFY24, 73.1% of children who received assistance with a health insurance application successfully obtained health insurance (2).

Gaps exist between children with and without special health care needs. Between 2017-2023, 9.5% more CYSHCN on average lacked adequate or continuous insurance compared to children without special health care needs (3).

1. Child and Adolescent Health Measurement Initiative. 2022-2023 National Survey of Children's Health (NSCH) data query. Standardized Measure: Percent of children, ages 0 through 17, who are continuously and adequately insured. Data Resource Center for Child and Adolescent Health supported by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). Retrieved 06/23/25 from https://www.childhealthdata.org/browse/survey/results?q=11346&r=1&r2=44

2. REDCap. (2024). CHANT Care Coordination [dataset]. Data from 10/21/2024.

3. Child and Adolescent Health Measurement Initiative. 2017-2018 National Survey of Children's Health (NSCH) data query. NPM 15: Percent of children, ages 0 through 17, who are continuously and adequately insured. Data Resource Center for Child and Adolescent Health supported by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). Retrieved 06/23/25 from https://www.childhealthdata.org/browse/survey/results?q=7280&r=1&r2=44&g=731&a=11486.

ESM MH.12 - Percentage of children with and without SHCN who schedule an exam with a primary care provider
NPM – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - MH

Measure Status:	Active
Goal:	Increase the percentage of children with and without SHCN who schedule an exam with a primary care provider in CHANT by 3% annually
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of children under 21 who needed an exam and scheduled an exam on the Medical Home pathway in the FFY **Denominator:** Number of children under 21 who needed an exam and started the Medical Home Pathway
Data Sources and Data Issues:	Data will come from the CHANT REDCap
Evidence-based/informed strategy:	Strategy: The ESM measures strategy, Dedicated Care Coordinators, uses dedicated care coordinators to develop relationships with families to increase timely attendance of well-child visits and respond to the needs of families. Research shows that designating a care coordinator with protected time to make outreach calls and identify patient needs are effective strategies for improving connections to the medical home. The care coordinator can identify and coordinate care with patients through establishing early relationships by making “welcome calls” to families which include congratulating them on the baby, welcoming them to the practice, reminding them of their appointments, and acting as the point-of-contact for caregiver’s concerns. The care coordinator can also serve as a critical component in connecting and referring families to needed services for community organizations outside of the provider’s office.[1] Alternatively, the care coordinator role can also be part of a home visiting program. (see strategies for Strengthening Service Coordination Between Home Visitors and Pediatric Primary Care Providers). Evidence: Strategies with this rating typically trend positive and have good potential to work. They often have a growing body of recent, but limited research that documents effects. However, further study is needed to confirm effects, determine which types of health behaviors and conditions these interventions address, and gauge effectiveness across different population groups. The CHANT program provides dedicated care coordination, which is used to assist families with scheduling appointments for family members with their primary care provider while removing barriers to scheduling and completing a primary care visit. Source: MCH Evidence https://www.mchevidence.org/tools/strategies/details.php?medical-home-overall-02
Significance:	According to the NSCH, in 2022-2023 survey year, 19% of children in Tennessee did not have an annual preventive care visit; nearly 10% more children without special healthcare needs (21%) went without an annual preventive care visit compared to CYSHCN (11.2%) (1).

Data from the National Survey of Children's Health showed that in the 2022-2023 survey year, nearly one-quarter (24.2%) of CYSHCN did not have a personal doctor or nurse and 11.2% did not have an annual preventive visit with a provider (2).

References:

1. Child and Adolescent Health Measurement Initiative. 2022-2023 National Survey of Children's Health (NSCH) data query. Indicator 4.1a: During the past 12 months, how many times did this child visit a doctor, nurse, or other health care professional to receive a preventive check-up? (A preventive check-up is when this child was not sick or injured, such as an annual or sports physical, or well-child visit) Data Resource Center for Child and Adolescent Health supported by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). Retrieved 06/23/25 from https://www.childhealthdata.org/browse/survey/results?q=11100&r=1&r2=44&g=1167&a=22746.

2. Child and Adolescent Health Measurement Initiative. 2022-2023 National Survey of Children's Health (NSCH) data query. Indicator 4.1a: During the past 12 months, how many times did this child visit a doctor, nurse, or other health care professional to receive a preventive check-up? (A preventive check-up is when this child was not sick or injured, such as an annual or sports physical, or well-child visit) Data Resource Center for Child and Adolescent Health supported by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). Retrieved 06/23/25 from https://www.childhealthdata.org/browse/survey/results?q=11100&r=1&r2=44&g=1167&a=22746.

ESM MH_PDOC.1 - Percentage of children with and without SHCN who receive a referral to a primary care provider NPM – Percent of children with and without special health care needs, ages 0 through 17, who have a personal doctor or nurse - MH_PDOC

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase the percentage of children with and without SCHN who receive a referral to a primary care provider in CHANT by 1% annually.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of children under 21 who needed a primary care provider located at a patient-centered medical home (PCMH) on the Medical Home pathway in the FFY</td></tr>
<tr><td>Denominator:</td><td>Number of children under 21 who received a referral to a medical provider on the Medical Home Pathway and needed a primary care provider</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data will come from the CHANT REDCap</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>Strategy: The ESM measures strategy, Dedicated Care Coordinators, uses dedicated care coordinators to develop relationships with families to increase timely attendance of well-child visits and respond to the needs of families.

Research shows that designating a care coordinator with protected time to make outreach calls and identify patient needs are effective strategies for improving connections to the medical home. The care coordinator can identify and coordinate care with patients through establishing early relationships by making “welcome calls” to families which include congratulating them on the baby, welcoming them to the practice, reminding them of their appointments, and acting as the point-of-contact for caregiver’s concerns. The care coordinator can also serve as a critical component in connecting and referring families to needed services for community organizations outside of the provider’s office.[1] Alternatively, the care coordinator role can also be part of a home visiting program. (see strategies for Strengthening Service Coordination Between Home Visitors and Pediatric Primary Care Providers).

Evidence: Strategies with this rating typically trend positive and have good potential to work. They often have a growing body of recent, but limited research that documents effects. However, further study is needed to confirm effects, determine which types of health behaviors and conditions these interventions address, and gauge effectiveness across different population groups.

The CHANT program provides dedicated care coordination, which is used to assist families by helping them to identify a primary care provider and working closely with families to remove barriers to scheduling and completing a primary care visit.

Source: MCH Evidence

https://www.mchevidence.org/tools/strategies/details.php?medical-home-overall-02</td></tr>
</table>

Significance:	A well-functioning system includes a primary care provider who can help children keep up with preventive exams. According to the 2022-2023 National Survey of Children's Health, 27.1% of children in Tennessee did not have a personal doctor or nurse. Specifically, 24.2% of CSHN and 27.9% of children without special health care needs lacked a personal doctor or nurse (1). According to the NSCH, in the 2022-2023 survey year, about one-quarter (24.2%) of CSHCN in Tennessee did not have a personal doctor or nurse (2). Between 2017-2023, 3.4% fewer CYSHCN (average: 48.2%) had a medical home compared to children without special health care needs (average: 51.6%) (3). Child and Adolescent Health Measurement Initiative. 2022-2023 National Survey of Children's Health (NSCH) data query. Indicator 4.12a: Do you have one or more persons you think of as this child's personal doctor or nurse? Data Resource Center for Child and Adolescent Health supported by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). https://www.childhealthdata.org/browse/survey/results?q=11130&r=1&r2=44. Child and Adolescent Health Measurement Initiative. 2022-2023 National Survey of Children's Health (NSCH) data query. Indicator 4.12a: Do you have one or more persons you think of as this child's personal doctor or nurse? Data Resource Center for Child and Adolescent Health supported by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). https://www.childhealthdata.org/browse/survey/results?q=11130&r=1&r2=44. Child and Adolescent Health Measurement Initiative. 2017-2018 National Survey of Children's Health (NSCH) data query. NPM 11: Percent of children with special health care needs, ages 0 through 17, who have a medical home. https://www.childhealthdata.org/browse/survey/results?q=7274&r=1&r2=44.

ESM TAHC.1 - Number of transition resource kits disseminated
NPM – 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 - TAHC

Measure Status:	Inactive - Not continuing this ESM in the 2026-2030 cycle
Goal:	To increase the number of youth with special health care needs that receive resources necessary for successful transition.
Definition:	**Unit Type:** Count **Unit Number:** 2,600 **Numerator:** Number of kits disseminated **Denominator:**
Data Sources and Data Issues:	CYSHCN MCH/Title V Program data
Significance:	Youth who receive education and knowledge on transition planning are expected to be successful transitioning to adult independence.

ESM TAHC.2 - Number of youth with special health care needs trained as mentors
NPM – 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 - TAHC

Measure Status:	Inactive - Not continuing this ESM in the 2026-2030 cycle
Goal:	To increase the number of youth with special health care needs that receive mentor other youth with special health care needs to serve as leaders on the Youth Advisory Council.
Definition:	**Unit Type:** Count **Unit Number:** 75 **Numerator:** Number of youth with special health care needs trained as mentors **Denominator:**
Data Sources and Data Issues:	CYSHCN MCH/Title V Program data
Significance:	The program is to encourage active participation and involvement of the youth and families in policy development.

ESM TAHC.3 - Number of parents and youth with special health care needs who receive leadership and self-advocacy training
NPM – 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 - TAHC

Measure Status:	Inactive - Not continuing this ESM in the 2026-2030 cycle
Goal:	To increase the number of parents and youth with special health care needs that receive leadership and self-advocacy training.
Definition:	**Unit Type:** Count **Unit Number:** 500 **Numerator:** Number of parents and youth with special health care needs who receive leadership and self-advocacy training **Denominator:**
Data Sources and Data Issues:	CYSHCN MCH/Title V Program data
Significance:	Youth and parents are provided leadership training and are able to provide mentoring and peer to peer support to other parents and youth with special health care needs. Trained parents and YSHCN are better equipped to become self-advocates and participate in the decision making process and policy development.

ESM TAHC.4 - Percentage of CSS-eligible YSHCN, age 14-21, who complete a transition plan
NPM – 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 - TAHC

Measure Status:	Active
Goal:	Increase the percentage of YSHCN, age 14-21, who are in the CSS program and completed a transition plan by 1% annually.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of CYSHCN 14-21 years old who are enrolled in CSS and active (eligible) and completed a transition plan in the FFY **Denominator:** Number of CYSHCN 14-21 years old who are enrolled in CSS program and active (eligible) in the FFY
Data Sources and Data Issues:	Data will come from the CHANT REDCap
Evidence-based/informed strategy:	Strategy: The ESM measures strategy, Planning for Transition + Transfer Assistance + Care Coordination, provides planning, transfer assistance, and care coordination to prepare adolescents for the transition from pediatric to adult health care services. A structured health care transition process results in positive outcomes in population health, patient experience of care, and utilization. Interventions that combine planning with transfer assistance and care coordination seem to increase the likelihood that youth will successfully transition from pediatric to adult health care services. Examples of studies that showed positive outcomes using this three-pronged approach combined the following: 1) disease education/skill-building for youth and families during the planning phase; 2) transfer assistance that included identifying an adult provider; assisting with appointment scheduling; and fostering communication between pediatric and adult providers/joint pediatric and adult meetings; and 3) care coordination administered by a designated transition coordinator who acted as a system navigator.[1-3]. Evidence: Strategies with this rating are likely to work. These strategies have been tested more than once and results trend positive overall; however, further research is needed to confirm effects, especially with multiple population groups. These strategies also trend positive in combination with other strategies. The CHANT program provides dedicated care coordination, which is used to assist youth with special health care needs prepare for the transition from pediatric to adult care. Source: MCH Evidence https://www.mchevidence.org/tools/strategies/details.php?transition-09
Significance:	All youth with special health care needs should receive the services required to facilitate a successful transition to adult health care and independence. As they grow older, transitioning from parent-managed, patient-controlled care to independent, patient-centered care is crucial for their growth and development. The 2022-2023 National Child Health survey indicates that 75.5% children and youth with special health care needs aged 12-17 in

Tennessee did not receive the services necessary for transition to adult health care.

References:

Child and Adolescent Health Measurement Initiative. 2022-2023 National Survey of Children's Health (NSCH) data query. NPM: Percent of adolescents with special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care. Data Resource Center for Child and Adolescent Health supported by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). Retrieved 06/23/25 from https://www.childhealthdata.org/browse/survey/results?q=11328&r=44.

Form 10
Evidence-Based or -Informed Strategy Measure (ESM) (2021-2025 Needs Assessment Cycle)

2021-2025: ESM BF.1 - Number of credentialed lactation professionals within WIC
2021-2025: NPM – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months - BF

Measure Status:	Active
Goal:	To increase the number of credentialed lactation professionals within WIC (e.g., IBCLC, CLC, and CLS)
Definition:	**Unit Type:** Count **Unit Number:** 250 **Numerator:** Number of credentialed lactation professionals within WIC **Denominator:**
Data Sources and Data Issues:	WIC monitoring reports
Significance:	One barrier to breastfeeding is the lack of access to lactation professionals. Breastfeeding promotion and support is an integral part of the WIC Program. Increasing the number of trained lactation personnel will assist WIC mothers to make the best decision regarding infant feeding.

2021-2025: ESM BF.2 - Percent of Breastfeeding Welcomed Here (BFWH)-designated businesses with ideal workplace lactation policies
2021-2025: NPM – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months - BF

Measure Status:	Active
Goal:	To increase the percent of BFWH-designated businesses with ideal workplace lactation policies
Definition:	<table><tr><td>**Unit Type:**</td><td>Percentage</td></tr><tr><td>**Unit Number:**</td><td>100</td></tr><tr><td>**Numerator:**</td><td>Number of Breastfeeding Welcomed Here (BFWH)-designated businesses with ideal workplace lactation policies</td></tr><tr><td>**Denominator:**</td><td>Number of Breastfeeding Welcomed Here (BFWH)-designated businesses</td></tr></table>
Data Sources and Data Issues:	BFWH Tracking Spreadsheet
Evidence-based/informed strategy:	Re-enforce lactation policies that positively influence breastfeeding practices in the workplace.
Significance:	Lack of lactation support in the workplace continues to be a significant barrier for mothers returning to work. Breastfeeding initiation and duration rates tend be higher in in workplaces that have developed lactation policies, offer breastfeeding support programs, and designated spaces for mothers to breastfeed or express milk.

2021-2025: ESM BF.3 - Recognition process implemented for Breastfeeding Welcomed Here (BFWH)-designated businesses
2021-2025: NPM – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months - BF

Measure Status:	Active
Goal:	To implement a recognition process for BFWH-designated businesses with lactation workplace policies for employees.
Definition:	**Unit Type:** Text **Unit Number:** Yes/No **Numerator:** Implement recognition process for Breastfeeding Welcomed Here (BFWH)-designated businesses with lactation workplace policies for employees **Denominator:**
Data Sources and Data Issues:	FHW Program data
Significance:	Lack of lactation support in the workplace continues to be a significant barrier for mothers returning to work. BFWH businesses that have ideal workplace lactation policies will be recognized to celebrate businesses with policies and practices that seek support working mothers.

2021-2025: ESM SS.1 - Percent of hospitals receiving national recognition or implementing approved safe sleep policy
2021-2025: NPM – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding D) Percent of infants room-sharing with an adult during sleep - SS

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase the number of hospitals teaching parents to place infants in a safe sleep environment.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of birthing hospitals (1) recognized as a National Cribs for Kids certified hospital or with an approved safe sleep policy, and (2) submitting crib audit reports with ≤ 10% of infants being found in an unsafe sleep environment</td></tr>
<tr><td>Denominator:</td><td>Number of birthing hospitals in Tennessee</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Family Health and Wellness tracking tool</td></tr>
<tr><td>Significance:</td><td>The infant sleep behaviors modeled by hospital staff after birth have been shown to be important in determining the practices new parents adopt when returning home. Because of this highly influential role, it is key to ensure that all birthing hospitals in Tennessee are exemplifying proper safe sleep behaviors and demonstrating to parents that babies should sleep alone, on their back, and in a crib, bassinet, or pack n’ play. By increasing the number of hospitals that meet this standard, we can increase the number of Tennessee parents who benefit from a positive example of safe sleep and, by extension, the number who continue to put their infant to sleep safely at home.</td></tr>
</table>

2021-2025: ESM SS.2 - Number of diaper bags with safe sleep educational materials distributed
2021-2025: NPM – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding D) Percent of infants room-sharing with an adult during sleep - SS

Measure Status:	Active
Goal:	Increase the number of diaper bags with safe sleep educational materials that have been distributed
Definition:	**Unit Type:** Count **Unit Number:** 2,000 **Numerator:** Number of safe sleep diaper bags that have been distributed **Denominator:**
Data Sources and Data Issues:	REDCap CHANT and EBHV data collection tools
Significance:	The Safe Sleep Diaper Bag Project was created in 2018 to provide EBHV participants with 1) standardized safe sleep education from their home visitor and 2) a diaper bag containing materials with safe sleep messaging. In 2019, the project was expanded to also include participants of the CHANT program. Diaper bags include several useful materials to aid in safe sleep including a onesie, sleep sack, safe sleep door hanger, Sleep Baby Safe and Snug book, Calm Baby Gently book, and nightlight. As of July 2021, over 1600 safe sleep diaper bags have been distributed to EBHV and CHANT caregivers. When asked by their home visitor whether the items in the diaper bag had caused them to change how they put their infant to sleep, 35 percent of EBHV recipients and 53 percent of CHANT recipients reported making a change. Going forward, Tennessee aims to continue to increase the total number of EBHV and CHANT clients who receive the safe sleep diaper bag, particularly in areas with historically high rates of sleep-related infant death. Evaluation data collected so far demonstrate that substantial percentages of caregivers report that the bag was useful in causing them to adopt the recommended safe sleep practices for their infant, validating Tennessee’s effort to increase the project’s reach as much as possible throughout the state.

2021-2025: ESM PA-Child.2 - Percentage of TN counties in which trainings related to mental health and physical health have occurred
2021-2025: NPM – Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day - PA-Child

Measure Status:	Active
Goal:	Collaborate with DOE to increase the number of counties receiving professional learning opportunities that connect mental health and physical health for PHEs and Health Councils, and youth (i.e., trauma-informed care, Youth Mental Health 1st Aid trai
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of counties receiving training, resources, and tools to promote the connection between mental health and physical health **Denominator:** Total number of TN counties (n=95)
Data Sources and Data Issues:	Reduce the proportion of children and adolescents with obesity — NWS04 Increase interprofessional prevention education in health professions training programs — ECBPD08 Increase the proportion of children and adolescents who get preventive mental health care in school — EMCD06
Evidence-based/informed strategy:	Support school-based efforts to promote physical activity and good nutrition
Significance:	There is a synergistic relationship between good mental health and physical health. For example, physical activity promotes healthy weight as well as good mental health. Trusted county professionals and organizations, such as PHEs, health councils, local schools, and youth groups, are a key channel for raising awareness of the connection between mental health and physical health. TDH can support these professionals and groups with evidence-based training, technical assistance, and other resources. Values for this measure will be simple counts derived from program reports and tracking databases that are being developed.

2021-2025: ESM PA-Child.4 - Percent of LHD primary care clinics writing HPHP prescriptions annually
2021-2025: NPM – Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day - PA-Child

Measure Status:	Active
Goal:	To increase the percentage of LHD primary care clinics writing HPHP prescriptions annually.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of LHD primary care clinics writing HPHP prescriptions **Denominator:** Total number of LHD primary care clinics
Data Sources and Data Issues:	NWS-04: Reduce the proportion of children and adolescents with obesity; PA-09: Increase the proportion of children who do enough aerobic physical activity
Evidence-based/informed strategy:	Community Health Services (CHS) - list or map of LHD primary care clinics; TDH electronic health records (Provider Rx); No known data issues
Significance:	Regular physical activity among children is a critical component to maintaining healthy weight or losing excess weight. The HPHP provides an easy and fun way for people to use state parks to remain active, and the program provides incentives for participation as well. Electronic health records show provider referrals from the West region are low as compared to other TDH regions. Increasing provider referrals from TDH clinics in the West region will promote physical activity. Values will derive from the number of LHD primary clinics writing HPHP prescriptions.

2021-2025: ESM PA-Child.5 - Number of Healthy Parks Healthy Person prescriptions written
2021-2025: NPM – Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day - PA-Child

Measure Status:	Active
Goal:	Increase the number of TN Healthy Parks Health Person (HPHP) prescriptions written
Definition:	**Unit Type:** Count **Unit Number:** 850 **Numerator:** Number of TN Healthy Parks Health Person (HPHP) prescriptions written **Denominator:**
Data Sources and Data Issues:	TDH EHR tracking of HPHP prescription check off box. This check off box has not yet been incorporated into the TDH EHR template.
Significance:	Studies have shown that when a doctor or other health care provider writes a prescription or recommends a certain course of action or behavior to a patient, the patient's likelihood of adopting that behavior increases tremendously. In that regard, there has been good success thus far with the HPHP prescription program encouraging patients to download and use the HPHP app. Values will derive from the number of times the TDH EHR system shows that the HPHP prescription program was used with a patient, provided that a check off box is developed for the system.

2021-2025: ESM PA-Child.6 - Percentage of TN counties with completed built environment projects
2021-2025: NPM – Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day - PA-Child

Measure Status:	Active
Goal:	Increase the number of school and community based physical activity clubs or completed built environment projects
Definition:	**Unit Type:** Count **Unit Number:** 812 **Numerator:** Number of physical activity clubs or completed built environment projects **Denominator:**
Data Sources and Data Issues:	The CDHP/OPP tracking database of physical activity clubs and the OPP and Project Diabetes tracking databases of completed built environment projects. Historically, it has been difficult to determine what PA clubs are current and/or still active.
Significance:	Physical activity clubs and community built environment projects increase both access to and availability of physical activity opportunities in the community. Clubs have the additional benefit and reinforcement of being a fun, group activity. Values will be simple counts of the number of such clubs and projects as reported to TDH through LHDs and other sources.

2021-2025: ESM PA-Child.7 - Percent of eligible venues offering the Double Up Food Bucks Program
2021-2025: NPM – Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day - PA-Child

Measure Status:	Active
Goal:	To increase the percentage of eligible venues (e.g., farmers' markets and farmers' stores) in counties targeted by Nourish Knoxville that offer the Double Up Food Bucks Program.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of eligible venues in targeted counties that offer the Double Up Food Bucks Program **Denominator:** Total number of eligible venues in targeted counties
Data Sources and Data Issues:	Nourish Knoxville tracking database and program reports related to eligible venues and the reach of the Double Up Food Bucks Program in targeted counties (currently six); no known data issues
Significance:	The consumption of healthier foods, especially fruits and vegetables, and healthier beverages is critical to maintaining or achieving healthy weight. Studies have shown that accessibility of healthy food choices influences healthy eating patterns. Concerted community planning and action among a diversified network of partners is critical to addressing low food security and increasing availability, access, affordability, and consumption related to healthier food and beverage options. Farmers' markets and farmers' stores, the TN Department of Health, the TN Department of Human Services (SNAP), and organizations such as Nourish Knoxville are key stakeholders in this effort. Partnerships can leverage shared resources in an effective and efficient manner. Values for this measure will be a simple list and number of eligible venues and the number of those venues offering the Double Up Food Bucks Program.

2021-2025: ESM PA-Child.9 - Percent of families with improved protective factors score
2021-2025: NPM – Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day - PA-Child

Measure Status:	Active
Goal:	To increase the percentage of families who have an improved protective factors score
Definition:	<table><tr><td>**Unit Type:**</td><td>Percentage</td></tr><tr><td>**Unit Number:**</td><td>100</td></tr><tr><td>**Numerator:**</td><td>Number of families enrolled in home visiting with an improved protective factors score at the time of reporting</td></tr><tr><td>**Denominator:**</td><td>Number of families enrolled in home visiting during the reporting year who have at least one protective factors score</td></tr></table>
Data Sources and Data Issues:	EBHV REDCAP Data Collection System, Annual Protective Factors Survey
Significance:	Protective factors are characteristics of strong parenting skills that reduce the effects of toxic stress and build resiliency in children. Protective factors have been shown to be essential in preventing ACES. Examples of protective factors include a parenting relationship that promotes literacy through healthy conversation and dedicated time to reading with an adult. A core activity of home visiting curriculum seeks to support parents in building resiliency for their families. This measure will demonstrate the capacity of home visiting to increase protective factors in families. Centers for Disease Control and Prevention, Kaiser Permanente. The ACE Study Survey Data [Unpublished Data]. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention; 2016. Healthy People 2020 [Internet]. Washington, DC: U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion [cited 06/18/20]. Kidcentral TN. “Adverse Childhood Experience: Protective Factors”. https://www.kidcentraltn.com/support/crisis-services-for-children/adverse-childhood-experience--protective-factors.html [accessed 06/19/20].

2021-2025: ESM PA-Child.10 - Percent of families enrolled in CHANT care coordination who partially or fully complete pathways identified
2021-2025: NPM – Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day - PA-Child

Measure Status:	Active
Goal:	To increase the number of families enrolled into CHANT care coordination who partially or fully complete pathways identified
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of enrolled families + families that exit and fully or partially complete pathways **Denominator:** Total number of referrals received
Data Sources and Data Issues:	CHANT REDCap Database Limitation(s): 1) includes only participants of CHANT in the state, 2) in any given reporting period, the numerator and denominator may not include the same sample since the receipt of services can take place in a different reporting period than the referral.
Significance:	Health status and related health behaviors are determined by influences at multiple levels: personal, organizational/institutional, environmental, and policy. Because significant and dynamic interrelationships exist among these different levels of health determinants, educational and community-based programs are most likely to succeed in improving health and wellness when they address influences at all levels and in a variety of environments/settings.

2021-2025: ESM PA-Child.11 - Proportion of local education agencies (LEA) offered professional development on improving/maintaining moderate to vigorous physical activity in PE
2021-2025: NPM – Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day - PA-Child

Measure Status:	Active
Goal:	Increase the percentage of LEAs offered professional development on improving/maintaining moderate to vigorous physical activity in PE.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of LEAs offered PD on improving/maintaining moderate to vigorous physical activity in PE **Denominator:** Number of LEAs Statewide
Data Sources and Data Issues:	TDE added a question to their 2023 District Application survey to capture this information. There are no known data issues.
Evidence-based/informed strategy:	1) The number of local education agencies offering professional development on improving/maintaining moderate to vigorous physical activity in physical education. 2) Healthy People 2030 Objectives: Reduce the proportion of children and adolescents with obesity — NWS04 Increase the proportion of children who do enough aerobic physical activity — PA09 3) By increasing vigorous to moderate activity minutes increase in PE classes, then so will the percentage of kids 6-11 being physically active for at least 60 minutes per day
Significance:	Direct professional development and technical assistance among school and LEA staff is essential to producing opportunities to increase both physical education and physical activity within the school setting. Values will be simple counts of LEAs offered professional development divided by the total number of LEAs statewide.

2021-2025: ESM WWV.2 - Percent of family planning encounters that occur via telehealth
2021-2025: NPM – Percent of women, ages 18 through 44, with a preventive medical visit in the past year - WWV

Measure Status:	Active
Goal:	To increase the percentage of family planning encounters that occur via telehealth.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of family planning encounters occurring via telehealth **Denominator:** Total number of family planning encounters
Data Sources and Data Issues:	Tennessee Department of Health's Patient Tracking Billing Management Information System (PTBMIS).
Evidence-based/informed strategy:	Increase rural access to family planning services through telehealth.
Significance:	There are many barriers to accessing health care services, especially among poor and rural populations. These include lack of transportation, long travel distances, lack of childcare, and lack of sick leave. Providing family planning services via telehealth is one way to address these barriers and help clients access needed services.

2021-2025: ESM WWV.3 - Number of women receiving patient navigation for women's health services
2021-2025: NPM – Percent of women, ages 18 through 44, with a preventive medical visit in the past year - WWV

Measure Status:	Active
Goal:	To increase the number of women receiving patient navigation for women's health services
Definition:	<table><tr><td>**Unit Type:**</td><td>Count</td></tr><tr><td>**Unit Number:**</td><td>3,000</td></tr><tr><td>**Numerator:**</td><td>Number of women receiving patient navigation services</td></tr><tr><td>**Denominator:**</td><td></td></tr></table>
Data Sources and Data Issues:	To be determined (possibly electronic health record data or data collected via REDCap)
Evidence-based/informed strategy:	Increase access to women's health services by addressing and eliminating barriers to care through client navigation.
Significance:	Patient navigators are individuals whose primary responsibility is to provide personalized guidance to patients as they move through the health care system. Navigators can help remove barriers to care, foster patient autonomy and provide patients with information that enhances their ability to make appropriate health care choices and/or receive medical care with an enhanced sense of confidence about risks, benefits and responsibilities. Potential benefits of patient navigation include improved health outcomes, increased patient satisfaction, decreased no-show rates and reduced challenges in care.

2021-2025: ESM WWV.4 - Percent of births covered by hospitals implementing data-driven, clinical recommendations
2021-2025: NPM – Percent of women, ages 18 through 44, with a preventive medical visit in the past year - WWV

Measure Status:	Active
Goal:	To implement trainings at the facility level on patient safety recommendations to prevent maternal death.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of hospital births state-wide covered by facilities implementing data-driven, clinical recommendations from MMRIA data **Denominator:** Number of hospital state-wide births
Data Sources and Data Issues:	MMR Program Notes
Evidence-based/informed strategy:	Hospital Education: Provide training to hospitals on top causes of maternal death as identified by MMRC
Significance:	Documents (including infographics) on challenges in maternal health shows the gap in interventions and areas of need. These documents will also inform the public and stakeholders in maternal health on populations and health conditions that need tailored interventions.

2021-2025: ESM WWV.8 - Percent of recommendations with who/what/when components
2021-2025: NPM – Percent of women, ages 18 through 44, with a preventive medical visit in the past year - WWV

Measure Status:	Active
Goal:	To provide recommendation for preventing maternal deaths
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Recommendations with who/what/when components **Denominator:** Number of recommendations
Data Sources and Data Issues:	Maternal Mortality Review Information Application (MMRIA)
Significance:	Recommendations from the MMRC provide actionable plans in preventing future maternal deaths. This measure is important to determine the domain of recommendation for prevention of maternal death.

2021-2025: ESM SMK-Household.1 - Number of tobacco-free sports teams
2021-2025: NPM – Percent of children, ages 0 through 17, who live in households where someone smokes - SMK-Household

Measure Status:	Active
Goal:	To support smoke free environments as the social norm
Definition:	**Unit Type:** Count **Unit Number:** 400 **Numerator:** Sports teams making initial tobacco-free pledge **Denominator:**
Data Sources and Data Issues:	Tennessee Tobacco Control Program data
Significance:	The measure is significant in that it underlies the social norm change affected by youth leaders publicly pledging to their school, peers, and community to be tobacco free. The number of sports teams taking the tobacco-free pledge will consist of sports teams which are making their initial pledge (excluding re-pledges in subsequent years).

2021-2025: ESM SMK-Household.2 - Number of social media posts promoting text-based cessation services
2021-2025: NPM – Percent of children, ages 0 through 17, who live in households where someone smokes - SMK-Household

Measure Status:	Active
Goal:	To increase youth tobacco cessation.
Definition:	**Unit Type:** Count **Unit Number:** 40 **Numerator:** Number of social media posts promoting text-based cessation services **Denominator:**
Data Sources and Data Issues:	Tobacco Control Program data
Significance:	Cessation-supporting text services have been shown to be effective for youth and young adults who are experimenting with or currently using tobacco products. TDH and partner promotions of these services through social media aims to increase text service utilization.

2021-2025: ESM SMK-Household.3 - Number of anti-tobacco social media posts
2021-2025: NPM – Percent of children, ages 0 through 17, who live in households where someone smokes - SMK-Household

Measure Status:	Active
Goal:	To decrease youth tobacco use.
Definition:	**Unit Type:** Count **Unit Number:** 700 **Numerator:** Number of social media posts to TDH and TNSTRONG social media accounts **Denominator:**
Data Sources and Data Issues:	TDH Communications Office will track the number of anti-tobacco focused social media posts via Facebook, Twitter, and Instagram using designated hashtags.
Significance:	Anti-tobacco messaging is another cornerstone of tobacco control efforts and impacts the rate at which youth experiment with and initiate smoking and tobacco use. Social media's influence and pervasiveness among adolescents enables TUPCP and youth advocates to reach the target population more effectively.

2021-2025: ESM SMK-Household.4 - Number of youth who attend the state anti-tobacco conference trainings
2021-2025: NPM – Percent of children, ages 0 through 17, who live in households where someone smokes - SMK-Household

Measure Status:	Active
Goal:	Decrease tobacco use among youth through peer-to-peer intervention and youth advocates for anti-tobacco policy.
Definition:	**Unit Type:** Count **Unit Number:** 450 **Numerator:** Youth attendees at annual TNSTRONG conference/trainings **Denominator:**
Data Sources and Data Issues:	Tobacco Control Program - TNSTRONG Attendee Registration system
Significance:	TNSTRONG attendees, similar to ambassadors, are trained on peer-to-peer interventions and policy change, and are an essential component to reaching and influencing youth throughout Tennessee. TNSTRONG youth attendees are defined as school-aged individuals who attend the TNSTRONG event in their capacity as students (as opposed to presenters or chaperones).

2021-2025: ESM SMK-Household.5 - Number of ambassadors recruited
2021-2025: NPM – Percent of children, ages 0 through 17, who live in households where someone smokes - SMK-Household

Measure Status:	Active
Goal:	Decrease tobacco use among youth through peer-to-peer intervention and youth advocates for anti-tobacco policy.
Definition:	**Unit Type:** Count **Unit Number:** 26 **Numerator:** Number of ambassadors recruited **Denominator:**
Data Sources and Data Issues:	Tobacco Control Program data
Significance:	Youth who are recruited to serve as TNSTRONG ambassadors represent an important component of the TCP's efforts to reach and influence local youth. Ambassadors are often leaders within their schools and communities and are trained on peer-to-peer intervention and policy change. The number of ambassadors recruited will be tracked annually and will consist of the total number of ambassadors inclusive of those in their second year (of a two year cycle).

2021-2025: ESM SMK-Household.6 - Percent of eligible women who enroll in Baby and Me Tobacco Free
2021-2025: NPM – Percent of children, ages 0 through 17, who live in households where someone smokes - SMK-Household

Measure Status:	Active
Goal:	Increase percent of eligible women who enroll in Baby and Me Tobacco
Definition:	<table><tr><td>**Unit Type:**</td><td>Percentage</td></tr><tr><td>**Unit Number:**</td><td>100</td></tr><tr><td>**Numerator:**</td><td>Number of women enrolled in Tennessee's Prenatal Smoking Cessation Program for the state fiscal year</td></tr><tr><td>**Denominator:**</td><td>Number of women who gave birth during the state fiscal year who reported smoking during the third trimester of pregnancy (from birth certificate data)</td></tr></table>
Data Sources and Data Issues:	Vital Statistics birth statistical file
Evidence-based/informed strategy:	Reduce infant deaths due to prematurity and low birthweight by reducing infant exposure to tobacco
Significance:	Smoking during pregnancy increases the risk of preterm birth, low birth weight, and birth defects of the mouth and lip in developing infants. Tennessee's rates of prenatal smoking are nearly two times that of the nation as a whole and significant differences exist by race/ethnicity and place, with higher rates seen for Non-Hispanic White women and those in the eastern part of the state. Tennessee's Prenatal Smoking Cessation Program is an evidence-based smoking cessation program which uses education, support, carbon monoxide monitoring and incentives (vouchers for diapers and wet wipes) to encourage and support abstinence from cigarette smoking. Studies have demonstrated that infants of women who receive psychosocial interventions for prenatal smoking cessation have a lower risk of low birthweight, and neonatal intensive care unit (NICU) admission. Reducing the percentage of Tennessee pregnant women who smoke during pregnancy is critically important to reducing the rate of poor birth outcomes and preterm-related infant mortality.

Form 11
Other State Data

State: Tennessee

The Form 11 data are available for review via the link below.

Form 11 Data

Form 12
Part 1 – MCH Data Access and Linkages

State: Tennessee

Annual Report Year 2024

	Access				Linkages	
Data Sources	(A) State Title V Program has Consistent Annual Access to Data Source	(B) State Title V Program has Access to an Electronic Data Source	(C) Describe Periodicity	(D) Indicate Lag Length for Most Timely Data Available in Number of Months	(E) Data Source is Linked to Vital Records Birth	(F) Data Source is Linked to Another Data Source
1) Vital Records Birth	Yes	Yes	More often than monthly	0		
2) Vital Records Death	Yes	Yes	More often than monthly	0	Yes	
3) Medicaid	No	No	Never	NA	No	
4) WIC	Yes	Yes	Daily	0	Yes	
5) Newborn Bloodspot Screening	Yes	Yes	Daily	0	Yes	
6) Newborn Hearing Screening	Yes	Yes	Daily	0	Yes	
7) Hospital Discharge	Yes	Yes	Quarterly	6	Yes	
8) PRAMS or PRAMS-like	Yes	Yes	Annually	18	Yes	

Form Notes for Form 12:

None

Field Level Notes for Form 12:

None

Form 12
Part 2 – Products and Publications (Optional)

State: Tennessee

Annual Report Year 2024

Products and Publications information has not been provided by the State.