



HRSA

Health Resources & Services Administration



Title V MCH Block Grant Program

TENNESSEE

State Snapshot

FY 2020 Application / FY 2018 Annual Report

November 2019

Title V Federal-State Partnership - Tennessee

The Title V Maternal and Child Health Block Grant Program is a federal-state partnership with 59 states and jurisdictions to improve maternal and child health throughout the nation. This Title V Snapshot presents high-level data and the executive summary contained in the FY 2020 Application / FY 2018 Annual Report. For more information on MCH data, please visit the Title V Federal-State Partnership website (<https://mchb.tvisdata.hrsa.gov>)

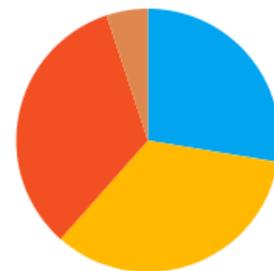
State Contacts

MCH Director	CSHCN Director	State Family or Youth Leader
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Funding by Source

Source	FY 2018 Expenditures
Federal Allocation	\$11,817,625
State MCH Funds	\$14,525,370
Local MCH Funds	\$0
Other Funds	\$14,278,869
Program Income	\$2,180,291

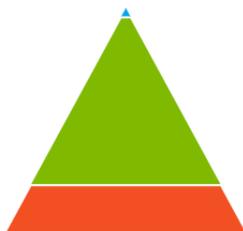
FY 2018 Expenditures



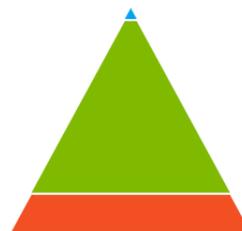
Funding by Service Level

Service Level	Federal	Non-Federal
Direct Services	\$427,333	\$1,403,169
Enabling Services	\$8,873,446	\$22,391,178
Public Health Services and Systems	\$2,516,846	\$5,009,892

FY 2018 Expenditures
Federal



FY 2018 Expenditures
Non-Federal



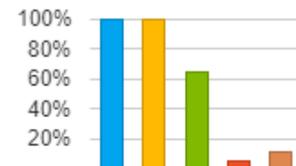
Percentage Served by Title V

Population Served	Percentage Served	FY 2018 Expenditures
■ Pregnant Women	100.0%	\$435,471
■ Infants < 1 Year	100.0%	\$2,264,953
■ Children 1 through 21 Years	64.0%	\$10,148,707
■ CSHCN (Subset of all Children)	5.0%	\$7,093,338
■ Others *	11.0%	\$17,524,066

FY 2018 Expenditures
Total: \$37,466,535



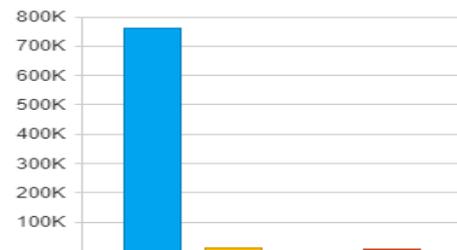
FY 2018 Percentage Served



*Others– Women and men, over age 21.

Communication Reach

Communication Method	Amount
■ State Title V Website Hits:	761,821
■ State Title V Social Media Hits:	11,971
■ State MCH Toll-Free Calls:	15
■ Other Toll-Free Calls:	6,223



Selected National Performance Measures

Measure #	Measure Short Name	Reporting Domain(s)
NPM 1	Well-Woman Visit	Women/Maternal Health
NPM 5	Safe Sleep	Perinatal/Infant Health
NPM 6	Developmental Screening	Child Health
NPM 7	Injury Hospitalization	Child Health, Adolescent Health
NPM 8	Physical Activity	Child Health, Adolescent Health
NPM 11	Medical Home	Children with Special Health Care Needs
NPM 12	Transition	Children with Special Health Care Needs
NPM 14	Smoking	Women/Maternal Health, Child Health

Evidence-Based or –Informed Strategy Measures

NPM #	NPM Short Name	ESM #	ESM Title
NPM 1	Well-Woman Visit	ESM 1.1	Number of press releases, PSAs and/or social media messages promoting preventive health care visits for women of reproductive age
NPM 1	Well-Woman Visit	ESM 1.2	Number of webinars for providers on increasing preventive care visits among women in their clinics
NPM 1	Well-Woman Visit	ESM 1.3	Number of site-level family planning utilization reports distributed to local health departments
NPM 1	Well-Woman Visit	ESM 1.4	Number of region-level pregnancy-related service utilization reports distributed to regional health departments
NPM 5	Safe Sleep	ESM 5.1	Number of safe sleep educational material distributed
NPM 5	Safe Sleep	ESM 5.2	Percent of infant deaths to be reviewed by child fatality review teams
NPM 5	Safe Sleep	ESM 5.3	Percent of VLBW (Very Low Birth Weight) infants being delivered at Level III or IV birthing facilities
NPM 5	Safe Sleep	ESM 5.4	Percent of newborns with a positive metabolic screen who receive follow-up to definitive diagnosis and clinical management
NPM 5	Safe Sleep	ESM 5.5	Number of individuals served by the Tennessee Adolescent Pregnancy Prevention Program (TAPPP)
NPM 6	Developmental Screening	ESM 6.1	Number of unique page views to the Developmental Milestones and Developmental Screenings kidcentraltn.com sites
NPM 6	Developmental Screening	ESM 6.2	Number of health department nurses trained in the START Autism and MCHAT-R/F program
NPM 6	Developmental Screening	ESM 6.3	Percent of Developmental Screenings performed across the state for participants enrolled in an Evidence-Based Home Visiting Program
NPM 7.1	Injury Hospitalization Ages 0 through 9	ESM 7.1.1	Number of parents and caregivers receiving car seat education
NPM 7.1	Injury Hospitalization Ages 0 through 9	ESM 7.1.2	Number of counties that adopt Count It! Drop It! Lock It! educational programs
NPM 7.1	Injury Hospitalization Ages 0 through 9	ESM 7.1.3	Percent of families who receive injury prevention education through the AAP checklist among families participating in Evidence Based Home Visiting programs
NPM 7.2	Injury Hospitalization Ages 10 through 19	ESM 7.2.1	Number of schools in the top ten crash rate counties (among ages 15-18) that conduct evidence-informed teen safe driving programming
NPM 7.2	Injury Hospitalization Ages 10 through 19	ESM 7.2.2	Number of drug disposal bins installed statewide
NPM 7.2	Injury Hospitalization Ages 10 through 19	ESM 7.2.3	Number of press releases, social media posts and presentations about adolescent falls

NPM 7.2	Injury Hospitalization Ages 10 through 19	ESM 7.2.4	Number of suicide-related articles, social media posts and trainings provided by TDH
NPM 8.1	Physical Activity Ages 6 through 11	ESM 8.1.1	Number of Gold Sneaker-recognized childcare facilities in Tennessee
NPM 8.1	Physical Activity Ages 6 through 11	ESM 8.1.2	Average number of monthly calls to the Tennessee Breastfeeding Hotline (TBH)
NPM 8.1	Physical Activity Ages 6 through 11	ESM 8.1.3	Number of Baby Friendly-designated Tennessee birthing hospitals
NPM 8.2	Physical Activity Ages 12 through 17	ESM 8.2.1	Number of Physical Activity Clubs in K-12 schools
NPM 8.2	Physical Activity Ages 12 through 17	ESM 8.2.2	Number of school gardens in Tennessee public schools
NPM 8.2	Physical Activity Ages 12 through 17	ESM 8.2.3	Number of Healthy Parks Healthy Person app users
NPM 11	Medical Home	ESM 11.1	Number of providers trained and provided information on medical home implementation
NPM 11	Medical Home	ESM 11.2	Number of families that receive patient centered medical home training
NPM 11	Medical Home	ESM 11.3	Percentage of children served by the Children's Special Service (CSS) program receiving services in a medical home
NPM 11	Medical Home	ESM 11.4	Number of children referred from the Tennessee Birth Defects Surveillance System (TNBDSS) program that were linked to appropriate supportive services
NPM 12	Transition	ESM 12.1	Number of adolescents on the Adolescent Advisory Council
NPM 12	Transition	ESM 12.2	Number of providers who receive technical assistance and information on transition for youth and young adults with and without special health care needs
NPM 12	Transition	ESM 12.3	Percentage of youth served by the Children's Special Services (CSS) program age 14 and older who have an annual transition plan
NPM 12	Transition	ESM 12.4	Number of youths and parents/legal guardians who have completed the Transition Readiness Assessment tool
NPM 14.1	Smoking Pregnancy	ESM 14.1.1	Number of reproductive-aged female tobacco users (15-44 years) who received online or phone counseling services through the Tennessee Tobacco Quitline.
NPM 14.2	Smoking Household	ESM 14.2.1	Number of child care facilities that voluntarily implement a tobacco-free campus policy
NPM 14.2	Smoking Household	ESM 14.2.2	Percent of primary caregivers enrolled in home visiting who reported using any tobacco products at enrollments and were referred to tobacco cessation counseling or services within three months of enrollment

State Performance Measures

SPM #	SPM Title	Reporting Domain(s)
SPM 1	Percentage of children ages 0-17 experiencing two or more adverse childhood experiences	Child Health
SPM 2	Percentage of infants born to Tennessee resident mothers who initiate breastfeeding	Child Health
SPM 3	Percent of live births that were the result of an unintended pregnancy	Women/Maternal Health

Executive Summary

Program Overview

Needs Assessment

At the beginning of a new five year grant cycle, states are required to conduct a comprehensive needs assessment to identify priority needs of the maternal and child population and to determine the capacity of the public health system to meet those needs. During the years between the comprehensive needs assessments, states are expected to conduct on-going needs assessments in order to identify any significant changes in needs and capacity.

The Tennessee Department of Health (TDH) conducted the Needs Assessment for the 2016-2020 cycle during 2014/15 in conjunction with over 70 MCH (maternal and child health) stakeholders. Key components of the Needs Assessment included:

- Broad community input through 26 focus groups and 5 community meetings across Tennessee. The groups consisted of key MCH populations, including: health department consumers, under-represented minorities, families with young children, families of children and youth with special health care needs, and healthcare providers.
- Quantitative analysis of more than 160 key indicators of the MCH population.
- Synthesis of input and priority-setting by MCH stakeholder group.

As a part of the ongoing needs assessment, the state hosts MCH stakeholder meetings twice each year. These meetings are open to anyone, and effort is made to extend the invitation broadly. During the meetings, participants are asked to consider the progress made on performance measures during the past year, and then based on that evaluation make recommendations for the next year's action plan.

Needs and Priorities

States are required to identify at least one priority in each of the population health domains, except for the Cross-cutting/Systems Building domain which is optional. There are a total of six domains:

- Women's and Maternal Health
- Perinatal and Infant Health
- Child Health
- Adolescent Health
- Children with Special Health Care Needs
- Cross-cutting/Systems Building

As a result of the Needs Assessment, TDH identified priority needs for the MCH population for the 2016-2020 Block Grant cycle. These priorities include:

- Improve utilization of preventive care for women of childbearing age.
- Reduce infant mortality.
- Increase the number of infants and children receiving a developmental screen.
- Reduce the number of children and adolescents who are overweight/obese.
- Reduce the burden of injury among children and adolescents.
- Reduce the number of children exposed to adverse childhood experiences (ACEs).
- Increase the number of children (both with and without special health care needs) who have a medical home.
- Increase the number of children (with and without special health care needs) who receive services necessary to make transitions to adult health care.
- Reduce exposure to tobacco among the MCH population (pregnancy smoking and secondhand smoke exposure for children).

Program Planning

The MCH/Title V Program is managed within the Tennessee Department of Health's Division of Family Health and Wellness. This division includes sections for:

- Reproductive and Women's Health
- Perinatal, Infant, and Pediatric Care
- 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

The variety of MCH content areas in FHW pairs well with the subject areas of this grant. Therefore, each priority has a team within FHW that consists of at least one program and one epidemiology staff member. Teams are responsible for developing and reporting on the action plan and corresponding measures. This is done in conjunction with the MCH Stakeholder Group. This group was formed during the last needs assessment and has met twice a year since then. The group reviews the action plan and measurement progress, and suggests changes for the coming year. They also partner with the MCH/Title V Program to complete the activities

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

Performance Reporting

The epidemiology staff for each priority team takes the lead on tracking and reporting on each measure. The MCH Block Grant coordinator 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 Stakeholder group) to view the overall progress made among all priorities.

Assuring Comprehensive, Coordinated, Family-Centered Services

The MCH/Title V Program assures comprehensive and coordinated services in a number of ways. Core services such as WIC, family planning, breast and cervical cancer screening, preventive care for children (EPSDT and immunizations), health promotion, community outreach and the care coordination services of Help Us Grow Successfully (HUGS) and Children's Special Services (CSS) are offered in all county health departments. Rural health departments report to regional office and to the Community Health Services (CHS) division of the state health department. Metro health departments are independent and accountable to local governments but operate closely via contract with TDH. This organizational structure assures that Title V and other state and federal funds are administered comprehensively to all 95 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 directors to assure multi-directional transmission of key information and provide opportunities for sharing of ideas. Other core Title V services such as newborn screening provide services to the entire state but are centrally located at the state lab to assure excellent communication between the lab and the FHW clinical follow up team for lead, genetic disorders, hearing loss, and congenital heart disease.

The MCH/Title V Program continues to work with families to assure comprehensive coordinated family-centered services by providing education around the importance of receiving services in a patient-centered medical home, and how to partner with providers in the decision making process. The program provides the "Partnering with your Provider Booklet" statewide for distribution at community events, as well as medical providers for distribution in their practices. Staff has also collaborated with the Bureau of TennCare, the state Medicaid agency, in their Primary Care Transformation Strategy "Patient-Centered Medical Home". There are currently over 85 participating provider organizations in over 500 locations, covering over 37% of the TennCare population.

For the MCH/Title V CYSHCN program specifically, staff include a dedicated Family/Youth Engagement and Involvement Director whose primary responsibility is to work with Family Voices to ensure opportunities for family and youth training on patient centered medical homes, transition and policy/advocacy. Title V funds have also been used to expand the division contract with family voices to provide consultation and training for all programs within FHW. In addition, several programs continue to expand their own advisory and family groups to better inform programs and services. For example, the Perinatal Advisory Committee (PAC) and Genetics Advisory Committee have always been open meetings, and recently family representatives have been sought out to attend those meetings. Likewise, the family planning program has 13 required community and client advisory boards in each rural and metro region. Additional input from reproductive justice groups has also been sought to review program guidelines and messaging around contraception and neonatal abstinence syndrome. Furthermore, in the comprehensive redesign of the CSS, HUGS, and Community Outreach programs into the streamlined Community Health Access and Navigation in Tennessee (CHANT) program has incorporated family engagement in the design process to assure that the needs of children and families are being met appropriately.

Partnerships

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

For example, a multitude of local, state, and national partnerships have emerged statewide regarding the opioid crisis and prevention of neonatal abstinence syndrome. In 2018, this resulted in the first year to year decline (14%) in cases reported to the NAS surveillance system since 2013. The NAS subcommittee met regularly from 2013-19 with representatives from TDH, Department of Mental Health and Substance Abuse (TDMHSA), Department of Education (DOE), Department of Children's Services (DCS), TennCare, Department of Human Services (DHS) and several others to review NAS surveillance data and research and to plan interventions together. TDH has partnered with the PAC, regional perinatal centers, rural hospitals, Tennessee Hospital Association and the Tennessee Initiative for Perinatal Quality Care (TIPQC) to share best practice and information regarding treatment of drug exposed mothers and infants. TDH is partnering closely with TennCare, TIPQC, and TDMHSAS in the multi-state Opioid Use Disorder, Maternal Outcomes, and Neonatal Abstinence Syndrome Initiative (OMNI) Learning Community. Much of this work has centered on supporting TIPQC in the roll out of maternal and neonatal quality bundles in the care of substance exposed mothers and infants. In addition, TDH has partnered with local drug coalitions, law enforcement, multiple state agencies and insurance companies to fund and promote medication take back sites in all 95 counties. The response to the opioid epidemic has been complex and growing, involving legislative action, law enforcement, regulation education, prevention messaging, and treatment.

Infant mortality reduction efforts have likewise relied extensively on partnerships. For example, DOE, DCS, EMS entities, the medical community, and the judicial system have been critical to maintaining the Child Fatality Review. Local review teams in all judicial districts serve on a volunteer basis and are essential to determining cause of death for infants and children. This data guides the priorities for the upcoming years, and the local review teams serve as bodies to dissemination information to local communities

as well. Given the lack of improvement in the infant mortality rate in the state, the infant mortality strategic plan was revised during this reporting year with the assistance of numerous partners including Tennessee Chapter of the American Academy of Pediatrics (TNAAP), TIPQC, the PAC, academic partners such as Vanderbilt University and Children's Hospital, the Children's Hospital Alliance of Tennessee, the Tennessee Breastfeeding Coalition, federally qualified health centers, MCH directors statewide, and community advocacy groups.

Obesity is likewise a complex problem requiring a multi-dimensional approach and many partnerships. DOE and the Office of Coordinated School Health partner in both data collection and programming for schools across the state. Obesity has also been a priority for the Governor's Children's Cabinet and the state agencies represented. Recognizing the importance of the built environment and culture change for obesity prevention, TDH has partnered with the Department of Environment and Conservation to promote state parks via the Park Rx and rewards program, the promotion of youth activity clubs, and training state park restaurants to become Responsible Epicurean Agricultural Leadership (REAL) food certified. TDH also coordinates with Governor's Foundation for Health and Wellness to promote Healthier Community designation and Healthier Tennessee business initiatives. Academic partners such as Middle Tennessee State University, East Tennessee State University, and Vanderbilt have also been critical for data analysis and program implementation across the state for efforts in both obesity reduction and tobacco prevention. The Department of Human Services has been instrumental in training child care facilities and assuring the inclusion of the seven Gold Sneaker policies regarding physical activity, nutrition, and tobacco were included in the star rating system for centers.

Leveraging of Federal and Non-Federal Funds

Aligning Title V funds within the Division of Family Health and Wellness allows for planning across programs to address population health priorities by leveraging both federal and state funds. This occurs for all priority areas. For example, reducing and mitigating the effect of ACEs is a priority area for Tennessee Title V since the most recent needs assessment, and activity around this topic has escalated dramatically over the last 5 years in all areas of the state. Title V state and federal funds have been used to support data collection and dissemination, workforce training of thousands of health department staff, and facilitation of multiple partnership meetings across the state. Assuring supportive infrastructure for families is essential to preventing ACEs, and FHW has an active role in this via WIC food security (federal), family planning (federal Title X, reimbursement, and state and federal MCH), investment in the built environment (state Project Diabetes and additional dedicated built environment funds). Positive youth development is promoted via federal rape prevention education funding, state and federal adolescent pregnancy prevention funding, and state funding for youth tobacco prevention councils in 86 counties. Specific programs in FHW also address social determinants of health, enhance parenting skills, and improve community linkages. These include state Healthy Start and federal MIECHV evidence based home visiting programs and the care coordination programs of HUGS and CSS. TDH also participates in several inter-agency and community partnerships targeting ACEs including the Children's Cabinet's "no wrong door" Single Team Single Plan approach to service coordination, the Three Branches Institute, the Young Child Wellness Council, and the Early Success Coalition via federally funded Project LAUNCH.

How Federal Title V Funds Support State MCH Efforts

MCH/Title V federal funds are essential to meet state and local needs in a manner that is intentional, flexible and accountable. States are held accountable for planning and progress in priority areas and must report how both state and federal funds are spent. A needs assessment occurs every five years and is updated annually by review of available data and input of stakeholders. Similarly, the action plan to address the needs with available state and federal resources and a wide range of partners is revised annually. Tennessee has consistently met both maintenance of effort and state funding match requirements of the federal MCH/Title V block grant, ensuring that both funding sources are utilized for MCH needs. The flexibility of the block grant is particularly critical to meet emerging needs when obtaining needed funding from annual appropriation cycles can be significantly delayed. Examples in recent years include the Zika response when MCH funded infrastructure for newborn screening had to be utilized for case management and core MCH programs such as family planning were critical for prevention. Additional CDC funds were used to enhance birth defects surveillance, a primary driver of infant mortality and an MCH priority. MCH and SSDI funds have been used to supplement birth defects efforts so that additional infrastructure and care coordination built with Zika funds could be sustained and expanded.

MCH Success Story

Community Health Access and Navigation in Tennessee (CHANT) is the TDH initiative to improve maternal and child health through enhanced family and community engagement, as well as medical and social service care coordination for all members of a family unit. It employs a screening to identify service needs and then delivers care coordination via sixteen potential pathways of care. Target populations include pregnant and postpartum adolescents and women, children birth to 21 years, and children and youth with special healthcare needs birth to 21 years. Families are assigned to a Care Coordinator to navigate, refer and follow-up on all services to minimize redundancy and burden on families with multiple needs. The average number of pathways for those currently enrolled is seven.

CHANT engagement is initiated by referral from internal and external public health programs, evidence-based home visiting programs, medical providers, self-referrals, targeted community outreach events, and those at moderate or high risk for infant mortality based on factors identified in their birth file. The goal of CHANT is to reduce infant mortality, maternal morbidity and mortality, Adverse Childhood Experiences (ACEs), as well as increase well child visit adherence, healthy behaviors, health access, personal economics, and education attainment. This program was made possible by weaving of Title V funds with additional state funding in order to impact high priority goals.

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

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

Provided below is a link to a document that lists the MCHB discretionary grant programs that are located in this state/jurisdiction for Fiscal Year 2018.

[List of MCHB Discretionary Grants](#)

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