HRSA
Health Resources & Services Administration

Title V MCH Block Grant Program

TENNESSEE

State Snapshot

FY 2021 Application / FY 2019 Annual Report

November 2020

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 2021 Application / FY 2019 Annual Report. For more information on MCH data, please visit the Title V Federal-State Partnership website (https://mchb.tvisdata.hrsa.gov)

State Contacts

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Funding by Source

Source	FY 2019 Expenditures
Federal Allocation	$11,449,081
State MCH Funds	$14,002,061
Local MCH Funds	$0
Other Funds	$0
Program Income	$1,853,003

FY 2019 Expenditures

Funding by Service Level

Service Level	Federal	Non-Federal
Direct Services	$738,880	$1,172,056
Enabling Services	$7,265,675	$10,646,523
Public Health Services and Systems	$3,444,526	$2,183,482

FY 2019 Expenditures Federal

FY 2019 Expenditures Non-Federal

Percentage Served by Title V

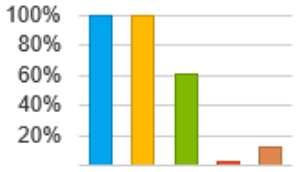
Population Served	Percentage Served	FY 2019 Expenditures
Pregnant Women	100.0%	$205,254
Infants < 1 Year	100.0%	$1,910,448
Children 1 through 21 Years	61.0%	$7,027,149
CSHCN (Subset of all Children)	3.0%	$5,878,853
Others *	12.0%	$9,736,230

*Others– Women and men, over age 21.

FY 2019 Expenditures

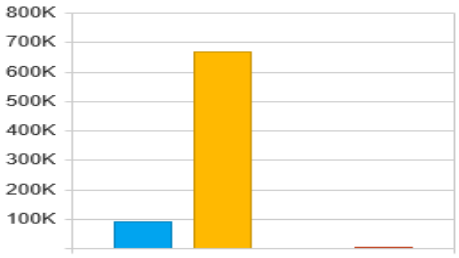
Total: $24,757,934

FY 2019 Percentage Served



Communication Reach

Communication Method	Amount
State Title V Website Hits:	91,724
State Title V Social Media Hits:	667,817
State MCH Toll-Free Calls:	0
Other Toll-Free Calls:	5,700



The Title V legislation directs States to conduct a comprehensive, statewide maternal and child Health (MCH) needs assessment every five years. Based on the findings of the needs assessment, states select seven to ten priority needs for programmatic focus over the five-year reporting cycle. The State Priorities and Associated Measures Table below lists the national and state measures the state chose in addressing its identified priorities for the 2020 Needs Assessment reporting cycle.

State Priorities and Associated Measures

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

Decrease pregnancy-associated mortality NPMs • NPM 1: Percent of women, ages 18 through 44, with a preventive medical visit in the past year SPMs • SPM 2: Percent of facilities implementing patient safety recommendations • SPM 3: Number of non-clinical Maternal Morality Review Committee (MMRC) recommendations implemented • SPM 4: Percent of staff reporting high or very high understanding of suicide warning signs post training • SPM 5: Percent of community level recommendations implemented SOMs • SOM 1: Rate of pregnancy-related mortality to live births • SOM 2: Number of pregnancy-associated, but not related, deaths • SOM 3: Rate of pregnancy-associated mortality	New	Women/Maternal Health
Increase breastfeeding NPMs • NPM 4: A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months SPMs • SPM 6: Percent of newborns who initiated breastfeeding • SPM 7: Percent of WIC infants breastfeeding at six months • SPM 8: Composite score of maternity care practices and policies	New	Perinatal/Infant Health
Decrease infant mortality NPMs • NPM 3: Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU) • NPM 5: 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	Continued	Perinatal/Infant Health

infants placed to sleep without soft objects or loose bedding SPMs • SPM 9: Percent of time-critical presumed positive dried blood spot specimen results reported out by day of life 5 • SPM 10: Percent of dried blood spot specimen results reported out by day of life 7 • SPM 11: Number of evidence-based home visiting workforce receiving IMH Endorsement®		
Decrease overweight and obesity among children NPMs • NPM 8.1: Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day SPMs • SPM 12: Percent of state LEA elementary and middle schools that provide or require daily physical education • SPM 13: Percent of state LEA secondary schools that do not sell less healthy foods and beverages SOMs • SOM 4: Number of public school 6th graders who are overweight or obese	Continued	Child Health
Increase prevention and mitigation of Adverse Childhood Experiences (ACEs) SPMs • SPM 14: Percent of children with two or more ACEs • SPM 15: Percent of substantiated child maltreatment cases among families served by home visiting programs • SPM 16: Percent of caregiver substance abuse among families served by home visiting programs • SPM 17: Percent of caregivers who experience intimate partner violence and do not receive professional support services among families served by home visiting • SPM 18: Percent of caregivers with depression who receive referrals for services SOMs • SOM 5: Percent of adults with Major Depressive Episode	Continued	Child Health

• SOM 6: Percent of adults reporting Chronic obstructive pulmonary disease (COPD)		
Decrease tobacco and e-cigarette use among adolescents NPMs • NPM 14.2: Percent of children, ages 0 through 17, who live in households where someone smokes SPMs • SPM 19: Percent of high school students currently using cigarettes • SPM 20: Percent of high school students currently using e-cigarettes • SPM 21: Number of adolescents enrolled in cessation program SOMs • SOM 7: Percent of adults reporting cardiovascular disease • SOM 8: Age-adjusted mortality rate from tobacco-attributable cancers among Tennesseans aged 35+	Revised	Adolescent Health
Increase medical homes among children with special healthcare needs NPMs • NPM 11: Percent of children with and without special health care needs, ages 0 through 17, who have a medical home SPMs • SPM 22: Number of providers adopting the medical home approach in their practice • SPM 23: Number of CYSHCN receiving care in a medical home • SPM 24: Number of families confident speaking to their provider • SPM 25: Number of providers providing resources and behavioral and mental health referrals • SPM 26: Number of care coordinators with increased knowledge • SPM 27: Number of vendors with increased knowledge • SPM 28: Number of children who complete an annual visit with their primary care provider	Revised	Children with Special Health Care Needs

Improve transition from pediatric to adult care among children with special health care needs NPMs • NPM 12: Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care SPMs • SPM 29: Number of YSHCN receiving transition services • SPM 30: Number of transition self-advocates	Continued	Children with Special Health Care Needs

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 women, infants, children, adolescents 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, 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 comprehensive needs assessment for the 2021-2025 cycle during 2019 and 2020 in conjunction with over 100 stakeholders. Key components included:

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

As a part of the ongoing needs assessment, 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 2021-2025 Block Grant cycle. These priorities include:

- Increase family planning
- Decrease pregnancy-associated mortality
- Increase breastfeeding
- Decrease infant mortality
- Increase prevention and mitigation of Adverse Childhood Experiences (ACEs)
- Decrease overweight and obesity
- Decrease tobacco and e-cigarette use
- Increase medical home
- Improve transition from pediatric to adult care

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 content areas in FHW pairs well with the identified priorities. Therefore, each FHW section (including both program an epidemiology staff) leads a priority. Teams are responsible for developing and reporting on the action plan and corresponding measures. This is done in conjunction with the MCH Stakeholder Group. This group was formed during the 2015 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 MCH/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 MCH/Title V services such as newborn screening provide services to the entire state but are centrally located at the state lab to assure excellent communication between the lab and the FHW clinical follow up team for lead, genetic disorders, hearing loss, and congenital heart disease.

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 81 participating provider organizations in over 400 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 MCH/Title V lies in its partnerships. In addition to the intentional engagement of families and customers listed above, TDH has pursued partnerships of all types using the collective impact framework. The descriptions below are not exhaustive and serve as examples of the myriad of partners valued by the agency and the division.

For example, a multitude of local, state, and national partnerships have emerged statewide regarding the opioid crisis and prevention of neonatal abstinence syndrome. In 2019, this resulted in the second consecutive year to year decline (26% from 2017) in cases reported to the NAS surveillance system since 2013. The NAS subcabinet 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 2019 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 64 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

The federal-state MCH/Title V partnership has enabled surveillance of SARS-CoV-2 (the virus that causes COVID-19 disease) among pregnant women in Tennessee. With the MCH population in mind an MCH/Title V supported epidemiologist analyzed data from the SARS-CoV-2 Case Report Form. Through this analysis stark ethnic disparities where identified among pregnant women.

Typically 11% of births in Tennessee are to Hispanic/Latina women. However when reviewing SARS-CoV-2 confirmed cases in pregnant women almost half were among Hispanic/Latina women. This is a difference in magnitude of 4.2, showing that these women were being infected at a much higher rate than expected.

These findings were communicated to the Tennessee Department of Health’s Division of Health Disparities, as well as the emergency response leadership. MCH/Title V staff reached out to multiple stakeholder groups, including the Health Disparities Task Force and Statewide Regional Call for Health Officers, both of which confirmed these findings were consistent with what was happening on the ground. Staff then worked with the Office of Communications to produce a COVID-19 and pregnancy PSA specifically featuring a Hispanic/Latina pregnant woman and included messaging around the importance of receiving prenatal care. This PSA was distributed to partner organizations around the state and is featured on the Spanish website for COVID-19: https://www.tn.gov/health/cedep/ncov/covid-19-resources-information-in-spanish.html

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

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

Provided below is a link to a web page that lists the MCHB discretionary grant programs that are located in this state/jurisdiction for Fiscal Year 2019.

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.