CHANT

Community Health Access and Navigation in Tennessee

What is CHANT?

Navigating the complex system of health and social services can be challenging for many individuals and families, and depending on individual needs and medical diagnoses, care may involve several programs, providers, and personnel. To overcome these challenges, the Tennessee Department of Health recently streamlined three public health programs, Help Us Grow Successfully (HUGS), Children's Special Services (CSS) and TennCare Kids Community Outreach into one integrated model of care coordination called the Community Health Access and Navigation in Tennessee (CHANT). CHANT is a voluntary care coordination service through the Local Health Departments to assist families with coordinating medical and social service needs. Through screening and assessments CHANT determines the needs of families and begins the process of connecting them to resources. Individuals may also qualify for services that provide reimbursement for medical services and assistance with co-pays, deductibles and co-insurance for children with physical disabilities from birth to 21 years of age. CHANT teams aim to provide enhanced patient-centered ***engagement*** through ***navigation*** of medical and social service referrals and make a positive ***impact*** on child and maternal health outcomes.

Who is eligible?

Individuals eligible for CHANT include:

- Pregnant and postpartum adolescents and women
- Children (Birth – 21 years)
- Children and Youth with Special Health Care Needs (Birth – 21 years)

Have a referral?

CHANT Care Coordination teams are in each of the 95 Tennessee counties within local health departments. Referrals are accepted from all medical providers and social service agencies. Self-referrals to CHANT are also accepted. Referral forms, instructions and a listing of local CHANT teams are available by accessing the website at www.tn.gov/health/health-program-areas/fhw/early-childhood-program/chant.html or by contacting the CHANT Program Director, brittney.stewart@tn.gov or (615) 532-8192

Comprehensive Screening and Assessment

Each member of the family unit is screened for the following:

- Social services needs
- Mental /behavioral health risk
- Child health and development milestones
- Special health care needs
- Medical risk
- Health insurance
- Medical and dental services

Pathways of Care

- Behavioral Health
- Child Health and Development Education
- Children and Youth with Special Health Care Needs (CYSHCN)
- Dental Home/Referral
- Developmental Screening/ Referral
- Employment
- Family Planning
- Health Insurance
- Housing
- Immunization Screening/ Referral
- Maternal Loss
- Medical Home/Referral
- Pregnancy/ Postpartum
- Perinatal Loss
- Smoking Cessation
- Social Service Referral
- Transition of CYSHCN 14+ yrs.

Care Coordination

- Link patients and families with resources to facilitate referrals and respond to medical and social service needs
- Communicate Care plans and goals and proactively track patients as they go to and from clinical care to communities
- Identify and refer eligible high risk patients to available EBHV Programs