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 various programs, providers, and personnel. To overcome these challenges, the Tennessee Department of Health 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, the Community Health Access and Navigation in Tennessee (CHANT). CHANT teams assist individuals in navigating medical referrals, social services and other needs that impact pregnancy, child and maternal health outcomes in positive ways.

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?

A CHANT Care Coordination team is located at the Williamson County Health Department. Referrals are accepted from all medical providers, social service agencies or even self-referrals. To access a referral form, please visit https://stateoftennessee-cvlyz.formstack.com/forms/chant_referral_form or contact the Williamson County Health Department's CHANT Program by calling (615) 465-5348 or (615) 465-5335.

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 Evidence Based Home Visiting Programs