GRANT SUMMARY SHEET

Grant Name:	Nashville Strong Babies II 25
Department:	HEALTH DEPARTMENT
Grantor:	Health Resources & Services Administration
Pass-Through Grantor (If applicable):	
Total Award this Action:	$1,008,333.00
Cash Match Amount	$0.00
Department Contact:	Brad Thompson 340-0407
Status:	CONTINUATION

Program Description:

A grant from Health Resources & Services Administration is to improve health outcomes before, during, and after pregnancy, and reduce racial/ethnic differences in rates of infant death and adverse perinatal outcomes. This action funds Year 1 of a 5 year project.

Plan for continuation of services upon grant expiration:

Grants Tracking Form

Part One

Pre-Application	Application	Award Acceptance	Contract Amendment
○	○	◉	○

Department	Dept. No.	Contact	Phone	Fax
HEALTH DEPARTMENT	038	Brad Thompson	340-0407	

Grant Name:	Nashville Strong Babies II 25		
Grantor:	Health Resources & Services Administration	**Other:**	
Grant Period From:	05/01/24	(applications only) **Anticipated Application Date:**	
Grant Period To:	03/31/25	(applications only) **Application Deadline:**	
Funding Type:	FED DIRECT	**Multi-Department Grant** ☐ → **If yes, list below.**	
Pass-Thru:		**Outside Consultant Project:** ☐	
Award Type:	COMPETITIVE	**Total Award:**	$1,008,333.00
Status:	CONTINUATION	**Metro Cash Match:**	$0.00
Metro Category:	Est. Prior.	**Metro In-Kind Match:**	$0.00
CFDA #	93.926	**Is Council approval required?** ☐	
Project Description:		**Applic. Submitted Electronically?** ☑	

A grant from to Health Resources & Services Administration is to improve health outcomes before, during, and after pregnancy, and reduce racial/ethnic differences in rates of infant death and adverse perinatal outcomes. This action funds Year 1 of a 5 year project.

Plan for continuation of service after expiration of grant/Budgetary Impact:

How is Match Determined?

Fixed Amount of $		or		% of Grant		Other: ☐

Explanation for "Other" means of determining match:

For this Metro FY, how much of the required local Metro cash match:

Is already in department budget?		**Fund**		**Business Unit**
Is not budgeted?		**Proposed Source of Match:**		
(Indicate Match Amount & Source for Remaining Grant Years in Budget Below)				

Other:

Number of FTEs the grant will fund:	8.25	**Actual number of positions added:**	0.00	
Departmental Indirect Cost Rate	24.17%	**Indirect Cost of Grant to Metro:**	$243,714.09	
***Indirect Costs allowed?** ○ Yes ◉ No **% Allow.**	0.00%	**Ind. Cost Requested from Grantor:**	$0.00	**in budget**

***(If "No", please attach documentation from the grantor that indirect costs are not allowable. See Instructions)**

Draw down allowable? ☐

Metro or Community-based Partners:

Part Two

Grant Budget

Budget Year	Metro Fiscal Year	Federal Grantor	State Grantor	Other Grantor	Local Match Cash	Match Source (Fund, BU)	Local Match In-Kind	Total Grant Each Year	Indirect Cost to Metro	Ind. Cost Neg. from Grantor
Yr 1	FY25	$1,008,333.00	$0.00	$0.00	$0.00		$0.00	$1,008,333.00	$243,714.09	$0.00
Yr 2	FY									
Yr 3	FY									
Yr 4	FY									
Yr 5	FY									
Total		$1,008,333.00	$0.00	$0.00	$0.00		$0.00	$1,008,333.00	$243,714.09	$0.00

Date Awarded:	06/27/24	**Tot. Awarded:**	$1,008,333.00	**Contract#:**	2 H49MC32719 06 00
(or) **Date Denied:**		**Reason:**			
(or) **Date Withdrawn:**		**Reason:**			

Contact: juanita.paulsen@nashville.gov
vaughn.wilson@nashville.gov

Rev. 5/13/13
5738

GCP Received 6/27/2024

JP

GCP Approved 6/27/2024

Department of Health and Human Services
Health Resources and Services Administration

Notice of Award
FAIN# H4932719
Federal Award Date: 04/29/2024

Recipient Information

1. Recipient Name
NASHVILLE & DAVIDSON COUNTY, METROPOLITAN GOVERNMENT OF
PO BOX 196300
Nashville, TN 37219-6300

2. Congressional District of Recipient
07

3. Payment System Identifier (ID)
1620694743A7

4. Employer Identification Number (EIN)
620694743

5. Data Universal Numbering System (DUNS)
078217668

6. Recipient's Unique Entity Identifier
LGZLHP6ZHM55

7. Project Director or Principal Investigator
D'Yuanna Allen-Robb
dyuanna.allen-robb@nashville.gov
(615)340-0487

8. Authorized Official
Melva Black
Deputy Director
melva.black@nashville.gov
(615)340-8549

Federal Agency Information

9. Awarding Agency Contact Information
Tya T Renwick
Grants Management Specialist
Office of Federal Assistance Management (OFAM)
Division of Grants Management Office (DGMO)
trenwick@hrsa.gov
(301) 594-0227

10. Program Official Contact Information
Shontelle Dixon
Project Officer
Maternal and Child Health Bureau (MCHB)
sdixon@hrsa.gov
(301) 443-0543

Federal Award Information

11. Award Number
2 H49MC32719-06-00

12. Unique Federal Award Identification Number (FAIN)
H4932719

13. Statutory Authority
42 U.S.C. § 254c-8

14. Federal Award Project Title
Healthy Start Initiative-Eliminating Racial/Ethnic Disparities

15. Assistance Listing Number
93.926

16. Assistance Listing Program Title
Healthy Start Initiative

17. Award Action Type
Competing Continuation

18. Is the Award R&D?
No

Summary Federal Award Financial Information

19. Budget Period Start Date 05/01/2024 - End Date 03/31/2025	
20. Total Amount of Federal Funds Obligated by this Action	$1,008,333.00
20a. Direct Cost Amount	
20b. Indirect Cost Amount	$0.00
21. Authorized Carryover	$0.00
22. Offset	$0.00
23. Total Amount of Federal Funds Obligated this budget period	$1,008,333.00
24. Total Approved Cost Sharing or Matching, where applicable	$0.00
25. Total Federal and Non-Federal Approved this Budget Period	$1,008,333.00
26. Project Period Start Date 05/01/2024 - End Date 03/31/2029	
27. Total Amount of the Federal Award including Approved Cost Sharing or Matching this Project Period	$1,008,333.00

28. Authorized Treatment of Program Income
Addition

29. Grants Management Officer – Signature
LaShawna Smith on 04/29/2024

30. Remarks

This grant is under Expanded Authority.

HRSA
Health Resources & Services Administration

Notice of Award
Award Number: 2 H49MC32719-06-00
Federal Award Date: 04/29/2024

Maternal and Child Health Bureau (MCHB)

31. APPROVED BUDGET: (Excludes Direct Assistance)

[X] Grant Funds Only

[ ] Total project costs including grant funds and all other financial participation

a.	Salaries and Wages:	$0.00
b.	Fringe Benefits:	$0.00
c.	Total Personnel Costs:	$0.00
d.	Consultant Costs:	$0.00
e.	Equipment:	$0.00
f.	Supplies:	$0.00
g.	Travel:	$0.00
h.	Construction/Alteration and Renovation:	$0.00
i.	Other:	$0.00
j.	Consortium/Contractual Costs:	$0.00
k.	Trainee Related Expenses:	$0.00
l.	Trainee Stipends:	$0.00
m.	Trainee Tuition and Fees:	$0.00
n.	Trainee Travel:	$0.00
o.	TOTAL DIRECT COSTS:	$1,008,333.00
p.	INDIRECT COSTS (Rate: % of S&W/TADC):	$0.00
	i. Indirect Cost Federal Share:	$0.00
	ii. Indirect Cost Non-Federal Share:	$0.00
q.	TOTAL APPROVED BUDGET:	$1,008,333.00
	i. Less Non-Federal Share:	$0.00
	ii. Federal Share:	$1,008,333.00

32. AWARD COMPUTATION FOR FINANCIAL ASSISTANCE:

a.	Authorized Financial Assistance This Period	**$1,008,333.00**
b.	Less Unobligated Balance from Prior Budget Periods	
	i. Additional Authority	$0.00
	ii. Offset	$0.00
c.	Unawarded Balance of Current Year's Funds	$0.00
d.	Less Cumulative Prior Award(s) This Budget Period	$0.00
e.	AMOUNT OF FINANCIAL ASSISTANCE THIS ACTION	**$1,008,333.00**

33. RECOMMENDED FUTURE SUPPORT:
(Subject to the availability of funds and satisfactory progress of project)

YEAR	TOTAL COSTS
07	$1,100,000.00
08	$1,100,000.00
09	$1,100,000.00
10	$1,100,000.00

34. APPROVED DIRECT ASSISTANCE BUDGET: (In lieu of cash)

a. Amount of Direct Assistance	$0.00
b. Less Unawarded Balance of Current Year's Funds	$0.00
c. Less Cumulative Prior Award(s) This Budget Period	$0.00
d. AMOUNT OF DIRECT ASSISTANCE THIS ACTION	**$0.00**

35. FORMER GRANT NUMBER

36. OBJECT CLASS
41.51

37. BHCMIS#

38. THIS AWARD IS BASED ON THE APPLICATION APPROVED BY HRSA FOR THE PROJECT NAMED IN ITEM 14. FEDERAL AWARD PROJECT TITLE AND IS SUBJECT TO THE TERMS AND CONDITIONS INCORPORATED EITHER DIRECTLY OR BY REFERENCE AS:
a. The program authorizing statue and program regulation cited in this Notice of Award; b. Conditions on activities and expenditures of funds in certain other applicable statutory requirements, such as those included in appropriations restrictions applicable to HRSA funds; c. 45 CFR Part 75; d. National Policy Requirements and all other requirements described in the HHS Grants Policy Statement; e. Federal Award Performance Goals; and f. The Terms and Conditions cited in this Notice of Award. In the event there are conflicting or otherwise inconsistent policies applicable to the award, the above order of precedence shall prevail. Recipients indicate acceptance of the award, and terms and conditions by obtaining funds from the payment system.

39. ACCOUNTING CLASSIFICATION CODES

FY-CAN	CFDA	DOCUMENT NUMBER	AMT. FIN. ASST.	AMT. DIR. ASST.	SUB PROGRAM CODE	SUB ACCOUNT CODE
24 - 3898020	93.926	24H49MC32719	$1,008,333.00	$0.00	N/A	24H49MC32719

HRSA Electronic Handbooks (EHBs) Registration Requirements

The Project Director of the grant (listed on this NoA) and the Authorizing Official of the grantee organization are required to register (if not already registered) within HRSA's Electronic Handbooks (EHBs). Registration within HRSA EHBs is required only once for each user for each organization they represent. To complete the registration quickly and efficiently we recommend that you note the 10-digit grant number from box 4b of this NoA. After you have completed the initial registration steps (i.e.,created an individual account and associated it with the correct grantee organization record), be sure to add this grant to your portfolio. This registration in HRSA EHBs is required for submission of noncompeting continuation applications. In addition, you can also use HRSA EHBs to perform other activities such as updating addresses, updating email addresses and submitting certain deliverables electronically. Visit https://grants3.hrsa.gov/2010/WebEPSExternal/Interface/common/accesscontrol/login.aspx to use the system. Additional help is available online and/or from the HRSA Call Center at 877-Go4-HRSA/877-464-4772.

Terms and Conditions

Failure to comply with the remarks, terms, conditions, or reporting requirements may result in a draw down restriction being placed on your Payment Management System account or denial of future funding.

Grant Specific Condition(s)

1. **Due Date: Within 60 Days of Budget Start Date**
   Within 60 days of receiving this Notice of Award, recipient shall submit a revised SF-424A budget form and budget justification totaling the federal award amount. Please note, details of the required changes will be transmitted via email upon release of this Notice of Award. Responses to the conditions must be submitted via EHB within 60 days of receiving the award.

Grant Specific Term(s)

1. This award is governed by the post-award requirements cited in Subpart D-Post Federal Award Requirements, standards for program and fiscal management of 45 CFR Part 75 except when the Notice of Award indicates in the “Remarks” section that the grant is included under “Expanded Authority”. These recipients may take the following actions without prior approval of the Grant Management Office:
   Section 75.308 c(2)(d)(1) Incur pre-award costs up to 90 calendar days before the award. See also 75.458.
   Section 75.308 c(2)(d)(2) Initiate a one-time extension of the period of performance by up to 12 months unless one or more of the conditions outlined in paragraphs (d)(2)(i) through (iii) of this section apply. For one-time extensions, the recipient must notify the HHS awarding agency in writing with the supporting reasons and revised period of performance at least 10 calendar days before the end of the period of performance specified in the Federal award. This notification must be submitted through the Electronic Handbooks (EHB). This one-time extension may not be exercised merely for the purpose of using unobligated balances.
   Section 75.308 c(2)(d)(3) Carry forward unobligated balances to subsequent periods of performance.
   Except for funds restricted on a Notice of Award, grantee organizations are authorized to carry over unobligated grant funds up to the lesser of 25% or $250,000 of the amount awarded for that budget period remaining at the end of that budget period. If the unobligated balance is in excess of 25% of the total amount awarded, or $250,000, whichever is less, and the grantee wishes to carry the funds forward, the grantee must obtain prior approval from the Grants Management Office.
   The grantee must notify the Grants Management Office when it has elected to carry over unobligated balances under Expanded Authority and the amount to be carried over. The notification must be provided under item 12, “Remarks”, on the initial submission of the Federal Financial Report (FFR).
   For all other Post Award request refer Standard Term 5 below.
2. This action reflects a new document number. Please refer to this number when contacting the Payment Management System or submitting drawdown requests.
3. 45 CFR Part 75 applies to all federal funds associated with the award. Part 75 has been effective since December 26, 2014. All references to prior OMB Circulars for the administrative and audit requirements and the cost principles that govern Federal monies associated with this award are superseded by the Uniform Guidance 2 CFR Part 200 as codified by HHS at 45 CFR Part 75.
4. All post-award requests, such as significant budget revisions or a change in scope, must be submitted as a Prior Approval action via the Electronic Handbooks (EHBs) and approved by HRSA prior to implementation. Grantees under “Expanded Authority,” as noted in the Remarks section of the Notice of Award, have different prior approval requirements. See “Prior-Approval Requirements” in the DHHS Grants Policy Statement: https://www.hhs.gov/sites/default/files/grants/grants/policies-regulations/hhsgps107.pdf.
5. The funds for this award are in a sub-account in the Payment Management System (PMS). This type of account allows recipients to specifically identify the individual grant for which they are drawing funds and will assist HRSA in monitoring the award. Access to the PMS account number is provided to individuals at the organization who have permissions established within PMS. The PMS sub-account code can be found on the HRSA specific section of the NoA (Accounting Classification Codes). Both the PMS account number and sub-account code are needed when requesting grant funds. **Please note that for new and competing continuation awards issued after 10/1/2020, the sub-account code will be the document number.**

You may use your existing PMS username and password to check your organizations' account access. If you do not have access, complete a PMS Access Form (PMS/FFR Form) found at: https://pmsapp.psc.gov/pms/app/userrequest. If you have any questions about accessing PMS, contact the PMS Liaison Accountant as identified at: http://pms.psc.gov/find-pms-liaison-accountant.html

6. This Notice of Award provides funding that aligns with the eleven-month budget period of 5/1/2024 – 3/31/2025.

Program Specific Term(s)

1. The management Team, including key personnel, must reflect the cultural diversity of the Community to be served.
2. Each project is expected to establish a plan to recover, to the maximum extent feasible, third party revenues to which it is entitled for services provided; garner all other available Federal, state, local, and private funds; and charge beneficiaries according to their ability to pay for services without creating a barrier to those services. Where third-party payors, including Government agencies, are authorized or are under legal obligation to pay all or a portion of charges for health care services, "all such sources must be billed for covered services, and every effort must be made to obtain payment. Each service provider receiving Federal funds, either directly or indirectly, must have a procedure to identify all persons served who are eligible for third-party reimbursement."
3. All MCHB discretionary grant projects are expected to incorporate a carefully designed and well-planned evaluation protocol capable of demonstrating and documenting measurable progress toward achieving the stated goals. The measurement of progress toward goals should focus on systems, health and performance indicators, rather than solely on the intermediate process measures.
4. In accordance with the requirements of the "Government Performance and Results Act (GPRA) of 1993" (Public Law 103-62), MCHB has established measurable goals for Federal programs that can be reported as part of the budgetary process, thus linking funding decisions with performance. Performance measures and data elements for all MCHB-funded grant programs including Healthy Start have been finalized. As previously communicated all Healthy Start projects are expected to participate in the MCHB reporting requirements system.
5. Grantees must use the Healthy Start Data Collection Tools (i.e., the Demographic, Background, Prenatal, and Parent/Child forms) to collect standardized client-level data elements and must report the collected data on a quarterly basis to the Division Healthy Start and Perinatal Services (DHSPS) by uploading it to the Healthy Start Monitoring and Evaluation Data System (HSMED). Grantees must screen all Group-Based Health Education and Case Management/Care Coordination participants using the data collection tools and screening procedure/implementation guidance/form administration process provided by DHSPS.
6. Grantees must respond to requests for information from DHSPS and the Technical Assistance and Support Center (TASC). Grantees are required to participate in the National Healthy Start Evaluation activities, which may include, but is not limited to, grantee convenings, data collection, staff interviews, and program case studies.
7. HRSA reserves the right to reduce base awards for grantees that consistently maintain unobligated balance greater than $100,000.
8. A grantee can propose to include an evidence-based home visiting model as part of their Healthy Start (HS) program if each component of the program addresses all Health Start (HS) program requirements, and the evidence-based model allows for the HS program to collect the data included in the HS screening tools. That is, the requirements of any curriculum or model chosen do not supersede the requirements of HS.
9. HRSA reserves the right to reduce funding if, after receiving technical assistance, grantee cannot fulfil the requirements of the grant. i.e. progress on benchmarks, number of participants served.
10. Grantees are to budget for up to 3 persons to attend all mandatory regional meetings and the Healthy Start convention.
11. A change in service area must be approved by HRSA and require a prior approval submission in HRSA's Electronic Handbook (EHB).
12. Grantees must allow for the provision of clinical services to Healthy Start participants and will be expected to dedicate 12 percent of their award to support nurse practitioners, certified nurse midwives, physician assistants, behavioral health specialists, and other maternal-child advanced practice health professionals dedicated to HS projects. As part of the 12 percent, funds may also be used to support health educators by having clinical staff conduct trainings on associated topics, such as Urgent Maternal Warning Signs.

Standard Term(s)

1. Your organization is required to have the necessary policies, procedures, and financial controls in place to ensure that your organization complies with all legal requirements and restrictions applicable to the receipt of federal funding, per HRSA Standard Terms (unless otherwise specified on your Notice of Award), and Legislative Mandates. The effectiveness of these policies, procedures, and controls is subject to audit.

Reporting Requirement(s)

1. **Due Date: Within 90 Days of Award Issue Date**

The grantee must submit a Performance Report within 90 days after receipt of the NoA. This report should include completing the financial forms, project abstract, grant summary and performance measures. The performance report must be submitted using the Electronic Handbook (EHB).

2. **Due Date: Annually (Budget Period) Beginning: Budget Start Date Ending: Budget End Date, due 90 days after end of reporting period.**
   The recipient must submit, within 90 days after budget period end date, an annual Federal Financial Report (FFR). The report should reflect cumulative reporting within the project period of the document number. **All FFRs must be submitted through the Payment Management System (PMS).** Technical questions regarding the FFR, including system access should be directed to the PMS Help Desk by submitting a ticket through the self-service web portal (**PMS Self-Service Web Portal**), or calling 877-614-5533.

Failure to comply with these reporting requirements will result in deferral or additional restrictions of future funding decisions.

Contacts

NoA Email Address(es):

Name	Role	Email
Melva Black	Authorizing Official	melva.black@nashville.gov
D'yuanna Allen-Robb	Point of Contact, Business Official	dyuanna.allen-robb@nashville.gov
D'yuanna Allen-Robb	Program Director	dyuanna.allen-robb@nashville.gov

Note: NoA emailed to these address(es)

All submissions in response to conditions and reporting requirements (with the exception of the FFR) must be submitted via EHBs. Submissions for Federal Financial Reports (FFR) must be completed in the Payment Management System (https://pms.psc.gov/).

IN WITNESS WHEREOF, the parties have by their duly authorized representatives set their signatures.

METROPOLITAN GOVERNMENT OF NASHVILLE AND DAVIDSON COUNTY

DocuSigned by:
Gill C Wright III, MD
0460AC21E1CC408...
Director, Metro Public Health Department — 6/27/2024
Date

DocuSigned by:
Tené Hamilton Franklin
BEBF0DBF14D14B0...
Chair, Board of Health — 6/27/2024
Date

APPROVED AS TO AVAILABILITY OF FUNDS:

Kevin Crumbo/mal
Director, Department of Finance — 7/12/2024 | 2:26 PM CDT
Date

APPROVED AS TO RISK AND INSURANCE:

Balogun Cobb
Director of Risk Management Services — 7/15/2024 | 12:34 PM CDT
Date

APPROVED AS TO FORM AND LEGALITY:

Courtney Mohan
Metropolitan Attorney — 7/15/2024 | 12:33 PM CDT
Date

FILED:

Metropolitan Clerk — Date

GRANT APPLICATION SUMMARY SHEET

Grant Name:	Nashville Strong Babies II - 24-29
Department:	HEALTH DEPARTMENT
Grantor:	HealthResources&ServicesAdministrati
Pass-Through Grantor (If applicable):	
Total Applied For	$5,500,000.00
Metro Cash Match:	$0.00
Department Contact:	Brad Thompson 340-0407
Status:	CONTINUATION

Program Description:

This is a continuation application. The Nashville Strong Babies Project aims to improve perinatal outcomes and change the health expectations of the community as well as the accountability of healthcare systems by utilizing a pathways hub approach to partner with culturally experienced medical/clinical providers, community and service providers, and other key partners. NSB will give women access to a variety of important services including medical/clinical services, social services, traditional public health services, and an assortment of education opportunities emulating the life course to include prenatal nutrition and parenting for pregnant women, and infant development and well-woman support for interconception women.

Plan for continuation of services upon grant expiration:

Services will be discontinued.

APPROVED AS TO AVAILABILITY OF FUNDS:

Kevin Crumbo/mgw — 11/21/2023 | 8:20 AM CST

Director of Finance **Date**

APPROVED AS TO FORM AND LEGALITY:

Courtney Mohan — 11/21/2023 | 3:53 PM CST

Metropolitan Attorney **Date**

BB AP

APPROVED AS TO RISK AND INSURANCE:

Balogun Cobb — 11/21/2023 | 8:43 AM CST

Director of Risk Management Services **Date**

Freddie O'Connell — 11/21/2023 | 2:40 PM PST

Metropolitan Mayor Date

(This application is contingent upon approval of the application by the Metropolitan Council.

kjw

Grants Tracking Form

Part One

Pre-Application ○	Application ◉	Award Acceptance ○	Contract Amendment ○

Department	Dept. No.	Contact	Phone	Fax
HEALTH DEPARTMENT	038	Brad Thompson	340-0407	

Grant Name:	Nashville Strong Babies II - 24-29		
Grantor:	HEALTH RESOURCES & SERVICES ADMINISTRATION	**Other:**	
Grant Period From:	04/01/24	(applications only) **Anticipated Application Date:**	12/08/23
Grant Period To:	03/31/29	(applications only) **Application Deadline:**	12/15/23

Funding Type:	FED DIRECT	**Multi-Department Grant** ☐ → **If yes, list below.**	
Pass-Thru:		**Outside Consultant Project:** ☐	
Award Type:	COMPETITIVE	**Total Award:**	$5,500,000.00
Status:	CONTINUATION	**Metro Cash Match:**	$0.00
Metro Category:	Est. Prior.	**Metro In-Kind Match:**	$0.00
CFDA #	93.926	**Is Council approval required?** ☐	
Project Description:		**Applic. Submitted Electronically?** ☑	

This is a continuation application. The Nashville Strong Babies Project aims to improve perinatal outcomes and change the health expectations of the community as well as the accountability of healthcare systems by utilizing a pathways hub approach to partner with culturally experienced medical/clinical providers, community and service providers, and other key partners. NSB will give women access to a variety of important services including medical/clinical services, social services, traditional public health services, and an assortment of education opportunities emulating the life course to include prenatal nutrition and parenting for pregnant women, and infant development and well-woman support for interconception women.

Plan for continuation of service after expiration of grant/Budgetary Impact:

Services will be discontinued.

How is Match Determined?

Fixed Amount of $		**or**		**% of Grant**	**Other:** ☐

Explanation for "Other" means of determining match:

For this Metro FY, how much of the required local Metro cash match:

Is already in department budget?		**Fund**		**Business Unit**
Is not budgeted?		**Proposed Source of Match:**		
(Indicate Match Amount & Source for Remaining Grant Years in Budget Below)				

Other:

Number of FTEs the grant will fund:	8.25	**Actual number of positions added:**	0.00	
Departmental Indirect Cost Rate	21.47%	**Indirect Cost of Grant to Metro:**	$1,180,850.00	
***Indirect Costs allowed?** ◉ Yes ○ No **% Allow.**	14.56%	**Ind. Cost Requested from Grantor:**	$839,628.00	**in budget**

***(If "No", please attach documentation from the grantor that indirect costs are not allowable. See Instructions)**

Draw down allowable? ☐

Metro or Community-based Partners:

Part Two

Grant Budget

Budget Year	Metro Fiscal Year	Federal Grantor	State Grantor	Other Grantor	Local Match Cash	Match Source (Fund, BU)	Local Match In-Kind	Total Grant Each Year	Indirect Cost to Metro	Ind. Cost Neg. from Grantor
Yr 1	FY25	$1,100,000.00						$1,100,000.00	$236,170.00	$174,966.00
Yr 2	FY26	$1,100,000.00						$1,100,000.00	$236,170.00	$174,765.00
Yr 3	FY27	$1,100,000.00						$1,100,000.00	$236,170.00	$167,956.00
Yr 4	FY28	$1,100,000.00						$1,100,000.00	$236,170.00	$166,488.00
Yr 5	FY29	$1,100,000.00						$1,100,000.00	$236,170.00	$155,453.00
Yr 6								$0.00	$0.00	
Total		$5,500,000.00	$0.00	$0.00	$0.00		$0.00	$5,500,000.00	$1,180,850.00	$839,628.00

Date Awarded:		**Tot. Awarded:**		**Contract#:**	
(or) **Date Denied:**		**Reason:**			
(or) **Date Withdrawn:**		**Reason:**			

Contact: juanita.paulsen@nashville.gov
vaughn.wilson@nashville.gov

JP

Rev. 5/13/13
5738

GCP Received 11/13/2023

GCP Approved 11/13/2023

OMB Number: 4040-0004
Expiration Date: 11/30/2025

Application for Federal Assistance SF-424

* 1. Type of Submission:
- [ ] Preapplication
- [x] Application
- [ ] Changed/Corrected Application

* 2. Type of Application:
- [x] New
- [ ] Continuation
- [ ] Revision

* If Revision, select appropriate letter(s):

* Other (Specify):

* 3. Date Received: Completed by Grants.gov upon submission.

4. Applicant Identifier:

5a. Federal Entity Identifier:

5b. Federal Award Identifier:

State Use Only:

6. Date Received by State:

7. State Application Identifier:

8. APPLICANT INFORMATION:

* a. Legal Name: Nashville & Davidson County, Metropolitan Government of

* b. Employer/Taxpayer Identification Number (EIN/TIN): 62-0694743

* c. UEI: LGZLHP6ZHM55

d. Address:

* Street1: 2500 Charlotte Ave
Street2:
* City: Nashville
County/Parish:
* State: TN: Tennessee
Province:
* Country: USA: UNITED STATES
* Zip / Postal Code: 37209-4129

e. Organizational Unit:

Department Name: Metro Public Health Department

Division Name:

f. Name and contact information of person to be contacted on matters involving this application:

Prefix: Mrs.
* First Name: D'Yuanna
Middle Name:
* Last Name: Allen-Robb
Suffix:

Title:

Organizational Affiliation: Metro Public Health Department of Nashville

* Telephone Number: 6153400487
Fax Number:

* Email: dyuanna.allen-robb@nashville.gov

Application for Federal Assistance SF-424

*** 9. Type of Applicant 1: Select Applicant Type:**

B: County Government

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

* Other (specify):

*** 10. Name of Federal Agency:**

Health Resources and Services Administration

11. Catalog of Federal Domestic Assistance Number:

93.926

CFDA Title:

Healthy Start Initiative

*** 12. Funding Opportunity Number:**

HRSA-24-033

* Title:

Healthy Start Initiative: Eliminating Disparities in Perinatal Health

13. Competition Identification Number:

HRSA-24-033

Title:

Healthy Start Initiative: Eliminating Disparities in Perinatal Health

14. Areas Affected by Project (Cities, Counties, States, etc.):

Add Attachment | Delete Attachment | View Attachment

*** 15. Descriptive Title of Applicant's Project:**

Nashville Strong Babies II

Attach supporting documents as specified in agency instructions.

Add Attachments | Delete Attachments | View Attachments

Application for Federal Assistance SF-424

16. Congressional Districts Of:

* a. Applicant: 5,6,7 | * b. Program/Project: 5,6,7

Attach an additional list of Program/Project Congressional Districts if needed.

Add Attachment | Delete Attachment | View Attachment

17. Proposed Project:

* a. Start Date: 04/01/2024 | * b. End Date: 03/31/2029

18. Estimated Funding ($):

* a. Federal	5,500,000.00
* b. Applicant	0.00
* c. State	0.00
* d. Local	0.00
* e. Other	0.00
* f. Program Income	0.00
* g. TOTAL	5,500,000.00

*** 19. Is Application Subject to Review By State Under Executive Order 12372 Process?**

☐ a. This application was made available to the State under the Executive Order 12372 Process for review on .

☐ b. Program is subject to E.O. 12372 but has not been selected by the State for review.

☒ c. Program is not covered by E.O. 12372.

*** 20. Is the Applicant Delinquent On Any Federal Debt? (If "Yes," provide explanation in attachment.)**

☐ Yes ☒ No

If "Yes", provide explanation and attach

Add Attachment | Delete Attachment | View Attachment

21. *By signing this application, I certify (1) to the statements contained in the list of certifications and (2) that the statements herein are true, complete and accurate to the best of my knowledge. I also provide the required assurances** and agree to comply with any resulting terms if I accept an award. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties. (U.S. Code, Title 18, Section 1001)**

☒ ** I AGREE

** The list of certifications and assurances, or an internet site where you may obtain this list, is contained in the announcement or agency specific instructions.

Authorized Representative:

Prefix: | * First Name: Melva

Middle Name:

* Last Name: Black

Suffix: Ph.D.

* Title: Deputy Director

* Telephone Number: 615-340-8549 | Fax Number:

* Email: melva.black@nashville.gov

* Signature of Authorized Representative: Completed by Grants.gov upon submission. | * Date Signed: Completed by Grants.gov upon submission.

ATTACHMENTS FORM

Instructions: On this form, you will attach the various files that make up your grant application. Please consult with the appropriate Agency Guidelines for more information about each needed file. Please remember that any files you attach must be in the document format and named as specified in the Guidelines.

Important: Please attach your files in the proper sequence. See the appropriate Agency Guidelines for details.

1) Please attach Attachment 1	Attachment 1 - Project Area P	Add Attachment	Delete Attachment	View Attachment
2) Please attach Attachment 2	Attachment 2 - Work Plan.pdf	Add Attachment	Delete Attachment	View Attachment
3) Please attach Attachment 3	Attachment 3 - Staffing Plan	Add Attachment	Delete Attachment	View Attachment
4) Please attach Attachment 4	Attachment 4 - BioSketch.pdf	Add Attachment	Delete Attachment	View Attachment
5) Please attach Attachment 5	Attachment 5 - Letters of Sup	Add Attachment	Delete Attachment	View Attachment
6) Please attach Attachment 6	Attachment 6 - Project Organi	Add Attachment	Delete Attachment	View Attachment
7) Please attach Attachment 7	Attachment 7 - Additional Dat	Add Attachment	Delete Attachment	View Attachment
8) Please attach Attachment 8	Attachment 8 - 5th Year Budge	Add Attachment	Delete Attachment	View Attachment
9) Please attach Attachment 9	Attachment 9 - Evaluation Pla	Add Attachment	Delete Attachment	View Attachment
10) Please attach Attachment 10	Attachment 10 - MPHD Org Char	Add Attachment	Delete Attachment	View Attachment
11) Please attach Attachment 11	Attachment 11 - Community Com	Add Attachment	Delete Attachment	View Attachment
12) Please attach Attachment 12	Attachment 12 - 2024 Indirect	Add Attachment	Delete Attachment	View Attachment
13) Please attach Attachment 13		Add Attachment	Delete Attachment	View Attachment
14) Please attach Attachment 14		Add Attachment	Delete Attachment	View Attachment
15) Please attach Attachment 15		Add Attachment	Delete Attachment	View Attachment

Attachment 1: Project Area Proposed to be Funded

A. Project area is defined by: ☑ County

Enter all of the counties that contain all or part of the project area separated by commas:

Davidson County

Enter all of the Zip Codes in the project area separated by commas:

37013, 37211, 37027, 37115, 37221, 37207, 37086, 37076, 37209, 37217, 37072., 37214, 37138, 37205, 37206, 37215, 37203, 37216, 37212, 37208, 37204, 37210, 37218, 37080, 37220, 37189, 37143, 37248, 37245, 37228, 37247, 37237, 37213, 37201, 37219, 37232, 37246, 37243, 37249, 37202, 37011, 37024, 37070, 37116, 37222, 37227, 37224, 37229, 37230, 37235, 37234, 37236, 37240, 37238, 37242, 37241, 37244, 37250

For project areas defined by Census Tracts, enter all of the Census Tracts in the project area separate by commas:

N/A

B. Project Area Map (See Enclosed Boundary Map)

C. Urban/Rural Classification

Based on the results of the Rural Health Grants Eligibility Analyzer, is your ☑ NO

D. Priority Points Eligibility

area has 60 or more infants deaths in target population over	☑	**YES**	
Priority 2. Proposed project area within at least one county meets at least three of the perinatal indicator criteria	☑	**NO**	The proposed project area meets at least two perinatal indicators

E. Factors Demonstrating Need for Target Population

Table 1. Factor Demonstrating Need for the Target (Priority) Population, 3-Year Cohort							
Source: Davidson County Natality, Mortality, & Fetal Death Files, 2019-2021, Tennessee Department of Health							
2019-2021 Data for target population in project area: Davidson County	**# Live Births**	**# Infant Deaths**	**3-year IMR**	**# LBW Births**	**3-year LBW Rate**	**# Preterm Births**	**3-year PTB Rate**
NH Black/African American	**7,810**	**116**	**14.9**	**1,147**	**14.7%**	**1,197**	**15.3%**
TOTAL	29,652	210	7.1	2,699	9%	3,185	10.7%

*Rates with numerator <5 should be considered unstable. **Total may include events for which race/ethnicity is unknown
^Target area is Davidson County

Table 2. Priority Points for Infant Deaths and Other Perinatal Indicators					
Source: Davidson County Natality, Mortality, & Fetal Death Files, 2019-2021, Tennessee Department of Health					
Data for Project Areas	**Pre-pregnancy or gestational Diabetes (>=9.0%)**	**Pre-pregnancy or gestational hypertension (>=12.3%)**	**Pre-pregnancy obesity (>=35.7%)**	**1st trimester PNC (<=71.1%)**	**Target Population Infant Deaths (>=60 deaths)**
Davidson County, TN	6.30%	4.60%	**36.90%**	**68.70%**	**116**

Davidson County Zip Codes

Attachment 2 Work-Plan and Performance Measures

The workplan reflects clinical services, case management and care coordination services and group-based education to 700 participants per year as well as a robust referral network for community-based social services and a maintained Community Consortium.

Project Period Objectives	CY	Goal	Num.	Dem.	Actions	Responsible
BM1. By 12/31/28, increase the proportion of HS women and child participants with health insurance to 90% (reduce uninsured to less than 10%). Data Source:	**Baseline**: 12% uninsured Data Sources: ACS, B27001; % women 19-44 with no health insurance				1). Ensure at least 90% of pregnant participants have health insurance for prenatal care, delivery and at least 56 days post-partum coverage. ▪ Assess pregnant in need of coverage as early as possible in her pregnancy; ▪ Enroll participants in presumptive eligibility coverage 2). Ensure interconception women, infant/child participants have health insurance ▪ Support participants completing the Medicaid Part B application for coverage after delivery; connect to a safety net provider; ▪ Support families to add child to private ins. plan post-delivery; ▪ Support participants in completing the CoverKids (State Children's Health Insurance Plan); connect to a safety net provider	▪ Certified Application Counselors (CAC) ▪ Case Manager (CM), Care Coordinator (CC), Nurse Manager (NM) *Documented insurance.
CAREWare; HRSA Tool	**CY2024**	**87%**	370	425		
CAREWare; HRSA Tool	**CY2025**	**88%**	374	425		
CAREWare; HRSA Tool	**CY2026**	**88%**	374	425		
CAREWare; HRSA Tool	**CY2027**	**89%**	378	425		
CAREWare; HRSA Tool	**CY2028**	**90%**	383	425		
BM2. By 12/31/28, increase the proportion of pregnant HS participants who receive prenatal care in the first trimester to 80%. Data Source:	**Baseline**: 70% Data Sources: Davidson County Natality, 2019-2021;% live births with 1st trimester prenatal care				Recruitment and outreach efforts focus on pregnant women as early in pregnancy as possible: ▪ Central Referral System priorities early 1st trimester referrals to NSB; ▪ Assess insurance status at intake; ▪ Assist with presumptive eligibility enrollment (if applicable); ▪ Refer to Clinical Services Contractor for prenatal appointment; ▪ CSC priorities 1st trimester NSB participants for weekend appointments	▪ CM, NM, CC ▪ Clinical Services Contractor (CSC) *Documented 1st trimester prenatal visit
CAREWare; HRSA Tool	**CY2024**	**70%**	175	250		
CAREWare; HRSA Tool	**CY2025**	**72%**	180	250		
CAREWare; HRSA Tool	**CY2026**	**74%**	185	250		
CAREWare; HRSA Tool	**CY2027**	**76%**	190	250		
CAREWare; HRSA Tool	**CY2028**	**80%**	200	250		
BM3. By 12/31/28, increase the proportion of HS women participants who receive a postpartum visit to 80%. Data Source:	**Baseline**: 65% Data Sources: NSB CY22 project data % HS women with postpartum visit between 4 to 6 weeks after delivery				▪ Provide at least 1 ed. session on the importance of the post-partum (PP) visit during prenatal visit encounters (3rd trimester); ▪ Ensure PP visit appointment is scheduled immediately after delivery or within 48 hours post-discharge; ▪ Follow up with all women to remind them of their PP appointment at least a week in advance; ▪ Follow up with all women to send reminders (calls, texts, visits) about the PP appointment at least 3 days before appointment to make sure women have adequate transportation, childcare, etc.; ▪ Follow up on missed appoints. to reschedule	▪ CM, NM, CC ▪ Clinical Services Contractor (CSC) *Documented PP visit
CAREWare; HRSA Tool	**CY2024**	**65%**	163	250		
CAREWare; HRSA Tool	**CY2025**	**69%**	172	250		
CAREWare; HRSA Tool	**CY2026**	**73%**	181	250		
CAREWare; HRSA Tool	**CY2027**	**76%**	191	250		
CAREWare; HRSA Tool	**CY2028**	**80%**	200	250		
Project Period Objectives	**CY**	**Goal**	**Num.**	**Dem.**	**Actions**	**Responsible**

Attachment 2 Work-Plan and Performance Measures

BM4. By 12/31/28, increase proportion of HS women participants who receive a well-woman/preventive visit in the past year to 80%. Data Source:	**Baseline**: 64% Data Sources: PRAMS, 2020 % TN women who had a health care visit in the 12 months before pregnancy				Focus on interconception women to ensure they have a usual source of care for preventive/well-woman care: ▪ Provide education session on the importance of establishing a medical home/usual source of care within the first 6 months interconception; ▪ Connect interconception women to CSC to receive well-woman supportive education; ▪ Connect interconception women to safety net provider if she lacks health insurance coverage; ▪ Follow up with interconception care women with an established source of care to document well woman visit within 18 months interconception	▪ CM, NM, CC ▪ CSC *Documented usual source of care
CAREWare; HRSA Tool	**CY2024**	**64%**	160	250		
CAREWare; HRSA Tool	**CY2025**	**68%**	170	250		
CAREWare; HRSA Tool	**CY2026**	**72%**	180	250		
CAREWare; HRSA Tool	**CY2027**	**76%**	190	250		
CAREWare; HRSA Tool	**CY2028**	**80%**	200	250		
BM5. By 12/31/28, increase proportion of HS infants placed to sleep following safe sleep practices to 80%. Data Source:	**Baseline**: 78% Data Sources: PRAMS, 2020 % TN women reporting infant most often laid on back to sleep				▪ Provide at least one education session on infant safe sleep during the prenatal visit encounter (3rd trimester); document where family intends to sleep the infant when the baby comes home; ▪ Document infant safe sleep education in hospital discharge education; ▪ Reinforce and observe infant sleep behavior during the first post-discharge visit; ▪ Provide families who are in need of a safe place to have their infant sleep (pack-n-plays, sleep sacks, etc.) with safe sleep support; ▪ Reinforce infant safe sleep education during the visit encounters through 6 months post-delivery with all infant caregivers; ▪ Document infant safe sleep behaviors (sleeping on the back, in a crib with no other objects in the crib)	▪ CM, NM, CC *Documented safe sleep behaviors
CAREWare; HRSA Tool	**CY2024**	**78%**	137	175		
CAREWare; HRSA Tool	**CY2025**	**79%**	138	175		
CAREWare; HRSA Tool	**CY2026**	**80%**	140	175		
CAREWare; HRSA Tool	**CY2027**	**80%**	140	175		
CAREWare; HRSA Tool	**CY2028**	**80%**	140	175		
BM6. By 12/31/28, increase proportion of HS infant participants who were:						
A. Ever breastfed/given breast milk to 82%. Data Source:	**Baseline**: 79.9% Data Sources: Davidson County Natality, 2019-2021; % AA live births breastfed on hospital discharge				▪ Educate on benefits of breast-feeding (BF) for mom and baby during prenatal visit encounters to mom and father/partner (3rd trimester); ▪ Document hospital breast-feeding (BF) initiation; ▪ During first post-discharge visit, discuss support to continue breast-feeding and plans to express breast milk; ▪ For mothers needing additional support, connect mom to an available BF peer counselor; ▪ Doula contractors also contacted for additional lactation support	▪ CM, NM, CC ▪ Doulas *Documented BF initiation
CAREWare; HRSA Tool	**CY2024**	**80%**	140	175		
CAREWare; HRSA Tool	**CY2025**	**80%**	140	175		
CAREWare; HRSA Tool	**CY2026**	**81%**	142	175		
CAREWare; HRSA Tool	**CY2027**	**81%**	142	175		
CAREWare; HRSA Tool	**CY2028**	**82%**	144	175		
Project Period Objectives	**CY**	**Goal**	**Num.**	**Dem.**	**Actions**	**Responsible**

Attachment 2 Work-Plan and Performance Measures

B. Breastfed or fed pumped milk at 6 months to 50%. Data Source:	**Baseline**: 48%Data Sources: NSB CY2022 project data% ever fed infants still breastfed at 6 months				▪ For mothers needing additional support, connect mom to an available BF peer counselor ▪ Doula contractors continue providing peer breastfeeding support ▪ Refer mothers to community-based breastfeeding peer support group	▪ Doulas *Documented BF continuation
CAREWare; HRSA Tool	**CY2024**	**48%**	84	175		
CAREWare; HRSA Tool	**CY2025**	**48%**	84	175		
CAREWare; HRSA Tool	**CY2026**	**49%**	86	175		
CAREWare; HRSA Tool	**CY2027**	**49%**	86	175		
CAREWare; HRSA Tool	**CY2028**	**50%**	88	175		
BM7. By 12/31/28, increase proportion of HS participants who abstain from cigarette smoking or using tobacco products to 90%. Data Source:	**Baseline**: 93.7% Data Sources: Davidson County Natality, 2019-2021; % African American maternal smoking during pregnancy (6.3%)				▪ Assess pregnant participants tobacco/smoking use; ▪ Smokers who are identified are connected to the GIFTS program to assist with helping moms to quit smoking (incentives included) ▪ Reinforce tobacco abstinence during interconception and referral for permanent cessation after delivery.	▪ CM, NM, CC ▪ CSC ▪ GIFTS staff *Documented tobacco abstinence
CAREWare; HRSA Tool	**CY2024**	**89%**	223	250		
CAREWare; HRSA Tool	**CY2025**	**89%**	223	250		
CAREWare; HRSA Tool	**CY2026**	**90%**	225	250		
CAREWare; HRSA Tool	**CY2027**	**90%**	225	250		
CAREWare; HRSA Tool	**CY2028**	**90%**	225	250		
BM8. By 12/31/28, increase the proportion of HS child participants who receive the last age-appropriate recommended well-child visit based on AAP schedule to 90%. Data Source:	**Baseline**: 80% Data Sources: NSB CY2022 project data; % enrolled NSB infants receiving last age-appropriate well-child visit per AAP				▪ Provide pediatric care access via weekend clinic or mobile unit and follow up with reminders about well-baby visits; ▪ Document completed well-baby visits in participant file; ▪ Provide education and scheduled transportation, childcare arrangements, etc.	▪ CM, NM, CC ▪ CSC *Parent reported well child visit; up to date immunization record for eligible children
CAREWare; HRSA Tool & TENIIS	**CY2024**	**80%**	140	175		
CAREWare; HRSA Tool & TENIIS	**CY2025**	**83%**	144	175		
CAREWare; HRSA Tool & TENIIS	**CY2026**	**85%**	149	175		
CAREWare; HRSA Tool & TENIIS	**CY2027**	**88%**	153	175		
CAREWare; HRSA Tool & TENIIS	**CY2028**	**90%**	158	175		
Project Period Objectives	**CY**	**Goal**	**Num.**	**Dem.**	**Actions**	**Responsible**
BM9. By 12/31/28, increase the proportion of HS women participants who:						

a). receive depression screening to 90%. Data Source:	**Baseline**: 99.5% Data Sources: NSB CY2022 project data; % of women participants who receive perinatal screening				All enrolled participants will be frequently screened for depression using the Edinburgh screening tool with referrals for support as applicable. Specific activities include: ▪ Administer Edinburgh at 6 weeks PP; ▪ participants with a positive PP depression screening will be referred to the safety net providers and the contracted Behavioral Health Specialist for services; ▪ follow up with participants to track the extent to which depressive symptoms have resolved or are being treated	▪ CM, NM, CC ▪ CSC and co-located behavioral health provider *Documented depression screen
CAREWare; HRSA Tool	**CY2024**	**90%**	225	250		
CAREWare; HRSA Tool	**CY2025**	**90%**	225	250		
CAREWare; HRSA Tool	**CY2026**	**90%**	225	250		
CAREWare; HRSA Tool	**CY2027**	**90%**	225	250		
CAREWare; HRSA Tool	**CY2028**	**90%**	225	250		
b). Of those who screen positive for depression, increase proportion who receive referral to 95%. Data Source:	**Baseline**: 76% Data Sources: NSB CY2022 project data; % of positive screens referred				All enrolled participants will be frequently screened for depression using the Edinburgh screening tool with referrals for support as applicable. Specific activities include: ▪ Administer Edinburgh at 6 weeks PP; ▪ participants with a positive PP depression screening will be referred to the safety net providers and the contracted Behavioral Health Specialist for services; ▪ follow up with participants to track the extent to which depressive symptoms have resolved or are being treated	▪ CM, NM, CC ▪ CSC and co-located behavioral health provider *Documented referral and additional services (as applicable)
CAREWare; HRSA Tools & Referral Log	**CY2024**	**76%**	24	31		
CAREWare; HRSA Tools & Referral Log	**CY2025**	**81%**	25	31		
CAREWare; HRSA Tool & Referral Log	**CY2026**	**86%**	27	31		
CAREWare; HRSA Tool & Referral Log	**CY2027**	**90%**	28	31		
CAREWare; HRSA Tool & Referral Log	**CY2028**	**95%**	30	31		
BM10. By 12/31/28, increase the proportion of HS women participants who:						
a). receive interpersonal violence (IPV) screening to 90%. Data Source:	**Baseline**: 100% Data Sources: NSB CY2022 project data; % of women participants who receive IPV screening				All enrolled participants will be frequently screened for IPV using the HITS screening tool with referrals for support as applicable. Specific activities include: ▪ IPV screening conducted at intake and every 3 months through 18 months interconception; ▪ participants with a positive IPV screen will be referred to the city domestic violence center (Metro Davidson County Office of Family Safety) for follow up and assistance	▪ CM, NM, CC ▪ CSC *Documented IPV screen and services (as applicable)
CAREWare; HRSA Tools & HITS Tool	**CY2024**	**90%**	225	250		
CAREWare; HRSA Tools & HITS Tool	**CY2025**	**90%**	225	250		
CAREWare; HRSA Tools & HITS Tool	**CY2026**	**90%**	225	250		
CAREWare; HRSA Tools & HITS Tool	**CY2027**	**90%**	225	250		
CAREWare; HRSA Tools & HITS Tool	**CY2028**	**90%**	225	250		
Project Period Objectives	**CY**	**Goal**	**Num.**	**Dem.**	**Actions**	**Responsible**
b). Of those who screen positive for IPV, increase proportion who receive referral to 95%. Data Source:	**Baseline**: 100% Data Sources: NSB CY2022 project data; % of positive screens referred				All enrolled participants will be frequently screened for IPV using the HITS screening tool with referrals for support as applicable. Specific activities include:	▪ CM, NM, CC ▪ CSC and co-located
CAREWare; HRSA Tools & Referral Log	**CY2024**	**76%**	19	25		

CAREWare; HRSA Tools & Referral Log	**CY2025**	**81%**	20	25	▪ IPV screening conducted at intake and every 3 months through 18 months interconception; ▪ participants with a positive IPV screen will be referred to the city domestic violence center (Metro Davidson County Office of Family Safety) for follow up and assistance; ▪ *Refusals are documented as referred but refused services*	behavioral health provider *Documented IPV screen and services (as applicable)
CAREWare; HRSA Tools & Referral Log	**CY2026**	**86%**	21	25		
CAREWare; HRSA Tools & Referral Log	**CY2027**	**90%**	23	25		
CAREWare; HRSA Tools & Referral Log	**CY2028**	**95%**	23	25		

Focus 2. Community Participants Completed Group-Based Education

By 3/31/2029, increase number of community participants completing group-based education sessions to 1,250.

Project Period Objectives	PP	Goal	Actions	Responsible
By 3/31/2025, increase number of community participants completing group-based education to 250.	**PP1**	**250**	▪ Conduct monthly outreach and recruitment of community participants; ▪ Facilitate weekly/bi-weekly prenatal and parenting classes using evidence-based and evidence-informed curricula; ▪ Maintain attendance roster of participants by session; ▪ Provide retention supplies to participants completing at least 50% of sessions; ▪ Provide meals, childcare and transportation (as needed) for maximum session participation	▪ CC, Group education contractor (GEC), Fatherhood Engagement Contractor (FEC) ▪ Doula and Education Manager (DEM)
By 3/31/2026, increase number of community participants completing group-based education to 500.	**PP2**	**500**	Same as above	Same as above
By 3/31/2027, increase number of community participants completing group-based education to 750.	**PP3**	**750**		
By 3/31/2028, increase number of community participants completing group-based education to 1,000.	**PP4**	**1,000**		
By 3/31/2029, increase number of community participants completing group-based education to 1,250.	**PP5**	**1,250**		

Focus 3. Clinical Services Access

By 3/31/2029, provide access to monthly weekend clinics for prenatal, postpartum, and behavioral health services for enrolled case managed participants.

Project Period Objectives	PP	Goal	Actions	Responsible
a). By 7/31/2024, begin administration of weekend prenatal and postpartum clinics and provide access to behavioral health appointments.	**PP1**	9 clinics	▪ Refer & schedule appointments for enrolled participants in need of usual source of care; ▪ Use existing contract with Meharry Medical College to provide services immediately (4/1/2024 – 10/31/2024; ▪ Initiate Metro contract procurement process for	▪ CM, NM, CC ▪ Meharry Medical College (MMC) ▪ PD, PM ▪ Metro Procurement Team

b). By 3/31/2025, increase prenatal and postpartum clinics and access to behavioral health appointments to 9 monthly clinics			competitive bid for permanent contract (11/1/2024 – 3/31/2029)	▪ Clinical Services Contractor (CSC)
By 3/31/2026, increase prenatal and postpartum clinics and access to behavioral health appointments to 21 monthly clinics.	**PP2**	21 clinics	▪ Refer & schedule appointments for enrolled participants in need of usual source of care; ▪ Host monthly weekend clinics and behavioral health appointments	▪ CM, NM, CC ▪ Clinical Services Contractor (CSC)
By 3/31/2027, increase prenatal and postpartum clinics and access to behavioral health appointments to 33 monthly clinics.	**PP3**	33 clinics	Same as above	Same as above
By 3/31/2028, increase prenatal and postpartum clinics and access to behavioral health appointments to 45 monthly clinics.	**PP4**	45 clinics		
By 3/31/2029, increase prenatal and postpartum clinics and access to behavioral health appointments to 57 monthly clinics.	**PP5**	57 clinics		

Focus 4. Community Consortium

By 3/31/2029, maintain Community Consortium with at least 25% community member representation and implement action plan with at least 5 performance measures focused on addressing the social determinants of health.

Project Period Objectives	PP	Goal	Actions	Responsible
By 5/31/2024, increase annual Health Education Plan to 1.	**PP1**	**1 plan**	▪ Draft initial health education plan (participant education and on-going development for NSB staff); ▪ Submit draft Community Consortium (Community Transformation Network, CTN) Core Leadership Team (CLT) review and input; ▪ Convene CLT for final review; ▪ Submit annual plan.	▪ PM, DEM, PD ▪ CLT * 1 Health Education Plan
a). By 6/30/2024, convene Community Consortium (CTN) and begin CTN Action Plan development. b). By 7/31/2024, Community Consortium (CTN) membership is at least 25% community member representation. c). By 10/30/2024, obtain community-buy-in for CTN Action Plan that has at least 5 performance measures related to SDOH foci.	**PP2**	**10 meetings**	▪ Review existing CTN membership and invite new members according to need; ▪ Identify and train CTN Participant Representative; ▪ Announce new grant award and send meeting "Save-the-Date"; ▪ Host CTN meeting at time that works best for maximum community participation; ▪ Compensate community member attendance (non-grant funds); ▪ Facilitate monthly CTN meetings	▪ PD, PM, Core Leadership Team; ▪ Community Consortium Coordinator (CCC) ▪ Participant Representative (PR) *1 CTN Action Plan * HS COP attendance

d). By 11/1/2024, begin implementation and tracking of CTN actions to address SDOH. e). By 3/31/2025, regularly participate in Healthy Start Community of Practice f). By 3/31/2025, increase Community Consortium convenings to 10 monthly meetings.				
By 3/31/2026, increase Community Consortium convenings to 14.	**PP2**	**4 quarterly meetings**	▪ Facilitate quarterly CTN meetings and monthly CTN workgroup meetings; ▪ Track and report on implementation progress and performance measure benchmarks; ▪ Disseminate annual implementation report and revise action plan as needed; ▪ Review NSB project performance and advise annual health education plan; ▪ Assist with expanding resource network and collaborations	▪ CCC, PR, PM ▪ CTN CLT ▪ CTN workgroup chairs/co-chairs ▪ CTN members * Annual dissemination report * Annual plan revision
By 3/31/2027, increase Community Consortium convenings to 18.	**PP3**	**4 quarterly meetings**	Same as above	Same as above
By 3/31/2028, increase Community Consortium convenings to 22.	**PP4**	**4 quarterly meetings**	Same as above	Same as above
By 3/31/2029, increase Community Consortium convenings to 34.	**PP5**	**12 meetings**	▪ Facilitate monthly CTN meetings and monthly CTN workgroup meetings; ▪ Track and report on implementation progress and performance measure benchmarks; ▪ Review NSB project performance; ▪ Disseminate annual implementation report; ▪ Create and adopt project sustainability plan	▪ CCC, PR, PM ▪ CTN CLT ▪ CTN workgroup chairs/co-chairs ▪ CTN members * Sustainability plan

MPHD utilizes the enterprise business system, **Kronos**, for accurate employee timekeeping. Electronic timeclocks are located at all Metro government sites throughout Davidson County and are specifically located near the employee elevators at MPHD sites. The MPHD Bureau of Finance and Administration maintains the Kronos system and is responsible for ensuring allocable time is accurately recorded and reviewed each pay period (26 annual pay periods) via time studies of allocable time. An employee whose time is dedicated in part to a specific project (any time less 100% effort) is reviewed via the pay period time study to prepare monthly invoices. The same time entry and review process will be utilized for the NSB project.

Staffing: The NSB Project includes the following **federally funded staffing plan**: Program Manager (1.0 FTE); Nurse Manager (1.0 FTE); Care Managers (1.0 FTE) x5 ; Care Coordinator (1.0 FTE) and Finance Officer (0.25 FTE). NSB also includes **the following non-federally funded key staff positions**: The Population Health Assistant Bureau Director/Project Director (0.10 FTE), the Doula and Group Education Manager (1.0 FTE), and Community Consortium Coordinator (0.25 FTE). All positions are currently filled with existing staff except the Care Coordinator position. See **Attachment 6_NSB Project Organizational Chart**.

Program Manager (1.0 FTE): ***Angela Williams***

Position Description: This position is responsible for the programmatic management of the Nashville Strong Babies (NSB) Project in the Bureau of Population Health with overall program oversight and staff supervision responsibilities. Also oversees the activities of the Community Consortium and the Consortium Coordinator (CC) as well as external contractors (Clinical Care, Evaluation, Fatherhood Support) who support enabling services. Supervises the Nurse Manager and reports to the Assistant Bureau Director for Population Health.

Specific responsibilities include: Provides supervision, performance monitoring and coaching of the Nurse Manager role; Oversees the multi-disciplinary Community Consortium activities and works collaboratively with the Consortium Coordinator and Participant Representative to focus on implementing improvements that address the social determinants of health. May elicit actionable recommendations and reasonable strategies to reduce preventable perinatal disparities; Provide fiscal oversight of external contractors as well as prepare and submit monthly, quarterly, and annual reports as required per grant contract; Ensure NSB staff has on-going training and quality improvement support in the implementation of the NSB project for the project performance periods. **Relevant Experience:** Existing employee has served as the NSB Program Manager since August 2020. The employee is a trained of Technology of Participation (TOP) facilitator and holds a Master's Degree in public health.

Nurse Manager (1.0 FTE): ***Angela Boffah***

Position Description: This position is responsible for oversight of direct services (case management/care coordination services), managing participant retention efforts and supporting referrals and linkages to clinical care and support services addressing social determinants of health. Supervises the Care Managers and reports to the Program Manager. **Specific responsibilities include:** Supervises the Care Manager staff (x5) in their provision of direct services to enrolled participants; Reviews participant retention strategies to maximum participation through 18 months interconception; Reviews assessment documentation for accuracy and completeness; Carries a small case load of high risk pregnant women to ensure timely recognition of early maternal warning signs; Monitors Care Manager staff daily activities and interaction with participants (assessing need, creating service plan, connecting participant to

a service, following up with participant to document that service was received and the outcomes of the service connection). Provides staff training as needed. Reviews intake assessments, creates the participants risk/resilience profile and assigns the participant to the appropriate team (care coordination/care support/case management). Performs the 48-hour post discharge home-visit for newborns enrolled in NSB. Hosts weekly case consults with the NSB teams. Acts as a member of the care coordination team for NSB participants and attends team meetings as needed. **Relevant Experience:** Existing employee has served as the Nurse Manager since December 2020. She has over 10 years of experience as a Registered Nurse and home-visitor.

Care Managers x 5 (1.0 FTE):

Position Description: Provides direct contact with NSB enrollees and potential enrollees in the target area to include conducting daily visit encounters (in-person, in-home or virtual) and documenting encounters in a timely manner. Uses evidence-informed home-visiting curricula to deliver education on a variety of topics from prenatal through parenting. Follows up with enrolled participants to connect them to services as needed, documents service received and the outcome of the service; reports to the Nurse Manager. **Specific responsibilities include:** Uses evidence-informed home-visiting curricula to deliver education on a variety of topics from prenatal through parenting. Completes documentation and periodic assessments as indicated and appropriate. Acts as member of the NSB care team, attending monthly case consults with the Nurse Manager and other care providers. Notifies the Nurse Manager when appropriate, when there is a change in the participant status (high risk to med./low risk). Participates in on-going training as needed. **Relevant Experience**: Four (4) of the 5 existing Care Managers have served as NSB Care Managers for at least 2 years. The staff include 1 Spanish Bilingual Care Manager who has served in NSB since April 2023. The Care Managers all have at least 5 years of case management/home-visiting experience. All Care Managers have at least a Bachelor's degree in a health related field and 3 years of full time experience in a case management and/or home-visiting capacity prior to joining NSB.

Care Coordinator (1.0 FTE): To be hired

Position Description: Processes incoming program referrals and assesses client interest in case management services. Provides direct contact with a case limited number of low risk NSB enrollees to include conducting daily visit encounters (in-person or virtual) and documenting encounters in a timely manner. Uses evidence-informed home-visiting curricula to deliver education on a variety of topics from prenatal through parenting. Follows up with enrolled participants to connect them to services as needed, documents service received and the outcome of the service; reports to the Nurse Manager. **Specific responsibilities include:** Uses evidence-informed home-visiting curricula to deliver education on a variety of topics from prenatal through parenting. Completes documentation and periodic assessments as indicated and appropriate. Conducts outreach to the primary population and assists with the facilitation of monthly group parenting classes with partners. Participates in on-going training as needed.

Non-Grant Funded Staff Positions

Project Director (0.10 FTE): *D'Yuanna Allen-Robb*

Position Description: The Assistant Bureau Director for Population Health serves as the Project Director (PD). The PD (10% effort is non-grant funded) supervises the Program Manager and provides administrative oversight and leadership for the grant activities as well as leading the

Core Leadership Team monthly meetings. **Specific responsibilities include:** Supervises the Program Manager, monitoring employee performance and providing regular feedback and coaching; Serves as the department liaison for the HRSA healthy start project, attending Project Officer calls and other required funder meetings as well as ensuring compliance with all grant requirements. **Relevant Experience**: The Assistant Bureau Director for Population Health has served as the NSB Project Director since April 2019. She holds a Master's Degree in public health and has over 17 years of public health administrative and grants management leadership experience.

Doula and Group Education Manager (1.0 FTE): *Dawn Smith*

Position Description: This position works collaboratively with NSB Care Managers, Nurse Manager, Program Manager, and Doula Contractors to ensure enrolled case managed participants receive high quality Doula support services and all participants (case managed and community participants) have access to high quality group based prenatal and parenting education. **Specific responsibilities include:** Ensures doulas are available to support high risk prenatal case managed clients; Coordinators monthly group based health and parenting education sessions in the service area; Manages external doula contractors; Ensures evidence-informed health and parenting curricula are used to deliver group based education sessions. Works collaboratively with the Nurse Manager. **Relevant Experience**: The existing employee has served with NSB as the Doula Project Coordinator since May 2022. Dawn is a Registered Labor and Delivery Nurse and Certified Doula with over 20 years of experience providing perinatal support to women.

Community Consortium Coordinator (0.25 FTE): *Nicole Barr*

Position Description: The Population Health Bureau Assistant Home-Visiting Coordinator will serve as the Community Consortium Coordinator (CC). The CC is responsible for scheduling and hosting the monthly consortium meetings, ensuring the meeting proceedings are documented, implementation strategies are documented along with the progress and outcomes of strategies. **Specific responsibilities include:** Facilitates the monthly Community Consortium meetings and serve as Co-Chair with the NSB Participant Representative; Meets with Co-Chair in advance to prepare meeting agenda and meeting design; Identifies any relevant subject matter experts or partners to attend meetings; Maintains roster of CC members and works to make sure at least 25% of participants are community members/healthy start participants. **Relevant Experience**: The existing employee has 10 years of experience serving a home-visitor in an evidence-based home-visiting program. The employee is a member of the Metro Public Health Department Facilitator Community of Practice and holds a Bachelor's Degree in a related field.

Finance Officer (0.25 FTE): *Jenny Avedisian*

Position Description: The Grants Management Finance Officer is responsible for the fiscal operations of the NSB grant program. **Specific responsibilities include:** Prepare monthly budget-to-actual reports, review and prepare budgeting documents or forecasting needed by programmatic staff. Meet monthly to review budget-to-actual, upcoming expenses, unexpended budget, and expected changes. Review contractor budgets, review invoice payables, complete annual contractor audit. Prepare quarterly expenditure reports submit drawdown requests. Complete all required federal financial reports. **Relevant Experience**: The existing employee serves as the Finance Officer for NSB since 2021. The employee holds a Bachelor's Degree in a related field.

Attachment 4 Biosketch: Key Personnel

NAME: **Angela Williams** PROJECT POSITION TITLE **Program Manager**	ORGANIZATIONAL POSITION TITLE **Metro Public Health Department** **Nashville Strong Babies Program Manager**

EDUCATION/TRAINING (*Begin with baccalaureate or other initial professional education and include postdoctoral training.)*

INSTITUTION AND LOCATION	DEGREE *(if applicable)*	YEAR(s)	FIELD OF STUDY
Florida Agricultural & Mechanical University Tallahassee, Florida	B.S.	2010	Health Science, Rehabilitative Services Management
Florida Agricultural & Mechanical University Tallahassee, Florida	M.P.H.	2016	Health Policy & Management

A. Personal Statement

Angela Williams is a skilled professional with over five years of experience in strategic development and program planning. Her recent accomplishments were the administration of the design, development and implementation of a performance management system integrated with health equity strategies and metrics to monitor the improvement of population health within Metro Nashville-Davidson County, and oversight and implementation of the health department's initial public health accreditation process. She has over five years of strategic development and program planning including social services, public health, and early childhood education areas. Her experience includes organizational/community engagement and partnership development, documentation infrastructure and standardization, quality/process improvement, improvement implementation, fiscal and contract management, federal grant compliance, policy research and analysis, data compilation and analysis, project management and training. In previous roles, she administrated federal grant programs and provided oversight for grant and direct service provider contract compliance.

B. Positions and Honors.

Positions

Nashville Strong Babies Program Manager 2020-Present
Metro Public Health Department
Responsible for programmatic oversight of Nashville Strong Babies; development and continuous improvement of NSB's policies and procedures; development and maintenance of strategic stakeholder relationships/partnerships; supervision and implementation of case management and consultation processes; management of medical/clinic and program subcontractor agreements.

Accreditation and Quality Improvement Coordinator 2016-2020
Metro Public Health Department
Responsible for developing and managing department-wide efforts performance management and quality improvement programs using a data-driven focus that sets priorities for improvements aligned to ongoing strategic goals; establishing policies and assuring procedures for ongoing program and project management processes.

Government Operations Consultant II 2015-2016
Florida Department of Health, Performance Assessment & Improvement
Responsible for providing technical assistance, consultative services, and direction for development, implementation, evaluation and expansion of programs of service in public health departments including public health accreditation and organizational quality improvement.

Consultant
Anchor Preparatory Academy, Inc. 2014-2016
Responsible for federal, state, and local educational institution funding attainment, and business capacity development. Established a solid documentation infrastructure to improve grant management practices.

Financial Assistance Coordinator 2013-2015
Family Endeavors, Inc.
Responsible for the federal grant administration, coordination of services, and processing of invoices and payments to third party and direct service providers by verifying contract deliverables and monitoring provider contractual adherence.

Attachment 4 Biosketch: Key Personnel

NAME: **Dawn Smith**	ORGANIZATIONAL POSITION TITLE **Doula Support Project Coordinator**
PROJECT POSITION TITLE **Nashville Strong Babies Doula and Education Manager**	

EDUCATION/TRAINING *(Begin with baccalaureate or other initial professional education, such as nursing, include postdoctoral training and residency training if applicable. Add/delete rows as necessary.)*

INSTITUTION AND LOCATION	DEGREE	YEAR(s)	FIELD OF STUDY
Tennessee State University (Nashville, TN)	RN	2002	Nursing
Doulas of North America (DONA)	Certified	2012	Doula
Tennessee Midwifery Assistant Training Program	Certified	1997	Midwifery Assistant

Dawn Smith is a Registered Labor and Delivery Nurse and Certified Doula with over 20 years of experience providing perinatal support to women.

RELEVANT WORK EXPERIENCE

Nashville Strong Babies (NSB) Healthy Start Doula Support Project Coordinator
Metro Public Health Department May 2022 to present

Currently serving as a member of the Maternal Child and Adolescent Health team and reporting to the Maternal Child Adolescent Health Program Director; also working collaboratively with NSB Care Managers, Nurse Manager, Program Manager, and Doula Contractors to ensure enrolled participants receive high quality Doula support services. Overseeing supplemental federal grant management for the doula support project, doula contractor management, quality assurance and improvement management. Overseeing outreach and promotion aspects for the program for the duration of the grant project

Community Health Access Navigation Tennessee/ Children's Special Services (CHANT/CSS) Nurse Reviewer
Metro Public Health Department July 2021 to May 2022

Collaborated with the Medical Service Lead and CHANT teams to provide nursing support to facilitate and enhance care coordination for children and families; particularly those with special health care needs. Worked collaboratively with the Medical Service Lead to evaluate referrals for medical services for Children and Youth with Special Health Care Needs. Review, approve, deny, and close CSS applications/cases. Reviewed and approve Family Service Plans and Transition Plans. Received and log medical records and admitting treatment plans for applicant processing and CSS participants. Provided follow-up to Newborn Screenings received from Tennessee Department of Health (TDOH) to ensure that families are aware of potential medical issues of their newborn child. Provided updates to TDOH State laboratory.

Fetal Infant Mortality Review Medical Abstractor and Coordinator
Metro Public Health Department March 2018 to July 2021

Responsibilities included organizing and maintaining the FIMR medical record review case load. Requested and fully abstracted hospital, obstetric, pediatric, and social service records to collect data for synthesis. Coordinated data collection and research with Epidemiologist and FIMR Parental Interviewer. Prepared

case summaries for review and analysis by the case review team. Coordinated and facilitated the case review meetings. Maintained the National Reporting database. Shared facilitation of workgroups.

Registered Nurse- L&D-PRN
St Thomas Rutherford Medical Center March 2018 November 2018

Provided high-risk antepartum care. Responsible for timely, efficient, and accurate triage response.

Attachment 4 Biosketch: Key Personnel

NAME **D'Yuanna Allen-Robb** PROJECT POSITION TITLE **Project Director**	ORGANIZATIONAL POSITION TITLE **Assistant Bureau Director, Population Health** Metro Public Health Department of Nashville and Davidson County

EDUCATION/TRAINING (*Begin with baccalaureate or other initial professional education, and include postdoctoral training.)*

INSTITUTION AND LOCATION	DEGREE *(if applicable)*	YEAR(s)	FIELD OF STUDY
University of Tennessee, Chattanooga	B.S.	2001	Biology
University of Tennessee, Knoxville	M.P.H.	2004	Public Health Administration

A. Personal Statement

Ms. D'Yuanna Allen-Robb, MPH, leads local and national strategic program and policy initiatives to ensure the replication of culturally relevant program models to improve the health status of women. She previously served as the Interim Executive Director of Birthing Project USA (BPUSA), a global non-profit organization dedicated to improving the health status of women of color through mentorship before, during and after pregnancy. During her tenure at BPUSA, she was responsible for generating and managing over $800,000 in program and operational funding in a 2-year period as well as managing a 4-state regional program office. She serves as a member of the National Association of County and City Health Officials (NACCHO) Adolescent Health Infrastructure Project Expert Panel, working to increase the capacity of local health departments to improve adolescent health as a strategic priority. D'Yuanna has published and presented numerous abstracts at national public health and academic conferences focused on reproductive health and youth engagement in public health practice. She currently serves as the Assistant Bureau Director for Population Health at the Metro Public Health Department of Nashville/Davidson County.

B. Positions and Honors

Positions

2022-present **Assistant Bureau Director, Population Health**
Metro Public Health Department of Nashville/Davidson County
Responsible for the overall leadership and support to 133 employees, 6 divisions, 29 programs and annual budgets exceeding $18million. Directly supervise team responsible for managing complex, multi-year direct federal funding: HRSA Healthy Start and CDC Community Health Worker Projects.

2016-2022 **Maternal Child and Adolescent Health Director**
Metro Public Health Department of Nashville/Davidson County
Responsible for the overall grant and program management of state and local funded infant, child and adolescent health programs with an annual operating budgets exceeding $5.8 million; Develop strategic relationships with diverse, multi-sector stakeholders – corporate, non-profit, community-based organization, healthcare, social services, etc. – to connect political will and resource capital to support systems improvements to reduce infant mortality disparities using a Lifecourse perspective; provide leadership to management team of 5.0 FTE direct reports and 18 division staff.

2015-2016 **Fetal Infant Mortality Review Director**
Metro Public Health Department of Nashville/Davidson County

Responsible for the overall grant and program management of state funded program with an annual operating budget of $318,000; Develop strategic relationships with diverse, multi-sector stakeholders – corporate, non-profit, community-based organization, healthcare, social services, etc. – to connect political will and resource capital to support systems improvements to reduce infant mortality disparities; Oversee 37 member organizational partnerships that comprise the FIMR Community Action Team to include panels of physicians, nurses, and other healthcare professionals; manage team of 2 FTE direct reports.

2012-2014 **Interim Executive Director**
Birthing Project USA, New Orleans, LA
Responsible for the development and management of new program and capacity building resources for a national non-profit organization with an annual operating budget of $550,000; Oversee the management of ten active grant-based project teams, working closely with program staff to develop competitive funding proposals and providing oversight of external contractors; Generated over $800,000 in grant funds to support central office operations as well as program implementation in a four (4)-state regional area.

2005-2012 **Director, Adolescent Health Office**
Metro Public Health Department, Nashville, TN
Consult and administer fiscal oversight of annual operating budgets exceeding $1.7 million and consult on inter- department and community-led related maternal and child health program and research initiatives, including operations control, budget analysis, project management planning, implementation, evaluation and reporting of project outcomes within the Family, Youth and Infant Health Bureau.

Attachment 4 Biosketch: Key Personnel

NAME: **Wanda (Nicole) Barr**	ORGANIZATIONAL POSITION TITLE **Assistant Home-Visiting Coordinator**
PROJECT POSITION TITLE **Community Consortium Coordinator**	

EDUCATION/TRAINING *(Begin with baccalaureate or other initial professional education, such as nursing, include postdoctoral training and residency training if applicable. Add/delete rows as necessary.)*

INSTITUTION AND LOCATION	DEGREE	YEAR(s)	FIELD OF STUDY
Tennessee State University (Nashville, TN) Volunteer State Community College	BS AS	2021 2015	Sociology Humanities

Nicole Barr is a community educator with over 18 years of experience working with new and expecting mothers from diverse populations within Nashville/Davidson County.

RELEVANT WORK EXPERIENCE

Assistant Home-Visiting Coordinator
Metro Public Health Department
July 2022 to present

Currently serving as a member of the Maternal Child and Adolescent Health team and reporting to the Maternal Child Adolescent Health Program Director; also working collaboratively with NSB Care Managers, Nurse Manager, Program Manager, and Doula Contractors to ensure enrolled participants receive high quality Doula support services. Overseeing supplemental federal grant management for the doula support project, doula contractor management, quality assurance and improvement management. Overseeing outreach and promotion aspects for the program for the duration of the grant project

Fetal Infant Mortality Review Safe Sleep Coordinator
Metro Public Health Department
February 2020 through June 2022

Provided community education and awareness regarding sudden infant death syndrome (SIDS) and preventing sleep-related deaths.

Healthy Beginnings Family Support Worker
Metro Public Health Department
March 2001-July 2014 and December 2017 through February 2020

Provided in-home visitation services to families with children, prenatal to age three. The primary focus was on supporting families by providing them with information on child development, tips and strategies to ensure a healthy pregnancy, and positive parenting skills. As a Home Visitor, I also provided developmental screenings, made referrals for additional resources, and assisted parents in setting family goals.

METROPOLITAN GOVERNMENT OF NASHVILLE AND DAVIDSON COUNTY

FREDDIE O'CONNELL
MAYOR

October 27, 2023

Lee Wilson
Director, Division of Healthy Start and Perinatal Services (DHSPS)
Attn: Healthy Start
Maternal and Child Health Bureau
Health Resources and Services Administration
5600 Fishers Lane
Rockville, MD 20857

Re: Metro Public Health Department of Nashville/Davidson County's Strong Babies Initiative

Healthy Start Initiative Grant Committee:

This letter is written in support of the Metro Public Health Department of Nashville/Davidson County (MPHD) HRSA-24-033 *Healthy Start Initiative: Eliminating Disparities in Perinatal Health* grant submission. The Office of Mayor Freddie O'Connell is honored to continue to support Nashville Strong Babies (NSB) to accelerate perinatal health improvements related to healthy pregnancy outcomes, breast-feeding initiation and sustainment, infant safe sleep, reduction of preterm birth, and much more. MPHD has a long history of mutual collaboration with community residents, community-based organizations as well as leading healthcare and public health systems to impact and improve health outcomes of our city's youngest residents. For example, in 2016, Nashville celebrated a 29% decline in sleep-related infant deaths, a result of well-coordinated multi-sector and multi-strategy efforts led by MPHD in partnership with hundreds of stakeholders.

As the innovative care management approach for Nashville and Davidson County's most at risk population for experiencing poor perinatal and infant health outcomes, Nashville Strong Babies has produced impressive results for Nashville residents. Breastfeeding rates for African American infants increased to 95% for those who received NSB doula support! We are excited to see the continued health improvements with renewed healthy start funding.

The Office of Mayor Freddie O'Connell sees this partnership with the Metro Public Health Department as opportunity to accelerate health outcomes improvements for Nashville/Davidson County residents. We are working together to open doors of opportunity so Nashville is a place where residents want to stay - and can stay - and experience optimal health.

We sincerely hope that you will give full consideration to this proposal.

Sincerely,

Freddie O'Connell
Mayor

OFFICE OF THE MAYOR
METROPOLITAN COURTHOUSE • NASHVILLE, TENNESSEE 37201
PHONE: (615) 862-6000 • EMAIL: mayor@nashville.gov

TN Department of Health

October 26, 2023

Lee Wilson
Director, Division of Healthy Start and Perinatal Services (DHSPS)
Attn: Healthy Start
Maternal and Child Health Bureau
Health Resources and Services Administration
5600 Fishers Lane
Rockville, MD 20857

Re: Metro Public Health Department of Nashville/Davidson County's Strong Babies Initiative

Healthy Start Initiative Grant Committee:

This letter is written in support of the Metro Public Health Department of Nashville/Davidson County (MPHD) HRSA-24-033 Healthy Start Initiative: Eliminating Disparities in Perinatal Health grant submission. The Tennessee Department of Health Division of Family Health and Wellness (FHW Division) is honored to support and work with the proposed Nashville Strong Babies Project as the case management and care coordination approach for Nashville and Davidson County's most at-risk population for experiencing poor perinatal and infant health outcomes. The proposal will further accelerate population health improvements related to breastfeeding initiation and sustainment, infant safe sleep, reduction of preterm birth, etc. The FHW Division has a long history of mutual collaboration with MPHD, particularly with cross collaboration on maternal and child health priorities. For example, since 2015, the FHW Division has served as an advisor on the Nashville Infant Vitality Collaborative. Likewise, MPHD serves as an advisor for Tennessee's Infant Mortality CollN (Safe Sleep) as well as for the Maternal and Child Health Title V Block Grant and the Tennessee Infant Mortality Reduction Strategic Plan.

The FHW Division looks forward to continuing to collaborate with MPHD in the successful implementation of the proposed Nashville Strong Babies Project through representation on the Community Consortia and service as a state advisor to the project.

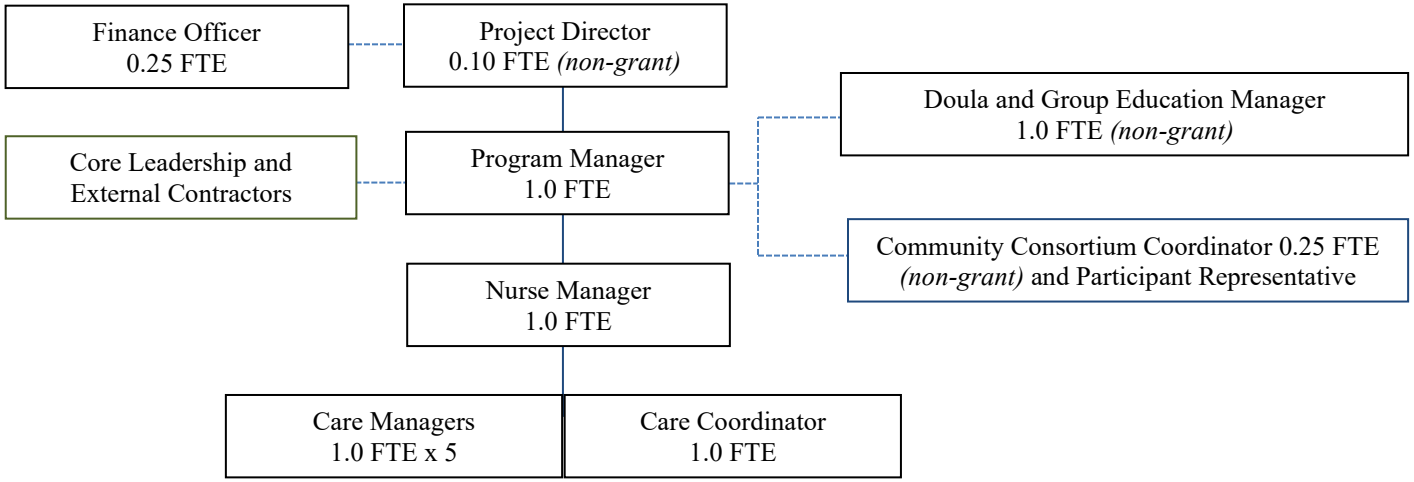
The Tennessee Department of Health Division of Family Health and Wellness sees this partnership with the Metro Public Health Department as an opportunity to accelerate health outcomes improvements for residents in Tennessee's state capitol and an opportunity to spread and scale successes in Nashville/Davidson County across the state. We sincerely hope you will strongly consider this proposal.

Sincerely,

Elizabeth M. H
Elizabeth Harvey (Oct 26, 2023 21:33 CDT)

Elizabeth Harvey
Assistant Commissioner
Title V, Maternal and Child Health Director

Attachment 6 – Nashville Strong Babies Project Organizational Chart



To ensure organizational leadership support and alignment, the Assistant Bureau Director for Population Health serves as the Project Director (PD). The PD (10% effort is non-grant funded) supervises the Program Manager and provides administrative oversight, leadership, and systems leverage for the grant activities. The Program Manager supervises the Nurse Manager and provides overall program management, including oversight for the Community Consortium and Consortium Coordinator (CCC), external contractors (Clinical Care, Evaluation, Fatherhood Support) who support enabling services, and the Doula/Group Education Manager. The CCC (25% effort is non-grant funded) is responsible for facilitating the monthly consortium meetings and co-chairing with the NSB Participant Representative. The Nurse Manager supervises the five (5) Care Managers and the Care Coordinator and is responsible for oversight of direct services (case management/care coordination services), managing retention efforts and supporting referrals and linkages to clinical care and support services addressing social determinants of health. The Care Managers provide direct case management and care coordination service to enrolled prenatal participants and their infants/children. The Care Coordinator (CC) contacts incoming program referrals and assesses interest in case management. The CC also coordinates care for low risk participants, conducts periodic community outreach and assists with the facilitation of education groups. The Doula and Group Education Manager (100% effort is non-grant funded) ensures doula services are available for the highest risk prenatal participants and manages the community-based group prenatal and parenting education. Project Management coordination for fiscal, program implementation, monitoring and evaluation with be coordinated by the PD in conjunction with appropriate MPHD systems (Bureau of Finance and Administration, Division of Epidemiology, Performance Management System, etc.). Finally, the Finance Officer (FO) is responsible for the review and fiscal approval of contractor payments, review of approved and allocable expenses and review and forecasting expenditures and internal controls. The PD will be the primary communication linkage between internal MPHD processes and systems, external contractors and partners and program management. All positions are currently filled with existing staff.

Attachment 7 Data Tables and Charts

Table 1. Community characteristics, Davidson County, 5 Year Cohort, 2017-2021					
Source: American Community Survey: 5 year estimates for the period 2017 - 2021.					
VARIABLE	**NH Black**	**NH White**	**Hisp**	**Other**	**Total****
Estimated Total Population	188,857	394,503	73,908	51,222	708,490
% Total Population	26.7	55.7	10.4	7.2	100
Estimated Female Population	101,455	202,480	35,002	27,047	365,984
Female Population 18-44 years of age	42,447	89,876	14,592	12,377	159,292
% of Female Population, 18-44 years of age	**27%**	56%	9%	8%	100
Table 2. MCH Population Outcomes^, Davidson County, 3 Year Cohort, 2019-2021					
MCH VARIABLES	**NH Black**	**NH White**	**Hisp**	**Other**	**Total****
# Live Births	**7,810**	**14,273**	**6,038**	**1,372**	**29,652**
# Live Births w/1st Trimester entry into care	5,369	11,531	2,715	963	20,664
% Live Births w/1st Trimester entry into care	68.7	80.8	45.0	70.2	69.7
% Inadequate prenatal care, APNCU	19.4	11.4	36.2	18.1	18.9
% Adequate or more than adequate prenatal care, APNCU	68.9	74.1	49.4	68.4	67.3
# Infant Deaths	**116**	46	42	4	**210**
Infant Mortality Rate (per 1,000 live births)	**14.9**	3.2	7.0	2.9	7.1
Neonatal Mortality Rate (per 1,000 live births)	**8.3**	2.4	5.5	2.2	4.6
PostNeonatal Mortality Rate (per 1,000 live births)	**6.5**	0.8	1.5	0.7	2.5
***SUID Rate (per 1,000 live births)**	4.2	0.5	0.5	0	1.5
% Infant deaths that were sleep-related	**31.9**	19.6	7.1	0	23.3
# Fetal Deaths	53	36	23	1	118
% Fetal deaths among multiparous individuals	75.5	69.4	73.9	100.0	72.9
# Low Birth Weight (LBW) <2500 grams	1,147	933	485	117	2,699
% LBW <2500 grams	**14.7**	6.5	8.0	8.5	9.1
# Preterm Births (PTB) <37 weeks gestation	1,197	1,228	626	120	3,185
% PTB <37 weeks gestation	**15.3**	8.6	10.4	8.7	10.7
% live births to mothers < than 20 years old	6.5	1.6	10.4	2.1	4.7
Age-specific fertility rates per 1,000 females aged 15-19 years	23.7	9.4	64.2	10.3	23.4

Attachment 7 Data Tables and Charts

% Live births to first time mothers (primiparous)	29.7	42.5	28.9	38.6	36.1
% Live births breastfed on hospital discharge	**79.9**	93.7	88.4	93.0	88.9
% women with chronic prenatal hypertension	**4.6**	1.5	1.8	1.2	2.4
% women with gestational diabetes	**6.3**	6.1	8.0	13.1	6.9
% women with chronic diabetes	1.4	0.5	1.4	0.7	0.9
% maternal smoking during pregnancy	**6.3**	4.6	0.6	0.9	4.0
% mothers who were married at delivery	26.4	81.1	38.3	81.6	57.8
% mothers enrolled in WIC	40.4	13.0	41.9	28.2	26.9
% mothers experiencing obesity prior to pregnancy	36.9	15.5	26.4	12.6	23.3
% Multiparous women with poor previous pregnancy outcome	2.7	2.5	2.8	3.3	2.7
% Multiparous women with short pregnancy interval (<=18 m	18.5	19.2	15.1	14.6	17.9
% Births paid by state Medicaid (TennCare)	**60.5**	18.8	61.6	30.3	39.2

*Rates with numerator <5 should be considered unstable. **Total may include events for which race/ethnicity is unknown; Target area is Davidson County. Source: Davidson County Natality, Mortality & Fetal Death Files, 2019-2021, Tennessee Department of Health.

Table 3. Selected Population Indicators, Davidson County, 2019-2021, or 2021

Sources: Kids Count (KC21); ACS 2021; PLACES, BRFSS (BRFS-21) 2021; County Health Rankings 2021 (CHR)

Indicators	NH Black	NH White	Hisp	Total**	Source
% high school graduation	82.3	87.2	73.4	81.7	KC21
% individuals below poverty level	21.5	9.4	21.3	14.3	ACS; S1701
% with no health insurance	12.0	7.7	38.2	12.2	ACS; S27001
% women 19-44 with no health insurance	12.6	8.2	50.4	5.7	ACS; B27001
% of family households with own children of the householder under 18 years	26.8	17.5	42.5	22.0	ACS; S0201-21
% female-headed households w/own children < 18 years	16.3	3.0	11.7	7.0	ACS; S0201-21

Attachment 7 Data Tables and Charts

% female-headed households with related children of the householder under 18 years below poverty level	42.8	27.8	55.6	38.2	ACS; S0201-21
% female householder with children under age 18 receiving food stamps/SNAP				30.9	ACS; S2201-21
% households receiving food stamps/SNAP	52.9	31.2	6.8	9.8	ACS; S2201-21
Median Household income	$49,100	$77,300	$55,200	$65,500	CHR 2021
Average household income (with earnings)	$63,980	$114,788	$84,555	$99,843	ACS; S0201-21
No leisure-time physical activity among adults >=18 years				24.7	BRFS-21
Diagnosed diabetes among adults aged >=18 years				11.3	BRFS-21
Obesity among adults aged >=18 years				32.6	BRFS-21
High blood pressure among adults aged >=18 years				32.5	BRFS-21
Taking medicine for high blood pressure control among adults aged >=18 years with high blood pressure				62.7	BRFS-21
Depression among adults aged >=18 years				25.1	BRFS-21
Educational Attainment - % of population 25 years and older					
% less than a high school diploma	11.8	4.8	37.0	9.6	ACS; S0201-21
% high school diploma	28.4	18.1	26.6	21.2	ACS; S0201-21
% some college or associate degree	28.1	21.9	16.9	22.5	ACS; S0201-21
% bachelor's degree	20.4	34.5	11.8	28.9	ACS; S0201-21

Notes: Any field that is blank represents an estimate that was unavailable or incalculable from the data available.

Federal Healthy Start Proposed Budget (Nashville Strong Babies)		
SF424A Federal Budget		
Object Class Codes	**Year 5**	
Budget	**$ 1,100,000**	
a. Salaries & Wages		
Full-time	516,844	
Part-time	-	
Total Salaries & Wages	**$ 516,844**	
b. Fringe Benefits	**$ 230,001**	
c. Total Personnel Costs	**$ 746,845**	
d. Consultant Costs	**$ -**	
e. Equipment		
Items < $5000	-	
Items > $5000	-	
Total Equipment	**$ -**	
f. Supplies	**$ 12,100**	
g. Travel		
Local travel	5,502	
National travel	5,000	
Total Travel	**$ 10,502**	
h. Construction	**$ -**	
i. Other	**$ -**	
j. Contractual	**$ 175,100**	
j. Total Direct Charges	**$ 944,547**	
k. Indirect Charges	**$ 155,453**	
l. TOTALS	**$ 1,100,000**	

Attachment 9 Evaluation Plan (Nashville Strong Babies)

Table 6. Nashville Strong Babies Initial Evaluation Plan – The evaluation plan outlines data collection, analysis and reporting for 4 Focus areas.

Focus Area 1. CASE MANAGEMENT PARTICIPANT BENCHMARKS				
Tactic & Activities (BM#)	**Individual & Group Process Measures**	**Outcomes and Impact Measures**	**Start/Stop Frequency**	**Responsibility**
- ACA Outreach and enrollment **(BM1)** - Coordination and facilitation of access to health care services **(BM1,2,3,4,8)** - Comprehensive assessment, case management **(BM1-10)** - Support for prevention, interconception health, and health promotion; assistance with childbirth **(BM1-10)** - Service coordination and systems integration with a usual of care **(BM1-10)** - Focus on prevention and health promotion **(BM4, 5)** - Core competencies for workforce **(BM1-10)** - Standardized curriculum and intervention **(BM1-10)** - Support mental and behavioral health	▪ # contacts; # outreach events and # reached; # enrolled in 1st trimester; # enrolled in ACA; # enrolled in presumptive eligibility; # completed Medicaid Part B after delivery; # HS participants with usual source of care; # weekend clinic appointments; # referred to safety net provider (if denied coverage); # children covered after delivery / coverage type; # children referred to safety net provider; ▪ # assessed by topic/tool; # / type risks; # / type protective factors; ▪ # referrals made/ completed; # CM/CC/NM visits; adequacy prenatal care (#/X̄ prenatal visits); # medical visits; # medical visit reminders (e.g., calls, text, visits, etc.); # referred/enrolled in GIFTS maternal cessation program; ▪ # depression screen ÷ screen positive; # / type toxic stress risks; # PP screened IPV; # safety plans; # staff trained on trauma informed care; # MH referrals ÷ completed of coverage and # reached; # materials distributed; # pack-n-plays distributed; # requesting breast feeding support; # Health education lessons to HS participants individually; # Health education classes / # & who attends; # scheduled transportation services; # childcare arrangements; ▪ # MOUs; # interagency "release of information" forms completed; # developmental screens; ↑ in staff competencies; Implementation fidelity; # ASQ screenings completed / # referrals; # / frequency children screened & #	**OUTCOME** % women and child participants with health insurance coverage; % PP with postpartum visit; % PP with well-women visit; % HS participants with medical home; % age-appropriate well-child visits; % HS participants engaged in safe sleep; % HS participants ever breastfeed; % HS participants breastfeed @ 6 mo.; % pregnant PP who abstain from smoking; # / % PP IPV screen; % PP depression screen +; % PP receiving depression services **IMPACT** % women of childbearing age in target area with health insurance coverage % population served with case management ↓ duplication of services in the community; ↓ in sleep related deaths; ↑ in breastfeeding in priority population; ↑ in sustained breastfeeding in priority population ↑ age appropriate well child immunization in priority population	4/1/24 to 5/31/29 Ongoing Collection, Quarterly Review, Annual Report	NSB Care Manager, Care Coordinator, Nurse Manager Lead Evaluator

	developmental/socio-emotional issues identified; # children referred for developmental issues			

Process, Outcome & Impact Measures Data Source: Program Records; CAREWare Data; HRSA Tools; Priority population data (e.g., perinatal stats, ACS, etc.)

Focus Area 2. GROUP-BASED EDUCATION PARTICIPANTS

Tactic & Activities (BM#)	Individual & Group Process Measures	Outcomes and Impact Measures	Start/Stop Frequency	Responsibility
- Address toxic stress and support delivery of trauma-informed care - Childbirth education and advocacy - Promote father involvement - Improve positive parenting	▪ # health education lessons (e.g., post-partum visits, safe sleep, breast feeding, usual source of care, smoking cessation, depression, early maternal warning signs, etc.) disseminated for case managed and community participants; # activities to increase community knowledge and awareness of health promotion topics; ▪ # parenting lessons available to community and case managed participants ; # parenting classes / attend; # transportation requests; # childcare requests; ▪ # staff trained; Implementation fidelity	**OUTCOME** % prenatal participants completing childbirth education; % prenatal participants with completed birth plan; # postpartum participants attending breastfeeding support classes; # participants attending parenting classes; # of participants completing parenting classes; # of participants completing prenatal classes **IMPACT** ↑ community / provider awareness of prevalence of toxic stress on pregnancy and its impact ↑ positive parenting practices in Priority Population	4/1/24 to 5/31/29 Ongoing Collection, Quarterly Review, Annual Report	Doula and Education Manager, doulas CC, NM, CM Group Education Contractor Lead Evaluator

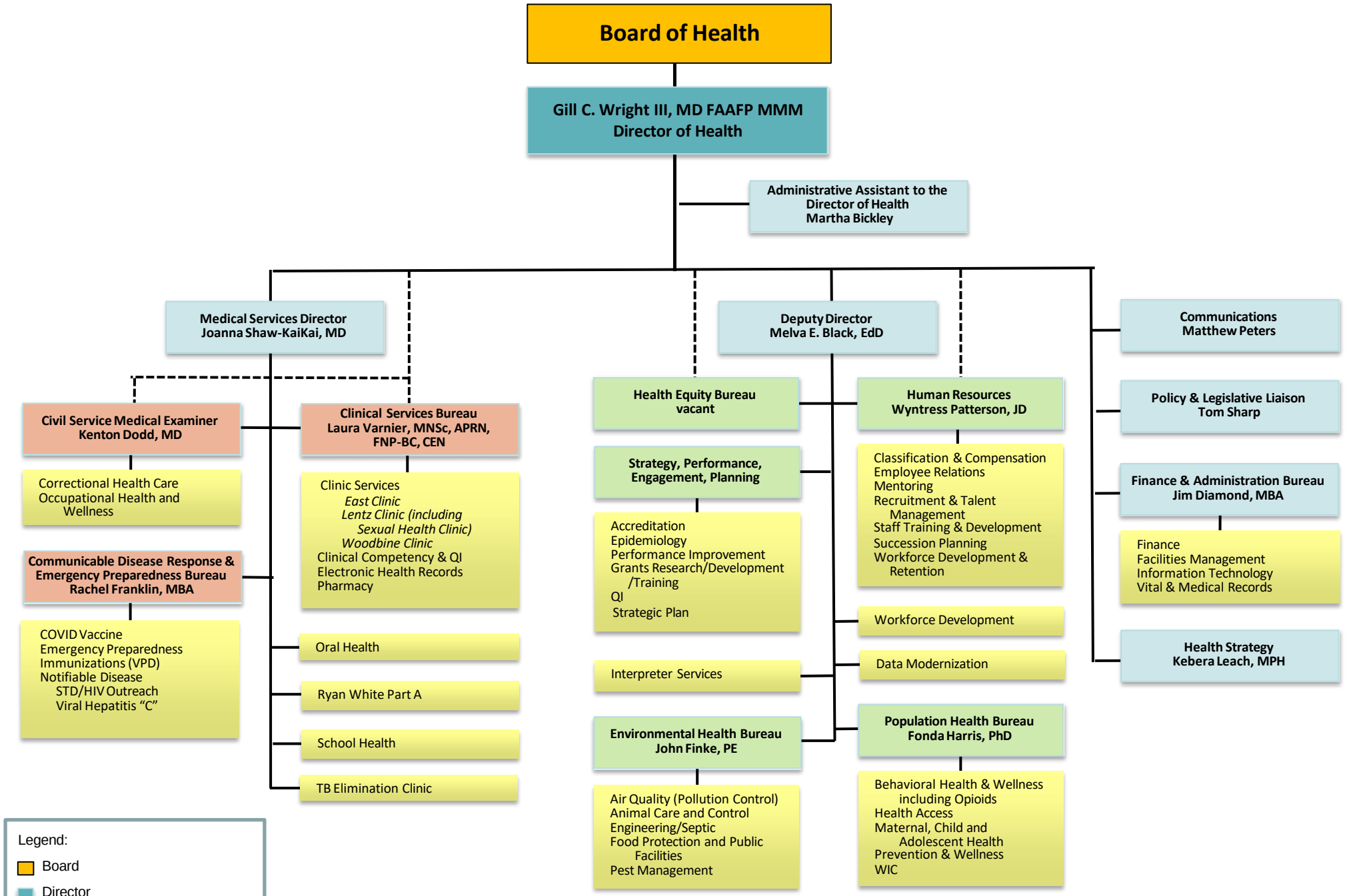
Process, Outcome & Impact Measures Data Source: Program Records; CAREWare data; HRSA Tools; Priority population data (e.g., perinatal stats, ACS, etc.); Group participant pre/post-tests

Focus Area 3. CLINICAL SERVICES

Tactic & Activities (BM#)	Individual & Group Process Measures	Outcomes and Impact Measures	Start/Stop Freq.	Responsibility
- Offer weekend prenatal and postpartum clinics for case managed participants - Offer behavioral health appointments for case	# of weekend clinics scheduled; # of behavioral health appointments scheduled; # and % of case managed participants screened for usual source of care; ; # and % of case managed participants screened for	**OUTCOME** # of weekend prenatal/postpartum clinics executed; # of behavioral health appointments executed; % case managed participants attending	4/1/24 to 5/31/29 Ongoing Collection,	CM, CC, NM Clinical Services Contractor

managed participants - Offer transportation for participants to attend appointments - Schedule participants for weekend prenatal/postpartum clinics	satisfaction with usual source of care; # health promotion sessions on importance of usual source of care; # and % of case managed participants screened for behavioral health concerns/needs; # of case managed participants assessed for behavioral health needs/concerns; ;# of case managed participants referred to clinics; # of case managed participants referred for behavioral health services	weekend clinics; % case managed participants completing behavioral health sessions **IMPACT** ↑ postpartum visit completion for priority population ↑ usual source of care for priority population ↑ preventive health practices in priority population	Quarterly Review, Annual Report	Lead Evaluator
Process, Outcome & Impact Measures Data Source: Program Records; CAREWare data; HRSA Tools; Priority population data (e.g., perinatal stats, ACS, etc.); Group participant pre/post-tests				

Focus Area 4. COMMUNITY CONSORTIUM (COMMUNITY TRANSFORMATION NETWORK)				
Tactic & Activities (BM#)	**Individual & Group Process Measures**	**Outcomes and Impact Measures**	**Start/Stop Freq.**	**Responsibility**
– Develop and use Community Transformation Network – Use quality improvement – Conduct performance monitoring Conduct evaluation	▪ # Consortia (CTN) members / type members (PPs); Consortia (CTN) member retention; Consortia (CTN) member involvement by activity; # collaborative efforts; types of collaborators; PPOR Analyses Completed; # Website Hits; ▪ # Recommendations Made; # barriers identified; # PP Leadership Trainings; # PPs Trained# QI Meetings; # QI Projects; # Focus Groups; # PP surveys ▪ # Reports completed; # Reports timely; # and type of evaluation activities # parenting lessons to PP; # parenting classes / attend; # transportation/childcare requests;	**OUTCOME** % Consortium actions (CTN) implemented; % participants/community members in Consortium (CTN); QI implemented **IMPACT** Systems change, systems change that address SDOH, quality/efficiency improvements, primary participant satisfaction, recommendations implemented ↑ assets ↓ barriers in Priority Population ↑ collaboration between providers and community entities, community members	6/1/19 to 5/31/24 Ongoing Collection, Quarterly Review, Annual Report	Staff Consortium (CTN) Lead Evaluator Epidemiologist
Program Records; Consortium (CTN) records, Consortium (CTN) survey; community forums; key informant interviews, QI records, PP satisfaction survey and focus groups; Evaluation reports				



Attachment 10 Metro Public Health Department Organizational Chart (Nashville Strong Babies)

Attachment 11 Proposed Community Consortium Members
(Existing Community Transformation Network members)

2022 CTN & FIMR Themes for Perinatal Systems Change:
• High Quality Health Care; • Improved Access to Healthcare; • Nurture Relationships and Safe Neighborhoods; • Affordable and Stable Physical Environments; • Safe Sleep; • Mental Health Support; • Initiatives for chronic disease

Community Tansformation Members				(Other Notes)	
Stakeholder First Name	**Stakeholder Last Name**	**Stakeholder Organization**	**Sector Representation** (*Ex. Government, hospital, business, etc.)*	**Expertise** [*Subject Matter, Lived Experience, Other*]	**Area of Expertise** (*Ex. Housing, education, health, business, childcare, etc* .)
D'Yuanna	Allen-Robb	Metro Public Health Department	Government	Subject Matter	Maternal public health
Jessica	Young	Vanderbilt OB/Gyn, Firefly	Hospital	Subject Matter	OB/GYN, Substance Use Disorder treatment
Cheryl	Major	March of Dimes	Nonprofit	Subject Matter	Maternal Child Health
Anna	Morad	Vanderbilt Pediatrics	Hospital	Subject Matter	Pediatrics
Stephanie	Devane-Johnson	Vanderbilt Nurse Midwives	Hospital, Acedemia	Subject Matter	Nurse mifwifery, academia
Karen	Scott	Birthing Cultural Rigor LLC, OB/GYN, Epi	Nonprofit	Subject Matter	Maternal health, equity, epidemiology
Brenda	Barker	TIPQC		Other	
Elise	Krews	Metro Public Health Department	Government	Subject Matter	Equity, Reproductive Policy
Nicole	Barr	Metro Public Health Department	Government	Subject Matter	Maternal Public Health
Joan	Jenkins	BlueCare TN	MCO	Subject Matter	

Attachment 11 Proposed Community Consortium Members
(Existing Community Transformation Network members)

Community Tansformation Members				(Other Notes)	
Stakeholder First Name	**Stakeholder Last Name**	**Stakeholder Organization**	**Sector Representation** (*Ex. Government, hospital, business, etc.)*	**Expertise** [*Subject Matter, Lived Experience, Other*]	**Area of Expertise** (*Ex. Housing, education, health, business, childcare, etc*.)
Sarah	Loch	Vanderbilt Child Health Policy- Firefly	Hospital, Homevisiting	Subject Matter	Maternal Child Health, home visiting
JoAnne	Hunnicutt	Amerigroup	MCO	Subject Matter	MCO
Nichelle	Foster	Metro Public Health Department	Government	Subject Matter	Mental Health, substance use disorders
Nancy	Hughley	Nurses for Newborns	Nonprofit	Subject Matter	Home visiting
Chemyeeka	Tumblin	CityMatCH	Nonprofit	Subject Matter	Social media
Bethaney	Scalise	TDH- MMR	Government	Subject Matter	Maternal health
Tobi	Amosun	TDH	Government	Subject Matter	Maternal child health
Jona	Bandyopadhyay	TN Care	Government	Other	Payor; CMS
Cornelia	Graves	TN MFM	Hospital	Subject Matter	Maternal health
Russell	Keisha	MPHD	Government	Subject Matter	Tennessee's Medicaid program
Tyus	Pendella	Juvenile Court (Attendance Center)	Government	Subject Matter	Juv. Justice system
Christensen	Tonya	Tenn. Dept. of Children's Services	Government	Subject Matter	
Yolonda	Radford	MPHD	Government	Subject Matter	Maternal/Child public health

Attachment 11 Proposed Community Consortium Members
(Existing Community Transformation Network members)

Community Tansformation Members				(Other Notes)	
Stakeholder First Name	**Stakeholder Last Name**	**Stakeholder Organization**	**Sector Representation** (*Ex. Government, hospital, business, etc.)*	**Expertise** [*Subject Matter, Lived Experience, Other*]	**Area of Expertise** (*Ex. Housing, education, health, business, childcare, etc* **.)**
Castro	Jessica	MPHD	Government	Subject Matter	Maternal/Child public health
Jones	Shetuka	MPHD	Government	Subject Matter	Maternal/Child public health
Shehata	Amany	MPHD	Government	Subject Matter	Maternal Child public health
Robert	Taylor	New Life Center	Nonprofit	Other	Fatherhood support
Amanda	Ables	Ascension St. Thomas	Hospital Foundation	Other	Nonprofit hospital
Kristin	Meija	Homeland Heart Birth	Nonprofit	Subject Matter	Doula support
Mary Kate	Mouser	Ascension St. Thomas	Hospital Foundation	Other	Nonprofit hospital
Gloria	Morrison	Nurses for Newbords	Nonprofit	Other	Home-visitng
Mark	Wright	Be a Helping Hand	Nonprofit	Other	Housing
Hanna	Davis	Mayor's Office, Barnes Funds	Government	Subject Matter	Housing
Rasheeda	Fetuga	Gideon's Army	Nonprofit	Other	Community Safety
Gini	Langum	The Children's Playroom	Childcare	Other	Childcare

Attachment 11 Proposed Community Consortium Members
(Existing Community Transformation Network members)

Community Tansformation Members				(Other Notes)	
Stakeholder First Name	**Stakeholder Last Name**	**Stakeholder Organization**	**Sector Representation** (*Ex. Government, hospital, business, etc.)*	**Expertise** [*Subject Matter, Lived Experience, Other*]	**Area of Expertise** (*Ex. Housing, education, health, business, childcare, etc*.)
Talice	Thomas	Envision Napier	Government	Other	Childcare
Joy	Teal	High Wired Communities	For profit	Lived Experience	Transportation
Kimberlee	Wyche	Meharry Medical College	Medical	Subject Matter	Maternal Child public health
Erica	Mitchell	United Way	Foundation		Foundation
Indigo	Harris	(former) NSB participant	Community	Lived Experience	Lived Experience of priority population
Fonda	Harris	MPHD	Government	Other	Safety Net Consortium
Stephen	Patrick	Vanderbilt Center for Child Health Policy	Hospital	Subject Matter	Perinatal Substance Use Disorder
Henri	Murphy	TN Departmet of Education	Government	Other	Childcare; Head start
TBD		Raphaa Institute	Nonprofit		

MAXIMUS

Indirect Cost Rate Proposal
Nashville-Davidson County, Tennessee
Metro Public Health Department

FY 2024
Indirect Cost Rate Proposal

Based on actual expenditures for the
Fiscal Year ended June 30, 2022

Indirect Cost Rate Proposal
Nashville-Davidson County, Tennessee
Metro Public Health Department

FY 2024
Indirect Cost Rate Proposal

Based on actual expenditures for the
Fiscal Year ended June 30, 2022

Certificate of Indirect Costs

METROPOLITAN GOVERNMENT OF NASHVILLE/DAVIDSON COUNTY

Metro Public Health Department

Fiscal Year July 1, 2023 through June 30, 2024

This is to certify that I have reviewed the indirect cost proposal submitted herewith and to the best of my knowledge and belief:

(1) All costs included in this proposal to establish cost allocation or billing rates for FY 2024 (July 1, 2023 through June 30, 2024) based on actual costs for the fiscal year ending June 30, 2022 (July 1, 2021 through June 30, 2022) are allowable in accordance with the requirements of the Federal/State/Local award(s) to which they apply and 2 CFR 200 – Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards. Unallowable costs have been adjusted for in allocating costs as indicated in the indirect cost rate proposal.

(2) All costs included in this proposal are properly allocable to Federal/State/Local awards on the basis of a beneficial or causal relationship between the expenses incurred and the agreements to which they are allocated in accordance with applicable requirements. Further, the same costs that have been treated as indirect costs have not been claimed as direct costs. Similar types of costs have been accounted for consistently and the Federal government will be notified of any accounting changes that would affect the predetermined rate.

I declare that the foregoing is true and correct.

Government Unit: Metropolitan Government Nashville Davidson County, TN

Signature: _____

Name of Official: Tim Diamond

Title: Director of Finance & Administration

Date of Execution: 7/18/25

NASHVILLE-DAVIDSON COUNTY, TENNESSEE
METRO PUBLIC HEALTH DEPARTMENT ~ ICRP
FOR THE FISCAL YEAR ENDED JUNE 30, 2022
Table of Contents

NASHVILLE-DAVIDSON COUNTY, TENNESSEE
METRO PUBLIC HEALTH DEPARTMENT ~ ICRP
FOR THE FISCAL YEAR ENDED JUNE 30, 2022
Table of Contents

Section A: Cost Allocation Methodology and Process

A. Cost Allocation Methodology and Process

The Cost Allocation Plan (CAP) provided in *Section C* was prepared by Maximus Consulting Services, Inc. (Maximus) for NASHVILLE-DAVIDSON COUNTY, TENNESSEE. Utilizing our proprietary, web-based cost allocation system, MAXCAP™, Maximus used cost data and allocation statistics to allocate the costs to departments/divisions/programs for Fiscal Year (FY) 2022.

MAXCAP uses a double step-down allocation procedure to distribute costs among Central Services and to departments that receive benefits. Using MAXCAP, costs are input by cost center identifications consistent with the entity's accounting code structure, which allows for efficient balancing with the entity's financial reporting systems. Additionally, MAXCAP provides for the inputting of allocation statistics appropriate for the distribution of the identified indirect cost pools. Credits for direct-billed payments, cost adjustments, and other valid and applicable costing factors are also facilitated within the software.

In this section, we provide an overview of our cost allocation methodology and process used to develop the CAP.

A.1 Cost Allocation Methodology

Maximus employs a double step-down procedure that allows all Central Service Departments to allocate costs to all other Central Service Departments. Since Central Service Departments' costs are not simultaneously allocated, the process must be performed sequentially, one department after another. The second step-down allows for the equitable allocation of the costs the Central Service Departments receive from one another.

Typically, CAPs are compiled using a single step down or "waterfall" methodology in which the costs of Central Service Departments are allocated in an ordinal sequence with emphasis placed on ordering non-departmental and departmental cost groupings to optimize the flow of costs to recoverable program areas. Although this is an acceptable method resulting in accurate program allocations, it provides only partial information as to the costs of individual Central Service Departments and their significant activities.

To demonstrate the potential inequity of a single step-down, consider the costs of the Facilities Management and Purchasing activities. Facilities Management manages and maintains the office space that Purchasing uses to serve departments. Facilities costs are rightfully allocable to all the departments that have space in government buildings. If Facilities Management costs are allocated after Purchasing, the cost of Purchasing's space will be allocated to the other departments in the building. It could be argued that this method then allocates costs to departments disproportionate to the benefit received from those costs.

Maximus double step-down approach mitigates potential allocation inequities and has been widely accepted by federal cognizant agencies for more than 30 years.

A.1.1 First Step-Down

The first step-down allows each Central Service Department to allocate to any other department, regardless of the sequence of the departments. The department also can allocate to itself providing the statistical measurements indicate a basis for the allocations.

Process
The process of allocating during this round is achieved sequentially, consistent with the order of the Central Service Departments. As each Central Service Department performs its allocations it allocates:

- Costs from entity financial records
- Cost adjustments
- Credits
- Costs received from other Central Service Departments that have completed their first round allocations
- Results

At the completion of the first step-down, each Central Service Department has the allocated costs from itself and from the Central Service Departments sequenced before it.

A.1.2 Second Step-Down

The rule for the second step-down is that each Central Service Department can allocate only to another department sequenced after the allocating department; provided that the statistical measurements indicate a basis for the allocations.

Process
The process of allocating during the second step-down is achieved sequentially and consistent with the order of the Central Service Departments. As each Central Service Department performs its allocations, it allocates:

- Costs received from other Central Service Departments that have completed their second round allocations
- Costs received in the first step-down from itself and from the Central Service Departments sequenced after the allocating department

Results
At the completion of the second step-down, each Central Service Department has completed all allocations and all Central Service Departments have been cleared of all costs. The costs have either been adjusted out of the cycle or sent to Receiving Departments based on the allocation statistics.

A.1.3 Supplemental Comments

When the relationship between and among the Central Service Departments is greatly intertwined, it may be prudent to implement three or more step-downs. Typically, the double step-down is sufficient to accomplish an equitable allocation of all costs.

If more than two step-downs are required the rules for all rounds of allocation — except the final round – are the same as defined above for the first step-down. The final round always follows the rules, as defined above, for the second step-down.

A.2 Cost Allocation Process

The process utilized by Maximus in developing the CAP and tracking costs within it is discussed below.

A.2.1 Initiating the Process

Working in conjunction with the entity, Maximus determines data to be included within the cost allocation process based on:

- Application of federal cost principles or full costing principles, as applicable
- Interviews
- Review of financial documents
- Review of organizational structure
- Analysis of statistical data relative to benefit of services provided

A.2.2 Establishing the Cost Pools to be Allocated

Maximus analyzes the organizational structure of the entity to determine which departments or cost pools provide services to other departments/divisions/programs. These cost pools become the “Central Service Departments” in the CAP.

Next, each cost pool is evaluated to determine the activities or services provided. The costs are then broken into subparts or activities such that each activity can be allocated on a statistical measure that is relevant to the service provided and the benefit received.

Line items of expenditures are analyzed to determine which activities receive the benefit of the costs. Distributions of these costs are made according to the determined benefit of each activity.

A.2.3 Establishing the Statistical Measurements or Bases for Allocation

Maximus evaluates available statistical measurements to establish the most equitable and meaningful basis for allocating each activity within each Central Service Department. Consideration is given to determining the measurement that most appropriately demonstrates its relationship to the receiving units. For example, an activity that is driven by the number of employees within the benefiting departments can be allocated by number of employees. Similarly, an activity that is driven by the number of transactions for each benefiting department can be allocated by the number of transactions.

A.2.4 Accommodating Exceptions and Adjustments

Applicable cost adjustments for unallowable costs and/or capitalized assets are incorporated into the appropriate schedules. Credits for direct billings, special revenues, etc. are entered into the computation.

A.2.5 Developing the CAP

The Maximus Cost Allocation Plan typically is organized as follows:

- Cover
- Certification, if required
- Table of Contents
- Cost Allocation Methodology and Process
- Organizational Chart

- CAP: Summary and Detail Schedules
- Supplemental Materials

Below, we discuss each of the summary and detail schedules included in a CAP.

Summary Schedules
The summary schedules provide a recap of the results of the cost allocation process. The following explanations define the purposes of each of the typical schedules included in the cost allocation plan.

Schedule A – Allocated Costs by Department: Schedule A demonstrates for each Receiving Department the costs received from each Central Service Department. This schedule answers the question: Which Central Service Department actually allocated the costs to each Receiving Department?

This schedule does not necessarily demonstrate the Central Service Department from which the costs originated. For example, costs sent from Purchasing to Accounting and then to a Receiving Department will be recorded on Schedule A as being from Accounting.

Schedule C – Summary of Allocated Costs: Schedule C is the simplest report to use when balancing to the financials. It demonstrates the costs to be allocated, the adjustments made to these costs, and the results of the allocations. This schedule demonstrates the full sequence of all departments with the Central Service Departments listed first and in the order of their allocating sequence.

The Receiving departments follow the Central Service Departments with the total allocations received from all Central Service Departments.

Schedule E – Summary of Allocation Basis: Schedule E demonstrates, for each Central Service Department, the services or activities of the Central Service Department and the basis for the allocation of each activity. This schedule is a convenient reference for reviewing the activities identified for each Central Service Department. This is particularly important when preparing a new plan and incorporating organizational and services changes.

Schedule F – Indirect Cost Rate Proposal: Schedule F computes an indirect cost rate for selected Receiving Departments. The total allocated costs are divided by the indirect costs rate base to compute the indirect cost rate for each Receiver Department. For example, the indirect cost rate base used to compute the rates could be salaries, salaries and benefits, or modified total direct costs, etc. A composite rate is also computed at the bottom of the schedule.

Detail Schedules
The detail schedules demonstrate the original costs being allocated by each Central Service Department. In these schedules, the adjustments are applied; the activities are defined; the incoming costs from other Central Service Departments are detailed; the allocation calculations for both step-downs are documented; and the results for each Central Service Department are summarized.

When tracking costs, typically the schedules are reviewed in reverse order tracking from summary information back to detail information. This is discussed further in *Section A.2.6: Tracking Costs within the CAP*.

Schedule _.1 – Nature and Extent of Services: Schedule _.1 is a brief narrative defining the purpose of the Central Service and the benefit it provides to the Receiving Departments. The narrative also describes the allocation basis used for each activity and any other relevant information on expenditures.

Schedule _.2 – Costs to be Allocated: Schedule _.2 provides an overview of the total costs allocated by

each Central Service Department including:

- Expenditures from the financial reports — balances to Schedule C
- Adjustments to financial reports — balances to Schedule C
- Incoming costs from other Central Service Departments

The incoming costs are presented in columns that represent when these costs are allocated by the Central Service Department, not when the costs are received. As explained in *Section A.1: Cost Allocation Methodology*, the costs that are received from Central Service Departments sequenced after the given department are held for allocation in the second step-down.

Schedule _.3 – Costs to be Allocated by Activity: Schedule _.3 provides the following:

- Expenditures from the financials are defined by type of expenditure and by activities (to the extent deemed necessary) to ensure the application of allocation bases that closely correlate to the benefits derived by the Receiving departments. Each activity is represented in its own column. The totals balance with both Schedule C and Schedule _.2 expenditure amounts.
- Adjustments to the financial reports are applied to expenditures and the results spread to the appropriate activities.
- Incoming costs are demonstrated first in total and then spread to the appropriate activities for allocation for each step-down. The totals for each step-down balance to the totals on Schedule _.2. It should be noted that incoming costs may be coded to spread to only the activities that receive benefit from the services.

Schedule _.4 – Detail Activity Allocations: Schedule _.4 represents the allocation results by activity. Each activity defined on Schedule _.3 is demonstrated on a Detail Allocation Schedule. Because the number of activities varies, the number of the last of these schedules varies.

Schedule _.4 includes:

- Statistical measurement used as a basis for allocation
- Identification of statistical measurement
- Source of the statistical measurement
- Percent relationship of each statistical measurement to the whole or total statistical measurement base
- Results of the first step-down — balances to functional total after first additions on Schedule_.3
- Results of the second step-down — balances to functional total of second additions on Schedule _.3

The totals allocated from both step-downs balances to the functional grand total from Schedule _.3. Note the results of the second step-down. This schedule clearly demonstrates how the second step-down allocates only to departments sequenced after the allocating department.

Schedule _.5 – Allocation Summary for each Central Service Department: Schedule _.5 provides a summary of costs allocated by each activity. The activity totals balance to the totals from each Detail Activities Allocation schedule defined above.

The totals allocated to the Receiving Departments will balance to Schedule A for the allocating department.

A.2.6 Tracking Costs within the CAP

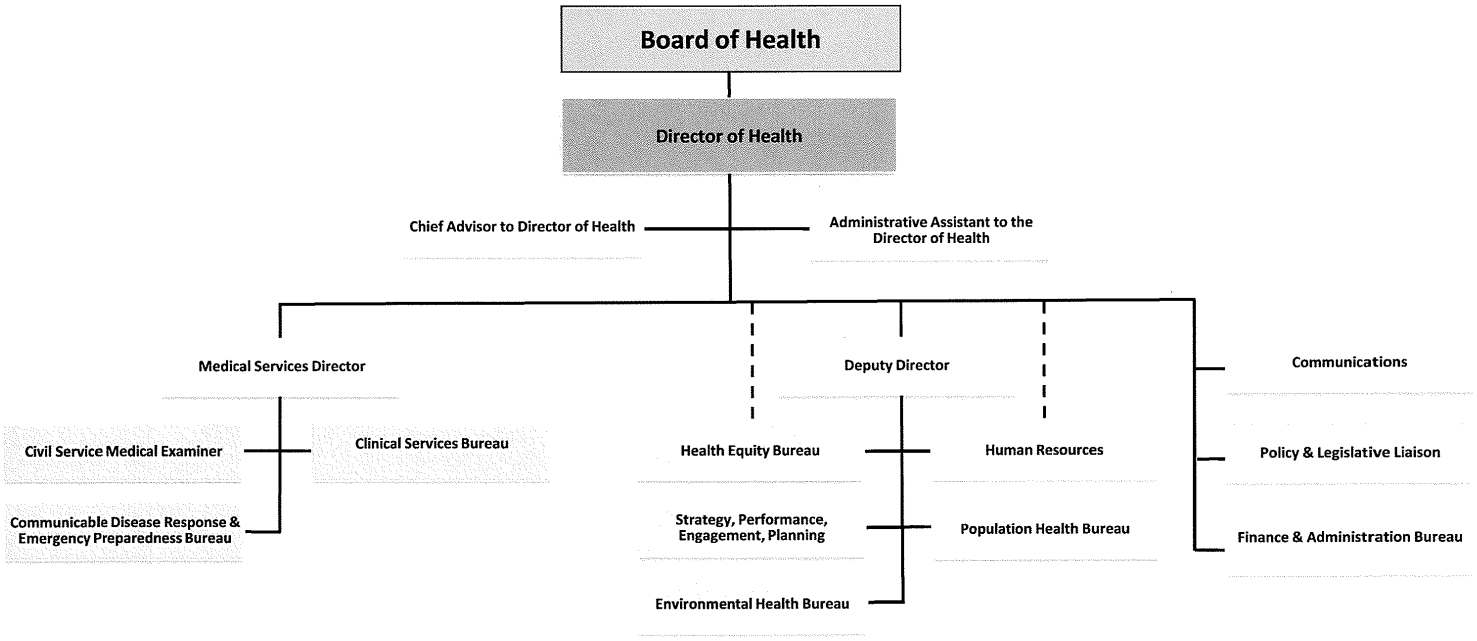
When costs are questioned, Maximus utilizes our standard tracking process in order to resolve any issues with Schedule A where the questioned cost is usually identified.

From Schedule A, we identify the allocating Central Service Department. From the CAP Table of Contents the appropriate detail schedules for the allocating department are identified. Tracking begins with the last detail schedule. Once the questioned amount is located, our analysis of the summary amounts by activities indicates which detail allocation schedules to review.

Review of each detail schedule will demonstrate the relative benefit received by the Receiving Department for the portion of the questioned cost attributable to each activity. Continuing backward through the detail schedules, the composition of the total functional costs is reviewed.

At this point, any remaining questions are typically in regard to the incoming costs. If these costs are questioned, we can use Schedule _.2 to identify which department allocated the questioned incoming costs. Referring again to the CAP Table of Contents, the detail schedules for the sending Central Service Department can be located. Tracking continues by repeating these steps until all issues have been resolved.

Section B: Organizational Chart



Approved March 16, 2022
Metropolitan Board of Health of Nashville and Davidson County

Section C: Cost Allocation Plan

NASHVILLE-DAVIDSON COUNTY, TENNESSEE
METRO PUBLIC HEALTH DEPARTMENT ~ ICRP
FOR THE FISCAL YEAR ENDED JUNE 30, 2022
Schedule A - Allocated Costs By Department

Central Service Departments	2 CFR 200 LOCAP Costs	Depreciation Expense	38160810 Executive Leadership	38160110 Information Technology	38160210 Facilities Mgmt
Communicable Dis & Emergency Prepare	600,558	0	168,018	76,803	181,135
Population Health	1,039,002	0	262,528	120,004	283,023
Community Health	1,894,853	0	546,058	249,608	588,687
Environmental Health	943,174	0	296,657	135,605	319,816
Clinic Operations	538,969	0	131,264	60,002	141,511
Clinical Services	47,994	0	15,752	7,200	16,981
Health Equity	90,944	0	26,253	12,000	28,302
Finance & Administration	121,946	0	49,880	22,801	53,774
Executive Management	216	0	0	0	0
Medical Examiner	51,616	0	0	0	0
Total Allocated	5,329,272	0	1,496,410	684,023	1,613,229
Direct Billed	0	0	0	0	0
Unallocated	0	0	0	0	0
Cost Adjustments	(5,985,931)	(17,008)	0	0	0
Disallowed				2,113,215	137,600
Total Expenditures					

NASHVILLE-DAVIDSON COUNTY, TENNESSEE
METRO PUBLIC HEALTH DEPARTMENT ~ ICRP
FOR THE FISCAL YEAR ENDED JUNE 30, 2022
Schedule A - Allocated Costs By Department

Central Service Departments	38160310 Human Resources	38160410 Finance	38160610 Records Mgmt Services	Allocated Costs for Fiscal 2022
Communicable Dis & Emergency Prepare	60,025	89,092	151,246	1,326,876
Population Health	93,789	288,186	236,322	2,322,855
Community Health	195,081	330,024	491,550	4,295,862
Environmental Health	105,982	121,210	267,044	2,189,487
Clinic Operations	46,895	82,932	118,161	1,119,734
Clinical Services	5,627	5,269	14,179	113,002
Health Equity	9,379	12,042	23,632	202,552
Finance & Administration	17,820	20,873	44,901	331,996
Executive Management	0	672	0	887
Medical Examiner	0	0	0	51,616
Total Allocated	534,598	950,299	1,347,037	11,954,868
Direct Billed	0	0	0	0
Unallocated	0	0	0	0
Cost Adjustments	0	0	0	(6,002,939)
Disallowed				2,250,815
Total Expenditures				8,202,744

NASHVILLE-DAVIDSON COUNTY, TENNESSEE
METRO PUBLIC HEALTH DEPARTMENT ~ ICRP
FOR THE FISCAL YEAR ENDED JUNE 30, 2022
Schedule C - Summary of Allocated Costs

Department Name	Total Expenditures	Disallowed	Cost Adjustments	Unallocated	Direct Billed	Total Allocated
2 CFR 200 LOCAP Costs	0		5,985,931		0	
Depreciation Expense	0		17,008		0	
38160810 Executive Leadership	1,362,051		0		0	
38160110 Information Technology	2,674,339	(2,113,215)	0		0	
38160210 Facilities Mgmt	1,596,759	(137,600)	0		0	
38160310 Human Resources	451,624		0		0	
38160410 Finance	870,527		0		0	
38160610 Records Mgmt Services	1,247,444		0		0	
Communicable Dis & Emergency Prepare						1,326,876
Population Health						2,322,855
Community Health						4,295,862
Environmental Health						2,189,487
Clinic Operations						1,119,734
Clinical Services						113,002
Health Equity						202,552
Finance & Administration						331,996
Executive Management						887
Medical Examiner						51,616
Totals	8,202,744	(2,250,815)	6,002,939		0	11,954,868

Deviation: 0

NASHVILLE-DAVIDSON COUNTY, TENNESSEE
METRO PUBLIC HEALTH DEPARTMENT ~ ICRP
FOR THE FISCAL YEAR ENDED JUNE 30, 2022
Schedule E - Summary of Allocation Basis

Department	Allocation Basis	Allocation Source
2 CFR 200 LOCAP Costs		
1.4.1 Employee Support	Number of Employees by Business Unit/Line	FY 2022 Active Employees Report - Human Resources
1.4.2 Financial Support	Actual Expenditures by Business Unit/Line	FY 2022 Expenditure Report - Finance-Operations
1.4.3 Benefits Support	Actual Salaries & Wages by Business Unit/Line	FY 2022 Expenditure Report - Finance-Operations
1.4.4 Medical Examiner	Direct Allocation to Medical Examiner	Direct Assignment as Primary Beneficiary of Services
Depreciation Expense		
2.4.1 Depreciation	Actual Depreciation Expense by Business Unit	FY 2022 Asset Master Report - Finance-Operations
38160810 Executive Leadership		
3.4.1 Executive Leadership	Number of Employees by Business Unit/Line	FY 2022 Active Employees Report - Human Resources
38160110 Information Technology		
4.4.1 Information Technology	Number of Employees by Business Unit/Line	FY 2022 Active Employees Report - Human Resources
38160210 Facilities Mgmt		
5.4.1 Facilities Management	Number of Employees by Business Unit/Line	FY 2022 Active Employees Report - Human Resources
38160310 Human Resources		
6.4.1 Human Resources	Number of Employees by Business Unit/Line	FY 2022 Active Employees Report - Human Resources
38160410 Finance		
7.4.1 Finance	Actual Expenditures by Benefiting Business Unit/Line	FY 2022 Expenditure Report - Finance-Operations
38160610 Records Mgmt Services		
8.4.1 Records Management	Number of Employees by Business Unit/Line	FY 2022 Active Employees Report - Human Resources

NASHVILLE-DAVIDSON COUNTY, TENNESSEE
METRO PUBLIC HEALTH DEPARTMENT ~ ICRP
FOR THE FISCAL YEAR ENDED JUNE 30, 2022
Schedule F - Indirect Cost Rate Proposal

Receiving Departments	Central Service Costs	Dept Admin Personnel Costs	Dept Admin Other Costs	Total Indirect Costs	Indirect Cost Rate Base	Indirect Cost Rate
Communicable Dis & Emergency Prepare	1,326,876	0	0	1,326,876	4,513,007	29.4000%
Population Health	2,322,855	0	0	2,322,855	14,853,443	15.6400%
Community Health	4,295,862	0	0	4,295,862	17,366,564	24.7400%
Environmental Health	2,189,487	0	0	2,189,487	6,605,026	33.1500%
Clinic Operations	1,119,734	0	0	1,119,734	4,544,143	24.6400%
Clinical Services	113,002	0	0	113,002	291,873	38.7200%
Health Equity	202,552	0	0	202,552	655,124	30.9200%
Finance & Administration	331,996	0	0	331,996	1,114,929	29.7800%
Executive Management	887	0	0	887	34,838	2.5500%
Medical Examiner	51,616	0	0	51,616	5,711,714	0.9000%
Composite Rate	11,954,868	0	0	11,954,868	55,690,661	21.4666%

The OMB Local Cost Allocation Plan (2 CFR PART 200 LOCAP) quantifies the level of generally funded support services consumed by each of Nashville-Davidson's departments. The County-wide indirect (overhead) costs allocable to the Metro Public Health Department are identified in this schedule. These costs represent central service departments that provide services to the Health Department. These indirect costs are reported on the Summary Schedule – Allocated Costs by Department of the FY 2022 OMB Central Services Cost Allocation Plan for Nashville-Davidson, Tennessee.

For cost allocation plan purposes, the 2 CFR Part 200 LOCAP Costs cost pool is functionalized as follows:

Employee Support - Costs identified to this function represent central service employee-related support services provided to the Health Department. These costs are allocated based on the number of active employees per business unit/line of business.

Financial Support - Costs identified to this function include central service financial-related support services provided to the Health Department. These costs are allocated based on the total actual expenditures by business unit/line of business.

Benefits Support - Costs identified to this function comprise fringe benefits-related costs attributable to the Health Department. These costs are allocated based on the total salaries and wages recorded to each business unit/line of business.

Medical Examiner - Costs identified to this represent LOCAP costs allocable to the Medical Examiner. These costs have been allocated directly to the Medical Examiner as the primary beneficiary of the services and costs.

NASHVILLE-DAVIDSON COUNTY, TENNESSEE
METRO PUBLIC HEALTH DEPARTMENT ~ ICRP
FOR THE FISCAL YEAR ENDED JUNE 30, 2022
Schedule .2 - Costs To Be Allocated
For Department 2 CFR 200 LOCAP Costs

	1st Allocation	2nd Allocation	Sub-Total	Total
Expenditures Per Financial Statement:	0			
Cost Adjustments:				
Depreciation	1,587			
001 Administrative - Employee Benefits	3,023,120			
001 Administrative - Facility Rental	15,632			
001 Administrative - Insurance	206,209			
001 Administrative - Post Audits	19,412			
001 Administrative - Miscellaneous	388			
003 Metropolitan Clerk - Records Center	37,377			
006 Law	282,769			
008 Human Resources	365,085			
010 General Services - Facilities	902,163			
010 General Services - Fleet Management	54,483			
010 General Services - Mail Services	497			
014 Information Technology Service	204,325			
015 Finance - Accountability	0			
015 Finance - Business Assistance	2,455			
015 Finance - Grants & Cost Planning	63,629			
015 Finance - Office of Mgmt & Budget	59,274			
015 Finance - Operations	137,340			
015 Finance - Payroll	29,543			
015 Finance - Property Administration	14,772			
015 Finance - Purchasing	81,132			
015 Finance - Treasury	8,742			
015 Finance - Diversity Equity & Inclus	8,995			
030 Sheriff's Office - Security Services	296,695			
038 Health - Employee Health & Wellness	141,279			
048 Internal Audit	29,026			
OMB CAP Rounding Adjustment	2			
Total Departmental Cost Adjustments:	5,985,931			5,985,931
Total To Be Allocated:	5,985,931			5,985,931

NASHVILLE-DAVIDSON COUNTY, TENNESSEE
METRO PUBLIC HEALTH DEPARTMENT ~ ICRP
FOR THE FISCAL YEAR ENDED JUNE 30, 2022
Schedule .3 - Costs Allocated By Activity
For Department 2 CFR 200 LOCAP Costs

	Total	G&A	Employee Support	Financial Support	Benefits Support
Deductions					
*Total Disallowed Costs	0	0	0	0	0
Cost Adjustments					
Depreciation	1,587	0	1,587	0	0
001 Administrative - Employee Benefits	3,023,120	0	0	0	3,023,120
001 Administrative - Facility Rental	15,632	0	15,632	0	0
001 Administrative - Insurance	206,209	0	206,209	0	0
001 Administrative - Post Audits	19,412	0	0	17,956	0
001 Administrative - Miscellaneous	388	0	359	0	0
003 Metropolitan Clerk - Records Center	37,377	0	37,377	0	0
006 Law	282,769	0	277,489	0	0
008 Human Resources	365,085	0	365,085	0	0
010 General Services - Facilities	902,163	0	902,163	0	0
010 General Services - Fleet Management	54,483	0	54,483	0	0
010 General Services - Mail Services	497	0	497	0	0
014 Information Technology Service	204,325	0	204,325	0	0
015 Finance - Accountability	0	0	0	0	0
015 Finance - Business Assistance	2,455	0	0	2,455	0
015 Finance - Grants & Cost Planning	63,629	0	0	63,171	0
015 Finance - Office of Mgmt & Budget	59,274	0	0	55,377	0
015 Finance - Operations	137,340	0	0	136,777	0
015 Finance - Payroll	29,543	0	29,543	0	0
015 Finance - Property Administration	14,772	0	13,664	0	0
015 Finance - Purchasing	81,132	0	0	81,132	0
015 Finance - Treasury	8,742	0	0	8,089	0
015 Finance - Diversity Equity & Inclus	8,995	0	8,404	0	0
030 Sheriff's Office - Security Services	296,695	0	296,695	0	0
038 Health - Employee Health & Wellness	141,279	0	141,279	0	0
048 Internal Audit	29,026	0	0	26,849	0
OMB CAP Rounding Adjustment	2	0	0	0	0
Functional Cost	5,985,931	0	2,554,791	391,806	3,023,120
Allocation Step 1					
Reallocate Admin Costs		0	0	0	0
Unallocated Costs	0	0	0	0	0
1st Allocation	5,985,931	0	2,554,791	391,806	3,023,120
Allocation Step 2					
2nd Allocation	0	0	0	0	0
Total For 2 CFR 200 LOCAP Costs					
Schedule .3 Total	5,985,931	0	2,554,791	391,806	3,023,120

NASHVILLE-DAVIDSON COUNTY, TENNESSEE
METRO PUBLIC HEALTH DEPARTMENT ~ ICRP
FOR THE FISCAL YEAR ENDED JUNE 30, 2022
Schedule .3 - Costs Allocated By Activity
For Department 2 CFR 200 LOCAP Costs

	Medical Examiner
Deductions	
*Total Disallowed Costs	0
Cost Adjustments	
Depreciation	0
001 Administrative - Employee Benefits	0
001 Administrative - Facility Rental	0
001 Administrative - Insurance	0
001 Administrative - Post Audits	1,456
001 Administrative - Miscellaneous	29
003 Metropolitan Clerk - Records Center	0
006 Law	5,280
008 Human Resources	0
010 General Services - Facilities	0
010 General Services - Fleet Management	0
010 General Services - Mail Services	0
014 Information Technology Service	0
015 Finance - Accountability	0
015 Finance - Business Assistance	0
015 Finance - Grants & Cost Planning	458
015 Finance - Office of Mgmt & Budget	3,897
015 Finance - Operations	563
015 Finance - Payroll	0
015 Finance - Property Administration	1,108
015 Finance - Purchasing	0
015 Finance - Treasury	653
015 Finance - Diversity Equity & Inclus	591
030 Sheriff's Office - Security Services	0
038 Health - Employee Health & Wellness	0
048 Internal Audit	2,177
OMB CAP Rounding Adjustment	2
Functional Cost	16,214
Allocation Step 1	
Reallocate Admin Costs	0
Unallocated Costs	0
1st Allocation	16,214
Allocation Step 2	
2nd Allocation	0
Total For 2 CFR 200 LOCAP Costs	
Schedule .3 Total	16,214

NASHVILLE-DAVIDSON COUNTY, TENNESSEE
METRO PUBLIC HEALTH DEPARTMENT ~ ICRP
FOR THE FISCAL YEAR ENDED JUNE 30, 2022
Schedule .4 - Detail Activity Allocations
For Department 2 CFR 200 LOCAP Costs

Activity - Employee Support

Receiving Department	Allocation Units	Allocation Pct	Gross Allocation	Direct Billed	Allocation Step 1	Allocation Step 2	Total
38160810 Executive Leadership	10	1.597444	40,811		40,811		40,811
38160110 Information Technology	5	0.798722	20,406		20,406		20,406
38160210 Facilities Mgmt	14	2.236422	57,136		57,136		57,136
38160310 Human Resources	6	0.958466	24,487		24,487		24,487
38160410 Finance	10	1.597444	40,811		40,811		40,811
38160610 Records Mgmt Services	11	1.757188	44,892		44,892		44,892
Communicable Dis & Emergency Prepare	64	10.223642	261,193		261,193		261,193
Population Health	100	15.974441	408,114		408,114		408,114
Community Health	208	33.226839	848,876		848,876		848,876
Environmental Health	113	18.051118	461,168		461,168		461,168
Clinic Operations	50	7.987220	204,057		204,057		204,057
Clinical Services	6	0.958466	24,487		24,487		24,487
Health Equity	10	1.597444	40,811		40,811		40,811
Finance & Administration	19	3.035144	77,542		77,542		77,542
Schedule .4 Total for Employee Support	626	100.000000	2,554,791		2,554,791	0	2,554,791

Allocation Basis: Number of Employees by Business Unit/Line
Allocation Source: FY 2022 Active Employees Report - Human Resources

NASHVILLE-DAVIDSON COUNTY, TENNESSEE
METRO PUBLIC HEALTH DEPARTMENT ~ ICRP
FOR THE FISCAL YEAR ENDED JUNE 30, 2022
Schedule .4 - Detail Activity Allocations
For Department 2 CFR 200 LOCAP Costs

Activity - Financial Support

Receiving Department	Allocation Units	Allocation Pct	Gross Allocation	Direct Billed	Allocation Step 1	Allocation Step 2	Total
38160810 Executive Leadership	1,362,051	2.154679	8,442		8,442		8,442
38160110 Information Technology	2,674,339	4.230637	16,576		16,576		16,576
38160210 Facilities Mgmt	1,596,759	2.525973	9,897		9,897		9,897
38160310 Human Resources	451,624	0.714441	2,799		2,799		2,799
38160410 Finance	870,527	1.377119	5,396		5,396		5,396
38160610 Records Mgmt Services	1,247,444	1.973378	7,732		7,732		7,732
Communicable Dis & Emergency Prepare	4,621,869	7.311507	28,647		28,647		28,647
Population Health	14,950,382	23.650567	92,664		92,664		92,664
Community Health	17,120,809	27.084046	106,117		106,117		106,117
Environmental Health	6,288,077	9.947343	38,974		38,974		38,974
Clinic Operations	4,302,326	6.806010	26,666		26,666		26,666
Clinical Services	273,317	0.432370	1,694		1,694		1,694
Health Equity	624,691	0.988222	3,872		3,872		3,872
Finance & Administration	1,082,864	1.713023	6,712		6,712		6,712
Executive Management	34,838	0.055112	216		216		216
Medical Examiner	5,711,714	9.035573	35,402		35,402		35,402
Schedule .4 Total for Financial Support	63,213,631	100.000000	391,806		391,806	0	391,806

Allocation Basis: Actual Expenditures by Business Unit/Line
Allocation Source: FY 2022 Expenditure Report - Finance-Operations

NASHVILLE-DAVIDSON COUNTY, TENNESSEE
METRO PUBLIC HEALTH DEPARTMENT ~ ICRP
FOR THE FISCAL YEAR ENDED JUNE 30, 2022
Schedule .4 - Detail Activity Allocations
For Department 2 CFR 200 LOCAP Costs

Activity - Benefits Support

Receiving Department	Allocation Units	Allocation Pct	Gross Allocation	Direct Billed	Allocation Step 1	Allocation Step 2	Total
38160810 Executive Leadership	991,777	3.702160	111,921		111,921		111,921
38160110 Information Technology	376,185	1.404244	42,452		42,452		42,452
38160210 Facilities Mgmt	644,738	2.406714	72,758		72,758		72,758
38160310 Human Resources	323,244	1.206623	36,478		36,478		36,478
38160410 Finance	624,865	2.332531	70,515		70,515		70,515
38160610 Records Mgmt Services	382,374	1.427347	43,150		43,150		43,150
Communicable Dis & Emergency Prepare	2,753,404	10.278060	310,718		310,718		310,718
Population Health	4,769,434	17.803609	538,224		538,224		538,224
Community Health	8,328,497	31.089077	939,860		939,860		939,860
Environmental Health	3,925,890	14.654781	443,032		443,032		443,032
Clinic Operations	2,731,497	10.196284	308,246		308,246		308,246
Clinical Services	193,295	0.721542	21,813		21,813		21,813
Health Equity	409,934	1.530224	46,261		46,261		46,261
Finance & Administration	334,008	1.246804	37,692		37,692		37,692
Schedule .4 Total for Benefits Support	26,789,142	100.000000	3,023,120		3,023,120	0	3,023,120

Allocation Basis: Actual Salaries & Wages by Business Unit/Line
Allocation Source: FY 2022 Expenditure Report - Finance-Operations

NASHVILLE-DAVIDSON COUNTY, TENNESSEE
METRO PUBLIC HEALTH DEPARTMENT ~ ICRP
FOR THE FISCAL YEAR ENDED JUNE 30, 2022
Schedule .4 - Detail Activity Allocations
For Department 2 CFR 200 LOCAP Costs

Activity - Medical Examiner

Receiving Department	Allocation Units	Allocation Pct	Gross Allocation	Direct Billed	Allocation Step 1	Allocation Step 2	Total
Medical Examiner	100	100.000000	16,214		16,214		16,214
Schedule .4 Total for Medical Examiner	100	100.000000	16,214		16,214	0	16,214

Allocation Basis: Direct Allocation to Medical Examiner
Allocation Source: Direct Assignment as Primary Beneficiary of Services

NASHVILLE-DAVIDSON COUNTY, TENNESSEE
METRO PUBLIC HEALTH DEPARTMENT ~ ICRP
FOR THE FISCAL YEAR ENDED JUNE 30, 2022
Schedule .5 - Allocation Summary
For Department 2 CFR 200 LOCAP Costs

Receiving Department	Total	Employee Support	Financial Support	Benefits Support	Medical Examiner
38160810 Executive Leadership	161,174	40,811	8,442	111,921	0
38160110 Information Technology	79,434	20,406	16,576	42,452	0
38160210 Facilities Mgmt	139,791	57,136	9,897	72,758	0
38160310 Human Resources	63,764	24,487	2,799	36,478	0
38160410 Finance	116,722	40,811	5,396	70,515	0
38160610 Records Mgmt Services	95,775	44,892	7,732	43,150	0
Communicable Dis & Emergency Prepare	600,558	261,193	28,647	310,718	0
Population Health	1,039,002	408,114	92,664	538,224	0
Community Health	1,894,853	848,876	106,117	939,860	0
Environmental Health	943,174	461,168	38,974	443,032	0
Clinic Operations	538,969	204,057	26,666	308,246	0
Clinical Services	47,994	24,487	1,694	21,813	0
Health Equity	90,944	40,811	3,872	46,261	0
Finance & Administration	121,946	77,542	6,712	37,692	0
Executive Management	216	0	216	0	0
Medical Examiner	51,616	0	35,402	0	16,214
Direct Bill	0	0	0	0	0
Total	5,985,931	2,554,791	391,806	3,023,120	16,214

Nashville-Davidson's Metro Public Health Department is entitled to claim year-to-date depreciation expense on generally funded assets in use by the administrative business units to provide services department-wide. Depreciation is based on the acquisition value of assets expended over the expected useful life for each class of fixed asset. The costs identified in this schedule represent the total depreciation expense for generally funded buildings, improvements (renovations) and equipment identified in the Fixed Asset Master Listing.

For cost allocation plan purposes, the **Depreciation** cost pool is allocated using the actual depreciation expense identified to benefiting business units.

NASHVILLE-DAVIDSON COUNTY, TENNESSEE
METRO PUBLIC HEALTH DEPARTMENT ~ ICRP
FOR THE FISCAL YEAR ENDED JUNE 30, 2022
Schedule .2 - Costs To Be Allocated
For Department Depreciation Expense

	1st Allocation	2nd Allocation	Sub-Total	Total
Expenditures Per Financial Statement:	0			
Cost Adjustments:				
Equipment Depreciation	17,008			
Total Departmental Cost Adjustments:	17,008			17,008
Total To Be Allocated:	17,008			17,008

NASHVILLE-DAVIDSON COUNTY, TENNESSEE
METRO PUBLIC HEALTH DEPARTMENT ~ ICRP
FOR THE FISCAL YEAR ENDED JUNE 30, 2022
Schedule .3 - Costs Allocated By Activity
For Department Depreciation Expense

	Total	G&A	Depreciation
Deductions			
*Total Disallowed Costs	0	0	0
Cost Adjustments			
Equipment Depreciation	17,008	0	17,008
Functional Cost	17,008	0	17,008
Allocation Step 1			
Reallocate Admin Costs		0	0
Unallocated Costs	0	0	0
1st Allocation	17,008	0	17,008
Allocation Step 2			
2nd Allocation	0	0	0
Total For Depreciation Expense			
Schedule .3 Total	17,008	0	17,008

NASHVILLE-DAVIDSON COUNTY, TENNESSEE
METRO PUBLIC HEALTH DEPARTMENT ~ ICRP
FOR THE FISCAL YEAR ENDED JUNE 30, 2022
Schedule .4 - Detail Activity Allocations
For Department Depreciation Expense

Activity - Depreciation

Receiving Department	Allocation Units	Allocation Pct	Gross Allocation	Direct Billed	Allocation Step 1	Allocation Step 2	Total
38160110 Information Technology	11,834.89	69.586218	11,835		11,835		11,835
38160210 Facilities Mgmt	2,641.70	15.532541	2,642		2,642		2,642
38160310 Human Resources	2,530.93	14.881241	2,531		2,531		2,531
Schedule .4 Total for Depreciation	17,007.52	100.000000	17,008		17,008	0	17,008

Allocation Basis: Actual Depreciation Expense by Business Unit
Allocation Source: FY 2022 Asset Master Report - Finance-Operations

NASHVILLE-DAVIDSON COUNTY, TENNESSEE
METRO PUBLIC HEALTH DEPARTMENT ~ ICRP
FOR THE FISCAL YEAR ENDED JUNE 30, 2022
Schedule .5 - Allocation Summary
For Department Depreciation Expense

Receiving Department	Total	Depreciation
38160110 Information Technology	11,835	11,835
38160210 Facilities Mgmt	2,642	2,642
38160310 Human Resources	2,531	2,531
Direct Bill	0	0
Total	17,008	17,008

NASHVILLE-DAVIDSON COUNTY, TENNESSEE
METRO PUBLIC HEALTH DEPARTMENT ~ ICRP
FOR THE FISCAL YEAR ENDED JUNE 30, 2022
Schedule .1 - Nature and Extent of Services
For Department 38160810 Executive Leadership

The executive leadership for the Metro Public Health Department provides oversight/leadership to department staff, determines rates for services as well as other general non routine services for the Health Department. Direct costs are accounted for in Fund 10101 GSD General and business unit 38160810 HEA ALOB Executive Leadership.

For cost allocation plan purposes, the **Executive Leadership** cost pool has been allocated using the number of employees identified to each business unit/line of business.

NASHVILLE-DAVIDSON COUNTY, TENNESSEE
METRO PUBLIC HEALTH DEPARTMENT ~ ICRP
FOR THE FISCAL YEAR ENDED JUNE 30, 2022
Schedule .2 - Costs To Be Allocated
For Department 38160810 Executive Leadership

	1st Allocation	2nd Allocation	Sub-Total	Total
Expenditures Per Financial Statement:	1,362,051			1,362,051
Inbound Costs:				
2 CFR 200 LOCAP Costs	161,174		161,174	
38160810 Executive Leadership		24,333	24,333	
38160110 Information Technology		10,616	10,616	
38160210 Facilities Mgmt		26,366	26,366	
38160310 Human Resources		8,861	8,861	
38160410 Finance		25,047	25,047	
38160610 Records Mgmt Services		23,057	23,057	
Total Allocated Additions:	161,174	118,280	279,454	279,454
Total To Be Allocated:	1,523,225	118,280		1,641,505

NASHVILLE-DAVIDSON COUNTY, TENNESSEE
METRO PUBLIC HEALTH DEPARTMENT ~ ICRP
FOR THE FISCAL YEAR ENDED JUNE 30, 2022
Schedule .3 - Costs Allocated By Activity
For Department 38160810 Executive Leadership

	Total	G&A	Executive Leadership
Other Expense & Cost			
501101 Regular Pay	852,857	0	852,857
501102 Leave Pay	89,429	0	89,429
501103 Holiday Pay	33,311	0	33,311
501104 Overtime Pay	1,063	0	1,063
501105 Out of Class Pay	4,867	0	4,867
501109 Longevity	4,510	0	4,510
501134 Paid Family Leave	0	0	0
501160 YE Biweekly Sal/Fringe Accr	5,740	0	5,740
501172 Employer OASDI	53,453	0	53,453
501173 Employer SSN Medical	13,595	0	13,595
501174 Employer Group Health	126,791	0	126,791
501175 Employer Dental Group	3,563	0	3,563
501176 Employer Group Life	1,492	0	1,492
501177 Employer Pension	118,317	0	118,317
501181 FSA Pre-Tax Savings	176	0	176
501182 Cafe Plan Pre-Tax Savings	3,532	0	3,532
502229 Mngt Cnsltnt Srvc	11,700	0	11,700
502401 Transport Non-employee	0	0	0
502451 Employee Out-of-town Travel	0	0	0
502452 Employee Air Travel	0	0	0
502453 Employee Local Travel/Park	794	0	794
502503 Cell Phone Service	0	0	0
502801 Advertising & Promot'n	0	0	0
502851 Subscriptions	371	0	371
502883 Registration	5,354	0	5,354
502884 Membership Dues	2,775	0	2,775
503050 Host & Hostess	318	0	318
503100 Offc & Admin Supply	19,166	0	19,166
503120 Computer Software	143	0	143
503200 HHold & Jnitr Supply	49	0	49
503210 Food & Ice	0	0	0
503350 Educational Supply	82	0	82
503400 Medical Supply	45	0	45
505208 Insurance-Liability/PropDmg	6,445	0	6,445
505252 Software License	1,704	0	1,704
505282 Professional Privilege Tax	409	0	409
Departmental Total			
Expenditures Per Financial Statement	1,362,051		
Deductions			
*Total Disallowed Costs	0	0	0
Functional Cost	1,362,051	0	1,362,051
Allocation Step 1			
Inbound - All Others	161,174	161,174	0
Reallocate Admin Costs		(161,174)	161,174
Unallocated Costs	0	0	0
1st Allocation	1,523,225	0	1,523,225

NASHVILLE-DAVIDSON COUNTY, TENNESSEE
METRO PUBLIC HEALTH DEPARTMENT ~ ICRP
FOR THE FISCAL YEAR ENDED JUNE 30, 2022
Schedule .3 - Costs Allocated By Activity
For Department 38160810 Executive Leadership

	Total	G&A	Executive Leadership
Allocation Step 2			
Inbound - All Others	118,280	118,280	0
Reallocate Admin Costs		(118,280)	118,280
Unallocated Costs	0	0	0
2nd Allocation	118,280	0	118,280
Total For 38160810 Executive Leadership			
Schedule .3 Total	1,641,505	0	1,641,505

NASHVILLE-DAVIDSON COUNTY, TENNESSEE
METRO PUBLIC HEALTH DEPARTMENT ~ ICRP
FOR THE FISCAL YEAR ENDED JUNE 30, 2022
Schedule .4 - Detail Activity Allocations
For Department 38160810 Executive Leadership

Activity - Executive Leadership

Receiving Department	Allocation Units	Allocation Pct	Gross Allocation	Direct Billed	Allocation Step 1	Allocation Step 2	Total
38160810 Executive Leadership	10	1.597444	24,333		24,333		24,333
38160110 Information Technology	5	0.798722	12,166		12,166	960	13,126
38160210 Facilities Mgmt	14	2.236422	34,066		34,066	2,688	36,754
38160310 Human Resources	6	0.958466	14,600		14,600	1,152	15,752
38160410 Finance	10	1.597444	24,333		24,333	1,920	26,253
38160610 Records Mgmt Services	11	1.757188	26,766		26,766	2,112	28,878
Communicable Dis & Emergency Prepare	64	10.223642	155,729		155,729	12,289	168,018
Population Health	100	15.974441	243,327		243,327	19,201	262,528
Community Health	208	33.226839	506,120		506,120	39,939	546,058
Environmental Health	113	18.051118	274,959		274,959	21,697	296,657
Clinic Operations	50	7.987220	121,663		121,663	9,601	131,264
Clinical Services	6	0.958466	14,600		14,600	1,152	15,752
Health Equity	10	1.597444	24,333		24,333	1,920	26,253
Finance & Administration	19	3.035144	46,232		46,232	3,648	49,880
Schedule .4 Total for Executive Leadership	626	100.000000	1,523,225		1,523,225	118,280	1,641,505

Allocation Basis: Number of Employees by Business Unit/Line
Allocation Source: FY 2022 Active Employees Report - Human Resources

NASHVILLE-DAVIDSON COUNTY, TENNESSEE
METRO PUBLIC HEALTH DEPARTMENT ~ ICRP
FOR THE FISCAL YEAR ENDED JUNE 30, 2022
Schedule .5 - Allocation Summary
For Department 38160810 Executive Leadership

Receiving Department	Total	Executive Leadership
38160810 Executive Leadership	24,333	24,333
38160110 Information Technology	13,126	13,126
38160210 Facilities Mgmt	36,754	36,754
38160310 Human Resources	15,752	15,752
38160410 Finance	26,253	26,253
38160610 Records Mgmt Services	28,878	28,878
Communicable Dis & Emergency Prepare	168,018	168,018
Population Health	262,528	262,528
Community Health	546,058	546,058
Environmental Health	296,657	296,657
Clinic Operations	131,264	131,264
Clinical Services	15,752	15,752
Health Equity	26,253	26,253
Finance & Administration	49,880	49,880
Direct Bill	0	0
Total	1,641,505	1,641,505

Information Technology oversees and guides all of the technology-related activities for the Metro Public Health Department. Direct costs are accounted for in Fund 10101 GSD General and business unit 38160110 HEA ALOB Information Technology.

For cost allocation plan purposes, the **Information Technology** cost pool is allocated based on the number of employees identified to each business unit/line of business.

NASHVILLE-DAVIDSON COUNTY, TENNESSEE
METRO PUBLIC HEALTH DEPARTMENT ~ ICRP
FOR THE FISCAL YEAR ENDED JUNE 30, 2022
Schedule .2 - Costs To Be Allocated
For Department 38160110 Information Technology

	1st Allocation	2nd Allocation	Sub-Total	Total
Expenditures Per Financial Statement:	2,674,339			2,674,339
Deductions:				
502951 Info Systems Charge	-1,865,100			
502957 Telecmmnct'n Charge	-248,115			
Total Deductions:	-2,113,215			-2,113,215
Inbound Costs:				
2 CFR 200 LOCAP Costs	79,434		79,434	
Depreciation Expense	11,835		11,835	
38160810 Executive Leadership	12,166	960	13,126	
38160110 Information Technology		5,308	5,308	
38160210 Facilities Mgmt		13,183	13,183	
38160310 Human Resources		4,431	4,431	
38160410 Finance		49,179	49,179	
38160610 Records Mgmt Services		11,528	11,528	
Total Allocated Additions:	103,435	84,589	188,025	188,025
Total To Be Allocated:	664,559	84,589		749,149

NASHVILLE-DAVIDSON COUNTY, TENNESSEE
METRO PUBLIC HEALTH DEPARTMENT ~ ICRP
FOR THE FISCAL YEAR ENDED JUNE 30, 2022
Schedule .3 - Costs Allocated By Activity
For Department 38160110 Information Technology

	Total	G&A	Information Technology
Other Expense & Cost			
501101 Regular Pay	327,600	0	327,600
501102 Leave Pay	27,945	0	27,945
501103 Holiday Pay	12,049	0	12,049
501109 Longevity	1,595	0	1,595
501134 Paid Family Leave	4,870	0	4,870
501160 YE Biweekly Sal/Fringe Accr	2,126	0	2,126
501172 Employer OASDI	21,336	0	21,336
501173 Employer SSN Medical	4,990	0	4,990
501174 Employer Group Health	67,842	0	67,842
501175 Employer Dental Group	1,826	0	1,826
501176 Employer Group Life	837	0	837
501177 Employer Pension	48,183	0	48,183
501181 FSA Pre-Tax Savings	260	0	260
501182 Cafe Plan Pre-Tax Savings	2,030	0	2,030
502229 Mngt Cnsltnt Srvc	16,525	0	16,525
502453 Employee Local Travel/Park	0	0	0
502520 Postage & Delivery Srvc	0	0	0
502851 Subscriptions	0	0	0
502920 Other Rpr & Maint Srvc	0	0	0
*502951 Info Systems Charge	1,865,100	0	0
*502957 Telecmmnct'n Charge	248,115	0	0
503100 Offc & Admin Supply	11,012	0	11,012
503120 Computer Software	790	0	790
503130 Computer Hardware <$10K	6,007	0	6,007
503200 HHold & Jnitr Supply	23	0	23
503320 Uniforms/Work Related Items	233	0	233
503400 Medical Supply	0	0	0
505252 Software License	3,045	0	3,045
Departmental Total			
Expenditures Per Financial Statement	2,674,339		
Deductions			
*Total Disallowed Costs	(2,113,215)	0	0
Functional Cost	561,124	0	561,124
Allocation Step 1			
Inbound - All Others	103,435	0	103,435
Reallocate Admin Costs		0	0
Unallocated Costs	0	0	0
1st Allocation	664,559	0	664,559
Allocation Step 2			
Inbound - All Others	84,589	0	84,589
2nd Allocation	84,589	0	84,589
Total For 38160110 Information Technology			
Schedule .3 Total	749,149	0	749,149

NASHVILLE-DAVIDSON COUNTY, TENNESSEE
METRO PUBLIC HEALTH DEPARTMENT ~ ICRP
FOR THE FISCAL YEAR ENDED JUNE 30, 2022
Schedule .4 - Detail Activity Allocations
For Department 38160110 Information Technology

Activity - Information Technology

Receiving Department	Allocation Units	Allocation Pct	Gross Allocation	Direct Billed	Allocation Step 1	Allocation Step 2	Total
38160810 Executive Leadership	10	1.597444	10,616		10,616		10,616
38160110 Information Technology	5	0.798722	5,308		5,308		5,308
38160210 Facilities Mgmt	14	2.236422	14,862		14,862	1,938	16,801
38160310 Human Resources	6	0.958466	6,370		6,370	831	7,200
38160410 Finance	10	1.597444	10,616		10,616	1,384	12,000
38160610 Records Mgmt Services	11	1.757188	11,678		11,678	1,523	13,200
Communicable Dis & Emergency Prepare	64	10.223642	67,942		67,942	8,860	76,803
Population Health	100	15.974441	106,160		106,160	13,844	120,004
Community Health	208	33.226839	220,812		220,812	28,796	249,608
Environmental Health	113	18.051118	119,960		119,960	15,644	135,605
Clinic Operations	50	7.987220	53,080		53,080	6,922	60,002
Clinical Services	6	0.958466	6,370		6,370	831	7,200
Health Equity	10	1.597444	10,616		10,616	1,384	12,000
Finance & Administration	19	3.035144	20,170		20,170	2,630	22,801
Schedule .4 Total for Information Technology	626	100.000000	664,559		664,559	84,589	749,149

Allocation Basis: Number of Employees by Business Unit/Line
Allocation Source: FY 2022 Active Employees Report - Human Resources

NASHVILLE-DAVIDSON COUNTY, TENNESSEE
METRO PUBLIC HEALTH DEPARTMENT ~ ICRP
FOR THE FISCAL YEAR ENDED JUNE 30, 2022
Schedule .5 - Allocation Summary
For Department 38160110 Information Technology

Receiving Department	Total	Information Technology
38160810 Executive Leadership	10,616	10,616
38160110 Information Technology	5,308	5,308
38160210 Facilities Mgmt	16,801	16,801
38160310 Human Resources	7,200	7,200
38160410 Finance	12,000	12,000
38160610 Records Mgmt Services	13,200	13,200
Communicable Dis & Emergency Prepare	76,803	76,803
Population Health	120,004	120,004
Community Health	249,608	249,608
Environmental Health	135,605	135,605
Clinic Operations	60,002	60,002
Clinical Services	7,200	7,200
Health Equity	12,000	12,000
Finance & Administration	22,801	22,801
Direct Bill	0	0
Total	749,149	749,149

The Facilities Management business unit of the Metro Public Health Department ensures routine maintenance, repair, and custodial services are provided to the operational divisions of the department. Direct costs are accounted for in Fund 10101 GSD General and business unit 38160210 HEA ALOB Facilities Mgmt.

For cost allocation plan purposes, the **Facilities Management** cost pool is allocated using the number of employees identifed to each business unit/line of business.

NASHVILLE-DAVIDSON COUNTY, TENNESSEE
METRO PUBLIC HEALTH DEPARTMENT ~ ICRP
FOR THE FISCAL YEAR ENDED JUNE 30, 2022
Schedule .2 - Costs To Be Allocated
For Department 38160210 Facilities Mgmt

	1st Allocation	2nd Allocation	Sub-Total	Total
Expenditures Per Financial Statement:	1,596,759			1,596,759
Deductions:				
502954 Radio Shop Charge	-20,300			
502977 Fleet Management	-110,000			
502983 Surplus Property	-7,300			
Total Deductions:	-137,600			-137,600
Inbound Costs:				
2 CFR 200 LOCAP Costs	139,791		139,791	
Depreciation Expense	2,642		2,642	
38160810 Executive Leadership	34,066	2,688	36,754	
38160110 Information Technology	14,862	1,938	16,801	
38160210 Facilities Mgmt		36,913	36,913	
38160310 Human Resources		12,406	12,406	
38160410 Finance		29,363	29,363	
38160610 Records Mgmt Services		32,279	32,279	
Total Allocated Additions:	191,361	115,588	306,948	306,948
Total To Be Allocated:	1,650,520	115,588		1,766,107

NASHVILLE-DAVIDSON COUNTY, TENNESSEE
METRO PUBLIC HEALTH DEPARTMENT ~ ICRP
FOR THE FISCAL YEAR ENDED JUNE 30, 2022
Schedule .3 - Costs Allocated By Activity
For Department 38160210 Facilities Mgmt

	Total	G&A	Facilities Management
Other Expense & Cost			
501101 Regular Pay	528,782	0	528,782
501102 Leave Pay	65,664	0	65,664
501103 Holiday Pay	21,662	0	21,662
501104 Overtime Pay	9,005	0	9,005
501108 Injured on Duty Pay	1,418	0	1,418
501109 Longevity	9,708	0	9,708
501134 Paid Family Leave	4,820	0	4,820
501160 YE Biweekly Sal/Fringe Accr	3,679	0	3,679
501172 Employer OASDI	35,559	0	35,559
501173 Employer SSN Medical	8,316	0	8,316
501174 Employer Group Health	186,833	0	186,833
501175 Employer Dental Group	5,635	0	5,635
501176 Employer Group Life	2,130	0	2,130
501177 Employer Pension	82,574	0	82,574
501182 Cafe Plan Pre-Tax Savings	5,166	0	5,166
502101 Electric	77,109	0	77,109
502102 Water	11,176	0	11,176
502103 Gas	10,465	0	10,465
502105 Cable Television	6,509	0	6,509
502111 Stormwater	5,760	0	5,760
502227 Landscaping Srvc	88,996	0	88,996
502229 Mngt Cnsltnt Srvc	99	0	99
502302 Security Services	3,991	0	3,991
502303 Refuse Disposal	0	0	0
502306 Hazard Waste Disposal	4,822	0	4,822
502331 Temporary Service	154	0	154
502333 Laundry Services	0	0	0
502334 Pest Control Srvc	125	0	125
502335 Janitorial Srvc	13,304	0	13,304
502345 Lock & Key Service	0	0	0
502453 Employee Local Travel/Park	0	0	0
502503 Cell Phone Service	0	0	0
502520 Postage & Delivery Srvc	21,231	0	21,231
502701 Printing/Binding	67,494	0	67,494
502883 Registration	2,349	0	2,349
502884 Membership Dues	0	0	0
502911 Plumbing/HVAC Maintain Srvc	1,127	0	1,127
502912 Electrical Repair Service	575	0	575
502920 Other Rpr & Maint Srvc	4,729	0	4,729
*502954 Radio Shop Charge	20,300	0	0
*502977 Fleet Management	110,000	0	0
*502983 Surplus Property	7,300	0	0
503100 Offc & Admin Supply	29,728	0	29,728
503120 Computer Software	378	0	378
503130 Computer Hardware <$10K	607	0	607
503150 Furniture/Fixtures<$10K	7,547	0	7,547
503200 HHold & Jnitr Supply	25,797	0	25,797
503300 Personal Use Supply	0	0	0
503320 Uniforms/Work Related Items	7,567	0	7,567
503350 Educational Supply	888	0	888
503400 Medical Supply	8,586	0	8,586

NASHVILLE-DAVIDSON COUNTY, TENNESSEE
METRO PUBLIC HEALTH DEPARTMENT ~ ICRP
FOR THE FISCAL YEAR ENDED JUNE 30, 2022
Schedule .3 - Costs Allocated By Activity
For Department 38160210 Facilities Mgmt

	Total	G&A	Facilities Management
503500 Ag & Animal Supply	9	0	9
503600 Repair & Maint Supply	84,019	0	84,019
503720 Signs	411	0	411
503850 Small Equipment Supply	0	0	0
505233 Rent Equipment	0	0	0
505252 Software License	2,456	0	2,456
505259 Alarm Permits	200	0	200
Departmental Total			
Expenditures Per Financial Statement	1,596,759		
Deductions			
*Total Disallowed Costs	(137,600)	0	0
Functional Cost	1,459,159	0	1,459,159
Allocation Step 1			
Inbound - All Others	191,361	0	191,361
Reallocate Admin Costs		0	0
Unallocated Costs	0	0	0
1st Allocation	1,650,520	0	1,650,520
Allocation Step 2			
Inbound - All Others	115,588	0	115,588
2nd Allocation	115,588	0	115,588
Total For 38160210 Facilities Mgmt			
Schedule .3 Total	1,766,107	0	1,766,107

NASHVILLE-DAVIDSON COUNTY, TENNESSEE
METRO PUBLIC HEALTH DEPARTMENT ~ ICRP
FOR THE FISCAL YEAR ENDED JUNE 30, 2022
Schedule .4 - Detail Activity Allocations
For Department 38160210 Facilities Mgmt

Activity - Facilities Management

Receiving Department	Allocation Units	Allocation Pct	Gross Allocation	Direct Billed	Allocation Step 1	Allocation Step 2	Total
38160810 Executive Leadership	10	1.597444	26,366		26,366		26,366
38160110 Information Technology	5	0.798722	13,183		13,183		13,183
38160210 Facilities Mgmt	14	2.236422	36,913		36,913		36,913
38160310 Human Resources	6	0.958466	15,820		15,820	1,162	16,981
38160410 Finance	10	1.597444	26,366		26,366	1,936	28,302
38160610 Records Mgmt Services	11	1.757188	29,003		29,003	2,130	31,132
Communicable Dis & Emergency Prepare	64	10.223642	168,743		168,743	12,391	181,135
Population Health	100	15.974441	263,661		263,661	19,361	283,023
Community Health	208	33.226839	548,415		548,415	40,272	588,687
Environmental Health	113	18.051118	297,937		297,937	21,878	319,816
Clinic Operations	50	7.987220	131,831		131,831	9,681	141,511
Clinical Services	6	0.958466	15,820		15,820	1,162	16,981
Health Equity	10	1.597444	26,366		26,366	1,936	28,302
Finance & Administration	19	3.035144	50,096		50,096	3,679	53,774
Schedule .4 Total for Facilities Management	626	100.000000	1,650,520		1,650,520	115,588	1,766,107

Allocation Basis: Number of Employees by Business Unit/Line
Allocation Source: FY 2022 Active Employees Report - Human Resources

NASHVILLE-DAVIDSON COUNTY, TENNESSEE
METRO PUBLIC HEALTH DEPARTMENT ~ ICRP
FOR THE FISCAL YEAR ENDED JUNE 30, 2022
Schedule .5 - Allocation Summary
For Department 38160210 Facilities Mgmt

Receiving Department	Total	Facilities Management
38160810 Executive Leadership	26,366	26,366
38160110 Information Technology	13,183	13,183
38160210 Facilities Mgmt	36,913	36,913
38160310 Human Resources	16,981	16,981
38160410 Finance	28,302	28,302
38160610 Records Mgmt Services	31,132	31,132
Communicable Dis & Emergency Prepare	181,135	181,135
Population Health	283,023	283,023
Community Health	588,687	588,687
Environmental Health	319,816	319,816
Clinic Operations	141,511	141,511
Clinical Services	16,981	16,981
Health Equity	28,302	28,302
Finance & Administration	53,774	53,774
Direct Bill	0	0
Total	1,766,107	1,766,107

Human Resources provides personnel related services to all of the Metro Public Health Department's business units. Among the services provided are recruitment, maintenance of each employee's personnel records, and staff training programs. Direct costs are accounted for in Fund 10101 GSD General and business unit 38160310 HEA ALOB Human Resources.

For cost allocation plan purposes, the **Human Resources** cost pool is allocated using the number of employees identified to each business unit/line of business.

NASHVILLE-DAVIDSON COUNTY, TENNESSEE
METRO PUBLIC HEALTH DEPARTMENT ~ ICRP
FOR THE FISCAL YEAR ENDED JUNE 30, 2022
Schedule .2 - Costs To Be Allocated
For Department 38160310 Human Resources

	1st Allocation	2nd Allocation	Sub-Total	Total
Expenditures Per Financial Statement:	451,624			451,624
Inbound Costs:				
2 CFR 200 LOCAP Costs	63,764		63,764	
Depreciation Expense	2,531		2,531	
38160810 Executive Leadership	14,600	1,152	15,752	
38160110 Information Technology	6,370	831	7,200	
38160210 Facilities Mgmt	15,820	1,162	16,981	
38160310 Human Resources		5,317	5,317	
38160410 Finance		8,305	8,305	
38160610 Records Mgmt Services		13,834	13,834	
Total Allocated Additions:	103,084	30,600	133,684	133,684
Total To Be Allocated:	554,708	30,600		585,308

NASHVILLE-DAVIDSON COUNTY, TENNESSEE
METRO PUBLIC HEALTH DEPARTMENT ~ ICRP
FOR THE FISCAL YEAR ENDED JUNE 30, 2022
Schedule .3 - Costs Allocated By Activity
For Department 38160310 Human Resources

	Total	G&A	Human Resources
Other Expense & Cost			
501101 Regular Pay	277,220	0	277,220
501102 Leave Pay	30,593	0	30,593
501103 Holiday Pay	11,117	0	11,117
501104 Overtime Pay	435	0	435
501109 Longevity	2,118	0	2,118
501160 YE Biweekly Sal/Fringe Accr	1,761	0	1,761
501172 Employer OASDI	18,644	0	18,644
501173 Employer SSN Medical	4,360	0	4,360
501174 Employer Group Health	38,281	0	38,281
501175 Employer Dental Group	1,829	0	1,829
501176 Employer Group Life	786	0	786
501177 Employer Pension	41,410	0	41,410
501181 FSA Pre-Tax Savings	489	0	489
501182 Cafe Plan Pre-Tax Savings	1,100	0	1,100
502221 Medical Services	448	0	448
502229 Mngt Cnsltnt Srvc	1,834	0	1,834
502314 Pre-Employement Checks	10,039	0	10,039
502453 Employee Local Travel/Park	125	0	125
502801 Advertising & Promot'n	736	0	736
502883 Registration	1,635	0	1,635
502884 Membership Dues	579	0	579
503050 Host & Hostess	72	0	72
503100 Offc & Admin Supply	2,578	0	2,578
503120 Computer Software	578	0	578
503200 HHold & Jnitr Supply	9	0	9
503210 Food & Ice	0	0	0
503400 Medical Supply	0	0	0
505254 Drug Test Fee	2,848	0	2,848
Departmental Total			
Expenditures Per Financial Statement	451,624		
Deductions			
*Total Disallowed Costs	0	0	0
Functional Cost	451,624	0	451,624
Allocation Step 1			
Inbound - All Others	103,084	0	103,084
Reallocate Admin Costs		0	0
Unallocated Costs	0	0	0
1st Allocation	554,708	0	554,708
Allocation Step 2			
Inbound - All Others	30,600	0	30,600
2nd Allocation	30,600	0	30,600
Total For 38160310 Human Resources			
Schedule .3 Total	585,308	0	585,308

NASHVILLE-DAVIDSON COUNTY, TENNESSEE
METRO PUBLIC HEALTH DEPARTMENT ~ ICRP
FOR THE FISCAL YEAR ENDED JUNE 30, 2022
Schedule .4 - Detail Activity Allocations
For Department 38160310 Human Resources

Activity - Human Resources

Receiving Department	Allocation Units	Allocation Pct	Gross Allocation	Direct Billed	Allocation Step 1	Allocation Step 2	Total
38160810 Executive Leadership	10	1.597444	8,861		8,861		8,861
38160110 Information Technology	5	0.798722	4,431		4,431		4,431
38160210 Facilities Mgmt	14	2.236422	12,406		12,406		12,406
38160310 Human Resources	6	0.958466	5,317		5,317		5,317
38160410 Finance	10	1.597444	8,861		8,861	518	9,379
38160610 Records Mgmt Services	11	1.757188	9,747		9,747	570	10,317
Communicable Dis & Emergency Prepare	64	10.223642	56,711		56,711	3,314	60,025
Population Health	100	15.974441	88,611		88,611	5,178	93,789
Community Health	208	33.226839	184,312		184,312	10,770	195,081
Environmental Health	113	18.051118	100,131		100,131	5,851	105,982
Clinic Operations	50	7.987220	44,306		44,306	2,589	46,895
Clinical Services	6	0.958466	5,317		5,317	311	5,627
Health Equity	10	1.597444	8,861		8,861	518	9,379
Finance & Administration	19	3.035144	16,836		16,836	984	17,820
Schedule .4 Total for Human Resources	626	100.000000	554,708		554,708	30,600	585,308

Allocation Basis: Number of Employees by Business Unit/Line
Allocation Source: FY 2022 Active Employees Report - Human Resources

NASHVILLE-DAVIDSON COUNTY, TENNESSEE
METRO PUBLIC HEALTH DEPARTMENT ~ ICRP
FOR THE FISCAL YEAR ENDED JUNE 30, 2022
Schedule .5 - Allocation Summary
For Department 38160310 Human Resources

Receiving Department	Total	Human Resources
38160810 Executive Leadership	8,861	8,861
38160110 Information Technology	4,431	4,431
38160210 Facilities Mgmt	12,406	12,406
38160310 Human Resources	5,317	5,317
38160410 Finance	9,379	9,379
38160610 Records Mgmt Services	10,317	10,317
Communicable Dis & Emergency Prepare	60,025	60,025
Population Health	93,789	93,789
Community Health	195,081	195,081
Environmental Health	105,982	105,982
Clinic Operations	46,895	46,895
Clinical Services	5,627	5,627
Health Equity	9,379	9,379
Finance & Administration	17,820	17,820
Direct Bill	0	0
Total	585,308	585,308

Finance is the central point through which all revenues and disbursements of the Metro Public Health Department are channeled. Finance provides general financial direction/guidance and coordinates the activities of all the business units. Direct costs are accounted for in Fund 10101 GSD General and business unit 38160410 HEA ALOB Finance.

For cost allocation plan purposes, the **Finance** cost pool is allocated using the total actual expenditures recorded to each business unit/line of business.

NASHVILLE-DAVIDSON COUNTY, TENNESSEE
METRO PUBLIC HEALTH DEPARTMENT ~ ICRP
FOR THE FISCAL YEAR ENDED JUNE 30, 2022
Schedule .2 - Costs To Be Allocated
For Department 38160410 Finance

	1st Allocation	2nd Allocation	Sub-Total	Total
Expenditures Per Financial Statement:	870,527			870,527
Inbound Costs:				
2 CFR 200 LOCAP Costs	116,722		116,722	
38160810 Executive Leadership	24,333	1,920	26,253	
38160110 Information Technology	10,616	1,384	12,000	
38160210 Facilities Mgmt	26,366	1,936	28,302	
38160310 Human Resources	8,861	518	9,379	
38160410 Finance		16,008	16,008	
38160610 Records Mgmt Services		23,057	23,057	
Total Allocated Additions:	186,898	44,824	231,722	231,722
Total To Be Allocated:	1,057,425	44,824		1,102,249

NASHVILLE-DAVIDSON COUNTY, TENNESSEE
METRO PUBLIC HEALTH DEPARTMENT ~ ICRP
FOR THE FISCAL YEAR ENDED JUNE 30, 2022
Schedule .3 - Costs Allocated By Activity
For Department 38160410 Finance

	Total	G&A	Finance
Other Expense & Cost			
501101 Regular Pay	541,312	0	541,312
501102 Leave Pay	54,585	0	54,585
501103 Holiday Pay	20,306	0	20,306
501104 Overtime Pay	37	0	37
501105 Out of Class Pay	0	0	0
501109 Longevity	4,846	0	4,846
501134 Paid Family Leave	0	0	0
501160 YE Biweekly Sal/Fringe Accr	3,779	0	3,779
501172 Employer OASDI	36,437	0	36,437
501173 Employer SSN Medical	8,521	0	8,521
501174 Employer Group Health	91,791	0	91,791
501175 Employer Dental Group	3,136	0	3,136
501176 Employer Group Life	1,286	0	1,286
501177 Employer Pension	76,274	0	76,274
501182 Cafe Plan Pre-Tax Savings	2,572	0	2,572
502229 Mngt Cnsltnt Srvc	2,532	0	2,532
502451 Employee Out-of-town Travel	0	0	0
502452 Employee Air Travel	0	0	0
502453 Employee Local Travel/Park	5	0	5
502520 Postage & Delivery Srvc	0	0	0
502883 Registration	0	0	0
502884 Membership Dues	45	0	45
502978 Finance	(10,000)	0	(10,000)
503100 Offc & Admin Supply	7,891	0	7,891
503120 Computer Software	167	0	167
503130 Computer Hardware <$10K	0	0	0
503150 Furniture/Fixtures<$10K	998	0	998
503200 HHold & Jnitr Supply	130	0	130
503350 Educational Supply	0	0	0
503400 Medical Supply	708	0	708
505174 Interest Expense MIP	23,169	0	23,169
Departmental Total			
Expenditures Per Financial Statement	870,527		
Deductions			
*Total Disallowed Costs	0	0	0
Functional Cost	870,527	0	870,527
Allocation Step 1			
Inbound - All Others	186,898	0	186,898
Reallocate Admin Costs		0	0
Unallocated Costs	0	0	0
1st Allocation	1,057,425	0	1,057,425
Allocation Step 2			
Inbound - All Others	44,824	0	44,824
2nd Allocation	44,824	0	44,824

NASHVILLE-DAVIDSON COUNTY, TENNESSEE
METRO PUBLIC HEALTH DEPARTMENT ~ ICRP
FOR THE FISCAL YEAR ENDED JUNE 30, 2022
Schedule .3 - Costs Allocated By Activity
For Department 38160410 Finance

	Total	G&A	Finance
Total For 38160410 Finance			
Schedule .3 Total	1,102,249	0	1,102,249

NASHVILLE-DAVIDSON COUNTY, TENNESSEE
METRO PUBLIC HEALTH DEPARTMENT ~ ICRP
FOR THE FISCAL YEAR ENDED JUNE 30, 2022
Schedule .4 - Detail Activity Allocations
For Department 38160410 Finance

Activity - Finance

Receiving Department	Allocation Units	Allocation Pct	Gross Allocation	Direct Billed	Allocation Step 1	Allocation Step 2	Total
38160810 Executive Leadership	1,362,051.00	2.368705	25,047		25,047		25,047
38160110 Information Technology	2,674,339.00	4.650869	49,179		49,179		49,179
38160210 Facilities Mgmt	1,596,759.00	2.776880	29,363		29,363		29,363
38160310 Human Resources	451,624.00	0.785407	8,305		8,305		8,305
38160410 Finance	870,527.00	1.513910	16,008		16,008		16,008
38160610 Records Mgmt Services	1,247,444.00	2.169396	22,940		22,940	1,106	24,046
Communicable Dis & Emergency Prepare	4,621,869.00	8.037765	84,993		84,993	4,099	89,092
Population Health	14,950,382.00	25.999798	274,928		274,928	13,258	288,186
Community Health	17,120,809.00	29.774325	314,841		314,841	15,182	330,024
Environmental Health	6,288,077.00	10.935422	115,634		115,634	5,576	121,210
Clinic Operations	4,302,326.00	7.482057	79,117		79,117	3,815	82,932
Clinical Services	273,317.00	0.475318	5,026		5,026	242	5,269
Health Equity	624,691.00	1.086383	11,488		11,488	554	12,042
Finance & Administration	1,082,864.00	1.883179	19,913		19,913	960	20,873
Executive Management	34,838.00	0.060586	641		641	31	672
Schedule .4 Total for Finance	57,501,917.00	100.000000	1,057,425		1,057,425	44,824	1,102,249

Allocation Basis: Actual Expenditures by Benefiting Business Unit/Line
Allocation Source: FY 2022 Expenditure Report - Finance-Operations

NASHVILLE-DAVIDSON COUNTY, TENNESSEE
METRO PUBLIC HEALTH DEPARTMENT ~ ICRP
FOR THE FISCAL YEAR ENDED JUNE 30, 2022
Schedule .5 - Allocation Summary
For Department 38160410 Finance

Receiving Department	Total	Finance
38160810 Executive Leadership	25,047	25,047
38160110 Information Technology	49,179	49,179
38160210 Facilities Mgmt	29,363	29,363
38160310 Human Resources	8,305	8,305
38160410 Finance	16,008	16,008
38160610 Records Mgmt Services	24,046	24,046
Communicable Dis & Emergency Prepare	89,092	89,092
Population Health	288,186	288,186
Community Health	330,024	330,024
Environmental Health	121,210	121,210
Clinic Operations	82,932	82,932
Clinical Services	5,269	5,269
Health Equity	12,042	12,042
Finance & Administration	20,873	20,873
Executive Management	672	672
Direct Bill	0	0
Total	1,102,249	1,102,249

The Records Center provides for the storage and retrieval of public records. Direct costs are accounted for in Fund 10101 GSD General and business unit 38160610 HEA ALOB Records Mgmt Services.

For cost allocation plan purposes, the **Records Management** cost pool is allocated based on the number of active employees identified to each business unit/line of business of the Department.

NASHVILLE-DAVIDSON COUNTY, TENNESSEE
METRO PUBLIC HEALTH DEPARTMENT ~ ICRP
FOR THE FISCAL YEAR ENDED JUNE 30, 2022
Schedule .2 - Costs To Be Allocated
For Department 38160610 Records Mgmt Services

	1st Allocation	2nd Allocation	Sub-Total	Total
Expenditures Per Financial Statement:	1,247,444			1,247,444
Inbound Costs:				
2 CFR 200 LOCAP Costs	95,775		95,775	
38160810 Executive Leadership	26,766	2,112	28,878	
38160110 Information Technology	11,678	1,523	13,200	
38160210 Facilities Mgmt	29,003	2,130	31,132	
38160310 Human Resources	9,747	570	10,317	
38160410 Finance	22,940	1,106	24,046	
38160610 Records Mgmt Services		25,362	25,362	
Total Allocated Additions:	195,908	32,803	228,711	228,711
Total To Be Allocated:	1,443,352	32,803		1,476,155

NASHVILLE-DAVIDSON COUNTY, TENNESSEE
METRO PUBLIC HEALTH DEPARTMENT ~ ICRP
FOR THE FISCAL YEAR ENDED JUNE 30, 2022
Schedule .3 - Costs Allocated By Activity
For Department 38160610 Records Mgmt Services

	Total	G&A	Records Management
Other Expense & Cost			
501101 Regular Pay	331,689	0	331,689
501102 Leave Pay	31,661	0	31,661
501103 Holiday Pay	12,796	0	12,796
501104 Overtime Pay	25	0	25
501109 Longevity	2,035	0	2,035
501134 Paid Family Leave	2,122	0	2,122
501160 YE Biweekly Sal/Fringe Accr	2,046	0	2,046
501172 Employer OASDI	21,822	0	21,822
501173 Employer SSN Medical	5,104	0	5,104
501174 Employer Group Health	77,578	0	77,578
501175 Employer Dental Group	2,794	0	2,794
501176 Employer Group Life	1,263	0	1,263
501177 Employer Pension	40,325	0	40,325
501181 FSA Pre-Tax Savings	0	0	0
501182 Cafe Plan Pre-Tax Savings	2,169	0	2,169
502229 Mngt Cnsltnt Srvc	673,052	0	673,052
502303 Refuse Disposal	5,636	0	5,636
502331 Temporary Service	0	0	0
502520 Postage & Delivery Srvc	1,758	0	1,758
502920 Other Rpr & Maint Srvc	2,880	0	2,880
503100 Offc & Admin Supply	29,150	0	29,150
503120 Computer Software	1,089	0	1,089
503200 HHold & Jnitr Supply	103	0	103
503400 Medical Supply	347	0	347
Departmental Total			
Expenditures Per Financial Statement	1,247,444		
Deductions			
*Total Disallowed Costs	0	0	0
Functional Cost	1,247,444	0	1,247,444
Allocation Step 1			
Inbound - All Others	195,908	195,908	0
Reallocate Admin Costs		(195,908)	195,908
Unallocated Costs	0	0	0
1st Allocation	1,443,352	0	1,443,352
Allocation Step 2			
Inbound - All Others	32,803	32,803	0
Reallocate Admin Costs		(32,803)	32,803
Unallocated Costs	0	0	0
2nd Allocation	32,803	0	32,803
Total For 38160610 Records Mgmt Services			
Schedule .3 Total	1,476,155	0	1,476,155

NASHVILLE-DAVIDSON COUNTY, TENNESSEE
METRO PUBLIC HEALTH DEPARTMENT ~ ICRP
FOR THE FISCAL YEAR ENDED JUNE 30, 2022
Schedule .4 - Detail Activity Allocations
For Department 38160610 Records Mgmt Services

Activity - Records Management

Receiving Department	Allocation Units	Allocation Pct	Gross Allocation	Direct Billed	Allocation Step 1	Allocation Step 2	Total
38160810 Executive Leadership	10	1.597444	23,057		23,057		23,057
38160110 Information Technology	5	0.798722	11,528		11,528		11,528
38160210 Facilities Mgmt	14	2.236422	32,279		32,279		32,279
38160310 Human Resources	6	0.958466	13,834		13,834		13,834
38160410 Finance	10	1.597444	23,057		23,057		23,057
38160610 Records Mgmt Services	11	1.757188	25,362		25,362		25,362
Communicable Dis & Emergency Prepare	64	10.223642	147,563		147,563	3,683	151,246
Population Health	100	15.974441	230,567		230,567	5,755	236,322
Community Health	208	33.226839	479,580		479,580	11,970	491,550
Environmental Health	113	18.051118	260,541		260,541	6,503	267,044
Clinic Operations	50	7.987220	115,284		115,284	2,877	118,161
Clinical Services	6	0.958466	13,834		13,834	345	14,179
Health Equity	10	1.597444	23,057		23,057	575	23,632
Finance & Administration	19	3.035144	43,808		43,808	1,093	44,901
Schedule .4 Total for Records Management	626	100.000000	1,443,352		1,443,352	32,803	1,476,155

Allocation Basis: Number of Employees by Business Unit/Line
Allocation Source: FY 2022 Active Employees Report - Human Resources

NASHVILLE-DAVIDSON COUNTY, TENNESSEE
METRO PUBLIC HEALTH DEPARTMENT ~ ICRP
FOR THE FISCAL YEAR ENDED JUNE 30, 2022
Schedule .5 - Allocation Summary
For Department 38160610 Records Mgmt Services

Receiving Department	Total	Records Management
38160810 Executive Leadership	23,057	23,057
38160110 Information Technology	11,528	11,528
38160210 Facilities Mgmt	32,279	32,279
38160310 Human Resources	13,834	13,834
38160410 Finance	23,057	23,057
38160610 Records Mgmt Services	25,362	25,362
Communicable Dis & Emergency Prepare	151,246	151,246
Population Health	236,322	236,322
Community Health	491,550	491,550
Environmental Health	267,044	267,044
Clinic Operations	118,161	118,161
Clinical Services	14,179	14,179
Health Equity	23,632	23,632
Finance & Administration	44,901	44,901
Direct Bill	0	0
Total	1,476,155	1,476,155

Section D: Supplemental Data

NASHVILLE-DAVIDSON COUNTY, TENNESSEE
METRO PUBLIC HEALTH DEPARTMENT ~ ICRP
FOR THE FISCAL YEAR ENDED JUNE 30, 2022
Indirect Cost Rate Calculation as a Percentage of Direct Salaries and Wages

	Line of Business										
Direct Cost Base	**Communicable Disease and Emergency Preparedness**	**Population Health**	**Community Health**	**Environmental Health**	**Clinic Operations**	**Clinical Services**	**Health Equity**	**Finance & Administration**	**Executive Management**	**Medical Examiner**	**Grand Total**
Salaries & Wages (i)	$ 2,753,404	$ 4,769,434	$ 8,328,497	$ 3,925,890	$ 2,731,497	$ 193,295	$ 409,934	$ 334,008	$ -	$ -	$ 23,445,959
Internal Fringe Benefits (i)	1,049,932	1,886,234	3,389,990	1,469,207	1,054,535	46,944	77,774	91,441	-	-	9,066,057
External Fringe Benefits (ii)	310,718	538,224	939,860	443,032	308,246	21,813	46,261	37,692	-	-	2,645,846
Total Fringe Benefits	*1,360,650*	*2,424,458*	*4,329,850*	*1,912,239*	*1,362,781*	*68,757*	*124,035*	*129,133*	-	-	*11,711,903*

	Line of Business										
Indirect Costs	**Communicable Disease and Emergency Preparedness**	**Population Health**	**Community Health**	**Environmental Health**	**Clinic Operations**	**Clinical Services**	**Health Equity**	**Finance & Administration**	**Executive Management**	**Medical Examiner**	**Grand Total**
Allocated Indirect Costs (iii)	$ 1,326,876	$ 2,322,855	$ 4,295,862	$ 2,189,487	$ 1,119,734	$ 113,002	$ 202,552	$ 331,996	$ 887	$ 51,616	$ 11,954,867
Indirect Costs less External Fringe Benefits	1,016,158	1,784,631	3,356,002	1,746,455	811,488	91,189	156,291	294,304	887	51,616	9,309,021

	Line of Business										
Proposed Indirect Cost Rates as a Percentage of Direct Salaries & Wages	**Communicable Disease and Emergency Preparedness**	**Population Health**	**Community Health**	**Environmental Health**	**Clinic Operations**	**Clinical Services**	**Health Equity**	**Finance & Administration**	**Executive Management**	**Medical Examiner**	**Grand Total**
Allocated Indirect Costs	48.19%	48.70%	51.58%	55.77%	40.99%	58.46%	49.41%	99.40%	N/A	N/A	50.99%
Indirect Costs less External Fringe Benefits	36.91%	37.42%	40.30%	44.49%	29.71%	47.18%	38.13%	88.11%	N/A	N/A	39.70%
Internal Fringe Benefits	38.13%	39.55%	40.70%	37.42%	38.61%	24.29%	18.97%	27.38%	N/A	N/A	38.67%
External Fringe Benefits	11.28%	11.28%	11.28%	11.28%	11.28%	11.28%	11.28%	11.28%	N/A	N/A	11.28%
Total Fringe Benefits	49.42%	50.83%	51.99%	48.71%	49.89%	35.57%	30.26%	38.66%	N/A	N/A	49.95%

SOURCE:
(i) - FY 2022 SUMMARY OF ACTUAL EXPENDITURES BY LINE OF BUSINESS
(ii) - FY 2022 METRO PUBLIC HEALTH DEPARTMENT COST ALLOCATION PLAN ~ SCHEDULE 1.4.3
(iii) - FY 2022 METRO PUBLIC HEALTH DEPARTMENT COST ALLOCATION PLAN ~ SCHEDULE A

NASHVILLE-DAVIDSON COUNTY, TENNESSEE
METRO PUBLIC HEALTH DEPARTMENT ~ ICRP
FOR THE FISCAL YEAR ENDED JUNE 30, 2022
Actual Indirect Costs

Cost Allocation Plan	038 Health

Sum of FY22 Actual (Rounded)	Fund No. & Description 10101 GSD General	Security BU No. & Description					Grand Total	
Object No. & Description	38160110 HEA ALOB InformationTechnology	38160210 HEA ALOB Facilities Mgmt	38160310 HEA ALOB Human Resources	38160410 HEA ALOB Finance	38160610 HEA ALOB Records Mgmt Services	38160810 HEA ALOB Executive Leadersh		Direct Allocation
501101 Regular Pay	327,600	528,782	277,220	541,312	331,689	852,857	2,859,460	
501102 Leave Pay	27,945	65,664	30,593	54,585	31,661	89,429	299,877	
501103 Holiday Pay	12,049	21,662	11,117	20,306	12,796	33,311	111,241	
501104 Overtime Pay		9,005	435	37	25	1,063	10,565	
501105 Out of Class Pay						4,867	4,867	
501108 Injured on Duty Pay		1,418					1,418	
501109 Longevity	1,595	9,708	2,118	4,846	2,035	4,510	24,812	
501134 Paid Family Leave	4,870	4,820			2,122		11,812	
501160 YE Biweekly Sal/Fringe Accr	2,126	3,679	1,761	3,779	2,046	5,740	19,131	
501172 Employer OASDI	21,336	35,559	18,644	36,437	21,822	53,453	187,251	
501173 Employer SSN Medical	4,990	8,316	4,360	8,521	5,104	13,595	44,886	
501174 Employer Group Health	67,842	186,833	38,281	91,791	77,578	126,791	589,116	
501175 Employer Dental Group	1,826	5,635	1,829	3,136	2,794	3,563	18,783	
501176 Employer Group Life	837	2,130	786	1,286	1,263	1,492	7,794	
501177 Employer Pension	48,183	82,574	41,410	76,274	40,325	118,317	407,083	
501181 FSA Pre-Tax Savings	260		489			176	925	
501182 Cafe Plan Pre-Tax Savings	2,030	5,166	1,100	2,572	2,169	3,532	16,569	
502101 Electric		77,109					77,109	
502102 Water		11,176					11,176	
502103 Gas		10,465					10,465	
502105 Cable Television		6,509					6,509	
502111 Stormwater		5,760					5,760	
502221 Medical Services			448				448	
502227 Landscaping Srvc		88,996					88,996	
502229 Management Consultant	16,525	99	1,834	2,532	673,052	11,700	705,742	
502302 Security Services		3,991					3,991	
502303 Refuse Disposal		-			5,636		5,636	
502306 Hazard Waste Disposal		4,822					4,822	
502314 Pre-Employment Checks			10,039				10,039	
502331 Temporary Service		154			-		154	
502333 Laundry Services		-					-	
502334 Pest Control Srvc		125					125	
502335 Janitorial Srvc		13,304					13,304	
502345 Lock & Key Service		-					-	
502453 Employee Local Travel/Park	-	-	125	5	-	794	924	
502520 Postage & Delivery Srvc		21,231			1,758		22,989	
502701 Printing/Binding		67,494					67,494	
502801 Advertising & Promot'n			736				736	
502851 Subscriptions						371	371	
502883 Registration		2,349	1,635	-		5,354	9,338	
502884 Membership Dues		-	579	45		2,775	3,399	
502911 Plumbing/HVAC Maintain Srvc		1,127					1,127	
502912 Electrical Repair Service		575					575	
502920 Other Rpr & Maint Srvc	-	4,729			2,880		7,609	
502951 Info Systems Charge	**1,865,100**						**1,865,100**	**1,865,100**
502954 Radio Shop Charge		**20,300**					**20,300**	**20,300**
502957 Telecmmnct'n Charge	**248,115**						**248,115**	**248,115**
502977 Fleet Management		**110,000**					**110,000**	**110,000**
502978 Finance				(10,000)			(10,000)	
502980 Payment Services		-					-	
502983 Surplus Property		**7,300**					**7,300**	**7,300**
503050 Host & Hostess		-	72			318	390	
503100 Offc & Admin Supply	11,012	29,728	2,578	7,891	29,150	19,166	99,525	
503120 Computer Software	790	378	578	167	1,089	143	3,145	
503130 Computer Hardware <$10K	6,007	607					6,614	
503150 Furniture/Fixtures<$10K		7,547		998			8,545	
503200 HHold & Jnitr Supply	23	25,797	9	130	103	49	26,111	
503210 Food & Ice			-			-	-	
503300 Personal Use Supply		-			-		-	
503320 Uniforms/Work Related Items	233	7,567					7,800	
503350 Educational Supply		888		-		82	970	
503400 Medical Supply		8,586		708	347	45	9,686	
503500 Ag & Animal Supply		9					9	
503600 Repair & Maint Supply		84,019					84,019	
503720 Signs		411					411	
503850 Small Equipment Supply	-	-			-	-	-	
503999 Credit Card Clearing		-					-	
505174 Interest Expense MIP				23,169			23,169	
505208 Insurance-Liability/PropDmg						6,445	6,445	
505233 Rent Equipment		-					-	
505242 Elevator Permit		-					-	
505252 Software License	3,045	2,456				1,704	7,205	
505254 Drug Test Fee			2,848				2,848	
505259 Alarm Permits		200					200	
505282 Professional Privilege Tax						409	409	
Grand Total	**2,674,339**	**1,596,759**	**451,624**	**870,527**	**1,247,444**	**1,362,051**	**8,202,744**	**2,250,815**

NASHVILLE-DAVIDSON COUNTY, TENNESSEE
METRO PUBLIC HEALTH DEPARTMENT ~ ICRP
FOR THE FISCAL YEAR ENDED JUNE 30, 2022
Calculation of Modified Total Direct Cost (MTDC) Base

ALLOCATION OF DIRECT ALLOCATION EXPENDITURES

Cost Allocation Plan	038 Health

Sum of FY22 Actual (Rounded)	Fund No. & Description	Security BU No. & Description	
	10101 GSD General		Grand Total
Object No. & Description	38160110 HEA ALOB InformationTechnology	38160210 HEA ALOB Facilities Mgmt	
502951 Info Systems Charge	**1,865,100**		**1,865,100**
502954 Radio Shop Charge		**20,300**	**20,300**
502957 Telecmmnct'n Charge	**248,115**		**248,115**
502977 Fleet Management		**110,000**	**110,000**
502983 Surplus Property		**7,300**	**7,300**
Grand Total	**2,113,215**	**137,600**	**2,250,815**

Business Line	Salaries & Wages	Relative %	Direct Allocation
Clinic Operations	2,731,497	11.65%	262,224
Clinical Services	193,295	0.82%	18,556
Communicable Disease and Emergency Preparedness	2,753,404	11.74%	264,327
Community Health	8,328,497	35.52%	799,537
Environmental Health	3,925,890	16.74%	376,886
Executive Management		0.00%	-
Finance & Administration	334,008	1.42%	32,065
Health Equity	409,934	1.75%	39,354
Medical Examiner		0.00%	-
Population Health	4,769,434	20.34%	457,866
Sub Total	**$ 23,445,959**	**100.00%**	**$ 2,250,815**
Administrative Cost Pool	3,343,183		
Exclude - COVID/Disaster	449,658		
Exclude - Included in LOCAP	489,727		
Grand Total	**$ 27,728,527**		

TOTAL ALLOCATIONS	**$**	**2,250,815**
TOTAL TO BE ALLOCATED (CONTROL)	**$**	**2,250,815**
VARIANCE (S/B $0)	**$**	**-**

NASHVILLE-DAVIDSON COUNTY, TENNESSEE
METRO PUBLIC HEALTH DEPARTMENT ~ ICRP
FOR THE FISCAL YEAR ENDED JUNE 30, 2022
Calculation of Modified Total Direct Cost (MTDC) Base

CALCULATION OF MODIFIED TOTAL DIRECT COSTS (MTDC) BASE

Business Line	Object Type Salaries & Wages	Fringe Benefits	Operating Expenses	MTDC
Clinic Operations	2,731,497	1,054,535	495,887	4,281,919
Clinical Services	193,295	46,944	33,078	273,317
Communicable Disease and Emergency Preparedness	2,753,404	1,049,932	445,344	4,248,680
Community Health	8,328,497	3,389,990	4,848,540	16,567,027
Environmental Health	3,925,890	1,469,207	833,043	6,228,140
Executive Management	-	-	34,838	34,838
Finance & Administration	334,008	91,441	657,415	1,082,864
Health Equity	409,934	77,774	128,062	615,770
Medical Examiner	-	-	5,711,714	5,711,714
Population Health	4,769,434	1,886,234	7,739,909	14,395,577
Grand Total	**$ 23,445,959**	**$ 9,066,057**	**$ 20,927,830**	**$ 53,439,846**

CALCULATION OF ADJUSTED MODIFIED TOTAL DIRECT COSTS (MTDC) BASE

Business Line	MTDC	Direct Allocation Expenditures	Adjusted MTDC
Clinic Operations	4,281,919	262,224	4,544,143
Clinical Services	273,317	18,556	291,873
Communicable Disease and Emergency Preparedness	4,248,680	264,327	4,513,007
Community Health	16,567,027	799,537	17,366,564
Environmental Health	6,228,140	376,886	6,605,026
Executive Management	34,838	-	34,838
Finance & Administration	1,082,864	32,065	1,114,929
Health Equity	615,770	39,354	655,124
Medical Examiner	5,711,714	-	5,711,714
Population Health	14,395,577	457,866	14,853,443
Grand Total	**$ 53,439,846**	**$ 2,250,815**	**$ 55,690,661**

NOTE: Modified Total Direct Cost (MTDC) Base *excludes* Care of Persons (Object 502363), Furniture and Fixtures (Object 507300), Motor Vehicles (Object 507480), and Transfers (Objects 531001, 531099, and 531103). MTDC Base *includes* Info Systems Charge (Object 502951), Telecmmnct'n Charge (Object 502957), MIS Tech Revolving Charge (Object 502976), Fleet Management (Object 502977), and Surplus Property (Object 502983).

NASHVILLE-DAVIDSON COUNTY, TENNESSEE
METRO PUBLIC HEALTH DEPARTMENT ~ ICRP
FOR THE FISCAL YEAR ENDED JUNE 30, 2022
Summary of Actual Expenditures

Sum of FY22 Actual (Rounded)		Object Type						
Fund No. & Description	Security BU No. & Description	Salaries & Wages	Fringe Benefits	Operating Expenses	Non Operating Expenses	Transfers	Grand Total	Business Line
10101 GSD General	01101614 ADM Forensic Medical Examiner			5,712,464			5,712,464	Medical Examiner
10101 GSD General	38150271 HEA Population Health Bureau	109,243	43,773	2,997			156,013	Population Health
10101 GSD General	38150273 HEA Health Equity	181,648	31,449	5,675			218,772	Health Equity
10101 GSD General	38151001 HEA Behavioral Health Services	402,416	146,190	3,582			552,188	Population Health
10101 GSD General	38151032 HEA Public Health Clinics	1,417,723	604,173	305,135			2,327,031	Clinic Operations
10101 GSD General	38151034 HEA Family Planning Clinic Fee			57,438			57,438	Clinic Operations
10101 GSD General	38151036 HEA Maternal Child Adolescent	325,526	122,064	4,872			452,462	Population Health
10101 GSD General	38151046 HEA * Children Special Services			-			-	Population Health
10101 GSD General	38151051 HEA Oral Health Svcs	449,640	176,180	98,981			724,801	Community Health
10101 GSD General	38151072 HEA Epidemiology Research	361,987	125,835	8,395			496,217	Population Health
10101 GSD General	38151091 HEA Correctional Health Svcs	119,886	35,426	71,831			227,143	Clinical Services
10101 GSD General	38151111 HEA Forensic Med Exam Office			(750)			(750)	Medical Examiner
10101 GSD General	38151121 HEA Turberculosis Elimination	294,204	81,071	27,101			402,376	Communicable Disease and Emergency Preparedness
10101 GSD General	38151131 HEA STD/HIV Prevent&Interventn	510,782	188,973	60,745			760,500	Clinic Operations
10101 GSD General	38151141 HEA Commable Disease Emer Prep	421,299	169,726	2,127			593,152	Communicable Disease and Emergency Preparedness
10101 GSD General	38151151 HEA Community Develop and Plan	44,165	16,938	4,149			65,252	Population Health
10101 GSD General	38151171 HEA Project Access Nashville	160,508	61,461	1,585			223,554	Population Health
10101 GSD General	38151172 HEA * Community Health Admin	197,507	63,147	1,845			262,499	Community Health
10101 GSD General	38151173 HEA Pharmacy	73,409	11,518	(38,753)			46,174	Clinical Services
10101 GSD General	38151181 HEA Health Care for Homeless			355,200			355,200	Finance & Administration
10101 GSD General	38151191 HEA Civil Srvc Med Exam Clinic	489,727	161,998	376,736			1,028,461	Exclude - Included in LOCAP
10101 GSD General	38151201 HEA * Air Quality	129,173	43,549	10,862			183,584	Environmental Health
10101 GSD General	38151203 HEA Air Pollution	226,565	73,934	7,010			307,509	Environmental Health
10101 GSD General	38151222 HEA Animal Services All Other	1,390,261	530,481	631,142			2,551,884	Environmental Health
10101 GSD General	38151224 HEA Engineering Svce Investiga	124,725	47,504	6,901			179,130	Environmental Health
10101 GSD General	38151226 HEA Ofc Environmental Health	160,265	41,003	581			201,849	Environmental Health
10101 GSD General	38151227 HEA School Health	650,537	260,591	9,872			921,000	Community Health
10101 GSD General	38151233 HEA Food & Public Fac Protectn	1,165,480	448,877	56,476			1,670,833	Environmental Health
10101 GSD General	38151239 HEA Mental Health Cooperative			2,531,907			2,531,907	Population Health
10101 GSD General	38151241 HEA Pest Mgmt Svcs	206,530	74,078	12,623			293,231	Environmental Health
10101 GSD General	38160110 HEA ALOB InformationTechnology	376,185	147,304	2,150,850			2,674,339	Administrative Cost Pool
10101 GSD General	38160210 HEA ALOB Facilities Mgmt	644,738	326,213	625,808			1,596,759	Administrative Cost Pool
10101 GSD General	38160310 HEA ALOB Human Resources	323,244	106,899	21,481			451,624	Administrative Cost Pool
10101 GSD General	38160410 HEA ALOB Finance	624,865	220,017	25,645			870,527	Administrative Cost Pool
10101 GSD General	38160610 HEA ALOB Records Mgmt Services	382,374	151,055	714,015			1,247,444	Administrative Cost Pool
10101 GSD General	38160810 HEA ALOB Executive Leadersh	991,777	320,919	49,355			1,362,051	Administrative Cost Pool
10101 GSD General	38161000 HEA Nonpayroll Exp Clearing			2,459			2,459	Finance & Administration
30003 General Fund 4% Reserve	38201000 4% HEA Health Department			149,430			149,430	
30006 Animal Control Donations	38701000 HEA Animal Control Donations			28,050			28,050	Environmental Health
30072 Animal Education and Welfare	38702000 HEA Animal Education/Welfare			2			2	Environmental Health
30099 COVID-19 Pandemic	38902020 HEA COVID-19	174		4,929			5,103	Exclude - COVID/Disaster
30112 COVID Reserve Post 2020	38902022 HEA COVID Reserve Post 2020			1,794,893			1,794,893	Exclude - COVID/Disaster
30116 COVID FEMA	38302022 HEA COVID FEMA			12,030			12,030	Executive Management
30117 COVID Vaccination Distribution	38702021 HEA COVID Vaccination Distribution			22,808			22,808	Executive Management
30204 Health Title V Clean Air Act	38700100 HEA Title V Clean Air Act	58,911	20,135	185			79,231	Environmental Health
30206 Health Clean Air Permit Prgm	38700200 HEA Clean Air Permit Prgm	160,180	72,903	1,323		59,937	294,343	Environmental Health
30216 American Rescue Plan Act-COVID Stimulus	38902027 HEA Behav Health Pilot Prog W POL Pcts			485,805			485,805	Population Health
32200 HEA Health Dept Grant Fund	38350265 HEA Tobacco Settlement	74,239	28,427	3,499		20,564	126,729	Population Health
32200 HEA Health Dept Grant Fund	38350268 HEA Chronic Disease PreventMgt	35,448	12,842	1,087	-	9,700	59,077	Population Health
32200 HEA Health Dept Grant Fund	38350400 HEA HIV PreP	117,172	50,025	3,351		7,717	178,265	Clinic Operations
32200 HEA Health Dept Grant Fund	38350500 HEA Chant Grant	1,237,082	533,140	82,526		117,410	1,970,158	Population Health
32200 HEA Health Dept Grant Fund	38350600 HEA STARS Grant	65,617	28,191				93,808	Population Health
32200 HEA Health Dept Grant Fund	38351015 HEA Health Start Grant	203,485	99,555	9,579		10,652	323,271	Population Health
32200 HEA Health Dept Grant Fund	38351020 HEA Immunization Svcs Grant	50,714	19,542	4,339		12,360	86,955	Communicable Disease and Emergency Preparedness
32200 HEA Health Dept Grant Fund	38351021 HEA Family Planning Grant	606,156	186,702	67,515			860,373	Clinic Operations
32200 HEA Health Dept Grant Fund	38351027 HEA School Hea Gr CAH AllOther	3,526,468	1,430,221	4,410,331			9,367,020	Community Health
32200 HEA Health Dept Grant Fund	38351031 HEA ChildCare Immunization Aud	35,002	18,156	784		-	53,942	Communicable Disease and Emergency Preparedness
32200 HEA Health Dept Grant Fund	38351034 HEA Breast & Cerv Cancer	79,664	24,662	1,703		12,690	118,719	Clinic Operations
32200 HEA Health Dept Grant Fund	38351037 HEA Minority AIDS Initiative	16,092	4,879	298,428		1,941	321,340	Population Health
32200 HEA Health Dept Grant Fund	38351044 HEA WIC Grant	3,026,402	1,261,675	192,486		457,782	4,938,345	Community Health
32200 HEA Health Dept Grant Fund	38351045 HEA Healthy Start Initiative	376,468	162,362	363,849		151,889	1,054,568	Population Health
32200 HEA Health Dept Grant Fund	38351053 HEA Oral HealthTDH Grant	477,943	198,176	135,025		96,000	907,144	Community Health
32200 HEA Health Dept Grant Fund	38351060 HEA Fetal Infant Mortality Rat	203,834	103,552	6,076		14,791	328,253	Population Health
32200 HEA Health Dept Grant Fund	38351064 HEA Child Safety Seat			4,259			4,259	Population Health
32200 HEA Health Dept Grant Fund	38351082 HEA Cities Readiness Grant	46,900	11,701	100,441			159,042	Communicable Disease and Emergency Preparedness
32200 HEA Health Dept Grant Fund	38351087 HEA Hospital PreparednessGrant	53,882	9,353				63,235	Communicable Disease and Emergency Preparedness
32200 HEA Health Dept Grant Fund	38351123 HEA * TB Drug Study Grant	(50)	91	-		4,748	4,789	Communicable Disease and Emergency Preparedness
32200 HEA Health Dept Grant Fund	38351124 HEA TB Outpatient Grant	792,330	339,078	146,145	1,758	206,934	1,486,245	Communicable Disease and Emergency Preparedness
32200 HEA Health Dept Grant Fund	38351128 HEA * TB Epidemiologic Studies	-		282		1,265	1,547	Communicable Disease and Emergency Preparedness
32200 HEA Health Dept Grant Fund	38351133 HEA STD Grant STD	103,076	49,143	3,772		6,863	162,854	Communicable Disease and Emergency Preparedness
32200 HEA Health Dept Grant Fund	38351134 HEA HIV AIDS Grant	314,148	120,002	2,575		23,199	459,924	Communicable Disease and Emergency Preparedness
32200 HEA Health Dept Grant Fund	38351137 HEA Ryan White Grant	340,071	97,740	3,059,927		45,428	3,543,166	Population Health
32200 HEA Health Dept Grant Fund	38351138 HEA HIV Rapid Testing	78,096	19,633	546		4,920	103,195	Communicable Disease and Emergency Preparedness
32200 HEA Health Dept Grant Fund	38351139 HEA Ryan White Medical Service	56,170	31,128	727		5,755	93,780	Communicable Disease and Emergency Preparedness
32200 HEA Health Dept Grant Fund	38351146 HEA Emerg Preparedness Grant	278,095	93,658	155,770		94,380	621,903	Communicable Disease and Emergency Preparedness
32200 HEA Health Dept Grant Fund	38351163 HEA Health Promotion CPHE AllO	106,342	44,264	7,411		30,100	188,117	Population Health
32200 HEA Health Dept Grant Fund	38351166 HEA Tobacco Grant	37,949	13,552	-		11,933	63,434	Population Health
32200 HEA Health Dept Grant Fund	38351174 HEA CDC 1807 Grant			58,901		-	58,901	Population Health
32200 HEA Health Dept Grant Fund	38351204 HEA 103 Grant	83,050	23,883	6,179		-	113,112	Environmental Health
32200 HEA Health Dept Grant Fund	38351205 HEA 105 Grant	220,750	92,860	34,452	-	-	348,062	Environmental Health
32200 HEA Health Dept Grant Fund	38351218 HEA Food Inspector Training			-			-	Environmental Health
32200 HEA Health Dept Grant Fund	38351219 HEA * Animal Ctrl Medical Svcs			(1,968)			(1,968)	Environmental Health
32200 HEA Health Dept Grant Fund	38360450 HEA Grant in Aid	334,008	91,441	299,756			725,205	Finance & Administration
32200 HEA Health Dept Grant Fund	38361310 HEA Ryan White-COVID			525,269			525,269	Population Health
32200 HEA Health Dept Grant Fund	38361800 HEA Child Fatality Review Serv			7,000			7,000	Population Health
32200 HEA Health Dept Grant Fund	38361900 HEA Prenatal Presumptive Eligi	80,143	29,423	1,971			111,537	Population Health
32200 HEA Health Dept Grant Fund	38362000 HEA Viral Hepatitis Grant	51,282	22,141			7,276	80,699	Communicable Disease and Emergency Preparedness
32200 HEA Health Dept Grant Fund	38363100 HEA HIV/AIDS Early Interv Serv	33,928	13,143	34		3,731	50,836	Communicable Disease and Emergency Preparedness
32200 HEA Health Dept Grant Fund	38363200 HEA PPHF Grant	144,328	52,366	701		-	197,395	Communicable Disease and Emergency Preparedness
32200 HEA Health Dept Grant Fund	38363300 HEA Friends of MACC			39,225			39,225	Environmental Health
32200 HEA Health Dept Grant Fund	38363600 HEA Opioid Overdose Reduction Grant	170,549	72,119	(2,701)		58,017	297,984	Population Health
32200 HEA Health Dept Grant Fund	38363610 HEA High Impact Area Opioid	254,929	87,696	189,262		82,380	614,267	Population Health
32200 HEA Health Dept Grant Fund	38363630 HEA PHEP COVID Grant	379,899	122,833	9,542,803	1,874,491	-	11,920,026	Exclude - COVID/Disaster
32200 HEA Health Dept Grant Fund	38363640 HEA Immunizations - COVID	69,585	14,285	560,663	-		644,533	Exclude - COVID/Disaster
32200 HEA Health Dept Grant Fund	38363650 HEA Behav Hea Crisis Resp Initiative	88,582	25,906	54,661			169,149	Population Health
32200 HEA Health Dept Grant Fund	38363660 HEA COVID Disparities Grant	228,286	46,325	122,387	8,921	-	405,919	Health Equity
32200 HEA Health Dept Grant Fund	38363670 HEA A Step Ahead Grant			(8,181)			(8,181)	Population Health
32200 HEA Health Dept Grant Fund	38363680 HEA Health Accelerator Plan	3,342	1,308	329		-	4,979	Population Health
32200 HEA Health Dept Grant Fund	38363690 HEA Comm Overdose Prev&Emp NACCHO Grar	-	-	-		-	-	Population Health
32200 HEA Health Dept Grant Fund	38363700 HEA Prevent Child Abuse TN	61,578	24,373	-			85,951	Population Health
32200 HEA Health Dept Grant Fund	38363710 HEA COVID ELC Reopening Schools Grant	-	-	26,016	-		26,016	Population Health
32200 HEA Health Dept Grant Fund	38363720 HEA COVID ELC Travelers HealthFund Grant			-			-	Population Health
32200 HEA Health Dept Grant Fund	38363800 HEA COVID Response Resilient Comm CCR	9,839	644	7,449		-	17,932	Population Health
32200 HEA Health Dept Grant Fund	38363900 HEA Music City PreP Grant			-			-	Population Health
32201 HEA Donations Fund	38601000 HEA David Trowbridge Donation			-			-	Population Health
Grand Total		27,728,527	10,637,580	36,944,438	1,885,170	1,560,362	78,756,077	

Administrative Cost Pool
Excluded - Transfers and Capital Projects
Excluded - COVID/Disaster Funds
Excluded - Central Service in LOCAP

Health Department

10/27/2021

All LOD "3" BU's will have a Budget only Posting Edit Code

FY2022 Chart of Accounts

Business Units	BU Description	Grant Cat Code 16	Fund	BU Type	Program	LOD
	Clinic Operations					
38151032	Public Health Clinics		10101	A1	A1A	4
38902026	Electronic Medical Records System		30216		ARP Fund	
38351021	Family Planning Grant		32200	A1	A1A	4
38151034	Family Planning Clinic Fee		10101	A1	A1A	4
38351034	Breast and Cervical Cancer Grant		32200	A1	A1A	4
38151131	STD/HIV Prevention and Intervention		10101	A1	A1A	4
38350400	HIV Prep Grant		32200	A1	A1A	4
	Clinical Services					
38151091	Correctional Health Services		10101	A2	A2A	4
38151191	Occupational Health & Wellness Services		10101	A2	A2B	4
38351192	Employee Benefit Board		32200	A2	A2B	4
38151173	Pharmacy		10101	A2	A2C	4
	Communicable Disease and Emergency Preparedness					
38151141	Notifiable Disease		10101	A3	A3A	4
38151121	Tuberculosis Elimination (TB)		10101	A3	A3B	4
38351123	TB Drug Study Grant		32200	A3	A3B	4
38351124	TB Outpatient Grant		32200	A3	A3B	4
38351128	TB Epi Grant		32200	A3	A3B	4
38351146	Emergency Preparedness (BT) Grant		32200	A3	A3C	4
38351082	Cities Readiness Imitative Grant		32200	A3	A3C	4
38351087	Hospital Preparedness Grant		32200	A3	A3C	4
38362000	Viral Hepatitis Grant		32200	A3	A3C	4
38363630	PHEP COVID -ELC		32200	A3	A3C	4
38351133	STD Grant		32200	A3	A3D	4
38351134	HIV AIDS Grant		32200	A3	A3D	4
38351138	HIV Rapid Testing Grant		32200	A3	A3D	4
38351139	Ryan White Medical Services Grant		32200	A3	A3D	4
38363100	HIV/AIDS Early Intervention Services Grant		32200	A3	A3D	4
38351020	Immunization Services Grant		32200	A3	A3E	4
38363640	Immunization COVID Grant		32200	A3	A3E	4
38363200	PPHF Grant		32200	A3	A3E	4
38351031	Child Care Immunization Audit Grant		32200	A3	A3E	4

Health Department

10/27/2021

All LOD "3" BU's will have a Budget only Posting Edit Code

FY2022 Chart of Accounts

Business Units	BU Description	Grant Cat Code 16	Fund	BU Type	Program	LOD
	Community Health					
38151041	WIC		10101	A4	A4A	4
38351044	WIC Grant		32200	A4	A4A	4
38151051	Oral Health Services		10101	A1	A4B	4
38351053	Oral Health TDH Grant		32200	A1	A4B	4
38151227	School Health Local		10101	A4	A4C	4
38351027	School Health Grant		32200	A4	A4C	4
38151172	Community Health Administration		10101	A4	A4D	4
	Environmental Health					
38151203	Air Pollution		10101	A5	A5A	4
38351204	103 Grant		32200	A5	A5A	4
38351205	105 Grant		32200	A5	A5A	4
38700200	Title V Grant		30206	A5	A5A	4
38700100	Title V Clean Air Carry Over		30204	A5	A5A	4
38151233	Food and Public Facilities Services		10101	A5	A5B	4
38351218	Food Assessment		32200	A5	A5B	4
38151222	Animal Care and Control		10101	A5	A5C	4
38351219	Animal Control Medical Services		32200	A5	A5C	4
38363300	Friends of MACC		32200	A5	A5C	4
38363300	Friends of MACC (Emergency Medical Fund EMF)		32200	A5	A5C	4
38363300	Friends of MACC (SNF - Safety Net Fund)		32200	A5	A5C	4
38363300	Friends of MACC (FieldServ)		32200	A5	A5C	4
38363300	Friends of MACC (Micrchip)		32200	A5	A5C	4
	MACC Donation Fund					
38701000	Animal Control Donations		30006		Revenue Code 409300	
38702000	Animal Education and Welfare		30072		Revenue Code 407775	
38151224	Engineering Service Investigations		10101	A5	A5D	4
38151241	Pest Management Services		10101	A5	A5E	4
38151201	Air Quality - Vehicle Inspection		10101	A5	A5F	4
38151226	Office of Environmental Health		10101	A5	A5G	4
	Health Equity					
38150273	Health Equity		10101			4
38363660	COVID Diversity		32200			4

Health Department

10/27/2021

All LOD "3" BU's will have a Budget only Posting Edit Code

FY2022 Chart of Accounts

Business Units	BU Description	Grant Cat Code 16	Fund	BU Type	Program	LOD
	Finance & Administration					
38160110	Information Technology		10101	A6	A6A	4
38160210	Facilities Maintenance		10101	A6	A6B	4
38160310	Human Resources		10101	A6	A6C	4
38160410	Finance		10101	A6	A6D	4
38360450	Grant in Aid		32200	A6	A6D	4
38160610	Vital and Medical Records Management Services		10101	A6	A6E	4
38151181	Health Care for the Homeless		10101	A4	A6F	4
38151111	Forensic Medical Postmortem Reimbursement		10101	A6	A6G	4
38161000	Nonpayroll Expense Clearing Account		10101	A6	A6H	4
38160020	ALOB Compensation		10101	A6	A6H	4
	Population Health					
38151001	Behavioral Health Services		10101	A8	A8A	4
38902027	Behavioral Health Pilot Program-Partners in Care		30216	A8	A8A	4
38363650	Behavioral Health Crisis Response Initiative (BHCR) - Substance Abuse - Governors Grant		32200	A8	A8A	4
38363800	COVID Response Resilient Communities CCR		32200	A8	A8A	4
38151239	Mental Health Cooperative		10101	A8	A8A	4
38363600	Opioid Federal Grant		32200	A8	A8A	4
38363610	Opioid HIA State Grant		32200	A8	A8A	4
38363700	Prevent Child Abuse TN		32200	A8	A8A	4
38151151	Community Development & Planning		10101	A8	A8B	4
38351163	Health Promotion Grant		32200	A8	A8B	4
38350268	Chronic Disease Grant		32200	A8	A8B	4
38351166	Tobacco Grant		32200	A8	A8B	4
38350265	Tobacco Settlement		32200	A8	A8B	4
38151046	Children's Special Services		10101	A8	A8C	4
38350500	CHANT Grant		32200	A8	A8C	4
38151171	Project Access Nashville		10101	A8	A8C	4
38361900	Presumptive Eligibility		32200	A8	A8C	4
38151036	Maternal Child and Adolescent Health		10101	A8	A8D	4
38351015	Health Start Grant		32200	A8	A8D	4
38351045	Health Start Strong Babies Grant		32200	A8	A8D	4
38351174	CDC 1807 Grant		32200	A8	A8D	4
38351060	FIMR Grant		32200	A8	A8D	4

Health Department

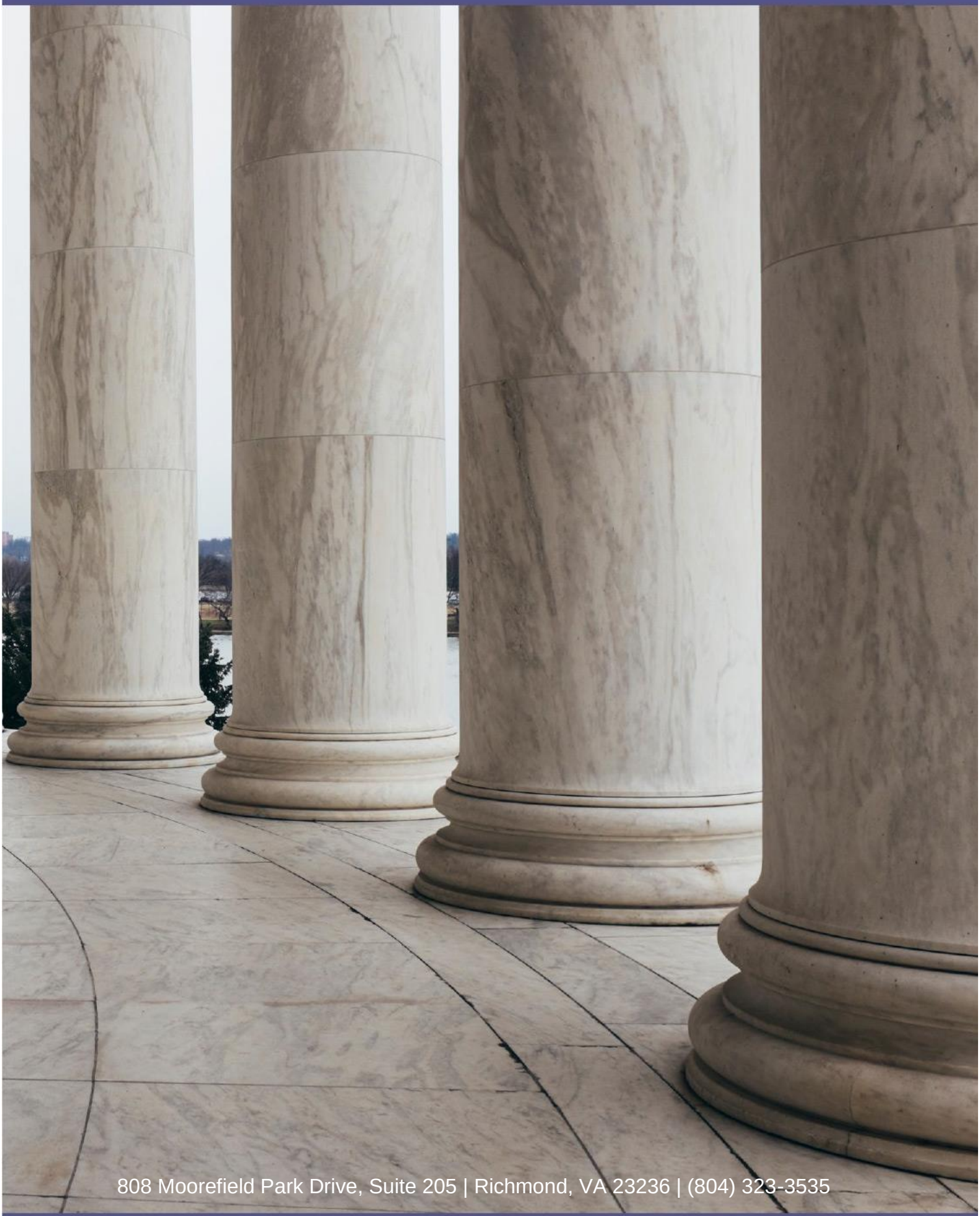
10/27/2021

All LOD "3" BU's will have a Budget only Posting Edit Code

FY2022 Chart of Accounts

Business Units	BU Description	Grant Cat Code 16	Fund	BU Type	Program	LOD
38351064	Child Safety Seat		32200	A8	A8D	4
38361800	Child Fatality Services		32200	A8	A8D	4
38351137	Ryan White Grant		32200	A8	A8E	4
38351037	AIDS Minority Grant		32200	A8	A8E	4
38361310	Ryan White COVID Grant		32200	A8	A8E	4
38150271	Population Health Administration		10101	A8	A8F	4
	Executive Management					
38160810	Executive Leadership		10101	A9	A9A	4
38151072	Epidemiology Research		10101	A9	A9B	4
38350600	STARS Grant		32200	A9	A9B	4
38902020	COVID - prior to Dec2020		30099			
38902022	COVID - vaccination efforts		30112			
38702021	COVID - Testing efforts		30117			
	Administrative Business Units					
01101613	Correctional Health Contract Services		10101			
01101614	Forensic Medical		10101			
30722910	Correctional Hlth Contract Monitor Sheriff Office		30145			
12501000	Employee Benefit Board		10101			

MAXIMUS



808 Moorefield Park Drive, Suite 205 | Richmond, VA 23236 | (804) 323-3535

Helping Government Serve the People®

OMB Number: 4040-0010
Expiration Date: 11/30/2025

Project/Performance Site Location(s)

Project/Performance Site Primary Location

☐ I am submitting an application as an individual, and not on behalf of a company, state, local or tribal government, academia, or other type of organization.

Organization Name: Nashville & Davidson County, Metropolitan Government of

UEI: 078217668000

* Street1: 2500 Charlotte Avenue

Street2:

* City: Nashville

County:

* State: TN: Tennessee

Province:

* Country: USA: UNITED STATES

* ZIP / Postal Code: 37209-4129

* Project/ Performance Site Congressional District: TN-mid

Project/Performance Site Location 1

☐ I am submitting an application as an individual, and not on behalf of a company, state, local or tribal government, academia, or other type of organization.

Organization Name:

UEI:

* Street1:

Street2:

* City:

County:

* State:

Province:

* Country: USA: UNITED STATES

* ZIP / Postal Code:

* Project/ Performance Site Congressional District:

Additional Location(s)

Add Attachment | Delete Attachment | View Attachment

Project Narrative File(s)

*** Mandatory Project Narrative File Filename:** Nashville Strong Babies Project Narrative.pdf

Add Mandatory Project Narrative File | Delete Mandatory Project Narrative File | View Mandatory Project Narrative File

To add more Project Narrative File attachments, please use the attachment buttons below.

Add Optional Project Narrative File | Delete Optional Project Narrative File | View Optional Project Narrative File

ii. Project Narrative

INTRODUCTION

Population estimates are from the American Community Survey (ACS) from the US Census Bureau 2017-2021 for Davidson County. Mortality and natality estimates were calculated from Davidson County vital records files and are for the years 2019-2021.

Nashville/Davidson County Overview

Nashville/Davidson County, TN is an **urban center** that has a population of 708,490 (2020) with a racial/ethnic distribution of approximately 26.7% Non-Hispanic African American (AA), 5.7% Non-Hispanic Caucasian (NHC), 10.4% Latino and 7.2% Other. Both the NHC and AA populations have declined since 2016 at approximately 1% each while the Latino and Other population has increased by nearly 1.8%. Due to historical and systemic inequities, numerous stark racial disparities persist. While high school graduation rates are nearly equivalent, AA households are 2.3 times more likely to live below poverty than NHC household (21.5% and 9.4%). The median household income lags at just under $50,000 (AA) versus $77,000 (NHC). While educational attainment has increased, 11.8% of AA women 25 years of age and older have less than a high school education compared to only 4.8% of NHC women. 12% of AA 18 – 64 years of age lack health insurance compared to 7.7% NHC. Additionally, AA women of childbearing age are less likely to enter 1st trimester prenatal care than NHC women (69% vs. 81%). Due to inequities, the burden and distribution of poor perinatal outcomes are concentrated among African American women and infants as well.

The **AA infant mortality rate of 14.9 per 1,000 live births is 4.7 times higher than the NHC infant mortality rate of 3.2 per 1,000 live births and nearly twice the national average**. During the 3-year cohort period, 116 AA infants died before their first birthday. AA infants are 2.3 times more likely to be born low birth weight, 77.9% more likely to be born premature and nearly 3.5 times as likely to die as any other racial group in the first 28 days of life. While infant mortality rates have improved for Caucasian women in Nashville/Davidson County since 2008, perinatal outcomes **worsened** for African American women and infants during the COVID-19 pandemic. Additionally, statewide African American women are 2.3 times more likely to experience a pregnancy-related death as NHC women (TN MMR Report, 2023) with largest portion of deaths occurring 7 to 42 days postpartum. Overall, 79% of pregnancy related deaths were deemed preventable. When locally compared, African American women are 3 times more likely to have experienced chronic hypertension during pregnancy. While gestational diabetes rates are comparable, AA women are 2.5 times more likely to experience chronic diabetes than their Caucasian counterparts, contributing also to the higher aggregate state rates of maternal mortality. While overall breast-feeding rates have improved – from 80.9% (2013-2015) to 88.9% (2019-2021), improvements have not been made fast enough for African American women and children (79.9%) compared to their Caucasian counterparts (93.7%).

Service area: The service area for Nashville Strong Babies is the **entire county**, Davidson County, TN. Davidson County, TN is comprised of 58 zip code areas. Previously funded healthy start projects served a single zip code (37208 zip code for 2008 healthy start project) or a cluster of zip codes (7 zip codes for 2019 healthy start project) in which the AA infant deaths were the most concentrated. Natural disasters (2020 tornado) and gentrification of the urban core have caused migration of the AA female population 18 to 44 years of age (child-bearing population) out of the urban core. While the AA female population declined nearly 45.7% in the current 7-zip code service area over the last 5 years, there are comparable increases in the AA female

population dispersed throughout Davidson County suburbs and less densely populated parts of the county. **Of the 210 infant deaths that occurred in the 3-year cohort (2019-2021), 55% of those infants were AA.** To address the impact of these inequities and to support faster perinatal improvements for African American women and infants, the Metro Public Health Department proposes to **continue** implementation of the **Nashville Strong Babies Project** (NSB), a comprehensive, culturally relevant case management and care coordination approach for AA women and infants at greatest risk for experiencing a poor perinatal outcome. NSB includes individual perinatal case management via home-visiting services, group prenatal and parenting education, and extended hours clinical care (prenatal and pediatric) as well as support to eliminate transportation and childcare barriers to improve perinatal and infant health outcomes for 250 pregnant women, 175 infants/children, 25 fathers and 250 community residents each year. By providing comprehensive support, within 5 years, these efforts can cut the overall number of AA infant deaths in half!

Based on the 3-year vital statistics data and Perinatal Periods of Risk analysis, the **NSB Project priority population is African American women living in Davidson County and infants at greatest risk for experiencing a poor perinatal/infant health outcome to include but not limited to women with a history of previous preterm birth, chronic medical condition (hypertension/diabetes). The NSB project will serve 700 individuals in the service area each year: 250 pregnant women, 175 infants/children and 25 fathers with case management services and 250 community participants with group based health and parenting education.**

ORGANIZATIONAL INFORMATION: *RESOURCES/CAPABILITIES*

The Metro Public Health (MPHD) is the existing agency that implements NSB and has served the public health needs of Nashville and Davidson County residents for over 154 years. MPHD has 500 employees, 45 programs and 6 locations, to serve the approximately 700,000 Nashville/Davidson County residents. The MPHD mission is to "protect, improve, and sustain the health and well-being of all people in Nashville and Davidson County." MPHD seeks to achieve excellence in personal, environmental, and community health by providing direct care services, regulatory authority, research, and leading collaborative capacity building and collective impact initiatives across the city. The Metro Public Health Department (MPHD) is governed by an appointed Board of Health (BOH) and is organized into eight operating units (bureaus): Administration, Community Health, Environmental Health, Clinical Services, Communicable Disease and Emergency Preparedness, Health Equity, Population Health, and Office of the Director of Health) (See Attachment 10_MPHD Organizational Chart). Nearly 60% of the overall MPHD budget is grant funds - federal, state, and local sources. The Administration Bureau (AB) has proven and reliable systems, policies, and procedures in place for managing funds, equipment, and personnel for grant recipients. Grants management staff complete required federal *Grants Management training.* The BA provides program managers with projected budgets, monthly budget-to-actual statements, and works closely with all grantees to assure accurate billing and payment. BA also conducts monthly monitoring activities of grant contracts (reporting deadlines, required expenditure tests, etc.) to ensure timely and consistent review of grant activities and to identify and work with program staff to trouble shoot financial, contractual obligations. An additional layer of compliance is offered through the Metropolitan Government of Nashville & Davidson County Finance Department. The Metro Government Finance

Department oversees all contracts for each of the 52 Metro Government Departments (including MPHD) and includes a Grants Monitoring Division which conducts fiscal monitoring and annual audit to ensure compliance with federal, state, and local laws, regulations, stated outcomes and results, and specific requirements of the grant program.

Direct and Enabling Service Experience and Capacity: MPHD takes pride in its approaches to address the needs of Davidson County women and families. MPHD has administered evidence-based home-visiting and perinatal case management programs with fidelity since 1994. Home-visitors and case managers assess client needs/risks, create service plans with families to mitigate risks and reinforce strengths, deliver perinatal and parenting education via evidence-based and evidence-informed curricula, identify, and connect families to resources and advocate for systems changes to prevent poor perinatal outcomes. MPHD will continue to rely on its 29 year track record of consistently delivering high quality direct and enabling services with enrolled case management participants. Additionally, there are than 25 programs primarily administered in the Population Health Bureau (PHB) that regularly collaborate with Nashville Strong Babies to coordinate care for case management participants and support group based prenatal and parenting education. Pregnant women are identified and referred for home-visiting services via the Central Referral System (CRS). CRS has been in existence since 1999 are coordinates referrals for home-visiting services for programs internal and external to MPHD. CRS processes over 7,000 referrals annually for hospitals, OB providers, pediatricians, child protective services, etc. CRS is the primary referral partner for NSB. From August 2022 to August 2023, CRS processed and assigned 545 referrals to NSB. The Women, Infant and Children's program (WIC) provides individual nutrition counseling as well as group prenatal and parenting education classes to enrolled WIC participants. WIC also certifies families at hospital discharge as well as at community sites throughout Davidson County via the mobile WIC service. WIC is the primary group education partner for NSB. WIC holds group education sessions while families are waiting to certify their WIC benefits. WIC operates 4 clinics sites and serves over 17,000 families receiving WIC annually. Housed in the PHB, the GIFTS program provides maternal tobacco cessation support; NSB refers prenatal participants and their partners to GIFTS for tobacco cessation support. To ensure timely access to medical care, families are connected to health insurance via the PHB Presumptive Eligibility program (for pregnant women) and the PHB Health Access program (all non-pregnant adults and children). Uninsurable individuals can receive care through the Safety Net Consortium to which NSB refers participants. In addition to internal collaborations, several external collaborations also support direct/enabling services as well as group based education. Usual source of medical care for pregnant and pediatric participants is administered through an existing partnership with Meharry Medical College (MMC). MMC serves as the preferred medical provider for NSB participants who do not have an established usual source of care or who want to change their usual source of care. MMC offers night and weekend appointments exclusively for NSB participants, including behavioral health services. Fatherhood case management and community-based parenting education support is provided by the New Life Center (NLC). NLC was established in 2012 and is the preferred fatherhood support provider for NSB fathers/partners. Homeland Heart Birth and Wellness Collective provides community-based doula training to increase the local capacity of doulas to support NSB participants and provides supervision to trained community based doulas seeking certification. **It is reasonably anticipated that the internal and external collaborations and partnerships will continue**.

Multi-sector consortium convening experience and capacity: MPHD has at least a two decades of convening and facilitating multi-sector collaboratives focused on systems change and improvements that address the social determinants of health (SDOH). The Healthy Nashville Leadership Council (HNLC, established 2002) is a mayoral appointed multi-sector collaborative responsible for drawing attention to public health problems and encouraging ownership of their solutions. The HNLC with convening and facilitation support by MPHD is responsible for the implementation of the county's community health needs assessment (CHNA) and the development of the county Community Health Improvement Plan (CHIP). The 2023-2025 Community Health Improvement Plan is based on equity as an overarching lens with strategic SDOH focus on housing and transportation; economic opportunity and job skill development as well as food access and community resource navigation. Similar multi-sector maternal child health collaboratives include the Community Transformation Network (CTN). The CTN has been meeting as the local strategic perinatal systems change body since its inception in 2016. While the name of the body has changed over time (Nashville Infant Vitality Collaborative to CTN) this cross-sector convening body is currently made up of more than 40 organizations working together to eliminate perinatal and infant health inequities. The CTN meets as a full body once per quarter with monthly workgroup meetings and collaboratively works to eliminate housing insecurity (advocacy and partnerships for affordable housing specifically for pregnant women and families with young children under 2 years of age); eliminate preterm birth inequities (focus on improving quality of care for pregnant women at the 5 birthing hospitals), and; improve mental health support access for families (reviewing models for telehealth, night and evening appointments and embedding mental health professionals with home-visiting appointments).

Staffing Plan:
The Population Health Bureau (PHB) will have management authority of the NSB. Nearly all key personnel are existing staff, representative of the communities being served (African American and LatinX) and include: Project Director; Program Manager; Nurse Manager; Care Manager; Doula and Education Manager, and; Community Consortium Coordinator. The Care Coordinator is the only new hire position proposed. The PHB Assistant Director serves as the NSB Project Director (PD, 10% effort). The PD has over 17 years' experience in public health administration, is an MPHD senior leader, and provides overall grant administrative support. The Program Manager (PM, 100% effort) reports to the PD, supervises NSB project staff, monitors external contracts and collaboratively directs the Community Consortium and community participant education strategies. The PM has over 10 years' experience in public health administration and quality improvement. The Nurse Manager (NM, 100% effort) reports to the PM, supervises the Care Managers and Care Coordinator, and provides direct/enabling services to high risk prenatal participants. The NM is Registered Nurse with over 10 years' experience labor and delivery nursing as well as perinatal home visiting. The Care Managers (CM, 100% effort) provide strengths-based direct/enabling services to case management enrolled participants. The 5 CM staff each has over 5 years' case management experience. The Care Coordinator (CC, 100% effort) provides strengths-based resource navigation to low risk case management participants, health promotion, outreach to potential participants and assists with the delivery of group based prenatal/parenting education. The CC is to be hired and it is anticipated that this position will have at least 1 year experience engaging with the priority population in a similar health or social services capacity. The Doula and Education Manager (DEM, 100% effort) reports to the PD and works collaboratively with the PM to ensure delivery

of high quality doula services for high risk prenatal case managed participants as well as high quality prenatal/parenting education groups for community participants. The DEM is a Registered Nurse with over 10 years' experience in labor and delivery as well as doula care in the service area. The Community Consortium Coordinator (CCC, 25% effort) is responsible for convening and facilitating the Community Consortium – the Community Transformation Network. The CCC is a member of the MPHD facilitator community of practice and previously convened the evidence-based home visiting program community advisory board. The CCC has 10 years' experience in home visiting services. **See Attachment 3_Staffing Plan** for position descriptions and **Attachment 4_Biosketches** for additional details.

Evidence of Impact (HRSA-19-049 Recipient)

Individual and Family Impact

NSB uses a socio-ecological framework and employs various strengths-based strategies to improve the health and well-being of enrolled participants. During calendar year 2022 (CY22), NSB provided direct/enabling services through one on one home visiting services; worked with partners to provide extended obstetrical and pediatric care (night/weekend clinics) for participants, group based prenatal and parenting education for fathers/partners, birth, postpartum and lactation doula support for participants; and worked with collaborators to remove engagement barriers such as limited access to transportation and childcare for participants. The combined efforts of staff, partners and collaborators resulted in **NSB meeting or exceeding 15** of 19 HRSA benchmarks (CY22). Notable benchmark highlights include:

Table 1. Existing Grantee Evidence of Impact

CY22 Goal	CY22 Performance	Benchmark Met or Exceeded
89%	**95%**	Women and children have health insurance
85%	**98%**	Women participants with a documented reproductive life plan
80%	**95%**	Women and children have usual source of care
80%	**81%**	Interconception women had a well woman visit
75%	**87%**	Enrolled infants reported to engage in safe sleep
67%	**89%**	Enrolled infants ever given breast milk
83%	**93%**	Prenatal abstinence from cigarette smoking
50%	**67%**	Enrolled child participants read to at least 3 times per week

Prenatal participants who received doula support had even more impressive results in CY22: 95% of participants who had doula support initiated breastfeeding/gave breastmilk; 89% of participants delivered full-term infants (at least 37 weeks gestation) and less than 50% of participants requested an epidural for pain relief during labor. Completed client satisfaction surveys yielded overwhelmingly positive qualitative experiences reported by families:

Table 2. Abbreviated Participant Quotes

"Muy pediente de mi en todo memento me sirvio'de mucho apoyo y estoy muy agradecida"
Translation: My doula was "very attentive to me at all times, she gave me a lot of support and I am very grateful"

"My doula was by my side during my birth and 2 days after my birth she saved my life because my blood pressure was very high and she sent me to the hospital"

"My Care Manager really helped me. I was alone and she was there for me along the way."

Economic and family stability are also a focus on NSB. In CY22, 3 families graduated from the Corner to Corner Academy. , Corner to Corner is a Nashville community non-profit organization

that offers entrepreneurial and business coaching for minorities to launch businesses that serve the community. Systems and policy change efforts are organized through the Community Transformation Network (CTN). During CY22, the CTN dissemination activities helped to spur legislative action to introduce several bills to expand doula care access and to position doula care for state Medicaid reimbursement (2022).

Perinatal Impact

Perinatal estimates were calculated from Davidson County vital records files and are for the years 2019-2021

Regarding NSB impact on perinatal health, the MPHD Division of Epidemiology provided a perinatal statistical analysis and cohort comparative analysis of infant deaths occurring in the NSB service area 2013-2015 (hereinafter 2013) and 2019-2021 (hereinafter 2021). The CY22 NSB service area includes the following 7 zip codes: 37115, 37207, 37208, 37210, 37216, 37218 and 37221. Between the 2013 and 2021 cohorts, there was an **overall 4.5% reduction in infant deaths in the NSB service**. Most of the reduction in infant deaths seen in 37208 (50%), and 37216 (75%) **resulted from reduction in African American infant deaths**.

NEED

Population estimates same as previous section unless otherwise stated. Prevalence of chronic conditions is from Behavioral Risk Factor Surveillance System, 2020 and 2021.

The **African American (AA) infant mortality rate of 14.9 per 1,000 live births is 4.7 times higher than the Non-Hispanic Caucasian (NHC) infant mortality rate of 3.2 per 1,000 live births and nearly twice the national average**. During the 3-year cohort period, 116 AA infants died before their first birthday. AA infants are 2.3 times more likely to be born low birth weight, 77.9% more likely to be born premature and nearly 3.5 times as likely to die as any other racial group in the first 28 days of life. While infant mortality rates have improved for Caucasian women in Nashville/Davidson County since 2008, perinatal outcomes **worsened** overall for African American women and infants during the COVID-19 pandemic. Additionally, statewide African American women are 2.3 times more likely to experience a pregnancy-related death as NHC women (TN MMR Report, 2023) with largest portion of deaths occurring 7 to 42 days postpartum. Overall, 79% of pregnancy related deaths were deemed preventable.

The Davidson County female population, 18-44 years of age, is 27% AA, 56% NHC, 9% LatinX and approximately 8% Other races/ethnicities. The median household income for AA families is 64% that of NHC families at $49,000 and $77,000 respectively. 16% of female-headed households with children are AA, 3% are NHC and 12% are LatinX. With regard to SNAP benefits, 53% of beneficiaries are AA, 31% are NHC; 7% are LatinX and 10% are Other races/ethnicities. While unemployment is less than 3% overall, AA unemployment is 1.8 times higher than NHC. Approximately 10% of the population aged 25 years and over never graduated from high school represented as 12% AA, 5% NHC, 37% LatinX and 10% Other races/ethnicities. While prevalence of chronic conditions is not available at the target population level, county-wide Behavioral Risk Factor Surveillance System (BRFSS, 2020 and 2021) estimates reveal that an estimated 11.3% of residents 18 years and older suffer from diabetes, 33% are obese; these statistics are unchanged from the 2015 BRFSS estimates. 25% of residents reported no leisure-time physical activity and 33% reported having hypertension and 63% reported taking medicine for high blood pressure control. 84% of women aged 21-65 years had a cervical cancer screening. Furthermore, 12.2% of the county population had no health insurance and 25% of adults, 18 and older, reported depression. Intimate partner

violence (IPV) services data (Office of Family Safety Annual Report, 2021) indicate clients served were 35% AA, 29% NHC, and 11% LatinX. 78% of clients identified as women.

(2019-2021) Perinatal Statistics: See Attachment 7_Davidson County Data Tables.
(a) There were **29,652 live births**, an average of 9,884 births per year. Those births were 26% AA, 48% NHC, 20% LatinX and 5% Other races/ethnicities. Of all births, 5% were to females under the age 20: 10% of those births were to LatinX young females, 7% were to AA young females and less than 2% NHC. While 40% of overall births are covered by TennCare (state Medicaid), TennCare disproportionately covers 61% of AA births.
(b-d) There were a total of **210 infant deaths** resulting in an overall **infant mortality rate of 7.1** per 1,000 live births in Davidson County. The AA IMR is 14.9 per 1,000 live births. 10.7% of infants born were preterm (PTB) of which 15% were AA infants and 9% NHC respectively. 9.1% of infants born were low birth weight (LBW) of which 14.7% were AA infants and 6.5% NHC respectively. 15.1% of AA births are born preterm compared to 9.5% NHC. Additionally, 68.0% of AA infants were breastfed, compared to 85.0% DC. The overall rate of sudden unexpected infant deaths (**SUID**) per 1,000 live births is 1.5 per 1,000 live births but AA infants are 8.4 times more likely to experience a SUID than NHC. Likewise, AA infants are 62.8% more likely to die in a sleep-related incident compared with NHC infants.

Current Perinatal System Overview: Davidson County is approximately 526 square miles consisting of urban, suburban, and rural topography. According to the 2020 Census, the population density was 1,135 people per square mile. All of Davidson County is encompassed under the consolidated Metropolitan Government of Nashville and Davidson County. Historically, perinatal services have been concentrated in the urban core of Davidson County to include prenatal care as well as labor and delivery services at 5 birthing hospitals. Perinatal services were otherwise accessible to residents living in the urban core (downtown and zip code areas immediately north and southeast of downtown), particularly low-income residents living in public housing. Services for low-income individuals and traditional neighborhood-based services **continue to be supplanted** by urban redevelopment (multi-unit million dollar condo complexes, boutique shopping, etc.) and overall rising costs of living. For example, according to the Metro Social Services 2021 Community Needs Assessment, from the 4th quarter of calendar year 2109 to the 4th quarter of calendar year 2021, the average Nashville apartment rent rose 63% while the cumulative Nashville wage increased only 12% (2018 to 2022). The median monthly rent was $1,172 with nearly half (49.3%) of all renters estimated to be cost burdened: 30% or more of household income used to pay rent. According to the MIT Living Wage Calculator, a family of 3 (2 working adults and 1 child) must earn at least $70,676 before taxes per year to actualize a living wage in Davidson County (2022). Half of Nashvillians experience living wage poverty, earning below the wages needed to sustain basic household requirements (e.g., food, childcare, housing, transportation, medical care, etc.). The overall median Nashville home sales price increased 55% from $297,915 to $461,620 (March 2018 to March 2022), making the average house price 5.6 times the median annual household income (2020). Public housing and available affordable housing are also severely lacking with a persistent wait list of over 10,150 people waiting to use allocated Section 8 housing vouchers (2020). The result of these dramatic demographic and economic shifts includes displacement of low-income individuals outside the urban core and into areas where perinatal services are either not available or no longer easily accessible.

Health Systems

Resource list is abbreviated for brevity and to provide an overview of available federally qualified health centers, birthing hospitals, and indigent medical care.

Several entities serve the priority population throughout Davidson County. The major prenatal care providers include: 1). ***Metro General Hospital at Meharry (NGH)*** - provides OB/GYN services through residency programs in OB/GYN and Family Practice. It serves a total population which is 48% African American (AA), 32% Non-Hispanic Caucasian (NHC) and 20% Other race/ethnicities, delivering approximately 341 babies annually (2021). 64% of individuals who receive care at the city's hospital are uninsured. NGH also deploys an innovative food pharmacy, providing food as medicine prescriptions to over 1,100 patients and delivering almost 108,000 food totes throughout the community (2021). 2). ***Neighborhood Health Services*** - provides family planning, prenatal care, and pediatric services through a network of ten clinics with racially and ethnically diverse providers throughout Davidson County. It serves a total population which is 33% LatinX, 35% African American AA), and 28% Non-Hispanic Caucasian (NHC) and provides prenatal care to 698 patients with 448 deliveries. 63% of prenatal patients have early entry into prenatal care and the combined low birth weight/very low birth weight percentage is 5.36% (UDS, 2022). 3). ***Matthew Walker Comprehensive Health Center (MWCHC)*** – provides family planning and OB/GYN services. The health center provides prenatal care to approximately 244 patients with 91 deliveries. 60% of prenatal patients experience early entry into prenatal care. MWCHC serves a total population which is 25% LatinX, 40% AA, and 19% NHC. 19% of the population is insured by TennCare (state Medicaid) or 59% is uninsured. 4). ***Connectus Health (CH)*** – provides family planning and OB/GYN services. The health center provides prenatal care to approximately 881 patients with 480 deliveries. 48% of prenatal patients experience early entry into prenatal care and the combined low birth weight/very low birth weight percentage is 5%. CH serves a total population which is 46% LatinX, 20% NHC, and 27% AA. 5). ***St Thomas Hospital*** - Each year, more babies are born at Ascension Saint Thomas Hospital Midtown than any other facility in Tennessee, delivering over 6,500 babies per year (2021). High Risk OB/GYN services are available through private practices. Only a few OB/GYN providers at St. Thomas accept TennCare for payment, limiting access to services to a large segment of the priority population; 6). ***Centennial Women's Hospital*** – provides close to 2,000 deliveries annually. OB/GYN services are also available through private practices; however, similar to St. Thomas, TennCare acceptance is limited; 7). ***Vanderbilt Medical Center*** - provides OB/GYN services is the largest Level 3 regional perinatal center. With approximately 5,000 deliveries annually, Vanderbilt Medical Center, offers the largest array of services of the birthing hospitals. Additionally, well-woman care/family planning services are provided by the following: 8). ***Metro Public Health Department*** – provides family planning appointments and services, reduced cost pregnancy tests, and referrals to providers, when necessary, at 2 clinic locations (Lentz and East); 9). ***Planned Parenthood*** - serves women with a full range of reproductive clinical services including birth control, emergency contraceptives, women's health care and pregnancy testing; 10). ***Lloyd Elam Mental Health Center Rainbow Program***- provides inpatient and outpatient treatment for pregnant and postpartum women in need of substance use or alcohol misuse treatment. The program also assists with housing, counseling, food, clothing, childcare and transportation to facilitate long-term sobriety. 10). ***Home Visitor Case Management Programs*** - Nurses for Newborns uses registered nurses to serve approximately 321 caregivers and medically fragile infants in a 7 county region, including throughout Davidson County. The evidence-based home-

visiting programs Prevent Child Abuse TN (MIECHV-funded), primarily serves first-time mothers, reaching approximately 75 women per year. A portion of the uninsured/uninsurable population is provided healthcare service through Project Access Nashville (PAN), a community driven initiative that links uninsured residents of Nashville to a network of 21 medical homes to receive primary care, dental, mental health, and substance abuse clinics that serve patients based on their ability to pay. PAN also provides help with prescription medications for a nominal co-payment. Charity care at the hospitals or uncompensated care at the federally qualified health centers makes up access for the rest of the uninsured population.

Social Supports

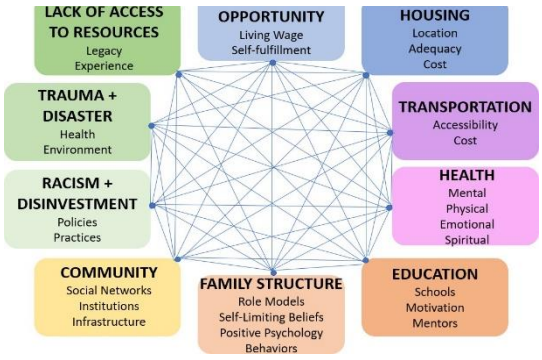
Resource list is abbreviated for brevity of available resources and to highlight existing resource network for NSB participants.

Food: In addition to WIC, there are at least 13 agencies, namely churches, that provide free meals and emergency food bags to low income families with children. **Second Harvest Food Bank** maintains the largest network of food distribution locations in Davidson County, many within walking distance or accessible by public transportation in low-income population areas. Second Harvest also distributes food via their Mobile Pantry, providing more than 140,000 individuals with 1 to 2 weeks of groceries annually. ***Utilities and Rental Assistance:*** Several agencies provide some type of utilities or rental assistance to low income individuals. **Metro Action Commission**, the local government social services agency, is the largest provider of emergency public assistance, responding to requests for energy assistance (gas, electric, water bills), emergency assistance (rent, property taxes, rental deposits, prescribed food/medical equipment), summer meals for children and youth, GED and other adult education support as well as administration of 8 Head Start and Early Head Start sites in Davidson County, serving an average of 40,000 families per year (2020-2021). ***Housing:*** Metro Development and Housing Authority is responsible for the administration and normal routine maintenance of affordable housing properties in Davidson County, including scattered sites. MDHA owns more than 6,700 units, 36 housing development communities, manages more than 7,000 section 8 vouchers providing stable housing to approximately 30,000 residents. Income limits for property eligibility vary from 30% to 80% area median income. ***Homelessness Support***: The Metro Office of Homeless Services (OHS) is the newest local government entity to support homelessness data management and to lead solutions to reduce homelessness. OHS leads the city's Coordinated Entry System – the single point of entry to coordinate housing and services for residents experiencing homelessness. The Coordinated Entry system prioritizes pregnant women in the 3rd trimester of pregnancy for first available housing and single fathers/partners with young children. More than 600 organizations (non-profits, churches, businesses, private landlords, etc.) participate in the Davidson County Continuum of Care, working together to achieve functional zero for 1,916 people experiencing homelessness in Davidson County (PIT Count, 2022). ***Interpersonal Violence:*** The Family Safety Center is the largest coordinated hub of interpersonal violence services in Davidson County. The center provides the following free and confidential services: safety planning, danger assessment, orders of protection, counseling, shelter/housing assistance, support groups, children's services, etc. The Mayor's Office of Community Safety also provides financial support to community-based organizations in North and Eastern Davidson County to address community violence. The Office works with agencies to train and hire community violence interrupters to reduce incidence of interpersonal violence in high occurrence neighborhoods. ***Leisure and Family Enrichment:*** The Metro Public Library maintains a system of 21 free and neighborhood based libraries with free or low-cost enrichment

activities for families with young children. Their *Bringing Books to Life* program is a preschool literacy initiative emphasizes the importance of developing literacy skills for parents and preschoolers. Uniquely attuned to the physical and mental wellbeing of library patrons, the library also offers *Be Well at NPL*, the series of free exercise, meditation, cooking and other healthy living events all locations.

Transportation is a significant barrier for low-income women overall and increasing road congestion makes timely transit an issue for all Davidson County residents. After a May 2018 failed city referendum to raise taxes to support a $5.5 billion dollar transit plan designed to boost public transportation options across Davidson County, the public transportation system remains difficult to access. It offers limited ability to transfer buses without traveling to the downtown transfer station and has inconvenient schedules and routes. Currently, transportation to and from medical appointments is through the TennCare transportation program. Appointments are made to pick up TennCare recipients and take them to their providers. However, the provided transportation is often late and does not have provisions to transport dependents if they are not the one with the appointment. This means a woman with a child is not eligible for this service for her appointments unless her child is receiving care. Additionally, there are no provisions for childcare for women who have healthcare appointments. Childcare services are not available within the community based health centers, health department or hospitals. Lack of childcare prevents many women from seeking routine care. The cost for children to attend formal childcare is often prohibitive. To address these barriers, the NSB provides comprehensive linkages to medical services, including transportation and childcare designed to fill gaps in the current perinatal system without duplication of existing efforts. To further ensure no duplication, the NSB Community Consortium (Community Transformation Network, CTN) will continuously evaluate changes in the current level of care; actively seek to leverage resources from multiple sources, including public and private entities, to establish proven models of care with demonstrated success. Finally, the CTN will review individual and community-level influencers and reinforcers of socio-ecological factors (see illustration) that impact perinatal health on an annual basis.

Illustration 1. Influencers and Reinforcers on Perinatal Health



APPROACH

Nashville Strong Babies (NSB) uses a strengths-based centralized care coordination and case management model to provide direct prenatal and parenting support, clinical care, education, and service coordination for a minimum of 700 program participants (per year) to improve perinatal and infant health outcomes for the African American priority population. Contractors provide father/partner case management and group parenting education, prenatal, postpartum, pediatric care, and behavioral health care as well as doula support care for participants.

Direct and Enabling Services

NSB will **continue** providing direct and enabling services **for 450 case managed participants** – 250 pregnant participants, 175 infants and 25 fathers/partners. The direct and enabling services are designed to address the main drivers of infant mortality (preterm birth and sleep-related infant death) as well as promote optimal maternal and infant health. Using best practices, NSB participants are recruited, their risk and resilience factors are assessed, and a risk/resilience factor (RR) profile is established. The level of service provided for each client is determined based on a standardized risk assessment. The risk assessment (abbreviated list) includes screening for:

- *Pregnant women*: Combination of medical risk factors, social determinant risk factors and social services needs: Low income, Unstable housing, Hx or current substance abuse**, No/late prenatal care,**,Hx of poor pregnancy outcomes**, Hx of a previous premature birth/low birth weight/failure to thrive**, Hx of, or current depression and/or other mental health issues**, Domestic violence**,Limited social support, Hx or current Child Protective Services involvement**, Homeless/transient.** *One of these makes client ↑ risk*
- *Interconception women/infants*: Same combination of medical risk factors, social determinant risk factors and social services as pregnant women plus: Children born within 2 years of each other, An infant at risk for or with developmental delay, Limited social support, Limited parental bonding.

Once the RR profile is established, participants are assigned to a continuum of either **Case Management** (high risk/low resilience profile), **Care Coordination** (medium risk/medium resilience profile) or **Care Support** services (low risk/high resilience profile), working with a skilled and trained NSB team member to connect to and consistently use high quality health and social services, prenatal through 18 months interconception. NSB staff use **standardized HRSA participant assessments** (Background, Prenatal, Parent-Child) to assess participant needs. NSB staff provide one-on-one education and resource support In-home (staff goes to participant's home), In-person (participant comes to health department or partner site) or virtually (telephonic or web-based). Table 3 illustrates the services provided based on the RR.

Table 3. Risk/Resilience Profile for 250 Pregnant Participants enrolled in Nashville Strong Babies/year

Risk Profile	Risk Factors	Services Provided	Frequency	Duration	NSB Staff	% Client
↓Risk	1 to 2 social service risk factors	Care Support: Reminder phone calls, cards, etc. of appointments, follow-up of missed appointments, delivery of health education	▪ 1st in-person visit @ intake ▪ Every 3 months follow-up call encounters	Each trimester until delivery	Care Manager (CM); Care Coordinator (CC)	50% (125)
Med. Risk	3 to 5 social service risk factors & SDOH risk factors	Care Coordination services to include monthly home visits, health education, coordination of health services, referral & follow up social services	▪ 1st in-person visit @ intake ▪ Alternating monthly in-person visit and call encounters until delivery	Monthly until delivery	CM	38% (95)
↑ Risk	>5 risk factors with	Long term Case Management services with all care	Monthly home visits until 3rd trimester then 1 to	Monthly until delivery	CM, Nurse Manager (NM)	12% (30)

	medical non-compliance risk factors or 1 or more**	coordination services plus monthly home visits until 3rd trimester then every 1-2 weeks until delivery	2 weeks until delivery			

Interconception NSB participants include those born into the project plus additional enrolled infants (up to 6 months of age) for a total of 175 infants served per year. All high risk NSB infants born to a participant will receive a post-discharge initial well baby assessment and well-mom visit by the Nurse Manager (NM). She will document any concerns and reassess the risk/resilience profile of the mom and baby to determine what, if any, additional supports are needed and to update the service plan accordingly. Based on the updated service plan, mom and baby will receive the appropriate care coordination, care support, or case management services. Table 4 illustrates the services provided based on the RR.

Table 4. Risk/Resilience Profile and services for 175 infants/interconception NSB participants

RR Profile	Services Provided	Frequency	Duration	NSB Staff & Partners	% Client
↓Risk	Same as OB	▪ Call encounters at 2 weeks and 6 weeks post-partum ▪ Every 3 month call encounter	Quarterly thru 18 months	CM, CC	50% (87infants)
Med. Risk	Same as OB	▪ Same as ↓ Risk +In-home encounter at 2 and 6 weeks post-partum ▪ In-person every other month until 6 months ▪ Quarterly virtual encounter until 18 months	Every other month thru 18 months	CM	38% (67 infants)
↑Risk	Same as OB	▪ Same as MR + In-home encounter at 2 & 6 weeks post-partum ▪ Virtual encounter at 4 weeks (PP) ▪ Monthly in-person encounter visit until 6 months ▪ Every other month virtual encounter until 18 months	Delivery thru 18 months	CM, NM	12% (21infants)

Fathers/partners living in the household with an enrolled woman/child participant is eligible for case management services as well. The CM will schedule family visits to support both parents/partner needs. Fathers/partners will primarily receive health education and resource navigation (low risk services) during visit encounters. Fathers/partners will high case management needs will be referred to the NSB Fatherhood Contractor to provide intensive case management support.

To serve 450 case management participants each year, the following caseloads are assigned:

- The NM has a max case load 5 high risk prenatal participants and 5 infants.
- The five (5) CM staff will have a max case load distribution of 5 high risk prenatal participants, 19 medium risk prenatal clients and 19 low risk prenatal clients; 3 high risk infants, 13 medium risk infants and 12 low risk infants.
- The CC has a max case load of 60 participants (all low risk prenatal and infants)

A family service plan is developed with the participant and allows for maximum flexibility to support family autonomy and engagement. This interaction is critical to establishing a foundation of trust and to ensure buy-in from the participant in choosing their course of care. Together the two, prioritize problems/issues and select the most pressing ones to address first. The customized service plan is reviewed/revised at least every 3 months and updated as circumstances change. NSB staff deliver perinatal and parenting education during visit encounters using the **Partners for a Healthy Baby** curricula. The **Fathering in 15 curricula** is used for father/partner case visit encounters. Health education messages are matched with individual participant needs as identified on the service plan. However, all participants will receive at least the same baseline standard messages related to the primary drivers of infant mortality in Davidson County – preterm birth and sleep related infant deaths – and messages related to the 10 required HRSA benchmarks. At a minimum, all prenatal participants will receive education on the importance of early prenatal care, tobacco abstinence, and early warning signs of preterm labor. Postpartum participants will receive education on signs and symptoms of depression, the importance of the postpartum visit, breastfeeding support, early warning signs of postpartum hypertension, and infant safe sleep. Parenting participants will receive education on the importance of infant safe sleep and well-child visits. Culturally relevant topics such as self and child advocacy with one's provider will also be included so participants know how and when to use their voice in their medical care. Participant supply items – pack and plays, car seats, etc. – will be provided to families who have limited means of acquiring a safe place to sleep their infant/those not eligible for a car seat through the Davidson County Car Seat program.

NSB uses a network of partners and collaborators to facilitate participant access to direct medical services. An initial indicator of preterm birth is late/no prenatal care, and prenatal care can be delayed due to insurance needs. All participant insurance status is assessed via the appropriate **standardized HRSA data collection tool** (Background/Parent-Child) upon initial intake. Uninsured pregnant and child participants are referred to the MPHD Health Access Program for insurance enrollment – presumptive eligibility (PE) for pregnant women and TennCare/CoverKids/ACA Marketplace for children. On an annual basis, Health Access enrolls over 1,000 women in Medicaid/insurance (FY2017). NSB staff will also work with Health Access to connect participants to a network of safety net providers and indigent care resources in the region for the underinsured and uninsurable population. Additionally, participants will have access to mobile prenatal, postpartum, pediatric care and behavioral health services via the **NSB Clinical Services Contractor (CSC)**. The Clinical Services Contractor will provide after-hours appointments (nights/weekends) for case managed participants in need of a usual source of care outside of traditional business hours regardless of insurance status. Participants can also access **behavioral health services** with the CSC, eliminating long appointment waitlists. NSB maintains a network of birth and postpartum doula providers to support the labor and delivery of higher risk prenatal participants. **Doulas** will be assigned to prenatal participants assessed as higher risk by the NM to help prepare participants to give birth and receive lactation support for at least 3 months postpartum.

Group Education Services

NSB will use partners - WIC and community organizations – to provide group based prenatal and parenting education to **250 community participants** annually. Group education is designed to increase knowledge and skills to promote family health and wellness as well as positive

parenting. NSB will partner in the use the **Nurturing Parenting curricula (NP)** and **Strengthening Families curricula (SF)** to deliver group based parenting education. The Nurturing Parenting approach is implemented by several home visiting programs, family and children services, court-involvement programs, and others. SF is also used for families with school aged children and aligns as a continuum support for families who graduate from NSB at 18 months of age. Group based education for pregnant community participants will be provided using the **Partners for a Healthy Baby** curricula and will focus on prenatal nutrition, childbirth education, labor and deliver preparation and lactation. Prenatal WIC participants are the primary audience. The Doula and Group Education Manager (DEM) will be responsible for ensuring group based education is available to both case managed and community participants. The DEM will work with partners to maintain a list of on-going parent education workshops to make warm hand-offs to. To keep participants engaged in education sessions, participant supplies (baby items) will be used as well as transportation services (when necessary). Participants completing at least 50% of anticipated group sessions will be considered complete and are eligible to receive a participant supply item from the NSB baby bucks store. See Table 5.

Table 5. Unduplicated Group-Based Education Delivery

Curricula	Anticipated Sessions	Minimum Sessions	Audience and # of participants/year
Partners for a Healthy Baby	4	2	50 pregnant participants
Nurturing Parenting	9	4	100 parenting individuals
Strengthening Families	16	8	100 Fathers/partners and parents

Outreach and Recruitment: To recruit and serve a minimum of 700 participants per year, NSB will oversample recruitment of at least 1,400 omen per year with a presumed 50% enrollment rate, using 2 primary approaches:

- *Central Referral System (CRS)*: The CRS was established in 1999 as a system to reduce duplication and increase coordination of home-visiting services for pregnant women and families with children. The CRS is well-established as the centralized referral and intake system in Nashville/Davidson County, processing more than 7,000 referrals annually. Referring organizations use the CRS standardized referral form (available on the MPHD website and hard copy) to fax or email referrals. All referrals for pregnant women and infants received by the CRS and eligible for NSB will be assigned to NSB first for initial risk assessment and intake. If the eligible participant declines to participate in NSB, she will be referred to the appropriate home-visiting or care coordination service for follow-up. All referrals will be documented in the CRS Database system to track and monitor incoming referrals and assignments. Additionally, CRS will send referrals directly to the NSB Care Coordinator using the NSB referral form via email fax to ensure referrals are linked to NSB within 1 business day receipt. CRS will account for 90% of enrolled referrals (630).
- *Outreach and recruitment network*: As Davidson County is large and dispersed, effective and culturally appropriate outreach strategies are needed to identify and recruit the priority population. NSB will use the support of the Care Coordinator and Community Health Workers (health and violence interruption focused) to provide outreach. Community Health Workers are responsible for identifying community participants, providing, and documenting health promotion messages and connecting them to an available group education opportunity. Community Health Workers provide weekly outreach and engagement activities to set-up information distribution hubs at various locations throughout Davidson County to include provider offices, community centers, daycares, public schools, etc. As Community Health

Workers engage members of the eligible population, they will share information about NSB and if a participant expresses interest, they will be connected to group education or case management, documenting the participant's interest and enrollment. Community outreach will account for 10% of enrolled referrals (70). Unduplicated bi-directional referrals will also be made. Community participants will also be offered home visiting services and case managed participants are offered group education opportunities.

Community Consortium

The Davidson County MCH professional community has a long-standing history of partnership, collaboration, convening as action groups to lead systems change and utilizing data to advance action. It is anticipated that the **existing Community Transformation Network** will be the convening body for the required Community Consortium. The CTN has been meeting as the local strategic perinatal systems change body since its inception in 2016. While the name of the body has changed over time (Nashville Infant Vitality Collaborative to CTN) this cross-sector convening body is currently made up of more than 40 organizations working together to eliminate perinatal and infant health inequities. The CTN meets as a full body once per quarter with monthly workgroup meetings and collaboratively works to eliminate housing insecurity (advocacy and partnerships for affordable housing specifically for pregnant women and families with young children under 2 years of age); eliminate preterm birth inequities (focus on improving quality of care for pregnant women at the 5 birthing hospitals), and; improve mental health support access for families (reviewing models for telehealth, night and evening appointments and embedding mental health professionals with home-visiting appointments). Examples of **recent CTN successes** include leveraging a public-private partnership to prioritize use of affordable housing funds to **build family housing for** enrolled NSB **participants** (2019). Additionally, the **CTN dissemination** activities helped to spur **legislative action** to introduce several bills **to expand doula care access** and to position doula care for state Medicaid reimbursement (2022, 2023). The CTN has an existing **strategic action plan to improve perinatal systems in Davidson County (adopted June 2022)** and it is reasonably anticipated that action implementation will continue with guidance and direction from current/former healthy start participants and community residents with lived experience, with **convening starting immediately but no later than 90 days of period performance start**.

a. Community Transformation Network - Structure

The existing CTN composition is primarily local government, community-based organizations, and hospital/medical care practitioners. The state Title V Office is represented along with hospitals, federally qualified health centers, childcare and transportation representatives as well as housing providers. The NSB Core Leadership Team (CLT) evaluates the CTN member roster annually to identify opportunities to populate members with a delineation of expertise, sector, organization type and role in the CTN. The CLT uses the **Technology of Participation (TOP) *Circles of Involvement* tool** to identify specific roles needed and specific individuals to fill those roles. The *Circles of Involvement* tool uses a matrix approach to strategically assess types of roles (E.g., core team members – the individuals directly responsible for execution of activities - to champions – the individuals who have political and policy leverage to advance systems changes). Table 6 illustrates the matrix for CTN membership.

Table 6. CTN Membership Matrix				
Expertise	**Sector**	**Org. Type**	**Role**	**CTN%**
Maternal child health best practices	Government	Local Government	Influencer	38%
Policies affecting health of women/children	Government	State Government	Policy Partner	5%
Healthcare services to women/children	Hospital Systems/Medical Providers	Public/private medical providers	Practitioner	23%
Services available to optimize health and mitigate SDOH disparities	Community-Based Organization	Community groups	Partner Services	30%
Financial strategies to support MCH best practices	Payor, MCO	Financial	Funder	3%
Lived experience	Community	Beneficiary	Expert	3%

By the end of the 90-day post award performance period, at least 25% of CTN members (n=8) will be individuals who have the lived experience of the target population (Ex. interconception African American women who were at risk for poor perinatal and/infant health outcome). Additionally, at least 50% of all CTN membership will be racially representative of the target population (African American men and women). Ideally, CTN membership will be 25 to 30 members engaged in network meetings and in the sub-group meetings to advance strategic action (work or action groups). The CTN will **reconvene on a monthly basis** for 90-minutes as a full membership group in the first year to initially **update** strategic priorities for the 5-year project period, to organize the strategic priorities into manageable structure (i.e., workgroups or action groups) and to determine processes for decision-making, communication and follow-up. After the initial year, the CTN will meet quarterly for 90-minutes for years 2-4 for updates on advancement of strategic priorities, to hear from the NSB Project Director on emerging systems, policy and environmental change opportunities based on NSB participant experiences and to formulate new approaches as needed. In year 5, the CTN will meet monthly to prepare for sustainment and continuation of the NSB and CTN strategic priorities. Each year (anticipated in December of the calendar year), the Consortium (CTN) will meet review emerging trend themes, review the updated **Perinatal Periods of Risk (PPOR) data trends** and review community assets/resource needs. Consortium (CTN) meetings will be held in the late afternoon/early evening hours (or at other times deemed suitable by community representatives on the CTN) to ensure community representatives are able to fully participate. The NSB Community Consortium Coordinator (CCC) will be responsible for convening the CTN and managing the network processes, co-chairing meetings with the NSB Participant Representative and with support from the NSB Program Manager. The Participant Representative is a former participant who has received meeting facilitation training and who will be compensated for their time and effort. The CCC will also oversee the development and implementation of the community transformation plan. It is anticipated that the CCC will use the TOP facilitation method and CTN decisions will be made by group consensus using the TOP **consensus building workshop** and subsequent **action planning workshop** approaches or the Results-Based Accountability approach. Workgroups or action teams are supported using the FSG *Supporting Collective Impact workgroup* tools to support the retention and engagement of CTN members. Additionally, the CTN membership will be asked to contribute to the documentation of CTN activities (E.g., activities advanced in individual CTN member organizations) using an agreed upon documentation system. For example, CTN members can capture mutually reinforcing activities

through the electronic database, Kansas University *Community Toolbox* site. Aggregate reports are compiled each quarter to demonstrate activities that are advancing strategic priorities. NSB **maintains** copies of CTN member agreements – written agreements that both the individual and organization sign, signifying their commitment to the Community Transformation Network – that will be signed annually. Having the organization representative sign the member agreement also ensures that if the individual CTN member vacates his/her employment/association with the organization or his/her current role, the organization will immediately assign a new CTN member for organizational representation. See Attachment 9 for List of current CTN members.

b). CTN Action Plan Development

It is reasonably anticipated that the CTN will **continue to follow** similar processes of common agenda and objective development as was completed in June 2022. The CTN hosted a 1.5 day action planning workshop in June 2022 to redefine strategic perinatal systems actions from lessons learned during the height of the COVID-19 pandemic. The workshop agenda included an environmental scan (presentations by subject matter experts on maternal mortality/morbidity, infant mortality, family housing and homelessness, childcare and substance use disorder support for pregnant women). The environmental scan data drivers come from annual PPOR, Maternal Mortality, Child Fatality and Fetal Loss reviews as well as the annual Metro Social Services review. Each of these reviews offers insight not only into clinical drivers of poor perinatal health outcomes but also social determinants of health drivers (housing, childcare, transportation, wealth building and education, etc.). The environmental scan was followed by screening of ”Toxic”, the mini documentary illustrating the weathering effect and toxic stress impact of racism on perinatal outcomes for AA women. Attendees engaged in a consensus building workshop and action planning session. The consensus building workshop process (4 hours) illustrates the areas where team members have consensus on what to focus on and what to prioritize. Once the consensus building concluded, the next half day focused on the action planning workshop to determine which actions will be initiated and by when. Workgroup or action groups were formed based on strategic priorities and a sub-group chair/co-chair structure was used to support the small group meeting needs and documentation of activities planned and executed. The resultant action plan focused on 3 strategic SDOH areas: 1). eliminate housing insecurity (advocacy and partnerships for affordable housing specifically for pregnant women and families with young children under 2 years of age); 2). eliminate preterm birth inequities (focus on improving quality of care for pregnant women at the 5 birthing hospitals), and; 3). improve mental health support access for families (reviewing models for telehealth, night and evening appointments and embedding mental health professionals with home-visiting appointments). One additional result of the CTN action plan was the inclusion of behavioral health services at the Meharry Medical College Salt Wagon clinic. The Salt Wagon Clinic is a medical resident run clinic offering after hours appointments for individuals.

It is anticipated that similar processes will continue to meet the Community Consortium requirements. To obtain community buy-in, final plan edits will be reserved for input from the participant representative serving on the CTN. NSB participants will be asked to provide annual feedback on the plan as part of the program evaluation approach. Participants may provide feedback via listening sessions or text/web-based survey. Progress on plan actions will be disseminated quarterly at CTN member meetings, via CTN newsletter to member organizations and to enrolled participants. Results will also be shared annually with the Davidson County Board of Health, the Mayor’s Office, and the Healthy Nashville Leadership Council. **See**

Attachment 5_Mayor's Office Letter of Support. NSB uses regular and ongoing measurement of plan implementation and progress. Participating organizations are asked to document their mutually reinforcing activities via monthly reporting in the workgroups and quarterly at member meetings. Quantitative results will be captured via monthly web-based report system of the group's choosing (Kansas University Community Toolbox, REDCap survey) to document activities in support of the action plan. The Community Toolbox allows users to code activities to capture quantitative data. For example, Meharry's integration of behavioral health services in the Salt Wagon Clinic is captured and coded as an activity designed to reduce disparities. Coding of activities is an evaluation function that occurs monthly to track SDOH impact. Annual goals and objectives will be further defined with benchmarks for success. Each goal will be tracked (monthly, quarterly, annually) to determine progress. No less than 5 performance measures will be prioritized and tracked.

c). Year One Objectives

The NSB Program Manager, Project Director, Community Consortium Coordinator, Community Consortium (CTN) Core Leadership Team and Participant Representative will work together to implement the following program management objectives for year 1:

Objective 1. By May 31, 2024, develop and submit annual Health Education Plan for participants and ongoing development for NSB staff.

Action 1.1: Program Manager and Project Director draft initial health education plan (4/15/24)
Action 1.2: Program Manager shares draft plan with CTN Core Leadership team (4/30/24)
Action 1.3: CLT reviews draft and provides input. Program Manager finalizes plan and submits to HRSA. (5/31/24)

Objective 2. By June 30, 2024, convene the NSB Community Transformation Network and begin CTN action plan development.
Action 2.1: Program Manager reviews existing CTN membership and invites new members according to need (5/15/24).
Action 2.2: Program Manager identifies and ensures training for Participant Representative (5/30/24).
Action 2.3: Community Consortium Coordinator, Program Manager and Participant Representative convene the CTN and facilitates consensus building workshop (6/30/24).

Objective 3. By July 31, 2024, Community Consortium (CTN) membership is at least 25% community member representation.

Action 3.1: Program Manager reviews existing CTN membership and seeks input from NSB staff to invite former/current NSB participants to join CTN (5/15/24).
Action 3.2: CTN meetings are held at times convenient for community member participation (6/30/24 and on-going).
Action 3.3: CTN community members are compensated for their attendance at CTN meetings (non-grant funding) (6/30/24 and on-going).

Objective 4. By October 30, 2024, obtain community buy-in for Community Consortium plan that has at least 5 performance measures related to the social determinants of health (SDOH).

Action 4.1: Community Consortium Coordinator and Participant Representative facilitate action planning workshop (7/31/24).

Action 4.2: Community Consortium Coordinator and Participant Representative facilitate community review of action plan (8/31/24 – 9/30/24). NSB participants (former and current) are invited to provide feedback. Program Manager integrates feedback into plan for presentation.
Action 4.3: Community Consortium Coordinator and Participant Representative facilitate CTN action plan adoption meeting (10/30/24).

Objective 5. By November 1, 2024, begin implementation and tracking CTN actions to address the SDOH.

Action 5.1: Program Manager and Community Consortium Coordinator set up access to Kansas University Toolbox for CTN member action tracking (9/30/24).

Objective 6. By March 31, 2025, Program Manager, Community Consortium Coordinator regularly participate in the Health Start Community of Practice through the Supporting Healthy Start Performance Project.

Objective 7. By March 31, 2025, facilitate 10 monthly CTN meetings.

Anticipated Year 1 Outcomes: Populated Consortium (CTN) membership with at least 25% community representation; completed consensus building work-shop; Completed annual Health Education Plan; Reviewed NSB program activities and progress report out; Completed 5-year action plan with timeline of proposed activities that address SDOH, performance measures and benchmarks, individuals/organizations responsible and at least monthly feedback loop processes (online documentation system, frequent sub-group meetings, etc.) to document and maintain accountability for actions moving forward.

Ongoing plans for facilitation and support: The Community Consortium Coordinator (CCC) is an existing organizational employee and is supported by the MPHD Facilitation Community of Practice (COP). The MPHD COP is designed to develop and deepen facilitation skills of employees whose positions require facilitation as part of the delivery of a service. There are approximately 10 employees who are in the COP. It is anticipated that the CCC will continue to receive facilitation support through the COP and through the HS Community of Practice. It is also anticipated that the Participant Representative will have access to facilitation trainings and skill building workshops available through MPHD and/or the HS Community of Practice. CTN workgroup chairs/co-chairs will have also have access to meeting facilitation training to keep members engaged and implementing actions that address SDOH. The MPHD COP employees will be asked to support facilitation activities as needed for effective workgroup support. Finally, community members and NSB participants will be compensated for participation in CTN meetings and activities (non-healthy start grant sources).

iii. Local, state, regional and national leadership
The MPHD Assistant Bureau Director for Population Health/Project Director (PD) works in close collaboration with the State Title V Director, Dr. Elizabeth Harvey. The State Title V Director/designee has historically served on the CTN and **will continue to serve**. The PD serves as an advisor for the state Title V priority setting stakeholders, attending the quarterly Title V stakeholder meetings and serves on the Tennessee Infant Mortality Reduction Task Force and Maternal Mortality Reduction Task Force. The PD has regular bi-monthly (6 times per year) conference calls with the state Title V office to coordinate strategies to improve infant, women, and family health. The calls also include the Title X office, MMMR staff calls, injury-

prevention, WIC, FIMR, Adolescent Health prevention staff, etc. The NSB Program Manager will also participate in both the Davidson County Fetal Infant Mortality Review (FIMR) and Perinatal Periods of Risk (PPOR) as a community advisor and the Tennessee Maternal Mortality and Morbidity Review as a community stakeholder. Additionally, the PD currently serves as the Board Chair CityMatCH (2023-2025), the national organization representing local, urban MCH professionals across the United States. The monthly Board of Directors calls facilitate information sharing of updates from HRSA MCHB, the CDC Division of Reproductive Health, and the Association of Maternal Child Health Programs (AMCHP) to inform local strategies to improve women's health. It is reasonably anticipated that the PD will continue to serve as a conduit for information sharing with the NSB program. The PD also receives pertinent list-serve information (E.g., MCHB, CoIIN, etc.) and attends the annual Healthy Start Gathering to support connection of the local NSB work with regional, state, and national initiatives; **See Attachment 5_Title V Letter of Support.** The Tennessee Alliance on Innovation in Maternal Health (AIM) project focuses on obstetrical care of women who suffer from opioid use disorder and is supported by the Tennessee Initiative for Perinatal Quality Collaborative (TIPQC). TIPQC is the organization that supports the adoption of maternal safety bundles and supports birthing hospital adoption of pilot approaches. MPHD is a public health member of TIPQC, attending and presenting at the annual conference and supporting linkages of hospital-based quality improvement efforts to public health approaches. The Director of TIPQC previously served on the CTN and supports the public health linkages locally. Other public health leadership roles for key staff include:

- FIMR: The Davidson County FIMR has existed since 2009, reviewing cases of fetal loss and infant death among Davidson County residents through the Case Review Team (CRT) as well as identifying and enacting systems improvement processes through the Community Action Team (CAT). The CAT currently functions as a workgroup of the CTN. FIMR is housed in the Population Health Bureau in the line of authority of the Assistant Director with staffing and administrative processes to support monthly case reviews, parental interviews, and systems improvement processes for both FIMR and the Davidson County Child Fatality Review. FIMR also serves as a referral source for families who have experienced a loss.
- Child Fatality Review: The Davidson County Child Fatality Review (CFR) is mandated to review the deaths of all Davidson County residents under the age of 18 years of age. Most child death cases reviewed annually are infant deaths (an average of 75 per year). Home visiting providers regularly attend CFR meetings to provide information on any infant/child deaths that occurred if there was contact with the family. The Project Director and Program Manager will attend CFR meetings as appropriate when deaths involve any enrolled NSB participants.
- PPOR: The MPHD Division of Epidemiology conducts annual Perinatal Periods of Risk Analysis annually since 2004, completing phase one and phase two analyses. It is reasonably anticipated that the current PPOR process will continue to be updated each year during the 5-year performance period and presented to the CTN. The CTN will use the CityMatCH Readiness Tent tool to assess community readiness to address disparities and inequities and regularly disseminate data and program metrics related to inequity elimination.

It is reasonably anticipated that the CCC will participate in the HS Community Consortium Community of Practice, attending monthly meetings and demonstrating implementation of innovation/lessons learned from the CoP support.

Sustainability Plan: It is reasonably anticipated that additional funds will be sought to sustain the case management and care support components as well as the transportation and childcare

services of the NSB project at the end of the 5-year period. The MPHD will continue to provide identification and referrals of at risk women and infants in the target area through the Central Referral System and will continue Care Coordination activities to link low risk women/infants to care and follow up on the care they receive. Clinical services will continue to be available to participants in the target area who need a usual source of care for their prenatal, well-woman and well-baby care. It is anticipated that the CTN will develop the sustainability plan to transition all participants in the NSB to a usual source of care at the end of the 5 years.

WORK PLAN

As indicated in the Approach, it is reasonably anticipated that MPHD will contract externally via the Clinical Services Contract, Group Education Contract, Fatherhood Engagement Contract (FEC) as well as an Independent Evaluation Contract for: outreach, recruitment, and father/partner case management and group education support; mobile prenatal, postpartum, behavioral health and pediatric care for case managed participants, and; quality improvement, process and impact evaluation of the NSB project. The review of the NSB model and this funding proposal was developed in consultation with individuals and organizations with expertise that corresponds to the expertise sought in the selection of external contractors. See Attachment 2 for the Work-Plan and Performance Measures.

External Contractor Oversight: MPHD relies on grant funded partnerships and non-funded collaborations to execute services and systems changes for program and community participants. As such, MPHD requires subcontractors must maintain records in accordance with federal guidelines, allow MPHD access to such records, provide MPHD with an annual independent audit report and adhere to Office of Management and Budget policies. The Administration Bureau (AB) serves as a check and balance for all Metro grants, assuring accuracy of budgets, payments, and charges as well as internal contract and activity monitoring. The Project Director, Program Manager and the NSB Finance Officer meet monthly to review program expenditures and quarterly projected expenses. Contractors are required to submit annual budgets and workplans that must be approved before work can begin. Contractors submit monthly program reports to the Program Manager, documenting progress and completion of approved activities. Deviation from approved activities is prohibited unless expressly approved in writing by the Program Manager. Annual fiscal and program audits are performed with subcontractors to ensure OMB adherence, HRSA requirement adherence and satisfactory performance. **The same practices will continue for the performance period 2024-209.**

The Metro Public Health Department follows the Metro Government of Nashville and Davidson County (Metro) procurement protocols for purchases and contracts to ensure contract bids are competitive, open, and practical. For contract purposes, Metro issues request for proposals (RFP) to procure goods/services from registered vendors for purchases that exceed $25,000. While requests for proposals are issued frequently through the Metro Business Opportunities Bulletin (BOB), the contracting process can exceed 120 days. **To meet the HRSA requirement to stand up clinical services for participants within 90 days of grant award and convening the Consortium, it is anticipated that MPHD will continue the existing contract with Meharry Medical College (contracted through March 31,2025) to provide clinical services effective April 1, 2024.** This will allow time for continuity of clinical

care for participants until the required Metro contract procurement process is fully executed. Similarly, group based education for fathers/partners/parents will continue under the existing contract with the New Life Center (contracted through March 31, 2025) until the competitive contracting process is complete. It is reasonably anticipated that the existing funded partners will respond to RFP process. ***Process for contract selection***: Metro uses the iSupplier System in which businesses and individuals are registered vendors and vetted to do business with Metro Government. The bid process and vendor selection occurs in a few steps. The RFP is posted on the Metro Nashville and Davidson County website. Interested businesses who are Metro vendors may respond to the RFP by submitting a proposal in the format required by the RFP. The proposals are reviewed and scored by a team of Metro employees. The final selection is made by the team and the contract is established with the selected vendor. It is reasonably anticipated that the RFP for the NSB contractors will include preference for public health expertise, history providing similar services to the target population and in the target area, and capacity to deliver services within the contract scope.

5-Year Project Performance Period Timeline (Abbreviated)

The 5-Year project timeline highlights required activity milestones (implementation, reporting and evaluation) as well as demonstrates the approach to ensure all required activities including the 10 performance measures are completed. Activities that are repeated each year (Ex. Outreach activities, visit encounters with case managed participants, case consultations, attendance at annual healthy start conference, etc.) are aggregated as recurring weekly, monthly, quarterly, and annual activities. Activities specific to Year 1 during the initial 3-month start-up phase include the on-boarding of the Community Consortium Coordinator (existing staff member) and NSB Participant Representative (existing former participant), convening the Community Consortium, developing the Community Consortium strategic plan, develop and submit annual Health Education Plan, begin offering clinical services, and finalizing contracts for evaluation, clinical services, doula services and fatherhood support. The following required grant administrative activities will also be completed: 1). Submit annual progress and performance reports (June/November annually through 2029); 2). Submit HS aggregate data (Monthly through March 2029), and; 3) Complete and submit all administrative forms (Annual based on budget year and calendar year reporting timelines to include program-specific data forms within 90 days from the end of the performance period). The Consortium (CTN) will meet monthly in Years 1 and 5 to support the development of the action plan and strategic priorities (Year1) and to prepare for continuation and sustainment activities (Year5); CTN workgroups will continue to meet monthly and the full CTN meets quarterly (Years 2-4). The quarterly meetings will focus on progress updates, training, and collaboration opportunities to advance the CTN action plan focusing on SDOH impacts.

Years 2 – 4 (Performance Period)

Recurring Weekly and Monthly Activities remain the same as Y1 activities. Quarterly activities include Consortium meetings, Quality improvement meetings and data review, evaluation and monitoring meetings as well as continuation of visit encounters with low risk case managed participants. Annual activities include dissemination of CTN plan results, annual evaluation reporting, and submission of required health promotion plan. Additionally, staff will attend required annual trainings/conferences (annual Healthy Start conference) as appropriate. A sample timeline of recurring activities follows:

Year 1-5 (Performance Periods)		**PP Q1 (2024-2029)**			**PP Q2 (2024-2029)**			**PP Q3 (2024-2029)**			**PP Q4 (2024-2029)**		
Recurring Weekly Activities	**Lead**	**Apr**	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Outreach and recruitment	Care Coordinator (CC); Community Health Workers (CHW)												
Process referrals	Central Referral System (CRS)												
Assess referrals	CC												
Create R/R profile; assign to NSB team	Nurse Manager (NM)												
Initiate service plans & visits with participants	CC, Case Managers (CM), NM												
Recurring Monthly	**Lead**	**Apr**	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Host ↑ risk case consults	NM, CM												
Host Consortium meetings (Years 1 and 5)	Community Consortium Coordinator (CCC), Program Manager (PM); Participant Representative												
Participate in HS Community of Practice	CCC, PM												
Submit monthly aggregate data reports	PM												
Clinical services available for participants	PM, Clinical Services Contractor*												
Visit encounters w/HR/ MR participants.	CM, NM												
Doula support for ↑ risk pregnant participants	Doula and Group Education Manager (DEM), doulas												
Father/partner education sessions	Father Engagement Contractor (FEC)												

Group prenatal and parenting education sessions	DEM, Group Education Contractor(s)												
Recurring Quarterly	**Lead**	**Apr**	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Visit encounters for ↓ participants	CC; CM												
Initiate QI meetings	PD, PM, Evaluation Lead (EL)												
Evaluation/monitoring activities; meetings	EL, PD, PM												
Host consortium meetings (Years 2 – 4)	CCC, PM, PR												
Recurring Annual	**Lead**	**Apr**	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Update and present PPOR data analysis	Division of Epidemiology												
Evaluation, monitoring and assessment reports	EL												
Annual performance period report (budget and performance)	PD												
Annual progress report with annual health promotion plan	PD, PM												
Annual Consortium action plan progress dissemination and presentation	CCC, PD, PM, Participant representative												
Attend NHSA annual convening	PM/designated staff												

RESOLUTION OF CHALLENGES

It is noted and anticipated that there are individual participant, community systems and social determinants of health barriers to be identified and mitigated. Actions and resources to mitigate challenges are addressed in detail below.

Program participant barriers: The two (2) primary program participant barriers anticipated include failure of NSB clients having a usual source of care due to insurance coverage and convenient service access. Many women lose their medical coverage 6 weeks after they deliver. For this reason, many do not return for their post-partum visit, and are lost to follow up until they either become pregnant again or become eligible for another type of coverage. Nashville lacks an accessible, economical, and affordable public transportation system. Without a comprehensive public transportation system, many women who cannot afford a car or the gas to drive a private vehicle, are left dependent on others to get them to appointments or other places. Resolution of participant barriers: All participants will be evaluated and helped to establish a usual source of care. Project Access Nashville will be used to help women who do not qualify for insurance to establish a usual source of care within the safety net network. All infants born into the program will have the option of continuing care with the Clinical Services Contractor as their usual source of care home. Participants with the highest risks and support needs will receive a ride-share voucher to get her to and from medical appointments without having to experience the inefficiency of TennCare transportation or public transit.

Community barriers: There are several potential barriers that could hamper participants from enrolling and remaining in the NSB program. These barriers include system issues as well as personal and are to the same for both pregnant and interconception care. The exception will be health coverage which most pregnant women are eligible for if they qualify for Medicaid. **The systemic issues and the strategies for addressing them are noted below:**

Lack of adequate public transportation to get to multiple appointments in multiple locations around the city. By having multiple services located in one physical location in the target community there is less need for participants to commute to multiple locations. For example, a participant may have a prenatal appointment, a social service consult, and behavioral health consult. For services that are not offered at the CSC site, ride share vouchers and bus passes will be available when needed.

Frequent changes of residence and instability of housing and social situations- The staff will use Coordinated Entry for housing needs and link families with community resources.

Lack of general understanding around the need and benefit of preventive services. Prevention is the principle theme of this project and the importance of it is woven into all aspects of the program. Preventive health messages are stressed by all team members, including Community Health Workers. These messages are uniform and consistent so participants receive the same information several times. This is done to improve retention and to create a sense that all providers are on the same page regarding caring for each client. By echoing prevention messages in every aspect of the program, and having constant messages being reiterated through multiple venues, it is the hope and expectation that the community will start to expect health and increase utilization of the available preventive services.

Personal barriers and strategies: Lack *of trust in the "system":* Trust is earned and takes time to establish. By having NSB staff present in neighborhoods and by stressing the importance of staff continuity, and familiarity, the program hopes to establish trust within the target community. Also involving the participant in the identification and solution of her issues helps earn trust as well. As the participant begins to understand that people care and can help them with problems and services are easier to access a positive reputation will be built, and this will create a positive ripple effect in the community.

Lack of appreciation of the importance of preventive services: As mentioned above, the message of prevention is deeply engrained in all aspects of the program. Participants are also educated regarding the effect of chronic diseases like hypertension, obesity and diabetes and their effect on present as well as future birth outcomes. Also emphasized is the importance of a medical home and consistent follow up care for these conditions. Women are encouraged to take an active role in their health, and the health of their children. *Communication barriers, especially those related to low literacy.* All material purchased or created for this program will have a readability level at or around the 4th grade level. Part of the assessment that is completed for each participant is an assessment for functional literacy. For participants that do not score as being functionally literate, referrals will be made to an adult education program, and improving this aspect of life will automatically become part of the client's care plan. The additional issue of lack of local data collection is a serious barrier. Many health indicators are not collected, and therefore cannot be reported, or analyzed. This is especially true when trying to identify risk factors at the neighborhood level. The capacity has not yet been realized to support a system that would make this possible. Another major barrier is assuring that all key stakeholders are at the table. As mentioned earlier, the CTN is established and has representation from many of the key players that work with the impacted community. However, representation from these agencies is very often not the decision maker. This results in wonderful ideas, and a true passion to improve, but little ability to institute change. As the CTN moves forward it will be requested that decision makers take ownership and empower their designees to make key decisions regarding resources, services, and actions. This will be stated in the Memorandum of Agreement/work agreements that all organizations represented on the CTN will be asked to sign. The last challenge is related to the CTN meetings. Given the diversity of the group, it is challenging to expect participants to attend meetings during traditional work hours and for systems partners to meet during non-traditional hours. To help mitigate attendance concerns, hybrid meeting models will be used with both virtual and in-person meeting attendance options. Community members and participants will be polled to determine the best meeting times for them. They will be compensated for meeting attendance and meals will be provided (non-healthy start funds). All other key stakeholders will be asked to attend the meetings at the convenience of community members.

There is currently a lack of community interest when it comes to perinatal outcomes, which is paired with a focus on the social determinants (SD) needs such as affordable housing and transportation. The community gets inundated with many different health messages without resolution of social determinants needs. This must change if there is going to be any significant change in community behaviors. One of the principle objectives of this project is to connect messaging about health to the SD and to leverage policy and resources to improve SD for NSB participants. In addition, because there is much work needed to unify the agendas of the many agencies potentially involved in the CTN who may be competing for limited resources, it will be necessary to continuously monitor self-promoting behaviors. Having community and program participants involved in the CTN and training them for leadership positions will ensure that the direction of the CTN is always in the best interest of the group and not individual organization.

EVALUATION AND TECHNICAL SUPPORT CAPACITY

It is reasonably anticipated that MPHD will contract with an external evaluator (Evaluation Lead, EL) to provide monthly data dashboard reports and annual project assessments. Additionally, the Division of Epidemiology (Epi) will provide annual perinatal statistical analysis, available comparable population data and Perinatal Periods of Risk analysis. The MPHD Division of Strategic Planning and Performance Management (QI) will provide consultation on Quality Improvement strategies. Working together, the EL, Epi and QI team support the overall evaluation

approach. The basis of the evaluation and performance monitoring is use of standardized data collection processes. See Attachment 11_Evaluation Plan.

Performance Monitoring

The NSB Performance Monitoring Plan include a focus on standardized and timely data collection, tracking processes and progress towards annual project goals and objectives and continuous quality improvement.

Standardized data collection: Systematic and continuous data collection during the project period is critical to ensure fidelity of program implementation and measure program success. **MPHD will maintain use of existing data management processes** to support the required data collection and monitoring of project performance. NSB direct service staff completed HS data collection training in May 2020 for the new forms (HRSA Background, Prenatal, and Parent-Child forms). New staff are required to complete training within the first 3 months of hire. NSB administers the data collection tools per HRSA instructions (at appropriate enrollment, phase change and annual update) and will use the HS CAREWare (CW) system to ensure monthly upload of individual client files to the HSMED. Program staff input benchmark data, both individual and group-level, into software in real-time using laptops/tablets or within 2 business days of gathering data. Benchmark data are reviewed monthly from the HRSA data collection tools as well as program-specific documentation (referrals for resources and outcomes of referrals) for participants receiving case management/care coordination. The Program Manager conducts monthly randomized case file reviews, quarterly review of participants service plans and notes from case consultations on high risk participants. The Nurse Manager regularly reviews Care Manager charts and provides feedback during individual supervisory meetings to monitor and respond to individual participant outcomes. Reports on progress and achievements in meeting specified benchmarks and program objectives are submitted to HRSA within requested reporting timeframes – monthly HSMED uploads, bi-monthly Project Officer calls, annual progress, and annual performance reports. Additionally, the LE will direct program monitoring activities. LE will analyze CAREWare process data, such as the number, proportion, type of participant (case managed or community participant), demographics of participants and type of case coordination care services needed, completion of required HRSA data collection tools and provide oral and written dashboard reports monthly. The dashboard will also include notes on any missing required data and data that may be reported in error. The dashboards are prepared and presented by the 10th of each month to the Program Manager, Nurse Manager and Project Director. Care Management staff are directed to complete any missing data/data corrections (as needed) prior to the required HRSA HSMED upload due on the 15th of each month.

The LE will also analyze CW data monthly to ensure that program is on track to meet benchmarks. The analysis will include a review processes (# of visits completed, education provided, referrals made, etc.) and progress towards goals. Program leadership will discuss any benchmarks (BM) that are below target during the monthly reporting period with changes made as needed in the following month to meet the targeted goals. For example, CM and CC staff will engage and encourage new HS mothers to engage in safe sleep behaviors with new infants (BM 5). CM/CC will document (both paper and in CW) observed and self-reported practiced safe sleep behaviors during visit encounters. During monthly review by LE, if the proportion of mothers engaging in safe sleep behaviors falls below the calendar year target, this will be flagged for quality improvement. The Program Manager will meet with the NSB staff to share the BM progress and engage staff in identifying barriers and facilitators for improvements. The PM will also consult the QI office on proposed improvement strategies. Action plans will be constructed for that benchmark. The Plan-

Do-Study-Act (PDSA) cycle and input from the QI team and program leadership will be used to make program-wide adaptations in accomplishing benchmarks as needed.

Healthy Start Benchmarks: The Lead Evaluator (LE) will direct program-monitoring activities. The QI team will review this information to ensure the program is on track to meet project period process targets. Outcome data for individuals, the program, and the community at large will also be collected and included in annual reports. Individual and group outcome data will be collected and analyzed utilizing the same methods listed above for process data. Community-wide outcome data will be used for comparison purposes in annual reports. See Attachment 2 for Work plan.

Quality Improvement: MPHD expects **to continue three levels of analysis** to improve NSB processes (identification of participants, assessment of participants, etc.), provide feedback to providers on the quality of services referred to/engaged/received as well as the NSB overall. MPHD utilizes the expertise of internal Quality Improvement staff to implement the "Plan, Do, Study, Act" (PDSA) process to monitor health department activities – promoting health and preventing disease – raising the process standards after each project year. In 2017, in preparation for accreditation, MPHD implemented quality improvement strategies in each of the bureaus, creating a Quality Improvement Council of 6 Quality Improvement Coordinators to initiate and support improvement processes in MPHD programs. The department's quality improvement work is now supported in the Division of Strategic Planning and Performance Management. The PM will support project continuous quality improvement (CQI) by following QI intervals established by the evaluator and assisting with the provision of data for analysis. Additionally, the MPHD QI staff will be available for consultation and assist coordinating and facilitating internal CQI meetings. Under the guidance of the PM and LE, QI is supported by identifying tools to guide quality improvement (e.g., electronic tracking systems, etc.), coordinating and facilitating CQI meetings, electronically tracking the PDSA process based on the performance management plan and identified indicators and reporting findings during quarterly meetings. The QI team will comprise of the PM, QI, and the LE. MPHD will use a multi-tiered approach for CQI, specifically:

- Tier 1 - DATA ACCURACY. Fidelity of program data and processes will be ensured by consistent data quality assurance checks, including data file reviews. Reviews of a random sample of participant electronic and paper files, using a checklist to monitor dataset completeness, progression toward benchmark goals, and compliance with calendar period goals will be used. Additionally, the QI Team will monitor program implementation process (e.g., operational procedures, data collection, data processing, etc.), to ensure standardization of both administration and collection, according to proposed guidelines.
- Tier 2 - REGULAR REPORTING AND MONITORING of progress toward project goals and benchmarks. The PM and LE will present quarterly monthly reports known as Performance in Equity (PIE) days to NSB staff and QI team. Any performance measures that remain below target for more than three months will require the submission of an action plan by QI Team. The QI Team will identify strategies for improving outcomes for those targets that are not being met. When necessary, the PM and LE will establish additional action plans to ensure benchmarks are met within the required timeframe.
- Tier 3 - COLLABORATOR FEEDBACK. The project's success depends on a successful collaboration with all proposed contractors. Assessing the collaboration function is critical. The LE will assess and monitor the collaboration effectiveness by measuring, (1). partner relationships (group cohesion, working together effectively, trust, etc.); (2) competence (efficiency, decision-making processes, ability to set and meet goals); (3) sustainability (attitudes towards continuing and/or advancing the group's work, capacity to obtain additional funding), and; (4) communication (quality and frequency of communication between leaders and members and the process to communicate activities to the public). Key informant interviews at the end of each cycle will assess

collaboration success and suggestions for improvement annually. Using rapid cycles of change, progress on the benchmarks will be monitored every 90 days. Feedback received from team members during quarterly meetings will be used to decide whether the adoption of new approaches or the adjustment of existing approaches is needed to enhance program goals and improve progress on achieving objectives.

Program Evaluation

The local evaluation will **build upon the existing NSB evaluation that** measures and monitors process, impact, and outcomes using formative, process, and outcome evaluation methods. A mixed methods approach, including an outcomes study, will assess progress toward benchmark goals. This varied evaluation approach will ensure that quality improvement and evaluation activities are well coordinated, with each approach informing subsequent activities. The comprehensive evaluation plan is detailed in Table 6, featuring the program tactics, process, outcome, and impact measures with associated data sources, start date for data collection, end date, frequency (e.g., timeline) and staff responsibilities; evaluation particulars are summarized below.

Systematic documentation of process, impact, and outcomes

Process. Case management (CM) process data will be entered into the HS CAREWare (CW) by CM staff. The database is accessible to the Lead Evaluator (LE), who will routinely check data integrity. Data for events and other activities are kept by program staff. The PM will monitor process documentation to ensure all needed data for process evaluation are complete and available within one month of data gathering. For activities that are not recorded in CW, NSB staff will keep comprehensive program records, which will also be monitored by the PM (data collection strategy detailed below). For events (e.g., education sessions), the LE will develop template forms and procedures to methodically track and record attendance, demographic information, and agendas. Afterwards, the PM will complete a de-briefing form, recording any departures from the agenda, processes that worked well and those that did not. NSB participant feedback will be obtained through annual program participant surveys and mid-annual program participant focus groups. LE will ensure the feedback process is representative of individuals and families served as well as the population within the target areas. The survey and focus group questions will be developed by QI team to gather information about the HS program participant experience, the extent to which services are meeting needs, needs that are not being met, barriers to meeting service plan goals (i.e., incomplete referrals), and their experiences with implementing their reproductive life plans.

Outcomes. The focus of project outcome data will be HRSA Performance Measures. These data are collected during the CM process and maintained in CAREWare (data collection strategy detailed below). A detailed inventory of program outcome measures is provided in Table 6. For example, at least 82% of all new infants should be given breastmilk (BM6). CM's will meet with pregnant participants at least monthly, to discuss various topics of parenthood and caring for infants. Using the evidence-informed curriculum *Partners for a Healthy Baby*, CM's will inform and encourage pregnant participants to initiate breastfeeding immediately after birth. CM's will document in CAREWare, total number of consultations, how often breastfeeding was discussed, noting any shared barriers and questions, and any requests/referrals for breastfeeding support (process measures). After birth, CM's will identify if breastfeeding was initiated (outcome measure). If breastfeeding was not initiated, CM's will follow-up with participants to identify barriers to breastfeeding (QI data). Measurement protocols for other outcomes of interest, as suggested by the CTN, will be developed.

Impact. Impact data are collected at the community level. The PD and PM will work closely with the MPHD Division of Epidemiology to obtain PPOR and vital statistic data. Findings from the FIMR and CFR data collection and analyses will also be useful to identify changes at the

community level. The LE will conduct surveys, interviews, and focus groups with community members, CTN members and case managed participants. Specifically, LE will conduct an annual survey of CTN members utilizing the Coalition Member Assessment developed by Tom Wolff (2010) and included in his book, "The Power of Collaborative Solutions". This survey assesses members' perceptions of coalition's vision, leadership and membership, structure, communication, activities, outcomes, relationships, systems outcomes, and benefits from participation. The CTN relationships will also be assessed via the Wilders Collaboration Index. Open-ended questions are included to gather additional information that cannot be adequately captured with scaled items. Questions to ascertain the extent of impact and type of impact the CTN has will also be included. In 2025 and 2027, the LE, with the PM, will conduct key informant interviews with community leaders, providers and others working in the community to gain feedback about birth outcomes, services, and community changes. Questions on the semi-structured interview protocols will be designed collaboratively with program leadership staff and the CTN to gather information that can be used by the CTN and program staff for planning and collective impact.

Timely monitoring and tracking. **See Attachment 11_Evaluation Plan**. The LE will work with the PD and PM to develop an evaluation tracking system to ensure that all evaluation activities occur timely and as planned. The QI team will be responsible for monitoring ongoing processes and the project's progress toward meeting goals and objectives. Process outputs and progress toward benchmarks will be the primary focus guiding this committee. Throughout the evaluation process there will be consistent communication and collaboration between the PD, PM, and LE. All evaluation work will draw upon utilization-focused and empowerment models so information is useful and inclusive of all influenced by the program – program participants, target community members, collaborators, and staff. **Data collection and monitoring strategy**. CMs collect the greater part of case managed participant (i.e., individual level) data and enter the data into CAREWare (CW). All staff will successfully complete data collection training prior to initiating recruitment. To ensure the comprehensive and effective tracking of HRSA Performance Measures, CW was selected. Staff will receive training, consisting of data entry, monitoring and report creation. CMs will enter real-time data (e.g., during or immediately after home/hospital visits, assessments, etc.) into the system using program-provided, web-enabled laptops. User-friendly dashboards will facilitate tracking of HS participants, missing data elements, completed referrals and identified barriers or needs and resolutions. The PM and PD will have dedicated dashboards to track participant barriers or needs. Both care staff and the PM will be trained to monitor these elements routinely. This process will minimize missing data or incomplete referrals in the monthly QI assessment. The LE will collaborate with the PD and PM to present results of evaluative activities at national conferences. **Potential challenges and mitigation:** *Organizational Challenges*: coordination of this sizeable project is difficult for a local governmental agency. If awarded, PD and LE will meet with MPHD and the grants contract office representatives regularly to ensure HRSA requirements are clear, and deadlines are met. *Technical challenges*: CMs will collect, monitor, and enter considerable amounts data. The PM and PD, led by the LE, will train CMs, provide examples and opportunities for re-training annually. Additionally, software allows CMs to examine completeness of records on a weekly basis. *Community perception and reception*: engaging the community will be critical for success. PD, PM, and CM will employ multiple and various awareness campaigns to guarantee the program extends to the targeted population. *Lead Evaluator*: Per Metro procurement procedures, MPHD will contract externally for evaluation services. It is anticipated that the Lead Evaluator will lead and coordinate all evaluation activities. Qualifications of interest include previous experience serving as an evaluator of a healthy start project and 8 years of evaluation experience, particularly with maternal child health evaluation expertise.

CERTIFICATION REGARDING LOBBYING

Certification for Contracts, Grants, Loans, and Cooperative Agreements

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, ''Disclosure of Lobbying Activities,'' in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly. This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by section 1352, title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Statement for Loan Guarantees and Loan Insurance

The undersigned states, to the best of his or her knowledge and belief, that:

If any funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this commitment providing for the United States to insure or guarantee a loan, the undersigned shall complete and submit Standard Form-LLL, ''Disclosure of Lobbying Activities,'' in accordance with its instructions. Submission of this statement is a prerequisite for making or entering into this transaction imposed by section 1352, title 31, U.S. Code. Any person who fails to file the required statement shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

* APPLICANT'S ORGANIZATION	Nashville & Davidson County, Metropolitan Government of
* PRINTED NAME AND TITLE OF AUTHORIZED REPRESENTATIVE	
Prefix:	
* First Name:	Melva
Middle Name:	
* Last Name:	Black
Suffix:	Ph.D.
* Title:	Deputy Director
* SIGNATURE:	Completed on submission to Grants.gov
* DATE:	Completed on submission to Grants.gov

Budget Narrative File(s)

*** Mandatory Budget Narrative Filename:** Nashville Strong Babies Budget Narrative.pdf

Add Mandatory Budget Narrative | Delete Mandatory Budget Narrative | View Mandatory Budget Narrative

To add more Budget Narrative attachments, please use the attachment buttons below.

Add Optional Budget Narrative | Delete Optional Budget Narrative | View Optional Budget Narrative

Budget Justification Narrative and Line Item Detail Narrative

(*All figures are rounded unless otherwise indicated)*

5-Year Federal Project Budget	*Year 1*	*Year 2*	*Year 3*	*Year 4*	*Year 5*
a. Personnel	$477,484	$487,034	$496,774	$506,710	$516,844
b. Fringe Benefits (45.0%)	$214,798	$218,500	$222,267	$226,101	$230,001
c. Travel	$10,502	$10,502	$10,502	$10,502	$10,502
d. Equipment	$0	$0	$0	$0	$0
e. Supplies	$12,150	$12,100	$12,400	$12,100	$12,100
f. Contractual	$210,100	$197,100	$190,100	$178,100	$175,100
g. Construction	$0	$0	$0	$0	$0
h. Other	$0	$0	$0	$0	$0
i. Total Direct Charges (a-h)	$925,034	$925,236	$932,044	$933,512	$944,547
j. Indirect Charges (21.47%)	$174,966	$174,764	$167,956	$166,488	$155,453
k. TOTALS (i. + j.)	**$1,100,000**	**$1,100,000**	**$1,100,000**	**$1,100,000**	**$1,100,000**

The budget detail and justification provided is for Year 1 (Y1) and each subsequent year is noted.

***KEY PERSONNEL & ALL GRANT FUNDED POSITIONS* (Year One)**				
1. NAME AND POSITION TITLE	**2. ANNUAL SALARY**	**3. NO. MONTHS BUDGET**	**4. % TIME**	**5.TOTAL $ SALARY**
Finance Officer - J. Avedisian	$69,558.27	12	25%	$17,390
Care Coordinator - To be hired	$40,200.79	12	100%	$40,201
Nurse Manager - A. Boffah	$82,893.71	12	100%	$82,894
Program Manager - A. Williams	$77,887.86	12	100%	$77,888
Care Manager - Z. Jones	$49,349.67	12	100%	$49,350
Care Manager - L. Ensley	$52,418.53	12	100%	$52,419
Care Manager - C. Witt	$59,295.15	12	100%	$59,295
Care Manager - D. Jean-Jumeau	$49,349.67	12	100%	$49,350
Care Manager – D. Reyes-Montalvo	$48,699.02	12	100%	$48,699
			Total Federal Salaries	**$477,484**
			FRINGE BENEFT (45.0%)	**$214,798**
			TOTAL FEDERAL PERSONNEL	**$692,282**

a. Personnel **$477,484**

See Attachment 3 for a complete description of grant-funded positions, time effort and how each position contributes to the project objectives and required performance measures. Years 2-5 reflect a 2% salary increase that is most often realized by MPHD staff.

b. Fringe Benefits **$214,798**

Fringe benefits include OASDI, SSMed, insurance (health and life) as well as retirement (pension) benefits. The overall fringe benefit rate is applied as 45% for **1.0 FTE federally funded** staff. The 45% fringe benefit rate is calculated as follows in the Fringe Benefit Table. Years 2 – 5 reflect a 1.50% increase in the benefit rate that often occurs each calendar year.

Benefit	CY23 Rates	Notes/Comments
OASDI 501172	6.20%	6.2% of the first $142,800 of salary
SSMed 501173	1.45%	1.45% of total salary
Group Health 501174	$13,500	Rate depends on plan; Rates change January 1.
Dental 501175	$600	Rate depends on plan; Rates change January 1.
Life 501176	$300	Rate depends on plan; Rates change January 1.
Pension 501177	12.455%	Employer covers 100% of pension contribution.

c. Travel **$10,502**

Travel includes both local travel to support outreach, recruitment, and intake activities, in-person home-visits with participants and staff meetings as well as out of town travel for mandatory MCHB sponsored

meetings. Local travel mileage is based on the FY2024 Office of Management and Budget (OMB) local mileage rate of $0.655 per mile. MPHD follows the published OMB local mileage rate. Out of town includes accounting in accordance with the Metropolitan Government of Nashville/Davidson County travel policy for the most economical and efficient form of travel (e.g. economy class airline). Out of town travel is capped to not exceed $5,000 per year for up to 3 staff to attend required MCHB grantee meetings and applicable trainings.

Local* *$5,886*

Local mileage is reflected for the Care Managers, Care Coordinator, and Nurse Manager positions to conduct in-person and in-home visit encounters, conduct outreach, and host education groups.
7 staff x 100 miles/mo @ .655 mi X 12 months.
*Average amounts computed from current home visiting program staff usage.

Out of town **Required MCHB Grantee Meetings (annual)** *$5,000***

Airfare – [$700 roundtrip economy airfare x 3 staff]	$2,100
Lodging – [$250/night x 3 nights] x 3 staff	$2,250
Per Diem – [$79/day x 2 days + $59.25 x 1 day] x 3 staff	$652

**Out of town travel is reduced by $1.80 to not exceed a maximum of $5,000 per year for 3 staff.

d. Equipment (None)

e. Supplies **$12,150**

Supplies include general office supplies (pens, paper, notebooks, filing folders, staples, etc.) for staff to use and the estimate for general office supplies is based on current outreach and case management program expenditures. Staff have laptop computers/workstations and have access to network printing. As most staff spend significant hours (more than 5 hours per day) conducting outreach, recruitment, intake and assessment as well as visit encounters with NSB and potential NSB participants, each staff member has a cell phone that includes a monthly data and text messaging plan to facilitate ease of communication with participants as well as tracking staff in the field. Funding will be used for general office supplies, staff cell phone and Wi-Fi hot spot service, educational and brochures/information hand-outs for all relevant health topics. Emergency supplies are on hand for high risk pregnant case managed participants.

Cell phone and Wi-Fi hot spot service *$9,600*

Metro Government of Nashville/Davidson County has a negotiated contract with Verizon Wireless to provide cell phone coverage for Metro employees. The negotiated rate includes all applicable data and text messaging plans. [$100/month x 12 months x 8 staff]

Educational Supplies *$450*

March of Dimes educational and outreach materials for pregnant, postpartum, and parenting participants (case managed and group education participants). Brochures sold in bundles of 50 handouts per bundle on relevant health topics. [$50 bundles x 9 bundles]

Office Supplies *$600*

General office supplies include pens, file folders, staples, paper clips. [$50/month x 12 months]

Participant supplies *$1,500*

Emergency supplies for pregnant case managed participants who at high risk for preterm birth (diapers, sleep sacks, pack-n-plays, etc.) [$50/participant x 30 high risk pregnant participants]

f. Contractual **$210,100**

The following list of contractors are **proposed** contracts as Metro Government Procurement policy requires a bid process for contracts that exceed $24,999 in funding scope. This list of proposed contractors is based on the organization's expertise, capacity, or current contract to provide services related to the NSB project.

Clinical Services $110,100

The Clinical Services contractors will provide accessible prenatal, postpartum, and pediatric care as well as Behavioral health support to enrolled case managed participants. The accessible care can be provided via a mobile health unit and/or a weekend clinic monthly. The proposed clinical services contracts includes key personnel, fringe benefits, mobile unit supplies, and maternal health trainings for staff and providers serving NSB participants.

a. Clinical Services Personnel *$75,000*

Personnel	Annual Salary	% Effort	Project Months	Total Salary
Staff Obstetrician	$200,000	10%	12	$20,000
Nurse Practitioner	$96,000	25%	12	$24,000
Behavioral Health Therapist	$50,000	50%	12	$25,000
Staff Behavioral Health Specialist	$60,000	10%	12	$6,000
			Personnel Total	$75,000

The Staff Obstetrician will supervise the Nurse Practitioner. The Nurse Practitioner will provide prenatal care to enrolled pregnant and postpartum participants. The Staff Behavioral Health Specialist is licensed to supervise licensed therapists, unlicensed therapists as well as unlicensed therapists who are pursuing licensure. The Staff Behavioral Health Therapist will supervise the Behavioral Health Therapist. The Behavioral Health Therapist will provide behavioral health assessments, screenings, and initial therapeutic support to enrolled NSB participants.

b. Fringe Benefits *$30,000*

The maximum fringe benefit rate to contract for clinical services contractors (personnel) will be 40%. The FB rate is based on local federally qualified health center FB rates.

c. Supplies *$2,500*

Clinical services contract supplies include disposable medical supplies for patient care. Disposable supplies are calculated in patient bundles for gloves, disposable gowns, gel for doppler readings, disposable table sheets, thermometer covers, alcohol wipes, hand sanitizer, urine test kits. The estimated per patient supply cost is $10 per patient. [$10/patient x 250 patients]

d. Maternal Health Education and Training *$2,600*

Funding will be used to provide maternal health training to NSB staff and providers. Training topics of interest will be maternal early warning signs, maternal mental health signs, postpartum support for hypertensive conditions, postpartum support for gestational diabetes, etc. Training sessions include a flat rate honorarium for speakers and printing costs of training materials. [$500 speaker honorarium + $20 printing costs for training materials] x 5 training sessions annually.

Evaluation Lead $6,000

The Evaluation Lead will provide overall data management, data collection, quality improvement and performance monitoring and overall process, outcomes, and impact evaluation of the NSB project as well as data reporting. The Evaluation costs are estimated costs from current evaluation vendors who support NSB. The evaluation costs are billed based on work completed each month. It is anticipated that the Evaluation Lead (EL) will have significant experience (10+ years) leading public health evaluation efforts; preference is for an evaluator/evaluation group with experience evaluating federal healthy start programs. Evaluation costs are billable at a flat rate of $50/hour for Lead Evaluator or for team members of an evaluation group. [$50/hour x 10 hours/month x 12 months].

Group Education Support $24,000

The Group Education Support contractor(s) will provide logistical support, direct education and pre/post-test knowledge assessments of participants attending community-based prenatal and parenting education groups. It is anticipated that the contractor(s) will provide education to a minimum of 100 unduplicated community participants per year. The contractor will implement either the *Nurturing Parenting curricula*

or the *Strengthening Families curricula* and will already have established parenting groups. Funds will be used to compensate health educators, provide meals to families, activities for children, and retention supplies for participants.

▪ Health Educators *$7,000*

Health educators will be used to deliver the prenatal and parenting education groups. The Health educators will have completed training on the curricula being delivered. Compensation is an hourly rate that includes 1.5 hours for session preparation and 2 hours of session delivery (3.5 hours total per session) for a maximum of 10 education sessions. Each education cohort will include up to 25 community participants and a minimum of 4 cohorts will be supported annually.
[$25/hour x 3.5 hours/education session x 10 sessions/education cohort x 4 cohorts] x 2 health educators

▪ Participant Meals *$10,000*

Nutritional meals will be provided for individuals attending the prenatal and parenting education groups. Meals are capped at a maximum of $10 per person per session. [$10/participant x 25 participants/education session x 10 sessions per cohort x 4 cohorts]

▪ Participant Supplies *$400*

Participant supplies include pens, journals, and workbook sheets that align with each education session. Participant supplies are capped at a maximum of $4.00 per person. [$4/participant x 100 participants]

▪ Childcare Support *$1,600*

Childcare will be provided for parenting sessions when adult participants need to bring their children with them. Childcare staff will provide age-appropriate activities for children. Compensation is an hourly rate of $20 per hour. [$20/hour x 2 hours/education session x 10 sessions per cohort x 4 cohorts]

▪ Participant Retention Supplies *$5,000*

Participants need to attend at least 50% of education sessions to be deemed "complete". To keep participants engaged and retained in at least half of the education sessions, $50 restricted gift vouchers that only allow for the purchase of baby items will be distributed. [$50 restricted gift voucher x 100 participants]

Doula Support $15,000

Doulas continue to be an integral partner to NSB. NSB maintains a network of independent doula contractors who provide prenatal, birth and lactation support to NSB participants. Doulas will provide support to high risk pregnant participants at a flat compensation rate of $500 per birth that includes initial prenatal support. [$500 per birth x 30 births]

Fatherhood Support $50,000

The Fatherhood Support contractor(s) will provide community-based education groups for fathers/partners using *Fathering in 15* and *Strengthening Families* curricula reaching a minimum of 100 unduplicated community participants per year. It is anticipated that the contractor(s) will have prior training to use the stated curricula and at least 2 years of experience providing education and support to fathers/partners in the target area. Funds will be used to compensate key personnel and to provide retention supplies to participants.

a. Key Personnel
$25,000

Personnel	Annual Salary	% Effort	Project Months	Total Salary
Fatherhood Coordinator	$50,000	50%	12	$25,000
			Personnel Total	$25,000

The Fatherhood Coordinator is responsible for outreach, recruitment, logistical management, and delivery of the father/partner education groups, serving 100 father/partners per year.

b. Fringe Benefits *$10,000*

The maximum fringe benefit rate to contract for fatherhood contractor(s) (personnel) will be 40%. The FB rate is based on local non-profit FB rates.

c. Fatherhood Lead *$10,000*

The Fatherhood Lead supervises the Fatherhood Coordinator and leverages relationships to advance fatherhood strategies in Davidson County and Tennessee; attends state Fatherhood Commission meetings to leverage resources, partnerships, and support for NSB. The Fatherhood Lead is compensated on an hourly basis of $50 per hour.

[$50/hour x 20 hours per month x 10 months (average time)]

d. Participant Retention supplies *$5,000*

Like the prenatal and parenting group sessions, retention items are distributed to ensure father/partner participation. $50 restricted gift vouchers for the purchase of baby items will be given to fathers/partners who complete a minimum of 50% of education sessions.

[$50/restricted gift voucher x 100 fathers/partner participants]

Transportation *$5,000*

Using existing partners, ride-share transportation will be provided to case managed and community participants without adequate means to attend medical appointments or education groups. Transportation costs are based on current NSB transportation needs. [$50/roundtrip ride per participant x 100 participants]

g. Construction (None)

h. Other (None)

j. Indirect **$174,966**

The Metro Government indirect rate is 21.47% of all direct charges and each contract less than $25,000, plus $5,368 per contract over $25,000.

Budget Changes: Year 2 - Year 5 Justification

a. Personnel: As previously noted, there is a 2% salary increase for federally funded positions reflecting the projected and historical Metro government employee salary increase.

b. Fringe Benefits: Increases 1.5% to reflect projected and historical Metro benefits increases.

c. Travel: No change

e. Supplies: Noted changes include:

- **Year 2** Supplies decrease to **$12,100**. [$9,600 for staff cell phone and Wi-Fi service + $600 for general office supplies + $1,500 for participant supplies] plus $400 for educational supplies [$50 bundle x 8 bundles of materials]
- **Year 3** Supplies increase to **$12,400**. [$9,600 for staff cell phone and Wi-Fi service + $600 for general office supplies + $1,500 for participant supplies] plus $700 for education supplies [$50 bundles x 14 bundles of materials]. The increase if supplies in year 3 is reflective of needing new educational materials to address participant needs based on evaluation and participant feedback cycles.
- **Year 4 and Year 5** Supplies decrease to year 2 levels of **$12,100**. [$9,600 for staff cell phone and Wi-Fi service + $600 for general office supplies + $1,500 for participant supplies] plus $400 for educational supplies [$50 bundle x 8 bundles of materials]

f. Contractual:

1). Clinical Services Contract(s): No Change

2). Evaluation Lead:

- **No Change Year 2 and Year 3**

▪ **Year 4** increases to **$9,000** [$50/hour x 15 hours/month x 12 months]. It is anticipated that the evaluation hours per month will increase 1.5 times – from 10 hours to 15 hours – to prepare additional participant listening session and project impact analysis.
▪ Year 5 decreases to $6,000, reflective of year 1-3 costs.

3). Group Education Support Contract(s):
▪ **Year 2** decreases to **$11,000**. [$400 participant supplies + $1,600 childcare support + $5,500 retention supplies] plus $3,500 for health educator [$25/hour x 3.5 hours/education session x 10 sessions/education cohort x 4 cohorts] x 1 health educator. It is reasonably anticipated the contractor will be able to absorb a portion of the community education sessions in their regular operations, decreasing the number of health educators. As well, new partnerships will be created to provide meals for group sessions. Additionally, the participant retention supplies increase to $55 per participant for restricted gift vouchers x 100 participants.
▪ **Year 3 – 5** decreases to **$9,000** per year. [$3,500 for 1 health educator + $5,500 retention supplies]. Additional partnerships will be created to provide childcare during the group sessions.

4). Doula Support Contractors:
▪ Year 2, Year 3: No Change
▪ Year 4 and Year 5: Unfunded. It is reasonably anticipated that the capacity of trained and certified community-based doulas serving the primary population will increase, particularly doulas that offer birth services on a sliding fee scale. The project will work with the current network of doula providers to further sustain access to doula care for high-risk low-income participants in years 4 and 5.

5). Fatherhood Contractor(s): Unchanged

6). Transportation: Unchanged in Year 2; Unfunded in Years 3 -5. It is reasonably anticipated that the Community Consortia will create a transportation system strategy to provide higher quality, customer friendly transportation support to high-risk, low-income participants who lack access to transportation for medical appointments or group education sessions.

j. Indirect: The Indirect Amount includes the indirect rate of 21.47% applied to direct costs (Total Personnel, Supplies, Travel, and each contract less than $25,000) plus $5,368 per contract that exceeds $25,000 during the budget period. The Indirect Amount for Years 2-5 is reduced to not exceed the maximum award amount:

▪ Year 2: **$174,765**
$175,010 [(21.47% of direct costs) + $18,679 (21.47% on each contract under $25,000 and $5,368 for each contract over $25,000)] - $245

▪ Year 3: **$167,956**
$176,471 [$159,295(21.47% of direct costs) + $17,177 (21.47% on each contract under $25,000 and $5,368 for each contract over $25,000)] - $8,515

▪ Year 4: **$166,488**
$176,787 [(21.47% of direct costs) + $14,601 (21.47% on each contract under $25,000 and $5,368 for each contract over $25,000)] - $10,299

▪ Year 5: **$155,453**
$179,156 (21.47% of direct costs) + $8,587 (21.47% on each contract under $25,000 and $5,368 for each contract over $25,000) - $23,703

BUDGET INFORMATION - Non-Construction Programs

OMB Number: 4040-0006
Expiration Date: 02/28/2025

SECTION A - BUDGET SUMMARY

Grant Program Function or Activity (a)	Catalog of Federal Domestic Assistance Number (b)	Estimated Unobligated Funds		New or Revised Budget		
		Federal (c)	Non-Federal (d)	Federal (e)	Non-Federal (f)	Total (g)
1. Nashville Strong Babies II	93.926	$ 5,500,000.00	$	$	$	$ 5,500,000.00
2.						
3.						
4.						
5. Totals		$ 5,500,000.00	$	$	$	$ 5,500,000.00

Standard Form 424A (Rev. 7- 97)
Prescribed by OMB (Circular A -102) Page 1

SECTION B - BUDGET CATEGORIES

6. Object Class Categories	GRANT PROGRAM, FUNCTION OR ACTIVITY (1) Nashville Strong Babies II	(2)	(3)	(4)	Total (5)
a. Personnel	$ 2,484,846.00	$	$	$	$ 2,484,846.00
b. Fringe Benefits	1,111,668.00				1,111,668.00
c. Travel	52,510.00				52,510.00
d. Equipment					
e. Supplies	60,850.00				60,850.00
f. Contractual	950,500.00				950,500.00
g. Construction					
h. Other					
i. Total Direct Charges (sum of 6a-6h)	4,660,374.00				$ 4,660,374.00
j. Indirect Charges	839,626.00				$ 839,626.00
k. TOTALS (sum of 6i and 6j)	$ 5,500,000.00	$	$	$	$ 5,500,000.00
7. Program Income	$	$	$	$	$

Authorized for Local Reproduction

Standard Form 424A (Rev. 7- 97)
Prescribed by OMB (Circular A -102) Page 1A

SECTION C - NON-FEDERAL RESOURCES

(a) Grant Program	(b) Applicant	(c) State	(d) Other Sources	(e)TOTALS
8. Nashville Strong Babies II	$	$	$	$
9.				
10.				
11.				
12. TOTAL (sum of lines 8-11)	$	$	$	$

SECTION D - FORECASTED CASH NEEDS

	Total for 1st Year	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
13. Federal	$ 1,100,000.00	$ 275,000.00	$ 275,000.00	$ 275,000.00	$ 275,000.00
14. Non-Federal	$				
15. TOTAL (sum of lines 13 and 14)	$ 1,100,000.00	$ 275,000.00	$ 275,000.00	$ 275,000.00	$ 275,000.00

SECTION E - BUDGET ESTIMATES OF FEDERAL FUNDS NEEDED FOR BALANCE OF THE PROJECT

(a) Grant Program	FUTURE FUNDING PERIODS (YEARS) (b)First	(c) Second	(d) Third	(e) Fourth
16. Nashville Strong Babies II	$ 1,100,000.00	$ 1,100,000.00	$ 1,100,000.00	$ 1,100,000.00
17.				
18.				
19.				
20. TOTAL (sum of lines 16 - 19)	$ 1,100,000.00	$ 1,100,000.00	$ 1,100,000.00	$ 1,100,000.00

SECTION F - OTHER BUDGET INFORMATION

21. Direct Charges: 4,660,374

22. Indirect Charges: 839,626

23. Remarks: Indirect Cost Rate @ 21.47%

OMB Number: 4040-0010
Expiration Date: 11/30/2025

Key Contacts Form

*** Applicant Organization Name:**

Nashville & Davidson County, Metropolitan Government of

Enter the individual's role on the project (e.g., project manager, fiscal contact).

*** Contact 1 Project Role:** Program Manager

Prefix:

* First Name: Angela

Middle Name:

* Last Name: Williams

Suffix:

Title:

Organizational Affiliation:

* Street1: 2500 Charlotte Avenue

Street2:

* City: Nashville

County:

* State: TN: Tennessee

Province:

* Country: USA: UNITED STATES

* Zip / Postal Code: 37209-4129

* Telephone Number: 6153404616

Fax:

* Email: Angela.Williams2@nashville.gov

OMB Number: 4040-0010
Expiration Date: 11/30/2025

Key Contacts Form

*** Applicant Organization Name:**

Nashville & Davidson County, Metropolitan Government of

Enter the individual's role on the project (e.g., project manager, fiscal contact).

*** Contact 2 Project Role:** Doula and Education Manager

Prefix:

* First Name: Dawn

Middle Name:

* Last Name: Smith

Suffix:

Title:

Organizational Affiliation:

* Street1: 2500 Charlotte Avenue

Street2:

* City: Nashville

County:

* State: TN: Tennessee

Province:

* Country: USA: UNITED STATES

* Zip / Postal Code: 37209-4129

* Telephone Number: 6153408643

Fax:

* Email: Earletta.Smith@nashville.gov

OMB Number: 4040-0010
Expiration Date: 11/30/2025

Key Contacts Form

*** Applicant Organization Name:**

Nashville & Davidson County, Metropolitan Government of

Enter the individual's role on the project (e.g., project manager, fiscal contact).

*** Contact 3 Project Role:** Project Director

Prefix:

* First Name: D'Yuanna

Middle Name:

* Last Name: Allen-Robb

Suffix:

Title:

Organizational Affiliation:

* Street1: 2500 Charlotte Avenue

Street2:

* City: Nashville

County:

* State: TN: Tennessee

Province:

* Country: USA: UNITED STATES

* Zip / Postal Code: 37209-4129

* Telephone Number: 6153400487

Fax:

* Email: Dyuanna.Allen-Robb@nashville.gov

OMB Number: 4040-0019
Expiration Date: 02/28/2025

Project Abstract Summary

This Project Abstract Summary form must be submitted or the application will be considered incomplete. Ensure the Project Abstract field succinctly describes the project in plain language that the public can understand and use without the full proposal. Use 4,000 characters or less. Do not include personally identifiable, sensitive or proprietary information. Refer to Agency instructions for any additional Project Abstract field requirements. If the application is funded, your project abstract information (as submitted) will be made available to public websites and/or databases including USAspending.gov.

Funding Opportunity Number

HRSA-24-033

CFDA(s)

93.926

Applicant Name

Nashville & Davidson County, Metropolitan Government of

Descriptive Title of Applicant's Project

Nashville Strong Babies II

Project Abstract

Tennessee’s infant mortality rates (IMR) continue to be worse than most other states. Tennessee’s poor showing is due to the disturbing birth outcomes in the major urban areas, of which Nashville/Davidson County is the second largest. The 2019 – 2021 overall Davidson County Infant Mortality Rate (IMR) is 7.1 infant deaths (per 1,000 live births), however, the burden of infants dying before their 1st birthday is not evenly distributed. African American infants born in Davidson County are 4.7 times more likely to die before their first birthday as evidenced by the African American infant mortality rate of 14.9 infant deaths (per 1,000 live births). While infant mortality rates have improved for Caucasian women in Davidson County since 2008, perinatal outcomes worsened overall for African American women and infants. While high school graduation rates are nearly equivalent for the African American and Caucasian populations, African American households are 2.3 times more likely to live in below poverty, representing densely concentrated poverty and limited economic mobility within Davidson County.

Nashville Strong Babies (NSB), led by the Metro Public Health Department (MPHD) aims to improve perinatal outcomes and change the health expectations of the community as well as the accountability of healthcare systems by utilizing a pathways hub approach to partner with culturally experienced medical/clinical providers, community and service providers, and other key partners. NSB serves birthing people and families at highest risk for experiencing poor birth and infant health outcomes. Building on the successes of the 2019-2024 funded project, NSB continues to give women access to a variety of important services including medical/clinical services, social services, traditional public health services, and an assortment of education opportunities emulating the life course to include prenatal health for pregnant women, as well as positive parenting and infant development for interconception women. NSB will provide perinatal case management to 250 pregnant women, 175 infants/children (up to 18 months of age), and 25 fathers/partner as well as provide perinatal and parenting education to 250 community members, serving a total of 700 individuals per year.

Participants will receive need-based care coordination, care support, and case management services for themselves and their infants, access to risk reduction services, and special attention to their mental wellness. All services are community based and include after-hours/weekend clinics. Women are identified through a centralized referral system and outreach efforts. Once identified and interested, women will be referred into the program, and assigned a case manager/care coordinator. Pregnant participants can opt into mobile group prenatal and mobile group pediatric care delivery (infants). This is an innovative, active model of both prenatal and pediatric care that builds a support system of other women and creates a collectivist village for raising children, which are key elements in traditional African culture.

The NSB Project goes beyond the traditional model to address the looming problem of economic instability and housing insecurity. Additional partnerships will be developed with housing developers to allocate available single family housing units (at least 2 bedrooms) and with childcare providers for healthy start participants in geographically appropriate areas. By focusing multiple care coordination and case management efforts in the target area, the proposed Nashville Strong Babies project has the potential to dramatically cut the overall number of infant deaths in half within 5 years and serve as replicable model for Tennessee!

APPLICATION SIGNATURE PAGE
FOR
Nashville Strong Babies II

METROPOLITAN GOVERNMENT OF NASHVILLE AND DAVIDSON COUNTY

DocuSigned by:
Gill C Wright III, MD
0468AC21E1CC408...

Director, Metro Public Health Department

11/13/2023

Date

DocuSign

Certificate Of Completion

Envelope Id: 1C9195DA52034B90A15C8A449FA7BA16
Status: Completed
Subject: Complete with Docusign: Health - Nashville Strong Babies II 25 Ready.pdf
Source Envelope:
Document Pages: 177
Signatures: 6
Certificate Pages: 15
Initials: 1
AutoNav: Enabled
EnvelopeId Stamping: Enabled
Time Zone: (UTC-06:00) Central Time (US & Canada)

Envelope Originator:
Juanita Paulson
730 2nd Ave. South 1st Floor
Nashville, TN 37219
Juanita.Paulsen@nashville.gov
IP Address: 170.190.198.185

Record Tracking

Status: Original
7/10/2024 11:14:12 AM
Holder: Juanita Paulson
Juanita.Paulsen@nashville.gov
Location: DocuSign

Security Appliance Status: Connected
Pool: StateLocal

Storage Appliance Status: Connected
Pool: Metropolitan Government of Nashville and Davidson County
Location: DocuSign

Signer Events	Signature	Timestamp
Rose Wood rose.wood@nashville.gov Finance Admin Metro Finance Dept. OMB Security Level: Email, Account Authentication (None)	RW Signature Adoption: Pre-selected Style Using IP Address: 170.190.198.185	Sent: 7/10/2024 11:19:36 AM Viewed: 7/10/2024 10:05:36 PM Signed: 7/10/2024 10:05:47 PM
Electronic Record and Signature Disclosure: Not Offered via DocuSign		
Aaron Pratt Aaron.Pratt@nashville.gov Security Level: Email, Account Authentication (None)	Aaron Pratt Signature Adoption: Pre-selected Style Using IP Address: 170.190.198.190	Sent: 7/10/2024 10:05:49 PM Viewed: 7/11/2024 8:02:15 AM Signed: 7/11/2024 8:02:25 AM
Electronic Record and Signature Disclosure: Accepted: 7/11/2024 8:02:15 AM ID: 28b7b05e-65ec-4f56-8e19-72afb666876d		
Kevin Crumbo/mal Michelle.Lane@nashville.gov Deputy Director of Finance Metro Security Level: Email, Account Authentication (None)	Kevin Crumbo/mal Signature Adoption: Pre-selected Style Using IP Address: 170.190.198.185	Sent: 7/11/2024 8:02:28 AM Viewed: 7/12/2024 2:25:47 PM Signed: 7/12/2024 2:26:27 PM
Electronic Record and Signature Disclosure: Not Offered via DocuSign		
Courtney Mohan Courtney.Mohan@nashville.gov Security Level: Email, Account Authentication (None)	Courtney Mohan Signature Adoption: Pre-selected Style Using IP Address: 170.190.198.144	Sent: 7/12/2024 2:26:31 PM Viewed: 7/15/2024 12:13:29 PM Signed: 7/15/2024 12:33:39 PM
Electronic Record and Signature Disclosure:		

Signer Events	Signature	Timestamp
Accepted: 7/15/2024 12:13:29 PM ID: c55067fc-7e2f-476a-84f5-c10fed3389b6		
Balogun Cobb balogun.cobb@nashville.gov Security Level: Email, Account Authentication (None)	 Signature Adoption: Pre-selected Style Using IP Address: 170.190.198.144	Sent: 7/15/2024 12:33:42 PM Viewed: 7/15/2024 12:34:20 PM Signed: 7/15/2024 12:34:26 PM
Electronic Record and Signature Disclosure: Accepted: 7/15/2024 12:34:20 PM ID: 577388d1-e51f-4d34-b9b9-d90a1836538d		

In Person Signer Events	Signature	Timestamp

Editor Delivery Events	Status	Timestamp

Agent Delivery Events	Status	Timestamp

Intermediary Delivery Events	Status	Timestamp

Certified Delivery Events	Status	Timestamp

Carbon Copy Events	Status	Timestamp
Danielle Godin Danielle.Godin@nashville.gov Security Level: Email, Account Authentication (None) **Electronic Record and Signature Disclosure:** Not Offered via DocuSign	COPIED	Sent: 7/15/2024 12:34:30 PM
Sally Palmer sally.palmer@nashville.gov Security Level: Email, Account Authentication (None) **Electronic Record and Signature Disclosure:** Accepted: 7/15/2024 7:52:41 AM ID: b6968bb1-a4ce-4f29-aa77-765ab5ea3817	COPIED	Sent: 7/15/2024 12:34:31 PM

Witness Events	Signature	Timestamp

Notary Events	Signature	Timestamp

Envelope Summary Events	Status	Timestamps
Envelope Sent	Hashed/Encrypted	7/10/2024 11:19:36 AM
Certified Delivered	Security Checked	7/15/2024 12:34:20 PM
Signing Complete	Security Checked	7/15/2024 12:34:26 PM
Completed	Security Checked	7/15/2024 12:34:31 PM

Payment Events	Status	Timestamps

Electronic Record and Signature Disclosure