Governor’s Office of Children’s Care Coordination:
A Clear History, an Uncertain Future

By
Stefanie Cousins

A Master’s Paper submitted to the faculty of the University of North Carolina at Chapel Hill in partial fulfillment of the requirements for the degree of Master of Public Health in the Public Health Leadership Program.

Chapel Hill
2009

Advisor signature/printed name

Second Reader Signature/printed name

Date
# Table of Contents

Abstract .................................................................................................................. 3

Introduction ........................................................................................................... 5

Executive Summary .............................................................................................. 7

Purpose of the GOCCC .......................................................................................... 9

Structure as it Relates to Function ...................................................................... 10

Key Accomplishments of the GOCCC ................................................................. 17

Comparison to Programs in Other States .......................................................... 24

Recommendations for Increasing Effectiveness .................................................. 30

Report Follow-up ................................................................................................. 33

Conclusion ............................................................................................................ 34

References ............................................................................................................ 37

Appendix A: GOCCC Organizational Chart ......................................................... 39

Appendix B: Complete Catalog of the GOCCC’s Accomplishments ................. 41

Appendix B: References for Appendix B .............................................................. 54
Abstract

The Governor’s Office of Children’s Care Coordination (GOCCC) was established in 2004 by executive order to improve communication, interagency collaboration, and coordination of health care services for children in Tennessee. The challenge inherent in coordinating children’s services to reach all Tennessee children was highlighted in a 2003 lawsuit, known as the John B. Consent Decree, brought by a group of families whose children, then or future beneficiaries of Tennessee's Medicaid Managed Care Program (TENNCare), were not receiving regular checkups guaranteed by the Early Periodic Screening Diagnosis and Treatment Program (EPSDT). The GOCCC works to ensure that child-serving state departments are meeting the coordination requirements of the John B. Consent Decree as well as state and federal laws and various court orders relating to health services for children. After five years, the GOCCC is leading efforts to facilitate collaboration among the child-serving departments and focuses on infant mortality, substance abuse and preventative care to help improve health outcomes.

Several other states have bodies similar to the GOCCC that focus on improving the lives of children. Some states have Children’s Cabinets; others have State Councils, Commissions, Collaborations or Committees. The status of these entities varies from state to state, too – some are established by executive order alone while are others are legislatively mandated (Gaines, p. 5). In Tennessee, the GOCCC reports directly to Gov. Bredesen but it does not have statutory authority and, therefore, could be dismantled by January 2011 after a new governor is elected and if the state’s leaders cannot steward the GOCCC toward survival. To describe the GOCCC’s accomplishments and illustrate its long-term value to the General Assembly and others, Bob Duncan, the director of the GOCCC, requested a report that includes an overview of the Office’s purpose, structure and contributions, an analysis of the GOCCC’s current role and its potential to
expand that role in the future, a comparison of Tennessee’s GOCCC to similar programs in other states, and a plan for increasing the GOCCC’s effectiveness.

The written report provided the director of the GOCCC with the tools to manage the political environment through the end of the governor’s second term, convince the future governor to follow the report’s recommendations and work with the Tennessee General Assembly to pass a legislative mandate for the state’s Children’s Cabinet.
**Introduction**

Over the past six months, several state governors have declared public health emergencies and disasters to prepare for and respond to cases of Swine Influenza A (H1N1) in their respective states (The Centers for Law and the Public’s Health, 2009). These state executives were acting in their capacity as the leaders of their respective states to protect citizens by following guidelines handed down from the Centers for Disease Control and Prevention. As chief executives, responsible for the budget and the executive branch of state government, these governors were carrying out the responsibilities of their elected positions. Making such a declaration, however, triggers a number of policy and budgetary decisions for the state and begs the question: What is a governor’s role in public health?

In general, governors are provided with the power to implement a number of policies that could improve the health of their citizens. But what happens to the policies, programs and decisions governors establish after they have served their terms and leave office? When governors are replaced by successors who do not share their predecessors’ views, the decisions they have made by executive order (i.e. not established by a statute) run the risk of being dismantled by their successors. In some cases, the demise of these programs or policies could be constructive, if they were negatively impacting the state. On the other hand, if these programs were having a positive effect, then how do we as a society sustain the programs that are making a difference once their champions have been replaced? This is the dilemma of a democracy.

For example, in Tennessee, Gov. Phil Bredesen was required by law to comply with a consent decree requiring the state to meet federal standards for medical and dental screenings of children who qualify for TennCare, the state’s Medicaid program. In response, the governor created the Governor’s Office of Children’s Care Coordination, an entity outside the typical state
public health structure. The GOCCC not only fulfilled its role in responding to the requirements of the consent decree, but also expanded its reach to facilitate improvement in the state’s infant mortality rate, analyze policy and make recommendations to enhance child-serving systems, help reduce teen substance abuse and provide technical assistance to the Centers of Excellence (COE) that focus on behavioral outcomes for children in state custody (B. Duncan, personal communication, February 3, 2009).

It is clear that the GOCCC has put mechanisms into place that could significantly affect the state of public health in Tennessee. However, the director of the GOCCC worried that the next governor would dismantle the GOCCC once Gov. Bredesen left office in 2011. Therefore, the director requested the report below to illustrate the GOCCC’s accomplishments, review its current status and present recommendations for its effectiveness in the future. The survival of the GOCCC’s programs, projects, connections and relationships is crucial. The governor and the director of the GOCCC must act decisively and lead the GOCCC through a potentially treacherous year (B. Duncan, personal communication, February 3, 2009 and October 28, 2009).

The following report outlines the GOCCC’s purpose, defines its responsibilities and enumerates its successes. The paper also examines similar entities, such as the Children’s Cabinets in Maine, New Mexico and Ohio, and provides a comparison of all three states’ approaches to coordinating care for children. Finally, this paper will provide a follow up on the reception of the report, look at the political future of Tennessee and provide thoughts about leadership for carrying out the report’s recommendations.
Executive Summary

The Governor’s Office of Children’s Care Coordination (GOCCC) was established in 2004 by executive order to improve communication, interagency collaboration, and coordination of health care services for children in Tennessee. The challenge inherent in coordinating children’s services to reach all Tennessee children was highlighted in a 2003 lawsuit, known as the John B. Consent Decree, brought by a group of families whose children, then or future beneficiaries of TennCare, Tennessee’s Medicaid Managed Care Program, were not receiving regular checkups guaranteed by the Early Periodic Screening Diagnosis and Treatment Program (EPSDT). The GOCCC works to ensure that child-serving state departments are meeting the coordination requirements of the John B. Consent Decree as well as state and federal laws and various court orders relating to health services for children (GOCCC, Working Document 1, p. 1). After five years, the GOCCC is leading efforts to facilitate collaboration among the child-serving departments and focuses on infant mortality, substance abuse and preventive care to help improve health outcomes. (B. Duncan, personal communication, February 3, 2009).

Since 2004, the GOCCC has been instrumental in promoting the use of evidence-based practices (EBPs) to enhance the clinical competency of the provider network. Using EBP as a foundation for action, the GOCCC achieved the following milestones in its effort to ensure that all children receive the services to which they are entitled (GOCCC, Working Document 2, p. 2):

- **Infant Mortality reduction**: The GOCCC issues grants to providers, agencies and academic institutions to implement and evaluate EBP that have been demonstrated to improve outcomes. Examples include support of Centering Pregnancy, Community Voices and home visitation programs.

- **Legislation**: The GOCCC participated in development and support of legislation that requires the Department of Children’s Services (DCS) to implement EBP for the juvenile justice population.
Substance Abuse services policy analysis: The GOCCC used its Substance Abuse and Mental Health Services Administration (SAMHSA) grant to undertake a policy analysis of administration and funding of adolescent substance abuse services to support the development of interdepartmental resources and coordination to improve the service delivery system.

Substance Abuse services: The GOCCC is using the resources of its SAMHSA grant to provide training to the community in Evidence-Based Practices (EBP) for co-occurring disorders.

Mental Health services: The GOCCC issued a grant to the Centers of Excellence (COEs) to train, implement and develop a sustainable infrastructure for EBPs in the provider community in the areas of child maltreatment and attachment disorders.

Council on Children’s Mental Health: The GOCCC participated in SJR799, the children’s mental health study task force, and subsequently in P.C.1062, which established the Council at the leadership and committee level to ensure that EBPs are a core consideration.

The GOCCC’s other key accomplishments, impacts and influences are in the following areas:

Coordinating the child health Early Period Screening, Diagnosis and Treatment (EPSDT) component of Medicaid called TENNderCare (J. Napier, personal communication, February 18, 2009)

Reducing infant mortality in Tennessee through programs that promote women’s health (S. Miller, personal communication, February 26, 2009)

Analyses of policies, rules and regulations, conducting critical reviews of programs, administration and funding-related functions in order to enhance child-serving systems (M. Rolando, personal communication, March 11, 2009)

Strengthening the infrastructure focused on reducing substance abuse by Tennessee youths through the Tennessee Adolescent Coordination of Treatment (T-ACT) Project (S. Shapiro, personal communication, March 18, 2009)

Sustaining the Centers of Excellence (COEs) that assist the state in providing objective, evidence-based practices and science-based guidance to improve children’s health, behavioral outcomes, and improving systems serving children who are in state custody or at risk of entering state custody (GOCCC, Working Document 3, p.1).

The GOCCC reports directly to the governor but it does not have statutory authority. The GOCCC could be dismantled by January 2011 when a new governor is sworn in. To describe the GOCCC’s accomplishments and illustrate its value long-term, this document provides:

an overview of the Office’s purpose, structure and contributions
Governor’s Office of Children’s Care Coordination

- an analysis of the GOCCC’s current role and its potential to expand that role in the future
- a comparison of Tennessee’s GOCCC to similar programs in other states
- a plan for increasing the GOCCC’s effectiveness.

**Purpose of the GOCCC**

The primary focus of the GOCCC is to coordinate policies and activities related to maintaining and improving the health of the children of Tennessee. The office partners with child-serving state agencies to identify opportunities to collaborate and analyze systemic change to improve the health and well-being of children. The office coordinates activities that involve health care services to children from complex delivery systems involving multiple departments and the private sector, with an emphasis on the delivery of health care and evidence-based practices. Because the office is not administratively related to any of the many entities that directly serve children, it is able to bridge functions among these organizations, reducing interdepartmental and organizational silos. As a broker of programs that range from educational services to improvement in clinical care processes, the GOCCC is an independent office that has been successful in bringing a range of individuals and programs to the table in new and innovative ways and in unique collaborations (B. Duncan, personal communication, February 3, 2009).

The GOCCC also bridges the gap between science and public policy to enhance and coordinate services to children, by establishing appropriate partnerships with academia, community stakeholders, health care providers, faith-based institutions and private industry. Specific projects include advancing innovative strategies for decreasing infant mortality rates and racial disparities, promoting improved behavioral health and substance abuse treatment services, and addressing complicated issues around developmental disabilities. Additionally, the
office places a particular emphasis on children at risk of custody due to health-related issues, and monitors the contracts with the established COEs. The COEs provide psychiatric care to particularly challenging cases and support evidence-based practices of psychiatric services to children. (B. Duncan, personal communication, February 3, 2009).

The office also plays a key role in the state’s ongoing activities to comply with the John B. Consent Decree. The GOCCC works to ensure issues are appropriately addressed by various state departments involved in the delivery of EPSDT services. Among the responsibilities are reporting and documenting compliance with the John B. Consent Decree in a semiannual report to the Federal Court and strengthening regional, community, and private structures for a coordinated delivery network for EPSDT services (B. Duncan, personal communication, February 3, 2009).

**Structure as it Relates to Function**

Administrative independence of the GOCCC is essential to its success and underscores the focus on maintaining collaborations, bringing disparate parties to one table, and moving nimbly to be a change agent across systems. As a stand-alone office, the GOCCC reports directly to the governor, with the broad mission of coordinating the child-serving agencies to reduce interdepartmental silos, and thereby increasing the quality, efficiency, and continuity with which the state provides overall good health care to Tennessee’s children and youth. (*GOCCC organizational chart is in Appendix A.*) The office’s staff of 10 provides research, needs assessments, policy analyses, grants management and coordination across child-serving state agencies to improve the well-being of children and families in Tennessee. (B. Duncan, personal communication, February 3, 2009).
The GOCCC has a philosophical approach that is “child-centered,” rather than “agency-centered,” as change agents in state government with ears open to the state departments. The GOCCC listens to colleagues, liaisons and staff to understand where assistance is needed for development, implementation, and follow up for children's services. Changes have developed smoothly after key stakeholders have come together to share obstacles and discuss solutions for moving forward (B. Duncan, personal communication, February 3, 2009).

Before the GOCCC was established, state agencies were challenged by the complex needs of the 800,000 Medicaid children eligible for TENNderCare, the EPSDT program in Tennessee for low-income, special needs children and youth under the age of 21. The seven child-serving departments (TennCare, Department of Health, Department of Human Services, Department of Children’s Services, Department of Education, Department of Mental Retardation, and Department of Mental Health and Developmental Disabilities) did not communicate with each other routinely, and did not coordinate care in the absence of a compelling reason to do so. The GOCCC has brought a foundation to the state structure that is now finding success in providing more health screenings and well-child care for children than federal guidelines require. The office has done a tremendous job of developing collaboration among child-serving state departments, managed care organizations, and public and private organizations, ensuring children are receiving screenings and the best health care services possible (J. Napier, personal communication, February 18, 2009).

In the current structure as a neutral agency, separate from but collegial with the departments, the GOCCC has the potential to accomplish even more on behalf of the state’s children and youth. While individual departments appropriately focus on issues and areas within their defined scope, the GOCCC can help identify connections and collaborative opportunities to
ensure better health for children. Its independence provides a sense of non-competition and its focus on supportive process means that it works both in tandem with and in service to the child-serving agencies of the state (J. Napier, personal communication, February 18, 2009).

**GOCCC Survey**

In fall 2008 nearly 150 internal and external stakeholders were anonymously surveyed through Survey Monkey about the GOCCC’s mission, activities and contributions – 12 out of 15 internal stakeholders responded to the survey, and 45 out of 132 external stakeholders responded. Overall, the responses provided in-depth, candid feedback and addressed the extent to which the GOCCC’s contributions to solving problems saved stakeholders time and money, allowing them to spend resources on implementation rather than development (Duncan, B. 2008).

When asked why they chose to work with the GOCCC, 92.3% of the external stakeholders surveyed responded that it was due to impact on programmatic, policy, or procedural aspects of improving health outcomes for children in Tennessee; 76.9% said that it was because of diversity of colleagues within the office; 76.9% credited the translation and dissemination of evidence-based practices; 69.2% appreciated the interaction with partners; and 61.5% acknowledged the development of leadership throughout the state (Duncan, B. 2008).

These same external stakeholders were also asked if the GOCCC had improved their ability to identify opportunities and communicate concerns to partners and why. Eighty percent said they somewhat or strongly agreed with that statement and several of them gave detailed reasons (Duncan, B. 2008):

*Steering Panel provides the opportunity to discuss shared concerns and plan for ways to address specific problems. It also provides an excellent opportunity for creating informal networks and contacts. One specific example was action taken by the Department of Education following a Steering Panel meeting which raised concerns about the too many frequent school expulsions of very young children with behavior problems in one county.*
The fact that GOCCC does not have programmatic responsibilities nor direct oversight of other state entities makes the office a particularly ideal convener and "broker" of collaborative efforts.

The groups brought together in Nashville are very diverse and have provided valuable information on current programs and planning for joint or community-wide efforts. In one case, they have actively supported a limited partnership between program and managed care that did not cost anything, but through current resources could test an idea for improved children's health. It would have taken these partners longer to get together without the gentle, but persistent, push from the GOCCC staff.

The surveyed external partners also discussed how information shared through the GOCCC has affected their awareness of resources in the state or improved their department and/or program’s services. Their answers address benefits of the GOCCC’s Steering Panel meetings, efficiencies provided by its evidenced-based programs sponsorship, the office’s excellent collaborative approach to Tennessee’s Early Intervention System (TEIS) restructuring, infant mortality reduction, and its top-notch research capabilities. The following are a few complete responses from the surveys (Duncan, B. 2008):

The GOCCC Steering Panel meetings have made me aware of many resources as well as issues being addressed by the task force, such as the use of telemedicine, the work around infant mortality, the work around improving substance abuse treatment, the funding issues facing juvenile court judges for mental health evaluations, the ways to locate resources for autism and other developmental disabilities, etc. It promotes greater awareness of policy issues and efforts to improve legislation and department policies.

GOCCC has sponsored several evidenced-based programs to address infant mortality and investigated others. This process has saved countless hours in investigating such resources.

GOCCC has been able to coordinate actual movement on children’s issues rather than a rehashing of issues, lack of funding, etc...

The collaborative process utilized by GOCCC in the approach to TEIS re-structuring, infant mortality reduction and A&D issue resolution has been a good model to emulate. The office excels in 1) identifying ALL stakeholders (and not simply the "traditional" ones) and 2) presenting information in new ways to make the challenges (and thus the solutions) relevant to multiple parties.

Information was generated for GOCCC that we would not otherwise have gotten regarding low birth weight and infant mortality in Nashville. It is compelling us to rethink our services.
We believe the Substance Abuse Collaborative will help shape a common interdepartmental approach toward resource utilization and move funds to more appropriate levels of care (community based rather than restrictive and costly residential).

When asked about the GOCCC’s most valuable contributions and strengths, respondents addressed the benefits of the office’s neutrality, its “purposeful guidance” and desire for a “measurable impact,” its efficiency, solicitous nature and listening abilities, its role as “a springboard for cross-agency and cross-region problem solving” and “a facilitator of understanding the bigger picture.” The stakeholders were also asked how they would quantify the GOCCC’s contributions or impact: 81.8% said “better collaboration,” 77.3% said “better coordination,” and 54.5% said improved outcomes for children’s health. The following quotes were taken directly from the surveys (Duncan, B. 2008):

The GOCCC serves as a springboard for cross-agency and cross-region problem solving. It brings administrators and department heads together with ground-level service providers and advocates. This feeds information in both directions which promotes better problem-identification and problem-solving. It facilitates understanding of the bigger picture of the priorities of the state and this governor related to children’s health and well-being.

A place to start with an idea and end up with a product. A ‘neutral’ ground in government where there can be an exchange of ideas and concerns with ‘amnesty’.

Purposeful guidance on children’s physical, emotional, social, and academic development.

Ability to bring partners together and to distribute funds to evidence-based and community-based programs.

Most valuable are diverse community planning efforts...keeping many in the loop. Bringing in foundations, funders, managed care companies, etc... also keeps these folks in the loop on community needs. Strength is their knowledge of what works elsewhere. Also very directional in wanting a measurable impact and clear on what that is.

Coordination of efforts to reduce duplication and increase impact of funding streams.

GOCCC solicited input from key stakeholders. They use the information to make recommendations. They listened.
The external stakeholders involved in the GOCCC survey were also asked to provide specific examples of the GOCCC’s contribution or impact on their department or program. Respondents cited significant improvements in their work areas as a result of the GOCCC’s expertise in coordination and collaboration (Duncan, B. 2008):

*The biggest contribution is the opportunity to get to know specific individuals in various departments and agencies that then become resources. Also, my knowledge/awareness of legislative issues and funding issues/solutions is enhanced.*

*Working to ensure that partners are not re-inventing or duplicating services, implementing evidenced-based outcomes and data systems.*

*GOCCC identified an evidence-based intervention to reduce smoking among pregnant women as one effort to improve birth outcomes. This intervention is now being used in TDOH’s home visiting programs as well, to provide coordination and continuity of service to post-partum mothers.*

*Our program is looking at new partners and using resources differently.*

*Collaboration and coordination between TennCare, DCS, and MHDD is improved because we are engaging systems experts to cover the same material with us instead of each department identifying models and approaches.*

*The GOCCC's ability to gather and distribute information from other state departments and private and public agencies eliminates my need to try and obtain such information.*

A section of the survey requested that both internal and external stakeholders recommend areas where the GOCCC could get involved and identify its top opportunities. The following list addresses these responses (Duncan, B. 2008):

**Recommended Services or Programs for GOCCC Involvement**

- Eating disorders (anorexia and bulimia)
- Childhood obesity
- Asthma
- Preschool services for children with disabilities
Governor's Office of Children’s Care Coordination

- Medical home promotion and innovation (especially for foster care)
- DCS's relative caregiver programs
- Promoting CoverKids, integrated primary care and behavioral health, and enhance school-based health centers
- Education from Head Start to graduation for children with special needs
- Helping Tennessee develop an Early Intervention Insurance Initiative
- Children's System of Care, including assisting with designating funding
- Reimbursement of hearing aids for Children's Special Services
- Strengthen school and community partnerships

Some stakeholders described in more detail top opportunities or roles the GOCCC might consider for the benefit of children in Tennessee. Among other ideas, they suggested the office coordinate public and private entities to address the environmental, social, financial and personal factors that lead to poor health indicators; continue to facilitate a model for collaborative leadership between the state and external stakeholders; staff the Children’s Cabinet; create a strategic plan; and improve the Tennessee ranking in poor health outcomes.

The following are a few complete responses from the surveys (Duncan, B. 2008):

Many of the poor health indicators for children are a reflection of environmental, social, financial and personal factors--many of which are "touched" peripherally by each state department. To the extent that we as a state can collaborate to fully address these "social determinants of health" we have a much better chance of successfully improving our health outcomes. GOCCC could function as the lead to facilitate collaboration among state and local, public and private entities.

Continue to facilitate a model for shared leadership and dialogue between the state and partners; help identify and disseminate evidence-based best practices; identifying funding sources, and promoting comprehensive policies affecting children across the state, possibly staffing the Children's Cabinet.
Create a clear strategic plan and disseminate to other divisions and partners in the state. Move the Tennessee ranking in poor health outcomes. Find what is working and fix what is problematic and wasteful regarding programs funded by this office. Make a solid case to administration regarding the importance of this office.

**Key Accomplishments of the GOCCC**

The GOCCC’s overall accomplishments come from the office’s unique function as a coordinator of public and private entities to promise the health and well-being of Tennessee children and youth. The office has created mechanisms to ensure that evidence-based practices are utilized to the greatest extent possible in order to guarantee good outcomes for children, youth and their families. Under the *John B.* Consent Decree, the state must conduct medical and dental screenings of at least 80% of all children served by TennCare. As of this writing, the state currently reaches 82.4% of these children for medical screenings and 67% for dental screenings. (J. Napier, personal communication, February 18, 2009).

Below is a sampling of the GOCCC’s successes in each of its focus areas (*Reference Appendix B for a more complete catalog of the GOCCC’s accomplishments*):

**Early Periodic Screening, Diagnosis and Treatment (EPSDT) Program (TENNderCare)**

According to the Tennessee Department of Health’s Website, “EPSDT is a program of scheduled checkups and screenings for children 21 and under to detect and treat health problems. EPSDT checkups are FREE for all children who have TennCare” (Tennessee Department of Health, 2009). To that end, the GOCCC is successful at engaging departments, divisions, and key stakeholders to effectively communicate, cooperate, and coordinate the improvement of children's health across Tennessee.

Since the establishment of the GOCCC, the state has seen a substantial increase in EPSDT screening rates in physical and dental screenings due to the creation of workgroups,
subcommittees and GOCCC-EPSDT liaisons. These liaisons assist with communication, cooperation and coordination among the child-serving departments. (J. Napier, personal communication, February 18, 2009).

The GOCCC has been responsible for the continuation of the EPSDT Workgroups and Subcommittees, including the Enrollee Outreach Workgroup, Limited English Proficiency Subcommittee, Teen Subcommittee, Dental Subcommittee, Special Needs Subcommittee and Provider Participation Workgroup.

The GOCCC Steering Panel was created in October 2005 with two main goals:

- Bring together key stakeholders to identify and address systemic issues in the provision of coordinated services to children; and
- Bridge the gap between science and public policy, utilizing national experts as appropriate, to improve the provision of EPSDT/TENNderCare services.

These goals are met through didactic presentations, information sharing from participating departments and agencies, and when appropriate, through case-based discussions (GOCCC, Working Document 2, pp. 3-4).

**Women’s Health and Infant Mortality**

The three major causes of infant mortality are preterm birth and low birth weight, congenital abnormalities and SIDS. Preterm birth, however, is overwhelmingly the strongest predictor of infant mortality and the greatest influence on infant mortality in Tennessee. Infant mortality, preterm birth and low birth weight are primarily influenced by maternal health prior to and during pregnancy. In general, healthy mothers have a greater chance of giving birth to healthy babies. However, maternal health, as a manifestation of myriad “non-health” influences along a lifespan, could predispose a mother to preterm birth (McPheeters, 2009).
According to the Tennessee Department of Health, data from 2003 shows that the leading risk factor for infant mortality in Tennessee is prematurity, with a rate of 51 deaths per 1000 live births compared to only 3.4 deaths per 1000 live births among term babies (as cited in Gunn & Warren, 2008). In the Annie E. Casey Foundation’s *Kids Count* publication based on data from 2005, Tennessee was ranked 45th in the nation for infant mortality, 43rd for the percentage of preterm births, 43rd for low birth weight babies, 45th for births to teens and 37th for the proportion of mothers receiving late or no prenatal care (as cited in Gunn & Warren, 2008). From 1995 to 2000 both the national and Tennessee infant mortality rates declined, at which point rates became stable with a slight increase nationally. At the same time, rates in Tennessee increased and remained much higher than that national rate (McPheeters, 2008). Today, the national average infant mortality rate is 6.9 per 1000 live births, while Tennessee’s rate is 8.9 per 1000 live births (as cited in Gunn & Warren, 2008).

It is never acceptable for babies to die – and that is why innovative and forward-thinking work is being done to address infant mortality in Tennessee. In 2006, Gov. Bredesen identified the GOCCC to lead the state in an intensive, structured and coordinated effort to decrease the number of premature or low birth weight births and reduce infant mortality and disparities in infant mortality in Tennessee. A major focus of the initiative is improving the quality of access to prenatal care to promote the health of women of reproductive age before conception and thereby improve pregnancy-related outcomes. While the initiative targets maternal health in TennCare-eligible women, the goal of the initiative is to improve the health at birth of infants and make Tennessee a safer place to be born (GOCCC, Working Document 2, p. 2). This initiative has five guiding principles (McPheeters, 2009):

- Use data to inform strategy development
- Evaluate all efforts
- Develop partnerships to promote cooperation and collaboration
- Empower the community to drive initiatives and instigate change
- Implement evidence-based programs.

Far too few women nationally and in Tennessee access prenatal care early in pregnancy. While 83% of women in the U.S. seek prenatal care early, only 70% of women do so in Tennessee. The reasons for this are myriad, but one reason is likely the type of prenatal care available to them does not necessarily serve their needs. Tennessee has allocated more than $17 million across the state over the past two years for work that expands programs in health education, home visiting, enhanced clinical care for mothers and babies, and capacity building at the local level. The GOCCC is implementing EBPs and well-researched programs from around the country in communities throughout Tennessee and has developed a roadmap for systemic change (McPheeters, 2009).

The comprehensive approach to achieving GOCCC goals to reduce infant mortality includes the following ongoing efforts (GOCCC, Working Document 6, pp. 1-3):

- Reviewing regional and statewide data related to birth outcomes to identify target areas and inform intervention development and implementation efforts.
- In close collaboration with the Department of Health, establishing Fetal Infant Mortality Review (FIMR) teams to shore up infant mortality reduction efforts:
  - This summer a five-member team in Shelby County began studying the cause of 65 annual infant deaths and reviewed medical, social, environmental and nutritional factors that might have contributed.
  - Similar teams in Davidson and Hamilton Counties and 10 counties in East Tennessee are being planned for the future.
Funding Centering Pregnancy, an EBP model of group prenatal care programs, in Shelby (four sites), Monroe (one site) and Davidson (three sites) Counties Centering Pregnancy is an evidence-based model of group prenatal care that

- takes a different approach to prenatal care by bringing together a group of women for their prenatal visits rather than individual prenatal care by a health provider.
- has been shown to improve birth outcomes, decrease rapid repeat pregnancy, improve rates of breast feeding and increase attendance of prenatal care visits.

Policy Analysis

Among the responsibilities given to the GOCCC is analyzing public policy issues. Policy experts conduct critical reviews of program areas, administration and funding related to those policies and then, as appropriate, makes recommendations to restructure them to be more productive for children (M. Rolando, personal communication, February 11, 2009).

For example, at the request of the Department of Education commissioner in spring 2006, the GOCCC undertook a policy analysis of Tennessee’s Early Intervention System (TEIS) to examine ways in which the program might operate more efficiently and serve more children. At that time TEIS was a $34 million program governed by state rules and regulations and federal requirements of Part C of the Individuals with Disabilities Education Act (IDEA) as Payor of Last Resort. There were additional TennCare dollars and some resources of Children’s Special Services in the program (GOCCC, Working Document 4, p. 1).

The scope of the analysis was a comprehensive assessment of the service system, administration, and financing of the program. Among other recommendations to reform TEIS, the analysis resulted in administrative cost savings of $5.7M, creating nearly $5M to expend on early intervention services and a proposal to generate an estimated $10M of new revenue for developmental therapy (GOCCC, Working Document 4, p. 1).

Other projects include (GOCCC, Working Document 4, pp. 2-3).
Early Childhood Mental Health: the GOCCC hosted an initial meeting of professionals with interest or credentials in early childhood mental health who are trying to determine how they might advance communication among themselves and promote best practices relative to early childhood mental health issues.

Council on Children’s Mental Health: the GOCCC compiled the initial report to the Legislature required by P.C.1062 and serves in leadership roles in the Council and Workgroups.

Resource Mapping: the GOCCC has leading roles in the implementation of P.C. 1197, which requires the state to identify and quantify publicly-funded children’s services with an annual report of the findings to the Legislature as the end product.

Developmental Therapy: at the request of the Department of Education (DOE), the GOCCC is working with staff to develop a plan for the provision of developmental therapy as a TennCare reimbursable service, estimated to be $10M in new federal dollars.

**Tennessee Adolescent Coordination of Treatment (T-ACT) Project**

T-ACT is a DHHS/SAMHSA-funded infrastructure grant to improve the publicly-funded substance abuse treatment system for Tennessee adolescents. The T-ACT Principal Investigator who works at the GOCCC is responsible for providing leadership, guidance and oversight of grant activities and staff as well as to direct day-to-day operations of T-ACT management, delegating responsibilities, and serves as the grant’s spokesperson (S. Shapiro, personal communication, March 18, 2009).

The GOCCC has frequently been approached by departments for problem solving. A recent accomplishment was helping a small agency navigate the TennCare reimbursement process to quickly achieve an expedited reimbursement, when they were struggling to make payroll for their staff due to the down economy and a reduction of charitable donations. The office has the expertise and wide-reaching contacts to take on problems that may be too involved or outsized for an agency to manage. As part of T-ACT’s Substance Abuse Collaborative, the GOCCC has access to the documentation of Tennessee’s spending for treatment of adolescent...
substance abuse and can report back its analysis to relevant agencies to help them think critically and strategically about how funds are currently being spent, gain consensus as to how they would like the system to actually look, and move forward on a plan to shift from the current service provision to the identified more aspirational one (S. Shapiro, personal communication, March 18, 2009).

**Centers of Excellence for Children in Custody**

The state's Centers of Excellence (COEs) for Children in State Custody, under the GOCCC, typically work with at-risk children or children in custody who have complex behavioral and medical problems and provide direct services to these children including psychiatric and psychological evaluations and medication management. There are approximately 10,000 children in state custody at any given time. Children in state custody receive health care coverage from TennCare, Tennessee's expanded Medicaid program serving 1.2 million Tennesseans including approximately 640,000 children (K. Mallory, personal communication, March 12, 2009).

Through treatment plan review and development, case consultation and coordination with the Department of Children's Services and TennCare providers, and routine on-site case review, the COEs provide extra attention to seriously troubled youth in the state's care. For children with complicated medical problems, the COEs coordinate referrals and services to medical subspecialties and hospital services to meet the child's needs (K. Mallory, personal communication, March 12, 2009).

The COEs have been recognized by the American Psychiatric Association as one of the top four innovative programs serving children in the United States. The COEs currently reside at Vanderbilt University Medical Center, University of Tennessee-Memphis Boling Center,
University of Tennessee- Knoxville, East Tennessee State University Medical Center and the Focus Psychiatric Services, PC (K. Mallory, personal communication, March 12, 2009).

In 2006, TennCare funded an additional $1 million to expand the State's Centers of Excellence for Children in State Custody to help youth in state custody or at-risk for entering state custody. As an invaluable resource for these children, the COEs expansion was able to provide specific therapy and extra attention for troubled children (K. Mallory, personal communication, March 12, 2009).

**Comparison to Programs in Other States**

As stated above, the GOCCC may face some challenges in the future attributable to changes in the state’s executive leadership. In determining what the GOCCC might look like over the next five years, it is beneficial to look to some other states for comparison and information.

According to the Forum for Youth Investment, a nonprofit, nonpartisan organization dedicated to helping communities and the nation make sure all young people are ready for college, work and life by age 21, there are currently 16 state Children’s Cabinets and seven other high level coordinating bodies (State Councils, Commissions, Collaborations and Committees) for children. Governor’s Children’s Cabinets are collaborative governance structures that seek to promote coordination across state agencies and improve the well-being of children and families (E. Gaines & D. Evennou, personal communication, May 8, 2009).

A Children’s Cabinet can be instrumental in helping a governor institutionalize major reforms in delivering services to children and their families and building the groundwork for improving the effectiveness and efficiency of state systems over time. If a goal is to leave these efforts as a legacy to the state, a governor can seek to establish the Cabinet through legislation to
ensure continuation beyond his term in office. Legislation can help cement the Cabinet’s composition, goals and objectives for the long-term and ensure some degree of continuity even as governors and state leaders change (GOCCC, Working Document 1, p. 2).

A strong and effective Children’s Cabinet can improve coordination and efficiency across the state departments and local levels of government; mobilize resources around the governor’s priorities for children; facilitate a holistic approach to serving children; and strengthen partnerships with non-profit and private sectors. A Children’s Cabinet typically involves senior state officials and representatives of key stakeholders from the private sectors (GOCCC, Working Document 1, p. 2).

A Children’s Cabinet develops and implements a shared vision across a state’s agencies for improving child and family outcomes. This group becomes a mechanism to bring senior officials from various agencies together to overcome controversial issues, identify common goals and establish clear objectives with outcomes. A Children’s Cabinet also (GOCCC, Working Document 1, pp. 2-3):

- Facilitates cross-agency collaboration, improves coordination among policies and programs and ensures easier access to multiple services for families and children
- Improves the state’s economy and prospects for competition in the global marketplace by investing in the education and skills of children, the state’s future workforce
- Fosters public awareness of major children’s issues
- Helps raise the profile of children and families as key priority
- Engages new partners in public efforts to serve children and their families
- Creates energy beyond government and draws broader attention to major child and family issues by involvement of private sector and families
- Builds a long-term commitment to children’s issues and well-being in the state
Governor’s Office of Children’s Care Coordination

The following list provides general guiding principles for a Children’s Cabinet (GOCCC, Working Document 1, p. 3):

- Gubernatorial leadership is critical for success
- It must have a clear mission and specific objectives and measurable outcomes
- Cabinet members must share a high level commitment
- Cabinet should have dedicated staff
- It should consider including the private sector, which can foster a wider sense a shared responsibility for achieving Cabinet goals
- Cabinet members and staff should regularly solicit the public’s input and consider it seriously.
- The real measure of a successful Children’s Cabinet is the improved outcomes for the children and families on which it focuses.

A Children’s Cabinet assumes the following duties (GOCCC, Working Document 1, p. 3):

- Creating strategic plans about children’s issues and policies for the state.
- Setting goals with measurable outcomes for their member agencies to achieve.
- Making funding and policy recommendations to the governor.
- Pooling diverse funding streams to improve service deliver across agencies or leveraging new resources to support children’s initiatives.
- Setting policies, tracking outcomes and providing technical assistance to local and state government, and/or distributing and overseeing grants to local initiatives or organizations.

The Tennessee Governor’s Children’s Cabinet was created by executive order in 2003 in response to calls for coordination of state services for children during the gubernatorial campaign. Similar to other Children’s Cabinets, its membership includes the commissioners of child-serving agencies, including the Departments of Children’s Services, Health, Mental Health
and Developmental Disabilities, Education, Human Services, Mental Retardation Services, Bureau of TennCare, and Tennessee Commission on Children and Youth and the Select Committee on Children and Youth Executive Directors. The GOCCC and two community stakeholders are also members. It is chaired by the assistant to the governor for special projects. The Governor’s Children’s Cabinet is a diverse group of political officials and key stakeholders that can direct resolutions to issues that are in disagreement by two or more child-serving departments when coordination is necessary to resolve the situation for children and families (Gaines et al, 2007, p. 26).

According to the State Children’s Cabinets and Councils 2008 Directory, the states of Maine, New Mexico, and Ohio have well-established Children’s Cabinets. The table on the next two pages illustrates the approach they have taken to promote coordination across state agencies and improve the well-being of children and families in these states (Gaines et al, 2007, pp. 15-25).
<table>
<thead>
<tr>
<th><strong>Maine Governor’s Children’s Cabinet</strong></th>
<th>History</th>
<th>Leadership</th>
<th>Membership</th>
<th>Mission</th>
<th>Areas of Focus</th>
<th>Accomplishments</th>
<th>Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>1995 established by executive order</td>
<td>Governor John Elias Baldacci and First Lady Karen Baldacci, co-Chairs</td>
<td>Commissioners of five child-serving departments (Education, Health and Human Services, Public Safety, Corrections and Labor) two senior policy advisors in the Office of the Governor; executive and senior staff as well as citizen stakeholders.</td>
<td>To provide cross-agency coordination, and program and policy development with a common mission -- to measurably improve the well being of Maine’s children, youth, and families through evidence-based practices and strength-based approaches to positive child and youth development</td>
<td>Early Childhood Youth in Transition Adverse Childhood Experiences (ACE)</td>
<td>Ability to solve systems challenges and barriers to effective services. Maximizing and consolidating resources State plan to create humane systems for families and parents of young children. Engaged more youth and families in decision-making and policy-development.</td>
<td>Cabinet receives most funding from private and federal grant administrative fees. Private funding is needed for special initiative sand programs that state is unable to support.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>New Mexico’s Children’s Cabinet</strong></th>
<th>History</th>
<th>Leadership</th>
<th>Membership</th>
<th>Mission</th>
<th>Areas of Focus</th>
<th>Accomplishments</th>
<th>Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003 established by executive order</td>
<td>Lt. Governor Denish, Chair</td>
<td>Secretaries of 15 departments (Public Education, Health, Human Services, Children, Youth and Families, Aging and Long Term Care, Corrections, Public Safety, Economic Development, Labor, Finance and Administration, Workforce Solutions, Cultural Affairs, Indian Affairs, Taxation and Revenue), legislative and community partners</td>
<td>The need for closer coordination and cross departmental communication between all state agencies charged with addressing the needs of our children to ensure that we are maximizing results for our children</td>
<td>Health, education, safety, support and involvement</td>
<td>Development of a statewide youth alliance that provides an avenue for positive youth engagement. Development of a clear report card and budget analysis accessible to the public. Legislative successes such as the passage of the New Mexico Pre-K Act, establishment of the Next Generation Fund and school based health centers in all of the counties, and high school reform.</td>
<td>New Mexico Children, Youth and Families department is fiscally responsible for the operational costs of the Cabinet.</td>
<td></td>
</tr>
<tr>
<td><strong>Ohio Family and Children First (OFCF) Cabinet</strong></td>
<td><strong>History</strong></td>
<td><strong>Leadership</strong></td>
<td><strong>Membership</strong></td>
<td><strong>Mission</strong></td>
<td><strong>Areas of Focus</strong></td>
<td><strong>Accomplishments</strong></td>
<td><strong>Funding</strong></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Codified by statute in 1993 following a cluster model and piloting local Family and Children First Councils. In addition, a 2007 Executive Order established the Early Childhood Cabinet which works in partnership with the OFCF Cabinet.</td>
<td>First Lady Frances Strickland</td>
<td>Cabinet Council includes: seven Directors of children and family serving state agencies (Alcohol and Drug Addiction, Education, Health, Job and Family Services, Mental Health, Mental Retardation and Developmental Disabilities, Youth Services), two Health and Human Services representatives from the Governor’s Office.</td>
<td>Purpose is to partner with state and local government, communities and families to improve the well being of children and families through strategic coordination of resources.</td>
<td>Four core functions are to build community capacity; coordinate systems and services; engage and empower families; and share accountability with OFCF’s vision of improving child well-being.</td>
<td>Cabinet transitioned after a gubernatorial change and are refocusing successfully. Passage of the House Bill 289: Mandated annual planning and reporting on child and youth well-being. Ensures accountability at the state and local levels and increases efforts to improve child well-being. Building stronger internal structure within the Cabinet and the local FCF councils. County level connections and successes will contribute to the continuation of the Cabinet Council.</td>
<td>Cabinet funded through a general fund and a line item in the legislative budget. Cabinet to support specific initiatives.</td>
<td></td>
</tr>
</tbody>
</table>
Recommendations for Increasing Effectiveness

This overview of the GOCCC’s function, relationship to state government and numerous accomplishments illustrates the office’s unique role and success as a neutral agency that supports Tennessee’s child-serving departments in coordinating care for the state’s children and youth. With a gubernatorial election approaching, however, the state’s elected officials will need to decide the future of the GOCCC. As demonstrated above, there is no question that the existence of the GOCCC has dramatically improved health systems for Tennessee’s children and youth. To dismantle this office would be a disservice to the State of Tennessee. The recommendation is that the GOCCC become the staffing structure of the state’s Children’s Cabinet. The alternative is for the GOCCC to remain in its current position as an arm of the governor.

The GOCCC could transition its role from a neutral point of coordination to a significant component of a more robust children’s cabinet. If the current Children’s Cabinet absorbed the GOCCC, the office’s core strengths could bolster the Children’s Cabinet with its expertise in working with multiple agencies, research and academic documentation and managing special projects. It would continue to facilitate a model for shared leadership and dialogue among state and current partners, help identify and disseminate EBPs and promote comprehensive policies affecting children across the state. This new, stronger Children’s Cabinet would become a proactive, problem-solving entity that sets priorities and budgets as it expands to work with new partners to strengthen collaboration in Tennessee for children’s health.

To be sure, this new Children’s Cabinet would be stronger if it were established by statute instead of executive order. The executive order approach ensures the governor’s control over making appointments and establishes a direct link with governor’s office. Moreover, it allows the governor to establish the cabinet swiftly with fewer administrative or political issues
than with legislation. However, one disadvantage to an executive order is that the Children’s Cabinet and its initiatives or policy agenda may become associated with the founding governor. As a result the governor may not be able to preserve the legacy of the Cabinet’s work after his term ends. Thus, the future of the GOCCC rests with the will of the next governor (M. Warren, personal communication, March 10, 2009).

The GOCCC has carried out the essential work of improving EPSDT, implementing EBPs to reduce infant mortality across the state through programs that focus on women’s health, analyzing current health policy and making recommendations for improvement, strengthening the infrastructure focused on reducing substance abuse by Tennessee youths, and developing the services provided by the Centers of Excellence for Children in State Custody. Buttressed by staff from the current GOCCC, a new and expanded Children’s Cabinet would have more resources and more responsibility to supply research, needs assessments, policy analysis and grants management. By providing a common focus, the Cabinet could assist member departments with streamlining services and making more efficient use of funds to each area. Staff members would represent the Cabinet across the state, leading town hall meetings or other public forums to collect information and enhance public will for the Cabinet’s efforts. They would also provide support and technical assistance to Cabinet and local initiatives (B. Duncan, personal communication, February 3, 2009).

Ultimately, the goals the Governor’s Office of Children’s Care Coordination and the Governor’s Children’s Cabinet are the same: to align policies and programs, improve systems, remove barriers to effective services, engage youth and families in decision making and policy development and, finally, improve outcomes for the children and families on which it focuses. By including the private sector and other key stakeholders in the community, the Cabinet would
foster a wider sense of shared responsibility for achieving its goals. It is crucial to evaluate the GOCCC’s effectiveness over the past five years – to understand the impact it has made on the children on Tennessee – and decide what the next five years are going to look like. Our future depends on it.
Report Follow-up

When the above report was delivered in May 2009 to Director of the GOCCC, Bob Duncan, he and his staff reviewed its content. Other than some language changes for legal purposes that relate to the consent decree, the GOCCC staff had no modifications and were pleased with the report’s content. Next, Mr. Duncan presented the report to Gov. Bredesen and his senior staff, known as the First Circle. This group includes the governor, the governor’s assistant for special projects, his public information officer, his chief legislative aide and the deputy governor. Mr. Duncan delivered a verbal presentation, providing highlights of the report, the GOCCC’s accomplishments, its current state and potential changes for the future. Additionally, Mr. Duncan provided everyone with a copy of the report (B. Duncan, personal communication, October 28, 2009).

The First Circle also responded positively to the report. The governor and his team were pleased with the GOCCC’s work and were, moreover, pleasantly surprised by the depth and breadth of the GOCCC’s scope of work. They agreed with the recommendation for a legislatively mandated Children’s Cabinet, but suggested that it would not be possible to move forward any time soon given the current political and economic environment in Tennessee. The most recent state elections pushed the Tennessee State House and Senate to become Republican – this is the first time both have been Republican since before the Civil War. The current political environment in the General Assembly and the nation-wide budget crisis would not support this legislative mandate. In fact, the group suggested that the governor refrain from submitting such a request to the house and senate for the rest of his term for fear that placing a spotlight on the GOCCC could force too much attention on the office and face the possibility of being cut in the wake of the financial downturn. In fact, this past legislative session the house
and senate nearly decided to cut the GOCCC completely out of the state budget, but Mr. Duncan was able to avert the red pen (B. Duncan, personal communication, October 28, 2009).

The next legislative session, which begins in January 2010, is crucial. It is imperative that the GOCCC survive the budget slashes until June. At that point, all political matters will be in a holding pattern until the gubernatorial primary elections in August. After the Democratic and Republican candidates are nominated, Bob will meet with each of them to discuss future plans. Once the new governor is elected, Bob will assist with the transition and work with the new governor to choose to continue Gov. Bredesen’s Executive Order, write a new Executive Order for a GOCCC or recommend the legislative mandate of the Children’s Cabinet to the General Assembly (B. Duncan, personal communication, October 28, 2009).

Ultimately, Mr. Duncan expects the report’s recommendations will be followed in the future. He has met with all but one of the gubernatorial candidates and they are on board with the continuation of the GOCCC and, most likely, a legislative mandate. He thinks Bill Haslam, the current Mayor of Knoxville and a moderate Republican, will probably be Tennessee’s next governor. Mr. Duncan suspects that Mr. Haslam will want to push the for the General Assembly to green light a plan for the GOCCC to become the working body of the Children’s Cabinet and the legislative mandate for the Children’s Cabinet (B. Duncan, personal communication, October 28, 2009).

**Conclusion**

The GOCCC is an example of what happens when a governor within the state structure does something outside the legislative process. One of the challenges to entities like the GOCCC is their tie to term limits. The assumption is that the new governor will dismantle the GOCCC because he or she did not create it.
As the author of the above report, I was surprised when Bob Duncan informed me that the GOCCC would probably survive the 2010 gubernatorial election. During our first conference call in February 2009, Mr. Duncan was pessimistic about the future. He and Gov. Bredesen believed the report to be their final effort to help the GOCCC endure a new administration. With each interview I conducted for the report, that pessimism was reinforced by GOCCC staff members who also conveyed little hope for the future.

Throughout this process the questions that occurred to me in light of the political environment in which public health entities like the GOCCC must reside were equally pessimistic:

- What happens to the policies, programs and decisions governors establish after they have served their terms and leave office?
- How do we as a society sustain the programs that are making a difference once their champions have been replaced?

As a result of writing this report, I became cynical about the democratic process too. I wanted to understand how to sustain the good that public health does in a democratic structure that puts change on a pedestal despite the positive results of the status quo.

For the time being, I can rest assured that the GOCCC will indeed endure the democratic process. To be sure, Mr. Duncan has a long year ahead of him. He must shield the GOCCC from budget cuts by an unfriendly state legislature and navigate the GOCCC through a gubernatorial transition. If successful, he will lead the GOCCC through what will likely be a difficult legislative process to establish a children’s cabinet and transform the GOCCC from independent entity to the staffing structure of Tennessee’s Children’s Cabinet. Gov. Bredesen and his successor will support him, but as the GOCCC’s leader, Mr. Duncan will undoubtedly engage in several legislative hearings and negotiations which will require him to corral his problem
solving, negotiating and motivational skills. Having created a vision and having already begun aligning people, he will need to motivate and inspire others to share the innovation and courage needed to produce change for the future (Upshaw, V., 2006, slide 8).
References


Governor’s Office of Children’s Care Coordination (2008-09). Working Document 1. Nashville, TN. Received via email February 2, 2009 from Melissa McPheeters, PhD.

Governor’s Office of Children’s Care Coordination (2008-09). Working Document 2. Nashville, TN. Received via email February 2, 2009 from Melissa McPheeters, PhD.

Governor’s Office of Children’s Care Coordination (2008-09). Working Document 3. Nashville, TN. Received via email February 2, 2009 from Melissa McPheeters, PhD.

Governor’s Office of Children’s Care Coordination (2008-09). Working Document 4. Nashville, TN. Received via email February 2, 2009 from Melissa McPheeters, PhD.

Governor’s Office of Children’s Care Coordination (2008-09). GOCCC Working Document 5. Nashville, TN. Received via email April 24, 2009 from Melissa McPheeters, PhD.


Appendix A:

GOCCC Organizational Chart
Tennessee Governor’s Office of Children’s Care Coordination

Governor of Tennessee

Director of GOCCC

Office Manager/Executive Administrative Assistant

Director, Women’s Health

Coordinator, Early Period Screening, Diagnosis and Testing (EPSDT)

Coordinator, Centers of Excellence for Children in State Custody

Policy Analyst

P.I., Tennessee Adolescent Coordination of Treatment (T-ACT)

CDC Fellow

Administrative Assistant, T-ACT
Appendix B:

Complete Catalog of the GOCCC’s Accomplishments
Accomplishments of the GOCCC

The GOCCC’s overall accomplishments come from the Office’s unique function as a coordinator of public and private entities to assure the health and well-being of Tennessee children and youth. The Office has created mechanisms to ensure that evidence-based practices are utilized to the greatest extent possible in order to ensure good outcomes for children, youth and their families. Under the John B. Consent Decree, the state must conduct medical and dental screenings of at least 80% of all children served by TennCare. As of this writing, the state currently reaches 82.4% of these children for medical screenings and 67% for dental screenings.

Below is a sampling of the GOCCC’s successes in each of its focus areas:

Early Period Screening, Diagnosis and Testing (EPSDT)

According the Tennessee Department of Health’s Website, “EPSDT is a program of scheduled checkups and screenings for children 21 and under to detect and treat health problems. EPSDT checkups are FREE for all children who have TennCare” (Tennessee Department of Health, 2009). To that end, the GOCCC is successful at engaging departments, divisions, and key stakeholders to effectively communicate, cooperate, and coordinate the improvement of children’s health across Tennessee.

Since the implementation of the GOCCC, the state has seen a substantial increase in EPSDT screening rates in physical and dental screenings due to the creation of workgroups, subcommittees and GOCCC-EPSDT liaisons. These liaisons assist with communication, cooperation and coordination among the child-serving departments.

The GOCCC has been responsible for the continuation of the EPSDT Workgroups and Subcommittees, including the Enrollee Outreach Workgroup, Limited English Proficiency Subcommittee, Teen Subcommittee, Dental Subcommittee, Special Needs Subcommittee and Provider Participation Workgroup.

The GOCCC Steering Panel was created in October 2005 with two main goals:

- Bring together key stakeholders to identify and address systemic issues in the provision of coordinated services to children; and

- Bridge the gap between science and public policy, utilizing national experts as appropriate, to improve the provision of EPSDT/TENNderCare services

These goals are met through didactic presentations, information sharing from participating departments/agencies, and when appropriate, through case-based discussions.

The following initiatives and projects illustrate the GOCCC’s successes in the area of EPSDT:

Maplewood Health Panthers Pilot Project

The Maplewood Healthy Panthers Pilot Project began on March 31, 2008 and was completed on May 20, 2008. United Neighborhood Health Services (UNHS), AmeriChoice and the GOCCC collaborated to implement the program at a Metropolitan Nashville Public School, Maplewood
Comprehensive High School (MCHS), to increase EPSDT/TENNderCare outreach and screenings. The goal of the project was to conduct 100 EPSDT/well-child screenings before the end of the school year.

The initial strategy focused on creating awareness at the school of the availability of services and offering students incentives for completing an EPSDT screenings. AmeriChoice staff set up a table in the cafeteria where they signed up students for screenings and distributed parent consent forms. AmeriChoice staff gave out pens, lanyards, and back packs as incentives for students signing up. When students successfully completed an EPSDT/TENNderCare screening, they received additional incentives: a choice of either a movie ticket or a pass to a skating rink, and an entry into a raffle for an iPod. The class with the highest number of completed screenings would win a trophy to be presented to the principal at the end of the school year.

At the completion of the pilot project, 95 students completed screenings. They were performed through a UNHS school-based clinic and the UNHS mobile clinic. The grade level breakdown for screenings was eighth grade: 11; ninth grade: 18; tenth grade: 30; eleventh grade: 23; twelfth grade: 13. Although this approach is resource intensive, direct contact is needed to bring the hardest to reach students to the clinic who otherwise would not be screened or would forget their EPSDT/TENNderCare appointments. UNHS will continue this model in coordination with the AmeriCorps workers at the beginning of the next school year in the UNHS clinics located in Metropolitan Nashville Public High Schools.

**Act Early Summit Region IV Autism Summit, Jan 8-9, 2009**

The GOCCC has a leadership role in the state’s Act Early Summit team at the beginning of 2009, a joint project of the CDC and the Association of University Centers on Disabilities (AUCD). The Act Early Regional Summit Project started in January 2009 in the southeastern region and brought together key state leaders from the early intervention and early childhood community for the purpose of enhancing relationships and collaborations among key stakeholders. Providing a forum to share information and insights on the opportunities, challenges, and barriers for families and children with Autism Spectrum Disorders and related developmental disabilities in the identification, assessment, diagnosis and treatment areas, the team has been convened and is developing their next steps in specific areas of family support, media campaign, TEIS, and training. In addition, on behalf of TEIS, the GOCCC implemented a set of surveys to identify training needs for those working with infants and toddlers with autism spectrum disorders. The results of the surveys will strengthen the team’s efforts to enhance services for children with special needs.

**Child Health Week**

The GOCCC developed a planning committee comprised of key stakeholders from the Governor’s Office, TennCare, CoverKids, Department of Health, Department of Education-Coordinated School Health, TNAAP, Children’s Hospital Alliance of Tennessee and United Ways of Tennessee to serve as a clearinghouse for Tennessee’s first-ever Child Health Week (CHW). Governor Phil Bredesen, along with many of Tennessee’s mayors, issued an official proclamation to identify October 13-19 Child Health Week in Tennessee. The GOCCC created sample op-eds, articles, talking points and resources for partners such as schools, health care providers, state agencies and others to disseminate in promoting Child Health Week 2008.
Throughout the week partners across the state participated in CHW, including fitness events, health and dental screenings, nutrition, cooking demonstrations, classroom activities, media outreach, CoverKids and TENNderCare enrollment events. First Lady Andrea Conte participated in a walk and fresh fruit distribution at a Nashville-area school. A Public Service Announcement on CHW and the prevention of childhood obesity was shown at the University of Tennessee football game and a Vanderbilt University basketball game. Groups such as the Tennessee Chapter of the American Academy of Pediatrics and the Tennessee Public Health Association included articles about CHW and childhood obesity prevention in their newsletters. All of this was completed by partners across the state without additional state funding. The work of the planning committee and its partners culminated in a weeklong celebration of children’s health, spanning 63 counties, with over 230 activities. According to reports received from participating organizations, CHW events reached over 35,000 children and families in Tennessee. An estimated minimum of 450,000 individuals were reached through mass media efforts to improve the health of children and families.

Collaborative for Sexual Behavior Problems (CSBP)
The GOCCC, in collaboration with the Tennessee Department of Children’s Services, TennCare, Tennessee Department of Mental Health and Developmental Disabilities, Tennessee Commission on Children and Youth, Tennessee Association of Mental Health Organizations (TAMHO), Child Advocacy Centers, Administrative Office of the Courts, MCOs, private agencies and other stakeholders developed the CSBP, a collaborative to ensure that Tennessee has a prevention, assessment and treatment network that promotes community safety while meeting the treatment needs of children ages 12 and under with sexual behavior problems.

This group of children has been recently identified as a growing population and the collaborative is implementing multiple steps to meet their goals. First, information will be gathered from providers and other stakeholders to identify the needs of these youth and to survey existing services for children with sexual behavior problems and provider needs. Next, the collaborative will identify EBPs to implement with children with sexual behavior problems. Finally, the collaborative will develop and submit ideas for enhancement of the service array.

Women’s Health and Infant Mortality
The three major causes of infant mortality are prematurity and low birth weight, congenital abnormalities and SIDS. Preterm birth, however, is overwhelmingly the strongest predictor of infant mortality and the greatest influence on infant mortality in Tennessee. Infant mortality, preterm birth and low birth weight are primarily influenced by maternal health prior to and during pregnancy. In general, healthy mothers have a greater chance of giving birth to healthy babies. However, maternal health, as a manifestation of myriad “non-health” influences along a lifespan, could predispose a mother to preterm birth.

According to the Tennessee Department of Health, data from 2003 shows that the leading risk factor for infant mortality in Tennessee is prematurity, with a rate of 51 deaths per 1000 live births compared to only 3.4 deaths per 1000 live births among term babies. In the Annie E. Casey Foundation’s Kids Count publication based on data from 2005, Tennessee was ranked 45th in the nation for infant mortality, 43rd for the percentage of preterm births, 43rd for low birth weight babies, 45th for births to teens and 37th for the proportion of mothers receiving late or no
prenatal care. From 1995 to 2000 both the national and Tennessee infant mortality rates declined, at which point rates became stable with a slight increase nationally. At the same time, rates in Tennessee increased and remained much higher than that national rate. Today, the national average infant mortality rate is 6.9 per 1000 live births, while Tennessee’s rate is 8.9.

It is never acceptable for babies to die – and that is why innovative and forward-thinking work is being done to address infant mortality in Tennessee. In 2006, Gov. Bredesen identified the GOCCC to lead the state in an intensive, structured and coordinated effort to decrease the number of premature or low birth weight births and reduce infant mortality and disparities in infant mortality in Tennessee. A major focus of the initiative is improving the quality of access to prenatal care to promote the health of women of reproductive age before conception and thereby improve pregnancy-related outcomes. While the initiative targets maternal health in TennCare-eligible women, the goal of the initiative is to improve the health at birth of infants and make Tennessee a safer place to be born. This initiative has five guiding principles:

- Use data to inform strategy development
- Evaluate all efforts
- Develop partnerships to promote cooperation and collaboration
- Empower the community to drive initiatives and instigate change
- Implement evidence-based programs

Far too few women nationally and in Tennessee access prenatal care early in pregnancy. While 83% of women in the U.S. seek prenatal care early, only 70% of women do so in Tennessee. The reasons for this are myriad, but one reason is likely the type of prenatal care available to them does not necessarily serve their needs. Tennessee has allocated more than $17 million across the state over the past two years for work that expands programs in health education, home visiting, enhanced clinical care for mothers and babies, and capacity building at the local level. The GOCCC is implementing EBPs and well-researched programs from around the country in communities throughout Tennessee and has developed a roadmap for systemic change.

The comprehensive approach to achieving GOCCC goals to reduce infant mortality includes the following ongoing efforts:

- Reviewing regional and statewide data related to birth outcomes to identify target areas and inform intervention development and implementation efforts.
- In close collaboration with the Department of Health, establishing Fetal Infant Mortality Review (FIMR) teams to shore up infant mortality reduction efforts:
  - This summer a five-member team in Shelby County began studying the cause of 65 annual infant deaths and reviewed medical, social, environmental and nutritional factors that might have contributed.
  - Similar teams in Davidson and Hamilton Counties and 10 counties in East Tennessee are being planned for the future.
Governor’s Office of Children’s Care Coordination

- Funding Centering Pregnancy, an EBP model of group prenatal care programs, in Shelby (4 sites), Monroe (1 site) and Davidson (3 sites). Centering Pregnancy is an evidence-based model of group prenatal care that
  - takes a different approach to prenatal care by bringing together a group of women for their prenatal visits rather than individual prenatal care by a health provider.
  - has been shown to improve birth outcomes, decrease rapid repeat pregnancy, improve rates of breast feeding and increase attendance of prenatal care visits.

The GOCCC’s underlying approach is to empower communities to make the changes that will work in the lives of their citizens. Three community leadership groups in Shelby, Hamilton and Davidson counties are coordinating efforts in their respective counties, working closely with the GOCCC to identify and implement community-based and clinical programs. These counties were selected because they represent areas of highest infant mortality rates. The process brings to the table the thought leaders and go-getters in each community – people working hard to improve health and health care, but who might not usually interact. They encourage and review grants from within the community and recommend what should be funded. Each grant funded is required to include an evaluation component, which will allow us to identify what works in Tennessee and to share that information across the state and nation.

The comprehensive approach to achieving the GOCCC’s goals to reduce infant mortality includes the following accomplished projects and ongoing efforts:

- The GOCCC continues to review regional and statewide data related to birth outcomes to identify target areas and to inform intervention development and implementation efforts.
- Continues to work closely with the Department of Health, to raise awareness of the infant mortality initiative and to develop partnerships with other agencies and institutions to improve birth outcomes across Tennessee.
- Provides support and oversight to Infant Mortality Core Leadership Groups, composed of the key stakeholders from the academic, service, advocacy, faith, and business communities, in Shelby, Davidson, and Hamilton Counties.
- Provides support, funding, and oversight to the Infant Mortality Coordinators of Hamilton, Davidson, and Shelby Counties, who focus on the infant mortality initiative on a full-time basis and coordinate activities at the local level in conjunction with the GOCCC.
- In close collaboration with the Department of Health is establishing Fetal Infant Mortality Review (FIMR) teams to shore up infant mortality reduction efforts:
  - This summer a five-member team in Shelby County will begin studying the cause of 65 annual infant deaths and review medical, social, environmental and nutritional factors that might have contributed.
  - Similar teams in Davidson and Hamilton Counties and 10 counties in East Tennessee are being planned for the future.
- Issued a one-year grant to UT Health Science Center in Memphis for the Health Loop Clinics of Shelby County to update obstetric equipment to increase service capacity.
Issued a five-year grant to UT Health Science Center in Memphis for the Health Loop Clinics of Shelby County to improve prenatal care service capacity and quality and implement an evidenced-based, group-care prenatal program called Centering Pregnancy. Centering Pregnancy has demonstrated to increase patient satisfaction of prenatal care, increase attendance at prenatal care appointments, and improve birth outcomes of participants.

The GOCCC issued a four-year grant to University Community Health Services to provide clinical services in the areas of prenatal care and other obstetric and gynecological women’s health services at the Vine Hill Clinic in Davidson County. This clinic serves a target population of low-income pregnant and parenting women with the goal to improve prenatal care and psychosocial programs that result in improved birth outcomes.

The GOCCC issued a four-year grant to United Way of Tennessee to provide personnel to develop specific community-based opportunities to improve prenatal care and psychosocial programs to improve birth outcomes.

The GOCCC issued a four-year grant to ETSU to implement an evidenced-based smoking-cessation program called the “5A Model” for 4200 women in Northeast Tennessee, where rates of smoking during pregnancy are near 40%. This model has been shown to improve smoking cessation rates by 30-70%. In addition, the grantee shall provide case management services to 2100 women enrolled in the program for the support of smoking cessation efforts, to increase prenatal care utilization and access to other needed services, and to support the reduction of life stressors including domestic violence and depression.

Changes in infant mortality rates will not be immediate – these efforts always take time. However, the GOCCC is encouraged by the positive response among women to the new prenatal care approaches, by the energy with which community leaders are taking the new information they learn into their streets, by the commitment of our health system to implementing cutting-edge care, and by a statewide commitment to identifying and putting into place evidence-based practices.

**Centering Pregnancy**

Centering Pregnancy is an evidence-based model of group prenatal care. The GOCCC funds Centering Pregnancy programs in Shelby (4 sites), Monroe (1 site) and Davidson (1 site) Counties and plans to fund additional sites in Davidson and Hamilton counties in the near future.

Rather than individual prenatal care by a health provider, Centering Pregnancy takes a different approach to prenatal care by bringing together a group of women for their prenatal visits. The visit, which is a two-hour session, consists of one-on-one time with the provider – and individual check up performed by the provider, self-care time, when women measure and record their own weight, blood pressure and gestational age; and educational group time. During group time, the group meets with the provider to discuss topics such as stress reduction, nutrition, exercise, infant care and other perinatal health issues.

Centering Pregnancy provides benefits for mothers-to-be as well as policy makers and managed care organizations. For mothers, Centering cultivates a social support network for pregnant
women, supports development of parenting skills and improves satisfaction with prenatal care. For MCOs, the Centering has been shown to improve birth outcomes, decrease rapid repeat pregnancy, improve rates of breast feeding and increase attendance of prenatal care visits.

To date, one state-funded site is fully functioning and six groups of mothers (approximately 50 mothers) have gone through the program. They report extremely high levels of satisfaction with the program, have elevated attendance rates for prenatal visits (nearly 100%), have had good health outcomes, and have much higher than usual return rates for the postpartum visit.

Tennessee Initiative for Perinatal Quality Care (TIPQC)
In an ideal world, no baby would be born too early or have life-threatening medical conditions. But when it does happen, we have to be prepared to provide the best quality of medical care to our most vulnerable citizens. Tennessee is one of a few states in the country engaging in a unified and concerted effort to implement quality improvement in neonatal intensive care units across the state. This level of collaboration and commitment to quality improvement is being seen as a model for other states and they are watching closely to see how we implement it and with what success.

TIPQC (Tennessee Initiative for Perinatal Quality Care), funded by the GOCCC, is a statewide quality improvement initiative to reduce mortality and morbidity associated with premature birth and low birth weight. This collaborative is creating a system to support and encourage the adoption of a set of proven, EBPs at neonatal intensive care units across the State. These are practices known to increase the chance of premature and sick babies surviving. They include practices like making sure every woman in preterm labor gets antenatal steroids – medications that can help a baby’s lungs develop so that if they are born prematurely, they have a better chance of survival – and then making sure babies get a medication called surfactant as early as possible to prevent Respiratory Distress Syndrome.

Fourteen NICUs across the state have agreed to participate – and to share their data in order to track progress and identify key areas for improvement. This data sharing capacity will enable NICUs to quickly identify problems and react with changes that will improve the health of premature babies. Participating NICUs will also receive education and training on key activities such as nutritional support premature babies need when they are at risk for poor growth and other outcomes, or making sure that infection control practices reflect the latest and most evidence-based models.

TIPQC is nascent with ambitious goals to:
- Establish a statewide perinatal database
- Foster state-wide quality improvement initiatives to reduce mortality and morbidity associated with premature birth and low birth weight
- Promote system changes by provider organizations to increase use of EBPs for obstetric and NICU patients

The GOCCC is funding the basic infrastructure for this project through its initiative to reduce infant mortality, and the goal is that it will have a lasting and significant impact on survival rates of premature babies in the State.
Policy Analysis

(1) TEIS
At the request of the Department of Education Commissioner, in spring of 2006, the GOCCC undertook a policy analysis of Tennessee’s Early Intervention System (TEIS) to examine ways in which the program might operate more efficiently and serve more children.

At that time TEIS was a $34 million program governed by state rules and regulations and Federal requirements of Part C of the Individuals with Disabilities Education Act (IDEA) as Payor of Last Resort. There were additional TennCare dollars and some resources of CSS in the program.

The scope of the TEIS Analysis was a comprehensive assessment of the Service System, Administration, and Financing of the program. The Analysis resulted in the following principal recommendations to reform TEIS:

1. Unify TEIS, Tennessee Infant Parent Services (TIPS) and Early Intervention resources of DMRS through reorganization of State and District level administration, aligned with the new service model. Reduce the number of administrative positions in the programs collectively statewide from 110 to 54.
   Cost Savings: $5.7M

   Estimated Cost: $2.4M

3. Define and provide a new program of state Early Intervention services for families whose children are not eligible for Part B special education services at age 3 years when TEIS services are no longer available to them under the existing model, and who await entry into Pre-K programs. Fund new services with resources from administrative cost savings from the reorganization. (1200 children @ $2000 ea.)
   Estimated Cost: $2.4M

4. Leverage federal Medicaid dollars for Developmental Therapy with a portion of current state appropriations; implement other fund expansion opportunities.
   Estimated Revenue: $10M

The results to date are full implementation of recommendations 1 and 2; suspension of recommendation 3 for purposes of the budget conditions; and a proposal for achieving recommendation 4 is in development.

The outcomes to date are
Governor’s Office of Children’s Care Coordination

- an increase in child-find (the state was well below the national average);
- compliance with the 45 day requirement for development of IFSPs;
- adherence to the family: staff ratio of no more than 40 families per service coordinator
- finishing the fiscal year in the black.

(2) Collaboration on Funding and Administration of Adolescent Substance Abuse Services: the GOCCC led an analysis of the funding and administration of adolescent substance abuse services in collaboration with DMHDD, DCS, TennCare, DOE, and other child serving agencies. The purpose was to provide information which would permit the departments to achieve most effective, efficient use of resources. Some of the results follow.

**Fund Source as a Percentage of Total Funding in FY07**

<table>
<thead>
<tr>
<th>Fund Source</th>
<th>Agency</th>
<th>Amount</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Appropriations</td>
<td>DCS: Custodial Non-residential</td>
<td>$76,017</td>
<td>0.19%</td>
</tr>
<tr>
<td>TennCare</td>
<td>DCS: Custodial Residential</td>
<td>$2,163,899</td>
<td>5.46%</td>
</tr>
<tr>
<td>Title IV E</td>
<td>DCS: Custodial Residential</td>
<td>$613,410</td>
<td>1.55%</td>
</tr>
<tr>
<td>State Appropriations</td>
<td>DCS: Custodial Residential</td>
<td>$4,693,527</td>
<td>11.83%</td>
</tr>
<tr>
<td>State Appropriations</td>
<td>DCS: Juvenile Justice Youth Development Centers</td>
<td>$1,046,766</td>
<td>2.64%</td>
</tr>
<tr>
<td>TC Select</td>
<td>DCS: Non-custodial</td>
<td>$101,266</td>
<td>0.26%</td>
</tr>
<tr>
<td>NCLB fund</td>
<td>DOE</td>
<td>$4,274,786</td>
<td>10.78%</td>
</tr>
<tr>
<td>Juvenile Drug Court</td>
<td>F&amp;A</td>
<td>$315,530</td>
<td>0.80%</td>
</tr>
<tr>
<td>SAPT BG</td>
<td>DMHDD</td>
<td>$4,288,841</td>
<td>10.81%</td>
</tr>
<tr>
<td>State Appropriations</td>
<td>DMHDD</td>
<td>$4,747,341</td>
<td>11.97%</td>
</tr>
<tr>
<td>SPF-SIG</td>
<td>DMHDD</td>
<td>$312,414</td>
<td>0.79%</td>
</tr>
<tr>
<td>TennCare</td>
<td></td>
<td>$14,860,475</td>
<td>42.93%</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td><strong>$37,494,272</strong></td>
<td></td>
</tr>
</tbody>
</table>

Findings relative to all fund sources:
- The total amount of expenditures for adolescent substance abuse services was $37,494,272 from 7 fund sources
- Of that, TennCare is the largest source at slightly over $17M, almost 43% of the total.
- Residential Treatment at $9.1M and Custodial Residential Treatment at $7.4M account for $16.5M or over 42% of all expenditures.
- Outpatient and Intensive Outpatient services account for slightly over 12% of the total at $4.6M.
- The greatest expenditures were for youth age 15-18 at $20.1M.
- Why this information is important:
  Departments can match expenditures and service utilization with estimated prevalence and guide the deployment of resources to earlier, less intrusive services for more youth in need than devote the bulk of resources to costly residential services for far fewer youth.
- Knowing fund sources and amounts permits the departments to plan for changes that may occur in fund source amounts and rules/requirements.

Other Projects
- Autism/Act Early: On behalf of DOE, the GOCCC developed surveys of providers, academics and families to ascertain training needs of providers of services to children with Autism Spectrum Disorders. On behalf of the Boling Center and Kennedy
Center, the GOCCC enlisted representatives from other state agencies who have a stake in services for persons with ASD to participate as team members for the Region 4A Act Early Summit which will be January 8 & 9 in Nashville. The outcome will be an overall plan for serving children with ASD.

- Early Childhood Mental Health: the GOCCC hosted an initial meeting of professionals with interest or credentials in early childhood mental health who are trying to determine how they might advance communication among themselves and promote best practices relative to early childhood mental health issues.

- Resource Mapping: the GOCCC has leading roles in the implementation of P.C. 1197 which requires the state to identify and quantify publicly-funded children’s services with an annual report of the findings to the Legislature as the end product.

- CCMH: the GOCCC prompted demonstration of a collaborative approach in Systems of Care by joining forces with the co-chairs of the Council on Children’s Mental Health established in P.C. 1062, dedicating staff resources to develop the initial report to the Legislature, due 2/01/09, and conceptualizing the overall plan for a new system, due 7/01/2010.

- Developmental Therapy: At the request of DOE, the GOCCC is working with staff to develop a plan for the provision of developmental therapy as a TennCare reimbursable service, estimated to be $10 million in new federal dollars.

**Tennessee Adolescent Coordination of Treatment (T-ACT) Project**

T-ACT is a DHHS/SAMHSA-funded infrastructure grant to improve the publicly-funded substance abuse treatment system for Tennessee adolescents. The T-ACT Principal Investigator who works at the GOCCC is responsible for providing leadership, guidance and oversight of grant activities and staff as well as to direct day-to-day operations of T-ACT management, delegating responsibilities, and serves as the grant’s spokesperson.

A recent accomplishment was helping a small agency navigate the TennCare reimbursement process to quickly achieve an expedited pay-out, when due to the down economy and a drying up of charitable donations, they were struggling to make payroll for their staff. Oftentimes, the Office has been approached by a department to solve a sticky case or problem. The GOCCC has the freedom, based on our small size, nimbleness, expertise and wide-reaching contacts, to take on these problems that are too involved or outsized for the agency to manage. A licensed psychologist in the Office has been able to help with some tricky State Agency-Provider child placement conundrums, and has been able to advise on contracting language to minimize future disputes. As part of T-ACT’s Substance Abuse Collaborative, the GOCCC is able to get a handle on the universe of public spending for treatment of adolescent substance abuse, in order to report back to the different relevant agencies. The Office is able to help them think critically and strategically about how the resources are currently being spent, to gain consensus as to how they would like the system to actually look, and move forward on a plan to move from the current service provision to the identified more aspirational one.

**Centers of Excellence for Children in Custody**

The state’s Centers of Excellence (COEs) for Children in State Custody, under the GOCCC, typically work with at-risk children or children in custody who have complex behavioral and medical problems and provide direct services to these children including psychiatric and
psychological evaluations and medication management. There are approximately 10,000 children in state custody at any given time. Children in state custody receive healthcare coverage from TennCare, Tennessee's expanded Medicaid program serving 1.2 million Tennesseans including approximately 640,000 children.

Through treatment plan review and development, case consultation and coordination with the Department of Children's Services and TennCare providers, and routine on-site case review, the COEs provide extra attention to seriously troubled youth in the state's care. For children with complicated medical problems, the COEs coordinate referrals and services to medical subspecialties and hospital services to meet the child's needs.

The COEs have been recognized by the American Psychiatric Association as one of the top four innovative programs serving children in the United States. The COEs currently reside at Vanderbilt University Medical Center, University of Tennessee-Memphis Boling Center, University of Tennessee- Knoxville, East Tennessee State University Medical Center and the Focus Psychiatric Services, PC.

In 2006, TennCare funded an additional $1 million to expand the State's Centers of Excellence for Children in State Custody to help youth in state custody or at-risk for entering state custody. As an invaluable resource for these children, the COEs expansion was able to provide specific therapy and extra attention for troubled children.

The GOCCC continues to explore ways in which technology is used to increase the efficiency of service delivery systems. Because electronic patient management/medical record systems and tele-health are two venues that have the capability to increase efficiency, the GOCCC met with key stakeholders to investigate the status of the Electronic Medical Record (EMR) and tele-health in Tennessee. As a result of these meetings, the GOCCC facilitated the development of tele-psychiatry activities in the SE region through the SE Center of Excellence at three Department of Children’s Services offices. The SE COE is working with the DCS Regional Administrator to identify which offices to connect. Also as a result of this collaboration, the Community Health Network is funding connections/equipment to three Community Mental Health Centers (CMHCs) also in the SE region (sites to be determined) to allow the SE COE to provide assessment and consultation to the CMHCs.

The Centers of Excellence (COEs) assist the state in providing objective, science-based guidance to improve children’s health, behavioral outcomes, and to improve systems serving children. COEs are focused on serving children who are in state custody or who are at risk of entering state custody, and have served over 6,200 children to date. The COEs provide clinical consultation, evaluation and limited direct services to children with complex needs. This includes providing and/or establishing partnerships in the community to provide care through: psychological evaluations, psychiatric evaluations, pediatric consultation, and case reviews/consultation. After clinical assessment & consultation, COEs make recommendations & referrals that target a child’s specific health & behavioral needs. The GOCCC continues to explore ways to utilize the technology of Tele-health to increase the efficiency of service delivery systems. The Southeast COE, UT-Memphis COE and the Vanderbilt COE are utilizing Tele-health to provide consultations and evaluations for youth in or at risk of entering foster care.
The GOCCC, Children’s Advocacy Centers, Family and Children’s Services, Department of Children’s Services (DCS), Tennessee Voices for Children (TVC), Tennessee Commission on Children and Youth (TCCY), Tennessee Alliance for Children and Families (TACF), Division of Juvenile Justice, Department of Mental Health and Developmental Disabilities (DMHDD), and Tennessee Center for Child Welfare are participating in a Learning Collaborative to implement EBPs for the treatment of trauma and attachment disorders associated with child maltreatment among mental health treatment providers across Tennessee. The Collaborative is training practitioners in these EBP’s and will continue to identify and overcome barriers that inhibit the use of EBPs in this area. The Collaborative has successfully spread across the state and is actively working in West, Middle & East Tennessee, with one hundred and sixty-two mental health practitioners/supervisors and thirty-two agencies participating. Five hundred and ninety-two cases are currently using Trauma Focused Cognitive Behavioral Therapy.

The COEs identified a barrier that inhibited the ability of children in state custody to access Tennessee Early Intervention Services (TEIS) and special education services. In accordance with federal policy, biological parents must give consent for eligibility determination for TEIS, which created a significant barrier to access for children in state custody whose biological parents were difficult to locate. The GOCCC worked in partnership with DOE and DCS to eliminate this barrier. In response, DOE developed consent forms for both Part C Early Intervention services and Part B Special Education services that will be included in the intake packets used by DCS workers. Biological parents will be asked to provide informed consent for Part B and Part C education services. TEIS and Special Education forms were revised and finalized. It is anticipated that as many as 400 additional children will benefit from TEIS and an unspecified number will benefit from Special Education.
References for Appendix B

Governor’s Office of Children’s Care Coordination (2008-09). Working Document 1. Nashville, TN. Received via email February 2, 2009 from Melissa McPheeters, PhD.

Governor’s Office of Children’s Care Coordination (2008-09). Working Document 2. Nashville, TN. Received via email February 2, 2009 from Melissa McPheeters, PhD.

Governor’s Office of Children’s Care Coordination (2008-09). Working Document 3. Nashville, TN. Received via email February 2, 2009 from Melissa McPheeters, PhD.

Governor’s Office of Children’s Care Coordination (2008-09). Working Document 4. Nashville, TN. Received via email February 2, 2009 from Melissa McPheeters, PhD.

Governor’s Office of Children’s Care Coordination (2008-09). GOCCC Working Document 5. Nashville, TN. Received via email April 24, 2009 from Melissa McPheeters, PhD.


