The Children's Cabinet

Monday, September 28, 2015
DOA Conference Room A
10:00 a.m. – 11:40
Meeting Minutes
Approved 10/26/2015

Members in Attendance: Secretary Roberts, Chair; Jamia McDonald, Michael DiBiase; Regina Costa; Ken Wagner; Nicole Alexander Scott, MD; Melba DePena; Maria Montanaro; Jim Purcell and Scott Jensen. Absent: Governor Raimondo

❖ **Call to Order and Adoption of Minutes**:

Secretary Roberts called the meeting to order and asked if there were any amendments to be made to the minutes of August 17th. There were none. Secretary Roberts asked for a motion to adopt, Jamia McDonald made a second motion. Secretary asked all those in favor of adopting the minutes, all were in favor, 0 opposed. Motion passed and minutes were adopted.

❖ **Dr. Alexander-Scott's Presentation on Toxic Stress**:

Dr. Alexander-Scott introduced her presentation by stating her hope that the Children's Cabinet will drive policy, bring it to a state-wide discussion and advance what many colleagues have been working on for years. Dr. Alexander-Scott's Toxic Stress presentation is available on the Dept. of Health website: http://www.health.ri.gov/publications/presentations/2015ToxicStress.pdf

Dr. Alexander-Scott's presentation focused on the following objectives:

1. Review of terms and concepts
2. Overview of Rhode Island Toxic Stress Project
3. Vision for a public health response to Toxic Stress in Rhode Island

Review of Terms and Concepts

Dr. Alexander-Scott stated that the ACE model looks at adults where they are now and what happened to them during their childhood to get them to that point. She outlined and described three types of Adverse Childhood Experiences that contribute: 1) **Abuse** - physical, emotional and sexual; 2) **Neglect** - physical and emotional; 3) **Household Dysfunction** - mental illness, mother treated violently, divorce, incarcerated relative, and substance abuse.

Dr. Alexander-Scott shared the following data from R.I. Kids Count and the National Survey of Children's Health regarding ACEs in Rhode Island children:

- 48% of children may have one or more Adverse Childhood Experience
- 23% of children may have had two or more Adverse Childhood Experience
- 29% have had socioeconomic hardship
- 19% parental separation/divorce
- 12% household drug or alcohol problems
- 11% household mental illness
- 9% victim/witness of neighborhood violence
- 7% witness domestic violence
- 5% parental incarceration
- 3% experienced racial prejudice
- 3% have experienced death of a parent

Dr. Alexander-Scott stressed that it is key to understand that an ACE model looks at an adult and determines which childhood experiences they may have undergone but that a Toxic Stress Model looks at what the child is experiencing right now to identify interventions that can be put in place to impact their long term outcomes as an adult. Dr. Alexander-Scott stated that there are many different levels and elements of stress, and that the Department of Health's focus on the stresses children experience is not meant to suggest that a child should have no stress whatsoever. She specified that there are some components of stress that are beneficial, such as Positive Stress and Tolerable Stress. She stated that Toxic Stress occurs when children experience an adverse event or prolonged exposure to adversity, such as abuse, neglect, caregiver substance abuse. Dr. Alexander-Scott indicated that a child's response to trauma or Toxic Stress comes down to their development and learning.

Overview of R.I. Toxic Stress Project

Dr. Alexander-Scott stated that nationwide, there is only an early understanding of the components of Toxic Stress, and a better understanding of possible interventions. She shared that the Department of Health received a grant in 2013 for $140,000 a year for three years from the Maternal and Child Health Bureau to develop a Toxic Stress Initiative. Dr. Alexander-Scott outlined the two objectives of the R.I. Toxic Stress Project.

- Objective 1: Enhance systems of recognition, response and intervention to improve outcomes for children, birth to three years of age, once they experience Toxic Stress and/or trauma.
- Objective 2: Support a state infrastructure as a mechanism for aligning policies and programs to ensure that Rhode Island families who experience Toxic Stress can access services to mitigate its impact and support them to reach their full potential.

Dr. Alexander-Scott indicated that the second objective is currently in the process of being accomplished with the reactivation of the Children's Cabinet. She shared that a project team comprised of professional leaders that include state agency representation from BHDDH, DCYF, DHS, EOHHS and RIDE has been assembled. In addition to leaders in primary care, early childhood systems building, leaders from the family visiting program, early care and education, public health, research and consumer perspective. Dr. Alexander-Scott indicated that the working group first worked to define Toxic Stress and now needs to develop a screening tool that will help better identify a child's risk for Toxic Stress and develop training to support primary care and home visiting professionals to effectively screen and address Toxic Stress using the resources we already have in the state.

Vision for a Public Health Response to Toxic Stress in Rhode Island

Dr. Alexander-Scott stated that from a prevention standpoint, there is anticipatory guidance around positive parenting and violence exposure reduction being key to addressing toxic stress. With respect to the targeted intervention, Dr. Alexander-Scott noted that the state already has some mechanisms in place, for instance - family visiting programs, parenting programs and early intervention programs. She also noted that from a treatment standpoint, there are evidenced-based trauma and treatment approaches that can be used as a model such as the Parent Child Interaction Therapy (PCIT) or the Trauma-based Cognitive Behavioral Therapy perspective that is possible as well.

Dr. Alexander-Scott shared that the DOH's desired short term outcome is to increase awareness and understanding of Toxic Stress and its long term desired outcome is to have trauma-informed practices used by all programs serving children and families in Rhode Island. Specifically, she indicated a desire to ensure that state agencies have a coordinated approach to mitigating Toxic Stress that impacts young children and their families. Dr. Alexander-Scott indicated that the DOH's ultimate goal is to mitigate the impact of Toxic Stress and improve outcomes for families through a family-centered, multi-generation approach that includes accessible community-based services, multi-agency collaboration and integrated systems of referral and response.

Dr. Alexander-Scott closed her presentation by reiterating that having the Children's Cabinet reactivated will help move forward initiatives related to address Toxic Stress. She thanked her colleagues Dr. Blythe Berger and Dr. Ailis Clyne at the Department of Health and asked if there were any questions or comments.

❖ **Comments on Dr. Alexander-Scott's Presentation on Toxic Stress**:

Director Jensen commented that some of the hardest things for folks getting back into the workforce are emotional. "We see it all the time, our most innovative job trainers address that issue with people often. DLT has four one-stop centers around the state where people who lose their job come in to talk with job trainers about how they are going to get their career back on track. We need to figure out a way that our folks and your folks, especially in the one-stops can help each other intervene with people when they are having a hard time."

Director DiBiase stated that he thinks the DOH's Toxic Stress Initiative is terrific. "When you think about the resources that we array to help children, most of them are on the symptom level and not on the intervention level. To be able to shift those resources to the intervention level to attack the stress at the source would be great."

Secretary Roberts asked Dr. Alexander –Scott what the next step in this process is.

Dr. Alexander-Scott stated that DOH would like to develop an interagency working group with the staff that are at our agencies who have been experiencing and working on this for years, and task the group with bringing proposed implementation polices to the Children's Cabinet for direction and consideration.

Regina Costa indicated that she was intrigued by the impact toxic stress has on a child's brain that can affect future generations. "How do we intervene at that level? That's more of a physical intervention which is a slightly different than trauma treatment."

Dr. Alexander-Scott responded that the key to addressing the impact that Toxic Stress can have on a child's brain is being able to connect the dots. "The impact on the brain will ultimately develop if we don't intervene in the ongoing Toxic Stress that happens to a child. If we can intervene so that there is a protective supportive adult or mechanism in place to help the child adjust to the Toxic Stress it will have positive instead of negative impacts on the physiologically on that child."

Secretary Roberts stated that this is an important linkage and fits in well with our conversation about a strategic plan moving forward.

Susan Ursling from Family Service of Rhode Island stated: "We have a SAMHSA grant and collaborate with a number of community partners and are working with these families using evidence-based treatment models. We are teaching students in the school of social work, child care and psychotherapy, which is targeting these children and families, it might be important to be included to some degree with the community partners who are already practicing, identifying and treating these children."

Secretary Roberts agreed with Susan Ursling and stated that one of the Cabinet's goals is to have collaboration with the community partners.

Jamia McDonald stated that she believes most of population that DCYF deals with is already at a Tolerable to Toxic Stress level at the time DCYF encounters them.

Director Montanaro stated that there is an emerging body of evidence around treatment and evidence based models. "One of the things we need to look at from a policy standpoint, as a State when we are dealing with children entering systems of care that are publicly funded in particular, whether we are going to require the use of evidence-based models for that treatment." Director Montanaro indicated that similar work has been done in Connecticut. "There is a lot of work in surrounding states with their Children's Cabinets that have worked on that including the System of Care Model for children who are seriously and emotionally disturbed many of whom end up in the DCYF system and many who are not there and how the education system responds to that. It would be good to get a small workgroup together because most of the expertise is in the treatment community, it's not within the departments, but it's how we as departments respond to that in terms of policy, payment policy, coverage policy where we are really going to be able to have an impact."

Commissioner Wagner commented: "If the goal is to raise an awareness that there is a continuum of stress, we have to be alert for that continuum of stress and identify children/students who are more on the negative side of the continuum and by being alert we will need to provide some of the emotional booster work whether it be supportive caring adults or provide social-emotional skills for those students. All of the pillars of the system can only benefit from that heightened level of awareness and collective consciousness. However, if we start to turn that continuum into discrete diagnosis, for example – trauma - there is discrete diagnosis for post-traumatic stress disorder, emotional and social disorders like trauma that really require the services of not only the agencies collectively, but that require the services of professionals trained specifically to treat those diagnosis." Commissioner Wagner stated "We have to be mindful of which we are talking about, if it's the former, then everyone can help and I believe we will can do a lot collectively; if it's the latter and start talking about discrete diagnosis, and professionalizing those and creating payment structures around those, which there is absolutely a place for that, however our collective impact will be a lot less. As this workgroup moves forward we have to be cognizant of which continuum we are talking about."

Dr. Alexander-Scott responded: "There is definitely a spectrum that includes both elements and certainly what we discussed today can be in advance of when those ultimate diagnosis come into play so that we are not changing the treatment and mechanisms in place to address those diagnosis but there is a huge aspect before getting to that point or simultaneous to getting to that point that is not necessarily captured within the diagnosis that would have an economic and social standpoint."

Commissioner Wagner reiterated "The Cabinet should make sure our initiative stays as an empowering narrative and doesn't restrict itself prematurely beyond the students who really need special medical, psychiatric or psychological care that we don't lose the broader initiative by focusing on the latter initiative."

Secretary Roberts thanked Dr. Alexander-Scott for her presentation and asked Jill Beckwith from Kids Count to update the Cabinet with follow up information based on the questions raised at the last meeting.

❖ **Kids Count - Review of data and follow up questions from the August meeting:**

The Kids Count Data Presentation can be found at http://bit.ly/1QIRTjP

Jill Beckwith presented data and analysis in response to questions asked by the Cabinet at its August meeting.

In response to Dr. Alexander-Scott's question regarding trends in family structure over time Jill Beckwith stated that she looked at children in single parent families over time. Jill indicated that the data she reviews suggests that the percentage of children in single parent families has gone from 22% in 1990, to 27.4% in 2000, and 30.4% in 2010 and has gone up a little more in terms of the most recent data. She noted that the actual number of children is the same, but when you looking at the overall number of children, that changes over time.

In regard to Director DiBiase's question about the regional comparison to immigrant breakdown of nearby states, New England and Northeast; and Secretary Roberts' question as to whether RI changed much ethnically since the 1970s? Jill gave an overview of the trends and regional comparisons. She indicated that racial and ethnic composition of all ages, not just children, from 1980 to 1990 went from 93% of the overall population being white down to 76% in 2010. The Latino population grew quite a bit from 2% in 1980 to 12% in 2010, as well as an increase in the black population from 3% to 5%. Jill also stated there was a change in net population growth by decade and stated that between 1980-1990 there was a net population increase in Rhode Island of both non-hispanic white and the people of color; then from 1990-2000 there was a net decrease in the population of non-hispanic white and a net increase of the people of color and the same held true in larger amounts in terms of a decrease in the most recent decade. She suggested there are clearly economic shifts going on, and they are something the Cabinet may want to consider in its decision making.

In regard to questions related to the percentage of children living in immigrant families, the children themselves or one of their parents are foreign born Rhode Island stands at 26%, which is similar to Massachusetts, Connecticut. Jill reported that the national average is 24% and the numbers are lower in Maine, New Hampshire and Vermont.

Jill reported on Rhode Island's Early Learning System and indicated that different systems need to work together. In respond to Dr. Alexander-Scott's earlier presentation on Toxic Stress, Jill suggested that a high quality early learning experience is a key factor in mitigating Toxic Stress. Jill also indicated that families are in need of childcare in order for the parents to work. She reported that 72% of children are under 6 and 77% of those that are school age all have a parents in the workforce. She indicated that Rhode Island's rates are even higher than the national average in terms of families in the workforce.

Jill then discussed trends related to the Child Care Assistance Program, stating that in the late 1990's, when child care subsidies became an entitlement in Rhode Island, childcare benefits were first linked to cash assistance and other program benefits to help families. Jill described that child care subsidies are given to families who are working full time or part time at low wage jobs, the subsidy would allow them to afford the cost of child care. She reported that major policy changes in 2006 impacted the Child Care assistance program in RI. "The program was there, but rates were lowered and more eligibility requirements were put into effect, reducing it from 225% of poverty level down to 180%. There were increased co-payments for families to be part of the program. Also, there were no more subsidies for children over 12 and rates paid to school age providers were decreased. Therefore some families couldn't get in, some families couldn't stay in and there were providers that didn't want to participate or can't participate in the program anymore. In 2008, there was $1 million for rate increases in the Comprehensive Child Care Program which is the wrap-around support program giving families support to other social services, i.e. health services, nutrition, mental health, etc. were eliminated. However, in 2013 there was a Pilot program that went into effect that made some positive changes, allowing families that were in the program, stay in the program once they were past the upper limit so they don't fall out of the program once they are working and making money again."

Jill reported that the FY'2016 budget provides a 3% rate increase for providers serving children in the CCAP- first increase since 2008. In addition to the 3% rate increase, family child care providers will also receive $10 per week increase for infants and toddlers who are the most expensive to care for. She shared that child care subsidies are a mix of State and Federal funds, and there has been a tremendous decrease in state funding over the years ranging from $52.7 million in 2002 decreasing to $9.7 million in 2015.

Commissioner Wagner asked how Rhode Island compares to other states in the region in regard to their federal and state investments in the program, whether they have decreased as well over the years.

Leanne Barrett responded that the federal funding has stayed stable. Rhode Island was a high investing state in the past. We can follow up with actual comparisons to other states.

Jill Beckwith continued reporting on the following topics:

- **Child Care Affordability** – The median family income in Rhode Island is approximately $68,000, whereas the typical cost of child care for a 3 year old is $9,500 per year in a child care facility. Using the federal affordability guideline of 10% of family income, a Rhode Island Family would need to make $95,000 per year to afford the cost of child care for a 3-year old in a licensed child care center. So there is a cost burden to those families with children in child care.

- **Evidence-Based Home Visiting Programs -** The State has made a real investment over the years in terms of identifying high risk families with a variety of programs. There has been a tremendous growth of families enrolled in the program from 37 in 2010 to 869 in 2015. There are three Evidenced-Based Programs supported in Rhode Island: 1. Healthy Families America with 609 enrolled; 2. Nurse-Family Partnership with 143 enrolled; 3. Parents as Teachers with 117 enrolled. The Early Head Start program is also recognized with 376 families enrolled as well.

Secretary Roberts asked if there is a map across DCYF's population as to whom is in the home visiting programs.

Director McDonald stated that DCYF does have that information and that the department will be working closely with the Department of Health to discuss ways to expand the program.

Dr. Alexander-Scott stated that the plan is to make sure that everyone in DCYF automatically enrolls in the home visiting program.

Jill Beckwith continued her presentation by indicating the following:

- **Trends in Age of Housing** - Rhode Island ranks highly in the percentage of all children living in older housing (homes built prior to 1980). This is in correlation with the lead paint laws. In comparison with Massachusetts and Connecticut, the rates are similar, but Rhode Island is slightly higher and we are highest in the country. It is key to have lead poisoning prevention programs, lead inspections and making sure the homes are up to code.

- **Median Family Income -** Rhode Island is $64,985 for median family income above the national average of $60,654, however it is the second lowest next to Maine among the New England states.

- **Secure Parental Employment –** Between 2011 and 2013, 26,247 Rhode Island families lived in poverty:

    - 15% had at least one adult with full-time year round employment,
    - 37% had at least one adult with part-time employment, but no full-time employment,
    - 47% had no employed adults

Jill reported that according to the 2014 RI Standard of Need to make ends meet, single-parent families need to earn $28.41/hour $59,083 annually; and two-parent families need to earn $30.88/hour $64,234 annually and in Rhode Island there are not that many jobs at that income. This translates into 82% of Rhode Island single-parent families and 26% of two-parent families with two or more children earn less than the income needed to meet their basic needs without public benefit such as SNAP, EITC, child care assistance and health insurance.

Director DiBiase stated that he found the 15% statistic surprising, not so much about the wages, but that there are only 15% with a full-time job and expected that number to be higher.

Jill Beckwith responded that his observation could have to do with the fact that Rhode Island has a lot of hospitality jobs that are seasonal, and people working multiple part-time jobs, and what benefits and programs do they qualify for as a result of those jobs.

Director DiBiase asked whether or not two part-time jobs would be considered full time job in collecting this data.

Jill Beckwith stated that this information comes from the Census and she did not believe that two part-time positions would be calculated as one full-time position. Jill said she could look into that further.

Jill continued by reporting the following:

- **Children in Families Receiving Cash Assistance** – how we look at demand for cash assistance against the program determination, why is this happening and are families timing out before the recession.

    - In 2013, 42,247 children in the state lived in poverty, 19361 of whom lived in extreme poverty, yet only 9,077 received cash assistance in 2014.

    - The RI Works caseload had declined due to policies implemented in 2008, including time limits (a 48-month lifetime limit for benefits and a periodic time limit that limits assistance to no more than 24 months of assistance in any 60-month period) closing child-only cases when parents reach their time limit, and limiting eligibility for legal permanent residents to those who have had that status for 5 years.

    - From 2007-2011, Rhode Island was one of three states with the largest TANF caseload decline, having a 39% decline in its caseload while the U.S. as a whole saw a 10.3% increase in TANF caseloads due to increased needs during the recession.

Director McDonald responded that she and Director DePena had discussed that DHS is looking into this program and how we do a better job targeting the employment needs rather than just letting them time out of the program.

Jill continued by reporting the following:

- **Cash Assistance Funding –** for the fifth year in a row, no state general revenue was allocated for cash assistance. State general revenue spending for cash assistance has decreased steadily over the past 18 years. The cash assistance program is now entirely supported by TANF block grant funds.

- **Chronic Absence –** some families have issues with unstable housing, child welfare, juvenile justice involvement, lack of affordable and reliable transportation. Other factors that contribute include school climate, discipline policies, and concerns about bullying and unsafe situations.

Secretary Roberts stated that the resources that Kids Count bring to the Cabinet are very important, and she thanked Jill for coming back to follow up on questions from the previous cabinet meeting. The Secretary asked Commissioner Wagner to give an update on the Race to the Top Early Learning Challenge.

❖ **Race to the Top Early Learning Challenge Update**

Commissioner Wagner stated that RIDE is in the midst of a multi-agency implementation of the Early Learning Challenge work with approximately one more year to go, so it is mindful of not only the work that has been accomplished but what can be accomplished as well as what should be prioritized over the next several months. Commissioner Wagner reported that, to date, about 76% of the grant deliverables have been achieved and RI has drawn down about 60% of the budget. He indicated that the Race to the Top workgroups are focusing on the following over the next several months: is clearly a sizeable amount of work to do over the next several months.

- Bright Stars participation - currently at 80% of programs that have been rated and our goal is 100%. Only 7% of programs are rated in the higher tiers and our target is 15% so we are going to focus on that quality reading as well as that consumer tool for these programs.
- Pilot for the kindergarten entry profile - getting accurate information about readiness for kindergarten was a grant priority and the workgroup is going through a pilot process for that.
- Developmental screening - currently there are 20 pediatric practices involved in that screening process and the workgroup expects 30 more over the next year.
- Technical Goals – the workgroup is working toward rounding out the data system work to provide an integrated picture that it has come to rely on with partners such as Kids Count to make sure we have accurate information for policy and implementation services.

Director DePena added that DHS is currently engaged in the campaign that is going to help move some of the programs forward with the Rising Star campaign.

Jamia McDonald stated that to the Commissioner's point, the agencies are getting together to see how we can maximize with the time we have left to make sure we are fulfilling our obligations in order to set it in a better path going forward.

Secretary Roberts stated that this is an area where coordination was needed and there is a group now that is committed at the leadership level to that effort as well.

Commissioner Wagner stated: "The key thing here is not what we can get done over the next year, but to focus on sustainability of the programs. The teams are hard at work to come up with a sustainability plan that is smart and also within some of the limitations that we have."

❖ **Strategic Planning Process**

Secretary Roberts opened a conversation regarding the Children's Cabinet's Strategic Planning Process by reiterating that the Cabinet has a clear charge from the Governor and by statute to create a 5 year Comprehensive Strategic Plan for Children by December 1st of this year.

Secretary Roberts thanked Casey Family Programs who have been incredibly generous with their expertise and support to help us get this off the ground. Secretary Roberts introduced Elizabeth Gaines, Vice President of Policy Solutions for the Forum for Youth Investment, which is an organization that provides technical assistance to Children's Cabinets in various states around the country.

Elizabeth Gaines suggested that before the cabinet dives too deep into the details, it's important to have a framework for this Children's Cabinet to have a collective sense of purpose. Elizabeth stated that she has been working with Children's Cabinets across the country for over a decade, and pulled together this network and has studied them to try and understand what makes them successful and what doesn't.

Elizabeth began her presentation with an overview and objectives of the Children's Cabinet:

- Decide on an outcome framework
- Empower some teams of people that can help the Cabinet get to the core of the strategic planning work
- Identify data
- What evidence to supports the things that are already being discussed across the agencies?
- What are the policies and resources that we need to be paying attention to know whether we can invest in the right evidence-based programs and that we are using our partnerships accurately;
- next steps and timeline issues

Elizabeth indicated that the R.I. Cabinet is on an incredibly fast trajectory to get to a strategic plan.

Elizabeth continued by introducing the following concepts:

- The Readiness Target, a framework for addressing the physical, emotional safety and health of children and their social, cultural and civil connectivity needed to see improvements in child outcomes.

Elizabeth suggested: "When you think about the role of the Children's Cabinet, it shouldn't just be to bring the things that your agency is doing to the table, but it should be to bring issues like Toxic Stress that require everyone participating in order to make headway."

- The Insulated Education Pipeline, a framework for considering the idea that there are breaks in the education system and how community supports can keep children from falling through those breaks.

Elizabeth suggested that the Cabinet may want to consider the following strategies:

- broad partnerships;
- Set big goals big;
- Use the data
- Implement bold strategies.
- Look at quality and identify how the state currently aligns existing policies and resources
- Consider how the Cabinet will engage young people and families in its work
- Consider how to increase the demand for more and better services for young people

Elizabeth suggested "It's important to think about the scope of this body in terms of the vision and the mission, and to think about where the authority comes from, you really want it to be a decision making body where the key decisions on children and youth are made at this table.

Elizabeth pointed out that the Maryland model is a very sophisticated infrastructure that has been around for 20 years.

Secretary Roberts stated that this is an Administration that wants a level of specificity in terms of outcomes, so the Cabinet should identify measures under each strategy that will help it to accomplish goals more effectively.

Elizabeth Gaines responded: "This is where filling in the framework comes in, you want to be clear that an end goal is not the high school graduation rate, the end goals is the young person transitioning into the next level of education or into the workforce successfully. "

Jamia McDonald stated that we have just gotten past the mission of the Children's Cabinet and the next phase is, what everyone is doing that fits into that, so we can build that dashboard for the Governor.

Elizabeth Gaines showed a slide of a simple dashboard and suggested the Cabinet send along their strategic goals so that they could be plotted together to identify how they fit together, overlap and gaps.

Secretary Roberts asked how much is focused on the work that the Cabinet directly does and how much is focused on the work that is being done by the community stakeholders.

Jamia McDonald asked Elizabeth Gaines if she had seen a process where the Cabinet would fill in the dashboard and we also distribute it to the community stakeholders asking that they talk to us about those items and we get a more holistic community picture.

Elizabeth Gaines said yes, that it would be very useful.

Regina Costa asked about expanding the definition of well-being for children because agencies talk about well-being in different ways.

Jamia McDonald stated "The term "well-being" may be more narrow (for DCYF) because of our interaction, but (she) wouldn't know how Directors Jensen or DePena would define well-being from their constituency.

Secretary Roberts asked Elizabeth Gaines how we create a process that helps us move forward, given the Cabinet's monthly meeting structure.

Elizabeth Gaines suggested that between now and the next Cabinet meeting, the Directors have their staff teams come together and create a set of dashboards of what each department is doing. Elizabeth indicated that this would be good data for the Children's Cabinet to use in their decision making.

Secretary Roberts asked Director McDonald to discuss next steps.

Director McDonald introduced the new Children's Cabinet Policy Director, Dacia Read who comes from the Children's Defense Fund in New York. She announced that Dacia would be coordinating the Cabinet.

Secretary Roberts stated that Dacia will be coordinating a meeting with a workgroup consisting of staff from the respective departments, and asked Elizabeth Gaines what staff expertise the Cabinet directors should be looking to appoint to this workgroup.

Elizabeth Gaines suggested having the following staff from their departments assigned to the working group:

- Budget staff that has a sense of the budget streams in their department;
- Data Evidence Group, whomever may work with the Kids Count
- Partnership Groups, community stakeholders

Secretary Roberts asked the Cabinet to provide their Strategic Plans and Metrics as well as identify the appropriate staff from each of their departments to Dacia as soon as possible so she may conduct a workgroup meeting.

Jill Beckwith stated that she could provide Dacia with a list of staff from the Children's Cabinet agencies from whom Rhode Island Kids Count obtains data for as well as the corresponding indicators for which the data are used.

Secretary Roberts asked if there any public comments. There were none. The Secretary stated the next Children's Cabinet meeting will be held on October 26th and thanked everyone for attending.

Secretary Roberts asked for a motion to adjourn. Michael DiBiase seconded, and all were in favor. The meeting adjourned at 11:40 a.m.