The Children's Cabinet

Monday, April 25, 2016
DOA Conference Room A
10:00 a.m. – 11:30 a.m.
Meeting Minutes
Approved 6/27/16

Members in Attendance: Elizabeth Roberts, Chair; Ken Wagner, Vice Chair; Nicole Alexander Scott, MD; Melba Depena; Scott Jensen. **Absent**: The Honorable Gina Raimondo; Michael DiBiase; Jamia McDonald; Maria Montanaro; Jim Purcell; Jennifer Griffith.

❖ Call to Order and Agenda Overview:

Secretary Roberts called the meeting to order and thanked everyone for attending. Secretary Roberts thanked Commissioner Wagner for leading last month's meeting in her absence. Secretary Roberts stated that she had received great feedback about last month's conversation regarding the Workforce Innovation Opportunity Act, and thanked Director Jensen and his staff for their presentation as well as the public members who contributed to that important conversation. Secretary Roberts stated that there were a few Directors that could not attend today's meeting, Director Montanaro will arrive late, and that she will call for approval of last month's minutes once she has arrived.

Secretary Roberts stated that she had planned to welcome the new Child Advocate, Jennifer Griffith to the meeting today, however she was called to court unexpectedly. Secretary Roberts added that the Child Advocate's work and the work of her office are both critical to ensuring that we reach our desired outcomes for children related to the physical health and safety, and we look forward to having Jennifer join the cabinet and making sure the Child Advocate is a more relevant part of our oversight and policy development.

Secretary Roberts announced that on May 16th, Governor Raimondo will host her Governor's Summit on Early Childhood. The event will take place from 8:30-11:30 at the Providence Marriot. If anyone has questions about that event, they may reach out to Dacia Read for more information.

Secretary Roberts introduced Kim Paull the new Director of Data and Analytics at EOHHS. Secretary Roberts asked Kim to inform the Children's Cabinet more about her work because it serves to strengthen the Cabinet's capacity to reach some of its governance and service delivery goals related to making data driven and cross-system decisions that improve outcomes for kids. Kim had recently convened a cross-agency data analytics team to begin aligning outcomes and data systems across EOHHS. The team is taking a deep dive look at adolescent substance abuse data in support of our shared objective to support youth in this area. We know that we have several programs, services, grants and initiatives that impact youth struggling with substance abuse across the EOHHS agencies right now, and I look forward to hearing more about these efforts through our conversation.

Secretary Roberts turned the meeting to Kim Paull.

❖ EOHHS Data & Analytics Update: Youth Substance Abuse

Kim Paull stated that her current role is to coordinate a variety of activities and projects across the EOHHS agencies so we are serving our residents better, we are driving the fundamental mission at the agencies and to also get a better understanding the residents, members and beneficiaries because the agencies often serve the same people. The goal is to think about these residents and members as whole individuals and not just members in programs. Kim commended the Children's Cabinet because their leadership to this point has helped us look at these residents as whole human beings which has given great structure at the EOHHS level on how we actually put these pieces together. One of the ways to pull these missions together is to look at analytic ways of seeing certain populations that cut across our agencies as a whole. We are trying to maximize the collective

impact of the Executive Office in thinking about within this specific population of what kind of measures we have behind that to measure their progress, to measure our impact and to measure their well-being.

Kim reported that the pilot project in conjunction with the leadership of the Children's Cabinet is "Adolescent Well-Being". There is so much working being done on this topic in general about measuring these populations already, but wanted to offer this as an exercise to say even if we haven't linked our data across our agencies yet, what can we know now about the population. If we can pull together statistics from our Youth Risk Behavior survey, from Health Facts, Medicaid data and state health insurance data, what can we know about this population? Kim added that the Children's Cabinet wanted to focus on the health and safety of adolescents, and there were five or so specific measures that the Cabinet suggested in the Strategic Plan. Kim stated that a few other measures and another area of focus have been added. Kim stated that this is a draft and would appreciate the cabinet and public's insights for consideration and discussion. Kim stated that the other area of focus was that in addition to whether a child or adolescent have been to a primary care physician this year, are they insured? Are they in Current Care, which is the State's health information exchange? We are also thinking about additional measures of substance abuse and reproductive health that come from the Youth Risk Behavior Survey, in addition to some data sources from Health Facts RI. Kim added that they are also adding a workforce component as well as thinking about our consent decree population, where we want to make sure that our adolescents with developmental disabilities are meaningfully connected to work where appropriate. Kim stated that they are taking the lead in holistic looks at the individuals to put these data pieces together, and this is phase one, where we have the data, but it has not yet been linked, but how can the data be useful right now. Kim opened the floor to the cabinet members and the public members for comments and feedback.

Patricia Flanagan from Hasbro brought up a point with adolescents in Current Care stating that they will find among all of the citizens active in Current Care, adolescents are the least, and that has a lot to do with issues around confidentiality and who has access to the records. There are a lot of unclear issues around confidentiality and adolescent health care, and it becomes tricky when it comes to measuring Current Care participation in adolescents.

Kim Paull thanked Patricia and noted that as children turn the age 18 they are then moved out of Current Care.

Secretary Roberts explained that Current Care is the state's health information exchange, which is electronic medical record information that is able to be shared confidentially as you move through the health care system. The Secretary stated that you have to proactively enroll in Current Care which is one of the challenges for adolescents of how that happens and works.

Patricia Flanagan stated that the question is who has access to the exchange is part of the problem, and as it stands currently with the adolescents between 13-17 years of age there is a clause informing the providers who are using the exchange that adolescents within that age range have confidentiality rights, established by state law, and certain information cannot be shared, even with parents. Patricia added that there are certain conditions such as infections that are specifically carved out for adolescent confidentially, and there are other issues depending on insurance, whether you are on Medicaid, and where you are getting care; and it becomes very difficult to assist the adolescent population with the confidential care they are entitled to. For that reason, a number of exchanges across the country have kept the 13-17 year olds off the exchange.

Secretary Roberts stated that she would be interested to know how many children in general are enrolled in Current Care and whether we want to think through some of the reasons we would want to expand that and how to do it in a way it would be acceptable to families and children as they get older. If we want to coordinate care effectively, we should be thinking about the legal, ethical and practical issues and see if we can find solutions to them.

Commissioner Wagner stated that even in regard to the issues of signing up for Current Care and which issues of data elements follow and those which don't; and specifically those elements that do follow, carry a flag with them to signify extra levels of protection is conditional logic that is easy to put into a front end system. Systems can help support policy, and the data you have opens up policy options, and the policy options help guide the

data decisions. We may be assuming there are barriers, but those could actually be removed through system enhancements.

Secretary Roberts thanked Kim for her presentation and asked Dr. Alexander Scott to give her presentation on adolescent substance abuse.

❖ Adolescent Substance Abuse - Overdose Prevention and Intervention

Dr. Alexander Scott stated that in speaking about coordination, system enhancements and having data as a driver for substance abuse in youth is a perfect opportunity to strengthen the system. Dr. Alexander Scott proceeded to give an update of what is already happening with substance abuse specifically pertaining to our overdose epidemic.

In 2014, there were 239 deaths in Rhode Island due to overdose, and in 2015, there were 255 deaths. Children are a portion of that, but not a substantial proportion, but even one is too many. Dr. Alexander Scott reported that she and Director Montanaro are Co-Chairs of the Governor's Overdose Prevention and Intervention Task Force which includes a number of representatives from across the state, including members of the legislature, the recovery community, the healthcare community, insurers, etc. The Governor's Overdose Action Plan focuses on four specific and complementary strategies designed to cut the number of lives lost to overdose by a third within three years:

- Treatment – Expand the quality and availability of medication assisted treatment;
- Rescue – Ensure access to Naloxone in every community, including schools, first responders, public venues, families, etc.
- Prevention – Aggressively decrease the supply of opioids and better monitor opioid use through prescription monitoring program, and to focus alternative pain management options, particularly when talking about youth with sports injuries or other considerations. Starting now in changing the culture of what is offered to people to address those injuries and starting with something other than an opioid is a critical step in prevention. The issue of safer prescribing has been discussed, and the strategic plan has brought attention to the fact that co-prescribing opioids and benzodiazepine significantly increases the risk for overdose, which is something that was not routinely known or understood, but certainly important as we treat our youth to minimize the prescription of them both together, and to also promote registration and utilization of our prescription drug monitoring. Providers in the healthcare system also want to see a change and are interested in seeing parameters set to help enforce and implement such a change. Dr. Alexander Scott stated that they currently have a data point that shows patients who go to three or more pharmacies and/or providers, flagging that and being able to do something about it.
- Recovery – expand access to peer-recovery services and medication-assisted treatment.

Dr. Alexander Scott stated that the median age of drug overdoses in Rhode Island is age 41. The age ranges with the most overdose deaths are 30-34 and 40-49 years of age. We know this crisis is touching every community and demographic throughout the state, and our action steps are particularly relevant to making the changes among our youth population. Naloxone, a medication to reverse overdoses has been required to be in Rhode Island schools, and using that as an opportunity to not just make sure it's just for students, but teaching the use of Naloxone in schools allows for staff members, teachers, parents and family members who are being exposed within that environment to have and understanding of how to address the overdose response.

Dr. Alexander Scott discussed the relaunching of their public education campaign "Faces of Recovery", which has many young people who are suffering from the disease and raising awareness about their stories. Lastly, based on we have been learning through the Overdose Task Force, we are putting a focus on developing emergency department and hospital standards that would allow for a better understanding of how to connect adults and youth who are coming through the hospital with substance use or other disorders.

Dr. Alexander Scott concluded her remarks and introduced Kristine Campagna to expand further on a critical component of our overdose response and the cross-agency efforts focused on reducing the impact of neo-natal abstinence syndrome in Rhode Island.

❖ **Neonatal Abstinence Syndrome (NAS) Task Force**

Kristine Campagna acknowledged folks in the audience who are also working on this issue, Sarah Bowman and Christelle Farrow who are part of the NAS Team as well. Kristine reported that nationally and in Rhode Island there is increasing public health, medical and political attention paid to the parallel rise in the following trends:

- Prevalence of substance abuse disorder (including prescribed and illicit substances)
- Incidence of overdose
- Incidence of neonatal abstinence syndrome (NAS)

Kristine elaborated on the issue of Neonatal Abstinence Syndrome, stating that in-utero exposure to certain substances can cause neonatal withdrawal after birth when the exposure ends, and this withdrawal most commonly results from in-utero exposure to opioids but is also associated with exposure to benzodiazepines, barbiturates and alcohol. NAS refers to clinical findings associated with withdrawal symptoms (neurological excitability, gastrointestinal dysfunction).

Kristine stated that there were approximately 95 infants per 10,000 live births diagnosed with NAS from January to September 2015, and this information is reported through the hospital discharge database.

Kristine reported that the NAS Task Force was re-established and the goal of the task force is to improve a coordinated system for early identification and support of impacted women, children, and families with an emphasis on comprehensive, family-focused, cross-sector care coordination to support best health and social outcomes for baby and family. Kristine stated that the Task Force includes the state departments such as, child welfare, BHDDH, DHS as well as a cross sector of folks including the following:

- Early Intervention
- Parenting and family support
- Medical professionals
- Family Court
- Substance use treatment providers
- MAT providers
- Economic Support

The Department of Health plays a key role in linking various resources and providers by tracking substance-exposed infants through screening, assessment and service delivery.

Kristine stated that when the NAS Task Force was re-established, the first thing the task force did was establish process mapping of not only the current state but also what they wanted the system to look like. Mapping was established from pre-conception through birth and into the first year of life. The task force is currently broken into four subcommittees with a focus on the following:

- Training – training prenatal/substance use treatment providers and to ensure it is consistent across the continuum.
- Recovery Coaches – for new and expecting parents and to ensure they are specially trained to work with new and expecting parents in recovery.
- Hospital Protocols – ensuring all birthing hospitals have appropriate and consistent policies regarding identification and support for substance-exposed newborns and their mothers.
- Prenatal Referral Mechanisms – to ensure we are identifying pregnant women and families and to be sure we are supporting them at that point and getting those referrals to prenatal providers, substance use providers as well as the family home visiting program.

Kristine stated that a lot of things happen when the baby is born which is a critical period to ensure that the families are involved in early intervention and then continue or be supported by other early childhood programs.

Darlene Allen of Adoption Rhode Island asked if there was data that showed how many of those infants are being placed at home with the parent and how many are going into foster care.

Kristine stated that they are in the process of working with DCYF to share some data and to specifically look at that.

Director Jensen inquired as to how much more at risk are infants if the issue is not dealt with right away.

Dr. Alexander Scott stated that it is such a critical time in development and you can never underestimate the implications of that. In addition to the physical consequences, it could potentially impact cognitive development if not addressed quickly. The concerns that led to the exposure to begin with, may or may not continue if there isn't appropriate intervention, and the rest of the proper development that needs to occur could be at risk. For example, stable housing, nourishment and nutrition, social support and encouraging environment, all of that is critical early on and is a multidimensional element that requires a coordinated approach.

Sue Pearlmutter from the Rhode Island College School of Social Work discussed two large SAMHSA Grants that are moving in Rhode Island to provide SBERT training, which is the short assessment for substance abuse and referrals for treatment. One of those grants is in the Emergency Department at Rhode Island Hospital and the other is a multi-organizational grant that is training people throughout the state in the use of SBERT. Sue stated that SBERT can be very helpful, and stated that when you are looking for ways to have some influence on the assessment process, it can provide a very important tool.

Kristine Campagna agreed and stated that recently there have been some grant rounds happening with the OB providers and they have been talking about SBERT training with them as well.

Anne Grant from the Parenting Project inquired if there were ways to interface with the Family Court who are making decisions with DCYF very often, as to how punitive and how supportive this effort is.

Kristine Campagna informed Anne that it is a real critical connection that needs to be made and hopes through their role on the Task Force they can build stronger relationships with the courts.

Brenda Amodei of BHDDH stated that in regard to the earlier conversation and focus on adolescents; we have this information of when the infants risk status for a substance abuse problem is, given the conditions to which they are born. Brenda posed that question as to how we can use that information to not lose this family or infant when they are not eligible for these services and supports that they would get through age two. There doesn't seem to be anything in between that time frame and when they become adolescents. How can we bridge that gap as a preventative measure?

Dr. Alexander Scott stated that it is a key point of this effort when we mention Toxic Stress and looking at ways to intervene early on before you get to the later outcomes. It will only happen with coordination of services. Starting prenatally with a substance abusing mom, wanting to get them engaged at that time so we can minimize the child developing NAS, and to change the trajectory of a mom staying in a substance abuse mindset. This can be done with peer recovery coaches, medicated assistant treatment, DCYF and other engagement that is necessary, so by the time that infant becomes a teenager with a higher risk for substance abuse, there will have been steps put in place to change their course.

Kristine Campagna added that it really takes a coordinated effort as we think about children continuing in services and supports with their families. If, for example, a child is involved in a family visiting program, that program ends at the age of two. We are working hard to make sure that the child and family is supported and to make sure they enroll in early head start programs, Pre-k and have continued supports and resources wrapped around to be sure there is strong care coordination.

Secretary Roberts stated that there is a State Youth Treatment Grant through BHDDH. The Children's Cabinet is the coordinating entity for that grant and they are just beginning to convene the workgroups around youth substance abuse prevention and intervention. This gives us some opportunity to look at working across agencies and thinking about prevention. Secretary Roberts stated that in regard to the substance abuse and overdose prevention issues in schools, she is interested in knowing how tightly we have the schools connected into this conversation.

Dr. Alexander Scott stated that there has been a lot of discussion, particularly with the school nurse teachers and the schools in terms of rolling out Naloxone, both in terms of promoting the education of it and administering it. Dr. Alexander Scott stated that she and Commissioner Wagner have had discussions on how to further implement it, as there have been some dosing changes that have allowed for some challenges.

Commissioner Wagner added that so much of it is a general awareness of risk and knowing how to trigger support systems when risk is detected and that level of saturation is difficult and it takes time. In regard to the statutory change and the availability of Naloxone, there has been movement, but also nervousness about expanding the scope of the school nurse teachers to take on this role.

Secretary Roberts thanked Dr. Alexander Scott and Kristine Campagna for their presentations and asked Jill Beckwith from Kids Count to give highlights of the recent RI Kids Count Fact Book.

- **RI Kids Count Fact Book Update**

Jill Beckwith thanked the Cabinet and their staff who provided them with all the data from their departments for the Fact Book.

Demographics and Economic Well-Being - Rhode Island had the fifth lowest birth rate in the country in 2014 and our population continues to decline. Rhode Island is losing quite a bit of the child population which decreased by 14% between 2000 and 2014 (from 247,822 to 212,555). Rhode Island has also had a shift in the demographics, where the non-Hispanic White population has declined by 21% between 2000 and 2010, while the Hispanic population grew by 31% over the past 10 years.

Shifting Diversity - The shifting diversity and the percent of population identified as non-Hispanic White by age group and how it has shifted across the generations. Children 0-4 age category are less likely to be identified as non-Hispanic White than any other age group, so they are more likely to identify as Hispanic or other than white, compared with 90 percent of our 65+ population. In 2014, the median age of Rhode Islanders who identified as Hispanic was 26 years, compared with 45 years for Whites, 34 years for Native Americans, 32 years for Blacks, 31 years for Asians and 20 years for those who identify as two or more races, which is a fairly new racial category in the census being used by younger populations to describe themselves.

Secure Parental Employment - The employment status of parents were tracked by family type whether it be one or both parents in the labor force or no parent in the labor force. Unemployment is decreasing in Rhode Island where in December 2015 the unemployment rate was 5.4%, slightly above the U.S. average of 5.0%, and the 19th highest in the nation, but has gone down considerably from five years ago when the unemployment rate was 11.2%.

Median Family Income - We continue to see major racial and ethnic disparities. The median family income for all races is approximately $73,000 per year; white families are slightly higher at approximately $79,000; Asians are slightly lower than the median income at $69,000, and when looking at the Black at $39,000, Hispanic at $32,000 and Native American at $25,000 they are all considerably lower than the median income.

Poverty by Race and Ethnicity - Between 2010-2014, 20% (43,144) of Rhode Island children under the age of 18 with known income status lived below the federal poverty threshold. In 2015 the federal threshold was $19,096 for a family of three with two children. The following is a breakdown of children living in poverty: 15% White, 36% Black; 15 % Asian; 57% Native American, 41% Hispanic and 28% identified as two or more races.

Children in Families Receiving Cash Assistance - The cash assistance caseload has been steadily declining since the program began. Between 2014 and 2015, the Rhode Island cash assistance caseload decreased by 17%. Also, in Fiscal Year 2015, for the sixth year in a row, no state general revenue was allocated for cash assistance. It's entirely federally funded at this point.

Secretary Roberts questioned if that number is decreasing because people are now working or if they have reached their eligibility limit to collect.

Director DePena stated that based on the data we have, we know we are not doing a good job in getting people back to work, so that is not the variable that is accounting for the decrease. DHS is currently working with Brown University to get a better understanding of the data. Director DePena added that DHS has a very restrictive program with time limits, and they are looking at making legislative changes to help families remain stable. Director DePena also stated that they are not meeting the work participation rate for two parent families, and the Governor's Office and the Department are looking at ways in which could determine whether or not to go back to the stay at home program will be helpful to not only improve the work participation but also improve employment outcomes for families. The federal government has requirements about what work participation rates the State has to achieve which is 50% for all families and 90% for one parent families.

Children Receiving Supplemental Nutrition Assistance Program (SNAP) – Of the 165,098 Rhode Islanders enrolled in SNAP in October 2015, 63% were adults and 37% were children.

Children's Health Insurance - Rhode Island only has 3% of the children uninsured right now as the RIte Care enrollment rose to a new high of 141,901 in December 2015 (up from 130,639 in December 2014). Approximately 72% of the estimated 9,590 uninsured children were eligible for RIte Care based on family income between 2010-2014.

Children's Dental Care - Specifically the children enrolled in the Medicaid Assistance Programs, 44% of children who were enrolled in RIte Care, RIte Share or Medicaid on June 30, 2015 received a dental service during State Fiscal year 2015. Since RIte Smiles started in 2006, reimbursement rates have been raised for participating dental providers. The number of dentists accepting qualifying children increased from 27 before RIte Smiles began to 90 at the launch of RIte Smiles. In October 2015, there were 359 unduplicated dentists in 195 practice locations participating in RIte Smiles.

Children's Mental Health - In 2014, there were 2,744 hospitalizations of children under age 18 with a primary diagnosis of a mental disorder, a 53% increase since 2005). This is up slightly from 2013, when there were 2737 hospitalizations. Jill added that within this data, there could be a child that has been in and out of the hospital in any given year and be represented more than once.

Children with Lead Poisoning - Jill reported that we are making tremendous progress in the terms of decreasing the percentage of children being exposed to lead poisoning. However, there remain troubling disparities among the children in the four core cities as compared to the remainder of the state. There were 894 children entering kindergarten in the Fall of 2017 had history of confirmed elevated blood lead levels.

Infants Born at Highest Risk - is defined as babies born to unmarried teen mothers without a high school diploma. Between 2007-2015, births to single mothers declined from 47% to 45% to mothers without a high school diploma fell from 18% to 11%, and births to teen mothers fell from 10% to 5% of all births.

Declining Numbers of Youth in the Juvenile Justice System - The number of children and youth referred to Family Court for wayard and delinquent offenses declined 43% between 2009 and 2015, from 4,825 to 2,770. During the same period, the number of juvenile offenses declined by 38% from 7,829 to 4,885. Between 2006 and 2015, the annual total number of youth in the care and custody of the Training School declined from 1,123 to 470. Some of this decline is due to the cap that was placed on the population at the Training School in July 2008 of 148 boys and 12 girls on any given day. The population further declined by 47% between 2009 and 2015. On December 31, 2015 there were 88 youth at the Training School, which was good news as traditionally there are more than 100.

Decreases in Child abuse and Neglect - After increasing annually between 2011 and 2014, the number of child maltreatment reports, completed investigations, and indicated investigations of child abuse and neglect declined between 2014 and 2015 in Rhode Island (but remain at high rate).

Commissioner Wagner inquired as to the data showing of the cases that were referred against the percent and number of investigations were closed in a certain period of time. Does that mean we close fewer than half of the referrals within a year?

Secretary Roberts suggested that with Jamia's absence, she'd like to bring this question back so Jamia may give further detail on the data.

Children in Out-of-Home Placement - As of December 31, 2015, 34% (711) children are in foster care home with a relative; 32% (659) children are in a non-relative foster care home. There has been a decrease of children living in congregate care. On December 31, 2015, 400 children lived in a residential facility or group home, a decline of 11% from 449 children on December 31, 2014.

Child Care Subsidies - In December 2015, 84% of all child care subsidies in Rhode Island were being used by low-income working families not receiving cash assistance and 8% by families enrolled in the RI Works Program who were engaged in employment activities. Another 8% were used for children in the care of DCYF.

Children in Full-Day Kindergarten Programs - In the 2015-2016 school year, 88% of children who attended public kindergarten were in a full-day program. Also, in the 2015-2016 school year, 31 of the 35 elementary school districts and all of the public charter elementary schools in Rhode Island offer universal access to full-day kindergarten.

Third-Grade Reading and Math Skills - In 2015, 37% of Rhode Island third graders met expectations in reading on the *PARCC* English Language Arts Assessment. Also in 2015, 36% of Rhode Island third graders met expectations in math on the *PARCC*, compared to 25% of seventh graders.

Chronic Early Absence - Chronic early absence is the percentage of children in kindergarten through third grade (K-3) who have missed at least 10% of the school year (i.e., 18 days or more), including excused and unexcused absences. In the 2014-2015 school year, 18% of kindergarten children missed school and 31% of 12th graders missed school.

High School Graduation Rates - College Preparation and Access - We are seeing improvements in the graduation rates. The four-year graduation rate for the class of 2015 was 83%, up from 70% for the Class of 2007. Jill reported that in regard to the college preparation and access, 63% of Rhode Island students who graduated from high school in the Class of 2014 enrolled in college immediately. However there were gaps where 57% of higher-income students immediately enrolled in a four-year college, compared to 25% of low-income students.

Jill concluded her presentation of the 2016 Fact Book update.

Secretary Roberts thanked Jill and stated that the Fact Book is an incredible resource. Since launching the Children's Cabinet strategic plan, we have spent time discussing several performance measure indicators and population-level outcome indicators at past meetings, and we recently convened committed community stakeholders to discuss a range of indicators. One of the key issues raised was how do we focus on the Core City indicators, so that we can assess relative inequities across different regions of the State. It's very indicative of the disparities we are seeing, and it's important for us to develop some strategies to address them. We want to make sure we are using our Data Dashboards appropriately to track population-level child outcome indicators that serve as strong and reliable indications of our progress toward desired outcomes. Secretary Roberts asked Dacia to give an update on the Data Dashboards.

Dacia stated that through several conversations and research, we have identified the following narrow set of indicators that are regularly collected in Rhode Island, largely able to be disaggregated by race, gender, and

geography; and strong proxies for the outcomes and objectives that we laid out in our strategic plan. Dacia reiterated that this narrow list is not inclusive of all of the population and performance indicators available to us as we monitor child-well being and set desired benchmarks moving forward. Rather, they connect to our current desired outcomes and objectives.

2016 Children's Cabinet Data Dashboard Indicators (a/o 4-25-2016)

Physically Healthy & Safe	Behaviorally Able & Emotionally Hopeful	Academically Prepared & Career Ready	Socially, Civically, Culturally Engaged	Supported by Stable Families & Communities
Health Coverage % of children without health insurance.	Mental Health - Depression % of HS students who felt depressed, sad or hopeless.	School Readiness % of children enrolled in Pre-K.	Multilingualism Rate of participation in dual language programs.	Child Poverty % of children under 18 living HH with incomes below the FPL.
Maltreatment Child abuse and neglect indicated victims rate (per 1,000).	Mental Health - Hospitalizations Rate of hospitalization for children under 18 due to mental health conditions.	Third Grade Reading % of 3rd graders meeting expectations in reading.	Bullying % of out-of-school suspensions for harassment/intimidation.	Mother's Education Level % of total births to women with less than a high school diploma.
Asthma Prevalence Rate of hospitalizations for asthma where asthma was the primary diagnosis per 1,000.	Mental Health – Suicide Rate of suicide amongst children under 18.	Chronic Absence Rate of chronic absenteeism.	Disconnected Youth % of teens not in school and not working.	Homelessness % of children under 18 who stayed at a shelter or transitional housing facility.
Lead Exposure % of children with >5 mcg/DL blood lead level.	Substance Use – Marijuana Proportion of adolescents reporting use of marijuana in past 30 days.	Graduation Rate Rate of student graduation after four years.	Juvenile Justice % of children and youth referred to Family Court for wayward and delinquent offenses.	Housing Cost Burden % of renters spending >30% of household income on rent.
Infant Mortality Rate of infant mortality per 1,000 live births.	Substance Use – Alcohol % of high school students currently drinking.	Post-Secondary Readiness % of RI HS graduates requiring remediation at CCRI.		Secure Parental Income % of children living with at least one parent who has full-time, year-round employment.
Gun Violence Gun-related ED visits among children and youth.		Career Readiness % of HS students earning industry recognized cred.		

Dacia added that through this entire process, we have learned that we are a very data rich state, with the Fact Book which is an incredible resource, unique sources such as RI Data Hub, as well as a lot of data research and policy organizations that guide us with a lot of insight. Our agencies are really committed to using data to set benchmarks for our programs and how well we are implementing interventions for some of the outcomes we want to see. Using the Dashboards will keep a pulse on how we're doing towards outcomes, then sticking to outcome specific indicators, and not program measures, is a way for us to have that picture on a regular basis

and to make sure that we are using data that is regularly collected and something we can go back to and look at trends over time. The current Dashboard is a narrowing down proposed set of indicators that fit into that set of criteria and also tightly tied to our outcomes and objectives, and therefore is a recommendation for the Children's Cabinet to have conversation around and to start off as a round one set of indicators with the understanding that as other issues arise, we can certainly add to it. Dacia invited the Cabinet to respond with any immediate reactions they may have.

Director Jensen referred to the Career Readiness Percent of High School students earning industry recognized credit, and asked about the percentage of high school students entering employment. Some students will graduate from high school and enter into a career as opposed to some students who may get into a dead end job.

Dacia stated that she will look more deeply into that indicator as she understands the outcome piece, but needs to identify what source has been tracking that data.

Director DePena added that summer youth employment should also be factored, as there are some children that are not exposed or do not participate in employment until they graduate or drop out of high school and then there is no connection.

Dacia stated that she will look at how the employment is defined in different ways and bring that information back to the Cabinet.

Commissioner Wagner added that on the linkages between the P-12 and Workforce, we are almost there, but believes we need an indicator that helps us get there.

Secretary Roberts opened the floor to Public Comment.

❖ **Public Comment**

Sue Pearlmutter inquired about the data, and stated that in many communities these kinds of data are trapped longitudinally, individually, and what's reported is the aggregate, but you have one source of data that follows people over a long period of time so you can see who is achieving outcomes, not just that an outcome was achieved. You can define who is achieving them, who isn't and what all that information looks like. Sue wanted to know if that is the direction we are moving in, because other communities have found that use of data provides the best information on the long term consistent direction of programs that are intended to help vulnerable populations.

Director Jensen asked Sue which communities she was speaking about.

Sue Pearlmutter stated that the community she is speaking about and is most familiar with Kioga County, Ohio, which has a very interesting population group and they have been working with a large community database for years and in the last five or six years, they established a children's agenda through their County Commissioners so it is a very similar set up of government organizations contributing data, which the University then links together to produce these regular reports then convening the government agencies and community providers to help them look at what's going on and where they are succeeding and where they are failing to meet the outcome goals.

Secretary Roberts stated that the cabinet and public were just briefed by Kids Count with information that breaks down across population and across communities; and asked Sue Pearlmutter what the opportunity is in creating a whole different structure as compared to the data that we use now.

Sue Pearlmutter stated that what she is talking about is similar to what the Providence Plan is using, because their structure is based on the structure that is used in Kioga County, which is individual level data.

Secretary Roberts stated she understands the structure, but what is the opportunity that it gives us, that we don't get right now through our current data reporting structures.

Sue Pearlmutter stated you can look and match data across all of these groups across what you are getting from Kids Count and other data providers to be looking at the people who are receiving services from the programs. It looks at individual outcomes and then those individual outcomes are aggregated.

Dr. Alexander Scott added that this is not far of Ms. Pearlmutter is referring to, as we certainly have the aggregate data collection side of this, and understand her point of the reminder that each agency that pulls this data together to provide for the Dashboard should be looking at the individual and coordinating in a confidential manner on how to address the interventions needed for those individuals.

Andrew Bramson from the Providence Plan stated that he and the Providence Plan are very familiar with the work that Claudia does in Kioaga County, she is a fellow partner with them at the National Labor Indicators Partnership and stated that they have some unique advantages in that they are working in a County Government system which gives them much better access to some of the health data services that we don't have here in Rhode Island. When looking at the 20+ indicators on the current Dashboard, we probably have individual level record data across health, education and workforce that we can do that individual linkage and produce that aggregate level information, but some of the indicators are only collected in aggregate information so the real science is how to maximize those areas where you can do individual level linkage and then how to piece together some of that aggregate information to give a broader and clearer picture. There is a lot of information on the Dashboard that the Data Hub already has and there is more forthcoming around Juvenile Justice and some of the Human Services and TANF areas, and we are making progress.

Dacia added that in the Cabinet's Strategic Plan we have a strategy called "Shared Measurement and Accountability" and under that we itemize the different methods of for which we want to use data to make decisions and there is one that we articulate that uses Dashboards to simply keep a pulse on outcome data and to have a sense on an annual basis and getting updates from the Fact Book which provides that aggregate data picture in a much more robust way, and also having some that are related outcome indicators for us to be looking at. Having that high-level aggregate data on dashboards was a method for us to keep ourselves looking at how we are doing with trends and how we are doing across population. We also have another series of different uses of data for setting benchmarks, and program interventions and being able to link data from person to person which we are currently doing with our early childhood work in trying to bring the DCYF and DOH data together as well as an individual level to track how we are doing with care coordination. To the capacity that we can use data on the more objective projects across agencies, it's definitely not mean to be suggested to be excluded from the creation of dashboards that provide us with that big picture on how we are doing with outcomes and we are in a unique position with people who are really committed to using data in different ways to not keep ourselves in one direction or the other.

Dr. Elizabeth Lowenhaupt from the RI Council for Child and Adolescent Psychiatry commented the previous presentation of adolescent substance use. First, in terms of how the kids end up addicted to substances is different than it is with the adults. It's typically not a doctor prescribing them pain medications to the adolescent, but rather they are usually getting it as they anything else that is through risky behavior, such as stealing from parents, getting them through pimps, other adults, etc. So there is a different approach that we would probably need to think about for them on that aspect. Second, in terms of the treatment and access to care, child and adolescent psychiatrists are in short supply, and with the shortage of substance abuse providers and the overlap between the two is almost non-existent, there are probably five people in the state who are willing to do both. It should be a priority for us to focus on treatment wise.

- **<u>Adjournment</u>**:

Secretary Roberts asked if there were any further comments or questions. There were none. Secretary Roberts stated the next Children's Cabinet meeting will be held on Monday, May 23rd, a week earlier as the last Monday of the moth is Memorial Day Holiday. Secretary Roberts thanked everyone for attending and asked for a motion to adjourn. Director Jensen made a motion to adjourn, Dr. Alexander Scott seconded. All were in favor, 0 opposed. The meeting adjourned at 11:30 a.m.