The Children's Cabinet
Monday, September 26, 2016
DOA Conference Room A
10:00 a.m. – 11:35 a.m.
Meeting Minutes
Approved 10/31/16

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

❖ **Call to Order and Agenda Overview:**

Secretary Roberts called the meeting to order and thanked everyone for attending. The Secretary asked for a motion to approve the minutes from the August 29th meeting. Jamia McDonald made a motion to approve and Director Jensen made a second motion. Secretary asked the Cabinet if there were any comments or amendments to be made to the minutes. There were none. Secretary asked all those in favor of adopting the minutes, all were in favor, 0 opposed. Motion passed and minutes were adopted.

At our last meeting, we set out to identify opportunities for coordinated action that can improve behavioral health outcomes for our children, adolescents and young adults in Rhode Island. As we engaged in our community brainstorm, we began asking several important questions about system structure, values, objectives and services. As we continue our internal review of children's behavioral health services across the agencies, we want to continue this important conversation with the members of the Cabinet and our valued stakeholders.

It was evident last month that each agency of the Cabinet play an important role in improving children's behavioral health and redefining service delivery. The insightful conversations we have at this table serve as critical guideposts for our work together. Finally, we will again ask for your help defining guideposts for our work related to two goals recently announced by Governor Raimondo, around education goals that are going to be fundamental to the success of our children the success more broadly in our community. Secretary Roberts turned the meeting over to Dacia.

❖ **Children's Behavioral Health Overview**

Dacia gave an overview of the last meeting where the following was discussed:

- **Children's Behavioral Health Dashboard Indicators**
  - **2,744** children under 18 hospitalized with primary diagnosis of mental disorder.
  - **26.4%** of HS students reported feeling depressed, sad or hopeless in the last two months.
  - **11%** of children under 18 report attempting suicide one or more times in the last year.
  - **24%** of high school students report using marijuana in past 30 days.
  - **26%** of high school students report current alcohol consumption.

- **Truven Report Findings**
  - Children in RI face greater economic, social and familial risks for developing mental health and substance use disorders than children in other New England states and the nation.

- **Truven Report Recommendations**
  - Reduce Risk
  - Responsive Program Models
  - Population Health Approach

- **Community Brainstorm:** Definitions, Outcomes and System Structure

During our community brainstorm, we took time to interrogate and align system definitions to ensure that they reflect our state-wide system, and state-wide commitment to improving outcomes for children and adolescents.

Defining Terms

- **Population Health**:
  - Physical and behavioral health of the population.

- **Children's Behavioral Health**:
  - Mental health and substance abuse of children ages 0-21.

  Briefly at our last meeting, we discussed the age ranges that define our system of supports for children and adolescents, and we need to be thinking of this as we build our system.
  - Pre-natal
  - 21 = Agency Transition Age
  - 24 = CC Scope
  - 26 = Coverage Transition Age

- **Children's Behavioral Health Services:**
  - Prevention, residential and community-based treatment, and other community-based, social-emotional supports.

  Briefly at our last meeting, we began defining the types of children's behavioral health services in R.I.

    - Focus on Prevention
    - Continuum of Responsive Services
    - Multiple Points of Entry
    - Serving Children, Adolescents & Families
    - Publically and Privately Funded

What had been apparent in speaking with staff from different agencies, was that we had developed more than one way across state government to address the mental health and substance use of children and adolescents, and that if we were going to add or improve any elements of the behavioral health service array in RI, our efforts would be strengthened by assessing how all of the parts of our system make up a whole. Our system is both public and privately funded, and a lot of services that can help people might come through with private coverage or state administered programs. While there may be some traditional diagnosis-driven services that are traditionally referred to as "children's behavioral health services," or statutory definitions requiring certain actions by certain departments, for the purposes of our shared system mapping exercise and subsequent efforts to apply our collective impact to improve outcomes, we discussed the definitions above.

Much of our conversation raised critical questions about system values, objectives, outcomes and services. Having been engaged in several conversations with stakeholders in the room, we began looking at how other states had defined these things.

System Values

Through agency strategic plans, we have each demonstrated commitments to these values in each agency; this is an example of a single coordinated application of these values for the children's behavioral health system specifically. These are system values from our two neighboring states – notice, they reflect several of the themes we discussed last month.

Massachusetts	**Connecticut**
• Child-Centered and Family Driven	----------Family-Driven and Youth-Guided
• Strengths-Based	Community-Based
• Culturally Responsive	----------Culturally and Linguistically Appropriate
• Collaborative and Integrated	Trauma-Informed
• Continuously Improving	

Secretary Roberts asked Dacia for clarification on the meaning of Strengths-Based listed in the Massachusetts system value.

Dacia stated that Massachusetts had a commitment in their plan to promote programming that was building on the strengths of the local community. It is a family or place-based strengths programming that would be supportive of positive mental or behavioral health.

Acting Director Boss suggested that on a service level that we look at Strengths-Based clinically by individual, so that when we are addressing a problem with an individual, you are focusing on their strengths as opposed to their deficits as a way to drive planning to address the problem.

System Objectives

Dacia shared a series of system objectives from our neighboring states, as well as New York state – a state similar to ours in that Medicaid finances much of the behavioral health system.

Several of these objectives are reflected across states, and align with recommendations from the Truven Study.

Massachusetts

- Increase Timely Access to Appropriate Services
- Expand Array of Community-based Services
- Reduce Health Disparities
- Promote Clinical Best Practice and Innovation
- Establish an Integrated Behavioral Health System across State Agencies
- Strengthen, Expand, and Diversify Workforce
- Mutual Accountability, Transparency and Continuous Quality Improvement

Connecticut

- System Organization, Financing and Accountability
- Health Promotion, Prevention and Early Identification
- Access to a Comprehensive Array of Services and Supports
- Pediatric Primary Care and Behavioral Health Care Integration
- Disparities in Access to Culturally Appropriate Care
- Family and Youth Engagement
- Workforce

New York

- Early intervention
- Evidence-based practices and accountability for outcomes
- Team based, family-centered approaches that addresses unique needs
- Family advocacy
- A continuum of care (via managed care)

Secretary Roberts asked whether these states were just thinking about children who are served by the state or are they looking across all payers?

Dacia stated they are thinking across all payers and were distinct in some of the ways they describe their service models or state financing, but in terms of setting out statewide objectives these were for the service array as a whole.

Acting Director Boss suggested that the Cabinet focus on the Health Promotion, Prevention and Early Identification as listed in the Connecticut model as well as the Early Intervention as listed in the New York model.

Director Jensen added that in reference to the Team-Based Approach as listed in the New York Model, the Rhode Island WIOA Plan, also has a Team-Based Approach. In Rhode Island when people come into the one-stop looking for assistance in getting a job, sometimes we will run across a person who needs assistance in other areas. This Team-Based Approach would allow to call in a team with colleagues from different departments, such as someone with housing issues, or substance abuse issues, etc. Director Jensen suggested that the Cabinet consider the same Team-Based Approach model.

Director DePena also stated that through their assessments at DHS, they find persons may have mental health issues, language barriers, housing issues; and the idea is to have an interagency approach to understand what those barriers are so they can assist the people appropriately.

Acting Director Boss stated that going back to the clinical level, in the community with Children's Behavioral Health the team-based family centered approaches take that model but they take it to the clinical delivery setting. It's multi-disciplinary, with psychiatrist, nurse, a vocational specialist, or someone else who may be addressing a problem with a family. On the community level, it's really important especially with kids, and those are some of the evidence-based practices around early intervention which brings many teams together with the family to address

the problem in the community as opposed to the traditional response which has been hospitalization. It is something we need to think about on both levels, being clinical and interagency.

Secretary Roberts added that as we think about this issue, we don't have a broader approach that informs our programs and policies. We all have programs and policies of our own, which we think overlap with each other. There is a difference that we should address.

Acting Director Boss added that in reference to the Secretary's point, for example, BHDDH has efforts towards expanding the workforce that is culturally and linguistically appropriate, whether or not we are sharing our efforts across the departments is the question and whether or not we could be working better together towards those ends.

Commissioner Wagner added that it is not waiting for senior leadership to tell people to communicate, it is the person at the ground level with local leadership making a call, making a judgement and then activating a network. We need to get to the people providing the services an expanded awareness of what their resources are and having the legitimate positional authority to activate those resources. We need to decide at a leadership level whether we are comfortable with that or not, and that could take us into two dramatically different directions.

Secretary Roberts stated that we not only have to be comfortable, but we need to be sure the resources are available. We are responsible for where those resources are, so that person can actually accomplish the task.

Dacia stated that the capacity to gain community level input on our system of supports, is obviously very important to the Governor and this Cabinet – as evidenced by these meetings, DCYF's provider forums, etc. We see such themes defining the children's behavioral health system in other states. Marti Rosenberg of the SIM project and Rebecca Boxx of the Providence Children and Youth Cabinet have been asked to share more with this Cabinet about their recent work collecting community input and developing and implementing intervention services.

- **<u>Example of Community-Driven Programming in RI</u>**

    - Child Psychiatry Access Program
    - Providence Children and Youth Cabinet – CBITS

    <u>Items for Consideration</u>:
        - Which values?
        - Which objectives?
        - Which services?
        - Which outcomes?
        - Which access points?

Marti Rosenberg of the SIM Project presented on the Child Psychiatry Access Project, one of the top priorities of SIM that started on September 15th and is one of the first procurements out for SIM. The project has a lot of the values that the Cabinet has discussed, with multiple points of contacts, community-based, public and privately funded, as Lifespan and Bradley Hospital are contributing to the dollars spent as well. It is behavioral health integration, engaging primary care providers with psychiatric providers, not just providing services to those children or adolescents in the moment, but providing training over a long period so that after three years we hope to see primary care offices that will know a lot more about children psychiatric needs and are able to cover some of their needs in the primary care offices without kids having to go larger institutions for longer-term care. This will help separate those who can be served less restrictively and provide more resources to those kids who need those resources. The project is specifically designed to increase the availability of mental health care for children and adolescents by introducing psychiatric consultation services into the scope of primary care practices. This will also create strong primary care and specialists mentoring relationships and then use those resources for the ones in need the most. Any child or adolescent presenting to a pediatric primary care practitioner with a possible or likely mental health need is able to be treated. They are going through the 240 pediatric primary care practitioners mostly, although SIM is exploring what other folks might be able to refer to project. There will be about 2,500 children and adolescents served by these providers annually. The project is imbedded in Bradley Hospital's Pediatric Referral Consultation Clinic (PRCC), which supports the integration of psychiatry in the scope of

pediatric practice. The activities include enrolling the primary care practices - to ensure that if the primary care provider has a child in their office that is having an issue, they can call the psychiatrist at Bradley and within a half hour they will get a call back with help in regard to medication and dosage. Also the need for referral, – what else needs to happen for that child, it could lead to a face-to-face evaluation of the child by Bradley; and brief treatment on the transitional basis if necessary and then figuring out where to go next, hopefully sending them right back to their primary care practice where they will be able to monitored over the long term. There are a number of different training opportunities built into project so that it is sustainable: Grand rounds, presentations to the practitioners in their respective trade associations; list-serves and other conferences. In every way, the community versus inpatient treatment, is the goal for children and adolescents. We expect there to be 4,000 service encounters for those 2,500 children annually, broken down into the following:

- 40% telephone consults
- 29% peer coordination
- 11% face to face
- 10% telephone discussions with the parents and families
- 3% face to face follow up visits

Marti concluded her presentation stating the outcome is to help the primary care practices become more integrated and more connected on a long-term basis.

Secretary Roberts asked in regard to the connections with the community mental health organizations, do we have a connection in terms of the referral patterns, and are they currently in the conversation?

Acting Director Boss stated that to the best of her knowledge, not so much, it's been mostly the pediatricians and primary care practices as opposed to the CMHO's which tend to be the stop at the end when we don't have any other resources.

Marti stated that in the project's work plan, Bradley will take steps to build a stronger referral network with ongoing outreach and dialogue with referral partners in local communities.

Dr. Alexander Scott added as we discussed the connection point between pediatrics and the community mental health centers, to add to that question, is there a comfort level that there is capacity within the community mental health centers to respond to pediatric psychiatric needs?

Acting Director Boss stated that most likely not for all, as you cannot expect them to respond to the entire needs of the community. We need to develop greater capacity within the community itself and not just specific centers.

Jamia McDonald asked Marti if the metrics will capture that information or at least understand what the need versus capacity is.

Marti stated that there is a needs assessment included in the work plan that Bradley is to conduct mostly to the practitioners who are referring, but as they figure out the referral patterns, they will need to figure out where the folks are not able to get treatment.

Dacia thanked Marti for her presentation, and introduced Rebecca Boxx of the Providence Children's Youth Cabinet (PCYC) to give her presentation.

Rebecca Boxx stated that the Providence Children's Youth Cabinet is focused on three outcome areas: 1) social and emotional well-being; 2) chronic absence and 3) positive school climate. All of these issues are intertwined and dependent on each other, therefore we try to look at them holistically. Rebecca stated that the Children's Youth Cabinet is the national pilot site for Evidence2Success, which is a partnership with Annie E. Casey Foundation. Through that framework, they have been able to look at extensive risk and protection data received through citywide school surveys, where they are able to identify shared priorities and evidence-based programs that our community have been shown to move the needle on those priority outcomes. Through that participatory process, they have identified six evidence-based programs to implement in Providence, ranging from universal programs that are happening in school classrooms, to much more targeted prevention programs that are more therapeutic in nature.

Rebecca reported that one of the programs identified early on based on the data, is called Cognitive-Behavioral Intervention for Trauma In Schools (CBITS). It was selected due to the elevated levels of Post-Traumatic Stress Disorder in the community, and the positive behavioral outcomes that the program has been shown to have. The program is administered in middle schools, and while piloting the program last year, the preponderance of PTSD was beyond what they estimated or expected. For a program that had forty seats, there were over 100 students at the very first screening that qualified. As a result of that pilot they applied for and received a 5 year $1.8 million grant through SAMHSA which will allow them to take the pilot and scale it across all the middle schools in the city of Providence. The project is called Building Trauma Sensitive Schools (BTSS), a five point strategic initiative that when successfully implemented will result in population level decreases in Post-Traumatic Stress Disorder among adolescents in Providence middle schools with elevated levels of trauma. To ensure youth engagement, they are partnering with Everett Theater and Stage Company who have done a lot of work over the years engaging young people in the performing arts to emolliate trauma. We also want to think about the schools as a system that can become more trauma informed and will deploy a variety of professional development, training, and in-service opportunities to school system personnel for building trauma-sensitive schools. This particular program, CBITS is one of a continuum of evidence-based programs, and as we think about how those programs are being implemented and rolled out there are a few things we have learned. The first is how we fund this continuum of supports, and can do so, by leveraging existing dollars and finding new dollars to fund shared outcomes. Currently some of the programs identified by the community already have been funded, such as Nurse Family Partnership, funded by DOH. We are also looking at new dollars, and SAMHSA is our first big federally funded investment, we have also received Community Development Block Grants through the City to fund some of the preventative services. We are at $1.2 million annually between dollars raised and dollars leveraged. Almost all of programs selected were either centered on schools or the schools play a critical role in terms of a referral pipeline. The process was very participatory in terms of identifying the outcomes, there were residents, systems leaders, and local leaders participating in the identification of the outcomes which has given a sense of ownership, ongoing engagement, and accountability.

Director DiBiase asked if Rebecca considered the middle schools to be a significant source of the trauma.

Rebecca stated she would not consider the schools to be the source of trauma, but rather how can the entire school community understand what the manifestation of trauma is that kids are coming to school with. We have to understand where the behavior is coming from, and if it is trauma, how does a school system understand that and respond appropriately. There are a lot of community based questions, such as, has the child witnessed violence or have they been a victim of fighting, etc.

Dacia thanked Rebecca, and stated the Child Psychiatry Access Program and CBITS are two examples of targeted interventions that provided outcome-driven, community-driven capacities to our continuum of supports.

As conversations continue regarding system values and objectives, we will be looking at services and financing to ensure that we are promoting the outcomes we want. As described last month, we have already begun this process with the SIM project, by engaging a system scan with Providence plan and DataSpark.

Dacia shared some preliminary data stating they just completed round one of the scan. The information gathered is still ongoing, they have not yet identified programs, however they have identified streams, and will need to do more to figure out dollar amounts and total of targeted people reached, but there is a level of additional inquiry that we encourage feedback on.

Children's Behavioral Health Services Scan*:*

To date, we have identified 76 distinct programs that are administered through 5 state agencies - BHDDH, DCYF, DOH, Medicaid, RIDE. Information gathering is still ongoing.

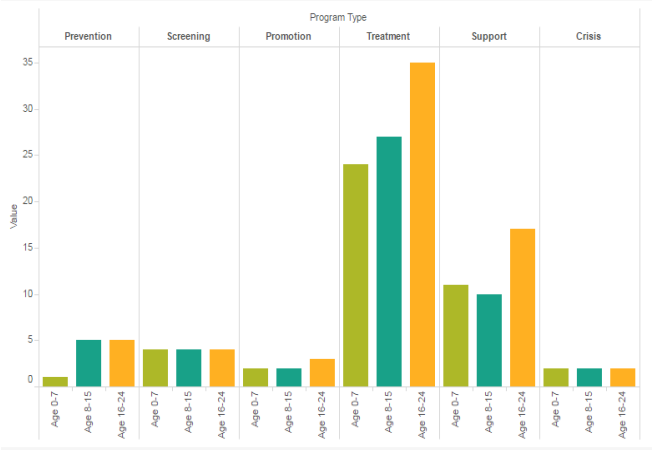
Preliminary Findings:

Program Types:

- The majority of programs provide direct treatment (36), followed by support services (20).

Access:

- While only 7 programs have specific geographic eligibility requirements, the location of provider(s) may limit access to others.
- 44 programs serve 0-7 year olds
- 50 programs serve 8-15 year olds
- 66 programs serve 16-24 year olds

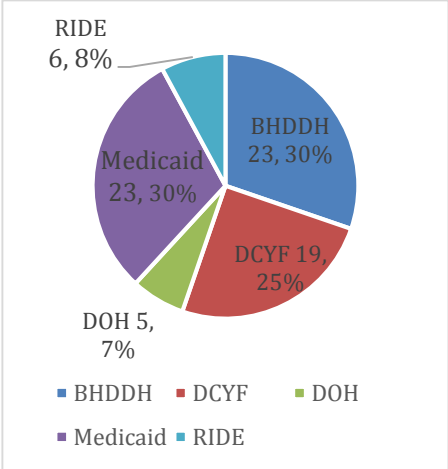


- Age ranges are not mutually exclusive; some programs serve 2 or 3 age groups.
- Some programs have multiple programmatic approaches, like screening and clinical treatment. They are categorized by primary program type here.
- Total numbers of programs do not reflect total reach of programs.
- **Promotion** refers to programs that broadly promote positive health behaviors, as opposed to targeted or clinical interventions. For example, a community education program to reduce BH stigma would be categorized as promotion
- **Treatment** refers to targeted BH treatment in which a patient receives clinical interventions from a BH professional
- **Support** refers to supportive services for children or families with BH needs that address issues beyond clinical care. This includes connection to resources, educational services, and environmental supports.

Secretary Roberts inquired as to whether we are looking at the local government level, such as local housing authorities, local education agencies, etc.

Dacia stated that in mixing of some of the funding streams will capture those, however, there are some gaps.

Dacia shared preliminary data of the total programs by administering agency, stating that they may have already begun collecting data, while with others they may need to be looked at more deeply.



Program Types Include:

- Prevention
- Screening Promotion
- Treatment
- Support
- Crisis

Program Focuses Include:

- General Mental Health
- Substance Abuse
- Family Support
- Life Skills
- Emotional Disturbance
- Crisis Response
- Serious Mental Illness
- Suicide Trauma

Dacia concluded her overview of the Children's Behavioral Health data and turned the meeting to the Secretary.

Director DiBiase added that we should understand there are a lot programs that are the product of federal funding streams, grants and departmental budgets and encouraged that we have a strategic plan to focus on the various missions of Children's Behavioral Health.

Secretary Roberts added that while we are thinking about strategic direction, we should be looking at where we have actually seen some success and do some strengths based planning.

❖ **Governor Raimondo's Goals for Kids**

Secretary Roberts acknowledged Governor Raimondo's recently announced goals for children and young adults in Rhode Island.

By 2025:
- Double the percentage of third graders reading at grade level by 2025.
- Ensure that 7 out of 10 working-age Rhode Islanders have a degree and the skills they need to compete for job in the 21st Century.

These are goals that our agencies are already working toward. They reflect several of the agency objectives were catalogued in our strategic plan, and many of the stakeholders in this room have been involved in informing and implementing strategies to realize these goals.

Keeping us accountable, Governor Raimondo has now set a deadline for us, and in many ways, these deadlines allow us to re-group, re-consider strategies and make sure we're on an outcome-driven path toward our goals. We received a series of recommendations from the Early Learning Council that can help us reach our third grade reading goal, and I look forward to working with them over the coming weeks. We have also heard from DLT and our education colleagues regarding Prepare RI investments and WIOA.

The Secretary asked the Cabinet and stakeholders for additional considerations they think should be made at this time in relation to these two goals.

Commissioner Wagner stated that what's important is that the Governor's goals were structured so that it is the lifespan of the children who have to hit the target, starting with children born this year. Commissioner Wagner stated that there are roughly 10,000 children per grade level and suggested we identify a cohort that can identify the families with the children born this year to be tracked through the third grade.

Secretary Roberts stated that those children can be tracked rather quickly as almost all the children are born at Women and Infants Hospital and they are currently doing a longitudinal study and have the ability to contact those families. The Secretary suggested that this needs to be a mission and not a program driven initiative. It is something that we need to get the broader community and families to commit to and drive change across the community.

Director DePena concurred that this needs to be campaign as the Governor has asked to double the percentage of third graders reading at grade level by 2025. There are children with developmental disabilities that may need early intervention, etc. and it can be complex. Director DePena suggested to look at organizations such as Kids Count that are already engaged in these areas, as well as involving the PTO's and the child care providers.

Director Jensen asked what the percentage of children who are reading at the third grade level now.

Commissioner Wagner stated that 38 percent of children are reading at the third grade level.

Jamia McDonald asked Commissioner Wagner if he knew what the barriers were that are prohibiting the other 62 percent of children from not reaching the third grade reading level.

Commissioner Wagner stated that our percentage is not very different from other states, and it is all of the typical issues such as, expectations, supports, housing, labor, etc. there really isn't a single element that creates the barrier for the children.

Acting Director Boss added that it's also related to all of the discussions we are having around the Truven Report and the kind of factors that lead to increased incidents of behavioral health amongst children, those factors are not going to help them be third grade readers. In our efforts, we will need to look at those factors and how to tie this all in together.

Director DePena suggested that a task force be established to develop ideas along this campaign, as she is concerned that in their effort double the percentage of children reading at a third grade level, there may be some children left behind and it may be more difficult to get them to read.

Dr. Alexander Scott added that the attention to this campaign will set us up for driving policy and putting together some form of statutory or regulatory bundle that takes into account some of the policy changes that are needed whether among schools, housing concerns, employment concerns, and taking into account whole families starting from pregnancy working its way up. All of these issues connect, when we address behavioral health, toxic stress, housing, employment and family supports, and those are the things that will set us up to get better third grade level of reading.

Secretary Roberts agreed and recognized those issues, stating that we need a strategy that will apply to everyone in how we help them learn to read so they can build a successful educational experience. Secretary Roberts asked Director Jensen if he had an update in regard to the second goal of ensuring 7 out of 10 working-age Rhode Islanders have a degree and the skills they need to compete for job.

Director Jensen stated they are trying to drive change in systems from the job demand and reengineer going forward. They are working on CT programs that are going to be relevant for someone who wants to take that path, so that a kid gets to see a job at the end of that training. This also applies to adults in the workforce who have struggled. Rhode Island has a lot of underemployed people where we need to have their talents applied in more productive spaces in the economy.

Director DePena added that this mission also includes the TANF population, and reported that DHS and DLT will be conducting a more comprehensive assessment of the needs of underemployed and unemployed individuals have, so they can provide those skills.

- **DCYF Director Search Forums**

Secretary Roberts thanked Chief Strategy Officer, Jamia McDonald, for her important work at DCYF over the last 18 months. She has reflected several of our defining values as a Cabinet by leading data-driven, outcome-based reforms at DCYF, and facilitating a critical decline in the utilization of congregate care settings.

Two forums will be convened in October to inform our search for a new DCYF Director. Secretary Roberts asked the providers and stakeholders to attend one of the forums as it is important to hear from the community as well as families to share their experiences, whether it's in the preventive side of services or their foster family involvement.

- **Public Comment**

Secretary Roberts opened the room for public comment.

Gail Mance-Rios of the Office of the Postsecondary Commissioner informed the Cabinet that in her work at the RI Higher Education Assistance Authority, they used the College Bound Fund to start the College Bound Baby Program and worked closely with the Department of Health. The program worked very well, where they had contact with every newborn's family and provided them with tools, resources and incentives along the way as they entered kindergarten and reading levels reached by the child. Gail also added that with respect to the 70 percent of individuals having a degree or certificate, they are working with the Governor's Office and RIDE on the New Skills for Youth Grant. One of the tools that could be used more robustly is the "Way To Go RI" website which could give more information to students at the time they are interested in it and to be sure they are channeling the students properly into the right careers for them.

Ron Seifer of Bradley Hospital stated there has been work over the last twenty years to develop comprehensive plans for early childhood but simply has not been implemented in a systematic way. The plans are well articulated and should be reviewed to see what can or cannot be implemented and work from there.

Jill Beckwith of Kids Count stated as the United Way and Kids Count continue their work on the grade level reading campaign, she will be sure to share information with the Cabinet and stakeholders through the list serve about future ways that groups can get involved in the campaign. The building blocks for it are generally school readiness, which have a lot to do with quality child care and health determinants such as chronic absence, and being sure kids have access to literacy rich learning environments at home, child care and in schools.

Dr. Phyllis Dennery of Chief of Pediatrics at Hasbro Children's Hospital added that in focusing on behavioral health and the high need that exists, there is a great opportunity that they were just awarded though the NIH which focuses on the environmental impacts on child health. It goes across the spectrum of physical health, mental health, etc., and they will be setting up clinical sites to better understand these outcomes and birth cohorts. There will be an opportunity to link with some of these activities to understand what's going on with the kids, how can we improve their behavioral and physical health, and their determinants of health.

Secretary Roberts stated that many of the departments have overlapping grants and we could leverage a lot more benefit from them if we coordinate how we are doing our work. Secretary Roberts asked Dr. Dennery to coordinate with Dr. Alexander-Scott to be sure those connections are made.

Lisa Guillette of Foster Forward added that she has been following and supporting the Yes on 7 for homes bond campaign, and was curious if thought has been given to how those investments could be strategically leveraged across the health and human services agencies to ameliorate issues such as children with chronic absenteeism and not achieving grade level reading, many have asthma and are in sick homes. Also there are many foster homes, particularly relative homes that cannot be licensed because of lead issues.

Secretary Roberts stated that she sits on the Inter-Agency Council on Homelessness where there is some of that overlap but it is more strategically focused on kids who are at higher risk. The Secretary wanted to think more about it and connect with Barbara Fields at Rhode Island Housing.

Dr. Alexander Scott stated that they have put forward a performance management Lean initiative for a statewide assessment of how we can better approach and coordinate activities regarding housing including lead, asthma and other issues.

Dr. Hollingshead stated that in reference to following a birth cohort of children born in 2016 to the class 2025, there is an advantage in that all newborns are screened and added into a registry and tracking system through KidsNet. Using that data, would show which children may have received early intervention services and other programs. It is also connected to the school database once the children reach kindergarten. In regard to literacy campaign, we should keep in mind that reading to any child is also extraordinarily healthy for the adult during reading, many of whom have struggled themselves with education. It is at least a two generation issue.

Ben Lessing of Community Care Alliance added that the recently completed certified community behavioral health clinic project that BHDDH is spearheading is probably the most comprehensive conceptual plan for children's behavioral health services that we have seen in twenty years. Ben strongly advised the Cabinet to review it as it covers birth through early adulthood. Ben also suggested that the Cabinet take their Children's Cabinet meetings to the community and have these conversations about children's behavioral health and how it intersects with child welfare, primary care, employment and training, etc. There is a need to understand what is going on in a challenged community, and offered to host a meeting in Woonsocket. Ben added that several years ago the State chose to move most of children's behavioral health into managed care. One of the things that was lacking relative to that decision was something that was addressed in a more positive way relative to adults with integrated health homes and acute community treatment was that the needs of the population were taken into consideration, such as what services were needed, length of service. That does not exist for children's behavioral health, and what they often see in Woonsocket are kids and families going through cycles of a few months of treatment, then they are moved to outpatient and then the cycle repeats itself. If that cycle was tweaked, they could be of more assistance to their local community so that the challenges that DCYF faces with the transition of kids from residential care and foster care.

Professor Stephen Buka of the Brown University School for Public Health stated in regard to the third grade level reading, we want to not only double the number of children reading at grade level, but to also improve the full spectrum of third grade readers. We want to think not only about the 38 percent of children that have crossed the threshold and are currently reading at grade level, and the 38 percent of children that are approaching the threshold, but also the 24 percent of children that are at the lowest reading levels and not near to the desired threshold. In order to improve reading scores for the full range of third graders, he would support Dr. Alexander Scott's position that a more fundamental review of programs and policies that address toxic stress, behavioral health and larger systemic issues is needed to impact the lowest achieving children and families. Secondly, he commented on the number of presenters who sought to identify and implement evidence-based programs that make a difference for kids here in Rhode Island. He noted the very limited evidence on what is known to be effective and that works for children. Professor Buka underscored that Rhode Island can be a leader not only in the consumption of evidence-based research but also in the production of such knowledge. Professor Buka offered the services of the Brown University School for Public Health to the Children's Cabinet to help achieve both of these goals.

Susan Duffy President of the American Academy of Pediatrics reiterated that we can focus on behavioral health issues, but we are challenged to think strategically about the mental health and the mental well-being of kids. It is really about the social and emotional wellness of families. We need to think about what programs currently exist to support and promote so that behavioral health is a secondary issue. The Governor's program is very tangible in how we promote mental health in kids, if they are ready to read and they are a creative person then that will promote mental health. In regard to the primary care, developing primary care homes where developmental screening can occur and kids can be channeled into programs early will support behavioral health initiatives within primary care. We can talk with CPAC which is a great program to help pediatricians manage mental health problems by imbedding mental health within primary care.

Secretary Roberts asked if there were any further public comment. There was none.

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

Secretary Roberts stated the next Children's Cabinet meeting will be held on Monday, October 31st. The Secretary thanked everyone for attending and asked for a motion to adjourn. Director Jensen made a motion to adjourn, Jamia McDonald seconded. All were in favor, 0 opposed. The meeting adjourned at 11:35 a.m.