COMMISSION TO ELIMINATE CHILD ABUSE AND NEGLECT FATALITIES

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Presenters:

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- MaryAnne Lindeblad, Director, Washington State Health Care Authority, Washington State Department of Social & Health Services
- Amy Baker, Children's Mental Health Director, Addictions and Mental Health Division, Oregon Health Authority
- Helen Bellanca, Maternal and Child Health Program Manager, Health Share of Oregon
- Myles Edwards, Independent Consultant
- Don Graham, Walter R. McDonald & Associates
- Ryan Vogt, Oregon Department of Human Services
- Joan Zlotnik, Director, Social Work Policy Institute, National Association of Social Workers Foundation
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- Kathleen Noonan, Co-Director, PolicyLab, and The Children's Hospital of Philadelphia

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DR. SANDERS: Good morning. We're going to get started, so if you could just take your seat. Good morning to everybody, and welcome to the Commission to Eliminate Child Abuse and Neglect Fatalities public meeting in Portland, Oregon.

We are going to get started with today's agenda, which is, as all of our agendas have been, packed, and I'm just going to go through very briefly the charge of the Commission, a little bit about how we do our work, and then have the Commissioners introduce themselves and we'll get started.

So I'm David Sanders, and I am with Casey Family Programs, and the Chair of the Commission. Our charge from Congress and the President is to put together a report within two years of our initiation, so that would be late this year, that outlines how, as a country, we can create

a national strategy to eliminate child abuse and neglect fatalities.

And we are focused on two primary areas. One is how do we better count fatalities? And every time I say that I think that it sounds like a dry topic, but if you think about if we didn't know how to count lung cancer, if we defined it differently, if we diagnosed it differently, if we weren't certain of who was doing the diagnosis, it would be very difficult to come up with solutions. And that's where we are with child abuse and neglect fatalities.

So the counting is really critical to our second charge, which is to produce a set of recommendations that ends up eliminating or reducing child abuse and neglect fatalities and really looking at what works and what doesn't work, and what Congress and the President can do to advance strategies -- to advance policy that will improve outcomes for children. We've done our work through a series of public hearings, and this obviously is one of those public hearings, and we've had the opportunity to hear from researchers, from practitioners, from policymakers, from advocates and others in identifying best practices, identifying strategies that are promising, and looking at potential changes in policy that might improve outcomes for children.

We have today a split agenda, where most of the morning and early afternoon will be spent hearing from panelists, including the Secretary here in Oregon, as well as one of the lead federal child welfare officials, and a -- teams from Washington and Oregon that will talk about best practices in the Pacific Northwest.

Let me have the Commissioners introduce themselves. And we also, I believe, have two on the telephone, but we can begin with Commissioner Dreyfus.

COMMISSIONER DREYFUS: Good morning, my name is Susan Dreyfus. I'm the CEO of The Alliance for Strong Families and Communities, and formally the Secretary of the Washington State Department of Social Health Services, and I love being in the Pacific Northwest.

COMMISSIONER STATUTO BEVAN: I'm Dr. Cassie Statuto Bevan. I have spent 20 years on Capitol Hill, I lecture at the University of Pennsylvania, and I'm the Chair of the Policy Subcommittee of the Commission.

COMMISSIONER ZIMMERMAN: Good morning, my name is Marilyn Bruguier Zimmerman. I'm an enrolled member of the Fort Peck Assiniboine-Sioux Tribes. I currently serve as the Director of the National Native Children's Trauma Center at the University of Montana.

COMMISSIONER RUBIN: Good morning, I'm David Rubin. I'm a general pediatrician and a professor of Pediatrics at University of Pennsylvania School of Medicine, and the co-director of our PolicyLab at the Children's Hospital, Philadelphia.

CHAIRMAN SANDERS: And we have two Commissioners, Commissioner Covington and Commissioner Rodriguez who are here and a bit late. We had three who were going to be here, and for various reasons had to cancel at the last minute, and then two on the telephone. I believe all five who are not here in person will be joining us for a portion of the meeting, but I believe we have Commissioners Martin and Petit on the telephone. Are you

there?

COMMISSIONER PETIT: Hello.

CHAIRMAN SANDERS: All right. We will go ahead and get started with our first presentation, which is Erinn Kelley-Siel, State Secretary for Oregon. Welcome.

ERINN KELLEY-SIEL: Thank you so much. Good morning, welcome to Oregon. On behalf of our Governor, Kate Brown, and those of us who commit our work-lives and professional lives to serving children and families, I just want to thank you all for the task you've undertaken on this Commission. For the time that I know that it takes, and for the important work that you do, in addition to what you're doing here, thank you so much.

As I was talking with Liz [Oppenheim] and Tom [Morton] about my role in today's conversation with you, my first question to them was is there anything that I could talk to you about that you haven't already heard? You've been meeting for a while. You've been, I think, receiving lots and lots of really great information from various smart people who have committed their lives to this issue. And so what I thought about was two points that I really want to speak to you about that have been important to me in my career here serving children and families.

I want to talk about the prevention of child abuse and neglect fatalities as not only the responsibility of the child welfare system. I think that's a big theme for you today in general, and I want to make a few observations about that, and some lessons that we've learned here in Oregon. And then I want to talk about the fact that when a fatality does occur, some things that we've learned here in Oregon in our child welfare system around the importance of transparency, accountability, learning from mistakes and being able to have a response system that commits to system improvements and conversations with communities, with partners, with the public, about how we can and will do better on behalf of our kids.

In Oregon, I'm -- in 2013, which is the last data that we have complete, at least right now, and published, we had 10 child abuse and neglect fatalities. None of those had prior child welfare history, none of them occurred while a child was in DHS [Department of Human Services] custody, and none of them were as a result of abuse or neglect by a foster parent. The safety risk factors that contributed to those ten fatalities in 2013 were drug use, co-sleeping or bed sharing, guns in the home, the religious beliefs of parents, and trauma, or the history of the parent having had experience as an abused or neglected child themselves.

In Oregon, we have started a tradition with our public health partners of two times a year convening a statewide fatality review team, and it's especially important for us because that conversation captures child abuse and neglect fatalities that do not touch the child welfare system like the ten that occurred in 2013. In that conversation, people talked about lessons learned, and we identify things we can do together to get ahead of the issue and to act on the opportunities for prevention. What came out of the 2013 endeavor was a targeted conversation across the state with medical providers, childhood service providers and child welfare providers about co-sleeping and bed sharing.

We also have committed and worked on and have started in 2014 a shared database so that information can be tracked and shared and we can make sure that we're thinking about that issue of counting that you all are thinking about. I'm not the expert on that, but I know we'd be happy to have someone who is to talk more with you about it. But, again, we have a commitment to having a data-driven conversation in this realm, and having access to accurate data is imperative to be able to do that.

I want to talk a little bit about the continuum of work that we're doing with our system partners and why we think this is so important. The things I just mentioned that were drivers of those fatalities are also things that come up for us in the child welfare system on a regular basis as drivers of risk that contribute to child abuse and neglect as a whole for children and their families. So we have targeted partnerships with our drug and alcohol treatment providers that are looking at ways to expand the focus on family-based treatment, not just child-based or adult-based treatment. And this comes up later in a conversation that I'll have with you about some of our fatality reviews we've done.

Domestic violence comes up frequently as a fairly, very significant issue in our system, and there's a philosophical issue that we continue to work on with our domestic violence partners and advocates in the communities around protective parenting and parental capacity and the child welfare system. And one of the things we've done here in Oregon is we've actually co-located domestic violence advocates in our child welfare and self-sufficiency offices so that those individuals with that expertise in that particular field are available to families who are having a domestic violence experience and who come seeking service from us, and also to our staff who have reported to us that they very often aren't sure what to do when someone presents as a domestic violence survivor and is trying to be protective of a child and doesn't know what to do or where to go.

One of the things I've personally worked on, because these two programs are within my jurisdiction as the state director, is the overlap and the importance of collaboration across the self-sufficiency TANF, the Temporary Assistance for Needy Families program, and the child welfare program. We track data in Oregon around the number of families who are in the foster care who have experienced abuse and neglect, who had recently in the last two months been in the TANF system. And what we're finding is that nearly one-third of children who end up coming to the attention of child welfare have previously been served through the TANF program.

So what does this tell me as someone who is committed to the issue of prevention? It tells me that TANF is a child abuse prevention program and that we need to start treating it that way. We need to think about the dual purpose of TANF, not just as an employment program for parents, which is a critically important function that it plays, but also as a child-serving program that creates family stability and opportunity for parents to be successful with their kids so that we can keep their kids safe.

Early learning is a big conversation here, and when you look at the issue—the child abuse neglect and fatalities, we know that children under five are more at risk then children over the age of six and older. And so we have been actively working with our—the development of a stronger Early Learning System here in Oregon on issues like parent training, home visiting,

child developmental screening, which is also a partnership with the medical community, and quality childcare and training for childcare providers who are serving kids.

And last, but not least, I think in terms of this issue of broad system partnerships, is our commitment to community engagement and to being a present community partner as child welfare practitioners that really believe that the safety of our children really depends on all of us in our communities being connected and involved, depends on our families being connected and involved, and hopefully the touch of child welfare in a family's life is as minimal as it possibly can be as we work on the issue of safety, but we know families continue to need that social capital that comes from connectivity, that comes from community connection, and so we've been actively working to make sure the community feels welcome with us, that we're partnering actively with the community, and that families then benefit from the connections and partnerships that we make as a system and have that connectivity to stand by and to live with as they leave our services in the child welfare system.

I also want to just reflect for a few minutes about the importance of what happens when fatalities do occur and our accountability in the child welfare system, and something that I have personally taken really seriously in my time in state government. I started in state government in 2003 under then Governor Ted Kulongoski, and at the time, there were some very serious cases that were in the news involving child abuse and neglect fatalities.

And we had a conversation with the department at that time, I was a policy advisor of the Governor, and what was becoming increasingly difficult for us all was the inability that we felt to communicate with the public about the difficulty of the work, the accountability for the work, and so we created a critical incident response process that is designed to focus more on accountability and transparency when bad things happen in child welfare.

So in the system, which is focused on fatalities and serious injuries to children that were known to the child welfare system, and mandatory when something occurs for a child that had been touched by our system in the previous 12 months, we pulled teams together within 24 hours of those incidents. The teams often include partners other than child welfare. Importantly include law enforcement, district attorneys because, as you know, in those cases we often have co-occurring criminal cases, we don't want to get in the way of those, but we also include other partners as needed in the review process, and we publish reports on the Internet of our findings in the review process.

If you go to the Oregon DHS website and you look up a CIRT, a C-I-R-T, Critical incident Response Team, on that website you will see the evolution of this process here in Oregon that started in 2004. Since '04 we have declared 35 CIRTs, and on the website you can read all of our reports that review our findings about this system and where the system needs to do better in order to prevent child abuse and neglect fatalities like the one that occurred in that case from happening again.

There are some common themes in this report; I re-read all 34 of them. We have one that's active right now that has no reports right now, but in preparation for this I re-read them. So let me talk about things we found and things we've done because of this basically quality

assurance process for our system. One of the major issues for us in our early years, and for me, as hard as it was to read these reports, it was also very rewarding because I saw the evolution of our practice model play out in front of me as I was re-reading them.

In the early years of the report, the issue of safety as a focus constantly came up as a challenge in the sense that we were not doing a good enough job including family history in our review of cases, we weren't doing incident-based reviews of situations that were playing out in families, and we very often were not including other things that we had known before, for a variety of reasons, including data systems, and so we changed our practice model.

We implemented the Oregon Safety Model here, I know other states have implemented safety models, and we've redoubled our focus on the issue of safety. I know it sounds really intuitive, but let me talk about one situation where when I first re-read this report I thought this is also something we should re-read now given where we are in our practice.

We were having family decision-making meetings, a best practice, a very important thing to have, but what was happening for child welfare practitioners, and what we found in one of our cases, is we were advocating our role around the issue safety for the good of the decision on the team that was being made. And that's a tough issue, but what it's allowed for us to do is we've looked again at the safety models.

It's allowed us to stay focused on our role and be able to raise with partners that issue of risk of safety as experts and keep it on the table even as we're trying to find strengths and work on a strength-based practice model for children and their families. That's been an important piece for us.

The issue of parental capacity. There was a time in our history where it was simply adequate for families to complete, check the box in terms of the requirements we were making for them to be able to continue to have access to their children, or to have their children returned to them. That is no longer acceptable practice in Oregon. We now require demonstration of behavior change. It's not enough just to go to a class.

The conditions for return, if you will, have changed in Oregon, and we have stepped up our game in terms of really working with parents to ensure that whatever services we're offering to them have a meaningful impact on their parental capacity, and actually improve and strengthen it so we can prevent bad things from happening again to kids in those families. The issue of communication among different types of child welfare staff. In Oregon, cases don't stay with one caseworker from beginning to end. We have different workers that perform the CPS, Child Protective Services investigations, and then who carry the cases on-going. And in some of our Critical Incident Review Team findings we were experiencing a lack of communication between parts of our own program.

We've changed our business protocols, we've changed our IT [information technology] systems, we've made sure that internally people know what the other person is doing. Again, it sounds really intuitive, but in a big and complex system like child welfare, being intentional, implementing, having intentional business practices in the work of social work is not always intuitive, and so we've paid really close attention to that. We have new staffings

that are required among different types of child welfare practitioners, different forms of communication that are actively happening among our own staff as a result of these findings.

I want to talk, too, about the roles and responsibilities of child welfare staff in relation to other partners, because I started out with an emphasis on the other partnerships as critically important, but I also want to emphasize that in these reports we were finding that sometimes that issue of safety plays out, as I've mentioned, but also that we needed to go back and really remind our partners of our role, of their responsibilities as mandatory reporters and really have some hard conversations, especially with certain types of providers in the mental health field and education, about how it is they can communicate, what kinds of things we respond to and what we don't, and then how we can meet that gap in the middle. I'll talk about a particular case in a minute where this became a really big deal.

We've passed a new law in Oregon around medical consultations. This was also a very big deal for us in some of our most serious cases. It's called Karly's Law, and it requires medical consultation when we have concern that an injury that we're seeing in a child may have been the result of child abuse and neglect, and we now have different and better and improved partnerships with people who specialize in the medical field in identifying with us the child abuse and neglect that may be occurring, and that's been huge improvement for us.

So, for me, as I look back at critical incident reports and I see the challenges we've identified, the recommendations we've made, and then I see the changes to the system, I look at that 2 year and the results that we had in that year and the fact that child welfare had not touched the lives of those kids that had fatalities in that year and I think we are getting to different points in our conversation around prevention and improvement because of the things that we've learned through some of these bad incidents.

And that was the point, that the system would change, that we would learn lessons. But it was also the point that we do that transparently. And I just want to mention this, we -- our lawyers aren't very happy with us when we do this because we create exposure when we publicly post on the Internet that we've done something that wasn't consistent with policy or practice, or that we had room for improvement, but as a director my response to that is it doesn't matter.

We're a system whose job it is to protect children, and we're not here to protect ourselves. We are very careful about how we do this. We have had CIRTs where we find no systemic issues and we just say that, there weren't systemic issues here. We've also had CIRTs where we have found that there actually are policy issues that arise in the course of the conversation that we can't address in the child welfare system, and so we say that.

It's taken a while to establish trust with our workforce around the CIRT process. It's very intimidating to them, and it doesn't feel good when you have a CIRT, but frankly, what that's really about is that these are workers who dedicate their lives, and what really doesn't feel good is something happened to a child on their watch.

And so as we work with them to show that this isn't about punishing the system, it's about improving it and we need to do that in partnership with building trust and credibility with the

public, I believe that even those -- even in those instances we keep getting better with our staff. And even when there is a CIRT our staff feels included, and they feel like they can see the system improving as a result of what happened, which ultimately makes all of us feel like we're making meaningful progress in the work, which is very important to do.

We also have a review process that includes legislators. I just want to mention this, and I know I'm getting a warning, but -- thank you. We -- I consider our legislators our board of directors, and often child welfare is a mystery to them. They, as you know, get a lot of complaints from constituents about our work, and it's hard for us because some of the issues around confidentiality, to share information about cases with our legislators.

We have a process in Oregon where either they can request of me, or I can convene what's called a sensitive case review. We also publish those reports on the web, and we review closed cases with them in confidence, and we learn from them. And we had a case that we reviewed that -- recently, that included the child welfare system, the early learning and education systems, and the medical systems, and I can tell you the legislators who participated in that review came into it, based on the media reports, based on the media in this particular case imagining they were going to find lots of bad practice in child welfare.

What the report ended up coming out with was a very strong set of comprehensive recommendations, only one of which was about child welfare in our state practice. The rest of which were about practice as it related to the medical community, and as it related to the early childhood community, and those findings are now influencing some of our conversations here in Oregon as we work on health care transformation and standing up our system in a stronger way.

As I'm closing, I just want to mention four quick things for you to take home and think about as sort of challenges that frankly have really challenged us beyond even ourselves here in Oregon, and I would just ask that you as Commissioners on this body think about them. First of all is interstate mobility, and the fact that -- and the ability of child welfare agencies to -- and child serving practitioners to easily have notice and information about families that go between states. This is a huge challenge. It's come up in several CIRTs, and in spite of our best efforts around the interstate compact and to have good partnerships with neighboring states, it continues to present a real challenge for us in very critical situations.

Social isolation of families. In Oregon, we have frontier and rural areas, but even in our urban areas we have some families who choose to be detached, or to detach at a critical and stressful point in their lives from community and community resources. We need to collectively do better around those families and to think about how we keep that from happening to those children, because we've had several really terrible incidents where a family has been actively engaged with lots of people, suddenly they disengage and a year later we have a child who suffers serious consequences as a result.

Cross-system information sharing specific to a child and a family. I don't need to tell you this, but what happens when these cases become a conversation in the public and they have information from all of the different systems that have served them is this natural intuition to say why didn't somebody tell somebody else what was going on? And as you all know really

well, we have serious constraints around our ability to share information with one another, particularly as it relates to behavioral health, which is a driving risk factor, Child Protective Services work, and even in education. This is going to continue to be something we need to work on together.

Finally, prevention needs to be better prioritized in terms of funding. For me, really enhancing parental capacity and family economic stability is the most important way that we're going to prevent trauma and child abuse and neglect from happening in the long run. And, unfortunately, when a child abuse and neglect fatality happens we tend to focus on disinvestment, we lose confidence or we focus on investing more in the response system than we do on the prevention side of things.

I just want to make sure we have a balance. It's important we do both. The response system needs to be adequate and the best it can be, but we need to focus on getting ahead of these issues to prevent these from happening. So thank you for the time to share a few of my thoughts. On behalf of the more than 2300 child welfare workers in the state who are my heroes, who do this every day, we very much appreciate your commitment to children and to families, and we look forward to continuing to provide you whatever you need to get this important work you're doing done.

CHAIRMAN SANDERS: Thank you very much, Director Kelley-Siel. Will you be here for any of the remainder of today or tomorrow in case commissioners have questions? We won't have the opportunity for formal questions now, but --

ERINN KELLEY-SIEL: I will be able to be here for half of the day today, and I'll be happy to answer questions after you all leave, and I'll leave my e-mail contact information as well.

CHAIRMAN SANDERS: Thank you. Thank you very much. Before bringing up the next panel I want to make sure we have a chance to introduce a couple Commissioners. Commissioner Rodriguez, do you want to introduce yourself?

COMMISSIONER RODRIGUEZ: I'm Jennifer Rodriguez, and in my life outside of the Commission, I'm the Executive Director of the Youth Law Center, a national organization that does advocacy for youth in the juvenile justice and child welfare system.

CHAIRMAN SANDERS: And Commissioner Petit, I believe you've joined us on the telephone?

COMMISSIONER PETIT: Yes, I'm on the phone. I am former Commissioner of Maine's Human Services Department, [former] Deputy Director of the Child Welfare League of America (CWLA). Recently, the founding President of Every Child Matters Education Fund. I have a question. Can you hear me?

CHAIRMAN SANDERS: We're having trouble hearing you, Commissioner Petit. We're hearing every other word.

COMMISSIONER PETIT: I'm director -- (indiscernible.)

CHAIRMAN SANDERS: If you want to text or send an e-mail to Amy, then she can relay the question. But we're not able to hear you yet, Commissioner.

COMMISSIONER PETIT: Okay.

CHAIRMAN SANDERS: So I'm going to call the next panelist up, and that's MaryAnne Lindeblad, Amy Baker, and Helen Bellanca. And just some logistics as they're coming up, we'll have the opportunity to hear from each of the panelists, and we'll have an opportunity for questions from the Commissioners. We do adhere closely to the timelines, and so each panelist will have about 15 minutes each to present, and then there will be opportunity for Commissioners to ask questions. There is not an opportunity for the audience to participate in the questioning, as this is really for the work of the Commission, but the audience does have the opportunity to send in comments to our website.

We heard from Director Kelley-Siel the importance in Oregon of the broad system partnership, and that's really the focus of this panel. We'll hear them expand on that concept with some detail about work in both Oregon and Washington, so we'll turn it over to them. Sounded like Commissioner Martin was trying to get in.

COMMISSIONER MARTIN: Yes, this is Patricia Martin, and I'm on the phone.

CHAIRMAN SANDERS: Great. Thank you. Commissioner Martin is in Chicago, and a judge in Cook County, so the Chief Judge for Juvenile Court. Thank you, Commissioner Martin. So I'm going to turn it over to the panel. I believe Ms. Lindeblad, you're starting.

MARYANNE LINDEBLAD: Yes, I think I'm starting first. Okay. Thank you. Good morning, I am MaryAnne Lindeblad, and I'm the Medicaid Director in the State of Washington, and I appreciate the opportunity to be with you all this morning. I'm going to talk a little bit about what I see in the role of Medicaid, and how it can play a role in reducing child abuse and neglect, and the kinds of things that have happened with the Medicaid expansion, which I'm proud to say Washington is one of the states that did the Medicaid expansion, and also our partners in Oregon.

But before I get into that, I just wanted to talk a little bit about a couple things that we have going on in Washington that I think are somewhat unique, and I just want to share that. We have a really long history of great collaboration with the child welfare agency and the Medicaid program, and really to find ways that we can make sure that children in foster care get quality health services and the parents -- foster parents are supported, and also ways to try and support those biological parents.

So we quickly recognize that children that go into foster care need quick access to medical services, so we've done some work to make sure that we have a team of folks that can just respond to eligibility questions, make sure the foster families have the health records of the children, how providers that are going to serve that child have ready access to medical records on any newly placed child.

We've had that team in place for a number of years and it's been really successful. It was put in place because foster children were not getting the health care services they needed immediately when they were placed. Medications weren't -- prescriptions couldn't get filled, medications weren't readily provided. A few years ago acknowledging, too, that the kind of care coordination and health care needs of foster children were not met in the way that we had hoped and desired, so we set up what we call our fostering well-being team [Fostering Well-Being (FWB) Program]. It's a group of nurses and pediatricians that are actually placed in child welfare offices throughout the state in six different locations.

Case managers that can help support caregivers and social workers. They work to identify the health care needs of the individuals, and we have a very unique predictive risk tool that we have in Washington that we call PRISM [Predicting Risk Intelligence System]. And what PRISM does, is the majority of the children in foster care have been served by the Medicaid program, so we have a fair amount of medical information about them. So we have this tool that we can actually look at their health care needs anyway, and kind of the risks that they have, these risk scores in terms of predicting what their future health care needs will be, so we can use that tool and identify, at least from a health care delivery system, high needs and high risk children.

And that's been very successful in terms of being able to outreach to families where these children are being placed, and also making sure that those children are connected, our health care providers are connected quickly; that the families that are serving those children have access to community resources; that they have educational materials around the health issues that the children they're serving.

This team really serves as a case manager to make sure that the providers for these children have the kind of information that they need to serve them. Medications can be an issue, and so we want to make sure that these children have timely access to medications, there's no barriers in getting medications, and they help support that, and then these regional medical consultants are there to help serve social workers that are on site and provide them the kind of support they may have and need when they have questions related to the medical needs of that child. That's just little bit of some of the things we're doing in Washington.

I think the other thing is even prior to the Affordable Care Act [(ACA)], the State of Washington did a number of things to really help and support low income families on the medical side. So, for example, we had provided services to pregnant women up to five percent of poverty, [Federal Poverty Income Guidelines (FPIG)] focusing on specialized services for women that are substance abuse using. So a special program that we have is where they're actually in treatment, they can have their newborn with them while they're in treatment, and an array of support services for pregnant women and children in the first year of life for individuals that have high social needs. So individuals that have substance abuse, mental health, they have domestic violence in their lives, they need additional social support, so we've got an array of service to support pregnant women.

Also, we cover children up to 300 percent of poverty, and we've done that in Washington for years. We also have very robust family planning programs, so looking to support ways to avoid unintended pregnancies. So today, really having ready access to family planning, women who

don't qualify for other Medicaid services. If they're birth parent was on Medicaid they can get family planning services for a year after that, and then making family planning services available to other individuals who for whatever reason aren't eligible for Medicaid.

I think also making sure well child screens are provided and that we pay higher for foster children so those screens can be provided. Also, looking at the use of evidence-based practices, big focus for us on the child welfare side, and for children that are in that system, but also for children in general and for families in general. So we have added a number of services and done trainings for providers out in the community and making it easier for pediatricians to bill things like Triple P, [Triple P—Positive Parenting Program (Triple P)] trauma-informed care, and other evidence-based practices that help support that family, even families that sit outside the child welfare system.

Also, of course the use of anti-psychotics has been -- and other psychotropic [medication] has been a big issue for foster children, and for young children in general in Washington, was a very early adopter of a second opinion program for the prescribers if psychotropic-medications are being prescribed and you're a child under the age of five. We have a second opinion program that reviews that to make sure that it does meet a tested medical necessity. I think one of the great things is, as I mentioned earlier, is this new opportunity with the Affordable Care Act. So when Congress gave states the choice to expand Medicaid -- as I said, Washington was one of the states that accepted that -- and what that does is it takes eligibility for Medicaid up to 8 percent of poverty [FPIG], which is about $16, a year for a single individual, and for individuals that don't have children in the home or low income parents.

And what has really been great about that is it really is about a broad-based insurance coverage, so now Medicaid has become part of a continuum of insurance for families, so very low income families now don't have to go without coverage. So prior to the implementation of the ACA, if you had a parent that had substance abuse issues or mental health issues and they weren't eligible for Medicaid, they may not get that service -- they likely may not get that service.

So what the opportunities under the Affordable Care Act has provided is mental health, substance abuse, and that parody to other health care benefits, so the insurance coverage is broad, it can't be limited by the number of visits you get unless you limit other visits like your medical visits. So it's been a great addition to the benefit for individuals that weren't -- that in the past didn't have access to that.

Also care coordination service, so folks that have health care needs that need more intervention, that those are available now through Medicaid. And also, for the State of Washington, providing health care services through them so we have more ability to develop an accountable delivery system. And, you know, one of the things we're doing, or a couple things we're doing in Washington, that really helps strengthen the delivery system for families, one is the integration of behavioral health and physical health.

So right now in Washington, and a number of states, the delivery systems are such that behavioral health systems sit on one side of the state and physical health system in another.

We recognize and acknowledge that we need to do whole person care for best outcomes for individuals, best outcomes for families, but we can't have this bifurcating them and splitting off the head from the rest of the body. So we're working towards that full integration of services. We're on a trajectory to have fully integrated delivery systems by the year 2020. Sounds like a long way away, but it's a more complicated issue when you're trying to bring two delivery systems together that right now don't talk to each other very well.

Also looking at payment reform. Looking at how you pay providers differently. So today many providers are paid on what we call fee-for-service for the visits, you get paid for every visit you get. What we wanted to do, and what we're building towards, is paying providers for outcomes. So better outcomes, better health. Making sure that individuals are getting the health screens they need, they're getting the preventive services that they need, and that they're engaging in care.

So looking at things like pay-for-performance are different mechanisms that can support a different kind of payment and delivery system than we have today, and that really is about improving accountability in the delivery system overall. I think another big piece to this, and to make it successful, is that we have to have access to data analytics. We have to know what's going on in the delivery system, so we put together a series of performance measures that we hold our delivery system accountable for, and those look at preventive related activities for children and for families, looking at how acute care is being manage and how chronic illness is being managed. Also a key piece, and we heard a little about earlier in the presentation, is data sharing.

The providers and organizations that are involved with families, they need to know what's going on. We created what's called Clinical Data Repository (CSR) so providers can access information, know what services a child has gotten, know what's been available to parents, if the parents are engaged in services, and we are just launching that mid -- this coming year. I think one of the unique things that we're building, that I think really when you talk about strengthening families, is what we're calling Accountable Communities of Health (ACHs).

We have regionalized the State of Washington recently into nine different regions, and in those regions the communities are coming together to really look at ways to build a stronger community and build a healthier community. So bringing individuals that are involved, whether it's the health plans that we contract with, the hospitals, the schools, the housing authorities, the service providers, for a variety of services and kind of you-name-it, coming to the table; that those are the folks that have an interest in the health of the community.

So instead of looking at health care we're really looking at health and looking at focusing on the social determinants of health, bringing together the folks that can help support families more broadly than just getting their health care needs, but having everybody at the table to help solve them and look at those issues and problems. For example, a community identifies that they are community with really high Adverse Childhood Experiences (ACEs) scores. That ACH that comes together thinks about what can we could to reduce that, what are the interventions we can take, whether it's within the health care delivery system, social service system, or wherever, to take to reduce those.

Those are being launched now. We've got two pilots going, but we see some real promise in that -- in terms of addressing health care needs, in individuals. I think the reason I put this slide up it has really helped us more than health care. So you can have a period of interventions on the health care side, but if you weren't looking at things like housing and the kinds of supports that families need, and what's going on in the criminal justice system, and making sure people are employed, and education, if all those wheels don't come together you won't have -- we won't have successful families. And health care can't do it alone, but that's a major component of what the system needs.

So just in wrap up, we're moving forward in a couple of things. We're moving foster children into one single managed care plan. And, again, a single point of accountability, making sure that their care needs are being addressed, that information can be shared across systems. Also, the recognition of children that come out of foster care and that age out of foster care, what is that community transition?

So how do we help individuals transition out of foster care to make them a successful adult? We also -- the children that are in foster care can stay on Medicaid program up until age 26, and they age out at that point. We will keep them in that single manage care plan as long as they're a part of that delivery system, so that's, I think, a really important piece, too, that happened with the ACA, being able to keep children in the Medicaid system to age 26, and then also doing a lot of ACEs and training providers.

So, in fact, just in the next week we have training that health care plans are sponsoring, providers can get continuing education credits (CECs) to do this so they understand more and more about ACEs and what that means to the families they serve.

CHAIRMAN SANDERS: Thank you very much. I believe we have Ms. Baker next, but before that we have two more commissioners. Commissioner Covington, do you want to introduce yourself?

COMMISSIONER COVINGTON: Hello, I'm really sorry I'm late. I'm Theresa Covington. I run the National Center for the Review and Prevention of Child Deaths.

CHAIRMAN SANDERS: And Commissioner Cramer is on the telephone. Commissioner Cramer, are you on mute? We'll continue with Ms. Baker, and know that we have now have three commissioners on the phone who will also be involved in the questioning.

AMY BAKER: Hi, my name is Amy Baker, and I'm the Children's Mental Health Director for the State of Oregon. And in full disclosure, I'd just like to say I really hate public speaking, so if I sound like an idiot, I apologize in advance.

So I have been in the behavioral health field for about 20 years, and I started out with kids mental health, I ended up working in a very large not for profit organization serving adults with mental health and addiction issues, and throughout the course -- and I've gone back and forth, and now I'm back in the children's world.

And throughout the course of my career I have watched kids in the foster care system grow up, I watched them go into adult mental health systems, watched them have kids of their own, I watched those kids be removed by foster care, and the pattern repeats. And when I had the opportunity to take this position I jumped at it in part because I think we really have to do better than this. I can't believe that this is the best that we can do.

So this slide is basically -- this piece of information right here is what keeps me awake at night, because basically what the Center[s] for Disease Control [and Prevention (CDC)] is saying is that children's mental health disorders are increasing. Frankly, that scares the pants off me because we're barley able to serve the kids that we have now. And really, if we don't get ahead of this particular problem, then where are we going to be in ten or 15 years? And so of course one has to ask why?

Why are kids' mental health disorders increasing? I think the adverse childhood experiences is certainly one answer. It's not the entire answer, but it's one answer. And if you look at this slide, basically what it demonstrates is the huge impact that adverse childhood experiences has on health care. It's not just mental health, it's multiple physical health conditions and risky behaviors. And essentially, the oil slick in the middle there that shows the ACEs, if you were to suck up those ACEs, that's the percentage of problems you would reduce in those different areas.

And so essentially, what this illustrates is that this is a serious public health problem and that we need to address this as public health problem. I have promised everyone that I will stop showing pictures of the brain when we start implementing policies that include brain science. But for now you're going to have to suffer through my brain pictures.

And, essentially, why I think this is really important is that we obviously know that in early childhood kids' brains develop enormously in the first five years of life, and that really, in some way, that is the most critical juncture. The other piece of this, too, though, in talking about the evolution of the brain, is that when you look at the picture on the right, what they refer to as the lizard brain, and, frankly, who doesn't like saying lizard brain.

That's the survival center of the brain, and that is when you are in a situation of toxic stress and constant stress your ability to use your prefrontal cortex is severely impacted, and that's the state of the families that we're working with constantly. Most of our policies are designed for people who can use a functioning brain, and yet when you are chronically exposed to toxic stress that's not accurate.

So this is a quote from Tony Biglan, that basically what we've learned from the last 50 years is that we need to create nurturing environments if we want kids to be successful; that, essentially, healthy families raise healthy kids. Even to take it a step further, healthy communities raise healthy families.

But what do we know about risk factors for child abuse and neglect fatalities? Well, they're essentially the same risk factors for child abuse and neglect. And given the fact that this is such a huge public health issue, and really should be treated in the same way that we treated lead poisoning 20 years ago, same approach should be used; that if we're trying to stop CAN

[child abuse and neglect], and we happen to reduce child abuse and neglect, what a huge impact that will have on health care, the criminal justice system, the education system, really the country as a whole.

So what are we doing in Oregon? We have a children's health policy team, and these are some of the particular issues that we're addressing right now. The children's health policy team consists of public health and mental health and Medicaid, the early education system, and developmental disabilities. And really it is -- we have to look across our systems and look at what our policies are and to determine whether or not our policies are perpetuating toxic stress or not.

Many of our approaches are very child-centered, and part of that I think is because people go into this field and they want to save children, and you can't save children without saving families. We have to get over our ambivalence about helping families as adults who should be able to take care of themselves, but then when we remember the fact that toxic stress disallows that we have to get over our ambivalence about helping families.

We need to include community and family voice in our policies. And, frankly, for the money, we got to focus on the little kids and develop a long-range cross system vision to interrupt the multigenerational transitions of ACEs and poverty. This is not going to be a very easy task. There are segments of families, and they are the highest risk families, that it is not going to be easy to get them out of poverty. It's going to take things like a dual generation approach to be able to make that happen.

In Oregon, one of the great vehicles that we have to do this work is the creation of the Coordinated Care Organizations [(CCOs)], and the Coordinated Care Organizations did a lot of -- really, in some ways, it's the perfect infrastructure. It created integration between behavioral health and physical health and dental care, but what it did for the CCOs was it created a global budget. So that means if you're a CCO, you have one budget for all of your services.

It also set a cap on spending. We can't go above the two percent cost group or we risk paying $2 billion back to the feds. So, essentially, what that's done is it set up a system where you can't throw good money at bat, like you really have to focus on what is going to do effective cost savings. And as the CCOs, and they're all in different developmental stages, but as they start to bring down the high health care costs of adults who are using the EDs and the inappropriate specialty care, it gives us the opportunity to reinvest in prevention and little kids.

We also have performance metrics which all CCOs are accountable to, and some of them are really highly related to that. And those are things like early childhood well visits and screening for A & D, depression, timeliness of prenatal care. Essentially, what this does is, the physical health care system is really an awesome opportunity for intervention; this is 95 percent of families give birth to their babies in the hospital. What a great time to be able to assess high risk families and to offer them services.

Additionally, we are -- Oregon has implemented Parent-Child Interaction Therapy [(PCIT)], which is an evidenced-based practice. It's for kids who are two to seven years old. We have it in counties, and over 95 master level clinicians trained in it. And, essentially, it is a very impressive therapy that uses ear bud technology with clinicians behind a one-way mirror where they're coaching parents in the moment.

And it's increasing the parent's ability to be sensitive to their kids cues, which you know is really important to parenting, and then also to be able to slowly, as their relationship improves with their child, to be able to start giving them commands so that you don't end up with kids with significant behavioral health issues.

Nurse Family Partnerships [NFP]. We have home visiting in every single county in this state, including our nine tribes. Nurse Family Partnerships make up about 25 percent of our home visiting. And, again, very effective intervention at preventing child abuse and neglect. We're prioritizing the zero to three population within mental health that includes kids who are zero to three. It's not a population that we historically served. It's really hard to diagnose a baby, but we are exploring codes to be able to diagnose the environment, the stress, the family, so that the child does not have to actually display problems before we can serve them.

And then I also wanted to talk just a little bit about the early childhood system of care. One of our former governor's big initiatives was the Early Learning System, and essentially, what's that done has created a system of care for young children, and it links together all the different partners who have the capacity to be able to intervene early. So that includes head starts, relief nurseries, home visiting, mental health, physical health, TANF, and all the other partners who actually can make a difference at that point.

And last, but not least, Trauma-Informed Oregon rolled out this year. It's a partnership between Portland State University and Oregon Health Science University, where we are essentially increasing the equity and the ACEs literacy for health care and helping professional. We think that if people in this state all have a common understanding of what's happening with our children and families that's going to create a better environment, and it's going to create better service for folks.

Lastly, I think it would be incredibly powerful if we started giving this information to our clients as well. Wouldn't it be great if they knew from their perspective, why it is that I'm having the problem that I'm having? There's not something wrong with me, it's something that happened to me. So that's it. Thank you.

CHAIRMAN SANDERS: Thank you, Ms. Baker. Final presenter is Helen Bellanca.

HELEN BELLANCA: Yes, thank you. Good morning, and thank you for the opportunity to address you this morning. It's a real privilege to be here. My name is Helen Bellanca. I'm a family physician, and I work for one of the Coordinated Care Organizations that Amy Baker mentioned. So I'm here to talk to you a little bit about what we're doing in health care transformation to address child abuse and neglect.

As Amy mentioned, I think Coordinated Care Organizations are really worth talking about; it's a really promising strategy. And Oregon is really unique in approaching health care transformation in the way that we have. We're the only state that is really focusing its health care transformation efforts exclusively on the Medicaid population, and as Amy mentioned, this global budget is what's really powerful about it. Instead of the state paying physical health care providers and other providers for mental health care, CCOs hold a global budget for all those services, and it compels us to talk to each other and to work together to understand where we can reduce redundancies and improve efficiencies, but also really approach whole person care in a really different way.

Coordinated Care Organizations are a form of accountability care. Again, as Amy mentioned, this testimony that we're talking about is the same thing. We are accountable to a budget and we are holding the line at what we can spend. We also are accountable for quality metrics. There's a bonus pool of Medicaid dollars that's reserved for our performance on certain metrics, and that's been one of the most powerful tools we've seen for health care transformation, specifically as it relates to early childhood care, and I'll mention those a little bit more later.

There are 16 CCOs in Oregon. They are arranged geographically, and electively, communities came together in ways that made sense to them, and they have tremendous flexibility to figure out how to improve quality and reduce cost. I work for Health Share of Oregon, which is the largest of the CCOs. We have 240,000 members and we are in the Tri-County area around Portland Metropolitan area, so of our membership, 47 percent are children or adolescents, typical for most Medicaid plans.

Where this -- where all of this work has coalesced for us in thinking about where we're spending money, and where care is inefficient, or care isn't as best high quality as it could be, we have been focusing almost exclusively on adult population and adults who have chronic physical illness, mental illness, or addictions.

Their utilization of services, quality of care, and what we've come to realize is that not only is their own care an important consideration, but they are also parenting young children often and developing the next generation of high utilizing, chronically ill people in our community. So we have recently developed a prevention strategy, and the core of our prevention strategy is thinking about how physical health and mental health and addictions can derail a healthy life course, and then also trying to prevent that from perpetuating into the next generation.

Our prevention strategy focuses almost exclusively on pregnant women and children before the age of six, and the goal again is to address all of those factors that can derail a healthy life course. So what we think is involved is that maternity care needs to go beyond care of the actual pregnancy and delivery; that maternity care is a really key opportunity and a key touch point in the system for thinking about what families really need. And that starts even actually before the pregnancy happens, so focusing on unintended pregnancies is a key portion of it, and thinking about integrating behavioral health services, mental health, domestic violence treatment, addiction care as part of maternity care.

We know that there are things that are predictable about child abuse and neglect. One thing that's predictable about child abuse and neglect is that if parents say they don't want to parent or aren't ready to parent, then that sets them up for being in a situation for abuse and neglect. And if parents are dealing with their own mental health and substance abuse disorders which leads them to have a chaotic life, or a life filled with stress, that those issues need to be addressed before they become effective parents.

So we're taking the opportunity to address this as a core prevention effort. Our first initiative really focuses on contraception. We're the first state in the country to have contraception as a quality metric. This goes beyond making sure family planning is available to all citizens. We've had that for decades, and still, despite having very available family planning services, we know that 50 percent of all of our pregnancies are unintended, and that number goes way up if you just look at all our Medicaid populations.

So families are experiencing unintended pregnancies at incredibly high rates, and it sets them up for abuse and neglect of children. So what we've done is make this quality a metric, and really focus it on a proactive prevention approach regarding contraception for women at risk of intended pregnancies. We're holding primary care accountable for whether or not their women who were at risk for unintended pregnancies were able to access effective contraception.

So that's a very new thing. We're kind of out on our own on that one, but I think it's one of the most promising things we can do for families is really address contraception proactively as prevention. We had a great set up for that in the Affordable Care Act, which called out contraception as a core preventive service, and we've really taken that to heart. It's not an optional service that's over here, it's really a core part of preventive services for families.

This year it has become part of our core set of the incentive metrics, the pay-for-performance metrics that CCOs are accountable for, so there's actually money attached for performance of that metric, and the metric itself is, effective contraceptive use among women at risk of unintended pregnancies.

The second initiative that I wanted to tell you about gets to both what Amy and MaryAnne mentioned in their talks, which is that when families are pregnant, we have to do a much better job of capturing issues that are going to put them at risk for child abuse and neglect while they're pregnant; and instead of waiting for delivery actually in the hospital, we have a very captive audience in prenatal care.

So what we are launching right now is what we're calling the Oregon Family Well-Being Assessment. It's a fifty-ish question survey that asks families about their mental health, their substance use, domestic violence and social stresses; like food insecurity, housing insecurity. And the purpose of the Family Well-Being Assessment is two-fold. One is when women are pregnant and about to become parents, and thinking of them as pre-parents and not just as pregnant women; we need to address all of the care that they need during pregnancy and not waiting for the child to be born.

And then the second purpose of the Family Well-Being Assessment is for us to get a better understanding of what do our families need. We are in a phase right now where there's a lot of interest in investing in mental health resources, in social work, and home visiting, and we don't really know how to strategically asses those limited resources in standardized ways. With aggregated data collection we can actually understand how communities are different and what resources they may need so we can build systems that are efficient and effective at meeting the needs that families have.

The third initiative I wanted to mention to you is what we're calling Project Nurture, and it's an integrated maternity care with addiction treatment. One of the things that I see in terms of the biggest risk for families is, when parents are substance using and their risk for neglecting and abusing children is pretty high. On the other hand, when we know that women who are addicted and they're also pregnant our current maternity system does a terrible job at meeting their needs.

It's a system full of shame and judgment, and when women come in their biggest fear is that their clinician is going to report them to DHS and so they avoid care, show up in crisis late in the pregnancy, and then the child is sometimes removed as part of the hospital stay or shortly thereafter. And these women and families who are already traumatized in using substances, because of their own history of the trauma, are then further traumatized by the removal of their child.

So of course we want all children to be safe, but we know that in order for that attachment to occur that's going to be part of the healing of both the mom and the child, and we need to do a better job at addressing her care while she's still pregnant. So we've built two sites of Project Nurture so far in Portland, and they're pilot sites, and we're testing them out, but they're locations where women can get both prenatal care and addiction care in the same place.

Project Nurture extends through the intra-partum stay for maternity care so that women have advocacy and support when they're in the hospital, and then we see them back for a year postpartum. So it really is a whole episode of care around the birth of a child up to a year postpartum, with the goal of helping mom to be in treatment and to stay in treatment, and to provide parenting support for mom so she stays in recovery and can be a safe and healthy parent. We know that fostering that attachment is really what's going to break the cycle and help her own healing.

One site is an addiction treatment center that is bringing prenatal care in, and then a second site is a midwifery clinic. That's bringing the addiction care into their services, so we're approaching it in two different ways to see what are the pros and cons of each way, and hopefully if we have good results with this program, we will be spreading it to other areas state wide.

There are a couple of key opportunities and barriers that we have found in our work with CCOs that really seem critical to moving this work forward that I want to impress upon you. One is the integration of systems, and we all know that, you know, behavioral health is a good part of physical health care, and we're not alone in Oregon incorporating behavioral health

care into our healthcare system, but there really is something profound about the way those services are paid for, that really makes it feasible or not feasible.

If you're limited to a really strict payment systems for mental health and physical health systems, fee for services and physical health -- and separate payment systems for mental health -- it's really hard to do effective integration. So what we've done here and what we've learned is really freeing up the payment system for how those services are paid for is what's going to be effective.

So when we can pay for addiction services and mental health services and physical health services out of the same budget, and with a broader perspective for what people need not based on fee-for-service, but based on a global episode of care, that's what's going to get us to where we want to go.

The second piece is pay-for-performance metrics. Quality metrics and accountability are a core part of what we do, and we've known for decades that foster kids need extra coordination, that pregnant women need good care, and that all adults should be screened for mental health and substance abuse disorders. We've known that for decades, that's not new, but I'll tell you things really changed when there were pay-for-performance metrics in place.

When we held primary care accountability for those things we measured them, we gave back data, and we held back money, and paid based on their performance on those metrics, all of a sudden people got very interested in those things. So currently our pay-for-performance metrics include; depression screening, substance abuse screening for adults and adolescents, foster care coordination, so every child in foster care needs a physical health, a mental health, and a dental health assessment within 60 days, and then contraception as a core preventive service.

So those things are part of our quality system, and we can report data to all of our providers, we can tell them how they're doing, and we hold them accountable for it, and that's what really moved the dial. Contraception as preventive health care, I really thing we're onto something with this issue.

Again, we're leading in the nation on our approach to unintended pregnancies and making contraception really a preventive issue; but when families don't want to parent, we need to respect that, and get them the most effective contraception we can so that they're only parenting when they feel ready to parent. And then; primary care transformation is a model for maternity care transformation.

We know that a huge proportion of women never show up for primary care, so while all of our healthcare reform efforts are, rightly so, focused on the primary care system, we need to recognize that maternity care is a key touch point, and a key intervention point for behavioral health integration, for substance abuse treatment, for addressing social issues like domestic violence; including housing and food insecurity, and all issues of poverty that can lead to child abuse and neglect. And we really take what we've learned in the primary care system and apply it to the maternity care system and make sure all women and all families

get what they need to provide optimal health for their children.

Those are all the comments I have. Thank you so much again for the opportunity to talk with you today and for your commitment to this work, I really appreciate it.

CHAIRMAN SANDERS: Thank you. Thanks to the panel for the very informative focused comments, and so I'm going to ask if Director Kelley-Siel, if you could come up with this panel because I know there's at least one question for you.

I'm going to start with Commissioner Rubin and Commissioner Zimmerman with questions. I know there will be other questions here. I'll go to the phone for Commissioners Cramer and Martin and Petit, and then we'll come back with questions in here. Commissioner Rubin.

COMMISSIONER RUBIN: Yeah, thanks everyone. I just want to say, as pediatricians, we're going all around the country, and one of the most amazing aspects of being part of the commission like this is to hear about local innovation. And I was particularly excited to come to the Pacific Northwest to hear about what Washington and Oregon are doing. I really believe that in this corner of the country you guys are really a laboratory for the nation on how we should be orienting upstream services for families, all right.

Now, in that context, I'm going to ask a question not for one of you, but for each of you to think about this and answer it, because, as a provider, all right, I sort of think about the implementation of all these upstream initiatives as how are we eventually going to support the provider, feeling they can sustainably support the navigators, the folks doing those family health assessments, right, in the nursery, the types of initiatives that would allow us to build stronger programs around PCIT.

And I think from the context both of -- and ultimately as you roll this up past the provider to the health care system, to the Coordinated Care Organizations, to the Medicaid Program, and to Child -- you know, to DHS, right? It's about finance and regulatory actions that we could be doing to allow states and local communities the flexibility to orient their funding streams to permit the kind of innovation that can be sustainable, all right.

And so the question to all of you is, to reflect on as we are trying to think about that, think about Maternal Child Health funding, we think about title IV-E, title IV-B, Social Services Block Grant [SSBG], we think of all these different funding methods. You can think of appropriations, you can think of regulatory action, and as we start to coalesce our recommendations; what can we recommend that will allow you guys to get us out of the way and be able to more flexibly use your financing and your regulatory mechanisms at the state level to engineer what you're doing? Shoot.

AMY BAKER: I'll take a shot at that, because I've been complaining about this for years. So part of the arrangement between Coordinated Care Organizations and basically between Medicaid and CMS [Center for Medicare and Medicaid Services], is that the deal that we cut with them was, again, around the two percent and staying within our budget, but we're still dependent on sending them service data.

So basically what we talked about in a fee-for-service system, for every dollar I give you, you give me $1 of service. And I think that the eventual goal is to get away from that service data and to pay solely based on outcomes: but we're not there yet. And I think that as long as we're dependent on people turning in service data to continue to receive funding, it really gets in the way of being able to do some pretty innovative prevention work.

Let's face it, give you a perfect example, a kid in foster care has been in mental health services, probably is getting about $10,000 a year in mental health service, child welfare, we have the opportunity to place this kid with her grandma, and her grandma lives in California, but we can't place the kid with grandma because the grandma's roof needs to be fixed. I can't encounter that as service data.

Now, as luck would have it, we had two organizations that ponied up the cost to fix the roof, sent the kid to live with grandma in California, and she's doing great, she's not in mental health services anymore. We saved hundreds of thousands of dollars by being able to do that. I think the eventual goal is that we'll get there, but we're not there yet. I think as long as we're dependent on the show me what you did for every dollar that we gave you, it really gets in the way of doing some pretty innovative stuff.

ERINN KELLEY-SIEL: I'll weigh in just as a child and family-serving agency. We looked within [title] V at our Oregon Health and Authority partner that had one federal organization to navigate with, to negotiate a waiver, and that waiver was unprecedented around the opportunity for a global budget. But, still, the reason it happened was because they had one entity with which to negotiate.

And when you think about the different federal entities that contribute federal funding streams that are in support of family economic stability and child safety, and people have said to me, why can't we have a global budget for kid programs? And I don't think the answer is that we can't. I think the level of effort, however, of working across the federal programs is so enormous and daunting -- although, trust me, we're thinking about it here in Oregon because we've never met a waiver that we don't like -- but even within -- and I don't mean to be critical of our federal partners, but even within some of federal partnerships we have trouble. For instance, having real conversations between the TANF program and the child welfare program, and that's inside one -- responsibility for one federal agency.

So I think there are opportunities to do what Amy is saying, which is to -- and it's hard. I mean, it's hard for us as well, because at every level of this we can wear the hat that we're also critiquing, right? It's also hard for us to let go and trust and create outcome-based contracts that are less regulatory; it just is. And it's that issue of control, but really the insanity of the last three decades has got to stop, multiple decades.

One thing for me is I think there should be recommendations about moving the federal dial in a different direction around a holistic child and family approach and how those funding's can come together. And it will require trust and it will be scary, but Oregon is ready to work with you all if you would like to do that to try and figure out how to make that happen.

I think the other piece that I was talking with Susan about earlier is; I really think that some level of investment to help the system be more innovative is really warranted. This is a field that I think has been stagnating for a while, and you talked about how when performance metrics came to be, when there were incentive payments, the dial moved on things we've known for a really long time.

And I think what we've encountered, as we've worked with non-profits in our field, around really wanting to move in that direction is a strong willingness and desire to go in that direction, but a real lack of capacity and knowing about how to do it because our system hasn't been designed that way for so many years. So we're looking to philanthropy to -- even our state legislators, to say we need startup money, we need to be able to help with the transformation, to turn the clock, and then begin a different accountability process with providers.

It's not something this field has always done, and I think that agencies need incentives, they need to be able to use their dollars differently, and especially when you get started and you're trying to teach people how to use data to manage results to create data systems that actually measure outcomes instead of just outputs, those are big infrastructure and capacity issues and require a lot of training, so I think that's another area where I think strong recommendations would be helpful.

CHAIRMAN SANDERS: We're going to come back, because we have a number of questions. I want to make sure everybody gets a chance to weigh in, but I saw that you have something, and we will get to you in just a second. Commissioner Zimmerman.

COMMISSIONER ZIMMERMAN: My questions are going to be very much more focused. First of all, it's really great hearing this testimony. It's very innovative, as Dr. Rubin said, and going across the country and hearing about the different systems is by far very creative. And it also, for me, aligns with the cultural values most tribes -- all tribes in the country, that is very holistic in not just looking at the individual and looking at the family and the communities.

So I guess I would ask you to describe the Coordinated Care Organizations and the involvement of tribes in those organizations, and how it's working or what the challenges are. That's one question. And then the second question is even more discrete. It's because of the cultural implications around children, and the sacredness of children in tribal communities, how are health care providers -- or are they finding challenges with promoting contraception in tribal communities as a part of this work?

AMY BAKER: So, in Oregon, in most cases the nine tribes have really elected to not roll into the Coordinated Care Organizations in part, I think, that there has been concern around not wanting to have another entity actually manage their care. So most of them are still considered fee-for-service, so they bill the state directly, and there's really no utilization management process that happens.

In regards to the contraception piece, I really -- I can't speak to that piece.

HELEN BELLANCA: I can speak to that a little bit. We've been part of the initiative, and this was prior to my work with the CCOs, so as part of a non-profit advocacy group I was part of an initiative to talk about unintended pregnancies and the effects on our communities and to promote pregnancy intention screening among all providers. And I have to say, the tribes were incredibly receptive to that, and we had at least two tribes in the Northwest Indian Health Board who jumped right in and endorsed the initiative, and then asked for our help and technical assistance to come to the tribe and help women in the clinic.

The initiative is really about asking the women about pregnancy intentions, and then supporting them if they want to have a child or they don't want to have a child. So if they do want to get pregnant, what can we do optimize your health now to reduce the risk to pregnancy, and then if you don't want to have a child, what can we do to get you to contraception. So when we frame it in the sense of pregnancy intention it's incredibly well received because it equally supports women who want to have a child and women who don't.

MARYANNE LINDEBLAD: I would just say, in Washington I think true, as you mentioned about Oregon, about tribal members tend to sit outside manage care plans, development of the accountability communities of health, but we are working to make sure that they're at the table. So having a seat, having a role, being participatory in the conversation, meeting with them quite regularly to make sure they are engaged in part of this and actually working on a tribal centric behavioral health delivery system; so how do we meet the specific needs of the tribes?

And we have 29 tribes in Washington, and I think that's perhaps another complication in terms of just making sure that we can pull them all together and be able to create delivery systems that are respectful and culturally competent and we meet their needs. I think the focus on behavioral health has been, I think, a good start for us in really working with them. It has been a several year endeavor, but we're making progress.

CHAIRMAN SANDERS: Thank you. So I'm going to read the question from -- Commissioner Petit, on the telephone, had a question for Erinn Kelley-Siel, and then I'm going to see if Commissioner Cramer or Martin have questions and come back in here, because I'm guessing everyone in here will have questions. This is from Commissioner Petit.

COMMISSIONER PETIT: Can you hear me?

CHAIRMAN SANDERS: Let me read your question, Michael, because I think I have it here, and you can -- in case we have trouble hearing you, we can make sure she's able to respond and we'll see if I've gotten this right.

Can you confirm that all ten children killed in 2013 were completely unknown to the department; no reports, screen outs, investigations unsubstantiated, no contact whatsoever, and since you're one of the few states with no deaths in 2013, and perhaps the highest population state which there were no child abuse and neglect, can you say what's happened in 2014?

ERINN KELLY-SIEL: Thank you, Commissioner. I do feel good about data for 2013, and I haven't seen the data yet for 2014. It's just coming together. It comes together at the end of the year, and it's just February of 2015, so we should be publishing that shortly.

CHAIRMAN SANDERS: Commissioner Petit, I think we can hear you now. Go ahead.

COMMISSIONER PETIT: I'm hoping there's no echo, is there? The ten cases unknown to the department previously on the one hand -- (indiscernible.)

CHAIRMAN SANDERS: We're not able to hear you, Commissioner Petit. You're going in and out again. Commissioner Petit, we're unable to hear you. So if you want to, again, jot the question down for Amy and she can pass it on, we'll make sure it gets to Kelley-Siel.

COMMISSIONER PETIT: Okay. I'll do that.

CHAIRMAN SANDERS: Commissioner Martin or Cramer, do you have any questions?

COMMISSIONER CRAMER: This is Bud Cramer, I have no questions.

COMMISSIONER RODRIGUEZ: Did we get the confirmation that those ten deaths, that there was no contact whatsoever with the child welfare system?

ERINN KELLY-SIEL: That's right.

COMMISSIONER RODRIGUEZ: Thank you.

CHAIRMAN SANDERS: Commissioner Covington.

COMMISSIONER COVINGTON: Thank you. I could sit and listen to you guys all day long. Our prevention committee that's been working on trying to craft recommendations looking at child maltreatment and fatalities way upstream, you sort of -- you're hitting it exactly where we're going with our recommendations, so we just really could use some more of your time and your amazing thinking on this. I just had a couple specific questions to help us think through some of our issues at our end.

When you created the global budget, what did you have to do to get through federal -- I mean, how did you do it? What specifically did you do, because, that would be, for me, one of the recommendations we would use at a national level is how you would help other states to be able to kind of get through those mine fields?

MARYANNE LINDEBLAD: So I can answer that from a Medicaid perspective, because actually, Washington is going down a pathway right now with the federal government to see about doing not exactly similar to what Oregon is, but models after much of that, and I'll tell you that it is not an easy process by any stretch of the imagination.

And we actually, in Washington, we're really fortunate because we have gotten some technical assistance from the National Governor's Association [NGA]. We're one of the three

states that got this technical assistance, so we right now have some really direct access to key senior leaders at CMS to help us think through what we can do and what that negotiation can look like.

But it is a -- defining what you want to do, what your goals are, how you want to do the innovation. It's called an 11-15 [Medicaid Demonstration] Waiver, it's a demonstration waiver. It's something that has to be replicable, and you have to be able to define what you're demonstrating and defining, how you're going to make sure that this costs no more than what it would cost otherwise to deliver services within the Medicaid budget.

So it is a real back and forth negotiation with CMS. There's, you know, it can take, you know, in some cases a year, two years, to get to where you want to be, and CMS is actually moving forward with some other supports to try to define what they want from states when they want to request an 11-15 Waiver, to make that request simpler, and how those waivers get negotiated.

So, you know, even at a federal level they're seeing that it can be a real slog, and we want to make that a process that's easier, more simpler. So we're right in the middle of defining a concept paper, getting that out and working with CMS in terms of that negotiation of how we would move forward with it, but it really is, because each state is different, each waiver gets negotiated in a different way.

HELEN BELLANCA: Director Kelley-Siel just mentioned to me, too, that one of the things that contributed to our success with it is not only did we promise we wouldn't spend more money, we put a cap on it and we promised to reduce the rate of growth of spending by two percent, and so we're being held accountable to that growth. It's a pretty compelling argument.

We're the only state that has accountability to a hard line growth rate spending, so we have to keep under that. I believe it's 3.3 percent per year we can grow, and it used to be 5.3 percent and growing, so we had to cap the rate of growth.

MARYANNE LINDEBLAD: And we're looking at doing the very same model because -- by the ability to do that, and we heard a little touch about this on investment, and actually what happened in Oregon, too, there was investment that CMS made to the state to help do some of the startup and the development and that sort of work; so asking for the same thing. And then we guarantee that over a period of whatever it is, three years, five years, or whatever, we're going to save them more than they invested, and then that's that opportunity to create that savings; but also give states some flexibility in their funding's, create opportunities to have some money that you can use to invest in strategic initiatives in communities.

HELEN BELLANCA: And they go together, because it's recognizing that there's a lot of inefficiencies in the system, and it's by integrating the mental health and addiction treatment with the physical health care that you can achieve those savings, so you can't really achieve savings if you're going to keep maintaining these silo systems, and so they really go together.

COMMISSIONER COVINGTON: I have one more question. I have sort of a simple question. We really like your family well-being assessments. Are you set up to meet the needs that you get identified through those assessments? We've heard that throughout the country that that's a problem.

HELEN BELLANCA: Well, you know, I think we don't know. We're just getting started on it, and one, I resist the idea that all screening results in the need for more services, because I think a lot of times we are working with the family and we think we're addressing one thing, and really, there's all kinds of other things going on in the background that we don't know about. And so, to me, the family well-being assessment is about being clear on what the family issues really are.

As everyone in the room who works with children knows, sometimes you're addressing one behavioral problem and you think it's about this, and you realize all the traumas and chaos going on, and so I think it's the same thing with family systems; that really understanding from the get-go what issues are with the family helps you make efficient decisions.

And so when there's domestic violence going on, for instance, is a great example. When we don't ask about domestic violence, then we're treating all kinds of other things that are related, but not the cause of the problem. So I think to some extent right now it's not an issue because we're very early on. So we've made it very clear that there are two purposes. We've made the family well-being assessment a set of standardized questions with not open-ended answers, and we agreed on that as a community because data aggregation is really important to us.

And so one of the purposes is to understand what the community needs are. So if we find needs that we can't address in the community, it helps us to invest more resources in that area, but what I anticipate is that we'll just be more prepared and accurate about how we care for families, and it will be about more efficient care and reducing redundancy and ineffective care because, we're talking about real issues that have affected their health and not kind of the surface issues.

CHAIRMAN SANDERS: Commissioner Rodriguez.

COMMISSIONERS RODRIGUEZ: I have two questions for you. One I think is larger, and one is pretty technical. The first is, I can't say how excited I am to hear you talk about the intergenerational approach, and also the thoughtfulness by which you're looking at it. I mean, I think that the issue around the second generation or the third generation is real, and it's one of the groups that we really should prioritize since so many of those the historical trauma comes from the experiences within our child welfare system.

And so I just wanted to say, as somebody who grew up in foster care, I'm very appreciative to the attention you're giving to that. But I'm wondering if you're thinking at all in using your Coordinated Care System, since those young people up to 26 are staying in that system and are likely parenting in that system as well, so to make the transition from just being a child to actually being a parent of a child, if you are targeting that group at all, for one, dealing with any of the sort of ACEs related trauma that might be inhibiting their ability to parent, or

doing any special preventive care or outreach around the mental health services and the substance abuse issues that we know those in people are struggling with.

HELEN BELLANCA: I can say that there are two interesting efforts on that front. One is that another one of our pay-for-performance metrics has been around adolescent well-visits. At first people were resistant to that as a metric, we're not sure why we should be seeing adolescents for a routine well-visit, but how we've been framing that is adolescence is really a key time for all of us. Between 12 and 21 is when we're making decisions about our habits, and about risk behaviors, and about our overall health, and so, what makes that adolescent well-visit meaningful is that risk assessment and asset assessment, too, figuring out where those adolescent's needs are. We have extended depression screening, substance abuse screening down to adolescence, and then contraception, too.

So those three issues where we talk about their mental health, substance abuse and need for contraception extends down to adolescence. So we really think about them at that age and trying to approach it from a preventive place of saying you're about to make some decisions about whether or not you want to parent. What can we do to support you in choosing healthy behaviors and reducing your risk?

And then the other initiative that's very small, but I think is going to catch on big, you've heard a lot of talk about ACEs and adverse childhood events, and recognizing that if you experience those things as a child you're likely to propagate those in your owner parenting. We talk so much about ACEs in Oregon, and there's a lot of great conversations brewing about what do we do about it and how do we prevent that cycle.

And there are couple of pediatric clinics, actually, where the pediatrician will ask the mother of every four month old about her own or his own ACEs as a child, and if they have had ACEs as a child they talk about how that might affect their parenting. So there's not anywhere to refer them, or not any services that we give to people that have had adverse child events. But it's acknowledging and creating a culture where if you have those experiences, as Amy was saying, it makes sense those are going to impact your parenting.

We also have a really interesting [Oregon] Parenting Education Collaborative [OPEC] that's happening. Four of our major foundations in Oregon have partnered together to supply money, and what they're trying to do is set up parenting hubs in all of our counties. And parenting hubs offer free parenting support for any family, for whatever reason. It could be home visiting, it could be classes, it could be whatever they need. I think it's this culture and acknowledgement that parenting support should be opt out and not opt in.

I think we think of parenting support as something that if you're doing something wrong we're going to send you to parenting classes, right? And really, we all need support with parenting, right, and it should be more of an opt-out system. I think the combination of the ACEs work and the health system and the parenting support that's going on in our communities is going to create a culture where everybody is entitled to parenting support. You're welcome to opt out of it, but we assume everybody is going to need that at some point in time.

COMMISSIONER RODRIGUEZ: But just to be clear, there's no efforts made to specifically target young parents that are coming either from child welfare or juvenile justice system where we know they're struggling with ACEs?

HELEN BELLANCA: No, I think we're probably mostly in the infancy of really looking at that. That conversation has come up multiple times through the children's health policy team, as you heard from folks. I think that Oregon is -- we're really in a piloting phase. We have the infrastructure that allows us the creativity of trying different pilots, and that's one that we started to talk about, but there's not been a specific effort statewide.

COMMISSIONER RODRIGUEZ: Thank you.

MARYANNE LINDEBLAD: I would just add, one of the reasons we're going to be enrolling all of our foster children into one single managed care plan, and then they can stay in that plan to age 26, as they age out it develops those unique set of services or requirements as part of that so you can support those children differently than we would with the rest of our service delivery system.

COMMISSIONER RODRIGUEZ: Thank you. My second question is around ACEs screening. I'm wondering to what extent that screening has actually been adopted as part of the safety assessment tools or practices that child welfare workers are using during investigations and trying to -- I mean, it seems really innovative and great on the preventive, but it also seems like it would be extremely valuable to use when a case has come to the attention of the child welfare system?

Also, frankly, it seems really valuable to be using as a part of assessing the appropriateness of caregiver's homes, like the relative, the foster parent, the out of home placement, and I'm just wondering has there been that leap made with the use of the screening?

ERINN KELLEY-SIEL: I think right now, as Amy said, there are a lot of really good ideas that are being thrown on the table. I think the place where we're trying to leverage that work is some new work we're doing in Oregon. We're just now implementing a differential response system, which is now in three counties, and we have a roll out process scheduled through December of 2017.

And I think where we're really seeing that partnership intervention and that opportunity for different kinds of trauma intervention particularly around families that have experienced neglect, and we're having different kinds of partnership relationships after we have done a safety assessment, and we know that we can maintain the issue of safety, and then what are we doing in terms of our services that we offer for families and how are we responding in a supportive way?

There's a story from one of these that recently came to my attention about a young woman who had a lot of domestic violence and mental health trauma. We had multiple contacts with her and family. We got a phone call from the school because she was not -- around the issue of neglect. The bus driver had dropped the five year old off and nobody was there for two or

three hours.

Instead of dragging her into court and going back through a very court intensive child removal process with her kids, even though we had history, we engaged some different providers in the conversation with her and really what she needed was housing, some additional support for her mental health, and she wanted to find a job and needed childcare.

So we put those things in place, her children were able to stay with her, and she now is voluntarily engaging with other parents in a positive and proactive way with partner organizations in her small rural community to say, don't be afraid of childcare, they're here to help, and they do it in a way that helps you feel supported.

That's the kind of transformation as we start to integrate ACEs into what we're doing. It may not become part of the safety assessment itself, but it's especially relevant to how we intervene. I think sometimes they are two different things.

CHAIRMAN SANDERS: So we have -- we are slightly over the time. We're going to continue with questions, because clearly there's a lot of interest. We have two follow-ups to some of the comments that have been made, and three more commissioners will have questions.

COMMISSIONER RUBIN: I want to go back to Amy about the response to the assessments for ACEs with parents, et cetera. I think in -- I feel like I'm having an epiphany, because in a global budgeted world there's opportunity to rethink sort of how you bill, right? And so, for example, we can think about doing maternal depression screenings in pediatrics, but wouldn't it be amazing if we also have treatment provider there, or a PCIT provider who was ready to go when we identified that maternal depression?

And can I then, if I'm the pediatrician to support this, bill for the child's Medicaid treatment to the mother? So we're talking about dual generation reimbursement strategy. So have you guys thought about sort of creating flexibility as to who you're billing in a family centered approach, and what that might lead to in terms of recommendation that we might make back to up Medicaid and CMS?

HELEN BELLANCA: That's exactly the direction we're heading. I'm not sure about pediatrician's billing for the mother's care, because that presents a whole other set of problems about whose patient they are, but in terms of exactly what you said, parenting behaviors or mental health practitioners, and in our case, the Project Nurture is embedding addiction providers with the physical health providers, and those payment systems are dramatically different, but that's exactly the kind of idea we have.

I have to say that this is kind of in our third year now of coordinated care work, and everybody has been very, very hesitant to make huge waves right at the get-go. First, we just wanted to get organized and we continue to pay as we always have, but part of our contract and contractual obligations, so think about alternate payment methodologies that gets to these core issues, and that's exactly the direction we're heading. We just have to kind of get there slowly and figure out how addiction care is paid for, how is mental health care paid for, and how can we loosen up the restrictions around physical health. I really like what

Amy was saying, getting away from this fee-for-service model.

We have several primary care clinics who are doing alternate payment methodologies where they get a case rate, a monthly payment for the number of patients they see, and it doesn't matter how many visits they have, and it doesn't matter what the diagnosis is, what matters is let's see every month how you're performing on certain metrics. Are your diabetics controlled? Are your pregnant women getting adequate prenatal care? Are you reducing preterm births? Those kinds of things. Are all your kids getting well child visits? Are you getting developmental screenings on time? How's your immunization rate?

We're looking at those kind of outcomes, and then just paying a set fee per month, per member -- I guess, per patient, per month to the clinic to manage all the care. And then when you do that, and if you could do that in combination with your mental health budget you could really pay differently because then you could help the mental health provider. With the addiction folks, one thing we're talking about with the maternity system is a stratified system, paying for maternity care where you get paid on a base -- maternity care is paid on a global rate for prenatal care, and delivery you get your base global rate, but then if they have complicated behavioral health issues, mental health or addictions, you get an enhanced rate and tier.

One question is where is that money going to come from, because we might not have it in the physical health care system, but we're supposed to be integrating it with mental health and addiction? So if we really operationalize a global budget, it hasn't been fully operationalized yet, it's just kind of in theory, it's there, but we're still dolling things out as we always have, but if we really operationalize that global budget you could enhance maternity payments with addiction dollars for programs that provide that specialized care.

That's exactly the direction that we're going, embedding behaviors, embedding social workers, embedding mental health professionals, and I think kind of a take-away for nationally is this primary care home. You asked before about how do we support providers? We have got to get away from this idea that it's the doctor providing care to the patient one on one in the exam room; that's ridiculous. That's not what families need, and it's not efficient or effective, or possible. It's really a team-based approach.

While we're thinking about whole family as a system of health, we also have to think about the health care delivery team as a whole system. We need nurses and social workers and behavioral and mental health professionals and addiction counselors all working together with the clinician to provide the best care. And so then you really -- it can't be a fee per service model, you have to think about paying globally and paying for what you get as opposed to what you did.

CHAIRMAN SANDERS: So before others jump in, we have number of other questions. I want to make sure we get to them. Commissioner Dreyfus, I assume you have a follow-up to that?

COMMISSIONER DREYFUS: Erinn, this is really more for you. So I have to believe, just sitting here and listening to Helen talking about what it is that the State of Oregon believes is possible and wants to be achieving, we could probably think about those ten children that

were never known to the system, and all of a sudden my head immediately went to, well, maybe they would have been prevented, number one, but if risks were there hopefully they would have been known to the system, right? That a call would have been made, that intervention would have happened?

So Helen, my question to you is, what are you guys doing, because we really -- State of Washington, State of Oregon, I'm sitting here very thrilled because I'm thinking as a commission to eliminate child abuse and neglect fatalities, from a prevention standpoint, you guys get right to what you're envisioning, and I think you are going to show the country that we indeed can eliminate fatalities from abuse and neglect.

But as you listed with these ten children that we were talking about from 2013, and you think about if it works the way you're envisioning, what's happening with the knowledge and skills of that team about maltreatment that they would have made that call to child protective services if they were concerned and that that call would have been made?

I guess then the question would be had that call been made, you're sitting in an environment where the federal government gives very little attention to child protective services from a financial standpoint, right, and yet we're being asked to have kind of a child protective services system in our country that is ready to stand up and be responsive, right, intervene earlier, be able to go out, be able to put the necessary supports in place so we're not having to remove kids, or when we do we're quick about it and effective.

And so I'm also wanting to ask you Erinn, as you talked to me a little bit about what are you going to do to make sure the team is identifying and making those calls to CPS when needed, but also questions from federal government's perspective, Erinn, what needs to happen so the State of Oregon has the quality of child protective services [CPS] system, right, that's going to be necessary? Because there's very little attention federally paid financially on CPS.

HELEN BELLANCA: Well, I would say that I would love to see if there would be a number of different touch points at which those risks would be identified and that call would be made. The first is before she's even pregnant. I'm assuming we're talking about the mother here, but it could be the father, that at any point if the mother or father was seeking care that their mental health and their substance abuse needs would be met, and met more effectively and efficiently than they are now, and as part of their mental health care, that we think of them not only as adults, but as parents, or potential parents, and have that lens every time we work with chronically ill adults.

And then that she would be screened for her pregnancy intentions, and if it was a woman who didn't want to be pregnant at all, and that was the reason for the child abuse and neglect. If she wasn't ready to parent then she would be directed toward effective contraception before the pregnancy ever happens. Once she's pregnant and in care, that she would be screened in family well-being assessment, which would pick up mental health issues, substance abuse disorders, domestic violence, and kind of alert everybody to the risk of child abuse and neglect because of these known risk factors, and that we would direct her towards service and care that was better meeting her needs. And then once the child was born that we, again, we just have an idea, we'd know more, have a different lens. We'd think of them as

adults, as parents, or pre-parents, and we'd think of their mental health and chronic issues that need to be addressed.

COMMISSIONER DREYFUS: So will there be training of everybody on the team on child safety, the identification of children that are at risk?

HELEN BELLANCA: Yeah, right.

COMMISSIONER DREYFUS: I'm just sitting here, as a former child welfare director, saying I appreciate that those kids were not known to CPS, but they were known to somebody.

HELEN BELLANCA: That's right. That's right. That's right. So I would say that is a good strategy. We're not in a position to sort of direct teams that way, that everybody must be give certain training. We don't have that authority over provider community, but we set up systems like these are things we care about, these are things we're looking for, and then we allow provider groups to figure out what that means in terms of what their teams need to be trained for.

I think this whole approach about ACEs and parenting really clues people in to this idea, and that that would be picked up earlier. And the training is rampant, so if people want training, it's available. Yeah, so we set the stage and the structure, we say this is what you're accountable for, this is what we think is important, and then we allow the provider community to figure out how to get there in whatever way makes sense to them.

CHAIRMAN SANDERS: Ms. Kelley-Siel, before jumping in, I do want to also read part of Michael Petit's question, because I think it's consistent with what Commissioner Dreyfus was raising in her follow-up to you. And that is, that it's great that zero cases were known to child protection; but if ten died should they have been known, and what will be different? So as you're responding to Commissioner Dreyfus, if you could also respond to that.

ERINN KELLEY-SIEL: Yeah, I have two thoughts. First, just in response to the issue of our people getting training around risk and safety. This has been something that's come up in one of the sensitive case reviews. It's something we're looking at in two different ways. One is really connecting differently to professional associations and how is it that we can embed in ongoing medical -- I'm an attorney, so we call them CLEs [Continuing Legal Education], but continuing learning opportunities, CMEs [Continuing Medical Education] for medical communities?

HELEN BELLANCA: CMEs.

ERINN KELLEY-SIEL: How do we integrate those? A conversation, especially for child-serving, family-serving providers, conversations around risk, safety, and how to evaluate and assess it. Also, more education about what the Child Welfare System actually does and is.

You're bringing up something for me that I had wanted to say, and I went over my time earlier, and I think we're at an interesting crossroads as a nation around the role of Child Protective Service systems. This is a system, and you're going to talk later today, I was glad

to see it on your agenda, that's extremely intrusive. It's the most extreme type of intervention in a family's life that possibly can happen, and in my world we take that really serious.

We are a response system. We -- those 2 people that I mentioned that work for me who do the work of child welfare in this state happen to prevent a lot of child abuse and neglect fatalities because of the work they do, but they are responding once something already has occurred. I don't think we want this extremely intrusive system to become the prevention system. I think we want this system to be really excellent at responding, and also having strong connections and relationships in such a way that allow providers who are prevention-oriented, who are community-based to be able to evaluate and assess risk adequately, understand our concerns about safety, understand our role in that, but then also take up their charge around the issues of addressing the needs and concerns that are arising in a family that are often the result of trauma, et cetera.

So when I looked at those ten cases, some of them never should have been calls to us. I mean, I think that's why we went out and did the co-sleeping, bed sharing campaign. Many parents, myself included, choose to share a bed with their child. It's just about how to do that in a safe way. That's a public health -- it's a public conversation. However, if those parents had an addiction issue, my hope is that earlier in their experience, as Helen and others have described, if by chance they were choosing to co-sleep when they were intoxicated, or had had a drink or two, or had mental health issues, then that's a different kind of conversation, and one that I want to be having with the medical community about, hey, we see this as it causes fatalities in kids, how can you help me prevent those?

It's not that we don't have a seat at the table or a role to play, because we have that information, but I don't know that it's my system that should be the one that's always intervening in those families. I want people to call us any time they have a concern, but I also -- and this was something else that we were finding in our CIRTs, we also have to figure out how to make sure our system has strong enough partnerships where we do warm hand-offs when the right intervention is not with us; it's with a partner that is serving children and families, and then the trauma-informed training to be able to intervene in an appropriate way. And I'm encouraged by --

CHAIRMAN SANDERS: We're going to have to go ahead and close.

ERINN KELLEY-SIEL: -- having a differential response, but I think there's still a big gap, but I think the federal government needs to help us close that gap in between.

CHAIRMAN SANDERS: Thank you. I know you've been trying to get in a couple of times, but I have a question specifically for you, and then Commissioner Bevan. So you really mentioned an incredible array of efforts that are being implemented in Washington that seem consistent with all of the things that we've been hearing as best practices. So it would be helpful if you could help us to understand what seems to be happening in terms of the actual data.

So it appears that the number of children who have died during abuse or neglect either has remained stable or increased over the last four or five years in Washington. The initial abuse

victims have remained about the same, reoccurrence has remained about the same or gone up. Do you think we're measuring the wrong things? Is it that it will take time for there to be an impact? Help me to understand, because I think that as we look to report to Congress one of the things that's going to be important is to say efforts have had an impact on child abuse and neglect fatalities, or at least have potential to, and so help us a little to understand how that's -- what's happening in Washington and what we might want to look at.

MARYANNE LINDEBLAD: Part of the work that we're doing right now is on that measurement piece, so are we measuring the right things, and looking to define what we're measuring and building a more robust analytics capability than we have today? And I think the other thing I believe is somewhat unique about Washington, too, is the fact that we do have an integrated database that pulls in information from many, many systems.

So Medicaid data, education data, criminal justice data, child welfare data, there's a variety of inputs that come into the system that we have access to, but what I'm saying is we probably haven't used it as effectively as we could. And whether we are measuring the right things, again, that's part of the conversation that we're having today around, you know, building these accountabilities, delivery system accountabilities, communities of health, and identifying the kind of measures that we need to develop.

So we've had a significant amount of work that's gone on in just identifying measures over the last year. We've done a lot of coordination and collaboration across delivery systems, including behavioral health, early learning, whole variety of folks at the table to help us identify some key measures that will go -- that will start to be implemented and reported on this year and next year; we're just not there yet.

CHAIRMAN SANDERS: That's -- so I probably will want to follow up on that a little later as we go through the conversation, because I think that the question about fatalities and how to reduce fatalities is clearly central to our task. And it seems that what we will need is more beyond hypothesis that it will, and I think that's been the theme as we've talked throughout. And so I think understanding the process that you're going through in Washington would be very helpful.

And let me extend that question to Ms. Kelley-Siel, because clearly the data you presented on 2013 is outstanding. As we look at the federal report there's a lot of information missing from Oregon, and I wonder is that information that's not reported to the federal government around child fatalities through NCANDS [National Child Abuse and Neglect Data System]? Is that information you have? Is it easily accessible? Are there things that would help us to better understand what's happening in Oregon than just looking at the national data that includes a lot of missing pieces for Oregon?

ERINN KELLEY-SIEL: I appreciate the question and chance to clarify, because I certainly don't want us to look better than we actually are. The data team that's here with me wants you to make sure that you know those ten children, of them -- no prior contacts within the previous 12 months, but there were six that had not -- that had touched the system with a phone call or something previously, but it had not been within the prior year, so I apologize if I wasn't

clear about that earlier.

The data issue for us has been a significant issue, and I appreciate the question. I'm probably not the one most capable of answering it. I'd love to have somebody on our team get back in touch with you. I will say, uniquely for us, we've had some struggles as of late as we switched our SACWIS [Statewide Automated Child Welfare Information System] system over, and so I know that sometimes our federal reports are not including data that we may have, or are missing things that we know about, but we're just not able right now because of our SACWIS system to get them to the right place, but I'd be happy, Commissioner, to follow-up with you on that.

CHAIRMAN SANDERS: It sounds like you have information that might be helpful for us to see, even if it's not part of the federal report. Is that accurate? With some of the data that might be available to you in the state?

ERINN KELLEY-SIEL: I think that's probably accurate because we do have longitudinal -- we have kept things that we've known prior to our SACWIS switch, and I think if you're trying to look holistically you've got to look outside the SACWIS system. We're also embarking on different kinds of looking at our data across systems and across programs and tracking. We've got a project right now with Department of Corrections and the Oregon Youth Authority looking at our systems and a predictive analytics model with them. We've also got a foster care predictive analytics model that we're building with the Early Learning System, so we do have other data that you might be interested in knowing about.

CHAIRMAN SANDERS: Commissioner Bevan, and this will close our panel.

COMMISSIONER STATUTO BEVAN: Okay. I have three questions, quick ones. First one is would each of you answer the question, who is the client?

MARYANNE LINDEBLAD: If I'm understanding, from my perspective, from a service perspective, for us, it's the people. We service the families we serve. I mean, is that --

COMMISSIONER STATUTO BEVAN: Yeah, I'm looking -- yeah. It's your answer. It's whatever you believe. But I have follow-up.

MARYANNE LINDEBLAD: For us, it's the families we serve.

AMY BAKER: Well, I'm kid's mental health, so from my perspective, although state government, I have many clients. I have the service system, I have my partners, but from my mission it's particular to kids and their families.

HELEN BELLANCA: And I would say for us, focusing on the maternity care system, it's the mother and infant as a unit.

ERINN KELLEY-SIEL: I think for us it's the family as a unit as well.

COMMISSIONER STATUTO BEVAN: So I thought you guys would say that. And my concern here, or at least what I don't understand, because I guess I'm kind of old fashioned, is what -- Ms. Baker, what you said about really evaluating what the government can do, that we should reevaluate child centered approach and develop more effective family center policies and practices in terms of someone in the policy government type, I couldn't find -- I am trying to figure out, are you looking at sort of dual services?

I mean, how do you want us to change, and what programs do you want us to change that are currently child-centered?

AMY BAKER: To give you a couple of examples, there's a lot of -- in the history of mental health there's been a lot of situations where we've done individual therapy for kids and have not done a very good job bringing families in.

I also think that some of our early learning programs are really exceptional in terms of outcomes they produce, but you if have kids who live in families where there's high toxicity and frequent moves, we have the potential of losing those effects. And so I think there really has to be an approach of helping kids develop skills they need, but we also really need to support families and getting them out of poverty.

That's sort of the dual generation approach that I was referring to. That poverty is so well researched in terms of its impact on kids, that that's not something that I can service a family out of with, you know, parent therapy, family therapy, that there really needs to be a concerted effort to help move them up out of that situation if we want to sustain the gains that we've made with particular children.

ERINN KELLEY-SIEL: Conversely, I would just say have fatalities in which the parents were actively involved in treatment and recovery services, but as we looked back through those records they were never asked about the stressors they were facing as parents in those recovery services and they ended up murdering their child. And so we have -- you know, we made an observation out of that, that we would love clinicians to actually relate the parent's experience back to parenting, to know that the individual they're serving is a parent, and to talk about how their issues around addiction and recovery are actually impacting their ability to safely parent and connect to their kids.

And in the TANF program also, as we're working to try and move parents into the workforce, be mindful that we're also asking them to parent. We have this incredible opportunity with them and with the childcare providers to think about child development, and that's what we mean, is just instead of a measurement that's only been tracking, for example, parent engagement in a program, let's look at parent engagement, and let's also look at child development. Or let's look at child development and look at what's going on in the household for that child.

COMMISSIONER STATUTO BEVAN: I understand that, but we're specifically looking at fatalities, and I am -- for me, most of the legislation I see is child safety is paramount, that's the law. And to move away from child-centered and toward the family approach, as obvious as it might seem, which it's pretty obvious, but I'm not clear if there's a direct correlation

here.

I mean, what information do you have that if we move from child-centered to family-centered that we're going to reduce or eliminate child fatality? We don't know anything about that.

ERINN KELLEY-SIEL: I think we have information. If you look at key drivers, like mental health and addiction or domestic violence, if we just looked at those two interventions, for example, and thought differently about how we worked with parents and children in those circumstances I think you would have a huge impact on child fatalities.

COMMISSIONER STATUTO BEVAN: I'm all for family treatment, trust me.

AMY BAKER: I also think that do I believe there's some families that we're not going to be able to help? Yes, I do. But I think that too often we end up writing families off too easily without really giving -- and without applying the best efforts that we possibly can. And from the kid's mental health perspective, I have watched kids grow up in the foster care system so damaged because they don't have people who care about them.

COMMISSIONER STATUTO BEVAN: Right.

AMY BAKER: And the system raises crappy kids. So as a system, we need to do everything we can to support that family and help them if we can. And if we can't, then let's find somebody in the extended family, let's find a grandparent, let's find somebody who cares about that kid, but until we weave our systems together, really, if you can create a metric that was across all of our different systems, health care systems is not going to fix this problem.

We're going to be a very significant part of the solution, but we're not going to fix the whole thing, right? It is really all of us together doing our part that is going to change the trajectory of child abuse and neglect fatalities.

MARYANNE LINDEBLAD: Community. It's got to be about community.

COMMISSIONER STATUTO BEVAN: Here's my last question. In terms of determining level of risk and their safety assessments, determining level of risk is important for differential responses and for predictive analytics, so I would like to know more about how you determine the level of risk.

ERINN KELLEY-SIEL: Commissioner, I'm not a practitioner of child welfare every day. I'd love to get you more information. Lois Day would have been here, and she would have easily answered that for you. We have our Ways and Means Budget presentation in front of our legislative committee this morning on child welfare, so that's why she's not here, I apologize. But if her deputy is here, he can talk to you on a break, or we can have someone else get back to you after the meeting.

COMMISSIONER STATUTO BEVAN: Okay. Thank you very much.

CHAIRMAN SANDERS: Well, on behalf of the Commission, thank you, panel. That was really outstanding. And, obviously, we extended the time because there was considerable interest, so thank you very much for your presentation.

CHAIRMAN SANDERS: We're going to take a break until 10:30, and we'll reconvene with the next panel on practice.

(Break.)

CHAIRMAN SANDERS: Under our next panel we have four presenters, and each will have 12 minutes in looking at child welfare capacity to prevent fatal maltreatment, which was certainly a theme discussed in the last panel as well, as was Kelly-Siel's presentation. So we have Myles Edwards, Don Graham, Ryan Vogt, and Joan Zlotnik. We'll go ahead and get started with you.

MYLES EDWARDS: Thank you, Commissioner Sanders, and thank the rest of the commissioners and the staff for the opportunity to present these thoughts today. I want to address child welfare workload, and I would like to do it from a series of questions. Our approach to workload and outcomes has been hampered by the data that we have, so that what we've found is that over the years no definitive results relating to workload by itself is related to outcomes.

In fact, workload is probably not directly related to child welfare outcomes by itself, but rather all the practice model effects we just heard about over the last couple of hours are driving features of it. And we ask, what is the logic model for producing outcomes? And we heard quite a few things in terms of the preventive types of activities, service integration and so forth, in that outcomes are the result of treatment, and that what we've seen in workload outcomes research is various types of treatments produce different outcomes, and sometimes they don't produce different outcomes.

The mediating factor often then becomes the fidelity of the implementation of a practice model. When I think of a constructive approach to workload, I think we want to keep the focus on the children and the families and what they require rather than on what the staff do. Traditional workload question has been how much work does a person have to do, how much can they do?

In looking at child welfare workload, over the years we've found it to be very helpful to focus on what do the children and families need in order to succeed and produce -- and get to the outcomes that improve their lives. This shift has several major advantages for us. We're allowed then to do planning of staffing based on children and families rather than staff. We're allowed then to start thinking about what the children and families actually receive rather than how the staffing is configured.

There are a lot of policies and organizational requirements that we all have for various accountability and monitoring reasons, and we can debate how much paperwork is really necessary, how much is duplicative, but there's probably some, certainly in terms of having people in jobs. There are requirements in terms of leave time, training, staff meetings, that

aren't involved in direct services to children and families.

These case supportive requirements vary across jurisdictions and venues and organizations, and even within states there can be a great range. I know in Montana they talk about the amount of windshield time that's needed to deliver services. If we continue to think about services received by a case as the workload, then what we have is a client-centered perspective on workload and all else can become case supportive. By divvying that up, then the workload question becomes separate from the organizational issues on the one hand, and the practice model issues on the other.

So the metric we look at oftentimes is what percent of a typical staff person's time can be involved in case-related or practice model activities as opposed to the maintenance types of things. I think at this point, too, a piece that came out to me from this morning's presentation was when Amy Baker was talking about the ability of a parent or a child to actually use this service, the reduction and prefrontal lobe effectiveness, if you will. I think this is something that we haven't had as a variable in our workload considerations.
We've tried to look at issues of severity or difficulty of caseload that comes in, but I think very different variables are being brought up when we talk about the ability of a client to benefit from services and how that impacts workload, and that would be a new question for me, you know, what is the work and workload?

I've referred to practice model several times, you know, performing the actions to implement the practice model, and I think that gets me to the point of thinking of workload as a necessary condition for practice model success, that if we're expecting somebody to do work that's not possible to do in the time allotted we're really setting the staff members and ourselves up for failure. I've been particularly pleased to hear your opening remarks, Commissioner Sanders, about counting and what is a case, and there was another question later on about what is considered a case?

And I think that definition of case is critical to understanding workload. In accounting they talk about cost objectives. Cost objectives simply is what are costs gathered around. In the same way, the case is something that work is gathered around. Case receives work, and as we talk about workload, it moves with our definition of a case. The question often comes up about the range of workload values we find between the states or between counties and a state; oftentimes, that has its root in the changing notion of a case.

For example, when we were working with Washington State, they had recently changed from including services as part of the assessment phase of the case to trying to separate them out. Well, assessment plus initial services is a different set of workload than assessment by itself with some different boundaries and when the service hand-off needs to happen. So when we talk about workload, the notion of service hand-offs becomes very critical.

As we've moved away from the individual practitioner models, thinking about a physician in an exam room with a patient, as a mental health clinician doing an individual psychotherapy session, as we move away from that, workload changes. So the workload again is no longer a staff persons, but rather what a child and family receive. Because of the range of practice models and even ways to implant a given practice model I've come to think of the myth of

national standards.

We'd like to think of guidelines and so forth as something that is a piece of security there for us, and I'm here to say that there really isn't; that what we've got are accidental circumstances where numbers come together. In fact, when we look at the range of some of the values in studies done by the same research teams, even across the states, we find quite large percentage differences.

And these percentage differences have to do with how the cases are defined or how the work is actually performed, so with workload there's this elastic effect that can be driven by a couple of different dimensions. The real workload question for me is, you know, what are the services needed, and what are the services needed to be received? By getting to the point where we talk about services received by a case, we'll be able to start collecting data that way so that we talk about all the services received by a case, not just a small portion of investigations or assessments for foster care services.

And by having case level service data then we can talk about the workload received by the case and relate that directly to outcomes at the case level, and that would be what we need. I think that what we can have is a change in our SACWIS methodology that would accomplish that. Thank you very much.

CHAIRMAN SANDERS: Thank you. Mr. Graham.

DON GRAHAM: Commissioner Sanders, and to the Commission, I appreciate the chance to share some thoughts this morning about the studies and child fatalities. I'd like to back up a little bit and just put the context of what the purpose of workload studies are and how then that relates to child fatalities.

Workload studies are basically ways to assess business practices and offer approaches to improve how businesses actually run, and it basically looks at the availability and resources in the face of what is defined as what is the work? And it is basically that studies are basically the tool and not an end result. As mentioned a little earlier, what work is being measured is actually the response of an agency to alleged abuse?

That may be a first -- a response to an initial call, or it may be the actual heavy work of an active case later on in the process, but in any case, it's not really conducting prevention per se, or preventing injury or neglect to children that have not been known to the agency, and so what we're looking at is the business model itself, as Myles mentioned, as fidelity of the implementation that was intended by the agency against what its resources are.

Typically, there's a gap between the amount of work and the amount of resources and opportunity to do a workload study allows the agency to look at how big that gap is, and what is the nature, what's going on, what the type of work is, elements of programming involved in that gap? The workload studies generally is not a new field; it's been around for decades. There are a variety of techniques, sometimes 30-day census where every minute of staff members is measured against certain activities, sometimes it's more limited to random moments that have a number of different techniques, and there are a variety of resources

available to conduct workload studies.

Some states have invested in developing their own capacity and having resources available to be able for their own staffs to conduct that kind of work, and there's a variety of consulting firms that have been involved in the conduct of workload studies around the country over the last 20 years. I think we have McKinsey, we have -- there's ICF [ICF International (ICF)], WRMA [Walter R. McDonald & Associates, Inc.] Deloitte [LLP], a whole number of resources. It's not that there's any particular lack of available skill sets to conduct workload studies. I have submitted an article called prerequisites for pre-workload studies that kind of sets the stage for what triggers the onset or implementation of a workload study. It isn't something that just happens out of hand, but you can read that when you have a chance.

The basic idea of this workload study is to measure the size of the gap with the actual work and what resources are available and then to assess what's going on within it. So as Myles suggested, it's looking at the fidelity of the implementation of the intended practice model, and so there's maybe work that's needed, or resources needed to do work that isn't being done. There may be work being done with resources that are available and so everything is okay. And there may be work being done with resources -- well, maybe not necessary either by that type of person or at all, so maybe you don't need social workers to do a certain type of filling out of forms, or whatever it happens to be.

So typically a workload study looks at those kinds of things in a global sense, and so what does this have to do with child fatalities and where does that fit in? Well, workload studies, as Myles suggested, have not been really implicated in preventing child abuse in general, but it does look at the issue of reoccurrence, meaning trying to stop any bad acts from happening on our watch, on the agency's time when they have control or have some knowledge. Now, it may be in the practice model it might be defined as the past six, 12 months.

As I just mentioned, in Oregon, maybe the practice model might be defined that maybe they will look back more than 12 months to say we're making practice models for everyone to know when the kid was involved with the agency. But in any case, the issue is that work is assigned to address children and families known to the agency, and the actual activity related to child fatalities needed to be looked at. How reoccurrences is addressed within the agency, maybe safety assessment, or other kinds of risk processes.

But it does provide an opportunity for the agencies to catch their breath for a little bit and take a look at their practice model and whether it's actually being implemented, or whether the practice model might be changed a little bit based on best practices, given the opportunity to assess where resources and workload are aligned or not aligned. So typically, based on the precedence to a workload study, typically it's generated from some sense of something is off where there's a need for resources. Sort of not necessarily clearly defined, but some suggestions that that would be the issue. Typically, those studies end up not so much saying how many people are needed to do the work, but also addresses some kind of assessing alternatives to simply adding staff.

So as result of workload studies, there's almost always perhaps incidents that aren't formally designed in this study design that there's a way to realign or redirect resources. And some of

this ends up not being necessarily so intuitive, just adding more resources to do the same. There may be an opportunity to look at, well, maybe the different practice model emphasis. It may not be intuitive, like in Los Angeles County they're thinking about adding public health nurses on early intervention calls for the -- or the early responding calls for abuse or neglect, and so it's not intuitive necessarily to say we're going to add people in the front end, but -- especially if they're not in the agency, if they're related to another agency.

The other opportunity is to determine if there are new methods or technologies to apply to the work and practice model. You've heard some examples in earlier hearings, from the technology examples in Florida where they're applying machine learning, homing technologies to risk assessments to try to assist the risk assessment teams better see through the data that's maybe either not apparent or overwhelming in the amount.

So I think that's the kind of 30,000-foot view of workload. It's a little bit back in the system from prevention, but does not necessarily touch a lot of what was described this morning, which is excellent efforts to do peer prevention, workload may be more considered secondary prevention to known people, known cases, known -- actually known responsibility, you know you have some contact and some target people to work with. With that, I'll conclude.

CHAIRMAN SANDERS: Thank you. Mr. Vogt.

RYAN VOGT: Thank you, Chairman Sanders, and members of the committee. Thank you so much for having us here today. My name is Ryan Vogt, and I'm with the Department of Human Services here in Oregon. And as you've heard a bit about workload models and kind of their inception and what they do, I'm going to talk a little bit today for you about our experience with implementing the workload model here in Oregon. I hope that helps inform your thoughts about where you're going with this committee.

You heard Director Kelley-Siel speak earlier today about kind of her value set and where we've been moving this organization around transparency and accountability within our Child Welfare System, even in painful reminders about how difficult it may be to have those conversations with the public.

In 2008 we had a lengthy conversation with the legislator about efficiencies in government. I don't think that's foreign to anybody here in the room about -- criticisms about whether or not the government is efficient in everything that it does, and we brought McKinsey & Company on board to evaluate how we were doing as an organization, the Department of Human Services, and whether or not we were -- what our opportunity for efficiencies could be.

Within that contracted engagement, we also asked them to take a look specifically at our child welfare program. I think that the tenant of the belief of child welfare programs across the nation is that there is chronic under resourcing conversations, but it is pretty intangible in terms of being able to put your finger on how under resourced or over resourced it really is. So while McKinsey & Company were here talking about efficiencies within government, and efficiencies specifically within our organization, we asked them to also take a look at child welfare organizations and let us know how efficient we are or aren't, where our areas of

opportunity are.

In 2008 they came on board, and as I said, it was part of more global vision, and they developed for us a workload model for which you've already heard kind of backgrounds of what a workload model does and what its shortcomings are. We -- in 2008, we administered a survey to all of our child welfare caseworkers across the state, a three-day survey, in which they answered to kind of what activities they were engaged in throughout the day.

I will let you know as point of history as we move through these slides, that in 2010 we re-administered the survey, and that was just prior to us implementing the new SACWIS system, and then we just recently in 2014 re-administered it again thinking that enough time had passed. We were over the initial shock of implementing a new technology solution, that we had a better sense of kind of how people had adapted to that solution at this point to get a more accurate model of the survey.

So, briefly, you've heard some of this already, that the workload versus caseload pros is that the traditional caseload model is based on kind of a fixed amount of work. It assumes that over time our families don't become more complex, it assumes over time that our work stays the same, that our service array remains the same, and that the expectations of the community and the expectations of our legislative body remains the same.

In a workload model it gives us a real picture as to where our workers are spending their time, which in a system that is believed to be under funded or under resourced, you know that workers are making priority decisions every day about what is most important to them and whether that is a push-pull from the court system, or a push-pull from the community system, or is centered in their values.

Every day they have to make decisions about what it is they get done and what it is they don't, and in a workload model we are able to take a look at where they are actually spending time, and that tells us a couple of things. It tells us, one, what's not getting done in terms of what our expectations are, although there is a level of precision we need to work with. And then, two, of the things they're getting done that they're focusing, on how much time are they spending doing those things, and from values-based components are we okay with the amount of time they're spending on it. I'll touch on that again in just a moment.

And then the types of things that I would say are a bit of disadvantage related to workload versus caseload, one, is even in a workload model you're only measuring what it is that you're doing, and you're having to speculate a bit about those things that aren't being done and how much time it would take for you to really realize what kind of gap you're talking about.

Also, in a system such as ours, our legislative body was pretty used to caseload models, so every legislative session they were able to have a conversation about this is where we funded you last time, whatever that percent was, this is what's happened to your caseload, and therefore it's easy to have a conversation about what our investment should be this time and what we should expect in terms of outcomes related to them.

So this initial conversation, it turns out that the workload model showed a larger gap in what our workforce to workload really was than what our caseload model had done. But, concurrently, McKinsey also was able to make fantastic recommendations about efficiency areas, so we went to the legislative body in 2009 not with just an ask for more staff, it certainly wasn't a we told you so, we were under resourced, it was now we have a better picture of where people are spending time, and we know that we're under resourced, but we also know internally that we weren't as efficient as we would like to be.

And so we were able to have a measured conversation about where do we want to be at the end of this two year cycle, and at the end of that two year cycle how much is the legislator willing to invest to bring us up, and how much do we think that we can become more efficient to close the gap? And so that was the conversation we were able to have, and how are we going to measure whether or not we're actually implementing those efficiencies, and whether or not we're investing those staff wisely that the legislative body gave to us.

That conversation I think was very productive dialogue, and even though we were in what is now being coined just a great recession, or the greatest new recession, the legislature was able to invest in some additional staff for us. We were also able to set forth in motion that as an organization we were going to train everybody and ascribe to learn practices; that we were going to look at the way we performed business functions and try to find ways to streamline those, and implement business protocols that allowed us to do business kind of in a replicable way, and in a way that was as streamlined as possible and kept as many hands out of the pot as needed to be.

And that we were also going to give the power to caseworkers and front line staff to continuously suggest opportunities for how we can improve the way we do business, and we have a continuous feedback loop that allows them to make recommendations about how we become more efficient and where we have processes that are broken that we should be able to fix quickly.

You will see that as a workload model has happened workers have begun to recognize the importance of their contribution to the workload surveys; that their voice is heard in this and that it -- being able to tell the story about what work they're getting done and what work they're not getting done is a really important narrative to tell.

This slide basically tells you that when we re-administered this survey. This is the response rate, so when you ask your child welfare or front line workers to spend a little extra time at the end of the day, or throughout the course of the day, to document the bodies of work they have done over the course of that day you'll see that while it drops off a little bit and you adjust for people on vacation the first day, 95 percent of our caseworker filled out the survey and responded to it, and by the third day we were still at 69 percent adjusted for people who were on vacation.

So that is a commitment that assists us with the validation, but it is not enough to just ask workers what is it that you're doing. The first time that we did surveys it was impressive the number of workers that we were able to calculate out that were working considerably more than an eight hour day. It's not to say that they weren't, but trying to figure out when they

were dual tasking and how they singly reported that was a little bit trickier.

But this time we sent survey administrators out to half of the states to sit in offices, do ride-alongs with workers, conduct focus groups, interview workers to validate the results of the survey. We got some great things out of this. One is, we were able to validate pretty cleanly that we've gotten to a point with administering this three times now that workers are really accurately reporting how it is that they're spending their time. The other thing we got out of these focus groups in working directly with the workers from a survey perspective, is we got to have a conversation about the values that related to that.

Myles commented earlier from moving to say what are you doing, to say what is it that families need? And by this time, sitting down with workers, we were able to say this is where we're at state-wide in terms of face-to-face contacts, but the amount of time workers are saying they're conducting face-to-face contact is probably insufficient to where we want to be. We were able to use this kind of quantitative data to now begin to form qualitative conversations. It's evolutionary, it takes time, but it was great for us to be able to have this conversation this time around.

You can see from this slide, it's a little bit jumbled, but this tells you, essentially, over the last couple of years, you'll see it in the next slide as well, the conversations that we have had with our legislative body and the efficiencies that we have made. This is where we feel confident we can stand in the conversation with legislators about how we have resourced child welfare workers at this point. We are now at the place where when McKinsey first came on board in 2008 they assessed the child welfare organization as being at approximately 52 percent of the workload out there and that we had substantial efficiency rates.

At this point in time, legislature has made legislative investments over the course of the last three biennia, and we are now approximately 85 percent of the workload. And a lot of that has been not just investment of the staff, but it has also been efficiency gained. Here's just to show you how legislative body --

COMMISSIONER SANDERS: Mr. Vogt, we're going to have to wrap it up.

RYAN VOGT: Yeah, this is my last slide. This is how the legislative body has invested in staff over the last couple of biennia, and we have been able to demonstrate just in this last year alone with efficiencies closing, and the investment in additional staff, our face-to-face contact percent has gone up by--percent this last year, and our foster care rate has been safely reduced by eight and a half percent in this last year.

And one thing we did not expect to see, that is, that our turnover has gone down. As we have increased our staffing, people are starting to feel this job is more doable and our turnover has gone down, so thank you. The last slide is really, as social workers, we don't always ascribe well to math, and so this is just a simple picture of how the math worked out. Thank you.

CHAIRMAN SANDERS: Thank you. Ms. Zlotnik.

JOAN ZLOTNIK: Thank you, Commissioner Sanders and all the Commissioners today for the opportunity to speak with you today. I'll see if I can master this. Thank you very much for the opportunity to speak with you today. In your deliberations, it's really critical to address issues related to the child welfare workforce that permeates the delivery of Child Protective Services in this country and really impact the safety of children.

As Amy Baker said earlier, people choose this work because they wanted to help children, but it's also critical to make sure that we choose the right workers, we have enough workers, that workers stay and have the critical skills to do a very, very hard job. We really have no very specific information on the education and training of child welfare workers. We do have some data, most recent from national study of the child and adolescent well-being, that analyzed the caseworkers in the cases that were in the study, and about less than 40 percent of them had a BSW [Bachelors of Science] or MSW [Masters of Social Work] degree.

The majority of those would be people with Bachelor's degrees and not Master's degrees, and this varies greatly across states; with some states having child welfare workers with less than ten percent of them having a Bachelor's in social work, or Master's in social work degrees; yet, the public perception is the people who are doing child welfare work are people that are trained professionally to do the job.

We did make an effort in the reauthorization of Child Abuse Prevention and Treatment Act in 2010. Specifically, there's a provision that asks states to report the numbers of their CPS personnel, the average caseload, education and training requirements, demographic information and workload requirements. However, in the most recent "Child Maltreatment, 13," there is some data with a lot of gaps around the number of Child Protective Service workers, with many of the other questions remaining unanswered.

It's not clear if the states aren't yet reporting it, or that it's being reported but the federal government hasn't reported this information out, but it's very important just in terms of what Ryan was just saying about the impact of having more workers actually keeps workers as well. The high rates of turnover is also a great concern, and once again, it can even vary within a state or within a county in a state administered system with some rates as high as 50 percent. And we know these issues of workload are major, and that just in the last few months there have been reports in Vermont, Colorado, South Carolina, Georgia and Massachusetts requested by governors or legislators addressing workload issues. In the Colorado study, for instance, they said they needed an additional 574 workers, or 49 percent increase, but we know these are not new issues because the same states or other states have had the same studies going on for many years.

One of the other critical issues is that for the child welfare workforce, for the expectations that we have of them around risk and safety assessment, around the implementation of evidence-based interventions, about really needing to understand the issues of substance abuse, maternal depression, and other risk and protective factors, is that in most instances the child welfare workers don't have the clinical training and assessment skills to actually perform the jobs that we hope them to be able to do.

We also don't see any research that's specific to impact related to fatalities. However, we do have other research that's related to other expectations of the Child Welfare System, and we know that workforce and worker turnover impacts other outcomes. Research in Milwaukee County a number of years ago found that the child who had more workers also was more likely to have more foster care placement, so it was an issue of placement stability from the data mining from Eckert.

There's recent data they have just been receiving how worker turnover turned out to be high factors in cases where children returned to care. So really surprising, number three in one county and number five in another county. We also know that there's research that says workers with social work degrees can be more effective in terms of achieving permanency outcomes, greater sense of competency and self-efficacy, greater frequency of child visits, better use of community resources, and services that are more specific to the level of severity of risk for future abuse and neglect.

Much of the research around workforce has really focused on these issues of retention, and these are important things to think about in terms of who the workers are and why they're going to stay, some of these issues around personal commitments to child welfare, and sometimes that's because of people's own previous experience in child welfare, even as a recipient of services, or as a volunteer or their family's involvement with foster care and adoption, and sense of self-efficacy in terms of their sense of competency, and also low level of emotional exhaustion.

And then there are motivational factors like quality supervisors, co-worker support, sense of fairness, salary and benefits, and job satisfaction. So addressing some of these workforce gaps that Ryan was talking about, you can begin to address some of these issues that I'm not being so put upon in my job. Workers are expected to use clinical judgments in terms of their critical thinking; they need knowledge and skills that are specific to child welfare; they need adherence to ethical practices.

When we hear the media about workers who have falsified records, or said they made visits that they didn't, we need the strong assessment skills, a sense of continuous learning and supportive supervision and coaching to be effective in their jobs. Because fatalities are low incident and high impact, in terms of what they do in terms of the system, we need to make sure the workers have the core knowledge and skills, and agencies have a practice model and expectations for ethical practice by the workers that are gauged in optimizing child and family outcomes.

A number of years ago we did a study with the American Public Human Services Association [(APHSA)], and one of the questions we asked was how many actually adhered to a specific code of ethics or ethical practices and expectations in terms of training of the workers so that we really are reliant on professional judgment. However, in the major funding source to train child welfare workers, which is the title IV-E Entitlement in the Children's Bureau Policy Manual, it specifically says title IV-E training dollars cannot be used to train for clinical skills or for Child Protective Services investigations.

You can do assessments, and so what happens is that agencies and universities take advantage of this funding, part of it they have to play this semantics game so they don't use certain words in their curricula, whether it's the agencies training program or the universities, to actually provide the skills that people actually need to do their job.

So while we have these needs for autonomy and the expectation on the ground that the workers are going to need to be able to make some very quick judgments about both safety and risk, and have expertise, we know that the reality is that situation can cause great emotional stress and exhaustion and burn out because they're very vulnerable to liability. If something happens to a child on their caseload, they're vulnerable to media scrutiny.

There's limited recognition of the professional role and professional decision-making; they're vulnerable to the political climate because child welfare workers are often changed with different governors, different administrations, or when -- so there's a lot of turnover in the system, and different people come in with different priorities. So one person might come in and there's big focus on really supporting families.

And many of the important things we heard in the first panel this morning, and the next administrator and governor might come in and say, well, we really need to make sure that kids are safe and their desires to remove kids from their families goes to working with the efforts to work with families in their community and with their kids goes down.

So there's a lot of play which really gets back to what my colleagues were talking about in terms of lack of adherence to a practice model that's done consistently, and that there's an absence of sort of a learning organizational culture and climate. We know that in hospitals people die and there's a review and you change practices. In child welfare, someone dies and maybe the director loses their job, maybe supervisors, maybe some workers, and you think maybe there's a big study, but things don't actually change, and that's what we really need. We also know there's insufficient availability of quality service and support for children and families. As the panel was speaking this morning, and we talk about other efforts around service delivery, I was thinking we used to be very reliant on the public mental health system, but the public mental health system isn't available in terms of the kind of preventive service that it can be providing to the families, especially as people have more access to care for the parents in terms of the implementation of the Affordable Care Act [ACA].

One of the other critical issues, as I mentioned, in terms of some organizational issues is really around supervision. There has been a lot of research related to supervision. It really makes a difference in terms of goal attainment, assessment engagement, client satisfaction, and that when workers feel they're well-supervised they have feelings of emotional support, creates their sense of competence, and helps achieve their organizational commitment, their own personal satisfaction and job satisfaction.

I think as we look to the issues we also have to think about the fact that worker turnover is costly to agencies. So it has to do with the cost of recruiting and hiring and retraining, and it's also costly to the other workers in terms of increase case workloads, problematic organizational climates, absence of peer support, working more hours, so you have work/family imbalance, emotional exhaustion, and supervisors who are supposed to be

supporting the staff end up providing direct services.

So I think that one of the things we need to do in terms of some of our unanswered questions --

CHAIRMAN SANDERS: Ms. Zlotnik, we're also going to have to wrap up.

JOAN ZLOTNIK: All right. I just want to conclude with the thought that as fatality reviews happen we look at child characteristics and family characteristics, but do we look at sort of how many workers a family had? What the educational background was? How long the worker was on the job, and what kind of training they had? These issues aren't new. I brought with me something that John Mattingly of Annie E. Casey Foundation and former New York Police Commissioner wrote in 1998, "Child Protection Workers Make Easy Targets." And so we really have to think if we want to keep kids safe, we really have to make sure that we're keeping the child welfare workers supported as well. Thank you very much.

CHAIRMAN SANDERS: Thank you. So we'll have about 20 to 25 minutes for questions. Commissioner Zimmerman.

COMMISSIONER ZIMMERMAN: So to the point -- I want to make a comment so it's on the record, and there may be another question as I think about this. We work in -- the trauma center that I direct works with tribes across the nation, and we're focusing on particular regions of the Bureau of Indian Affairs [(BIA)] Child Welfare staff.

As many of us know in this room, that child welfare practices in Indian Country is federal within the Bureau of Indian Affairs, to be tribal with contracts that provides services to their own tribal members, or the state, if it's like Oregon, is a state, so the state can provide oftentimes, unless the tribe elects to do it themselves, those services, so it can look very different depending on the community.

But one thing I want to have on the record is that we're working in regions now where the FTE [full-time employees] is at 47 percent, so over half of the positions are languishing, empty. And these are rural reservation communities where during the sequestration of 2013 there was one MSW covering over two million acres, and all of the communities that are -- were in those -- within those two million acres, and believe me, they're never close by each other.

So I just want to get on the record that the workload conversation really has to happen in Indian Country because there's so many issues around retention. There are different stressors for tribal child welfare workers. Those stressors can include being a member of the tribe, working with your own relatives, just being in that community and living in that community your entire life with the historical and intergeneration trauma that the community has experienced and you're a part of that community.

So I think there has to be a conversation for Indian Countries about the unique stressors, but the unique strengths of the tribes. But I just -- on the record, tribal communities are suffering from a lack of a workforce. We would love to be able to get to the conversation about how to support the workforce, but we need to have one first. So there's no question,

just that statement.

CHAIRMAN SANDERS: Commissioner Bevan.

COMMISSIONER STATUTO BEVAN: I have three quick questions. And my first one is about CAPTA [Child Abuse Prevention and Treatment Act] reauthorization, since obviously that's coming up. One is, we know there are three reviews required: Citizen Review, foster care review, fatality reviews. I don't know -- do you have any thoughts about the fact -- do we still need that requirement of three? Should we change it to one? Should there be requirements around it?

There are very few requirements other than have a report, so I'm really hoping that if I don't get an answer now, that I do get an answer at some point. Because I think it's really important in terms of efficiency that we start looking at what appears to be a duplication, or not clarity about the terms that we use, which is really important that we use these very carefully about the terms that we use, so that's my one child abuse question.

Any other child abuse questions from CAPTA has to do with these CIRT teams. I mean, that's not in CAPTA. There is no requirement to have a 24-hour rapid response or critical incident. Do you think that should be in; that that should be a requirement? Or the fact that states have pretty much ignored a lot of CAPTA requirements why add another one?

JOAN ZLOTNIK: Those are hard questions to answer, and I'm not sure I would be the best person to answer the first question about the reviews except to say that there has to be a balance between sort of accountability system which reviews provide with the resources to actually improve the service delivery impacts and the efforts in terms of service delivery. I think the model that they talked about in Oregon in terms of the CIRT review was very powerful, but there's probably a bunch of different ways that different states are getting at it. And I think that might be the kind of thing, whether it's the sort of existing fatality review, foster care reviews, and the kind of CIRT team is for states to really be able to look at these issues about accountability and having a much better sense of what the systemic issues are.

And I know Commissioner Covington, from her work, you know, really has a good sense in terms of working with a lot of states about what really makes those systems work best, but I think that the issue really is that we haven't looked fully enough. That's why I have the suggestions about have we looked at all about the issues around workers? How many agencies were involved with the child -- with different workers?

There's a lot of questions that if we're not looking holistically at it, and we're not asking them, we're really not going to get to the systemic changes that we need.

COMMISSIONER STATUTO BEVAN: I think child abuse review, citizen review, fatality review is -- these are reviews that hold the system accountable; they're not the same as critical review or rapid response team that is focused around an individual child.

JOAN ZLOTNIK: I think that part of the CIRT team, as I heard it, was that it was actually holding the system accountable because it was creating an opportunity for the system to change its practice.

COMMISSIONER STATUTO BEVAN: Right, but the focus is on the individual child. Where, in the other three reviews, the focus is not on the individual child, it's on factors related to the system.

JOAN ZLOTNIK: Well, it's based on individual cases.

COMMISSIONER STATUTO BEVAN: What I'm saying is, when you want to know about the death of a particular child, we want to know the characteristics and the circumstances surrounding the death of that particular child.

JOAN ZLOTNIK: I think it goes back to something that was in the first panel, and it kind of came up in this panel also, is that the issues of really looking at the incidents of a particular child death from maltreatment is instructive to how we have to change practice overall.

And so it's not just what would have been different in the case of Susie, and we don't do anything except look at that particular piece, but we have to look at it from the broader system model; how the agencies work together, what decisions were made if a call came in, and it wasn't followed through, you know, looking at some of the research that Emily Putnam-Hornstein has provided to the commission I think are all very instructive to really looking at service delivery structure changes and what the skills are that are needed, so we're not just like sort of passing people on among agencies.

COMMISSIONER STATUTO BEVAN: I'm not trying to substitute one for the other. I think they're completely different, they have different purposes, but my focus is, and my belief is, that when a child dies the child is not just falling through the cracks of a system, the child is falling through somebody's fingers and I want to know whose.

So my last question is to clarify, because I think you have a good point that I didn't know this on title IV-E. In title IV-E you're saying the funding that's allowed for training is not allowed for the improvement of clinical practice, or clinical skills, or to learn how to do child safety assessments?

JOAN ZLOTNIK: Not child safety assessments. It says it cannot be used for Child Protective Services investigations.

COMMISSIONER STATUTO BEVAN: Oh, for investigations.

JOAN ZLOTNIK: It's semantics. And part of that -- and I know --

COMMISSIONER STATUTO BEVAN: But it's a barrier for you --

JOAN ZLOTNIK: I know that the Associate Commissioner for the Children's Bureau is going to testify next, so -- but part of the issue I think is because the issue of title IV-E is a program to

administer the child welfare system, and so the structure has been around learning the -- it's the administration and management and not the clinical service delivery, but there is no real other funding source to provide that.

COMMISSIONER STATUTO BEVAN: I understand that. I'm just saying that if there's a piece that's already dedicated to training, we shouldn't carve out certain exceptions; that would make sense.

CHAIRMAN SANDERS: Commissioner Dreyfus.

COMMISSIONER DREYFUS: Workload study. So Oregon, in part what we want to do as a commission right is, we know there's knowledge that's missing, and so we want to have some recommendations around where more new research is needed. Could we be starting to get at a recommendation we should make around research needs that would start to validate? And I'll just throw out a few things. What should be part of a workload study? How often workload studies should be done, right, by an agency? Is there some best practices that have the ability, because of the experience you've all had, and states that have done it? I'm pretty impressed with Oregon how often you've done it. I don't know that I can say I know too many states that have done it as frequently as you have, so good action, but should we be doing something to get more research into this area of workforce -- workload study, and getting it more hard-wired into how all Child Welfare Systems are functioning across the country than just that it happens to happen in one state and not another? Or how frequently it happens, or the best practices that are being used to conduct that study?

RYAN VOGT: Thank you, Commissioner. What I can say is the workload model that we've invested in. Oregon has worked to fit a particular need in Oregon, and whether or not a universal workload study that would be applicable across all child welfare programs, I'm reticent to say that's an absolute solution.

What I can say is the system of operating under a caseload model that is stagnant doesn't adequately account for when we have emerging populations, when we have changes to practice, you know. Couple off-hand, Oregon was kind of disproportionately impacted maybe ahead of the curve by the methamphetamine epidemic a number of years ago.

Currently, we're delving into, as I think nationally there's a lot of conversation among commercially sexually exploited children and kind of how these emerging populations impact our practice. Under a traditional caseload model there's not a good way to have a conversation about what does this now mean for families? Twelve cases is no longer cases, 15 cases is no longer 15 cases, what have you.

So whether or not an absolute workload model is the right solution, I'm not sure. But for Oregon, it's given us that flexibility to say we now know how that's impacted. It's still after the fact, it still measures what has happened after it's happened, but it allows us to have a more timely dialogue about how, of the shifting dynamics of our family and the shifting demographics of the challenges we're facing are impacting our workforce.

COMMISSIONER DREYFUS: Time and again we hear about child deaths, so oftentimes we hear about workload, right? It seems to connect right along with those cases oftentimes. I think my question to you, although, is there research needed in this area that would get us as a field to understand, and legislators and governors and others, that it's imperative to be doing workload studies, what -- not the workload study that should be done, but the best practices fidelity that needs to sit within any workload study that's done, how often it should be done, and how it should be applied and used.

Is there more that's needed to get underneath this issue? Because it comes up time and time again in child deaths that workers have too high of a caseload.

DON GRAHAM: I would say the effort might be focused on how to review the practice model and what best practices might be considered periodically for adjusting the practice model and seeing workload studies as a supportive tool in assessing the workload -- the practice model, so that I don't know if there's a particular advantage in looking at standards for workload studies themselves, but in combination with looking at it, the practice models, so that workload studies would follow the changes in the practice model.

So let's just say for instance that suddenly states decided that there's a portion of the child welfare agency that should actually do true prevention and actually go with the teams out in the community and sit with the parents and family and doctors and whatever and, with no known kid, with no known call, it's just they're out there.

We say that prevention is now a portion of the child welfare, you know, that would adjust the practice model, so how much of that should there be, or could there be, or how much is the payoff for that kind of -- what is the impact of putting a certain amount of creating, first of all, a workload that, you know, prevention paradigm for getting ahead of phone calls and getting out in the field and how much investment do we put in that, and then the workload study might be able to assess that impact.

So you might be able to get some review of possibly a pay off in assigning the work as part of the model of prevention. So, of course, prevention may be, you know, better actually housed in another place like school districts or wherever, people training parents and that kind of thing, so you have to figure out what the practice model actually should be for a child welfare agency.

But as far as child deaths, that may be in with the agencies that are seeing every child every day, like schools, or doctors, or whatever, and get to the notion that we're treating -- or addressing services. Prevention belongs working on the denominator of the fraction that Dr. Sanders was mentioning, like March of Dimes solved polio by looking at denominator fraction rather than defining that numerator so much, so that a threshold policy question would be where is -- when we say prevention, where does that live?

And maybe it's everybody's job, but does everybody own it, and how do we know that's going on. Anyway, I think workload would follow the answer to that question.

CHAIRMAN SANDERS: So we're -- I want to move on. I want to thank this panel and then ask -- we have Associate Commissioner Chang here, and I want to make sure that she has a chance to give her presentation, but would like to -- I know there are a number of other questions for this panel, so after Chang's presentation we'll bring everybody up and be able to ask questions. So thank you very much, and we'll bring you back up for additional questions.

So we've heard a lot about the federal role, and now we have the opportunity to hear from the Associate Commissioner of the Children's Bureau, JooYeun Chang.

JOOYEUN CHANG: Thank you for the invitation, good morning. I think it's still morning here, everyone, and thank you so much for the invitation to join you here today and to talk a little bit about the work that we've been doing at the Bureau and with our partners at HHS [U.S. Department of Health and Human Services] overall.

I have a lot of slides here. I will not go through all of them, I promise. I know I'm standing between you and lunch, so what I did want to do though is provide as much information as I could, recognizing folks will look at the slides online, and just to make sure that you had as much information as possible.

What I'm really hoping to do today, recognizing what a monumental task all of you have in the commission to come up with recommendations of how we can prevent and better meet the needs of children at risk of fatalities by abuse and neglect, we wanted to do our part and try and provide some context for what we have done on this issue to this point, and to the earlier point about the intersection of prevention and of child abuse and neglect overall, and the prevention of fatalities.

Talk a little bit about our work on prevention as well, just so you have some concepts of things that have already been done, lessons we may have learned as you explore your recommendations moving forward, and then finally, I want to present some issues for consideration based on that -- our experience, that you might want to think about, and then finally we have some policy recommendations, or -- I should not say recommendations, we have some things for you to think about as you may be considering policy recommendations that are part of the President's fiscal year '16 budget.

Those are the four things I'd like to cover this morning. Those are the things I want to cover, and I'll begin by talking just very, very briefly about who we are at the Children's Bureau and what we do and how we do our work. We are a partner with other federal agencies, with states, tribes, and local agencies. Our mission is a shared one: To improve overall health and well-being of children and families, but particularly vulnerable children and families.

And the way we do our work is primarily by providing both financial support, but also guidance, technical assistance on three primary areas: How we can strengthen families and prevent child abuse and neglect in the first instance, but when abuse and neglect has occurred protecting children, and if that means entering into the foster care system through that particular intervention, but then finally ensuring that every single child who comes to our attention has a permanent family or family connection.

So what have we done to-date on the issue of understanding and addressing the issue of child abuse and neglect fatalities? This is a collection of work that we've done at HHS. The first is that, kind of a backwards glance, and I'll talk in a little more detail on the US Advisory [Board on Child Abuse and Neglect] report that was done in 1995 on this topic. There's also the National Center for Child Death Review that Commissioner Covington helps lead.

We've done work around the issue of data collection; we've examined how child fatality review teams, a cross system fatality review project can do their work more effectively; we've issued guidance and technical assistance, and then we have a series of grants that we wanted to talk to you about as well.

So the U.S. -- in 1992 Congressional hearings resulted in a mandate to create a report on the nature and extent of child abuse and neglect fatalities and how they might be prevented. So this is an issue that Congress and policymakers have paid attention to for many decades now, so there's good news and bad news here. The challenging news is that some of the findings are -- still remain challenges, right? So one of the things that this report identified is that we have a lack of knowledge on the scope and nature of child abuse and neglect fatalities. Twenty-three years later, I think all of you now can probably agree that that is still something we really struggle with.

There's good news, too, though. There are a number of recommendations that we think progress has been made. One of those is the fourth recommendation, which was to enhance joint training on identification and investigation of child abuse and neglect fatalities. I'll talk more about the Children's Justice Act [CJA] later, but that has been a source of federal funding that has really promoted joint training on identification and investigation. CJA funds are also used to support CACs [Children's Advocacy Centers], which often include a focus on joint and multidisciplinary training.

There are two other recommendations where we've seen some progress. There was a recommendation that all states should have state level child death review teams, and the good news is that every state does, and in many states there are both regional and local communities as well. Another recommendation that state and federal legislation must identify is safety as a goal. In fact, the Children's Bureau has included in the Child and Family Service reviews, which is our way of monitoring state performance, safety is a critical factor, and that's been true for all three rounds at the CFSRs [Child and Family Services Reviews].

The 21st recommendation was to create an array of primary prevention services that includes home visiting, and that really these prevention services have to be available to all communities. I think we've made some progress in this area. We have a source of funding called the community based child abuse prevention, which is funded out of CAPTA, which is really dedicated to creating local and community base prevention efforts.

And then with the Affordable Care Act, which created the Maternal Infant and Early Childhood Home Visiting [MIECHV] programs, we have seen an explosion in the availability of evidenced-based home visiting programs. I think this is something we have to acknowledge has been a forward movement in the field, and to see what, if any gap remains. The 23rd recommendation was the importance of integrating services on child abuse and domestic

violence and addressing interagency training.

I think this is critical. The type of work that you're doing in exploring child abuse and neglect fatalities we know occurs in the context of some of the hardest to serve families, families where it is not just child abuse, but family violence that is persistent. And so we have done some work in this area, most notably the Green Book Project in 1999, which really brought intentionally the child welfare and domestic violence communities together to come up with joint plans on training and work efforts.

This slide just talks about Maternal and Child Health Bureau [(MCHB)] efforts. They have been involved in this issue for many, many years. And there was an ad hoc group that was brought together in 92 by then Secretary of HHS. This report about -- that issued also some recommendations on child fatality reviews, was then issued one year later in 93, and The National Resource Center for Child Deaths and Reviews is a resource for both states and local CDR [Child Death Review] programs.

I don't have to tell that to Commissioner Covington, who really leads that effort, and we think has done -- has made a tremendous impact in the field. In addition, there has been really clear guidance from Congress about how we can better report child abuse and neglect fatalities. There was, in the Child and Family Services Improvement and Innovation Act in 11, a new state plan requirement that required title IV-B agencies to describe the sources of information that they used to report this information and why they chose not to use certain types of information, including vital statistics, et cetera.

I will note that we have collected and are starting to do some analytics on what states have included in their state plans, as you may know. This past year, states had to submit new five-year plans, so we started to take a look at that section of all state plans to see what we found. This is the work that we did in 2011 and 2012 at ACYF [The Administration on Children, Youth and Families] to try and improve our understanding of how states and communities were addressing child abuse and neglect fatalities.

We did that by examining how these fatality review teams operated and how they worked in a cross system way. As a result of that review, there were four tools that were created, and those are listed there. One of those that I think is really important is a self-assessment tool that we encourage states to use to see where they can make improvements.

What we found was that there were a series of recommendations that were consistent across a lot of the states that were reviewed about areas where they can make improvements. So I encourage you to go to the website to find out more information about the findings and the products they created. So this is one of the things that we have also been looking at, which is what we call the web of reviews. I think Commissioner Bevan, you referenced this, too.

I think this, quite frankly, is why that first recommendation, or the first challenge that the 95 report identified still remains, which is that understanding the extent and scope of cremains a major challenge for all of us. I think this at least in part explains why, you know, that even though we call them child abuse and neglect fatalities, the organizations that are responsible for collecting and understanding and, quite frankly, making those determinations are so

varied and go across systems, right?

It's not just limited to child welfare agencies, they include military child fatality reviews, many states have internal child welfare agency reviews, there's a fetal and infant mortality review, there are 200 of those in 40 states. The domestic violence fatality reviews, there are 144 of those teams, so it just shows how complex this system of getting information is.

So I just wanted to talk about some of the efforts we have funded that we think might be good for consideration as you're thinking about next steps and what we have learned from them. The Children's Justice Act is a funding source available to states to use on a whole range of activities around investigation, and 15 states have specifically reported that they have used their CJA funds on initiatives that are focused on supporting the prevention of child fatalities or addressing the investigation of such activities.

So they typically use these funds to support fatality and review teams, improve its functioning, provide training or data collection assistance. Some of the specific examples are listed there. The coroner training with CJA funds I think is a really important example, since we know that the fact that many states still use coroners to report fatalities can be challenging because of the type of training or lack thereof that exists for them.

This next slide talks about how CB efforts have also focused on assessing the safety of the child. This was something that I think Joan talked about earlier. The way we approach that is by looking at both the threats to the individual child, as well as the caregivers' ability to respond to the needs of their child. And most recently, we provided training and technical assistance through the National Resource Center for Child Protective Services [NRCCPS]. And what that National Resource Center did was to really help individual states who were seeking TA [technical assistance] to implement assessments with fidelity. Because we all know there may be very promising and effective safety assessment tools, but if the states aren't properly trained and don't implement them with fidelity they're not going to get the results they were designed to get.

We've also really focused on identifying some of the greatest risk factors that impact families, the families who really need most of our -- a great deal of our attention, and we focused a great deal on prevention or protective factors as a source of prevention. So the community-based child abuse prevention, or CBCAP, is funded by title II of CAPTA.

Just to give you a sense of the scale of those investments, in fiscal year '13 we invested $41.5 million across all states. So these funds are given to state lead agencies and are dispersed to community-based programs that can provide abuse and neglect prevention activities. These are some examples of the types of funding that states have provided.

We also, in addition to formula grants, have some discretionary grants that we have issued. I'm not going to go through these in much detail. I know we want to make sure there's time for Q and A, but just to give you a sense of how the Children's Bureau itself has invested in things like home visiting, some of the requirements, and Quality Improvement Centers on Early Childhood [(QIC-EC)].

I note this because we do know that if we are to look at specific populations who are most at risk of child abuse and neglect fatalities, we know they're young children. It's one of the reasons why we have focused some of our discretionary grant activities on young children who have come to our attention and how we can both diminish the risk factors, but also strengthen protective factors.

So this is just our theory of change for that particular Quality Improvement Center on early childhood, and it really does spell out how we're working across agencies, and we are looking to both increase protective factors and decrease risk factors to achieve those outcomes. The Quality Improvement Center I should note, too, is really designed to test innovative approaches at multiple levels of care.

Okay. These two slides will talk about our regional partnership grants [(RPGs)]. The RPG builds on the work initiated by SAMHSA [Substance Abuse and Mental Health Services Administration] and ACYF when it created the National Resource Center on Substance Abuse and Child Welfare [(NCSACW)]. I raise this example because we also know that one of the challenges that many families who come to the attention of the Child Welfare System face is addiction, or other substance abuse issues.

We also know there is not only that risk factor for all kids who come to our attention, but that it may have a special particular impact in child abuse and neglect fatalities, so I wanted to talk a little bit about the work that we did there. Through these grants we set -- we created a set of performance indicators through broad consultation with the field, as well as grantees. And really, these grants are designed to promote partnerships between child welfare agencies and substance abuse providers.

We have a number of grants out in the field now, we've made significant investments, and I think it's important to think about what we've learned from these investments. I will note that the last two cohorts of this grant which were issued in 2012 and 14 were really instructed to build an evidence-based or evidence-informed intervention that was also trauma-informed to create -- that would create practice models that would strengthen the emphasis on improving child well-being.

This is another example of some of our discretionary grant activity that we just wanted to make sure was brought to your attention. This is our partnership to demonstrate the effectiveness of supporting housing for families in the Child Welfare System, and you may initially wonder why I mention this. These grants are really designed to examine and further the efforts of CPS to reduce family separation due to lack of housing, but I think the reason it may be of interest to all of you is that what we targeted were not the entire population of families who struggle with housing, but the hardest to serve families as a subset of that group.

So we're looking at families who not only struggle with housing, but also struggle with mental illness, substance abuse, domestic violence, et cetera. So I think often the work that you do really also looks at the hardest to serve families, and we are learning a great deal about how you serve them effectively. We are in the third year of this grant, and so we look forward to

continuing to learn, and would be happy to share with you our findings so far.

So this is just a map that shows you where those five sites are. I also point that out because it is a cross section I think geographically in both rural and urban communities, which is something I think we have to think about when we think of abuse and neglect fatalities as well. So this is also an example of the work that we are doing. This is a conceptual model about how we promote protective factors. This is an example of some of the work that we have done with our national partners, including FRIENDS [National Resource Center for Community-Based Child Abuse Prevention] and CSSP [Center for the Study of Social Policy] to talk about prevention, and this is our "2015 Prevention Resource Guide" that we make available every year.

Another activity that I wanted to make sure we brought to your attention was that Federal Interagency Workgroup on Child Abuse and Neglect. This is a group that has been brought together since 96 by the Bureau. We lead and coordinate this federal interagency group. It meets quarterly, as well as having calls. There's a lot of data sharing, but there are also subcommittees who can look at specific topics on a range of issues, including abuse and neglect fatalities, which they have not done so far, but we have the infrastructure to do that if that was a deemed recommendation by a group.

There is this link to the report to Congress on the activities that this work group has done if folks want more information, and I also wanted to just mention that we have a number of reports to Congress that will be coming out in the later part of this year that may be of interest. One is a study to identify and determine the feasibility of collecting data around shaken baby syndrome. The second is a report that documents efforts to coordinate programs related to abuse and neglect. And this looks at both federal and non-federal partnerships, so we just thought those two reports might be of interest to you.

So based on the work that we've done over many decades, it seemed to us there were at least a few opportunities, things for your group to consider as you're moving forward. One is the issue of near fatalities; the second is working across federal agencies; and finally, I wanted to talk a little bit about our budget proposal. It seems like near fatalities is really a crucial area that needs further investigation.

We -- CAPTA does define near fatalities as an act as certified by a physician that places a child in serious or critical condition. And in the context of child welfare, they must have provisions that allow for public disclosure of findings about near fatalities. I think some of the things that we think about when we struggle with this really complex issue is that near fatalities refer to children rather than acts, right, which is different from a lot of the data that we collect in the Child Welfare System.

Also, we're talking about children who are in a very specific condition as defined by the federal law, and there are lots of questions that we get from states in their efforts to implement this part of CAPTA about what it means to be a serious condition. I've been told by at least one state that they have consulted with their medical field and their physicians tell them we don't know what serious condition means, right? So it makes it very difficult and

challenging to implement that part of the law.

Near fatalities depend on a physician having found this condition, and then also reporting it to CPS. I think that's another layer of complexity that we think it would be great to get more guidance on, and provide guidance to the field on. Also, the issue of traumatic brain injury is another issue that we would put forward for consideration. We know that this is a major issue that can lead to death and permanent injury, but we also know that it's challenging because it can be everything from mild to severe and critical, right? So this is a serious condition, right? We also know that we don't know how many children die of shaken baby syndrome or may suffer an injury.

So this diagram outlines some of the events that could be part of determining near fatalities, and what it demonstrates, at least in part, is that it requires a close working relationship between physicians and hospitals in Child Protective Services. This graph identifies some places where we think data collection could be improved between hospital staff and CPS staff to try and better address this issue.

Okay. And this slide is really just to show the areas of intersection between child welfare and public health. You know, child fatalities, child abuse neglect fatalities is certainly both an issue that is something that child welfare agencies, but also public health agencies, really have to address. We think concerns are similar: Access to information is both with child welfare agency, but often sometimes alone with a medical professional, right? And in order to solve this issue it really will require that joint effort.

Okay. Now to the fun part. I wanted to provide in closing an overview of some of the President's budget proposals in child welfare that I think may have a direct impact on the issue of child abuse and neglect fatalities. Before I go into detail, I just wanted to give you a quick overview of all the areas that the President's child welfare -- the President's 2016 Budget does in the area of child welfare.

It's a collection of about eight different proposals that would collectively provide grants to improve investigation in child abuse and neglect reports. Invest in evidence-based prevention and post permanency reports for children at imminent risk and entry into foster care. It would expand the service array in rural areas to better meet the needs of children and families who have come to the attention of the Child Welfare System.

We know that's a great issue that's been identified by the CFSR year after year; that there's a gap of service in rural communities. We could encourage greater use of family-based care for children in youth in or at risk of entering congregate care of placements. We also, this year again, included the proposal to reduce the use of psychotropic medications for children in youth -- in the foster care system. We would extend the Chafee supports up to age 23 in recognition of fostering connections which allow young people to stay in the custody of the state to age 21.

We will provide grants to prevent youth in foster care from becoming victims of sex trafficking, or other forms of human trafficking, and to provide better services to young people who come to the attention of the Child Welfare System and have been identified as

victims of trafficking. We would also make a couple of different investments to assist tribes to help them better build the capacity and strengthen their child welfare programs.

So that's kind of a sense of the whole package of proposals, but I want to focus now a little on our prevention proposals. So we are asking for a $5 million grant through CAPTA discretionary [grant] program that would really be used to look at and develop better models of investigation at the state and local levels that would have two primary outcomes. One is to reduce child abuse neglect fatalities, and the other is to reduce disproportionality.

The reason we included this proposal was that we felt that investigations is at least, if not first, a very important part of the first stage of reducing maltreatment -- fatalities by abuse and neglect. I think there is -- we've talked a little bit, I heard the previous panel talk a little bit about workload, workforce, and I think what we want to do is better understand some of the emerging practices in this area which includes teaming, multi-disciplinary teams who go out.

I mean, I think the concept of one lone worker who is over worked, over stressed, often under trained going out and making these life and death decisions is really unrealistic and, quite frankly, untenable. What we want to do is build a body of knowledge about how to better do these types of investigations that will have immediate impact at least on reducing fatalities and reducing disproportionality, but for the general population as well.

The second proposal I wanted to bring to your attention is that we have a proposal to amend title IV-E. Commissioner Bevan, and I think Joan was talking a little bit about the limitation of title 3. This is designed to address some of those limitations. Right now, title IV-E dollars and everything that flows from it, including training, is really only allowed to be used when a child comes into the foster care system, right? So that means the training we provide has to be about foster care, and the services we provide, even if it's adoption and guardianship, is only after a child comes into the system. What we know is that there are effective prevention strategies and programs out there that can have a life and death impact, right? So we want to open up title IV-E to pay for those pre-placement and post placement services that are identified as part of a child's case plan. We would do that by amending the candidate section of the title IV-E program.

What we would require is that a majority of those funds be used to support an evidence-based, evidence-informed intervention. But we recognize that there is an important role for the federal government to support innovation as well, so that is why we have specified that as a majority, but we would open it up also for innovative practices. And then there are maintenance of efforts requirements to ensure that we are in fact increasing the investment in the system and that we're not just shifting dollars around from the federal government instead of the local or state government.

A couple of other proposals that we wanted to bring to your attention is the reauthorization of the CAPTA program and the discretionary grant activities within CAPTA. As we talked about, there are a number of important programs within CAPTA that help promote prevention of abuse and neglect, but also to address the issue of child fatalities. Then there are some special populations that we wanted to talk about in the proposal. We have a proposal to

reauthorize, but to modify and rename the Abandoned Infants Assistance Act to one that focuses on infants and young children.

The good news is that the Abandoned Infants Assistance Program was effective, and we have very few children who come to our attention who fall in this category, but we didn't want to give up the investment in young children because we do know they're at the greatest risk for abuse and neglect, they're at the greatest risk of entering foster care, and they're at the greatest risk of child abuse and neglect fatalities. So instead, we wanted to shift those existing dollars to look specifically at that population for that reason.

The other special populations that I wanted to bring to your attention is the investment that we would make in tribes and tribal communities. We would do that in two ways. One, by increasing funding in title IV-B, subpart II, which is known as Promoting Safe and Stable Families program by $20 million to support tribes in building their capacity to have an effective child welfare program. This is critical in meeting the needs of Native American children in the communities in which they live.

We also would increase -- this is where the rural child welfare program comes into play as well, so this is a tribal and rural communities program. We would invest $7 million in building the capacity in rural communities. Again, as I mentioned earlier the Child and Family Service reviews consistently told us that there was a gap in services, particularly specialized services for both children and families in rural communities.

We know that when we don't meet that service need we are placing children and youth at greater risk of abuse and neglect and fatalities, and then because this is an emerging area, we would devote $3 million to technical assistance, training, and evaluation. I think that's it. That's my contact information. I'll stop there.

CHAIRMAN SANDERS: Thank you. So we're going to -- we have about 45 minutes for questions, and so we're going to start with Associate Commissioner Chang and questions from Commissioners. I know there are a number, and then in about a minute, I'll ask the other panel to also come and join Ms. Chang up here and we can continue to ask her questions.

I'm going to start from the question with Bud Cramer, and then Commissioner Rubin, I believe you had a question. Commissioner Cramer said -- had a specific question which said that reports would be made to Congress. Can you say which committees of the House or Senate will receive the reports?

JOOYEUN CHANG: I believe our reports to Congress are made available to all members, but I can confirm that. We weren't specifically -- CAPTA is in the jurisdiction of the Health Committee in the Senate [Senate Committee on Health, Education, Labor and Pensions (HELP)], and Energy and Commerce in the House [U.S. House Energy and Commerce Committee] and then our reports on other child welfare issues, as well as the work -- the Committee of Jurisdiction for the other programs at the Children's Bureau is in the House Ways and Means and the Senate Finance Committee.

CHAIRMAN SANDERS: Commissioner Rubin.

COMMISSIONER RUBIN: Hi.

JOOYEUN CHANG: Hello.

COMMISSIONER RUBIN: Commissioner, I sort of have been thinking of the traverse we've taken this morning, and I'm trying to take a very different -- we had two very different panels, you know, the public health approach moving services upstream, and then we had a panel on workforce. I'll start -- the comment that stuck with me was Kelley's comment that she envisioned a Child Welfare System, because I think that's what we've seen as a theme across wherever we go, Child Welfare System is often seen as the place where family services are delivered, right? And her vision is one where that's more of community-based approach that says the Child Welfare System acts as a consultant to that system to determine safety risk for children.

It may feel like semantics, but it doesn't to me. And that's what gets to the workload panel, which started to suggest, well, you know, in some ways there are places that don't have enough child welfare workers, I get it, all right, but then there's also potential siloing in that approach, which is how many social workers do we need in our group, as opposed to starting to think what does the service array look like and what are the types of resources, meaning child welfare, public health behaviorist, et cetera.

Right now you have a focus in the public health community of waivers starting to develop around global budgets, and some facilitation of more flexible resources that every state seems to be craving as we go around the country. Have there been discussions or thoughts about starting to do larger type waivers that start to blend resources and might permit, let's say a state, from starting to blend both their child welfare and their Medicaid budgets together to start thinking about a larger umbrella for children and families?

JOOYEUN CHANG: So thank you for the question. I think, you know, there have been for many years conversations in the child welfare community about whether or not even title IV-E should be a block grant of some sort. I think the conversation about what is the best way to finance the system that we need is an important question, right?

I do think that there are benefits to certain waivers, title IV-E Waiver is an example of an opportunity for us to learn about how title IV-E dollars could be used in prevention and post permanency, since title IV-E doesn't currently allow for those uses, and it gives us a good way of how we might open up that entitlement program to support those types of activities. But I think protecting the entitlement is really critical here, so I think waivers can be used effectively, but I also think we also want to make sure that programs are used in the way it's designed, right? Title IV-E is really designed to address the needs of some of the most critical in-need vulnerable children and families, right? Medicaid has a much broader set of services and population that it seeks to serve. It's about providing health care to those who live in poverty.

We know that most families who struggle with poverty do not neglect and abuse their children. They complement one another, but they're not completely similar, right? So I think this administration has also used waivers to try and reduce -- to promote coordination and collaboration amongst similar serving programs by reducing the administrative burden. So we have waived certain elements in programs like reporting to federal agencies, and I think that can be really important.

I think it's a question of what is it that you waive and what is it that you continue to require, because I think some of those requirements are in fact protections for populations who need those resources the most.

CHAIRMAN SANDERS: Commissioner Petit, I think you're going to try on the new phone. Commissioner Petit? If it's a new phone, it's not working right now. Why don't you submit the question and I'll make sure that I read them for you. Commissioner Covington.

COMMISSIONER COVINGTON: I have a couple specific questions. One of the questions -- I'm part of the Measurement Subcommittee, and one of the things that we can't quite understand is why states aren't required to submit certain standardized pieces to NCANDS, and why NCANDS continues to be a voluntary system?

JOOYEUN CHANG: I think that's a great question for Congress, but it is the way the law is written, right? It's a voluntary program.

COMMISSIONER COVINGTON: I had one other. I lost it.

CHAIRMAN SANDERS: Commissioner Bevan.

COMMISSIONER STATUTO BEVAN: Can you provide the commission with more specifics on your web of reviews as the policy committee? We're real interested in efficiency and what are you getting out of all those reviews? I mean, do you need them all? And what are you getting out of them? I'm really interested.

My other question is from the CFSRs. The measurement of safety, is it just re-abuse, and what else is there? There's not much.

JOOYEUN CHANG: I'll answer the second question first. We look at both reports, as well as re-entry into the system, but one thing to keep in mind is that the CFSR is based on the data we have available to us through AFCARS [Adoption and Foster Care Analysis and Reporting System], right, and so there are limitations.

AFCARS, I'm happy to report, there is a new NPRMs that would revise and update AFCARS data elements, but as of now, they're a little over years old, and so the data we have is quite -- the data elements that were identified were done many, many years ago, and in order to change that we have to change the regulations. So we are limited by that, but those are the factors we look at.

COMMISSIONER STATUTO BEVAN: Do you think they're sufficient?

JOOYEUN CHANG: No, I absolutely think there's more that can be done to understand child safety.

CHAIRMAN SANDERS: Commissioner Rodriguez.

COMMISSIONERS RODRIGUEZ: I was really interested on the previous panel around child welfare practice models and fidelity to that. It made me think that I'm not really aware in child welfare agencies as a whole of any sort of specific holistic practice models versus some of the specific programs, like intensive treatment in foster care do really have practice models to them, so I'm just wondering what role ACF is playing in sort of collecting or disseminating or providing technical assistance to child welfare agencies on practice models and best practices as related to both safety assessments and interventions?

JOOYEUN CHANG: Sure, sure. So we actually used to provide technical assistance through a series of National Resource Center [(NRC)] that were identified topically, right? So we had a National Resource Center on prevention, early intervention. We had one on foster care, we had one on adoption. And we actually, just this year, completely shifted how we provide training and technical assistance [TA].

In part, it was to address your question about looking at the system in its totality, and so we have one umbrella organization that works with states on best practice, evidence-informed care, looking at things like a practice model from a comprehensive point of view. So we have a national capacity building center now that will look at all of those issues and work with the state based on an assessment of where that state is, what kind of needs they have to provide them with tailored technical assistance. We have similar National Resource Centers for tribes and another for courts. So, yes, we do provide technical assistance on looking at those.

There isn't one model though as a practice model that we promote. We try really hard as a federal agency not to promote particular business models or programs, but we do provide TA.

COMMISSIONER RODRIGUEZ: Is any of it focused specifically on this issue around reducing or ending fatalities?

JOOYEUN CHANG: It is looking at things like safety assessment, looking at prevention, absolutely. So we used to have National Resource Center dedicated to that topic, now it will be part of the larger national one.

COMMISSIONER RODRIGUEZ: Thank you.

CHAIRMAN SANDERS: Commissioner Chang, I have a question, and then I'm going to follow-up, then I'll ask the other panelists from the previous panel to come up, maybe a follow-up to two questions.

One was the question from Commissioner Covington. Has the administration ever made a proposal to mandate the reporting of NCANDS?

JOOYEUN CHANG: Not that I'm aware of, but I think one of the things that's really important to consider as folks think about that is, you know, someone once described CAPTA to me as this Christmas tree. It's a law that people love to attach things to, Commissioner Bevan is quite familiar with that.

I think if such a mandate were to move forward, we would have to ensure there was funding to accompany it to ensure states have the capacity to follow through with that law. I think that's quite frankly the challenge of CAPTA, right? It's a lot of mandates without any resources, and those types of laws have real limits.

CHAIRMAN SANDERS: And then follow-up to Commissioner Bevan's earlier comment about the web of reviews. Has there ever been a proposal that identifies a central point or streamlining of those reviews from the administration?

JOOYEUN CHANG: Not that I'm aware of, but it may be one of the things that our federal interagency groups start to look at. One of the things is they report that information to many different parts of the federal government, if at all, right, so, yeah.

CHAIRMAN SANDERS: Thank you. Commissioner Dreyfus.

COMMISSIONER DREYFUS: Two quick questions for you. One of the things we're struggling with is the wide difference across states and the definition of children who have been killed from abuse and neglect but were not known to the system. And we're struggling with what "not known" to the system means, because in one state it might just be that child, themselves, in other states it might be looking at the family, was the family known. In some states it might be six months, one year, all right, it's all over the board.

I'm just wondering if the Children's Bureau has done any work on that, might do any work on that to come to a more standardized definition of those kids who are killed from abuse and neglect but not known to the system, because we hear percentages all over the place.

JOOYEUN CHANG: I can go back and check on that. I'm not sure if we have or haven't. I know that we do work with other researchers and those in the field, and the states, quite frankly, to think about how we can improve the data collection, but I will check and get back to you on that.

COMMISSIONER DREYFUS: To follow-up with what Commissioner Sanders was talking about on central kind of contacts, and I appreciate the web of reviews, and I've never seen a chart where it lays it all out like that, but I'm going to think specifically about child death review teams just for the purposes of my question.

Could you envision, similar to the National Transportation Safety Board [(NTSB)], where there's some centralized federal entity where all of these reviews go into so that they can be looked at, right, more in an aggregate and instead of looking at it as data analytic standpoint,

trends, and a set of recommendations, right, that at the federal level that's also shared with states about best practices, about weaknesses in the system, but something that might pull this together?

Because if you're in a smaller state you have very few deaths, thankfully, and so it's really hard to have a large enough in, right, to really look at what you could be learning from them from a cross systems perspective.

JOOYEUN CHANG: I'd like to thank you for the question, Commissioner. I'd like to answer that question in a couple ways. One, I think absolutely it would be helpful to get a better sense of what the data means collectively, but I think Commissioner Bevan, you mentioned this earlier, too. I mean, there are different purposes for data, right? So it's important to know what happened in an individual case to understand what happened in that case, but part of the learning about how we can use it.

This systemic issue is another use of the data that I'm not sure could be done in an aggregate across all states, right, because we're talking about local systems, and state systems, and then national systems. I think the fact that the N is small means that you don't have a sense -- there might not be a system problem, right? I just think it's a matter of what type of question you're trying to answer and how you're trying to use the data.

With that said, I do want to make a point about data because I know it's something that I raised as a concern that existed 20 years ago and something we still struggle with, and for good reason, as kind of the web shows, right. I wouldn't want people to get stuck there, because I think the data -- the N will always be small, right?

So right now we say approximately 1,700 kids we know are killed from abuse and neglect every year, and I think there's some research that has tried to look at, well, if we did look at all of those other sources that were identified in the web what would be kind of a rough estimate of what the real number is, and I think there was one research study that showed it would be something like 2,500, right?

And so the reality is the N will always be small, and just focusing on the fact that we don't have the true N, I don't think is the best use of our time, to be honest with you. I think the best use of our time is to actually understand, and we do know who the kids are who are most at risk based on what we know, right, and how do you provide prevention strategies to try and address those needs?

I mean, there will always be a cluster within any N that you just couldn't anticipate, right? If you can't anticipate, you can't prevent, right? So we focus on the things we can anticipate, and the things that systems have control over, right? So I think that's what we should be talking about. How do we identify the most critical, at-need children and families, how do we improve prevention and intervention, which interventions work, right?

Those are the conversations I think we should be having. We know home visiting works, right? And we know home visiting works in even the hardest to serve families, but we have a program right now that is at threat of being zeroed out, right, if Congress doesn't act. We

also know that Child Protective Services is really important, right, how we do investigations is critical.

I heard of a model in Salt River in a tribal community where because they're small enough and they are dedicated enough, you know, they have a way of sharing information at the first instance of a report between law enforcement, child welfare, the attorneys that represent poor families in that community, and community advocacy centers. They all get the information at the same time. If anybody knows about that family, they share information and have a call so that people are making informed decisions. That's the kind of best practice we need to start seeing spread nationwide, and we don't invest in those things.

I mean, CAPTA funds states to do Child Protective Service at $26 million a year. I think what we have found is that that means some states get less than a senator makes in a year, right, to do all of the child protection in that state. And so the reality is, states are going to other sources of funding to pay for their child protection systems, and those programs are under threat right now, right?

So SSBG we know is a major source of funding for Child Protection Services. Compare how much states use in SSBG, which is approximately $325 million a year, to $26 million we give them through CAPTA, and now SSBG has threatened to be zeroed out, right? So we have pressing issues right now of eliminating the very few things we know actually works, not maximizing those things, and things that we know we can do better.

So I think numbers is important, data is important. I will always say that, and we should constantly be at a parallel track to pursue better use and understanding of the numbers, but we also have some really urgent things right at our front door, right?

CHAIRMAN SANDERS: So I'm going to ask the other -- the previous panel to come up to the table, because I know there are follow-up questions, and then want to see if Commissioner Petit can ask his question now. Commissioner Petit.

COMMISSIONERS PETIT: (Indiscernible.)

CHAIRMAN SANDERS: Commissioner Rubin.

COMMISSIONER RUBIN: I want to continue to follow along the themes, because I think in your proposal in the budget request this year is the amendment of title IV-E for pre- and post-placement services, that's brilliant. It's great. I think at the same time, because really the fundamental issue here that's being raised wherever we go, whatever state we go, is that flexibility to move services upstream.

But even then you're still requiring the kid to be reported, right? In order to kind of access services, right? And so I guess the question that I'm sort of raising is somewhere between block grants and fee-for-service as usual is -- are other funding formulas that might captivate kids in -- just like we do in health care, and what we're doing in global budgeting there, that it's still based on denominators and maybe has reassurance for epidemics, right, if there's a meth epidemic, you know, that might satisfy the needs for some flexibility in terms of hard

caps with some greater flexibility for states to plan around moving services upstream. I'm just trying to manage that, because I think you might get push back for that pre-placement if fee-for-service is, you know, can grow without end, right?

JOOYEUN CHANG: Right. So we did think about that quite a bit, and thank you for your support of the proposal, as part of why we didn't just make it any prevention service, right? There are two ways that we try to control cost in that proposal. One was to tie it to candidates, so these are not just kids who have been abused and neglected, these are kids who are imminent risk of entry into foster care, so that limits the pool there.

Let me be clear, that doesn't solve the issue of prevention, and it definitely isn't going upstream. What we wanted to do was an immediate intervention, because we know for kids who don't need foster care, it in and of itself can be a traumatic experience, and we need to at least limit the harm we do to kids, so that was one of the ways of controlling costs. The other was to make it a requirement that you invest most of those dollars in evidence-based, evidence-informed services. The sad truth is we don't have tons of those, right, but we hope over time if you change the entitlement program to open it up for those things that the systems will adjust to try and create programs that are in fact evidence-based and evidence-informed.

We think it slowly moves this field that's in the center that's, you know, around the hardest to serve kids a little bit closer upstream, but absolutely, Dr. Rubin, it doesn't get us where we need to go, but it's a first step, right?

COMMISSIONER RUBIN: First step.

CHAIRMAN SANDERS: So as a consolation to Commissioner Petit, I have some questions that are primarily I think are going to be yours, Ms. Zlotnik, about the workforce. First, is how many universities MSW programs are there in the country, and how many specialty track in public child welfare?

JOAN ZLOTNIK: So there are about 250 MSW programs in the country. I don't actually, off the top of my head, know the answer to specialty track and child welfare partly because schools all have flexibility. There's difficulties with flexibility, because then you can't answer questions easily, because some of them are children with family specialties that might be more clinical, so there's not an easy answer to that question, but I can get an answer to that question.

CHAIRMAN SANDERS: Sure. I'm sure that would be greatly appreciated. Let me ask you an easier one here. Given a choice, is there any research on whether it's better to have smaller caseload staff by BA [Bachelors of Arts] level workers or better trained workers, MSWs, with larger caseloads?

JOAN ZLOTNIK: I think that's an easy question, because I don't think there's any research that's specific to that. I know that in some of the retention research, caseload doesn't come out as the largest issue about what keeps workers. It's supervisors, it's the support, so it's not always caseload, but I think the issue, as [Associate] Commissioner Chang was talking about,

some of the thoughts around implementation of evidence-based intervention, that its skills and time spent with families that are really the critical issues.

So I don't think it's an either or, it's a combination that if we're really going to move to making sure that there are models of practice that we know work that are implemented consistently and with fidelity, then we're going to end up with a need for people to have more reasonable caseloads, whether it's a Bachelor's level or Master's level, because they bring different things to the table, and there's many different tasks that need to be provided in the Child Welfare System.

CHAIRMAN SANDERS: And one last one, does NASW have a national standard for child protection caseloads?

JOAN ZLOTNIK: We do not currently have a national standard. For many years, starting in 1981, when we first developed child protection standards we had a caseload standard and a supervisory standard, and because exactly of the conversation we were having earlier about the difficulties of, is that a child, is that a family, is it caseload, is it workload? In the most recent revision to the standards, it does not have specific ones. We tend to sort of, in our work with Child Welfare League of America, look at their standards, but then their standards right now aren't that recent either.

CHAIRMAN SANDERS: Commissioner Rodriguez, I think you had questions.

COMMISSIONER RODRIGUEZ: I think it's for Myles. When you mentioned in your presentation about fidelity to the practice model and its implementation being sort of one of the keys that -- one of the things that you have found that really correlates to outcomes, I'm just curious, could you -- I haven't actually heard this because most of the correlations that I hear are drawn to caseloads, and so could you just talk a little bit more about what you found, and what the research is, and what gaps in the research currently exist?

MYLES EDWARDS: The issue is for a practice model to work it has to be done, so that if the workload expectation is beyond the realm of what would happen in a typical workweek, then oftentimes what we see is caseworkers trying to work more. And then we have a lot of the workforce issues going on, not to mention the chronic and toxic stress that puts on the caseworkers. I've had more than six specific former caseworkers who left the field because of how they felt at night, that it just became intolerable then to take on that responsibility.

If an evidence-based or evidence-informed practice is premised on doing things in a certain way, and it's not done that way, then all bets are off, the practice isn't being implemented, so that the logic model is violated. And we typically don't know that that's occurring now because we're relying on workload studies. And I would say that it's time to move away from workload studies and move towards workload monitoring.

I think the comments about disconnecting funding mechanisms from service delivery is a good one, but it still leaves us with a need to track what does a child or family receive for services. One of the reasons we cannot look at workload very well right now is the same reason we can't look at case cost right now if we don't know what any individual child or family actually

receives.

COMMISSIONER RODRIGUEZ: So let me ask the question a little bit differently. I know we've been working with a group of child development researchers who also understand foster care who have sort of been trying to figure out what exactly is the practice model in child welfare sort of beyond responding to specific incidents and dealing with situations as they arise. Could you give examples of what a child welfare agency practice model is?

MYLES EDWARDS: Certainly. I think you heard that this morning from Oregon. I think they had excellent detail on what their practice model intentions were anyway, and there's been a lot of implementation on that, but I think it's a work in progress. One of the problems we have with practice models is the question you're asking.

When we were doing workload studies in Colorado recently they were interested in differential response workload. So we asked people, are you working on differential responses as the service for this case? Twice as many -- workers in twice as many counties said they were, as were counties approved by the state. So the state said, no, they can't do that because they don't have the legal option for a differential response disposition in those states, but the workers felt they were working that way. So what was their practice model at that point?

So there's a confusion oftentimes in terms of what the practice models are. Health care in the early '90s, when the guidelines started coming out, was in a similar state. We weren't sure what any given physician was going to take as an approach to a condition. That's changed a lot over the years, but child welfare doesn't have practice models now. Safety assessment is a practice model.

I'm sure we could come up within this room people saying there's half a dozen well-developed approaches to doing safety assessment right now, all of which would have certain degree of validity, but they would be very different ways of going about the practice. So that practice model for me is more is there an explicit clarity to it, for whom are you doing something, what are you trying to do, and what do you expect the results to be, simply put.

And the more specificity that gets built into that, the better the science. But until we understand workload at a case level, and not just a one-month time study, but rather throughout the life of the case, what are all the services that are received, and that can be expanded now into the more what I'm hearing as the global approaches as funding --

CHAIRMAN SANDERS: I know we have a couple more questions. I want to make sure yours was answered.

COMMISSIONER RODRIGUEZ: I understand. Thank you.

CHAIRMAN SANDERS: Commissioner Rubin?

COMMISSIONER RUBIN: No.

CHAIRMAN SANDERS: Commissioner Covington.

COMMISSIONER COVINGTON: Commissioner Chang, I have a question for you, and we haven't addressed it today at all, but it goes to the whole question of confidentiality when there's been fatal deaths. And I know the Children's Bureau has danced around this a lot because of the CAPTA language. I don't think a week goes by that I don't get a call from a press person asking for data even out of our case reporting system, and then they explain all their frustration in working through their own states when there have been fatalities.

Where is the Bureau going? I know there's an FAQ [Frequently Asked Question] that describes what's in CAPTA, but even that's a little murky. What are your feelings in the values that are coming from this administration around confidentiality and fatalities and near fatalities?

JOOYEUN CHANG: It's a really important question. I think this administration obviously values transparency in that we think sharing information is really important to making the system work effectively. In the issues around child welfare though, there's always this delicate balance in protecting, quite frankly, the child's interest and making sure that the interest of open dissemination of information is also respected.

So it is something that we are also bound by other laws on, right, so we have to make sure that we acknowledge their HIPAA [Health Insurance Portability and Accountability Act] confidentiality rules that we have to make sure states are abiding by. So I think it's a balance, and I think it's about making sure that it's not used as a way to shield information that's necessary to the field, but I think, to be honest, I think we all know child welfare agencies are working to prevent fatalities.

And fatalities are the worst thing that can happen for a child welfare leader, right? It brings all this attention to them, it puts a lot of pressure in ways that I don't think they can participate or desire. So it's not they want to not deal with it, right, it's just that they also have a responsibility to protect information that they're legally bound to protect.

CHAIRMAN SANDERS: So we're going to try a new advance with technology. Michael Petit is on speakerphone, here. We'll see if he can actually ask his question. Commissioner Petit?

COMMISSIONER PETIT: Hello, David. Can you hear me?

CHAIRMAN SANDERS: Yes, it works.

COMMISSIONER PETIT: All right. So this question is for the Commissioner, and Commissioner, you have obviously a major responsibility in the protection of the children in the country as a top federal official on this review. Right now that number, and I don't want to dwell on numbers either, but the 2,500 is -- (interruption in call) -- is something I wrote four or five years ago and/or it was taken from three peer review journals.

And in estimates under ascertainment of child deaths of significantly higher, and in my reading it the estimate was really closer to 3, than it is to 1,700, but that number seems so large we thought we would just go as conservative as can be, so that's where the 2,500

number comes, from my perspective, but it really is an understatement of the problem.

So I'm talking about being in crisis in child protection, and I think you said well, and the President has said well, that this crisis is not just a crisis in child protection. It's because it's a crisis among so many families in terms of the needs that they have, whether it's mental abuse, substance abuse, or whatever happens to be. I would say in present day, and I would say length of being helped in one state versus another varies substantially as an action in geography, so I would include that the problem facing the country in protecting children is a much greater problem than the current level of resources that are being brought to address that problem. So I have several questions along that line.

The first one is, have you and your staff calculated what the dollar gap is between what the current task is at addressing this problem and what the actual magnitude of what this problem is? So in some points dollars matter and I'm just wondering in terms of where you guys are going with all of this. And I understand what the political climate is, but I know that the legislation to create the commission was passed 330-77 and 100-0 in the Senate, so clearly it's brought bipartisan support on both sides of the aisle to do something about this issue.

So the first piece that I have is in comparison to the need, how big is the gap in comparison to what the problem is? Can you guys calculate that? Are you in the process of calculating that? Does it belong to you?

JOOYEUN CHANG: Okay. So I think I heard that question. So I think the question was what is the gap between what it takes to address these needs and what we currently invest in them. So I guess it depends on how we define what "it" is, right? I mean, are we talking about keeping all kids safe from abuse and neglect? Are we talking about helping all vulnerable families? Are we talking about abuse fatalities?

And thank you by the way for clarifying what the 2,500 was; that's really helpful to know. So I will just -- let me be direct. We have not done that calculation, but we -- I think the budget proposal reflects where at least we think the most immediate gaps are and how we can reasonably address those gaps, right? And it's everything from childcare to early intervention [EI] and child abuse and neglect prevention. I mean, we think about the data we do have, that nearly seven percent of the fatalities are the result of a paramour living in the home, right, usually a mother leaves their child with because they have to go to work and they don't have any other form of childcare. So we know childcare needs is a major issue in this.

You know, the President's budget would allow every child who lives in poverty who needs childcare to be able to get childcare. Those are some of the calculations we've done, Commissioner Petit, but we haven't done it quite in the way that I think you may be looking for. I know others in the field have done so, and there is quite a gap.

COMMISSIONERS PETIT: Let me ask as a follow-up to that. We receive, all the commissioner members receive, and I suspect you receive as well, the Child Welfare in the News publication, and additional research as well, but that every day more children are served as being victims of fatalities, more agencies are seeing the executives being fired, and more

social workers are being fired, and things that happen to children are terrible, and of course it's sensationalized across the country.

You have a relatively small department that's supposed to be overseeing this, and I'm wondering if you can convey to us the sense of urgency that the operation, that you have, brings to this issue between now and the time we serve our report, which will be about 12 months from now, there will be another 3,000 children killed. We know most of those children are -- they are now known to somebody. We don't know specifically 3,000, but we know 3, children are going to die.

How are you guys approaching this in terms of making the politics and public awareness, media and public support, engaging them in this kind of battle that these kids are experiencing?

JOOYEUN CHANG: So I do think it's a struggle. The -- to your point, the new stories I think create an unrealistic picture of what the Child Welfare System actually struggles with on a day-to-day basis, so it is challenging because every single life that is lost is an absolute tragedy, and we have to have a sense of urgency about investing in the things that we know work.

At the same time, we have to make sure we are supporting our public agencies who take on this daunting and thankless job every single day in a way that we never -- that we currently, at least don't at the federal agency, right? So I think our sense of urgency is about making sure we don't lose the sources of support we have today for prevention, right, and those are under threat right now, and we have to protect those things.

At the same time, we have to think bigger than that and create a vision of what we do need if we could get greater investments to help these vulnerable families. So it's certainly an urgent issue for us, and appreciate you raising it as such. We think we have to work collectively right now to make sure that we move forward and not backward in this field.

COMMISSIONER SANDERS: Commissioner Petit --

COMMISSIONERS PETIT: Please allow me one last question, very brief. Just one last question, and that is, [Associate] Commissioner, recently, a group issued a report called "U.S. Shame," [Shame on U.S., A Look at The Child Welfare Crisis] and I'm sure it's been brought to your attention. In the report, the federal government for a lack of oversight in the states, and that there's such unevenness among the states where children are protected or not, varies very, very widely.

What's your response to that report? Do you believe that it has merit? Do you believe it does not have merit? How will you guys be responding to the specifics they provide on what they claim is weak federal oversight of states with respect to their compliance with federal law?

JOOYEUN CHANG: Sure. Thanks for the question. I am familiar with the report. I think we are not planning on providing any kind of direct response to that report. I think that there are valid points in it, and I think that their intention of trying to improve the system to

protect children and families is a very important one and we applaud them for that. There's certainly parts of the report that we disagree with, and I think the issue of improving oversight is critical, and we hope that we get resources to do that.

We also think it's really important that as much passion and energy is spent in trying to make sure state and local communities get their resources to do that job. Right now we're not giving it to them, and to say they're not doing something that we don't fund them to do is a little challenging in my mind. So I think that the focus needs to be on what are the gaps and resources and let's make sure the folks who need it get it.

CHAIRMAN SANDERS: I'd like to thank you, Commissioner Petit. I'm glad this worked and you were able to ask your question. I actually have a quick observation, and if there's any response that's contrary it would be helpful to note. And then Commissioner Rubin has one last question before lunch.

Commissioner Martin is on. Do you have a question, Commission Martin?

CHAIRMAN SANDERS: So let me make my observation. We've heard quite a bit of this; I've had an opportunity to review a lot of research. Is it safe to say we don't know that there's not evidence of a correlation between lower caseloads and fewer fatalities?

MYLES EDWARDS: I know of no correlations that's been established on that because I don't know of any research related to workload, caseload, and fatalities, per se. What we have seen in the Kessler, et al, paper that I provided a reference to, they speak to caseload being a factor in the Casey Alumni success. It was one of the many variables that were looked at that were related.

CHAIRMAN SANDERS: I think my major point is striking, because we have found correlations between other factors and caseload, we have not for fatalities, and I'm not sure for recurrence of abuse, and I'm not sure of some of the other safety measures, but I want to get to David Rubin's questions, and then we're going to close. If there are comments contrary to that, we can talk about them during lunch.

COMMISSIONER RUBIN: One more question for Commissioner. I know in the last few years ACF and the Children's Bureau had been engaging CMS in an interagency at the federal level on a number of really interesting things in terms that are culminating in the President's appropriation request to Congress for a large investment in trauma-informed service.

We heard this morning about the Triple P [Positive Parenting Program] program being reimbursed by Medicaid in Washington. The comment I had offline was wouldn't it be great if CMS, Children's Bureau and other agencies came around permissible uses of Medicaid funding and helped guide Medicaid to help resource the type of services that can support the service you guys need? Can you talk where you're going with CMS and what your hopes are for the future there?

JOOYEUN CHANG: Sure. We have been working in close partnership with both CMS and SAMHSA, recognizing there are really some gaps in health services, as well as others, help for

needs for our population. And we have focused primarily on trauma up to this point, really trying to see what the intersection is between our three agencies and the best way to address trauma, both with children who come to our attention, but also their parents as well.

We have started actually, as part of the drafting of this year's budget proposals, thinking more intentionally about the specific intervention to your point, and what is it that Medicaid should cover? Part of our interest in that is knowing what we should ask title IV-E to cover if Medicaid is not going to cover it, right? So we are absolutely having those conversations. They're, as you can imagine, not easy conversations to have, as CMS is a much bigger agency than ACYF, but we are certainly starting to make those end roads.

COMMISSIONER RUBIN: I just want to send a shout out to the stenographer for that last exchange. Make sure you put that on the record.

COMMISSIONER SANDERS: Thank you very much. Thank you Associate Commissioner Chang, and thanks to the four panelists, very informative. We're at a point of our break for lunch. We'll reconvene at 1:40, which is about ten minutes after we had originally planned, but thank you everybody.

(Lunch break.)

CHAIRMAN SANDERS: All right. We're going to start in just a minute for our afternoon presentation. I think we're going to make a slight modification to the afternoon agenda. We will take a break right after Ms. Noonan's presentation, re-adjust the table and then go into subcommittee reports. That will be around 2:30, 2:40, and the rest of the day will be in subcommittees.

So we're going to go ahead and get started with Ms. Noonan, who is in -- are we back on the phone, do you know? So we're going to go ahead and get started, and Kathleen Noonan is an attorney at Policy Lab with Children's Hospital of Philadelphia, and knows as much about legal rights as anybody I know. Thank you.

KATHLEEN NOONAN: Thank you, Commissioners, for asking me to come today. I also want to thank the Executive Director of the staff, Liz Oppenheim and Tom Morton for sort of helping me prepare, and then Sarah Zlotnik and Lee Wilson from Policy Lab, so thanks everyone.

So I'm Kathleen Noonan from Policy Lab, and today I hope that I can provide a little bit of guidance in helping with your formidable task in trying to eliminate child fatalities. Now, you've asked me to provide guidance on how the law can inform the decisions that you have to make as a commission, and I want to start out with a warning, which is that there aren't any easy answers, but I'm going to try to give you some framework so it will help you in your decision making. Also, I know there are some lawyers on the commission, so just a little bit of patience because I'm trying to distill a lot in a little bit of time.

So what I'm going to do today is actually first talk you through individual rights and state rights so that you have a good sense of what those are, and then I'm going to talk to you

about how do you reconcile the rights when they clash, and then finally I'm going to talk about their application in child welfare.

What I thought about a lot doing for this talk is to actually give you the tests that the court would do if it had to actually judge some of the recommendations you make, and then give you some frameworks that will guide you as you make those recommendations.

Okay. So let's dive in and start with individual rights. Okay. So all of us have individual rights. The right comes from the 14th Amendment, it's also in the 5th Amendment, and it's the life, liberty, property without due process law. Now, really what we have is the right not for the state to infringe those rights, and the Supreme Court over the years has given us some examples of what is a liberty right. And so, an example of a liberty right, according to the Supreme Court [of the United States (SCOTUS)] is the right to marry.

Another right that we have is right to procreate, and then another right we have is the right to direct education and the education and upbringing of our children. So in the Supreme Court over the years, as it has been asked to interpret what a liberty right is, they have interpreted it to mean these different things, okay? So these are examples, and these actually are the ones that are related to the work of the commission.

So I'm not going to dive into this case a lot, I just want you to know it's a case that everyone seems -- knows in the child welfare world, DeShaney versus Winnebago County in Wisconsin, and it's a terrible case involving a little boy who was hurt by his dad. The state didn't intervene, and the Supreme Court said that there really wasn't a constitutional right at that point. There wasn't a constitutional right from harm by the state.

In other words, the state didn't have to provide the child with every protection needed to prevent the harm. That's a hard thing for us -- that's a hard pill for people to swallow, and we're not going to talk about that too much today, but what I do want you to take away from the DeShaney case [(DeShaney v. Winnebago County)] and what is important to your work as a commission, is one, that DeShaney stands for the fact that parent's rights are very broad.

So when the DeShaney -- when the County struggled with whether to remove that child or not, it's because they were really balancing parent rights against the sort of interest of the child. And then the second thing you should take away from that -- the case, and this doesn't get talked about a lot, but it's really important, even though the Supreme Court said there wasn't a constitutional right for protection from the state agency, they said that the state could actually put in place laws, state laws, that could be more rigorous about protecting the child's rights.

So the court was really only looking at the constitution and whether Winnebago County had violated our federal constitution, but there was nothing that would prevent Wisconsin as a state to actually decide they were going to require more of their systems, and I think that's important to the deliberations of this commission, and so I wanted to make that point.

Let's talk about other rights we have as we're sitting here today. We also have the right to consent to treatment. This has been part of our liberty rights for a very long time. The

Supreme Court said in a case called Crusan versus The Director of Missouri, Department of Health, this was a case involving someone a right to die. Basically, the court said that every human being of adult years in sound mind has a right to determine what shall be done with his own body. That also extends to mental health and that right extends to parents as far as what happens to their children.

There are exceptions, and actually, child welfare falls with that protection; imminent harm, medical emergencies, but here's another exception that's actually very important to the work of the commission and important to what you were talking about, if I got it right, around denominator.

The other exception is compulsory education. The reason why that's an exception is because there's been public policy decisions in universal programs, and so you do have a right as a state to trump consent. And so I think that's very important because I'll talk to you later about as the commission thinks about universal versus segmented programs and why universal is appealing in many ways from the rights of perspective.

What are state's rights? There's a fancy legal term calls parens patria which is a doctrine which allows the state to take action to protect the rights of their citizens. And they can basically do it in three ways; the state can do that, it can actually do it by stepping in and saying it wants to protect people from harm; it can step in and say it wants to substitute judgment, so that is the case, like if someone who has been found out to be incompetent.

But then the last place is a very paternalistic place, and that's the state stepping in and basically saying we're going to be making a decision for you. It's not because we've decided that there's harm, and it's not because we decided you're incompetent, and that -- education falls into that, again, right, where you didn't make a decision, you were incompetent and didn't make decision about harm necessarily, we just decided this was for the good of you. So let's talk about what is really sort of most relevant to this commission is the clash of these rights and how do we reconcile them. And judges actually do this by applying balancing tests, which are very fact-based. There are no absolute answers, and I know that's probably disappointing, but I unfortunately don't have absolute answers for you, but I will give you some insight, and I know that probably the lawyers on the commission, too, as you think about things, what lawyers tend to do is balance things between two sets of facts based on the rights that either party has. And so hopefully I can give you a little bit of ability to actually think that way as you go through thinking about some of your recommendations. Let's talk about balancing tests and how the court applies them. So one balancing test is a balancing test that really focuses around compelling state interest, and that's that if the state is going to override -- I'm going to use the example here of parental liberty, they must do it in a narrowly tailored way that is done to produce the least intrusive interference.

So I'll give you an example of coming out of compulsory education. The Amish said that they didn't need their kids to go to school for certain periods of time, all right. The court actually balanced the needs of the kids versus the needs of the state, and what they came up with was an exception for two years of high school, right? So the kids had to go to school until they were 14, but they were allowed to miss the last two years of school.

So it's when a compelling state interest is going to be challenged, it's going to be looked at through this lens of is there any way we can do this with less interference to the family and what they want. In thinking about compulsory education, I think it's really important for purposes of this panel, because when you go back in history, right, 100, 5 years ago, like, a lot of people didn't want compulsory education. A lot of people said you're getting in the way of my child working on the farm, getting in the way of my child working in the business, and so the state actually had to override that and decide there was greater interest in doing that. So I think that that's -- as you think about public health applications to some of the work you do -- a really good example to remember. And, Commissioner Dreyfus, I'm looking at you, but I've looked at these historical education documents, and in Wisconsin, just as an aside, not only was there disputes about public education, but there were lots and lots of German residents in Wisconsin who wanted the schools to be in German and not in English, and that was a big debate at the time, too.

So lots of these things, if you look at the historical roots of them, you know, it sounds crazy now for some of us to recommend things as universal, but at one point the craze was recommending school was universal. Let me just tell you about the compelling state interest standard that set a high bar for a state, all right?

So if you're going to interfere in a fundamental right, like the right to parent, you had better have a lot of evidence as the state, right? So when states decided to interfere, for example, in education, they actually did arm themselves with a lot of evidence, even though they decided it was for a public good, the evidence was all about how kids were harmed in child labor. That's a really, really important part of these tests.

So the second test I want to tell you about is the best interest of the child. And I know that there are -- Judge Martin, who is on the phone -- anyway, she could probably do a better job of talking about this than me, but suffice to say that the best interest of the child standard comes up when there's a clash sometimes between parents, sometimes between parents and the state, in custody situations.

Again, you look at a number of factors, very data heavy analysis, and in child welfare I'd say the place where this is most relevant to policy discussions is around the threat of harm. And so if I were making a case around expanding threat of harm, I would be thinking about what would be -- what I would be seeing from a best interest point of view.

The last balancing test for you to keep in mind as you deliberate is a balancing test on protecting public health. That requires the state to show a substantial relationship to protecting public health when it actually trumps someone's consent; that comes up in compulsory vaccination cases. And so what's important to know is that even, you know, in 05 when the State of Massachusetts [(Jacobson vs. Massachusetts)] was sued because they were trying to require someone to get a small pox vaccine, the state was actually required to bring scientific evidence to the court to show that the vaccine was effective, and the court actually listened to rebuttal from the plaintiff's doctors, or other people he brought in, saying the vaccine wasn't effective. So I can't stress enough that when you're in a place where you are looking at a clash of rights, you have to be prepared to bring data to the table because the

court really has an obligation to look at that.

So just a couple of other key take-aways from the balancing test, and then we'll apply it in the child welfare context. But tests are applied by the courts, evidence is critical, and because it's a balancing test, that facts depend on it means the results are going to be variable. A court that might do balancing tests in New York might come up with a different finding than a court that comes up with balancing test in a different state, okay?

An example in child welfare is of course just looking at states; that some states decided that domestic violence, per se, observing -- a child observing domestic violence was, per se, neglect, and other states decided that they weren't going to adopt that. So we just have -- we have variable results because it's a balancing test that is -- that looks at facts, but is also informed by the norms of that jurisdiction.

So let's look at applications of these balancing tests, and this sort of clash of rights in child welfare. I can tell you that looking at child welfare now, if you look at the broader definitions of abuse and neglect, threat of harm, failure to educate, medical neglect, that this all shows balancing tests that ended up tipping in favor of the state and not the parent's rights.

Those are much more expansive definitions than were in place, you know, 20 years ago, 30 years ago, so we have expanded as a country federally, and then at a state level, really the state's interpretation, we have expanded what we mean by abuse and neglect. What's happened simultaneous though, is that we've also expanded requirements on the family side as far as reunification, as far as kin, and so those things continue to sort of operate in parallel.

So we're both expanding definitions of how a child can come in, but we're also expanding sort of how -- what we have to do as far as reunifying the family. So that just creates a sort of complication. In child welfare also, if you look at the expansion in newborn and prenatal assessment, I mean, these are major expansions in terms of triggering an investigation because they're being triggered by not an event, but by status.

And typically in child welfare we have always had a trigger based on an event and not based on status, so I would say that this is a sort of, again, a shift on the compelling state interest side towards intervention. And I would, if I were the commission, certainly in any of the states up there, I'd want to have a lot of data about that, because I have to tell you that these states, at least to my knowledge, none of them have been challenged legally yet, but it's possible that some could be.

And, you know, thinking back again on the example of domestic violence, remember that New York City put in place domestic violence as if a child observed domestic violence that the child could be removed, and they were sued on that and they lost as infringing too much on the parental right's side.

The other sort of observations I just want to make about expanded newborn and prenatal assessment is that I think they're all based -- they all are sort of focused on women and

entries really triggered by the mom's pregnancy. And I don't think -- I don't see many examples on the expanded newborn prenatal assessment side that's really getting at triggers around dad's status at all, so right now it's really all focused on mom's status.

And the other thing I'd say is that they are all individual sort of status triggers as opposed to population health triggers, right, so it's not that we're going to trigger all moms who have this particular category, it's a particular mom, at a particular birth, and so it really is not on the universal side of things.

So let me -- before I open it up for questions, because I feel like this topic sort of compels a lot of discussion, let me just leave you with a couple of frame works that I think you might use as you're thinking about the recommendations you might make. The first is, is that I think you have to think a lot about universalism versus segmentation. As far as universalism goes, at least as far as we've seen the law so far, if you have the ability to create a universal program you are less likely to be infringing on one person's rights.

If you can create a compelling state interest around a universal program, you can have data that that program protects from a certain overall harm, like compulsory education. You're on sort of safer legal ground. If you segment a population, so maybe all moms who have low birth weight babies are you -- you have to have more data because you're at risk of being accused of identifying someone based on their status, and the lawyers here know that in criminal cases, right, you're not supposed to bring in past crime that someone has committed, right? In this country we believe, actually, that you should try people based on what we think they did related to this particular allegation and not based on their past behavior.

So you're always sort of on trickier ground if you're trying to trigger something because of status. It doesn't mean it's not possible, right, we have programs that are segmented all the time, you just have to sort of think about that as you make your decision. I think it means you probably have to have more evidence if you're going to create a program for a segmented group of people.

The second thing you have to think about is whether you want to do preemptive intervention versus reactionary intervention. I think if you're going to do preemptive intervention, you have to be out of the child welfare and in another system, like health, or public health, or education, where you can create a universal program that isn't based on a potential abuse or neglect, but that's just based on threat of harm or best interest of the child, but that you're not trying someone for abuse or neglect, you're in fact deciding as a government that you want to provide this service preemptively.

So home visitation for everybody, for example, not just a small population of women, you know, based on something they did in the past. And then the last thing is mandatory versus voluntary, and I think the problem right now in our prevention programs in child welfare, to be honest, is that they're not mandatory.

And I think at least in one fatality review, I'm on the Act 33 Group in Philadelphia, which is our fatality review group, we know that the child welfare workers when they refer people to prevention they assume they're going to go to prevention. And I think they have to assume

they're not going to go to prevention under the way the decision making works right now because they have no obligation to go to prevention.

And so I think that we have to think differently about prevention, and maybe prevention can't be in child welfare, it has to be in another system like public health. Anyway, I realize I've raised a lot of questions and this is, you know, this is why some people go to law school and some people don't, but let me stop there and sort of see what questions you have about what I've raised.

CHAIRMAN SANDERS: Commissioner Dreyfus.

COMMISSIONER DREYFUS: Thanks Kathleen. I want to go back to the chart that you gave us about the summary of state programs that allow newborn prenatal child welfare cases, because you've raised something we've talked about before, and that's dads. I know from my own past child welfare experience when we would have child fatalities it may or may not be the birth father, but a paramour in the home, right, oftentimes was a significant risk to the child.

And you talked a lot about the focus being on mothers, right? So I kind of got a sense that there's a little bit of recommendation coming out and you didn't want to quite say it that way, but is there something these laws are missing, from your perspective?

KATHLEEN NOONAN: I think we haven't figured out yet how to bring dads in. For example, in most of the cases that I sat in on where there's been a fatality, and there's been a guy, he has other kids, it might not be his kid who is killed, but he has other kids, and so I would ask is he delinquent on child support, does he have -- I mean, any of the other various risk factors where you might say that could come up. So is he on probation? Are there parole issues? Things like that. I'm not, by the way, trying to suggest that's my recommendation. I just don't think we've delved into those as much as we've delved into the female side, mom side.

CHAIRMAN SANDERS: Commissioner Covington.

COMMISSIONER COVINGTON: Where does this leave us with predictive analytics in terms of using those as tools to identify high risk kids like they're doing in -- you're saying take completely out of child welfare system and put it in a completely different framework?

KATHLEEN NOONAN: No, I'm saying collecting data on those things is really important because if they were challenged you'd need to actually have the data to back your case. I would want to be able to say the reason why I'm targeting these kids is because I have the data that backs this many kids that had this similar criteria resulted in this harm.
So what I'm saying is that the more you segment, the more you have to be careful that you have good data to back your program. So I look at all these things and think of them as pilots for the child welfare field, but I review them that way.

COMMISSIONER COVINGTON: The other question I had is drug exposed infants and where that goes and how -- some thoughts in how all of this fits in with those, because so many times they do get reported but nothing ever happens because threat of harm is murky. I don't think

people really -- and there's so many in so many communities that it overwhelms the system anyway. How do you think that fits into some of this?

KATHLEEN NOONAN: Well, I mean, I think the fact we have so many jurisdictions that you can bring -- I mean, whether a jurisdiction identifies drug abuse on its own or it just comes in under threat of harm, it's possible to bring children in under that criteria, but I think a lot of workers feel unsure about bringing them in maybe because they feel mom's functional, maybe they feel like it's going to ruin her treatment program if you bring the kids in.

I mean, I think if workers aren't doing something, it's usually because there's some reason why they're not doing it, and so figuring out the answers to that. I don't think these are easy questions, so I don't think -- as I said, I don't have any easy answers for you, but I don't think we figured out a way how to work with the drug program as a child welfare community to make it any easier.

So, for example, you know, I know that most people I know in the recovery community, if someone has relapsed, we'll say are they back on their program? And if you say, yes, they say great. If you say that same fact to the child welfare community, they say they're violating their case plan, right? So we have to acknowledge that we either have to change our view of things, right? Somebody has got to change their view of things, because as long as we have clash we're not going to have child welfare workers bringing in people in for things like substance abuse.

CHAIRMAN SANDERS: Commissioner Rubin.

COMMISSIONER RUBIN: I'm going to stay on predictive analytics, because if you think about it, there's been a lot of advocacy before this commission around predictive analytics, using data in some ways, data that may be circular; that people with certain characteristic status, as you said, are predicted to have a likelihood of their child being reported to child welfare.

But there's a circularity there built on disproportionality and other stuff like bias, and so there may be potential values in terms of threat or harm to the child, but there's threat or harm to those families, and in trying a balanced approach how does that factor in? Because you can provide the data that shows a strong association, but that harm of someone looking in on that family and then potentially reporting that family because they're not like me or something I observed, just that contact increases risk of family and separation from the parent.

KATHLEEN NOONAN: First of all, if the court were looking at whether you could show the data, I don't think it would be whether -- just that based on predictive analytics, you predicted this one child matched up. You'd have to look at the whole population and say there were so many people where there were false negatives or false positives that it wasn't possible, that you infringed on so many people by doing this, that it was just tipped too far on the side of infringing parents. That's the worry about predictive analytics, you know.

I think that thinking about things like universal pre-k, you know, more childcare, the things that we think are actually the solutions might be -- you just have to think about what's the

way to go. Should child welfare spend more time developing -- thinking about advocacy around those things that we think those families need, then on trying to do this predictive needle in a haystack?

I don't know if we have all the evidence yet, so that's why I said, to me, predictive analytics is a pilot, and interesting, and whether it yields anything I don't think we know yet as a field.

CHAIRMAN SANDERS: Commissioner Bevan.

COMMISSIONER STATUTO BEVAN: I have two quick questions. Under CAPTA, the required safe care plan for newborns, it is not being followed. And it's not bringing them into a system, it's providing services to the family, and it is not yanking this kid. But when you said, you know, when things aren't followed there might be a reason that social services wouldn't want to get involved, but that sort of concerns me.

I don't know what my question is, except how do you get compliance in something like that? You have to change the culture. You have to send out a message that says if a baby is born substance abused then we need to get this family in care rather than I don't know what other message going out, but it's not being followed and it's of concern.

KATHLEEN NOONAN: I don't think it's being followed, and so I think it's an area -- I know this committee has thought about research. I think it's an area where it's not just in some states it's not being followed, and it's not red states or blue states, right, it's really -- it's a very complicated issue, and it means, to me, it's a complicated issue for the front line.

So I feel like we need to know more about it, that it's not simply just compliance, it's what is it that -- what's the reason they're not following this? Obviously, they think that there's some risk, and they think bringing the child in would cause more harm? I don't know the answer to that.

COMMISSIONER STATUTO BEVAN: Okay. Clearly, when you talk about mandatory and voluntary, I mean, I think of reporting, you know, and there's a lot of discussion about should we change reporting and not have reporting -- we have the required mandated reporters, but then, you know, we have the neighbor, the anonymous reports we are more likely to be unsubstantiated.

So, you know, does it make any sense to focus on just mandatory reporting, or does it -- I mean, it's not one of the balancing tests, but it's an issue in terms of –

KATHLEEN NOONAN: We have -- I feel like we have labs, right, because we have some states that have requirements that everybody is a reporter, right? Nobody is -- Rhode Island, at least as far as I know, requires that everybody reports. And I don't know if there's any difference in Rhode Island than there is anywhere else.

And so, I mean, child welfare, it's interesting because people know I work in health care, and I work in child welfare, child welfare is so under resourced on the data side that we just don't know so many things. And that's one, Commissioner Bevan, where we don't know whether

Rhode Island -- I just don't know if those states that have a more expansive or a broader definition of mandatory reporting or just everybody's a reporter results in different outcomes, yeah.

COMMISSIONER STATUTO BEVAN: Thank you.

CHAIRMAN SANDERS: Thank you. I have a question, and it's I think following-up on what Commissioner Rubin asked about predictive analytics, and preemptive intervention versus reactive, just to use that as an example. So there's a report, there's an investigation, and there may be services delivered, and so at which point is it actually reactive?

So for the report, can you expand reporting based on the evidence that the risk is higher but it's not necessarily at the point that it becomes reactive? I'm just not clear.

KATHLEEN NOONAN: It's reactive as soon as it's based on a past event, right? If it's based -- either what you did to your child yesterday, or based on your status which is based on a past event, it's reactive. If it's preventive, it's taking a sort of population health perspective and saying for all moms who have low birth weight babies we're going to provide, you know, home visiting, right?

And that is not based on their history of abuse or any kind of status of theirs other than that you think that at the population level these babies and moms need that, so that's what I mean. And that would be preemptive because there would have been no -- there's no history of abuse and no reports of abuse.

CHAIRMAN SANDERS: And so your earlier recommendation -- and so maybe you can explain a little further, the preemptive intervention should -- I heard you say -- always happen outside of the child welfare system or child protection system?

KATHLEEN NOONAN: I think given how the child welfare system operates currently that it would probably be more beneficial for the preemptive intervention to happen outside.

CHAIRMAN SANDERS: So you weren't necessarily making the recommendation from a legal and rights perspective, or were you?

KATHLEEN NOONAN: I was making it from an ease of governance perspective.

CHAIRMAN SANDERS: Thanks. Commissioner Covington, then Commissioner Rubin.

COMMISSIONER COVINGTON: So differential response though, isn't some of that sort of preemptive, or do you see that as being completely reactive?

KATHLEEN NOONAN: No, because it's all based on reports of abuse. Once you're reporting abuse you're talking about a retrospective analysis. You're really talking about sort of preemptive perspective services, and I think that has to happen from a health population perspective. I just think it does, and I think the more universal you can make it, the better.

COMMISSIONER COVINGTON: I agree with you.

KATHLEEN NOONAN: But, I mean, the better actually than legal, by the way. The better legally then you're on much better ground if you're not intervening because of a particular parent's history, but because it's just you've made a case like compulsory education or pre-k for all that it's just what government wants to do.

COMMISSIONER RUBIN: Yeah, I was going to make -- I'm just wondering about the other distinction, because if it goes into preemptive and the public health approach, I think what's potentially a game changer to me, and you can agree or disagree, is voluntary versus required, because you're still segmenting on poverty and requiring a whole population of poor families to let's say have home visiting, if you believe in universal home visiting.

In many ways it's, you know, the number of false positives in there is going to be even greater because you're not dealing with the highest risk of the population. So is universal, unless it's really the whole population, really an infringement then on family rights?

KATHLEEN NOONAN: I mean, I don't -- I guess someone could see it that way. I mean, I think the more we can make things like pre-k or, I mean, just –

COMMISSIONER RUBIN: As long as it's voluntary?

KATHLEEN NOONAN: Yeah, as long as it's voluntary. Yeah.

CHAIRMAN SANDERS: Commissioner Dreyfus.

COMMISSIONER DREYFUS: One follow-up. I want to go back and think about the cases where the decision is made to return a child back to their family, right, and -- because it's viewed the parent is ready for the child to come back into the family.

And then oftentimes you will hear -- again, I'm just talking from a former child welfare director looking at these cases, listening to some of the former foster youth in the system who would talk about so you're returning us back home, our parents aren't ready for us to come back home, and then you wonder why bad things are happening, what about my rights? What about me as an individual, and how you're thinking about my rights?

You're looking at somebody that really wants to figure out how to keep kids with their families when that's in their best interest to do so, but I guess that's the issue, it's in their best interest to do so. So in this whole conversation here today, as you think about those really tough decisions, we as systems have to make the return of a child back to their home and what goes into that decision about the parent, but as well as the child.

KATHLEEN NOONAN: Yeah. Well, I think that -- I mean, on the best interest side I don't think that we do enough for kids say 11, 12, and older in terms of hearing what they have to say because you can hear a child that age say, you know, my mom drinks but that's -- I'm good with it.

Like it's okay, I'm not hurt, you know, versus a child saying my mom drinks, I don't want to go in. I mean, best interest analysis should actually take that into consideration. So the best interest analysis isn't just what the court thinks, or what the agency thinks, but it's also what the child brings to the analysis.

So that's one thing, at least, about that older child, but I think if you were going to -- let's say you go back to the example of home visiting for all low birth weight babies. You might make the case from a best interest perspective that based on what we know about these kids it's really important to do home visiting for them, and you'd focus on what's best for the kids as opposed to focusing on what you think might be wrong with the parenting.

And it changes the analysis a little bit too, to do it that way, and so I think that it may be on the child welfare side if some of this preemptive -- if we put more preemptive interventions into place, I think we have to think less about what's wrong with the parent and more about why we need to do this for the kids and sort of have that evidence.

COMMISSIONER DREYFUS: That's a great answer. Thank you.

CHAIRMAN SANDERS: Thank you. That was different content than anything we've had at this point. It was really very informative, thank you, and we are going to take a short enough break to put this table into a square so that as we go into the subcommittees we're not all sitting in a line.

Bud Cramer is on the phone, and so I think Bud and Jennifer are going to lead the next part of the conversation, so we'll want to make sure we can start right away because I think his time is limited.

(Break.)

CHAIRMAN RODRIGUEZ: So I'm leading the presentation on the children that are known to the system on some recommendations we have, and just to start off with, our recommendations today are going to focus really exclusively on one area that our subcommittee is charged in looking at, and that is at the safety assessment.

And so just know, before we kick off our presentation, that our subcommittee will be making other recommendations on, I think perhaps our subcommittee has the most areas that we're tasked at looking at, and so we know we have our work cut out for us. We'll be making recommendations around workload, around confidentiality issues, around agency practices, around resources, accountability, but we chose to start with safety assessments.

Because while it sounds like they're sort of a small and technical piece it's a really critical and central piece to the role of the child protective agency. It's one of the first decision points, and as we will talk about in a little bit it's one of -- it's a decision point where we are largely working off not evidence and a certain way of looking at the case that may not be helpful to be sure making children stay safe.

So we're actually going to start off our presentation with Tom presenting a case study that was recently in the news in Florida, the Phoebe Jonchuck case, and while I know all of us have learned and know about many, many children, we thought that it would be important to start off with this case because it's so recent, and because I think that this particular case highlights in really an important way a number of issues around the safety assessment concern.

So as you listen to Tom's description, some of the areas that I just wanted to flag, so that you know what you're listening for, is some of the failures in looking at safety assessments, sort of using an incident or point in time approach versus looking at what risk down the line, what impending threats there might be to a child's safety.

I think it's also important to note the challenges in this case of sharing information between systems. This was a family that we -- like the families that we talked about at previous meetings, where this family was actually known to many systems and had a lot of contact, actually generations worth of contact with systems.

It was likely a family where folks had that bad feeling that we talked about before, that something bad might happen but didn't have a specific sort of incident to work off of. It's also a good illustration of sort of the challenges looking at safety and risk assessment through present and impending an emerging or perspective lens.

So I'm going to turn it over to Tom to walk us through the case, and then we'll get back to -- we can have a discussion about it, and then we'll get back to our subcommittee's actual recommendations.

TOM MORTON: Thank you, Commissioners, and -- excuse me. Good afternoon, Commissioners. I want to start by saying that our objective in looking at this case in no way is intended to be a retrospective analysis or criticism of the action or decisions of professionals in Florida, but rather that this case raises I think a number of issues around the concept of threat of harm, and where the threshold for threat of harm is established in creating a basis for intervention by Child Protective Services.

For those of you looking through your notebooks, I know you were up late cramming for the test last night, and may or may not remember everything you read, but there is a handout called Phoebe Jonchuck Case Overview, if you've located it. For later reference, there's a document called Safety Assessment Practice and Child Protective Service Recommendation for Discussion and Possible Action.

Two other documents I would point to is an example of the structured decision-making [SDM] safety assessment instrument from Indiana, and just after that there are two instruments from West Virginia that reflect the action for child protection model of safety assessment. So, you know, at some point, not necessarily right now, you might want to look at this case, and what we knew in the context of those two safety assessments and if they had applied, what decision might have resulted.

Secondly, I guess I would say this summary is not a complete overview of everything that was known. It was taken from a couple of articles published in the press in Florida; and secondly, from the Critical Incident Review Teams reported by the Florida Department of Children and Families [DCF]. And so it's not intended to be like a full child death review or case review, but rather just to highlight these critical issues.

For the benefit of the people in the room who don't have access to this particular piece of paper, I want to provide just a brief overview of what happened in this particular case, and this comes from the report itself, review teams report. Early on the morning of January 8, 2015, five-year-old Phoebe Jonchuck was dropped by her father, John Nicholas Jonchuck, Jr., over the edge of the Sunshine Way Bridge in Tampa. She fell approximately 60 feet and drowned in the water below.

In the days preceding her death there were two calls screened out by the Florida abuse hotline in which concerns had been raised about Mr. Jonchuck, Jr. The first was on December 29, 2014, and this caller's concerns were raised about past physical violence, and the second call that was received less than 12 hours before Phoebe's death, concerns were raised about Mr. Jonchuck's behavior earlier that day.

In Hillsboro County, Child Protective Service Investigations are conducted by the Hillsboro County Sheriff Child Protection Investigation Division. At the time of the incidents, the Sheriff's office had an open child welfare investigation regarding Phoebe's mother, Michelle Kerr. The allegations of that investigation included family violence, inadequate supervision, and substance abuse.

The Jonchuck family had a history of generational reports beginning when Mr. Jonchuck, Jr. was a child. The Jonchuck's, rather, struggled with Mr. Jonchuck's mental health issues, self-injurious behaviors and delinquency during his teen years. During his adult life, he was involved in three separate calls to the Florida abuse hotline.

If you look a little further down you'll see a summary of this criminal history. There were at least I believe six, if not more, arrests for battery and domestic violence. The report actually contains no information about prosecution or conviction for any of these prior arrests. There are other things alluded to here. An interesting note I suppose here is that Mr. Jonchuck also sought restraining orders against Ms. Kerr and was denied both, but there was reference in some other materials that I read about battering by -- looking for the word -- but essentially his act of seeking domestic violence orders against her was an act of battering in an effort to gain custody of the child.

To move on, minimally there might have been five prevention pathways that one could look at. One of which is the Department of Children's family involvement with him as a child and his mental health issues and the extent to which those mental health issues were appropriately addressed, and if they had been appropriately addressed would this day have never occurred as it happened later.

The Florida Children's Mental Health Services -- I said that -- is involved as child and as an adult. Repeat arrests by law enforcement for battery and domestic violence, if those had

been prosecuted or acted on differently would the outcome have been different? Would that have influenced the court's decision about his custodial and parental access to Phoebe? Family court apparently granted Mr. Jonchuck custody of Phoebe at one point, or at least joint custody. And then law enforcement interpretation of the Baker Act as it applied in Florida.

If you look down under the section called "Implications," law enforcement determined that Mr. Jonchuck, Jr., did not meet the criteria for involuntary evaluation in Florida. Essentially, not stated here, but the conclusion was based on their statement that he did not state that he intended to harm himself or anyone else and therefore did not meet the criteria in the Baker Act. Whether that's true or not I don't know, but I add that as a piece of information. The hotline worker on the day of Phoebe's death stated that she also identified the potential maltreatment as inadequate supervision and the criteria for accepting the call was not met. I think one of the things that this reflects was the orientation of CPS at the hotline to the need for a present allegation; either abuse has occurred or is occurring now, or neglect has occurred in the immediate past or is occurring right now.

The dilemma in this regard was that Phoebe was not at that point in the present physical care of Mr. Jonchuck, Jr., so this was his attorney calling, saying he's acting very erratically and I'm very concerned about his behavior and what could happen. So in a technical sense she could find no allegation upon which to accept the report and initiate a CPS investigation. The hotline worker indicated she had understood the caller was concerned about his state of mind, but also noted the caller was unable to describe concerns that the child might be harmed.

And another point being the fact that Phoebe was reported to be with her step-grandmother and not with Mr. Jonchuck, Jr., at that time of the call which led her to conclude that the child was not in immediate danger. Approximately 12 hours later Mr. Jonchuck was in physical possession of his child, drove to the bridge and threw her off the bridge to her death. So I toss this out and open it up for a discussion.

And I think the question I would put to you, as I said, is not so much who did what wrong, who should have done something differently, per se, but what are the implications of this case where the deliberations of the commission, in terms of what you need to be thinking about in looking at as you consider the concept of threat of harm, and where that threshold is established in moving forward in the ability to intervene in families. I had a discussion with Kathleen Noonan that -- going back to your comment, Dr. Rubin, about preemptive, it's not preemptive in the sense that there is history here, but one could argue that if someone had acted preemptively at the time of that report, even though there was no harm or endangerment at that point in time the outcome would have been different.

I think this -- in my experience as a child welfare director in working in the field, is the characteristic of a lot of cases. And as Kathleen Noonan implied, people in the field struggle mightily with threat of harm, and clearly, neglect is a type of threat of harm. Eighty-two percent of children who are neglected are not harmed by that neglect. On the other hand, in a circumstance that presents danger, because the dangerous elements of that environment

exceeds the child's capacity to avoid personal injury or harm.

But this moves it back a little further into a realm of where we have a caregiver who prospectively might harm a child, though there is no indication of an immediate threat or statement of intent to do so. And how should the system be capable of dealing with such kinds of cases? So I end with that.

COMMISSIONER DREYFUS: Just a quick clarifying question. Back to the in-take worker and her feeling is that she didn't have the ability to -- what is the term you used? How did she state that she didn't have the ability to screen it in?

TOM MORTON: She tried to find an allegation that fit the current circumstance, and the best she could come up with was inadequate supervision.

COMMISSIONER DREYFUS: No, no, the point I'm trying to clarify is, is there anything that's written in state standards in Florida that would have validated her reason to make the screen out decision -- that's what it was. You said she wasn't in the custody of him at the time, therefore, she couldn't use that.
TOM MORTON: What I can say as a follow-up, that as a result of the Florida investigation they changed their policy.
COMMISSIONER DREYFUS: So it was policy; she was acting according to policy.

TOM MORTON: I think the worker on the report a week earlier was suspended eventually for three days because of failure to verify the address and do certain things to follow-up and she closed out the case when she shouldn't have. But this particular worker made decisions based on existing policy.

I think that was sort of upheld by the report, as I read it, but they have since changed their policy to basically allow for these circumstances to be considered as threat of harm and neglect, which was not the case before. So you could say it was in policy, or it wasn't policy, but it was not clear. Pick one of those two options.

CHAIRMAN SANDERS: Commissioner Rubin.

COMMISSIONER RUBIN: Yeah. I think this comes closer -- I mean, I feel like maybe it's just the media is reporting everything, but there is a subset of cases that we have barely scratched the surface on, and those are the murder suicides, those are the really impulsive acts where that's kind of similar to this story in the sense that there isn't a sort of history of harm to the child, there may have been domestic violence in the family that was unrecognized.

Usually there's some level of separation or something else going on, but there's imminent threat to the child. And I don't know -- like, I think as a commission, because we're hearing about these like almost on a daily basis another murder suicide, you know, in the press, and who can help us think about what is the strategy for those cases when a neighbor or an attorney or a family member, some of this resides in our thinking about domestic violence and restraining orders in law enforcement, but it doesn't neatly fit into child abuse reporting

laws.

And I don't know how we're going to investigate that as a commission, but I would think nowadays with what we're hearing, and the number of deaths we're hearing, in that situation we should think about where our strategy is going to be there.

CHAIRMAN SANDERS: So you're -- you're thinking there's a category and one of the elements of domestic violence and understanding more than just the kind of narrower reporting child protection.

COMMISSIONER RUBIN: Yeah, it's an impulsive type of domestic violence that leads to the murder of children. I mean, but there may have been violence between the husband and the wife, or the partners, but there's not clearly a history of violence against the children, right? So it doesn't neatly fit into child abuse law. And I don't know in how many of those cases was there a community member or family member who were worried about the threat to the child even though there was no history of harm from that like it's how -- what should we be doing in those cases?

COMMISSIONER RODRIGUEZ: In this case, and maybe I'm particularly sensitive to it just because I was removed from a mom who was paranoid schizophrenic, there wasn't just violence. I mean, there was mental illness, which I think the mental illness combined with other factors leads us to that other discussion about not just imminent, but the emerging sort of assessment of harm.

Because I think looking at it from that sort of perspective you see caregivers who really are impaired in their ability and where exactly what you're describing, that impulsivity that you're equipped to care possibly at this moment, but if you go off your meds tomorrow you're in a completely different state, that that seems to me like that's not necessarily something that we can't predict.

COMMISSIONER ZIMMERMAN: That's the point I wanted to make. I think that there are -- it can seem as if it's an impulsive act, but really there are risk factors that can be identified early on around suicidality, and probably because that's -- I know that that's some of the work that I do. I'm not real sure about domestic violence, but I'm sure there are key factors that can be evaluated as putting that individual or that family at risk for something like this.

CHAIRMAN SANDERS: Go ahead, Michael. We can hear you, at least that statement.

COMMISSIONER PETIT: Jennifer, I guess --

CHAIRMAN SANDERS: I'm being accused of jinxing you. (Indiscernible.)

CHAIRMAN SANDERS: We can't hear it. Tom, your question, and I guess where it seems there's at least a couple of areas we need to think about, one is the -- I'm guessing it's not an independent policy that the agency did, that policy was based on legislation in that the question about does there need to be an incident is beyond, I think, the child protection agency. And it seems to get into some of the things Kathleen was talking about, about the

rights of parents and so forth and how do you balance that.

I think that's an issue that we haven't looked at as much, and I think we've heard testimony to suggest that there's probably -- that the incident-based finding and intervention may not be the most accurate way to predict, and I think what Commissioner Zimmerman was just saying would be a much more accurate way, but I'm not convinced we have a model, the second piece of that, a 22-year-old child protection worker going out and being able to apply that expertise to actually predict.

And so I think both the issue of the balancing of rights, as well as the capacity of the system to do some of those predictions, I think is -- I think are both questions for us. There are people who have that expertise.

COMMISSIONER COVINGTON: They call it in the report comprehensive family functioning. You know, how do you expect a 22-year-old caseworker to understand that?

COMMISSIONER DREYFUS: I think it goes even deeper than that, though, because I think -- I can't remember who was it -- oh, Joo. I don't know if she is still here, and she was saying, kind of questioning our continued reliance on a single person, right, to screen a call, or a single person to go out and knock on someone's door and be able to assess the entire situation and make that decision.

And we know we've got a supervisory model in child welfare, and I think we've never been satisfied with it in terms of really developing supporting, guiding, decision making on cases, so it just goes back to something that I tried to say earlier on in our work. I think we've got a 20th century CPS system in a 21st century world and we keep trying to figure out why it doesn't work, and it's because it's not going to work today. We need to come up with a different model for child protection.

BUD CRAMER: This is Bud, and I know you can't hear me, but amen, I agree with you. That's all it took.

CHAIRMAN SANDERS: And I know, Jennifer, you started out by saying safety assessment was kind of one piece, but I think this seems to hit some of the other elements that are going to be important. It's not just a safety assessment, it's who does it, what's the structure, what are the supports offered. It's a variety of things that seem to be a part of that.

COMMISSIONER RUBIN: I just simply want to know what's the epidemiology of these murder suicides? We talk about touched by the system. I'm talking about touched by -- were there folks who tried? Like, you know, I think we need to understand that given -- is that increasing in this country, or is it just simply because we're reporting more of them, right? But I think we have to understand the epidemiology of these kinds of murder suicides and whether they were reported to --

COMMISSIONER COVINGTON: Except this wasn't murder suicide. This was --

COMMISSIONER RUBIN: Yes, but the difference here -- the similarity being that you had a situation where someone who historically had not been an immediate threat to the child but was now an imminent threat and they had no data --

COMMISSIONER COVINGTON: They don't know that for sure.

COMMISSIONER RUBIN: We don't know for sure, but there was similarities of whether there was suicide involved, but a similar context there of impulsive actions usually come out in context of family functions.

COMMISSIONER COVINGTON: The FBI has done analysis or murder suicides. I don't know if they're increasing. We sure hear more about them, but there are --

COMMISSIONER RUBIN: We should hear more about them, because the number of kids that are --

COMMISSIONER COVINGTON: And domestic violence tends to really be underlying. It may not be reported, but when you go back and do family histories on it, they tend to see a lot of power issues, power and control issues in those families.

CHAIRMAN SANDERS: Commissioner Petit, can you hear?

COMMISSIONER PETIT: Did I hear you mention my name?

TOM MORTON: All right.

COMMISSIONER PETIT: Is there -- can you hear me all right now? Okay. Just two observations. One is, and this relates in part to what was raised earlier by Ms. Noonan, but it also spills into this. I don't know how much you've spoken, because I'm having a hard time hearing this, but the parental role is clearly not an ownership role.

It's a stewardship role, and I think the state exercises its discretion broadly, and has permission to exercise this broadly, and it's a public safety issue on this thing. But in the case of which we're hearing about now, this Miami case and the throwing the child over the bridge, personally, I don't feel like this is an area of gray, I think it's very black and white; that when a kid is in that kind of environment somebody needs to be doing face-to-face contacts on a regular basis. And I think it's more an issue of resources than it was a question of what did the child present.

I mean, they must have done something with the father in terms of mental illness, the meds he was taking, his history of violence. I mean, if that isn't a kid who doesn't fair watching on a regular basis, I don't know what kind of kid was on this thing. Do we know, Tom, when the last time the child had been seen directly face-to-face with the adults in his life or in her life?

TOM MORTON: I didn't see anything in the report that indicated the point of last contact between DCF. It was an investigation opened against the mother, but not against the father

at that point in time.

COMMISSIONER PETIT: Right, but in my mind what we're looking at is when you have scarce resources, trying to cut the line very fine, we're not that knowledgeable in terms of being able to say the ones that are really at truest risk or not, and so this one doesn't sound as riskful as some others, so I guess we won't send somebody else. If they had somebody waiting in the wings, they would have sent them out in hearing what the father's behavior looked like, and the fact no one had contact to see how the child was --

TOM MORTON: I would add, Michael, Commissioner Petit, as we move into the report, the report has some discussions about impending versus present danger. The new safety model in Florida incorporates both concepts, and in a present danger model, it's likely someone would have gone out and said the child is not in danger right now because there's nothing happening right now; whereas, the child, because of all the things that all of you have cited, is impending danger, and impending danger has to be treated like present danger because of the unpredictability of when the dynamic will manifest itself in terms of harm to the child.

COMMISSIONER PETIT: I know standard is we err on behalf of the child, so we're not sure the action we take could err on the child's behalf, even if it means coming in contact with the parent's rights, otherwise the child gets killed.

COMMISSIONER COVINGTON: When you say there wasn't clear and present danger, so to speak, wasn't there just a therapist --

COMMISSIONER PETIT: I'm sorry, I can't hear.

COMMISSIONER COVINGTON: Wasn't there a call, someone trying to put a 911 call in? Wasn't there a call that very same day from the therapist, that very same day? They don't mention it in this report, but I recall hearing about that a mental health counselor had called in and said I've got real concerns with this father. I'm really worried for the child.

TOM MORTON: There was a call from the father's attorney, which is interesting to get a call from an attorney. But she basically said I'm very concerned about his behavior, he's running around town in his pajamas, he's acting erratically, and there was a little bit more detail than that, but that's the call that the worker screened out, because -- in the worker's statement during the report she said I couldn't really identify anything specifically from the attorney that constituted a threat by him to harm the child.

COMMISSIONER RODRIGUEZ: Back to the discussion before with Kathleen. I mean, one of the things that I think about is that the focus on the adult in the situation versus the child in the situation, because when I think about sort of my family's own contact with CPS, I think that at three and four I actually wasn't able to articulate how scared I was in my home, and so I was sometimes removed, sometimes not removed, always returned.

However, when I was 12 I could clearly articulate how terrified I was in my home and at that point, the system listened. And so it just seems to me that we have to actually have a way for the young children who are most likely to be killed, but who aren't able to articulate it, of

being able to pick up on that danger. Because it's just -- it seems extremely unfair for kids who are most vulnerable, who cannot articulate on their own how challenging they feel their home environment is that we should know enough. And if we don't know enough, then we have to learn enough to be able to in terms of not speaking.

COMMISSIONER PETIT: I'm sure the training manual does not say if a client's attorney comes to your attention to consider that a very high visibility warning sign. I'm sure that specific example is not in the policy, but I would think that most people knowing that lawyers are supposed to be representing the best interest of their client, if somebody breaks confidentiality as the attorney with their client, and assuming I'm a known crackpot to begin with, I'm talking about the attorney, the attorney coming in saying I'm really worried about this client, this child, I would say that's certainly a five-alarm fire. How many times does that happen, that an attorney calls and reports on their client? I mean, it's not a common thing.

COMMISSIONER RODRIGUEZ: They're meeting at the collaboration at that point.

COMMISSIONER RUBIN: I think there's a commonality in that I totally agree with what Commissioner Petit just said. It makes sense in that situation, but the reporting hotline wasn't set up in some ways to handle this is a very unique kind of case. And so I think the real question is -- I mean, part of the testimony you have, I mean, because these calls probably, more or likely, come into law enforcement, I would think, right, than they do to CPS.

So I would want to know from law enforcement community how do they handle phone calls of imminent threat? This gets back to what Commissioner Petit talked about when other members of the community are saying something bad is going to happen here and have we really gotten our hands around a strategy where everyone -- or there are people in another area who are saying something bad is going to happen here and how the community says, okay, red flag alert. Something needs to be done imminently, and how we need to make sure we provide safety mechanisms or can't, because they're not just preventable.

BUD CRAMER: This is Bud, and I hope I can be heard again. But, to me, this type of situation speaks to the whole safety assessment issue. You've got law enforcement, you've got CPS, hotline workers, mental health therapists, you've got a history here with facts in the history, you've got a child that probably shouldn't be with father, who was thought to be with a grandparent or something. This child -- if a team was reviewing this child's situation, it just seems to me that this child was not being protected, was very vulnerable, and there should have been some intervention.

TOM MORTON: I would add to Commissioner Cramer's comments, this also speaks to somewhat the tunnel vision with which different systems look at it. Law enforcement did go out earlier. Their focus was on whether or not the father could be involuntarily evaluated and they decide he couldn't.

Their focus did not appear, and I don't have information to support what I'm about to say, but it did not appear that the law enforcement focus was on was he a potential danger to his child. Although, again, their statements were he made no threats, verbal threats to harm himself or the child, so therefore their work was done when they concluded that the Baker

Act didn't apply to him.

COMMISSIONER COVINGTON: Can I ask a question? Or at least it's an issue, and I don't know the answer at all, it's an observation, is that in many counties in Florida, child protection is done out of law enforcement. This was in the Sheriff's Department, and I wonder what implications that has for how these cases are looked at in terms of a comprehensive family view versus an incident-only piece using law enforcement rather than social workers, so to speak. They may have social workers on staff, I don't know that they don't. I think it definitely has a law enforcement feel in many of the counties in Florida that are doing CPS.

COMMISSIONER RUBIN: The other way you can look at it is, too, there's nature of we've defined who a mandatory reporter is for a child, right, but when a treating psychiatrist or mental health professional, right, for an adult has concerns about risk to someone else, or to a child within that individual patient's purview, or if they have -- or if in this case an attorney -- there are certain professionals who are working with the adult clients, right, for which there should be clarification around the reporting mechanisms of imminent harm.

TOM MORTON: And there are some systems where all calls for mandatory reporters receive a CPS response, so that's not uniform.

COMMISSIONER PETIT: It's hard for me to hear what people are saying, so I don't mean to be repeating or being redundant on it, but I would say the knowledge that we have about human behavior is such that there isn't a professional out there that can absolutely predict how someone is going to behave 0 percent of the time, so since you can't create a demand response, call response, kind of a situation that takes into consideration every contingency, again, if we overshoot, and we overshoot on behalf of a child, who else has the ability to rectify that at some point?

I keep returning to five-alarm fire and a fire department going out on everything. They don't care what the substance is that's burning, whether the people are burning or not, they go out to check, and it's consequence of being wrong or serious, and that's the situation I think right now with child protection.

COMMISSIONER DREYFUS: I'm going to add something. One of the things I always found, because I -- when I think about Erinn earlier talking about how her folks who work for her are heroes, that just can't be stated strongly enough. But I will tell you one thing that always used to strike me when doing these case reviews is, with the best of intentions, how our staff had become somewhat immune from the realities of what we were facing.

It was like we had started to normalize, right, behavior that in any of our households we would say that's a five-alarm fire. One of the things we had to step back and remind ourselves, and I just say this to the commission, is that most children in this country are never reported to CPS, and then when a child is reported to CPS it is a sentinel event.

It is a big, darn deal for a child in this country to be called into Child Protective Services, and somehow those of us that work in the field, we have somehow become inoculated or something from our understanding that when someone calls on a child in this country that is a

sentinel event that deserves more than a single person taking a call, making a screening decision, right?

And this is where I just go back to again, if we think we're going through this whole notion of those kids known to the system, and we're going to assume that our recommendations are that we continue to have the same CPS system we have today, we're going to be the same commission 20 years ago from now looking back on our recommendations where a whole lot of them didn't move the needle on the issue either.

Because I just -- I think that when a child gets called in it is a big darn deal. And we have lost our sense of understanding that most children are never ever reported to CPS. And yet, we just take this screen in, screen out decision, single person making that decision, and you look at a case like this, and I appreciate someone who said, well, this is an unusual case, but I don't know how unusual it is.

I suppose what actually happened to the child is unusual, but the fact of mental illness, the fact of a child not able to protect themselves, and I don't think that's all so unusual in what comes through our phone systems today.

COMMISSIONER RODRIGUEZ: I guess I would add to what Susan said, is that I think -- let me try to figure out how to say this nicely. That I think that it is an unusual event, and for some children in some communities it's more usual than for other children in other communities, but it gives us even more reason why there has to be an assessment and a worker administering the assessment who is competent, and who has experience, and who knows what they're looking at, and an assessment that's grounded in evidence and knows how to assess not just the imminent harm, but also harm that may come in the future.

Because they really have to be able to use an individualized sort of approach to looking at the case, but then also take what we know already, what's been established in evidence to make a decision. I think it's very complicated in expecting people who are not trained and not well supervised, and who don't actually have -- we'll talk in a second about safety assessment tools, but know that it's grounded in service of folks in the field.

It's not -- it is sort of the tools that we use to make this critical, but where it came from initially was not from body of rigorous evidence, but we've used it for decades and it's grounded in surveys about what folks thought were some of the predictive elements.

CHAIRMAN SANDERS: Can I just maybe add to that? And both a comment and a question, because I might be more convinced of the efficacy of going out on more calls if we have some evidence that we know what to do once that happens. And we've had testimony in now, six sites, where we've heard very little evidence that more or less seeing makes a difference. I think we have to start thinking of something different versus more or less, at least that's what I've concluded to this point. I also think as a committee commission this forces us potentially to think about what the role of the federal government is.

Because while we have the leeway obviously to look at local and state policy, I mean, I'm unclear whether federal policy derives any of what we've talked about at this point. I just

don't know. Maybe it does, maybe it doesn't, but it seems at the state and local level there's much more to look at, and I think where you were at David, Commissioner Rubin, in thinking about this from an epidemiological perspective kind of, because I'm not sure we know enough to intervene on an individual case situation in these situations. Maybe we do, maybe we don't.

COMMISSIONER RUBIN: Yeah, I'm sort of following it through in my mind because we thought of screen in, screen out. Let's say the worker took this phone call, made the right decision, and said, okay, we'll open the case and see you in a couple hours, that kid probably still would have died, right?

And the question is, is there another pathway which is, okay, I'm trying to figure out my safety assessment, whether I'm going to open a case and refer on to child welfare, but I'm calling the police right now to go do a well-being check on this child in the next hour or two, all right, and figure out whether there's imminent threat.

And I'm not familiar enough with the safety protocols on how that is done or standardized, because that would -- this case would have illustrated that.

COMMISSIONER COVINGTON: Well, my thing is we're talking safety assessment. But a safety assessment didn't come to play in this case because it didn't even make it that far, so it goes to that other situation. The other important situation we have to talk about is I can't tell you sitting on child death reviews how many times we get to a case where there had been multiple referrals that always, always get screened out.

None of them ever got screened in, so this family never quote, unquote, became known to the child welfare because the calls were screwed up and they end up dying. So I think taking a step back at safety assessment, to me, I know it's a resource issue, but why is it we have one person sitting at a desk or at a phone bank making these decisions? It always blows my mind why it's not -- you don't have a cop going out on this, it would be two cops. You don't have a cop going out to domestic violence calls, you'd have two. Maybe, you know, they think a lot alike, but maybe they don't. I just never understood why this stuff isn't being thought about in more of a team approach.

COMMISSIONER RUBIN: I think that's where we're going, because they say why can't the police stop? The police stopping over or law enforcement coming by to help determine whether to case the screen or not.

COMMISSIONER RODRIGUEZ: This is exactly where we're going with our recommendations related to that, and I don't think we want to spend a lot of time on the particulars of this case, what they did and didn't do, but we use it as sort of highlighting the challenges the family was having in thinking about imminent risk versus future risk to the child, as well as the need for multidisciplinary approach. If it's okay with everybody, I think we'll walk into the recommendations of our subcommittee.

COMMISSIONER DREYFUS: Clarify where you are?

COMMISSIONER RODRIGUEZ: We're second -- third. Third blue tab, "Safety and Child Protection Services, Recommendation for Discussion and Possible Action."

CHAIRMAN SANDERS: Let me make one point. Commissioner Cramer, are you trying to get in to say something? So we had looked at last time, and would like to approach the same this time with the recommendations, the sense of we can live with them, we're completely opposed, do we need more information?

Just so the subcommittee has a sense of are they on track or not. I think that would be valuable. We aren't committing to anything at this point, but at least being able to provide feedback about the direction.

COMMISSIONER RODRIGUEZ: Yeah, just want to do a quick time check. So I am going to move -- not start with page one here, because we've already discussed the background and the charge, and our guiding questions and the findings.

I will note that on page 4, though, there is -- Tom put together a really good definition of present danger versus impending danger, emerging danger and perspective safety that I think are worth reading and becoming familiar with sort of the differences in all of those.

And then on page 5, looking at the things that safety assessment practice requires, I'll quickly go through those. Those are a set of reasonably valid indicators of future severe harm. A set of clear decision rules for evaluating those indicators and for taking action; staff who are adequately trained and have necessary critical thinking skills; staff who have access to information critical to decisions that must be made; staff who have reasonable work demands that allow them the time needed to gather and evaluate information; access to expertise of other disciplines, such as law enforcement, mental health, substance abuse, domestic violence, health care, and legal consultation; and real-time feedback from effective quality assurance reports that permits adjustments necessary to prevent a disaster.

I think we actually just talked about most of those in the discussion we just had, and so let's see, before I move into the actual recommendations, just to point out some of the things -- some of the findings that we have summed up from the past presentations that we've had in other states, are that this is a really challenging job. It's a really key decision point, and that we are not currently doing it in multi -- we're not doing these assessments in a multidisciplinary way; that we don't really have any research or an evaluation of how effective these tools are, and we also don't have research looking at how these actually get used in a case, how they're implemented.

Sort of one thing to research of whether they work or not, and then another thing to look at how the tool is actually used. They were -- that we typically look at them at one point in time in the case, however, we need different tools that can be used at different points in the case so there's sort of one assessment that might get done in making decisions about whether to remove a child or not, but then you also need ways of continuing to reassess the safety of a child.

Because obviously this is a decision that's just as important when you're making a choice about whether a child should be reunified or not, and that we also have this present danger orientation that doesn't serve us very well in terms of looking at impending or emerging danger; that we have very limited training right now that's available to folks on how to use these; that there is a critical link between law enforcement and the folks that are doing the safety assessment that is missing.

And just want to highlight here this electronic suspected child abuse reporting system that was developed in Los Angeles that has real-time cross reporting between law enforcement and CPS. We don't know how often quality assurance is used to look at how the safety assessments are conducted, we don't know whether the plans for keeping a child safe in the home, we don't know whether those work or not. We have a lack of research and evidence about that, and I'll sort of skip through the rest of these because I think we're going to talk about them in the recommendations.

So now I'm on page 8, at A. And so you see the first category we have here, that's the smaller of the two, are recommendations for federal policy and research. And so these are really recommendations that are designed to get at the fact that we need more research, and we need to have a better area -- more practice developments that are out there.

So we are asking from the feds to develop metrics to measure and record the severity of child maltreatment, including a scaling threat of harm where no actual harm occurred, but serious harm was a highly likely outcome. That's the first one. The second one here under A is conducting research on the association of both dynamic and non-dynamic variables with serious harm, threat of serious harm and death, to permit more accurate identification of unsafe children.

The third being conducting research on the efficacy of current safety assessment protocols, including, but not limited to classification, validity, inter-reliability and fidelity of use and decision making, and then lastly, conducting research and supporting development of more effective safety assessment protocols and procedures throughout the life of the case.

These are recommendations that basically say if this is really as important as we think it is in terms of making a decision, and the safety assessment being sort of the key decision point after that first one about whether to screen in a call or screen out the call, about whether to leave a child in home, leave them in home with a safety plan, remove them, bring in other services, then we really have to know more about whether these work, how they work, how they should be administered, how they fit into a larger practice model, and so we'd like to see this be an area that gets prioritized at the federal level. So I'll stop there and to see if -- what comments people have.

COMMISSIONER RUBIN: It makes a lot of intuitive sense. As a read through the recommendations looking for more teeth, you know, I think we can intuitively agree with the need for research, but who?

Are you asking the Children's Bureau to support a number of demonstration projects? I'd like to see -- for us to have some impact, we're going to have to have some actionable things. So

some of that might reside on the Children's Bureau, some might involve the trauma related branch, or the violence prevention branch at CDC, or the trauma related group over at NIH [National Institute of Health], and try and differentiate and unpack what lies where would be great.

We'll talk more about the public health subcommittees and our ideas. Some of it may be if we're going to ask states to submit plans, that one of the essential elements -- plans around sort of prevention of child abuse and neglect fatalities under some rubric, that one of the essential elements is going to be trying to not define how they're going to measure safety, but they have to submit a safety plan, and it has to include certain elements we found from our deliberations were important.

COMMISSIONER RODRIGUEZ: I want to say, I should have said at the beginning, totally agree. I think if we're actually going to make any of these recommendations that they will have to be more detailed and flushed out, but this first round is meant to be more a vetting process to let you all know this is where we're thinking at this point.

Is it something folks are in agreement with? Are there pieces that we're missing? Are there different approaches that we should be taking? And then ideas as we move forward, and add more detail to these recommendations, things we should be thinking of.

COMMISSIONER COVINGTON: Can I ask, this first set of recommendations are just around safety, you guys aren't done with your work, correct?

COMMISSIONER RODRIGUEZ: Oh, no.

COMMISSIONER COVINGTON: Because there's a whole other world out there in terms of how you respond.

COMMISSIONER RODRIGUEZ: This is a very small piece of it. We sort of -- I think we're not approaching it at sort of this point in time because we skipped over the screen in, screen out piece of it, but this seemed like a very tangible concrete thing to start with, given that we've heard so much testimony already about the safety assessment and its use.

COMMISSIONER COVINGTON: My comment is -- I guess, Michael, can you hear us? Because this is really a comment that I thought would come from you, is if we focus so much on state and local policy we're still left with geography really mattering. Because what happens to a kid in Oregon is very different than a kid in North Carolina, South Carolina, so I'd like to think what can be done at a federal level to force the utilization of appropriate tools? I mean, that's sort of how I feel, because right now this just leaves it up to geography for these kids.

COMMISSIONER RUBIN: But at the same time, I would also caution that like, for example, some of the recommendations about exactly what CPS agencies should be doing can be so prescriptive as to create a whole other level of bureaucracy that it really interferes with someone laying eyes on the child, you know, because there's so many rules we're instilling. So we have to balance the need for some level of standardized expectations with not overreaching for stuff that may have come from someone really smart, right, but maybe we

don't have enough evidence to say everyone should be doing it in every local city, right?

COMMISSIONER RODRIGUEZ: I think that's why we'd like some of this to be founded and researched, and researched to be evaluating efficacy in different settings. And so looking at small rural areas versus large urban areas, and that right now we don't have any of that.

COMMISSIONER DREYFUS: So David, so what -- to finish what you said, do you think there's something instead of the federal government mandating what tools you're using, right, as you were talking about challenging us and getting too prescriptive, is there anything that we would recommend that the federal government is doing to report on the -- in this area of CPS to do more reporting on state performance? Because really there's very little to no reporting at the federal level on the performance of child protection.

COMMISSIONER RUBIN: I think it's about incentive and accountability, right? So I actually -- what I've been impressed upon as we've gone around is that if you incentivize states to develop their plans with some common ingredients, and give them flexibility to design locally generated solutions, and then have some level of accountability for which they can be rewarded if they're succeeding, then you get really innovative plans. And that's particularly important at a time where we're not sure exactly what's going to work, right? And so you're looking for that innovation.

COMMISSIONER PETIT: Can you guys hear me?

COMMISSIONER RODRIGUEZ: Yes.

COMMISSIONER PETIT: Can I comment here? David Rubin, I understand -- I think I understand what you're saying, but let me say from my perspective, having dealt with the states on this for many, many years of all political persuasions, we are not close to being, in my opinion, in an overreach situation.

Right now we're in a very under-reach situation. We received a report recently that laid out in numbing detail with the U.S. Shame thing, you know, case by case, point by point, where the federal government is failing to enforce these regulations. And I would say in the end that what we have here is a lot of political dynamics to all of this, not just at the federal level, but at the state level as well, and that is something that we have to overcome.

Right now the Children's Bureau, as far as I'm concerned, is very lowly placed within the Department of Health and Human Services. This is not a priority issue for them at this point. It -- or our federal government -- so before we start, in my mind, to start worrying about are there excessive regulations and rules on these things, let's first agree these are American kids first, and whether they live in Texas or Maine, they're entitled to the same degree of protection.

COMMISSIONER STATUTO BEVAN: Look at what Tom put together on federal policy related to safety assessment, put that together with what the Commissioners -- Assistant Commissioner Chang talked about, you will find that there is considerable instructions to the states about safety assessments, and there is considerable money that is going -- given the

fact we have such a small child abuse amount of money in there, and we had $20 million just to look at an emphasis on improving caseworker decisions, I mean, do we want to change that?

Under title IV-B II, do we want to change some of the current laws in terms of the federal guidance under title IV-B I and title IV-B II in CAPTA? I mean, there is money, if you look at Tom's papers here, there is language and there's money from the federal level. But the federal government is not going to supplant this state loss. It is not going to do it. It views itself as constitutional, not possible, and it will not do it.

So the most that we can do is set up the requirements, fund it, and then hold them accountable. But at the moment, you know, I think it was recognized we have CAPTA requirements that -- we have a lot of requirements that are just being ignored, so unless we deal with those and the funding, I don't think we can get to where we want to get to.

CHAIRMAN SANDERS: If I could make a comment, and maybe it's building off of that, maybe it's a little different. But I think that there's something that Commissioner Rubin said about more teeth. I think when I look at the first set of recommendations my reaction is this is: Assuming that our basic model works and that we want to -- we're putting continued effort into building on that model.

And I was thinking about you looking at other industries, an airline industry in terms of improving safety has to look at buildings and redundancies. It seems to me that B III, recommendation about the multi-disciplinary reviews, teaming, things like that, are ways to say the approach of a siloed child protection worker going out and doing the very best safety assessment in the world is -- I'm just not sure we have evidence that that's where we should put all of our resources.

It seems that the CAC model, some of the things that hopefully we'll see when we go to Salt River, some of the things we've heard about the fact that families fall through the cracks, the fact that the system is structured on -- it's incident based, it's not based on threat of safety, it seems to me that we should be thinking about what this ultimately looks like in a way that then drives the recommendation versus building off of the current structure.

That's at least my reaction, and I think what I heard from Casey is that over and over we continue to add more requirements, and it has left us where we are right now, and that's in some ways, my reaction to what I see here.

COMMISSIONER RODRIGUEZ: I'll just speak for myself and say that makes a lot of sense to me, and I think I've been accepting this approach with the understanding that we are acknowledging that our existing CPS system, that it's flawed, and that the way we're currently doing business doesn't work and that we're going to get to that, but maybe it makes more sense to actually flip our approach and start with the what is that, and then figure out how this builds into the new model.

COMMISSIONER RUBIN: Remember, one of the things we're trying to achieve here that's different from a CPS geared approach is to move this a little bit upstream from CPS, because

part of the problems that I'm finding with CPS is that they're not getting that level of involvement from their other partners, right? That's your issue? That's your federal requirements, your issue, et cetera, and so when you hear us talk about public health subcommittee and what we're trying to route in is much more of a state response that cuts across agencies and then have that process articulate a safety plan.

Well, the safety plan obviously includes your Child Protective Service system, but it also includes law enforcement, includes folks in public health and how they relate to each other during these times of crisis. And so I think you can add some level of expectation or requirement to build that larger strategy and then let the states figure out how they're going to interpret that without adding sort of more requirements to the existing requirements that are already there for folks in CPS.

COMMISSIONER RODRIGUEZ: I think no matter what you still get back to this question though, because even if you move more of the services and sort of the plans upstream you still are going to have children that will get called into a CPS agency, and you still are going to need to have a multidisciplinary approach to it sort of happening. You'll need to have the same process parallel to be at a later point rather than earlier point.

So I still think it's worth -- I mean, I'm processing right now what that means for our two subcommittees working together, because it seems like we've been working independently, which if we are thinking about doing this differently it actually doesn't really make sense to do that.

COMMISSIONER RUBIN: It's not different. It's actually -- Let me be more concrete about -- let's say hypothetically, right, this is my opinion, right? Let's say hypothetically the states were required, and in relationship to whether it's to the Maternal Child Health (MCH) funding, or however we think to put some teeth into this recommendation, the states were required to submit a plan for, you know, reducing child abuse and neglect fatalities, or protecting their kids, and that we allow them to submit their plans to be some -- at some level, reviewed at the federal level, that we didn't over define the elements, but we said part of one of the sections of your plan has to include your response to safety, particularly within the CPS environment, but you're asking the plan be submitted at a higher level outside of CPS, so it's actually developed collectively.

It will still be in there, and you can define what elements would be important for them to include in that section of their state plan, and that gets to it's not -- it's about unifying all these subcommittees and rolling it up to a strategy that I think requires every state to take a higher level of participation across agencies in developing a collective response.

Because right now, when you look at let's say paternal child health plans, I think we were told no one submits a plan for child abuse and neglect fatalities. I would like to see a situation where everyone -- where we permit an environment where every state has to roll up a collective response and that would feed from the individual agencies involved.

COMMISSIONER DREYFUS: CPS would be a piece.

COMMISSIONER RUBIN: CPS would be a piece, and you guys would be informing the elements you think should be the start of that state plan they would address in their state plan.

COMMISSIONER RODRIGUEZ: I think Tom wants to make a comment.

TOM MORTON: My comment would be that CPS is unique in employing any kind of safety protocol, whether they're good or bad. The evidence I've been able to gather is that I haven't been able to find any law enforcement agency that uses a formal safety assessment protocol when they go out.

COMMISSIONER COVINGTON: Does that include the Florida CPS or just law enforcement?

TOM MORTON: Consider it -- I'm sorry.

COMMISSIONER COVINGTON: That's all right. Do you mean law enforcement that's outreach of CPS, or just law enforcement?

TOM MORTON: I'm talking about the beat cop, so to speak. In Florida you have CPS part of it, which is largely, but they're trained, as well as law enforcement, but you also have the criminal side. So I'm going to the criminal side in law enforcement. When an officer goes to make a welfare check on a child, there's no form of protocol.

The strongest protocol you have out of there are lethality assessment protocols [LAP] used in domestic violence, which some of the newer ones also include threats towards children. From a public health standpoint, I would guess if you say nurse visitation programs, the home visitation programs, the nurses use any kind of safety assessment protocol while they're making their visits to check on the safety of children, I'm not prepared to answer that, but I see people shaking their head no.

So if I extend that to mental health, you know, we tried in Vermont to bring people in to say, "How do you consider safety?" And we got, oh, we do it all the time. How do you do it? Well, we do it all the time. And so the strength of safety assessment across domains is kind of weak. The last comment I would just toss out is that the subcommittees have done a little bit of exploration around another arena of information, which has to do with proactive safety management as opposed to reactive safety management.

We had a conversation with Dr. David Woods at Ohio State University, and certain environments, you've mentioned some of them, aviation, as an example, I think the federal government requires that all airlines have a proactive safety management program, hospitals and medical institutions are required to have a proactive safety management program. The concept of a proactive safety management program plan is non-existent in public child welfare, and probably is something in a parallel sense that I would like to see the commission consider.

COMMISSIONER RUBIN: Yeah, I guess what I -- as we start to move towards deliberations around a report, like we can envision all these subcommittees producing recommendations, right, for CPS, here's some things we'd like you to do; public health, here's some things we'd

like you to do. And I think that would be a disservice, because we want to roll this up in a way, if we were to be successful, that we created this interagency capacity or responsibility at a state level --

COMMISSIONER COVINGTON: A system's approach.

COMMISSIONER RUBIN: A system's approach, that is required, and you can define what the elements would have to be in that safety plan that we talked about, you know, and if there's a lack of clarity about safety approach right now and how that's assessed, then in those situations you have to provide more flexibility to allow people to define their plans versus is something really strictly evidence-based that you're really going to be prescriptive about.

COMMISSIONER RODRIGUEZ: I agree with that. I mean, I think you just have to look at B I, where we're saying every single call on a child of five, somebody should go out on and do welfare. That assumes that we actually have a robust sort of public health, mental health, substance abuse, domestic violence system that's available to those families; that they're getting something other than just a social worker at their door who's going to fill out a tool and leave. I mean, I think this is assuming that we have an entirely different holistic system in place.

COMMISSIONER COVINGTON: You know, on that one, I don't know if anybody has followed up with Michigan, because they instituted that policy where after I think it was three referrals for kids under five they're required to take the case whether, you know, they think there's a valid reason or not they have to take it, and they were going to do an evaluation of that. I'd be curious to see -- Tom, you might be able to follow up on that. Steve Yager really talked about that one.

COMMISSIONER RUBIN: That's a good, concrete example. For example, you might say is that too prescriptive to say every child under five should be visited? I'm not generating a yes or no. Part of what you would think is, well, is there evidence to support that recommendation that it actually reduces at least child abuse neglect or imminent harm to a child? You don't want to take away Michigan's ability to say maybe it's three or more referrals under five, and so how much flexibility do you want to allow when there isn't a lot of -- you want to give states the flexibility to tailor it to what they want, but maybe the question is you want every state to tell you to actually submit where they think they draw that line, right? You know, are there certain subgroups of children they're going to mandate an immediate response?

COMMISSIONER COVINGTON: Is that already in their CAPTA plans or not? Is that defined in their state plans?

COMMISSIONER DREYFUS: I don't think so.

COMMISSIONER RUBIN: Well, I was just saying it was trying to say you can take something that's very prescriptive, which is every child under five must be visited, or you might say, look, what you're really asking the states to do is define their populations, and then you have heterogeneity.

You embrace that heterogeneity to evaluate which programs were successful; are we at a point where we're going to federally require something that prescriptive, or are we at a point where we're still looking for guidance on how the state views that particular required imminent responsibility?

COMMISSIONER RODRIGUEZ: It seems like, though, if you're going to allow that much discretion you tell us who you think needs -- is at most risk and priority; that there's some obligation on part of the federal government to say here's what research already can tell us about that.

Because I think that states are in various positions when it comes to -- and tribes as well, when it comes to sort of what their knowledge or exposure is to the existing body of research that's out there about risk factors and who actually ends up being killed. So, I mean, I think there's something in the middle that exists, and sort of because I -- maybe I'm being naive about it, but I feel like if states know that information right now that they would be already dealing with this. They would already be setting their own protocols that are formally asking them to do, that doesn't necessarily get you there unless you give them a little bit more support and information.

COMMISSIONER RUBIN: Well, so yes and no. Everyone is very busy, and so this case we just started this whole session out with, right? I think right away when a client's attorney calls and says he's about to do something bad, like that might be one that, you know, people haven't sat down and said, yeah, that's one that every time that comes into the hotline we're going out and we're calling the police right now to go track them.

You know, people may define it differently, but often we don't do things because we're just so busy and we have a lot of terrible cases that happen and no one actually sits down and says, okay, there's a threshold here where there's not a 24-hour we're going to visit, there is a law enforcement response that we're going to make sure that kid is not at imminent harm right now, and have them think about that. And when people think about that, they can codify that among the front line.

COMMISSIONER STATUTO BEVAN: To make something clear, the way state's operate, in the federal law there was a requirement in title IV-E, that caseworkers visit monthly, and that was auto assumed to be 12 months, 12 times a year, once a month, the caseworker visits, right?
You have how many organizations, at least the National Conference [of State Legislature (NCSL)] and state legislature, the NGA [National Governors Association], I don't know how many other state organizations there were, but there was American Public Human Service Association where there was pressure put and said 12 out of 12 is too much, we can't do it. We can't do it, so now there was a formula that says well, you have to be -- make sure that a child is visited 90 percent of the time because the state was getting -- the states were getting penalized if they didn't do 12 out of 12.

So now they have this formula where it says, okay, you can basically miss one time, isn't that how it goes, and it's 90 percent of the time? My point is that it's -- there are other elements that will argue against us on a lot of this stuff; that we can't do it in isolation. If SAMHSA is

not talking to ACF in this -member working group, if they're not working together and sending out information, if they have never taken a fatality and how long have they been in existence, with over 40 members, I don't know if there's public will to do it. I don't know if there's a governmental will to do it. I don't know.

But one of the ways of getting something to change, and I hear what you're saying and I want it to change, too, in ASFA, the Adoption Safe Families Act, we rewarded states that increased the number of adoptions over the previous year. Adoptions have been -- for 20 years adoptions were 20,000, 20,000, every year, no matter how big the foster kid population went up and it went down, up and down, still got 20, every year. Then you say to states, okay, we're going to reward you for increasing the number of adoptions over the previous year. We now have 50,000, 57,000--52,000, but it worked.

I mean, we do have -- nobody wants to call it an incentive or a bonus because that doesn't sound very social working, we don't want to put a bonus on people's heads, but it worked in terms of creating an incentive. It costs money, you know, and I don't know if it would work in this area, if we can increase -- if we can say to the states -- do you even know how to decrease? Do states know how to decrease the numbers of deaths? I don't know.

COMMISSIONER RUBIN: Looking for reverse, too, Cassie. This is, to me, where we fold in predictive analytics because, to me, once a child is in the system, the idea that -- so that policy that we're going to visit 12 -- every kid in our child welfare system every month for 12 months in a population health approach, I would say that's very inefficient use of resources. There are some kids that might need to be visited every week, and some kids every few months that you pop out based on the level of risk.

So what we need when you add the research requirement, and so it just popped in my head, is we -- figuring out how -- creating more flexibility to evaluate. Because you can draw back the visits and have no impact on child abuse, and that would be great, too, to be able to withdraw some of those resources.

When Dean Gelles, or former Dean Gelles at Penn [University of Pennsylvania] talks about this, what a great way to reposition resources back to the front end if we didn't need to actually go visit every one of those kids every month, but there was a subset of kids that our analytics told us, just the way they're doing in Tampa, that actually may need more.

COMMISSIONER DREYFUS: To follow up on what Cassie said, because as a former state person, I'll tell you, and this is human nature, we do what we measure. We do what we measure. And so there's -- I think we're just hearing today what are the two safety measures in CFSRs. It's all about repeat. Kids are already in the system, right? There's nothing on CPS. So I do think there is something to be said about this commission saying that these are things that should be measured in all states. They should be reported on by all states, and the federal government should put out an annual report on state performance on those things, or how it should factor into CFSRs reviews, but right now, as a nation, as a country, we put very little focus on child protection. It's all about kids in the outer home care system.

And as I said before, I know this sounds terrible, but I wonder as a nation how much, when it's all said and done, do we -- are we really caring as a nation about those kids, about those kids that are being called into CPS. The assumptions we make about them, the assumption we make about their families and the value of their life?

I know that sounds like that's a pretty strong thing to say, but I've kind of come to that. I just like where David was taking us, and I think Cassie took it a little bit further, and that is what kind of a system we would need to ensure the safety of children? I think when Tom talked about proactive safety programs, and you talk about building and redundancy, I mean, what would it need to look like for us to believe that we would have a system that could ensure the safety of kids, but I also think we've got to do better job of what states have to be reporting on, and what kind of reports the feds are putting out on state performance as it relates to child safety, because it's really non-existent.

COMMISSIONER COVINGTON: I would just add that I think some of the overlap between public health and CPS is that I think about the example that we had in Los Angeles. There are, I don't know, fifty-some police jurisdictions, and if you look at the policies in the company, child protection workers on criminal cases, it varies dramatically.

And when you look at the percentage they go out on and it varies hugely. And you look at the prosecution that occurs as a result, huge variation, because there are really different standards from community to community, and one of the issues was shouldn't there be more consistency that actually can create the redundancy?

So it's not a matter of more resources, it's actually child protection and law enforcement should work jointly on those situations that are applicable. And this case that we looked at had, what, six arrests for domestic violence? That's not -- I get that we're trying to improve the child protection safety assessment, but law enforcement is out there just as frequently. And what we found was that law enforcement would close a case, CPS wouldn't know, vice versa, they hadn't necessarily shared information.

It seems to me that there's considerable amount that we can build on using what's in place right now, but thinking about it much more broadly than just the individual child protection worker. I think that's a completely different view. And also, from what you were saying earlier on this issue of measuring, why is it the child protection agency would be producing those reports?

Isn't that a broader state responsibility that does include the responsibility that law enforcement has, and others have, around this issue? And I think it's we think more broadly, which I think the public health subcommittee brought. I mean, it seems like we should be thinking the same with child protection.

COMMISSIONER RUBIN: Isn't that when you think about it from the larger collective response, differential response is not totally arbitrarily to say these kids are never going to be visited, all right, they're going out to community services. You can say you had young mom at risk, maybe she had a positive drug screen, all right. She gets reported to child welfare, all right, is open and voluntarily commits to a home visiting program like nurse family partnership. And

maybe there was enough risk there, they open for service. I don't know if someone needs to come out every month and visit that kid because that mom voluntarily agreed, her analytics actually showed us that she wasn't at risk for imminent harm with the child, and you have eyes on the child.

COMMISSIONER DREYFUS: I'm a little bit worried that -- I understand where you're going, but I'm worried we're going to swing a pendulum too far, as we normally do, and we're going to blur the line too much. So when I think about a crime is committed today in Portland, Oregon, ultimately, with as many actors who might be around that circumstance, ultimately it will be law enforcement who will need to make a decision about arresting -- investigating, arresting, right, and the DA is going to make a decision about charging, right?

It's very clear, and I agree with you that there is a larger shared responsibility around Child Protective Services, but I do think the agency, as it relates to a child not being safe, a response must be made. They have a responsibility to be working collaboratively with these multiple systems, to be working with them on protocols, right? I get all that, but at some point I don't want to blur the lines that we lose that point of ultimate accountability.

COMMISSIONER RUBIN: That, I'm not touching. I'm sort of just touching about a different -- it's adding in the formalized safety plan, the use of predictive analytics, to be a little bit more strategic about how a differential response really looks across the entire system, because at the end of the day we're trying to create a situation where you take advantage of that redundancy in some ways, but also try to redirect the limited resources that a CPS agency has, potentially, to be more intensive with the kids that everyone is sounding the alarms on.

And so allowing that flexibility by thinking about how that collective CPS response is going to look at a higher level than just the child welfare system I think can be helpful to managing resources when they're scarce.

CHAIRMAN SANDERS: When you said Dave, which Dave were you talking about?

COMMISSIONER DREYFUS: You. I'm worried about blurring of lines.

CHAIRMAN SANDERS: I actually think the roles can be clear, they just need to be conducted jointly versus separately. So I think in this kind of situation, rather than the CPS worker making a decision based strictly on their information, and the law enforcement professional making it on theirs, that at least a step should be have the two of them -- do the two agencies know what each other is doing?

They're different roles. They have to make decisions that are independent, but they should be fully informed. And I think at least what we found is that generally they weren't fully informed of decisions, and so the issue of building redundancy wasn't happening because people were making decisions on what they knew and not necessarily on information that was shared. So it's not that they play the same role, but they should do it in tandem. That's the idea.

COMMISSIONER DREYFUS: I absolutely agree with you, but share with me in that scenario who, ultimately, from the standpoint of leadership, take David Sanders, when he was head of child welfare in Los Angeles, would have been leading, bringing everybody together to develop that part of the CPS response in this collaborative way, with the redundancies, with the you're going to do this, I'm going to do this, we end up with an agreement, blah, blah, blah, and ultimately be accountable that that CPS function is performing as it should and kids aren't falling through the cracks. I worry about blurring of lines and everything is going like this.

CHAIRMAN SANDERS: I think that Los Angeles is probably not a good example to use for structure, but I actually think that's what I was suggesting; that it's not the CPS agency solely, that it probably needs to be somebody who is in an elected position or senior position that can look across systems. I think the CPS agency has limited information, has limited resources, and I think we need to think about who beyond the agency is actually responsible, not only at the early end, but at the later end. So I'm not sure it's a CPS agency, I think it rests higher in the state.

COMMISSIONER DREYFUS: Okay.

COMMISSIONER RUBIN: Philadelphia created Deputy Mayor of Health and Opportunity for that reason, right, to coordinate at a higher level across behavioral health, the public health department, and child welfare. Now, was it successful? We can argue about how successful that approach was, but it was the same concept that there needed to be a higher level of organization for activities.

CHAIRMAN SANDERS: Jennifer, in terms of the recommendations, you've gotten a lot of feedback, but, Michael, if there are folks still on, how do you want to take this and move forward?

COMMISSIONER RODRIGUEZ: It almost seems that we need to go back and sort of revise, and maybe we should have a joint meeting with the upstream part of this to make sure that we're working with the same vision. I mean, that doesn't mean that we need to meet jointly forever, but to make sure that we're on the same page, in the same direction, and then from there run backwards --

COMMISSIONER RUBIN: I propose the Big Island for that one.

COMMISSIONER RODRIGUEZ: Wherever Michael is.

CHAIRMAN SANDERS: It does seem to be that thinking about the role of the federal government versus state and local is also part of this, and we've looked at it in the public health subcommittee with some of the recommendations, and it seems like that's going to be one of the things to consider.

COMMISSIONER RODRIGUEZ: I think, my personal opinion, is that we actually have enough barriers and challenges that sit at the federal level to take this on.

We didn't talk about it, but number 12 here, all of the issues around information sharing and confidentiality between agencies to me are huge. We talked on subcommittee -- I just had a situation last week, I have a friend who's a worker who ended up -- she's in the front end, ended up having a case come across her desk. She has a side job as a mental health provider for a hospital and happened to have seen this family the week prior, and so knew that the mother was admitted to the ER because she had planned to drown her kids.

That information wasn't contained in the report, CPS had no idea that that had happened, and no access to that. And so, you know, there was a situation where clearly there was information on the health side about this family that you just couldn't make any good safety assessment, or any plan to keep the child safe unless you had access to that information.

And so I think that would be an example of the type of thing where there may or may not be federal challenges to information sharing and confidentiality, but if there is or isn't, those should be clarified. And if there is, then we should be thinking about what to do about those because it's sort of a cross area. It's not just law enforcement that should be involved, it should also be mental health and all of those other agencies and, to me, that piece is huge.

COMMISSIONER COVINGTON: Well, we heard that through Commissioner Chang today. Even though she was talking about information going out --

COMMISSIONER RODRIGUEZ: Right.

COMMISSIONER COVINGTON: -- but even within agencies, a lot of agencies use federal laws, and I don't think they were meant for those purposes. People cite HIPAA all the time in terms of why they can't give CPS confidential information. There's a clear statement in HIPAA that says, "In the event of child abuse information, HIPAA no longer applies," but people don't use it.

I was hoping to hear today that there would at least be some federal work being done in figuring out how all these laws get in the way. We'll hear it from Department of Defense, that's probably going to be the number one concern is they have to go and change 50 state laws to be able to have, you know, information shared with CPS. And, you know, installation, family advocacy on a daily basis, and that's insane that that's something that can be done at a federal level, for me.

COMMISSIONER RUBIN: The other thing, as you continue, it makes sense, since you're focusing on safety assessment within the system, that that's -- you're probably going to own the predictive analytics sort of recommendations, so it's both information sharing and the degree to how we're going to support the evolution of predictive analytics around this sort of triaging of risk within the system, right?

COMMISSIONER ZIMMERMAN: Can I just -- you're going to have a challenge when you're dealing with federal agencies like Indian Health Services and Bureau of Indian Affairs that are providing the services to, for example, create a universal safety assessment. It's going to be very interesting how that could get accomplished, if at all, in those two very large federal

agencies.

COMMISSIONER STATUTO BEVAN: Tom, would you be able to, in the work that you did on the federal policies related to Safety Assessment and Safety Goals, would you be able to give -- to flush that out a bit and tell us more about the requirements, like the state plan requirements under CAPTA and under title IV-B I and II? Because -- and then 11-30, I didn't know the demonstration -- the waivers had so much on infants, children, and youth, especially in terms of preventing child abuse and neglect.

I don't know how many waivers have been done that way, how long -- has that been evaluation of the waiver? The waivers have to have evaluation, right?

TOM MORTON: I would be glad to say yes, Commissioner, because it was the policy staff that put that together, so it'd be easy for me to go back and ask them. I would comment about that, though, that there's a lot of mention of safety in title IV-B, title IV-E, et cetera. The only federal legislation that has specific language around safety assessment that we found really was CAPTA, and it was very difficult to determine what real activity is going on in support of strengthening safety assessment --

COMMISSIONER STATUTO BEVAN: Right.

TOM MORTON: -- out there. In other words, language says you can use CAPTA money to do this, but we don't know if anybody is, and if they are, what they're doing with it. Not saying they aren't, I'm just saying we didn't access that information.

COMMISSIONER STATUTO BEVAN: Right. I don't know either.

TOM MORTON: So it's another sort of issue with what does CAPTA really include or not include, or what is happening as a result of that language in CAPTA. That was about the only support we found in federal legislation for strengthening safety assessment.

COMMISSIONER MARTIN: This is Pat Martin. Hi, how is everyone? I wanted to chime in and ask a question about safety evaluations by the agencies. Do you guys here an echo when I speak?

I did a training with Dr. Mary Clyde Pierce -- and I think Steve knows her -- just recently, and Mary is a pediatrician that specializes in research and child abuse, and particularly severe physical injuries, and it was a training for judges. She put up a screen with a toddler, a two- or three-year-old kid with raccoon eyes and a big gash in his forehead where he cracked his skull.

Then aside to that picture she put up a two-month-old child infant that had a bruise on its cheek and she asked the general question to the judges: Which do you think is most severe injuries based on this visual? And just about everyone said the raccoon-eyed toddler. She said, which one would pose the greatest safety risk to put back in the same placement where these injuries occurred? And all of the judges said the raccoon-eyed kid.

She went on to explain that the raccoon-eyed kid basically was playing superman out of a window, hit his head and his skull did exactly what it was supposed to do, which was to protect the brain, and he got the raccoon eyes because of the injury to the back of his head and the blood rushed forward.

However, with the infant and the bruise mark on his cheek, which is a soft spot, she was more concerned about that child because that injury had to occur from an intentional act. And she said this is a real case that she was working on, and the worker, although she kept telling the worker that she was concerned about the infant and the bruise, the worker kept talking about a minor bruise.

And so that led to the question about what do the workers -- what type of assessments do the workers make when they go out for investigations? And so I'm asking people who have been prior directors, kind of where would a worker fall on that? Because if a worker, based on his or her assessment, is likewise like the judges making a determination that the severity of the injury relates to the severity of the risk, I'm wondering if we're getting the right message. Do you understand my question?

TOM MORTON: If I could respond to that, Commissioner. Historically, CPS has weighted the severity of the injury somewhat inappropriately in judging the future safety of the child and therefore has been biased to more severe injuries as more unsafe, less severe injuries as more safe. And it's a mistake that we've tried to rectify over the years, but it still exists as a bias out there.

Secondly, I gave you all a synopsis of the Texas child fatality study, which is complex to read and dense in formulation, but nevertheless it was an attempt to look at less serious cases that eventually ended up in fatalities and what predicted that. It's a curious study because it's actually prospective in that it looked at what was known at the time of the last report before the fatality occurred and, therefore, what information was actionable at that time that might have prevented the future fatality.

I think there are a couple of interesting findings about that, that in some cases the more significant information was what they called less actionable; meaning, it's not as immediately obvious, for example. What do I mean by that? A boyfriend's intense jealousy of his partner's child, you don't know that immediately within 45 minutes when you go out, unless he's beat the child that night. But I think that our mistake is, in a sense, that -- it's why we put one recommendation in here. It's recommendation B II, that there really needs to be a second layer safety assessment after the secondary assessment that looks at less serious cases in the context of other variables that may also be predictive, but are not necessarily immediately predictive of if I don't remove the child right this minute the child is going to be dead by morning. So I don't know if that totally responds to your question.

CHAIRMAN SANDERS: Pat, let me just add my two cents on it, and that is that we wouldn't ask in the health field anybody less than a nurse or a physician to understand that, and we expect that child protection worker to understand not only that, but how much substance usage is going to impact kids, what their mental health is, and so forth.

So I think, at least, the struggle in the jurisdiction that I was part of is how do you -- can you train 22-year-olds out of college with maybe a degree in social work maybe, or not, to understand the situations well enough to be experts in them, and we're asking them to predict for the most serious consequences, so I think it varies hugely by jurisdiction, and I'm not sure if we can get to a point where everybody has the ability to recognize what the trainer was teaching the judges.

COMMISSIONER MARTIN: Can I push back on that just a little bit?

CHAIRMAN SANDERS: Sure.

COMMISSIONER MARTIN: So if in fact Dr. Pierce would train the workers like she was the judges, and give us one liners like bruises on soft spots shouldn't happen, then at least we have a red flag that that's something we need to look into further, and so I bring it up because I don't really know, and I actually did reach out to my state agency to ask them a similar question, and what they're talking about is doing cross training and, you know, further reevaluating their cross training and bringing in Dr. Pierce and other actors to talk about these general theories.
And so I do wonder whether or not if not more training, then certainly different types of training would give us a better sense of where the more urgent matters may be.

CHAIRMAN SANDERS: Yeah, I don't disagree. I'm not sure it's an either or. I think that ultimately, if we know, and I've heard this consistently from Dr. Rubin, if they're -- that many of the kids that we're talking about are seen in child protection, but they're also seen elsewhere, and it seems that they're experts in health, they're experts in law enforcement, experts in substance abuse or domestic violence, who in many cases have already -- who are interacting with the families, and it seems rather that really on the individual child protection for social workers to learn all of the things that those other experts learn, it seems that another option is to pair the experts with the child protection worker in many more effective ways so the information is shared more quickly and there's an ability to act in ways that will rely on the expertise of those who truly are trained to deal with some of these situations.

COMMISSIONER DREYFUS: Isn't that what Reggie said in Colorado, that he's going to be putting teams into homes with the CPS?

CHAIRMAN SANDERS: Yeah, yeah.

COMMISSIONER DREYFUS: Did he say they're going to triage like which ones? I'm just saying there's an example where he told us clearly about RNs [registered nurses], substance abuse professionals.

CHAIRMAN SANDERS: Pat, will you -- was there something else you were adding to that?

COMMISSIONER MARTIN: No, I was done. Thank you.

COMMISSIONER RUBIN: You know, there's a whole continuum there, too, as well, because part of what we need to articulate is our near fatalities. What unites this space that we're

talking about is the need to be able to grade different levels of imminent risk as opposed to looking at the incident and sort of what is -- how can we accurately do that when a child is hospitalized with -- or is found to have a series of non-fatal injuries, all right, you know, we have to articulate are we going to require just like we're requiring fatality review team communities to have near fatality reviews like we have in Philadelphia?

TOM MORTON: If I can indulge this one last comment, I think you also have to be able to recognize dangerous parents. By the time you see the result of dangerous parents on a child, you know, we're treading dangerously close to have passed the safety threshold, so I commented this to Sarah in an earlier conversation that I think Public Health Work Group is doing really great work around other points of contact with children. I would add to that you ought to think about points of contact where people recognize dangerous parents.

CHAIRMAN SANDERS: Jennifer, anything?

COMMISSIONER RODRIGUEZ: Well, I did want to say one thing. It's a little bit off track, but it's just concerning me, is that the idea that I think I'm hearing around maybe moving resources in the system to in the entire child welfare system to be focused much more on the investigatory phase, and to sort of be having a different front end, front end CPS system concerns me.

Because I do think once we remove kids -- it wouldn't concern me as much if we had systems for kids who are in care that was flushed with resources and did them well and was able to ensure their well-being, we don't have that. We actually have systems that are stretched for resources for those kids, and so I hate the idea that we have to be talking about let's move from here to bolster up here and do it right.

I feel more comfortable with the discussion around what do we need at this stage of the system to make this operate correctly and not touch the limited amount of protection and services that we have for the kids we do remove from care and that we've made an obligation to see through the permanency. So I just wanted to make sure -- I've been thinking that. I'm not sure if that is what people are thinking, if I'm hearing that correctly around sort of the idea of moving resources, but I think it's a mistake to do that, if that is what I'm hearing, and you can correct me if I'm wrong on that.

COMMISSIONER MARTIN: This is Pat. I mean, I think that all of us know that the system really doesn't work well, but I don't know if that's our charge to correct the system. I think we have to figure out what part of the system we can make the best improvement that directly affects -- or affects the fatalities the best. And so I think we have to be careful and remember what our mission is when we start having these conversations.

COMMISSIONER RODRIGUEZ: I agree completely, and that's why I was pushing back a little bit on what I thought I heard, but I could have been mishearing. Because I don't think we have the time or the authority in this committee to talk about what -- if we did move resources, then how would you readjust our system for caring for kids? Who did we make a decision to remove on?

And, to me, if you did divert resources you'd have to have that other discussion as well. You couldn't simply say we're moving caseloads of workers so that kids in care who don't get visited are going to get visited every three months, or once a year, and we're going to lower the caseloads of the workers that are doing the investigations, you know, I think that would be a mistake.

COMMISSIONER RUBIN: What I'm saying is I think we've seen in all of our local testimony that the requirements themselves and the siloing of those requirements in individual systems can be so burdensome as to act as a deterrent to actual good practice. So what I'm saying is I'd like to unshackle local systems to be able to create a plan for how they're going to use what resources they have.

COMMISSIONER DREYFUS: The resource is broader than the child welfare system.

COMMISSIONER RUBIN: Yeah, and so they make larger investments if they so deem in their community, but I think we have to respect the fact that geography matters and that what we want to do is make it easier for people across systems to plan together and to actually create a more collective response so that quilt I keep talking about is tighter.

COMMISSIONER RODRIGUEZ: I support that approach. I just know too often we end up going front end will move resources, or back end will move resources, as if we're talking about one pot instead of -- to me, based on the discussions we're having and what we've had in our subcommittees, it actually sounds like we need an entirely different investigation system less linked actually with sort of foster care and ongoing case management and more linked with public health and a multidisciplinary approach in that it almost is a different system with a different focus, and that that gets out many of the issues we've talked about, about workers making decisions about whether to remove or not remove, because they're thinking about I don't want to have to place this kid, because I don't think there's any place I can actually place them, but that they're freed up to make a decision based on what's the actual risk to this child, this family right now.

COMMISSIONER COVINGTON: I almost heard something different today, which was get the investigation away from prevention services and just start being more -- not de-fund them or take away of their resources, but start being more robust with early identification of risk and then deal with harm, or anticipated harm when you see it coming. I mean, I heard two different things, really.

COMMISSIONER RUBIN: I worry, too, because I think some of this is happening, but it's happening like, you know, when you look at differential responses. So CPS deems they're going to send this kid out to community, and they may contract with community agency, but how often is public health or the head of mental health sitting at the table to think about what is a differential response looking at a larger level?

And that's what I worry about more, because then under that circumstance we're not getting any accountability to find out how many of those kids in differential responses are coming back and being killed or, you know, et cetera. And so it's -- so the field is moving ahead with

a lack of sort of expectation of what this larger response looks like.

COMMISSIONER DREYFUS: I'm worrying a little bit here that we're thinking there's CPS and the wall goes down and there's kids in the system. And safety assessment, right, assessment of safety, you know, child is due to not be safe within foster home, CPS is called back out again, right? And then just the competencies you need in that outer home care workforce when they make that decision about returning home and different things.

I just don't want us to be thinking CPS is just this thing that happens on the front end only, but a lot of these same approaches would be really important throughout the life of a case and making critical decisions about removal, about return home, about safe placement.

COMMISSIONER RUBIN: Sure. So because the kid was open for services and family disagreed to certain level of services, but things weren't going well there should be a trigger that if the communication between the systems is running the way you want you could elevate your safety response.

I mean, what was so elegant about the mind share work was that they're constantly doing this based on active feedback data saying the kid's missing school, and so red flagging cases that actually prompt a change in the response of the system, all right?

COMMISSIONER COVINGTON: For me it's almost taking about what we heard this morning in terms of the healthcare systems that Oregon is building, and kind of building that into a child protection system so that there is much more cross service. I mean, it goes to the piece of, you know, you pull the kid out, or you want to pull him out, or you notice there's risk because of substance abuse.

Where is the cross coordination of getting the family substance abuse services? How is that being done, mental illness? I mean, you didn't get any sense in this case in Florida even though, you know, community mental health a call was made to them in terms of trying to get this dad services when people within a very short time frame realized there was a real serious problem.

I don't know, Jennifer. In your own personal story you talk about mental illness in your family. Is there are any kind of attempts to blend child welfare and some of the support services for families? It always seems like external referrals; we're going to make referrals out there rather than what's there for the family.

CHAIRMAN SANDERS: I also think we will see if for those who have the opportunity we'll hear about it in the tribal visit to Arizona, but the Pima-Maricopa Salt River approach, that family assessment approach that they use I think is a concrete way of getting to some of what we've talked about.

I think it is a reflection of what you just described in Oregon. It's an example of that, but I think it's well developed and it really is thinking differently, not just about the investigation, but how you support families, and it's incorporating multiple systems in ways -- at least I

haven't seen it work in a way that really begins to get it.

COMMISSIONER COVINGTON: That was a great presentation, by the way. The materials were wonderful. I really like how you started out with the case.

COMMISSIONER RODRIGUEZ: Well, we'll back up and start over.

COMMISSIONER COVINGTON: I feel really bad, you have such a big task.

COMMISSIONER RODRIGUEZ: I think lots of stuff that we have under state and local we can move up to be elements of things that we would like to see studied under research or practice development and that we'll think about those big chunks of things like confidentiality, like practice and intervention that are more under the jurisdiction of the federal.

COMMISSIONER DREYFUS: Jennifer, I'm looking at this and I don't think there is any disagreement that everything you guys are laying out here isn't sound and needed. I think what we're saying is can we envision a different way than our current linear CPS in-take assessment investigation model. I think we're saying all these elements are critically important, but can we envision a different construct within which they're achieved?

CHAIRMAN SANDERS: And I actually think, I mean, Bud Cramer is with the CAC [National Children's Advocacy Center (NCAC)]. It's one element of that envisioning differently, so, yeah, I think that captures what I was saying.

COMMISSIONER MARTIN: David, can we go back to what I think Steve may have mentioned, and that is kind of like a death review or a multi-disciplinary staffing on near fatalities. Because everything we've heard is that the difference between fatalities and near fatalities is really kind of lumped. I mean, they're the same cases. And if in fact you had a real good assessment, and maybe this is what was said earlier, that we don't need just this multidisciplinary assessment at the beginning, but we may need it throughout the life of the case.

COMMISSIONER COVINGTON: There are -- it goes back to the old MDT model, which still is in existence in a lot of places, where they still do multi-disciplinary team reviews of live kids that are in care.

COMMISSIONER MARTIN: That's one of our problems in Cook County. We do a real great integrated assessment in the beginning, but we don't look at risk in that depth for the rest of the case. And I think if it's so good at the beginning, and realizing what kind of services are mostly effective and appropriate, circumstances change and that's why we're working with the family, we're assessing things. So why are we not just as intent on making certain that the assessment has the similar level during the life of the case?

CHAIRMAN SANDERS: I think that my sense is that's one of the things that the subcommittee has been looking at as part of the process, and I assume that that will continue. I'm looking

at Jennifer.

COMMISSIONER RODRIGUEZ: Yes, it is one of the things that we've been looking at. I think with just the disclaimer, that I don't think we're saying that they're done well at the beginning of the case either. So I think we're envisioning a system where they would be done better at the front of -- the beginning of the case, and then whatever that better system is, it would be used periodically through the life of the case.

CHAIRMAN SANDERS: So I think that at least for right now, because it sounds like there's some steps you have planned, we'll finish this discussion and close off with our thank you, Jennifer. I know Michael has signed off, and I assumed Bud has, too. Thanks, Tom. The -- Commissioner Zimmerman and Martin I think I have three minutes of material.

COMMISSIONER ZIMMERMAN: That's about right. So I just want to do a very brief update, that there's going to be a special hearing focusing specifically on Tribal issues and federal tribal jurisdiction issues. We're going to be meeting at the Pima-Maricopa Salt River Reservation at the top in Stick Resort at the end of March, 25th and 26th, I believe.

And we will begin that process on the Thursday before the hearing by having a tour for the Commissioners with the team of Maricopa Child Advocacy Center and looking at some of their best practices, which we're pretty excited about. The hearing is going to include just four panels. We're going to concentrate on jurisdiction as a panel, data collection as a panel, practice, early intervention, prevention as a panel, and the ending day with the federal response recommendations.

We're going to be hearing from National Native Organizations from National Native TA providers, Tribal leadership, U.S. attorneys, trainers of U.S. attorneys around Indian federal issues and what the landscape really looks like around child fatalities and Indian country.

There has been some testimony previously that American Indian children are not necessarily dying as a result of abuse or neglect; rather, they are experiencing higher levels of neglect than abuse. But I don't know that we really know that because we really don't have the databases. We don't have the information; it doesn't exist. We'll probably be looking -- I think Pat is going to talk more about disproportionality tomorrow, but we'll be looking at disproportionality of American Indian children in care.

The three states that come to mind are South Dakota, Montana, and Alaska, where I believe in Alaska, for example, please don't hold me to these statistics, it's been a while, I think there are about percent of the child population of Alaska, but they make up over 65 percent of the children in care. That's unreasonable, we think, and there has to be a way for us to address those disproportional issues.

So we're really looking forward to it. It's the only time in the hearings that we're going to be focused specifically on Tribal issues. We will be traveling -- the subcommittee will be traveling to Washington DC to meet with Bureau of Indian Affair Officials at headquarters, Indian Health Service Officials, some other Department of Justice Officials that work really

well with tribes, or have the responsibility to serve children in tribal communities. That's my three-minute update.

CHAIRMAN SANDERS: Any questions? I don't have a half of an hour worth of material; I'm not sure I have a minute worth of material. We had a long, productive day. Thank you CPS subcommittee for the afternoon, and thanks to all the panelists who stayed all day. Thanks Pat for persisting on the phone with us, and our condolences for having to do that for all day. We'll be back tomorrow at 8:00 with the policy subcommittee. Thanks everybody.

(At the hour of 4:40 p.m., the hearing was concluded.)

End of Day 1

2015-02-27

DR. SANDERS: Good morning, we're going to get started in just a minute with our Commission Meeting for Friday, February 27th. Today's meeting consists of the commission deliberations, and we will have reports from the commission subcommittees.

Before we get started with the substantive discussion, I wanted to check with the commissioners. I think most are scheduled to be on. Commissioner Martin, are you on? Commissioner Petit? Commissioner Cramer? Commissioner Horn?

COMMISSIONER HORN: I'm on, David, but I can only be on for the first hour, I apologize.

CHAIRMAN SANDERS: Are you hearing us okay? Because we had trouble at yesterday's hearing.

COMMISSIONER HORN: I can hear you fine.

CHAIRMAN SANDERS: Commissioner Ayoub?

COMMISSIONER AYOUB: I am, thank you.

CHAIRMAN SANDERS: And can you hear Commissioner Horn?

COMMISSIONER AYOUB: I can.

CHAIRMAN SANDERS: I reckon we might have gotten a break today. So policy subcommittee is going to start with their report, so I'll turn it over to Dr. Bevan and Dr. Horn.

COMMISSIONER STATUTO BEVAN: Thank you very much. Let me start with our framework. The framework that the policy analysis subcommittee intends to take is putting a policy lens on four focused areas. One is clarification of a current law, or of the specific policy we're looking at; effectiveness, accountability, and efficiency. So clarification, effectiveness,

accountability and efficiency.

In our -- what we mean by clarification is identifying the specific social policy problem we are examining: Child abuse and neglect. This comes, Wade, out of your question when we were on the phone about identifying this population. Do you want to talk a little about that?

You asked us, and we all agreed, that we need to identify -- to be clearer about defining the population of victims of child abuse and neglect. So we wanted to look -- develop an overview of the victims of child abuse and neglect and fatalities to include information about the circumstances of their death, including a description of the perpetrator and factors that put these children at risk.
We will also include an explanation of gaps in our knowledge, such as those that stem from variations in child abuse neglect, and practices and policies. That's on clarification. And we will have other examples of activities that we need to do to clarify what it is we're looking at, like who the victim of child abuse and neglect fatalities are.

Effectiveness: Here we want to look at, as our mandate, examining the effectiveness of existing policies and services. So here we're looking mostly at title IV and title XX, and then including -- and adding CAPTA [Child Abuse Prevention and Treatment Act]. As you know, title XX is SSBG [Social Services Block Grant], and title IV is under the Social Security Act [SSA]. So we want to look at conducting detailed policy analysis of those federal and state policies that are specific to achieving safety goals for at-risk children.

We're kind of narrowing our job, because we want to focus specifically on fatalities from child abuse and neglect as much as we can, and we want to look at the policies we have currently and how they're working and what the gaps are. For one, we want to look at fatality review processes for child abuse and neglect; we want to look at and, you know, I've been harping on it, now I can refer to it as the web of reviews, but citizen review panels, child death review panels, fetal and infant mortality, domestic violence, you know, the whole range.

We want to look at them. We want to see what is the information that the Children's Bureau is getting from all of these reviews and what's the reliability and validity, if any, of these -- of this information, and what action is taken in response to the recommendation of these panels.

And mostly what we want to know, because we don't see any requirement in the law for either the composition or the output of these -- all these different panels, we want to see where the oversight is, who holds these panels accountable, and are there differences in the different purposes and composition, and are these panels a substitute to the development of a rapid response team or are they separate?

I assume they're separate, but we are trying to sort through the web of federal policy to understand are we getting the information we need, and if we're not, why not? In terms of the Plan of Safe Care, again, it's federal law that, you know, CAPTA requires states to have policies and practices. Policies and procedures, including appropriate referrals to child protective service systems [CPS] to address the needs of infants born and identified as being

affected by illegal substance abuse or withdrawals due to drug exposure.

In this requirement, it's the hospital that is supposed to notify child protective services of the occurrence of such conditions, but the referral is not in the sense a true referral. It is not calling this child abuse and neglect, it is just an attempt to connect these two services and agencies, the hospital and CPS, in an attempt to get some eyes on the house as the mother goes home, some services into the house, and some assessment of what's needed to keep that baby safe.

That, as I think we learned yesterday, there's -- it's not being followed. We did this whole development of a Plan of Safe Care which is just not happening. And I have been in contact with former Congressmen James Greenwood from Pennsylvania, he put this language in on the floor of the house, and I worked with him on it, because it was very controversial in the committee, and so he couldn't get it through committee. We had to go to the floor and see if we could get it put in there, and we did -- he did.

And so my point is there was -- that we went through the hurdle of getting this language in and now it's being ignored. And we also were careful the way we -- it was -- the way the language was written so that it didn't include, for example, alcohol. So now the question is should we be including alcohol, but that's legal so, you know, we had problems with that one politically.

And how is the effectiveness measured of the safe plan if it's put in place? What state agency is responsible for sending somebody to the home for checking on this baby and the mother? Again, can we strengthen these policies? They're in CAPTA. CAPTA is going to be reauthorized. What else can we do to make sure that this Plan of Safe Care is not ignored, that it is a requirement with CAPTA?

And the problem with CAPTA requirements generally is that because the pot of money in CAPTA is so small, that making state plan requirements conditioned upon the state receiving their money doesn't work in this case because it's not a nuclear amount of money, as we call it, it's not a nuclear option.
The nuclear option would be pull out all title IV-E and pull out all title IV-B and then you'll comply. Pull CAPTA? You get $22 million in your state for CAPTA? You know, go ahead. There's not enough teeth or interest to withhold the money, you know, and there's not enough interest to, if you violate it, to comply. So we have a real problem with CAPTA requirements.

COMMISSIONER HORN: Cassie, can I ask a question? Do we know whether that penalty, though insufficient as it may be, has ever been applied?

COMMISSIONER STATUTO BEVAN: No, we don't know. We don't even know how many states are attempting to even fulfill this requirement. It looks like not very many. So, no, we will look at that.

COMMISSIONER HORN: Yeah, I think it's important for us to look at the facts. Penalty may or may not be sufficient, but it's certainly not sufficient if it's never applied.

COMMISSIONER DREYFUS: This is Susan, Wade. One of the things you could also get at this is if the penalty is not enough to generate the motivation is there a way to get these things into the CFSRs [Child and Family Reviews] because that's very public, right, a state's report about their compliance in CFSRs is very public. The process has been gone through, they come in and do reviews, as well as the ultimate, and then it requires an improvement plan [Program Improvement Plan—PIP] So it may not have a direct fiscal penalty, but it sure has something that's holding states accountable for it being transparent that indeed they're not performing on a federal requirement and that it has to be part of their program improvement plan of how they will get into compliance.

So I'm just wondering if the CFSR might not be the route for the accountability on CAPTA and some of these other areas that you're covering where there's clear responsibilities, but there's no teeth or way for the feds to hold folks accountable.

COMMISSIONER STATUTO BEVAN: Wade, do you know if have you to go through OMB [Office of Management and Budget] to get an item added to the CFSR?

COMMISSIONER HORN: Yes.

COMMISSIONER STATUTO BEVAN: There's our problem. But, yes, I think you're right.

COMMISSIONER COVINGTON: I had a question, too. Even with the penalty, is there any kind of monitoring system in place to states within CAPTA?

COMMISSIONER STATUTO BEVAN: No.

COMMISSIONER DREYFUS: State government perspective?

COMMISSIONER COVINGTON: Yeah.

COMMISSIONER DREYFUS: The amount of money the feds give in CAPTA and the amount of requirements that are in it, we just -- I mean, at some point we were even saying we're just ready to turn the money back, this is getting ridiculous.

COMMISSIONER HORN: I think most of the CAPTA -- I may be wrong about this, but we should try to find it out. I think a lot of it is just self-adaptation in their plan.

COMMISSIONER STATUTO BEVAN: It's just what? I'm sorry.

COMMISSIONER HORN: It's self-application. In other words, it says do these things and if you say yes then everything is fine.

COMMISSIONER STATUTO BEVAN: Yeah, that sounded like yesterday when we had Associate Commissioner Chang here yesterday and we talked about safety measures under CFSRs, and there were two safety measures; re-abuse and re-entry into foster care. I mean, that's it.

COMMISSIONER HORN: I was talking about CAPTA and not CFSR. CFSRs they use --

COMMISSIONER STATUTO BEVAN: I know what you mean. No, in CAPTA I think you're right, there's just a blanket, okay. I don't think they go through all the requirements, because there are so many, and that's why we were kind of cautioned yesterday about adding any more, you know. Why would you want to add more requirements to CAPTA and think you're going to be doing anything?

COMMISSIONER COVINGTON: Can you --

COMMISSIONER HORN: Obviously, we can't solve this issue today but, again, I'd like to know the degree to which that penalty has been applied to failure to do this. That's not adding a requirement.

COMMISSIONER STATUTO BEVAN: I have it written down. And I also think we'd like to know how much -- how that varies by states. Because, you know, the amount is all dependent on the amount of money.

COMMISSIONER COVINGTON: Can you help me, because I'm always -- I get really confused about where CFSRs originate from and what -- where they get their target evaluation measures from. It's not tied by title IV-E money?

COMMISSIONER STATUTO BEVAN: Yes.

COMMISSIONER DREYFUS: That's where the penalty comes from.

COMMISSIONER STATUTO BEVAN: They're nuclear penalties.

COMMISSIONER COVINGTON: But they're based on penalties required through title IV-E, that's what I'm trying to figure out when they come up with a plan what they're trying to remedy.

COMMISSIONER STATUTO BEVAN: They're trying to hold states accountable for the activities funded under title IV-B and title IV-E.

COMMISSIONER COVINGTON: So it just addresses title IV-B and title IV-E because one thought --

COMMISSIONER DREYFUS: It's not getting child protective services.

COMMISSIONER HORN: But it's supposed to look at the child welfare system as a whole, but the penalties made associated with title IV-E, title IV-B, but it's supposed to assess the child welfare system as a whole, and it does include outcome measures, not just profit measure.

COMMISSIONER STATUTO BEVAN: That was the big deal. Used to be before this was put in there was a paper compliance check and every state would just check it off, yup, yup, that was it, there was nothing. So the CFSRs actually were an attempt, and do hold the states, at

least make it public, what the states are doing and how many states have passed the safety requirement, or the permanency requirement, well-being requirement.

COMMISSIONER HORN: I know this fairly well, since I was the secretary who implemented the CFSRs, but the idea is we want to improve the child welfare system, not simply penalize states. And so just because a state does not meet all of the outcome measures in the CFSR does not mean they're automatically dinged in terms of the financial penalties, but rather they go into corrective action processes in order to improve the process.

COMMISSIONER STATUTO BEVAN: It's Program Improvement Plan, PIP, is what it's called. But I always remember testimony before the Ways and Means [U.S. House Committee on Ways and Means] from APHSA [American Public Human Services Association] to say -- and their response to the Program Improvement Plans were, "We're too pooped to PIP." And I'll never forget it, because they were saying the states just, you know, they just couldn't follow through on their PIP because they had too much going on.

COMMISSIONER RUBIN: My observation locally is that, you know, the CAPTA requirement around substance abuse exposed newborns, right, that's a public health response. But you're placing it at the seat of child welfare and it gets back to this fundamental problem. I think the challenge at the state level is this, sort of, are these our kids? Is it really a child welfare response? Should this be a public health response with child welfare involved in that public -- in that response?

And so I think we may have opportunities as we go on to the public health subcommittee to think about if we're thinking about the essentials of state plans that actually elevates some of our issues. It could be part of the essentials might be to articulate how they're going to meet requirements with respect to substance abused newborns. If we start to think about state plans and its redundancy, whether or not that has teeth, it actually elevates it to a public health response at the state level, and may actually get more action at the state level in terms of a response.

COMMISSIONER STATUTO BEVAN: Could it get added to anything in public health, like Medicaid?

COMMISSIONER RUBIN: I think we should talk about that, right?

COMMISSIONER STATUTO BEVAN: I don't know MCH [Maternal and Child Health Bureau]. I know it's a block grant.

COMMISSIONER RUBIN: Absolutely.

COMMISSIONER STATUTO BEVAN: CAPTA money, conditions of CAPTA money doesn't work.

CHAIRMAN SANDERS: And it seems the way that you've structured this, particularly if we find CAPTA hasn't been effective, then it seems incumbent to look at what are those that might be more effective, and that seems to go beyond only CAPTA as an option. I think policy subcommittee would be very helpful to look at what's been effective along the lines of what

they're saying.

COMMISSIONER HORN: I would just again reiterate that it's difficult to determine -- impossible to determine effectiveness of this division if the penalty has never been applied to a single state.

COMMISSIONER STATUTO BEVAN: You're right. I would, because of the reauthorization, think about the fetal alcohol syndrome [Fetal Alcohol Spectrum Disorders (FASD)]. I don't know how much of an issue it still is, but I know we got a lot of push back from many people because of it.

COMMISSIONER RUBIN: Actually, from an outcome perspective it has more significant impacts on that child's neurocognitive development than a lot of the -- for example, cocaine. Everyone worried about cocaine for a long time. The outcome studies on exposed infants have not worn out the degree of disability that's created for kids with fetal alcohol syndrome.

COMMISSIONER STATUTO BEVAN: Okay.

COMMISSIONER COVINGTON: It's much more serious.

COMMISSIONER STATUTO BEVAN: So we really have to think about it, but then the question is relating to fatalities. I mean, you know, does that relate -- well, we know that substance -- when we talk about substance abuse do we usually include alcohol?

COMMISSIONER DREYFUS: Yes.

COMMISSIONER RUBIN: The overlap to fatalities are neglected. I think the testimony in Tampa, this is why I think it's a public health response, is because part of it is the safety of the child, the other -- actually, around co-sleeping, right? It's developing a response in those situations where I was really struck by that group in Tampa who were providing bassinets to the mothers and they reduced the number of child deaths related to co-sleeping in that county whether we think if that data is true, right?

COMMISSIONER COVINGTON: There's been pretty good studies that have done universal meconium screenings on infants, and most of those were out of Detroit Medical Center, which is the largest birthing center in Detroit. They really -- these are probably ten year old studies, but they found drugs -- single drug use like cocaine and alcohol really did not lead to higher rates of fatality because of the drug specifically, unless it was a multi-combination of drugs, which just meant the mom was probably in deeper distress. But it was really long-term outcomes --

COMMISSIONER HORN: The other thing we want to see if there's any research on is whether or not a child who was born compromised by substance abuse, prenatal, and whether that -- it's not just whether that baby goes on to die, but that exposure, or whether that is a signal that this family is at higher risk for child abuse and neglect and fatalities.

There may be none, but it may be that maybe it's not the exposure itself that causes the child to die, but it's a signal that this is a high risk family and that those families are more likely to perpetrate child fatalities.

COMMISSIONER DREYFUS: This is Susan. I just want to go back to CFSRs for a minute, because I don't want us to lose, having gone through that process myself. I think the federal government could do more to really be as states are preparing for their CFSR, the inclusiveness and the transparency of the processes that states are using in their preparation for the CFSRs, and the federal conduct of the CFSRs, and then what is assumed to be the responsibility of governors when these PIPs are not just about the quote, unquote, child protective agency, but these PIPs have representation across systems, right?
I mean, if anything is coming through this whole process with us this past year has been this cross system interface that has to get created, and I think CFSRs is one more way to do that, and I hope we can do a little bit more thinking about that.

COMMISSIONER STATUTO BEVAN: Well, thank you. And if afterwards you think about more, like if you think about the studies, Teri, or if any of you think of anything, just send it to us and we'll --

COMMISSIONER DREYFUS: Cassie, one clarification. On IV-B, before you go to the next section?

COMMISSIONER STATUTO BEVAN: Yes.

COMMISSIONER DREYFUS: I'm not sure what you guys mean in this section. Are these panels a substitute to the development of a rapid response team?

COMMISSIONER STATUTO BEVAN: Well, I think in the minds of a lot of policymakers the fatality review process was an attempt to hold agencies responsible for contributing to the death of the child, to the extent to which they contributed, and just looked at it.

So a citizen review panel was really an attempt to not have -- it was supposed to be volunteers, which is probably why it did not get good review in that latest report, but the attempt was to hold agencies to not have people who were part of the agencies, but to really have an outside look at, you know, what happened.

COMMISSIONER DREYFUS: What's the connection to the rapid response team?

COMMISSIONER STATUTO BEVAN: Hey, the connection is the law makers are thinking that they were holding agencies accountable. In rapid response teams they're looking at individual cases, right? We want to see how many -- this is holding agencies accountable, but in a rapid response team, within hours someone is supposed to come out and review, right, and we also want to know -- I mean, where is there any requirement for rapid -- development of a rapid response team. There isn't, right?

COMMISSIONER COVINGTON: Well, it depends on the state. So a lot of states have rapid response teams that are internal within child welfare, for example. So what Florida did with

this case review, that was what I would call a rapid response. They got a team together, it wasn't multi-disciplinary, but it was a team of folks from child welfare in Florida that went into that community and looked at the case of the little girl that was thrown off the bridge. That was rapid response team.

It doesn't necessarily tie back into their state wide child fatality review board, but a lot of states -- in fact, I got the percentages on it, most states say that they conduct critical -- what they call Critical Incident Reviews.

COMMISSIONER STATUTO BEVAN: CIRTs?

COMMISSIONER COVINGTON: Yeah, but those are internal to the agency, where they're looking specifically at agency policy and practices; did we follow the right policy? Were the right things done? Do we need to take corrective action against employees or supervisors? However they want to do that, do we need to change policies? That's really different than the more kind of public multi-disciplinary case views that are being done, and very few citizen review panels are doing fatalities across the country.

If you read carefully in CAPTA it's not a requirement, it's an option. It's an option, so that's how a lot of places are meeting. I think people started thinking it was a requirement. We did for a long time until we went back.

COMMISSIONER STATUTO BEVAN: It says one.

COMMISSIONER COVINGTON: It's an option on review of several different foster care --

COMMISSIONER STATUTO BEVAN: Citizen Review, foster care review, or fatality.

COMMISSIONER COVINGTON: Right, right.

COMMISSIONER STATUTO BEVAN: But they should have one.

COMMISSIONER PETIT: Cassie, it's Michael. Can you hear me?

COMMISSIONER STATUTO BEVAN: Yes.

COMMISSIONER PETIT: Listen, I missed the first part of this call, technical difficulties, but I think it sounds like we might be all right now.

What was the final word that Associate Commissioner Chang gave us -- Chang, gave us yesterday with respect to the follow up on the Shame on U.S. findings about the federal oversight? Are they planning to do any kind of response or are they not? I thought a lot of stuff that Shame on U.S. reported on was strikingly consistent with my own experience with it and many others that I've talked to. Are they responding to it or are they just not?

CHAIRMAN SANDERS: She was clear they are not.

COMMISSIONER STATUTO BEVAN: She was pretty clear, but Dave -- Wade, do you ever remember the federal government responding to any prior report?

COMMISSIONER HORN: Responding to any prior report?

COMMISSIONER STATUTO BEVAN: Responding to a prior report, like Michael was asking if the Children's Bureau or ACF [Administration for Children and Families] intends to respond to the Nation of Shame Report, and the answer yesterday was no.

COMMISSIONER COVINGTON: Shame on U.S. Report. There's the, "A Nation's Shame: Fatal Child Abuse and Neglect in the U.S." was 20 years ago, this is Shame on U.S.

COMMISSIONER PETIT: Let me ask you, Wade, as you try and recall, as you may recall, that's what the Congress exists for. If somebody is saying the Children's Bureau is dropping the ball in this area, and I think they are dropping the ball in this area, then the Congress can examine a private report and bring the agency in and ask them to respond to it.

So while the agency may not be responsive to a federal commission like ours that is saying what is your response on it, I think we should formally ask them what their response would be. If they don't respond to the commission, certainly Congress can get them in there and ask them where they are with this federal oversight.

COMMISSIONER HORN: There's two issues here. One: Did the federal government respond to the reports? The answer is, yes, they responded to the reports. If the question is did the Children's Bureau review each of the recommendations -- the recommendations of that particular report and track -- and say we're going to implement all these recommendations, we're going to track whether they were all implemented or not? No?

But I'm not sure that's a requirement any more than I think that our report becomes a direction that the Children's Bureau must take every one of the recommendations. So I think there's two issues.

COMMISSIONER RODRIGUEZ: Would this section around fatalities also be a place to see if any policy exists on the near fatalities as well?

COMMISSIONER STATUTO BEVAN: Yeah, CAPTA does have -- has language in there.

COMMISSIONER RODRIGUEZ: I feel like pushing that area is particularly important to starting to get at some of these systemic issues, because it increases that end.

COMMISSIONER STATUTO BEVAN: I don't even know what data's they're collecting. Does anybody know if they're collecting data on near fatalities?

COMMISSIONER COVINGTON: We have data on the number of the states that are conducting near fatalities reviews, and of course some information goes into NCANDS [National Child Abuse and Neglect Data System].

CHAIRMAN SANDERS: But wasn't part of the issue that the near fatalities is defined in CAPTA, but it is not the definition physicians necessarily use. It seems, again, gets at the issue of who might ultimately be accountable and is CAPTA the right place to define something if physicians aren't using that. That's what I heard as testimony, I believe.

COMMISSIONER COVINGTON: Physicians, a lot of different groups. We pulled out states to say what was their definition on near fatalities and we didn't get one match, everyone had a completely different definition they were using. And very few were using the formal CAPTA definitions.

COMMISSIONER STATUTO BEVAN: I know this sounds obvious, but is there a connection between near fatalities and infanticide?

COMMISSIONER RUBIN: Absolutely. I think the evidence is extremely strong, all right. If you remember Dr. Joanne Wood studying the epidemiology, age demographics, to me, the only difference is those kids, we kept them alive.

COMMISSIONER COVINGTON: I think Joanne Wood's testimony in Philly was great for that.

COMMISSIONER DREYFUS: Teri, as our expert on reviews, could you see in this whole area of policy where I appreciate state rights, I appreciate the feds wanting to give states flexibility, certainly do, but do you think it's time for the federal government to be looking at minimal definitions? Floors of definition? A minimal definition of safety?

You can go beyond that state, but you cannot go below it. A minimal definition of a near fatality; you can go beyond that, but you can't go below, right? Are we at a point now where it's time for -- and Cassie, I'm sure we were just talking earlier, where there are some examples you were saying of this. I'm just wondering is that something we should be thinking about is that it's time for there to be a national definition of some of this stuff as a floor?

COMMISSIONER STATUTO BEVAN: Wade, what do you think?

COMMISSIONER HORN: Sure. I want to get back to Michael's question, because it's a really important one. So, for example, when the National Commissioner on Children issued this report the federal government didn't respond to it, but it is -- reports such as commission's reports are not mandatory that each of the recommendations be implemented. So what the National Commission [On Children] did, is they actually got an additional appropriation, commission staff then continued to actually function past the report, and it was the commission staff that actually tracked implementation of those recommendations.

So, David, you tell me if I'm wrong here, but I don't believe our commission has the authority to mandate that the federal government do anything, but rather we issue recommendations and it's up to Congress, to do, in its wisdom, to take those recommendations into account, also the administration, but our recommendations are recommendations, they're not mandates; is that correct?

CHAIRMAN SANDERS: That's correct. That's certainly how I read legislation.

COMMISSIONER COVINGTON: We don't get to make -- unfortunately, we don't get to make law, correct?

COMMISSIONER HORN: Right. We haven't been elected king.

COMMISSIONER STATUTO BEVAN: Teri, did you have a response to Susan's question?

COMMISSIONER COVINGTON: Well, you know, one of the things that's frustrated us forever, for years since I've been doing child fatality review is there's never been a minimum standard. We have them, but there's no requirement that anyone meets them. There's no --

CHAIRMAN SANDERS: Minimum standard? I'm not sure.

COMMISSIONER COVINGTON: Of what Child Death Reviews ought to look like, what fatality reviews ought to look like?

COMMISSIONER DREYFUS: Definition of safety, what's near fatality?

COMMISSIONER COVINGTON: Exactly.

COMMISSIONER DREYFUS: What's viewed to be fatality from abuse and neglect?

COMMISSIONER COVINGTON: Right, right. That goes back to our measurement committee, too, in terms of trying to define what is a child abuse and neglect fatality. But we -- you know, I mean, if you think about it, there's all this emphasis on fatality reviews across the country there's never been a penny coming from the federal government to pay for a fatality review team process in the state. They're all borrowing and begging from other state -- and, you know, sometimes private sources of funding just to do these reviews.

There's never been a dedicated source of funding saying here's some funding to actually make this happen. As much emphasis they put on it, it's always baffled me, and it's been a struggle. Because there's -- just like everything else in this country, there's huge variation across states. Some states have zero dollars, and then you get Missouri and they put $5,000 state general funds into their process, so it's wildly different.

COMMISSIONER PETIT: This is Michael again. So going back to Wade's point in continuing I think as part of the same conversation is, Wade, I don't think -- I'm sure you were kidding when you said we're not king makers, these are recommendations for both the executive branch and Congress, that that's all they are is purely recommendations.

However, they're recommendations based on some finding of facts and some knowledge about what's happening out there due to the fact-finding aspect of what we've been doing. So I guess the question for me is when you look at that Shame on U.S. Report, just stick with that for a moment, and there have been many other reports, but let's just stick with that because I think it's the most current and comprehensive.

Do we agree with it? Is it what we have found? So the Congressional committee doesn't need to look at Shame on U.S., they can look and see what we found. Do we agree with what's in that report? I don't think we're in a position to comment necessarily at-depth right now, but I think it's something that does deserve attention. And at that point Congress does have sight function, they're the board of directors for the Executive branch, and the Executive branch needs to say, you know, yes or no. And then Congress needs to say, well, if you agree, do it, great; if not, we're going to make you do it.

Whatever the solution is, but I don't think we should put this 50-or 60-page report, which is very specific about the federal role, go unexamined by us. Do we agree with it or not? Maybe we don't agree with it, maybe we disagree, but it's more than anything I've seen anyplace else.

COMMISSIONER HORN: I do not disagree with that David -- Michael. The only point I'm making is that Congress can also decide not to pick up a recommendation and hold the administration accountable for it. For example, the National Commission on Children's recommendation for a thousand dollar refundable tax credit for child. That eventually become law, but they didn't have to.

So should we examine the report and pull out what makes sense? Absolutely. Do I believe that commission reports have power? Absolutely. Do I think that Congress should take into significant consideration the recommendation of this commission? Absolutely. But I don't think -- my only point is that it's important to know that we are recommending things that others can pick up on or not. They should have power precisely because the reasons you just said.

COMMISSIONER PETIT: Wade, I can't think of a single person who would disagree with the fact that we all understand that we're simply making recommendations. Presumably they're informed recommendations that aren't driven by any ideological considerations from any particular perspective.
The facts are there are several thousand kids a year that are killed, we haven't made much improvement on it over the last 40 years, they're still being killed, by every means possible. We know who the vast majority of these children are in the system at some point, including as recently as yesterday when we were told none of the ten had any prior contact with the Department, but then you found out how about after a year and a day? Then we find out six out of the ten had contact with it.

All I'm saying is this is a big issue. A lot of kids are being killed and where is the Congress on it? Well, I think what they said to us is by a combined vote of 30 to 77, 100 nothing, provide us some guidance on to it. So when we have the Children's Bureau come in and say we're not talking, and we say what are the specific initiatives that are being put on the table that you're proposing that approach the magnitude of this problem? And from what I got out of that was not much.

I mean, what we were being told is this is not a priority issue. If I'm wrong, great, I'd like to see that it's a priority issue, but it seems to me until Congress opens up this issue to public discussion and the attendant publicity and press coverage, and then the Executive Branch is

forced to respond. Until Congress gets serious about it, and I think they are serious about it, they spent money and time on this, that's who I think our principle audience is, as well as the Executive Branch, but especially the Congress.

COMMISSIONER HORN: I don't think I said anything in conflict with that.

CHAIRMAN SANDERS: Michael -- Michael, let me just jump in for a second because we're on the recommendation of the policy subcommittee, and so I would like to understand if you're making a link between the Shame on U.S. Report and the policy subcommittee recommendations, or is that -- is the recommendation around response to the Children's Bureau separate from them?

COMMISSIONER PETIT: I think they're related, but they're also separate. I don't know who yet from the commission, whether the 12 members of the Commission or the staff have actually examined the Shame on U.S. report and said they're not accurate, they're wrong, it's not what our experience has been, or they're close to the truth or not, I think it's all woven together.

We have an outside party looking at it, and I think they're credible, I don't know if they're not credible, but I think the merits of the argument need to be examined. And so in terms of the policy committee, I would think they have either begun a process of reviewing it, or we're going to agree now on how it's going to be reviewed, but I don't think it could just be bypassed.

COMMISSIONER RUBIN: I think a good next step, because I agree with what Commissioner Petit is saying, would probably be the folks who did the report, have them present before the commission.

COMMISSIONER PETIT: Yeah, yes.

COMMISSIONER RUBIN: And I think we clearly need to learn more about the reports and the assumption about the report, about where responsibility or oversight lies, et cetera, and then we can make informed decisions as a group as to relevance to our recommendations.

COMMISSIONER PETIT: I highly endorse that.

COMMISSIONER COVINGTON: I do, too.

CHAIRMAN SANDERS: I guess I would like to have maybe -- I don't know if it's a child protection committee policy. I'd like to have somebody actually provide us with a little more detail. I mean, I've reviewed it, but I'm not sure how it stands out beyond other things that a variety of people might say. And so I'd just like to get some clarity on how we would distinguish that report from others that might come out.

COMMISSIONER RUBIN: So maybe it's not that report, but maybe it's a panel we put together for a future meeting that has to do with critiques of the federal oversight process for states

around safety.

COMMISSIONER STATUTO BEVAN: When we get to efficiency in here -- we are reviewing in our efficiency section and we are reviewing recommendations of prior panels. I don't know, Michael, if you want -- yes, we want to review the nation -- the Shame on U.S. report.

COMMISSIONER COVINGTON: Shame on U.S.

COMMISSIONER PETIT: Shame on U.S.

COMMISSIONER PETIT: We look at it, either one subcommittee or two subcommittees, and certainly I can't speak for Jennifer or for Bud Cramer, but speaking for myself I'd welcome an opportunity to go through that feedback to the full commission interpretation of what we think it said, and do that as a subcommittee, or if it requires two subcommittees, that's fine. But I think it deserves more examination, especially after the testimony I heard yesterday.

CHAIRMAN SANDERS: I'd suggest that we move on. And, particularly, Cassie, if you and Wade want to address that as part of the four areas, that's fine. If not, then after the policy subcommittee recommendations we can consider whether it should go to child protection, but I think that we should probably make sure we get through the rest of your recommendations.

COMMISSIONER STATUTO BEVAN: Right. Under effectiveness, we also want to look at the requirement for termination of parental rights under ASFA, the Adoption Safe Families Act. In there, there's language that says if child has been abandoned as an infant, or one parent has committed murder or manslaughter, then the requirement that -- and if anything is resulting in bodily injury or death, that you don't have to do a reasonable effort to reunite or provide services to that family, you can move to TPR.

And what we were trying to figure out is how many state statutes follow in any way this requirement, because it appears that the requirement for TPR and fatalities is not being followed, and that would help us a lot with fatalities if we were not returning siblings of the dead child to the parents who perpetrated the death in the first place.

So we, you know, there's something here that we really need to look at, which is you can avoid -- states can do more and follow the law as well.

COMMISSIONER DREYFUS: Cassie, can you guys just add into that what the issue of boyfriend is in the home? You know, I appreciate parents and -- but what about the parent with a -- typically, given my experience, with a boyfriend in the home and the parent not being willing to take the necessary steps to protect the children when it's been viewed that person in the home is all of these things that you're just saying, right?

COMMISSIONER STATUTO BEVAN: Uh-huh.

COMMISSIONER DREYFUS: But they're not the parent.

COMMISSIONER STATUTO BEVAN: In the bypass language I think there's language, but I can look to see if it's not just limited to the parents, it shouldn't be.

CHAIRMAN SANDERS: But states can go beyond the federal --

COMMISSIONER STATUTO BEVAN: Yes, in another section for aggravated circumstances, which is an illustrative list of chronic abuse, torture, these are all lists. It's a list that states were allowed to add to or subtract in terms of being able to deny a portion of parent's reunification with this child.
No state, from what I can tell, has gone beyond our illustrative list. Even though, when we met with the state bodies they told us that states would take our list and expand upon it because, you know, you didn't know what you were leaving on and what you were leaving off, and you didn't want to do that so we created this illustrative list and states would, on their own, bypass reasonable efforts, but that doesn't happen.

And so there's implications there for child fatalities. If you're not using this list, or any kind of -- it's being ignored. I mean, ASFA is totally being ignored both in terms of being required -- to bypass reasonable and aggravated circumstances. So we want to look at how many states are driving -- are using loopholes and moving right through ASFA. For example, under aggravated circumstances, you require -- you can allow TPR, but you have three exceptions.

One is the child is in care of relative; two, services haven't been provided; and three, that the agency doesn't have TPR as a goal for that child. States are driving a truck through those three exceptions, and so we're not getting the results that we intended. And our question is what can we do to again take federal law and get it implemented or at least examined if it's not being implemented.

So we'll move on to accountability. We have things we want to look at. I was getting at it yesterday with Tom. Requirements under title IV-B, Sub-part II, we want to look at, you know, state and -- that's discretionary money, that the state Child and Family Service Plan [CFSP] contain assurances that the safety of the child to be served shall be of paramount concern.

So how is that mechanism being implemented, being accounted for, measured? I don't think it's happening, so we really need to see to the extent -- worked hard on that language to say safety of the child shall be of paramount concern. And yesterday when I asked who the client was to the four agencies we had in front of us, the client was everybody that comes to their agency or was families.
The client, according to federal law, is the child. Child has to be paramount. So CAPTA requires also safety assessments and prompt investigations of reports, you know, what do those look like? And Teri, if there are -- where is Teri? There are the web of reviews, I want to know -- and she's critical to this, I want to know of those reviews, there's so many of them, which apparently there are, which of those are not effective, which of those are duplicative, and if we got rid of some of them would we have any money for one review that's, you know, what we want?

Because obviously I think we all know we're working under budget constraints, we're not going to be able to recommend, and that was my concern about Michael's report. We're not going to be able to recommend a report that has $30 billion of extra spending. We're not going to do that. We need to find some money under programs that are not effective or duplicative, then we need to use it wisely.
So efficiency, and that's where it leads right to efficiency. We'll look at the summary of recommendations from all these panels and see if we can find almost like a meta-analysis. Can we find the common theme? Can we find the recommendation that's been -- that holds the most promise in terms of alignment with research, alignment with policy and practice, and has reduced or eliminated fatalities as an outcome?

Again, we also do want to look at CFSRs and find out what we should be measuring. We want to look at tracking of federal allocation of funds. I mean, here we want to look at Maternal and Child's Health (MCH), Early Head Start (EHS), Head Start (HS), IDEA [Individuals with Disabilities Act], you know, all of these programs, we want to be able to track the allocation and see if they're sufficiently being used.
We also want to look at, under the same section, collaboration and coordination of public agencies. I mean, when we heard yesterday about this over 40 agencies in this interagency -- federal interagency working [Federal Interagency Workgroup on Child Abuse and Neglect] with child and neglect. I've heard about that agency for 30 years, they haven't yet come up with a recommendations or even studied fatalities?

I mean, it's time for that interagency work group to work on truly collaborating and coming up with some recommendations on how we should be maximizing the resources through all these departments that they -- I mean, they range from, you know, defense, education, interior, justice, state, they're all over. And they meet once, what is it, four times a year?

COMMISSIONER COVINGTON: Cassie, one thought I had when I heard that yesterday, because that group, I've attended that meeting several times, so I'm really speaking only from a limited experience attending that meeting. But it tends to me to not be a group that works on creating interagency recommendations or what have you.

It's a -- I hate to use because it sounds diminutive, but show and tell. Where you go around the table and people talk about what they're working on. They have invited me in three times I think to actually talk about fatality review, but there's never been a what do we do with this information kind of across an integrative approach.

COMMISSIONER RUBIN: It's because no one owns its.

COMMISSIONER COVINGTON: Pardon? Nobody owns it. It's more of a network. I would describe it, and I shouldn't because I'm not the one who runs it, but when I've been there my sense of it is a networking meeting more than a working federal group trying to make integrated services happen across the board. And maybe that has changed, because I haven't been there in over a year.

COMMISSIONER DREYFUS: Does that work group have any Congressional oversight? Was it simply something they put together themselves? They don't have to make a regular report to

Congress --

COMMISSIONER COVINGTON: No.

COMMISSIONER DREYFUS: -- with a specific objective?

COMMISSIONER COVINGTON: I think the Children's Bureau just started to bring other agencies to say what are you guys doing around child maltreatment? And really my first meeting was years ago almost, and that's what it was. It's expanded. I mean, I remember the first I went there were ten people around the table, and the last time I went it was standing room only, it was 40, 50 people. So it's grown.

CHAIRMAN SANDERS: Wade, do you have more information on this?

COMMISSIONER HORN: I'm sorry, I was transitioning to my car. What was the question?

CHAIRMAN SANDERS: Talking about the interagency work group. Do you have information on that that would be helpful for us?

COMMISSIONER HORN: Not off the top of my head. I know that it exists; it's been while.

COMMISSIONER STATUTO BEVAN: That's basically --

COMMISSIONER RUBIN: Sounds like they don't have a charge. I just said over here, it sounds like that group doesn't have charge. And I think in the context of how we make our recommendations as we move forward, emboldening them with a charge, particularly if we're organizing federal responsibility, whether -- if you guys agree with some of the recommendations we might make around broadening this to larger collective public health response, then they will have a job to do, right now, above and beyond a reporting function of what they're working on.

COMMISSIONER STATUTO BEVAN: Yes.

COMMISSIONER PETIT: There is not a mandate at this point out of the Congress or White House for this issue to be priority. And until that happens, until it moves into the ranks of top leadership of Congress, top leadership within this administration saying we want this paid attention to, it's going to be the way it's being dealt with, which is quietly, mid-level of one of the very large bureaucracies.

I think one thing we should do is ask for a meeting with the Secretary on this as well. I don't think it should be left to the level of the Children's Bureau. Similarly with leadership, we need a committee with Congress to be asking for some kind of briefing we can present either to staff or to members themselves. But at this point, I think it's safe to say there is no sense of urgency that I get out of the federal government, especially the Executive Branch that says this needs to be made a high priority.

COMMISSIONER COVINGTON: There was a comment made yesterday, I don't have her exact quote, but I thought about it last night when she said that she didn't think really coming to understanding what the true N is really something that is worth the time right now, that there's other things on their plate. And I was thinking we're in charge of trying to figure out how to measure things, and to hear it coming from the administration that they didn't think that was something that was of value there seems to be some disconnect for me.

COMMISSIONER DREYFUS: I also think we always make this mistake where we focus in on -- we're talking about elimination of child fatalities abuse and neglect, I get our charge. But if we are successful in reducing that N, no matter how small that N is, the cascading influence of that throughout the child, quote, unquote, welfare system, is more than just the influence on that N. And I think that's --

COMMISSIONER COVINGTON: What she was saying?

COMMISSIONER DREYFUS: No, I don't think that's what she was saying, that's how I would have responded back to what she was saying.

COMMISSIONER PETIT: I would just note that I think there are five Ebola cases recorded in the U.S., so for -- and I'm not sure any were U.S. citizens, and we've got 3,000 deaths of these kids. The Ebola thing goes through the roof, 3,000 kids gets played out daily in terms of what a disaster it is, and then we talk to the federal government and it's like not that big of a deal.

COMMISSIONER RODRIGUEZ: I'll just say I think I heard that differently, at least, yesterday. I think what I heard from her was to not get hung up in sort of the technical details, because no matter what the number is, it's too big, and no matter how we look at it, it will always be too small. And given the limited amount of time that we have on this commission, and the huge sort of charge that our commission has been given, I think what she was suggesting to us is to think expansively about -- that was the way -- I may have been giving her the benefit of the doubt, but I think the message that I got from her was just don't get caught up in the technical pieces that actually could be the duration of what we focused on was getting an accurate count.

Can I ask a different, sort of naive question about the federal accountability piece? So I think when we've been talking about the federal accountability we've been talking about it in terms of basically how can the federal government penalize these states if they're not meeting compliance. And, I mean, I could be cynical, but I don't think I've actually ever seen federal government do a good job around changing practice by doing accountability efforts in that way.

And I'm just wondering are there other examples in any of the federal statutes where not complying triggers a different type of response from the feds to the states, more like a technical assistance response? Because I'm not sure that some of the state agencies, like you were saying, this was never the intent of this statute was to focus on this. And I guess I don't have confidence that leadership in different agencies actually even understands what the intent was of some of these statutes, and particularly around child fatalities.

It would seem to me that it might be more effective in terms of getting change to actually not just think about penalizing, but to think about how to bring up practice if they're -- if somebody isn't complying does that then trigger a mandate, whether it's from whatever the technical assistance branch that she talked about was, or if it's from them sort of triggering a mandate that experts be brought in to help that system come up, too.

We had an interesting conversation last night about nurturance of sort of systems getting you quicker to sort of a positive result as opposed -- I mean, it's just over the years it just -- I have not seen in any of the states that we worked in when we walked in and said do this, that that had a change for the kids quicker than sort of explaining to them here's what the intention was, here's some best practices from other states, let us help you get there as quickly as possible.

COMMISSIONER PETIT: Jennifer, I think you're making a very good point, but I don't think the two are exclusive. I think there were numerous examples, Department of Justice, for example, overriding local decision making in terms of investigating police brutality. It's true in the environmental area, it's true in energy policy. I mean, there is an attempt to work with the states to get certain things done, but the federal government usually resolves for itself some ability to come in and ensure that federal law is being in compliance.

I've been in bales where every kid in the jail had not seen an attorney, every kid was black. Kids were going into jails for the slightest, you know, shoplifting potato chips, going to jail for weeks without counsel. It was only when the Department of Justice came in and brought an action against the state. I mean, every decision there was made locally. It was only when DOJ [Department of Justice] came in and said, hey, wait a minute, this is out of compliance with federal statutes that the state complied and ended their policies and built new facilities, it happens I think regularly.

COMMISSIONER RODRIGUEZ: Michael, I'm not suggesting this approach replace accountability reproach or strategy that uses penalties. What I am saying is that that hasn't worked up until this point. Maybe we should be thinking and, so there's really an effort. If we're not seeing actually states do what they should do for kids, if it hasn't been working then can we add something additional.

COMMISSIONER COVINGTON: That's what the performance improvement plans are, though.

COMMISSIONER DREYFUS: And all the resource centers.

COMMISSIONER COVINGTON: Right. All the resource centers as well.

COMMISSIONER RODRIGUEZ: So not just compliance and not just in CFSRs, but in other areas would trigger TA [technical assistance] from --

COMMISSIONER COVINGTON: They work together with the federal government, they create benchmarks for where they want to improve over time.

COMMISSIONER RODRIGUEZ: I mean, I know that the plans sort of get developed, but I'm wondering does non-compliance trigger both a response where there's sort of a punitive response, as well as a TA response, where there's some sort of prioritization. Because I don't necessarily get the sense from the TA folks that they're prioritizing the systems that are most in need, but instead that they're sort of -- whoever requests help in my experience has been, oftentimes has been the people who most need help don't even know their system is in trouble, because they don't understand what the end goals were.

COMMISSIONER RUBIN: I think it's balance of penalties and incentives. In some ways, I think it's a major incentive. These states are all huddling together bringing health systems, public health, everyone together to try to write these state implementation grants because there's real money there to help coordinate sort of a regional accountability around health care. So there's both positive and negative incentives, and I think, you know, people respond to that if there's some grant funding to be able to build capacity.

COMMISSIONER DREYFUS: Jennifer, to your point -- I don't -- I haven't been around it in a long time, so maybe somebody else will have a better understanding, but I think the resource centers [the Children's Bureau's National Resource Centers (NRCs)], and I know the feds have just done some consolidation of the resource centers, I don't know, and David, maybe you know, is there anything more specific -- and this gets to policy recommendation, about the National Resource Centers where it isn't just sitting back and waiting for a state to ask for resources, but more there is a more direct connection between the PIP and the resource centers, right, coming alongside it. Not just waiting to be invited in, but becoming an active part of a state's progress in their PIP. She is raising --

CHAIRMAN SANDERS: I would make a suggestion kind of based on the comments. Because if we think about the goals of the presentation today, about general agreement opposed or need more information, in this area I'm wondering if we also would consider making a recommendation that the administration develop a plan for a Congressional oversight around reduction of fatalities due to abuse and neglect, similar to what you've described for the state plan, to begin to tie all of these things together so that there's kind of a clear picture of how things are related, what the chariots are, what the stick is going to be and so forth, because we don't have anything like this at this point and that may help us get these in things.

COMMISSIONER STATUTO BEVAN: I think we can charge the 40-member agencies. I mean, we can, you know, yank their chain and give them a specific charge.

COMMISSIONER DREYFUS: By Congress.

COMMISSIONER STATUTO BEVAN: Well, we as -- as a recommendation, because we're looking for -- what we want to look at does the working group provide effective coordination, collaboration, and national leadership on these issues and I think the answer is no. Wade, I wanted to add that we're looking at safe haven laws, and we want to see how frequently these safe haven laws have served to protect the lives of at-risk kids, and what other mechanisms states are using to publicize these laws. Finally, how we're going to work.

COMMISSIONER RUBIN: Can I ask a question before you, in terms of how you're going to work? So the elephant on the table, we heard the commissioner yesterday, at least the commissioner yesterday, talk about her -- the Children's Bureau recommendation around sort of pre-placement and post-placement, flexibility for the use of title IV-E funds. So this idea of child welfare finance reform and using the diverse constituency on this commission, and the acknowledgement that every state leader has asked for flexibility in terms of directing resources.

If we tie that into better oversight and stronger state plans around this issue, are you guys going to look at child welfare finance reform and having us make a pragmatic, bold recommendation?

COMMISSIONER STATUTO BEVAN: I think we are going to look at child welfare reform not in a -- enforcing any specific reform, but the issue of bringing up that everybody is looking for flexibility, and that flexibility doesn't necessarily mean leaving it up to the states with no strings attached, that there needs to be some -- I always call it block grant with principles, but something that we still hold on to, but allow the states to have the flexibility.

I mean, it worked in TANF [Temporary Assistance for Needy Families program]. When I heard -- the testimony yesterday the TANF is a child protection program I couldn't believe it. But with flexibility, and then we will have to work with them, that's how we're operating. We have to work with the NGA [National Governors Association], we do have to work with the National Center for State Courts [NCSC], I mean, we have to work with these groups; and CWLA [Child Welfare League of America], APHSA [American Public Human Services Association], and we have to find out more about, you know, what they want to do and what they need, as well as working closely with and getting technical assistance from all the groups that most of you have been meeting with.

COMMISSIONER DREYFUS: To Dr. Rubin's issue of federal finance reform, I do think like yesterday the conversation about pre-placement, post-placement. I get that, I love the idea. I just think let's not hide from the reality that since 1996 there has been a quiet, steady erosion of the federal/state partnership as it relates to title IV-E financing in the system.

So I appreciate having pre-placement, post-placement, but the bottom line is that I don't know if this is a commission's role or not, so I'm not at that point yet, I have to think about that, but I do think there's got to be recognition that there has been a quiet and very steady erosion of federal participation in child welfare because of the look back, and because states have been reducing the number of kids in out of home care, right?

I mean, the estimate is if we do nothing on finance reform this year we're looking at another half billion dollars. And CBO [Congressional Budget Office] has child welfare financing scored just like this. Why? Because of the look back and because states are doing a better job of not having as many kids in the system.

COMMISSIONER COVINGTON: Especially if SSBG disappears there's some serious decreases going on in child welfare funding.

COMMISSIONER DREYFUS: The other thing I'll just add is there's a lot of knowledge I think sitting in what states have -- that's why when Erinn said yesterday, you know, Oregon has never seen a waiver we didn't like, I mean, the bottom line is there are reasons why states love those waivers, because it feels like the infusion of new capital into your systems to do innovation, to build up front-end capacities in your system because of the flexibility you have over a period of time with a finite amount of resources. So I just -- to David's point, I do think there's got to be some consideration raised by the commission where do we factor in on this issue of refinancing?

COMMISSIONER STATUTO BEVAN: Well, we just need to tie it to fatalities. If we're going to look at financing then we have to look specifically what the barriers are in current law and how --

COMMISSIONER DREYFUS: How do we influence that?

COMMISSIONER STATUTO BEVAN: How do we tie it to fatalities, we can't have mission creep.

COMMISSIONER DREYFUS: How would it influence it?

COMMISSIONER STATUTO BEVAN: That's our mandate.

CHAIRMAN SANDERS: Let me just throw this in and then come back to you, Judge. That it seems like the financing is one of the areas the policy subcommittee is going to look at and will come back with some ideas and we can then decide is that sufficient or not. And then the other is this issue of Shame on U.S., the report, and we'll come back to that.

But it seems like what I'm hearing is general agreement with the direction that the policy subcommittee is going, and that there might be a couple areas that are either already considered or could be more specifically focused on. Have I missed any of the things? So, Judge Martin, go ahead.

COMMISSIONER MARTIN: I just wanted to go back to the comment about waivers and reform. And granted, the waivers I'm most familiar with are the ones that the State of Illinois has utilized for, you know, permanency, particularly to subsidized guardianship program in the late '90s and early 2000s, but I do think it's imperative, as Cassie said, that we have some way to connect any kind of, you know, serious efforts into finance reform recommendations with how that's going to minimize or eliminate fatalities.

I think that, you know, having flexible funding is great for states as I understand it in terms of budgeting and figuring out how to do placement and safety and reform issues, but if it's not going to be directly tied to fatalities I'm not sure that we're really staying on mission. I don't disagree that it needs to be done, and the more I've had conversations with the commissioners around the table the more I believe it needs to be done, but I'm just not sure that this is the place to do it, if in fact we can't specifically tie it to the fatality issue.

COMMISSIONER RUBIN: I think the fact that, you know, we can argue the numbers, but at least, you know, half the kids are not known to the child welfare system to not provide some

capacity through finance reform to allow states to move resources upstream, whether it's to meet their CAPTA requirements around how they're going to have a collective response around substance abused babies in the nursery.

Look, I think, to me, the overall principle lies, in my mind, that we're going to get more skin in the game at the state level. We're going to require greater participation across the table. We're also going to hopefully tie that to some level of real skin in the game. So like, you know, right now penalties all rest at CPS, whether it's CAPTA or the CFSRs. What if penalties actually rested in the maternal health child block grant or even go so further to Medicaid, right?

That you're going to create skin in the game, but at end of the day states are going to say where's the flexibility we're going to have to bring to group going to elicit a response around safety at a community level? And I think that's where finance reform fits in, it's part of that package.

CHAIRMAN SANDERS: Can I just suggest -- I don't think we have the information in front of us yet to actually debate it.

COMMISSIONER DREYFUS: Right.

CHAIRMAN SANDERS: I'm thinking the policy subcommittee should continue to look at this, bring more specific information about what the --

COMMISSIONER STATUTO BEVAN: Barriers there are.

CHAIRMAN SANDERS: Right. What's incurred, what the loss of funding has been and the issue you're raising, and then I think we'll have to debate is that tied to fatalities closely enough that we can have it as part of our report or not. But I think we need a little more information before we can get to that point.

COMMISSIONER PETIT: Yeah, David, this is Michael. I would certainly agree with that. I think what is exactly the child welfare spending reform that we're talking about? In a specific way, not just in a general way, but very specifically, and does it include the conversion of title IV-E into a block grant. Is that what somebody is proposing or not?

I mean, I'd like to see what the specifics are of this so the states are given the flexibility they need to reflect local culture, et cetera, but there is an overriding national goal, so to the extent that the state tactics and strategies and initiative support the national goal, that's fine. But make no mistake about it, there's a national goal here. And some states do better in adhering to it, some states do better in responding to it than others.

Again, what would it mean in terms of that flexibility if we said states now have more discretion over this money? You know, when I was a commissioner we had mental health and we had maternal child health services as well as child welfare, as well as TANF, et cetera, all of this other stuff. There were certainly vehicles for tying things together at a state level

working with the governor, working with legislators, whatever.

I mean, in a lot of places flexibility is being exercised, so I guess I would want to see what the specifics are of what the finance reform would look like. Do we have a paper?

CHAIRMAN SANDERS: We're not at that point.

COMMISSIONER STATUTO BEVAN: We're not going to recommend anything. Let me explain how our subcommittee is going to work, because we're not making those kind of recommendations.

CHAIRMAN SANDERS: After this we'll need to wrap up so we can get to the other ones. Go ahead.

COMMISSIONER STATUTO BEVAN: When you were also out of the room, Teri, I want to really look at the web of reviews.

COMMISSIONER COVINGTON: I'm happy to help you guys with that.

COMMISSIONER STATUTO BEVAN: Please, we really want to see if we can find some money.

COMMISSIONER COVINGTON: Did you just say find some money?

COMMISSIONER STATUTO BEVAN: Yes, I knew you would wake up then. But your group is a not-for-profit. It's not a government agency, right?

COMMISSIONER COVINGTON: No, we're funded by HRSA [Health Resources and Services Administration] to support the -- we're the only group out there that is through the federal government. It has a charge of --

COMMISSIONER STATUTO BEVAN: It's always changing though, right?

COMMISSIONER COVINGTON: Yeah, yeah. There's a new competition that they just released that's due March 20th.

COMMISSIONER STATUTO BEVAN: So if we looked at the web -- if we look at this web of reviews and then maybe we can find something maybe we can structure the money, structure something differently. We can't make a recommendation of money, or even look at -- the way we're looking at things is not -- making -- Michael, we're not making recommendations.

What we're doing is running the policies that already exist through our policy lens of efficiency, accountability, clarity, and effectiveness. We're just running it through to see where it ends, but we're not making recommendations.

COMMISSIONER PETIT: I mean, now or ever?

COMMISSIONER STATUTO BEVAN: I don't know ever. No, no, not now or and have I ever been. What we will end up doing is coming up with some pros and cons of what we found, I mean, and leave it up to the commission.

We're not going to do more than that because I don't think that's our role, and I think there was a lot of push back when we tried to do more of that and I want to stay away from that. What we're -- that's what we're going to do, come up with series of questions, and come up with pros and cons web pages to see how things are.

COMMISSIONER COVINGTON: I'd love it if you came up with recommendations, frankly, personally, around some of the policy issue around compliance and what have you.

COMMISSIONER STATUTO BEVAN: Well, we'll see how we go.

COMMISSIONER RUBIN: I think it would be helpful for the commission to have a panel at one of our state meetings that we -- that educates us on is there an intersection on the child welfare finance reform issue and child fatalities. And so we can bring in people from different vantage points.
It's the elephant in the room in every state meeting we've been in, every DHS [Department of Human Services] director has walked in here, whether conservative or liberal states, or, you know, blue or red, they all talk about flexibility as a key issue at the state level. So it's hard for us not to at least evaluate that.

COMMISSIONER STATUTO BEVAN: Responding?

CHAIRMAN SANDERS: Yeah. It seems -- I think let's go through the other subcommittee reports today and kind of identify where there are some gaps. This may very well be one of them, but I'd like to hear the others to kind of get a sense of that.

COMMISSIONER STATUTO BEVAN: Okay. So we're wrapping up by just saying upon requests, we're taking requests. Upon request, if the subcommittee wants us to run their whatever through our policy lens, through these four factors, you know, we will do it and come up with maybe one page of pro and con, but what I also want to say in policy is that, as Michael has pointed out for this legislation, there has never been legislation in child welfare policy, ever, that has not been bipartisan or bicameral. We won't get anything done unless it's bipartisan or bicameral, and that's the spirit with which we have to move forward, I think.

COMMISSIONER PETIT: Yeah, and can I say on that, relative to David's point, in terms of this flexibility question, because I'm hoping it's not going to come down to states versus federal. It's state and federal, right? And so I'd like to see exactly what this list is and where there is more flexibility needed. I mean, I've heard it generally, but specifically can somebody tell us where that is? Is one of the committees looking at that that's saying this is where the states need more flexibility and not generally platitude, but specifically what do they need more flexibility with that they're not able to exercise right now? I'd like to see what that list is because I haven't seen anything.

CHAIRMAN SANDERS: I think, Michael, what my personal view, that's why we suggested that we wait until we hear all of the subcommittees, is that we haven't yet identified a set of strategies that are effective at impacting fatalities, so --

COMMISSIONER PETIT: Right.

CHAIRMAN SANDERS: -- I'm not sure we've heard that from states yet. So I think we need to get a better sense of that before we can determine so how does funding connect to that. I'm hoping we hear some of that from the public policy subcommittee. I don't think we've yet heard from any others, and I think we're going to have to wait to hear it from the American Indian -- I'm a little hesitant to move into how we focus on funding without a sense of what we collectively believe there are things at work.

COMMISSIONER RUBIN: Yeah, but it's not about that, David. I think that the -- I don't think we're ever going to find that there is a single prescriptive plan. However, I believe if we do this correctly we're going to ask the states to develop their plans based on their own geography, people where they live, and ultimately, how they're going to fund that approach is going to be a question that they raise, and so we have to provide the means for them to develop their plans.

CHAIRMAN SANDERS: We technically -- we haven't heard your recommendations on that. That's what I'm suggesting, let's get through recommendations and let's debate that, and if that's one in things we recommend then it logically would follow why we need to look at other things. I think we're having the discussion without having heard kind of the full complement of recommendations that we're making.

COMMISSIONER PETIT: Yeah. David, just my final take on this is that I, again, I think that flexibility and funding are related, but they're also independent and free standing. They're related, but they're also separate. And the question of whether or not more resources are needed in addition to more flexibility, less flexibility, more laws, less laws, with respect to that there is this question, is there a resource gap in comparison to the size of the problem that we're looking at?

And we haven't had that conversation yet. We're researching it right now in the CPS committee that I'm involved with, and so I think that's going to be an important issue when it comes up. And, you know, for us to be able to say is there more or less resource that's needed? And I don't think we can declare that yet.

COMMISSIONER ZIMMERMAN: I just want to make a comment about, first of all, reports that are already existing for Indian country. The Indian Law and Order Commission created a report called, "The Road Map to Safer American Indian Communities," something like that, I'm butchering it, [A Roadmap for Making Native America Safer]. And then the attorney general advisory committee on exposed violence to children just came out with a report, and we strongly recommended that the federal government have a financial response to it because of the unique trust responsibility between tribes and the federal government.

Because as -- for all services, and the flexibility of braiding funding and using it for different things in tribal communities because they know what works in their community, they know how to get it done, but as we heard with the domestic violence centers often, in Indian country anyway, often the funding that they do receive can serve the direct victim, but there was no funding for services for the children.
And so tribes are thinking about well, just let us do this, but let us be flexible with how we do this. And so I am, because of the unique trust responsibility, I think our subcommittee is going to have some strong recommendations about funding of tribes, particularly because on this commission we also heard that tribes only get in the last ten years about one to two percent of CAPTA, that's all they really are able to do.

So there's got to be a huge piece for -- being able to have the resources to be able to build the kind of programs that tribes need to build around child protection issues, not just fatalities, but that lead to fatalities.

COMMISSIONER STATUTO BEVAN: So would you provide us with those two reports, so when we review the recommendations we include --

COMMISSIONER ZIMMERMAN: I will. Yeah, absolutely.

CHAIRMAN SANDERS: So I think we're ready to shift to the public health subcommittee.

COMMISSIONER RUBIN: I'm going to ask our staffers, Sarah Zlotnik, is going to present a lot of the details. Commissioner Covington and Dreyfus can also chime in as well, too. I think as we have examined this issue in our subcommittee, and we have had a number of meetings, and continue to start to break ground with the Center for Medicaid Services [Centers for Medicaid Services (CMS)], meeting with the acting lead there, Vikki Wachino [Vikki Wachino, Acting Director, Center for Medicaid and CHIP Services (CMCS)] coming up, but we've already met with some of her staff.

Also kind of going to CDC [Center for Disease Control and Prevention], to SAMHSA [Substance Abuse and Mental Health Services Administration], and so on and so forth, and then what I thought was our most productive meeting was at HRSA, actually. That block grant, that Maternal and Child Health Block Grant [MCHG] an organization that's been set up is really skeleton for public home work for maternal child health work, and really involved, and knowledgeable folks with a lot of deep connections to the states now through the MIECHV [Maternal, Infant and Early Childhood Home Visiting (MIECHV)] program, as well as home visiting, et cetera.

So we've done a lot of researching and trying to prepare folks to come back and talk to the commission, and that's coming in future meetings. But I will say the vision that seems to be we're creating is the idea -- and it gets back to what Michael said a little while ago, which is unless we elevate this issue it's going to continue to be buried like, you know, in the government. And I think elevating this issue, and Commissioner Dreyfus said this yesterday, if we came out with a statement that said this is a public health emergency, or this is an issue, just the idea that our report was framed that way, that we were not going to just allow this to sit at Children's Bureau, or sit in CAPTA, right, that created a level of urgency in terms of

our approach, talking about trying to avoid as we make recommendations downstream to say, okay, here are the recommendations for child welfare, here are the recommendations for Medicaid, and continue the siloing of this approach that happens throughout state and federal government.

Instead, if we took an approach that said, look, we are actually going to require states at a higher level beyond their CPS system to develop their state plans around how they're going to prevent child abuse and neglect fatalities, and it's going to bring everyone around the table, what would it look like to do that? And we have some ideas about creating some skin in the game through Medicaid and the Maternal Child Health Block Grant, but I'm going to let Sarah present some of those ideas now, and suffice it to say we have to think about ways to tweak that.

Commissioner Covington was already thinking about ways not to -- to potentially -- we're not looking to the Maternal Child Health Block Grants to siphon resources away from the states. But it is a potential way to put skin in the game in terms of putting money at risk if they don't develop these plans? And there may be new resources we need to talk about, as Michael talks about.

So, Sarah, why don't you talk about some of the other things we are starting to vet.

SARAH ZLOTNIK: Thanks, and to let everyone know there's a summary, four-page summary, that should be under the binders. Amy added it this morning, and another draft was passed around yesterday, so that's what we'll be talking through. Great. So thanks, Commissioner Rubin.

So with that, you'll see the document, much of it looks very familiar to what the commissioner's presented in Phoenix really regarding the approach of the subcommittee that we're taking a system's level approach, so not just targeting and looking at individual children and families, but really trying to figure out how do we have that cross system approach that Dave mentioned, as well as targeting it from different system levels, as well as thinking both about the web of formal supports and informal supports as we're thinking about this strategy.

And so as we're talking through the buckets of the direction of our recommendations we want to make sure you have that framework as part of the overarching look. So what we have at this point are really four directions that we are looking to go.

And we see them very intertwined in terms of making this successful, and also see them very intertwined with the work of the other subcommittees, and a lot of that has already come up, and so hopefully this opportunity today will give us a chance to better align them and better think about those in tandem. And so the first one is actually on page 2.

So it's, "Require states to develop and implement a comprehensive state plan to prevent child maltreatment and fatalities." So the commissioners on the subcommittee have been alluding and referencing this throughout, and I think there's already a bunch to build on, but we really see this as the cornerstone recommendation.

So there would be guidance that we would put forward around what are the core elements that would need to be incorporated, but that there would be a lot of space and flexibility then for states to identify how they would address those core elements that we saw were incumbent and part of prevention.

COMMISSIONER RUBIN: For example, each of the other subcommittees, so for the measurement committee, you know, can imagine as you provided federal guidance, and let's say this was organized, we can decide where it can be organized, maybe through HRSA or whatever, but as you provided in federal guidance one element would be how are you going to review your fatality and fatality reviews?
Another would be how are you going to meet CAPTA requirements around kids? So we can define elements that need to be part of that plan and leave the flexibility to the states to think about how they're going to respond to those elements, but it's a way to provide a skeleton or a backbone to the recommendations of our report.

COMMISSIONER DREYFUS: Right. So for everybody to understand, too, is it's not just what are the core elements that have to be taken into consideration for their plan, but also at a minimal level who are the key partners that have to be part of the development of the state plan to eliminate fatalities from abuse and neglect, and not just the responsibility of the Maternal Child Health Block Grant, but the responsibility of the various funding streams of those entities that intersect on the issue, and how they're going to go back to their own home territory and make necessary changes and adaptations.

So it really is, and it's very similar to I think work we've been seeing more coming out of the federal government all around this place-based work, and what we've been seeing more around the country and around this larger collective impact, you know, kind of an approach.

COMMISSIONER PETIT: If I can just add if you go into this thinking about it. This is Michael. On Maternal Child Health, I know of no program that I would spend more money on to deal with this overall issue of child well-being and development, and ultimately fatalities in Maternal Child Health Services. We should all be aware that in 1981 we went from a Maternal Child Health program, essentially, it was entitlement program, to one that was block granted.

At this time there were around six hundred million, today there are around six hundred million, so 30 years later there's a lot of money that has effectively not risen. Now, ACA [Affordable Care Act] has just provided a pathway for doing more of that, and what we know is that half the states don't want it. They say no, forget that. So there's an issue there beyond what HRSA's core principles are, which have been strong since they were founded, I think around 1912 when they were doing horseback, nurses going into West Virginia to deliver service to kids. I wasn't around then, but I heard about it. But I think, David, this business MCH framing is critical. I think it's been around for a while and just the resources have just not kept pace with the need.

COMMISSIONER RUBIN: I think we have to put it on the table. I agree with you. You know, I think to some degree we have to think about what resources are needed to organize this at a state level, and think about that grant, but what I think what's nice about it is I was very struck at the HRSA meeting, the comment that the state's currently submit their plans on how

they're going to use the Maternal Child Health Block Grant money.

There's a precedent for requiring states -- all the states to submit around areas that was in-home visiting creating precedent for states to illicit or describe approach to home visiting. What I would think is that we would require them to -- it's not to say use their Maternal Child Health Block Grant, but we require them to receive Maternal Child Health Block Grant that they articulate a comprehensive state plan. Because the resources I think we should debate because it might be, Michael, we need to recommend increased appropriation if this is where we're going to organize these activities.

COMMISSIONER PETIT: Did you meet with the Maternal Child Health Association [Association of Maternal & Child Health Programs (AMCHP)]?

SARAH ZLOTNIK: At the staff level we've met with AMCHP. Hope Cooper and I met with AMCHP to begin to get their feedback on some of the recommendations.

COMMISSIONER RUBIN: Now, the other place to actually put the teeth in is Medicaid, too. I like the idea if you have a child welfare related issue, and you provide skin in the game, you know, with the public health infrastructure in this country and that actually brings them to the table and requires them to be at the table. Go ahead, Sarah.

CHAIRMAN SANDERS: Just a question for clarity, or Sarah. So regardless, let's say it's Maternal Child Health Block Grant, if part of the plan includes the thinking about Medicaid, would that mean that the state's Medicaid plan would also have to change? How is all this ultimately aligned, or is that too detailed?

COMMISSIONER COVINGTON: Can Sarah get through it first and then we can maybe -- we haven't even talked about the Medicaid piece yet.

COMMISSIONER RUBIN: The answer is, yes, but I'm going to let Commissioner Dreyfus answer.

COMMISSIONER DREYFUS: David, I think, is getting at something really important. And the vision here is that this would be somewhat different than what we've seen in the past when states are required to put a plan out. So this is really -- this notion of is there leverage to be gained by bringing these cross systems together to develop a single plan and to share accountability for that plan?

I mean, the worst thing that can happen is if we walked away from here and thought all things beginning and ending with Maternal Child Health and Medicaid are responsible for that state plan. The idea here is that the CPS agency is sitting at the table, law enforcement is sitting at the table, education is sitting at the table, everybody is seeing and understanding their role and responsibilities.

Now, where the federal piece comes in it, would be good to hear Cassie's view on this, this is why this all starts intersecting on us, is what would have to happen at the federal level to require states -- for instance, if I was in the State of Washington and I was submitting back to the federal Government my CAPTA plan, my title IV-B plan, or whatever, that I had to submit

back what our piece is in our state comprehensive plan for the elimination of fatalities from abuse and neglect, that I had to put that back out in my state plan for my specific funding area, right?

CHAIRMAN SANDERS: So that's exactly what's being considered as part of this. Thanks.

COMMISSIONER DREYFUS: Yeah, but I think we're on some new ground here.

COMMISSIONER COVINGTON: It goes into what we were learning.

COMMISSIONER PETIT: But we have the tail wagging at this moment because all the expenditures translating into power statutes, predominance in the press, legislator, those other departments have 10, 20, 30, 40 times the amount of assets that they're managing than MCH. So to give MCH a role in all that what would it be a coordinating role. They wouldn't be able to start making allocation for other units. I think MCH is critical in all this, but we should know as they're presently constant they are a tiny part of each state government's budget, tiny.

COMMISSIONER ZIMMERMAN: So I just need to insert this here for the record. I think what whatever recommendations we're making, because we're talking a lot about states is, is that there are those states that provide child welfare services for tribal people, but in those states that don't I think we have to always, always connect that states will authentically engage with tribes.

Too often I've heard testimony across the nation, I've heard anecdotal stories about states getting funding for something, using the data from tribal programs that really up the needs, and then afterwards, after it's funded, the tribes often don't see those resources, or if they do it's provided in a way that's not helpful.

COMMISSIONER DREYFUS: Marilyn, it would really help us if you would give us -- because what I think what we want to do is at a minimum who's got to be at that table and what does their active participation and shared accountability need to look like.

COMMISSIONER ZIMMERMAN: I think that's a question that we should ask at the tribal hearing in Scottsdale next month.

COMMISSIONER DREYFUS: Great idea.

SARAH ZLOTNIK: All right. So this dovetails very well then with a more specific attributes that we're trying to look at then that would bolster and support this plan, and just as Commissioner Dreyfus said, really the goal is to have the potential home be in public health, but that the responsibility exists across and how to coordinate and build that system, and I think very much need input and direction from you all about what would be best operationalized to do.

So the second component of this is to leverage opportunities in different public systems, to improve the identification of children and families at risk. And so I think the testimonies we

had yesterday provided one potential platform and examples of some of the ways that some states are thinking about those attributes. And just so as Commissioner Petit just mentioned, we really see the health care system as one, and Medicaid, as one of the key places to look and help them have skin in the game in holding some of the accountability and engagement around these issues both because we know for young children that they're often one of the few systems that regularly touches kids. As we heard yesterday, 95 percent of births are taking place in hospitals. So starting from prenatal care and obstetric care to well-child visits, and then continuing during that early childhood period and across.

Also, with the Affordable Care Act, we're really interested, particularly as we're preparing for the upcoming meeting that many of you are participating with CMS in how we can take this Affordable Care Act implementation and infusion of resource and deliver transformation to states, and this increased focus on prevention, to begin to think about how to better engage the health system and these questions.

And so we did have a couple directions we were looking at that we just want to highlight in this section as we're thinking about that piece. So one in particular is the role of health information exchanges to identify some of the red flags and the ways that states are building interoperable systems as well that are not just specifically within health, but engaging TANF, engaging some of the public systems as they're doing that front end enrollment linkages.

Second is the pediatric quality measures. Again, we heard testimony yesterday about the impact that looking at quality measures are having around shifting practice. And so both the current quality measure, for example, developmental screening is one of them, is that a window to look at in terms of implementation of existing ones, or potentially new ones, like Commissioner Rubin has talked about, with failure to thrive and follow-up for failure to thrive.

The third piece we've been looking a lot at and want to better understand is improving screening at emergency departments. We had a great recommendation that came forward from CMS in jurisdictions that are actually using health information exchanges, particularly around the readmission requirements, so they're actually building a system to create a red flag if an individual is going to multiple emergency departments and going in and out of care.

And so could that infrastructure that's being built actually for another purpose be used to create red flags if a kid is having multiple injury visits at hospitals. And CMS was surprised and said we're building this, is this something we can quickly work with jurisdictions, but it's not something we were thinking about. That was one window we wanted to put forward, as well as engaging with HRSA, with our children emergency services.

Fourth is EPSDT [Early and Periodic Screening, Diagnostic and Treatment] screening, so behavioral health, as well as how EPSDT screening is being used for not just children with identified problems, but children at risk and how would that portion of EPSDT used to get children services. And then last is this enhanced risk screening from obstetric care, prenatal care, well-child visits, as well as on the other side for parents who are seeking mental health treatment, substance abuse treatment, or receiving support service domestic violence and

how do we better integrate those opportunities for prevention.

COMMISSIONER RUBIN: I would just add that -- and this came up yesterday, better federal guidance around the permissible use of Medicaid to support services that are upstream for kids who are at risk, right?

Whether it's like Triple P [Triple P—Positive Parenting Program] or Safe Care or PCIT [Parent-Child Interaction Therapy] or services, or we were even -- I'm not sure if you're bringing this up, dual generation reimbursement, we'll talk about that right now. But even that level of guidance participation can create resources for a collective response that don't rely on title IV-E, right?

SARAH ZLOTNIK: Excellent. So, again, these all feed to each other. So the next bucket is ensuring access to high quality prevention and intervention services. So as we're identifying children and families in need, how are we figuring out that continuum of resources, and what are those appropriate resources at the individual level, at the family level, or potentially at the community level with that.

So we're paying careful attention to ACEs [Adverse Childhood Experiences] and trauma. Again, some of those models were incorporated and discussed yesterday. We're very interested in better understanding in developing recommendations related to home visiting, and so we're looking at the National Home Visiting Conference in May [Fifth National Summit on Quality in Home Visiting], and so setting up a conversation with the experts that will be there for the commission, and so we'll keep you posted on that and see that as a real opportunity to better dig into what those particular recommendations should be.

COMMISSIONER RUBIN: For those who are interested in the overlap of home visiting, which is a big space, you know, in terms of early childhood, that meeting we're setting up with the Home Visiting Research Network [HVRN] you're going to have some really good people in the room. Mark Chaffin is going to be there, and Doug Powell is doing the National Evaluation, these are people we were trying to get before the commission. So I would encourage as many commissioners that can get to that DC meeting would be a valuable use if you're interested in that issue.

COMMISSIONER ZIMMERMAN: Can I just very -- make a comment? I'm not sure who -- so my trauma center is part of the National Child Traumatic Stress Network [NCTSN], so have we got like somebody representing that network to come and provide testimony? And if we haven't, could you look into that?

COMMISSIONER RUBIN: We'll look into that.

COMMISSIONER ZIMMERMAN: Yeah, because I think there's a meeting occurring in Washington DC next week, and a doctor is giving basically a presentation about toxic stress. And the network has been in existence for at least 12 years, minimum, and they have got a lot of research.

COMMISSIONER ZIMMERMAN: Good point.

SARAH ZLOTNIK: Yeah, and we've definitely been looking into their work, but I think around what the recommendations are here, that's a place where we need to continue to flush out, so that would be really helpful.

And so with this piece we're both focusing then as well on the recommendations where interventions related to substance abuse, domestic violence, mental health, so not specifically for the child, but ones that are targeting the family. And then to get to Commissioner Rubin, what he was just mentioning, this rally all sits within a larger strategy that needs to think well then what is the funding infrastructure that can support these interventions and what will help support the continuum of services?

As Commissioner Dreyfus mentioned, the Place-Based Strategies, and trying to figure out how we can really help and support and build community capacity, and support, embed resources in our highest need communities. As Dr. Rubin just mentioned, we're trying to think about dual generation funding strategies, and some of that came up yesterday. So potentially can you use the child's Medicaid funding, the child's Medicaid coverage to support parents, particularly in jurisdiction without Medicaid expansion, or places for parents who don't have health care coverage.

Or how can we get better clarification from Medicaid about supporting parent and child receiving treatment together, so in Triple P, or Child Interaction Therapy [PCIT] where there continues to be funding barriers in one of those programs.

COMMISSIONER DREYFUS: Listening to this is always good because it keeps us thinking how we can continue to improve our recommendations. I'm thinking that probably we're talking a lot about screening, earlier identification, you know, appropriate referral of kids, but I also think this issue of parent skill building, we've got to wire that in more in terms of, you know, so I think about Marc Cherna out in Allegany County [Department of Human Services], he's doing some very significant work upstream work with obstetrics and prenatal, not just around earlier identification of risk, but around parent skill building.

So I just think that's got to be about earlier identification. It's about that and parent skill building and how we're going to wire that into these interactions that people have long before they come to the attention of the CPS system.

SARAH ZLOTNIK: The last funding piece and then I'll turn it back to the Commissioners that we wanted to highlight is really also identifying where can we support federal flexibility to blend funding and grade funding to implement these strategies. And one model we've been looking for is the performance partnership pilots for disconnected youth is just one particular model where there's language that specifically enables states who are going to those grant opportunities to be able to identify where there are potential barriers, and -- where there are potential barriers and flexibilities are needed in order to implement the strategy that actually creates an active pathway and conversation with the federal government to be addressing those.

And so that's potentially again one window of opportunity as we're thinking about how to support and create the language to lay out the support for states and jurisdictions in tribal communities to develop these efforts.

COMMISSIONER RUBIN: Anyway, for me, as I've been thinking about this all along, and it gets to we're going to elevate this issue, right, and we're going to create accountability and compliance that doesn't just rest in child protective services, so that when my state, you know, which would usually say, oh, there's another CAPTA thing coming down, we'll send this down to OCYF [Office of Children, Youth and Families], and they will work with the county and figure out, well, my gosh, now my Maternal Child Health program is involved and my Medicaid program.

And if we create potential implications for each of those programs over this issue, now it's my Department of Human Services (DHS) secretary saying what are we doing? And they're organizing it, and it elevates it, and it provides us the teeth that I think if we can think about this in the right way. There are things we need to talk about, and Commissioner Covington eloquently expressed this.
Number one, we don't want to be seen as going after -- I think Maternal Child Health makes a lot of sense in terms of a coordinating role, but you don't want to place other programs at risk because of the limited resources. We also don't want to create a situation where there's four or five cooks in the pot and no one feels responsible. I think that comes down to how we put the teeth in in terms of ensuring that this resided high enough within the state that there -- that it's a meaningful state plan and folks are focused on it.

COMMISSIONER DREYFUS: David Sanders, do you remember in our state government work aren't there examples where, yes, it might be this agency or that agency, but that the governor actually is the one whose responsibility is to convene, to appoint the group, you know, to create the plan on this, that, or the other thing? Is there a federal?

CHAIRMAN SANDERS: Using that example, I don't know if there's federal example, but certainly --

COMMISSIONER DREYFUS: That the feds require that, that it comes through the governor's office?

CHAIRMAN SANDERS: I can't think of anything off-hand, there may be.

COMMISSIONER DREYFUS: Yeah, I can't either.

COMMISSIONER COVINGTON: But governors have done it.

CHAIRMAN SANDERS: Well, for the waivers they had to sign off. For the title IV-E waivers --

COMMISSIONER PETIT: Almost all money that goes directly to the governor's office. The legislator signs off on it, but all this federal money that's coming in doesn't go directly to the departments, it goes to the governor's office. If the governor's office wants to bring cabinet members together and direct them to do this or that, the department heads would have the

legal responsibility for managing the money well, if they want to keep their jobs, follow what the governor's direction is on it, right. The legislator then confirms it, right?

It doesn't go directly to any of the departments, it goes directly to the government to sign off on all this stuff. Head Start is one of the few exceptions that bypasses the governor's office and goes directly to agencies.

COMMISSIONER MARTIN: This is Pat Martin. Dr. Rubin, are you guys done with your report? I'm sorry.

COMMISSIONER RUBIN: Yeah, we're done.

COMMISSIONER MARTIN: So my question is, I'm not trying to make a comment about the policy you're putting forth or the program and structure you're putting forth. My question is, do you envision then that if a family comes into your practice and there are some issues of -- medical issues that give you rise to be concerned about the well-being of this child, the safety and well-being of an infant in that family, do you envision that that will ultimately get to the court system or not?

COMMISSIONER RUBIN: I guess as a mandated reporter if I was worried I would report that kid, right?

COMMISSIONER MARTIN: Right.

COMMISSIONER RUBIN: The example I've used before is the example of a child who's not gaining weight, that's more of a gray area, and has missed a few visits, may be behind on immunizations. Now, if there is currently no accountability on the Medicaid side to ensure that kids don't slip through the cracks, and if that came down through the Medicaid program to the Managed Care Organizations [(MCO)] and they contracted with us, and one of our quality measures was about how often we were seeing at-risk kids, or certainly a child wasn't gaining weight, who's failure to thrive, then can I guarantee you if there was money involved there that our health system would respond by creating accountability mechanisms that would ensure that we knew when that kid didn't come back, and that either we called them or we made a report to child welfare.

Because otherwise it's like in my mind, you know, in a practice of 15,000 kids, and so that's the example that I use that talks about what does it look like to have Medicaid skin in the game. What does it look like in the ER [emergency room] that an ER physician would know that this kid has been to three emergency departments for skeletal fractures?

That this one skeletal fracture where you're not really sure what happened, you're not sure you're going to report, well, if you knew the kid is eight-months-old and already had two other skeletal fractures, right? So we need to ratchet up the pressure, particularly on Medicaid I'm using as an example here, to really spend the time and think about how they're going to contribute to this issue.

COMMISSIONER MARTIN: I agree with that, and I think that's a great way of looking at this, and I think it also will get to a lot of kids that we aren't necessarily seeing right now. My overall concern is that I'm wondering whether or not families who traditionally use ER as primary care office, for instance, may then have more oversight and they're suggested to more hotline calls than a family who doesn't. And that's where my question is going.

I guess what I'm trying to find out is if in fact we put this program that you're talking about in place tomorrow, is there going to be an uneven likelihood that some people will be brought to the attention of CPS than others?

COMMISSIONER RUBIN: So here's -- because you and I had have a long conversation with this, and I agree with the concerns about disproportionality. I think if it's medical -- in the context of Health Information Exchanges [HIEs], knowing whether that child has been in multiple ERs for fractures, for example, is a piece of information medically that would be helpful to a clinician who's treating.

I think it's a whole other ball game to say we would have access to CPS histories on our patients at the point of care. I think that gets more to your concern which is family has been reported, you know, oh, should that be a contributing factor in how I evaluate this fracture that this child has a CPS history? I don't think that's where we want to go because of the exact concerns that you said.
So, to me, I think there's a limit, but I think information on the medical side is germane to what we do, and to me doesn't necessarily -- wouldn't in and of itself lead to more disproportionality.

COMMISSIONER MARTIN: Okay. And maybe I'm not looking at it as closely as I should, but it seems to me though, for instance, take your suggestion of failure to thrive case. If in fact that kid came into your practice tomorrow, and you decided that you've had prior contact with this family and this is not the first time you've explained this nutrition for the mother, or the nutrition that the child needs to the mother, and you're concerned that the mother is not following your instructions, your medical instructions after they leave your office, yes, if you got to the point where you were so concerned about the immediate care of this child you would call the hotline, and I don't have a problem with that.

What I need to make certain is that if we put this kind of system in place every -- not every, but most docs that have a similar situation as you do, then also call the hotline about that child at the same time. I want to make certain that if you go to an ER in Cook County, the response is going to be similar to the ER at Lake Forest. That's what I'm trying to find out.

COMMISSIONER RUBIN: Yeah, I understand what you're saying. I think in this case I use that as an example, and is not something we would ever be prescriptive about, but I will say failure to thrive is a core fundamental of what we do in pediatrics. And it really -- the overwhelming majority of these kids don't reside in child protective services, all right. So even among those kids -- you know, the expectation that those kids would follow-up let's say every six months and, you know, as -- an infant, you know, that you can create a bar in which everyone to a reasonable degree would expect someone to follow up.
And a child who is not gaining weight comes in the next time, our instinct is not to report for

that alone. There are other reasons, sometimes it's constitutional, you know. So I'm actually not worried in that kind of case about the disproportionality just because we're asking -- we should be seeing our kids with failure to thrive and parent should be coming in.

If someone disappears for, you know, I'm more concerned about the stories on fatalities in which children have been locked in a closet and died due to malnutrition, those stories are all fitting and include contact with health care system.

COMMISSIONER DREYFUS: I think we're -- just because where we've been, but also happening in health care reform, I don't think ERs over this fixation on people who have high utilization of ERs is the only way we should look at this. Because as states are moving to manage care they're implementing electronic health records. And so if those children are going to a primary care doc, right, that electronic health record of that child's interface with the health care delivery system, however that's happening, is going to be there for that doc to see.

So, you know, I think, yes, I appreciate that the example we're using is ER, but this move to electronic health records is going to be available for kids who are not being seen at the ER, but at a practice.

COMMISSIONER RUBIN: Yeah, and the response as well could be, to me, multiple skeletal fractures in a kid that resides in Medicaid program, we often might not even see in the ER, but these MCOs know which kids are going to the ERs and it may not be child protective response. It may be I have an infant who has three or more skeletal fractures before the age of one that that elicits a call to Maternal Child Health program and a nurse goes out and just knocks -- or we call the primary care doctor, do you know what's going on? Are you worried about this kid?

But I think those are sort of what I call low hanging fruit, that any reasonable person would say, yeah, this one doesn't feel like disproportionality, it's very concrete and it's based on just ensuring well-being.

CHAIRMAN SANDERS: And that actually to me is where we want to go. Is that -- Pat, you may have a different experience, but my concern is that now there aren't the supports prior to the call to the child protection agency, and so by default that becomes the service response, whereas this is offering the opportunity to say, physician, you have an obligation beyond just to report to the child protection agency if these factors appear to do something, or at least that's built in in the incentive.

COMMISSIONER RUBIN: Yeah, we have a responsibility to provide for the health of our population, and this is where health care reform is going. We have accountability measures that we send a throat culture when we were -- I mean, that are meaningless to outcome. So I think it's all -- I think we're getting to the details of an individual what this might look like, but there are many ways in which the Medicaid program could take a much larger visibility in terms of accountability and quality of service delivery for kids that are short of reporting.

They're an important touch point. The numbers of kids in Medicaid in CHIP [Children's Health Insurance Program] right now is 45, it's like in the mid-40s now, right, in this country. It's 50

percent of all the enrollees in the Medicaid program are children, all right? And so I think it's a natural place to think about how the resources are going to support, how their quality programs are going to support a level of ensuring the health and well-being for children.

COMMISSIONER DREYFUS: But not just for triaging risk identification and referral --

COMMISSIONER RUBIN: No, no, no.

COMMISSIONER DREYFUS: -- but as I went back before, like we heard yesterday with Oregon, right, you know what they're doing around contraception and making sure people are ready to parent, want to parent. The work that they're doing around skill building, right, and seeing that that's part of the responsibility with obstetrics.

So I hope that people on the commission aren't just viewing our recommendations through the lens of triaging high risk kids. This gets more upstream than that. It's included, but it's part of a more upstream approach.

COMMISSIONER MARTIN: This is my suggestion. I would like for the Commission to ask your subcommittees to kind of give some guidance or give some thought to how we can make certain that we are not, you know, there's not problems with the law, it's problem with the implementation. And I don't disagree with what you guys are suggesting, all I'm saying is that I see a high level of potential for certain groups getting attention to child welfare getting hotline calls and others not.

And so what I would ask is if there's some kind of attention paid to that issue, and kind of think about whether or not there's a way within your recommendations in your thought patterns to kind of make certain that every kid, no matter what side of the city they come on, no matter what hospital, private or public, that they're treated in an equitable way. That's all I'm asking.

COMMISSIONER RUBIN: These are the kind of tradeoffs I think if we were to write -- as we think about writing the report, it gets to the unintended consequences. And you want to ensure the way we write this that we acknowledge those potential unintended consequences and what our goals are. I think that's totally relevant, and I agree with it.

CHAIRMAN SANDERS: Before we continue the conversation we've been at this for two hours, it seems like a good time to take a break for 15 minutes and then we can come back.

(Break.)

COMMISSIONER RUBIN: We're ready to get started again if people could take their seats. In terms of the formal presentations, we're done.

I think one of the things I think in terms of moving forward, I'd like to get feedback of commissioners just in general. Obviously, there's lot of specifics we need to work out. This idea of back-boning the report about elevating this issue across the states, and I think contextually it acknowledges that even HRSA hold us that even for the Maternal Child Health

Block Grant not a single state identified child abuse and neglect fatalities as a priority, so the idea that we might result in a recommendation that could lead to 50 state plans to address this issue, it's not that everyone would be effective, per se, because it would be a learning process, but you'd imagine some states would really galvanize around this and that would be great.

COMMISSIONER DREYFUS: The other thing, I would appreciate hearing from commissioners is to this same end, what then would we want to recommend is happening federally in support of technical assistance to, accountability to, the ability -- the implementation of those state plans, the successful implementation of those state plans. So is there a federal piece here that we're missing?

CHAIRMAN SANDERS: And let me see if those on the phone, since oftentimes we have the conversation and then you have to jump in. Amy, Mike, Pat, if anybody else is on, do you have any comments to the questions raised or any other comments?

COMMISSIONER MARTIN: I'm still thinking about the comments.

COMMISSIONER AYOUB: This is Amy, I don't.

CHAIRMAN SANDERS: Let me make an observation that I think we probably need to think through. I think the approach is exactly on target, but what I heard is really a population-based approach in thinking about how we approach our work in that way, that underneath that and kind of trying to picture it, the child protection agency is a piece of that, but there's a very broad population-based approach that could be applied across communities, across states, however.

Which is I think is -- I think is outstanding, but I also think that what we heard yesterday was really more of the kind of individual child approach. And it seems that the observation I would have is that we probably need to come together, and so what is the headline for our report? Is this a public health crisis, or is this a crisis of our ability to investigate individual children?

And then think about what the federal role is in -- what the federal role is from that perspective, because I don't -- I think we have very different views from the federal perspective of how they oversee the work. And we could be a lot clearer in making a recommendation if we think this is a population-based approach, that should apply across multiple agencies versus each agency kind of having their own approach.

COMMISSIONER DREYFUS: David, would you extend that, when you say population level approach, it's a shared responsibility approach because I think Michael has done a really nice job overall of our time together articulating all these many actors, right, who need to interface on this issue. And so I don't know that I see it as just a population approach that we're talking about, but where we're truly hard wiring into these multiple players a shared sense of accountability for this issue and allocation of resources.

CHAIRMAN SANDERS: Let me make a general comment and then a specific one. I think what I'm just suggesting is that this moves us in a way that we want to be as precise as possible about kind of what we're talking about. Because I think that right now, the federal oversight suggests either it's not present because there isn't somebody identified specifically for the responsibility, or it's overly the responsibility of the child protection agency.

And so I think just being precise about that, but specifically the issues around funding that the flexible funding is looked at in a different way from what you described than flexible funding for title IV-E. I mean, that title IV-E still is applied to individual children; whereas, what you're talking about is flexibility across multiple funding streams conceivably, and looking at the full population and allocation of resources to help in that area.

So I'm just suggesting -- I don't know how we want to approach it exactly, but that we be as precise as possible about how we think about this collectively, that these approaches aren't at odds, but what exactly does it look like?

COMMISSIONER DREYFUS: Yeah.

COMMISSIONER RUBIN: You can probably do both as you write the report. You can lens it from the population, and then you can lens it from the child in that, you know, in terms of how you frame it. I'm not sure they're mutually exclusive. The question of how you frame the entire report; do we think this is a public health emergency and crisis?

I think that although the numbers we could say could be flawed by just increased reporting, the numbers at the children's hospitals on severe non-fatal injury, to me, have been fairly consistent matching fatality numbers over the time. We think that we're not even accurately counting them. The sheer numbers that we're talking about, potentially, are pretty significant.

And, to me, framing this in the context of opening people's eyes to just the sheer magnitude of what we're dealing with on these most severe cases, and as a crisis, that needs to be elevated to a level of public health importance.

COMMISSIONER DREYFUS: The other thing that is disruptive is the reframe, that this isn't just about the quote, unquote, child welfare agency, because that's been our national fixation.

COMMISSIONER COVINGTON: It reminds me of, my gosh, in the '90s when youth violence was declared a public health problem. Commissioner Cooper I think it was [U.S. Surgeon General C. Everett Koop] man, it was amazing what happened. It went from all of a sudden being something out of the Department of Justice and police agencies where they started to think about what's the public health intervention on this? And there's been a lot that has gone into place since around youth violence and youth development as a result of it.

COMMISSIONER RODRIGUEZ: I almost think you need both things, because no matter how -- no matter how sort of well-funded and resourced you have at an upstream level, you're still going to have children who you can't catch and who end up coming to the attention of CPS agencies, and in those cases then you need to have -- we do have a failure to investigate

properly and to respond properly.

I think what I really like the recommendations, and part of what I think is that oftentimes our failure to respond when they come to CPS is because we have no intervention and sort of no services to refer to. I think currently many of these agencies that you've called out, like substance abuse, domestic violence, mental health, they don't actually prioritize these families, and so it's very -- child welfare ends up creating their own services for families that are really pathetic.

And so if there is a sort of a catch upstream, but then also an ability to get families back around if we miss them the first time and referred back in, I think that's really important. I did want to answer I think one of the things that would be really important around the question about sort of what the feds need to do is that I've -- I felt that all of the information that we've gotten from basically each and every panel during my time in the commission has really helped me understand both what the problem is, what the prevention science is, and what the approach should be.

And it seems to me that if you're going to have 50 state plans and folks coming together that you need to get people on the same page first about what it is that we're talking about, about what the science says, about what the data is, and so one of the roles the feds could play is before all of these agencies come together to make their plan to sort of really make information available and in some kind of innovative way.

I mean, so that everybody has all of the information that we've been privy to on this commission about what best practices are, what practices don't work, what the science says, what the data tells us, so that folks don't have to start from scratch when they're making their plans. I mean, I know there are some states who they have this information and they have the expertise, but I think there are some states who really have never thought about this and don't have any access whatsoever.

And, to me, that would be an important sort of equity piece to make sure that before we give them that charge of going off onto their own that we're making sure here's what the feds say here's everything that we know and you should consider about your development plan. And then the last things I want to say is something very specific, and I realize this is sort of coming, but I really think, particularly on the recommendations that are about the access to the high quality prevention and intervention services, that I'm hoping that your subcommittee thinks about a targeted approach to those young parents who we have control of who are in the child welfare and the Juvenile Justice System who we know really, really need all of these services and are probably some of our most at-risk parents who actually I think they get less than most of our parents who are outside of the system, because people think that simply because their system-involved they don't need the prevention and intervention services because they're already in.

And so I realize that's down the road, but I just wanted to say now, as you're thinking about the dual generation approaches, that I really am hopeful that this -- our recommendations include some specific thinking about how to prioritize them for the interventions.

COMMISSIONER DREYFUS: Can I ask you a question?

COMMISSIONER RODRIGUEZ: Yeah.

COMMISSIONER DREYFUS: I really like where you're going, but would we get there if -- we don't want the feds to be overly prescriptive to state's abilities to come together and create their plan and then be accountable for an issue. But at the same time, I've been in part of enough of these state planning efforts where there is guidance that's given.

And one of the guidance that we can recommend that be a part of the guidance given to the states is what we know to be high risk populations, and maybe that's a way that we can get at this issue of youth -- of parenting youth in the juvenile justice, as long as the data warrants why we would lay claim to here is a few high risk populations that must be specifically included in your state plan.

COMMISSIONER RODRIGUEZ: I would say yes, and, because I think it's not just that they're high risk populations, it's they're high risk populations often because of our action and inaction in these existing systems. I mean, it's almost like these are youths in particular we're responsible for, and oftentimes the reasons they have risk factors is because the very system we're asking to intervene that we created --

COMMISSIONER DREYFUS: Help me think how we might message so it's not a deficit message.

COMMISSIONER RODRIGUEZ: That's how we came to prevention and intervention approach, that I'm not thinking about sort of improving denitrification of children and family as risk. I'm thinking these are young people who we have responsibility for and we have a real opportunity to do a dual generation approach with them.

And so I actually -- I do think that they're worth calling out among other populations because they're a captive group, they're a group that we know a high number of them, now with foster care extended to 21, the estimates are that, you know, over half of them will be parenting by the time they exit care.

COMMISSIONER COVINGTON: I think some of the lessons we heard yesterday might be really useful in terms of what they're doing with their foster kids through 26.

COMMISSIONER RODRIGUEZ: Exactly.

COMMISSIONER COVINGTON: I thought that was exciting stuff.

COMMISSIONER RUBIN: I can imagine, you know -- sorry, go ahead.

COMMISSIONER COVINGTON: So I don't -- I don't really have a problem calling them out because they're already in service, it may be thinking through a more comprehensive wrap-around for them as they go into parenting.

COMMISSIONER RODRIGUEZ: I think it's both about their increased need, but about our increased responsibility as a system to say -- I mean, it's sort of both at the same time, that these are kids that we owe a special effort to give them our best preventive service and best prioritization of all the services that exist.

COMMISSIONER RUBIN: So imagine, you know, we're in guidance to create your state plan, and we're in the section that was talking about how treatment services are being aligned, how you're basically working with other systems like child welfare, juvenile, you know, to provide access that you would explicitly ask what would be your intergenerational strategy for young mothers who are in your care.

COMMISSIONER DREYFUS: Right. That's a nice way of saying that.

COMMISSIONER RUBIN: In the guidance you would ask them to address that issue in their state plan.

COMMISSIONER DREYFUS: So back to David Sanders and the population child thing, it's got me thinking. I appreciate that really we are looking at a population level approach, right, across systems, but I'm also wondering if in that federal guidance -- now, I could be wrong when I give these examples, but we know from what we've learned law enforcement, the child protection agency, the medical community, the education community seem to be four really key actors in child specific responses.

I'd love to have Michael Petit comment on those four, but would we want to know that in a state plan, as it relates to the response to risk, right, that a part of that plan is what they're going to specifically be doing for that specific child response.

CHAIRMAN SANDERS: And so I think that's a great example. The way I was thinking about that, that's why I think it's more -- I think this is a significant point for how we think about our approach, that in some ways we were asked to reduce, I don't know, pneumonia by improving emergency room services, and we're saying you have to have a public health approach in order to reduce the incidents. You have to have that and you have to improve the emergency room response.

COMMISSIONER RUBIN: That's right, you have to do both.

CHAIRMAN SANDERS: So I think we can capture both, it's just that it's a shift from the very narrow focus of title IV-E, title IV-B, and title XX. I think we need to make sure we're clear about how we made that shift and what the implications, for us, will be. That's what I was trying to get at.

COMMISSIONER DREYFUS: Cassie, do you think we need to do testing with key congressional staffers about this is where we're going?

COMMISSIONER COVINGTON: It's in the Act. It tells us to look for recommendations around prevention.

CHAIRMAN SANDERS: Right.

COMMISSIONER COVINGTON: It's right there.

COMMISSIONER DREYFUS: Okay.

COMMISSIONER COVINGTON: In bold.

CHAIRMAN SANDERS: But we're getting beyond that in terms of funding issues, which I think is exacts. That's why I thought for the funding flexibility. Some may be thinking just of title IV, but this is really pushing beyond that.

COMMISSIONER RUBIN: To some degree, flexibility can be created by states providing their own guidance on how they're going -- Like, so, I think there might be an appetite for this because, to me, this part there may be -- we may need to have hard discussions about new resources, right, but in this degree a lot of this is about identifying resources that exist in other systems and leveraging them, right?

COMMISSIONER COVINGTON: And in the Oregon example, cutting it two percent, you know, being willing to have flexibility and being willing to actually drop a couple percent.

COMMISSIONER DREYFUS: We're talking Justice Department gets implicated here, education gets implicated here, Medicaid certainly does, but the other thing this might do, and that's why I said before, how do we close the loop here with these plans and the federal agencies, this could start to frame the role responsibility of this interagency group that seems to be more about show and tell of what everybody is doing individually. It might start framing their role.

COMMISSIONER COVINGTON: I'll bet CMS isn't even at that table.

COMMISSIONER DREYFUS: They're not?

COMMISSIONER COVINGTON: I bet not. I mean, I don't know.

COMMISSIONER STATUTO BEVAN: If we're going to look at flexibility across all of these different agencies we're going to have to look at different eligibility levels and different eligibility requirements. And if we do that we can, you know, change, look back at title IV-E, right there we'll have some, we'll get some money. I don't know about the eligibility requirements on Medicaid and some of these other agencies.

COMMISSIONER RUBIN: I do know that with respect to Medicaid leads with -- or Medicare, whatever they're doing, quality accountabilities is picked up by the employer -- it's not like we do something completely separate. I mean, quality measures are usually derived around work from federal programs and they extend out to the contracting for kids with other types of insurance.

So issue of equitability, the health system doesn't design delivery based on this one contract, right? So if it's required to do it, so I'm not so much worried about the eligibility issue as the fact they are the leaded imprint for health coverage for children in this country, they're going to lead the market, you know.

COMMISSIONER STATUTO BEVAN: Well, no, I was just looking at because costs for the admin of determining eligibility, if we save them some of that admin we could capture the money.

COMMISSIONER RUBIN: I see what you're saying. That's a good point.

CHAIRMAN SANDERS: Is there any -- it sounds like there's a consensus around the areas that you're focused on with some -- is there any concern about moving forward that anybody has? And it does seem that the coordination across the child protection subcommittee now and the public health one will be critical, and it seems like that's going to happen. And our partial headline is: We have a public health crisis?

COMMISSIONER COVINGTON: That's right.

CHAIRMAN SANDERS: I mean, that's the different area.

COMMISSIONER COVINGTON: Child Welfare is a public health problem.

COMMISSIONER RUBIN: Public health crisis that we're not even sure we can measure, right?

COMMISSIONER DREYFUS: Wow, that's a headline.

COMMISSIONER MARTIN: A public health crisis that potentially affects every one of our kids.

COMMISSIONER STATUTO BEVAN: And come on, United States, we need skin in the game. I think that's our motto, "skin in the game."

COMMISSIONER MARTIN: I don't disagree, and I agree with everything that's been said. I do not want us to lose site of the individual child though.

COMMISSIONER DREYFUS: That's where we create the nice interface between committees. So we're talking about this is a public health issue, this is a cross system, cross sector responsibility issue, there needs to be state plans around this, because there's no state plans right now, but a subset of those plans needs to be the interface of the CPS, law enforcement, education, medical community interface as it relates to the individual child and risk.

And I think that's where then, hopefully, with everything we heard yesterday, if you take that broader view like we were talking about, then those recommendations fit in beautifully to what then we want to see coming through those state plans that get developed. I think it does this. Do you agree?

COMMISSIONER RODRIGUEZ: Yeah, I definitely agree. Like I said, I think that in my mind I don't necessarily understand the terminology. I don't understand how a population-based

approach excludes an individual -- looking at individual children or families. I'm not -- but I'm guessing it's just because I'm not familiar with the terms.

But I definitely think we're going to have both -- in this report you'll have recommendations that deal with both sides of this that say we want to make sure that we can serve many more families in a meaningful way that actually gets them the help they need, and when that help isn't enough we need a child protection system that can actually be responsive and that can keep kids safe.

COMMISSIONER DREYFUS: And the child protection system is more than the child protection agency alone.

COMMISSIONER RODRIGUEZ: Right.

CHAIRMAN SANDERS: And I think I'm just emphasizing in part, our policy approach to this point in child protection is primarily -- does primarily fall under title IV-E, which is about serving individual children. There isn't at this point a policy direction that captures a more broad -- other than I think some of the things that you mentioned earlier today, but there are very few things that actually reference a prevention strategy that's more population based and universal.

So that seems -- it's a big shift that we're suggesting, unless there's something I'm missing. So 'm just suggesting that we recognize that and as we move forward really think about how this is linked together.

COMMISSIONER DREYFUS: David, that's concerning me a little bit because I don't think we want to get way outside of scope here either is, but don't you think if you were in a state and you're needing to create a plan to eliminate fatalities from abuse and neglect, and it needs to be data driven, right, using the science, what we know about the issue, aren't you most likely to be looking at this from a -- not just the broadest swath of population, right?

Maybe some minimal things that you're doing around, you know, parent skill building, things like that, but when it comes down to kids at risk won't the data start driving you to a specific population subset?

CHAIRMAN SANDERS: I would just say from my observation, and I could be wrong, when it's driven as it has been primarily by newspaper articles, that it has improved the child protection response. That that's where states end up going, or maybe the court's response. It's not let's look at who's at risk and how to reduce fatalities, that's not what I've seen.

COMMISSIONER STATUTO BEVAN: Right.

COMMISSIONER DREYFUS: You're not concerned we're getting too outside?

COMMISSIONER RUBIN: You never know about the kid whose death you prevented, right? You never hear about that, right? And so I think -- I do think there's a role for transparency. I mean, so it doesn't eliminate the need around transparency, around child deaths, around

standardization, around the emergency response, like you said, so I don't see population health versus individual services to children being different.

COMMISSIONER RODRIGUEZ: No. I -- so David clarified for me it's really talking about how do we resource it, how do we think about it as opposed to it being population health deals with groups and there's no individual, I get it.

COMMISSIONER COVINGTON: If you look at Maternal and Child Health, that's how that's set up. I mean, they do a population-based work, but they never focus on the individual mom and baby. So it's always done --

COMMISSIONER RODRIGUEZ: Exactly.

COMMISSIONER RUBIN: I sort of think of it as perspective on the front line, individual approach on the front line, are the things we're doing, population perspective is going to allow me to hire the person I need to hire to allow me to do this work.

Is it affecting the way we deliver services to that family when they come in the office, whether it's in health care, or for -- if you are articulate, a strategy around better connecting Medicaid reimbursement and services to children in child welfare system, and the child welfare system actually uses that to create novel programs to do exactly what you talked about then it's worked, the population approach has worked and you can prove it because you can show at the individual level we delivered more services, or improved the well-being of individual kids and families.

COMMISSIONER DREYFUS: Just one –

COMMISSIONER PETIT: I'm not sure the novel idea is what's necessarily going to carry us over the top. The novel idea at one point was Maternal and Child Health. There's long history, and people on this call can all testify, in one way or another, their knowledge of the impact of Maternal and Child Health Services over a 50-year period sharply reducing at some point infant mortality rates, increasing immunizations, and all sorts of things.

So we have that knowledge, now go to Texas. 400,000 live births, 40 percent get little to no medical care, and someone is willing to pay for it. So on this point there's shock aspect to this, there's urgency aspect to this, public safety aspect to this, there's political and media aspect to this in things that prompts behavior. We know a lot about Maternal and Child Health.

I don't view anything about Maternal and Child Health as a novel idea. It's been a well-established program for protecting babies and women for decades. So the question is, is it up to scale, and if you can get it up to scale financially can you get a political system to implement it?

So I think all this conversation for me is interesting in the specifics into what we're talking about, but it's going to come down to we have a three-year-old girl, she's at risk now, how are we going to protect this child now or downstream two, three, four years. I'm saying this is

not about knowledge it's about different political beliefs and cultural briefs that we need to also raise issues about.

CHAIRMAN SANDERS: So that sounds like we're all in agreement that we're headed in the right direction on this?

COMMISSIONER PETIT: That's worrisome.

CHAIRMAN SANDERS: You're not in agreement?

COMMISSIONER PETIT: Yes, I'm in general agreement. I'm saying when you get 12 zeros then you got to wonder how you got to there but, yeah.

CHAIRMAN SANDERS: So Pat, do you want to go over where we are with your thinking about disproportionality and some of the steps taken?

COMMISSIONER MARTIN: Sure. I'd like to kind of talk about in general though where disproportionality sits in this whole commission. So let me start it off by saying this; my understanding is that disproportionality is an issue we're going to look at and see whether or not that we find any programs that across this country are specifically geared toward looking at minority communities in general and how we can prevent or eliminate the deaths of those children, whether they're in foster care or not in foster care.

And so with that, I thought that was kind of clear, and so with that I've started engaging in and having discussions with people about what programs are specifically designed around minority communities. Today I was given an e-mail or sent an e-mail to question whether or not this commission actually has a subcommittee that's looking at disproportionality.

Quite honestly, I've been walking into someone's office and saying, Mr. Sanders, thank you for agreeing to meet with me, you know, I represent the disproportionality subcommittee as a commission, and I go into what the committee is about and kind of what the focus is here and the scope so I think I need to so that I know what I'm supposed to be doing.

CHAIRMAN SANDERS: So I would just add that we have agreed that this is an issue because we know that at least three times the number of percentage of fatalities are occurring with African-American and American Indian children. That the only thing that I was questioning was that we have not officially created a subcommittee in part because of the question of whether this applies across all subcommittees, should we create a subcommittee, or are there other ways that we want to approach it?

And so all of the things that you said about the steps, which would include finding out what we know about research from other fields, were exactly what we had agreed to. In fact, I believe that we had charged -- we had prepared Rachel and the research team for looking at that work. So I think the only question was did we -- had we created a separate subcommittee, which had not been the official sanction from the commission, but all of the things that you said are exactly right.

COMMISSIONER MARTIN: Well, then can we clarify that now on this call or are we not in the position to clarify that now?

CHAIRMAN SANDERS: I think we can always examine that, sure.

COMMISSIONER MARTIN: So I'm putting on the table that I'd like to examine that.

COMMISSIONER PETIT: Pat, what's the clarification?

COMMISSIONER MARTIN: Well, I guess what I'd want is clarification that this subcommittee -- or that this commission has a subcommittee of overrepresentation, or looking at programs and practices specifically designed around minority communities for elimination and -- and eliminating child abuse and neglect fatalities.

COMMISSIONER COVINGTON: I guess I thought we did have one, so I'm in support of it.

COMMISSIONER RODRIGUEZ: I support it, too, because I think having folks who are specifically focused on those issues and are willing to do the work is really important given the -- I mean, theoretically we should all be including this in our subcommittee work, but given the tasks that we all have it seems like somebody has to actually get the work done, and so I'm appreciative if folks are willing to do that work to have the subcommittee.

COMMISSIONER COVINGTON: Maybe one way to approach it beyond having just a subcommittee is making sure that we work with you, Pat, and staff to address the issue across our recommendations to make sure that it's addressed in a cohesive, deep way rather than just something superficial. I don't want this issue of disparity to be sitting off on the side as one little element that just sort of sits out there. I know in the public health subcommittee it's a huge issue when you look at disparities in these communities.

COMMISSIONER RODRIGUEZ: But even the role of the subcommittee could be thinking of the questions that each subcommittee needs to be asking themselves as they come up with recommendations and their strategies. That in itself would be really helpful.

COMMISSIONER ZIMMERMAN: I think I would like -- this is Marilyn -- I think I would like to know, too, from the research from the staff is, is there any place where they reduced disproportionality? Because if they have, we need to know about that. I mean, I cited yesterday the Alaska, Montana, and South Dakota numbers. I've gotten something from Nickwell where Multnomah County has higher rates of disproportionality of American Indian [AI] children in care than the rest of the counties in the State of Oregon.

So why is that occurring in this particular county, and what are the recommendations that we could make that point folks instead of sanctioning states and saying naughty, naughty, states don't do that, but not only naughty, naughty states, don't do that, but here's some best practices around how do we reduce disproportionality.

COMMISSIONER MARTIN: I think reducing disproportionality, and then looking at whether or not there's specific programs designed for minority communities around eliminating fatalities

are separate things. For instance, Cook County, you know, when I became the presiding judge in 2000 had over 38, kids in foster care, today we have less than six kids in foster care.

The majority of my families are black so just by reducing sheer numbers, I reduced the sheer numbers of minority families in foster care. That does not mean that I really touched the disproportionality rate, but I've reduced disproportionality. And so what I'm saying is that is separate and apart, and that's a separate and apart commission, I think, that whether or not this nation has taken it upon ourselves to look at programs specifically designed to look at minority families and whether or not there are ways in which, and thoughts around how to target minority families and reducing fatalities. Citing fatalities and reduction of disproportionality are two different questions.

COMMISSIONER ZIMMERMAN: Except that, Pat, as I think about the work I do in tribal communities, often we see the research that shows American Indian communities tolerate much higher levels of violence. I don't know if the word tolerate is the right word, but they experience higher levels of violence than any other minorities in the country, and so to me that's an indicator of potential very high risk for death or near fatal injuries. And so I guess they are separate, but they are connected.

COMMISSIONER MARTIN: I would say they're related. Okay. What does everyone else think about disproportionality being -- all of our subcommittees are interrelated. I think we started realizing that when Carrie and David presented us that first deliberation that we scheduled and had on the agenda when we were talking about accounting and data. We were all talking about, well, we're looking at that, too, we're looking at it in slightly different ways.

So I think that minority issues do touch on each of our subcommittees, but my question to you, the fact that the majority of our kids and families involved in child welfare, and although I recognize we're not just talking about the child welfare kids that die, but the majority of kids in child welfare who die are minorities.

And it seems to me that we can't issue any kind of report that doesn't have some indication that we've looked at this issue, and we've looked at it in detail, and to see whether or not there's any work that's being done specifically around this population, but that's my opinion.

COMMISSIONER STATUTO BEVAN: I'm not sure if that's true that of the kids who die that it's -- are you saying it's a majority of the kids who die are African-Americans, or are you saying it's a disproportionate number?

COMMISSIONER MARTIN: A Disproportionate number, I apologize. Thank you for correcting me.

COMMISSIONER STATUTO BEVAN: Here's my fear. If the numbers are right about victimization, then there's a disproportionality of victimization right from the start. So how do we -- I mean, we have to fix the -- right there. If there's a disproportional victimization rate, then we don't want to have a response that doesn't address that. We don't want to have removal into foster care as the only response, and we don't want services as response but we

have to have a response.

COMMISSIONER MARTIN: Let me make sure -- I'm trying to understand exactly what we're saying, Cassie. Are you suggesting then that we -- it's inappropriate without first addressing how to actually eliminate disproportionality?

COMMISSIONER STATUTO BEVAN: No. Susan wants to say something.

COMMISSIONER DREYFUS: Yeah, so Pat, it seems to me picking up on what Cassie is saying, it seems to me the reason why we need this subcommittee is a couple of fold. And one is we need to -- we need to state, right, with evidence that this indeed is an issue.

And I think we need -- if indeed the evidence shows that it is, right, and then we need to be able to talk about based upon what we have learned, what the research is telling us, what the data is telling us why we believe that to be so, right?

So I think there's an education role the commission needs to play here on this issue that's beyond just our recommendations. I'm going to get there, but I think there's an education role we have to play using data, using research that calls attention to the fact that the majority of children, as David said, who are killed by abuse and neglect, are children of color; is that correct?

CHAIRMAN SANDERS: No.

COMMISSIONER DREYFUS: No, that's not correct. You said three times as many.

CHAIRMAN SANDERS: Percentage-wise, in terms of the total population.

COMMISSIONER PETIT: Total represented.

CHAIRMAN SANDERS: It's three times the rate for African-American and Indian children who are killed.

COMMISSIONER DREYFUS: So let's take that --

CHAIRMAN SANDERS: Although, actually, the majority may very well be children of color if you look at -- it's hard to tell because we don't have information on all of the children who were reported who died, so it may be accurate.

COMMISSIONER DREYFUS: I'm just saying isn't there a reason for our report to talk about this from an education standpoint, and then I love where Jennifer went with the subcommittee having an interface across our committees, right, in keeping us mindful of how our recommendations are or aren't, either perpetuating possible overrepresentation, disproportionality, or reducing that number.

COMMISSIONER RODRIGUEZ: I think there are many ways that communities of color have been vocal about the existing systems not serving them well, and not being designed around

their needs, and not actually empowering communities to be able to develop their own approaches that get at some of the systemic issues. And so, to me, those are things that both of our subcommittees should be considering as we -- and so all of those sort of considerations would be very helpful.

COMMISSIONER ZIMMERMAN: This is Marilyn, Pat. The other thing, going back to what the administrator from ACF shared with us yesterday, is focusing on the data is, for American Indian, Alaska Native children, the question is often, or we've heard testimony previously by a representative that works in those communities, that according to the National Indian Child Welfare Association [NICWA], children -- American Indian and Alaska Native [AN] children are more likely to experience severe forms of neglect and not die by maltreatment or neglect.

Well, that's a wonderful statement, but here's -- the reality is we really don't know what we don't know because we don't have databases in Indian Country. And because of the jurisdictional -- I'm going to butcher this word, jurisdiction moray around who is counting those deaths and why they count them, who's doing the investigations of the death, where does that go from there?

I mean, we can't -- prosecutions, who does that? What does that look like? There's coroners often that are local tribal police officers who have been on the job for six months that are declaring the death an accident when potentially it could not -- or a suicide when it might not be because they don't have the skill set.

So that -- the data for Indian country becomes critically important and complicated because, again, there's 566 federally recognized tribes, and more state tribes, about 3 to 400, so how do we vet those databases? Are they hand done with check marks? Where are they kept? How long are they kept? We just don't have the answers to those questions, and I think that's, for me, a consideration when we're talking about the federal agencies that serve tribes across the country, the IA [Indian Affairs] and Indian Health Service [IHS], can help us think about where and how we can build those databases along with other federal agencies.

COMMISSIONER DREYFUS: Marilyn, do you feel the measurement subcommittee got at that in their recommendations? Because that would be, again, this interface.

CHAIRMAN SANDERS: And when we do our five-minute summary, that's one of the issues that we have clearly agreed we do not -- the measurement subcommittee did not address that issue.

COMMISSIONER RUBIN: Commissioner Martin, this is Dave. So depending on where you want to go with the subcommittee, I guess the first question you could choose or not choose to answer is, is there an increased risk for child abuse fatality, right, or is this just literally confounded by poverty or socioeconomic status, what does the evidence show us?

The second issues you got into are there certain initiatives that are being targeted towards, or lack of initiatives being targeted, you know, in other cases, towards certain communities, and what do we know about the success of those programs? I think the infant mortality space would be a good space to look at. I think there's two sides to that coin though, because I

think one of the questions that you need to pose in whether we're going to have a statement on that it should be targeted initiative.

Because there's also an unintended consequence, like we've talked about earlier this morning, that you can, you know, spread the net and target a community, but you're also going to reel in some other kids and contribute to disproportionality to kids involved in the system. And to what degree -- how do you balance what may be necessary targeting of resources to, quote, higher risk communities with also a need to not kind of bring everyone in at the same time and expose other families to harm who are not at that same level of risk?

COMMISSIONER RODRIGUEZ: For example, I'm thinking of Dr. Nadine Burke Harris, like the Center for Youth Wellness in San Francisco, they're in Bayview Hunters Point. They have -- they do pediatric care, and they have a comprehensive approach that's sort of based on the fact the majority of kids they're serving are kids of color who are living in neighborhoods that are plagued by violence, who are being raised by parents who have experienced a lot of trauma themselves, and so their approach is very different to working with those children than a primary care clinic that was in, I don't know, you know, Portland might be.

I think it's worth looking to see what innovations are out there where folks have really tried to take -- where it's been borne of the community and people have tried to take the needs and the specific strengths and challenges of the community into account and seeing if there's anything we can learn as we're developing our systems approach from those individual interventions.

COMMISSIONER ZIMMERMAN: The other comment I'd like to make, David, is that we already know American Indian children are dying, they're dying by suicide at alarming rates, and there's been lots of resources focused in that direction. But what we don't have in Indian Country -- we also know is there's one child death fatality review team in the entire nation that's on a reservation, and it's only just getting started, and that's on the Navaho reservation.

So I keep saying the data is important not necessarily because it's a targeted population, we really honestly don't know what we don't know. We just don't know.

COMMISSIONER RUBIN: That's important to say.

CHAIRMAN SANDERS: I don't want to over simplify this, but basically our charge is to produce recommendations around counting, create a national strategy, and focus on strategies that are effective. And the subcommittees are really a way of dividing up our work so that we can identify the priorities and hopefully create a report that tells a story about how to move forward. And I think the question is do we create a formal separate subcommittee on disproportionality as part of that or not?
I mean, it's not -- I think we can go either way without overly complicating this. It seems like the consensus to this point is we should have a subcommittee. I'm fine either way, it's just we did not formally agree to that, and that's not -- so do we want to do that with a clear charge or not? Is that part of how we want to divide up our work?

COMMISSIONER STATUTO BEVAN: Judge Martin? Judge Martin?

COMMISSIONER MARTIN: Yes, I was on mute, sorry.

COMMISSIONER STATUTO BEVAN: Is it important for you, you were talking about going into different places, is it important politically, with a small p, that we state that we have a racial disproportionality subcommittee?

COMMISSIONER MARTIN: So let me -- give me the liberty of answering this as a commissioner. I am part of this group. I am a commissioner just like you are. So whether our personal opinions, whether it's personal preference is kind of irrelevant.

COMMISSIONER STATUTO BEVAN: I didn't mean personal. I meant you talked about you wanted to know who you were representing when you walked into a room, that's what I was referring to, and I wanted to know if it makes it easier if you refer to a subcommittee as giving credibility to whatever it is you're talking about when you go into this -- to whatever room you're going into. You know what I'm saying?

COMMISSIONER MARTIN: The way I look at it is when I say that I represent part of the subcommittee on overrepresentation and minority focus, what I'm saying to these people is this commission recognizes the importance of looking at minority families and looking at minority children because there's so many of our nation's minority children in foster care and experiencing some of these issues that we're talking about.

So I'm walking in with all of you guys behind me saying that this issue is really important, and as an expert in the area of, you know, whatever it is, so like going to Ryan Samuels and sitting in his office and saying that this commission thinks this is so important that I need you to help me think through these issues, and what are the terms that we have that deals specifically with minority children as it relates to child abuse and neglect fatalities.

And so that's how I use it, because that's what I thought I had. I thought I understood that we thought it was important. So that's the way I've seen it. That was my gratis walking in.

COMMISSIONER STATUTO BEVAN: We do -- I think it's important. I haven't heard anybody here say it isn't important. So I think we support, you know, if we want to call it a separate subcommittee, then call it a separate subcommittee. I don't have opposition to that.

COMMISSIONER DREYFUS: I thought we had it.

CHAIRMAN SANDERS: So if you look at the memo that was sent out after the conversation, there was six subcommittees, this was not identified as a subcommittee.

COMMISSIONER DREYFUS: It wasn't, okay.

CHAIRMAN SANDERS: No.

COMMISSIONER DREYFUS: I just thought they were working on it.

CHAIRMAN SANDERS: That was the documentation.

COMMISSIONER RUBIN: Let's go ahead.

CHAIRMAN SANDERS: Let me say two points. One, Amy, wants to make sure she's able to weigh in on the issue of subcommittee, can't transfer to support. She wants Commissioner Martin to decide how this happened with or without subcommittee. Let me read some of the data, because I think it should inform us, and I would suggest that it's worthy of us highlighting, but I think there's still more information that we need, but we can do this clearly through having a formal subcommittee.

So if you look at what's in the 2013 Child Maltreatment Report, and I'll read the rates in a second, but I'm going to read some of the narrative that goes along with this, because I think it was a concern, and I was sharing it with Commissioners Bevan and Zimmerman, based on data from 42 states. First of all, we don't know nationally what the percentages are.

It's 42 states, because the states with more than 45 percent of race or ethnicity is unknown or missing or excluded from the analysis. So this is a report on race and ethnicity and fatalities, so we have enough states that were excluded that about six hundred of the children who died in the race and ethnicity is unknown, at least according to the child maltreatment report. So that's a major concern.

The percentages for African-American children rate per 100,000 children is 4.5 percent. For American Indian or Alaska Native is 2.85 percent, but I was just noting there are 14 fatalities among American Indian and Alaska Native, and I have to at least wonder if that's anywhere close to the actual number. But -- so that's the percentage.

For Hispanic it's 1.44, Pacific Islander it's 4.66, and for White it's 1.53. So clearly there's an issue if we feel this is an important area to highlight, and the data would suggest it is, I think it's fine for us to have a subcommittee. It really was just we hadn't done that, and if we want to do it we should make sure it's staffed, we identify the data behind it, the reason behind it, and the charge. Michael, go ahead.

COMMISSIONER PETIT: David, I would certainly support a disproportionate subcommittee. Let me just make a couple points. One is then the question that needs to be posed is why is there this disproportionate impact, and then the other question is what would you do differently, or what would you do that was specifically oriented toward disproportionately represented families, what is it you would do.

And let me just tell you, I'm in Maine more than I use to be, and I can tell you that almost every day there is front-page stories about domestic violence, kids being killed, et cetera, and they look in and profile a lot to what other kids in other states in term of circumstance in their households, and Maine is the whitest state in the country. They can't get this off the front pages. DHHS is like constantly reeling on this issue.

So I support the idea of minority disproportionality being looked at, but I also know that a lot of this is very much associated with poverty and substance abuse, et cetera, and in a state like Maine that's small and white, they have got serious on-going problems, and it's among white children. I want to make sure we don't lose sight that there's serious conditions that respond and promote this stuff, and that happens all over the place.

COMMISSIONER RODRIGUEZ: I don't think focusing on children who are minority is at the expense of children who are not. I think the idea is that we know the rates are higher, that's what the data is saying, which warrants a deeper look to answer the question about why, and if there are additional strategies or focus that we need to take as a commission to make sure that those rates are brought down.

CHAIRMAN SANDERS: So --

COMMISSIONER PETIT: I'm all for it.

CHAIRMAN SANDERS: And so we have Commissioner Martin who would be part of the subcommittee, anybody else?

COMMISSIONER ZIMMERMAN: I think I'll join Patricia Martin on that subcommittee.

COMMISSIONER RODRIGUEZ: I would also like to be part of it.

CHAIRMAN SANDERS: Anything else on that?

COMMISSIONER MARTIN: Not right now.

CHAIRMAN SANDERS: We will identify a staff person as the liaison for that then. Let me go to the measurement subcommittee, then we have military, and that's it. The measurement subcommittee we -- really, two things. One is we did talk to the American Indian subcommittee about the idea that our recommendations really are not sufficient to cover counting for the measurement for American Indian youth; that we will learn much more next month in our tribal meeting, and then we'll reconvene to look at specific recommendations around American Indian children, so just to clarify that point. Anything you would add, Marilyn or Pat?

COMMISSIONER ZIMMERMAN: No.

CHAIRMAN SANDERS: And then the other is the understanding the policy implications of the recommendations made, and eventually we'll have to look to the policy subcommittee to help because -- And particularly the conversation we had today about CAPTA, because it probably causes us to rethink kind of where things might fall, policy-wise.

And so those were the two things that we had agreed to follow up on, but we may want to rethink a number of areas from policy perspective given the larger recommendations.

COMMISSIONER DREYFUS: David --

COMMISSIONER PETIT: Right now where's confidentiality parked?

CHAIRMAN SANDERS: I would think it's child protection.

COMMISSIONER RODRIGUEZ: The last meeting it was moved.

COMMISSIONER PETIT: We're waiting, we haven't written that up, right, Jennifer?

COMMISSIONER RODRIGUEZ: We haven't taken that on. We've only gotten to safety assessment.

CHAIRMAN SANDERS: Commissioner Dreyfus.

COMMISSIONER DREYFUS: Yeah, so yesterday the conversation I think -- I can't remember who brought it up about NCANDS being optional.

CHAIRMAN SANDERS: We recommended this being mandated.

COMMISSIONER DREYFUS: You did, all right. I just couldn't remember if that was part of your report or not.

CHAIRMAN SANDERS: Yeah, one of our recommendations was that -- again, it raises a number of questions of kind of what this looks like from a policy perspective as we move through some of the other recommendations, because that obviously is the first set of recommendations. We'll look comprehensively, and then be able to identify the best places for something like that to fall if the commission ends up agreeing.

COMMISSIONER ZIMMERMAN: I don't know why this is coming to mind, but as we're thinking about it, going back to the financing piece and thinking about how do we fund this with the less -- I found out it's less than one percent of CAPTA has gone to tribes over the last ten years. The other piece is, is that Congress loves to pass legislation and then not fund it in Indian County.

A perfect example of that was the Indian Child Protection and Family Violence Prevention Act in the mid '90s, and it didn't pass reauthorization which didn't seem to make a difference because they never found appropriations for it. So I think that's a big piece of the conversations when they're thinking about policies and what we want the federal response to be with end state response is, that we boldly say, and you will fund these, and you will find the appropriations to be able to fund these, please.

COMMISSIONER STATUTO BEVAN: You will.

COMMISSIONER PETIT: Marilyn, didn't we hear the number when you say one to two percent, I think Indian children present no more than one to two percent in the entire population?

COMMISSIONER ZIMMERMAN: It's less than one percent, but as I said yesterday, when you go by state they make up -- Alaska it's about 15 percent, maybe it's 13 to 15, maybe 10 to 15, but they're over percent of children in care. That's a huge -- that's hugely disproportionate.

COMMISSIONER PETIT: It is.

COMMISSIONER ZIMMERMAN: So we got to take a look at that.

COMMISSIONER PETIT: What's your thinking on requiring reporting of those statistics by the tribes?

COMMISSIONER ZIMMERMAN: I don't know in Alaska that the tribes have the statistics. The states do -- the state does. I think there's ongoing, to be kind, dialogue between tribes in the state of Alaska about that kind of information and who has access to it. I don't think in Alaska many of the tribes have access to state databases, and I don't think that Alaska is necessarily going to be very willing to give those up.

COMMISSIONER PETIT: Why not require it under the law as a condition to receiving money? They have to report on that as well, as well as rest of Indian country. Why can't they be required to report on that? They're being paid to gather information.

COMMISSIONER ZIMMERMAN: Well, it's a recommendation.

COMMISSIONER PETIT: I mean, I think they should be compelled to provide the information.

COMMISSIONER ZIMMERMAN: Well, I think that Congress should be compelled to build the databases in tribal communities, that's what I think. I think we need to support sovereignty of tribes, and we have to support the -- basically, the fulfillment of treatise and the trust responsibility that the federal government has towards tribes. And part of that is giving them the resources to be able to sustain their own work in their own communities and do the best practices that they know work in their own communities, but it has to include being able to have access or -- and/or the resources to build those databases.

COMMISSIONER PETIT: I think it's essential. It's a good idea.

CHAIRMAN SANDERS: I think then, unless there's anything else on measurement, then military subcommittee.

COMMISSIONER RUBIN: Yes. So Teri has been doing a lot of the direct conduit to the Family Advocacy Program [FAP] nationally, and we're trying to stage a couple meetings. One is to kind of review some of the newer data that, you know, are being -- that are coming out of FAAP, and that work involves trying to articulate what the degree of risk is to kids across deployment cycles, and so there's a lot we don't know.

I think there's a tremendous concern that's coming out with this data of the lack of fundamental understanding of what the true child abuse rate is among children of folks involved -- folks in military. Part of that reason is because of confidentiality issues and data

sharing issues between civilian authorities and the military. So the military has their own family advocacy program.

And the family advocacy program runs into a lot of barriers in terms of receiving those reports, yet, the Army Central registry and FAAP report out child abuse rate based on what they know, all right. There is no linkage going on, and so it looks like their rates are much lower than the civilian population, and we don't know that to be true.

Nor do I think have we ever taken death certificate data and done a linkage to Army registry or other military registry data to identify what is the fatality rate among children of folks in the military. Is it lower? Is it the same? Is it higher, right? And so there's some real needs there.

I think what we're trying to do is work towards a presentation here where FAAP -- the family advocacy program has some time to deliberate about the recommendation that would strengthen their ability to know who was at risk, a direct -- and actually use our group as a subcommittee -- or as a platform from which to advance some programs around strengthening families within the military, identifying more accurate rates, understanding the fatality issue, et cetera.

So it's in progress, and I think that's where we're going, and I imagine that our recommendations would seat within the family advocacy program of the military.

COMMISSIONER ZIMMERMAN: So I have a question. I think that one of the -- the question is that from my rudimentary crude understanding there is for the non-officer military personnel is very much overrepresented by people of color. So I wonder if that's going to overlap into the disproportionality at all in that conversation or not.

COMMISSIONER RUBIN: Yeah, we'll talk to you guys as another subcommittee to think about that. Like I said, I feel -- I almost feel like, you know, that our understanding of child abuse in the military is even more rudimentary than it is on the civilian side right now. There's not been a lot of research, and there are tremendous concerns about kids slipping through the cracks because of that failed sort of report back to family advocacy, right, and what that means.

You know, the question I would have for the group right now is, is there a level of urgency in having -- should the government do this for us in terms of linking death certificates back to registry data to actually look at what is the fatality rate? You know, at least I know we don't have accounting. But you can look at excluding perinatal and look at kids during their first year of life and excluding perinatal congenital anomaly related deaths, and it's a mixed group of acute illness, some preventable deaths, Sudden Unexplained Infant Death (SUID), and then homicides. But even that kind of crude linkage compared to the general population could give us a sense of what the numbers are, and I don't know how well they articulate race, for example, in those data, but you can try to estimate by race as well, too.

COMMISSIONER STATUTO BEVAN: David, can you -- under our clarification and policy, I'm really mixed up, and I've been reading a lot, about the different terms used like infanticide,

mortality, all those different terms. We're dealing with fatalities, but I want to know what those different terms are because I know when I was sitting on D.C. review team those were not exactly neutrally exclusive, and sometimes people would just switch it and all of a sudden it was called something else. So I would like to be able to like right in the beginning be able to clarify what fatalities -- what terms we're using.

COMMISSIONER RUBIN: That's why there's resistance -- that's why I'm averse to trying to get too specific in the manner of death, kind of, you know, breakdown, because depending on where you live or who your medical examiner is you can change, but I do think the dichotomy between perinatal and congenital anomaly deaths versus all others gives you some level of the trends on early childhood mortality.

COMMISSIONER STATUTO BEVAN: Wait, I don't know mortality and morbidity.

COMMISSIONER RUBIN: Morbidity think about it as more folks who are alive, sort of the morbidity of disease within a population. So mortality is death, right? And so morbidity gets to the prevalence of disease in the population and the consequences of that right?

COMMISSIONER STATUTO BEVAN: I think you need to clarify.

COMMISSIONER RUBIN: Infanticide is the unique category of mothers who smother their babies.

COMMISSIONER STATUTO BEVAN: Only smothers?

COMMISSIONER RUBIN: Well, people who murder -- it's a little -- I think of it as different than child abuse homicide. It's different. It's a unique category.

COMMISSIONER STATUTO BEVAN: I want to know how it's different, because I don't think the regular world will know either, how it's different.

COMMISSIONER RUBIN: But I say I wanted some guidance there. I will tell you, just to give you a sneak peek of some of the data, we have two studies from our center, because we have a project with the Army right now that are in peer view, one that looks across deployment cycles, and we know as long as time there's a high rate of neglect related issues for kids during deployment, right, which makes sense.
But we identified in the majority of soldiers who were only deployed once, the first six months after return home from theater there were significant elevations of serious physical abuse, including high risk injuries, which are the severe, non-fatal injuries, compared to any other point along the line, and that makes sense.

And based on our testimony in Colorado, they actually designed their intervention around that knowledge. They had eight child abuse deaths in the military that was overrepresented within that Colorado Springs area, and they designed a solution that involved both civilian and family advocacy programs within the area to deliver resources to families for soldiers who were coming home.
So those are the nature of the recommendations, but the woman from the family advocacy

program said it's commander specific. She was looking for more standardized recommendations coming from the Pentagon around expectations of delivering types of services at specific times to specific high risk. And it may -- you may identify to avoid the disproportionality issue those soldiers who were returning home, where there's a young infant in the home that you might actually think about what the solution would be to try to ensure the safety and potentially deliver services related to reintegrating the soldier.
The second piece of information is that we looked at medical diagnoses of child abuse from physician claims in the TRICARE area, which is the health insurance database for all active duty military. Only one in five medically diagnosed child abuse cases across the military, across the U.S. Army were ever detected with a report to FAAP, or in their database.

So one in five, which means that 80 percent of medically diagnosed child abuse, as diagnosed on a physician claim, ever was detected. In fact, that doesn't mean that the 80 percent weren't seen, many of those kids may have been reported to child protective service at the civilian side, and the cross talk back never happened, but you can imagine that's a tremendous risk given the fact that these kids move all over the country, they're moving all the time, there's interstate issue, right, and then you have the issue whether there's good communication between authorities. Family advocacy has a lot of resources to help families.

There's a potential issue there in terms of kids falling through the cracks, and that's where the urgency is. I would like to know what the fatality rate is among young children who are born within these military families. I think we need to know whether it is lower, the same, or higher than other civilian families.

COMMISSIONER PETIT: Dave, you bring up something in terms of a close study, you said where that only one out of five kids who were abused were actually reported abused. I don't know if you've seen the national study that HHS did, but they show less than a third, at least last time I looked, less than a third of all cases where there was abuse and neglect going on is being reported, so instead of three million reports they're saying basically nine million reports would more accurately reflect it. So I think drilling down as they did, it's not surprising that they would find more than were unreported when they go into it, which is what NIS [National Incidence Study] has found consistently over the last twenty years. I think they have done three or four of these and each time that's what they've found.

COMMISSIONER RUBIN: Those are some of the issues we'll explore, and tap those, that they will be an active partner in this. I think they would like to strengthen their ability to help military families. It's its own unique culture, and we're seeing this less as a top down where the commission is making recommendations to the military as opposed to working with FAAP, for them to identify recommendations with their leadership around strengthening their ability to supports families.

COMMISSIONER DREYFUS: Just to clarify, you didn't say the 80 percent aren't reported, they're not reported to FAAP. They might have been reported to the CPS agency?

COMMISSIONER RUBIN: Part of our subsequent work that we're developing now is to actually try to work with a couple states to link in civilian data to get a more accurate count on how many kids were at least touched by a system, whether civilian or military. That's the follow-

up we're trying to do.
These were young children. These were children zero to two years of age we looked at for the study. The highest were severe injuries, and the fatal injuries, with medical diagnosis of child abuse or high risk injuries, which included skeletal fractures or traumatic injury, so we're talking about the same kids, all right?

So that's where this is going, and I think it's important that we kind of work with them to figure out what's going on and how we can get a better handle on this issue in the military. There are specific reasons, obviously, why young infants in certain situations can be more at risk in military families.

CHAIRMAN SANDERS: Anything else then on the military subcommittee? Is that it? So there were two issues that we need to come back to. One is the flexible funding and where we're going to go. And I think you're -- the public health subcommittee report suggests that it's beyond title IV-E that we want to look.

And it seems it would be helpful for the commission to have information on the funding streams that fall under the proposed plan, and what's the flexibility within those right now, what's the charge right now, and I believe that policy staff have done some of that already, and maybe we can have that for ourselves to better assess what flexibility exists right now, what doesn't exist, are there different missions for each of the funding streams, different eligibility, where might we find savings things like that?

COMMISSIONER RUBIN: Germane to the conversation, the woman Emilie Stoltzfus, was that her name, who gave us that wonderful lecture on title IV-E and the child welfares. She had mentioned to me casually after I said is there anyone who does more Medicaid who could educate? And so she'd be a good contact for the staff to ask about who could kind of get into that.

I think the other comment that Michael made which is you say flexibility, what does that mean? I think we have these local panels, we prepare them in advance for the meeting. I would ask them to explicitly address that issue, what ways do funding streams help or hinder you in terms of your ability to coordinate a response to this issue so that we understand in a much more granular way what they're talking about, right?

COMMISSIONER PETIT: Also, you should know that we've been working, Hope and Marcie and others, have been looking at what the state CPS budgets are. So what the state child welfare budgets are, and within this that what is the CPS spending. And they just did something on the federal side, but I'm looking forward to seeing what state reports as their individual CPS budgets, so that will give us some sense as to how much they're spending in proportion to the number of kids who are being reported and so on.

CHAIRMAN SANDERS: So having that information in the next discussion, would that be sufficient? Is there more that we want to do around the flexible funding for right now?

COMMISSIONER DREYFUS: I think what we're kind of saying is that knowing that we're not going to be able to put out a report where we're saying we need to be spending millions and

millions and millions of new dollars, right, I think what part of what seems to be a consistent theme, that we've been hearing from people, that David brought up earlier, is this issue of flexibility.

So I think we have to look at, as we've identified here, how are these funding streams today flexible, inflexible, right, but I just keep going back to I think as a nation we haven't learned everything we can learn from the waivers. At the end of the day, the reason why Erinn likes waivers, right, is because the flexibility she has within this finite period of time to move dollars flexibly and build capacity in her system today that she doesn't have. I think we're getting there.

COMMISSIONER PETIT: Susan, I just heard you say something about we're not going to be able to recommend millions and millions. It seems to me we need to recommend what we think it is we need to do get the job. Whether Congress agrees with us, whether they can find money for it, whether they want to spend money on it is a different matter, but if we conclude that, look, this is under-resourced and here's what it needs, I don't think we sweep that under the rug.

We say we think this is what's needed. If they want to fund it, as Wade discussed earlier, all we're doing is making recommendations, so I think these kids and these families and these social workers and these legislators need to adhere to whether or not we think this is adequately funded in proportion to the size of the problem. Maybe it is, maybe it isn't.

I mean, I think we still need to go over that, but I don't think we should accept as a conclusion, at this still early stage of our recommendations, that we're not going to be recommending additional money.

CHAIRMAN SANDERS: Anything you want to say, Susan?

COMMISSIONER PETIT: To be determined.

COMMISSIONER DREYFUS: I mean, I'm just -- I guess it's just hard for me because I'm living in my own reality with my day job that, you know, if anything is coming to the floor it better be funded.

COMMISSIONER PETIT: Right. But our job is to help understand why this is in the best interest of the country, why it's in the best interest of children. So we're not just doing a descriptive, we're doing prescriptive on this as well. And if we're not going to put it out there who is going to put it out there?

COMMISSIONER DREYFUS: I guess the question I'd have to the staff then, are we gearing up our report now with the idea that we would be saying today it's funded like X and Y would be the more appropriate funding level, and I haven't heard that.

COMMISSIONER PETIT: I think we need to see what the fact-finding will give us. We still haven't completed all the information yet, we haven't seen what states are spending on this yet. What we know is the federal government is spending a very modest amount in

comparison to some other things, whether it's related to children or other kinds of things, so I think it still remains to be seen whether or not there's additional resources. I'm waiting for what some of the reports are on, you know, efficacy of the certain program and so forth, we'll see.

COMMISSIONER DREYFUS: Okay.

COMMISSIONER PETIT: I think we need to be open to the possibility.

COMMISSIONER ZIMMERMAN: So this is Marilyn. I think that, as I've already stated earlier, the recommendations are going to be for appropriations of funding for tribal communities because there's such a huge need. But the other piece of it is the creative funding. For example, in the Rocky Mountain Region of the Bureau of Indian Affairs [BIA], they're 47 percent and it's not because of lack of funding, because the positions are there, funding is there to fund those positions, but it may be that the Bureau needs to look at the ways that they are recruiting and restrictions on who they're placing on who they can hire.

And so it's not necessarily a question of give us more, it's how do we do this better so we can get these positions filled so that, you know, kids aren't at risk?

COMMISSIONER PETIT: Yeah.

COMMISSIONER RUBIN: I sort of think somewhere -- I'm with you, Michael. I think in the context of writing the reports I think we have to acknowledge the impact of the look back, impact of what's going on title IV-E, impact of current reduced funding, there's studies in terms of the amount of spending, and to ask states to develop a comprehensive plan, their response is going to include some degree of interoperability of what exists now to try to create some capacity.

But we can't hide from the fact that to elevate this to a public health crisis without acknowledging the need for some stability in terms of funding, whatever that may be, I think that's our role. I think we have to -- otherwise, people are either -- it's going to be an unfunded mandate.

COMMISSIONER DREYFUS: I don't have a problem with it, but I haven't heard anything so far that tells me -- maybe I'm wrong, maybe Liz would say this is exactly how we're thinking in staffing this, to be able to say we're funded at X, but it needs to be Y. I haven't heard anything in any of our work that says we're getting to recommendations like that. I'm not saying we should, but I don't think there's anything going on right now that says that.

COMMISSIONER PETIT: For example, if we see that some states right now have caseload ratios which are 50:1, and recommended standard is say 10:1 then I think we need to say a calculation needs to be made as to what it would take to bring these caseloads over a period of time, whatever time they want, from 60 to 20 or 60 to 30.

We had already know for some states they are hugely understaffed, they can't purchase treatment services, they can't purchase mental health, et cetera. We have states that say

our internal rate is only 35 to 40 percent, it's only 35 to 40 because the workers just say I'm getting the hell out of here. I'm in the line of high, people want to fire me, people want to prosecute me, and I'm forced to triage between 50 cases, so I think you need to look at it.

That's where our friend in the Children's Bureau, there are national standards that are supposed to be developed, and it sounds to me this is the furthest thing in their mind, and where this standard has been developed, they don't enforce them so what chance do these kids have?

CHAIRMAN SANDERS: I would go back to our charge, which is ultimately to reduce or eliminate fatalities. And I think we'd have to have specific ideas about how to do that and then figure out the resources to support it. And some of those resources may come from things that are identified as ineffective, some things may come from new resources.

I think we're not at a point yet of having the debate other than ideological one and I'd rather have it on the recommendations and facts that are in front of us.

COMMISSIONER PETIT: I agree. And I know Susan and I have been working together for years, and let's see where the information takes us.

CHAIRMAN SANDERS: I think if we come up with ideas that can save the lives of 500 children and it costs money we are obligated to make the recommendation that money be spent on saving the lives of 500 children. If we don't have ideas then I think we'd be hard pressed to make recommendations from funding. So I think this is a premature discussion.

COMMISSIONER DREYFUS: I agree.

COMMISSIONER PETIT: I agree. What's the next topic?

CHAIRMAN SANDERS: So the last one is the report, the -- what is it? Shame on U.S. report. And what I heard the policy subcommittee suggest was that there would be a look at reports, but that included the formal reports from previous sanctioned commissions by Congress or by the Administration. I think the question is should we be looking at reports that fall outside of that, because I wouldn't distinguish one report. If we're going to look at reports are there other reports we want to take a look at that are done by private citizens, private organizations?

COMMISSIONER STATUTO BEVAN: I want what Marilyn mentioned about two reports on Native Americans that we want to add to the list.

COMMISSIONER ZIMMERMAN: Yeah.

CHAIRMAN SANDERS: So we would have at a minimum the policy committee at least look at the list of previous reports that have been done by private organizations and give us some --

COMMISSIONER DREYFUS: National reports?

CHAIRMAN SANDERS: That's what I would have to assume, that it's a national report.

COMMISSIONER PETIT: I think Susan, that's a very good point. I don't know if you guys see the same stuff that our subcommittee sees, that Tom prepares every day, but in many, many states, I think we're up to 15 or 20 states in the last just year or two years that have been special blue ribbon legislative, Speaker of the House, New York Times, whatever, special investigations within a state, basically saying our system is in crisis.

I mean, that's what law makers are saying, that's what governors are saying, it's why people are being fired, people are being hired. So I think that, David, while we're interested in the national stuff, there aren't that many national reports. There have been many, many state reports. Just since we've been in operation there have been these blue ribbon panels and investigative specials and all that laying out in detail what they think the problem is, so I think we should certainly be mindful of those.

Tom has really assembled a lot of that stuff, and I think he's got paragraphs or two on each one. I don't know if you distribute that or not? Tom, you're not on the phone, right? I think he's prepared something like that that we should share with the full commission.

CHAIRMAN SANDERS: You're right. Tom has done reviews of some of the local reports.

COMMISSIONER PETIT: Local being state.

CHAIRMAN SANDERS: I think Shame on U.S. report is a little different in that it's -- I guess it seems like we're agreeing the policy subcommittee should at least take a look at the national reports that have been done, and over some period of time and bring that forward as part of our consideration which seems like it addresses this issue.

COMMISSIONER PETIT: David, some of the state reports, like Kentucky and others, they are really, really well done. They go into detail into what the problem is. Whether it's the commission or whether it's the newspaper that's done a special investigation, like Minnesota recently had extensive coverage by the press that's led to, you know, the creation of new panels and reviews and everything else, and it's all the same themes. I read these all day, the themes are all the same.

COMMISSIONER DREYFUS: Michael, do they do anything specific to say and this is where the federal intersection is?

COMMISSIONER PETIT: No, they don't. They almost don't say a word about the federal stuff. And even though 40 to 50 percent of spending from federal side, they don't have much to say about that. They do have specific recommendations, like that crazy recommendation they had in Minnesota that said you can't look back to see if this family was ever reported, you know?

I mean, it's like the rape victim before the DA [district attorney], you can't bring up her sexual history. In this particular case you couldn't bring up whether or not this family was ever reported. That was adopted by law, and when the legislator saw what that was doing they

immediately repealed it because too many kids were being killed because you couldn't go back and consider whether there had been ten reports on them previously.

So it is generating change in some states, but it's absolutely in crisis mode. I think we looked at it, something like 10 child welfare directors have been fired, much less working supervisors, but actual child welfare workers it's like, bring on the next guy.

CHAIRMAN SANDERS: I would suggest that as with other things that that's a question of best practices either in a public health approach or child protection in that it really does fall under, at this point, the child protection subcommittee for kind of most of them, and some of them potentially are recommendations at a state level around a public health approach, although not many. Most are focused almost exclusively on those children known to the system. I think if it's to be incorporated in our report it really should be these are the things being seen at the state level and captured in child protection recommendation.

COMMISSIONER RUBIN: Can I ask on an immediate data need, because I agree it's too premature to talk about funding in terms of it. But I didn't get a very good answer. I mean, caseworker turnover has been associated with a lot of different things, and we've even seen it associated with reduced placement stability for kids in foster care, right?

Is there a state that has a large enough fatality rate over time, and has a strong enough SACWIS system [Statewide Automated Child Welfare Information Systems] where you could look at case-worker turnover for the kids who died, who were known to child welfare to ask the question is there association between caseworker turnover and caseload size and likelihood of death due to child abuse?

COMMISSIONER STATUTO BEVAN: Yesterday we heard, no, there wasn't.

COMMISSIONER RUBIN: I heard different. I heard more like I don't know of any data that anyone has looked at it. Part of that you need a good data system where you can take a cohort and look at association control for a few things. I don't know where the really sophisticated systems are, but we can get that answer from a couple systems.

CHAIRMAN SANDERS: So I do think that it hasn't been done. I think it could be conceivably, depending what the questions are and what the system is, although -- because then it may be worth exploring.

COMMISSIONER RUBIN: Because then if you see this --

COMMISSIONER PETIT: David, to my knowledge, it has not been specifically looked at in a very, very precise way, you know. But, intuitively, and I know intuition isn't enough, but intuitively better trained workers with smaller caseloads seems to be preferable to less trained workers with higher caseloads, right? I mean, so do we have the absolute evidence on that? I don't know.

One of the things we're asking the states to tell us is some people say what you do is ineffective, what's your response? And I'm anxious to see what they come back with and say,

no, no wait a minute, look at these deaths we prevent. Tom has some researcher, Andy Barclay, and maybe somebody in the audience knows about where this stands, but he's supposed to be doing a look back in terms of what child fatality ratio would be if there wasn't a CPS agency in place.

So, I mean, that might be helpful. It may or may not direct us in one way or another, but clearly the answer is we don't absolutely know. But that's okay, we don't have to absolutely know to recommend something. There's a lot of stuff when it's first proposed, that isn't certain. Whether it's the Internet system or drones, or whatever the hell it is, people at some point propose something that seems plausible and then they measure it.

CHAIRMAN SANDERS: So for the previous reports is the suggestion that the policy subcommittee take a look at the national kinds of reports and that if there are local reports they should fall under the child protection subcommittee? Does that address that issue or is there something additional people would like --

COMMISSIONER PETIT: That makes no sense to me. Jennifer, does it to you? And, Cassie, does it to you?

COMMISSIONER RODRIGUEZ: Theoretically, it makes sense to look at the recommendations. I feel worried about the amount of work that the CPS subcommittee has to do and the areas that we've committed to developing recommendations on and the amount of time we have left on the subcommittee to both complete and present those recommendations to the subcommittee.

And so I am -- yes, if we can figure out a very efficient way to get through all of these dozens and dozens and dozens of reports and look at recommendations and consider those I would say, yes, but I guess I'm saying yes with hesitation, knowing that we actually have a significant amount of work that we need to complete on our subcommittee.

COMMISSIONER PETIT: Jennifer, I understand. I definitely do share your concern. I do think there have been about 12 that were, you know, state legislative, state governor driven, and they usually put in reports, and they have got an executive summary session, and I think if we pull those together and take a look at it, we may see some common themes.

I can see setting up a matrix. Let's talk to Tom and see what he thinks is involved in doing it. But I'm wondering if Cassie, will you look at that Shame on U.S. Report?

COMMISSIONER STATUTO BEVAN: Yes, sir.

COMMISSIONER PETIT: In detail?

COMMISSIONER STATUTO BEVAN: Yes, sir.

COMMISSIONER PETIT: So, David, does that answer your question? I think your suggestion would be divided up responsibility.

CHAIRMAN SANDERS: I think to Jennifer's point, it seems like all subcommittees, as well as full commission, to have dedicated times to those areas that will be most effective, and that really is a subcommittee decision.

COMMISSIONER PETIT: Yeah.

CHAIRMAN SANDERS: All right. Anything else that we have for today?

COMMISSIONER PETIT: Bob, are you with us? No.

CHAIRMAN SANDERS: So our next meeting is in Arizona. Do you want to say anything Marilyn about that?

COMMISSIONER ZIMMERMAN: No, just that it's going to be called at the Talking Stick Casino in the Pima-Maricopa Salt River Tribe, tribal lands, and that there is an opportunity to provide written testimony. If you go to our website -- what is our website address? Eliminatechildabuse.gov. So if we -- we're being very discrete about who we're asking. We want to give time for panels to be able to provide sort of a depth of information, rather than overview, and time for the commissioners to be able to ask questions, but we would really highly recommend that anybody interested in these tribal issues, whether it's national organization or individual, that you provide -- please feel free to provide written testimony. We will be reading it and taking it into account.

COMMISSIONER PETIT: Marilyn, is there any conflict of interest if any of the commissioners go to the casino tables?

COMMISSIONER ZIMMERMAN: You can't use commission dollars.

COMMISSIONER RUBIN: Sure.

COMMISSIONER PETIT: I was worried about for a minute.

COMMISSIONER RODRIGUEZ: It just actually occurred to me that we do have that report that was given to us by Deidre and Myles that sums up many of the other reports and sort of their findings. So I think for both the policy committee and the CPS committee we have a starting place.

COMMISSIONER PETIT: Good point. That's right. They do the national ones.

COMMISSIONER ZIMMERMAN: This is Marilyn again. Please disregard the website that I told you before. The actual website is eliminatechildabusefatalities.sites.USA.gov, but if you look -- if you just Google childhood fatalities we come up and you can click on our site.

CHAIRMAN SANDERS: All right. I think we've covered a lot again today. Thanks to the subcommittee for the report and we are adjourned.

COMMISSIONER PETIT: David, I have a question.

CHAIRMAN SANDERS: Yes, Michael, although we're adjourned. Go ahead.

COMMISSIONER PETIT: Yeah, I know. After August do we have any tentative dates for any meetings set at this point?

CHAIRMAN SANDERS: No, we don't. We will almost certainly need to see how the next couple of meetings go.

COMMISSIONER PETIT: All right.

(At the hour of 12:00 p.m., the hearing was concluded.)

End of Day 2