Children's Cabinet

February 29, 2024

RHODE ISLAND
Children's Cabinet

Agenda

- Welcome and Introductions
- Vote on adoption of January meeting minutes
- Infant/Toddler Presentation
- Public Comment
- Adjournment

Month	Proposed Topics
January	FY25 Governor's Recommended Budget
February	**Age-cohort 1: Infant/Toddler Focus:** • Data on current trends and early experiences for infants/toddlers in RI • Infant/Early Childhood Mental Health Plan • Infant/Toddler Early Learning Strategic Planning
March	Age-cohort 2: School Age Focus: • Trauma Informed Schools Commission • Chronic Absenteeism Working Group • Adolescent substance use/BH
April	Age-cohort 3: Young Adult/Postsecondary Focus • Higher education enrollment and graduation outcomes, and key initiatives such as RI Reconnect • Career Pathways & PrepareRI • Voluntary Extension of Care
May	Progress Report on Strategic Priorities • Early Childhood Care & Education Strategic Plan + Governance Implementation • Learn365RI • Children's Behavioral Health System of Care
June	Community Engagement: Roundtable with youth @ community location (note: would need to be at a time that is accessible for young people)
July	FY25 Final Budget & Legislative Outcomes
August	Back to School – Priorities for 24-25 School Year
September	Cross-agency focus: Workforce Strategies: • Per Capita Income plan • Workforce trends • Gaps and strategies for key workforce areas (HHS, Early Learning, K-12, etc)
October	2030 Plan Updates & Progress
November	Community Engagement: Roundtable with parents @ community location
December	End of Year Report Outs on Key Priorities & Metrics

Notes:

- Agendas subject to change to address emerging needs / topics
- Highlight & celebrate awareness months

Infant Toddler Discussion

February Children's Cabinet Meeting

Objectives

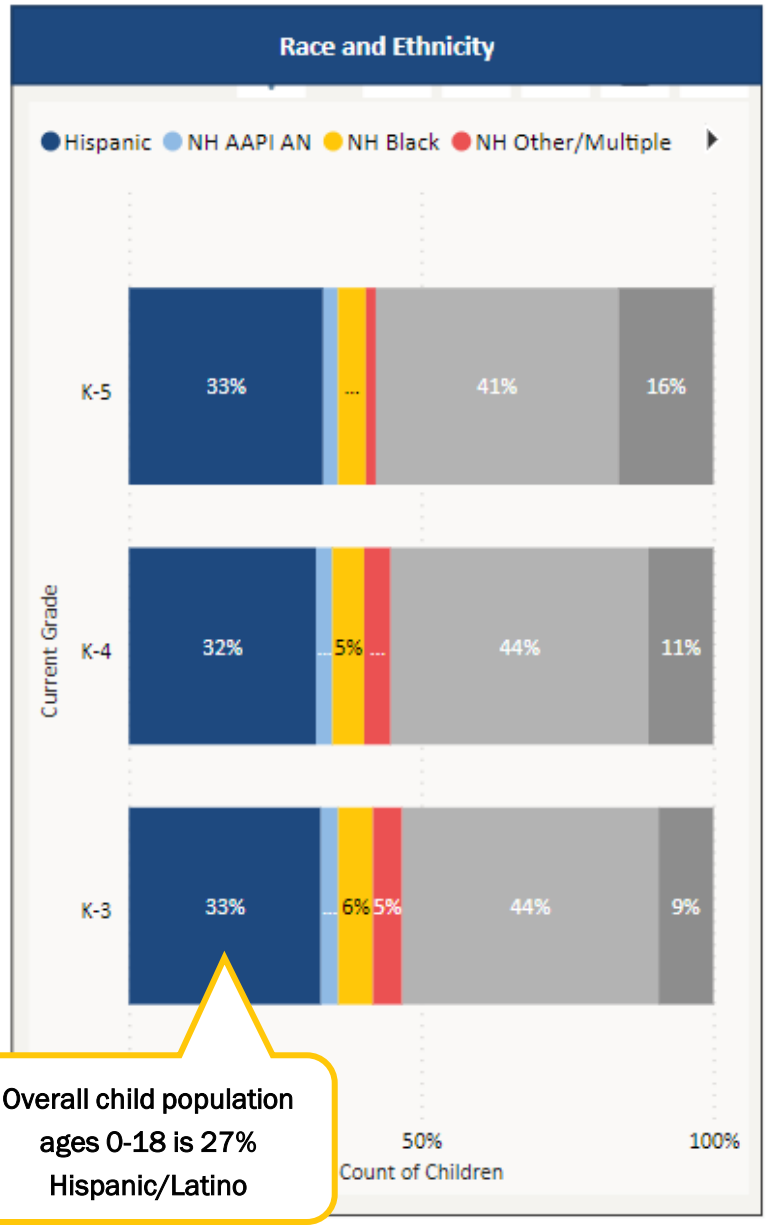
- Build shared understanding the current demographics and experiences of children ages 0-2 in Rhode Island today
- Discuss existing programs that serve this population & key actions underway
- Discuss potential gaps in support & opportunities for cross-agency collaboration to support improved outcomes

The early, vital experiences of infants/toddlers is rooted in the social determinants of health.

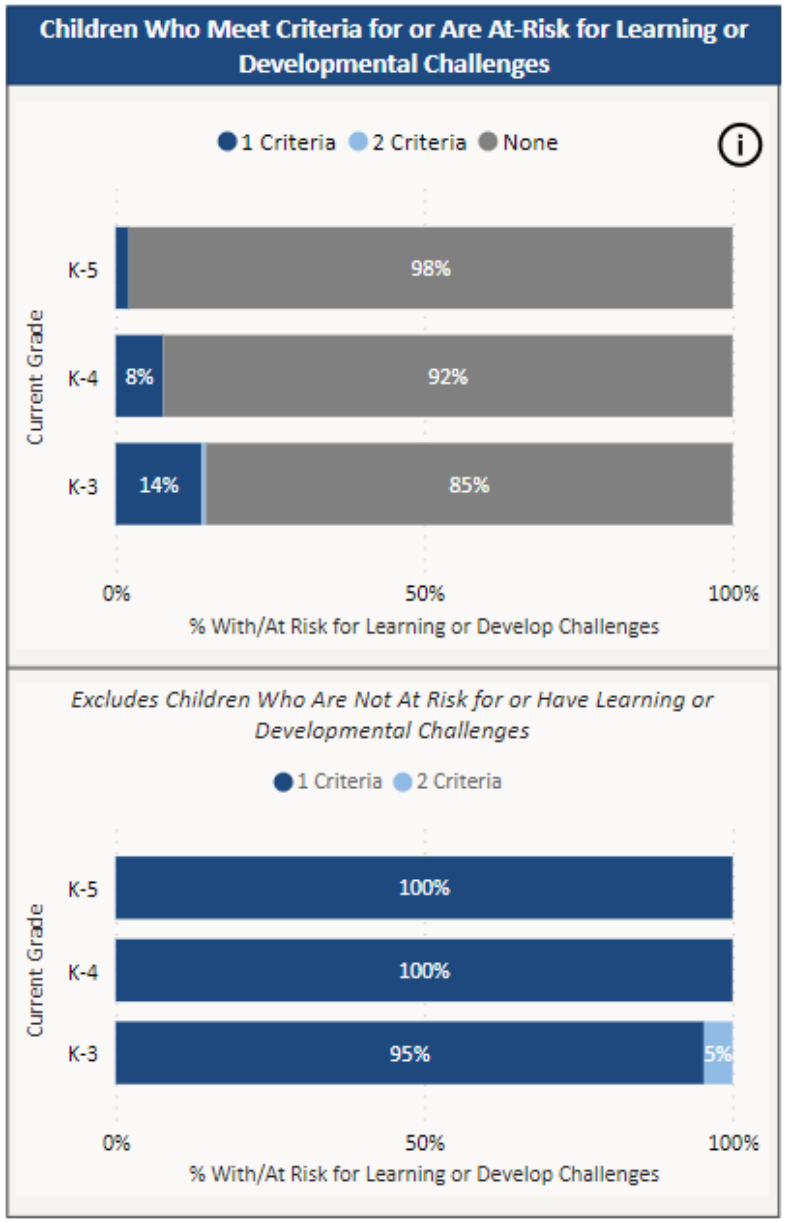
The first three years of child's life are some of the most important for development –**more than 80% of brain development happens before age 3.** However, in the United States:

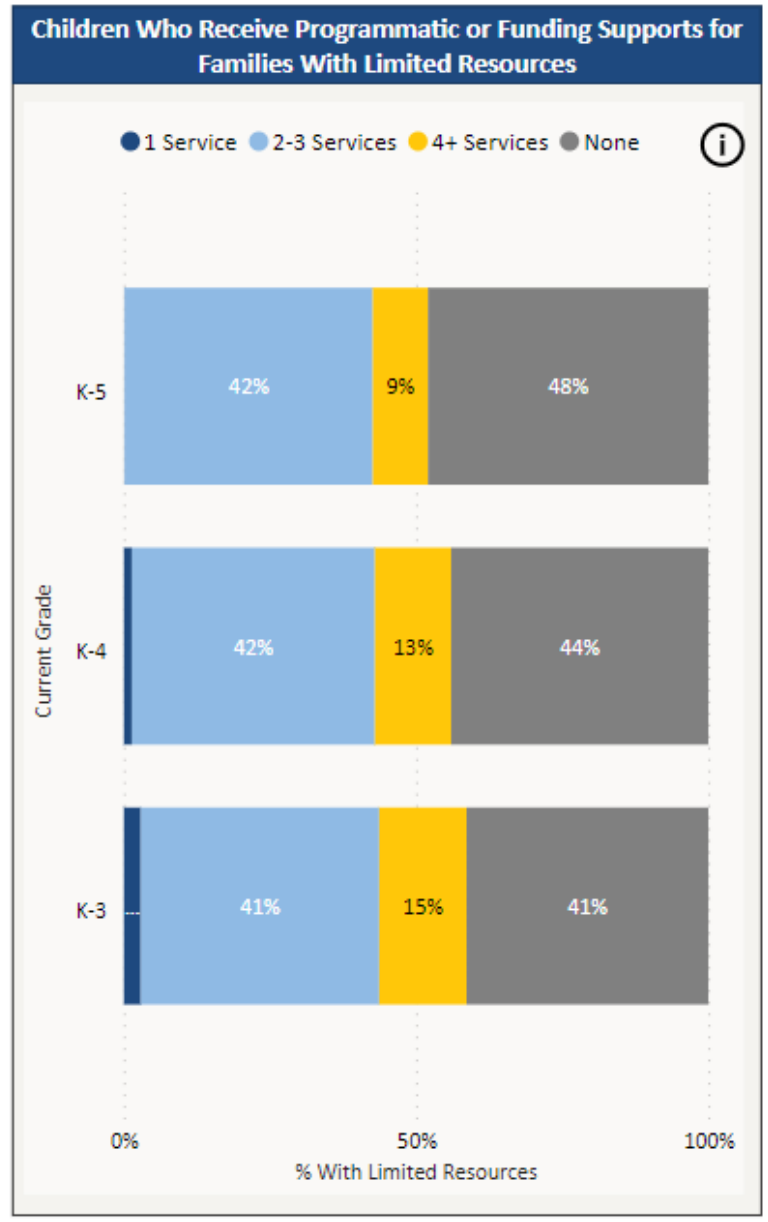
- Infants are the age group most likely to be **living in poverty**
- Children ages 0-5 are the most likely population to be **facing eviction**

Demographics & Experiences of Infants and Toddlers (Ages 0-2)

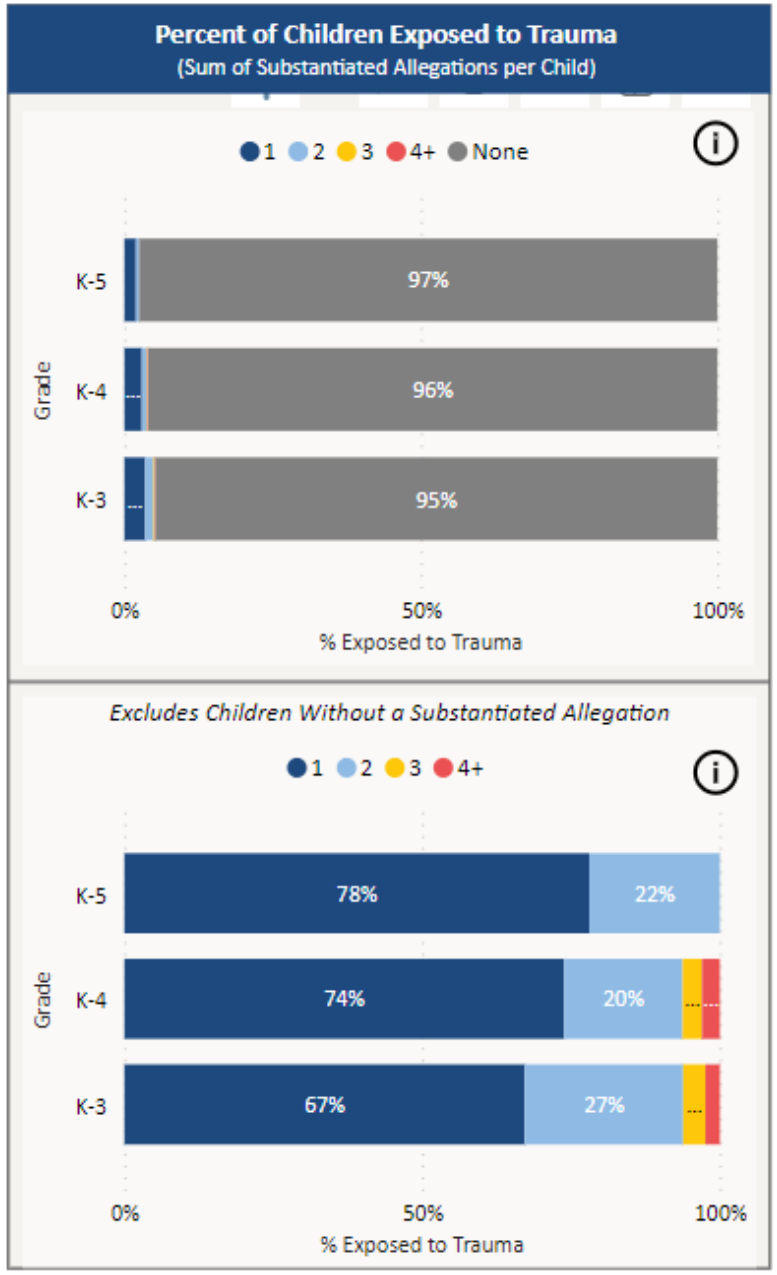


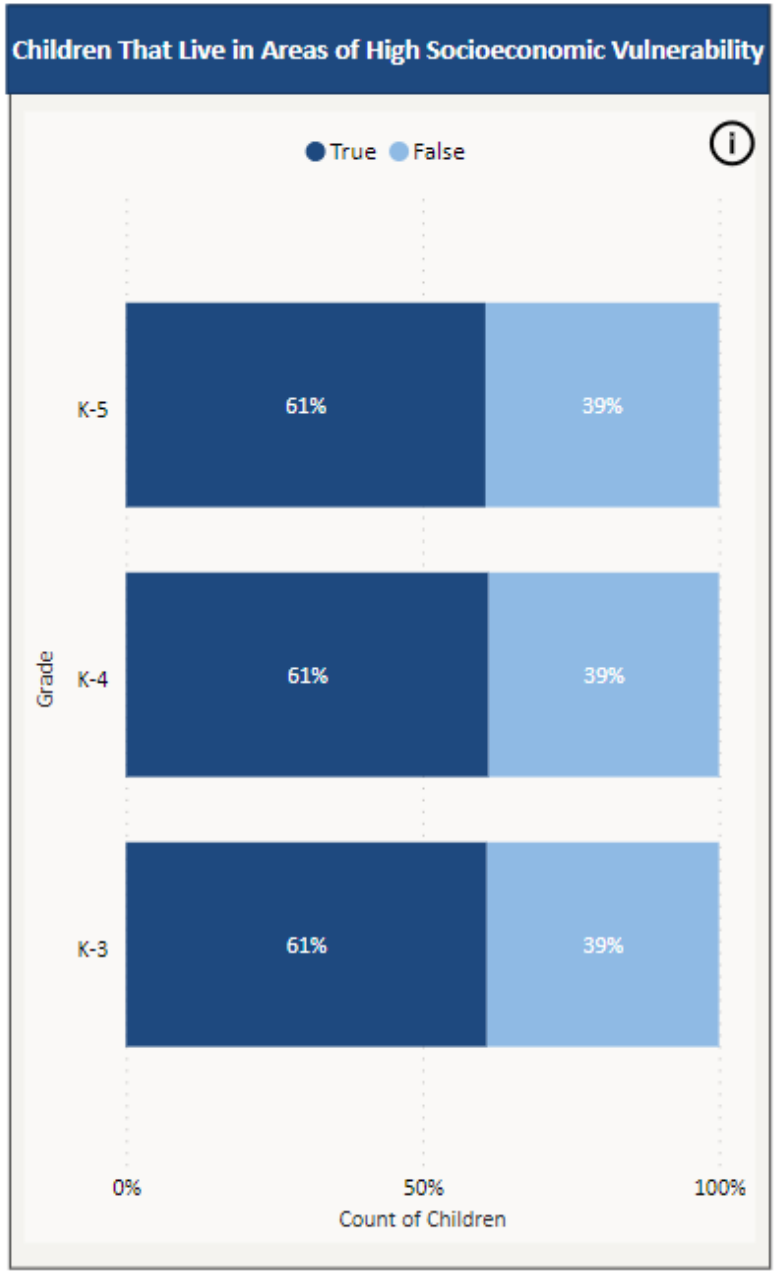
Overall child population ages 0-18 is 27% Hispanic/Latino

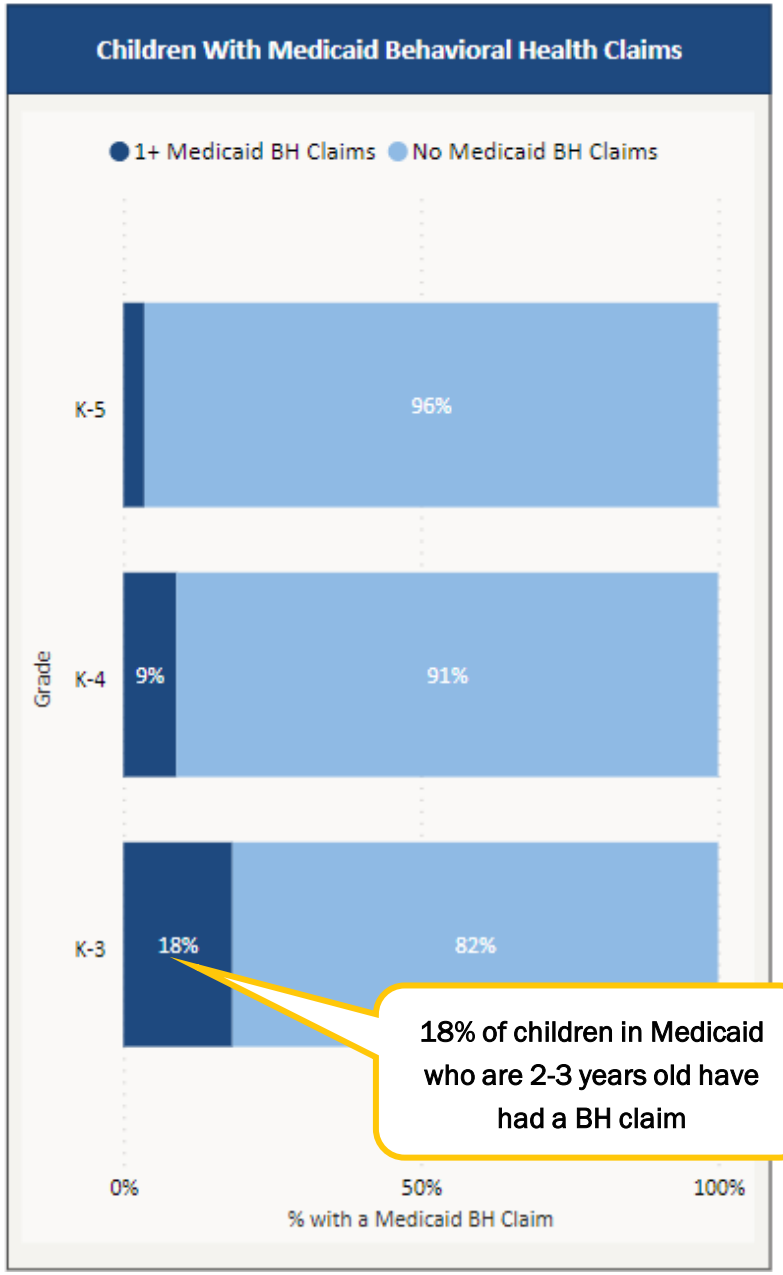




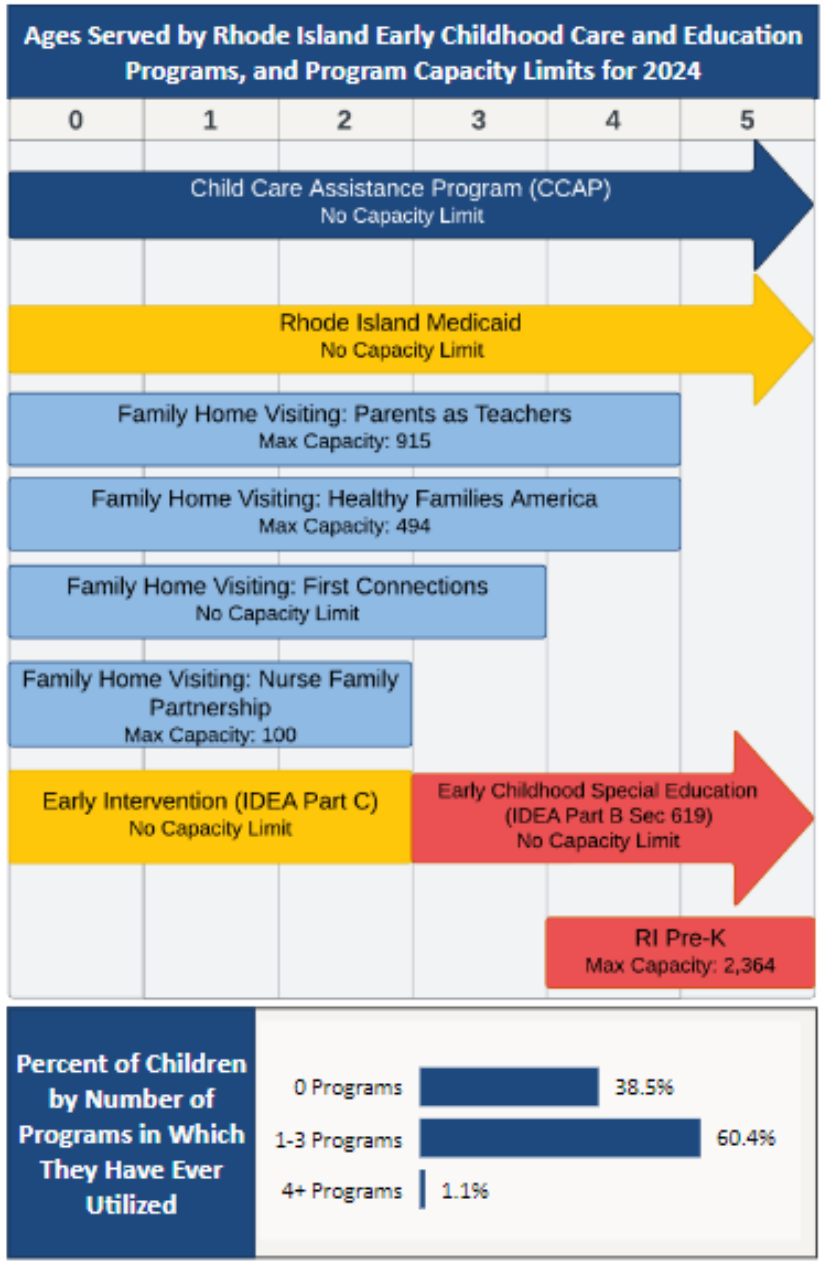
Demographics & Experiences of Infants and Toddlers (Ages 0-2)







Medicaid and First Connections are the programs that serve the greatest proportion of the infant/toddler population.



Percent of Children Ages 0-2 who have participated in each program:

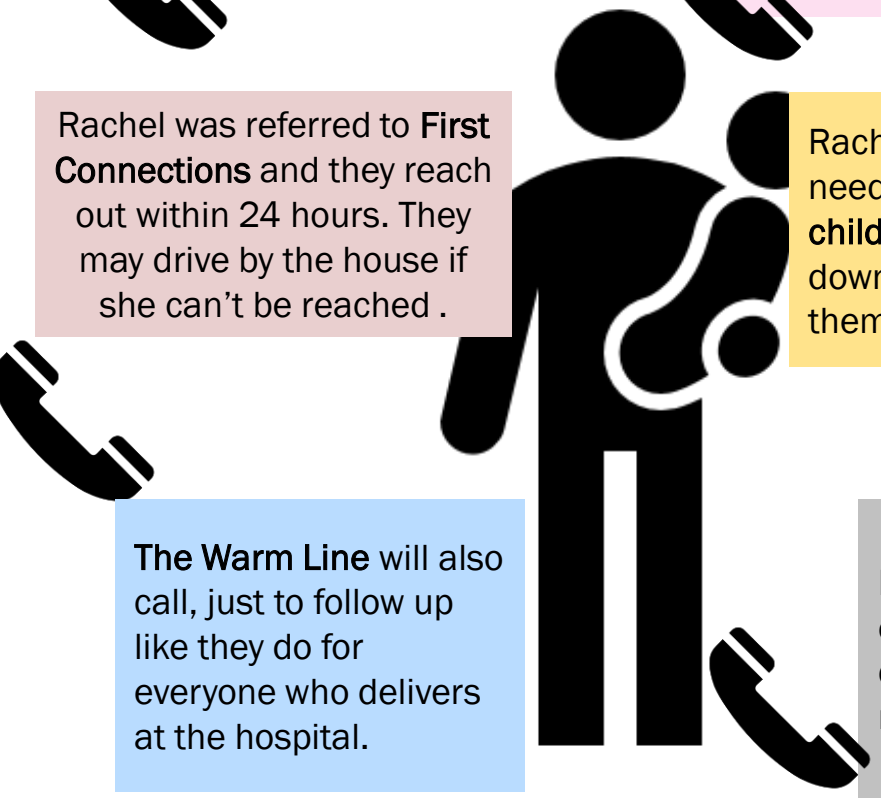
- 55% ever enrolled in Medicaid
- 25% ever enrolled in First Connections
- 10% ever enrolled in Early Intervention
- 7% ever enrolled in Child Care Assistance Program (CCAP)
- 6% ever enrolled in a Long Term Family Visiting Program

The majority of children ages 0-2 are enrolled in at least 1 early childhood program.

A hospital Social Work referred Rachel to HFA.

The Family Follow Up Clinic invited Rachel to join their program and will call to follow up.

Rachel was referred to **First Connections** and they reach out within 24 hours. They may drive by the house if she can't be reached .



Rachel knows that she needs to schedule a **well child visit** and writes down the number to give them a call.

Which calls does Rachel take? **Are these teams talking to each other?** Does it all feel helpful or overwhelming?

The Warm Line will also call, just to follow up like they do for everyone who delivers at the hospital.

Rachel thinks she is eligible for **WIC** but does not want to make one more call.

Rachel did not engage with any support service parentally, she may have said no thank you, or simply did not know they were an option.

She is on methadone and everything is going smoothly but her baby had NAS symptoms after birth and was at the hospital for a week and a half.

When she gets home, the phone starts ringing off the hook.

When it doesn't go smoothly

If Rachel does not schedule a visit or decline First Connections they continue to reach out – wanting to make sure that things are going smoothly back home.

These teams may not know whether or not Rachel is already involved with each others programs, or with **Early Head Start**, **Youth Success**, a DCYF funded **FCCP** program or **other DCYF funded services.**

Partnerships that make systems work

State agencies engage in multiple partnerships to blend resources and alig polcies and pgorams to make the system work more smoothly for families

- **RIDOH/EOHHS:** - Supports funding for family visiting programs, funding for HEZ to increase supports to families, funding to support infrastructure and parent involvement/leadership in systems.
- **RIDOH/BHDDH:** - Supports families with substance exposed newborns to access needed services and supports like peer support, family visiting, and basic needs.
- **RIDOH/RIDE:** – Supports early childhood mental health consultation to child care and Pre-K sites.
- **RIDOH/EOHHS** – Supports family home visiting and coordination with Early Intervention
- **RIDOH/DHS** – Supports family home visiting and coordination with other DHS programs
- **RIDOH/DCYF** – Supports implementation of CAPTA legislation and coordination of care for families working with both agencies

Rachel began working with am **HFA family visitor** during her pregnancy. They supported her in setting goals for her pregnancy and once her baby was born.

Rachel was asked by her OB and Family Visitor about **substance use**. She was not using anything and had no concerns but they were ready to recommend a prenatal consult at the hospital, and linkage to substance use treatment if needed.

After birth WIC got Rachel a breast pump!

Her family visitor told her about **WIC** and let her know her pregnancy made her eligible for nutritional supports, and health education. The visitor made sure she had health care for the baby., and helped her schedule the first visit. She asked if Rachel will need child care

At the birthing hospital Rachel's baby received **newborn screening** for a number of conditions at birth including **hearing**. health conditions developmental assessment, and social determinants of health.

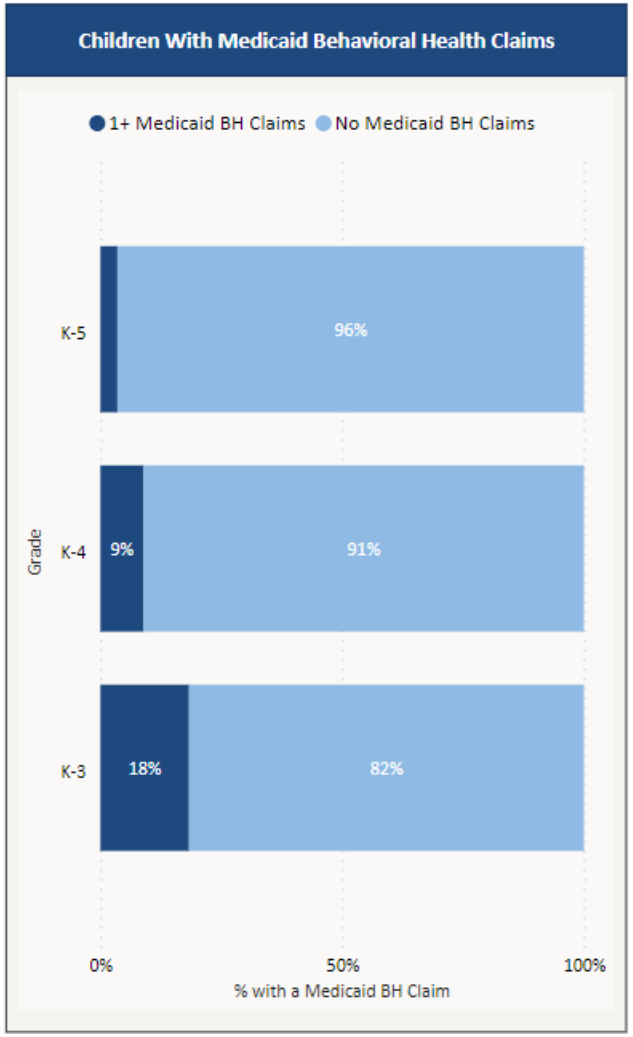
When it all goes smoothly

After she got home, Rachel was offered a **First Connections visit**. She was happy to talk with a nurse. They ask how she was doing and confirmed that she was still connected with WIC, Family Visiting, and had a visit with the pediatrician.

They offered to come back, but Rachel said she was all set with support from her Family Visitor and the WIC team

At the birthing hospital Rachel's also received education on **safe sleep**. Similar content will be covered by her pediatrician, WIC provide, family visitor and others.

Focus Area: Infant/Early Childhood Mental Health (IECMH)



Infant/Early Childhood Mental Health Plan Priorities

1. Implement Coordinated IECMH Workforce Development And Support: IECMH Clinicians
2. Implement Coordinated IECMH Workforce Development And Support: Broader Early Childhood Workforce
3. Advance Policies To Address Underlying Inequities And Root Causes Of IECMH Challenges
4. Universally Promote The Importance Of IECMH
5. Screen, Evaluate, And Connect Parents and Caregivers to Treatment
6. Screen And Refer Children To Evaluation And Treatment For IECMH Challenges
7. Ensure A Robust and Coordinated System Of Preventive Interventions And Support
8. Provide IECMH Consultation In Early Childhood Settings
9. Expand Access To Evidence-Based, Family-Based Dyadic IECMH Treatment
10. Promote Developmentally Appropriate Assessment and Diagnosis

Interagency considerations: Adult mental health, wellbeing, and economic security

Infant/Early Childhood Mental Health 2024 Activities

With funding from the Home and Community-Based Services Project, EOHHS, RIDOH, and DCYF have been able to support the following programs, to help implement the Infant/Early Childhood Mental Health Plan

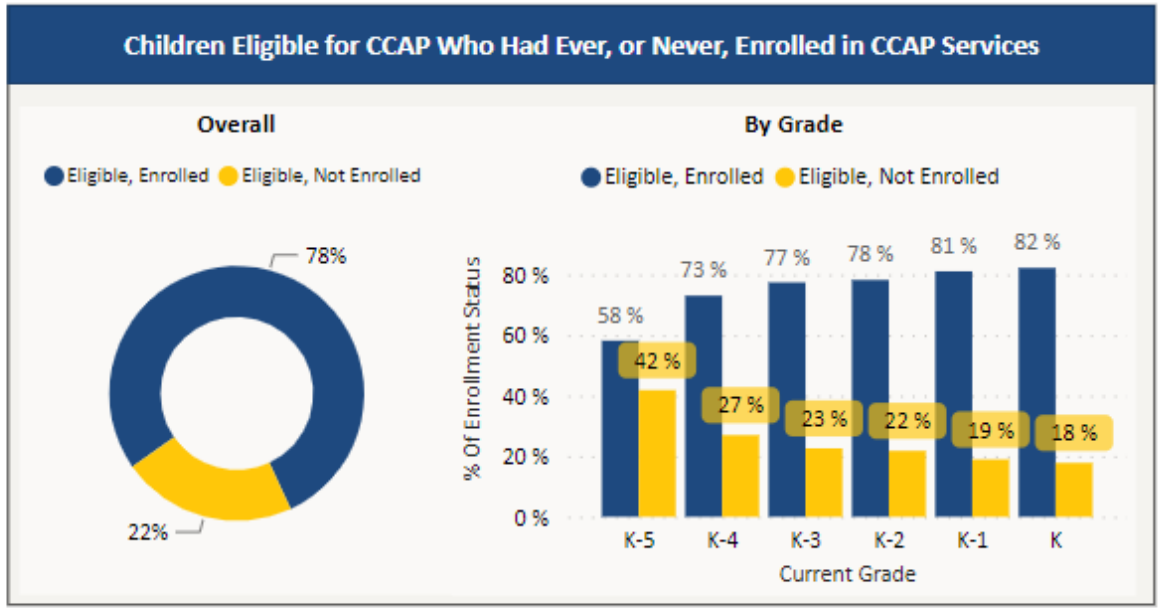
- Pedi-PRN – EOHHS is providing matching dollars for a federal HRSA grant. Pedi-PRN is a telephonic consultation program that encourages pediatric primary care providers (PPCPs) to consult with mental health specialists, thus improving access to and delivery of high-quality pediatric mental health services. The free service is offered to all PPCPs in Rhode Island – and any child or adolescent in Rhode Island who comes to a pediatric primary care practitioner with evidence of a possible, or likely, mental health disorder is eligible for the free service.
- Moms-PRN – EOHHS is support the Rhode Island Maternal Psychiatry Resource Network (RI MomsPRN), which is a free psychiatric telephone consultation service for health care providers who treat pregnant and postpartum people in Rhode Island. RI MomsPRN is a collaborative project between RIDOH and Women & Infants Center for Women's Behavioral Health, established to build the capacity of providers to screen for behavioral health and substance use disorders in their pregnant and postpartum patients, and respond with appropriate treatment and referral.

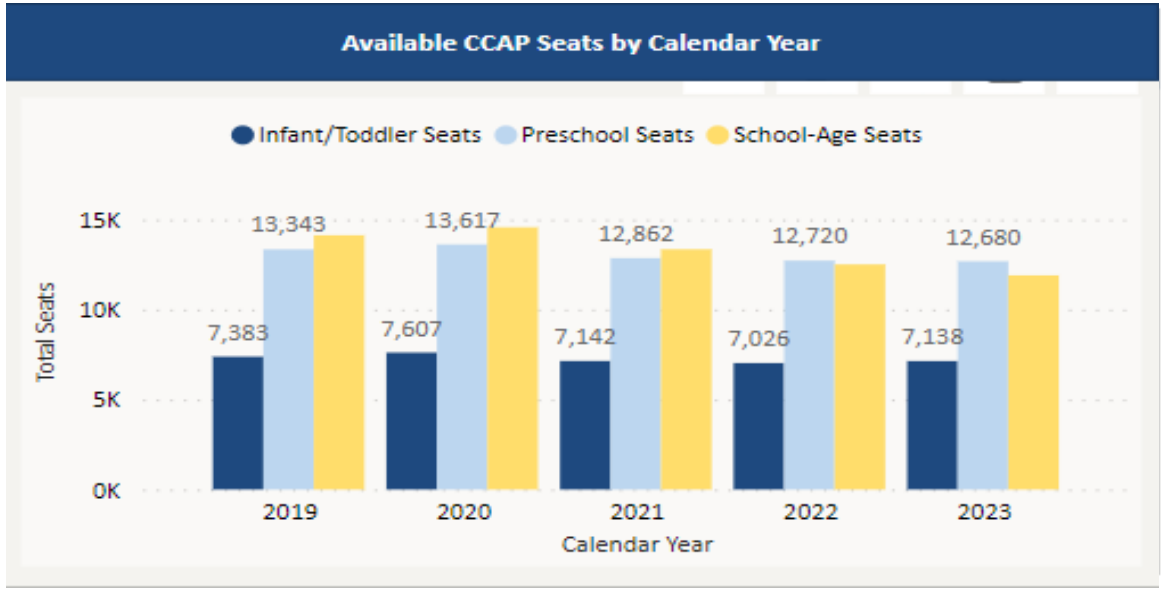
Infant/Early Childhood Mental Health 2024 Activities

With funding from the Home and Community-Based Services Project, EOHHS, RIDOH, and DCYF have been able to support the following programs, to help implement the Infant/Early Childhood Mental Health Plan

- **Professional Development Training for the Infant/Early Childhood Workforce**, led by the RI Association for Infant Mental Health. This comprehensive program includes general trainings, Leadership Development, and a Train the Trainer Program.
- **DULCE** – DULCE is a universal, early relational approach to strengths-based, family-centered child health care during the critical first six months of life. EOHHS is supporting a new cohort of pediatric and family medicine practices to participate in the training program.
- **Extension of Community Healthcare Outcome (ECHO) sessions and Learning Collaboratives for OB/GYN** - EOHHS is supporting a learning collaborative for OB-GYNs, with a focus on perinatal behavioral health given its impact on the health and well-being of the dyadic pair.

Focus Area: Infant/Toddler Early Learning Access: There are too few Infant/Toddler seats available in the early learning system, leading to children not having an early learning spot & families not being able to return to the workforce.





Infant/Toddler Early Learning Access:

- RI Pre-K Expansion Plan speaks specifically to sustaining infant/toddler capacity and the need for investment in this areas
- Using PDG funds, DHS will be kicking off an interagency infant/toddler early learning strategic plan process

Discussion

- What struck you most from the data? What are your key takeaways?
- How can this type of information help communities /school districts to support children and prepare for the next generation of students?
- How do we continue to build and sustain cross-agency partnerships to support infants and toddlers?

Public Comment

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Appendix

Data Summary

BH Claim Ever: The Scorecard leverages the Ecosystems standardized BH_Flag for each Medicaid claim.

- **Definition:** Children who have ever had Medicaid Medical Claim that is "flagged" for behavioral health. These criteria are as follows:
  - Has a claim with a primary diagnosis of a non-IDD behavioral health condition (e.g. ADD/ADHD, infant feeding/eating disorders, trauma exposed, anxiety)
  - OR has any primary diagnosis, but received a behavioral health procedure (e.g. Family assessment by a BH professional, received a multidisciplinary evaluation)
  - OR received care from a behavioral health facility
- Most infants/toddlers are flagged positive for BH as a result of receiving BH procedures.

High Socioeconomic Vulnerability Zip Code:

- CDC established the Social Vulnerability Index by assessing key determinants of health derived from the Census to determine communities that may benefit from support within the context of an emergency or natural disaster. Each census tract is ranked from 0-1 based on their percentile rank across five socioeconomic indicators. We matched these census tracts and their vulnerability rank to RI zip codes, took the average percentile rank by zip code, and zips that had an average percentile rank in the 75th percentile (top 25% of all values), were considered to be vulnerable in this data.