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CAN STATE IMPROVE CHILDREN'S HEALTH BY PREVENTING ABUSE AND NEGLECT?

A FUTURE OF CHILDREN EVENT

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P R O C E E D I N G S

MR. HASKINS: So, Ron Haskins. I'm the co-director of Center on Children and Families, along with my colleague, Belle Sawhill, and we're here today to announce the release of our 21st volume of *Future of Children* since the Princeton-Brookings Group took it over many years ago.

This volume is on "Policies to Promote Children's Health." It's full of great chapters. I highly recommend it. They're available outside, and they're also on the Internet and you can download whatever you want to and print it.

And we also have a policy brief on child abuse and neglect, which will be our focus today, because child abuse and neglect, as the volume points out in at least two chapters, is a major issue in children's health.

So, here's how we're going to proceed. Jan Currie, from Princeton, is the senior editor of the volume, along with Nancy Reichman, and she's going to give us a brief overview of the volume. She's a Henry Putnam professor of economics and public affairs. She's the chair of the Department of Economics. She's a director of the Center for Health and Well-being. And she's the senior editor of the *Future of Children*. She could not decide what job to take, so she took them all. (Laughter) Amazing. I don't -- maybe she sleeps, I don't know.

Then I'm going to give you a brief overview of the policy brief on preventing abuse and neglect, and then as compared with the previous speaker you'll get a significant upgrade when we turn to Patrick McCarthy, who is the president and CEO of the Annie E. Casey Foundation. It's one of the leading foundations in the nation, along with Casey Family Programs, that support study and innovation in child welfare policy. Patrick's been at Casey since 2010.

And then following individual speakers, we'll have a question opportunity

for you to question the first two speakers, and then we'll turn to a panel and I'll tell you more about the panel when we get there.

So, Janet?

MS. CURRIE: Do I have to do something to get my slides?

MR. HASKINS: I think you're on.

MS. CURRIE: Oh, there we go, okay. Maybe full screen would be good.

Okay, so, as Ron said, I'm here to give an overview of the volume. We're talking about policies to promote child health, and the volume takes a very expansive view of child health. So, starting, for example, from the WHO's definition, health is a state of complete physical, mental, and social well-being, not just the absence of disease or infirmity. So, this little graphic here is supposed to give an overview of the chapters in the volume.

Starting at the top we talk about early childhood programs. We also talk about medical programs. We talk about food and nutrition. There's a chapter on mental health. There's a chapter on housing and neighborhoods. There's a chapter on family programs. And then I think a very interesting chapter is about the legal framework that kind of animates our approach to child well-being in the United States.

So, we start with talking about physical health. This graphic shows a great success story, which is the increase in the health insurance coverage of children. This is big bipartisan success story, which largely preceded the Affordable Care Act. The Affordable Care Act also has some provisions that affect children, such as the ban on excluding people for preexisting conditions and dependent coverage up to age 26. So, those are also discussed in the volume.

We also start off with an overview of the state of health of children, and I like to point out that even though we tend to focus on the remaining problems, which is

very natural, child health is a huge success story in this country. If you just think about over time, the trends -- in this case in death rates for children age 1 to 4 -- you see continuous improvement over time. Of course, you also see some obvious problems that jump out from this graphic, for example, that the death rates for African-American children are so much higher than the death rates for white children and that they basically stayed that way over a long period of time.

These disparities come up in many different places in the volume. This graphic is looking at the incidence of low birth weight and pre-term birth for different groups. And, again, one can see that African-American children have the highest rates.

You can look at things through other lenses besides race. Looking at education of the mothers or looking at marital status of the mothers, you see similar types of disparities. So, socioeconomic disparity has a very real impact on people's health.

Now, looking at this long-term view, another way to think about it is looking at how the health threats have changed over time. So, if you start, you know, at the beginning of the century, mostly you're dealing with infectious disease. Fast-forward to today and you're looking at a lot of injury. So, this is feeding into our focus on child maltreatment in the rest of our session today. You see that looking at top causes of mortality among children, homicide is always there; injury is always there. So, those are things that are reflective of the problem of maltreatment.

These graphics look at a little bit more compressed period of time, 2007 and 1970. You can see the green slice of the pie is unintentional injuries, which is a very big health problem. If you look at the sort of light blue slice of the pie, that's homicide. So, this is showing that as a percentage of deaths, homicide is actually up. That could be partly reporting, but it also reflects a very real and persistent problem.

There's a chapter, as I said, on mental health disorders. This is, again, a

persistent problem, one where reporting may be contributing to the increase in prevalence but, nevertheless, something that's a very real problem.

This graphic, which is from the volume, is trying to show how, if you look at the middle axis, we normally focus on: Well, if there's a health problem then we need a health care solution. But there are a lot of other things that feed into mental health problems, such as early childhood conditions, and early childhood programs might be part of that solution.

We have a chapter on nutrition and food problems. Food insecurity is a very persistent problem.

And housing conditions. Here, again, is something where we've had a lot of improvement, but we still have a great deal of disparity. So, this chart, for example, is showing that the percentage of poor households who live in housing that's physically inadequate is much higher, double the fraction of all households that live in such housing.

Looking at neighborhoods -- here again we see this theme of improvement but also persistent problems. The poverty rate has stayed relatively constant, or at least the fraction of children who are living in poor neighborhoods has stayed relatively constant.

Education levels are generally increasing, but the percentage of children living in female-headed households is increasing over time.

So, focusing again on the policy, one of the themes of the volume is what a patchwork we have. So, we have policy at the federal level, at the state level, at the local level. Policies are very fragmented, and there's a lack of consensus about what is the appropriate role for government; what is the appropriate level of government to be involved. And, overall, lack of coordination between different levels and different types of policy seems to be an important problem.

Many successful programs are implemented at the state and local level, even when the funding comes from the federal government. So, some of the examples that are discussed in the chapter on early childhood are the supplemental nutrition program for women, infants, and children -- or WIC -- Head Start, other public preschool programs, childhood immunization programs, and home visiting -- especially the Nurse-Family Partnership Program.

So, the chapter that I mentioned on the legal framework I think makes an interesting and controversial argument, saying that in the United States the legal doctrine is that parents have a liberty and trust to raise their children as they see fit and that as a result of this, the state only intervenes when the welfare of the child is perceived to be directly at risk. They argue that the state has no affirmative obligation to improve child welfare, at least in its own view that that's the legal doctrine, and that the absence of this kind of affirmative legal doctrine makes child health policies vulnerable to shifting budgetarian policy priorities. So, it's something that you do if you have the funding, but it's not something that you have directly an obligation to do.

Finally, I want to focus on the chapter that's most relevant for today's discussion, which is the chapter on the role of family-centered programs and policies. This chapter makes the point that many children suffer from inadequate parenting and maltreatment at the extreme of that array of inadequate parenting problems.

The strongest predictors of maltreatment are parent hyperactivity and anger, family conflict, and lack of family cohesion. Thirteen percent of U.S. children and 21 percent of African-American children experience confirmed maltreatment at some point between age 0 and 18. So, this is a very important threat to child health. And child protective services are often overwhelmed and understaffed and tend to be reactive rather than preventive of this problem.

So, this chapter discusses some of the interventions that have been proposed or been implemented to effect this problem -- programs like home visiting, the earned income tax credit, and parent training programs, which tend to focus on the individual family. Other programs that you'll hear more about today target communities, and those include the Durham Family Initiative, the Los Angeles Prevention Initiative Demonstration Project, and the Triple P -- Positive Parenting Program.

So, these are all models that have enjoyed some success. And another conclusion of the volume, though, is that the jury's still out on which of these approaches is best in terms of being the most cost effective.

So, without further ado, I will turn it over to Ron and just urge you, if you're interested in any of these topics that I've talked about, to have a look at the volume.

Thank you. (Applause)

MR. HASKINS: As you can tell, my staff has learned over the years never let Haskins touch any kind of electronic equipment (laughter), because -- you'd be surprised -- push two buttons and I can get them reversed or push the wrong buttons and so forth.

Well, I hate to tell you this, but the audience often wants a lot of ado when it's my turn to speak next, but here I am, so I'm going to talk to you about 10 minutes about the policy brief.

So, let me start with an overview of the child welfare system. Janet did a great job of giving the introduction to it, but to understand the issue here. There are probably a couple of people in the audience who are not great experts on child protection, so I thought it would be good to just run down these numbers. They're pretty fascinating in their own right.

So, there are about 75 million kids in the United States. There are 3.5 million referrals alleging maltreatment, abuse, and neglect. Most of them are neglect. I read recently, that up to 80 percent could be neglect. So, it's mostly neglect, but of course physical abuse, sexual abuse, and mental abuse are also a big issue.

As a result of that system, 679,000 were actually confirmed who have had some incident -- there's some suspicion that something did happen, that they were either neglected or abused, including 1,520 deaths in 2013 -- and then 255,000 children in foster care.

So, the system works like a funnel. You start off with huge, huge numbers and gradually work them down to numbers that are somewhat more workable. But 255,000 are the ones that entered foster care in that year, but at the end of 2013 there were 402,000 children in foster care, which means a lot of kids are in there for longer than a year -- much longer than a year in some cases. And this is a crucial point: Only 159,000 of the kids in foster care got a payment from Title IV-E of the Social Security Act, which is going to be one of our main topics. I'll return to this in a minute.

But the number of foster care, 402,000, is down from a peak of 567,000 in 1999. Most people I think believe that indicates something is going well, that the states are doing a better job, and localities are doing a better job. There's a lot of dispute about exactly what the causes are, but the foster caseload has been declining for quite some time, and in the last two years probably, in the one year for sure, it's gone up just slightly. So, maybe the decline is over and we're in a period when it will level off or we'll get more cases of foster care.

And why would the caseload reduce like that? Again, these are all pertinent to the discussion that we're going to have progress this session.

Reduce lengths of stays in foster care: There are many states that made

a tremendous effort to try to get the kids out of foster care as soon as possible. I think there now almost -- Patrick may talk about this -- there's a huge agreement that it's not necessarily good for kids to be in foster care. It's better to get them in a permanent setting and, indeed, that's one of the three overall goals of the child protection system. So, permanency, getting kids in a placement as rapidly as possible, and that probably is one factor that accounts for reduced foster care caseload.

The second is more adoptions. We passed federal legislation, give the states cash on the barrelhead. It's amazing. We list an economist and pay them to do a certain thing and they more of it, and the states really -- if you look at the adoption date, it's amazing that it went up the year after -- actually two years after legislation passed, and as you can see here there were 38,000 adoptions in 1998, and in 2013 there were 50,608, and in some intervening years there were even more than that. So, adoption is a big part of the story about why the caseload's going down.

There's also more kinship cares in which local departments of social service find relatives. Often a maternal grandmother will be willing to take care of the child. Again, this is a fairly good development, and it's grown quite a bit in the last decade or so.

And then, finally, more children are left at home. This also is a very crucial point we're going to discuss. This issue will be involved in the rest of our discussion here, because many of the states believe, as I said, that foster care is not great. They don't want to take kids away from their family. There's some evidence that if you take kids away from their family in borderline cases -- kind of strange research -- that the kids who stay at home do better, even though they're with a family where's there's confirmed abuse or neglect. Obviously, in cases that are extreme you have to remove the child from the home, because safety is also a major goal of the system. So, there's a

brief overview of the system.

Now, IV-E and IV-B -- this is a big important topic for the policy brief and for our event today. So, IV-B is basically services, and I've listed several kinds of services there. This system was created by legislation that Tom Downey and George Miller were, I would say, the Godfathers of way back in 1980.

And the other pair, the other part of the pair -- it's titled IV-E, which, roughly speaking now -- there are lots of footnotes here -- roughly speaking, pays for -- helps the children and families once the child is removed. So, mostly it pays for foster care and other placements for children who are removed from their home.

Now, as you can tell by the total amount of money, in IV-E, only the fosters. Also adoption, which is another more than 2.5 million -- we're leaving that aside, because it's not going to be part of the discussion. But 4.3 billion on foster care -- I'm sorry, from IV-E. It was available from IV-E, most of which was spent on foster care, and only -- much less than a billion dollars for Title IV-B. So, since IV-B is services and IV-E is primarily for when children are removed from the home, just from a broad perspective it looks like the system has incentives for DSS to use to remove kids from their home.

Now, states will deny that. People shake their heads, I've seen -- a head or two shaking in the audience right now -- but that is the nature of the system. And states constantly complain. And this I'm fully confident -- anyone shakes their head I'm going to disagree with you -- the states, more than ever in the past, are saying they could do a better job if they were able to provide front-end services -- front-end before the child is moved from the home, with prevention and with treatment -- that they would be able to keep the kids at home and produce a better result, not have to put them in foster care, and the whole system would cost less.

So, some of the money should be shifted from IV-E to IV-B, in effect, to

give the states more flexibility with providing treatment and services. And so this is why the states, many of the states -- and we've had, by the way, a discussion here sponsored by Casey Family Programs for the past almost two years in which we've been discussing this very issue about financing and the states constantly -- not every state but most states are saying if they had more flexibility they could spend the money better and they could keep the kids out of foster care and keep them at home, and there will be at least one person on the panel who will doubt that and criticize. So, that's why we have events like this.

And then there is also growing evidence of effective treatments and something that we're not going to discuss very much, but it's a very important point, and it's -- actually I would call it a mistake in the welfare reform legislation of 1996 -- that eligibility for the IV-E payment is anchored to this eligibility for the AFDC program, which has been defunct for, you know, almost two decades. So that -- and it's expensive to calculate. States don't like it. It's not a great way we should spend our money, and if they had the money with more flexibility, maybe they could serve whoever they want -- that would be at least one person -- so they could avoid that calculation.

I want to end with this. This is from a review paper that Casey Family Services recently did, and they reviewed -- in effect, this is evidence-based policy. These are programs that have evidence that that they work. So, the top -- the first batch are well supported by research evidence. So, there's evidence from either experimental or quasi-experimental designs -- many of them experimental with random assignment, the whole works -- that they actually produce the kind of impact we're looking for: something to help the family, help the child. And then there are another five that are supported by research evidence but the evidence is not quite as strong so there is some question about these programs. And then there are a whole bunch at the bottom -- there are 10, I

believe -- that have promising levels of evidence. This is a very -- I think -- I like this system a lot. I think it's a very good way to look at policy and programs and to try to figure out ones that really work and try to focus spending on the ones that really work.

The point here for our discussion today, though, is that there are a number of programs that have good evidence (inaudible) an assignment that they can produce the kind of outcomes we're looking for in child protection and justify keeping the kids at home and giving them prevention or treatment programs. And if they're using good programs, they -- I mean, you can still mess up even if you're using a good amount of program, that's obvious, but the odds that you'll be able to be successful are better, so at least we know theoretically it's possible to help the families and the children -- leave them in the home -- but the states need more money to do it. So, the question of flexibility and a relationship between IV-B and IV-E comes up, and we will discuss that on the panel in just one moment.

But now we'll have a discussion with our two first speakers.

Oh, sorry. (Laughter) I just lost one of my jobs. (Laughter) I'm so sorry.

MR. McCARTHY: A lot of money.

MR. HASKINS: A lot of money. Yeah, that's right. (Laughter. So, thank you. I'm so sorry, Patrick.

MR. McCARTHY: Good morning, everybody. First I want to congratulate Ron and Janet in the whole effort of *Future of Children*. I think this is an important topic, and I hope that we not only spark attention here but some lively debate.

I've got to start by saying I've got some trepidation standing in front of you, because I can pick out, as I look around the room, many, many folks who are more expert than I am on these complicated issues. In fact, if Ron was a better choice of talent, when he looked at our foundation for someone who'd want to speak, he would

have chosen Rob Gain, who's in the back. Not only is Rob much more informed about these issues and a much deeper thinker about them, just on a pure word-per-minute and idea-per-minute basis, you'd get a lot more from Rob.

So, I'm going to start, actually, with a story. I'm going to ask you to bear with me. I will get to the finance issues, but I want to start with a story.

A few weeks ago my daughter came to visit and brought a friend with her. Now, my daughter, one of four kids, is an MSW social worker, working in a private agency under contract with the state in a major city, which I won't name, and it's not Baltimore or D.C., and she works in intensive home-based services. And the young woman she brought home with her is her partner. They work on a team; they go into homes, small caseloads. They work very intensively to try to keep families together.

So, we're having dinner -- and my wife is also a clinical social worker, so you can imagine what my life is like -- and a discussion began where my daughter -- I'll call her Lauren, because that's her name (laughter) -- Lauren was complaining about this case she had where she had gotten it after the family had experienced removal of the children. Three kids. One was three years old. There was a 10-year-old and an 11-year-old. They had been reported to Child Protective Services a couple of times for neglect, lack of supervision.

Child Protective came in and decided to remove the children one night. The 3-year-old went to emergency foster care. The 10- and 11-year-old went to a shelter -- congregate care setting. They stayed there for three weeks. And finally the children were placed with the grandmother after three weeks, and Lauren and her partner were supposed to provide services to the entire family to see if reunification with the birth mom could take place. And Lauren was complaining about the decision that the social worker made.

Now, her partner, who I'll call Selena -- which is not her name -- Selena had just joined Lauren's agency, and she had been a Child Protective Services worker before that. She got a little steamed at Lauren, as Lauren was being critical of the worker who made the decision, and she said: You know, when I first started working in Child Protective Services I was 22 years old, I had a bachelor's in social work. I had one week of training before I was assigned to the field. That one week was mostly about how to fill out forms, what abuse and neglect meant, how to work the computer system, my keys, et cetera, and my first week on the job I was assigned to after-hours response.

So, she was the one, the 22-year-old who had never been a parent -- although she had a bachelor's in social work -- had never worked in child welfare, who would have been the worker sent out to knock on the door of this family. And she said: You know, it's late at night, you're on call, you're inexperienced, you might be able to reach a supervisor by phone. The supervisor that I was supposed to call was actually someone I didn't like much. I met them once in person and they didn't like me, I didn't like them, so I wasn't going to call them on these kinds of situations. Pressure to decide what to do, little information, conflicting information. Everybody wants me to make a decision. I'm trying to look like I know what I'm doing, and I'm trying to make a really tough decision.

Now, I know that it's very probable that this family could stay together if I knew which program I could get in touch with right then to make things work. I knew there must be somebody I could reach, but I didn't have the information in order to reach them. The mother was very upset, was not able to be helpful to me, and so in fact in a situation exactly like the one you're describing on my first week in the job, I was that worker. I placed those children and, yes, some of them went into shelter care.

Now, why do I tell you this story? Because the bottom line is the kinds of

things we talk about, which are really important at the policy level and have lots of complications all come down to what happens when there's that knock on the door. And the story I told you is about the worker's point of view.

Now, put yourself on the other side of that door. It's your door that's being knocked on, because one of your neighbors has called and for whatever reasons said they don't think you're doing a good job by your kids. And you open the door, who do you want to see on the other side? And what kind of support do you want them to have? And how do you want them to make a decision? And what information do you think they should have? And do you want them to know about your other family members who, even though you don't want to see your kids out of their own beds that night, you'd rather see them with your mom or with a cousin or with a brother? That's what we're really talking about here.

And what gets to this nitty-gritty stuff is the system that confines and constrains the choices that our workers have at the front lines.

One of my bumper-sticker statements is that a bad system will trump a good program every day of the week. So, a lot of the programs that we saw there, all of which have a lot of evidence behind them, if you embed them in a system that is not able to function, I promise you that program will not survive, and if does survive it will not do good work. So, I think this relates a lot to the issue we're talking about today, which is how do you finance a system so that it can do a good job?

We know that that worker in the field, in addition to what Lauren's new agency has provided to her -- this is the second agency she's worked at; the first private agency did not provide this -- is small teams, lots of training, lots of supervision, and team decision-making. And she could do her job even better if she had the technology to bring to bear to have the data that she needs when she's on the front line. Certainly, the public

system worker needs that. And the public system worker needs to know which programs work; where are the slots available; can I reach people.

We have technological solutions for this that we use in the private sector all the time in the child welfare sector. We are woefully inadequate, especially given how important the decisions are.

So, what's the goal? If the system works, we ought to, at the least, expect that every child is in the right place with the right supports. And the research tells us that the right place for a child is with a family.

Certainly there are some children who need a period of time in a different kind of a setting whether because of their behavior or because of threat to the system, et cetera, a threat to the community -- not threat to the system -- threat to the community. But the bottom line is that all children belong in families. We ought to reserve our deepest and most expensive interventions -- the group home interventions, the residential treatment interventions, the congregate care interventions -- only for those very, very, very small numbers of children who may require it for only the period of time required for them to do well.

And, finally, if a system is working well, we ought to be investing in evidence-based practice such as the kind that was discussed here earlier by Ron -- listed by Ron. The work done by Casey Family Programs is exactly the list that I would put on as well. So, why is it so hard to get there and why is it so hard to build and support and sustain systems that actually work?

Financing is our topic today, so that's what I'll focus in on. There are lots of other things that need to happen. I'm pleased to see that Brenda Donald's going to be here, because she knows a lot about what makes the system work. I know she'll be talking about finance today, but it takes a lot more about that.

What's wrong with our current way that we fund child welfare? Well, it's not completely aligned with what we know works best. We know that it is chronically underfunded and that as federal funding has shifted over time there's less and less support for what works from the federal investments in child welfare.

Back in September of 2013, the Annie E. Casey Foundation did come out with a series of recommendations around how financing could be better aligned with permanency; with good, solid workforce development -- remember that young woman knocking on your door, how you want her to be recruited and trained and supported? -- kinship care, which has been a hugely important part of the system; and building out the service arrays so there are more evidence-based programs.

I want to talk about flexibility, and I want to challenge some of the assumptions and perspectives in the policy brief so we can have a good, lively discussion when the real experts are up here.

Flexibility is absolutely key. There's no question that different communities, different states, different cities, et cetera, need flexibility so they can design their systems so it fits with their communities and with their states. But I would argue that flexibility itself is actually insufficient to bring about the kinds of changes that we're talking about. So, here are a few thought experiments.

Think about all the money spent on child welfare today -- not just the federal side but the state side -- all the money that's spent. Despite the chart that Ron puts up, which is the federal side, of the total money spent on child welfare today, 68 percent of those dollars are completely flexible. Tomorrow if Brenda wanted to wave a magic wand, she could take approximately 68 percent of the dollars that are not being spent in child welfare and use them anyway they want. As we look across the system, most of those dollars are spent where? In foster care. So, is flexibility the problem, or

are there other things driving those kinds of decisions?

When you start to include beyond IV-E and IV-B, remember that states also use TANF money, SSBG money -- some use Medicaid money -- as part of their child welfare financing. And most of those dollars have flexibility built into them. The states spend $10 billion a year just on the portion of their foster care system that is not reimbursed by the Feds. That's $10 billion, which in theory could be shifted to things other than foster care as is being recommended.

We also had a look at is there any correlation between the states who have achieved more flexibility under waivers, et cetera, and those who haven't? Is there any difference in child welfare outcomes? And we don't see a difference.

So, again, the bottom line here is not that flexibility is a bad thing, but it is not sufficient. In fact, even when you look at the numbers of kids who are eligible for IV-E reimbursement -- as Ron said, you do the math -- it's 40 percent of the total number of kids in care. So, that means that 40 percent is reimbursed at roughly 50 percent. It's like 20 percent of the money for those in care in fact is not flexible.

So, again, this child welfare work is very tough. I'm going to just jump to what I think are some things that I would include on agenda for finance reform. I know Becky Shipp is with us. She's another expert on this and will have lots of thoughts on the extent to which this is pie in the sky or realistic.

Number one, we need to streamline. Our financing streams are now hopelessly complicated. Part of that, as Ron has sad -- this is really critical to delink the eligibility for reimbursement for foster care from the 1996 AFDC eligibility standards. I mean, not only is that sort of crazy on its face, it means that states spend literally millions and the Feds have to reimburse portions of those millions in order to go through this complicated eligibility process. If we could streamline the financing systems, we'd cut out

some of the bureaucracy and take some of those dollars and put it into that young worker who's knocking on the door in the middle of the night.

We also need to figure out how to protect the existing federal investment. Because the funds are now linked to the 1996 standards, we run the risk of those dollars shrinking as time goes on.

Second, we need to expand the IV-E coverage to include time-limited family preservation and family reunification services. As we streamline, we ought to recognize that many families can be kept together safely and with better outcomes for kids if we support the kinds of intensive home-based services that my daughter does, not just because that means she'll have a job but because it's the right thing to do for families.

Third, we've got to figure out how to use federal funding to incentivize innovation, to provide those out in the field, essentially, with both incentives as well as cover, quite frankly, for attempts to innovate within the system. Flexibility itself is not the same as innovation. It depends on how that flexibility is targeted and what incentives are built into it.

Fourth, and I think Casey Family Programs has done a terrific job on this -- our own child welfare strategy group at Annie E. Casey works on this as well -- we've got to be able to provide high-quality technical assistance to the public systems and to the private providers who work with those systems in order to bring about movement from this overreliance on congregate care and deep-end and, when not necessary, foster care.

And in order to do that, we've got to work with, for example, the large providers who have already started to make this shift, providers who started as primarily residential providers who have now moved into family-based and community-based service provision, get them to work with other providers around the country so they

reinvent themselves, and we move the field in that way as well.

Fifth and finally, we've got to figure out how to take these kinds of evidence-based programs that were listed a moment ago and the promising practices to take them to larger scale. And that means two things:

One is those kinds of interventions that were listed and the research that was done -- very, very important, but they've got to be adapted for the public systems within which they work. Even if they're being provided by private providers, that will be under contract with the public system, and if you don't think through what the changes are on the system side to have to happen, than I promise you those programs don't work well.

Secondly and related to that, when you look across these programs, when you unpack what's inside these evidence-based programs, there are some common themes which I would argue can be brought to bear within those public systems. And Brenda -- I keep calling her out, but Brenda is doing some of that here in D.C. For example, many of these programs that work, work because they take a trauma-informed approach to practice. And Brenda's agency is taking that concept and embedding it in all the work that they do.

Many of these things work because they are based on teaming. And, most importantly, many of these work because they are just fanatical about how you engage families in a very real way as partners in working on solutions. That's very hard to do. It takes lots of training, but that's why a lot of these programs work -- MST and multi-dimensional treatment foster care, functional family therapy, on and on and on and on and on.

So, again, I just want to congratulate everybody who worked on this edition of *The Future of Children*. I think the policy brief ought to be one that leads to lots

of debate and discussion. I'm going to participate as much as I can, but, again, if you've got a real question, Rob Gain from our shop is somebody I'd encourage you to talk to.

Thanks very much. (Applause)

MR. HASKINS: Okay, good. Thank you very much. I'm sure glad I knew all about how the event was going to proceed and explained to everybody and then violated the whole explanation. I'll hear about this later, I have a feeling.

MR. McCARTHY: I think so.

MR. HASKINS: So, let me begin with Janet. I want to ask you one question. We see in several of your charts -- we see the same thing in school achievement, see the same thing in preschool performance. Almost every dataset you look at, blacks are always at the bottom. And you're starting -- some of your charts are -- right from the very beginning there at the bottom. What can we do about that?

MS. CURRIE: I have to thank Ron for giving me the really easy questions. (Laughter)

So, one of the things that I try to do in these types of presentations is to not only focus on the negative, the disparity, but also on the improvement over time. So, yes, it's true that African-American children tend to be at the bottom on many different scales. It's not very surprising that that's the case, given poverty rates, single-parent families, and so on. You do see, though, a lot of improvement over time, right? So, what that suggests is that a lot of the things that we're doing are working and we need to do more of them, which is basically in keeping with the comments that both of you were making.

There are successful programs. We do see improvements over time. So, we have to stick with the effort, and it's not going to be an overnight improvement. It's going to be a many, many years improvement. But that doesn't mean that we

shouldn't be putting in the effort.

MR. HASKINS: Okay, so tell us one or two things that we could do early that you would recommend that we would do that would have an impact and, if you want to, make a comment about financing.

MS. CURRIE: And so I guess everybody has their own favorite list of programs, but in terms of early childhood programs, I think that the Nurse-Family Partnership is a very successful program. It targets people who have the greatest need, and it has been shown to have effects on maltreatment. So, in terms of improving that outcome, that's an effective program.

I think Head Start is an effective program. Even though many people like to criticize it for uneven quality and so on, I think on the whole it's been a successful program. It has closed gaps.

WIC is a very successful program. WIC improves birthweight. So, one of the ways that disparities start is -- if you recall the chart that I had showing that the incidence of low birthweight and prematurity is about twice as high -- so, it's not like people are starting in the same place and then diverging. They're starting in very different places, because kids are born with deficits. So, to the extent that you can address that by things like food and nutrition programs, home visiting, better medical care, that's giving people a better start in life.

MR. HASKINS: Good. Okay, so, mostly programs that we already have should be more -- should be fully funded, so to speak, or at least spend more on these folks.

Patrick, one thing that you emphasized, especially with your introductory comments, is also a problem with almost every system I'm aware of, and that is the person who actually delivers the assistance, the teaching, whatever it is, is a problem.

It's teachers in the public schools, teachers in preschool, the social workers in the child protection system. Tell us what you think should be done (a) to recruit better people and (b) to train them so that they're prepared to do the difficult things that you describe.

MR. McCARTHY: I'm tempted, Ron, to say, in the words of Ronald Reagan, "There you go again," because actually I wasn't saying that the worker is the problem. What I'm saying is that our attention to not only recruitment, which is a really important issue -- we ought to come back to that -- but how we train, support, and recognize the challenges that that front-line worker faces, right? So, these are folks -- and I know many of them well -- who enter this profession deeply committed to doing well by families. These are not folks who just wandered in off the street and said: Oh, looks like a good job, I think I'll take that. Looks easy. Not how they walk in the door. But after they walk in the door, the typical experience they have is incredibly outdated technology. So, they can spend 40 to 50 to 60 percent of their time transcribing things they wrote on paper into an outdated computer system, which drives them crazy and drives them out the door. So, there's that.

Their training is woefully inadequate. Their supervision is woefully inadequate. And if they make the wrong decision, all of us are ready to say: How could you have possibly made that decision? Even though these are the most difficult, distraught close calls often that you see, there are very few cases where you walk in and it's very clear the child's at risk and you'd better take them right away; and there are very few situations where you walk in and you know for a fact that that child's okay. The less experience you have and the less support you have and the less team decision-making you have, the more you're out there, and when things go south, it's on you. So, I challenge that it's about the worker. It's really about us. We don't own this.

And if I can just quickly editorialize on the question you asked Janet, I

would argue that the first step in how to address racial disparities is to truly believe and act as if these are all *our* kids. These are not African-American kids, Latino kids, white kids. Yes, the disparities are there, but we've got to really accept that these are our kids and we really feel that way, then we start to invest in things like poverty reduction, two-generation strategies, intensive early interventions of course, but we also have to take on all of the, frankly, cultural barriers that mostly white folks bring to this, right?, which is mothering of folks and saying it's a result of *their* culture as opposed to looking at what's *our* culture that tolerates the kinds of experience that the average American-American family has on a day-to-day basis.

Sorry, just wanted to jump in on that one, too.

MR. HASKINS: Thank you for doing it.

MS. CURRIE: If I can just one add one thing about that.

MR. HASKINS: Yeah, go ahead, absolutely.

MS. CURRIE: So, being located in New Jersey, I have followed the court-ordered changes in the Child Protective Services in New Jersey. You know, once there was a court order, then the money was found to do exactly the things that you're talking about, like, make sure that the supervisors are better trained, reduce the ratios of supervisors to staff, and so on.

MR. McCARTHY: It's doable, and there are systems that demonstrating that it can be done and doing it well. We need to align our financing to support that.

MR. HASKINS: Well, this goes back to -- I think you'll agree that this was one of your points regardless of what you think about preparation of workers, and that is that the system is really the key, and if the system doesn't work, it will ruin all kinds of other things -- you could have a great program -- if the system doesn't know how to integrate it, how to train the people properly, and so forth. So, that's what you're saying,

is it also applies to the black/white differences as well.

MR. McCARTHY: I think so. I mean, just the analogy I would use is that everybody in this room has had the experience of going to the DMV and standing in line and standing in line and standing in line and as you're there you start to think about: You know, in an hour I could design a better system than this. And there are good DMV systems, but most folks hate them. Imagine if that DMV system was going to make a decision about your child. That's what our families are facing when there's that knock on the door. It's the equivalent of a DMV being charged with the question of is your child going to sleep in his or her bed that night. Is that what you want? It would get pretty quickly to the question of how I'd make the system work better.

MR. HASKINS: Patrick, let me ask you, I don't think, with anything you said in your testimony, but let me bring up one other issue that I think should be considered here and I hope will be discussed during our panel, and that is that Congress, in its wisdom, gave the states flexibility to apply for waivers (inaudible). A lot of them to do that. And right now 30 states are in various stages of implementing waivers, and all of the waivers -- every single one of them -- involves some aspect of using IV-E funding, the funding that's not as flexible, to do things other than pay for out-of-home care. If the states didn't feel that they had a need to use money more flexibly, why would they do that?

MR. McCARTHY: It's a great question. I'm glad you asked it, because I actually have a response to it. (Laughter)

So, we looked at what folks, what states are actually doing with the IV-E money that has been made more flexible. We asked the question: Could the states have done what they're now doing without the waiver? And in almost every instance, they could have. So, it's a logical question: Well, why didn't they? If that's what they wanted

to do, what was stopping them? And I think you'd go back to what folks like Brenda and other child welfare administrators are constrained by in their day-to-day life. I was in that kind of position when I was in juvenile justice.

Your budget from year to year is heavily allocated and heavily rigidly allocated. Despite the rules or lack of rules on how you use the money, once you make decisions, and usually your predecessor -- remember, most folks turn over every two and a half years on these jobs -- your predecessor and predecessor's predecessor and the predecessor before that made decisions about how that budget was going to be structures, and now it has a whole constituency behind it. So, although on paper you have flexibility, in actual point of fact unless you're pretty gutsy -- and again like Brenda -- it's really hard to step and in free up dollars and reinvest them in different kinds of places, especially if right around the corner there might be a horrible child tragedy which will be lifted up to say: See that, because you took money from foster care, which is how it will be talked about, from foster care and put it in the silly notion that families ought to stay together, this child has died or been severely injured. That's the reality of jobs that child welfare administrators face.

So, how does the waiver help? The waivers have been tremendously important in a couple of ways. One is it provides these leaders with some predictability for a period of time of what money is going to come to them as opposed to with eligibility requirements going back to 1996. Every year they've got a shifting number of what they can count on for four years. The number one predictability, absolutely critical, ought to be built into the system rather than on a waiver basis.

Second, the dynamics of being an administrator in a complicated system is that you constantly need to take advantage of whatever political cover you can get, so to be able to turn around and say to your boss, whether it's the mayor or the governor,

and to the legislature: Look at us, we put together an innovative program. We got a waiver from the state. We're going to try this experiment, and we're going to use money that otherwise we wouldn't use this way but it's the Fed's money, et cetera. That's the reality of wanting these systems. That gives you the flexibility that actually you had before if you were willing to walk into the legislature and say: You know what, all this money we're spending over here I want to take a portion of it and do this project. And then, believe me, the questions you get from the legislature, from the press -- and if something goes wrong, and I mean even a little wrong, the political games and the press games start.

So, in my view, that's why the waivers have been so important. But they're not sustainable. I would be very surprised -- and I have no crystal ball -- I'd be very surprised if in fact the Congress continues to authorize waivers. It's time for us to get to the deeper problems.

MR. HASKINS: The have said that they're not going to -- at the least the Senate has said that they're not going to reauthorize waivers. So, when an end comes to the waivers, a lot of the advantages you talk about are going to be gone, right? So, there does need to be some provision for flexibility in the use of IV-E funds.

MR. McCARTHY: There needs to be a provision for innovation and support for that innovation, but that so-called flexibility -- trust me -- goes away within a year or two of the first thought unless you build in incentives towards experimentation, innovation, and evidence. It's got to be explicit.

MR. HASKINS: Okay, thank you very much. Thank you both.

And please join me in thanking in both of our guests. (Applause)

(Recess)

MR. HASKINS: Okay. So thank you members of the panel for being here. And you'll probably notice that there's a empty chair. Our good friend, Don Winstead, has a medical difficulty that required him to stay in Florida. We just found out of this on Friday. So we wish him well. It's too bad he's not here. He would add a lot to the discussion.

But we still have a terrific panel, and I think you'll see that there are going to be some differences of opinion here. And I personally know all the members of the panel at least somewhat, and I know some of them very well. And none of them are shy so I would expect we'll be able to have a good discussion.

So let me introduce the members of the panel. First is Brenda Donald, who is the Deputy Mayor of the District of Columbia and a former Director of Child Welfare in the District, who has been involved in the system for long time as Patrick mentioned on several occasion.

Next is going to be Christine Calpin, my good friend from Casey Family Programs, who is working this area for a long time. Used to be a staffer of the Ways and Means Committee so she know the ins and outs of the programs as well as well a about implementation.

And then third, Ken Dodge from Duke. There, I said it just easily. He's the Director of the Center for Child and Family Policy and the William McDougall Professor of Psychology and Neuroscience at Duke. So Ken, thank you so much for coming here from -- what's that city? Durham.

MR. DODGE: Yeah.

MR. HASKINS: And then Becky Shipp, my good friend, who is with the Finance Committee and has been there for a long time. I think you founded the Finance Committee, didn't you?

MS. SHIPP: Yes.

MR. HASKINS: Her title is Health and Human Resources Policy Advisor for the Senate Finance Committee and so she deals with these issues on a daily basis and has well developed opinions about what we should do. As you've probably figured out about we're gonna not have waivers pretty soon and the Senate Finance Committee has taken that position unequivocally.

So we're going to begin with opening statements. and then I'm going to ask some questions, and then we'll give the audience a chance to ask some questions. So we begin with Brenda.

MS. DONALD: Right. Thank you. Good morning. Good everybody. Good morning. I am really happy to be here and I think it's going to be more fun than I even thought it was going to be based on some of the earlier discussion.

As Ron said, I'm currently Deputy Mayor for Health and Human Services for the District of Columbia. And that includes a big portfolio of all of the health and human services agencies inside D.C. government. So it's health, it's mental health, it's child welfare, juvenile justice, healthcare finance, aging, even parks and recreation.

So it really is the, it's the full gamut. And I think that goes to some of the issues that were discussed. But I want to talk about, I was asked to talk specifically about child welfare and I just recently stepped into this role after heading the D.C. Child and Family Services Agency.

And so in reading materials ahead of this discussion, I certainly agree with Lawrence Berger and Sarah Font that health should be viewed in a broad context, right, that includes the social, emotional, behavioral, and physical health.

But on a similar note, I think if you consider child welfare systems in a broader context, that is not just child protective services or CPS, then child welfare can also play an important role in child health.

And as the authors point out, as the authors point, CPS has a limited ability to influence child health because it primarily intervenes only after harm has occurred. And that was pointed out too earlier in the charts that it is reactive, but not necessarily.

And so in Washington, D.C., our child welfare system includes many stakeholders including mental health, public health, TANF, other human services. Of course, the courts, community organizations, and, of course, families. And, in fact, if you ask anyone, I think everyone in the Child and Family Service Agency about, they will say we are the child welfare agency. We are not the system.

And so I think it's important for everyone to understand. And we developed a graphic that we handed out to everyone to show child welfare in this broad context and we call it our Four Pillars. And it really lays out the framework for child welfare in D.C., and it's based on a set of principles, and also shows it in that context of the agency, the system, and the broader community.

So I'm not going to go into all the pillars. I think it's really important to understand that in setting up this framework, we started implementing our child welfare system's reform, and it really started paying off in reducing the number of kids in foster care safely. And we have matrix to determine that. We can talk about that a little bit later.

But really for us, the payoff was more at the front door. And that's about narrowing the front door. And Patrick mentioned a number of things that are really, really important in terms of decision making, in terms of training, and we invested heavily there

so that the worker doesn't go out absent any information. In fact, calls that come into our hotline, we have a process we call the Red Team Process of bringing everybody to the table to determine how, in fact, we are going to respond and if it's going to be a CPS response or a differential response.

And so that has helped us to really reduce and make decisions, reduce the number of kids coming into foster care. We're also doing a lot more with kinship diversion, and with family stabilization and preservation.

So the payoff for us was a reduced number of kids in foster care, and in just three years, we reduced the number of kids by about 37 percent, 1,750 kids in foster care down to about 1,100. And that's what then led us to think about what is the system and how does the system need to be financed, and goes to our decision to go after the IV-E Waiver.

When we saw the mix of children and family served in our system from about 50-50 kids in foster care, largely financed or partially financed through with IV-3, to kids in home. So we were about 50-50 for about 15 years when we started tracking that.

And then we started moving more, 60 percent more in home and 40 percent in foster care which meant that our ability to draw down the federal dollars was reduced. And so -- and I agree with Patrick and I heard Rob Bean in his ear about the flexibility that states have to use their dollars. D.C. is a very well financed system locally, so we do have a lot of flexibility.

But, I shouldn't say this in front of Becky Shipp, but I would say I'd rather spend my uncle's money before I spend my daddy's money. So the federal dollars we want to make sure that we were capturing as much money as we could so that we could reinvest in the front end of the system. And it was a sweet spot that we had in terms of our timing to go after the IV-E Waiver.

We had developed our business processes so that we were claiming at a maximum level. And then our population was going down so we determined with our colleague, Don Winstead, who had really helped us, the Casey Family Program, that we could hit a point where we could receive a maximum amount of federal dollars as our population was going down in foster care.

And based on the reforms that we were doing, we knew that we were going to continue to see declines. We started leveling off a bit, but we really weren't starting to see all of the reforms yet in terms of our permanency outcomes, as well as our front end reforms.

So that's what we did. We hit that. We got the IV-E Waiver and really started investing more on that front end. So we went from the front door to then what we called the front porch, and the front yard, and eventually we're going down the street.

And I know that it's time to wrap up my remarks now, but I just want to say that a lot of the whole menu of evidence-based practices in terms of investing in front end, we're doing. We're building those in. We're starting with the IV-E dollars, but also maximizing the use of Medicaid dollars which really wasn't discussed here.

The final point I want to make I think in terms of the whole argument about the IV-E and whether or not that needs to continue, the IV-E Waivers, if 30 states have applied, 30 of the 50 states, or the 52 or so counting D.C. and a couple of territories, have applied for and gotten IV-E Waivers, states are saying that the financing that the federal government has now for child welfare is not working. So if you're doing a work-around with a waiver, obviously, we want to have those resources available and used in ways to reduce, safely reduce kids in foster care and improve outcomes.

MR. HASKINS: Very good. Thank you so much. Christine.

MS. CALPIN: Thank you. Thank you, Ron, and I want to thank my colleagues and the Brookings Institution for the opportunity to be here today. My name's Christine Calpin and I'm the Managing Director for Public Policy with Casey Family Programs.

We're a national foundation committed to improving the lives of children throughout this nation. We're headquartered in Seattle. We have a history that spans 45 years, and we believe the goals of the nation around securing the well-being and health of children should be about both keeping children who have been abused and neglected safe from further harm, but also preventing abuse and neglect and the need for foster care in the first place by strengthening families and building stronger communities.

How do we do our work? We have a history as a direct service provider and still operate offices in the western part of this country. But we also have entered into very strategic partnerships with every state and a number of counties throughout the nation to really promote safety, permanency, and well-being, and to work alongside sort of where they're trying to go. And I thank Brenda for her kind remarks about our work, and my dear friend, Don.

So we're all here because we agree that the child welfare and the developmental research really tells us that it's important for the well-being and health of children to have one stable and committed relationship with the support of parent, caregiver, or adult.

But the funding and the briefs published by Brookings conveys the key reality that at the federal level we spend far more resources on removing children than preventing keeping them, preventing their removal in the first place.

And Becky and I and others have long recognized that there is probably a better way to target these resources. But we've struggled for decades with that

comprehensive solution. And I want to just convey that we as a foundation, believe there's a urgent need to restructure child welfare financing. And we believe that restructuring could support better outcomes, and this belief is informed by the partnership and the work that we see with the states.

I spoke with Don Winstead a little bit because I was excited that he would be here this morning to really talk about both the work he's done for us as a consultant in engaging with all the states, but also specifically about Florida. And he first began their waiver in 2006.

Don always begins in talking about that as a state Florida saw foster care as a way to keep children safe by removing them. But as Ron talked earlier, they were gaining a larger and larger appreciation that this removal was traumatic for the kids. So they believed if you could keep the home safe, it'd be better for the child.

But the challenge at the very basic level was that this requires tailoring resources. You want the person who knocks on that door to be able to identify any and all available ways to immediately secure that child and keep them safe. But the federal resources absolutely would not do this.

And, in fact, if they were successful, it would mean fewer federal dollars because by not removing that child from the home, they lost any federal reimbursement they would get on their behalf.

Florida also believed they could prevent entries into care. As like all the states and as we've talked about already, the majority of children enter care for neglect reason not for abuse. And for the kids in foster care, they believed they could shorten the time in care, which is an important conversation to be having about. There will be a small number of children for whom foster care is appropriate, but their time in care should be as short as possible. And we know again all of this leads to healthier kids.

So what has Florida seen in the year since they've implemented? They've seen a dramatic decline in the number of kids in care, and they've seen this without seeing any increase and recurrence of abuse or neglect or reentry into care.

So what does that tell us? That these kids are safely being maintained in their homes? They are not being quickly returned and then brought back into care.

I think what's also even more telling is that, again, this is about shifting services and about serving families differently. And if you look at the Florida evaluation when they talk to judges, what judges commented on related to the service array was that they weren't seeing cases in care any longer due to poverty reasons. The type of children who were coming to their attention were truly related to abuse. They were seeing a different cadre of families.

With the most recent round of waivers, there's been 27 states, D.C., and the Port Gamble S'Klallam Tribe in Washington. It's very exciting that we have a tribe, who is also demonstrating exactly what could happen.

But I think why we're here, the waivers are slated to end in fiscal year 2019. And we don't believe we need to wait until then to reform the system. We've learned some key lessons. I think first and foremost, the waiver is not a program. The waiver is a tool. All of this still comes down to the choices that the states and/or jurisdictions will make with these dollars.

And so it's not about whether or not the waiver succeeds. It's about whether or not the states are making the best choices around programs and services that can improve the outcomes for these children.

What's very exciting is that we have a list of evidence-based programs that do work. We do also still need to cultivate and grow that list because the argument is not that we should only be funding that evidence base of programs. We would be

missing a large number of children who come into care if we did that. These programs tend to be very intensive. They kind of focus on the older youth. They're not going to touch the zero to 3 population, who are the largest cohort of kids coming into care. So there does still need to be innovation. There does still need to be work.

But the waiver has given the states the opportunity to fund the prevention and the aftercare services that shift the service array. It's allowed them to sort of recognize there will always be a small number of children for whom foster care is appropriate. But that for other children that you see behind those doors, there is a much better way to respond and we want to equip them with being able to do that.

And this is important and it really is about the flexibility largely because the states do not operate two separate programs. They don't operate a program of what their IV-E dollars will claim (inaudible) of what state flexibility does.

They've put together a child welfare program. Polices at the federal level require that these policies cover all children in care irregardless of whether they IV-E eligible. So the compliance and a lot of the rules at the federal level have also tied the hand of states. And so the flexibility conversation needs to be broader than the funding, and needs to be about shifting the conversation about what we expect from the states.

If we want them to serve families differently, then it shouldn't be about measuring whether they visit a family once a month. It should be about measuring what are they doing during that monthly visit and what are we seeing?

Another different conversation about the outcomes and the accountability. And I hope with the colleagues here we're able to have that conversation.

MR. HAWKINS: Well, thank you. Ken Dodge.

MR. DODGE: Thank you, Ron for the invitation to be here. I'm excited to be here to tell you all what we're doing in Durham, NC. Like the man who positions

himself at the bottom of the waterfall catching children after they have fallen over or, perhaps, have been pushed over, our nation's social service system is largely after the fact, remedial, and rescuing.

Whether we place children into foster care or keep them at home, it's largely an after-the-fact system of very selectively attending to those most in need. And I think no one would design our system that way if we could start it all over again. We would position ourselves at the top of the waterfall and design a system to prevent children falling, from falling over in the first place.

When I asked the man at the bottom why doesn't he climb to the top of the waterfall, he appropriately says, this is not a fair choice. I have a dying child here. Or I could go up and build a whole new system with a bunch of fences that'll take a long time and maybe I'll save a few new children. It's not a fair choice. We obviously go with the dying children.

So what we need, I will argue, is a temporary period where we continue to have our system of protecting and rescuing dying children while we build a new system up at the top of the waterfall. And so in Durham, we've been working on a preventive system of care called Durham Connects. I'm going to tell you about it very briefly.

The system is designed to reach every baby born in Durham, NC. It's universal. At the time of birth, so it's immediately post natal. It's short term so that it's cheap. The program costs about $700 per baby born in Durham, 3,200 babies born in Durham so we're talking about $2 million a year just for that community.

It's a short-term nurse home visiting program. The essence is captured in three simple points. One, we connect with every birth in the hospital three or four weeks after birth. We reach out and try to reach every birth, every family. We congratulate the family on the birth. Welcome the baby into the community, and deliver a

message that no parent has ever been successful alone, and Durham is here to support parents. All right.

So the supports the parents need though are heterogeneous so we don't deliver one program. This is not a single program. Instead, we sit down with the family and assess needs in 12 empirically-derived different areas to identify individual family needs. Maybe it's substance abuse treatment. Maybe it's domestic violence. Maybe it's maternal depression, parenting skills, medical home, childcare quality, family financial stability, et cetera.

We assess those individualized needs, and then we move to the second connect, which is that after we connect with the parents, we connect the family with the community resource that would attend to those needs. And this is the changing of the whole system. We have a computer databank if 400 agencies in Durham that serve families of newborns, all right, and we match the nurse, trained nurse, matches a family with a particular system. These 400 agencies have gotten together. That's the changing of the system. All right.

We don't take over the parenting. The third connect is then we connect the parent with a community resource in order that the parents can connect with their baby. This a parenting support program. So we connect with parents to help them get connected into our community so that they can connect with their baby. I could tell you more details about it.

We've evaluated the program with a randomized control trial. We're in the middle of a second randomized trial with 4,800 consecutive births in Durham over an 18-month period of time. We randomly assign them to receive this intervention or not by the date on which they were born. Even birthdates, we randomly assign to receive the Durham Connect's program. Odd birthdates not.

We can look at administrative data as our outcomes so we followed these families over a 12-month period of time. First of all, we were able to reach families. 81 percent of all births that we targeted accepted the program for an initial home visit. Of those, 86 percent brought them to the conclusion, and 39 percent of all the births we were able to connect to a community agency.

What did the randomize trial show after 12 months of age? We looked at administrative records for emergency room visits and overnights in the hospital, and dollars spent on those activities. And for ever $1 spent on the Durham Connection intervention, $3 were saved in healthcare costs for emergency room visits and overnights in the hospital.

Seem to be very successful. We are now disseminating the program in six other communities in North Carolina, east and rural North Carolina, Greensboro, as well as some communities in the Midwest not counting Iowa, et cetera. But I've gone to the medical, the Director of Medicaid in North Carolina to say, all right, see what a savings we have? Why don't you buy the program and pay for it? Terrific person. She, Carol Steckle no longer in the position, but she was frank with me. She said sounds terrific. However, my funding just doesn't work that way.

First of all, I've got that dying child that I cannot ignore. Second of all, I don't have that lump sum up front infrastructure change and money that I'm going to need. I can dole out case by case. But that big lump sum investment, I don't have. All right. So that's where we're stuck.

I think that the opportunity is there. We figure out how not to abandon our current system and our current children and the hospitals and the foster cares and the bureaucracy and those professionals, but at the same time build a new system so

that we could, it's like putting up a new scaffold so that then we can take away the old system that had developed.

That's what we're up to. I'm happy to talk to more about. I firmly believe it. I get very excited about it. Thank you.

MR. HASKINS: Thank you, Ken. Your excitement shows. Becky.

MS. SHIPP: Thank you, Ron. Thanks the Brookings Institute for having us here. Thank my fellow panelists. My name is Becky Shipp and I'm an advisor to the Chairman of the Senate Finance Committee. A little disclaimer that I usually do before these gigs, my remarks are my own. They don't necessarily reflect the view of the chairman. They are not for attribution.

I'm very pleased that the policy brief that we're here to discuss has been released and this panel has been convened today. As everybody has indicated, child welfare funding is on a downward trajectory. The look back means that according to the Congressional Budget Office, every year the amount available for the dedicated IV-E entitlement decreases. So what that means for, you know, for someone in my position is if we just wanted to hold everything level, we would have to find offsets for that or, you know, face a budget point of order when we get to the floor.

As folks have indicated, there are 30 states that are operating under child welfare waivers which will expire in 2019. The chairman does not believe that we should continue to extend those waivers. The deal with the waivers were states get this up front flexibility to innovate. We learned from that. We legislate.

There are the spending in IV-E, the incentives, the sources of federal dollars are misplaced. The most federal money is spent on the least desirable outcome which is removing a child from their home and putting them in foster care. However, we

spend a lot of money on policies and practices that hurt kids such as an over-reliance on group homes and
over-medicating them with psychotropic drugs.

There is a desire among members to fund what works in the child welfare system and we're gaining an appreciation of that and fund what doesn't work. Some would argue that a way to address child welfare financing reform would be to adopt a block grant approach. And it seems that the policy brief before us today would support that approach.

There is a great disparity between the IV-E entitlement dollars and the IV-B prevention dollars. And it's true that the $4.3 billion that was on the chart we saw earlier is much greater than the approximately $650 million for prevention, it's also true that the $4.3 billion does not adequately cover current gaps in the foster care system such as an improved workforce, and the training and recruitment of quality foster families.

We also can't overstate the rule that TANF plays in funding child welfare services such as prevention and in some cases the foster care maintenance payments.

The policy brief that I was asked to respond to implies that the main problems to a block grant approach or a big flexible spending approach would be the increase in the foster care case load. And it argues that states can control the growth of this caseload.

I would argue that the controlling the growth of the foster care caseload is not the main challenge of a enormous flexible funding proposal. I think states can and do and will be able to control their caseload. I think there are more significant pitfalls to a block grant approach, however.

Under a block grant approach, policies and programs risk losing their vitality and their ability to accommodate new research and evidence-based practice.

Think what would have happened if we had block granted child welfare back in the 1990s.

Back in the 1990s, people thought that a child's brain was fully developed by the age of five. We no longer believe that. Thanks to the work around adolescent brain development, we know that the brain continues to develop. Our policies would have been stuck in that static perception of a child's brain development.

Many people thought back in the '90s that kinship care was bad. There was the theory that the apple doesn't fall far from the tree and if there's an abusive home with mom and dad, there would be an abusive home with uncle, auntie, or even grandma.

In the 1990s there were two camps in the child welfare field. There was sort of the pro-adoption camp and the pro foster care camp. And these two groups were consistently at odds with each other.

Additionally, block grants tend to wither on the vine. Examples are TANF and SSBG. In my work, there's probably about three people that understand TANF and I think two of us, not counting Ron, are here in this room right now.

Matt Winniger is back on the Hill.

So because there has just been -- so people think welfare is solved. It's a block grant. Nobody really understands it. Why is this? I believe it's because block grants follow the law of entropy wherein organized systems always if left unchecked become disorganized. I believe that unless programs and policies are not consistently updated, they fall victim to the law of entropy and rapidly become static and eventually become irrelevant.

In the child welfare space, Congress has been remarkably functional. Given the fact that we can't get much done, we have consistently over the past decade moved the legislative process forward and, hopefully, moved the field forward.

These pieces of legislation continue to be updated and have been informed by research and the consensus of the child welfare community. They include the extension of home visiting, improvements to adoption incentives, guardianship, and normalcy around foster care.

I'm concerned that under a block grant approach, these reforms might not have taken place. That is not to say, however, that the Congress is unwilling to move towards more innovative programs, more innovative structures. But rather than sort of look at that just give states a lot of flexibility, I think there is a desire to fund what works and not fund what doesn't work.

And example that might be relevant in the next few years is consistent with the administration's proposal. There is a desire to expand potentially IV-E for so-called candidates of care. These are children and youth who are at risk of being in foster care. There is also a desire on the part of the chairman of the Finance Committee to reduce spending on group homes and potentially psychotropic medications.

I can see a bipartisan proposal that moves the field forward where we're able to do one while not doing the other. I'm informed by HHS that relative to the waivers and expansion for candidates of care would address a number, in fact, the majority of policies that states are already doing with their waiver.

Again, thank you for the opportunity to chat with you and look forward to answering any questions.

MR. HASKINS: Thank you very much. That was great. Okay, so let's start with this last point that you made. We haven't talked much about the administration has made an interesting proposal which I think it's useful to think of it as kind of a step in the direction of more flexibility for the states.

So under current law we have this version called candidacy where states can do more than just remove the child and train workers and so forth with 485s. That if there is an imminent possibility the kid will be removed from the home, the states can do some prevention activities with their families.

So this would be very much like the kind of thing that could be funded under 4-B. It's used by some of the states. The administration would push that further and give the states more flexibility. What do you think of that, Brenda?

MS. DONALD: We actually already, we were approved for candidacy so we had started doing that before we got our IV-E Waiver. So that's part of why I say we were really maximizing every resource.

MR. HASKINS: But can you see, can you see --

MS. DONALD: Yes.

MR. HASKINS: -- that if you get, if it were expanded that it would be useful to you?

MS. DONALD: Absolutely. I mean, it makes a lot of sense. Again, I mean, it doesn't address the argument put forth in the paper about still being more reactive so it's still when a family comes to your attention. It doesn't go to the broader prevention. But still it widens that circle.

So if you think about our front door, then it's more the front porch. And clearly, you're able to use those resources to prevent a kid from coming into foster care. So absolutely. And I was glad when we went after that. And so I thinks states would benefit.

MR. HASKINS: Christine, what do you, you agree with that?

MS. CALPIN: I think the states have been very vocal and being clear that providing a broader array of services is what IV-Es should support. I do think that

there is a lot of research around the way they engage with families related to the trauma informed care that talks about sort of shifting sort of how we interact with families.

And if all we're doing is now sort of categorizing them as at imminent risk of abuse versus actually abusing, I think you're still affecting your relationship with the family in terms of being able to sort of create some trust. And so it would be good to think about how, and I think with the waivers what we're seeing is that there's not need to categorize them in any way other than they're in need of services.

And that seems to be the better way to sort of create a relationship to sort of create that trust and to really think about not just what can we fund but how do we actually help this family and sort of improve their outcomes.

MR. HASKINS: Okay. So on the one hand, it would give states more flexibility with the use of the money and allow them to provide services and so on to families that are at imminent risk. On the other hand, part of your argument is that that, first of all, that's not what the states want. It doesn't go far enough. But secondly, it is a problem because you'd have to classify the families as negative in some way. Do they have a big problem? It's a dangerous situation and so forth. And that gets the thing off on the wrong foot. It's not a trusting relationship for the family.

MS. CALPIN: Correct. And I think it's also, my understanding of what the administration is proposing is that it still would only be for the portion of children who are IV-E eligible and so you're still also not getting to the children who come to the attention of child welfare. You're still sort of in a lane that isn't the population of children that systems are serving.

MR. HASKINS: But do members of the panel agree that it's a step in the direction of more flexibility. States did it. Two years later, did something else. We haven't said this yet so let me say quietly that I've talked to people on the Hill. I think I

understand, definitely disagree with me if you don't agree, that it's a step too far to pass anything like a block grant. Now, that is not going to happen. The Congress will not pass it.

Okay. So we're looking for intermediate steps and you mentioned the administration. Do you think that's a reasonable intermediate step?

MS. CALPIN: I mean, I think, I think it offers some interesting guidelines. It would not surprise anybody from the administration. Congress is generally not of the view that we just sort of pick up what they do and pick up what they suggest in their budget and legislate on it.

But I think, you know, what we have heard is that there is a desire to flex up IV-E to address issues other than children who come from families that are really, really poor. AFDC 1996 poor. That's really, really poor.

There is a desire to make that more pliable for states, more flexible and address some of the front end needs. That seems reasonable to me. If it's the candidates of care approach, if it's another approach, it seems reasonable if we're expanding it for something that we think that we should do that's evidence based, the Triple P, and on your lists that were up there, then members can be sold on that if there is the complement of, well, we're not paying for things like an over-reliance in congregate care that not only is extremely expensive but actually ends up hurting the children that we're spending all of these massive amounts of dollars to place in these homes.

MR. HASKINS: Okay, good. Thank you. Patrick, I think wisely, brought up the issue of the system. Basically, the system can trump any great program. And, Ken, you mentioned this a couple of times during your presentation. And you have kind of

a theory about how you change the system that you build a new one alongside the old one and gradually tran

-- tell us a little more about how that works and is there something the federal government could do to use these dollars we're talking about here to incentivize that?

MR. DODGE: I do think that the system that exists is maybe about the best we could do after the fact. It is a huge bureaucracy. It's very expensive. But as Patrick pointed out, people are doing the very best that they can. I don't think that a reform of that system is going to shift us to that top of the waterfall and have a whole new preventive care.

We have a healthcare system that's in a Department of Public Health that may be a little bit more oriented in that direction so it makes sense to me to use federal dollars to build that system, a preventive system of care beginning prebirth. We've begun at birth. I'd love to go even earlier but then throughout the lifespan.

It builds on existing service providers. As I say, we have 400 community agencies in Durham who serve children birth to age five. They spend way too much time on poor matches, families that don't show up, families that are too severely in need for their program or overkill, not severe enough for their program. It's not a very well aligned system. It's a real patchwork. It's public, private, nonprofit, a combination.

What we've tried to do is to bring them together by understanding what they do. Very few of those systems like substance abuse treatment programs, maternal depression treatment programs, parenting support, very few want to be in the case finding business. They say bring me a case and I'll treat them.

So the system that we're building is a case finding, case matching. We're a matchmaker. That's what the agencies don't want to do. So we reach out to a family, identify what they need and what they want, collaboratively say, okay, you're

feeling depressed, mom. You can't even think about childcare right now because of that problem and we're not even going to address the domestic violence here that's off in the background. We're going to address the maternal depression. Let's get you there. I'll get you there on Tuesday at 2:00. I know the director. We've got an appointment for you.

You streamline the system. We even bring the mother to this place. Make her receive that service. And then get her rolling. So it's a reforming of a different system. It's not the child welfare system. It's not child protective service system. It's that community system of care that already exists. That's what I think federal dollars could build.

MR. HASKINS: Brenda, before you begin, let me put another question on the table and then you say whatever you want to. And that is what's the public role? What you described is you hardly mentioned the public role. What's the public role in this? I mean, we're talking about a lot of dollars and a lot of people. If we're going to change that system somehow, it's going to take more than just replacing it, I believe. Brenda, go ahead.

MS. DONALD: And that's what I was, where I was going. I don't see it, what you've described as a system and then we have the child welfare system over here. That's part of it. And I really think that we've got to understand that the system is a much broader continuum of services and opportunities to identify kids and families who may be at risk at any different point.

MR. HASKINS: I think you're right.

MS. DONALD: And that's why I love the seat I'm sitting in now with all of the agencies including Medicaid. And I'll send our guy down to you because he's very creative about how we use or Medicaid services, or Medicaid dollars.

But it really is about having a continuum and what everybody gets that there really is no wrong door and that's a term used and that there's some frameworks around that. But we look at it, I mean, there are many opportunities to see, let's say, a little hand being raised, but truancy for us, we're connected with our public school system. There's kids, little kids who are chronically truant suggestive of something going on at home.

Now, those kids would not necessarily come to the child welfare system. But because we're working together and looking at what are areas of risk for kids and families, then we're able to say, well, wait a minute. There's something that we need to pay attention to.

Those are the kinds of systems and I think the child welfare for E financing has a role, and, yes, the more flexible dollars you have you can be more responsive.

So we've got a big issue in D.C. with homelessness. And our mayor has raised her hand and said we're going to end family homelessness and chronic homelessness within the next few years. Well, we've got kids and families who are homeless and we know what kinds of conditions that they're in and what risks are -- they may not rise to the level of a child welfare knock at the door, but there's a kid not living an optimal situation.

And so because we're working together and we do have our IV-E dollars on the table and our Medicaid dollars on the table, and our TANF dollars on the table, we're creating a kind of system that is responsive to kids and families when they are in need that I think we'll get upstream. That's the kind --

MR. HASKINS: Anybody else want to comment on this? Yeah, go ahead.

MS. CALPIN: I would just say to the public role too. The agencies respond to the reports that they get. And so the public is largely the reporter (inaudible) of non treatment and abuse. You know, a lot of that comes from teachers. It comes from sort of a mandatory reporter category. But oftentimes those reports come. It's sort of like they've waited so long because the concern is that the intervention that the agency is going to provide is to remove that family.

And so for the general public to call and sort of make a claim to an agency, they're waiting until they're in a position where they, if that child is removed, they can live with themselves with that versus I can't see something going on, I'm going to call because there is no trust between the communities and the agencies right now that the community is not just going to go in and sort of bring the jackhammer versus the right response that a family needs.

And so how we build that trust between the community and the agency because for any of this to work, we have to be able to sort of identify these families at an earlier point to intervene and that's going to be a huge role of the public.

MS. SHIPP: Just sort of a quick aside. You know, in terms of sort like the public role, it shouldn't necessarily be, and I'm just responding to something that Christine said about sort of the candidates for care and the sigma, it shouldn't be a stigma to try and get help if you're having issues with your family.

Affluent people, middle class people, affluent people when there's an issue wit their child, they go get that kid a counselor. You know, they do family therapy. A lot of times it's in low income populations where things are just exacerbated to the sense that it's completely boiled over and out of control and that's when the system intervenes.

If there's a way to destigmatize reaching out and trying to get some help for your family or some services of treatments, I think it'll be a very positive step forward in terms of child welfare reform.

MR. HASKINS: Okay, quickly.

MR. DODGE: I think the way to destigmatize the system is to make it universal. You cannot offer the same program to everybody, but if you universally approach everybody, everybody should have a family physician and well baby care. Everybody should go to public school. These are universal systems that work. They're not stigmatized.

When we have a program for the poor, that's when the stigma begins.

MR. HASKINS: Okay, audience. Let me ask you to ask a brief question without a long comment because we have about 12, 13 minutes left and we want to get in as many questions as we can. We'll start right up here, Stephanie. On the aisle.

MR. STERNUM: Ray Sternum a developmental behavioral pediatrician at Johns Hopkins. I direct the Center for Promotion of Child Development through Primary Care.

MR. HASKINS: Thank you for coming today.

MR. STERNUM: Yes. And the conversation has moved from the crisis now (inaudible) to the pre waterfall. And Dr. Dodge has invented new structure to the universal. I think that in this conversation, we've been overlooking a structure that exists, the primary care health system and some interventions that are evidence based. Let me give you an example.

There's a program called Seek Safe Environment for Every Kid, to randomize control trials and (inaudible) maltreatment outcomes when conducted in the existing primary care health setting.

We've been that. We have an electronic system that supports comprehensive care, uses that system, provides motivational interviewing through the computer, aiding moment-of-care teaching for the doctor, post engagement care being used by 5,000 pediatricians across the country. But they're doing it on their own. There's no support. They are just adding it on. They're not getting paid extra to do that and no one's thinking about how to adapt to the form. The system from that disease-oriented system that was presented with the new morbidity that's a social determinant based.

MR. HASKINS: Anybody on the panel want to comment on that?

MR. STERNUM: So basically, supportive primary healthcare system so Dr. Dodge doesn't have to say, well, you know, I've got a new structure that doesn't fit in. There's one that's existing out there and the evidence in that system and using that system in more innovative ways hasn't been mentioned.

MR. HASKINS: Alan, you want to respond to that? Yeah, go ahead.

DODGE: Very quickly. The new system is the system with these community agencies linking. Great question is how do you reach the families? And I think the primary healthcare system is our best shot, the family physician, the pediatrician.

In Durham, we've tried that. The pediatricians in Durham are quite independent from each other and it's been hard to organize those. We've tried it through the Department of Health that has it own bureaucracy in a public system but that's an alternative model. The third is through the hospitals where birth occurs and it's a benefit to the hospital. But it's a terrific question about what kind of care can reach every family, say, birth to age five before schools begin. And I would love to figure out how to do it with primary healthcare, pediatricians, clinics, family practioners.

MR. HASKINS: Okay, let's go right here. Very good. Thank you.

SPEAKER: Sharon (inaudible) with the National Governors Association Center for Best Practices. So I'm interested in this issue of how these services are currently being funded. Prevention and treatment, IV-E versus IV-B. But I've also heard, obviously, Medicaid plays a role. in SSBG which is at risk for losing money going away.

MR. HASKINS: And TANf.

SPEAKER: And TANF. So what are the implications given all of the things bubbling in each of these funding areas for the ability to do this sort of broader kind of a system that you're thinking about, and in particular, what if SSBG goes away, what do the states have to worry about and then where can they draw from?

I mean, all of these funding streams, obviously, the patchwork, are interrelated. So what does that mean given what's going on in each of these funding area?

MS. SHIPP: Well, and that's why I think sort of words, massive child welfare financing reform write large is such, is so politically implausible right now. (inaudible) Center has back when we were in the minority did a bill that would have that would have redirected SSGB to a whole lot of stuff, you know, child welfare, supporting normalcy, addressing domestic sex trafficking.

And when the legislation was introduced, I focused on that key part of SSBG. And I said this is the canary in the coal mine in terms of child welfare reform. If we cannot redirect SSBG which was redirected in President Clinton's budge, which was determined by then vice president Gore's Commission on Government Accountability to meet none of its goals or outcomes, we can't redirect that. There is no way we're are going to take on exactly the programs you mention, TANF, Medicaid, IV-E, IV-B.

Regretfully, the canary died in the coal mine and there was a title wave of opposition. SSBG, I took a million meetings. The advocates have coalesced around trying to stop (inaudible) SSBG. Just like, okay, that's fine. But that will not sort of dissuade us. Not going massive, the sort of taking sort of then bit sized chunks and say, okay, we can flex up this. We can hold back on this and kind of move forward on that trajectory.

MR. HASKINS: That's one of the reasons the coal mines smells bad. They're full of dead canaries.

Anybody else want to comment on this? Yeah, go ahead.

SPEAKER: I would just comment that the biggest challenge to states shifting services for these families is identifying the funding to support a different infrastructure. And TANF, SSBG, all are for child welfare purposes subject to a year-by-year determination as to based on other priorities. What else might then be available for child welfare? The only dedicated child welfare spending that states spend is IV-E and IV-B. So starting there in terms of at least being clear about what can you be sure to have regardless of how many kids are in care and what can you spend is important, and that's what the waivers are seeing is that while the states are doing what is right and what they know, they're not also tying both hands behind their back by saying we're going to do this and guarantee less federal money because the waivers have allowed them to lock in what they have.

We have to shift that financial conversation to give them the ability to create an infrastructure of different services, or we could identify as much money as we want and we're not going to change the outcomes for these kids.

MS. DONALD: And I also think states have to be smarter and shrewder about how they use their money. Right? And prevention if it works is effective. It's a

whole lot cheaper than having a kid in care. I mean, the average cost of a kid in foster care in D.C. is $55,000 a year. I mean, (inaudible) a few dollars and if we take advantage of and learn and embed these evidence-based practices, research practices, things that work and build them into a system and do them systemically, rather than seeing them as funded programs here that may go away, then we've change the way that we practice, and we've changed us, and we've created a system that then works effectively and where you can do the kind of universal outreach at the front end.

And, I mean, that's where we have go. We can't look at it as these little pots of money.

MR. HASKINS: Okay, let's have two questions. Right here on the front and all the way in the back.

SPEAKER: Thank you.

MR. HASKINS: On the right there in the back.

Did someone in the back row have their hand up? Yeah, okay. So as soon as he gets through, you ask a question.

MR. TYNER: Okay. I'm Doug Tyner from American Psychological Association, the Office of Integrated Healthcare. And I guess from Professor Dodge's example, you're going to get multiple benefits from that kind of early intervention program and linking the services and you're going to see outcome benefits in your education system, in your child welfare system, in your healthcare system.

Right now only the healthcare system is starting to be set up that if you save money and improve outcome there are benefits back to the providers. What I'm saying is when you see these variables on the left, you get a lot of outcomes on the right. And (inaudible) be smart enough to measure all the outcomes on the right and let all the funding streams see if they save money.

And this could include improvements in parental health, and parental employability, reduction of parental -- we don't look at all the outcomes and to me that's the issue.

MR. HASKINS: All the way in the back.

MS. MITCHELL: Hi, I'm Mindy Mitchell from the National Alliance to end Homelessness and I work on youth homelessness policy. So a couple of youth homelessness-related questions.

One of the things that we're really struggling with is how to frame for the under-18 homeless, unaccompanied youth. Who's responsible for these kids? These are minors. They're not at home with their parent. They're not in the child welfare system. They don't want to be in the child welfare system. But they're minors. Somebody should be responsible. So that's just kind of an overarching thing I would love to hear your ideas on.

And another thing is that we know that the foster care system itself is a feeder into youth homelessness. So thoughts about that. We are thinking currently about are there ways to use things like FUB to combine a voucher with services maybe from HHS, Child Welfare, that actually involve continued being a part of the child welfare system, but using those funding in a flexible way?

MR. HASKINS: Panel.

MS. DONALD: We can all day about that. Is what we're doing in D.C. and, yes, we're doing on the back end so kids don't age out of foster care into homelessness. We've created a whole comprehensive set of housing and other strategies so that no child ever has to leave the foster care system and become homeless, and I can talk to you about that because I'm very proud of it.

But also in terms of up front of the kids who are underage 18 who are homeless and we look at that as the child is from the age 18. It is a family responsibility, but if the child is running away from a family that is abusive or neglectful, then it becomes a child welfare responsibility.

There is a no man's land in between and that's a much larger debate. But I'll be happy to have an offline conversation with you.

MS. SHIPP: Just from the health perspective, I mean, one of the things that, you know, that strikes me is that there is, you know, there is a tension between homeless advocates and the child welfare advocates. You know, I get a sense that the homeless advocates, I'm not guessing, they told me foster care kids, they've got it great, you know. They're living the life out there, you know, because of this, you know, all these dollars.

So, you know, a thing that you could do is sort of maybe try to harmonize kind of the ask for Congress from, you know, from the field. That would help. And in terms of aging out, you know, if you are, if you spend your entire life or a good portion of your development in a group home, you've been essentially institutionalized and there are two adult institutional systems, jail and homelessness.

So in my view, we, you know, we address homelessness by addressing issues associated with group homes.

MR. HASKINS: What about the first question about coordinating these outcomes and somehow measuring the multiple outcomes. Like in Ken's especially, the only you've talked about is hospital admission.

MR. DODGE: We talked, we address hospital costs, Medicaid costs, emergency room costs because those are the most immediate ones, 12 months. Those are the ones that have the best chance.

MR. HASKINS: I'm not criticizing that. I'm just --

MR. DODGE: But, yeah, I would think that a very good case could be made downstream. And we're following the children in our study so we'll measure whether these outcomes do spread to other areas. But there's a great argument you make that they ought to.

MR. HASKINS: One more questions. No more questions? Good. Okay. Hey, thank you very much. Please join me in thanking the panel. Good day.

(Applause)

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