

# **PROTECT OUR KIDS COMMISSION**

## **MEETING SUMMARY**

**May 11, 2015**  
**9:00 am – 2:00 pm**

**Texas Hospital Association**  
**1108 Lavaca Street, Suite 700**  
**Austin, Texas 78701**

The Protect Our Kids Commission held its fourth meeting on May 11, 2015 with a presentation on the work of the Center for Clinical Research and Evidence-Based Medicine at The University of Texas Health Sciences Center at Houston. Commissioners also heard reports from the chairs of the four workgroups: Child Fatality Review Teams, Data, Prevention and Sustainability.

### **Background**

The 83rd Legislature created the Protect Our Kids Commission, followed by the Commissioner appointments from the Governor, Lieutenant Governor, and Speaker of the House. The Legislature directed the POK Commission to:

- (1) identify promising practices and evidence-based strategies to address and reduce fatalities from child abuse and neglect;
- (2) develop recommendations and identify resources necessary to reduce fatalities from child abuse and neglect for implementation by state and local agencies and private sector and nonprofit organizations, including recommendations to implement a comprehensive statewide strategy for reducing those fatalities; and
- (3) develop guidelines for the types of information that should be tracked to improve interventions to prevent fatalities from child abuse and neglect.

### **Welcome from the POK Chairperson, Judge Robin Sage**

The meeting came to order at 9:15 a.m. A quorum was confirmed by Judge Robin Sage.

### **Workgroup Reports**

#### **CFRT Workgroup**

Carmen Dusek, Chair  
Lisa Black  
Julie Evans  
Leticia Martinez  
Judge F. Scott McCown  
Dr. Marian Sokol  
Luanne Southern  
Dr. Reade Quinton  
Amy Bailey  
Tammy Sajak  
Judge Robin Sage

The CFRT workgroup has held several conference calls since the March meeting and has identified the following areas to focus on and to continue researching and evaluating:

- A. Ways to alleviate strain, frustration and workload from CFRT members,
- B. The need for greater consistency in the review process, including obtaining autopsies,
- C. The need for increased training for Justices of the Peace and CFRT members,
- D. Shortening the time frame for cases to be reviewed, and
- E. Coverage of 100% of Texas counties.

### **Coordination, training and better consistency for CFRTs**

- 1) Recommend assistance to CFRTs for training, coordination, data entry, & technical assistance to provide greater team consistency and alleviate the demands on volunteer team members.
- 2) DSHS is already working on support for data entry, training and coordination for the CFRTs. We support and encourage this move by DSHS.
- 3) CJA and DSHS are discussing a pilot project to provide further training, technical assistance and coordination efforts for 2 CFRTs (1 urban team and 1 rural team). This pilot project will allow better evaluation of the impact of a full-time employee for each CFRT. The workgroup supports and encourages this collaboration and pilot project.

The workgroup requested that the Commission also note its support of the DSHS initiative in its final report.

Carmen Dusek discussed the possible pilot project between CJA and DSHS to fund two full time employees for two child fatality review teams in Texas. The workgroup's ultimate recommendation is that all eleven regions have at least one staff person to support the CFRTs.

### **Coverage of 100% of Texas counties**

Recommend elimination of the statutory requirement to be a county with a population of 50,000 or less to join with another county in a CFRT.

Additionally, as part of the pilot project discussed above, a CFRT Coordinator in a rural area could help establish teams where there are none and create a model to be replicated around the state.

### **Training for Justices of the Peace**

Recommend additional funding for JP training to be used for additional training in the specific areas of inquests and child deaths.

Dr. Quinton believes the JP courses are doing a good job at teaching JPs to know what they do not know and to know when to use an ME or obtain an autopsy. That said, better training would always benefit the process. Carmen Dusek has interviewed the JP who leads the Tom Green County CFRT. Judge Howard speaks highly of the National CFRT training courses as well as the use of training with dolls to educate law enforcement and JPs on investigation of infant deaths. This type of training is also recommended by the CJA. Dr. Quinton emphasized that any training on death certification and inquest procedures should be conducted by an ME.

Judges Sage and Sakai discussed the effectiveness of mandatory trainings and weighed some benefits and drawbacks of recommending required training for Justices of the Peace. Judge Sage noted that some mandatory training may be helpful for the JPs, especially more specific trainings on issues like sleep deaths. Dr. Giardino commented that rather than using mandatory trainings, hospitals highlight the successful programs and/or outcomes and present them as best practices. The workgroup agreed that the current basic training for JPs could use some support around child death procedures. The workgroup will take CJA's recommendations into consideration when formulating its own recommendation on this issue.

**The Workgroup noted that the following areas are still being researched and evaluated:**

### **Autopsies**

Currently, the death of any child under the age of 6 is required to be immediately reported to the medical examiner or, in counties without a medical examiner, a justice of the peace. An exception to this requirement is when the death is a result of a motor vehicle accident. A reported death requires the justice of the peace or medical examiner to conduct an inquest. One requirement of the inquest is an autopsy. Exceptions to the autopsy requirement are expected deaths due to a congenital or neoplastic disease. Under certain circumstances, a death caused by an infectious disease may also be exempted. Consent for an autopsy is not required, and the statutes allowing objections to an autopsy do not apply to required autopsies.

Tammy Sajak of DSHS is researching how many child deaths occur in Texas with and without autopsies. Dr. Quinton feels like all non-natural cases are receiving an autopsy and that if there is a question, an autopsy is performed. Dr. Quinton believes the autopsy process working in rural communities also, and this is consistent with what Carmen Dusek observed attending the CFRT meeting for Tom Green and surrounding counties.

Dr. Quinton believes the current law should cover most deaths. Dr. Quinton believes the best improvement would be to focus on better definitions and protocols for that small subset of non-injury cases. He would only recommend defining SIDS better, doing better education to cover the small percentage that may not be getting autopsied because they do not present with injuries and there is in misinformation about the meaning of SIDS. CJA has also recommended standardized autopsy protocols, and several from various states are being reviewed.

A question has been raised about "limited autopsies" which are permitted by statute and only involve a blood and/or fluid examination and testing and whether such "limited autopsies" yields sufficient information for a death prevention evaluation. Dr. Quinton does not agree with ordering limited autopsies such as toxicology and is of the opinion that if there is a question about a death, a full autopsy is called for.

Recommendations being considered are:

- 1) Use of standardized autopsy protocols,
- 2) Legislation excluding child deaths from a "limited autopsy" procedure,
- 3) Legislation requiring autopsies in specific types of cases (to address the SIDS issue),
- 4) Prioritizing child autopsies – recommend take priority,

- 5) Alternatively, recommend that all MEs and coroners follow the national organizations' standards of completion of an autopsy within 90 days.

### **Shortening the time frame for cases to be reviewed**

Likely recommendation that CFRTs obtain Death Certificates directly from County Registrars instead of waiting to receive a death certificate from DSHS, which has been shown to cut the time between the child's death and the review by several months, thereby allowing for a faster determination of the causes of deaths, faster observation of changing trends, and greater opportunities to provide outreach services to families after the death of a child.

The workgroup decided it needs some input on what burden this would create for county registrars; however, it is believed that teams could utilize preliminary death certificates to allow many cases to be reviewed within 90 days. Even 120 days would be a drastic improvement over the current 12-18 month average delay to review a child's death. If feasible, this recommendation could be accomplished legislatively or by training on successful models. It is recognized that not all deaths would be reviewed quickly if autopsy results are delayed or pending for long periods of time. However, this would dramatically increase the review time of many deaths.

### **Data Workgroup**

Dr. Nancy Kellogg, Chair  
Judge Peter Sakai  
Dr. Eric Higginbotham  
Madeline McClure  
Judge Robin Sage

The Data workgroup's focus is on charge 3, which states "Develop guidelines for the types of information that should be tracked to improve interventions to prevent fatalities from child abuse and neglect."

On March 17, 2015, TDFPS released a new report written jointly with TDSHS, "Strategic Plan to Reduce Child Abuse and Neglect Fatalities." In this report, data was combined from DFPS, DSHS, birth records, death records and community-level risk indicators, providing a broader view of child fatalities that is child-centric and focused on preventable deaths, consistent with a public health approach. In addition, specific focus areas for intervention are identified and action plans are elaborated based on identified areas of need. This report represents a commendable step forward in understanding why children die in Texas. Recommendations to enhance this data base are provided below.

The separate data bases maintained by TDSHS and TDFPS are still useful for tracking trends over several years and should continue to be reported every year. It is important to acknowledge the hard work, time commitment, and dedication of the individuals that gather, review, and enter this data, many of whom are volunteers committed to saving children's lives. Individuals that serve on child fatality review teams are to be commended for their work and particularly for the prevention strategies that have emerged from fatality reviews. Additional support for local CFRTs is needed to continue to identify and gather information that will improve intervention and prevention strategies to reduce child maltreatment deaths.

Current CFRT data collection should be evaluated for consistency and reliability to identify opportunities for improvement. This is also consistent with conclusions stated in the Strategic Plan to Reduce Child Abuse and Neglect Fatalities: “Improve identification, classification and data collection.” Currently, CPS employs disposition guidelines to consistently determine when abuse or neglect caused the death or was present but did not cause the death. In addition, CPS tracks the family’s involvement with CPS prior to the fatality. Expanding this to include cases where maltreatment contributed to the death (generally a CFRT determination) and cases where maltreatment caused near-fatality would enhance our understanding of child fatalities and inform strategies for intervention.

Most children dying of child maltreatment are under 3 years of age. There are 2 primary safety nets these children may encounter prior to their death: health care system and day cares. Current and future databases should incorporate information about medical care and daycare use by these children and their caretakers to evaluate opportunities for enhanced detection, intervention, and/or reporting to CPS prior to death. The Strategic Plan document indicates that most mothers involved in a confirmed child abuse or neglect fatality were enrolled in the Nutrition Program for Women, Infants and Children (WIC) during their pregnancies; in addition, risk factors for abuse and neglect may be identified during well- or sick-child visits and pre- and post-natal maternal health care visits. While re-referrals and child deaths are being tracked by CPS for families receiving in-home services, there are other in-home intervention and prevention services (NFP, HIPPI, SafeCare, Healthy Families/Precious Minds, Parents as Teachers, etc) and parent education programs (Period of Purple Crying, Triple P, etc) not directly affiliated with CPS that may impact child maltreatment rates; opportunities to track provision of these services to families at risk through PEI (DFPS) should be explored to determine effectiveness and utility of the programs among families with risks for child fatalities. In addition, DFPS should explore the feasibility of tracking services that were started but ended prematurely. Participation in home visitation programs may be tracked by DSHS.

### Recommendations

1. **Evaluate currently available child fatality data resources (CPS and CFRT data) and develop strategies to improve completeness, consistency, validity and utility of combined data bases by:**
  - a. **Improving data completion rates for CFRTs.** Evaluate mechanisms to ensure that all counties in Texas have CFRTs, and all unexpected infant/child deaths have autopsies and are reviewed. This may include recommendations for financial and technical support for CFRTs.
  - b. **Employ methods to make data more consistent and valid.** To improve consistency of data collected by CFRTs, guidelines and indications for autopsies should be reviewed and training should be provided to ensure that CFRTs work from the same base level of knowledge and expectations. Enhanced disposition guidelines were developed by DFPS to improve consistency; similar guidelines may also be useful for CFRTs, for example, in defining situations where child maltreatment contributed to the death.
  - c. **Expand current combined data base to include near-fatalities, where child maltreatment is determined by CPS to have caused the near-fatality.** Since the near-fatality designation requires physician input, a more specific definition for

“near-fatality” should be developed to facilitate a more consistent appraisal by physicians.

2. **Extend CPS record retention limits and types of data tracked so longitudinal trends can be accessed.** Support efforts to prolong the length of time records are maintained by CPS, such that Reason-to-Believe with removal, Reason to Believe with Disposition of RTB for Sustained Perpetrator, Reason-to-Believe without a removal, Unable to Determine, Unable to Complete, and Ruled Out with risk factors indicated, and Ruled Out with risk factors controlled case records are retained by CPS for 50 years, 20 years, 20 years, 5 years, and 5 years, respectively, following case closure.

- a. Specific types of CPS data to track would include:  
Prior contact with CPS including number of referrals and disposition of each prior referral, including:
  - (a) Priority None or Administrative Closure,
  - (b) Differential Response (call screened out),
  - (c) Alternative Response provided,
  - (d) Investigated and ruled
    - i. Unable to Complete,
    - ii. Unable to Determine,
    - iii. Ruled Out or
    - iv. Reason to Believe
- b. Disposition of “Reason-To-Believe (RTB) cases resulting in:
  - (a) Referral to family-based services;
  - (b) Inclusion of a safety plan;
  - (c) Services were offered to family, types of services and compliance/completion;
  - (d) Removal of the child

3. **Identify and track health care and child care services used or accessed by families with child fatalities occurring during the child’s first 3 years of life.** The Strategic Plan describes WIC enrollment among families with child maltreatment fatalities. Accessing additional sources of data, such as the Texas health Care Information Collection (THCIC), ECI, immunization registry, and data from Medicaid to determine whether and when such services were accessed by families with child maltreatment fatalities would enhance understanding of opportunities to intervene and prevent child fatalities. Infants and children with disabilities and compromised health, including prematurity and low birth weight are at greater risk for fatal maltreatment, and may be accessing health care more frequently than low-risk children. In addition to health services accessed on behalf of infants and children, maternal health services accessed in the perinatal period may provide opportunities to identify family violence and mental illness contributing to child risk. Currently, there is no reliable method to track use of day care by families with young children, although this data is sometimes collected by DFPS investigators, mechanisms to record and track this data should be explored. One study found that young children living in a home with an unrelated male were 50x more likely to die than children living in homes with two biological parents; the role for protective day cares for at-risk families may be further elucidated if this data is collected and analyzed.

4. **Identify and track law enforcement data involving violent and drug-related crimes among family members of young children.** This information is generally accessed by DFPS, but mechanisms for consistently recording and tracking law enforcement data should be explored. The purpose of gathering this data would be to determine whether children should be further assessed (medically or otherwise) when certain types of crimes are reported among adults in the household.
5. **Identify and track utilization of preventive programs, particularly home visitation programs that are 1) offered but not utilized by at-risk families, 2) offered, utilized, but ended prematurely, 3) offered and utilized by at-risk families and 4) not offered/not utilized by at-risk families.** These would include DFPS/PEI services, CPS Family Based Safety Services, and home visitation programs (?tracked by DSHS). The goals of collecting this data are to determine capacity for preventing child fatalities and to establish what barriers prevent families from utilizing or accessing these services.

### **Prevention Workgroup**

Madeline McClure, Chair

Dr. Jamye Coffman

Dr. Angelo Giardino

Luanne Southern

Sasha Rasco

Dr. Chris Greeley

Judge Robin Sage

**Dr. Chris Greeley, Center for Clinical Research and Evidence-Based Medicine at The University of Texas Health Sciences Center at Houston** presented and answered many questions regarding data on child maltreatment in Texas collected by UTHSC. Dr. Greeley's slides are included in this summary below.

Dr. Greeley's presentation covered three main areas of child maltreatment:

1. Child Sexual Abuse Risk Factors in Harris County
2. Child Abuse Hospitalizations in Texas and Harris County
  - a. Numbers and Rates
  - b. Risk Factors
3. Abuse in Children with Birth Defects in Texas

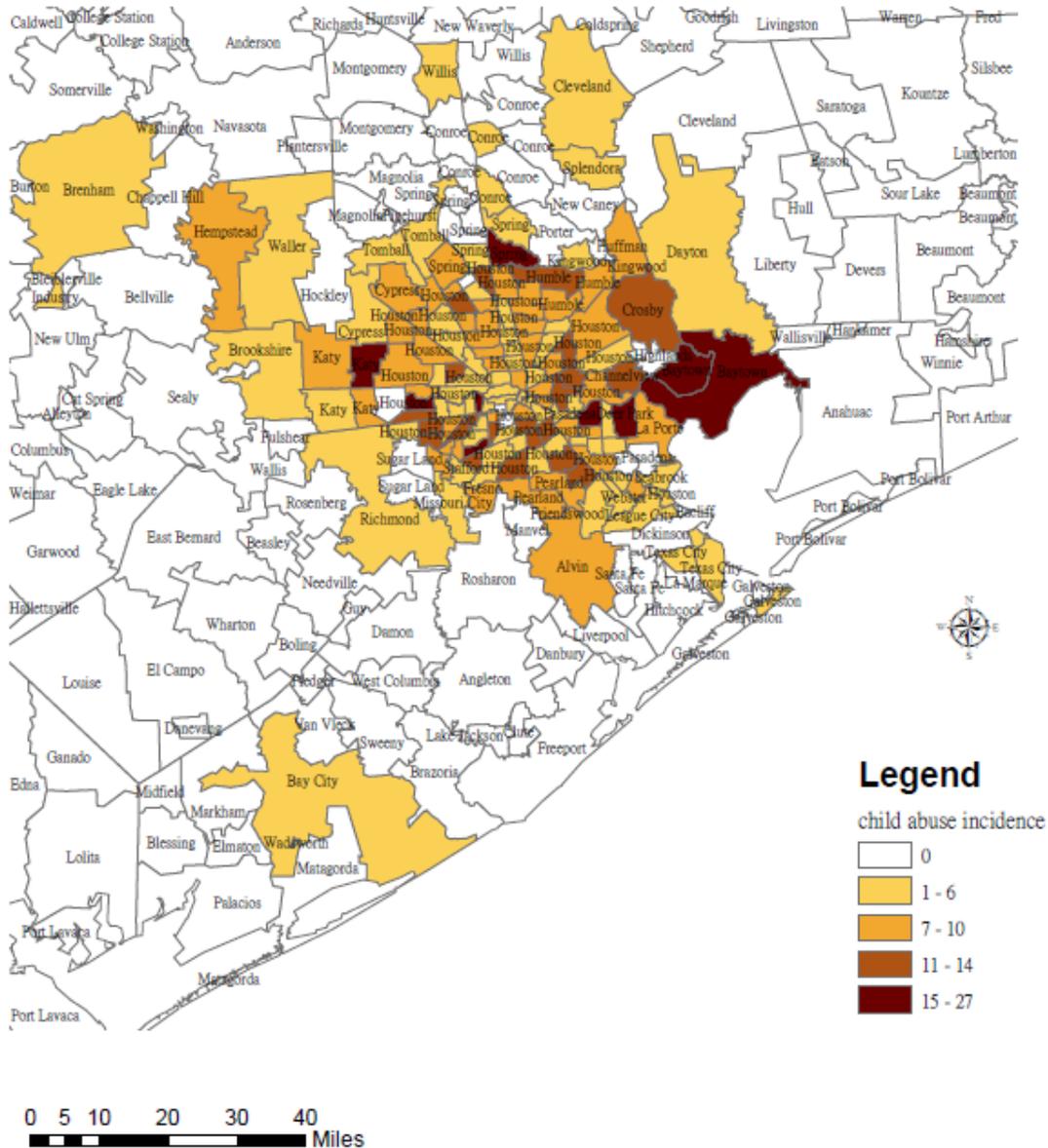
### **1. Houston Child Sexual Abuse Evaluations, 2009**

Purpose:

- a. To perform a demographic survey of all child sexual abuse (CSA) evaluations performed in Houston/Harris County for the 2009 calendar year
- b. Obtain epidemiologic data on incidence and clinical information
- c. To develop improved process, standardized clinical information/data, standardized testing, improved surveillance programs, and prevention strategies

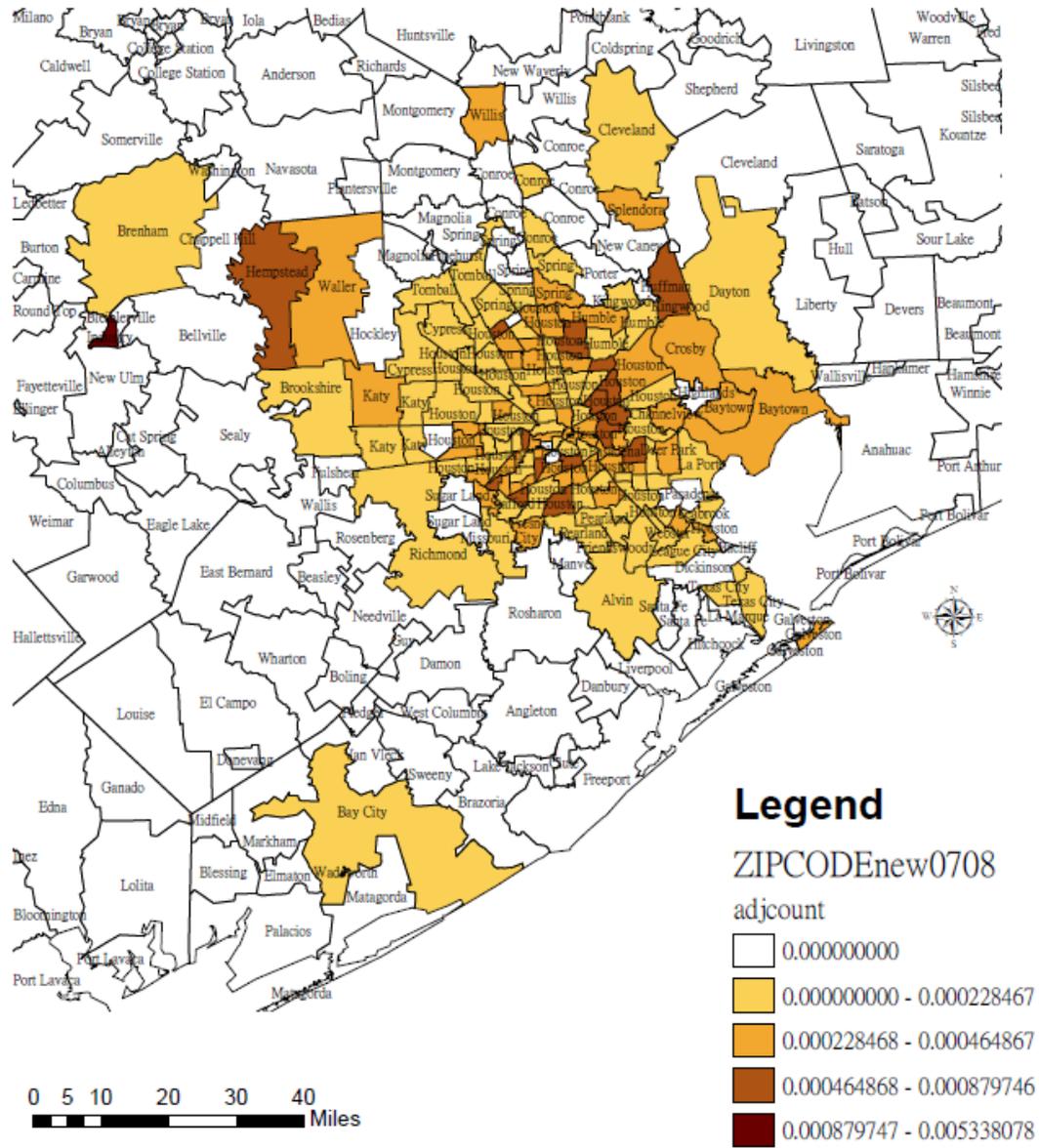
County level data:

### Incidence in Houston Area, 2009



Greeley, Chuo, Kwoh, et al (*in press*)

# Incidence density in Houston Area, 2009



Greeley, Chuo, Kwoh .et al (*in press*)

Zip code risk factors:

### Zip Code Socioeconomic Characteristics

Characteristics	U.S. Average	Texas Average	Houston Average
Average family size	3.19	2.79	3.26
Average household size	2.60	3.37	2.75
Unmarried partner at household (%)	2.2	1.8	1.6
Nonrelative household member (%)	12.2	12.8	12.4
Problematic marriage (%)	18.7	18.5	19.3
Female divorce rate (%)	11.8	12	11.3
15-19 fertility rate(‰)	27	44	45
Grandparents responsible for taking care of child (%)	40.3	44.9	47.8
Education level high school or higher (%)	85.4	80.4	79.8
Veteran population (%)	9.6	9.0	9.7
Foreign-born population (%)	12.8	16.2	12.9
Unemployed labor force (%)	5.6	4.7	4.5
Median household income (\$)	52,762	50,920	52,739
Household with food stamp (%)	10.2	11.2	10.8
Family below poverty line (%)	10.5	13.2	12.6
Vacant house unit (%)	12.4	12.2	17.5
New resident (moved in with 5 year) (%)	40.1	47.0	40.2
Race/ Ethnicity (%)			
White	64.2	45.8	56.0
Black	12.2	11.5	14.1
Hispanic	16.1	37.2	25.7

Greeley, Chuo, Kwoh ,et al (*in press*)



### Risk For Seeking Care for Sexual Abuse Concern

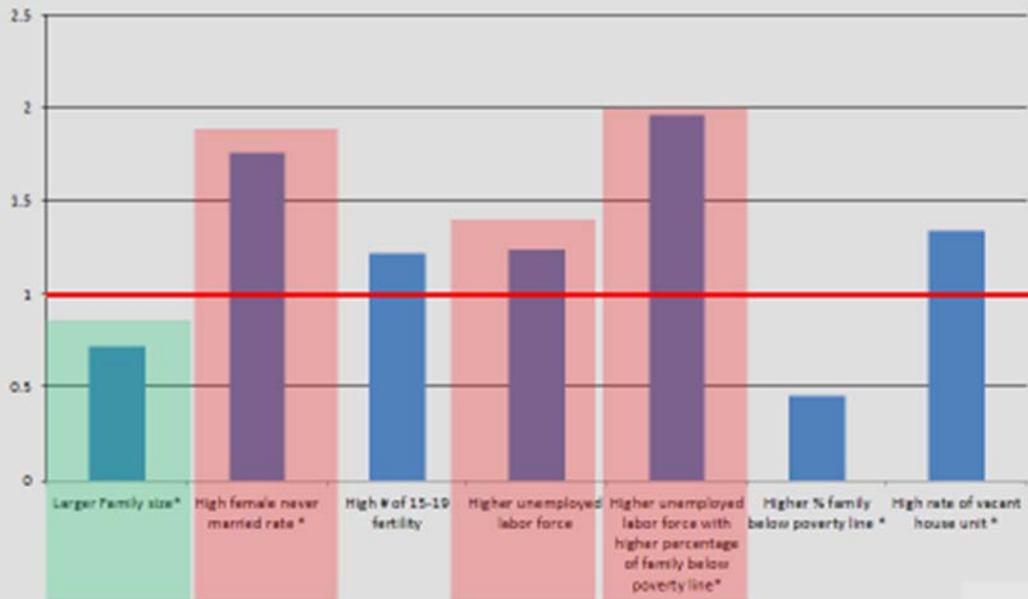
Zip Code Parameter	RR (95% CI)
Larger Family size*	0.72 (0.56,0.92)
High female never married rate *	1.76 (1.35, 2.30)
High # of 15-19 fertility	1.22 (0.97, 1.54)
Higher unemployed labor force	1.24 (0.91, 1.69)
Higher unemployed labor force with higher percentage of family below poverty line*	1.96 (1.12, 3.41)
Higher % family below poverty line *	0.45 (0.25, 0.82)
High rate of vacant house unit	1.34 (1.04, 1.72)

Greeley, Chuo, Kwoh ,et al (*in press*)



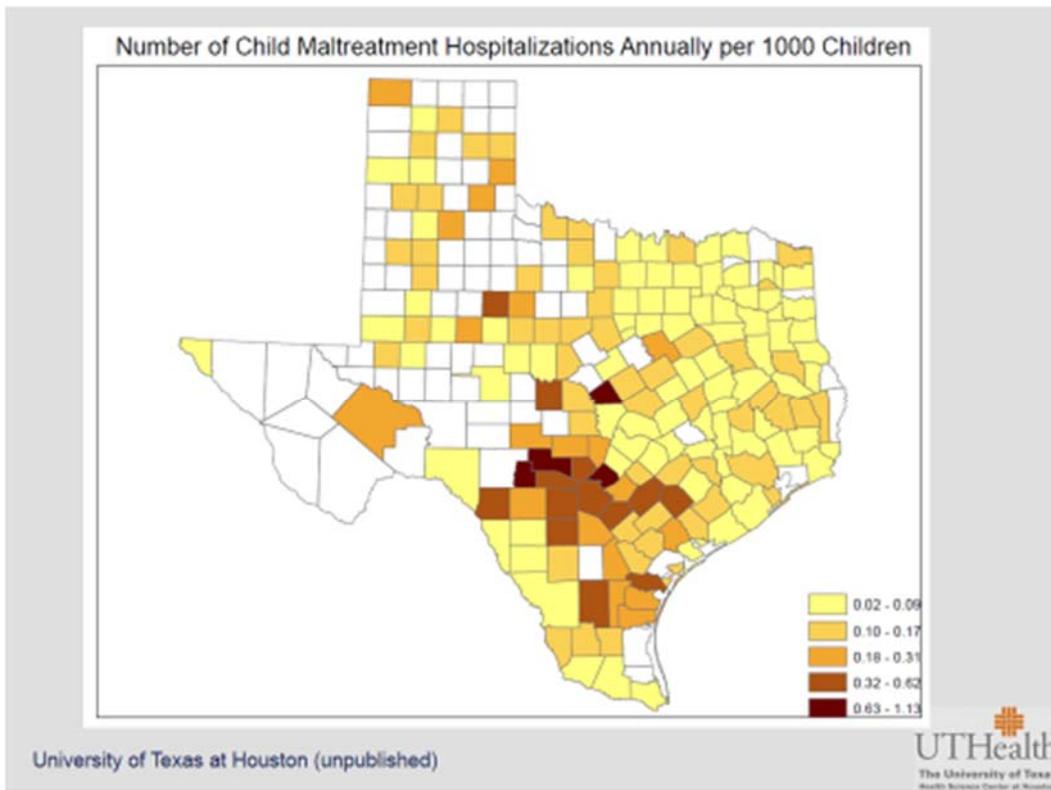
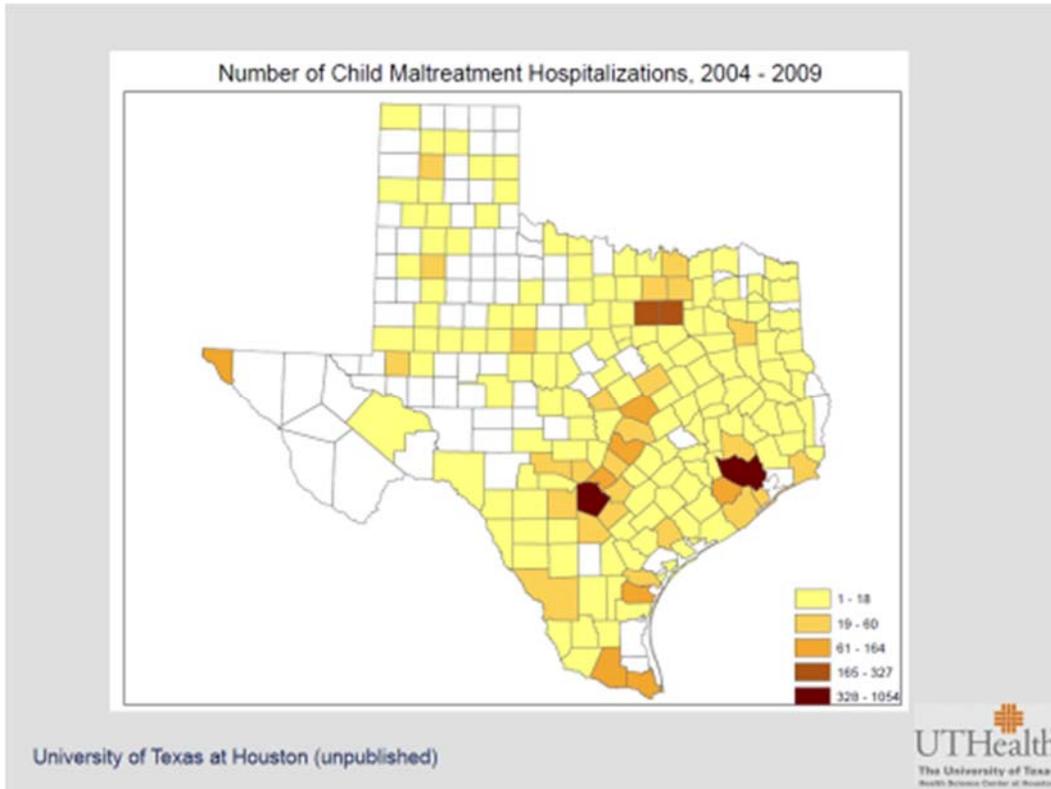
# Risk For Seeking Care for Sexual Abuse Concern

## Relative Risk

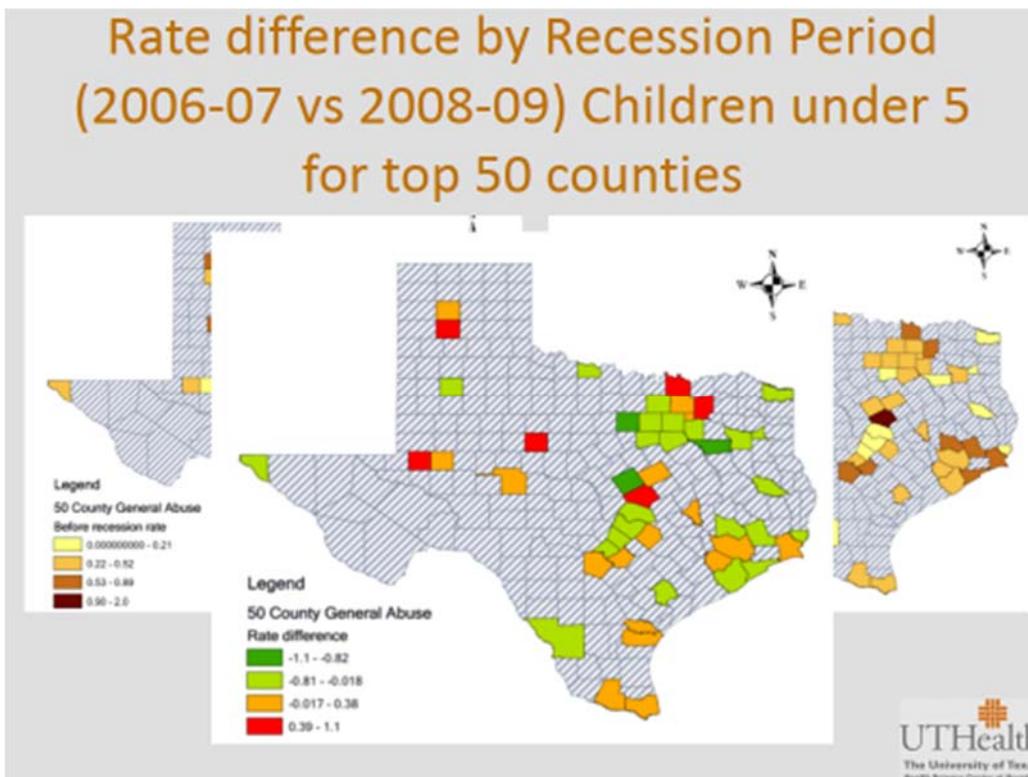
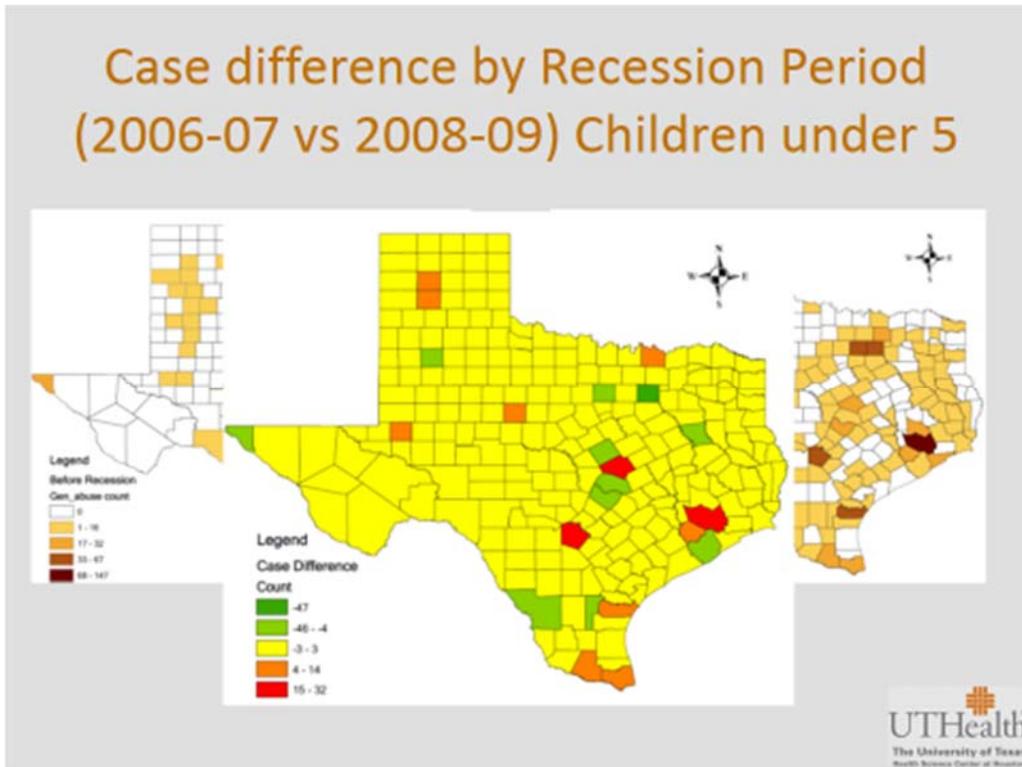


Greeley, Chuo, Kwoh ,et al (*in press*)

## 2. Child Abuse Hospitalizations in Texas



The slides below capture the role of the recession in child abuse hospitalizations. The data is based on the federal definition of the recession's start, December 2007. Dr. Greeley noted that the role of poverty is not straightforward. He also noted that migration from rural counties due to the recession is not captured in this data.



## Child Abuse Risk in Children with Birth Defects in Texas

Dr. Greeley presented on a study that he and Dr. Beth Van Horn conducted that aims to describe maltreatment among children born with and without selected birth defects and to identify and describe covariates of maltreatment in children with and without selected birth defects. The ultimate goal of the study is to inform the development and/or enhancement of prevention activities.

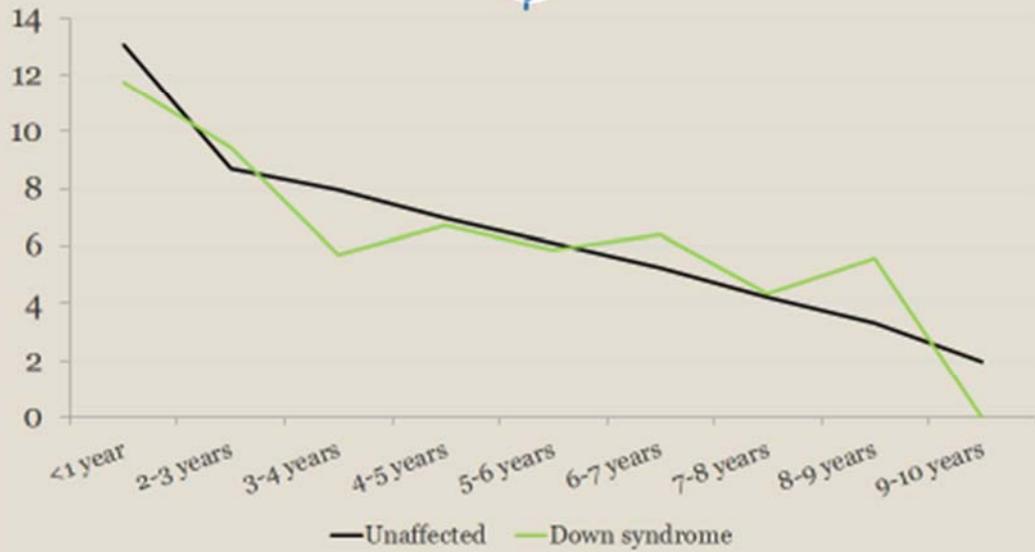
The study groups include:

- A. Children with no monitored birth defects (unaffected)
- B. Children born with Down Syndrome
- C. Children born with Cleft Lip and Palate
- D. Children born with Spinal Bifida

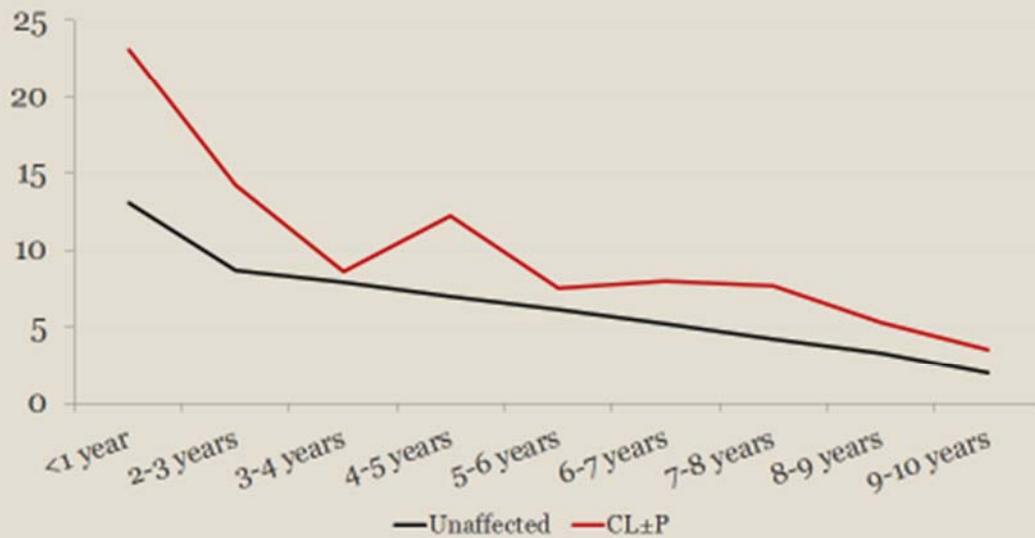
The slide below shows the overall risk of maltreatment for each of the groups during the first ten years of life, with data from the first two years and from 2-10 years. Dr. Greeley explained that in the first two years of life there was not an increased risk for children born with Down syndrome, but that those born with Cleft Lip and Palate and Spinal bifida had a significant increase during this period. He went on to explain that from ages 2-10, those with Down syndrome had an increased risk, while those with Cleft Lip and Palate persisted and those with Spinal Bifida had risks no different than an unaffected child during this period of life.

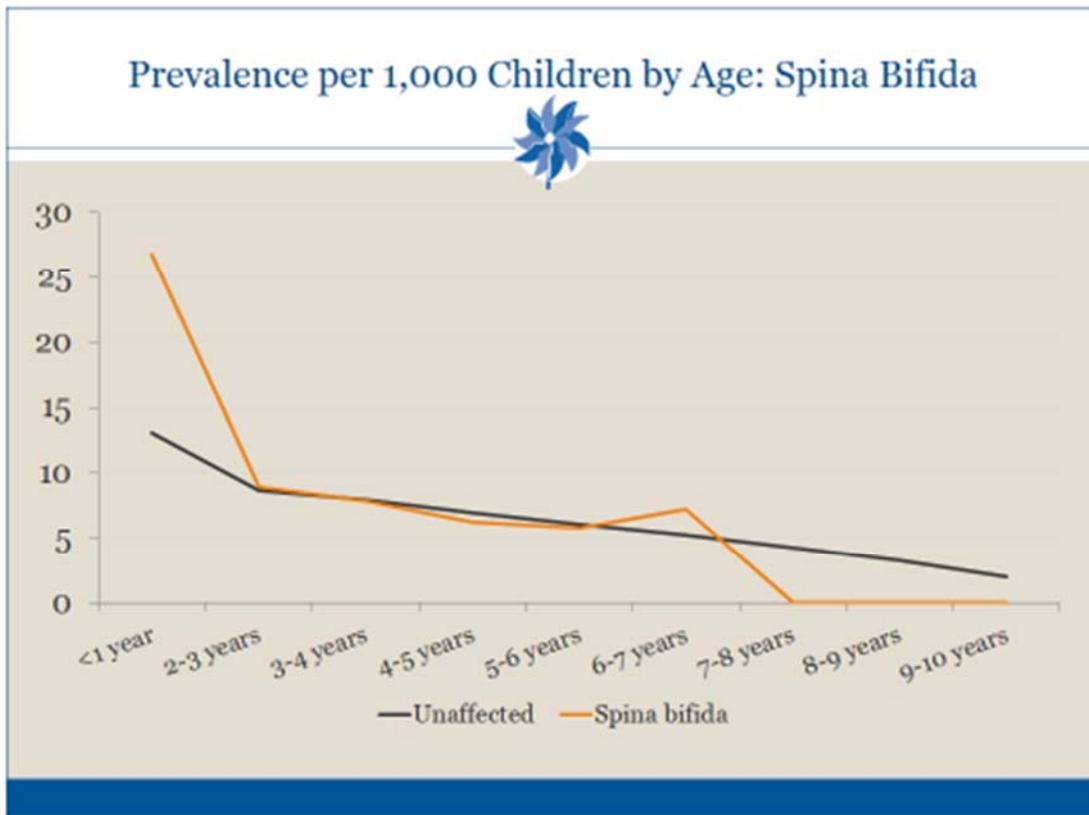
Overall Risk of Maltreatment							
Under 2 years							
	Total (N)	Substantiated Maltreatment	Crude RR	95% CI	Adjusted RR	95% CI	
Unaffected	3,020,278	67,166 (2.2%)	Ref.	-	Ref.	-	
Down syndrome	3743	74 (2.0)	0.89	0.71-1.12	1.08	0.85-1.37	
CL±P	2943	107 (3.6)	1.63	1.35-1.98	1.40	1.14-1.71	
Spina bifida	971	37 (3.8)	1.71	1.24-2.37	1.58	1.12-2.24	
Ages 2-10 years							
	Total (N)	Substantiated Maltreatment	Crude HR	95% CI	Adjusted HR	95% CI	
Unaffected	2,945,273	86,216 (2.9%)	Ref.		Ref.	-	
Down syndrome	3,503	98 (2.8)	0.98	0.80-1.20	1.32	1.06-1.64	
CL±P	2,670	115 (4.3)	1.47	1.23-1.77	1.26	1.01- 1.56	
Spina bifida	893	24 (2.7)	0.94	0.63-1.40	0.90	0.56- 1.44	

### Prevalence per 1,000 Children by Age: Down Syndrome



### Prevalence per 1,000 Children by Age: CL±P





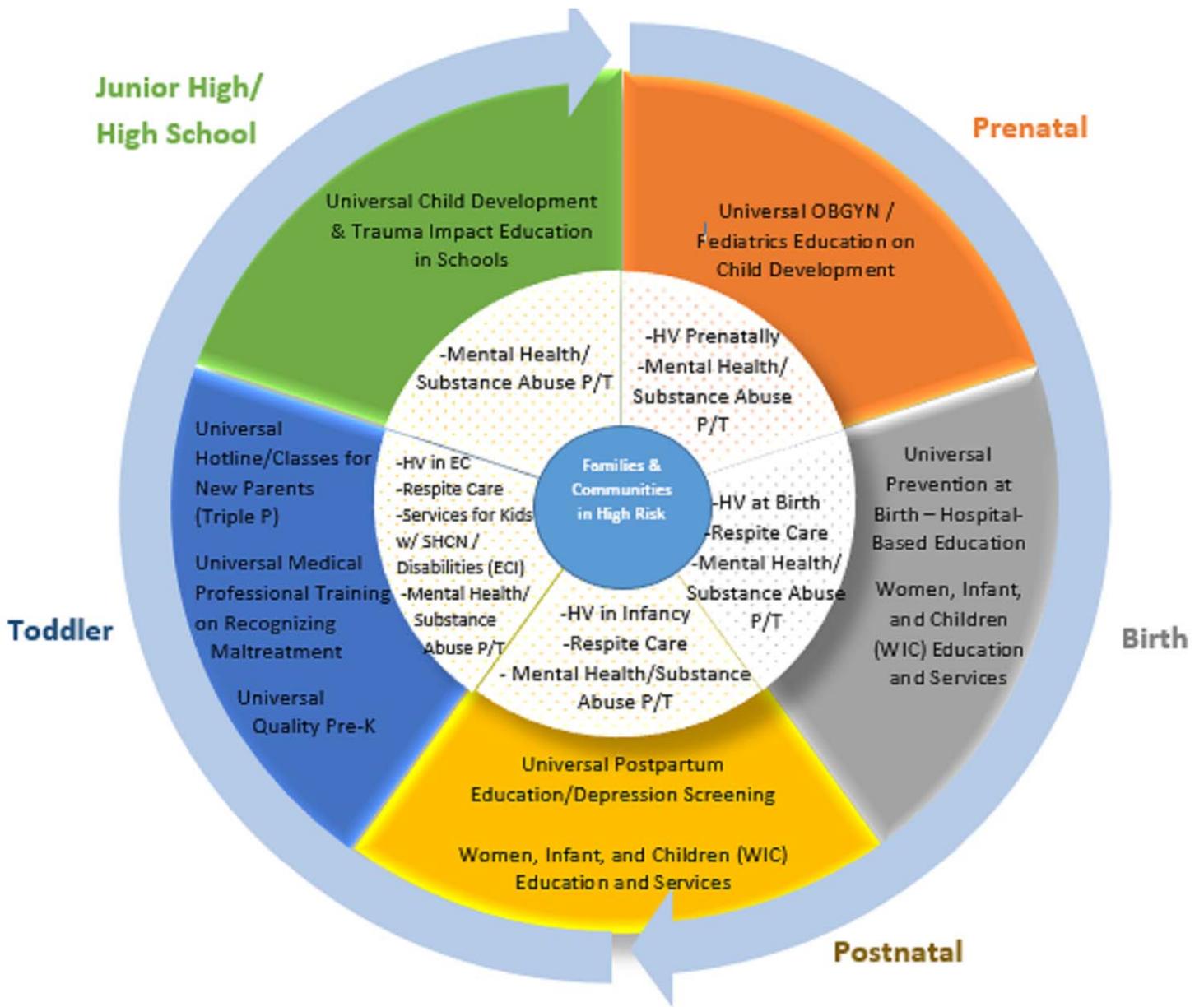
Madeline McClure, chair of the POK Prevention Committee, presented on the workgroup’s focus on charges 1 and 2 from the legislation.

- I. Background: Extent of Texas child fatalities, child abuse fatalities, near-fatalities and confirmed physical abuse and neglect
  - a. Utilize DFPS data reports, CPRT data, aggregate hospital data; graphics showing trend lines
  
- II. Epidemiology: Determine patterns of risks for child fatalities in Texas- Family, parental, child variables that are associated with physical abuse and neglect
  - a. List multiple variables: Select top factors most closely associated with child abuse fatalities: i.e. child abuse confirmations; past child abuse fatalities/child deaths; domestic violence; substance abuse; mental illness; teen pregnancy; family poverty (all currently collected by DFPS/DSHS except teen pregnancy)
  - b. Include DSHS/DFPS data and income – inequity data
  
- III. Communities where risk is concentrated

- a. Create geo-mapping analysis of high-risk catchment areas of the state
  - b. Include zip-code level data analysis reflecting top risk factors
- IV. Inventory: Current Texas Prevention investments in evidence-based and promising practices:
- a. DFPS-PEI, HHSC and DSHS-list programs and funding within agencies, including DFPS's public service campaigns regarding safe sleep; car safety and drowning prevention.
  - b. Map programs with location and families served overlay on family risk geo-map.
  - c. Develop matrix of both Texas programs and other U.S. evidence-based promising practices for possible development/implementation in Texas.
- V. The POK Prevention Group's assessment of need
- a. Determine gaps between areas served with high-risk and high-quality programs and areas underserved with high risk and low quality or no programs.
- VI. Recommendations to meet the need and reduce child abuse fatalities:
- a. Utilize a public health approach/model in creating strategic plan in coordination with DFPS, DSHS and HHSC. Include public-private experts and stakeholders to advise strategic plan. Experts and stakeholders would include Texas Pediatric Society Child Abuse members; members of POK Commission; prevention research and implementation experts (BRTF recommendation)
  - b. Consolidate prevention programs under one Texas agency, especially those serving duplicate targeted populations to improve coordination and service delivery. (BRTF Recommendation)
  - c. Concentrate investment in evidence-based strategies while allowing for investment in promising programs. (BRTF recommendation).
  - d. Utilize a combination of targeted approach (home visiting for high risk populations) and universal approach (DFPS public campaigns including safe sleep, drowning prevention and car safety; Triple P Universal messaging and Period of Purple Crying post-birth for Abusive Head Trauma reduction).
  - e. Concentrate/Pilot investments in the higher risk areas of the state
    - i. Create a demonstration site or pilot to utilize comprehensive prevention framework at interception points. (see diagram 1 below);
  - f. Utilize existing statutory language in structuring child abuse fatality prevention programming (Home Visiting Accountability Act SB 426- 83 (R) including:
    - i. Defining evidence based and promising practices;
    - ii. Proportion of state funding utilized for evidence based vs. promising practices;
    - iii. Monitoring programs for implementation fidelity and QA/QI; and
    - iv. Evaluating programs for efficacy and cost-effectiveness
  - g. Evaluate currently funded programs lacking documented evidence of efficacy: partner with state-funded universities to provide pro-bono evaluations.
  - h. Identify and maximize federal, local government and private funding streams to bring most evidence-based and cost-effective programs to scale. (BRTF recommendation)

1. Review TANF, MIECHV, Title IV-E, Title V, CBCAP, Medicaid, Medicaid Texas Health Steps and Medicaid 1115 Waiver and other federal funding and/or federal matching opportunities;
  2. Review, revise and maximize funding and implementation of the Child Abuse Prevention Trust Fund and other state GR funds; and
  3. Create private foundation partnerships and leverage other private funding via social innovation financing.
- 
- i. CPS Staffing Model review:
    - i. Designate specialized units or caseworkers to conduct child fatality investigations based on expertise/tenure (preferably housed at a Child Advocacy Centers);
    - ii. Utilize high risk geo-mapping to determine staffing levels, lower caseloads, increased expertise and specialized training in areas of highest need.
  
  - j. Train external stakeholders to identify, recognize, report and prevent child physical maltreatment and neglect
    - i. Expand SB 471 (82-R) and SB 939 (83-R) which mandate training of child care workers, all school staff (principals to janitors) and University professionals with access to minors;
    - ii. Include medical professional training

**Diagram 1: Example of Comprehensive Prevention Framework across Interception Points**



**Key:**  
 Solid Colors (outside circle) Represent Universal Services  
 Dotted Colors (inside circle) Represent Targeted Services  
 EC = Early Childhood  
 ECI = Early Childhood Intervention  
 HV = Home Visiting  
 P/T = Prevention and Treatment  
 SHCN = Special Health Care Needs

## **Sustainability Workgroup**

Judge Robin Sage

Judge Peter Sakai

Judge F. Scott McCown

*We may not know what recommendation we want to make in terms of sustainability until we know:*

- 1) what our other recommendations are; and*
- 2) the effects of any new legislation from this session.*

*Our Commission dissolves December 31, 2015.*

Questions to consider:

- Does the specific work we are doing need to be carried on beyond that point?
- If the Commission does not continue, are there parts of the work that need to be carried on? For example, recommendations about prevention policy? How to spend funds?
- Specific things to elevate State CFRTs and give them a bigger voice?
- Sustained funding?

The workgroup discussed its desire to create a mechanism that would capture a wider audience for the annual State CFRT report.

The next meeting was announced for September 25, 2015. Each workgroup will send final recommendation to Kristi Taylor by July 15, 2015. The Commission agreed that another meeting be held in early November to finalize the report. The Commission also agreed to add Sarah Abrahams, Sasha Rasco, and Dr. Chris Greeley to the Prevention workgroup.

Meeting adjourned.