accenture

HEALERS IN THE SYSTEM: FROM THE HEALTH FIELD TO CHILD WELFARE LEADERSHIP

VIDEO TRANSCRIPT

John Kelly: All right, we got a little bit more of a critical mass here, and I'm sure we'll have some more folks file in as we get going. But it being late in the afternoon on the East Coast, I do want to make sure that we get the full conversation in. So welcome everybody to Healers in the System, from the Health Field to Child Welfare Leadership. This is going to be a really great conversation. We got doctors and nurses in the house to talk about their experiences. I'm really excited for this one. My name is John Kelly. I am the co-executive director of Fostering Media Connections, which is a national nonprofit that uses the power of media and journalism to lead the conversation about children, youth, and families in America. And we do that through a couple of different programs. Real quick, I will walk you through them.

The Imprint is our daily news site that covers child welfare, youth justice, and youth homelessness around the country. We have our Fostering Families Today publication, which goes out every other month to thousands of foster caregivers and kinship caregivers all over this great land of ours. And we also have our youth voice program through which we work with youth and young adults who have lived experience in the child welfare or youth justice systems to help them express themselves through writing and other ways, op-eds, writing for us through journalism internships, and what have you. So, that's just a little bit about us. We are presenting this event to you today in partnership with Accenture.

And so I'm going to actually hand it off at that point to Molly Tierney, who is the Child Welfare Lead for Accenture, who is going to be the moderator for today. So I will step back and pass it to her. I'll be here to get some questions to these guys. So anybody who's in our audience today, I would encourage you to use the chat function as these guys are having a conversation to throw in anything you're curious about. I will aggregate those up and get as many of them in front of these guys at the end of the discussion as possible. So without further ado, Molly, I will pass it over your way.

Molly Tierney: Thanks, John. And let me say what a pleasure it is to be in partnership with you today. And as always, appreciate all that you all do for the field of child welfare and family services. So thank you for your hard work. We've done a handful of webinars with Imprint, and this one is already my very most favorite one, because the group that we have gathered

here today is extraordinary. So let's take it from the top. I'm joined by my friend Terry Stigdon, who is an LPN and also the director of the Indiana Department of Child Services, and my friend Dr. Deb Shropshire, who is a pediatrician and also the director of Child Welfare Services at the Oklahoma Department of Human Services, and Dr. Charlene Wong, also a pediatrician and currently the assistant secretary for children and families at the North Carolina Department of Health and Human Services.

Now I invited the three of you here today, as the title suggests, as healers. And this is important for a couple of reasons. First, your appointments into your positions are a real departure for child welfare, right? Typically, states appoint of more traditional profile of person when they're selecting child welfare leadership, right? They tend to be government administrators, or judges, or former prosecutors, or just generally the type of folks into whom decision makers have confidence when they think child welfare needs fixing, fixing being defined as bringing into compliance, right? And you all bring a whole different kind of energy to bear, which brings me to the second reason why you're here. And that is because each of you are leading what I consider to be the most compelling work happening in child welfare in the United States right now. So with that, I would love to jump in and ask each of you to talk for a few minutes about your pathway from healing and health to child welfare. And let's take our states in alphabetical orders, so we start with my friend Terry Stigdon from Indiana.

Terry Stigdon: Sure. Thanks Molly. And just to correct, I'm a registered nurse.

Molly Tierney: Oh, sorry.

Terry Stigdon: A master's prepared. No problem. Just less people see my title that says MSN, RN, they're like, "Wait a minute. What?" So I was an LPN. I'm old now. So I've been an old nurse for 25 years. And my pathway is fascinating because I actually wanted to start out in geriatrics. Was working in a nursing home as a CNA. I needed a full-time job and I thought that was going to be my pathway, and little did I know life happens when you're busy making plans. So my life actually took me into pediatrics. I worked in the intensive care unit and in the emergency department, ended up doing leadership in both of those areas. And the emergency department I would say is really what opened the door to this work being a possibility.

There are so many parallels to how a child and family goes through the emergency department and how a child and family goes through the child welfare system. So those parallels were critical for me on learning this very steep learning curve of how to really lead this agency. In addition to working in the emergency department, as the director over the emergency department trauma program and patient behavioral health and radiology nursing, I also was very involved in the Emergency Nurses Association. So being involved in that national grassroots organization to advocate for frontline emergency nurses in the field, really help prepare me for state leadership and how to really meet people where they are and help them get what they needed in order to do the best job that they could do.

So the reason I got here, one of my doctors who actually used to be the secretary of FSSA here in Indiana, she was one of my emergency doctors and she recommended me for the position, and that opened the door. I wasn't looking, I loved the work that I did at the children's hospital, but this is a great opportunity to help children and families in a very different way. I always saw myself as an advocate for children and their families, and had no idea what I was talking about until I got into this work. So that's really my pathway. I went from wanting to work in a long term care to working in child welfare.

Molly Tierney: How about it? And that always the way though. It's a relationships that pull us in and the crooked pads make the most interesting lives. That's a great story. Thank you for sharing Terry. And Dr. Wong, could I invite you from

North Carolina to share your story?

Dr. Charlene Wo...: Sure. So clinically I'm a pediatrician and I specialize in adolescent and young adult medicine. So certainly my first interface with the child welfare system was being a pediatrician, and having these kids drop into my clinic who had just been put into foster care and needed that initial assessment and working with families and foster families who would bring their kids to me. I think like Terry was saying, you just observe things, right? You observe these patterns that you see when you're working clinically, where you're like, "There's only so much that I can do in this one-on-one patient interaction." And so those sorts of observations quite early on in my medical training led me to do some work. I used to work at the CDC. And then for me, one of my training programs, that really gave me a lot of those skills. Terry, like you were saying, when you build those skills, make that network. And health policy, health system leadership was the what was used to be called the Robert Wood Johnson Foundation, Clinician Scholars Program now called the National Clinician Scholars Program.

And it was really in that program that I gained a lot of those skills. And was networking with folks who... My world at that point as a physician in training, fellow in training was, for like the academic medicine world, people who do research. And it was really that training that opened my eyes to all the other things that physicians can also do to make a huge difference for children and families. And so, via that program and the network that I met there, I started doing a lot more of my work in the applied policy space. And so the next close intersection I had with child welfare is I led the application for North Carolina for what's called the North Carolina Integrated Care for Kids Model or NC InCK. This is one of these models that's funded by the Center for Medicare and Medicaid Services and specifically CMMI.

And it is meant to do awesome integrated care for kids, really that sort of whole child, whole family approach that you think we all should be doing, including integrating not just physical and behavioral health, but schools, and juvi justice, and child welfare, and food, and housing, and transportation. And so as part of this model, which we are about to launch in January in North Carolina as our seven other awardee across the country, we were really thinking about, "Okay, how do we integrate this model? How do we integrate with the key personnel who are in child welfare? What are the performance measures we need to all be looking at together? How can we find these shared goals?" That program was for Medicaid insured children. And so that was when I got closer to folks at the North Carolina Department of Health and Human Services. And then COVID happened and I flipped more heavily over to the department to take a leadership role in our response to the pandemic, which is still going on.

And then most recently I have transitioned into my role as assistant secretary for children and families. Really honored and humbled to be able to serve in this role for North Carolina, where the state is doing a lot of work and actually reorganizing and creation of this position to really be able to elevate children and families and how important it is to focus on them specifically. And among the top priorities is child welfare, with a strong prevention lens and thinking about the whole continuum through too. Also we've got kids who are sleeping in DSS offices and staying for weeks in emergency departments. And we need to address the whole spectrum.

Molly Tierney: That's lovely. I appreciate the urgency that you bring to your sense about this work and how important it is we move with such agility to respond to the whole person. So thank you for that. And Dr. Shropshire from Oklahoma, you're up to bat.

Dr. Deb Shropsh...: Yeah, so I don't like children very much. I am a pediatrician. But in start, wanting to be a pediatrician, I thought I would be an ER doctor. That's the direction I was headed in medical school, initially thinking about residency. But I did a rotation in child abuse and

neglect during my medical school training. And that rotation was largely not medical, it was largely with social workers, with law enforcement, sitting in the back of courtrooms, and experiencing really the other aspects of the child welfare system that I had really zero context for. I knew what I'd seen in the hospital as far as child abuse, I didn't know anything else about it. And it was those experiences that caused me to really just fall in love with the people who do child welfare work. And so that's actually what I fell for.

And in trying to figure out within the context of medicine how do I serve those folks so that they can serve kids and families, pediatrics was the right way to go because it got me close to child abuse and neglect to the child welfare system. And so I went through my residency program and started on faculty at the University of Oklahoma College of Medicine. And one of my early faculty jobs was serving as the pediatrician at a shelter for kiddos who were entering the foster care system, but did not have a placement. And I saw over about a 15 year period of time about 30,000 kids through that shelter as initial primary assessment for those kiddos. And didn't take very long, similar to what Dr. Wong was talking about, it didn't take me very long to where I was tired of one kid at a time and I was interested in systems change. And recognizing that the field of medicine for physicians at least doesn't really train us about systems, it trains us about individual patients.

So I actually went back to school. I was working and doing all the things, but I went back to school and did a master's in health administration policy so I could understand better how systems integrated. And in the course of that, had the opportunity to work alongside child welfare in Oklahoma. And in medicine, because that was the lens I was bringing to it, to develop a longer term foster clinic in our university and those kinds of things, really stayed in the medical track for quite a while, but always with an eye towards how I could serve the staff of child welfare.

And so there were seasons of time where I had more influence in child welfare from a partner angle. There were seasons of leadership where I didn't have a whole lot of influence within the agency, but what I had was influence in the community. And one of the things about being, I think, in these roles is that we are often invited to serve on boards for nonprofits and other kinds of organizations in the community. And I just leveraged all of that to work with community partners who were interested in serving in and around the foster care system.

So in 2014, I had the opportunity to step onto the child welfare executive leadership team and become the deputy director of community partnerships. And that was not something that existed prior, but the child welfare director called and said, "Hey, we want you to come and do this. We need help from our community. We can't do this by ourselves. This work of serving kids and families, of operating a system, that actually is killing as opposed to just compliant. And we need somebody who can focus on that." And I said, "Well what will we do?" And she said, "I don't know. We'll just make it up." And we literally made it up for several years, what did that community partnership work look like with child welfare.

So I served on the executive team and then had the opportunity a little over two years ago to step into the role as the child welfare director. And so I literally every single day get to serve in the deepest of ways this group of people that 25 years ago I fell in love with. Sitting in the back of a courtroom, sitting in the back of car when we were driving out to check on a priority one out in the middle of nowhere and all those things. And so it's truly a great pleasure to be in this space.

Molly Tierney: Thank you for sharing that. I so appreciate how for each of you the journey is started with a very personal way that you were caring about people. And then you all got to this one at a time isn't satisfying when you could see. So, I often think that's really what leadership is. It's a way of knowing things could be some other way and that let me help people step into another way of being. And so I think with that in mind, I would love to hear some more about how

your framework has impacted the way you practice your leadership. And if you thought about child welfare as... or you could think about it internally and externally, right? And if you first looked internally and thought a little bit just how you manage the operation, and then externally meet a little more by what result are you shooting for? How are we thinking about outcomes for the people you're serving.

But let's talk about internally first. So I know in the health field, in child welfare, there are compliance and regulations and stuff you got to follow. But from any of you, sound like that's what made your heart sing as you stepped into child welfare. So I'm curious, what is your experience thus far in your current roles been as to how child welfare systems manage their work and how they approached their notions of performance and outcomes? Anybody can take that question. Whoever feels moved.

Terry Stigdon: I can go ahead and start. I would say that I had to decide as a frontline nurse how I was going to continue to feel like a nurse, but not take care of patients directly. And so that applied really here. So coming to the department of child services, the most important thing to me were the people. How well were they cared for and able to do the very difficult work that they already have to do? And so I prioritized them knowing that I wasn't the expert in the child welfare world, but coming from a public health perspective and looking at child abuse and neglect from a public health lens, and saying what could I offer as a nurse to care for these people and help them see this very differently, that's how I prioritized. So compliance is almost a bad word, and it is in healthcare too. We do it because we have to.

Molly Tierney: Right.

Terry Stigdon: But it's not because we really love it because it's super amazing and super sexy. No, we just do it because we have to. Joint commission's coming clean up the unit, right? But in child welfare, compliance is everywhere.

Molly Tierney: Yes.

Terry Stigdon: Judgment is everywhere. Eyes are everywhere. But the people that have to do the work well in order to be in compliance, if they're not cared for, it doesn't matter what rules and policies and procedures you put in place, it's going to be really difficult to meet the excellent standards that you set because you really want to serve parents and children and their families excellently. So my focus when I started was to meet as many people as I could and find out what I needed to do to take care of them. And then I relied on them to teach me about what does this job entail and how can it really look differently? Does that make sense?

Molly Tierney: It does. And Terry, just to have it said, I've been your witness since you were appointed, and you have done a fine job of those tasks. I know that your people feel cared for by you. And it's just been awesome to watch. And it strikes me Dr. Shropshire that you have an angle on this too, as I'm going to care for the people who are caring for the children. I wonder if that sparked some thoughts for you.

Dr. Deb Shropsh...: Yeah. I have a couple of thoughts on that. One is, it's interesting how much of medicine does translate over to the child welfare world. Our state's been in a season of workload compliance, for example, caseload compliance, and really trying to make sure we had a workforce that matched the needs that our state has. That's no different than when on the medical side we went through resident work hours. I mean, I'm old. I might be older than the other ladies on this call, but when I was back in the old days when I was a resident, we didn't have any resident workout hours, we just worked until everything was done. And that might take a few days even sometimes at the hospital. There was a season where when I was on faculty, a young faculty member where the new residents coming in had these new requirements that were related to in effect workload, because there was an effort around trying to improve patient safety and making sure that young physicians had the ability to learn what they needed to.

That's not different than what we're doing with case workers right now. Some of the

improvements that have been made on the medical side around electronic medical records, decisions, support, some of those kinds of things are some of the exact same things that really are I think just now being translated into child welfare spaces. And so the idea of an academic center where you're taking young brand new medical students or residents and turning them into competent professionals is a lot what child welfare work often looks like with the field. And so, I find that it translates actually very well from medicine over into social work in terms of actually the practical side of trying to support the workforce.

One of the other things that I was thinking about is the policy you're mentioning, the policy and the instance procedures and restrictions and all of these things that have created the system that we have. You know, for better or for worse, a lot of those things really are aimed to support our work, but when they are in the way, we can never forget that we are the ones that created them.

Molly Tierney: That's right.

Dr. Deb Shropsh...: Now, it wasn't just me who did it, but that they were... We made this system up as a country, as a state, and those organizations that are local. We made it up, we can change it. Some things are easier or more difficult to change. But I tell my staff that all the time, "You imagine what families need. You tell me what families need or what kids need and let me worry about trying to figure out how to run the traps of figuring out if there's a barrier, can we move it? If we can't, then let's set that down and figure out what else we can do." But the idea of the rigidity in a sense of a child welfare system, I think is there is some reality to it, but there is also a lot of urban legend and forgetting that this system was developed by people like us who are working in these roles. It can actually be changed by other people like us as well.

Molly Tierney: So well said. And it strikes me that tees up you Dr. Wong quite nicely since you're actually reinventing how you're organizing it in North Carolina in some spectacular ways. I wonder if you want to talk [crosstalk].

Dr. Charlene Wo...: Yeah. So Dr. Shropshire, your comments totally were leading into some things I was writing down here. So I think one of the things that we're doing in North Carolina right now is, like I said, we're really working to think about how can we learn from what we've experienced and the way that we've learned to work differently in the pandemic places where we were able to serve children and families well, and frankly, places where we were like, "We have an opportunity to do better." And we are undertaking this realignment in our organization, including launching a new division of child and family well-being. Will not include child welfare, but we will be intersecting very closely with child welfare.

And one of the things that I'm doing in my position now is, when we're thinking about the workforce, it's connecting the dots across the different workforces, that we really need to all be in step, marching in the same direction with the direction that the child needs us to be marching in and trying to... I think like you all said, it's all about relationships. It's about that trust. And so really setting in place some of the structures that will facilitate child welfare staff, working with the staff and our MCOs that do [inaudible] services, working with our Medicaid agency now that we have these new MCOs that are coming in, because we just transitioned into fuller managed care in North Carolina.

So there are a lot of big transformative moving parts happening in North Carolina. And then I'll just hit on another thing that you guys were talking about, and I think in your original question, Molly, which is around performance outcomes. Part of that work on connecting the dots is also getting a line on what our shared goals are and understanding what data we have and really prioritizing where we need to fill some of these data gaps so that we can be more focused in our efforts, both on what actions we need to take but also geographically. We are a decentralized state. Here in North Carolina

we've got a hundred counties, and so also being able to focus where we need to invest our efforts, our time, into the different work to move whatever prioritize outcomes we're looking at. So a lot of, I would say, data and business intelligence muscle building and flexing. And again, something that we've learned from the pandemic, because we built so much of that so quickly that didn't exist before. And so really now trying to continue to use those best practices moving forward.

Molly Tierney: That's very helpful. I think that that's a good reminder. What they say, necessity is the mother of invention, right? To your point Deb. We could just decide to go ahead and invent some new stuff without waiting for, for instance, a global pandemic. But I digress. If you guys were to continue thinking and now turn your attention towards this question about outcomes. There's lots of discussions now about major shifts the field needs to take, whether it's we're going to abolish stuff, we're going to reform stuff, and how much of it is shifting away from the intervention that separates families and consciousness about the real damning impact it has had particularly on communities of color. If you thought about that as a framework, and bringing a healing approach instead of only the compliance approach, I wonder how you guys think about that work in the field? Does that question make sense?

Dr. Charlene Wo...: I think so. I mean, I'll jump in here. I mean, to me it's like prevention, just needing to get as far upstream as possible and doing universal services, because when you get far enough upstream, they just need to be universal. And then as you move down the line, being able again to use our data to be able to identify as we get further down the line, the kids who are more likely to then soon enter the system, to again focus those limited resources on those children and families who need the most at that moment.

Terry Stigdon: And I'll go ahead and add to that. When looking at outcome, I learned pretty quickly, especially in the emergency department, that the people that you serve will tell you what's working and what isn't. Data is a great start, but to make sure that it is well rounded and you have a complete picture, it helps to speak to the people that are actually receiving the service that you offer. And so that is one thing that we've worked really hard at and actually became a lot easier during the pandemic, because technology just really improved pretty quickly and became more widely available to connect with parents that have either had their children removed and their cases are closed, but they're part of our advisory council, and really engaging our youth. Because we can talk about these are our outcomes and they're like, "I don't know what you're talking about. This is my experience. And let me tell you about it.“

So I meet monthly with our young people that are either still in extended foster care or they are considered alumni to the foster care system. They're in their late twenties, some of them in their early thirties. And we meet once a month for a lunch to talk about what is it that you see that we are not seeing? So while my data may show this, what is outside of the data? That's really difficult to track. I learned that really looking at data is sometimes scary in the social service world. The feedback I received was, "Well, these aren't numbers, these are people." Well, yeah, they are people, but how else do we show what impact we're making? So we have to have a way to quantify that, because qualifying it is very easy to do. But it's not I would think as second nature as it is in healthcare to really look at times outcomes, long term, have a lot of research studies that show you long term outcomes of what you're doing. What we were doing 20 years ago in healthcare, we can see what was working and what wasn’t.

And the other piece is, in healthcare, we've learned you engage the people that are receiving care to make sure that they understand and that we're meeting them where they are. There is no [inaudible] to say this is what this person has to do every a single time. I think about diabetes. That is my best example to give to people. A juvenile diabetic, back when I was a

brand new nurse, kids were like, "This really stinks. Is this hard? I have to follow this plan. I have to calculate A, B and C.“

And today with the technology that we have, getting feedback from families, doing research studies with children and involving them, coming out on the other side where you have these continuous glucose monitors and you have insulin pumps, and kids, not that they should eat cake and candy all the time, but they have a little bit more freedom and can be kids and still have this chronic disease. That is a result of engaging the people that you serve. So if we can do the same thing here in child welfare and really engage the people that we serve and then combine that with the data, we will see better outcomes.

Molly Tierney: Very well said.

Dr. Deb Shropsh...: I love that. I think that the movement around engaging the voice of the people who are served, and not just listening to them but also letting them co-design, system change is a really powerful movement. It's been needed. I think it's almost even hard for me to imagine what five or 10 years of that will actually result in, in terms of a child welfare system. But I think if we're doing it alongside the people we serving, we'll probably get a better outcome for those families than anything we can come up with. I'll tell you one of the areas where I have changed my mind, coming over really deeper into the child welfare leadership space and into this space, from where it was 10 or 20 years ago, is probably in the idea of, can we in a sense end foster care?

And so, I was on the bandwagon of, if I move upstream enough, if I do my job well enough, if I can pull enough people up here to serve families earlier, then we can eliminate child welfare, or we can eliminate foster care and the need for foster care. And it's not that I don't still dream about that and push in that direction, it's that I think what I've shifted is thinking about intervention with families vertically like, we will start at the low level of intervention and then we may have to ramp up. And I've turned that sideways and said, "This is a horizontal continuum.“

And so practically in our child welfare system, for example, we've put our prevention strategies and programs alongside our permanency strategies and programs and said, just like in medicine, if you have a headache, most of the time you can just take some Tylenol or some ibuprofen. And then if that doesn't work, then maybe you have to go to the doctor and maybe you have to get a prescription medicine and so on from there. And in rare circumstances, maybe you have to get an imaging test, or even rare circumstances, maybe you have to go in the hospital. And under extreme circumstances you have to go in the ICU. But most people are served in this other space. That's how we're thinking about child welfare. How can we serve families on a continuum that looks similar to medicine? And the idea there is, no one is saying we should get rid of hospitals, we're all saying we should try to do as much as we can in our patient. But when I need a hospital, I need a hospital.

Molly Tierney: You need a hospital. That's [crosstalk].

Dr. Deb Shropsh...: And when I need an ICU, I need an ICU. But I will tell you, I don't really want the ICU if I can help it. I'm going to try to do everything I can to stay out of the ICU because people don't always come out there alive. And that's true with this system as well. We should fight for the kinds of services and supports and upstream work that we're doing with families. We should fight hard for that. We should also recognize there are probably going to be some families who need a level of intensity.

And when they get to that point, I want to do it really well for them so that the odds are that they can go home, instead of so that the odds are that their family will be disrupted or that the child may have a bad outcome or those kinds of things. And so that's how we're thinking about it, is along that continuum of care and service with

excellence at every step. But it's changed my mind from the let's eliminate or get rid of child welfare or get rid of foster care, these things are awful, to saying, no, what we should do is put them in their proper place. And we should recognize the seriousness of a family when they are encountering those systems. If that makes sense. So it's a little bit [crosstalk].

Molly Tierney: It was so well said. I really appreciate that as the debate around protect children or abolish or reform squirrels around us. I really appreciate that perspective and share your sense that putting a kid in foster care should be a last resort. And when we have to do it, it should be brief, right? No longer should this be a lifestyle. I'm feeling particularly appreciative of the three of you, that the way you talk about it, without saying in so many words, each of you has elevated the end user to a new position as knowledgeable partner in decision making, with you as... Traditionally, child welfare has had the parents and kids or families to whom we are doing an intervention, and they're outside the sphere of decision making. So I'm just deeply appreciative. And that feels like a really important thing that you've all brought in from the health field. So I appreciate that.

Now, let's imagine for a moment, ladies, your phone's getting ready to ring, and it's going to be your governor saying your legislature has just approved for next year 100 million dollars in your budget. What are you going to do? Of course you're going to say yes. You're going to say, thank you.

Terry Stigdon: Yes. Thank you very much general assembly. I would put it right back in the communities. I wouldn't say for services for the agency, I would find out what it is that communities need to help strengthen family and allocate it to them, honestly. Because like Dr. Wong and Dr. Shropshire both said, going upstream is really what is most important. So what can we do to equip parents of what they need to be the parents that they want to be for their kids? Where we have families that are faced with homelessness, food insecurity, getting prepared to get a job that can pay them well enough to support their families, could be help with education, it would be thank you very much for the money. But instead of taking it, if I have the power to allocate it across the state to those with proven successes and really helping strengthen families, that's where I would put it.

Molly Tierney: Nice.

Dr. Charlene Wo...: I'm in a similar vein. I was actually even thinking after the last question, I think we are all touching on these social determinants of health or trying to help families meet these unmet social needs that they have, because we know that those can contribute so much to the wellbeing of children and their families.

And thinking about, I would do two investments. And so I want a million more money, Molly, I'll be honest with you, because I think these... Well, because let's be honest, right? These unmet social needs, to really meet those needs, it is really expensive. So that 100 million would go real fast when you start investing in those spaces. So I would invest definitely in that, again, wanting to be focused in where those investments are. I would also invest in some of that data infrastructure that we need to be able to make better data driven decisions. And actually for example, linking some of these data sets together so that we can actually identify these children earlier.

One of the things we're doing on that integrated care for kids model I talked about, that I am so excited about, because as an adolescent medicine pediatrician, it drives me bananas that we're not better coordinators with schools. Because when I'm seeing a kid, when they're seeing me, it's like they're my office. Most of the rest of the time, hopefully they're sitting in school. And a couple of the measures we're looking at are things like kindergarten readiness, because we are linking school data with Medicaid data, which is so exciting. And we're looking at rates of, for example, chronic school absentee, and which to me as an adolescent

medicine doc, I use that as my metric of overall child wellbeing.

If I'm seeing a teen and they're failing, even one class or more than one class, I don't care if everything in their physical health book is fine, something is not on track in that child's life, because their job is to be in school and learning. And so, if they're chronically absent or failing a bunch of classes, to me, that's a sign that they're off track. So I would put part of that investment into some of these data, and not just the system but the people and the lawyers and the... To make these things happen, it is a long and arduous journey. And so it needs investment, both for the data infrastructure but also the people who are going to make the agreements and all the stuff that needs to go around that so that the data systems can actually work and help people.

Molly Tierney: Makes perfect sense. I totally agree that this is going to be expensive and we should be unapologetic about that and not mislead people. I do want to say Dr. Wong, I want to be in your office the day you get this call and you tell the governor, "I'm sorry, that's not enough money [crosstalk]." That's going to be a shining moment for you. Okay. Sorry. Dr. Shropshire.

Dr. Deb Shropsh...: Yeah, I love that. I think you're right though. I mean the truth of the matter is, it sounds like a lot of money, but we spend so much money to operate a foster care system. I remember seeing this TED Talk, but some years ago, where someone talked about the fact that the system exists because it was funded to do what it does, right? And so if we are willing to fund it in the way that child welfare systems have been funded to do foster care and ultimately adoption in many cases, we have to commit funding upstream for families. And so it would echo and agree a hundred percent with what these ladies have shared as well. And say, if somebody called me and said, "Here's some extra money," it's going upstream to families. And I'm thinking also about our adoptive families in that mix, because the adoptive families are raising a generation of kiddos who came through this system. So I think it includes both natural families and our adoptive families in trying to really influence the next generation.

What I would also add, and I think this goes maybe back a little bit even to the outcomes question as well, is I think sometimes the outcomes that we report on, that we think are the important ones, may not actually ultimately be the most important ones. And this is where communicating with the people we serve really is critical. But I'll talk to my team from time to time about... and it's reflecting Brené Brown's work around value, people having worthiness, and those kinds of things. We can get to the end of a case and wind up with the termination of parental rights. And that bothers me as an outcome on paper, and yet it might be that in the process, if we have treated a mom or dad with a great deal of dignity and help them be hopeful that even though the legal process plays out in one way, the human process can actually have a different outcome that changes people's lives.

And so I think we do have to think about outcomes from a standpoint of the typical things we measure as a system, and on the other hand, what are the impacts to humans in terms of helping people understand [inaudible] experiences, understand the perspective on their own life, bringing their own trauma, and how to move forward regardless of this legal moment, or this terrible moment that's happening in their lives as they interact with the child welfare system. And so, as in thinking about an upstream investment, that investment has got to be inclusive of things that really help us wrestle with adverse childhood experiences, that really help us wrestle with things like helping people be hopeful and valued, and seen, because at the end of the day that may actually be the most powerful thing that we can do for families, even more so than some of the other kinds of outcomes that we tend to report on.

Molly Tierney: Sorry, I'm taking notes because that was quite poetic. I have long thought some of the most important work we'll do in the future

in child welfare will be about measuring the absence of things and comfort with that that's a sign that things have moved in the right direction. But we're in a world that wants everything to be measurable in widgets, and that's tricky. And so, well, let's think about that. Let's do this one last run, and then I want to go... I think people are popping questions up. But I want to give each of you an opportunity to imagine your child welfare systems or the field in five or 10 years, and what is your hope for where the field has moved by then and how would we experience that. How would we know what have changed?

Dr. Deb Shropsh...: Yeah, I'll start off on that one. I don't think I can imagine exactly what it ultimately will look like. What I would love to see though is a system that... One of the things I love to do is find what my people love to do, what they're passionate about, and empower them to do it. I think the more we can do that at a case worker and supervisor level the more creative they can be to serve families, the better our system is. I would love to see us be able to move in the direction of doing that with families, so that it's parents, it's youth, et cetera, that we are literally able to empower to serve... The families I'm serving today are empowered to serve the families that I encounter in five years, because I think that actually would make all the difference. And that in a sense, my job is just to make sure the resources and all of the stuff that sometimes get in the way is moved out of the way, and allow families to actually help other families heal.

Molly Tierney: There you go. That's beautiful.

Terry Stigdon: So I would love in five years... okay, in one year, but to have an agency full of people that know that they're in a psychologically safe environment. I'm constantly making parallel to healthcare. So I think about, you're in the middle of a code and anyone can speak up and say, "I think we may have missed something," and you don't dismiss that person, you listen. And people don't get in trouble for speaking up. But that psychological safety, I would want to be extended out, just like Dr. Shropshire said, and so the families to be able to say, "Something's not right here," instead of being dismissed and treated as less than, know that their voice is just as important because they're part of the team because son of a gun it's their family for goodness sake.

Molly Tierney: Right.

Terry Stigdon: So we should be listening to them as well. And to expand out into the community. This is a hard one, right? And while we've come a long way in the few years that I've been here, we have so far to go. But we have to change the public perception that expects us to be perfect, to understand that we are human beings and we're infallible, and in five years recognize that, and know that we all have a part in helping to strengthen families and help keep children safe. And to help them grow up to experience wellbeing and become well-functioning adults, that contributes society in the way that they want to, then in turn continue that great cycle instead of us talking about the negative cycle of child welfare.

Molly Tierney: Beautiful. Thank you.

Dr. Charlene Wo...: Totally agree with everything you said. I'm going to give an answer that's in a pretty different realm, and agree with everything you all said. I don't know if we can get all the way there in five, but in five years to really start seeing more of true integration of systems so that it's not like child welfare is over here working in asylum, we're trying to do these good things for kids, but rather it is how is our primary care pediatricians working with the payers, not just Medicaid, but all the different payers. Working with the school system, with child welfare, with public health, with our food and housing providers, with our early care and education providers, with our maternal OB-GYN providers so that really we are taking that true whole child, whole family approach to wellbeing, such that it is both addressing that upstream and will feed all the way through to when we have these children who have these high acuity needs. We need that

higher level of care like Dr. Shropshire was describing. That that system is wrapping around them, not just child welfare, but everyone else around them as well.

And that could look like things like having a single plan of care that the family has led, the development of family, guardian, youth, where child welfare, primary care, school, are all in on that together, systems of care like. But really being able to see that happen more often for more families, particularly those that are touching so many different systems. And I see some comments in the chat too about juvenile justice. They need to be in that mix as well. Molly Tierney: Of course, I appreciate those bold stances on what the future could look like, and you know I look forward to tracking your success at causing those things to come to pass.

Dr. Charlene Wo...: Can I say one more other even bolder [crosstalk]?

Molly Tierney: Yeah.

Dr. Charlene Wo...: And then the dollars, right? It's not the way that we deliver that care, right? But that the dollars also need to flow in a way that supports that type of integrated care. Sorry, my child just walked in.

Molly Tierney: That's okay. It's COVID, man. COVID bingo. It's good. I want to jump to some questions. I'm sure John can cue some up. But before we do, let me just say what a pleasure this conversation has been and in my opinion how fortunate the families and children of Indiana North Carolina and Oklahoma are to have you all leading this effort, not just in the management of them but in the concept of it. So thank you for that. John, are there questions that are rising to the surface that would be interesting for us to chew on in our final minutes?

John Kelly: Oh yes. We got a lot of good questions and comments. I'm going to focus on the questions. We got about 10 minutes, maybe a little more if you guys can hang around. I know we're headed to the end of the business space, so if not, it's okay. But I want to start with a couple that are more... We got some big picture questions. I'm going to start with some more practical ones about your job. Alicia Pointer asked, do any of you maintain a clinical practice? Do you feel the need to keep up your clinical skills? Very good one. What do you say?

Dr. Charlene Wo...: So I'll start. I do. I'm still a practicing primary care pediatrician. I do two half days of clinic per week and serve as both primary care and specialist for adolescents and young adults. And I should say, and I felt very committed to continuing my clinical practice because it really grounds me. Really again, so focused on wanting to be child and family led. And what a privilege position it is to be a primary pediatrician where you get these deep insights into the lives and what's going well and what's not going well for children and families, and what is working in a system and not working with them, to be able to do that systems level work.

John Kelly: Deb.

Dr. Deb Shropsh...: Yeah. And on the same, I actually do a couple of half days a month, is all I can pull off right now. I have a foster clinic called Fostering Hope that's gone a long track, primary care clinic for kids in foster care that also trains pediatric residents. And so I get to go spend time with the pediatric residents, seeing kiddos that are in care around our... We have a loose definition. So if your family is just to the train wreck, you can come to our clinic as well.

John Kelly: Good enough.

Dr. Deb Shropsh...: And so it's just very loose definition, but I love it. And Dr. Wong mentioned the idea of grounding. And it does that for me. I can tell you last week, in fact, because I go on Friday afternoon, so by noon on Friday, I was done being a child welfare director, because it's really hard. Going to clinic is in a sense my way of both remembering why I'm here, because that's the families and the workers and the foster families and kiddos that I'm serving. And it's also easier than this job. I've done that one longer, so

it's easier. But it also does remind me that sometimes I'll think that something is fixed, I'll be proud about, "Oh, we've solved this problem in the trouble welfare system." And then you go actually interact with the families or kiddos that are in the system and realize we still have work to do. And so it is grounding for me in several different direction. So yeah, still have clinical practice.

John Kelly: Terry, still nursing, to give out some vaccines in last year or so.

Terry Stigdon: Well, I have helped in that regard, partnering with the department of health. But I work actually in long term care. And that's intentional because, I know I said from geriatrics to child welfare back to geriatrics, that fills my cup. And so I get to completely disconnect from... Like Deb said, this is a really hard job, and working with the elderly fills my cup. So it gives me a chance a couple times a week to connect with them, hold hands, talk to them, and walk away seeing directly the impact I've had and not have to worry about answering a question about the budget, or bill, or whatever else we need to talk about.

Molly Tierney: That's true.

John Kelly: Right. This is a good one for the future child welfare leaders who are coming in from something else. But this question from Elizabeth Wilson, child welfare is such a specialized area of training, how did your view coming from outside the traditional space impact your leadership and buy-in in your agencies? Which is really an eloquent way of saying, how did you convince your workforce you knew what you were doing?

Terry Stigdon: So hi, Elizabeth Wilson, who used to work for Indiana DCS.

John Kelly: [crosstalk].

Molly Tierney: [inaudible] you're busted.

Terry Stigdon: All right. I'm like, "How are you?"

So it's really funny because I came in figuring that I probably had zero credibility, but there is a respect for those in the healthcare profession that I figured it wouldn't be too hard to gain that credibility. And I would say that that's been my experience, really spending the first four months of my job going around the state and meeting not only the people that work for the agency, but meeting CASAs and judges and prosecutors, because I don't have attorneys in my family. So really understanding what it is that happens in the courtroom I think really helped me understand that I could not only understand this work, but the fresh eyes that I brought would be, I believe, a good perspective.

And when I talked about the public health perspective, they got it. It wasn't really that steep of a curve of understanding for them to see, "Yeah, we could see the public health connection." And so I think that generalized professionalism and respect that I worked in pediatrics for almost 20 years, and the things that I saw in intensive care and in the emergency department that I could have something to offer for them. And then bringing that caring for them piece, I think really helped to build that very solid bridge between what I have in healthcare and what that could bring to this space.

John Kelly: And you Charlene, any thoughts there?

Dr. Charlene Wo...: Yeah. I'm in a little bit of a different positions since the position I'm holding in the state now. And I would say I think part of the perspective that I've been able to bring is being a little bit of that bridge builder between child welfare and some of these other entities that are really important for serving the health and wellbeing of children, and really working to build those bridges, which I think has been really appreciated.

And I think like Terry, I've done a lot of listening. I'm actually very new in my role. So I've been doing a lot of listening. I found some great mentors. I will say Molly has been a mentor to me, getting me up to speak, because I needed

child welfare one on one, is what I needed. I really came in knowing very little besides as a pediatrician I would sometimes care for these children. But I needed the one on one. And Molly and other great mentors sent me very focused materials for me to read over. And I had some very focused meetings to learn the basics, is where I needed to start. And I'm still learning a lot.

John Kelly: Deb, I'll start the next one with you. And if you want to throw some thoughts into this question as well, you can do that. But this is a good one. This is from Elena Hong. How do you normalize best health practices for involuntary clients sometimes who are often not as open to traditional medication or medical staff, especially those who are trans intern due to life circumstances? I think what she's trying to get there is you've got some clients in the child welfare system that might be resistant to something that as a doctor people are more ready there to receive. So what do you think there, Deb?

Dr. Deb Shropsh...: I think that's assuming that people who come to the doctor want to do what you tell them to do.

John Kelly: [crosstalk].

Dr. Deb Shropsh...: Because that is actually not true either. There is a whole lot in pediatrics. You're constantly collaborating with parents, and sometimes with parents that aren't together around children, and children have their own opinions, especially the older they get, well, even little ones too, right? Have you ever tried to get a little kid medicine? It's not very easy. And so I think actually the need to listen to people, to collaborate with them around what their goals are, actually is present in medicine. And I think that the more that's present in child welfare, the more successful we're likely to be. So I actually think those run pretty well together. The other thing is I think having a deep respect for people's... their personal decisions or their choices really matters deeply.

And certainly this is big debate right now around our country, but I mean the question of vaccines and things like that is not new. We've been in pediatrician offices talking to families about all different kinds of healthcare needs that their kiddos may have for years. Have always been very willing to be deeply respectful for families that have different perspectives on how they approach healthcare for their family. And the same is true with the families that engage with the child welfare system. Now, that's challenging at times when you're also as a pediatrician and in child welfare worried about the needs of a child, and sometimes those needs have to come first. But I think that the more we can hold parents with a great deal of respect, a lot of times it gets us long ways down the road in terms of helping families actually move forward with the goals that they have.

I'll go back to that other question as well, a little bit on the how do you gain respect from the workforce. I would just tell you it's not easy. And for those out there who are like, "Oh, if I could just get over in child welfare, I could fix that," that's probably the wrong approach. So if you think that you're going to do that, you're probably not going to be able to. For me, I was alongside child welfare for years, not just taking care of the kids they were trying to serve but also taking care of their kids, because many of the kids who were coming into our clinic were case workers bringing their kids. And so I developed relationships with staff for years, simply by serving them, by serving them with expertise that I had. And that was helpful.

And then also not assuming that I knew how to do their job better than they did. And so when I came over to this space more formally, I came assuming that I had a lot to learn. And I was right. I'm just telling you, for the doctors and the nurses out there, this child welfare space is at least as hard as medicine. And it might be harder. It is really challenging, complicated work, and many times less clear than often what we do in healthcare. And so deep respect for folks that have stepped into that as 22-year-olds, not

probably knowing what job they were signing up for. And I think that respect for our staff actually turns out to have served me well over the years.

Another thing I do is I leverage my degree for the outside people, not the inside ones. And this is what I mean by that. My staff don't call me doctor anything. I don't go by that. I don't sign that. I mean, I'm Deb. But I leverage that degree with judges, with attorneys, with people that are out there that for whom that title leverages on behalf of our staff, if that makes sense. So, that's how I leverage that. And I do that with community partners. I'll leverage the relationships I have with community partners for the good of our staff and the families we're serving.

And I think when people see that you're willing to put your reputation and your credentials on the line for them, that actually translates into a great deal of acceptance. And so, I would encourage folks that are out there that are looking on from the outside of child welfare, but saying, "I want to step over there and have influence," I'm going to tell you the best way you can have influence is just to serve, have deep respect for the people who are doing that work, and there will be opportunities that open up for you.

Molly Tierney: I see we're a time boundary. Let me just say that those closing comments, Deborah, I feel like echoed through the comments all of you have made, that this deep respect theme that you all clearly have 360 degrees around you, and I'm moved that you all came into this with the stance of, "I have a lot to learn." Most people come into child welfare with, "Y'all are doing your unit wrong and I'm coming here to fix it." And I think that just that stance opens up a world of possibilities. So I'm grateful to each of you for joining us today and appreciate your hard work and dedication to the families in your state.

John Kelly: Yeah, that seems like a good point to end on. So I want to join Molly and thank all of you guys for joining us for this. We will be sending a recording out to everybody and getting this out far and wide. So share it with friends. This was a really great conversation. Thank you guys again for joining us. And everybody have a lovely Tuesday evening.

Molly Tierney: Thank you everybody. Be safe.

Dr. Charlene Wo...: Thank you.

Molly Tierney: [crosstalk]. Bye-bye.

Terry Stigdon: Thank you.