Transcript

Good afternoon and welcome.

My name is Michael O'Neill from ZERO TO THREE and I will be presenting today with Rose to Monaco from RTI International

And Amanda Henley and Nicole Cooke, who are community coordinators with the Infant Infant Child Support Program in Minnesota.

Next slide, please.

Today I will be describing the National Infant Toddler Court program. Next slide the infant through the court program is a program in the division of home visiting and Early Childhood Systems with her maternal and child health. It sits alongside a number of other important systems integration and improvement programs with reach in many states and communities. The Infant The Court program seeks to improve early developmental health and well-being of infants, toddlers and families at risk for or involved with the child welfare system. Zero to three and its partners serve as the National Resource Center for the Infant for the Court Program. The partners are the American Bar Association's Center on Children and the Law, the National Council of Juvenile and Family Court Judges. The Center for the Study of Social Policy and RTI International as an independent external evaluator. The work as a National Resource Center for the program strongly aligns with their two thirds mission

to ensure that all babies and toddlers have a strong start in life. As a national nonprofit organization, ZERO to THREE informs trains and supports professionals, policymakers, and parents in their efforts to improve the lives of infants and toddlers. The National Resource Center provides training and technical assistance to states and local communities to support effective implementation and spread of infant child the court team. The primary audience for the TNTA is judges, attorneys, child welfare professionals and providers serving infants, toddlers and their families with the child involved with the child welfare system. This work also reaches a wider array of professionals who also serve this population, including pediatric and primary care providers, infant and early childhood mental health clinicians.

Substance use disorder, treatment providers and home visitors. The National Resource Center also disseminates resources on best practices for the workforce that serves infants, toddlers and families involved with the child welfare system, reads and coordinates policy practice and systems.

Efforts to advance early developmental health and well-being and conducts evaluation research to build the evidence base for infant toddler court teams mixed up with

And this is just a half the funding statement and disclaimer Infants and toddlers have unique and urgent developmental needs that are not always fully addressed in standard child welfare and court policies and practices. And yet it is this very age group that is overrepresented in terms of maltreatment rates, where children under

three make up 29% of all children who are maltreated and children under one year of age make up 15% of that. And children under three are also overrepresented in foster care entry, as you can see on this slide. As a side note, I do want to point out that in the child welfare arena, foster parents are now referred to as a resource caregivers out of respect for parents and recognition that these caregivers are really serving as resources to the child and the family.

Next slide please.

As a public health initiative, the Infant Toddler Court program provides training and technical assistance to promote a community driven approach to preventing child maltreatment.

Strengthening families and advancing long term health and development. Let me take a moment to explain how the program encompasses the three levels of prevention for children and families who are involved with the dependency court process or under court Jurisdiction meaning that a petition has been filed with the court and that safety concerns have risen to the level

that the court needs to be involved.

The infantile the court program supports implementation of a specific approach known as infant toddler court teams.

This approach was designed by zero to three and was previously called Safe Babies Court Team and it is often silver referred to that way.

This work is mainly at the level of tertiary prevention. The top of this pyramid when a petition has been filed with the court, the judge will need to decide if the child can remain in home under supervision or will need to be removed and placed in out-of-home care arrangement with either family members or in foster care.

Here, the focus is on mitigating the effects of a young child, exposure to abuse or neglect, the associated trauma due to an attachment disruption when a child is placed in out-of-home care and to prevent maltreatment recurrence. Note that for the vast majority of children, the reason they come into care is due to neglect and not abuse. For these reasons, the infantile the court teams work to build access to evidence based parenting interventions, effective mental health and substance use disorder services for parents and other needed services

These often include services and support that address concrete needs related to the social determinants of health, such as safe and affordable housing, employment opportunities and food insecurity.

Moving further upstream to secondary and primary prevention, the program has a broader reach for all prenatal to three families including those facing significant stresses. For this broader

population, the goal is to increase coordination and alignment across systems and to build a more equitable system of care for prenatal to three families. Much of this work takes place at the community level through one dimension of the Infant Health Report Teams which I will describe on the next slide.

The ITCP, or the Infant Health Care Program, also provides support at the state level to build the capacity for state leadership in implementing and spreading into toddler court teams. The work with states also more broadly focuses on promoting policies and practices that better support the needs of prenatal to three families, particularly those families facing significant stressors.

Next slide, please.

So now let me explain to you what the infant toddler core team approach is by walking you through this graphic.

A way to think of infants.

Way to think about and can tell their court teams is as a collaborative practice that improves alliance, integrates systems and builds community capacity.

The practice works at two levels at the child and family level.

The inner circle on this graphic and at the community level represented by the outer circle at the family level. A family team made up of the direct service professionals that are supporting the child and family in the child welfare process works in partnership with parents to make sure that families needs are identified through comprehensive screening and assessment and are addressed as quickly as possible. The work involves proactive, collaborative problems solving that is trauma informed, highly respectful of the family and centered on the urgent development developmental needs of the infant or toddler at the community level.

A group of community stakeholders representing a wide array of professionals and child and family service supports and child and family supports and services come together in the spirit of collective action to build and strengthen community capacity to meet the needs of very young children in their families. This stakeholder group is called the Active Community Team, and it includes prevention programs like home visiting alongside with more traditional child welfare services.

Their upstream focus also includes advocating for policies, services and supports that address the social determinants of health.

The family team and the active community team

are core components of the infant toddler team's approach. Another core component is the community coordinator, a unique role that is integrally and instrumentally involved in carrying out the work of both the family and the community level. A key function of the community coordinator role is outreach to build linkages across systems to improve access to services. The community

coordinator also provides a consistent, strong voice for the developmental needs of the infant or toddler and empowers families in the child welfare process. The infant toddler core team approach aligns with five strategic areas of focus which are represented by each of the five color shapes between the family and community level. To demonstrate that these focus areas cross both levels of work, the first approach you could thank you is interdisciplinary, collaborative and proactive teamwork. A key ingredient of the approach is professionals coming together in partnership across sectors to engage in collaborative and proactive teamwork. This teamwork depends on leadership and staffing that supports the shift away from doing business as usual.

And towards improvement.

Always keeping the urgent developmental needs of infants and toddlers at the center of decision making an essential piece of the strategic focus area as judicial and child welfare leadership. The next focus area is enhanced oversight and collaborative Problem-Solving

This includes more frequent review hearings than in typical child welfare cases, which allows the judge to provide close oversight of progress on the case and also includes frequent family team meetings where professionals and the family work together as partners. With a major emphasis on empowering parent voice and choice and decision making to engage in collaborative Problem-Solving to expedite timely screenings, assessments and referrals, the next is expedited, appropriate, and effective services. The judge, community coordinator and family team ensured that the child and family needs are systematically and fully identified as early as possible in the case process, and that referrals are made in a highly individualized way to address specific needs of the family with effective services and interventions.

The next is trauma, responsive support.

All professionals involved in infant.

All the court teams understand the impact of the family's trauma history, including experience of child maltreatment on adults and their very young children.

They collaborate in creating an atmosphere that promotes healing and resilience for very young children and their families.

The last focus area is continuous quality improvement, which is the engine that drives effective uptake and sustainability of infantile other teams. This means systematically collecting data and using it to reflect on and implement needed improvements. Finally, the image at the center of the graphic is a parent and child to represent that families with very young children are at the center of this work.

Next slide, please.

I know that I just described infatnt/toddler court teams court teams quite quickly. So for a more in-depth explanation of the Infant Toddler Court team approach, visit the AMCHP

Innovation Hub where infants the court teams are rated as a best practice. Next slide in this.

Here is a map of our national network.

The national network includes 105 active sites, meaning that they are implementing the infant toddler court team approach in their serving families. Additionally, there are currently five communities that are putting the infrastructure in place for infant toddler court teams which is known as installing the approach.

And then there are also 19 communities exploring the approach.

On this map. The state is blue indicates that there is at least one site or community in the state that is active installing the approach or exploring the approach. You can find a full list of the states and sites and the infantile program national network on the zero to three website Next slide, please.

And on this side, I just want to draw your attention to the fact that many target outcomes of the Infant Toddler Court program are in alignment with the Title five National Performance Measures and National Outcome Measures. The ones we have listed here are areas where we have shown impact or areas that we are focusing on an upcoming work

However, they are not the only areas that the program a lot aligns with, including the national performance measure.

Number one for well, woman visits the national performance measure 13.2 for preventive dental visits and others. It's also important to note here that the population of children served by infant toddler court teams meet the identification or the definition of children with special health care needs due to their risk of developmental delays associated with maltreatment, exposure and related risk factors.

And that's led and the evidence base for the infant.

The court team is impressive and growing.

I've selected a few exciting results from previous multi-site national evaluation studies to share today.

These studies have consistently demonstrated wide, wide ranging benefits, including the prevention of repeat repeat maltreatment expedited receipt of needed services for parents and children, and increased placements for can.

I will now pass it on to Rose Domanico from RTI, who will share the most recent findings from a study conducted by RTI International.

Thank you, Molly.

My name is Rose Domanico I am an evaluation researcher at RTI International, and this study is a product of the work done by RTI International, an independent evaluator of the National Resource Center for Infant Toddler Court Program at zero to three offers start with some background on the study.

I'll discuss some of our findings, focusing on three main topic areas, which includes access during the first year of the pandemic. Compared to the previous year to children's health care, access to developmental screenings, and children's special health care needs and developmental concerns.

Then I'll wrap up by noting the limitations of the study and how future studies could address these limitations. The number of children in the child welfare system in need of services is staggering, but young children in the child welfare system are less likely to receive needed services than older children. These missed opportunities to intervene can lead to negative, long term, physical, psychological and behavioral outcomes.

These are also opportunities lost in terms of strengthening families to prevent maltreatment recurrence, including with siblings or subsequent children, and to promote the family's health and well-being. Our study team used data from the Infant Court Project and compared data from 66 children enrolled at infant court sites. The year before the pandemic, with the data of 112 children enrolled the first year of the pandemic. Using these two groups, we analyzed services data through July 2021.

Overall we analyzed close to 800 children's services needs including physical health needs, developmental screening and relational health such as parent child dyadic needs. And we found that even in the face of considerable barriers associated with the COVID 19 pandemic, infant cohort sites continued to support child access to health services

Our data come from

11 sites across seven states.

The majority of the children in our sample were between zero and 12 months old, and there was nearly an even split between males and females in terms of race. We saw increases in the number of Hispanic families likely related to NRC efforts to support sites reaching Hispanic families, a group that in the past has been underrepresented in infant courts about a quarter of children were identified as having special health care needs based on the ages and stages questionnaire or the ASP three,

17% had one or more developmental areas classified as a concern.

We defined health care need as each instance in which a child was identified as needing any type of physical health services Children could have multiple needs for the same health service, as well as needs for multiple different health services. When I say access to a health care need, this means that the service was received at least the first appointment for physical health care.

So over half of children or 56% pre-COVID and 38% during COVID were identified as having a physical health needs pre-COVID health care was received for 99% of identified health care needs, compared to 97% of health care needs during the first year of COVID. The average number of days between referral and receipt was 24 days pre-COVID and eight days during COVID

Receipt of services for health care needs in 30 days or less was significantly more likely during COVID compared to pre-COVID. Cases opened during COVID compared to the year before COVID had nearly two times the odds of receiving physical health care services within 14 days or fewer of several from service referral

We included as an indicator of special health care needs that the child was identified as having premature birth, low birth weight small for age, medically fragile physical disability and or failure to thrive. Developmental concerns were based on any area of concern in the ages and stages questionnaire. Overall, independently of the COVID period, children with special health care needs had over six times the odds than those without special health care needs to receive health services within 30 days or fewer from referral and over five times the odds of receiving services within 14 days or less. Children with developmental concerns head over three times the odds of receiving health services within 30 days or within 30 or fewer days, compared with those without developmental concerns. As described by Molly, Infant Courts emphasizes identification and early access to services for both special health care needs and developmental concerns, which was confirmed by our analysis. Infant Court guidelines indicate that all children should be screened within the first three months of coming into the infant court. For newborns, served by the infant court.

The recommended practice is to wait until week eight to activate a service need for developmental screening. Among those in need that received developmental screening.

The average number of days between referral and receipt was 38 days pre-COVID and 37 days during COVID.

Receipt of service in 30 days or less pre-COVID was 58% of the time, and during COVID was 49% at the time.

But access to developmental screening was not maintained during COVID.

pre-COVID developmental screening needs were addressed.

89% of the time, compared to 74% of the time during the first year of COVID. So in conclusion, the RTI process evaluation indicates that the efforts by the infant courts during the first year of COVID resulted in remarkable successes in the area of physical health services as children were able to access health services at the same level as pre-COVID and even improved receipt of health services in 30 or fewer days from referral and 14 or fewer days compared to pre-COVID. The improvement in receipt during COVID is likely related to the use of virtual platforms and telehealth, while infant courts successfully facilitated access to physical health services.

Other services, like developmental screenings and relational health psychotherapy, were significantly reduced as clinical providers were temporarily or permanently closed

These relational health interventions are evidence based programs, and providers needed time during the first year of the pandemic to develop virtual protocols and

provide guidance to maintain fidelity. Developmental screenings and developmental evaluations struggle during the first year, as most of them require in-person assessment of children and virtual platforms and protocols had to be created by the purveyors of validated instruments. The ability of the infant cohort sites to rapidly transition to virtual platforms, their work with community partners and local resources to provide smart devices and Internet access to families and caregivers, and the use of innovative strategies to access medical homes. And tracking that health appointments were completed, likely allowed for the continuation of health care services

and the improvement of health care.

Of health services, Receipt within 30 and 14 days of referral during COVID. A major facet of infant court's is developing partnerships with pediatricians to establish a medical home for the child, calling pediatric centers during infant court, family team meetings and court hearings to check on health services status and developmental screenings and full evaluations and and inviting nurses to family team meetings to educate community members on health services and well-child visits. Infant courts have also adapted to turnover through ongoing training of child welfare units on how to track health care and ways to confirm that health services are indeed received, as health experts were sounding the alarm during the first year of the pandemic. Studies in the general population found that preventative health care for children, in particular well-child care and immunizations were severely disrupted by COVID and child morbidity and mortality increased in part due to resources being diverted during the health crisis during the pandemic. Moreover, the pandemic has been most detrimental to families living in poverty or near poverty, particularly families of color. Innovations from the infant court experience, which demonstrated the positive buffering effect of collaborative practice to closely monitor and support children's access to health services, should be applied and evaluated in future research with families with young children You're just a couple of quotes from infant courts when asked about responses during COVID. The first one reads, We have to provide smart devices to all of our families that don't have a smartphone. That actually has really improved our treatment provider attendance, but it's also improved our families engagement.

Another person says our community coordinator stays in close communication with the caregivers and the parents about well-child visits and try to ask them consistently to send a picture or something to show that they were at those visits In terms of limitations in future studies because of the limited sample size.

We saw marginal differences among race, ethnicity.

And therefore, future studies will require a larger samples to determine if these marginal results are an indicator of child services inequalities or if training and technical assistance support could improve.

That could improve race equity.

Finally, the impact of COVID will continue and evolve, and therefore, ongoing studies should assess the impact of COVID on children's services among families in vulnerable situations, including those involved with the child welfare system.

Dr. Cecilia Casanova, the lead author, will be available for the live Q&A and discussion.

You may also reach out to Dr. Casanova or myself with any additional questions or thoughts about the study. I am now going to pass the presentation to two infant court community coordinators from Minnesota, Amanda Penley, and Nicole Cook.

Thanks, Rose.

Hi, everyone.

I am Nicole Cook and I am a community coordinator in Virginia, Minnesota and we're here to talk to you today about the infant toddler court teams. I'd like to introduce also my co-presenter, Amanda, if you'd like to say hi, everybody.

My name is Amanda and I'm the community coordinator for the Safe Babies Core Team in Duluth, Minnesota. Next slide, so to really give you a little representation of our sites and where we're at in Minnesota and the yellow is Saint Louis County and I am in the Virginia site.

So it really covers mostly rural small town communities. The Virginia district is about 12,000 people, and we serve about six other communities in the area, which can be very about one hour drive.

To give you an example to the court and some services Thank you, Nicole.

And I am the coordinator for the South site.

So we are Duluth, Minnesota. And we the city of Duluth is is approximately 85,000, but we also serve some surrounding areas. And so as as opposed to Virginia, we are a more urban area of the state.

Next slide.

So really when we think about the Infant-Toddler Court programs in our site, we call it here safe areas, quiet kind of where. Where did this idea come from and where to Minnesota began and really where the stakeholders recognized that we had a problem, lack of cohesion, even with our county agency and families weren't being served effectively.

Key stakeholders gather to seek a solution, and that's how safe it is.

Quite a team was identified.

I'm to give a little background on, for example, we used to be in a in our old building public health and child and family services were in the same building, but often didn't even know who the coworkers were. We did not and we didn't really interact very often, but really we were working with the same families often. So those stakeholders really identified that we wanted to do something about that in our community.

Amanda, would you like to add anything on that? I think it's important to note that included in those key stakeholder hours were everything from our judges to our county attorneys and parents attorneys as well as guardians, ad litem and other leadership from social services and public health.

Next slide

So where we began, so we felt that or I would say our key stakeholder team thought because this is before Nicole and I were hired into our positions, that public health would really be a great place to embed safe babies. And so we were really looking at how they could how we could connect with those social determinants of health that were mentioned by Molly and Rose and how we could partner and continue to build those partnerships with services that could potentially and hopefully outlast any child protection services.

And so the decision was made that public health it is next site So really why embed in public health are key stakeholders recognize the ongoing opioid epidemic and the overdoses in our community we are seeing in our communities, we are seeing large increases of neonatal opioid withdrawal syndrome and neonatal abstinence syndrome and really about those relationships when visiting nurses build helpful and supportive relationships that really outlast social services engagement. Child protection is often in and out, and we really want to have that sustained change for our families.

Amanda, anything we'd like to add to that?

I just wanted to expand a little bit on the relationships. I think what we can see so often in home

visiting relationships is that it's it's voluntary.

And so families are often a lot more open to working with a voluntary service and being able to build that relationship without, you know, the heaviness of being engaged in children and family services. And sometimes there are both, but we we can support those relationships on a voluntary basis.

So it can be it can feel much different.

Next slide.

So the role of public health in our Safe Babies court, as we call it, here in Minnesota.

So Nicole and I were both positioned in our public health departments.

And so our supervision came from public health.

And to give a little background, I was a child protection worker before taking on this role andnd Nicole was a safety planner.

So we both were able to have both perspectives.

And so I think that really helped with our cross division collaboration. We were able to connect with our new departments, but work within that department with the knowledge of coming from children and families,

home visiting programs.

We really began to partner with in a way that that I know as a child protection worker I had never done before. So I would say in the time that I was doing child protection, I maybe had two cases where we had a home visitor. And so digging into safe babies and really amping that up and learning about home visiting programs and then helping train the children, family workers about how they can access and make those referrals was a really big part of that. CQI was is still a huge part of what we're doing with in public health. And Nicole will talk also about what they're doing in the north, but in the southern part of the county our secure project for this year is to increase not only the amount of families being referred for public health home visiting programs but also to utilize those home visitors when we are tracking those measurements. So we're talking about those postpartum depression screenings, those ASQs, the medical homes, and so we can partner with our public health home visitors to continue to build our safe babies practice.

Nicole, do you want to talk about yours in the north? A continuous called improvement, I would say is like we knew that was a hopeful outcome in our teams.

But I would really say it's been one of my favorite strengths and contribution that we're making in our communities.

Just an example of a recent continuous quality improvement I could really digress and go down quite a few over the last few years. But specifically, what we've been working on here in the Virginia site is marijuana and pregnancy and really looking at policy and procedure in response to public health and the children and family services workers developing using evidence based language services and changing that policy to have a more uniformed approach for our families.

So they really see where we're coming from as an agency So I just think that's something we continuously do and the tables that we're sitting at. When I think about the home visiting programs, also in our collaboration in our different divisions and how we're trying to partner in the infant toddler program, I think not only as being embedded and embedded in public health, but us really physically well in virtually over the last few years, being at the meetings and the table in these decisions and these conversations that are leading to this continuous quality improvement And I can also share, like in regards to our prevention area, the prenatal response pilot.

And so in a unique position for Amanda

and I were hired under the plan, a safe pair grant. And in Virginia, Minnesota, we have a public health workgroup that we use that meets monthly in which a public health nurse

responds to child welfare, prenatal exposure versus a child protection social worker. This is really hope into eliminate that stigma of child protection and really engage our families into the public health programs that they're able to offer to really evidence based home visiting programs and really helpful with good outcomes that can happen for the families. Amanda, anything you would like to add on that and I did just want to add that we even though that prevention prenatal response pilot did start in the northern part of the county, we now launched ours in Duluth as well. Now that we are kind of hopefully on on the downslide of COVID and there's more capacity to take that on because we have really built better relationships.

And then we will also be pulling in our community health partners as well within our hospital systems on that next site So really looking I really like this graph of like kind of looking at the role of the safe baby in a continuum. I'm here for both Amanda and I sites and the work that we're really trying to do across that continuum. So as you can see, prevention all the way through assessment, investigation, short term case management, ongoing case management, also quirks and then post reunification. So as I was mentioning on the previous slide about the prenatal exposure, that's really a lot of the work that we're trying to do in safe babies right here in North Saint Louis County.

We work on identifying those high risk pregnancies.

We work on engaging and avoiding ultimately how we can avoid out-of-home placement in courts.

But in the event that there is, then we have the services of short term case management ultimately maybe quite an out of home placement if needed. Amanda, anything you'd like to add on kind of that short term case management that's unique to your site?

Sure Nicole, thank you.

So in the Duluth site, we decided as a team that we would try taking some of what we call a support case. And those are cases where the it was deemed safe for the child to be in the home.

But it was a family that did need some case management. And so we've been able to take those cases and we've had them open kind of between like 75 days to even up to six months to really support the family, help connect them to other things that they might need and then to close, all while providing that stability with a new baby in the home in order to prevent any out-of-home placement. So it's been a really great thing to try, and that's part of the beauty of the approach of the infant child.

The court program is that you have some freedom there within the approach to be innovative and try different things.

Next slide

So we wanted to just pull up this graph again.

I'm not going to get into it too terribly much, but I just wanted to kind of show a little bit about how the role of the community coordinator works as a bridge with all of these different aspects of the program and things that impact our families.

So we've talked a lot about public health, and so that is in the in the top there.

And then we have everything from children and families to the judicial branch, ITCP zero to three and our families and our community and our providers. And so the community coordinator really kind of works as the glue within this program to kind of make sure that all of the the wheels are turning in in collaboration with each other next. So as Rosenbaum all I have mentioned in there in the presentation today, family team meetings and the active community team, I want to highlight about the family unit ins.

We do a lot of those to really wrap around the families to to identify the gaps, their strengths and really what we can do to build relationships to help them be successful.

The role of public health is really imperative in partnering in these family meetings.

They can come and offer services.

If it's a new family, they're also able to always be invited and continue to wraparound at these family team meetings. We also have those stakeholders, those public health leaders, public health nurses who are really involved in those active community teams where we're working on building those relationships.

We've also worked on building that partnership externally with the community in our health care partners and what we can continue to do when we identify gaps that our families are experiencing.

Amanda, anything that you'd like to add on this I don't think so.

Thank you. Looks like so. One of the ways that we have been able to team with our public health partners is in the development of what we called our home base. And unfortunately, this version of home base no longer exists, but we're working on a new one. But what we really wanted to develop was a place where families could come and be together and be able to have what we refer to as family time away from a visitation center and a place where our public health home visitors could actually come in, have their own space.

So we had a nurse's office and they would be able to be engaged in that family time when their families were there with their kids. And so for families especially who are unhoused or unstable, we house or maybe are comfortable with having a home visitor in their home. Those home visitors could come here to to our location during family time and have a home visit.

So it really worked beautifully and it helped to cement, I think, really well some of those relationships just personally with our home visiting nurses.

Next slide. So really looking at the impacts on public health practice, nurses develop relationships with those case managers and they're learning more about our child protection system.

Our court team and really kind of the role and vice versa. The child protection team is really working and learning more about like what the evidence based programs in the home, visiting and public health nursing can do, can do to help the families.

These relationships can be utilized by nurses who are working with families who are not in job protection, really doing highlighting that prevention that we're really trying to do in our communities. Home design nurses are engaged in prevention

of out-of-home placement for children and that prenatal exposure and increased referrals into those home design programs. Like we mentioned, the input is invaluable in the case planning and long term supports, and I just can't echo enough of the positive collaboration that we've experienced in this partnership.

Amanda, anything we would like to add on this? Yeah, I just wanted to talk a little bit more just about the case plans and how we've been very intentional when we're including home visiting in case plans that it's never a court ordered service. And that goes back to the voluntary nature and, and promoting that different type of relationship because we don't want it to end just because children and families is no longer involved. And so if we had it tied to a court order, then if that court order ended, the service could then end.

And so we just really want to help build that.

And by having those home visiting nurses coming into those family team meetings, it also gives more of more stability for the families to know that all of their providers are on the same page and those nurses are able to kind of continue to be the bug in the ear of the families a little bit and follow up on making sure those well-child checks are being scheduled or making sure that that they are, you know, doing exercises with their baby or things like that. So when we really look at at public health home visiting as a way to improve our health outcomes like this, right here is just really where the impact is being made. And then for that prenatal exposure is our goal in in these building, these responses to our prenatal is that the sooner we can get a home visit or engage with this mom is going to be even better for the outcomes of the child. Because now we're going to hopefully be seeing, you know, more follow through on prenatal care and more follow through when the parent is in the hospital.

And things like that.

So the ripple effect really continues to grow and the potential we see for these partnerships continues to grow.

And it's really, really exciting. And hopeful.

Next slide.

Well, I guess that actually brings us to our conclusion.

So we wanted to thank you all for joining us today.

And we look forward to the live question and answer session.

Thank you.