

1 THE CHILDREN'S TRUST HEALTH WELLNESS

2 WORK GROUP MEETING

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4 The Children's Trust Health Wellness Work Group Meeting
5 was held on Thursday, June 14, 2018, commencing at 2:29
6 p.m., at 3150 S.W. 3rd Avenue, Training Room, Miami,
7 Florida 33129.

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9 Committee Members

10 Karen Weller, Miami-Dade County Health Department
11 Gilda Ferradaz, Florida Dept. of Children & Families
12 Antonia Eyssallenne, At-Large Member
13 Tiombe-Bisa Kendrick-Dunn, Gubernatorial Appointee

14 STAFF:

15 James Haj, President/Chief Executive Officer

16 Juliette Fabien

17 Lisa Pittman

18 Lori Katherine Hanson

19 Maria-Paula Garcia

20 Patricia Leal

21 Rachel Spector

22 Sabine Edmond

23 Stephanie Sylvestre

24 Vivianne Bohorques

25 Zafreen Jaffery

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PROCEEDINGS

(Recording of the meeting began at 2:29 p.m.)

MR. HAJ: For those of you who joined me at the Champions, I think it was a phenomenal event, another feather in the Trust cap, another good day for the Trust.

I thought Laurie was going to be here today. She just told me she wasn't attending. But, like, a year ago, she wanted to start this health care -- is it a subcommittee or work group?

DR. HANSON: Work group.

MR. HAJ: Work group to look at our health initiatives. And I know before, I think, in the summer or right after summer, when we were looking at putting our solicitations, that Lori and the team met with some of you in this room individually or on the phone.

DR. HANSON: Juliette and I, yeah.

MR. HAJ: Yeah, and we were really about to bring this back in July and release it. But we just kind of want to see and just run it by you, that we got your input, we put it all together. We just want to make sure if there's any holes or if there's things you can add or things that we're doing right or things that we need to address before the July release.

1 So, with that, I'll turn it over to Lori.

2 DR. HANSON: Okay. So, you know, we really
3 wanted this to be an open discussion about some of the
4 topics. So, as you all know, the school health was at
5 the front of the line. It came out -- you guys, I
6 think, approved it in February or March, and so that's
7 been moving along.

8 We can do an update at the end if we have
9 time. But we wanted to prioritize the things that are
10 actually coming into the pipeline now. And so in order
11 of what they're coming to you, we're going to be
12 releasing the insurance enrollment and injury prevention
13 efforts in the next month, in July, and then we have
14 oral health and infant and early childhood mental health
15 consultations slated right now to be released in August.

16 So, those things are really pretty far along
17 in terms of the content that we've developed based on
18 some of the earlier Board discussions at Board meetings
19 and individual conversations.

20 I'd like to also mention that I did talk
21 with Dan. He was regretfully not able to be here today
22 because he's at a study session in D.C. But I did speak
23 with him about the work group as well.

24 So, we've had a chance to get a lot of input
25 and we just kind of wanted to give you a status update.

1 There are some shifts happening. The way I kind of
2 wrote them on the agenda was to indicate some of the way
3 we think we're steering the initiatives, and then just
4 have you reflect and give us any feedback or input on
5 some of those directions that we're headed in.

6 So, I think we'll just start and then have
7 an open discussion about each one. So, insurance
8 enrollment is something that the Trust has been involved
9 in for a long time, since the beginning of launching our
10 array at the time, at the beginning, which is called
11 "Health Connect" programs.

12 And so our insurance enrollment was rolled
13 out initially as "Health Connect in our Community." And
14 we really have focused a lot on enrolling people in
15 health insurance programs.

16 There's always been kind of a secondary
17 piece to that of enrolling people in other benefits
18 because you can do that at the same time as sort of
19 Medicaid and Kid Care enrollment applications.

20 But it's never been the major focus of our
21 initiative. The major focus has always been on health
22 insurance enrollment. We've had amazing, positive,
23 turn-the-curve kind of results in that area. Not that
24 the Trust necessarily can take credit for because the
25 federal changes in the law is really what led us to have

1 now the lowest level of uninsured children in forever.

2 But we also know that that may have sort of
3 an uncertain future. Right now, everything is still in
4 place that's making that happen, but every day,
5 something new happens.

6 But we also know -- and I was going to ask
7 Karen, sort of connected to this piece, to share -- and
8 you have in front of you the Forces of Change
9 assessment. This is part of the needs assessment that
10 the Health Department has been doing but really a nod to
11 sort of the social determinants of health, right?

12 And so that health is not really just about
13 health care and health insurance but it's about so many
14 other things that are necessary to shore up families'
15 economic and healthy lifestyle kind of approach.

16 So, I don't know, Karen, would you like to
17 talk a little -- say a little bit about the assessment
18 that you guys have been going through and some of the
19 themes that you came out of the Forces of Change
20 assessment?

21 MS. WELLER: Sure. We did have our Forces
22 of Change assessment, I want to say, last month. And
23 this is hot off the presses. So, anyway, this is the
24 results of the assessment.

25 We had community members come and talk about

1 what is going on in the community. And so, as part of
2 our assessment, basically, we were wondering, what were
3 some trends we're finding, what were some factors, what
4 are things that are occurring.

5 And basically, some of the -- I'm not going
6 to read all this, but basically, we were looking at,
7 what are the trends, what's happening in the government
8 nationally, locally, that might be having an impact on
9 health.

10 And again, as Lori was saying, health is not
11 just health care but it's our social activities and
12 everything else. So, we were looking at the trends. We
13 were looking at what factors in the community, looking
14 at ethnicity, population, the urban setting, what is
15 going on and what events are happening.

16 So, those are the things that we were
17 looking at. And on the back of this info-graphic, and
18 I'm just going to highlight what we are seeing so far
19 and what we're finding that people are concerned about.

20 People have been saying that there's a lot
21 of problems with social and mental health. And
22 everywhere you are going, that is something that is, you
23 know, showing up as a high factor.

24 Another thing that they're concerned
25 about -- and this is about our community, Miami-Dade

1 County -- they're concerned about the lack of affordable
2 health, and that's something that was brought about.

3 And the thing is, when we had this meeting,
4 it was not just health-related. We had people from the
5 Justice Department, from the County Attorney's Office.
6 We had -- it was multisectoral, so it was a very good
7 representation of the people in the community.

8 The other thing that they were concerned
9 about is the opioid epidemic. And there is a task force
10 that got together and came up with an action plan, but
11 that is something of concern that is going on in the
12 community.

13 Another area that they were very concerned
14 about is the lack of coordination between health care
15 providers. And that's something that I know we can
16 struggle with in the community quite a bit, and so this
17 is something that is going on. I think we're making a
18 little bit of progress but there's still some concerns
19 there.

20 There's also some concern about the way that
21 decisions are made. They would prefer that it be
22 data-driven with the decisions. So, that's something I
23 know that we've talked about here, but this is what the
24 community is talking about as a whole.

25 Another area is gun violence. And I know

1 that's something here at the Trust, we've been looking
2 at as well, but the community as a whole has been
3 talking about that.

4 Health care immigration, the policy change,
5 that was a big concern, and that will have an effect on
6 what we're talking about the insurance later on, but
7 that is something that has come up as a concern.

8 And then, of course, the lack of a fully
9 integrated data-sharing system, that everybody's
10 collecting data but actually being able to share, you
11 know, there's entities that are doing that. That's
12 something that we're having a problem really getting a
13 handle on.

14 So, this is just a quick overview. We are
15 in the process -- it's going to be a detailed report
16 with everything that we're finding. It's just, we're
17 not ready for publication yet, but this is just a quick
18 summary --

19 DR. HANSON: Teaser.

20 MS. WELLER: -- yeah, teaser of what is
21 happening. We're in the process of doing four different
22 assessments. We're looking at our public health system.
23 We are looking at Forces of Change, as I just mentioned.

24 We're right now actively doing a well-being
25 survey. And if it's okay, I'd like to pass this,

1 because this is something that will help not just for us
2 at the Department but this can be something -- we're
3 wanting everyone to have an opportunity to participate,
4 especially the providers. We're wanting to get the
5 people in the community to let us know what is their
6 concern.

7 We want people to fill them out. So, if you
8 live in the county, please fill it out. We're looking
9 at the economic development. We're looking at the
10 demographics of the community. We are looking at the
11 quality of life.

12 So, that's one assessment that we're doing.
13 And it should take about 15 minutes to fill out. We're
14 looking at the even driving, getting to work, your
15 economic status. We're looking at all of that.

16 And once we have all of these assessments
17 completed, then we're planning on doing a comprehensive
18 community health improvement plan that will include
19 everything that the community is doing so that we sort
20 of are working together, going in the same directions,
21 so I think these assessments help us with that.

22 So, I guess, as you get ready to talk about
23 the investments, just keeping these things in mind as to
24 what is occurring. Do you have a question?

25 DR. EYSSALLENNE: What are the community

1 leaders that are helping with the assessment process?

2 MS. WELLER: The community leaders -- oh,
3 the Health Department --

4 DR. EYSSALLENNE: The community said that
5 they have identified "this, this and this."

6 MR. HAJ: Yeah, I was going to ask you, do
7 you know, across the street, who was at the table,
8 because that was pretty impressive.

9 MS. WELLER: The people that were at the
10 table, we had law enforcement. We had representatives
11 from the Mayor's office. We had organizations like the
12 Federally Qualified Health Centers.

13 We also had major hospitals, everybody
14 coming to the table. We had Baptist. I want to say
15 Jackson was there as well. Nicklaus Children's Hospital
16 was there. Of course, your team was there, too, Jim.

17 We also had representatives from the, I want
18 to say, Early Learning Coalition was there, school
19 system. Oh, gosh, United Way, County Attorney's Office,
20 DCF. We tried to get a comprehensive, so those were the
21 community individuals that came. We had a whole list.

22 We targeted, I think, some of the -- I think
23 I saw the Commissioners but they sent representatives
24 there as well. So, we targeted those community people
25 to be at the -- and we had over 160 people attended from

1 the different organizations. So, we had representation
2 in all the different major --

3 DR. EYSSALLENNE: And how about churches and
4 schools? Did you hear from, like, the community, like,
5 people in the community, not just the organizations?

6 MS. WELLER: I'm glad you brought that up,
7 because they were not at that particular meeting, but
8 what we are doing is part of the survey. With the
9 survey that I just passed out, we're having focus
10 groups.

11 So, what we did do is, we divided the county
12 in 13 sectors. The entire county is divided. And so,
13 we are having focus groups in each of those sectors and
14 we're asking specific questions about the quality of
15 life and how are you going. It's a good point.

16 Okay. So, these Forces of Change was for,
17 you know, individuals. But the actual people in the
18 community, they're going to be done through our focus
19 groups. So, we have had two so far. So, we have 10
20 more to go and we're trying to get all the different
21 sectors. Any other questions?

22 (NO VERBAL RESPONSE.)

23 DR. HANSON: So, when I saw this come around
24 and knew we were going to have this discussion, I asked
25 Karen if I could share it and to share a little bit

1 about the themes with you all.

2 Because when I was thinking about our desire
3 to kind of re-vision the insurance enrollment to be a
4 more broad benefits enrollment and have a more broad
5 perspective on the social determinants, it seemed like a
6 number of the themes that were touched on were
7 supportive of that move.

8 And as I said, a number of our current
9 insurance enrollment providers also are enrolling in
10 public benefits. And so, we've been able to look at
11 some preliminary data from that and see the -- you know,
12 if you calculate out the average, you know, SNAP
13 savings, cash assistance, you know, earned income tax
14 credits that people have been able to get, and kind of
15 multiply that out by the numbers of families who are
16 seen through this, you know, it's a pretty amazing
17 return on investment.

18 So, one of the pilot contracts that we
19 looked at, that's been doing -- that does this as a big
20 focus of their agency has, like, a \$125,000.00 contract
21 through our insurance enrollment and is, you know,
22 probably leveraging more than 20 million dollars in
23 benefits to families with children, you know, for their
24 economic and nutrition and other health benefits.

25 So, we thought, maybe that's really what

1 should be in the front of this initiative rather than,
2 you know, the health insurance piece of it. And so
3 really, in the past, there had been some -- there had
4 been some discussion about this initiative and whether
5 we should be funding health care agencies to enroll
6 people in insurance so then they could bill and get paid
7 for those people to visit their agency.

8 And I think that this re-shifting can also
9 sort of overcome that, and it will hopefully diversify
10 our applicant pool. One of the current agencies that's
11 funded to do this insurance enrollment initiative is
12 actually a community agency that we fund in many other
13 initiatives, Gang Alternative.

14 And they have only a 20-something thousand
15 dollar a year contract. But what they've done is,
16 they've been able to pay for just a partial FTE within
17 their agency to focus on all of their program
18 participants, knowing that, you know, they have a high
19 proportion of their participants who are going to
20 qualify and maybe be a need for these types of services.

21 And so that's really another way to get a
22 really big bang for our buck. So, we want to really
23 promote this as a priority for reaching people who come
24 to Trust-funded programs and really encourage our
25 current funded agencies to think about models or ways

1 that they could leverage current staff or add a minimal
2 amount to their current staff and take on this other
3 function and service, really, for their population.

4 And then we would also still allow agencies
5 that are, you know, this is the main thing they want to
6 do to apply, but they would have to offer the
7 comprehensive array of benefits that we've been talking
8 about.

9 So, the other thing is, I had a conversation
10 with Gilda, earlier before the meeting, to talk about,
11 like, what's available. There's, you know, there are
12 tools that people can partner with DCF, that community
13 agencies can partner to access the electronic system
14 that's used for benefits enrollment.

15 So, the brochure that she sent me is copied
16 there for you in terms of some of the things that people
17 can access through the community partner network. So,
18 we would want to make sure that anybody that we're going
19 to enhance their staffing to carry this out, that we are
20 being very careful that they're not already -- that
21 we're not going to fund them to do something they're
22 already doing, number one, that they're going to be
23 expanding or enhancing what they're doing.

24 And number two, that we would want -- we
25 wouldn't want to fund somebody who didn't pursue a

1 partnership like this, because this partnership then
2 allows them to have the electronic access to facilitate
3 the service and to facilitate knowing the outcomes of
4 the supports, right? Did the people get benefits and if
5 so, at what level benefits, so we can know the benefit
6 that we've leveraged with our funding.

7 So, I think I hit the primary highlights, so
8 I'll just open it up to any thoughts or discussion that
9 people have about this broadening focus on social
10 determinants.

11 MS. FERRADAZ: So, just to piggyback on the
12 conversation that I had with Lori, at the Department,
13 for the Medicaid benefits but also for the SNAP food
14 benefits, we partner with, I think, we're up to, like,
15 400 and something community agencies to be community
16 partners and to help their clients or any other, you
17 know, people in their neighborhoods apply for benefits.

18 So, they get training. They get technical
19 assistance from us. We also monitor them to make sure
20 that they are, you know, compliant with privacy and, you
21 know, all of the other rules that we have.

22 But in addition, we actually have providers
23 that pay us for us to put a staff person in their
24 facility, mostly medical providers, because they're the
25 ones that are most interested in getting the client

1 signed up for Medicaid, and we actually share in the
2 cost of that position that's there.

3 We have different levels of partnership,
4 depending on what the provider is willing to commit to.
5 Some just want to serve their regular clientele. Others
6 want to open it up to the community and anybody else who
7 may or may not be their clients.

8 So, we actually have different levels of
9 partnership depending on what that provider wants to do.
10 It's a benefit, also, not just medical providers but,
11 like, we're at most of the homeless centers, we're at
12 warehousing projects, we're at elderly projects,
13 community health centers. I think we have somebody over
14 at the clinics -- at the refugee clinic. I think we
15 have somebody at the refugee clinic for the refugee
16 clients that come in.

17 And probably a lot of your providers -- and
18 I sent Lori a link to the where it has all the
19 providers. If you need the rest of the providers,
20 because those on the website are only the ones that are
21 shown to the public.

22 DR. HANSON: The public, yeah.

23 MS. FERRADAZ: But we may have other
24 providers who are partners who have chosen not to be on
25 the public website. So, if you need --

1 DR. HANSON: Yeah, I think it would be great
2 to cross-check any applicants.

3 MS. FERRADAZ: And like I say, we don't --
4 we don't pay them and in a few cases, they pay us.

5 DR. EYSSALLENNE: So, how does it work? So,
6 you have a family that needs food assistance?

7 MS. FERRADAZ: -- because all of our
8 applications are online.

9 DR. EYSSALLENNE: Who helps who apply?

10 MS. FERRADAZ: The CBO, the community
11 basically they are a part of this program. They will
12 actually help people that come in to apply for benefits
13 on-line. All the applications are on-line.

14 DR. EYSSALLENNE: How do they get referrals?

15 MS. FERRADAZ: However they choose to. They
16 either can serve clients that they're already serving
17 that want to apply, or if they want to be part of the
18 public access, we have their information on our website,
19 and anybody who wants to apply for benefits who doesn't
20 have a computer in their home, then they can apply on
21 their own on-line, they can go in and put in their zip
22 code and say, well, these are the community partners in
23 your area that can help you apply if you need
24 assistance, in addition to our own offices. I mean, we
25 have offices throughout the county, also. But this is

1 in addition to our offices.

2 We have staff at Jackson that they actually
3 get referred. It used to be the annex. They just
4 recently moved somewhere else.

5 DR. EYSSALLENNE: Was it the risk program?

6 MS. FERRADAZ: I think they might be
7 together. I don't know. But they were -- they were at
8 the annex (indiscernible) recently. And they actually
9 get referred, you know, patients from the hospital that
10 are referred to them. Before they leave the hospital,
11 they can apply for benefits.

12 DR. EYSSALLENNE: And the Trust is
13 funding -- is helping to fund that piece?

14 DR. HANSON: Currently, we have six
15 contracts, right, six contracts -- five contracts,
16 sorry. \$600,000.00 is our total investment right now.
17 Five contracts, I think, four out of -- three out of the
18 five are health care at Federally Qualified Health
19 Centers?

20 MS. FABIEN: Yes, we have two small CBO's, I
21 mean, two community service organizations, Gang
22 Alternative and the other one is FQAT.

23 DR. HANSON: Right. So, their models work
24 slightly differently. Gang Alternative, as I mentioned,
25 is focused on their agency clientele, right? So, people

1 are coming to them for something else already but then
2 they can give them a value-add of helping them through
3 the process of tapping into benefits.

4 And then, you know, Catalyst is more known
5 in the community where people may come to them for that
6 particular service, because that's their whole thing
7 about prosperity and economic development.

8 And then, of course, they have a million
9 partnerships with other agencies that they probably tap
10 into people through. And then the Federally Qualified
11 Health Centers are, you know, primarily taking the
12 people who come to the clinic, right, and then are in
13 need of, you know, as I said, right now, the front end
14 of our investment strategy has been around the health
15 insurance enrollment, right?

16 And so, as we've seen some potential
17 conflicts maybe in that, and then also the decreased
18 need to focus on that, we said, you know what, we really
19 took a look at what we've gotten out of the investment
20 beyond, you know, seeing the great trends in the health
21 uninsured rates going down, and some of the other
22 benefits have been, you know, these major economic
23 benefits for the families that are able to get that as
24 well.

25 So, that's our plan. We're writing that

1 content to put that \$600,000.00 back out for competitive
2 solicitation. We're hoping to get maybe some more
3 contracts with other Trust-funded providers maybe that
4 are going to be smaller in nature because it might only
5 need a partial FTE to kind of shore up what they can
6 offer as a value-add service.

7 And then, you know, we might still have some
8 other entities that are going to be offering sort of,
9 like, you know, anybody come in and get the service.

10 MS. FABIEN: One thing I want to add, Lori,
11 if I may, for the three Federally Qualified Health
12 Centers, they also have Health Connect In Our School, so
13 they get referrals from the school for the students
14 without health insurance.

15 DR. HANSON: Right.

16 MS. FABIEN: The other ones getting those
17 referrals to help them apply for insurance, because
18 that's a requirement for the nurses to screen for
19 insurance as well.

20 DR. HANSON: Right, yes. So, we try to knit
21 these two together as much as possible.

22 MS. WELLER: One of the things I'd like to
23 share, just from -- not just from the assessment, but we
24 are seeing a decrease in the people that are signing up
25 for our services. So, I think that's something to keep

1 in mind as you're putting it out.

2 Refugee has gone down tremendously, and that
3 was a concern that people are afraid to sign up for
4 anything because they don't want -- they're scared. So,
5 just to keep that in mind, because we definitely, even
6 in our clinics, that normally we don't ask any questions
7 or anything like that. We've seen a decrease.

8 DR. EYSSALLENNE: That's happening in
9 Jackson ER. People are leaving before they get treated
10 because they are afraid of getting deported.

11 MS. WELLER: So, that's a real concern.

12 MR. HAJ: People come in and leave?

13 DR. EYSSALLENNE: Like, if they get
14 admitted, (indiscernible). There's been -- we're seeing
15 more people coming in sick. Like, how it used to be
16 when I was in residency, people are just coming in at
17 death's door because they just don't --

18 MS. WELLER: They waited too long.

19 DR. EYSSALLENNE: And a lot of the chatter
20 of the residents has been that a lot of patients are
21 either leaving because they don't want to be in the
22 system, get a sanction from the City. All those things
23 have happened.

24 DR. HANSON: Which is another thing to be
25 said about the model of using Trust-funded after-school

1 programs, right, like, where people have a relationship
2 and maybe a more trusting, you know, like, some of the
3 award recipients that we saw today where, you know, the
4 parents, you know, really know that place and trust that
5 place, being able to offer something maybe can get a
6 better uptake. I don't know that we're going to turn
7 the tide on that entirely.

8 MS. WELLER: You know, at this point, it's
9 just to keep it in mind when you're looking at outcome
10 measures and things like that, so as we go high -- but
11 the reality is that there is a problem out there.

12 So, it's needed. We need them to go. But
13 at the same time, there is definite fear.

14 DR. HANSON: Right. Yeah, we heard that in
15 the 30 Million Words partnership as well, with a number
16 of the partners we were working with there, that they've
17 just seen that sort of chilling effect of coming out,
18 you know, out of the shadows for anything.

19 Okay. Should we move to the -- we're good
20 with this one? Okay. So, injury prevention education
21 is another thing that we've been -- we've been involved
22 in probably since the beginning of the Trust, but we've
23 shifted how we've been involved in it.

24 I would say, in the early years at the
25 Trust, we actually had a couple of different contracts.

1 We did a contract that was around research and
2 epidemiology and tracking local injury data and making,
3 you know, sort of public awareness fact sheets at the
4 time. That's how long ago that was, because nobody
5 looks at fact sheets any more. Now it's info-graphics
6 or whatever.

7 But we had a contract that did that, and
8 then we also had a separate contract that actually was
9 out doing community public health education with the
10 mobile unit, with home safety demonstrations inside the
11 bus, with car seat giveaways.

12 It was very -- more robust in the earlier
13 years. And then I would say about two funding cycles
14 ago, so, let's say, like, six years ago, we decided to
15 try to do something a little differently, which I would
16 say maybe -- you know, maybe we should -- part of what
17 I'm suggesting is that we maybe reconsider going back to
18 a more robust community-wide and data-driven approach.

19 But what we thought at the time was, you
20 know, one bus and one set of staff trying to reach the
21 whole community, it was a big challenge. And we've got
22 all these other programs that we're funding, what if we
23 just trained all the staff in all the Trust-funded
24 programs and then they would tell all their participants
25 and families about these injury prevention messages and

1 education points and then we would, you know, the idea
2 was to kind of multiply the dissemination in that way.

3 And what I would say is, we've had effective
4 training delivered to our staff of our funded programs.
5 But for many different reasons, that doesn't translate
6 into those staff then becoming injury prevention
7 messengers who give that out to their participants and
8 their participants' parents and families.

9 They have many, many other requirements and
10 things that they're supposed to do at their
11 primary-funded activities. And so, I think, maybe we
12 kind of had unrealistic expectations of what kind of a
13 dissemination vehicle that would be for us.

14 So, we have also, you know, our funding is
15 really kind of at a low amount for the past six years.
16 When we shifted to that, we started funding at a level
17 of \$250,000.00 a year, which is really just a couple of
18 staff members.

19 They're still using -- they still have the
20 mobile unit but it's the same mobile unit that 15 years
21 ago was purchased. It was purchased as a retired County
22 bus, so the bus was already retired from bus service and
23 then they revamped it. And now it really is on its last
24 wheels, I guess I would say.

25 So, there's a lot -- we really see a lot of

1 possibility. When we -- when we look back at the model
2 that we used to fund, which was really based on the
3 national model of injury-free kids coalition, which
4 really has -- where's my -- which has a couple of major
5 components to it.

6 It has the surveillance component of
7 monitoring your own local data closely. We used to fund
8 part of an epidemiologist at Jackson that, you know,
9 that kind of kept their finger more real-time on this
10 data.

11 And, you know, yes, we can eventually access
12 data through Forces charts, but then it lags a little
13 bit more. You know, at the time when we were investing
14 more seriously in that kind of data work, we could get
15 block-level, you know, we were kind of getting
16 block-level information even about, like, gun homicides.

17 So, it connects back into some of the
18 themes, right? They were on the Forces of Change of
19 some of the social issues that are happening. And, you
20 know, I would even say that not just the gun violence
21 thing but the opioid epidemic.

22 And I think I've even heard Dr. Schechter
23 speak about, you know, now that we have legal marijuana,
24 medical marijuana, there's increased risk for children,
25 you know, just like they could take the Tylenol by

1 mistake, they could take the marijuana by mistake. They
2 could, you know, illegal drugs could be ingested by
3 mistake by children if they have access that you
4 wouldn't want them to have.

5 So, there's a lot of -- there are many, many
6 issues that are -- so, surveillance is important to keep
7 our finger on. Because even though I know opioids is on
8 this list, we know Miami hasn't had the worst of that
9 yet. You know, we're still not seeing it as bad as some
10 other counties in some other communities.

11 But we do have our -- we have other issues
12 that are pretty serious for us, like, the gun violence
13 issue. And then some of these things touch both
14 unintentional injury, which is where most people think
15 about injury prevention, right, teaching them about the
16 cords on the blinds and water temperature and those
17 sorts of things.

18 But we also have a lot of intentional injury
19 issues that when you connect in with the gun violence.
20 We've talked at past Board meetings about the risk for
21 suicide and how the lethality of that is just so much
22 more when there's a gun involved.

23 So, surveillance, another major piece of
24 that, the national kind of framework for injury
25 coalition building is the coalition building piece,

1 right?

2 So, the piece that we're not right now, that
3 we've kind of started funding just -- training for our
4 providers. I kind of see that as a narrow slice of a
5 bigger model that we need to have in place. And so, you
6 need to be able to get the partners to the table, right,
7 the Children's Trust social media and be able to do some
8 more public awareness work, the school system, you know,
9 engaging them in sending sort of messages to parents,
10 which they do already.

11 Like, I got the parent newsletter and it had
12 a swimming program in it for the summer. But again,
13 it's a tiny little slice. So, how can we build and
14 enhance what the Health Department is doing, what all
15 the local different community groups are doing on
16 different issues so that coalition building is a part of
17 it.

18 And then using evidence-based models, so
19 depending on what our issues are, right, is it safe
20 sleep, is it, you know, you name it, is it gun violence,
21 what are -- and then, so based on what the issues are,
22 there are usually evidence-based education programs in
23 public health, through the CEC or through other
24 channels, that we can then choose to put in place in our
25 community.

1 And so, I think, you know, kind of the
2 discussions that we've been having is, we'd like to
3 see -- we think this is an important issue. We'd like
4 to see a more robust investment and activity around
5 injury prevention education. We'd like to have more
6 funders be involved in that because it's such an
7 important issue in our community.

8 And so we want to work the funder
9 collaboration part of this and try to see if we can get,
10 you know, I won't start calling names of other funders
11 yet but, you know, some of the other local players
12 around safety and injury and health in our community to
13 be part of this with us so that we could accomplish
14 perhaps a new and improved bus and then a realization
15 of being able to support the data work and a
16 coalition-building as well as the training, and have the
17 training not just focus on staff but have it come back
18 out to be inclusive of parents and community events as
19 well as maybe even other sets of providers than
20 Trust-funded providers, so, early care and education,
21 teachers and staff can be super key, right, to talking
22 about, do you have the right car seat in your -- and is
23 it forward-facing, backward-facing, are you trying to
24 put your nine-month-old in a booster seat.

25 You know, those are sorts of things that,

1 you know, you could tap into the early child care
2 provider community, health care providers, you know, how
3 do you ask your patient if they have a gun in the house,
4 because the gag thing was overturned but that's still a
5 pretty uncomfortable issue for people to raise.

6 So, giving training and education about how
7 to raise that in a way that doesn't seem political or
8 judgmental in any way, but give the safety message that
9 you need to have about safe gun ownership and storage.

10 So, those are some of the thoughts and
11 discussions that we've been having with the current
12 local provider and among our staff here about injury
13 prevention education.

14 MS. WELLER: I have a quick question. It's
15 been a while. There was an injury coalition. Is this
16 still going on?

17 DR. HANSON: Yes, that's our funded
18 provider, yes, through the Public Health Trust. It's
19 the Injury Free Coalition. And they are the Miami
20 member site, I think, is the terminology that's used for
21 the national injury free coalition for kids. That's the
22 national group.

23 And that's the model I'm talking about.
24 That national group has that model with the five
25 components that are, like, coalition building data,

1 evidence-based interventions.

2 And so, yeah, our Miami site is the same
3 organization. It's just that the organization has kind
4 of expanded and contracted over the years based on
5 funding.

6 MS. WELLER: Okay. I was just curious if we
7 still had it, because I know the person from the
8 Department that usually goes is no longer with us, so I
9 don't know who from the Department is going.

10 DR. HANSON: Okay.

11 MS. WELLER: But just so you know, injury
12 free prevention came up at the State level as a definite
13 need and especially, we're seeing a lot of falls and
14 poisoning and crashes. And so, it did come up in our
15 assessment.

16 So, this is the assessment at the State
17 level statewide. Locally, so far, we have not seen
18 that. But, you know, as we get ready to do -- some of
19 our questions has to do with that, so I guess it will a
20 state, too, unless they fund some more targeted at
21 Jackson. I don't know if you've heard anything
22 data-wise injury at Jackson.

23 DR. EYSSALLENNE: Yeah, I mean, they're
24 involved with this whole thing.

25 MS. WELLER: And it's housed there.

1 DR. EYSSALLENNE: We used to have a bus. A
2 bus used to be -- we used to rotate it as residents.

3 DR. HANSON: Right. Well, it's broken down
4 more that it's on the road now, so, yeah --

5 DR. EYSSALLENNE: I mean, I think, from the
6 pediatrics standpoint, all of those things that you
7 mentioned do happen. We see a lot of that going on.

8 MR. HAJ: And as Dr. Schechter always
9 reminds us, it's the leading cause of death amongst
10 children.

11 DR. HANSON: That's what I was going to say.

12 MR. HAJ: She also talked about -- remember,
13 she was talking about the drownings and that, you know,
14 you have kids that drown and people that do not drown,
15 and the violence that these people have to live with
16 lifelong issues.

17 DR. HANSON: Yeah, brain injury and -- it's
18 morbidity. It's not just mortality. It's morbidity,
19 right, when it comes to injuries.

20 DR. EYSSALLENNE: And there are support
21 services that are associated with that.

22 MS. WELLER: It's still a problem.

23 MS. FERRADAZ: And we see a lot of the
24 unsafe sleep that you mentioned, you know, and even
25 multiple deaths that we have are not drowning --

1 MS. WELLER: It's the sleep.

2 MS. FERRADAZ: They've gotten away from
3 calling it SIDS, because they see that there were
4 factors, that it wasn't just something that happened.

5 MS. KENDRICK-DUNN: So, I do have a question
6 as it relates to students that play sports or involved
7 in things like dance and cheerleading. So, I mean, I
8 know that a lot of the students, depending on the sport,
9 are prone to injury, but I think that there have been
10 (indiscernible) to prevention.

11 You know, my husband coached football for 25
12 years at the high school level, so there are things that
13 can be done, you know, like, educating the coaches and,
14 of course, they have trainers on staff and teachers.

15 But I don't know if that fits in here. And
16 even, you know, you have the prevention, of course,
17 which is best, but then what is the intervention, you
18 know, for those children because they're young, and
19 helping them to understand, along with their parents,
20 how to deal with injury and it's a whole other thing, if
21 those kids that are injured are talented in those areas,
22 because that sometimes correlates with depression and
23 some other things. It affects them in school.

24 But we have a lot of children that play
25 sports and that dance and that cheerlead and all the

1 other things, gymnastics and soccer. It's not just
2 football. Because football gets a bad rap, but kids
3 that play soccer get concussions, kids that cheerlead
4 fall, you know, we see it.

5 You don't hear a lot about it on the news
6 but it happens. There are kids that have brain injuries
7 and they come right back into the high school and
8 they're expected to just do work.

9 DR. HANSON: Yeah, and I think that's --
10 yeah, what the local issues are, that's what needs to be
11 addressed.

12 MS. WELLER: We actually have traumatic
13 brain injury as part of the assessment. It's definitely
14 there.

15 DR. HANSON: So this seems something that
16 you all see is worth investing and maybe expanding. We
17 are still finalizing budgets and so forth.

18 MS. WELLER: I think it might be a targeted,
19 but we also have a lot of providers that go out there
20 and are teaching these same things. So perhaps, if
21 there's a way to make sure that the messaging is the
22 same, a coordinated effort, that would be very helpful.

23 MS. FERRADAZ: Like, the Healthy Start
24 Coalition to concentrate on the safe sleep.

25 MS. WELLER: The safe sleep.

1 DR. HANSON: Yeah, I think that's why the
2 coalition building piece and kind of funding, you know,
3 somebody who's going to call those groups together on a
4 semi-regular basis to make sure that that consistency is
5 happening and that, you know, I know what you're doing
6 and you know what I'm doing and, you know, then we
7 deploy our resources in the way that makes the most
8 sense.

9 DR. EYSSALLENNE: Like, a piece that would
10 have to be some type of standardization, right? Because
11 you're talking about if the coalition is going to a
12 go-to place where everyone is going to funnel their
13 education from. How are you going to make sure that
14 you're standardizing, right?

15 DR. HANSON: Yeah, I mean, there already
16 does exist -- the Injury-Free Coalition does exist. I
17 don't know how active -- you're saying somebody's going
18 to the meetings?

19 MS. WELLER: I would need to check.

20 DR. HANSON: But there's -- there's a long
21 list of agencies that are part of that, you know, from
22 the school system to the County to the Fire Department
23 to the Police Department to Walk Safe and Drowning
24 Prevention Coalition and Safe Kids --

25 DR. EYSSALLENNE: Right, who knows what

1 they're doing.

2 DR. HANSON: Right. That's what I'm saying,
3 is that --

4 MS. WELLER: It has to be coordinated,
5 because if I'm not mistaken, I believe someone -- like,
6 we have a consortium. And so, I believe somebody from
7 Jackson does come there and is letting us know what is
8 going on at the injury prevention. It's just that I
9 have not heard lately any conversations, so that's why I
10 ask the questions.

11 DR. HANSON: I would say that one of the
12 things that I've heard from Dr. Schechter in the past,
13 when we made this shift two cycles ago, to train -- sort
14 of a train the trainer model, if you will, then as a
15 direct training model, one of the things that she's
16 consistently reminded us of is that we're not funding
17 evaluations, right?

18 We're funding them to do that training. And
19 she's, you know, she said at the beginning, nobody --
20 you know, nobody that she knew of nationally was doing
21 it that way. They were willing to try it because we
22 asked them to. And, you know, we didn't fund an
23 evaluation as part of that.

24 We kind of feel what we know is more
25 anecdotally, you know, from feedback after the past five

1 years now that that's been happening, that we've gotten
2 some traction in some places, right?

3 So, we would continue, for example, training
4 all the home visitors who are funded to do home visiting
5 programs in our portfolio, go through a home safety
6 training.

7 And it helps them, you know, to kind of
8 have, manage, you know, going out without, like, let me
9 have, you know, do you have the cords there, do you
10 have, you know, like, in an awkward way, or even to ask
11 about guns in the home.

12 So, that's a training that really has gotten
13 more traction and I think has been effective. Funding
14 the evaluation piece of it would be another piece that
15 we would need to consider.

16 And actually, that is -- I don't know -- I
17 didn't mention the word "evaluation" specifically, but
18 that is another piece of the national model, right, is
19 to -- it's really a loop, right, to use the
20 evidence-based models, look at your local data, figure
21 out what to do and then evaluate it, yeah.

22 MS. WELLER: Another thing is we look at our
23 indicators. Are they getting better, you know, looking
24 at our infant mortality rates that's creeping up. Why
25 is that? What is causing the deaths, you know? So,

1 those are things that we might need to look at overall
2 because it's not just one area that's going to affect
3 the change.

4 DR. EYSSALLENNE: There's so many
5 confounders for something like infant mortality, right?
6 There's just so many confounders. If you just look at
7 infant mortality, you don't know actually what's
8 contributing to that. It could be an improvement in
9 residency training --

10 MS. WELLER: It could be.

11 DR. EYSSALLENNE: -- or the type of quality
12 in the curriculum in the medical school or something
13 like that, right? So, it's kind of -- I think it's kind
14 of hard to just look at indicators because they're just
15 confounded.

16 MS. WELLER: This is true, but we're also
17 looking at some of the programs that we're doing. And,
18 you know, I mean, there's a lot of things that people
19 are doing, that it's hard to look at overall. But I
20 just use that as one example, but there might be some
21 subsets that we could look at.

22 DR. HANSON: For sure, the indicator trends,
23 you know, do two things. They guide where we put the
24 intervention and then we'd like to see hopefully that
25 the intervention makes a difference.

1 But I think we have to collect other
2 additional information about what exactly people did,
3 yeah, and where, you know, how many people, that kind of
4 thing, yeah.

5 Okay. Any other comments about the injury
6 prevention?

7 (NO VERBAL RESPONSE.)

8 DR. HANSON: So, the next one is oral
9 health. Okay. So, right now, so that you know what we
10 do, we fund one contract for oral health education
11 through Nova, and they have focused the last one cycle
12 or two cycles? This is the last cycle, isn't it?

13 MS. FABIEN: Yeah. At first, it was just a
14 one-year pilot and then --

15 DR. HANSON: Okay. So, like, three or
16 four -- the last three or four years, they've really
17 made amazing progress on training all the nurses that
18 are in the schools on doing oral health screenings and
19 preventive care -- let me make sure I have the right
20 term -- varnishes, right?

21 MS. FABIEN: Yes.

22 DR. HANSON: So, Nova makes sure that all
23 the nurses have the right training. They also go out
24 and do observations, make sure that they're doing it the
25 right way, and they give them the materials that they

1 need to do the work.

2 So, that's been a huge, amazing
3 accomplishment to have embedded in our school health
4 screening practices. But we see is that, you know, now
5 that sort of the major body of nurses has been trained,
6 we need to really fund at the level of turnover. The
7 materials and the visits still, but then, you know, for
8 new nurses that come on-board, we need to have the
9 training.

10 So, we have seen a way to reduce the funding
11 in training. And that's got us thinking about starting
12 to fund some direct oral health services. So, right
13 now, the plan has been -- and this was part of our plan
14 with health last year when we started talking about what
15 we'd invest in, is to be able to put out funding for
16 direct health oral health services.

17 So, that's kind of where we're at with that
18 one. And that one is slated, because it's brand-new,
19 well, so, for the training piece, that was one that you
20 would have seen in last month's Board meeting as one of
21 the gap kind of extension resolutions.

22 The training piece would have continuity
23 based on that, and we'll probably be bringing that to
24 you as a procurement exemption, because we have an
25 exemption both for training that's available in our

1 procurement policy as well as one that's available for
2 health services.

3 So, we think that that piece doesn't make
4 sense to start with a whole different provider. But
5 then the direct service piece, we never funded before.
6 So, that one is going to be released in August and
7 probably come back to you in January, I believe, so that
8 then we would start funding in February, some direct
9 oral health services.

10 Now, we like to see those, again, integrated
11 with the school health initiative but also extend down
12 to Head Start programs and early -- more early
13 childhood, you know, three and four-year-olds, that's
14 when they need to get that fluoride protection and start
15 those habits, right, those oral health habits that are
16 so important for people to get young. So, that's kind
17 of where we're at with --

18 MS. WELLER: You said it would start with
19 the school-aged children?

20 DR. HANSON: Not start with. It would
21 include both.

22 MS. WELLER: It would include both, okay.

23 DR. HANSON: Yeah, it would straddle -- so,
24 we want to keep our, you know, the nurses are doing, you
25 know, this now. And so if they see a kid that needs

1 something that they can't do, like, a sealant instead of
2 a varnish, you know, or they need a more thorough exam,
3 a dental exam, they would connect them through those
4 services, yes.

5 MS. KENDRICK-DUNN: So, what do the oral
6 health direct services look like?

7 DR. HANSON: Juliette?

8 MS. FABIEN: So, you know, they have some
9 evidence-based models nationally that use the sealant
10 school programs, so we think can incorporate that model.
11 And the most effective way to provide oral health in the
12 school or at a child care center to bring the actual
13 dental plan there, making sure where you have the child,
14 and then the parent has to sign the consent and you
15 provide the services.

16 Of course, education is the key to you have
17 to do oral health education. And what we've learned is
18 like when you really get the kids to be involved, they
19 have an inference of parents who have continued those
20 oral health hygiene practices that we're trying to
21 promote. So, it's really the primary oral health
22 screening and assessment. And you would be surprised to
23 see those little kids with candy and sugar and how many
24 cavities they have. So we do those primary services and
25 apply sealant. But we would not do extractions. So,

1 this initiative is not about doing major procedures or
2 anything like that.

3 MS. WELLER: It's more of the preventative.

4 DR. EYSSALLENNE: So, they're getting a
5 referral to dentistry?

6 MS. FABIEN: Yes.

7 DR. HANSON: Yes.

8 MS. FABIEN: That's the key. So, Lori and
9 I, we were just talking. Ideally, we would want, like,
10 a successful applicant or multiple applicants that would
11 be successful to have at their agency, like, a dental
12 clinic. And we have that in our community. And we know
13 that each of the referrals for most private dental
14 offices, they don't take Medicaid. So, that's an issue.
15 That's why we would encourage a community practice to
16 refer them to an FQAC (phonetic) that has a dental
17 clinic that will accept whether you have Medicaid or you
18 don't have insurance at all, they would provide a
19 service.

20 DR. HANSON: Any other comments about teeth?

21 MS. WELLER: It's very important and I'm
22 glad we're doing it.

23 DR. EYSSALLENNE: It's important.

24 DR. HANSON: And you don't think about it.
25 I'll never forget the examples, you know, of the kids

1 who, you know, ended up dying because of, like, an
2 infection in their mouth, went to their brain, you know.

3 DR. EYSSALLENNE: Pediatric dentistry is
4 like a unicorn. It's really hard to find --

5 DR. HANSON: It is.

6 DR. EYSSALLENNE: -- to actually have
7 insurance that covers dental.

8 (MULTIPLE SPEAKERS AT ONCE).

9 DR. EYSSALLENNE: At Jackson, you can't
10 refer people to have insurance that actually covers
11 them.

12 DR. HANSON: Right.

13 MS. FABIEN: Anybody could have dental
14 insurance if it's Medicaid.

15 DR. HANSON: Well, that's what I said, what
16 do you mean, if a kid has teeth rotting out, who's going
17 to see them and take care of them?

18 DR. EYSSALLENNE: Hire a dentist.

19 MS. FABIEN: Yeah, we have great partners.
20 Even now, we have some referrals, because when people
21 see our oral health portfolio, for direct services, we
22 get e-mails, and we connect them. Like, Nicklaus
23 Hospital, we have a relationship with them. And Dr.
24 Mascarena (phonetic) at Nova, they had a way, even now,
25 if we don't provide direct services, we try to make it

1 with places we know that they will see that child
2 whether they have insurance or not.

3 DR. HANSON: And historically, we actually
4 paid for the mobile dental units. Like, we did -- that
5 was a few years back with the Health Foundation, a match
6 to provide the mobile dental, like, with the chair, you
7 know, fully equipped mobile unit.

8 MS. FABIEN: Dental Quest came up with some
9 money but they needed a local match, so we provided,
10 like, five years ago, a local match to do, like, a
11 school-based oral health project. So, they call it
12 "Healthy Smile." Actually, it's one of -- if you look
13 at the RFP out there, they always list that as a best
14 practice because they're very successful. So, you have
15 two FQHC's, one in the south, CHI, and one in the north.
16 That way, we can cover the whole county.

17 So, what we did, as our portion, is we
18 purchased the dental chair. And that was, like, a
19 one-time cost thing. We purchased a dental chair. And
20 we didn't pay for dentists or hygienists or anybody.
21 So, the organization, the FQHC's and Dental Quest, they
22 pay for the staff but we just cover the equipment and it
23 was very successful.

24 DR. HANSON: Yes. So, we definitely know
25 there's a need out there. Anything you put out there,

1 it gets taken up immediately. Okay. So, then, we have
2 on the list -- the next one on the list is actually not
3 officially funded under the budget in our health and
4 wellness portfolio, but it certainly -- most certainly
5 is connected to health and wellness.

6 It's funded under our early childhood
7 development line which, as you all know, like, our
8 buckets, our categories are, you know, not really
9 separate buckets. They're very overlapping.

10 So, the infant and early childhood mental
11 health consultation service was another contract that
12 was in the extension resolution that you all saw last
13 month. That has -- historically, we've funded that as
14 part of Quality Counts.

15 So, with the contracts that we had to fund
16 sort of the coaching of the teachers, there were also
17 these early childhood mental health specialists that
18 would get called in.

19 If there was a kid that was having
20 challenging behavior or at-risk for kind of being kicked
21 out of the school and they would come in and sort of do
22 child-level consultation, they weren't always getting
23 the steady referrals that, you know, we were thinking
24 they should be getting, you know, to do more preventive
25 work.

1 So, we really, I think, engaged in a
2 partnership with the Early Learning Coalition and others
3 in the community, I don't know if maybe just with ELC.
4 Rachel, I don't know if you want to talk about, you
5 know, kind of looked at a few different national models,
6 went on some field trips.

7 MS. SPECTOR: Yeah, so Pam Hollingsworth of
8 ELC invited me to come along to Connecticut, which was
9 the beginning of our journey. And actually there were
10 many community partners. The staff from Lotus House;
11 United Way, many community partners to look at one
12 specific model for mental health consultations. And it
13 is an evidence-based model based on a lot of randomized
14 control trials.

15 So, we were interested in bringing that
16 model here. Unfortunately, the developer left
17 Connecticut and moved to Georgetown University, so they
18 aren't ready -- so they weren't ready at the time to
19 expand out.

20 But we did have calls with five other
21 states; Arkansas, Colorado, New Mexico, Ohio, someone
22 else, and we were looking at different models around the
23 country.

24 And they all staff from a framework at
25 Georgetown University, which is the early childhood

1 mental health consultation for school-based settings.
2 So, we have been working to kind of -- we contracted
3 with them for some consultant work and we've been
4 working to develop a model for Miami, basically.

5 And I would just add, what we've been doing
6 in the past was really being called in at the last
7 moment for child care programs, like, you know, this
8 child is going to get kicked out or suspended, expelled.

9 And so it was, like, a little bit too
10 little, too late for many children. And so this
11 approach is really more of a prevention method, which
12 really works in consultation with the teachers and the
13 families to just promote social and emotional well-being
14 instead of just focusing on the negative behaviors.

15 DR. HANSON: And so the model really has
16 three levels of consultation that the early childhood
17 consultants are trained to do. First of all, these
18 consultants have to be experts in mental health but also
19 experts in early childhood development, right?

20 And you have to bring those two skill sets
21 together, the clinical side and then the more consulting
22 side around development in general. And then there's
23 consulting that can happen. Yeah, the child level
24 consultation is still a piece that can happen.
25 Obviously, if there is a child in great need or with

1 some really challenging issues, you can have some
2 involvement with that child, with their teacher, with
3 their parent, and you can to help make things better for
4 that particular family.

5 But there's also consultation that can
6 happen at the classroom level, so that's really more
7 working with the teacher in ways to structure the
8 classroom environment and to run -- how she runs her
9 day, or he and she runs their day, to have that
10 positive, you know, well-run early child care classroom.

11 And then you can have consultation at the
12 agency level. So, that's really about the child care
13 directors and setting policy, what kind of policies do
14 you have around challenging behaviors, you know, is the
15 first step, you know, that you get a warning and the
16 second step, you're out?

17 Or maybe the first step is, hey, let's get
18 some consultation for this teacher, you know, and let's
19 see if we can help. And the teacher level classroom
20 consultation is really meant to benefit all the children
21 in the classroom, right? And then the agency level,
22 director level consultation is meant to benefit all the
23 kids that are in that child care setting.

24 So, it's a really nice comprehensive model
25 that we're very excited to be putting out. This one is

1 also going to be going out in August -- July, oh, I'm
2 sorry -- oh, it's out of order, sorry. I thought I had
3 it in timing order.

4 So, no, this one is going out in July
5 because this is one of the ones that we didn't want to
6 have a gap in service, right? So, this one will be
7 coming back to you all in November with recommendations
8 after the proposals come in and are reviewed.

9 MS. KENDRICK-DUNN: Is there consultations
10 with the parents and/or caregivers?

11 DR. HANSON: Absolutely, yes. With the
12 child level piece, when it's about a particular child,
13 that piece is a critical piece, absolutely.

14 DR. EYSSALLENNE: I don't know if you can
15 answer this, but how do you avoid labeling?

16 MS. FERRADAZ: How do you what?

17 DR. HANSON: Avoid labeling.

18 DR. EYSSALLENNE: Especially for early
19 child, because things are so hot to develop at that
20 early stage, things can change over time. And a lot of
21 the times, at least, what happens when you have a child
22 who's two, three years old, who's labeled as whatever.

23 DR. HANSON: This model is very --

24 DR. EYSSALLENNE: I mean, I don't know if
25 you can answer. I'm just curious.

1 DR. HANSON: I mean, so I don't know if
2 everybody knows that I'm a clinical psychologist. I
3 haven't been practicing in a long time. But when I did
4 practice, I was in the early childhood world.

5 And, you know, my sense of early childhood
6 mental health is that there's a lot less emphasis on
7 diagnostic categories and labels in early childhood.
8 There is -- they did create a DSM, you know, a zero to
9 three, yeah.

10 But still, I think, it's less emphasized
11 than it is, you know, once you get into school age. But
12 this model doesn't really come at it from that
13 perspective. The assessment tools that they're talking
14 about using within the framework are not --

15 MS. SPECTOR: They're not diagnostic.

16 DR. HANSON: -- diagnostic. They're really
17 more focused on the behavior and then how you structure
18 the environment and the adults around the children to
19 shape positive behavior.

20 MS. SPECTOR: And even the child-specific
21 intervention is less about an intervention directed at
22 the child but more about a consultative model for the
23 people in the child's life.

24 DR. HANSON: The environment, yeah.

25 MS. SPECTOR: -- to support the child's

1 social and emotional --

2 DR. HANSON: Yes, yes. It's a very strength
3 promotion model, which is one of the appealing things
4 about it.

5 MS. SPECTOR: And it could be as simple as,
6 we feel this child, not, like, they don't have to go
7 through a rigorous evaluation to be labeled to receive
8 services.

9 DR. EYSSALLENNE: I just bring it up because
10 what I see -- from what I see, a lot of kids who get
11 labeled as "ADD", for example. And it's just because
12 they're just -- they're just hyper. They don't have
13 ADD. But then someone labeled them that and it just
14 follows them forever. It's so hard to shake and it's
15 not even true.

16 And, so, I think, having the services
17 combined with school, it's important to just -- that
18 comprehensive holistic model that you're talking about
19 is awesome and that would have to be emphasized to try
20 to avoid that labeling that hurts a lot of kids,
21 especially (indiscernible).

22 MS. KENDRICK-DUNN: And in the schools,
23 typically, we like to classify children as
24 "developmentally delayed" for that purpose of that
25 development that can be rapid between zero and five.

1 So, typically, for us, unless it's a severe
2 disability, like a child is coming with Down Syndrome or
3 is clearly autistic, we put a "developmentally delayed"
4 classification and then they can be dismissed, because
5 we do have to have a meeting to look at the child to
6 see, do we think the child may have a disability or are
7 we going to dismiss the child because the services that
8 were provided that the child is caught up.

9 So, we don't even do labels, either, until
10 six, which is school age when you're looking at
11 kindergarten. But, you know, they can be dismissed and
12 we do dismiss quite a few children once they, you know,
13 confirm D.D. and they never move on to the special
14 education world. But what you're saying is, a lot of
15 things hurt the minority children with evaluations,
16 period.

17 DR. HANSON: Even if it's not a DSM label,
18 you could have an early childhood teacher who says,
19 your kid has ADHD and, you know, a parent might just
20 kind of hear that and think, that's it, right, that's,
21 you know --

22 DR. EYSSALLENNE: These programs should
23 incorporate something to protect them against this at
24 this point.

25 MS. KENDRICK-DUNN: I think they do. I

1 think, at the practitioner level, I think, to me,
2 professionally it's probably more of an issue because,
3 you know, for us, we have federal protections built in.
4 Like, every three years, you need to do certain things.

5 But, you know, it's up to the practitioner,
6 I think, because I don't think many people practice in a
7 culturally responsive manner as far as psychologists in
8 the schools. Everybody gets this test and this is what
9 we do and, you know, it does hurt kids.

10 I had a kid recently that he had Down
11 Syndrome. But he had Mosaic Down's, and I never knew
12 the difference. He sat in -- he was labeled
13 "intellectually disabled" from four to fourteen. He was
14 not. He was -- for 15, I mean, for 11 years of his
15 life, he was classified, was put on a different
16 curriculum, and he's not D.D. First of all, he came
17 from another language and somebody saw Down Syndrome.
18 They didn't do their homework.

19 DR. EYSSALLENNE: The other question I had
20 was, do these programs have a mental health label on
21 them? Like, does it say "consultation" --

22 DR. HANSON: The programs are branded not
23 with the word -- we haven't -- we haven't decided on our
24 language yet. But we certainly, like, it's funny,
25 because at the Reach Out and Read medical symposium, one

1 of the speakers was the policy director from Zero to
2 Three, the national organization.

3 And one of the things she talked about was
4 that they have this big -- this is one of the
5 frameworks, actually, that they are promoting is to have
6 more early childhood -- they used to call it "Infant
7 mental health consultation." Now, they call it
8 "Infant/early childhood mental health consultation,"
9 which is this crazy acronym, like, I/ECMHC.

10 And she said, we have a problem with our
11 name. And I'm, like, absolutely. So, you know, I'm not
12 sure, you know, we're re-branding our whole early
13 childhood portfolio to call it "555."

14 And, so, you know, we have to figure out --
15 but I totally agree with you. No, we're not going to --
16 because then, nobody is going to call you, right? If
17 you want to do the director level and the classroom
18 level stuff, it's really more about the social/emotional
19 learning.

20 And I know a lot of people are talking about
21 that now, so that maybe integrating that somehow into
22 the, you know, but really keeping that promotional
23 developmental focus is really the desire.

24 But I'm glad you mentioned the name thing
25 because we -- I thought that other people who've used

1 the framework have called it something, because you told
2 me that the ones that were doing it up to age eight,
3 what were they called?

4 MS. SPECTOR: Project Launch.

5 DR. HANSON: Project Launch.

6 MS. SPECTOR: But I think that they're
7 either referred to as specialists or consultants. I
8 mean, we used to call it "mental health" at Quality
9 Counts. We actually changed the name for that reason
10 because of mental health services. So, we changed the
11 name to "Social/Emotional Supports." But, yeah, we
12 haven't come up with a name yet.

13 MS. KENDRICK-DUNN: Yeah, I know Boston
14 public schools did the same thing. They have, like,
15 this huge, wonderful model how the whole entire -- it's
16 just amazing.

17 MS. SPECTOR: Yes, in base cities.

18 MS. KENDRICK-DUNN: They changed it to
19 behavioral health because I think they have a large
20 Haitian population and they didn't like that name, the
21 mental health piece.

22 DR. HANSON: That's a good point. Thank
23 you. Okay. So, if we want to continue on the mental
24 health theme, we could give you a little update --
25 actually, this day has been a big sandwich day for me

1 because we had -- and for Juliette.

2 We had a school health provider meeting
3 right before Champions and then we --

4 MR. HAJ: Right in this room.

5 DR. HANSON: We ran into Champions and then
6 we drove back here for this meeting. And so, yeah, so
7 we're working closely with the school system because --
8 so, you guys approved the additional mental health money
9 to fund 40 non-licensed but Master's level mental health
10 staff to go into our school-based health sites.

11 And that, of course, happened, you know, a
12 year and-a-half ago, a couple of years ago, that was in
13 the pipeline. And now it's going into contracts, right?
14 We've gotten through the solicitation and it's being --
15 kind of final touches.

16 And we started discussions with our
17 providers just around making sure that they're going to
18 utilize these folks in the way that we intended in the
19 RFP, not just to become another drop of water in the
20 ocean that you don't notice that you put in there.

21 So, we've been talking with them about sort
22 of some of the preventive models and the promotional
23 school-wide stuff, as well as kind of helping support,
24 you know, the licensed people and maybe take some of the
25 things they're doing so that they can do more clinical

1 intervention work.

2 And we've been -- we were in the midst of
3 those kinds of discussions and conversations, and we
4 were also starting to talk about the school -- with the
5 school district and student services about, like, which
6 schools would they wish that we would put those 40
7 people in based -- and they were sort of basing that on
8 the tiered school, the level of need. They have three
9 tiers of schools that are higher need.

10 And so we were in the midst of that
11 conversation when --

12 MR. HAJ: -- Parkland happened.

13 DR. HANSON: -- Parkland happened, and then
14 our legislature took some unprecedented action, right,
15 and actually passed some funding for school-based mental
16 health, which the district is now tasked with coming up
17 with, like, a plan, you know, by August 1st, I think --

18 MR. HAJ: All school districts have to
19 submit a plan and they're all scratching their heads
20 trying to figure this out.

21 DR. HANSON: Yeah, because it's also such a
22 tight turnaround time to figure it out and have it ready
23 for implementation in the fall.

24 MR. HAJ: And the money's not there.
25 There's money but it's not sufficient.

1 DR. HANSON: Yeah, it's not -- yes. So,
2 anyway, so part of what they smartly want to do is
3 figure out, well, what do we already have, right? We
4 already have a lot of stuff going on. We have this
5 additional investment coming in for mental health
6 services in school health.

7 We already have the school social workers in
8 place. You know, we already have some Together for
9 Children schools that are getting some additional
10 attention on social issues and needs.

11 So, really, that's kind of where we're at
12 right now, that we've shared detailed lists of the
13 school level services that we fund that are related to
14 mental health or even just social, you know, I wouldn't
15 say Together for Children is focused on mental health
16 because it's really focused on, you know, regular
17 attendance and some of the early warning system
18 indicators for kids.

19 But, you know, we kind of pulled all that
20 together. We also have the Miami Beach municipalities
21 that are putting some more resources into their schools.
22 So, we try to put all of that into one spreadsheet, a
23 big spreadsheet, and share that with the school system
24 so that as they plan how they're going to implement what
25 they need to do, everything is hopefully working as much

1 in concert as possible.

2 So, that's really where we're at. We have a
3 series of meetings. Our aim is by the -- I think we
4 have two more meetings, right, between now and mid-July,
5 you know, just in the next month or so, two more
6 meetings with the providers.

7 We're working on, like, today, we've focused
8 on looking at a compilation of the job description for
9 the new mental health positions. Everybody has
10 submitted their job descriptions to Sabine, and then she
11 had them pulled together and put the commonalities and
12 we talked about some of the things that we would like to
13 make sure are in, as the people are ramping up and
14 getting ready to sort of hire these 40 people.

15 I'm imagining in the next meeting, we're
16 going to be talking some about replacement, because I
17 expect to have that feedback from the school system
18 about where they would like us -- we already have
19 allocated the number of positions that each provider
20 gets. We did that through our competitive solicitation
21 process based on the number of schools that they have
22 already.

23 So, really, where there's wiggle room is,
24 you know, if I'm a provider at 10 schools and I'm going
25 to get three people, you know, we can say, hey, we want

1 you to put those three people at these schools as
2 opposed to just leaving it up to me where I want to put
3 the people. So that's where we're at on the
4 school-based mental health update.

5 MS. KENDRICK-DUNN: So, I have -- so, I
6 think what the legislature has done and what the
7 Children's Trust is doing is going to have the potential
8 to make a great impact on schools and the mental health
9 of the students.

10 But I wanted to know, like, during these
11 meetings, is it just on the School Board side, mostly
12 administrative and not representative of social workers
13 and -- I don't even know if they're counting them as
14 psychologists because some kind of way, I don't know if
15 people think that school psychobiologists are not true
16 mental health. I don't know if there's --

17 DR. HANSON: Yeah, so, at our -- the first
18 meeting we had with our providers, the school system
19 wasn't there. We had a meeting sort of just with our
20 providers to get their sense of, you know, what's
21 working in their schools, what's not.

22 So, you know that we fund some social
23 workers directly, 17. But then, of course, they also
24 work where they have schools where they have a nurse and
25 they're working with the district-funded social worker.

1 So, there's a couple different models.

2 So, we get their -- we've gotten the input
3 of our providers. And the people who come to those
4 meetings, while they tend to be, like, the directors,
5 they also usually include the staff, the social workers
6 who are working in the schools.

7 And so, you know, they kind of tell it like
8 it is. They kind of told us some of the challenges that
9 they had, like, how do I do a counseling session with
10 somebody if I don't have a room to do it in, right? So,
11 that came up today.

12 So, then, today, we were able to, you know,
13 because we were having separate conversations with this
14 district about where are they at in their planning
15 process, how is this going to go with them, what
16 information do they need from us to help in their
17 planning.

18 And so, you know, we let them know about the
19 other meetings. And today, there were three people from
20 the district that came. Ava Goldman did make a
21 specific --

22 MS. KENDRICK-DUNN: Isn't she the top dog?

23 DR. HANSON: Well, she made a specific
24 comment, though, that they were looking at how to look
25 at all the existing resources in place, and she actually

1 did use the word "psychologist." She did -- she did
2 call out -- so, I think, you know, I think, because the
3 ask of what is in the House bill that they have to do is
4 so much greater than what the funding is going to allow,
5 they have to look at every possible resource.

6 So, she was -- she was asked to come. And
7 then Mark's there -- was here with his staff person,
8 Brenda -- help me --

9 MS. FABIEN: Wilder.

10 DR. HANSON: -- Wilder. Brenda Wilder.
11 Brenda usually comes to the meetings, right, that you
12 all have representing -- because school health, which I
13 think the district really just sees as the physical
14 nursing part, is in operations now. But then, of
15 course, the social workers are in the other side, yeah,
16 right.

17 MS. KENDRICK-DUNN: But it doesn't sound
18 like there were any of the social workers or --

19 DR. HANSON: Well, we have the social
20 workers who work for our agencies, yeah, who were at
21 this meeting. Because it's really about planning for
22 the deployment of the positions that we're funding in
23 those agencies, so, yeah.

24 Now, maybe the districts -- I don't know in
25 terms of what they're doing internally to get feedback

1 and figure out their path.

2 MS. KENDRICK-DUNN: I just think, for me, I
3 think, just -- and I don't know either from the School
4 Board side, because I know you have administrators and
5 that's their job to kind of follow all the information,
6 but to not have -- to me, to not have the people that
7 are in the schools at that table because -- and even
8 some of the providers that are coming, you know, from
9 the Children's Trust, you know, with the health side,
10 just not being there.

11 Because you can hire people and then you can
12 have a law that passes and you can have money to bring
13 in more people. But it's just, there's no coordination.
14 I mean, going into a large school district like
15 Miami-Dade, and then even going into a school, it takes
16 me about a whole year just to learn staff, understand
17 the culture --

18 DR. HANSON: Absolutely.

19 MS. KENDRICK-DUNN: So, the people coming
20 from the outside that don't even understand, you know,
21 the system --

22 MS. FABIEN: That's why we're planning to do
23 orientation and training in August.

24 DR. HANSON: You're not talking about the
25 principal meeting, right?

1 MS. FABIEN: No, I'm talking about on the
2 outside, because we agree that we cannot just take
3 someone, a trained mental health professional. If
4 you've never worked in a school setting, you cannot just
5 go. It's the same for nurses. If you've been working
6 in a hospital, you cannot just place them in a school
7 without proper training about school culture and
8 protocols and those things, so I think you have a good
9 point there.

10 DR. HANSON: So, yeah, I would say that
11 theme came up in the first meeting where it was just our
12 providers. There was a theme of role clarity, the need
13 for role clarity, like, so people kept talking about,
14 like, well, but the social worker does this but then
15 so-and-so else does this, and we're not invited to these
16 meetings but we're invited to those meetings, or we
17 don't even know, you know, when this happens.

18 And, so, really, you know, we kind of -- one
19 of the takeaways was, you know, really getting more
20 clarity on the roles in the schools and then really, you
21 know, better -- shoring up the coordination and the
22 collaboration.

23 What I also, like, observed in the
24 discussions is that it's hard to control that from the
25 top, like, you can have, like, a theoretical model of

1 how it should work but then every school is run somewhat
2 differently --

3 MS. KENDRICK-DUNN: It's their own city.

4 DR. HANSON: Yeah, yeah, and so, you know,
5 then it's up to kind of each little team in the school
6 to kind of get together on the same page and coordinate
7 under the leadership of their principal in that school.
8 So, totally, I heard that from people. I totally can
9 see what you're talking about.

10 MS. FERRADAZ: On the school mental health,
11 the governor signed an executive order. I don't know if
12 you're familiar with Executive Order 1881 and it directs
13 our Department to convene with law enforcement school,
14 everybody, the coordinating of behavioral health
15 services to individuals in need.

16 And that's a meeting that is scheduled in
17 July, and there have been invitations sent to the school
18 system, all the law enforcement, the whole list --

19 DR. HANSON: What is that again? Say that
20 statement -- to convene --

21 MS. FERRADAZ: It's Executive Order 1881.
22 Directs the Department of Children & Families to enhance
23 corroboration with law enforcement offices in the County
24 and improve the coordination of behavioral health
25 services for individuals in needs.

1 Then it goes on to say, all of the partners
2 that have to be included. The school system is in there
3 as a partner. It's not services. It's just the
4 corroboration piece.

5 MS. KENDRICK-DUNN: Do they have
6 organizations like the state, you know, School
7 Psychological Association or Council for Social Work, do
8 they -- is it just the government entities and not the
9 actual people that do the work every day?

10 Because we have national, we have local, we
11 have state organizations and the social workers have the
12 same. And counselors have the same. But I just feel
13 like, as professionals, I can tell you, like, the
14 frustrations with the school psychologists and the
15 school, because people, like, see us as
16 pseudo-psychologists, like, we don't know how to counsel
17 and we don't -- and we do, I mean, we're the only ones
18 that can do evaluations, so there's not enough of us.

19 DR. HANSON: Right.

20 MS. KENDRICK-DUNN: We have about 200 to
21 350,000 students, so we're, you know, but not to be at
22 the table, because we do have -- we do have
23 organizations that do lobby. They have lobbies in DC.
24 They have one that lobbies in Florida. I don't know
25 if -- but maybe they are. I don't know --

1 DR. HANSON: I know that the model that we
2 put into our RFP came from the National Association of
3 School-Based Mental Health. I don't know if I have that
4 exactly right. But the pyramid model that we put in,
5 saying that we wanted to focus on that, you know, the
6 whole, all-student level stuff and then the screening,
7 you know, in the middle, that came from the National
8 Association.

9 But are you asking if they're at the table?
10 Like, when the governor creates an executive order, does
11 he get informed? Are you asking that?

12 MS. KENDRICK-DUNN: Well, that was, you
13 know, do they have one in their meeting? Do you have a
14 representative from school counseling and school social
15 work, you know, school nurse, I mean, all of the pieces?
16 The police are going to be there for sure.

17 But, I mean, we work closely with the police
18 as well. I mean, you know, our roles, there's some
19 similarities and there are differences.

20 MS. FABIEN: One thing I know, we send
21 information to all the departments at the school level
22 so whoever needs it can talk to them. We want to have
23 that type of feedback, especially for coordination,
24 because that's something we've been struggling with.
25 And one thing for sure, we're gonna end up with an

1 additional 40 people to improve things better, to have a
2 picture of what's happening at the school level.
3 Because without coordination, you can't implement
4 properly.

5 DR. HANSON: But one good thing that
6 happened today, I would say, of having the top person at
7 the table, for example, was that, you know, the
8 providers in the first meeting that we had, had
9 generated a list of some of the challenges, right?

10 We don't have space. We need to be able to
11 ensure privacy. We also need to be safe in that space,
12 so we either need a button or a two-way radio, right,
13 when we're alone with the client. We need locked file
14 cabinets, right? We need a land line. And there was
15 sort of a list generated.

16 And so then Mark Zehr, who was here, said,
17 even though as he said it, he said, I'm going to regret
18 saying this but, you know, I will work with you, once
19 you identify the schools, if you're going to put more
20 people in those schools, you know, let me know and I'll
21 try to help work on the operations side, making sure
22 that we find the space if at all possible, knowing -- he
23 did give the caveat, knowing that many of our schools
24 are already over-capacity than they're supposed -- like,
25 they get in trouble with the State because whatever.

1 MS. KENDRICK-DUNN: But they don't have
2 those things for the people that are --

3 DR. HANSON: Oh, Ava -- so, then, Ava, yeah,
4 so, that's when Ava Goldman definitely spoke up and
5 said, we have the same thing, you know, maybe our
6 psychologists get a little room to temporarily do the
7 evaluation in, but then when they're writing their
8 reports, they're, like, sort of hunched in a corner in
9 the front office, yeah.

10 So, she definitely acknowledged that that's
11 a system-wide challenge. And then, yeah, his point,
12 too, was, it's especially a challenge when you have
13 itinerant people, like, that are not there all the time,
14 right, so they can't keep, you know, squatter's rights
15 on their space. So, then, you know, the space gets
16 given away to somebody else. So, it's a chronic
17 challenge. But he did offer to make sure that they
18 worked with us to make sure that we could try to address
19 it as well as it can be.

20 MS. KENDRICK-DUNN: And this kind of stuff
21 is just going to take, I think, some time.

22 DR. HANSON: Maybe like the mobile dental
23 units, we should create some mobile counseling units,
24 like, drive the bus over.

25 DR. EYSSALLENNE: We could call it "the

1 mobile mental unit."

2 DR. HANSON: Call it a "mobile
3 social/emotional" --

4 MS. FABIEN: (Multiple speakers) Because
5 right now, the latest, I mean, we learned yesterday by
6 meeting with Amerigroup that really they reimburse now,
7 when they contract with medical providers, they
8 reimburse for mental health because they know the
9 challenges for privacy and everything. There's some
10 apps in Tenet (phonetic) health organization, like, the
11 child can go to a room and take the phone and have a
12 consultation. So, that's a way to kind of work through
13 that.

14 DR. HANSON: If the child still needs a room
15 where they can go to, to have that conversation, that's
16 the same -- I guess it can be a little bit smaller room
17 with only one chair instead of two.

18 MS. FABIEN: And people don't know what the
19 child is doing as far as privacy. You can just have
20 your headset and they don't know who you are talking to.

21 DR. HANSON: Yeah.

22 MS. KENDRICK-DUNN: Another thing, just one
23 more thing, I wanted to add about the people going into
24 the school, so, you know our district -- our student
25 population anyway is very diverse. I think we're

1 looking at -- I think the stats came out this year, 70
2 percent Hispanic and, I think, it's 20 percent Black,
3 now it drops and White is, like, 6.9 percent. The
4 Hispanic goes up and the others just decreases every
5 year.

6 But as far as these mental health providers,
7 I mean, is there anything that can be done when they're
8 looking at hiring people, having them -- to see if they
9 have backgrounds where they're going to practice in a
10 culturally sensitive and responsive manner because we do
11 have people that don't.

12 DR. HANSON: Yeah, that was part of what we
13 talked about today. We talked about the duties, right?
14 That's one section of the job description is, what would
15 they be expected to be focused on and then the
16 qualifications and experience.

17 And that was -- we didn't talk about that
18 extensively today but it was already in all the job
19 descriptions that, you know, these community -- and
20 remember, the people that we're funding to do this know
21 what you're talking about, right, because it's Jessie
22 Trice and it's Borinquen, you know.

23 These are the communities that they're in,
24 so, they, I think, have a special attention to when they
25 hire, making sure they're hiring, you know, culturally

1 competent staff who are going to be able to serve their
2 clientele. So, yeah, I think that we're definitely
3 paying attention to that.

4 MS. KENDRICK-DUNN: Okay, because that's a
5 big one for me. I know we had a provider at one school,
6 and a child was Baker-Acted. It was -- I think it was a
7 young black male.

8 But I'm not really sure, after I had to go
9 in and do the other pieces, that the child should have
10 been Baker-Acted, because some of the things they were
11 saying, you could look at it from a cultural
12 perspective. But that child now has that Baker Act,
13 right? That doesn't go away.

14 You know, when we go to graduate school, I
15 guess, you know, if it's still the same, we had one
16 class on multi-cultural something. So, it's something
17 that, I guess, you have to learn, you know,
18 developmentally as a mental health practitioner and you
19 have to make extra efforts to understand what's going
20 on.

21 But, you know, in some of our schools, we
22 have disproportionality with Baker Acting and referrals
23 to ADD. And I think some of the mental health
24 practitioners, including the professionals that are
25 school psychologists, have a big role to play.

1 Because that's always my gripe with the
2 school district. Even though ourselves, as school
3 psychologists, we are not always practicing in a
4 culturally fair manner because we're just trying to get
5 the cases done. But that's a big piece for me.

6 DR. EYSSALLENNE: I don't know how much the
7 Children's Trust can push this, but what about
8 linguistic bias training? Not necessarily training but,
9 like, having the partners assuring that they participate
10 in providing services, and this is something that we're
11 concerned about, they can take the bias test and that we
12 start the process of being aware of their unconscious
13 bias, and maybe that can help with the cultural
14 competence continuum. Like, I went to that course
15 (multiple speakers).

16 DR. HANSON: Yeah, exactly, yeah. And Pam
17 is actually going to be addressing the Board on some
18 similar topics at the Monday Board meeting, so maybe
19 that will be a place to have some other discussion about
20 whether that kind of training could be added to our
21 program and professional development supports that we
22 offer, right?

23 We train you on how to do differentiated
24 instruction and, you know, fun fitness engaging
25 activities, you know, we train you on your EBP, maybe

1 that's another thing that should be incorporated into
2 that library of training.

3 MS. KENDRICK-DUNN: I just want to tell just
4 a little story that goes back to this. I have a young
5 man that I'm in the process of evaluating. He's been in
6 and out of foster care. He's now with aunt and her
7 fiance here because he's from Brevard County.

8 But he can't read. He has some behavior
9 issues. I don't want to say they're significant, when
10 you look at the environment of a kid that is bounced
11 from home to home and has been separated from mom and
12 dad off and on.

13 And in the process of me looking at the
14 background of the child, his father went to school in
15 this district. And when I went back to look at his
16 father, we talk about the school to prison pipeline, I
17 looked at this father from kindergarten in this
18 district, his father failed every year until eventually,
19 he dropped out in 10th grade.

20 And I didn't see any evidence, when I looked
21 back, that he received significant help. He was
22 assigned to alternative schools because that's kind of
23 what you do. Sometimes you throw the kids away over at
24 JAN/MAN (phonetic) or wherever the place is, and you
25 wait for them to drop out. Now his dad, he's in prison.

1 And this little boy, it's sad to say, but --
2 and I don't want to put that on his life, he's at high
3 risk because he's stealing. He's doing -- he's eight.
4 He's a little, tiny -- he's going to be retained this
5 year. And like I said, he can't read.

6 And I've talked to -- you know, we have to
7 do something different with the intervention for this
8 kid because we see that we failed his father. I tried
9 to call the prison to talk to his father. He still has
10 rights to his child.

11 Oh, we don't -- we don't talk to schools.
12 We just talk with the lawyers and DCF. I was appalled,
13 because we're educating the child -- the kid and the
14 father, he's in prison. I can't -- you know we're
15 trained not to judge. I don't get into that. If you
16 want a relationship with the child and if it's okay with
17 your sister, who has your child, but we couldn't even
18 make a phone call.

19 And then you wonder about this poor little
20 eight-year-old, little black boy, what is his future
21 going to be like if we don't do not just the status quo
22 of leaving him in school, putting him in special
23 education until he drops out, too.

24 MS. FERRADAZ: That would be one of the
25 children identified through Together With Children.

1 They look at independence, they look at grades --

2 DR. HANSON: In elementary, it's focused
3 only on attendance. In elementary school, it's only
4 focused on attendance. In middle school, they're
5 looking at all the --

6 MS. BOHORQUES: In elementary school, the
7 indicator is attendance.

8 MS. EDMOND: Children of Inmates has a piece
9 that can coordinate around that.

10 DR. HANSON: But does Children of Inmates
11 work with people whose parents are in another place in
12 jail, not from Miami?

13 MS. KENDRICK-DUNN: No, he's in -- well,
14 he's in Tallahassee. He's in the State.

15 MS. EDMOND: -- in other states --

16 DR. HANSON: She does throughout the State?
17 That might be -- are they connected with that service
18 partnership?

19 MS. KENDRICK-DUNN: No. Stephanie sent me
20 information, so I'm working with the guardians because
21 that was my piece. Just don't want to see this --
22 because his father, too, he had a life of crime as well.

23 DR. HANSON: Right.

24 MS. KENDRICK-DUNN: I don't know if he's
25 going to change when he gets out in 2025. I don't know.

1 Maybe it would be a difference if he has a relationship
2 with his kid, coming out at 14 years old. By then, he
3 has enough time to do 50 million things and might not
4 have to deal with his father then.

5 But right now, today, the child wants a
6 relationship with his father and you have these
7 barriers. And he's angry. And you know what happens
8 with kids that are angry. It's not fair.

9 Do we have obesity anywhere in here?

10 DR. HANSON: Our healthy lifestyle
11 investment is embedded within our youth development
12 programs. So, all of the K-5 programs have to offer
13 regular fitness activities and healthy nutrition and
14 nutrition education. So, that piece is sort of embedded
15 within the after-school and summer programs for kids.

16 MS. KENDRICK-DUNN: We see a lot of obese
17 children. And even kids that have -- I can't think of
18 the disorder where they're at risk at five or six for
19 high blood pressure and diabetes some kind of syndrome.
20 So, I think that's -- I don't know. I think it may be a
21 big health issue for some of our children, if it's
22 nutrition, lack of exercise or both.

23 DR. EYSSALLENNE: Food? Dessert? Don't get
24 me started.

25 MS. WELLER: We could get started.

1 DR. HANSON: Okay. This will be our next --
2 the next -- the next year's -- the next year's budget
3 with the new issues that we want to take up, yeah.

4 MS. EDMOND: We do have the pilot thread
5 going on right now, the common thread in partnership
6 with our schools, health clinics where they're doing
7 education with the family and the child based on the BMI
8 and obesity as well as under-weight, because we have
9 those that come in through the health clinics as well.

10 MS. WELLER: My only thing would be -- well,
11 it could be another meeting. But there have been
12 investments made in the schools. We have the vending
13 machines and those sorts of things. There are a lot of
14 things going on.

15 My question would be, are they still
16 ongoing, you know, are they still going on? So, I
17 actually have a staff person who's taking it on as a
18 research project, so let's see.

19 MS. KENDRICK-DUNN: Don't forget the PTA,
20 because they can have a healthy vending machine but when
21 the PTA -- which was my argument this year, we don't
22 offer one fruit. Everything is chips and candy.

23 MS. WELLER: Anyway, I'm concerned with the
24 vending machine that we spend a lot of money on.

25 DR. HANSON: The other one I would add --

1 the other special sort of focus on that is, one of our
2 parenting, that you guys just approved last month, it's
3 been in the prior cycles but they competed successfully
4 and were approved again last month, is delivering the
5 Triple-P evidence-based model. But there's one
6 called -- help me, somebody -- healthy lifestyle?

7 MS. LEAL: Healthy lifestyle.

8 DR. HANSON: Is it called "healthy
9 lifestyle?" So, it's really targeted at kids -- at
10 parents and families who are trying to manage that
11 obesity issue with their child.

12 And so it's the parenting program, because
13 really, the behavioral parent training is about how to
14 shape your child's behavior, and that behavior might be,
15 you know, whether you're, like, on the screen all the
16 time or whether you're, you know, eating unhealthy or a
17 couch potato or whether you're, like, you know, acting
18 out in other ways, right?

19 So, they take those same constructs of the
20 parent education training but they layer in the healthy
21 lifestyle piece. So, we have pieces happening, you
22 know, within different parts of the portfolio, yeah.
23 But it would be good to maybe, at some point, kind of
24 pull those all together and look at them.

25 MS. KENDRICK-DUNN: Because down the road, a

1 lot of those children, if they continue down that road,
2 you know, they're at risk for -- they're at risk for so
3 many things when they become adults.

4 MS. WELLER: It's social determinants of
5 health as well, because we can tell them, okay, go
6 outside and play, but if they're having problems with
7 gun violence in their neighborhood, that's not
8 happening. So, you know, there's just so much, yeah.
9 But I agree with you, we need to look at it as well.

10 DR. HANSON: Right. So, those are all the
11 topics on our agenda, unless you have any other
12 health-related, health or wellness-related topics.

13 So, I think, as I explained, we have three
14 RFP's going out in July. We have three others that will
15 be coming in August. And then we have a set of maybe
16 eight or so more that need to come out probably in
17 October, not all related to health, but that's sort of
18 our timeline.

19 So, you'll start to see the first -- well,
20 you're going to see in this next month, in July, there's
21 ones that we've been going through the review process
22 now and, I think, Monday, we're going to be posting the
23 recommendations for the five RFP's that have been out
24 since the youth development and parenting.

25 And so, those recommendations will be coming

1 to you at the July meeting. And then you'll have a
2 little break in August -- no, we have a retreat.

3 MR. HAJ: No, we have a retreat.

4 DR. HANSON: We have a retreat in August.
5 And then, yeah, and then TRIM in September and so then
6 we'll start back up with funding recommendations in
7 October and November.

8 MR. HAJ: But I just wanted to thank you all
9 for individually giving us your time the last several
10 months leading individually and collectively. We have
11 different Board members with such great areas of
12 expertise in different areas. So, to be able to talk to
13 you collectively and individually tremendously helps us.

14 So, I know it's been a long day for some of
15 you, as some of you have spent the whole day with the
16 Trust. So, thank you for your time. I hope you get to
17 enjoy the summer. Thank you.

18 DR. HANSON: Thank you.

19 (Whereupon, at 4:07 p.m., the meeting was
20 adjourned.)

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REPORTER'S CERTIFICATE

STATE OF FLORIDA:

COUNTY OF MIAMI-DADE:

I, Fernando Subirats, Court Reporter and Notary Public in and for the State of Florida at Large, do hereby certify that I was authorized to and did report the proceedings in the above-styled cause; that the foregoing pages, numbered from 2 to 81, inclusive, constitute a true and complete record of my notes.

I further certify that I am not a relative, employee, attorney or counsel of any of the parties, nor am I a relative or employee of any of the parties' attorney or counsel connected with the action, nor financially interested in the action.

Dated this 5th day of July, 2018.

Fernando Subirats
Court Reporter

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