THE CHILDREN'S TRUST HEALTH WELLNESS WORK GROUP MEETING

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

Committee Members

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

STAFF:

James Haj, President/Chief Executive Officer
Juliette Fabien
Lisa Pittman
Lori Katherine Hanson
Maria-Paula Garcia
Patricia Leal
Rachel Spector
Sabine Edmond
Stephanie Sylvestre
Vivianne Bohorques
Zafreen Jaffery

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.

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

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

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

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

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

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

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

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

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

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

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

now the lowest level of uninsured children in forever.

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

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

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

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

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

We had community members come and talk about

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

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

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

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

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

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

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

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

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

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

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

Another area is gun violence. And I know

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

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

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

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

DR. HANSON: Teaser.

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

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

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

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

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

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

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

DR. EYSSALLENNE: What are the community

leaders that are helping with the assessment process?

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

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

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

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

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

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

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

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

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

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

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

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

(NO VERBAL RESPONSE.)

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

about the themes with you all.

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

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

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

So, we thought, maybe that's really what

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DR. HANSON: The public, yeah.

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

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

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

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

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

DR. EYSSALLENNE: Who helps who apply?

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

DR. EYSSALLENNE: How do they get referrals?

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

in addition to our offices.

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

DR. EYSSALLENNE: Was it the risk program?

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

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

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

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

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

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

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

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

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

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

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

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

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

DR. HANSON: Right.

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

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

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

in mind as you're putting it out.

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

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

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

MR. HAJ: People come in and leave?

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

MS. WELLER: They waited too long.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

right?

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

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

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

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

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

You know, those are sorts of things that,

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

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

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

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

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

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

evidence-based interventions.

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

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

DR. HANSON: Okay.

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

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

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

MS. WELLER: And it's housed there.

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

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

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

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

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

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

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

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

MS. WELLER: It's still a problem.

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

MS. WELLER: It's the sleep.

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

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

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

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

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

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

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

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

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

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

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

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

MS. WELLER: The safe sleep.

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

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

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

MS. WELLER: I would need to check.

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

DR. EYSSALLENNE: Right, who knows what

they're doing.

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

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

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

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

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

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

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

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

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

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

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

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

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

MS. WELLER: It could be.

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

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

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

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

Okay. Any other comments about the injury prevention?

(NO VERBAL RESPONSE.)

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

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

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

MS. FABIEN: Yes.

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

need to do the work.

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

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

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

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

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

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

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

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

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

MS. WELLER: It would include both, okay.

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

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

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

DR. HANSON: Juliette?

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

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

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

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

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

MS. FABIEN: Yes.

DR. HANSON: Yes.

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

DR. HANSON: Any other comments about teeth?

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

DR. EYSSALLENNE: It's important.

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

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

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

DR. HANSON: It is.

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

(MULTIPLE SPEAKERS AT ONCE).

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

DR. HANSON: Right.

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

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

DR. EYSSALLENNE: Hire a dentist.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MS. FERRADAZ: How do you what?

DR. HANSON: Avoid labeling.

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

DR. HANSON: This model is very --

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

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

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

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

MS. SPECTOR: They're not diagnostic.

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

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

DR. HANSON: The environment, yeah.

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

social and emotional --

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MS. SPECTOR: Project Launch.

DR. HANSON: Project Launch.

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

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

MS. SPECTOR: Yes, in base cities.

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

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

because we had -- and for Juliette.

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

MR. HAJ: Right in this room.

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

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

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

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

intervention work.

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

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

MR. HAJ: -- Parkland happened.

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

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

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

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

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

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

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

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

in concert as possible.

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

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

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

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

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

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

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

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

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

So, there's a couple different models.

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

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

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

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

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

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

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

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

MS. FABIEN: Wilder.

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

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

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

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

and figure out their path.

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

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

DR. HANSON: Absolutely.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DR. HANSON: Right.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DR. EYSSALLENNE: We could call it "the

mobile mental unit."

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

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

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

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

DR. HANSON: Yeah.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

They look at independence, they look at grades --

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

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

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

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

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

MS. EDMOND: -- in other states --

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

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

DR. HANSON: Right.

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

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

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

Do we have obesity anywhere in here?

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

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

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

MS. WELLER: We could get started.

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

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

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

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

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

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

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

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

MS. LEAL: Healthy lifestyle.

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

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

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

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

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

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

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

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

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

And so, those recommendations will be coming

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

MR. HAJ: No, we have a retreat.

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

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

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

DR. HANSON: Thank you.

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

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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