Joint Program Services and Childhood Health/ Ad Hoc Health Committee Meeting Transcript

February 28, 2022

THE CHILDREN'S TRUST JOINT PROGRAM SERVICES AND CHILDHOOD HEALTH/AD HOC HEALTH COMMITTEE MEETING

"In person quorum with some virtual attendants"

The Children's Trust Joint Program Services and Childhood Health/Ad Hoc Health Committee Meeting was held on February 28, 2022, commencing at 9:00 a.m., at 3250 Southwest 3rd Avenue, United Way, Ryder Conference Room, Miami, Florida 33129. The meeting was called to order by Pamela Hollingsworth, Chair.

COMMITTEE MEMBERS:

Pamela Hollingsworth, Chair
Karen Weller, Chair
Edward Abraham
Dr. Magaly Abrahante (Zoom)
Matthew Arsenault
Dr. Daniel Bagner (Zoom)
Dr. Dorothy Bendross-Mindingall (Zoom)
Constance Collins
Victor Diaz-Herman
Mary Donworth
Richard Dunn
Lourdes P. Gimenez

COMMITTEE MEMBERS (Continued):

Nicole Gomez

Dr. Malou C. Harrison

Dr. Tiombe Bisa Kendrick-Dunn

Marissa Leichter

Annie Neasman (Zoom)

Ken Hoffman, Ex-officio (Zoom)

Leigh Kobrinski

STAFF MEMBERS:

Bevone Ritchie

Blake Brown

Carol Brogan

Imran Ali

Jacques Bentolila

James R. Haj

Jennifer Moreno

Josefina Greene

Juana Leon

Juliette Fabien

Lisete Yero

Lori Hanson

Michele Mordica

Michelle Lopez

Muriel Jeanty

STAFF MEMBER (Continued):

Natalia Zea

Rachel Spector

Sandra Fish Mathurin

Sheryl Borg

Susan Marian

William Kirtland

GUESTS:

Brenda Wilder

Guerline Anderson

Kyrie Salters

Joanne Pierre

Joanne Pierre

Marta Pizarro

Stephanie Williams-Louis

Rosa Martin

Viviose Gustave

Dannielle Dixson

Precious Baker

Baltazar Martinez

Lyse Deus

Lissette Collazo

Pearl James-Isler

P R O C E E D I N G S

MS. HOLLINGSWORTH: Good to see you in person, by Zoom, today on this beautiful Monday morning. I think Karen is stepping out. So, we're going to go directly to public comments.

Is Ms. Stephanie Williams-Louis here? She's physically in the room?

MS. JEANTY: She is.

MS. HOLLINGSWORTH: Good morning, Ms. Williams-Louis. I understand that you have a public comment.

MS. WILLIAMS-LOUIS: Yes. Good morning. Are you able to hear me?

MS. HOLLINGSWORTH: Yes, we can hear you. Please state your name.

MS. WILLIAMS-LOUIS: Stephanie Williams-Louis. I'm actually with Community Care Plan, I'm director of community engagement. And I really just wanted to connect with this group because I'm fairly new to my role. And we are working with different nonprofit organizations throughout Miami-Dade County to learn more about some of the needs of the community, residents and clients that the nonprofits serve. And a number of people have directed me to connect with

Children's Trust and listen in on the meeting. So I just wanted to introduce myself and let you know that I'm here to listen and learn. If you have any recommendations of other groups that serve children and families, particularly around health/education and supporting any of the needs the community may have about removing barriers to healthcare, health access, based on some of the social deterrents of health. I would be happy to connect with anyone you would recommend. That's it.

MS. HOLLINGSWORTH: Thank you very much, Ms. Williams-Louis. Thank you for joining us. Glad to have you with us today, and we will take you up on that.

And at this point, I'm going to punt to Ms. Karen Weller for an overview of health investments.

MS. WELLER: Good morning, everyone, and welcome to our joint Committee Meeting of our Health Committee and our Programs Committee of The Children's Trust. The Ad Hoc Health Committee met back in December of 2019, and at that time we discussed the health investments of The Children's Trust. We did talk a lot about

children with disabilities at that time, and so we're looking forward to hearing from our CEO and program director for The Children's Trust, and that will give us an overview of the health investments.

So at this time I'd like to turn it over to Jim.

MR. HAJ: Karen, thank you.

So in front of you you have your program. We want to accomplish two things today, one is just the overview of the health investments, our current health investments that are coming this month in March to the full board meeting for approval. And a lot of discussions that we want to bring back, we've had in the last years regarding students with disabilities, regarding health. We haven't met -- last time we met was before COVID. So what does it look like? What are steps long-term in the next couple of years? Are we getting everything right? Are there gaps that we need additional investments? Are there things that we should keep an eye on? Just have a discussion and start -- that's why we want to have the joint Programs and Health Committee.

We came of the retreat. This was a big

topic that we wanted to include in the retreat, but we thought it would be best to keep it aside to have another full discussion, and then when we come back to the board recommendations next month and the following month of our steps forward. So it's going to be two-fold, one is Juliette is going to go through our current health portfolio and then we're going to ask Lori to chime in. There's other things that are not on the reso that we're involved in under different initiatives, but involve health. And we'll open up for discussion to see, again, are there any gaps, things we're doing well. So with that, I'd like to turn it over to Juliette, our Chief Programs Officer.

MS. FABIEN: So I'm going to share a couple of slides with you, just to give you a brief overview of what we currently fund under the health and wellness umbrella. I think there's about two initiatives included, as far as the resolution, and Lori will go over those at the end.

Good morning, everyone. Happy Monday. So, we ask the question, "Why health and wellness? Why do we fund this portfolio," right? So we

know there's many reasons, but I'm going to share a couple of bullets with you. We know child health and wellness significantly impacts children's behavior, good learning abilities and the quality of life, right. So what we do is make sure we have different strategies that take into consideration the inference of social determent of health. We address some of those social determents.

Our Trust investment and to increase access to healthcare services. And then its multiple, right. We have access in the school, we have access in the community, right. It's not just -- and then we have mobile unit you're going to see later on, that can be going to hard to reach population. So those are the six resolutions you have in your packet. We invest more than like 20 million dollars. So you're going to see reso A, school-based health, B, the pediatric mobile clinic, C, comprehensive vision, and D, all health services, E, injury prevention, F, benefit enrollment.

So as I'm going to the individual resolutions, you can feel free to refer back to your packets to see what I'm referring to because

this is only a quick summary. I'm not going to go into detail.

So for reso A, that's a major initiative. We put a lot of -- out of the 20 million dollars, I think more than $14 million goes, Lori, goes into school-based health. And this is a very comprehensive initiative that utilizes a multidisciplinary team. So you have nurses, social worker, mental health professional. They work together in the school to support a student. So we currently have six healthcare organizations funded to implement this initiative. And if you look at enrollment across 144 sites that we found, we say site as opposed to school because you may have one school with multiple sites. So we have about more than 100,000 students enrolled in the schools.

Last year, let's give you a quick summary, and keep in mind the circumstance under which those services were provided because in the past you'll see, if you compare from previous years, you'll see we provide way more services, right. So you might hear COVID a lot, and how even enrollment went down. If you look at enrollment for previous years, a lot of students moved from

coming to the school in-person to staying at home to get virtual services. So if you were to go back to previous years and compare, you're going to see differences and level of services provided. But we were so happy to see 77 percent of the visit resulted in those kids return to class meeting. The parent didn't have to come and pick them up and stuff, you know, what they doing if they have work, and some of them don't even have sick time. So they would have to be -- it's unpaid time, they would have to come to the school and pick up their kids. I think in the past, there used to be 84, under 80 returned to class. And I'm surprised to tell you the truth, we're still at 77 percent because we know now, every little symptom, people are so worried, you're going to send the kids home, right, you don't want them to go back to class because of the environment we are right now.

So we have more than 11,000 withdrawals, mostly from mental health services and we understand why. Even though we have a mental health professional in the schools, but sometime some student might need beyond one or two sessions, they may need a real therapist to

support them, right. And then, of course, mandated screenings such as vision, were provided as well. Thank you.

So let's look at Resolution D for a minute. You see our wonderful picture of the bus. I believe our program chair is in the picture as well. I don't know if you see that, Pam, you are in the picture when we were cutting the, I think it was last year, I believe, when we cut -- the ribbon cutting event. So with this mobile, we have more flexibility to really address some underserved communities because of the flexibility. We have more than 26,000 medical visits. Many, many mental health encounters and social services. And social services can be anything around, you see the child come and they need other support, they don't have health insurance. You may have a social worker assist them with that as well and other social services they might need.

We have about 38 immunization drives and that's a lot drive going on. They were like all over the place in the community, trying to do -- they do testing, they do immunization for children. So our vision program, to explain how

this program works. So we have our nurses, Reso A, that's where we have our school-based nurses. They are the one doing the initial vision screening, because you saw they have some need vision. So if a child fails the screening, then they get referred to Miami Lighthouse. In Miami Lighthouse, usually they have a mobile unit, they can come to the school, actually to the school to provide the comprehension vision examination. And if the child needs glasses, they also provide glasses. And you can see on the slide, all the examinations that were provided, conducted last year, and glasses provided.

So, Reso D, it's our community oral health services. So remember, the nurses, most of those screening, nurse screen also for oral health and vision. But this one, it's more like community providers going to childcare centers and other places to provide actual, more than what the nurse could provide because the nurse is not like an oral health professional. They are trained to do some screening, but if you have a child that need dental sealant, you need an actual oral health professional to do that, right. So that's through this initiative, that's how we are able

to go into communities and provide those services.

Reso E is about injury free coalition. This is also a mobile unit that we use. And I believe, Jim, the board meeting, we're going to have the board meeting outside. I don't want to steal your thunder, I don't know if you're going to announce that to the board, but it's going to be very exciting to see what a parent goes through when they do the training, to prevent a child from getting hurt. So you'll get an opportunity to see that in person during the board meeting.

So our last resolution is our benefit enrollment. And that's really, it's to this initiative, like we address some of the social determents of health. And you know during the pandemic, again, how important that was for people who lost their job, they are able to go for benefits. We know the burdensome of paperwork. It takes -- even us, educated people, going to -- if you try to apply for public benefit, I'm sure you will have a hard time. can you imagine like a typical parent trying to get those benefits. Through this initiative, we fund

people to sit with families and to help you through the paperwork process. And we see one of the big highlights, like you are able to leverage money more than 1.1 million dollars last year.

One thing I want to address quickly, so in case you see, if you're looking at the reso, you're going to see one difference with one provider. Based on the data it shows that they were not doing so well. And we can say we understand why, because the provider kind of had the expectation we're not in alignment with the other contract. So what we're going to do to the negotiation process, we're going to work with them to make more equitable expectation for the contract.

I think that's it. If you have any questions, I'll be happy to take them.

MS. HOLLINGSWORTH: Okay, thank you very much, Juliette.

FEMALE VOICE: Thank you. In terms of reso A, on the school-based screenings that take place, for example, the dental, the BMI and so forth, how do we communicate to parents what they should be doing at home to help with dental care, for example, of their children, with eating right

and obesity issues and so forth?

MS. FABIEN: That's a very good question. We always -- whatever screening that we do, first of all, we have to have the parent consent to do it. And then after, the nurses conduct the screening, the child itself -- because sometimes it's best to teach the child how to care for themselves, because most likely they're going to be doing brushing their teeth, when they floss, things like that, it would teach them, the nurse part of the services. Its oral health education, it's part of that. And then the parents will get a letter and we attach a little brochure with the letter to explain the importance of oral health care. That's a very good question.

FEMALE VOICE: Excellent. Thank you.

MS. HOLLINGSWORTH: Any questions from those tuning in by Zoom?

DR. BENDROSS-MINDINGALL: Yes, Madam Chair.

MS. HOLLINGSWORTH: Yes, please.

DR. BENDROSS-MINDINGALL: Thank you very much. Good morning. Thank you very much. Having been a principal in Miami-Dade County public schools and having had a clinic in the school, one of 12 principals in a certain

pattern, we had the best of services and I know it's still going on. But I want to know how are principals made aware of these services at this time, please?

MS. FABIEN: Yes. So principals play like a major role in the -- I mean, you already know they play a major role of the school, but as far as services happening in their school, we need their involvement, right. We need the -- and sometimes they delegate somebody, the principal may not be the ones dealing with the clinic directly, they may delegate someone and ask the same principal or something like that. But for the most part, every provider needs to share the plan, when they're going to address timeline, when they're going to have screening, so that way they know, we need their help. We include some of the material, part of the package that go home, so we have to work with administration in order for us to provide services. And if we having some medication immunization, we have some -- the paperwork may not be completed properly. Sometime the principal has to intervene to kind of push the family to get the information we need in order for the children, the children with

special needs, they can get the medication and things like that. We will have the principal a lot and the school to make sure the parents are aware and they utilize the services being provided.

DR. BENDROSS-MINDINGALL: Follow-up, Madam Chair. Thank you very much. Another question, please. I want to know, when I visit my schools, usually the schools have students who are having some kind of an issue with them. I don't see any information, any pamphlets or anything. I like the idea that you said they are provided. So is there any way that we can intercede and make sure that the parents get this information? I know that we can't do everything, but sometimes -- well, not sometimes, many times the parents depend on us to get information to them. And as The Children's Trust, I'm wondering if there's any way that we can make sure that the parents are getting this information, that we are available, that we do provide services, and the nature of the services.

MS. FABIEN: Absolutely. And we try -- we started doing the engaged parents initiative, you know, some parents are more involved than the

others. You're going to see the parent telling you, my child has allergies or something like that and they're going to want to be involved in the care of the child. So the different strategy we use to send information to parents, like we know the first day of school they have the big package, but we know some parents, they're going through so many paperwork, they might miss something. So before a screening is happening, for example, the oral health example that I used before, we send those material at different time. Even though at the beginning they know what's going to happen, but we send it again to make sure. And if your child is being seen in the clinic, you get -- the parent get -- part of the protocol, you need to call the parent and explain to them why they come, if -- and that's your opportunity, to provide any health education to the parent. And then you get a letter also, going home with the child's backpack. So we try different ways to engage.

DR. BENDROSS-MINDINGALL: Okay. Thank you very much. I have one more question, having perused this information, and you did mention the -- I think its Reso C, as we speak about the

vision of our children. How do we know that our children are being evaluated for a vision, how does that -- please walk me through that, if you will.

MS. FABIEN: Absolutely. So currently we have -- its mandated, like children in first, third and sixth grade, they receive a vision screening. And also any child new to state, if they were not in the state of Florida, it doesn't matter what grade they are, they need to get screened for vision. And even if you miss, let's say, during the screening, one child didn't show up, right, we also track when student was absent, that way we can do follow up screening. And sometime you will have teachers just saying the child cannot see. And that's a common referral to get referral from teacher, to say, make sure you screen this child because I don't think they can see the board. Once the nurse screen, because, you know, they trained to do a screening, but they're not a professional of services, so they will contact Miami Lighthouse. We have a clean referral process, it's a good handoff. It's not like you send a referral, you don't know what happened. Miami Lighthouse will

show up to your site with the van to provide the comprehensive vision services. Then if the child again needs glasses, then you provide glasses as well.

DR. BENDROSS-MINDINGALL: Wonderful. I've been to Miami Lighthouse, and you're right, they do an awesome job. Thank you so much for your responses. And thank you, Madam Chair. That is all for now.

MS. HOLLINGSWORTH: Thank you. Question?

MR. ARSENAULT: Hi, thank you. Great presentation. I have a question about the matching funding, the LIP funding, that's intended to be drawn down from this. Is that above and beyond the funding amount here, and I guess, what influence does the Trust have in the application of those funds and the programs that they're used for?

MS. FABIEN: Absolutely. It's one of my favorite project. When I started at The Trust, we see all those funds available at the state -- to draw down funds to our community. Because we have so many uninsured children in our community that don't get the services. So what we do through this initiative, we use -- we match -- we

do the agreement to bring down the local funding. So as far as influence, every organization, they already have how much money they are eligible to get to draw down and based on that we will cut the check to their state account, they send us invoice, it's like a transfer. Because that's the only mechanism we can use to draw back money. But yes, its above and beyond cutting down on this initiative.

MALE VOICE: My question is, so I know that we do that, so we act as, The Trust acts as the intergovernmental to transfer, to be able to hold down that funding. But then, for example, those FQHCs, they just use it for whatever purposes they want to We don't say it has to be used for these types of programs that we're authorizing the funding for --

MS. FABIEN: That's a good question because the stipulation as to all who can use -- with the money. So what we do, we incorporate that into an amendment process. We do the providers. Its underinsured, uninsured children who can only serve with the funding. Above and beyond, the services -- remember, the services occur in the school. The agencies will provide additional

primary care services in the facility. It's not in the school.

MS. HOLLINGSWORTH: Yes, Constance?

MS. COLLINS: Thank you. The investments we're making in our school-aged children are amazing. I'm wondering if you can talk a little bit about the investments we're making in services in the health arena for children who are not yet school-aged.

MS. FABIEN: So we have -- our early childhood, I think Lori is going to go over this later on to see other ways. Thank you. Other ways we provide early, like kids that are not in school yet, through our early childhood investment. And then oral health, the community oral health, it's really they go to childcare centers, but we target younger children to the oral health initiative. I think that's reso D or something like that. I don't remember. Miami Lighthouse also goes to -- I think in the past we used to focus on school-aged, then we started need to extend the services to younger children. Because they start -- you can identify as early as two-year-old, like a child that's having a vision problem. So the oral, both oral health

and comprehensive vision, they target a younger youth as well, it's not just older. Then other investments we have early childhood. Lori is going to talk about some today.

MS. KENDRICK-DUNN: I have a question or a couple of questions. Good morning, everyone. So my question relates to the health investments that The Children's Trust is investing in is critical and definitely is much needed. So my question relates to understanding social determinants of health. And so I know that many of the children that we serve and families that we serve and communities, not all, but many, we're dealing with some communities that parents and the children, economic marginalization may be a factor in their lives. Which we know eventually impacts health in the negative way.

So I'm just wondering, I see in the resolutions and in the information about the school health that prevention is something that we're looking at. And I'm just wondering, because in many communities where economic marginalization is an issue, there are increased health risk for the children and as it relates to nutrition and oral care and just so many things

that compound, and later when they become adolescents and later when they become adults, if that's not taken care of when they're kids, then you have higher risk for cardiovascular disease, you have high risk for type 2 diabetes, high blood pressure, issues with pregnancies, et cetera, et cetera. Because how you take care of your health when you're a child, there's a correlation to what your health will be like as an adult. And many of our underserved communities, overall health is a huge factor. I'm just wondering more about the prevention of these chronic diseases that we know impact communities of color, communities where we know there's a lack of economic resources. I guess more about that and then how we're measuring that to understand how -- what impact we are having as these children turn into adolescents, as they turn into young adults, because it's a -- the health piece is a big deal. It's always something that really impacts me. I was taking the bus to work this morning, for example, and I see three older black people get on the bus and all of them have walkers. And I know, just being black, right, it's like typical in a community,

oh okay, people are on medications for high blood pressure because you think that's the norm, but it should not be, right. We know lots of family members have diabetes type 2 or cardiovascular disease or because of not taking care of their diabetes, there's amputations. And these kinds of things are rampant in certain communities and others it's not.

So how do we, as their children, help children and families understand the importance of taking care of your health and how to do that. Because the prevention is absolutely key. So, I'll stop.

MS. HOLLINGSWORTH: Thank you.

MS. FABIEN: So health disparity is a real thing. It's a real, real issue that's very complex to address because we know, in our country we don't have -- we have a sick care system. We wait until people get sick and then try to address them. And I think that's what makes this portfolio more important. So we don't wait until somebody is sick to try to address that, we try to those preventions starting with little kindergartners who are just starting school, teaching them good habits and good health

hygiene. So what you say is not something just The Trust can address, I think it takes the entire country, not just organization to think about even something as simple as, as far as healthcare extension to additional -- for insurance extension, Medicaid extension. That's the basic, right. If you cannot -- some people don't even have health insurance. As far as going to seek services and prevention, that's going to be challenging. That's what we're doing to this portfolio, we try to tackle the issue but it's a bigger problem, it's a complex problem that takes a lot of us to make a plan, right.

MS. KENDRICK-DUNN: I agree with that, and I'm just hoping in the future maybe The Trust -- because it is a huge problem. You are so right. Maybe there will be great efforts or collaboration with different organizations to address this, because, for example, performing well in school is important, but if you're not healthy, if the children's parents are not healthy, those kind of things are going to impact the children, if the parents are the issue or if it's the child. So I'm hoping to see that. You're right, in our country, we do have a sick

care system. It is very hard to see because we have so many resources in this country, it's just a huge lack of knowledge. There are so many components, like you're saying, there's nutrition, there's medical care, there's oral care, there's mental health. It's kind of like how do we bring all of this under one umbrella, so we cannot have children experiencing obesity and the ramifications of that as they get older. So yeah, I just hope that we can. Because without health, without health you really have nothing. All the other things, it doesn't really matter as much if you're not a healthy person and you can't take advantage, it effects the quality of your life. It's just huge, so thank you.

MS. HOLLINGSWORTH: Thank you, Tiombe.

MR. DUNN: Can you hear me?

MS. HOLLINGSWORTH: Yes, Pastor Dunn.

MR. DUNN: Okay, thank you. I wanted to go back to the Miami Lighthouse project collaboration with The Children's Trust and the grant and try to raise the question in terms of at what level or levels does Miami Lighthouse for the Blind get involved with the children? I may have asked this question before, but I'm just

trying to refresh my memory, where a child has already been deemed by virtue of their physical appearance and maybe they've had -- I would like to raise the question, at what levels would the Lighthouse for the Blind get involved? I.e., we have many students who have the obvious visually impaired issues. I would think that it would create, to a certain extent, a low self-esteem issues, I don't know the proper terminology, maybe there's a crossing of the I's, maybe there's a, I don't know, please forgive me if I'm not using the right terminology, maybe they may have some type of false eye or something like that. At what level would Miami Lighthouse for the Blind, could they intervene at such levels as this when it's the obvious, when they've already been deemed as being visually impaired. They have some type of obvious, physical issues with their eyes where anybody can see that they have issues.

Is it a way that maybe there can be some type of corrective, and I know you're delving in deep now, some type of corrective eye surgery of some sort that might give them a better physical appearance and it may even help them with their

seeing? That's my question. I've raised this question before, maybe about a year or so ago, because constantly I run into students who you see and you see the obvious and you know that they have issues. It invites into certain things or certain confrontations with individuals because they were bullied or are being bullied or teased because of their physical eye condition. And I think that would play a major role in a child's ability to learn. Would someone help me out with that, can you speak to that, please?

MS. FABIEN: Yeah, I remember you asked that question last year when -- because I think you had a specific case, right?

MR. DUNN: That's right, you're correct.

MS. FABIEN: Yeah, I remember. So this process, we don't fund surgeries or anything like that, like you said, more involved level of care, but Miami Lighthouse has bene in the community for a long time and they have relationships, I could imagine they have relationships with other entities that do this type of work. If you want more assistance, you ask for that, I can have someone at the lighthouse call you or I can get the information and reach out to explain to you

how they work in the community for children with events, maybe events help.

MR. DUNN: To their credit, they did follow up with that with me. I may need a refresher.

MS. FABIEN: Yeah, we can get you a refresher.

MR. DUNN: Please, please, because I'm seeing it now and I'm at the elementary level now. And I'm seeing it quite obvious and it pains me when you see children like that. And I'm almost, I don't want to cross subjects, but yesterday in my ministerial obligation and duty, I went to the nursing home and I just saw the sick people and I was leaving out of there just thanking God for my health. So Ms. Dunn, I understand about health, how much of a blessing it is just to have a reasonable, as our for parents used to say, a reasonable portion of our health. And if a child does not have that good health, my God, you can imagine what kind of challenges, uphill challenges that they will face. I don't want to cross subjects, I want to stay on the Lighthouse for the Blind issue, but I could speak to the health issue overall because as a minister, often times I'm thrust into

environments, i.e. hospitals, nursing homes, et cetera, and it will break your heart when you see the living conditions of some people who have been deemed terminally ill for the rest of their lives. I don't want to get into that because I'll start trying to preach, so let me stop.

MS. HOLLINGSWORTH: Thank you, Pastor Dunn, and thank you Committee Members, and thank you, Juliette. There will be other opportunities for questions as we move through the resolutions. And Lori will be presenting at the end of our time today.

Let's move to Resolution 2022-A: Authorization to negotiate and execute contract renewals with six providers, identified herein, to deliver comprehensive school-based health services, in a total amount not to exceed $16,250,000.00, for a final term of 12 months, commencing July 1, 2022, and ending June 30, 2023, subject to funding appropriations; and also, to request authorization to use funds from this initiative to leverage federal funding through the Low-Income Pool program (LIP).

May I have a motion, please?

MR. ABRAHAM: So moved.

MS. HOLLINGSWORTH: Thank you.
DR. BENDROSS-MINDINGALL: Move it.
MS. HOLLINGSWORTH: And I'm told there are no recusals for this resolution.
MS. NEASMAN: Yes, yes. Annie, this is Annie, I have to recuse.
MS. HOLLINGSWORTH: For Resolution A, okay. Okay, let's move to discussion. Questions, from the committee.
MR. HAJ: Madam Chair, if I can bring up a brief comment. As a former high school principal, I had the benefit -- I seen both. I got the clinics while I was a high school principal. We did not have the clinics, then they put clinics in the schools. I don't know how we did it without these clinics. It is night and day to have 3,500 high school kids without a clinic. So I appreciate, as a principal, to have The Trust investment to have these, as well as, my years blend, four or five years ago, the board also made the commitment to add the mental health professionals in the school. So now you have the physical carrier of the mental health, the nurses get trained. When we started talking about sex trafficking, nurses were trained too, because

many of these times when the kids come through, the only point of entry, or the only way people catch it, is at the school site. So there's a lot of training with these nurses to catch, not only medical, social, emotional, but other things that may be impacting the child. And I'm also very proud that several years ago, too, we used our existing funds to go ahead and apply it for the low income pool, to draw down an extra $3.5 federal money into this community. So it really is a win-win that we're offering these clinics. Discussion long-term is how do we continue with virtual, with all the new technologies coming. What does the future look like to serve children throughout this community. But again, as a recipient of this, as a principal, I just don't know how schools do without having full-time clinics with full-time nurses in buildings. Thank you.

MS. HOLLINGSWORTH: Thank you, Jim.

MALE VOICE: So I just had a question, a clarification, and it actually links to what Jim was just saying. I would assume this is not in every school, it's in selected schools. And how are those schools selected? Because it is an

important program and there are a lot of schools involved, but I assume it's not every school.

MR. HAJ: I'm going to tell people to chime in in just a second. It's about half the schools in Dade County. We're at 140, what are we at, 145 schools? 145 schools. When it came out the door in 2007, Judy Schefter was leading the charge from the board and other members of the community. And there was a yearlong discussion about schools with the school board and putting them in high need areas and also keeping it within a feeder pattern. So that's how they were selected back in the day. And then there are capital costs, capital improvement to build out these clinics in these schools. So the schools that were selected are the schools that remain. They don't change out.

MALE VOICE: So can you provide some perspective about what the existing need is for other schools as well? It sounds like we're continuing with the schools, there was heavy need in those areas, but I'm sure there are other areas that have heavy needs that are not a part of this program and just how that issue can potentially be addressed.

MR. HAJ: There is. We also work with our partners. When we did this plan, it's a comprehensive plan with the health department, with the school system. These are the schools we take care of and then there are other entities that take care of other schools that we are not in. So there is -- there is, I believe, and Julie or Lori can help, chime in, that the health department and other entities take care of the schools that we are not in.

MS. FABIEN: Yeah, that's correct. We have -- I think the health department contract with Nicklaus Hospital, I believe, to serve those other schools. Its different level of services that provided at the school, but yes, there's other mechanisms, like they receive screening, like every school have to do, and things like that. So the other half are being taken care of by the health department.

MALE VOICE: So, I think I know the answer to this. It sounds like there's existent need in other schools, I'm sure this is budgeted limited, why the program can't be expanded to other schools, but its something for us to consider in the future, right? I would expect. Is that

right?

MR. HAJ: That's what we mentioned, as well as opportunities down the road, with telemedicine, with other things, are there ways that we can have a greater reach, knowing our dollar constraints. There's new technologies coming out, that we can reach parents and children where they're at, so. The discussion was, per the resos for this month, but what we do moving long-term and having those long-term discussions.

MALE VOICE: Yeah, I'm sure this is a discussion for another day, but using digital health modalities can really leverage resources, and of course there's a limitation about access by many of these families.

FEMALE VOICE: Quick question. Regarding the 145 sites, if I'm a principal at a school nearby one of these sites and I have a need for a mental health provider to come to my school and I have ten children who are in real big need, am I able to contact one of the 445 sites and request for assistance?

MR. HAJ: So, the mental health professionals are in the clinics, they don't go

to the schools. Because we have contracts with the providers for those specific schools. However, we work with the school system, because its significant funding for mental health, that when we plan where the gaps were, from where we're at to where the school system, we work together. So the school system has significant funding for mental health as well. So there shouldn't be gaps at schools where we have to move people, there should be, every school it should be taken care of.

MS. HOLLINGSWORTH: Thank you. All those in favor?

(WHEREUPON, the committee members all responded with "aye.")

MS. HOLLINGSWORTH: I understand we have another question?

MS. COLLINS: I'm sorry, I need to get some clarification on the recusal issues, my apologies. But I was advised a minute ago that I needed to recuse on 2022-F, because it involved Jesse Trice Community Health. But this one and many of the others all involve health care providers that provide services to women and children at Lotus House on a regular basis,

Citrus Health Network, Jesse Trice, Miami Lighthouse for the Blind, the list goes on. I mean, that's the point of our goals, is to always access health care services that are out in the community. And I just want to get some clarification. I always understood that if we are indirectly benefited, that I didn't need to recuse, but since I just learned about this, I'm wondering if I need to recuse from these various health measures.

MS. KOBRINSKI: I would defer to staff, but generally The Trust is under an adherence of impropriety standard, so if you feel uncomfortable -- it doesn't look like any of the funding is going directly to Lotus House --

MS. COLLINS: No, it's not.

MS. KOBRINSKI: -- for A, at least, so it's going to these health care providers that are providing services in the schools. I don't off the hand see anything, unless staff has learned anything from the contrary to this.

MR. HAJ: I agree. Its providers for school sites. I don't think you need to recuse.

MS. COLLINS: Understood. We have a lot of kids in school.

MS. HOLLINGSWORTH: Thank you for asking.
MS. KOBRINSKI: If that was the standard, everyone would probably recuse because they all have served children in a school system.
MS. COLLINS: I agree. And that applies to all of resolutions for today, pretty much, so that's why I wanted to put some clarification on this.
MS. HOLLINGSWORTH: Thank you. Let's go back to the vote. All those in favor?
(WHEREUPON, the committee members all responded with "aye.")
MS. HOLLINGSWORTH: Are there any opposed?
(No verbal response.)
MS. HOLLINGSWORTH: Resolution carries.
MS. KENDRICK-DUNN: Madam Chair, can I make a comment now that we voted on this resolution, please?
MS. HOLLINGSWORTH: Yes, Tiombe.
MS. KENDRICK-DUNN: Well, I just -- this is probably for the staff, and let me know if this is appropriate or not, but I'm just wondering as far as us as board members, is it possible to, when we're looking at presenting to the board, for us to receive information about health

disparities, social determents of health? And for us to really get a better understanding of the chronic medical conditions, such as allergies and asthma, et cetera, that occur with children and especially of children in underserved areas. I'm just thinking having that information, even if it was a presentation or a packet so that we can have a better understanding of what our -- what are the chronic medical conditions experienced by all children, especially those that are residing in underserved communities, and having a better understanding the definition of social determents of health and the definition of health disparities. So when we're asked to vote on measures such as this, that we have that foundational knowledge. Or background knowledge.

MS. HOLLINGSWORTH: Thank you, Tiombe.

MS. NEASMAN: Madam Chair, I don't know if it's appropriate, if I can say something at this time. It's Annie Neasman.

MS. HOLLINGSWORTH: Yes, please, Ms. Neasman.

MS. NEASMAN: Okay. I know I've been quiet because I know I had to recuse from this resolution, but I want to thank all of you for

the comments you've made and the questions raised. And, Tiombe, the staff has much of that information that you're asking for. I know you're asking for a global kind of assessment of information on this, but it is out there and we do collect a lot of it through the clinics as we're providing the services. And that's across all of these entities. But I just want to echo what Jim said about the future. The future is going to, in my mind, look a little different than it does today. We are looking and exploring quickly all of the digital aspects. I know there's the resolution coming up about pediatric mobile unit, but we do -- we're able to acquire, well we have one and are getting a second, mobile unit, and I think that is going to be a part of the answer for perhaps expanding some of the services in some of the schools. Because you all should know we don't do comprehensive services in those schools, in all of the schools. In all of the schools, but we have them as a theatre type pattern. But we should be able to do more because we were also awarded a telehealth grant for the next two years that will allow us to do some of this.

Jim, I'm really looking forward to some of those discussions as to what we can do in the coming years or as health services are concerned.

And, Tiombe, I'm like you, when I ride through the neighborhoods and I see folks on walkers and canes and know that it has to start early. I'm just excited about what the future will bring. So thank you all for this great discussion. And staff, thank you.

MS. HOLLINGSWORTH: Thank you, Ms. Neasman.

Resolution 2022-B: Authorization to enter into a purchase agreement with University of Miami Department of Pediatrics to support the Pediatric Mobile Clinic in providing comprehensive health services throughout Miami-Dade County, in a total amount not to exceed $100,000.00, for a term of 12 months, commencing July 1, 2022, and ending on June 30, 2023.

May I have a motion, please?

Mr. Dunn: So, moved, Richard Dun

MS. KENDRICK-DUNN: So, second, Kendrick-Dunn.

MS. HOLLINGSWORTH: We have a first and a second. I'm told there are no recusals for this resolution, so we can move into discussion.

Questions, Constance?

MS. COLLINS: Yes, I'm not recusing, but I am disclosing, once again, that Lotus House Shelter guests benefits from these services.

MS. HOLLINGSWORTH: Thank you.

Questions, observations from the committee?

FEMALE VOICE: Chair, just observation. I think it's an excellent program. It's really comprehensive, and I noticed in these services that are being provided, with mental health, due to COVID, a lot of new things are happening because of children being at home doing virtual learning and everything else that has come with it. And I especially like also the training, the services are being provided for more mental health providers to be trained to deal with those new problems. So I just think this is a great opportunity to do outreach to children throughout our county.

MS. HOLLINGSWORTH: Thank you.

Dr. Abraham?

DR. ABRAHAM: Yeah, just a question about this one. I know that it provides vaccinations as well. I assume that going back to the previous resolution, the vaccinations are

available through those clinics as well. It just is a reference to the fact that making sure children are vaccinated, not just against COVID, but common pediatric illnesses, measles, for example, outbreaks of that. That coverage is just very, very important and access to vaccinations for them. So it's just highlighting the importance of that activity as well.

MS. HOLLINGSWORTH: Thank you.

All those in favor?

(WHEREUPON, the committee members all responded with "aye.")

MS. HOLLINGSWORTH: Are there any opposed?

(No verbal response.)

MS. HOLLINGSWORTH: The resolution carries.

Resolution 2022-C: Authorization to negotiate and execute a contract with Miami Lighthouse for the Blind and Visually Impaired, Inc., for a comprehensive vision program, for a term of 12 months, commencing July 1, 2022, and ending June 30, 2023, in a total amount not to exceed $400,000.00.

May I have a motion, please?

MR. DUNN: So moved, Richard Dunn.

MS. HOLLINGSWORTH: Thank you. And a

second?

MS. KENDRICK-DUNN: Second, Kendrick-Dunn.

MS. HOLLINGSWORTH: Thank you. Second is Kendrick-Dunn. I'm told there are no recusals for this resolution.

Constance?

MS. COLLINS: Yes, I'm just going to make a disclosure again, that Lotus House Shelter guests benefit from these services.

MS. HOLLINGSWORTH: Duly noted, thank you.

Moving into discussion, observations from the committee?

Hearing none, all those in favor?

(WHEREUPON, the committee members all responded with "aye.")

MS. HOLLINGSWORTH: Are there any opposed?

(No verbal response.)

MS. HOLLINGSWORTH: The resolution carries.

Resolution 2022-D: Authorization to negotiate and execute contract renewals with three providers, identified herein, to deliver oral health preventive services, in a total amount not to exceed $548,014.00 for a term of 12 months, commencing October 1, 2022, and ending September 30, 2023.

May I have a motion, please?

DR. BENDROSS-MINDINGALL: Move it, Bendross-Mindingall.

MS. HOLLINGSWORTH: Thank you. And a second?

MS. GIMENEZ: Second, Lourdes Gimenez.

MS. HOLLINGSWORTH: And I understand that Ms. Weller and Ms. Neasman, are recusing this resolution?

MS. NEASMAN: Yes.

MS. WELLER: I'm recusing, I work for the health department. It's Karen Weller.

MS. NEASMAN: And I recuse. It's Annie Neasman with Jessie Trice.

MS. HOLLINGSWORTH: Thank you. Thank you. Moving now to discussion -- yes, Constance?

MS. COLLINS: I want to make a disclosure that Lotus House receives services from the Florida Department of Health and Jessie Trice Community Health System.

MS. HOLLINGSWORTH: Noted. Thank you.

Committee members, the floor is open for discussion, questions, observations.

(No verbal response.)

MS. HOLLINGSWORTH: Hearing none, all those

in favor?

(WHEREUPON, the committee members all responded with “aye.”)

MS. HOLLINGSWORTH: Are there any opposed?

(No verbal response.)

MS. HOLLINGSWORTH: The resolution carries.

Resolution 2022-E: Authorization to negotiate and execute a contract with the Public Health Trust of Miami-Dade County, d/b/a Jackson Health System, in partnership with the University of Miami Miller School of Medicine, to implement Miami’s Injury Free Coalition for Kids, in a total amount not to exceed $408,000.00, for a term of 12 months, commencing October 1, 2022, and ending September 30, 2023.

May I have a motion, please?

MS. KENDRICK-DUNN: So moved, Kendrick-Dunn.

MS. HOLLINGSWORTH: Kendrick-Dunn for the second.

DR. ABRAHAM: Second.

MS. HOLLINGSWORTH: Abraham for the first.

And I’m told there are no recusals for this resolution.

MS. COLLINS: I’d like to make a disclosure on behalf of Lotus House benefiting from the

services provided by this program.

MS. HOLLINGSWORTH: Noted. Thank you, Constance.

Discussion, observations from the committee?

MR. HAJ: Madam Chair, one comment. We have requested the bus be out front for the board meeting, so if you can come 15 minutes early to the board meeting, it will be right in front where you walk in. So you can tour the bus on two Mondays from now.

MS. HOLLINGSWORTH: Exciting. Thank you.

MALE VOICE: I just have a general question, Jim. How well is this program and the other -- how well are they integrated with the school clinics? It seems to me that there's a natural overlap here between these programs, what the clinics are doing. I'm just wondering how well they are put together.

MR. HAJ: The school clinics meet regularly. Through that we have the regular nurses with the school clinics, then we also have the mobile units. And we have five, six, six mobile units. So we have different groups that are reaching out to the community. Injury prevention, this bus has been -- I can't even remember, we funded a

year and a half ago, it is just getting going now. That's why we're kicking off -- the brand new bus will be here, I think this is the first time that people see it and its getting onto the street. But the injury prevention also was just not about the bus but working together with the community and marketing and pushing out for parents. We all know that the injury prevention is the leading cause of death for children. So how do we get the marketing, the social media, educating parents, not just on the mobile unit, but community wide. And we do that with the bus, with our communications department, with Jackson, with ourselves, as well as partnerships with the school clinics and everybody else that you talked about, that we're making sure that we're working very well together.

MALE VOICE: That's great. Thank you.

MS. HOLLINGSWORTH: Thank you.

Further questions?

(No verbal response.)

MS. HOLLINGSWORTH: Hearing none, all those in favor?

(WHEREUPON, the committee members all responded with "aye.")

MS. HOLLINGSWORTH: Are there any opposed?
(No verbal response.)
MS. HOLLINGSWORTH: The resolution carries.
And our final resolution, Resolution 2022-F: Authorization to negotiate and execute contract renewals with five providers, identified herein, to deliver public benefits enrollment, in a total amount not to exceed $730,750.00, for a final term of 12 months, commencing October 1, 2022, and ending September 30, 2023.
May I have a motion, please?
DR. BAGNER: So moved, Bagner.
MS. HOLLINGSWORTH: Thank you, Dan.
And a second, please?
MS. KENDRICK-DUNN: Second, Kendrick-Dunn.
MS. HOLLINGSWORTH: Thank you. And I have Constance and Annie for recusals for this resolution?
MS. NEASMAN: Yes.
MS. CONSTANCE: Yes, recusing, but also, again, this is an indirect benefit to the shelter at Lotus House. We don't receive funds from this grant.
MS. KOBRINKSI: I don't have the ethics opinion from the commission on ethics last year,

I'll just reiterate The Trust conflict of interest policy, is that Trust board members shall not vote on any matter presented to The Trust board, if the Trust board member will receive a direct financial benefit from the actual board. And the Florida statute on voting conflicts also, provides that a Trust board member shall not vote in an official class upon any measure which would, inure to his or her private gain or loss or he or she knows would inure to the special private gain or loss of any principle by whom he or she is retained or to the parent organization or subsidiary by which he or she is retained or would inure to the special private gain or loss to a relative or business associate of The Trust board member. And additionally, again, it says, it all depends board members and staff act in such a manner to avoid the appearance of impropriety. I have not seen the commission on ethics that advises that -- I don't know if it was a requirement or just a recommendation. Staff knows, but again, I don't see any direct conflict.

MR. HAJ: No, the recommendation was for Constance to recuse.

MS. COLLINS: I do want to be clear on the record that I serve as a full-time volunteer and receive no compensation from Lotus House in my capacity as a board member or as an executive director. And Lotus House does benefit from services provided by many agencies including Citrus Health Network, Jessie Trice Health Systems, University Of Miami, Florida Department of Health, Miami Lighthouse for the Blind, Lincoln Health Centers, and many others. I think it might be helpful to get some further clarification on this because it probably impacts just about everything I do.

MS. HOLLINGSWORTH: Thank you, Constance.

MS. KOBRINSKI: So just for the record, you are recusing just out of an abundance of caution, but I think it is worth discussing with the Commission on Ethics going forward.

MS. COLLINS: Yes, thank you. I am on this particular item, but making disclosures across the board and see if we can't get some clarification.

MS. HOLLINGSWORTH: Noted.

Committee members, floor is open for discussion, observations.

(No verbal response.)

MS. HOLLINGSWORTH: Hearing none, all those in favor?

(WHEREUPON, the committee members all responded with “aye.”)

MS. HOLLINGSWORTH: Are there any opposed?

(No verbal response.)

MS. HOLLINGSWORTH: This resolution also carries. And with that, I’m turning the floor over to Dr. Hanson.

DR. HANSON: Thank you. Okay, thank you everybody.

I just want to go over a few highlights to make the point that a lot of you have already made and that was reflected in the discussion that we had after Juliette’s portion, which is, health is more than just what we fund through our health budget category at the Trust, right. When you budget, you have to put things in buckets and that’s not usually how real world works. So I’m going to talked about some of the items that you see listed here. I also just want to go back and actually say that of the six resolutions you just passed, only one is focused exclusively on school-aged. All the other five include the full

developmental continuum in terms of assisting families with benefits, injury prevention. Of course early childhood is a high time of injury risk. So all of those, in addition to the one we mentioned earlier with the vision and the oral health services, and as well, the pediatric mobile clinic doesn't have an age limitation. So what we do have, a number of other things that are health services that are funded in other budget categories, such as early childhood, such as our youth development category and as well in our parenting and neighborhood supports.

So I'm going to kind of go through some of those highlights of the services that are funded so that we can have a more comprehensive discussion. And I'm going to also include some -- just basic overviews related to our policies and definitions related to serving and supporting children with disabilities because that's come up in a few different meetings. And then I'm going to just give you some dry technical background on procurements that are coming up and what our timelines are looking like.

So, first area is really this developmental screening assessment and early intervention.

This is part of our Thrive By Five investments. And many of you who are in this world, you already know that there are federal funds that come through states to support early intervention services. Those are managed through the Department of Health. They include things like physical therapy, occupational therapy, speech and language services, other developments on behavior and supports based on the delays that are seen between the time of birth and school entry. The system transitions at age 3 from one system to another and then into the school system for evaluations later.

We know that picking up on things early, whether it's a physical health condition, a social or emotional or other type of condition, you guys already made this point, the earlier you can start, the more likely you can get back on a positive trajectory for children. All of our -- so just in terms of screening, how does screening happen in our community, all of the school readiness programs that are funded through the early learning coalition in our community, all of the head start and early head start funds, which by the way were one of the counties in the

country that has one of the largest allocations for head start and early head start, we can still use more, believe me, but we have a very large allocation. And we also have Trust funded childcare scholarships that fund certain kids. All of those places do regular screening for child development and as well as focusing on social emotional development. And they of course make the requisite referrals into the state systems, which are early steps and the Florida diagnostic and learning resource system, also known affectionately as Fiddlers. Most people know it by that name.

So those systems, in addition, when we fund a parenting program, let's say that it has parents of young children in it, like our home visitation programs, we also require developmental screenings. So just in the Trust programs that we funded last year, more than 7,600 kids got screened. And so the three things that we have specific funding for in our budget are listed there. Some of you know that we fund specialized autism assessments through UM Nova - Center. Then we also have a short-term early intervention service for mild delays, right.

So one of the things that the state did a while ago now, probably a decade ago, is that they raised the criteria to qualify for early intervention services from being one and a half standard deviations away from the mean, to having to be more than two standard deviations away from the mean. This caused a little bit of a gap. Kids who have some delay, maybe mild, but could benefit from early intervention, we created early discovery as the program operated through the University of Miami and that has grown. They had a waitlist. We added funding probably five or six years ago and its very connected in with the systems, the early step systems, and the fiddler systems. So they know they can navigate families when they don't meet the state criteria, they can refer them into that short-term service program.

The third one is really another gap that exists. So when kids are past that two standard deviation and they do qualify for state services, many times those services are only available on an academic school year calendar. And if you know anything about early childhood, you know that a gap of two, three, four months in the summer is -- really doesn't make sense, right,

it's a time for refreshing, it's not a time to stop early intervention. So we also fund therapeutic early intervention summer day camp programs. Some of the providers are the same providers that provide those services through the state funding, such as Easterseals, the Ark, the Debbie schools, some of those programs that are really serving the high need populations of young children with serious needs.

So these are three of the things we fund health related within our early childhood. I don't have this on my slide, but I should -- oh no, it comes later, sorry. Sorry, I'm getting a popup here. So in our youth development programs, as you know is one of our largest investments, our afterschool and summer camps, especially for our elementary kids, we realize that things like healthy nutrition and physical activity are really important and these are things, that in our country, all of us don't do very well. We are junk food junkies and we like to sit on the couch and watch TV or the kids like to play video games.

So all of our afterschool and summer programs are required to have regular physical

activity component as part of their services. Many of them use evidence-based programs like Spark, some of them actually are specialized in some type of activity, like a dance program, where there kids are getting that physical activity. And you all have seen that we fund Flipany to be our food sponsor for the afterschool meals program that comes to the USDA, that helps us to leverage healthy foods and snacks, as well as suppers, actually, for some sites that have a demonstrated need to give kids healthy nutrition in these programs and beyond.

So another area that's really cross-cutting in our budget addresses -- are ways that we address through different programs, trauma, mental health, and just sort of preventive social emotional wellness supports and needs. These are embedded throughout, you heard already, some of our health programs, so in the school health program we don't just have nurses, but we have mental health professionals and social workers and we work closely with the district staff around mental health because they have a very large office. Through our early childhood, we have investments and through parenting and our

family and neighborhood supports.

The other place where we fund some specialized investments in this include both our innovation fund, where we have special projects that might have this focus and our early childhood community research partnerships. Some of those studies are really focused around these areas. So I already mentioned school-based health has a range. The mental health staff within school-based health provide a range of services, so sometimes they're just doing preventive school-wide education campaigns. Those are done in partnership with the school leadership, those are determined with partnerships through the school leadership and they're tailored through the school's needs.

So if a school is having issues with some suicide prevention, let's say, they might bring some supports in education or they might have some other issues around drug use or vaping or other types of things that intercept with mental health and wellbeing. But these professionals are licensed mental health professionals, so they also can go all the way to the other end of being there for crisis intervention. And then in

between as well, right, some short-term mental health counseling, some of them might do some group counseling as well as individual -- Juliette mentioned we they have kids who need more ongoing therapy, they're making those connections to the community, providers for those services.

And Jim already mentioned, too, that a few years ago we added about 40 mental health professionals to the school health teams, in addition to the social workers that we already had in that initiative. Then, this is what I was thinking of earlier, with our Thrive By Five quality improvement system, one of the key components really is an infant and early childhood mental health consultation component. So in this case, UM partners with a few subcontractors that include Family Central, Community Health of South Florida, and Jewish Community Services. And together those four agencies have 26 different consultants that are trained specially in doing mental health consultation. And through that, they actually work with the directors of programs, talking about policy, making sure we're not expelling our

kids, when they're two or three years old, for inappropriate or aggressive behavior. They're working with teaching staff in the classrooms, so that actually if they have a kid that they're learning new techniques with, the teachers are actually learning techniques, they're going to help all the kids and all the kids that come after that. And then of course they also do work with the children and the families when there's a specific child having particular issues.

Another area where we talk about social emotional wellness and awareness is an area that we -- that you all approved additional funding for in the coming year and its actually out in an invitation to negotiate right now as a part of our Trust academy partners. We are really looking at social emotional wellness and awareness to help create the environment that will be supportive of our racial equity and diversity inclusion training and awareness. So that needs to make people comfortable with themselves, comfortable with their surroundings and environments, and have that wherewithal to have those kinds of conversations and put the things in a clear way, so that they can be doing

continuous learning in their programs and supporting children to have that ultimate goal of improved wellbeing for the children that they're being served.

I mentioned before our parenting programs. We also have some that are called family strengthening that go more into the clinicals. So this is a continuum of services from universal prevention, again, our parent club giving basic workshops and education and awareness for parents, shorter term group intervention programs where parents learn about how to have positive parent-child relationships and interactions, communications, appropriate developmental expectations, all the way through to those that might be more ongoing, like a home visitation program might follow and work with a family over a two to three year period. So some of our clinical interventions that support family behavioral health, are actually family therapy programs, such as trauma focused cognitive behavior therapy and parent-child interaction therapy.

The care coordination aspect that we provide is also through our family and neighborhood

support partnerships that do the individualized wraparound coordination. They address a number of special populations, as well as communities that have high needs, to really build resilience and really to counter the effects of adverse childhood experiences. And we are currently, you know, as part of the prep for the new cycle that will start next October, we are in the process of building out a care coordination and community referral tracking system. That will be used be used by all the programs that get funded in the new cycle. And that will help us also to track more of the connections being made in the community or identify, perhaps, systematic, dysthymic, barriers to certain things that are needed in the community.

And then, of course, you probably all know that The Trust is one of the primary funders of the 211 Help Line that's operated through Jewish Community Services. That provides 24/7 crisis counseling, as well as the information and referral information that we mostly, usually, highlight that side of things more, in terms of people getting connected to basic needs or mental health services. But the suicide prevention and

crisis counseling, all of that, is available in three languages. And in multiple methods too, they have the phone, but they also have texting now and other methods of reaching people.

I'm trying to decide if we should pause here before we go into the Children With Disabilities stuff. Or should I just go all the way through and have questions at the end?

MS. HOLLINGSWORTH: Do you want to pause?

Any questions about what Dr. Hanson has presented thus far?

How about those that are attending via Zoom?

All right, let's go.

FEMALE VOICE: Madam Chair?

MS. HOLLINGSWORTH: Yes?

FEMALE VOICE: I did have a question. Excuse me.

With regard to participation and the parenting programs, we all know how difficult it is and a challenge for parents to get involved in PTA meetings, and in their children schooling in an active matter because of work and other obligations, but how important it is that they do so for the child's wellbeing. So, I'm wondering, have we seen an increase, a decrease, has it been

stable in terms of parent participation in our parenting and strengthening families programs?

DR. HANSON: You know, one of the interesting things that came out of the pandemic was that all of our programs now know how to deliver their services, you know, through virtual mechanisms. And so I think while we did see a decrease, you know, net decrease overall through the pandemic and the numbers that were served, in parenting we actually have a number of programs that are saying they're engaging more parents because they don't have the traffic, some of the other barriers that make it difficult for people to come to an evening class, for example, on a weekly basis.

So, we are really looking forward to learning more about that as we go forward. Because we know that the in-person engagement, also, is clearly, is powerful in those interventions. And I think, yeah, I think it's more of a challenge on the preventive end. But once parents are kind of having challenges, that increases their motivation to engage in something that's going to help them with those challenges. So I think we have, you know, a bit more

challenge on the one side of the continuum than the other, in terms of the engagement.

FEMALE VOICE: Right, and I'm sure that in the next normal we will continue to have this hybrid opportunity, in-person as well as virtual, since we've seen --

DR. HANSON: Yes.

FEMALE VOICE: -- that virtual really does open up access to everyone --

DR. HANSON: Yes.

FEMALE VOICE: -- really participating.

DR. HANSON: We have. We have. We are trying to set expectations to still keep some in-person, but we -- we're not expecting to go back to 100 percent in-person. Absolutely.

FEMALE VOICE: Great. Thank you.

DR. HANSON: Yes.

MS. HOLLINGSWORTH: Thank you.

Let's go on with the second part, please.

DR. HANSON: Okay. So, I just did want to clarify, because I think we have, you know, we have some new board members since, as Karen mentioned, we met almost two years ago, or about almost over two years ago, where we went into detail about The Trust definitions and policies

related to supporting children and youth who are living with disabilities. And you can see, on here, oh, the bottom part of my slide is not show, but these definitions have been in place since 2004.

The founding of The Trust had many strong advocates on our board who were part of setting this in place, as part of The Trust foundational policy. So we have always wanted to attend to the needs of kids from a wide variety, you could see all of the domains there that are a part of the definition.

On our website we actually have a more detailed set of definitions and when things should be reported. We have a child registration form that you could see, I'm going to show you a slide, in a minute, that shows you how some of the questions are asked of parents. Because we did make a change to that around probably 2000, I don't know, I don't want to say a date. But, a couple cycles ago, we changed how we were asking the questions to be more parent friendly. Because the first set of questions was just sort of like, does your child have a disability, you know, what documentation do you have of it? And

a lot of people, I think, said no, even when they maybe did, because we didn't give the context, why is this relevant, the reason we want to know is because we want the programs to help your child and meet their needs. So we have some more family friendly questions now. And we did see that the percentages changed when we switched those questions around.

So, on the form we do still ask about what conditions parents, kids might be having that are expected to last for more than a year. This is a self-report from parents. We're not collecting, you know, doctor documentation or IEP's, but we're asking on the registration form about the child's conditions and needs.

When we have a program that focuses on serving the parent, like the parenting programs and the registration form is about the parent, we ask the parent how many children they have in their care that have a condition expected to last for more than a year, that makes it hard for their child to do things that other children the same age can do.

And then you can see here the categories. In developing these questions, we worked closely

with several of our community providers that have this as their area of expertise. So the Advocacy Network on Disabilities consulted with us on developing these questions, as well as the FIU's Center for Children's and Families, at the time, Dan's predecessor contributed to the development of these questions.

So what we ask right now is, we ask them first, what, if any, help their child is receiving. So we ask about whether their child is already in OTPT, speech therapy, you know, counseling for emotional concerns. Again, it's may be a little sensitive to ask about those things, but this is all in the context of leading to what kind of support do you need to make your child's participation program successful.

So we ask about what supports they're getting. What conditions, we saw on the previous slide, that would be the list on those conditions. And then, the options to support your child, we have lists of accommodations that range from, you know, things like help holding a crayon or a pencil or fine motor type supports, to gross motor supports around the physical therapy requirements that we have in our

programs, how they might need to be adapted. Managing their feelings or behaviors. Using assisted devices. Activities that take into account visual or hearing impairments and also learning and reading activities or supports, are some of the accommodation areas that are discussed.

We also encourage our -- oh, if I'd looked at my notes, I would have seen that in 2015 is when we changed the questions. But we also have -- the Advocacy Network on Disabilities has a form that's called The Getting To Know Me Packet and we encourage -- that goes into even more detail than we would collect. But it's helpful information about the program we could use on getting to know that child's individual preferences, challenges. So they work with providers and recommend using that to help make the services inclusive.

And this a lot, I'm not going to read all of these, but just to kind of convey that across everything we fund, we require the inconclusion, the full inclusion, of all children, right. And all children includes children who have all sorts of different challenges in their life, including,

perhaps, living with a disability of some kind. So, we provide support for that, as you know. If providers are challenged in knowing how to do this, we have technical assistance through our Trust Academy. We do go up to the age 22, if -- for older youth, if they are still in school and having -- wanting to have participation still.

Depending on the initiative, we set different benchmarks of what's accepted in terms of the numbers of kids to be included. Of course, as children get older, they're more likely to start to experience these things. So, very, very, young children, the rates are lower of disabilities, different types of disabilities. And it goes -- so you'll see like some of our earlier childhood programs, the percentages might be a lower benchmark, as we go into school age. The floor is ten percent. I don't really know that we have anybody that is at that point, because what we do is, we look at the programs history, so like if the last three years you served 15, and 18, and 20 percent, we're going to negotiate a benchmark that continues at that level. That's expected based on what you typically see coming through your program. And

then, of course, many of our initiatives that focus on this as an enrollment criteria, some of them are 100 percent. Because they know that all the kids, for example, the short-term early intervention program that we talked about earlier, all of those kids are having some sort of delay. Some of our programs, also, within youth development, are specialized around serving a particular need or challenge. And so that's part of their enrollment criteria.

And some of the clinical interventions that we've talked about as well, right, they're not just going to have anybody come and go to trauma focus cognitive behavior therapy, right? There's probably some diagnosis involved there and some challenge. So those percentages seem, usually are much higher. And I'm going to show you that here.

This is actually straight out of our annual report. Just a plug, if you didn't get your copy at the retreat, this is a wonderful reference book to have. It's got lots of charts in it, and anything you probably want to know about, it's got something in there.

So, you could see here the range. The

bottom one you might be like, why, how come benefits enrollment is so low? And I'm going to tell you, that's because they don't ask the questions as much, right. They're asking them for lots of information about income and other types of things that they have to do to verify enrollment in health insurance or DCF benefits. And they, I, think this is a training issue for our providers, just for them to collect, to ask the question in a way that they're going to collect this information. So, I think that one is an outliner, but you could see we have, you know, a pretty strong support for children's with disabilities across our initiatives.

And then you might ask, yeah, but when you say you're serving kids with disabilities, what does that really mean? Who are you serving, and what kinds of kids are you serving? And so, this is just from last year, the top five challenges that were reported. So you can see attention and hyperactivity is more, about a quarter of the kids. But we also have a significant portion that are experiencing something on the autism spectrum or a speech language issues. And some of the other things there. Of course there are

other conditions that are lower percentages that are listed there.

And we have had prior discussions. In fact, at that last meeting in December of 2019, the Board approved for us to do a pilot of looking at adding program inclusion and funding to support children with significant and multiple support needs, right. So, kids that we know have big challenges, and sometimes may be attending one of our programs. And a story we might hear might be, the child in the wheelchair, or with some physical limitation might be told, on Friday we're going on a fieldtrip, so you need to stay home because we don't have the money to rent the bus that has the wheelchair lift.

So, you know, this is a hard budget item because that program, you know, didn't know to budget for that, if they didn't know which kids were going to show up to their summer camp, let's say. So we figured what we need to pilot, and what the Board approved, was an additional $200,000 that was actually managed separately outside of the contracts and that that funding would follow the kid. So that is managed right now throughout Advocacy Network on Disabilities.

When a provider calls up and says, hey, we now have -- another story, actually, from last summer, we have a deaf child who wants to come to our summer camp. Okay, let's find a sign language translator who can be at your summer camp, and by the way, they were then able to enroll six kids with hearing impairment, who participated in the summer camp because they had the sign language translator. But that wouldn't have been something that that program could have peaked out of their budget, right. So this is layered on funding.

So as you can see is we launched it sort of right before COVID. And then, of course, all of our programs shutdown. So the program inclusion aspect of it had a slow startup. But it's really catching up now. Last summer there were lots of examples in addition to the one I mentioned. They have several children who were having such strong behavioral problems that they were about to be suspended and kicked out of the after-school program that they were in. And they were able to bring in a behavioral analysis therapists to work with those children's behavior. And while they're on site, they're training the staff

in the programs on how to use these appropriate behavioral techniques. And those kids are all still in the programs now. They haven't been put out of the program.

So those are the kinds of things that they're funding for program inclusion. But one of the other benefits that came out of us having a slow start on the program inclusion side is that there was a really strong need for in-home support, right, respite care for parents of children that have these significant needs that it's such a stressor in the household. And so we were able to also incorporate in-home supports through these funds. And that's been going very well. We fully extended the funds last year.

Another just note is that they're finding that most, more than half of the families have more than one child that has a significant need in the family. So even the more reason to support those families. And just planting a seed, that since that was a pilot, and $200,000 doesn't go very far when you're talking about the types of needs that we're talking about, you know, this is a space where there can be potential expansion for funding. And so, as

we're looking at our budgets and available funding, you know, you may be hearing about this piece again.

Okay, I'm going to pause -- well, I'm going to go ahead, I have two more slides about procurement methods and timelines, then we'll go back to discussion. So, just, you know, hopefully we made the case that health is about any programs that we're investing in, not only the health budget items that you had in the resolutions this month. And I just wanted you to be aware that we have, in our procurement policy, which is modeled after the State procurement policy, there is an exemption to the competitive solicitation process for health services. Our exemption reads, that it's for prevention services related to mental health, including drug abuse prevention programs, and child abuse prevention programs, and health services involving examination, diagnosis, treatment, prevention, medical consultation, or administration as a part of The Children's Trust funded health program.

So, to put this in context, we have about four of our health services that currently use

the procurement health exemption from competitive solicitation. We have another four that you have approved recently, or will be approving at the next board meeting, that aren't currently under a competitive cycle because they were procured through competitive process. But that we're going to be -- we want to give you the heads up that we're going to be applying the health exemption in the coming year. I'm going to talk about the reasons for that in a minute. But we need to tell you this now because if there's any concern that you have about that we need to know because we have -- you heard in the retreat, the type of runway that we need to put out a competitive solicitation. So it's between nine and 18 months, right, depending on the extent of the complexity of the solicitation. So we want to make sure that you are aware that we're going on this, this assumption that we're going to be bringing school health services, oral health prevention, a short-term early intervention, and a summer early intervention services for their next renewals under the health exemption. We will still have six that are remaining under competitive solicitation process.

And, you know, why, why are we doing this and why some of them? And some of it has to do with your discussion earlier, even about school health planning, right. So we know that there are -- there are significant changes in the field around virtual delivery, around, you heard about the mobile services. And we also would like to expand our reach within school health to beyond those schools that we're in. But also making sure that we're doing it in coordination and collaboration with the major partners of the school system and the health department. So all of that type of planning really takes time. We want to make sure that we have that time built in to explore the best way to expand school health services.

And then for the others, it's really about continuity of care. The maintenance of some established infrastructure. So you heard me talk about how some of these things are meant to sort of plug in seamlessly. To, okay, you didn't qualify for the State early intervention services, go here, right. Not just like, sorry, and a door closes and you have to find your way to some new place, right. So we want to maintain

that connected infrastructure. You heard Jim mention that they've built out the capital buildings in the schools for the sites. You know, so that's, you know, you wouldn't want to just walk away and then put, you know, build new clinics somewhere else and have those not be used. So we need to make sure that we pay attention to those established infrastructures and the referral system connections.

So, the last slide is probably more information than you need or want to see, but it's just to give you the details behind of what I just said. It's showing you the list, the first six are the resolutions that you had today. So you can see that out of those six, three of them are under competitive solicitation. Five, which is typically a five-year cycle. The health exemption, by the way, is applied on an annual basis, so it's not a guarantee forever. You know, we could come back and say, oh, we've reworked the model, we have a new plan, strategic plan, going forward for the community for school health. And then maybe we would offer competitive solicitation again, right, when the time is right for that.

So you'll see that we're planning those for next year. And then you have all the ones that I went through with you. Some of them are out for solicitation now, such as the social emotional wellness. The parenting and family strengthening are on the list for next year. You guys talked about that one at your board retreat. The family and neighborhoods support partnerships are out right now. You guys approved the food and nutrition last year. And then, what you see, a little note there about the Thrive by Five QIS is the infant mental health, is a piece of that broader system. And, if you recall, in, I think it was January resos, we brought the QIS system for a procurement waiver. Because all of those connected pieces that were part of the system.

So, I'm happy to take any questions or comments on any of the sections that we went through around the health programming or the children with disabilities. I also have, if anybody wants to look at it, I could send you the link online or I could show you the copy of the registration form we use for children to ask the questions about disabilities.

FEMALE VOICE: Through the Chair, I have a

question. Lori, regarding the children we know that are registered and attending a program, per early intervention children that are birth to maybe four years old or three, I can see it's easy for the caregivers there to be able to identify the child has some type of developmental delay and refer him for screening and potentially to receive services of intervention. Do we have any data? Do we know if the children who stay at home with a parent or grandparent, may also have some type of delay, are they coming to us to find out, you know, can we have our counseling, you know, whether it's behavioral or whether it's another type of developmental delay that they have?

DR. HANSON: Sure, that's a great question. For those kids that don't go to formal childcare settings, right, is what you're saying. And I think that the key partnership for us in that is the pediatricians office, right. So we're in a number of clinics through reach out and read program, as well as a program through parenting called Healthy Steps, that actually put developmental therapists in pediatrician offices, in high need areas. And of course, in a perfect

world, all pediatricians are doing screenings and anticipatory guidance, and are connecting families. We know that doesn't always happen, but that's where we really are trying to have those connections through the pediatric environment, because hopefully at least the kids are going. That's one regular place that all kids should be going.

MS. HOLLINGSWORTH: Thank you for the question. This is excellent, Lori. Comprehensive and really gives us a look at the continuum, as well as how the system integrates within itself.

DR. HANSON: And if I can add, speaking of system integration, I think I would be remis if I didn't say that there is, because we were talking about healthy, the very important issue of health disparities and collaboration across the community and our committee, health committee chair is actually, I think, at the Health Department. Your office is the office that really operates the collaborative community planning group, which help, forgive me, Karen, because I'm forgetting the name exactly, but there's a cross disciplinary group that for years

has planned around coordinating health services and you're actually expanding on that with your CDC disparity funding now, correct?

MS. WELLER: That is correct. We were able to, under the office of community health and planning, we expanded to have a health equity office. And we are working a lot with the disparities and trying our best to coordinate all the services so that we're not duplicating. And so we're expanding and hope someday we'll be able to share everything that we're doing. But, we are expanding services and working, of course, with The Trust and with so many of the providers. So, we're excited about that. But we are looking to meet the needs of the disparities that are present in our community.

Thank you, Lori.

DR. BAGNER: Through the Chair, I do have a quick question for Lori, or a comment as well. So the overview, that was really helpful, in particular to defining children with disabilities. So, my comment really is, you know, I think our definition is very broad, which is a good thing, in many ways, because it includes a lot of different kids who are

challenged, who have a variety of different challenges. On the other hand, though, I think sometimes we may have this, quote, 10 percent cutoff, or whatever that cutoff is determined, limited by that broad definition. And so, I wonder if there is a way, I like that slide where you highlighted the most common disabilities, and so, I'm wondering if there's a way that in addition to the incentive-type program that you talked about, right, that we could do more of that. For example, if we have a summer camp, I know we have a summer camp of kids with ADHD, right, so 100 percent of those kids are eligible for camp and then that program reports that 100 percent of their kids have a disability.

With that said, kind of similar to what you were saying, Lori, kids with any physical disabilities, maybe no children in that camp with a physical disability. And wouldn't it be great if we as The Trust could identify that as an example and provide some sort of incentive for that program to include more of kids with physical disabilities. I'm just using that as an example, but I think if we could get it down to more specific disabilities, so we can identify

some gaps and kids with certain disabilities that are not included in certain types of programs, that we could try to increase that and improve that.

DR. HANSON: Absolutely. That's really the name of that pilot funding, and the Advocacy Network has really helped us use their network with parents to identify those kids that might have multiple disabilities, for example, like what you're mentioning, and greater needs. And probably you need to see this whole chart that has all of the listings, because it doesn't mean there's nothing, other than these five, these are the top five. And then we could track the numbers, perhaps, instead of percentages that we're increasing in some of those more complex conditions.

MS. HOLLINGSWORTH: Thank you.

Well, I want to thank all of you for showing up today, leaning in for the rich discussion. I'm going to punt it over to the Ad Hoc Committee Chair.

MS. WELLER: I'm just going to give a brief summary. We have heard The Trust health investments -- for our health investments and to

raise the Board's awareness of the use of the health programming exemption for all the reasons that were highlighted earlier. And, Lori, thank you so much for presenting and to everyone for presenting the information today. And with that, we're adjourned. Thank you, everyone.

MS. HOLLINGSWORTH: Thank you.

(Whereupon, at 11:00 a.m., the meeting was adjourned.)

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Christy Caldera, Transcriber

April 4, 2022