



Children & Families
Commission of Orange County

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**Agenda Item No. 6
November 7, 2007 Meeting**

DATE: October 30, 2007

TO: Children and Families Commission of Orange County

FROM: Michael M. Ruane, Executive Director 

SUBJECT: **School Nurse Initiative – Year 3 Evaluation and Implementing Funding Actions with Participating School Districts**

BACKGROUND:

In 2004, the Commission established the School Nurse Initiative to increase the provision of health services to young children and their families. The School Nurses provide health care services, education, referrals, outreach, and developmental screenings to children ages prenatal to five and are an important component of the school's education team. Authorization is now requested to further refine the School Nurse Initiative to address current challenges and better accomplish the goals and objectives of the program.

SUMMARY:

As in the first 2 years of the School Nurse Initiative, the Commission contracted with Evaluation and Training Institute's (ETI) to review the School Readiness Nurse Initiative to document the degree to which services met Initiative objectives, and barriers to achieving intended results. Overall, the school nurses continue to be successful in carrying out their scope of work. Families were screened for health insurance and medical home status; resources were leveraged by collaborating with health-related organizations, community clinics, family resources centers, social programs and other health professionals; and health awareness was raised through relationships with community daycare and childcare centers.

Important findings in the Year 3 evaluation report include:

- School nurses continue to meet the greatest number of immunization needs compared to all other services. *Of the 6 percent of children with incomplete immunization records, 97 percent became fully immunized as a result of School Nurse efforts.*
- School Nurses were more successful in Year 3 with identifying those in needs of medical home referrals: *Of the 11 percent of children in need of a medical home, 97 percent were referred and 38 percent of those referred were registered with a primary care provider.*
- The percent of children with known needs met was higher in Year 3. *This was true across all health referral categories by an average of 21 percent over Year 2.*
- Outreach efforts doubled those of year 2. *Visits to community daycare and recreation centers were cited most often comprising 59% of outreach to public locations.*

- School nurses conducted / coordinated over 10,000 hours of health related instruction through Orange County in FY 06/07. *Classes on nutrition, safety, hygiene, health education, and dental health comprised over 81 percent of the total hours of instruction.*

Documented program challenges include:

- The scope of practice is difficult to implement in some school districts based on the nurse to kindergarten enrollment ratio. *This concern was addressed in part by the Commission's June 2007 action to improve school nurse / student ratios. Districts are in process to recruit and fill the new positions.*
- School Nurses have been working to improve their success in making sure that a child's needs were met when they were referred for follow-up services. Follow-up efforts ranged from one to seven contacts per child, and an average of three attempts per child. On average, School Nurses spent two hours conducting follow-up activities in their attempt to ensure that each child's needs were met. Given the number of referrals made across districts, a School Nurse spends approximately 25 percent of her time on follow-up activities. *Commission staff will continue to work with districts to access interns, VISTA members, and other resources to extend the professional School Nurse time by conducting follow-up, respond to telephone inquiries, provide translations, and conduct Height /Weight / BMI screenings. Commission staff will also continue to work with School Nurses to identify approaches to streamline data collection.*
- Some School nurses felt ill-equipped to undertake the kind of outreach that the Initiative requires of them. *Commission staff and School Nurse Leadership will continue to enhance an active partnership and communications with Public Health Nurses who work in the field.*

School Nurse Staffing Costs

For most school districts, school nurse salaries are paid on teacher pay scales with higher salaries provided for nurses based on years of experience and degrees. Although the Commission was able to assist in recruiting nurses new to the school nurse profession, most of the current school nurses have significant experience and advanced degrees, including many that are pediatric nurse practitioners. In June 2007, the Commission took action to address this increasing district expense. Since that time, Commission staff has continued to review salary challenges that districts are experiencing due to hiring tenured staff with extensive experience in pediatric practice. Currently, six school districts have nurses whose salaries are 15 – 20% above the Commission's prior maximum allocation.

By prior Commission action, your Board approved a 10% budget increase and authorized the Executive Director to increase a contract by 10% of the maximum obligation. To address the School Nurse Initiative staffing expense issue occurring with a few school districts, staff recommends that the Executive Director be authorized to increase an individual School Nurse contract by an annual maximum obligation of up to 20% to compensate for the increased staffing costs. Increased funds will only be authorized for payment to districts following confirmation that the funds are required by the district for nursing staffing costs. The combined total of amounts in these Amendments to Agreements will not exceed 10% of the School Nursing Initiative budget.

STRATEGIC PLAN & FISCAL SUMMARY:

This program has been specifically reviewed in relation to the Strategic Plan and is consistent with the Healthy Children goal, among others. Funding will be available within the Commission's amended School Nurse Initiative annual budget total of \$3,118,586. The long-term funding for the school nurse staffing program will also be included in the update of the long-term financial plan and the outside strategic assessment currently underway.

PRIOR COMMISSION ACTIONS:

- June 2, 2004 - Commission adopted a resolution to authorize the Executive Director and Commission Counsel, or designee, to amend contracts to increase the maximum payment obligation in an amount not to exceed ten percent of the maximum payment obligation.
- June 27, 2007 – Commission authorized amended School Nurse Initiative contracts to add nurse positions and adjust staff compensation to align with district pay scales.

RECOMMENDED ACTIONS:

1. Receive the Implementation Evaluation of the School Readiness Nurse (SRN) Initiative, Year 3 Final Report, September 2007
2. Adopt resolution (Attachment 3) authorizing Executive Director to amend existing School Nurse Initiative contracts with participating school districts by a maximum of 20% of the June 27, 2007 maximum allocation as described in Attachment 2 for a school district based on documentation of actual school nurse staffing salary cost. The combined total of amounts in these Amendments to Agreements will not exceed 10% of the School Nursing Initiative budget.

Attachments:

1. Implementation Evaluation of the School Readiness Nurse (SRN) Initiative, Year 3 Final Report, September 2007
2. School Nurse Initiative Amended Maximum Allocation Chart FY 07/08
3. Resolution authorizing Executive Director to amend existing School Nurse Initiative contracts with participating school districts by a maximum of 20% of the June 27, 2007 as described in Attachment 2 for a school district based on documentation of actual school nurse staffing salary cost.

Contact: Alyce Mastrianni

Implementation Evaluation of the School Readiness Nurse (SRN) Initiative

**Year 3 Final Report
Executive Summary
September 2007**

Submitted to:



Children & Families
Commission of Orange County

**The Children and Families Commission of
Orange County**

Submitted by:



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I. Introduction and Methodology

In 2004, The Children and Families Commission of Orange County (CFCOC) established the School Readiness Nurse (SRN) Initiative in an effort to increase the provision of health services to young children and their families. School Readiness Nurses (SRNs) provide health care services, education, referrals, outreach, and developmental screenings to children ages zero to five, their family members, and service providers.¹ To accomplish these activities, the nurses work with teachers, school staff, School Readiness Coordinators, physicians, health care agencies, and Commission staff, just to name a few.

The Evaluation and Training Institute (ETI) was contracted by the Commission to evaluate program implementation and how effectively the SRN Initiative met its objectives. Data collection activities initiated during Year 1 included monthly quantitative data logs of SRN service contacts, review of OCERS progress reports, an online survey, a mini focus group, and telephone interviews. During Year 1, the evaluation collected baseline information, identified service delivery trends, and described the implementation process. During Year 2 the evaluation was expanded to include a parent survey and site visits, as well as continuation of service delivery data gathered during Year 1 and review of OCERS progress reports. Collective findings garnered from the Year 1 and Year 2 evaluation activities identified service reach and meeting health needs as primary areas of challenge. Evaluation activities for Year 3 were therefore designed to explore these two challenges in depth.

New activities were incorporated into the study design to facilitate an exhaustive analysis of these challenges. At the Commission's suggestion, ETI identified a sample of four districts with more than one Full Time Equivalent (FTE) SRN to form an Evaluation Task Force to assist in more concentrated data collection methods during Year 3. To closely track individuals who had received referrals for specific health needs, ETI developed a Needs Met Log.

This report contains a synthesis of evaluation findings for Year 3, derived primarily from Service Provision Data documented in ETI Data Logs, OCERS, Needs Met Logs, the Initiative and Non-Initiative Focus Groups, and the SRN Focus Group, and when applicable, a comparative analysis of data from Years 1, 2, and 3.

¹ There are 25 school districts in Orange County with elementary schools. In 2007, 21 of 25 districts were staffed by 27.5 Full Time Equivalent (FTE) SRNs.

II. Findings

Service Reach

To ensure that children five and under are physically healthy before they begin kindergarten, SRNs conduct a variety of health screenings: vision, dental, height/weight/body mass index (BMI), hearing, health/developmental, and immunizations.

ETI data logs maintained in Year 3 for the ten-month school year (September 2006 through June 2007) revealed that a total of 8,748 new children were served by the SRNs. This represented a monthly average of 875 and reflected a 23 percent decrease from an average of 1,130 new children seen each month in Year 2, but is 16 percent higher than Year 1 (average 752 new children a month).

Health Screenings

SRNs reported that 94 percent of the children screened in Year 3 had up-to-date immunizations (only 6 percent were incomplete and referred). Continuing a trend from Year 2, nurses met the greatest number of vaccination needs compared to all other services; 97 percent of children identified with incomplete immunization records became fully immunized as a result of immunizations conducted by SRNs or referrals made by SRNs.²

Aggregate data collected in Years 2 and 3 on health/mental health and developmental screenings indicate a drop in both the number of screenings (down 8 percent) and the number of children referred (down 26 percent). Similar to other services, however, the percentage of needs met substantially increased from 49 percent to 65 percent.

In sum, more children were screened in Year 2 than in Years 1 or 3 across every type of service. The total number of referrals, however, were about equal or greater in Year 3, suggesting that the SRNs may have been more successful in targeting children in need of screening. This may be the result of ETI's presentation of the Year 2 evaluation results to the SRNs, who used the findings to redirect their efforts to focus more heavily on meeting health needs.

Assistance with Insurance and Medical Home

SRNs reported that 11 percent of children screened did not have health insurance and 15 percent did not have dental insurance in Year 3. Although data from Years 1, 2, and 3 indicate the percentage of families in need of health and dental insurance assistance has been declining

² In Year 2, an "immunizations conducted" field was added to the data collection log in order to differentiate between individuals who received immunizations by the SRNs and those who were referred.

every year, a larger percentage of health and dental insurance referrals were made in Year 3 than in previous years.

Similar improvements were also made in the percent of known dental and health insurance needs met from Year 2 to Year 3. **Across all years, dental insurance needs met have seen a notable increase (Year 1 = 1 percent, Year 2 = 13 percent, Year 3 = 22 percent).**

SRNs were more successful in Year 3 with identifying those in need of medical home referrals: 97 percent of children in need of a medical home were referred and 38 percent of those referred were registered with a primary care provider as a direct result of the SRNs' efforts. **Although the percentage of children having their medical home needs met was higher in Year 2 (40 percent), the number of children having their medical home needs met was higher this year (Year 3 = 251 children with met need, Year 2 = 207 children with met need; 18 percent increase).**

Constant in Years 1, 2, and 3, more than 70 percent of children screened for health conditions or insurance/medical home enrollment did not require a referral for additional services.

Service Provision for Family Members

A family in crisis is often unable to respond to the needs of its children. In response, SRNs provide services to family members in addition to serving children from birth to five. Services include non-health-related referrals for housing, food stamps, and WIC, as well as health-related referrals and information.

During the 2006-07 school year, a total of 4,048 new and 3,673 returning family members were served. Compared to Year 2, service to new family members in Year 3 did decrease slightly from 494 to 405 average monthly contacts (18 percent). The average number of returning family members served each month decreased slightly from 417 in Year 2 down to 367 in Year 3.

Although the total number of family members seen in health-related visits more than doubled from a monthly average of 542 family members in Year 1 to 1,128 in Year 2, the Year 3 monthly average dropped to 726 family members. **About 50 percent of health-related and immunization referrals for parents were resolved in Years 1, 2, and 3.** Consistent with Years 1 and 2, health and immunization referrals made by SRNs were less than 20 per month in Year 3.

Non-health-related Referrals

One of the Commission Milestones on which the SRNs are expected to progress underscores the importance of referring families in need of resources such as social services, food stamps and HUD (i.e., **Milestone 22**). The number of family members referred to this type of assistance in Year 3 was about the same as Year 2 (155 and 178 family members; respectively). It should be

noted, however, that **non-health related needs met increased from 47 percent (n= 83) in Year 2, to 65 percent (n= 101) in Year 3.** This trend seems to follow the trend observed from Year 1 to Year 2 (Year 1 referrals= 71, need met= 28).

Outreach Efforts

Year 3 focused specifically on health fair and school fair outreach, collapsing all other outreach into one category (i.e., other). **Year 3 outreach effort numbers almost doubled (n= 9,375) those of Year 2 (n= 5,267), which had increased dramatically in comparison to Year 1 (n= 1,247).** Other outreach activities, such as visits to community daycare and recreation centers, were cited most often in Year 3 (n= 5,574), comprising 59 percent of outreach to public locations.

Home Visitation

On the monthly data logs, nurses documented their attempts and successes in reaching families through apartment complex and home visitation. Although the total number of apartment complex visits dropped significantly from 160 in Year 2 to 23 visits in Year 3, this decrease did not reduce the number of families contacted through these visits. In fact, **families contacted through apartment complex visits increased by 55 percent from Year 2 to Year 3.**

SRNs made fewer home visits in Year 3 (241 visits in Year 2 compared to 130 in Year 3), and contacted fewer families (n= 123) through home visits than apartment complex visits (n= 194) in Year 3.³ **While a handful of SRNs find value in meeting with families in their home environments, the majority consider the practice too time-consuming given the breadth of their job responsibilities.**

Classes

Working solo or in collaboration with other service providers, the SRNs conducted/coordinated 10,137 hours of health-related instruction to 6,321 family members, 5,423 children, and 1,435 providers for a total of 13,179 class contacts throughout Orange County between August 2006 and June 2007.^{4,5} Of the 696 courses taught/coordinated by school nurses during Year 3, 5,733 family members, 4,282 children, and 1,297 providers attended new classes, while the remaining class participants attended continuing

³ Year 1 home/apartment visitation data are not presented, as the values produced when the Year 1 data were analyzed indicated that the SRNs did not understand how to gather this information and incorrectly entered data into the home/apartment visitation fields of the data collection logs.

⁴ Class hours were determined by multiplying the number of individuals present by the total class time. For example, if 10 children were present for a one half hour nutrition class, class hours would be calculated as follows: 10 (children) X 0.5 (hours), for a total of 5 class hours. Class hours were rounded up to the nearest whole number.

⁵ Participant totals include duplicate counts as the same participants may have attended more than one class.

classes.⁶ In comparison to Years 1 and 2, the proportional distribution of family members, children, and new and continuing providers receiving instruction was similar.

Safety, the most popular class in Year 1, was replaced by nutrition in Years 2 and 3. Health education was ranked the lowest among all the class topics in Year 1, but rose to be one of the more popular class topics in Years 2 and 3. Classes on nutrition, safety, hygiene, health education, and dental health comprised over 81 percent of the total hours of instruction (8,295 class hours). The number of class hours provided for children and family members was approximately three times greater than the total class hours offered to providers. Similarly, more children and family members attended the classes than providers.

Milestone Analysis

SRNs were asked to track district-specific goals that mapped onto 30 milestones by entering quantitative data and progress notes for each milestone on a monthly basis from September 2006 through June 2007. Comparing this district-specific Milestone data with ETI data in certain areas anchors the evaluation findings in the context of the Initiative's goals, and furnishes additional information on the successes and challenges of the program.

Successes

Despite challenges in some areas, the nurses were largely successful in accomplishing service targets as put forth by the Milestones. **For 17 of 21 Milestones, the SRNs exceeded their target goal, sometimes by more than 100 percent.** The SRN's documentation of screenings for vision, hearing, dental, height, weight, health and developmental milestones in OCERS revealed that SRNs exceeded the assigned target quantity for referrals in 2006/2007.

Milestone SRN 12 asks the SRN "to ensure immunization compliance of children in district preschools, school readiness programs, and teen parenting programs," The SRNs accomplished this Milestone for 9,147 clients, exceeding the target of 7,564 children by 21 percent. ETI data support this finding. Up from 26 percent in Year 1 and 84 percent in Year 2, 97 percent of children referred for immunizations had their needs met in Year 3.

Challenges

Milestone SRN 06 asked SRNs to document "*follow-up on all referrals to assure treatment compliance.*" In this area, SRNs exceeded their target quantity by 111 percent. However, the OCERS system does not require SRNs to track whether those follow-up processes result in

⁶ "New" classes were defined as classes beginning during the current month of data collection. For classes that were a part of a series, the class was counted as "new" during the month the first class of the series was provided, and was counted as "continuing" for each month that it was offered thereafter.

meeting clients' health needs, whereas ETI asked the SRNs to document that health needs had been met in addition to documenting the number of referrals and follow-up efforts made. Thus, according to data collected with the ETI data logs and the online OCERS reporting system, **SRNs achieved their screening and referral goals, but continued to struggle to meet the health care needs of those children with identified health issues during Year 3, especially with respect to dental health and height, weight, and BMI.**

In Year 3, SRNs continued to struggle to access clients in greatest need of services. In Milestones SRN 07 and 08—ensuring that Orange County children are insured and that families utilize a primary care provider—health insurance referrals were 18 percent below target and medical home assistance was 15 percent below the target set by the Commission. Data collected with the ETI logs mirrored these findings, as just 11 percent of children screened were in need of health insurance or a medical home.

SRNs did not meet the goal of Milestone SRN 20 asking them to “refer families for conditions that inhibit access to care and education (e.g. social services, food stamps, HUD).” Upon completion of Year 3, SRNs made 428 referrals, 39 percent below the target quantity of 700. The ETI data collection logs produced similar findings, as only 155 families received non-health-related referrals in Year 3, representing a small portion of family members served.

Meeting Healthcare Needs

SRNs participating in the Task Force were asked to report whether they were successful in making sure that the needs were met for children they had referred. They completed a Follow Up Log after each attempt to follow up with the families, and a Conclusion Sheet at the end of the data collection period, once the child's needs had been met, or when the nurse determined that sufficient follow up had been conducted. **Follow up efforts ranged from one to seven contacts. Nurses made an average of three attempts to ascertain if each child's needs had been met. The time lapse between referral and the first follow up varied considerably from one to 160 days, with a mean of 46 days.**

SRNs were successful in meeting the needs of two-thirds (67 percent) of the children. Of note, this success rate is considerably higher than that for most referral types tracked by the SRNs using the monthly data collection logs. The act of tracking follow up activities using the Needs Met Logs may have increased the nurses' success rates due to a higher level of attention being placed on the follow up process.

In total, **on average, SRNs spent two hours conducting follow up activities in their attempt to ensure that each child's needs were met; total hours ranged from .05 to 10 hours.** These results are of interest given the number of referrals made during the 2006/2007 program year. Across 21 districts a total of 6,078 referrals were made for children under five years old, indicating an average of 289 referrals per district. Dividing this value by 1.5 full-time nurses, a single SRN would be responsible for conducting follow up on 192 referrals each year. If that nurse spent an average of two hours conducting follow up per client, she would spend

384 hours of her time per year on follow up activities, or approximately 25 percent of her time during 40-hour work weeks in a 40-week year.

SRNs' clients vary widely in terms of their presenting problems, response to referral, and the level of assistance required. While some parents are highly concerned about their children's wellbeing and eagerly follow the SRNs' suggestions, others are more resistant, require extensive follow up, are faced with challenges that limit their ability to respond, and in some cases are ultimately unable to take action to address their children's health needs.

III. Challenges

Summary of Challenges to Service Reach

Initiative and non-Initiative family member focus groups provided valuable insight into the barriers that prevent them from knowing about and accessing SRN Initiative services.

Immigration Status

While the SRNs will provide services to any child under the age of five, regardless of his/her immigration status, **many families assume they can not get health services for their children or fear that doing so will impact their immigration status.** When parents and/or their children are undocumented, their preference to remain below the radar, so to speak, runs counter to the SRNs' best endeavors to identify them.

Misinformation, Lack of Understanding, and Lack of Motivation

Many parents are misinformed about the requirements to access Initiative services, and believe they don't qualify to use services offered by the SRNs due to specifications regarding age, residency status, and income. They also fear that they will later have to pay for any services they utilize before legalizing their status because they weren't supposed to be using them. Additionally, previous failed attempts to access services have resulted in an unwillingness to try, and some families are simply unwilling to make the effort to access services because of the paperwork and *"all the hoops to jump through."*

Scheduling Conflicts

Some parents are unable to access Initiative services because of work schedules that do not allow them to visit the school when the nurses are available.

Language, Trust, and Literacy Barriers

Monolingual English-speaking SRNs continue to struggle to communicate with the Spanish-speaking majority of Initiative current and potential clients. One SRN confessed: *"In the whole time I've worked, I've never called a parent for follow-up because I know they won't speak English."* Lacking a common language prevents trust, according to another SRN: *"The parents don't trust me because I don't speak Spanish, and it's very hard to break through. This year I really made an effort to be in the classroom more with the parents and learn a few phrases, try to make that bond, but you can still see there's no trust there."*

Low education level and illiteracy are also barriers that keep potential clients from learning about and accessing Initiative services

Seven Task Force SRNs from four districts participated in a focus group at the end of Year 3, providing insight on barriers to service reach from the nurse perspective:

Priority Conflicts

The dual nature of funding for the SRN position contributes to subtle pressure on the nurses to make the accessible clients their priority. They seem to face a daily quandary as to how to allot their time given the **conflicting priorities of the school districts to serve their registered preschoolers and the Commission's mandate to reach out to the isolated and underserved.** The net effect of these conflicting pressures and mandates put the nurses in an either or position: *"Basically, it almost becomes one or the other. My question is, does the Commission want intensive services to maybe fewer children, or do they want to see big numbers in a more surface-level type of service?"*

Service Goal Expectations

Variations in service locations continued to play a key role in how much time each SRN devotes to accessing clients outside district-sponsored preschool programs. **Some SRNs in districts with large, state-funded preschools feel pressure by the school district to focus solely on that access point, leaving little time for outreach efforts to more isolated clients.**

Lack of Training and Limited Comfort Conducting Outreach

Some SRNs felt ill-equipped to undertake the kind of outreach the Initiative required of them. As one SRN in this situation put it, *"I don't know where to begin finding kids who aren't in preschool."* Another related that she was *"not used to having to do networking to establish a client base."* They also expressed a subtle reluctance to canvassing neighborhoods in search of potential clients and asserted that such outreach efforts took too much time. **SRN reluctance to conduct outreach to the underserved may be tied to doubt or ambivalence about**

their own ability to back up their outreach effort with service delivery. One SRN who had handed out fliers confessed: *“We got two or three who responded, interested in services, but we haven’t gotten back to them yet... You don’t want to offer something and not be able to follow through. So we’ll probably touch base with them or give them some resources, but as far as actually providing services, I just don’t think we can.”*

Autonomy as a Deficit to Service Reach

Given their high degree of autonomy, SRNs prioritized their work according to their individual strengths and interests. This allows them to be responsive to community needs they perceive to be most pressing, but also permits them to make service outreach to the isolated a lower priority, especially if they are ill-equipped to take it on. Most SRNs did not bring outreach skills to the position, so they applied their expertise where they could be most productive—serving children already enrolled in state-funded and private preschools.

Summary of Challenges to Meeting Healthcare Needs

The most salient finding gleaned from the SRN focus group was the extent to which administrative challenges (technology shortcomings, lack of administrative support, and the quantity of documentation/paperwork) influenced the nurses’ ability and available time to conduct outreach and follow up.

Administrative Challenges

SRNs agreed that paper-based documentation and record-keeping, exacerbated by the lack of an efficient computerized system consumed much of their time. Preparing to teach also seems to take a large portion of SRNs’ time. That coupled with a general lack of administrative assistance to handle the routine data processing that accompanies service delivery seemed to have a direct impact on how SRNs allotted their time: *“If you do one day of screening, you’ve got a couple days of just paperwork because you’ve got to put all the results and referrals somewhere, get that information out to the parents, and we don’t have aides. We have one part-time health aide who does so much other stuff that we end up doing a lot of that stuff ourselves.”*

IV. Summary & Recommendations

Strengths

While the evaluation of the School Readiness Nurse Initiative has allowed for the identification of areas that have presented a challenge to the nurses serving families in Orange County, Year 3 has also produced many successes:

- **A total of 32,576 children received health screenings.**
- **The percentage of children with known needs met was higher in Year 3 across all health referral categories by an average of 21 percentage points over Year 2.**
- **Year 3 also showed an increase of nine percentage points from Year 2 in health and dental insurance needs being met.**
- **Year 3 outreach numbers almost doubled (n=9,375) those of Year 2 (n=5,267).**
- **10,137 hours of health-related instruction were provided to 6,321 family members, 5,423 children, and 1,435 providers for a total of 13,179 class contacts throughout Orange County during Year 3.**

By offering health and non-health related services and classes to children, family members, and providers, the SRNs are contributing to the betterment of young children's health and school readiness in Orange County.

SRNs value their role and the opportunity to work for the Initiative: *"When I first came here, in on the ground floor, I was ready to do something really creative, you know, taking all my years of nursing and now somebody really wanted me to come up with ideas, not just follow what someone else did. To be involved in that kind of creating something new has been really exciting for me, for where I am as a nurse now."*

Recommendations

- **Bilingual administrative assistants to assist the SRNs to better identify, communicate, and meet client needs. Such individuals could conduct follow-up and respond to telephone queries when the SRNs are in the field.**
- **Additional translators to enable SRNs to dedicate a larger portion of their time to service provision and outreach.**
- **Bilingual paraprofessionals to help conduct Height/Weight/BMI screenings as this activity is time-consuming and does not require professional expertise. Bilingual paraprofessionals could**

assist with outreach by contacting schools and agencies, distributing flyers throughout the community, and identifying collaborative partners and community resources.

- Recognize and devise strategies to maximize the use of the neighborhood grapevine. Put the word-of-mouth conduit to work for the SRN Initiative, raising awareness of services and conveying the message that the Initiative is committed to reaching all children, without risk to immigration status.
- Formalize and invigorate active partnerships and communications with Public Health Nurses in the field.
- Delegate the service outreach component of the SRN position to motivated volunteers or paraprofessionals. Partner with and empower these volunteers through an informal or formalized *Promotoras de Salud* program, spearheaded by a dynamic SRN whose sole responsibility is to train, inspire, and reward these special teams for bringing in new clients and serving as translators and advocates for the Initiative.
- Provide SRNs with *know how* to access interns and VISTA volunteers or other resources for free assistance such as young people interested in nursing internships or community service projects.
- Implement a computerized system with a calendar feature to track referrals and follow up, and an alert feature to advise the SRN of the need to re-screen or conduct an initial screening because the child was absent. An efficient computer tracking system would greatly reduce the time SRNs spend on documentation and paperwork, thereby adding to the time they could apply to increasing service reach.
- If increasing service reach is to remain a top priority of the Initiative, reword the Milestones to clarify its position of importance. In tandem with this reemphasis, offer training to the SRNs to increase their networking and outreach skills, and reward them concretely for focusing a greater portion of their time on outreach efforts.

School Nurse Initiative
Amended Maximum Allocation Chart FY 07/08

Contract Number	School District	Current FTE Program Staffing	June 27, 2007 Action
FCI-SN2-01	Anaheim City	2	\$169,950
FCI-SN2-14	Brea Olinda	0.5	\$42,488
FCI-SN2-02	Buena Park	1	\$84,975
FCI-SN2-15	Capistrano	2	\$169,950
FCI-SN2-03	Centralia	1	\$84,975
FCI-SN2-04	Cypress	1	\$84,975
FCI-SN2-06	Fountain Valley	1	\$81,113
FCI-SN2-07	Fullerton	1.5	\$119,738
FCI-SN2-16	Garden Grove	2	\$169,950
FCI-SN2-08	Huntington Beach City	1	\$84,975
FCI-SN2-17	Irvine	2	\$162,225
FCI-SN2-18	Laguna Beach	0.5	\$42,488
FCI-SN2-09	La Habra City	1	\$84,975
FCI-SN2-19	Los Alamitos	1	\$81,113
FCI-SN2-27	Lowell Joint	0.5	\$42,488
FCI-SN2-10	Magnolia	1	\$84,975
FCI-SN2-20*	Newport-Mesa	2.5	\$204,713
FCI-SN2-11	Ocean View	1.5	\$119,738
FCI-SN2-21	Orange	2	\$169,950
FCI-SN2-22	Placentia-Yorba Linda	2	\$162,225
FCI-SN2-23	Saddleback Valley	2	\$169,950
FCI-SN2-24	Santa Ana	2	\$169,950
FCI-SN2-25	Tustin	1	\$84,975
FCI-SN2-12	Savanna	0.5	\$42,488
FCI-SN2-13	Westminster	1.5	\$119,738
	Total District Allocations	34	\$2,835,078
	10% of Total District Allocations		\$283,508
	Maximum Obligation plus 10%		\$3,118,586

- * Additional 1.0 FTE School Nurse to offset support to State Special Needs Demonstration Project. This one-time funding is not included in the district's on-going funding at this time.

CHILDREN AND FAMILIES COMMISSION OF ORANGE COUNTY

RESOLUTION NO. ____-07-C&FC

November 7, 2007

A RESOLUTION OF THE CHILDREN AND FAMILIES COMMISSION OF ORANGE COUNTY AUTHORIZING THE EXECUTIVE DIRECTOR OR DESIGNEE TO NEGOTIATE AND ENTER INTO AMENDMENTS TO SCHOOL NURSE INITIATIVE AGREEMENTS TO INCREASE INDIVIDUAL MAXIMUM PAYMENT OBLIGATIONS IN AN AMOUNT OR AMOUNTS NOT TO EXCEED TWENTY PERCENT OF THE MAXIMUM PAYMENT OBLIGATION PER AGREEMENT

WHEREAS, in order to facilitate the creation and implementation of an integrated, comprehensive, and collaborative system of information and services to enhance optimal early childhood development, the legislature adopted legislation set forth in the California Children and Families Act of 1998, Health and Safety Code Section 130100, *et seq.* (as amended, the "Act") implementing the Children and Families First Initiative passed by the California electorate in November, 1998 and establishing the California Children and Families Commission and County Children and Families Commissions, including this Children and Families Commission of Orange County ("Commission"); and

WHEREAS, Commission adopted its First Strategic Plan to define how funds authorized under the Act and allocated to the Commission should best be used to meet the critical needs of Orange County's children prenatal through five years of age as codified in the Act; and

WHEREAS, Commission grantees and Commission staff occasionally encounter a need to provide additional services and/or grant additional funds in order to accomplish goals and implement programs on behalf of the Commission; and

WHEREAS, in order to manage the School Nursing Initiative program more effectively, Commission desires to authorize the Executive Director or designee to amend School Nursing Initiative Agreements to grant additional funds and increase the maximum payment obligations based on documentation of specific School District need in an amount or amounts not to exceed twenty percent (20%) of the maximum payment obligation per Agreement; and

WHEREAS, the Commission desires to authorize the Executive Director, or designee, to negotiate and enter into such Amendments to Agreements and the Chair of the Commission to execute them; and

WHEREAS, Commission has reviewed the November 7, 2007 staff report relating to the Amendments to Agreements and hereby finds and determines that the proposed Amendments to Agreements are in furtherance of and consistent with the Commission's Strategic Plan; and

NOW, THEREFORE BE IT RESOLVED BY THE COMMISSIONERS OF THE CHILDREN AND FAMILIES COMMISSION OF ORANGE COUNTY AS FOLLOWS:

Section 1 The Commission finds and determines the foregoing Recitals are true and correct and are a substantive part of this Resolution.

Section 2 The Commission hereby authorizes the Executive Director or designee to amend School Nursing Initiative Agreements to grant additional funds and increase the maximum payment obligations based on documentation of specific School District need in an amount or amounts not to exceed twenty percent (20%) of the maximum payment obligation per Agreement.

Section 3 Commission hereby authorizes the Executive Director, or designee, to negotiate and enter into such Amendments to Agreements and the Chair of the Commission to execute them.

Section 4 The Clerk of the Commission shall certify to the adoption of this Resolution.

The foregoing was passed and adopted by the following vote of the Children and Families Commission of Orange County on November 7, 2007 to wit:

AYES Commissioners: _____

NOES: Commissioner(s): _____

EXCUSED: Commissioner(s): _____

ABSTAINED: Commissioner(s): _____

CHAIR

STATE OF CALIFORNIA)
)
COUNTY OF ORANGE)

I, DARLENE J. BLOOM, Clerk of the Commission of Orange County, California, hereby certify that a copy of this document has been delivered to the Chair of the Commission and that the above and foregoing Resolution was duly and regularly adopted by the Children and Families Commission of Orange County.

IN WITNESS WHEREOF, I have hereto set my hand and seal.

DARLENE J. BLOOM
Clerk of the Commission, Children and Families Commission of
Orange County, County of Orange, State of California

Resolution No: __-07-C&FC

Agenda Date: November 7, 2007

Item No. __



I certify that the foregoing is a true and correct copy of the Resolution adopted by the

DARLENE J. BLOOM, Clerk of the Commission

By: _____
Deputy