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NOTES OF COMMUNITY HEALTH CARE ROUNDTABLE

Thursday, March 17, 2005

FOCUS:

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- 2) Overview of Health Needs of FUSD Students; Challenges and Resources of FUSD Nursing Staff – Barbara Miller**, Director of Nurses, Fresno Unified School District, Pages 7 – 12
- 3) Overview of Programs Housed with Fresno County Department of Community Health, Rebecca Carabez**, Director, Maternal, Child, and Adolescent Health, Pages 13 – 15

The purpose of our Community Healthcare Roundtables and of our healthcare projects is to increase healthcare access that is appropriate medically, geographically, linguistically, and culturally and to improve public health. Funding for Fresno Metro Ministry's health, air quality, and hunger/nutrition programs is provided by individual donors, congregations, Vitamin Cases Consumer Settlement, The California Wellness Foundation, The California Health Care Foundation, Hewlett Foundation, The Kirsch Foundation, The California Women's Foundation, Kaiser Permanent, The California Endowment, USDA, MAZON: A Jewish Response to Hunger, Roundtable Sponsors, (Health Net, Kaiser Permanent, Children's Hospital Central California), Event and Activity Sponsors, and others. Thank you!

Brad Maggy, Director, Fresno County Department of Community Health

It is a pleasure to be here this morning. Talking before people now I'm finding is extraordinarily difficult because it's a goodbye as well as anything else, and I do find that difficult. I am going to back school next fall. It's something I've wanted to do for almost 30 years. That said, let me just spend a couple of minutes talking about the Department of Community Health in broad terms, where I think we've made changes that I'm most proud of over the last couple years since I've been director and where I think we should be going, and I believe it's a view held by our senior management and managers within the department.

The Department of Community Health has made a great effort to work collaboratively with other agencies in the community who share common goals in the area of healthcare

When I came on board as a director it became very obvious to me that our department was not integrated and a part of the broader community that is involved in the area of healthcare, both CBOs and advocacy groups as well as the private sector. There was a divide. It was "us versus them" in some instances, and so it seemed to me that it was absolutely essential to change that. It became incumbent upon us to start to look at those we work with and interface with in the

broader community as partners and as people that have equal value to us, maybe even more, and have very much to offer both in terms of their knowledge, their experience, and their energy for working on health issues within the community and also in terms of resources. It's abundantly clear to all of you and it became abundantly clear to me that many of the resources and contacts and relationships that you fine people have are ones that the Health Department does not have directly, nor will we ever, and to focus in on those, to become connected in a mutually supportive way with those organizations, with all of you that have those connections, is another very valuable way that we can reach out into the community and work. That's what I felt was perhaps the most singularly important need to address among many, and we've been actively engaged in doing that and I hope all of you would agree that we are working more closely with the community. We are building partnerships with a myriad of organizations and individuals that are involved in this stuff and hopefully we're seeing one another as equals and sharing common goals in regards to healthcare. I feel very good about that. It's not been work that I have done directly myself. It's been the work of the health officer, who has been just outstanding in that regard, the assistant director, Giang Nguyen, and all the division managers that have taken that approach to try to integrate ourselves into the broader community. That, in my view, is a central theme. There are some things I'm really, really delighted about having been here for a couple of years doing this work as a director and having the kind of relationship that our department and I personally have with Reverend Parry. This organization and some others mean a lot because that relationship was not there two or three years ago. That is something that we've changed that I'm very, very proud of.

There is a close working relationship between the Department of Community Health and the County Public Health Officer, Dr. Edward Moreno

Secondly, I've developed a close working relationship with the county health officer, Ed Moreno. We really have tried to develop a partnership working in a mutually supportive way and focusing on our strengths. It is a mutual partnership and mutual respect that is value based. It's not so much an issue of organizational structure as it is the desire and commitment of two people to work closely together in ways that are mutually supportive. I feel very, very good about that. I have gotten a lot of good feedback from that over the last couple of years as to the value of that to our community and to the Health Department.

The Fresno County Health Department is working with health departments in surrounding counties in an organization called the Central California Public Health Partnership

Thirdly, Fresno County Health Department has worked diligently to develop closer ties with the surrounding health departments. Dr. Moreno has done that with the health officers and I have done it with the surrounding county health directors. We do have a formal organization, the Central California Public Health Partnership, and we should find out within a couple of weeks whether we've gotten a grant from the California Endowment to do diabetes education and prevention on a regional basis. We have some cooperation amongst ourselves in which we mutually support each other, whether it's health education or other kinds of activities, that did not exist several years ago. It strengthens all of us as a region, particularly in the Central Valley where the vast majority of resources don't come to us. They skip over us. They go from the Bay Area to Southern California and we oftentimes get left out of the loop. By having six health

departments or more working closely together in advocacy I think we have a better chance of acquiring greater funds and getting ourselves recognized as an area that just can't be ignored any more. That's another area where I think we've made real progress in the last couple of years.

The Fresno County Health Department is administrator for one of the state's largest regions for Emergency Medical Services

Lastly, we have increased our Emergency Medical Services region. Our department is the administrator for four counties now. We added Tulare County. We have one of the largest EMS regions in the State of California now both in terms of geography and in terms of population. That has a profound impact upon our ability as a region to coordinate our efforts in emergency transport and other emergency services activities. That's all run out of the Community Health Department by Dan Lynch, our division manager. It makes us a leader in the Central Valley, and that's also something that's very, very important.

Funding for the Department of Health will be a problem in the future as dollars for health programs diminish and costs to the department go up

Where do we go from here? I'm not going to be calling the shots, but from my perspective, and I think it's shared largely by the management of the department, we need to continue to advocate for stable and secure funding for what we do as a Health Department, and that is extraordinarily difficult. Not only are dollars for health programs generally either stagnant or going down, but we are in a situation in our department as well as in most counties where our revenues, state realignment being the principal one, are pretty much stagnant. They may go up one to two percent a year, but our costs on the other hand are going up in the neighborhood of eight to ten percent. For example, as with most service organizations, our major cost and asset is our fine employees. Our costs went up ten percent. They're going up ten percent this year between the hikes in retirement, workers compensation, other issues, and salaries, although salary increases have been moderate overall. If our revenues and realignment are only going up one or two percent and our costs are going up ten percent, there is no place else for that loss to go other than to further restrict our ability to maintain our programs. I've mentioned this before, and it's not by any means a criticism of our fine board and county administrative office, but in many counties that gap is made up by counties investing general fund dollars to the local health department. It doesn't happen here and there are other counties where it doesn't happen. We're a very poor county in many respects. We are forced into a situation every year, particularly the last couple of years, where we have to try to manage without layoffs, which we have done and will continue to do, I believe, while absorbing increased costs. How do we do that? We do it by trying to make efficiencies, of course. We do it by keeping positions vacant for extended periods of time that we otherwise would fill. That's a challenge now and it's going to be a challenge for the leadership of the department subsequent to my departure.

Because of limited resources, the Department of Community Health will need to change their role from an investor of money to an investor of time, resources, and good will

Secondly, with the exception of some grants that we may get, and even then it's very specialized and specific, we will have limited resources. We're not going to have the resources to engage in

a lot of new programs and to be able to invest significant sums of money into the community here for public health activities. What we have to do is reinvent our role as a Health Department. In my humble view the role which we play is not so much of an investor of money, although to the extent it's available absolutely, but as an investor of our time, our resources, and our good will to become coordinators, facilitators, collaborators, supporters, and advocates for the community as a whole and for those organizations like us who share common goals and programs that affect the health of the public. That we can do. I think it is a role we should be playing, not in a superior relationship but as equal partners. We have the ability to help facilitate and educate. We can do all those things in collaboration and partnership with the community as a whole. I think that's something that needs to be stressed and it's really part of the metamorphosis of the department.

The Department of Health needs to re-prioritize what they do and how they do it by engaging in a comprehensive strategy planning process

Another thing that I think is of great importance as well is that the department needs to go through a comprehensive strategy planning process. Again, this is something that I won't be involved in and I can't commit Dr. Moreno or the assistant director or anyone else to, but to my knowledge it's never been done. We need to do it because we need to have the kind of cogent direction that we should have as a major public health department, the largest in the state. We need to do it in order to re-prioritize what we do and how we do it. Many of the processes we have need to be upgraded. It is not in any way a criticism of any of the fine people that manage the department. It's part of a process that the executive leadership, i.e. myself and Dr. Moreno and Giang Nguyen, need to begin, and in doing that we need to include all of you in the process of doing a good strategic plan. Not only do we have to partner with our employees but we also have to partner with the community as a whole and solicit your input and your ideas and try to be sensitive to those things and perhaps even build a structure in which there is a more formalized advisory structure from the community to the department. These are absolutely essential things that need to happen. I know that Dr. Moreno feels very strongly about that, as does Giang Nguyen.

The staff working at the Department of Community Health are very motivated and competent and are also very dedicated to this community

I've been asked what's going to happen from this point forward. We have the executive leadership and senior management leadership in place right now to take this department forward in ways that are very exciting. Dr. Moreno, Giang Nguyen, and our division managers are all very fine and competent people, and they have the ability to do an outstanding job. They're energetic, bright, well motivated, and dedicated to doing things, and I think by taking the general lead of working in such a collaborative partnering way with the community as a whole this department can really make some big changes. It never ceases to amaze me the quality of the people we have working in the department. The same applies, I'm sure, to Julie Hornback's department. We have wonderful people working for us, and I don't say that lightly. I've worked in the Bay Area. I worked in San Mateo County for many, many years. I'm familiar with San Francisco County and Alameda and Santa Clara, and I can tell you without reservation that the quality of the folks that we have here and the dedication is every bit as good if not better than

up there. We have people working both in the line staff and as managers that could easily make \$20,000 a year more and have a fraction of the headaches and hassles and difficulties that they have working for a local health department, and they do it anyway. They do it because they're dedicated to this community, and we're really lucky to have them. I've been so inspired by these people. I can't thank them enough.

So with that, thank you all very much for the experience and the trust you've placed in me and my colleagues and friends here for the last several years. Coming back to my home town after being gone for 20 something years to serve the public has really been a joy for me. I never thought I would come back here to do that, and circumstances just worked out that way. To come back to my home town and to contribute in what I feel is a somewhat meaningful way has meant a lot and I will miss that part of my continuing professional life. So thank you all very much.

Participant question: Brad, about two years ago as part of the process of thinking about a public health officer the Public Health Officer's Association in California helped us do quite a study of our Health Department. How has that all come out? Have we been able to use any of that? Have we made any changes because of it? What will the status of that be in any kind of new planning?

Brad Maggy: The status of that in new planning is not for me to say because I will not be involved in it. I don't know what decisions are going to be openly made by the county on the Department of Health, but I think the role that our health officer has now and the potential future role will be in accordance with or at least sensitive to those elements of the study. We do have a full-time health officer who reports directly to the board of supervisors and works, in my opinion, in a team relationship with the health director in terms of decision-making and guidance, and I think that's consistent with that plan.

Participant question: Brad, you and I worked together years ago surrounding the establishment of the Human Services System, which ostensibly and allegedly was established because there were communication and coordination problems between the Health Department and Social Services. We all know that the system has now effectively been dismantled and there are four departments now instead of two that couldn't communicate before. I'm wondering how you feel now that the communication, collaboration, and coordination of services to the poor is.

Brad Maggy: The four department heads still meet regularly. In fact, we meet in ways that are more collegial than we did in the past when we were the Human Services System. The four of us try to have lunch now once a week. We also regularly have more formal meetings every other week. The collaboration and information sharing and coordination is better now than it was when we had the HSS. Why? Because before we had this formal structure, as you know, and it tried to mandate that we work in a certain way together. Now it's voluntary and we work together because we want to, because we feel and see our commonality of interest. It's informal, yes. Does that mean that it's subject to change with changing participants? Yes, of course, but in terms of our ability to work together I feel much better about it now. What's your view, Julie?

Julie Hornback: I agree. We're in each other's lives because our funding streams cross over, if for no other reason. It's a constant struggle to ensure that we don't lose focus on our community and our overall objectives and goals, and we've gotten very expert at barrier breaking and breaking out of the mold and doing things creatively. It's an ongoing challenge.

Participant question: This coalition has a primary concern with healthcare for indigents, and it's sort of ironic that you are replacing Phil Hinton on this morning's agenda because to some degree the county and Community Hospitals have been partnering in this effort since Valley Medical Center was closed. Now that you've had a chance to look at that partnership for a number of years, what do you think the strengths and the weaknesses are of the Community Hospital/ Fresno County partnership in the delivery of health services to indigents?

Brad Maggy: First let me just preface my comments by saying that it is a partnership, whether everybody likes it or doesn't, between the County of Fresno and Community Medical Centers for the provision of indigent services as well as healthcare to our jail inmates and wards of the juvenile system. If Community decided to pull the plug right now, you can see as well as I can that we would be in a world of hurt to try to pick up from scratch and try to rebuild the complete infrastructure to run a county hospital, so we have a very clear invested interest in their success. Their success is our success. I think in the main Community Medical Centers is meeting their obligation under the contract. The statistics that we review lead us to that conclusion without any real reservation. It has allowed the Health Department in some ways to increase our kinds and levels of partnership in working on programs directly. Those types of things have improved because we are bound at the hip and we both know that we can't get away from it. Those are improvements. Do the county and the Health Department have as much influence as we want? We do have members on their board. It is outstanding to have Laurie Primavera on the board now. I think that is one of the best things to happen in a long time. But do we have the kind of influence in their policy and program decisions as I wish we had? No, we don't. The contract with the county does not provide the kind of safeguards in, for lack of a better term, intrusive measures or the inclusion in decisions that relate specifically to the indigents and the inmates and wards that I think should be in there. In my opinion that's an area of weakness. Would it be nice to see Community having the resources to expand indigent programs and to develop and experiment with new approaches to serve this population? Sure. Do I think that they really have the money to do that? No, they don't. They're like most hospital that deal with a safety net, as we all know, that are struggling just to keep the bottom line, and I think they're earnestly trying to do the best they can.

Participant question: I'm pleased to serve on a committee of the Medical Society with the label of Community Health Services. I find no communication in the epidemics of health that affect people such as foul air, obesity, and teenage pregnancy. There's no communication between your department and those of us who have had the obligation, the pleasure, and the opportunity to deal with health at the personal level. Are there such lines of communication? Are there any plans for such? I think that's essential if we're to approach those epidemics.

Dr. Edward Moreno: I've had the pleasure of attending some of the board meetings at Fresno/Madera Medical Society and I did attend a couple of the Community Health Services Committee meetings. Some of the issues that the committee is addressing in terms of the health

impacts related to air quality are the same issues that we recognize as public health issues. At the same time, we are dealing with the challenges of budget constraints, and so we have to figure out what our role is in this public health concern with the situation we're in now where air quality is impacting the health of people living in our community. There are some other ways that we are indirectly working with the physicians at the Fresno/Madera Medical Society. I'm working, for example, with Dr. David Pepper. I believe he's probably still on your committee. I'm working with him in trying to develop local capacity to research the health impact of poor air quality and other environmental hazards. I have been meeting with some of our state departments, for example, the Air Resource Board, and meeting with the Environmental Health Investigation Branch trying to get their support to develop our capacity to research the health impacts here locally rather than relying on studies that are conducted in Oakland or Los Angeles. We are currently identifying our role and moving forward in what capacity we can to address some of those issues. In the area of diabetes and obesity we have been able through our Prevention Services Division to get some funds from the California Healthcare Foundation to develop a collaborative effort between a local healthcare provider, in this case Sequoia Medical, ourselves, and recently Community Hospital basically trying to develop comprehensive approaches to the management of chronic diseases like diabetes, and so we are working, again, in our capacity with healthcare providers. We have worked with the Fresno/Madera Medical Society in trying to get information to healthcare providers. Last year with the West Nile virus we were able to get letters out to many of the members of the society with announcements on West Nile virus. We also did that with the influenza vaccine shortage. We were able to get letters out through the Fresno/Madera Medical Society using the roster of healthcare providers, so we are from time to time engaging and collaborating with the society.

Brad Maggy: Most recently we've asked for a volunteer amongst the physicians in the Medical Society to participate in the Children's Health Initiative by being part of the steering committee. We're still hopefully going to get an answer of a person who is willing to volunteer to help us with that. But we are trying. I think we can always improve and I think your point is really well taken. Those are just the kinds of things that we need to bolster and to expand our efforts on.

Barbara Miller, Director of Nurses, Fresno Unified School District

Good morning. It's an honor and a pleasure to be here to talk about two things that I love the most, and that's children and school nursing. Nursing in schools is very unique and rewarding. It's a combination of nursing, education, counseling, and numerous other disciplines all rolled into one. My objective this morning is to present background information on the role and definition of school nursing and to share with you the current challenges. Our charge per the State Education Code is to maintain fundamental school health services at a level that is adequate to accomplish all of the following: Preserve pupils' ability to learn; fulfill existing state requirements and policies, and there are a numerous amount of those; and to contain healthcare costs through preventive programs and education. Our goal is to strengthen and facilitate the education process, and we do this by improving and protecting the health status of children and by identifying and removing or modifying health-related barriers to learning. We are in the education business but we also are in the business of promoting and maintaining health among students.

School nurses have tremendous education and nursing experience and are involved in numerous activities from health assessments to identifying developmental issues in children

If you want to anger a school nurse go into her office and say, “Are you a real nurse?” and she will straighten you out right then and there. School nurses are registered nurses, they have a baccalaureate degree, they’ve already gone back to school for an additional 27 or so units with specialized classes in health assessment, counseling, health teaching, some electives in neurodevelopmental assessment, and so on. They come away with a School Nurse Services credential recognized by the State Commission on Teacher Credentialing, so when they’re walking in the door of a school as a school nurse they probably have a good six years of education. Fifteen of our staff nurses have a master’s degree. Some are clinical nurse specialists in different areas. Eight of our staff are nurse practitioners and they have tremendous education and nursing experience prior to coming to the schools to work with children. We have a number of specialty areas in the school district that nurses are assigned in. We’ve got preschool, child development centers, and parent and child education, which are PACE centers, where teen moms can bring their kids to school to get education and childcare. We have nurses who deal directly with student attendance and review. On the chronic absentee cases they follow the families and try to intervene as much as possible to get the kids in school. When that doesn’t work they are with the families when they have to go to court to explain why they aren’t attending school, and they’re excellent at identifying why kids can’t be in school. We have nurses who do just health education. One of the programs that we offer to our junior high students is Sex Can Wait, which is a great program and really makes a difference in student’s lives. We have nurses who go out and just do health screening, which is one of the mandates that we have by the State of California. We check hearing, vision, dental, and scoliosis among other things. We would like to in the future be able to screen for acanthosis nigricans, which is one of the indicators for being at risk for diabetes. We have nurses who are in the Lorian Infant Center, which is an infant care program identifying developmental issues in children so that they can go on to school. We have nurses who spend a tremendous amount of time with special education issues and are on 504 teams. We attend individualized education plan team meetings and do anything that we can to help a child reach academic success.

The average school nurse spends forty to sixty percent of her time every day working with special education students

So what do nurses do? A little bit of everything. They focus on preventive health, health assessments, resource and referral, interpretation of medical reports, and a lot of everything. They are the only medical person on a school site. The general public still does not have a lot of knowledge about medicine or health problems, so you will have staff coming to you with questions about medical reports that they have absolutely no clue what any of it means, and so we interpret and disseminate information as necessary. Special education has its own set of mandates. We’ve done some informal time studies to see how much of our time is spent just with special education, and the average nurse spends about forty to sixty percent of every day dealing with special education students doing health histories, three-year assessments, and attending meetings, and a lot of time is spent doing procedures. We have numerous kids who need to be catheterized several times during the day, tube feedings, tracheostomy care, suctioning, wound changes, you name it.

The number one issue for Fresno Unified right now is the reduction in nursing staff. Another major concern is the increase in the number of children receiving medication at school.

The number one issue for Fresno Unified right now is our reduction of nursing staff. We do have 71 nurses, and actually we should have more than that but there was a freeze on hiring before this year really even got underway, so we are facing a reduction of 28 people. That will bring our numbers down considerably, and our biggest concern is that we may lose some of the community services that we can offer because we'll be losing a lot of our nurse practitioner positions. Increase in medication at school is a big issue. If it's prescribed, it's at our schools. Right now we probably have 4,500 students receiving medication at school. Our top concerns are the kids on seizures medications and medications for attention deficit disorder, diabetes, and asthma.

School nurses love to teach students. Every student that comes through the door will learn something about their health before leaving the office.

When nurses are at a school site kids come into the office for a variety of reasons. We do have kids who we call our frequent fliers who come in and don't really need to be there, and we eliminate those. We saw over 94,000 kids in our schools last year that we did assessments on. Everyone who walks through the door is assessed. Nurses love to teach, and any kid who comes in the door is a teaching opportunity. They're not going to leave that office before they've learned something about their health or a positive lifestyle change, whether it's something as simple for little kids as covering your mouth when you cough to how to washing your hands appropriately to teenagers and pregnancy issues. The problems that we have in the schools are the same ones that you have in all of your different areas. We deal with cultural attitudes towards health, severe poverty, and our biggest thing is we have kids who don't have access to healthcare. That is a huge problem for us. That's going to be one of our focuses for the future. The recommended nurse to student ratio by the National Association of School Nurses is one nurse to 750 students, and that really would be ideal. The current state ratio is actually pretty good. It's one to 2,400. Our ratio this year with the staffing that we have is one nurse to 1,750 students. Next year it's going to be one nurse to 3,300 students, and so our challenge is to figure out how we're going to provide services to students at schools.

School nurses can barely get done what they need to do with the current number of staff, so thinking about a reduction in staff is overwhelming

In a typical day in the life of a school nurse they're doing many things. They're appraising every child who comes in the door. Depending on what they see with that child, they're writing a medical referral or they may be giving first aid or a medication. Some of the medications that we have in our schools are all types of controlled substances, anti-depressants, inhalers, insulin, glucagon for emergency administration, seizure medications, antibiotics, pain medications, and now we're seeing a lot of over-the-counter medications and even herbal remedies that the parents want to be given at school. We also deal with school employees. If the cook gets burned the first place she comes is to our office, and we deal with that and get them out for care. We do child abuse reporting, follow up on immunizations, sports physicals, procedures, the CHDP program that we have through our health center, and in-services. We can barely get done what

we need to do with the staff that we have, and so thinking about a reduction in staff is overwhelming at this point. Last year in our district we did 94,000 assessments. Nine thousand were for special education. With our hearing screening we did over 55,000. Almost 2,000 of those failed and were referred. The same number were vision screened. A larger number failed and were referred. On the dental screening we had 55,000 that we did and we referred over 14,000, but a better way of saying that instead of referring is that we just gave the parents notification because, as you all know, there aren't the services in the community to take care of the kids who don't have dental insurance. We have a health center where we do physicals. We have a nurse practitioner who does migrant health physicals. We have Terry who has the Parent Mobile. We have a second mobile health unit that goes to a few of the schools, and we did over 2,000 physicals last year. These physicals and these immunizations that we give are getting kids into school. We're trying to remove any barrier to getting them into school as well as any barrier that affects their learning, so we gave over 7,800 immunizations, 2,400 student TB skin tests, and we also do our employee TB skin tests. As far as future plans, we are always looking to improve services to students. We have tons of issues that we can barely even touch on – obesity, diabetes, teen pregnancy, and lack of health education. We want to continue providing our community services. Regarding future dreams, my dream is that we need a nurse in every school every day to really do what needs to be done.

School nurses make a difference in the lives of children. They meet needs that no one else can meet and they have expertise that others do not. They are vital to the life of the school.

I would like to take just another five minutes, if I may, to read a story I wrote when I received this state award. It gives you an idea of what it's like to be a school nurse. A reporter from a local newspaper came by my school for an interview. He asked me, "What do you get out of school nursing?" I told him I didn't know what I get out of it, but I could tell him why I love being a school nurse. I love being a part of a team whose goal is to help students succeed academically and become fully functioning adults. I love developing relationships with students. I encourage all of you to work in a high school if you ever get a chance. Teenagers are remarkable. They're curious, they're emotional, they're enthusiastic and full of life, and they're just trying to find their way in the world. I love school nursing because I get a chance to interact with them and tell them they matter. I love being a school nurse because of people like Tony. I met Tony when he was in first grade and then I ran into him again when he was a sophomore, a very quiet, tall, African American young man. One day he plopped down in a chair beside my desk and asked me, "Do you still make a gingerbread house every Christmas?" I thought, "Where did that come from?" It really took me by surprise and I said, "How do you know that I do that?" He said, "Well, when I was in first grade you made one and you brought it to school and I liked it so much that you let me take it home." He said, "I ate off of that for three weeks," and then of course after that I felt very guilty because I could only think of the tooth decay that that probably caused, but anyway, I referred him. I love school nursing because I have the privilege of watching students grow up. Every day at lunch there is a group of students who come in and hang out. This was when I was working at Sunnyside High school. They're usually freshmen. They know the health center is a safe place. I get to see them mature throughout the year. By the time they're sophomores they feel pretty good about themselves and I only see them when they come back to visit, so essentially they fly the nest. I love walking across campus and having students say, "Hi Mrs. Miller," or others jog over to ask a question, or those

like Alex who says, “I haven’t seen you for a while, Mrs. Miller. That’s a good thing, right?” He was one of my frequent fliers, so he had learned to not come in all the time. Or another student who says, “Mrs. Miller, how do you like my new glasses?” I love educating students. I love problem solving. I love just being there for students with an expertise that other members of the team don’t have. I love people like Ricky who will tell you if you meet him that I saved his life. This always makes me laugh because it seems so dramatic a statement. What he means is that I found a life-threatening health problem and acted immediately on it. Even though he was angry at his diagnosis and we had to deal with that for a while, he knew that taking care of the problem kept him alive. I love people like Eric, all 300 pounds of him. From the first day of school he stood out as a student at risk. He is asthmatic, has a speech defect, and has limited social skills. His attendance record was appalling. I spent a lot of time with him talking about his asthma, educating, consoling, encouraging. He was referred to the Student Study Team and has made some improvement, although minimal, but the bottom line is he doesn’t like school and it will always be difficult for him. I didn’t think our discussions meant anything until Christmas one year when I received a gift from him and a note saying thanks for caring about him and his education. I love learning about students. As I learn the details of their lives I find myself caught in a web of emotions, like Kimmy, a special education student who struggles with school. Two weeks ago her brother was killed in a hit and run accident. This week she was arrested for fighting. Or Cynthia, a teen mom, is having difficulty getting along with her mother. The grandmother has taken the role of primary caretaker for Cynthia’s child in spite of Cynthia’s protests. Sarah was just diagnosed with a seizure disorder but is actually glad that her illness has a name. Before she understood about seizures she was scared to death. I would like to say that I even love the angry parents or the staff that wants all the requests met today, but it would be a lie. Every job has its pitfalls, and angry parents are one of ours. However, those stressful situations often lead to positive dialogue about school nursing and health issues. I love the sense of humor that you must develop with the job – the kindergarten student who wants to know why my nose is just like a witch’s nose or the student that comes in and says her mom told her she has eggs. I ask her more about that and she says her mom was looking through her hair last night and said she found eggs – head lice. I spend a lot of time laughing at myself for all the times I don’t say quite the right thing, like blurting out to a student with a stomach ache after going through my usual list of assessment questions, “You aren’t pregnant, are you?” and then realizing I have just broken all rules associated with good communication skills, and I get one of two responses to this question. The first one is, “Mrs. Miller!” and a facial expression that tells you the thought of sex is the most disgusting thing this person has ever thought about, and I love those kids, or I get the downcast eyes and gloomy expression that tells me I hit the nail on the head. Then I come to my senses and proceed with caution, recalling all the best counseling techniques that I can from those days in the school credential program. I love being associated with a dynamic staff of nurses and the tremendous resource they are to me. Each one of them brings to school nursing a different aspect of nursing expertise. They are my strength and they are always willing to help me if I need it. I love planning health fairs, teaching CPR, getting out there where people can see what school nurses do and see who they are. I love managing, organizing, delegating, serving, and advocating. I love making a difference in the lives of children. Nurses make a difference in the lives of children. We solve so many health problems each day that we may minimize the importance of what is really happening, but what is happening is that we are helping students succeed. We are meeting needs that no one else can meet. We have expertise that others do not. We are vital to the life of the school. Children need

us, staff members need us, and parents need us. School nurses make a difference and we will be remembered by the lives we touch.

Participant comment: It has been our pleasure at Fresno Health Consumer Center to receive at least 100 referrals from the mobile unit where they have identified children who are not insured and we have provided enrollment applications to insure those children, so it's a great, great partnership and we're thankful for your leadership, Barbara, but also for the work that is being done in the field.

Participant question: As a former public health nurse and school nurse I found the situation with school nursing in California when I arrived here appalling. I did work in an agency that had public health nurses that also covered the school nurses on a temporary basis. I had six schools I visited about every other week. At that time we oriented and trained people in the community to do screenings. Is there any way that volunteers or retired nurses could be used to fill in that kind of a screening program as well as make home visits?

Barbara Miller: It would be great to use retired people, but most of them still want to be paid and so it becomes a problem in our budget. However, if you're shaking your head that you don't want to be paid, I may be calling you.

Rev. Walt Parry: Is asthma still the number one reason for students being absent? Secondly, how can we be supportive of restoring the nurse positions that are about to be cut?

Barbara Miller: The way that we keep records in Fresno Unified needs to be improved. We don't actually document why kids are absent, so when you see the numbers on asthma-related absences they are estimates. I'm not sure if that is our highest reason for kids being out of school. As far as how you can help, money is one way as well as just talking to board members and promoting the importance of nursing and the importance of health in our students. Talking to the board is usually very effective.

Rev. Walt Parry: At one point in time if students went to any personnel in Fresno Unified and talked about being engaged in sex with anyone there was supposed to be instant notification of CPS, which meant that students had no one to turn to. Is that still an issue or is there flexibility as to how that's dealt with?

Barbara Miller: We do not make an automatic call to CPS. We were instructed to do that a few years ago and then that policy changed, so we only do it when there is a large discrepancy between the age or if it involves any minor 14 and under.

Dr. Rebecca Carabez, Director, Maternal, Child, and Adolescent Health Department

My name is Dr. Rebecca Carabez and I'm the new Maternal, Child, and Adolescent Health director. I'm fairly new here to Fresno and I'm new to this department. I've been here for about a year and a half. I want to start out by saying that our program is very much related to what we know about our community and how we can meet the needs, so data really drives our program. The Maternal, Child, and Adolescent Health is really synonymous with what's called the Babies

First Program. We are part of a federal grant. The federal grant is to eliminate disparities in infant mortality and morbidity among very low-income, high-risk African American, Hispanic, and white families. We focus on metropolitan Fresno and Clovis.

A big focus of the Maternal, Child, and Adolescent Health Program is to reduce infant mortality rates

The Babies First is a consortium, and the three most visible ways that you will ever see Babies First is that we've had a June event where we have a conference. This year we're going to have it at the Radisson and we'll be focusing on adolescent health issues. This is one of the most visible ways that we interact with the community. We haven't had a committee meeting in a while, but we're having one next Tuesday, the 22nd. From that committee we have taskforces that work on perinatal depression, substance abuse, and breastfeeding, and we'll be looking also at adolescent health issues. We're also looking at the overall number of births in our community and also the number of preterm births, the number of very low birth weights, and of course, infant mortality. A big focus for our program is to lower the infant mortality rates. We also look at the number of women who receive prenatal care, the number of births to teen mothers, and then overall how many of those women are covered by Medi-Cal. Those are indicators that we look at to see who our community is and who we need to focus on. We also focus on improving the health outcomes of our women, children, and adolescents.

Ensuring good health outcomes for moms includes having access to care during the perinatal period. It's also important for pregnant women to stay drug free, alcohol free, and tobacco free and to have a safe environment to live in.

When we talk about good health outcomes, during the perinatal period the mom should have access to specialty services and prenatal care. Overall, we've done pretty well with this. We have pretty good rates with women who are receiving prenatal care. We're also looking at during the mother's life, but especially during the perinatal period, that they're drug free, alcohol free, and tobacco free. Substance abuse counseling and domestic violence prevention are assessed. There needs to be a safe environment for the mom and baby. When we talk about healthy outcomes for the baby we're talking about a full-term baby who has access to care, access to services if they need it, and that they're breastfeeding babies.

It's important to have information about prenatal care in English, Spanish, and Hmong in order to help reach out to all communities

We're really making an effort to provide all of our information in the three languages, Spanish, English, and Hmong. When we have our campaign we're making sure that we reach out to all the communities. We know that language is an issue when it comes to access to care, and we need to make sure that our clients are able to communicate with their providers. We also have community health aides that go along and provide assistance with translation and transportation.

African American women in Fresno County have the highest percentage of babies with low birth weight

Fresno has some pretty high numbers for children 0 to 17 years old living below the poverty level. They are nearly thirty-two percent. Fresno ranks among one of the poorest counties. We also know that about one in five in our population are women of reproductive age. The main payer source in our county is Medi-Cal at sixty-one percent, which is very high. Between 1992 and 2002 African Americans had the highest percentage of babies with low birth weights. We know that there are some contributing factors to low birth weight, which include inadequate prenatal care, smoking, and poor nutrition. Those are things that we try to address both in our home visits and in working with our comprehensive perinatal service providers. Hospital charges for a newborn without any complications are about \$1500, but for those infants with a principal diagnosis of prematurity it's about \$79,000. That depends, of course, on if they're in ICU and how long they're there. About twenty-five percent of those premature infants have longterm health problems. The Healthy People 2010 objective is that only five percent of all births would be of low birth weight. California hasn't met that objective and Fresno County hasn't met that objective. In 2002 our highest number was around twelve percent, and that was with the African American group. That's well over two times what is recommended. In 1992 nearly 40 per 1000 African American infants were dying. We've been working with the Healthy Start grant to do outreach to make sure that moms are getting into prenatal care. Even with that effort, ten years later we still have 17 per 1000 African American infants dying. While that's half the rate it was ten years ago, that's still very high. We have a very serious problem, particularly among African Americans, and the focus of our Black Infant Health Program is to make sure that we're reaching out and providing services, whether it's transportation or visits or education.

Several strategies are used to reach out to the community and provide education and services

We work with the EOC to have street outreach where they actually go door to door in the community and go to laundromats, nail shops, and health fairs. We have a lot of brochures in different languages. We do a media blitz with radio and television so that we can encourage our community to get prenatal care, to stop smoking, and not to drink or take drugs while they're pregnant. We also have case management programs. One is called the Nurse Family Partnership. That's for first time mothers and teen mothers. The other is West Fresno Comprehensive Case Management where we're working with moms. The third part of our strategy is to have increased awareness in education and training. We have a lot of health educators who are working on developing strategies and working on different brochures and different educational material. Educational material is really an important part. We're looking at other ways to communicate to our community. If a brochure is not the most effective way we want to know what some of the other effective ways are. We're looking at interactive, websites, CDs, and other ways we can communicate. We're not assuming that because we give a brochure to somebody health behaviors are going to change. The other thing that has been developed through efforts with Dr. Ira Chasnoff is a screening assessment referral treatment for women with perinatal substance abuse. This is a screening that we do with our providers to assess women going in for prenatal care to determine whether they're smoking or drinking. We also assess for domestic violence. We're finding a very strong correlation in women between having

a problem with substance abuse during pregnancy and having to deal with domestic violence. It's not surprising, but it just confirms some of the things that we already know in terms of risks. We also have a strategy to identify infants and young children prenatally exposed to substances. One of the efforts that has come out of that is the model of care that's at Exceptional Parents Unlimited. All of these strategies came out of looking at the needs in the community. We needed to have comprehensive care and a place where all kinds of assessments – developmental, physical, and mental – could be at one location.

There are many programs which provide services under the umbrella of Maternal Child Health

I want to give you an overview of the Maternal, Child, and Adolescent Health. Everything is under Maternal Child Health, which is our whole county effort, but these are specific programs. I mentioned already that we have an effort toward black infant health and domestic violence prevention. Another effort is the Fetal Infant Mortality Review. Healthy Start is the Babies First Program, which is more of our outreach and focus strategy on certain census tracts. We work with the EOC on the Perinatal Outreach and Care Coordination. Nurse Family Partnership and West Fresno Comprehensive Case Management are our two nurse home visiting programs. We also had a program that was in Huron and Coalinga where we were able to provide some case management and translation and transportation. The contract is ending at the end of June so we won't be able to provide those services, but it's been a very good program in the rural area. The next program is our mental health team where nurses are doing assessments for perinatal depression. They're using the Edinboro screening tool, and if the score is high enough we can refer them to our mental health team that will work with them by doing more assessments and some linkages to services. In many cases we're also doing therapy, which has been very helpful to the women. When women get that kind of support they're also able to stay in the program. Our programs like the Nurse Family Partnership are for two-and-a-half years, which is really a life course program since we're working with many teenagers and first-time moms to make sure that they have their resources, that they're finishing high school, in some cases that they're actually getting some job training. When they have services like mental health and other linkages we find more success with that. The next program is the Medi-Cal CPSP. We have 66 providers who are CPSP providers. That's about half of all OB-GYN providers in our community. We're trying to make sure that women that are on Medi-Cal have access to comprehensive care. The last program to mention is the breastfeeding program. We've made some real efforts to increase the awareness as well as educate our providers about breastfeeding. When babies leave our hospitals the breastfeeding rates are very low compared to other communities, and so we wanted to make a very deliberate effort to start increasing that awareness and also to train our community leaders and our health professionals about this. We had an effort last year where we were able to do breastfeeding counseling and education and we educated 200 professionals last year. It was a very good program and I think we're going to see some changes in terms of practice and making sure that our babies are breastfed.