



NORWALK PUBLIC SCHOOLS

125 East Avenue • P.O. Box 6001
Norwalk, Connecticut 06852-6001
Tel: (203) 854-4001 • Fax: (203) 838-3299
Email: papallo@norwalkps.org

William R. Papallo, Ph.D.

Interim Superintendent of Schools

August 14, 2009

BOARD MEETING INFORMATION

For AUGUST 18, 2009

FROM: William Papallo

ACTIONS

Approve signature changes for ED-099 Agreement -- This is a formality required by the State. It will designate me as primary signer of this report.

Approve contract for changes in Columbus Elementary School traffic pattern. We await the final copy of the contract from the City legal department.

INFORMATION AND REPORTS

There are two extremely significant items under information and reports which I plan to bring forward in the near future. They are time sensitive issues given that schools open on September 2nd.

The first item calls for the **reinstatement of the equivalent of one assistant principal** such that two of the four schools now designated for a .5 assistant principal would then have a full time assistant. The challenge at this time is to determine which two of the four schools should receive full time positions. An examination of the vital statistics shows them to be very close in terms of the statistics and a good case can be made for each. My mode of operation, when possible, is to include the affected staff in the discussions, thus central office staff and I will meet with the principals in question to discuss this issue. However, since at least one principal is on vacation we will not be able to meet until Monday. It is my plan to have a decision soon after that meeting.

The second item calls for the **reinstatement of the human resources assistant**. It would be impossible to overestimate the critical nature of the need for the reinstatement of this position. A detailed statement, financial information and back up material are included in the board's packet. I ask that you review this material carefully and think about the implications of each of the functions.

FYI – As I stated at the last board meeting, budget reductions are never easy as such reductions create a situation where there are no “good” decisions to be made. This year the problem was compounded because the reductions to the submitted budget were historic in nature. I know that no one, parents, community leaders, board members or staff wanted to see the dramatic reductions made to the board budget but there was no choice given the worldwide financial crisis. This applies to the two items discussed above and I know that it applies to many other areas of reductions as well since many such programs eliminated had been supported by the board for years. However, now that the reality of those reductions are becoming more evident by the day a much more clear view of the impact of those reductions can be seen thus making it essential to reinstate some of those items reduced.

The question which will be asked, “How is the decision made to recommend restoring one area over another?” It is a good question which is not easily answered as many decisions involve, in varying degree, quantifiable data mixed with the subjective. A major consideration is the effect of the item in question to the overall affect on the school system. **THE ASSISTANT PRINCIPAL:** This issue was given priority because of the many demands placed on our schools by daily needs and the demands required by the greater involvement of the federal and state governments. **THE HR ASSISTANT:** The decision to eliminate this position brought into sharper focus the highly technical nature of this position which requires not only a highly skilled person but one with a great deal of experience. Hundreds, probably thousands of people are affected by the areas of responsibility of this position. Additional information is included herein.

I apologize for not having adequate time to provide you with information much sooner but I am still playing “catch up” on this and a number of other issues. Thanks for your attention to these matters.

Portable Classrooms: As of this writing, reports indicate that all is on schedule and the portables will arrive on site on the 17th and will be ready for use on the 14th of September. The foundation and other necessary preparations are completed.

Central Kitchen: I met with Dan Cook, Mark Gorian and Jim Iezzi and all agreed with the redesign of the space and the changes are now in progress. All are happy.

OTHER INFORMATION

THE COMMISSIONER: I received a call from the Commissioner about the closing of Wright Tech and the fact that students who wish to attend a technical school will be able to attend Abbott Tech in Danbury (24 plus miles from here by way of route 7). I told the commissioner that the transportation funds from the closing of Wright Tech are already committed and he claimed that there would be some money available to assist us. I have been in contact with others on the staff but no specifics are available from them at this time relative to this issue. One thing that I was told by the SDE staff is that since the closing of Wright Tech happened so suddenly and after budgets were completed **that John Wayne Fox, the representative from Stamford, is planning to submit**

legislation containing a grant which would provide funds for VoTech transportation in such cases. I have a call in to the superintendent in Stamford about this issue and we will talk early next week. **I encourage all board members and others to contact our representative to endorse this legislation.** I was also told that the legislature may take up this issue in a possible session on August 27 or 28.

ATTACHMENTS

ADHD Awareness Week information
Rationale for reinstatement of HR position
Attachments A-F (Elementary Asst. Principals & HR position)

ADHD Awareness Week

- Letter to parents on District and School websites
- Information on ADHD available to all schools and school personnel
- Parent/teacher workshop at Columbus by CPAC on Understanding ADHD (English and Spanish)

Dear Parents:

The Norwalk Board of Education has designated the week of September 14-18 as 'ADHD Awareness Week'. Attached is a document provided by the National Resource Center on AD/HD entitled "The Disorder Named AD/HD". It is an informative document describing the disorder including symptoms, diagnosis and treatment.

The Connecticut State Department of Education has published the Report on Attention Deficit/Hyperactivity Disorder, 3rd Edition. It was written by the Connecticut ADHD Task Force and is available online at www.ctserc.org. Individual copies can be ordered by calling SERC (State Education Resource Center) at (860) 632-1485.

The Federal Department of Education has published Identifying and treating Attention Deficit hyperactivity Disorder – A Resource for Home and School. It is no longer available to be mailed out, but can be accessed online at www.edpub.ed.gov.

CHADD (Children and Adults with ADD) is the National Organization which provides valuable information for parents and teachers as well as individual diagnosed with ADHD. This organization can be accessed online at www.chadd.org.

If you have specific questions regarding ADHD, please contact the Special Education Supervisor, School Psychologist, School Social Worker or Special Education Instructional staff at your building.

Janie Friedlander
Director of Pupil Services



WHAT WE KNOW

The Disorder Named AD/HD

Occasionally, we may all have difficulty sitting still, paying attention or controlling impulsive behavior. For some people, the problems are so pervasive and persistent that they interfere with their lives, including home, academic, social and work settings.

Attention-deficit/hyperactivity disorder (AD/HD) is a common neurobiological condition affecting 5-8 percent of school age children^{1,2,3,4,5,6,7} with symptoms persisting into adulthood in as many as 60 percent of cases (i.e. approximately 4% of adults).^{8,9} It is characterized by developmentally inappropriate levels of inattention, impulsivity, and hyperactivity.

Although individuals with this disorder can be very successful in life, without identification and proper treatment, AD/HD may have serious consequences, including school failure, family stress and disruption, depression, problems with relationships, substance abuse, delinquency, risk for accidental injuries and job failure. Early identification and treatment are extremely important.

Medical science first documented children exhibiting inattentiveness, impulsivity and hyperactivity in 1902. Since that time, the disorder has been given numerous names, including minimal brain dysfunction, hyperkinetic reaction of childhood and attention-deficit disorder with or without hyperactivity. With the *Diagnostic and Statistical Manual, fourth edition (DSM-IV)* classification system, the disorder has been renamed attention-deficit/hyperactivity disorder, or AD/HD. The current name reflects the importance of the inattention characteristics of the disorder as well as the other characteristics of the disorder, such as hyperactivity and impulsivity.

THE SYMPTOMS

Typically, AD/HD symptoms arise in early childhood, unless associated with some type of brain injury later in life. Some symptoms persist into adulthood and may pose life-long challenges. Although the official diagnostic criteria state that the onset of symptoms must occur before age seven, leading researchers in the field of AD/HD argue that criterion should be broadened to include onset anytime during childhood.¹⁰ The symptom-related criteria for the three primary subtypes are adapted from *DSM-IV* and summarized as follows:

“ Although individuals with this disorder can be very successful in life, without proper identification and proper treatment, AD/HD may have serious consequences... ”

AD/HD predominantly inattentive type: (AD/HD-I)

- Fails to give close attention to details or makes careless mistakes.
- Has difficulty sustaining attention.
- Does not appear to listen.
- Struggles to follow through on instructions.
- Has difficulty with organization.
- Avoids or dislikes tasks requiring sustained mental effort.
- Loses things.
- Is easily distracted.
- Is forgetful in daily activities.

AD/HD predominantly hyperactive-impulsive type: (AD/HD-HI)

- Fidgets with hands or feet or squirms in chair.
- Has difficulty remaining seated.
- Runs about or climbs excessively.
- Difficulty engaging in activities quietly.
- Acts as if driven by a motor.
- Talks excessively.
- Blurts out answers before questions have been completed.
- Difficulty waiting or taking turns.
- Interrupts or intrudes upon others.

AD/HD combined type: (AD/HD-C)

- Individual meets both sets of inattention and hyperactive/impulsive criteria.

Youngsters with AD/HD often experience delays in independent functioning and may therefore behave in ways more like younger children.¹¹ In addition, AD/HD frequently co-occurs with other conditions, such as depression, anxiety or learning disabilities. For example, in 1999, NIMH research indicated that two-thirds of children with AD/HD have a least one other co-existing condition.¹² When co-existing conditions are present, academic and behavioral problems, as well as emotional issues, may be more complex.

Teens with AD/HD present a special challenge. During these years, academic and organizational demands increase. In addition, these impulsive youngsters are facing typical adolescent issues: discovering their identity, establishing independence, dealing with peer pressure, exposure to illegal drugs, emerging sexuality, and the challenges of teen driving.

Recently, deficits in executive function have emerged as key factors impacting academic and career success.¹³ Simply stated, executive function refers to the “variety of functions within the brain that activate, organize, integrate and manage other functions.”¹⁴ This permits individuals to appreciate the longer-term consequences of their actions and guide their behavior across time more effectively.¹⁵ Critical concerns include deficits in working memory and the ability to plan for the future, as well as maintaining and shifting strategies in the service of long-term goals.

THE DIAGNOSIS

Determining if a child has AD/HD is a multifaceted process. Many biological and psychological problems can contribute to symptoms similar to those exhibited by children with AD/HD. For example, anxiety, depression and certain types of learning disabilities may cause similar symptoms. In some cases, these other conditions may actually be the primary diagnosis; in others, these conditions may co-exist with AD/HD.

There is no single test to diagnose AD/HD. Therefore, a comprehensive evaluation is necessary to establish a diagnosis, rule out other causes and determine the presence or absence of co-existing conditions. Such an evaluation requires time and effort and should include a careful history and a clinical assessment of the

individual's academic, social, and emotional functioning and developmental level. A careful history should be taken from the parents and teachers, as well as the child, when appropriate. Checklists for rating AD/HD symptoms and ruling out other disabilities are often used by clinicians; these age-normed instruments help to ensure that the symptoms are extreme for the child's developmental level.

There are several types of professionals who can diagnose AD/HD, including school psychologists, clinical psychologists, clinical social workers, nurse practitioners, neurologists, psychiatrists and pediatricians. Regardless of who does the evaluation, the use of the *Diagnostic and Statistical Manual IV* diagnostic criteria for AD/HD is necessary. A medical exam by a physician is important and should include a thorough physical examination, including assessment of hearing and vision, to rule out other medical problems that may be causing symptoms similar to AD/HD. In rare cases, persons with AD/

“Research clearly indicates that AD/HD tends to run in families and that the patterns of transmission are to a large extent genetic.”

HD also may have a thyroid dysfunction. Only medical doctors can prescribe medication if it is needed.

Diagnosing AD/HD in an adult requires an evaluation of the history of childhood problems in behavior and academic domains, as well as examination of current symptoms and coping strategies. For more information, read *What We Know* #9, “Diagnosis of AD/HD in Adults.”

THE CAUSES

Multiple studies have been conducted to discover the cause of the disorder. Research clearly indicates that AD/HD tends to run in families and that the patterns of transmission are to a large extent genetic.^{16,17} More than 20 genetic studies, in fact, have shown evidence that AD/HD is strongly inherited. Yet AD/HD is a complex disorder, which is undoubtedly the result of multiple interacting genes. Other causal factors (such as low birth weight, prenatal maternal smoking, and additional

prenatal problems) may contribute to other cases of AD/HD.^{18,19,20,21} Problems in parenting or parenting styles may make AD/HD better or worse, but these do not cause the disorder. AD/HD is clearly a brain-based disorder. Currently research is underway to better define the areas and pathways that are involved.

PROGNOSIS AND LONG-TERM OUTCOMES

Children with AD/HD are at risk for potentially serious problems in adolescence: academic underachievement and school failure, problems in social relations, risk for antisocial behavior patterns, teen pregnancy, and adverse driving consequences.²² As noted above, AD/HD persists from childhood to adolescence in the vast majority of cases, although the symptom area of motor activity tends to diminish with time. Furthermore, up to two-thirds of children with AD/HD continue to experience significant symptoms in adulthood. Yet many adults with AD/HD learn coping strategies and compensate quite well.^{23,24} A key to good outcome is early identification and treatment.

MULTIMODAL TREATMENT

AD/HD in children often requires a comprehensive approach to treatment called “*multimodal*” and includes:

- Parent and child education about diagnosis and treatment
- Behavior management techniques
- Medication
- School programming and supports

Treatment should be tailored to the unique needs of each child and family. Research from the landmark NIMH Multimodal Treatment Study of AD/HD is very encouraging.²⁵ Children who received carefully monitored medication, alone or in combination with behavioral treatment, showed significant improvement in their behavior at home and school plus better relationships with their classmates and family than did children receiving lower quality care.

Psychostimulants are the most widely used class of medication for the management of AD/HD related symptoms. Approximately 70 to 80 percent of children with AD/HD respond positively to psychostimulant medications.²⁶ Significant academic improvement is shown by students who take these medications: *increases in* attention and concentration, compliance and effort on tasks, as well as amount and accuracy of schoolwork, plus *decreased* activity levels, impulsivity, negative

behaviors in social interactions and physical and verbal hostility.^{27,28} A new, nonstimulant medication—atomoxetine—appears to have similar effects as the stimulants.

Other medications that may decrease impulsivity, hyperactivity and aggression include some antidepressants and antihypertensives. However, each family must weigh the pros and cons of taking medication (see *What We Know #3*, “Managing Medication for Children and Adolescents with AD/HD”).

Behavioral interventions are also a major component of treatment for children who have AD/HD. Important strategies include being consistent and using positive reinforcement, and teaching problem-solving, communication, and self-advocacy skills. Children, especially teenagers, should be actively involved as respected members of the school planning and treatment teams (see *What We Know #7*, “Psychosocial Treatment for Children and Adolescents with AD/HD”).

School success may require a variety of classroom accommodations and behavioral interventions. Most children with AD/HD can be taught in the regular classroom with minor adjustments to the environment. Some children may require special education services if an educational need is indicated. These services may be provided within the regular education classroom or may require a special placement outside of the regular classroom that meets the child’s unique learning needs (see *What We Know #4* “Educational Rights for Children with AD/HD”).

Adults with AD/HD may benefit from learning to structure their environment. In addition, medications effective for childhood AD/HD are also helpful for adults who have AD/HD. While little research has been done on interventions for adults, diagnosis and treatment are still important.

SUMMARY

Although the symptoms of AD/HD—inattention, impulsivity and hyperactivity—are present to some extent in most children, when these symptoms are developmentally extreme, pervasive and persistent a diagnosis of AD/HD is warranted. This diagnostic category is associated with significant impairment in family relations, peer interactions, school achievement, and risk for accidental injury, which are domains

of crucial importance for healthy and successful development. Because AD/HD can become a lifelong disorder, careful diagnosis and treatment are essential. CHADD is seeking out solutions that will lead to improved quality of life for children, adolescents and adults.

SUGGESTED READING

Barkley, R. (1998). *Attention Deficit Hyperactivity Disorders: A Handbook for Diagnosis and Treatment*. New York: Guilford Press.

Brown, T.E. (2000). *Attention-deficit Disorders and Comorbidities in Children, Adolescents, and Adults*. Washington, D.C.: American Psychiatric Press, Inc.

Dendy, C.A.Z and Ziegler, Alex. (2003). *A Bird’s-Eye View of Life with ADD and ADHD: Advice from Young Survivors*. Cedar Bluff, AL: Cherish the Children York, NY: The Guilford Press.

Goldstein, S. (1998). *Managing Attention Deficit Hyperactivity Disorder in Children: A Guide for Practitioners*. New York, NY: John Wiley & Sons.

Hallowell, E.M. and Ratey, J.J. (1995). *Driven to Distraction: Recognizing and Coping with Attention Deficit Disorder from Childhood through Adulthood*. New York: Simon & Schuster.

Ingersoll, Barbara D. (1995). *Distant Drums, Different Drummers: A Guide for Young People with ADHD*. Germantown, MD: Cape Publications.

Jensen, P.S. and Cooper, J.R., editors. (2002) *Attention Deficit Hyperactivity Disorder: State of Science—Best Practices*. Kingston, NJ: Civic Research Institute.

Jensen, P. (2004) *Making the System Work for Your Child with ADHD: An Expert Parent’s Guide to Getting the Best Care*. New York, NY: Guilford Press.

Jones, Clare. (2003) *Practical Suggestions for ADHD*. East Moline, IL: LinguiSystems Publications.

Nadeau, Kathleen G. and Quinn, Patricia O., editors. (2002) *Understanding Women with AD/HD*. Silver Spring, MD: Advantage Books.

Nadeau, Kathleen G.; Littman, Ellen B.; and Quinn, Patricia O. (1999) *Understanding Girls With AD/HD*. Silver Spring, MD: Advantage Books.

Parker, H.C. (2002). *Problem Solver Guide for Students with ADHD: Ready-to-Use Interventions for Elementary and Secondary Students with Attention Deficit Hyperactivity Disorder*. Plantation, FL: Impact Publications.

Rief, S. (2003). *The AD/HD Book of Lists*. San Francisco, CA: Jossey-Bass.

Robin, A.L. (1998). *ADHD in Adolescents: Diagnosis and Treatment*. New York, NY: The Guilford Press.

Solden, Sari. (1995). *Women with Attention Deficit Disorder: Embracing disorganization at Home and in the Workplace*. Grass Valley, CA: Underwood Books.

Weiss, Lynn. (1997). *Attention Deficit Disorder in Adults: Practical Help and Understanding*. Lanham, MD: Taylor Trade Publishing.

Wilens, Timothy (1999). *Straight Talk about Psychiatric Medications for Kids*. New York, NY: Guilford Press.

REFERENCES

1. American Psychiatric Association (2000). *Diagnostic and statistical manual of mental disorders: DSM IV* (4th ed., text, revision), Washington, D.C.: American Psychiatric Association.
2. Mayo Clinic. (2002). How Common is Attention-Deficit/Hyperactivity Disorder? *Archives of Pediatrics and Adolescent Medicine* 156(3): 209-210.
3. Mayo Clinic (2001). Utilization and Costs of Medical Care for Children and Adolescents with and without Attention-Deficit/Hyperactivity Disorder. *Journal of the American Medical Association* 285(1): 60-66.
4. Surgeon General of the United States (1999). *Mental Health: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services.
5. American Academy of Pediatrics (2000). Clinical practice guidelines: Diagnosis and evaluation of the child with attention-deficit/hyperactivity disorder. *Pediatrics*, 105, 1158-1170.
6. Centers for Disease Control and Prevention (2003). Prevalence of diagnosis and medication treatment for attention-deficit/hyperactivity disorder. *Morbidity and Mortality Weekly Report* 54: 842-847.
7. Froehlich, T.E., Lanphear, B.P., Epstein, J.N., et al. Prevalence, recognition, and treatment of attention-deficit/hyperactivity disorder in a national sample of US children. *Archives of Pediatric and Adolescent Medicine* (2007), 161:857-864.
8. Faraone, S.V., Biederman, J., & Mick, E. (2006) The age-dependent decline of attention-deficit hyperactivity disorder: A meta-analysis of follow-up studies. *Psychol Med* (2006), 36: 159-65.
9. Kessler, R.C., Adler, L., Barkley, R., Biederman, J., et al. The prevalence and correlates of adult ADHD in the United States: Results from the National Comorbidity Survey Replication. *Am Journal of Psychiatry* (2006), 163:724-732.
10. Barkley, RA. (1998). *Attention deficit hyperactivity disorders: A handbook for diagnosis and treatment*. New York: Guilford Press.
11. Ibid.
12. A Cooperative Group. (1999) A 14-month randomized clinical trial of treatment strategies for attention deficit hyperactivity disorder. *Archives of General Psychiatry*, 56, 12.
13. Barkley, RA. (1998). *Attention deficit hyperactivity disorders: A handbook for diagnosis and treatment*. New York: Guilford Press.
14. Brown, T.E. (2000). *Attention-deficit Disorders and Comorbidities in Children, Adolescents, and Adults*. Washington, D.C.: American Psychiatric Press, Inc.
15. Fuster, J.M. (1997). *The prefrontal cortex: anatomy, physiology, and neuropsychology of the frontal lobe*. Philadelphia: Lippincott-Raven.
16. Tannock, R (1998). Attention deficit hyperactivity disorder: Advances in cognitive, neurobiological, and genetic research. *Journal of Child Psychology and Psychiatry*, 39, 65-99.
17. Swanson, JM, and Castellanos, FX (2002). Biological Bases of ADHD—Neuroanatomy, Genetics, and Pathophysiology. In P.S. Jensen and J.R. Cooper (eds). *Attention deficit hyperactivity disorder: State of the science, best practices*, pp. 7-1—7-20. Kingston, New Jersey.
18. Connor, D.R. (2002). Preschool Attention deficit hyperactivity disorder: A review of prevalence, diagnosis, neurobiology, and stimulant treatment. *Journal of Developmental Behavior Pediatrics* 23 (1Suppl): S1-S9.
19. Wilens, T.E., Biederman, J.; Brown, S.; Tanguay, S.; Monteaux, M.C.; Blake, C.; Spencer, J.J. (2002). Psychiatric co-morbidity and functioning in clinically referred preschool children and school age youths with AD/HD. *Journal of the American Academy of Child and Adolescent Psychiatry* 4(3): 26-28.
20. Teeter, P. (1998). *Interventions for AD/HD*. New York: Guilford Press.
21. Jones, C. (2003). *Practical Suggestions for AD/HD*. East Moline, IL: Lingui-Systems.
22. Barkley, RA. (1998). *Attention deficit hyperactivity disorders: A handbook for diagnosis and treatment*. New York: Guilford Press.
23. Barkley, RA, Fischer, M., Fletcher, K., & Smallish, L. (2001) *Young adult outcome of hyperactive children as a function of severity of childhood conduct problems, I: Psychiatric status and mental health treatment*. Submitted for publication.
24. Weiss G, Hechtman, L, Milroy T et al. (1985). Psychiatric studies of hyperactives as adults: a controlled prospective 15-year follow-up of 63 hyperactive children. *Journal of the American Academy of Child Psychiatry*, 23, 211-220.
25. MTA Cooperative Group. (1999) A 14-month randomized clinical trial of treatment strategies for attention deficit hyperactivity disorder. *Archives of General Psychiatry*, 56, 12.
26. Ibid.
27. Spencer, T., Wilens, T., Biederman, J., Faraone, S. V., Ablon, J. S., & Lapey, K. (1995). A double-blind, crossover comparison of methylphenidate and placebo in adults with childhood-onset attention-deficit hyperactivity disorder. *Archives of General Psychiatry*, 52, 434-443.
28. Swanson, JM, McBurnett K, et al (1993) Effect of stimulant medication on children with attention deficit disorder: a "review of reviews." *Exceptional Children*, 60, 154-162.

The information provided in this sheet was supported by Grant/Cooperative Agreement Number 1U38DD000335-01 from the Centers for Disease Control and Prevention (CDC). The contents are solely the responsibility of the authors and do not necessarily represent the official views of CDC. This fact sheet was approved by CHADD's Professional Advisory Board in 2004.

© 2004 Children and Adults with Attention-Deficit/Hyperactivity Disorder (CHADD).

Updated February 2008

Permission is granted to photocopy and freely distribute this What We Know sheet, provided that this document is reproduced in its entirety, including the CHADD and NRC names, logos and contact information.

For further information about AD/HD or CHADD, please contact:

**National Resource Center on AD/HD
Children and Adults with
Attention-Deficit/Hyperactivity Disorder**

8181 Professional Place, Suite 150

Landover, MD 20785

1-800-233-4050

www.help4adhd.org

Please also visit the CHADD Web site at

www.chadd.org

REINSTATEMENT OF A POSITION IN THE HUMAN RESOURCES DEPARTMENT

The attached is a representative selection of the material reviewed and developed in an effort to explain and describe the extreme importance of the need to reinstate this position. It is sincerely hoped that the attachments show the magnitude of the need for this position relative to the operations of the Norwalk School system. Many hundreds, maybe thousands, depend on the services provided by this position.

The documents submitted in support of the reinstatement of this position:

Document A provides a snapshot of the available funds for the reinstatement of the HR assistant position, should the board so decide. The compensation for this position is \$66,543 annually with a cost for benefits of \$22,988. The funds for this reinstatement are presented in the document. As you will see, this document also contains financial information about the reinstatements of full time assistant principals in two of the four schools now slated for .5 elementary assistant principal. This issue is discussed elsewhere in this material.

Document B1 & B2 lists some of the many functions that are extremely technical in nature. A reading of the list along with a few minutes of thought as to the various facets of each of these functions should provide the reader with the complex nature of each of these functions. They are functions that require that the person in this position have extensive training and years of experience to perform these functions. Each activity requires the knowledge of state and federal laws, contracts, the culture of the organization and more. It is impossible to fully explain the magnitude of the negative implications to the system if not reinstated.

Document C1 lists the major areas which will be impacted if this position is not reinstated. This document also presents those functions, which were added to the position recently. They are listed to present some idea as to how the area of responsibility for this position has grown over the years.

Document C2 provides background for document C1 above. A casual reading of this document should show that the areas of **Health Care, union contracts and the Munis human resources system** alone are major functions above and beyond the list of functions presented in document B1 and B2.

Document D represents the functions, which have been redistributed due to the loss of the Data Clerk Position

Document E represents the functions, which have been redistributed due to the loss of the Insurance Clerk

Document F provides information that you have seen before but I thought it worth including once again.

8/14/09

A**Funds Available Since 7/1/09**

* West Rocks Assistant Principal Vacancies		
Salary (1 for 2 months)		\$22,665
Health Benefits (2 for 2 months)		\$7,663
* Wright Tech Transportation		
		\$133,026
* Director of Technology Vacancy		
Salary (2 months)		\$24,572
Health Benefits (2 months)		\$3,831
Sub Total Available Funds		\$191,757

Cost if Human Resources Position is Lost

* Based on 26 weeks of coverage unemployment insurance		
		\$14,274
* Based on 4 months of coverage health insurance COBRA		
		\$5,213
* Restore Part time Subfinder Operator		
		\$21,000
Sub Total Available Funds		\$40,487

Total Funds Available	+	\$232,244
------------------------------	----------	------------------

Proposed Expenditure of Funds**Item #1**

Reinstate 1 Elementary Assistant Principal		
Salary (Step 2)		\$108,658
Benefits		\$22,988
		\$131,646

Item #2

Reinstate HR Assistant		
Salary		\$66,543
Benefits		\$22,988
		\$89,531

Total Proposed Expenditures	-	\$221,177
------------------------------------	----------	------------------

Remaining Funds		\$11,067
------------------------	--	-----------------

Reasons why HR Assistant functions cannot be shifted to others in the department or other departments.

(This position requires a college degree, knowledge of human resources processes and labor relations.)

The HR Assistant makes critical judgments regarding all aspects of employment for non-certified staff*.

- Assures funding for all vacancies
- Works with principals, directors and grant managers to properly post and advertise positions
- Reviews and processes all recommendations
- Conducts criminal background ground checks
- Meets with each new employee to review documents, policies and procedures
- Sets salary and benefits
- Negotiates with temporary staffing agencies
- Arranges and provides professional development for teacher aides and secretaries
- Conducts testing for all custodial candidates

The HR Assistant researches and analyzes information for non-certified staff.

- Contract negotiations
- Grievances
- Labor board hearings
- Longevity benefits
- Pension qualification
- Seniority rights
- Tuition reimbursement
- Vacation entitlements

The HR Assistant performs discrete aspects of labor issues for all employees.

- Unemployment processing (determines qualification for benefits, presents at hearings)
- Worker' Compensation* (Liaison to CIRMA and City Safety Committee)

Departments that would be impacted by the loss of this position

- School
- Curriculum
- Finance
- Payroll
- Facilities
- Food Services

The HR Assistant performs these duties without clerical assistance. The salary is barely above the salary of a clerical worker, but the duties are managerial.

*Teacher aides, secretaries, custodians, maintenance workers, security guards, monitors, technicians, food service workers. (Note the HR Assistant has taken on responsibility for food service workers which had been handled by the Central Kitchen and unemployment processing which had been handled by an outside contractor and has improved both functions.)

Major Areas of Impact on the loss of the Human Resources Assistant Position

- 1) The HR Assistant had previous training and experience in the areas of health care, unemployment compensation, and workers compensation.
- 2) The HR Assistant can translate written Spanish and knows basic oral Spanish.
- 3) The HR Assistant covers the office from 4:00 to 5:00 p.m. each day, to serve the public and employees who are unavailable at other times.
- 4) The work of the HR Assistant would be shifted to clerical employees who would be working out of their job descriptions and, monitoring their own union contract.
- 5) The HR Assistant is highly skilled in the areas of technology and has taken the lead for the office in transitioning to the MUNIS human resources system.
- 6) The HR Assistant supports our most vulnerable employees in the qualifying for public housing assistance, child care support, home heating support and other social service functions.
- 7) The HR Assistant has specific knowledge of the non-certified contracts relative to pension enrollment, longevity upgrades, and tuition reimbursement.
- 8) The HR Assistant works very closely with the Special Education Department to monitor special education aides and assure that IEP service requirements are followed.
- 9) The HR Assistant provides data and research that is critical to ongoing contract negotiations with non-certified groups.

Tasks which have been added to the HR department in recent years

- a. Management of health/dental/life plans for all employees
- b. Management of SubFinder (used to be a half time employee)
- c. Management of teacher and teacher aide requirements under NCLB
- d. Management of BEST program (used to be a stipend for a teacher)
- e. Management of increased CHRO claims
- f. Hiring and maintenance of coaches
- g. Hiring and maintenance of food service employees
- h. Intake and criminal background check of school volunteers
- i. Management of flexible spending and health saving account plans
- j. Responses to FOI requests
- k. Management of new requirements under FMLA
- l. Management of new COBRA requirements under ARRA.

Background for items on page 1.

1)

Health care – There are six different carriers of health and life benefits. Select NPS staff must be approved, trained and given permission to gain access to systems. Information is highly confidential.

Unemployment claims – There was a contract with a third party (\$\$\$) to support response to unemployment claims. The contract was cancelled because the service was poor and created more work than managing claims internally. Failure to respond to claims accurately can result in incorrect approvals. Issuing assurances of continued employment (especially during the summer months) results in significant savings.

Workers' Compensations claims – CIRMA represents NPS for work injury claims. It is essential to stay on top of these claims so that employees are properly reviewed and returned to work as soon as possible. Failure to monitor these claims can result in unnecessary loss of employee time at work and costs for replacement workers.

4)

Working out of job descriptions and monitoring their own union contract – The NFEP contract is one of the most detailed and work intensive. Some responsibilities would have to fall on the two clerical employees who are members of the NFEP union. Other work would be shifted to the schools, the finance department and payroll. All have also lost key employees.

5)

MUNIS human resources system – The Human Resources Office has been without a data system. Requests for funding have been denied for nine years. The MUNIS system has a human resources component which is not a match for our business, but must suffice. Training in Crystal Reports has allowed the production of some reports from the system; however, the HR Assistant has drawn on prior knowledge to assist others in the office and this support has been critical.

a. The HR department will enroll all new employees in health, prescription, dental and life insurance plans, update changes for current and retired employee, meet with employees who are experiencing difficulties with coverage, meet with representatives of the seven different providers to learn of changes to the processes and procedures.

d. The BEST program is being re-designed by the state. Responsibilities which were once managed by the state will be shifted to the local districts creating greater need for time and funding resources within the HR department.

Major Areas of Impact on the loss of the Free and Reduced Lunch Data Clerk Position

- 1) The FRL data clerk took major responsibility for the qualification of families for free and reduced lunch rates and following up on uncollected payments.
- 2) The FRL data clerk spoke fluent Spanish which improved the collection rate since a high number of families are Spanish speaking.
- 3) The FRL data clerk assisted in the verifying and reporting enrollments for district and state reports.

Outcome

The individual who held this position has resigned to take a job with a bank.

The functions will be returned to the schools with support from the Central Kitchen staff. Bilingual support will be provided by other bilingual staff on a limited basis.

Major Areas of Impact on the loss of the Insurance Clerk Position

- 1) The Insurance Clerk enrolled all new employees in health, prescription, dental and life insurance plans.
- 2) The Insurance Clerk updated changes for current and retired employees.
- 3) The Insurance Clerk met with employees who were experiencing difficulties with coverage.
- 4) The Insurance Clerk met with representatives of the seven different providers to learn of changes to the processes and procedures.
- 5) The Insurance Clerk maintained records of all premiums due and paid.
- 6) The Insurance Clerk submitted reports to the Teacher's Retirement Board for state subsidy for retired teachers.
- 7) The Insurance Clerk monitored monthly claims.

Outcome

The individual who held this position has retired.

Functions 1-4 have been shifted to Human Resources Office.

Functions 5-7 have been shifted to the Finance Office.

Position: HR ASSISTANT – NON-CERTIFIED (Aides, secretaries, custodians, maintenance workers, security guards, food service workers, technicians)

Current Responsibilities:

POSTINGS

- Post jobs on website
- Receive recommendations
- Inform unsuccessful candidates
- Keep website up to date and accurate

NEW HIRES

- Meet with new hires
- Inform of contractual benefits
- Establish compensation, benefit eligibility
- Perform all new hire paperwork, database checks, files
- State police check if needed
- Prepare all necessary correspondence for signatures

UNEMPLOYMENT (for entire district)

- Attendance at hearings
- Reasonable assurance letters/notifications
- Appeal claims
- Proof bills, prepare PO's for payment
- Appeal erroneous charges

WORKERS COMP (for entire district)

- Hearings
- Claims
- Reporting for CIRMA
- Liaison between district and schools
- Employee attendance verification/correction

TEMPORARY STAFFING

Position Responsibility Template-HR ASSISTANT

F

- Process requests for temporary staffing
- Negotiate rates for temp staff with agencies
- Orient temporary staff
- Proof bills, prepare PO's for payments

EVALUATIONS

- Prepare evaluations for all non-certified employees
- Send to schools
- Record received evaluations
- Arrange meetings for inadequate evaluations/non-renewals

TECHNICIANS CONTRACT

- Longevity-confirm eligibility and calculate
- Midyear longevity-confirm eligibility and calculate
- Tuition reimbursement for NFEP confirm eligibility and calculate
- Vacation entitlement notices
- Grievance management
- Manually update annual salaries

FOOD SERVICES CONTRACT

- Longevity
- Mid-year longevity
- Grievance management
- Manually update annual salaries

NFEP CONTRACT

- Longevity
- Midyear longevity
- Seniority lists
- Tuition reimbursement
- Vacation entitlement notices
- Grievance management
- Bumping/RIFing
- Manually update annual salaries

Professional day program development/notification

CUSTODIAN CONTRACT

- Longevity
- Seniority lists
- Vacation entitlement notices
- Grievance management
- Manually update annual salaries

REPORTS

- Holiday notices
- ED 162-mandated state reporting of all employees
- Seniority lists
- Negotiation reports
- OSHA report (annual) January
- Statistical/employee data for departments/schools
- Holiday calendar/notices

OTHER

- Filing
- Correspondence
- General office communication
- Noncertified substitute interviewing and hiring
- Cafeteria aide interviewing and hiring
- SCHEIG testing for all custodial applicants
- School to career student applications/payroll maintenance
- 21st Century grant applications/payroll maintenance
- Title I comparability reports
- Notary public
- State Police Record Check – trained and certified
- Workplace Safety and Health Committee

SUMMER SCHOOL/CAMP

Position Responsibility Template-HR ASSISTANT

F

Orientation for PF Camp
Summer Sports Camp
Hiring for noncertified staff

PENSION

Liaison for NMEA pension
Forms, enrollment, retirements