



CITY OF DANBURY
HEALTH & HUMAN SERVICES DEPARTMENT
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Mayor Mark D. Boughton
City Council
155 Deer Hill Avenue
Danbury, CT 06810

April 27, 2015

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Re: Health & Human Services Department Monthly Report

Dear Mayor Boughton and Members of the City Council:

The March 2015 Health & Human Services Department monthly report is provided for your review. Detailed reports are attached for each Service, including the Housing, Food Service, Lead Poisoning Prevention, Social Services transition, Seasonal Work, School Based Health Centers operations and Environmental Health which identify specific inspections, tasks and hours provided by our staff.

Main Topics:

The Department continues to work on the computer systems to test and update our inspector's programs to produce reports so the public may have access to inspection results and improve partnerships with the Hospital and other medical clinics to improve services have continued as well. Continued work and preparation for Public Health Emergency Response plans, Winter / Cold Protocol and actions with Schools, Health Care facilities, Regional Partners and EMS. You are encouraged to review all the information for each Division, as it provides details concerning ongoing activities. Also, I thank you for giving the Health & Human Services Department the opportunity to serve the Citizens of Danbury and feel free to contact us with any questions you may have.

Sincerely,

Scott T. LeRoy, MPH, MS
Director of Health & Human Service

TO: Mayor Boughton and City Council

FR: Social Services

RE: Activities during March, 2015

Mission Statement:

Our Social Services seek to provide the community and its residents with access to municipal and community social services in an expeditious, cost effective and comprehensive manner. Efforts are focused on improving access to housing and emergency shelters; improving access to medical care and coverage and improving social conditions for residents via collaboration and advocacy at the local, state and federal level by identifying and working to create systems of resources that are inclusive of all residents/clients in need.

The following are the highlights from our Social Services activities for March, 2015:

- I. Our Housing Caseworker managed approximately 56 active cases.
 1. The Day Center, located at the Emergency Shelter, had approximately 865 visits from homeless individuals or those at risk of becoming homeless (this includes weekend service meetings). The breakdown of visits include the following:
 - a. Initial Assessments(new clients): 3
 - b. Action Plan Development: 14
 - c. Veteran Referrals: 53
 - d. Referrals to Cash Assistance: 2
 - e. Bus Tickets: 2
 - f. Housing Related Issues: 3
 - g. Housing Placement:1
 - h. Job Searches: 11
 - i. Employment inquiries: 0
 - j. Case Management Services: 35
 - k. Showers: 136
 - l. Lunch: 445
 - m. Mental Health Referrals/Case Management: 0
 - n. Adult Medical Referrals: 4
 - o. Phone Usage: 6
 - p. Substance Abuse Referrals/Case Management: 141*
 - q. Clothing Vouchers: 0
 - r. Other: 9**

*MCCA counseling services have **RESUMED** on Saturday and Sunday from the hours of 9:00am – 3:00pm. In- house counseling referral and case management services at the Day Center are also provided Monday through Friday. Due to MCCA weekend counselor having 3 prior commitments, there was 3 weeks of no counseling services.

**coordinated access referral/call to 211, client verbal requests, and shelter from the cold.

The Homeless Management Information System (HMIS) is continually updated on a monthly and quarterly basis to reflect current clients and activities in the Social Services section of the Health Department and through constant liaison with Dream Homes (ARC).

1. Receiving weekly food donations from arrangement with Community Plates.
 2. Attended one (1) meeting of the Community Food Collaborative meeting at United Way.
 3. Meeting with Shelter Coordinator to discuss changes and new required documentation intake forms, vulnerability reports/intakes for Coordinated Access.
 4. Review and updating/completing initial documentation required of all clients at the Emergency Shelter for Coordinated Access.
 5. Working with clients for acceptance of grant funds for rapid rehousing.
 6. Meeting with staff at Emergency Shelter at night to coordinate and access extra number of homeless clients needing beds at all four community shelters.
 7. Food pick-up from Trader Joe's will be held every Tuesday for the City Shelter.
 8. Weekly meetings held at Danbury Mental Health Office with assorted community leaders and social service organizations/agencies for a weekly community care team for assisting our homeless clients for a variety of needs (i.e. housing, substance abuse, mental health issues, etc.).
 9. Attended one (1) meeting of the CoC.
 10. Conducted intake/interviews with homeless population for Coordinated Access at the Emergency Shelter on Tuesday and Wednesday mornings.
 11. Attended one (1) meeting of Coordinated Access Team.
 12. Attended one (1) meeting for Social and Supportive Service Committee of the Danbury Housing Partnership.
 13. Attended on (1) meeting for Housing and Community Development Committee of the Danbury Housing Partnership.
 14. 211 Emergency Shelter given to several homeless families through DOH winter protocol funding for the City of Danbury's Emergency Shelter.
 15. Medical and Behavior clinic opened at the Emergency Shelter, with assistance from the Community Health Center on March 26, 2015.
 16. Provided rapid re-housing for one client through 3 month rental assistance.
 17. Information given for 2 clients to submit paperwork and rental lease agreement for rapid re-housing assistance.
 18. Attended two day workshop for 100 day housing first for Fairfield Can and the Danbury community to rapidly re-house clients through 211 protocol, and Vi-Spdat vulnerability scoring.
 19. Submitted EFSP/United Way grant for Emergency Shelter.
 20. Attended one (1) meeting of the Food Collaborative Team at United Way.
 21. Follow-up meeting for Project Homeless Connect at the Danbury Police Station.
 22. Housing First Collaborative meeting held at City Hall.
 23. Submitted HMIS Data to Finance for DOH credit.
 24. Attended one (1) meeting of the Farmers' Market.
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School Based Health Centers (SBHCs)

Monthly Operating Report

March 2015

Brief Program Description: The School Based Health Centers (SBHCs) are freestanding medical centers, located on the grounds of Broadview and Rogers Park Middle Schools, Danbury High School, Henry Abbott Technical School and Newtown Middle School.

The SBHCs promote the physical and mental health of children and youth and ensure their access to comprehensive primary and preventive health care. SBHCs emphasize early identification of physical and mental health concerns and the prevention of more serious problems through early intervention.

Mission: Through improved access to care, children and adolescents will know and adopt behaviors that promote their health and well-being and experience reduced morbidity and mortality through early identification intervention.

Patient Utilization Data for Period July 1, 2014 – March 31, 2015:

(Note: Data is for all sites combined and cumulative through noted period)

	DHS, BMS, RPMS (DPH Funded)	NMS (DPH Funded)	HATS (Non-DPH Funded)
Total # of Students Enrolled in all Schools	4,975	829	640
Total # of Patients Enrolled in the SBHCs	4,830	114	404
% of Total School Population Enrolled	97% (Up 9% since Sept. 30 st)	14%	63* *Increase of 18% since 8/31/14
Total # of Patient Visits	4,252 (743 patient visits in March)	71 (70 patient visits in March)	119
Total # of Medical Visits	2,139 (362 medical visits in March)	22	119
Total # of Behavioral Health Visits	1,700 (309 BH visits in March)	49	n/a
Total # Dental Visits	413	n/a	n/a

**SBHC Annual Aggregate Billing Status Report
7/1/14 – 3/31/15**

For the period July 1, 2014 – March 31, 2015:

Billed Charges \$303,763.62

Cash Received \$281,465.65



Program Snapshot: Activities/Meetings held March 1, 2015 – March 31, 2015:

M. Bonjour - SBHC Manager

03/02/15 & 03/09/15 – Convened staff meetings with NMS SBHC staff to assess implementation progress.

03/03/15 & 03/31/15 -Participated in CIFC Management meetings held at OST administrative offices.

03/06/15 – Presented public testimony on impact of proposed budget cuts to SBHC DPH line item to members of the Appropriations Committee of CT State Legislature.

03/13/15 – Organized a public “ribbon cutting” event in recognition and celebration of the opening of the new NMS SBHC (See photo included the in Newtown SBHC Implementation Update section of this report)

03/25/15 – Convened SBHC staff meeting at OST Board meeting room.

03/25/15 – Participated in NMS SBHC Advisory Board meeting held at the NMS. Community outreach and upcoming DPH licensing inspection was discussed.

03/26/15 – Met with Claudine Constant, CHCACT AmeriCorps Program Supervisor to conducted A. Carini’s mid-year review.

03/30/15 – Joined D. Channing and D. Savarese in a brief presentation on CIFC’s proposed integration of behavioral health and primary care services to a United Way grant review panel. The SBHC model of integrated care was highlighted during the discussion.

0/31/15 – Participated in a roundtable on mental health led by U.S. Senator Chris Murphy and held at Danbury Hospital PraxAir Conference Center.

Clinical Staff – All Sites

All SBHC staff are up to date with completion of required Relias Training Courses.

03/02/15 - J. George and J. Sawyer attended Newtown District School Nurses Meeting at NHS to share information about SBHC services and referral processes

03/03/15 - All staff completed DPH contractual required annual Basic Life Support CPR for Health Care Providers certification and first aid refresher course which was led by C. Nespoli, APRN and N. Munn, APRN.

03/04/15 - 03/27/15 - NMS SBHC staff attended nine (9) Cluster meetings to introduce SBHC staff to students and meet all NMS academic teachers

03/11/15 – K. White, APRN, M. Bonjour and A. Carini participated in the Community Advisory Board meeting at Families Network of Western CT.

03/11/15 - SBHC mental health practitioners met at Broadview Middle School for monthly peer supervision.

03/12/15 - J. Sawyer, NMS LCSW met with Jill Pluta, Clinical Director of Newtown Youth and Family Services regarding referral processes

03/12/15 - SBHC staff attended a Drug Recognition Awareness Conference sponsored through Newtown/Brookfield Police Departments for school administrators, resource officers, & nurses.

03/15/15 – SBHC APRN’s met with Dr. Golenbock, MD for monthly medical supervision meeting.

03/19/15 – NMS SBHC staff participated in NMS Counselor/Nurse/Administration meeting

03/20/15 - Jenny Casey represented the SBHC programs at a meeting of Danbury’s Promise for Children Partnership Meeting.

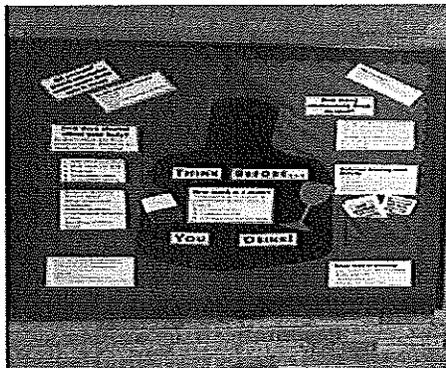
3/23/15 = K. White, DHS APRN attended Board of Directors’ meeting at Newtown Youth and Family Services.

Outcomes	Measures	Achievement of Outcome
<p>1. Improve access to and utilization of primary and preventive health care and other essential public health services.</p>	<p>a. There will be at least 70% percent of the school’s student population enrolled in the SBHC. Enrolled means that a signed parent consent form for the student is on file.</p> <p>b. At least 45% of students enrolled in the SBHC will receive one or more visits.</p> <p>c. At least 80% percent of the student population will receive an outreach contact regarding services available at the SBHC (through distribution of literature, invitation to an open house or event, participation in an educational forum, social media, or other contact).</p>	<p>a. DHS has 100% enrollment as of 3/31/15.</p> <p>BMS 85% enrollment as of 3/31/15</p> <p>RPMS 95% enrollment as of 3/31/15</p> <p>NMS 14% enrollment as of 3/31/15</p> <p>b. 17% DHS enrolled students rec’d 1 or more visits for this school year</p> <p>27% BMS enrolled</p>

		<p>students rec'd 1 or more visits for this school year</p> <p>39% RPMS enrolled students rec'd 1 or more visits for this school year</p> <p>25% NMS enrolled students rec'd 1 or more visits for this school year</p> <p>c.100% DHS students' rec'd outreach contracts as of 3/31/15.</p> <p>100% BMS students rec'd outreach contracts as of 3/31/15</p> <p>100% RPMS students rec'd outreach contracts as of 3/31/15</p> <p>100% NMS students rec'd outreach contracts as of 3/31/15</p>
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DHS SBHC –

Bulletin board for March was “Think Before You Drink



Dine and Discover student outreach activity for March focused on the topic of good nutrition. Along with the display board, SBHC staff had pamphlets on nutrition and healthy food options. Staff had students

enter a contest by answering three true or false questions based on information given on our presentation board. A winner was randomly selected and student was given a \$10 Peachwave gift card.

New SBHC registration forms are given to students at the time of visit, but unfortunately the return rate is minimal. At this point it is probably better to wait to send them in the mail to parents directly all at once.

A list of 12th graders was run in database for quality purposes. Student status as well as grades were checked against PowerSchool. List is only half way complete and I have identified many with incorrect grades as well as 19 students that should be removed from database.

BMS SBHC –

Geri Alpert, Office Manager, on an ongoing basis, is reviewing incoming registration forms and referring all uninsured students to the GDCHC for assistance with Husky Applications through Access Health.

School RN gives out registration forms to any students without registration forms whom she thinks would have benefited from our services.

GDCHC contact information is included with every letter sent home to SBHC members who need immunizations and/or physical exams.

Year to date = 13 referrals to local PCPs for a medical home (9 GDCHC).

RPMS SBHC –

In March, there were fifteen (15) reproductive presentations to four (4) eighth grade health classes. SBHC services are emphasized in relationship to what topic we are discussing and SBHC consents are available in the health classroom. We continue to receive new enrollees because of the school nurses, new entrants, teachers, guidance counselors and other outreach efforts.

The “Birthday Star” program, started by the MA in November 2014, continues with great success in accessing the entire student body over the school year. This program has been able to reach students who may not have stepped into our door otherwise. It is breaking any type of barrier that may exist within the school that would otherwise stop them from taking that first step in! Every student is welcomed in and wished a “happy birthday”, given a small goody bag with a Birthday Star sticker to wear for the day, School Based Health Center pencil, a small notebook, a chapstick, a small fun item, and most importantly, SBHC consent if they are not already registered.

MA continues to assist RPMS School Nurse with a group that meets after school for students who have been referred by their guidance counselors, school social workers, teachers, nurses or SBHC. The goal of the group is to introduce them to healthy after-school hobbies and activities that they may continue to enjoy and have interest in during their spare time. It has also proven to be a great opportunity for children who would not normally interact, to work together toward a common goal. During March, the group was able to utilize the occupational therapy room which has a kitchen. The students were taught how to make homemade strawberry jam and biscuits. This group has met on Thursdays since 02/05/15.

The MA continues to process new consents as they come in as a result of an additional consent being given to the student when they come in for the “Birthday Star” program, nurse referral, counselor referral or by new school enrollment, . The Dental program continues with the MA scheduling and coordinating student’s appointments to be seen by the Dentist and/or Hygienist. The dentist came in two extra days to facilitate getting students in for their dental needs. Dental consents are offered to all new enrollees, as well as any student who does not have a dentist on their consent form as they are seen in the SBHC. Distribution of the student survey began on 03/30/2015 whereas each student coming into the SBHC for services is given a survey either prior to or after their appointment.

As a measure of student outreach, a SBHC bulletin board display was created for spring with the caption “When we are healthy, our minds and bodies blossom!” surrounded by blooming flowers.

NMS SBHC –

The NMS SBHC enrollment packet cover letter was updated and on 03/10/15, and email blast went out to all NMS families with the SBHC enrollment form and informational page about the SBHC staff.

On 03/23/15, NMS SBHC staff distributed SBHC information to all NMS teachers. A cover letter and SBHC enrollment packets were left in each of 72 teachers’ mailboxes. Teachers were encouraged to distribute enrollment forms during conferences to parents of students whom they thought could particularly benefit from SBHC services.

On 03/24/15, NMS SBHC staff did outreach at parent teacher conferences. Staff set up an information table in the school lobby and talked to parents as they came in for conferences. Staff handed out enrollment packets and answer parent questions.

NMS APRN composed an Excel spreadsheet for patients who do not have a primary care provider (PCP) and who they are referred to. This spreadsheet includes name, the PCP who they are referred to, date, and comments. APRN screens each patient for a PCP. Every patient seen so far has an established PCP.

Outcomes	Measures	Achievement of Outcome
2. Reduce the occurrence of preventable disease among SBHC enrollees.	<p>a. Enrolled students will be immunized with vaccines recommended by Advisory Committee on Immunization Practices (ACIP) that are required by the State of CT. Annually the number of clinic users who received immunizations and the percentage of students behind in recommended intervals for immunizations who are brought up to date will be reported to the Department.</p> <p>b. The percentage of clinic users offered as well as the number who received Influenza Vaccine will be reported to the Department.</p>	<p>RPMS – No required vaccines were given in March, as all students are up to date.</p> <p>Five (5) recommended vaccines were administered in March.</p> <p>100% compliance with vaccines being given at the SBHC.</p> <p>100% RPMS students received education</p>

	<p>c. The percentage of clinic users who received influenza prevention teaching will be reported to the Department.</p>	<p>through classroom & open house presentations.</p> <p>Zero (0) flu vaccines given. APRN informed all reproductive & skin cancer classes of flu vaccine availability.</p> <p>BMS SBHC – See notes below**</p>
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** Selected as an outcome measure by RPMS SBHC only.

RPMS SBHC –

The APRN works closely with the school nurses to obtain current vaccine/PE records from providers as new HIPPA laws do not allow the medical providers to give a student's vaccine information to the nurses without parental consent. The APRN is available to provide vaccines to those enrolled who needed them after receiving parental consent. 2 HepA and 3 HPV vaccines administered for the month of March. There is 100% compliance with vaccine series being given at SBHC.

BMS SBHC – **

100% of students who presented to SBHC APRN with a diagnosis of asthma or who reported asthma in the medical history, received an asthma action plan if not done by PCP. March = 1 Year to date = 30.

Any student with a medical history of asthma whom does not have an albuterol inhaler and spacer with the school RN was given a medical authorization form, and prescription for both (or sample, if applicable). March = 1 Year to date = 30.

All SBHC enrollees (Husky/Uninsured) with a diagnosis of asthma were offered an inactivated injectable influenza vaccine. 54 letters were sent home on 11/10/2014. 6 students to date have received this vaccine as a result.

In reviewing the school nurse's records, identified all students in the school with diagnosis of asthma = 116. Crossed checked who is not a school based health center member = 17. In turn, a letter highlighting our services (especially asthma management) was sent home to these 17 students along with a registration form.

Outcomes	Measures	Achievement of Outcome
<p>3. SBHC enrollees will utilize mental health services to improve their psychosocial functioning through assessment, intervention and referral.</p>	<p>a. 90% of school staff receives information about the mental health services offered through the SBHC.</p> <p>b. 85% of clinic users identified with a mental health concern through risk assessment screening</p>	<p>RPMS SBHC-</p> <p>a. 100% of school staff reached with SBHC information via direct contact</p>

receive a mental health assessment administered by the SBHC mental health clinician or are referred for appropriate assessment.

c. 50% of clinic users receiving mental health services through the SBHC for at least three months or regular therapy demonstrate improved psychosocial functioning.

d. 90% of clinic users identified as having mental health needs that exceed the scope of service provided by through the SBHC are referred to an outside mental health specialty service.

and/or school mailings

b.100% of students seen by MH clinician received risk assessment through use of approved screening tool

c. Of 47 unduplicated students accessing counseling during the month of February, 19 have been seen regularly for 3 mths or longer. Of these, all 31 demonstrate improved psychosocial functioning. This results in 100% students demonstrating improved functioning after > 3 mths visits.

d. No students seen during the mth. of Mar. have been identified as having mental health needs that exceed the scope of services provided by the SBHC.

BMS SBHC –

a.100% of school staff reached with SBHC information via direct contact and/or school mailings

b.100% of students seen by MH clinician received risk assessment through use of approved screening tool

c. 99% students demonstrate improved functioning after > 3 mths visits.

d. 0% students required referral to outside provider

DHS SBHC --

a. 100% of school staff reached with SBHC information via direct contact and/or school mailings

b. 100% of students seen by MH clinician received risk assessment through use of approved screening tool

c. 65% students demonstrate improved functioning after > 3 mths visits as evidenced by GAF scores.

d. 0% students required referral to outside provider

a. 100% of school staff reached with SBHC information via direct contact and/or school mailings

b. 100% of students seen by MH clinician received risk assessment through use of approved screening

		<p>tool</p> <p>a. 100% of NMS school staff received information about the mental health services offered through the SBHC.</p> <p>b. 100% of NMS clinic users identified with a mental health concern through risk assessment screening received a mental health assessment administered by the SBHC mental health clinician or are referred for appropriate assessment.</p> <p>c. The NMS SBHC has been licensed for < one month; data for this outcome measure is not available.</p> <p>d. No SBHC users were identified as having therapeutic needs that exceed the scope of the SBHC. Two clients were identified as potentially benefitting from psychiatric medication referrals. One of them has consulted a psychiatrist; the other will be doing so in the near future.</p>
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The DHS clinician continues to provide ongoing psychotherapy and to receive new referrals from guidance counselors, parents and others. Two (2) of these students-only seen once-may require referrals for medication evaluations and physical exams. The DHS clinician had several contacts this month for two (2) patients seen by the DHS clinician. Additionally, another student required coordination of care with his medical doctor's office. Contact was via telephone. The meeting was held on the 10th of March and attended by the DHS clinician, the student and his mother, and DHS staff Silvia Borges-Bostik and Matt Laskowski.

One of the DHS clinician's clients presented to the DHS crisis counselor, Stan Watkins, LCSW pursuant to an increase in suicidal ideation. Parents were contacted and a crisis referral was done. Client was not admitted and is continuing to work with the DHS clinician. There is and will continue to be coordinated treatment efforts between Karen London, LCSW and Stan Watkins as well as increased treatment frequency as needed. Additionally, Ms. London will continue to work to provide guidance to parents who are reluctant to explore medication options for the student.

One (1) student has had ongoing issues in her Advisory Period. The DHS clinician spoke to the student's level administrator/assistant principal in order to coordinate efforts to help resolve the concerns.

BMS SBHC –

During the month of March 2015 the SBHC LCSW completed five (5) intakes for new students, saw thirty-three (33) students individually and facilitated six (6) groups per week, with a total of sixty-five (65) group participants. She met with one parent and made one referral to Family and Children's Aid. The SBHC mental health practitioners met at Broadview for peer supervision. Planning continued for the "Middle School United; A Week of Kindness and Inclusion" (formally known as Alternative to Violence Week).

On 03/11/15 and 03/25/15, J. Casey, Broadview SBHC LCSW, co-facilitated with Christine Miller, BMS Social Skills Counselor, meetings for students who are interested in being leaders for this year's "Middle School United; A Week of Kindness and Inclusion.

Planning has continued for "*Middle School United; A Week of Kindness and Inclusion*", the week-long activity formerly known as "Alternative to Violence Week" to be held May 18 - 21, 2015. Jenny Casey is coordinating this year's activities with Christine Miller, BMS Social Skills Counselor. They are meeting weekly with a group of student leaders to plan activities. A short video will be created showing how Broadview is already united, kind and inclusive. Each day that week will feature a special theme, such as "Mindful Monday" and "Thankful Thursday". Special activities and speakers are being planned with the week culminating in willing students signing a kindness and inclusion pledge.

RPMS SBHC –

The "Healing from Grief" group has been meeting weekly since November 12th. The group now has nine (9) students participating. Of these nine (9) students, eight (8) have lost a parent or primary caregiver in their life. Three of these students are dealing with multiple significant losses in their life. Several previously unidentified children have recently been referred to the SBHC as having a need for a grief group. Due to this identified need, a new group will be starting in April. The current group is coming to a close. The group is planning a balloon launch to close the group on April 1st. All members of the "Healing from Grief" group have been offered a spot in the newly forming group.

Three of the clinic social workers met for monthly peer supervision on March 11, 2015. The behavioral health staff from Broadview MS and Rogers Park MS have been meeting and talking to discuss school-wide programming for May. In the past, programs centered on alternatives to violence have been presented. Through discussion, we realize the needs of the students currently are more centered on improving and developing healthy coping skills and reducing social isolation. The focus on programming in May will be centered on building and fostering overall mental health well-being. The RPMS SBHC Counselor has been meeting with the school principal as well as support staff to identify current needs. One idea is to explore the option of bringing Yoga instruction to RPMS. The clinic counselor has been making outreach telephone calls to area instructors to assess the feasibility of this idea.

The RPMS SBHC Counselor was invited to join the Housatonic Valley Coalition Against Substance Abuse (HVCASA) as a middle school and SBHC representative. A meeting for a future parent awareness workshop was held on March 18th.

The RPMS SBHC Counselor had a family therapy session with a student and parent. This student was having difficulty in getting Mom to understand the things that were bothering her and impacting her depression. Both student and Mom reported the meeting to be very helpful.

The RPMS SBHC Counselor participated in three cluster team meetings with student/parents for three students currently being seen in the SBHC. Additionally, the counselor was asked to come talk with a parent struggling with issues with his teenage daughter. She was then introduced to the counselor as someone who would be able to offer support and assistance. This latter case being a student who had previously not been registered with the SBHC. Counseling services in the SBHC have been a valuable resource to the school guidance counselors as they meet with students having emotional difficulties or when meeting with parents struggling with issues with their middle school children.

NMS SBHC –

Three (3) students were referred to the Mental Health Clinician who have Social Anxiety Disorder. A weekly therapy group was therefore started to address the issues experienced by these students. Three (3) sessions have been held thus far.

The NMS LCSW has met with four parents, or sets thereof, prior to meeting with their children in therapy. In the cases of students whose parents the LCSW has not spoken with prior to their session, a call was made to all but one of the parents. In the case of one parent, the LCSW has been playing telephone tag with him.

No barriers to achieving contact with parents have existed.

Outcomes**	Measures	Achievement of Outcome
4. Reduce the severity and frequency of asthma symptoms among students with asthma who utilize the SBHC.	<ul style="list-style-type: none"> a. 90% of clinic users with asthma have a written asthma action plan. b. 80% of clinic users compliant with a written action plan show improvement in symptoms as documented by a health care provider in medical record. c. There is a 20% decrease in urgent visits (visits by clinic users seen in the SBHC due to asthma symptoms) as assessed by clinician notes, EHR or data base. d. 90% of clinic users with asthma have a document flu vaccine. e. E. The number of clinic users with asthma that report reduction in admissions to the ER during the school year is increased by 20%. 	<ul style="list-style-type: none"> a. 100% BMS and NMS patients with reported asthma have an action plans. b. See notes below c. See notes below d. See notes below e. See notes below

** Selected as an outcome measure by BMS & NMS SBHCs only.

BMS SBHC –

100% of students who presented to SBHC APRN with a diagnosis of asthma or who reported asthma in the medical history, received an asthma action plan if not done by PCP. March = 1 Year to date =30.

Any student with a medical history of asthma whom does not have an albuterol inhaler and spacer with the school RN was given a medical authorization form, and prescription for both (or sample, if applicable). March = 1 Year to date = 30.

All SBHC enrollees (Husky/Uninsured) with a diagnosis of asthma were offered an inactivated injectable influenza vaccine. 54 letters were sent home on 11/10/2014. 6 students to date have received this vaccine as a result.

In reviewing the school nurse's records, identified all students in the school with diagnosis of asthma = 116. Crossed checked who is not a school based health center member = 17. In turn, a letter highlighting our services (especially asthma management) was sent home to these 17 students along with a registration form.

NMS SBHC –

The SBHC APRN has scanned all patients for asthma. Only one (1) patient has been identified with asthma since the NMS SBHC has been officially open (February 26, 2015).

100% of clinic users with asthma have a written asthma action plan.

APRN has not seen the patient again after first encounter to see if there was an improvement in symptoms. The patient had an asthma action plan completed by another provider prior to the first appointment at the SBHC. This patient was seen by the SBHC APRN for a non-asthma complaint and had a normal respiratory exam at the time of the SBHC visit.

Decrease in clinic users in the SBHC due to asthma symptoms unknown; the one child seen for asthma has not returned.

100% of clinic users with asthma have a flu vaccine. This vaccine was not given at the SBHC.

The one patient seen at the NMS SBHC for asthma symptoms reports never going to the ED for asthma.

APRN has constructed an Excel spreadsheet to document the name, date of birth, if the patient has a medication administration form for the nurse and the date it was given, if an asthma action plan was given and then date, if the patient had a flu vaccine, amount of ED visits, and a list of dates of SBHC visits.

5. Reduce the proportion of SBHC users with obesity. (Not selected as a specific measure this program year)

See Attached: "Summary of Children's BMI-for-Age" compiled by the RPMS SBHC

Outcomes	Measures	Achievement of Outcome
6. Reduce the occurrence of STDs among student SBHC enrollees	a. 85% of sexually active students are screened for STDs.	<p>a. 100% DHS patients seen for possible STD screened for STIs to date (33 out of 33)</p> <p>0 % RPMS patients screened for STDs*to date - no one identified as sexually active.</p> <p>0 % BMS patients screened for STDs*to date - no one identified as sexually active.</p>

All students who reported sexual activity were screened for Chlamydia and gonorrhea using urine based testing method. The SBHC collaborates with the CT DPH STD Division and the State Lab to screen sexually active students. Students are referred to Planned Parenthood, the AIDS Project of Greater Danbury, the Danbury STI clinic and local GYN offices for additional services as needed.

RPMS SBHC –

The Nurse Practitioner assisted the Health teacher with the reproductive health unit. The APRN has given fifteen (15) reproductive classes in March to the four 8th grade health classes, completing two (2) groups. Since September eight (8) different 8th grade classes have received presentations for a total of 120 presentations for the first three 8th grade health rotations. Information is given regarding health throughout the lifespan, puberty, pregnancy, contraception and abstinence, STDs and the M&M game. This year there is a dedicated health class so reproductive classes are given to boys and girls together which is working well.

7. Increase access to and utilization of primary and preventive oral health care and other essential oral public health services to improve the health status of SBHC enrollees.

(Not selected as a measure this program year)

Alison Carini, 2014-15 HealthCorp member participated in the following activities during the reporting period:

Activities:

- Facilitated SBHC billing and patient electronic medical record maintenance •Designed and implemented two bulletin boards: a cold vs. allergies board for HATS and an underage drinking prevention board for DHS.
- Facilitated patient appointments at HATS and acted as a medical assistant.

Meetings attended:

03/10/15 Coalition for Healthy Kids meeting
03/10/15 CT Mission of Mercy Steering Committee meeting
03/11/15 Families Network of Western CT meeting
03/12/15 AmeriCorps Week Social Networking event with CYP
03/19/15 HATS Dine and Discover about bullying prevention
03/25/15 SBHC Staff meeting
03/25/15 Newtown SBHC Community Advisory Board meeting
03/27/15 CHCACT HealthCorps monthly meeting

Newtown SBHC Implementation Update:

The development and implementation of the new is well underway and project is moving along very smoothly.

SBHC staff continue to conduct outreach to students, parents, school faculty and community-based providers via a number of mechanisms including:

Holding a public “ribbon cutting” event on March 13, 2015 in recognition and celebration of the opening of the new NMS SBHC (See photo below)



SBHC staff participated in NMS SBHC Advisory Board meeting held at the NMS. Community outreach and upcoming DPH licensing inspection was discussed.

J. George and J. Sawyer attended Newtown District School Nurses Meeting at NHS to share information about SBHC services and referral processes

NMS SBHC staff attended nine (9) Cluster meetings to introduce SBHC staff to students and meet all NMS academic teachers

J. Sawyer, NMS LCSW met with Jill Pluta, Clinical Director of Newtown Youth and Family Services regarding referral processes

NMS SBHC staff participated in NMS Counselor/Nurse/Administration meeting



News/Case Studies from the Field:

*An 18 year old female presents to the SBHC for a sports clearance. Her clearance is complicated by the student's report of a history of tachycardia and hypertension. Upon examination, it is noted that her pulse is 100 beats/min and BP is 148/98. She is on medications for ADHD and anxiety/depression. Medical records are obtained from the school RN which shows a markedly elevated BP of 150/108 at her last

exam with her PCP. The PCP notes on her last sports clearance that the hypertension is secondary to anxiety and that she has been cleared by cardiology. The SBHC APRN calls the PCP to obtain the cardiologist's report and confers with the SBHC medical director before clearing the student for participation. The SBHC plans on following her pulse and BP readings and will contact her PCP to suggest the consideration of a change of medications which will treat ADHD and anxiety but also aid in lowering her pulse rate and blood pressure.

*An 18 year old male presents to the SBHC as a new user for 2 acute care visits during the month of March. Upon becoming familiar with the student it is discovered that he has a complicated social history including physical and mental abuse, DCF involvement and homelessness. Additionally, other issues are identified including the need to establish a medical home in the community and the need for an eye examination. The student is given a list of ophthalmologists and optometrists in the area that accept HUSKY insurance. He is also referred to the Greater Danbury Community Health Center to establish a medical home.

*SBHC LCSW has been meeting with a student by the name of H.J. She started NMS on 1/26/15, having transferred from a local town. She has a history of Social Anxiety Disorder, truancy and poor grades. During the last week of February, HJ's guidance counselor reported that HJ had been absent 11 times and tardy several more times. The Guidance counselor and I scheduled and held a meeting with HJ's parents the next day. HJ's anxiety disorder, her truancy and poor school performance were discussed at length. HJ's parents were encouraged to consider a medication evaluation to discuss the possibility of an anti-anxiety medication to reduce her level of anxiety. They agreed to bring her to the psychiatrist to whom they bring HJ's sister, whom also has been diagnosed with anxiety disorder. I scheduled an appointment with HJ for the next day, continued to discuss the manifestations of her anxiety with her and arrived at a plan with her whereby she would check in with me on Monday, Wednesday and Fridays at 7:30 A.M. as a means by which to improve her motivation to come to school. Her parents had, the night before, promised to give her a reward on Fridays if her attendance was improved.

Since the above date HJ has not missed a day of school. She has been tardy two times, but on both those days was able to come to school. During the week of 3/23/15 and the current week of 3/30/15, she has been at school each day and had no tardiness. She met with the above mentioned psychiatrist, has been attending all sessions with me and is positively responding to the reward system her parents worked out for her. HJ reported that her anxiety level has not decreased. We will continue to address it in the therapeutic venue. HJ reported in our session on 4/1/15 that she will be working hard during the next term to improve her school performance. Details of how she will attempt this were discussed on 4/1/15. HJ's attendance improvement is significant and a positive sign of her commitment to address her emotional and behavioral difficulties.

* A student presented to APRN with headache and sore throat. He sees the SBHC counselor because of depression, academic failure, domestic violence, deportation of father recently, and DCF involvement. APRN determined pain was caused by two dental abscesses and he had a low-grade fever. Antibiotics were started in clinic and called into pharmacy. Husky insurance problems prevented him from going for services. The MA spoke with EDS and obtained a temporary Medicaid number. He had been seen by a private dentist about a month ago for one abscessed tooth, treated with antibiotics but never returned because of insurance issues plus they didn't do root canals or sedation. He was seen back at SBHC the next morning for evaluation. He was significantly dental phobic with a large gag reflex and was unable to tolerate having X-rays done. A same day emergency appointment was made to a pediatric dentist who

sedated him and will do the root canals. His primary pediatric provider was called and given the temporary ID number so he could get his DCF required physical done. This shows the collaboration between SBHC staff in order to meet the needs of this multi-problem family. Unfortunately in March the student's mom didn't complete the Husky information completely and no longer was on Husky. He broke both of the teeth that required root canals and was sent back to the dentist to see if there was enough of each tooth left, or would he need extractions and spacers. Fortunately he could still have the root canals but had his appointment rescheduled because of lack of insurance. He now has appointment early April for his root canals as he has insurance.

APRN and Counselor are now working with a student who has significant family and domestic violence issues and missed many days of school because of asthma after a referral from Guidance. The student is part of the Danbury Grassroots Academy and they were also concerned about asthma and absences. Parent and student came in and it was determined student needed a long acting bronchodilator. The student was using the rescue inhaler frequently despite being on long acting steroid. The asthma symptoms improved but was absent again because of what the student perceived as asthma. History revealed possible GERD symptoms and Nexium was ordered along with other treatments to reduce GERD symptoms. What complicates diagnosing this student's symptoms is the severe trauma sustained that included being choked and beaten with a metal bar by a family member who is now in jail for 25 years for multiple abuse charges. First asthma attack coincided with the first domestic violence act of which the student was the victim. SBHC counselor is assessing for PTSD. We are monitoring our medical and mental health interventions to see if they reduce his symptoms and improve his attendance and grades.

*The Counselor and APRN just started working with a 12 year old severely morbidly obese student who is 61 inches tall and 300 pounds with a BMI of 54. Mom was 400 pounds before she had gastric surgery last year and has lost 100 pounds. The student had an elevated insulin and cholesterol level in 2012 but never attended the Fit Kid program and hasn't had a physical exam with the pediatrician since 2012. The pediatrician started seeing the child in October and December for weight checks and counseling but no labs or PE done. Their Husky insurance lapsed because mom didn't respond to the letter sent in December. A meeting was held with the mom, guidance, APRN, SBHC counselor, assistant principal and Mr. Lee, Environmental Specialist, because of the student's absences and weight issues. Student disclosed to mom that student wasn't going to school because didn't fit behind the desks, it was hard to get up off the risers in choir because of weight, and wasn't eating lunch because didn't want to eat in front of others. The student was going to be starting gym again and didn't want to participate. The student has SOB because of morbid obesity and doesn't move or exercise at all. Plans were made/coordinated for lab work, re-establishing Husky, getting a PE done, continued nutritional/exercise counseling, adaptive classroom and gym program, getting her to school daily, individual counseling through SBHC. Within a week of that meeting the student gained 3 pounds because she ate at Union Buffet and also had a double bacon cheeseburger and fries with mom. We are working with mom and student to develop a safe eating environment and limitations on eating out. The next week the student lost 2 pounds after NP spoke with mom. The family is now cooking at home and grandmother is no longer allowed to go grocery shopping as everyone is gaining weight.