



CITY OF DANBURY

HEALTH & HUMAN SERVICES DEPARTMENT
155 DEER HILL AVENUE, DANBURY, CONNECTICUT 06810

Central Health Office
203 - 797-4625
Fax 796-1596

Social Services Office
203 - 797-4569
Fax 797-4566

Mayor Mark D. Boughton
City Council
155 Deer Hill Avenue
Danbury, CT 06810

January 25, 2016

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Re: Health & Human Services Department Monthly Report

Dear Mayor Boughton and Members of the City Council:

The December 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 received two monetary donations listed in the report attached for any expense with the Operations of the Shelter, 1) \$400 from Pembroke Pumping, and 2) \$1000.00 from the Newtown Savings Bank. These funds will be used for any purpose to continue the operations, services, and clients' needs at the Day and Evening Shelter.

The Department also 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 Grant Funding, Public Health Emergency Response plans, CTDP Epidemiology Program follow-up, 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



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TO: Mayor Boughton and City Council

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FR: Social Services

RE: Activities during December, 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 December, 2015:

1. Our Housing Caseworker managed approximately 71 active cases.
2. The Day Center, located at the Emergency Shelter, had approximately 733 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): 10
- b. Action Plan Development: 0
- c. Veteran Referrals: 15
- d. Referrals to Cash Assistance: 0
- e. Bus Tickets: 6
- f. Housing Related Issues: 1
- g. Housing Placement: 0
- h. Job Searches: 2**
- i. Employment inquiries: 0
- j. Case Management Services: 33
- k. Showers: 106
- l. Lunch: 436
- m. Mental Health Referrals/Case Management: 17*
- n. Adult Medical Referrals: 14
- o. Phone Usage: 5
- p. Substance Abuse Referrals/Case Management: 10*
- q. Clothing Vouchers: 0
- r. Other: 78



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*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.

** Providing computer access in Emergency Shelter for job placement and availability.

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. Updating VA Grant per diem for VA representative to discuss summary reports, discharge amendments and plan of action reports for each veteran stay regarding the per diem veterans grant.
4. Meeting with Shelter Coordinator to discuss changes and new required documentation intake forms, vulnerability reports/intakes for Coordinated Access and updating VA forms.
5. The local community CoC has gone “live” for Coordinated Access at the Emergency Shelter on October 27, 2014. 3 appointments will be conducted Monday-Friday at the Emergency Shelter at 8:30am, 9:30am and 10:15am. Interviews with families will be conducted at 11:30am at the Women’s Center, Monday, Tuesday and Thursday. Ongoing appointments made with all local homeless clients staying at all 4 shelters in the community.
6. Attended one (1) meeting of the Continuum of Care.
7. Community Health Clinic has been conducting two clinics per week; medical and behavior clinics at the Emergency Shelter.
8. Attended three (3) meetings of the Community Care Team (CCT) of all community agencies, services and emergency services (Danbury Hospital, Danbury Police, Danbury EMT), to discuss chronic homeless clients in the community.
9. Attended one (1) meeting of the Housing Placement Committee (HPC) in developing a housing registry of clients that are chronically homeless and providing vouchers that are becoming available to the Danbury Community (approximately 30).
10. Finalization of vendors, food and agencies for Project Homeless Connect.
11. Conducted Project Homeless Connect at Western Connecticut State University on December 11th.
12. VA nurse inspection, dietary inspection and safety inspection. All paperwork and files were reviewed for the annual inspection.
13. Last quarterly report and cumulative report for VA GPD for Emergency Shelter.
14. Governor’s Winter Protocol in effect for all Emergency Shelters for clients.
15. Received two donations for the Emergency Shelter: \$400.00 from Pembroke Pumping and \$1000.00 from Newtown Savings Bank.
16. Finalized and presented 2016-2017 Fair Rent Commission Budget.
17. Gave Christmas gifts to over 60 families in the Danbury community through donations and sponsorship.
18. Received 25 food baskets from the Ladies of the Ancient Order of Hibernians for distribution to local needy families.
19. Distributed assorted gifts to our homeless clients on Christmas Eve at the Emergency Shelter from various donations and sponsors.



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School Based Health Centers (SBHCs) 4 Monthly Operating Report December 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 and Danbury High 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 December 1, 2015 – December 31, 2015: (Note: Data is for all sites combined and cumulative through noted period)

	DHS, BMS, RPMS (DPH Funded)
Total # of Students Enrolled in all Schools	5,010
Total # of Patients Enrolled in the SBHCs	4,354
% of Total School Population Enrolled	87%
Total # of Patient Visits	2,327
Total # of Medical Visits	1,218
Total # of Behavioral Health Visits	834
Total # Dental Visits	275

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

M. Bonjour - SBHC Manager

12/01/15 – Attended a meeting of the Statewide Dental Sealant Advisory Group held at Benecare, Rocky Hill at the request of Linda Ferraro, DPH Dental Director.

12/01/15 – Convened the monthly SBHC staff meeting in the Board meeting room, OST.

12/02/15 – 12/04/15 – Traveled to Washington, DC to participate in an on-site National Quality Initiative Collaborative Improvement and Innovation Network (NQI CoIIN) in-person learning session. The goal for the learning session was to equip core team members with quality improvement skills and provide them with practical guidance to build the capacity of the SBHC QI teams in implementing and measuring change. The two-day learning session was led by a distinguished group



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of expert faculty and seasoned improvement advisor who presented participants with useful information and facilitated 5 discussion. The learning session also offered opportunities for group activities and team planning to develop your next steps in the CoIIN.

12/10/16 – Met with representatives of the DPH regulatory and licensing unit along with members of the CT DPH SBHC Advisory Committee to explore the possibility of introducing regulatory changes to the Public Health Code to include minimum standard language specific to SBHCs.

12/10/15 – Participated in a SBHC RBA Report Card Workgroup meeting held at New Britain Hospital. The goal of the workgroup is to develop a common format and dataset(s) for reporting SBHC outcomes.

12/10/15 – Joined CIFIC management staff at OST in an initial focus group discussion as part of CIFICs strategic planning process.

12/14/15 – Participated in a final webinar of the national Policy Learning Collaborative. State achievements as a result of participating in the pilot project were highlighted, including CT's success in developing a state definition for School-Based Health Centers.

12/14/15 – Met with Victoria Penn of the Danbury Adult Education Program who shared information about the WERACE Program.

12/15/15 – Participated in a Community Action Planning Steering Committee Meeting at Danbury Hospital in the 6 Tower Conference Room. Mark Abraham from DataHaven presented results of a state-wide Well Being survey to the committee.

12/15/15 – Attended the quarterly meeting of the Families Network of Western CT Advisory Committee.

12/15/15 – Participated in the regional ESF-8 meeting held at Newtown Ambulance.

12/16/15 – Attended to CT Coalition on Orla Health Leadership meeting, Farmington, CT.

12/16/15 – Participated in a CT Association of School-Based Health Centers Conference Committee call.

12/16/15 – Chaired the monthly meeting of the CT Association of School-Based Health Centers Board of Directors. Agenda items included legislative and conference planning updates. Meeting was followed by a CASBHC Conference Committee meeting to review progress in conference planning.

SBHC Clinical Staff

All SBHC staff completed and are current with required Relias training courses.

All staff continue with the transition to electronic health records (EHR). To date, all SBHC have “gone live” on the medical component of the EHR. Behavioral health staff will enter visit codes and move to full use of EHR as soon as the system is cloud based to assure operational efficiency and record safety, and continue to meet as a team to provider peer training on use of the system until a more formal, targeted training is held.

12/01/15 – All SBHC staff convened for a monthly staff meeting at OST, board meeting room.

12/03/15 – J. Casey, LCSW attended the Anna Grace Project “Loves Wins” Conference held at WCSU.

12/07/15 – All SBHC behavioral health providers convened for a monthly peer supervision session.

12/10/15 – C. Cunningham, RPMS LPC attended a meeting of the Drug Free Schools Committee of the Housatonic Valley Coalition on Substance Abuse as a SBHC representative.

12/15/15 – M. Bonjour and K. White, APRN attended the quarterly meeting of the Community Advisory Board to Families Network of Western CT.

12/22/15 – SBHC medical providers met with Dr. Robert Golenbock, MD for monthly group supervision.

SBHC Outcome Measures

07/01/15 – 06/30/16

During FY 2015-16, SBHC staff will collect patient data and report on the following DPH required outcome measures listed below. Outcome data results will be updated cumulatively and presented in the CIFIC monthly BOD reports. Additionally, data will be utilized to prepare an annual SBHC RBA Report Card and compared to 2014-15 data, noting trends in reasons for visit or patient outcomes.



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Outcomes	Measures	Achievement of Outcome 6
<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 (40% for the NMS site) 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 94% enrollment as of 11/30/15</p> <p>b. 10% (620 visits by 276 users) of DHS enrolled students rec. 1 or more visit as of 12/31/15</p> <p>c. 100% DHS students received outreach contacts as of 12/31/15</p> <p>a. BMS has 76% enrollment as of 12/31/15</p> <p>b. 30% of BMS enrolled students rec. 1 or more visits as of 12/31/15</p> <p>c. 100% BMS students received outreach contacts as of 12/31/15</p> <p>a. RPMS has 78% enrollment as of 12/31/15</p> <p>b. 68% of RPMS enrolled students rec. 1 or more visits as of 12/31/15</p> <p>c. 100% students received outreach as of 12/31/15</p>

DHS SBHC –

New registrants continue to be verified in PowerSchool and entered. New CIFIC registration forms have been successfully mailed to all students in grades 9-11, and are returning slowly.

BMS SBHC –

Geri Alpert, MA continues to review incoming registration forms and referring all uninsured students to the GDCHC for assistance with Husky Applications through Access Health.

School RN and Guidance Department are giving out registration forms to any students without registration forms whom they think would benefit from our services.

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



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90% of parents are called by APRN after seeing their child, with the hope that a personal phone conversation will lend 7 towards the establishment of therapeutic relationship and in turn increase word of mouth positive feedback regarding the SBHC with other parents.

Year to date = four (4) referrals to local PCPs for a medical home (3 GDCHC). Year to date referrals to Access Health for Husky Insurance = 3.

Clare Nespoli, APRN continues to precept a YALE PNP student eight hours per week.

J. Casey, LCSW, was interviewed two times during the month of December by 8th grader students as part of an assignment to write a feature article on a person or topic for the BMS Bear's Den student newspaper.

RPMS SBHC –

The Birthday Star program continues on a daily basis with birthdays being announced each day and any student not enrolled being given another consent form to bring home for their parent or guardian.

The RPMS MA and one of the school nurses have begun the afterschool group for a select group of girls who are in need of some extra guidance and peer interaction/companionship. The group met for the first time this year on Dec. 9. The girls each made a “sock snowman” and rolled, cut out, baked and decorated cookies to eat and take home. Their appreciation was genuine and several said they would be giving their snowman to a family member as a gift for the holiday as they did not have anything else to give them.

*Selected as a DPH reportable outcome by the RPMS SBHC site only this program year.

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>c. The percentage of clinic users who received influenza prevention teaching will be reported to the Department.</p>	<p>a. No (0) required vaccines given during the month of December. There were six (6) recommended vaccines given: 6 HPV, and 1 Flu.</p> <p>b. One (1) influenza vaccines administered and reported to State Immunization Program during the month of December.</p> <p>c. 100% of all RPMS reproductive and SBHC orientation classes conducted in Dec. received influenza and flu vaccine information.</p>



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BMS SBHC –

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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 receive a mental health assessment administered by the SBHC mental health clinician or are referred for appropriate assessment.</p> <p>c. 50% of clinic users receiving mental health services through the SBHC for at least three months or regular therapy demonstrate improved psychosocial functioning.</p> <p>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.</p>	<p>a. 100 % of BMS school staff were reached with SBHC information via direct contact and/or school mailings</p> <p>b. 100 % of BMS students seen by MH clinician received a risk assessment through use of a DPH approved screening tool</p> <p>c. 98 % of BMS students receiving MH services 3mth or > demonstrated improved psychosocial functioning</p> <p>d. 100% of BMS students requiring additional intervention by community-based provider received referral</p> <p>a. 100 % of DHS school staff were reached with SBHC information via direct contact and/or school mailings</p> <p>b. 100 % of DHS students seen by MH clinician received a risk assessment through use of a DPH approved screening tool</p> <p>c. 75 % of DHS students receiving MH services 3mth or > demonstrated improved psychosocial functioning (LOF/GAF scores)</p> <p>d. 0% of DHS students required additional intervention by community-based provider during Nov.</p> <p>a. 100 % of RPMS school staff were reached with SBHC information via direct contact and/or school mailings</p> <p>b. 100 % of RPMS students seen by MH clinician received a risk assessment through use of a DPH approved screening tool</p> <p>c. 100% of RPMS SBHC users receiving mental health services for therapy for 3 mths or > showed improved psychosocial functioning. Of the 35 unduplicated users seen in Dec., 21 had recd. services during the last school year and 21 showed improved psychosocial functioning.</p> <p>d. In the month of Dec., zero (0) RPMS students were identified as having mental health needs that exceed the scope of services provided by the SBHC and was referred to a community provider.</p>



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DHS SBHC –

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The DHS bulletin board theme for the month of December was "Beat the Winter Blues." It was done with assistance from Ally Cafferty, AmeriCorps Member, and focused on symptoms of depression and how to obtain help. A corresponding Dine and Discover outreach activity conducted in the student cafeteria focused on stress, including causes and coping strategies. Brochures on signs, symptoms, and ways to manage stress were handed out. Students were encouraged to participate in a contest answering three brief questions, given a snack, and entered their name for a drawing of a prize (see photos below).

This month, a DHS SBHC patient contacted the SBHC behavioral health provider about a student who attends DHS who had reported suicidal ideation. Through a coordinated effort, they were able to get school staff involved. The guidance counselor was informed and the crisis counselor, Stan Watkins, was able to make an appropriate intervention.

The DHS clinician has maintained ongoing contact with guidance counselors, the crisis counselor and with administrator Domitila Pereira regarding students who appeared to be in some sort of crises. These included emotional, familial, and academic situations that peaked in the weeks prior to the Winter break. Additionally, the DHS clinician was involved in referring students who have not worked up to their academic potential to look at realistic options for their futures. One such example has been to explore Jobs Corps as an option.

Interestingly, the trend regarding bright, highly achieving students whose familial, emotional, or academic stressors have impacted them has continued. One such student who works with the DHS clinician, her guidance counselor, and the crisis counselor has always excelled and now, for example, may be in danger of not graduating due to a failing grade in her AP English class. The school staff and the SBHC clinician have coordinated efforts in order to try to stabilize the student. Another example is a young man who is working with the DHS clinician and Carol Glintencamp, a school social worker. He is an unusually bright young man whose chronically chaotic family life has left him feeling somewhat hopeless and without direction.

BMS SBHC –

J. Casey, LCSW had eighty-one (81) student appointments in the month of December, with thirty-five (35) group appointments and 46 individual appointments.

Group sessions were held during the month. The Family Issues group met twice in December. The 7th grade Girl Power group added a new member during the month and met two times. The 8th grade Girl's lunch group met four times in December and the 8th grade Stress Management group met three times.

12/15/15 and 12/17/15 - J. Casey, LCSW, collaborated with a 7th grade female student's outside therapist to provide her teachers with SNAP-IV-C Rating Scale forms in order to test the student for ADHD.

12/16/15 - J. Casey, LCSW collaborated with outside therapists for 2 students receiving supportive services at the BMS SBHC.

12/02/15 - J. Casey, LCSW co-facilitated the Leadership Club meeting with C. Miller, BMS Social Skills Counselor.

12/07/15 - The Leadership Club, co-facilitated by J. Casey, LCSW and C. Miller, BMS Social Skills Counselor, welcomed Mark Barden and Nicole Hockley, both of the Sandy Hook Promise, to BMS. Barden and Hockley came to honor the Leadership Club for their efforts with the "Say Something" project and to discuss ways in which to help other schools implement the program.

12/09/15 - J. Casey, LCSW co-facilitated the Leadership Club meeting with C. Miller, BMS Social Skills Counselor.

12/10/15 - J. Casey, LCSW, arranged for two families who utilize the SBHC to receive gift donations for the holidays. These gifts, coordinated by C. Miller, BMS Social Skill Counselor, were donated by the Danbury Fire Department.



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4. Reduce the severity and frequency of asthma symptoms among students with asthma who utilize the SBHC. 10

*Selected as a 2015-16 outcome measure for BMS SBHC only.

<p>1. Reduce the severity and frequency of asthma symptoms among students with asthma who utilize the SBHC.</p>	<p>a. 90% percent of clinic users with asthma have a written asthma action plan.</p> <p>b. 80% percent of clinic users compliant with a written asthma action plan show improvement in symptoms as documented by a health care provider in the medical record.</p> <p>c. There is a 20% percent decrease in urgent visits (visits by clinic users seen in the School Based Health Center due to asthma symptoms) as assessed by clinician notes, Electronic Health Record, or Data Base.</p> <p>d. 90% percent of clinic users with asthma have a documented flu vaccine.</p> <p>e. The number of clinic users with asthma that report a reduction in admissions to the hospital Emergency Department during the school year is increased by 20% percent.</p>	<p>**See notes below for BMS outcome measure findings</p>
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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. December = two (2); Year to date = nineteen (19).

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). December = two (2); Year to date = nineteen (19).

The school nurse's database revealed 95 students at Broadview Middle School have asthma. The SBHC database revealed 79 members have an asthma diagnosis. The lists were cross-checked and 21 students on the nurse's list were not SBHC members. Twenty-one (21) students were sent home registration forms with a letter highlighting our services in general with an emphasis on asthma management. In total, five (5) students have been registered as a result of this effort. N=79 SBHC members with asthma reported by parents on the SBHC registration form. Of those 79 students, 51 have Husky insurance or are uninsured. Letters were sent home to these 51 SBHC members offering the influenza vaccine this season. In all, five (5) of these 51 students received their influenza vaccine at the SBHC.

5. Reduce the proportion of SBHC users with obesity.

(Not selected as a specific measure this program year)

6. Reduce the occurrence of STDs among student SBHC enrollees.

*Selected by DHS SBHC only as a 2015-16 outcome measure

Outcomes	Measures	Achievement of Outcome
<p>6. Reduce the occurrence of STDs among student SBHC enrollees</p>	<p>a. 85% of sexually active students are screened for STDs.</p>	<p>a. 12 DHS students as of 12/31/15 were screened for GC/CT which was 100% of those reporting sexual activity</p>



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DHS SBHC –

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All students who report sexual activity will be 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 will be referred to the Dr. Foye, MD at GDCHC, Planned Parenthood, the AIDS Project of Greater Danbury, the Danbury STI clinic and local GYN offices for additional services as needed.

RPMS SBHC –

Thirteen (13) reproductive classes were given to two (2) new eighth grade health classes in December reaching fifty-nine (59) students total.

N. Munn, RPMS APRN submitted an abstract to CT Association of SBHCs along with a Yale educator Alison Moriarty Daley to present “Playing Games, strategies for successful reproductive health classroom presentations for adolescents” which includes the M&M game and Jeopardy Game. If selected it will be presented at the May 13, 2016 SBHC conference.

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)

HealthCorps Member Update:

Below is a summary of service hour activities completed during the month of December 2015 by Ally Cafferty, 2015-16 HealthCorps Member:

Meetings attended:

12/01/15 SBHC faculty meeting
12/04/15 Patient Navigation Training
12/06/15 planning for upcoming service project
12/11/15 Crazy Sweater with a Purpose event
12/18/15 AmeriCorps Monthly Member Meeting
12/19/15 Brotherhood in action food drive & We Care Community Center Children’s Christmas Event

Activities Performed:

- Plan bulletin boards
- Patient scheduling
- Input patient medical records
- Scan medical documents
- Collate student enrollment mailing forms
- Dine & Discover Outreach: Flu Season & Anxiety

News/Case Studies from the Field:

*A 17 year old male presents to the SBHC for a sports physical. His pre-participation history is obtained and of note is a recent concussion that occurred in November 2015. The student had suffered a blow to the head and was subsequently evaluated in the emergency room and also was seen by a local neurologist. The student reports that he still has an



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occasional headache. The ACE (Acute Concussion Evaluation) form is administered to the student. Clearance for sports 12 participation is not granted and he is advised to follow up with his neurologist. The SBHC continues to collaborate with neurology on a concussion management plan

*A 16 year old morbidly obese male who weighs in excess of 350 pounds is being worked up by the SBHC for obesity and insulin resistance. He presents to the SBHC reporting that he has finally had the blood work done that was ordered by the SBHC. His lab results are significant for an elevated insulin level, elevated triglycerides, elevated liver enzymes, abnormal thyroid panel and seriously low vitamin D level. After consultation with the staff at Dr. Arguella's office, a referral form along with the associated labs is faxed to the endocrinologist. The staff states they will call the family to set up an appointment. The SBHC will continue to follow this student to help with compliance to the treatment plan.

*The RPMS APRN evaluated and started a new uninsured student on ADHD medications. The student is being closely supervised because of fine tremors of her hands that are increased on the medication. The medication appears to be helping her focus in class.

Follow-up on student:

*The RPMS medical and behavioral health providers continue to work with a student who is morbidly obese. Unfortunately, the family did not provide recommended support and dietary/exercise suggestions over the summer. As a result, this student had gained an additional 16 pounds since the end of last school year and in November was 323.5 pounds. NP has communicated with local providers who see this student. In December, the student continued to gain weight, 326 pounds, and mother didn't make any outside referral appointments or return the providers calls. The student had fallen in school trying to get out of the cafeteria seat, was unable to get up without help and injured her knee because of her weight. The student continued to miss school or was tardy and was now in jeopardy of failing. A DCF report was filed after the SBHC medical provider consulted with two outside providers and the school personnel and DCF took the case. The mother had told the daughter that she wasn't concerned about DCF as they didn't scare her.

There is a lot of poverty facing children in Rogers Park. Through monetary, food and gift donations from the Nancy Munn (RPMS SBHC nurse practitioner's) church, Valley Presbyterian Church in Brookfield, the following items were provided:

- EpiPens for twins who have no insurance and are allergic to bees.
- Two uninsured students who the NP diagnosed with ADHD are having their medications paid for.
- Money was given towards a family's outstanding gas utilities bill so their heat wouldn't be disconnected over the holidays as well as a gasoline card so parent can continue to work.
- The church members also sponsored a family of 7 who took in 2 girls (nieces) whose mother died of cancer in August and were unsure how they were going to have a "Christmas" this year. For Thanksgiving and Christmas, all family members were provided with meals, turkeys, and presents including 2 tablets for the girls.
- Another student who has anxiety lives in a boarding house with his currently unemployed father and lacked food and a refrigerator to keep foods cold was given a dorm-sized refrigerator and non-perishable microwavable food and snacks plus a small Christmas tree for their room. The school teachers also gave him a gift card and clothing.
- Another student received winter boots from the church, and food and clothing from the teachers.
- Another family received a gift card to Walmart so they could purchase clothing or gifts for their children as there "wasn't going to be a Christmas this year" due to finances.

*BMI: Since the start of 2015-16 school year, 192 RPMS SBHC students had their BMI recorded, Of those 54% were between the 5-85th percentile, with 20% overweight and 25% obese Students are informed of their BMI status and what it means and ways to eat healthy and exercise. (See graph print-out, last page).