



# CITY OF DANBURY

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

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

February 22, 2016

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Re: Health & Human Services Department Monthly Report

Dear Mayor Boughton and Members of the City Council:

The January 2016 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) \$100 from Mr. Michael & Mrs. Linda White, 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 January, 2016

## **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 January, 2016:

1. Our Housing Caseworker managed approximately 72 active cases.
2. The Day Center, located at the Emergency Shelter, had approximately 757 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): 17
- b. Action Plan Development: 0
- c. Veteran Referrals: 0
- d. Referrals to Cash Assistance: 0
- e. Bus Tickets: 4
- f. Housing Related Issues: 11
- g. Housing Placement: 0
- h. Job Searches: 2\*\*
- i. Employment inquiries: 0
- j. Case Management Services: 13
- k. Showers: 115
- l. Lunch: 500
- m. Mental Health Referrals/Case Management: 4\*
- n. Adult Medical Referrals: 5
- o. Phone Usage: 1
- p. Substance Abuse Referrals/Case Management: 1\*
- q. Clothing Vouchers: 4



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r. Other: 80

\*MCCA counseling services have **RESUMED** on Saturday and Sunday from the hours of 9:00am –3:30pm. 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. Last quarterly report and cumulative report for VA GPD for Emergency Shelter.
10. Finalized and completed VA annual report.
11. Attended training for new Vi-Spdat 2.0 version to be initiated for the Fairfield CAN within the next 30-60 days.
12. Attended updating HMIS training in Hartford, CT.
13. Attended Housing Placement Committee meeting.
14. Attended training for Point In Time Count.
15. Attended Danbury Food Collaborative meeting.
16. Pick up donation of coats at the Danbury Emergency Shelter. Re-organize entire storage unit of assorted coats and clothing. Will have a coat distribution at the end of February at Dorothy Day Soup Kitchen in the morning around 7:00am.
17. Housing and Community Development committee meeting of the Danbury Housing Partnership.
18. Prepare contractor’s bid for the repair and maintenance of the two restrooms at the City of Danbury Shelter.



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19. Inspection/Investigation of elderly person whose landlord indicates that she has a hoarding 4 problem. Social worker and housing inspector assisted in meeting and inspecting her apartment. No apparent problem in apartment, though landlord insists it is a fire hazard. Taking steps to place elderly person into elderly housing asap.
20. Attended Farmers' Market meeting.
21. Fair Rent Commission meeting held in the evening of January 21, 2016.
22. Point In Time Count held at 3 homeless shelter. Shelter and unsheltered count held on Tuesday, January 26, 2016.
23. Couple being evicted due to housing complaint. Will assist in filing papers when Civil Summons is served to the individuals.
24. Two Fair Rent Complaints resolved through landlord/tenant mediation.
25. Received donation of \$100.00 from individual to be used for the Emergency Shelter.
26. Received donation of \$1000.00 from Newtown Savings Bank to be used for the Emergency Shelter.



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## School Based Health Centers (SBHCs) Monthly Operating Report January 2016

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**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.

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### **Patient Utilization Data for Period January 1, 2016 – January 31, 2016: (Note: Data is for all sites combined and cumulative through noted period)**

	DHS, BMS, RPMS (DPH Funded)
Total # of Students Enrolled in all Schools	5,007
Total # of Patients Enrolled in the SBHCs	4,373
% of Total School Population Enrolled	87%
Total # of Patient Visits	2,924
Total # of Medical Visits	1,500
Total # of Behavioral Health Visits	1,084
Total # Dental Visits	340

### **Program Snapshot: Activities/Meetings held January 1, 2016 – January 31, 2016:**

#### M. Bonjour - SBHC Manager

01/05/16 – Participated in the monthly Senior Management meeting held at OST, Danbury.

01/05/16 – Convened the monthly SBHC staff meeting in the Board meeting room, OST. Mid-year reporting requirements, performance and peer chart reviews and program sharing were highlighted.

01/07/16 – Welcomed and provided general orientation to Francesca Golightly, Spring 2016 WCSU intern from the Department of Health Promotion and Exercise Sciences. Ms. Golightly will be assisting all SBHC sites with a variety of health promotion, education and outreach activities during her 450 hour internship placement that will continue through early May 2016.



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01/11/16 – Participated in a CT Association of School-Based Health Centers Conference Planning Committee call to discuss on-going progress for the statewide conference to be held in May.

01/13/16 – Initiated mid-year performance reviews to be conducted in person with all SBHC staff.

01/15/16 – Attended Grand Rounds at Danbury Hospital – topic: Human Papilloma Virus (HPV)

01/15/16 – Met with Sandy Astanatof, Principal, Alternative Center for Excellence (ACE) to explore possibility of locating SBHC services on-site.

01/19/16 – Attending the weekly CIFC Leadership meeting held at 57 North Street to update the group on the early planning for locating SBHC on-site at the Alternative Center for Excellence (ACE) school facility.

01/19/16 – Participated in a HRSA webinar “Clinical Tools for Integration of Behavioral Health Services”.

01/20/16 – Attended a meeting of the Community Action Steering Committee held at Danbury Hospital to explore the feasibility of applying for an Invest Health Grant opportunity. The group agreed to approach the local health Director to determine interest as a required partner.

01/21/16 – 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.

During the month of January all medical and behavioral health providers conducted peer chart reviews of ten (10) randomly selected charts per provider. Additionally, Dr. Golenbock, MD completed medical provider chart reviews via eCW, reviewing an additional ten (10) charts per provider.

01/01/16 -N. Munn, RPMS APRN submitted an abstract along with a Yale educator Alison Moriarty Daley to the CT Association of School-Based Health Centers to present “Playing Games, Strategies for Successful Reproductive Health Classroom Presentations for Adolescents” which includes the M&M game and Jeopardy Game. The abstract was selected to be presented at the May 13th CT SBHC conference.

01/05/16 – All SBHC staff convened for a monthly staff meeting at OST, board meeting room.

01/11/16 – N. Munn, RPMS APRN C. Cunningham, RPMS LPC attended Drug Recognition Awareness Training conducted by the Newtown Police Department and held at Newtown Town Hall.

01/13/16 – All SBHC behavioral health provider met for monthly peer supervision.

01/22/16 – M. Mele, DHS MA met with Diana Trumbley, GDCHC Practice Manager to explore reporting needs through eCW.

01/22/16 – RPMS SBHC staff attended Grand Rounds at Danbury Hospital. Topic - Danbury Women’s Center Presentation of Support Systems available.

01/26/16 – SBHC medical providers met as a team with Dr. Golenbock, MD for monthly supervision.

01/28/16 – C. Cunningham, LPC and K. London, LCSW attended a Hospice workshop on “Managing Conflict and Finding Meaning while Supporting Families at Life’s End”.

01/29/16 – N. Munn, RPMS APRN and J. Sawyer, NMS LCSW attended Pediatric Grand Rounds at Danbury Hospital. Topic – “Domestic Minor Sex Trafficking and Commercialized Sexual Exploitation of Children”.

## **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 CIFC 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
<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 (<b>40% for the NMS site</b>) 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 95% enrollment as of 7 01/31/16</p> <p>b. 11% (776 visits by 321 users) of DHS enrolled students rec. 1 or more visit as of 01/31/16</p> <p>c. 100% DHS students received outreach contacts as of 01/31/16</p> <p>a. BMS has 73% enrollment as of 01/31/16</p> <p>b. 13% of BMS enrolled students rec. 1 or more visits as of 01/31/16</p> <p>c. 100% BMS students received outreach contacts as of 01/31/16</p> <p>a. RPMS has 79% enrollment as of 01/31/16</p> <p>b. 31% of RPMS enrolled students rec. 1 or more visits as of 01/31/16</p> <p>c. 100% students received outreach as of 01/1/16</p>



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## DHS SBHC –

New registrants continue to be verified in PowerSchool and entered in a database. New CIFIC registration forms are being given to students at time of visit, explaining if the current one on file will be expiring at the end of this school year. This will hopefully encourage those who need updated forms to return them.

Staff continue to carry out outreach activities to promote the SBHC through various media measures including educational bulletin board displays featuring health related topics. Topic for January was nutrition (see photo below).

### DHS January Bulletin Board Display on Nutrition

BMS SBHC – Geri Alpert, Office Manager continues to review incoming registration forms and refer all uninsured students to the GDCHC Eligibility Specialists for assistance with Husky Applications through Access Health.

School RN and Guidance Department continue to give out registration forms to any students without registration forms whom they think would benefit from SBHC services.

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

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

Year to date = 7 referrals to local PCPs for a medical home (5 GDCHC). Of note, 2 of these referrals to GDCHC did follow-through and are now patients. Year to date referrals to Access Health for Husky Insurance = 6.

Broadview is participating in the National School Health Services National Quality Initiative (SHS NQI). The mission of this initiative is to build the capacity of SBHCs to adopt and report standardized performance measures to improve quality of care. The five performance measures are as follows: annual well-child visit; annual risk assessments; BMI assessment and nutrition/physical activity counseling; depression screening, and chlamydia screening. This is a 15 month project with monthly data collection.

## RPMS SBHC –

All billing is now being done through eClinicalWorks (eCW), though not all information necessary for reporting is available on eCW. The RPMS MA continues to enter dental billing and new consents on Clinical Fusion. Consolidation of information by the RPMS MA from both systems is required to provide necessary numbers for reporting.

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 the School Nurses have begun the afterschool group for girls who are in need of extra guidance and peer interaction/companionship. The group met on January 20, 2016. During this group time, the girls were each given two 5' x 6' pieces of fleece fabric and given instruction on how to make "tie blankets". The girls were very excited to make a blanket of their own!

\*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.	a. Enrolled students will be immunized with vaccines recommended by Advisory Committee on Immunization Practices (ACIP) that are required by	a. No (0) required vaccines given during the month of January.



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	<p>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>There were one (1) recommended vaccines 9 given: 1 HPV.</p> <p>b. No (0) influenza vaccines administered and reported to State Immunization Program during the month of January.</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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Outcomes	Measures	Achievement of Outcome
3. SBHC enrollees will utilize mental health services to improve their psychosocial functioning through assessment, intervention and referral.	<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. 86 % of BMS students receiving MH services 3mth or &gt; 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>



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		<p>c. 75 % of DHS students receiving MH services 3mth or &gt; demonstrated improved psychosocial functioning (LOF/GAF scores) 10</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 &gt; showed improved psychosocial functioning. Of the 38 unduplicated users seen in Jan., 22 had recd. services during the last school year and 22 showed improved psychosocial functioning.</p> <p>d. In the month of Jan., 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 –

A trend occurring in January 2016 included an increase in the complexity of behavioral health cases presenting to the SBHC. Many of these have required, and will continue to necessitate, coordinated treatment with both the clinician and the DHS APRN. Some of these students have been ongoing patients while others are new.

Examples of issues include self-medication through the use of Cannabis and disordered eating behaviors such as significantly restricting food intake and/or purging behaviors.

DHS clinician has maintained continued contact and treatment coordination with many school staff. One such example involves a former patient who is involved with community treatment. Issues have arisen and the guidance counselor and crisis counselor have continued to share information and to solicit input from the clinician via phone, email, or meetings. The DHS clinician also met with a Level Administrator as well as a classroom teacher re a longtime patient about whom they had concerns. Another student, also seen currently, has continued to be in crisis and required frequent outreach by the DHS clinician to his guidance counselor. SBHC presence in the school allows this to be more seamless than



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it would be in another outpatient setting. Many referrals, crises, and even returning clients were scheduled more 11 expeditiously during the month of January since the SBHC is in the building. This is so even when students are not in crisis, but are in need of attention, such as a former client who returned to treatment and is overwhelmed. Her new guidance counselor was very helpful and open to coordinating our efforts.

A “Dine and Discover with the SBHC Staff” outreach activity focusing on suicide prevention awareness was held on 01/28/16 in the student cafeteria. For this Dine and Discover activity, DHS SBHC staff collaborated with Francesca Golightly, WCSU intern. The topic drew the interest of many. Students were asked to participate in a raffle answering three questions pertaining to awareness and prevention. Staff distributed stress balls, pamphlets, stickers and Twizzlers as incentives (see photo below).

### BMS SBHC –

J. Casey, LCSW had ninety-two (92) student appointments in the month of January, with twenty-six (26) group appointments and sixty-six (66) individual appointments.

A new group began this month, a Grief Group. This short-term, time limited group met twice in January, and started with three (3) members, although one (1) member decided not to continue. The Family Issues group met twice in January. The 7th grade Girl Power group lost a member this month and met twice. The 8th grade Girl’s lunch group met three times in January and the 8th grade Stress Management group met twice.

Throughout the month J. Casey, LCSW, held several in-person meetings and conducted telephone calls with parents to discuss their children’s treatment and progress.

J. Casey, LCSW collaborated with outside therapists and a court ordered co-parenting counselor for two (2) students receiving supportive services at the BMS SBHC.

01/22/16 - J. Casey, LCSW, attended a BMS cluster meeting with teachers and the assistant principal of one of her clients.

During the month of January, J. Casey, LCSW co-facilitated the Leadership Club meetings with C. Miller, BMS Social Skills Counselor. This club is one of the recipients of the Danbury Education Foundation Board’s 2015/2016 Classroom Excellence Grants. The club will receive a \$1,500 grant, \$1000 of which will be utilized for students to administer mini grants to other middle school students to create community service projects. The remaining funds will be utilized for a Leadership Conference to recognize and support the mini-grant recipients and the Leadership Club members.

### RPMS SBHC –

The RPMS behavioral health provider C. Cunningham facilitated seven (7) family therapy meetings with students during the month of January and participated in two cluster meetings for students.

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

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

1. Reduce the severity and frequency of asthma symptoms among students with asthma who	<ul style="list-style-type: none"> <li>a. 90% percent of clinic users with asthma have a written asthma action plan.</li> <li>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.</li> <li>c. There is a 20% percent decrease in urgent visits (visits by</li> </ul>	**See notes below for BMS outcome measure findings
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utilize the SBHC.	<p>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>	
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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. January = two (2); Year to date = twenty-one (21).

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). January = two (2); Year to date = twenty-one (21).

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.

Clare Nespoli, APRN, as a representative of CIFC, attended the newly formed Connecticut Asthma Initiative (CAI) Meeting on 1/14/16. *Please see attached summary of this meeting.*

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
6. Reduce the occurrence of STDs among student SBHC enrollees	a. 85% of sexually active students are screened for STDs.	a. 18 DHS students as of 01/31/16 were screened for GC/CT which was 100% of those reporting sexual activity

## DHS SBHC –

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 –

Eleven (11) reproductive classes were given to two (2) new eighth grade health classes in January reaching fifty-nine (59) total students.



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7. Increase access to and utilization of primary and preventive oral health care and essential oral public health services 13  
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 January 2016 by Ally Cafferty, 2015-16 HealthCorps Member:

### Meetings attended:

- 01/06/16 SBHC faculty meeting
- 01/12/16 Coalition for Healthy Kids Meeting
- 01/18/16 MLK Prostate Cancer Awareness Event
- 01/21/16 HATS Dine and Discover on smoking/e-cigarettes
- 01/22/16 AmeriCorps Monthly Member Meeting

### Activities Performed:

- Patient scheduling
- Scan medical documents
- Prepare for future bulletin boards
- Input patient documents
- Write meeting minutes

### WCSU 2016 Student Intern Activities

During the month of January, 2016, Francesca Golightly, WCSU 2016 student inter, participated in the following activities:

Dates	January Activities/Meetings/Seminars/Webinars
1/5/2016	School Based Health Center Monthly Staff Meeting
1/14/2016	Strategic Planning Focus Group at Danbury Head Start
1/15/2016	HPV Seminar at Danbury Hospital
1/19/2016	Integrating Behavioral Health Training into Primary Care Webinar (HRSA)
1/20/2016	Meeting at Danbury Hospital with Melanie and others regarding 'Invest Health' Grant opportunity
1/21/2016	Dine and Discover at Henry Abbott Technical School
1/21/2016	Strategic Planning Focus Group at GDCHC
1/22/2016	Dine and Discover at Newtown Middle School
1/25/2016	Meeting with Emilie Gibbs, P.A. and HATS Staff after school for Parent Day
1/26/2016	Meeting at Danbury High School with SBHC Nurses and Dr. Golenbock
1/27/2016	Sexual Health and HIV Prevention: A Patient-Centered Approach for Primary Care Webinar
1/28/2016	Strategic Planning Focus Group at Danbury Head Start



# CITY OF DANBURY

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

Central Health Office  
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1/28/2016	Dine and Discover at Danbury High School
1/28/2016	Meeting with Emilie Gibbs, PA for HATS Students

### News/Case Studies from the Field:

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\*An 18 year old male presents to the SBHC with complaints of worsening asthma symptoms. He has been prescribed a maintenance asthma medication by his PCP in the past which cost over \$300 so he has been using it sparingly opposed to as directed. Consequently, he has been needing to use his rescue inhaler daily. The APRN was able to dispense maintenance asthma med from the SBHC and also secure samples from an outside agency. A follow up was done and the student reported feeling one hundred percent better after starting the new medication. The APRN will continue following the student until he graduates in June.

\*A 15 year old male is referred to the SBHC by his mother for evaluation of headaches after a head injury. Student recently sustained a head injury while pole vaulting. Complicating the case is the presence of a prior concussion 18 months ago which resulted in a prolonged post concussive syndrome resulting in chronic migraines and insomnia. The APRN evaluated the student and counseled the mother to follow up with his neurologist at the Yale Concussion Center.

\*A 15 year old female presents to the SBHC requesting reproductive health information. She is interested in having testing for STIs including HIV. The APRN counseled the student about safe sex practices, pregnancy prevention, STIs, HPV vaccination and arranged for a staff member from AIDS Project of Greater Danbury to come onsite for risk reduction and testing for HIV.

\*A 16 year old male presents to the SBHC with complaints of upper respiratory infection. After interviewing the student it becomes known that the child has been under quite a bit of stress and is dealing with anxiety. He is new to Danbury, CT, has been cut off from his support system and his parents are in the process of a divorce. The student is referred to the SBHC social worker and is able to establish a relationship for mental health therapy.

The RPMS APRN is prescribing and following four (4) students on ADHD medications. The medication appears to be helping them focus in class but require close supervision because of side effects unique to each student.

### Follow-up on student:

The RPMS APRN and counselor 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. The APRN 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 NPs 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. DCF report was made after the APRN consulted with 2 outside providers and the school personnel. DCF took the case. The mother had told the daughter that she wasn't concerned about DCF as they didn't scare her. DCF has been able to get the sleep study done, enroll her in YMCA, will be getting Nutritionist appointment, and has Welmark in home for support.

There is a lot of poverty facing children in Rogers Park. Through monetary, food and gift donations from the APRN's church, Valley Presbyterian Church in Brookfield, the following items were provided:

One student's ADHD medications were paid for in January for \$57.

Snack foods, crackers, and canned goods have been purchased to give to students who do not have sufficient food at home and don't qualify for food stamps.

BMI: Since the start of 2015-16 school year, 229 students had their BMI recorded, Of those 55% were between the 5-85th percentile, with 21% overweight and 24% obese Students are informed of their BMI status and what it means and ways to eat healthy and exercise. (See attached graph print-out).



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Portion Control is a problem for most of us. I'm sure some of us recently over indulged during the holiday season. 15 Additional calories are unintentionally consumed when we eat larger portions.

Some tips to avoid large portions from the Centers for Disease Control and Prevention (CDC) are:

1. When eating out, some restaurants serve larger portions. Share these larger portions with a friend.
2. When snacking in front of the TV, put the items in a bowl instead of eating straight from the package.

For more assistance with portion control and healthy eating seek out these resources:

1. Visit the NMS School Based Health Center (SBHC), located between the Library and the C-Wing office. Our phone # is (203) 270-6114. The nurse practitioner, Nicole Woering, can assist with weight checks, healthy eating tips, discussion and diagnosis of diseases associated with high body mass index's (BMI), and can assist families with accessing dietitians in the community. The social worker, Jennifer Sawyer, can assist diagnosing and treating mental health illnesses associated with unhealthy eating habits.
2. Visit the next SBHC Dine & Discover informational table on Portion Control on January 22<sup>nd</sup> during all lunches in the cafeteria.
3. Visit [www.choosemyplate.gov](http://www.choosemyplate.gov)
4. Visit or call the UCONN Extension Food and Nutrition Education Program in Bethel. (203) 207-8440.

Written by Nicole Woering NP-C, APRN

- The new Connecticut Asthma Initiative Website [www.ctasthma.org](http://www.ctasthma.org) is a wealth of information, including a summary document about the initiative, a link to the CT Department of Public Health Asthma Action Plans, examples of ED discharge plans, an instructional video on proper use of an asthma inhaler with a spacer, a kid-friendly cartoon, "When Asthma Attacks.", and links to local asthma resources.
- Key points from presenters:
  1. Primary care providers partnering with school nurses - open the barriers to communication in order to identify uncontrolled asthmatics.
  2. Collaborating with community pharmacist and considering them members of the health care team. Pharmacists can aid in medication management and coordination, in comprehensive medication review for appropriateness, effectiveness, safety and adherence.
  3. New CT Dept. of Public Health Asthma Action Plan in the works - to be one page including medication authorization of the provider, as well as, an asthma action plan. The stoplight (red, yellow and green zone) asthma action plan easily understood by patients.
  4. Connecting patients with their PCP after ED or hospital discharge:
    - a. *Emergency Room Nurse Navigator at St. Vincent's*: A call is made by the Emergency Room Nurse Navigator directly to the primary care offices. Each primary care office will have a direct contact person for the Nurse Navigator to make an appointment that is convenient for the patient. A transition of care summary will be provided and the patient will have an action plan in place.
    - b. *Middlesex Hospital's Automated Phone Call Follow-Up*: Post 48 hour Hospital Discharge Automated Phone Call via IVR (Interactive Voice Response Technology).
    - c. *Community Health Network of Connecticut ED Intensive Care Manager Pilot Program*