2014 Program Report Card: Roosevelt School Based Health Center (6-8)

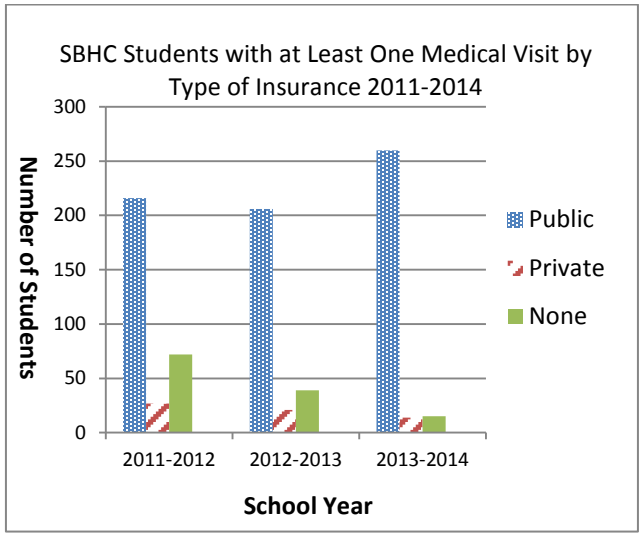
Quality of Life Result: All Connecticut children will grow up in a stable environment, safe, healthy and ready to succeed.

Contribution to the Result: School Based Health Centers provide healthcare access for school aged students, so that they are healthy and ready to learn.

Program Expenditures	DPH SBHC Funding	Other State Funding	Federal Funding (MCHBG, ACA)	Total Other Funding (Other federal, Local, Private) in-kind	Reimbursement Generated	Total Site Funding
Actual SFY 14	$123,515	0	0	$31,177	0	$154,692
Estimated SFY 15	$123,515	0	0	0	0	$123,515

Partners: Parents, Students, CASBHC, DPH, Board of Education, School Administrators and Faculty.

How Much Did We Do?
Access and Utilization

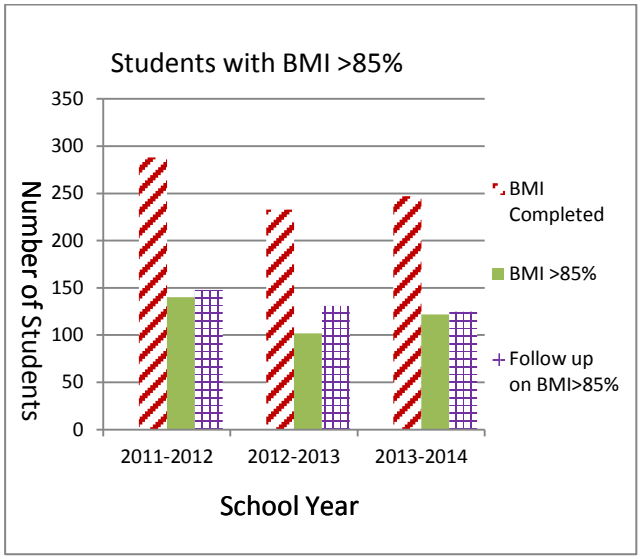


Story behind the baseline: The total school population for 2011-2012 was tracked by staff using spreadsheets. These spreadsheets contained information specifically for public and privately insured. The accuracy of number of other/unknown enrolled is not verified. The number of students with a least 1 medical visit in 2011-2012 showed 315 students. In 2012-2013 school the year, students with at least one medical visit dropped to 266. This was a result of the school population and demographics that was discussed. In 2013-2014 school year 289 visits were documented. This is a 23 student increase or 9%.

The total school population and demographics of this school has changed and will continue to change for the next four years. This school is currently being used as a transition school while different area schools are remodeled. Marketing efforts were increased in the 2013-2014 school year because of the school demographic changes. Letters and flyers with information about the SBHC were developed in English, Spanish and Polish (with a focus on health literacy) and sent home with every student. SBHC staff also presented information about the SBHC to parents of all incoming students and at open houses for parents. SBHC staff visited every classroom in school to present information about the clinic and resources available. A large number of students at Roosevelt were not coming from a school that had a SBHC. It was important to get the word out but because it is mostly elementary students. Historically, elementary school students do not self-refer.

Trend: [◄►]

How Well Did We Do?
Reduce Obesity in SBHC Users.



Story behind the baseline: Body Mass Index (BMI) is now documented for every student at the health center for every medical visit. The Community Health Center (CHC) data team developed a tracking system within the Electronic Health Record (EHR) to collect BMI results. In 2011-2012, approximately 288 (6.5%) of patients had their BMI calculated. Of the 288 patients, 148 students had a follow up visit. In 2012-13 school years, 233 students were

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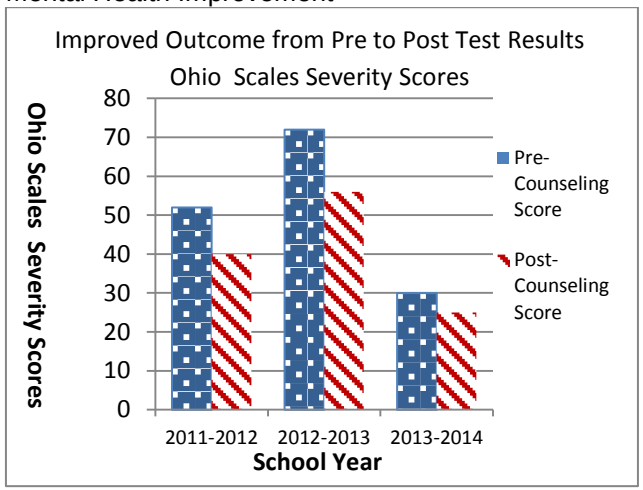
seen at the SBHC and had their BMI calculated. 102 (44%) of these students had a BMI > 85% and 131 follow up visits occurred. In 2013-2014 247 patients were seen at the SBHC 122 had a BMI greater 85% and 125 had a follow up visit. Every student with s BMI greater 85% did receive an opportunity for individual counseling (nutritional) with the SBHC medical provider and referrals to the CHC dietician. SBHC users improved nutrition and increased physical activity and those who received follow up reported a positive lifestyle change.

Trend: [◄►]

Is Anyone Better Off?

Mental Health Improvement



Story behind the baseline:

The number of enrollees and users of services varied greatly from the previous two years. The SBHC decreased from a one and a half full time clinician to a three day a week clinician at this site. However, demographically, the users of the services reflect the changing demographics of the school as compared to the city.

In the 2013-2014 school year, of the 30 students who completed three months of regular therapy and were re-administered the Ohio screen, 25 (83%) reported a decrease in problem severity and met their treatment goals. The remaining 5 (17%) that did not show improvement were identified as having mental health needs that exceeded the scope of services provided through the SBHC and were referred to an outside mental health agency for treatment.

Before participation in therapy, the average problem severity pre-treatment scores were 52 in 2011-2012, 72 in 2012-2013 and 30 in 2013-2014. A score of 20-36 on the screen indicates moderate severity. After completing three months of therapy, the average post-treatment score decreased. A score of 10-19 indicates mild severity.

Trend: [▲]

Notes:

Proposed Actions to Turn the Curve:

Access and Utilization:

1) SBHC staff will conduct additional orientations to all students and will attend the first Parent Night meeting to share information about the SBHC with parents/guardians. SBHC information will also be included on the school website; in the school newsletter and on school bulletin boards; and through the school message blast system that reaches the households of students attending the school. The SBHC also has a posting at central registration which is where each new student visits upon entering the school.

Obesity Reduction:

2) The Advanced Practice Registered Nurse (APRN) will offer a weight management group to students identified as at-risk for obesity and overweight. This group will discuss healthy eating, exercise, and community programs for weight loss and healthy living.

Mental Health Services:

3) SBHC staff will provide SBHC orientation sessions to all new and existing school personnel. Orientation will include information on the Behavioral Health services offered through the Center, the referral process and the importance of linkages with community service providers and other resources. SBHC staff will work collaboratively with school staff to identify students at risk and ensure a coordinated approach to addressing student/family need. SBHC staff will also establish and maintain collaborative relationships with new and existing community based providers to ensure continuity of care and access to needed resources.

Data Development Agenda:

Work with Electronic Health Record Vendor

- To align EHR generated reports to meet DPH requirements.