

2014 Program Report Card: Winthrop Elementary School Based Health Center (Grade K-5)

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

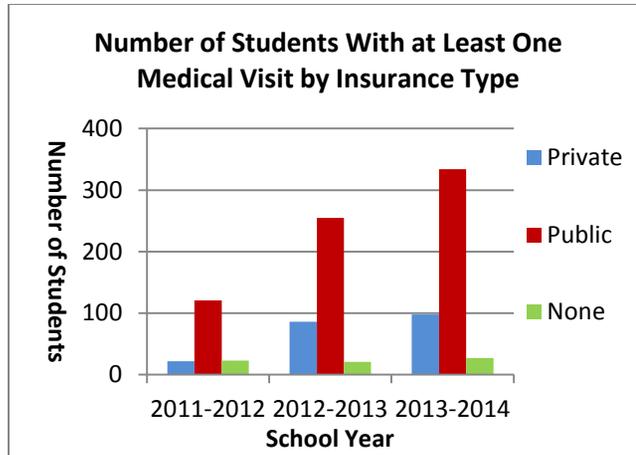
Contribution to the Result: School Based Health Centers provide healthcare access for school aged students, so that they are healthy and ready to learn.

Program Expenditures	DPH SBHC Funding	Other State Funding	Federal Funding (MCHBG, ACA)	Total Other Funding (Other federal, Local, Private)	Reimbursement Generated	Total Site Funding
Actual SFY 14	\$147,020	\$0	\$0	\$1,760*	\$56,723	\$205,503
Estimated SFY 15	\$189,308	\$0	\$0	\$2,258*	\$95,128	\$286,694

Partners: Parents, Students, CASBHC, DPH, DSS, DMHAS, DCF, The CT Chapter of the AAP, School Based Health Alliance, Board of Education, Local Health Department, School Nurses, School Administrators and Faculty, Child & Family Agency Programs, Child First New London

How Much Did We Do?

Access and Utilization



Story behind the baseline: The total school population has increased 63% from 331 in 2011-2012 to 539 in 2013-2014. This is due to consolidation of the elementary schools in New London. Enrollment in the health center has also increased from 269 students (81%) to 496 students (92%).

The number of students with at least 1 visit has increased annually. In 2011-2012, 166 students (62%) were seen and in 2013-2014, 354 (71%) students were seen, representing a 9% increase. (All students seen by the MH clinician are also seen by the nurse practitioner to review medical conditions, allergies, medications, etc.) This is done in order to identify any medical issues that may be impacting the student's mental health and to satisfy the meaningful use measures for the electronic health record.

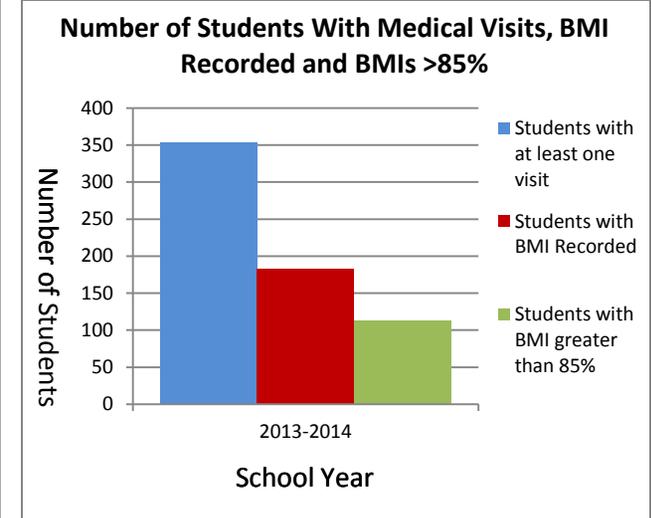
In the 2013-2014 school year there were 348 students (70%) who were publicly insured, followed by 104 students (21%) who were privately insured, and 44 students (9%) who did not have insurance. A similar distribution of insurance types was observed in the 2011-2012 and 2012-2013 school years.

Enrollment in the SBHC is marketed during Open House and through the school nurse and school social worker. Winthrop has been in operation since 1993. Now in its second year as a magnet school the overall school population continues to grow to include many students from cities/towns that have not traditionally been served by school based health centers. The SBHC team has worked throughout the year to increase enrollment, particularly amongst many military families who have joined the school community over the past two years.

Trend: [▲]

How Well Did We Do?

Reduction in percentage of SBHC users with BMI >85%



Story behind the baseline:

BMI screening at acute and well visits led to the identification of 113 enrolled students with BMIs above the 85%ile, 71 (63%) of whom had BMIs >95%ile.

The nurse practitioner focused efforts on working with twenty of the highest risk, with BMIs at the 98th-99 percentile.

Despite letters sent home and phone calls placed, only 6 parents were in contact with the APRN about matters related to efforts to help their children reduce their BMI during the year. The majority of these contacts were paper responses (ie. returned "5210" lifestyle screening tools). Only one parent was in contact with the APRN after the initial visit. Further, one of the 6 parental contacts was between the APRN and a parent requested that her child no

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longer receive weight management visits through school based health.

The children and families identified at risk for obesity were offered educational support based on 5-2-1-0 model * and ChoseMyPlate.gov. Both of these sources of wellness materials are free, culturally sensitive and available in multiple languages, which is important for our SBHC program.

*5 -2 -1- 0 (Daily goals for children/adults)

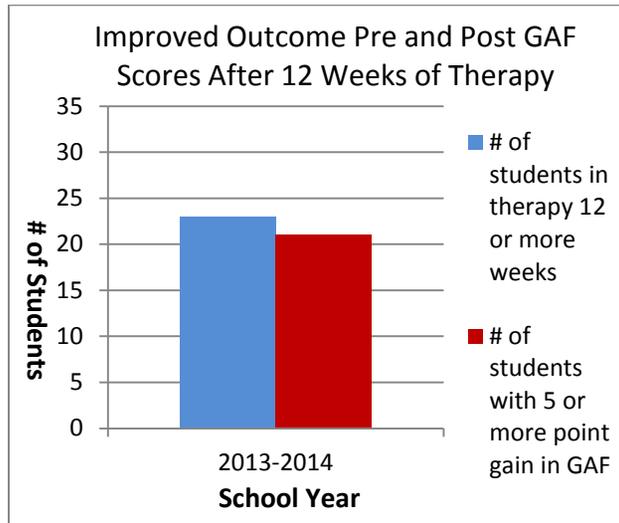
- 5 or more fruits and vegetables
- 2 hours or less of screen time
- 1 hour of activity/exercise
- 0 sugary drinks
-

One student out of 20 (5%) reduced her BMI below the 95%ile during the academic year. 15 (75%) maintained their starting BMI percentiles. Four students (20%) experienced an increase in BMI.

Of the students that maintained or increased their BMIs, many could nonetheless demonstrate an increased knowledge base regarding nutrition, and expressed proudly that they had incorporated increased physical fitness into their daily activities. These positive changes have the potential to lead to improved outcomes in the future.

Trend: [▲]

Is Anyone Better Off? Mental Health Improvement



Story behind the baseline: In 2013-2014, 48 students had at least one MH visit. Of those 37 were opened as clinical cases . 23 (67%)of them closed after at least 12 weeks of service. 21 of those 23 (91%) had a 5 point or more gain in their GAF score . The other 16 students discontinued therapy or were referred to higher levels of care, moved out of district or continued in therapy into the next school year.

Trend: [▲]

Notes: *Other funding is from United Way

Proposed Actions to Turn the Curve:

Access and Utilization:

In the next year letters for permission to give the flu vaccine will go out at the beginning of the school year with all the other school paperwork. For those students who are not yet enrolled, those forms will be provided to the parents. This strategy is expected to increase the SBHC enrollment and utilization by at least 10%.

Obesity Reduction:

In the next school year, increased efforts will be made to engage parents in weight management program goals, with physical presence at some visits with their child strongly recommended.

This will enhance the APRNs ability to support the entire family in its efforts towards healthy lifestyle changes.

Mental Health Services:

The clinician will increase efforts to promote the SBHC and its offerings to the parents and staff at Winthrop. The clinician will continue to work integrally to assess the needs of the client and the school to support their growth and to network with other sources of care (ex. higher levels of care).

Data Development Agenda:

1. Work with Electronic Health Record Vendor:
 - To align EHR generated reports to meet DPH requirements
 - To streamline the process of exporting our data from EHR to DPH
 - Further refine data collection capability of the electronic record to define parameters for better identification and management of specific conditions (ex. students who have participated in select programs, students who have an asthma action plan on record, etc.)

**Data presented represents 2013-2014 school year and is only to be used as a baseline.