Report to the Public Health and Education Committees
of the Connecticut General Assembly
On
School Based Health Centers

Submitted by
The Commissioner of the Department of Public Health
(Established by P.A. 06-195 as amended in Section 19a-6i of the CT General Statutes)

January 2011

School Based Health Centers Ad Hoc Committee
2009-2010 Summary

In response to Public Act 06-195 §51, (Appendix A: Public Act No. 06-195) An Act Concerning Revisions to Department of Public Health Statutes, the Commissioner of the Department of Public Health (DPH) established an Ad Hoc Committee for assistance in improving health care through access to School-Based Health Centers (SBHC), particularly by underinsured or uninsured people or Medicaid recipients. Members of the Ad Hoc Committee include representatives from DPH, the Office of Policy and Management (OPM), the Department of Mental Health and Addiction Services (DMHAS), and SBHC Coordinators. Based on the five focus areas identified in PA 06-195, DPH invited the Executive Director from the Connecticut Association of School Based Health Centers (CASBHC) and representatives from the Department of Social Services (DSS), Department of Children and Families (DCF), and the State Department of Education (SDE) to participate on the committee (Appendix C: Ad Hoc Committee Members).

The Committee did not meet from 7/1/09-6/30/10 (Appendix B: Excerpt Sec. 19A-61). However when reconvened in September 2010, committee members agreed to submit information to DPH reflecting work done on behalf of SBHC during the last year for the purpose of this report. The activities identified below are aligned with the following Ad Hoc Committee focus areas:

Statutory and Regulatory

- The Connecticut General Assembly (CGA) approved passage of Senate Bill 400**:** *An Act Concerning Insurance Payment Reimbursement to School Based Health Centers*. The bill states, "Each insurer licensed to do business in this state shall, at the request of any school-based health center or group of school-based health centers, offer to contract with such center or centers to provide reimbursement for covered health care services to persons who are insured by such licensed insurer. Such offer shall be made on terms and conditions similar to contracts offered to other providers of health care services. " (Public Act 10-118). CASBHC created the initial language for the bill and provided testimony during legislative hearings. DPH supported Senate Bill 400 with written testimony. Several CASBHC members met with commercial insurance company representatives to discuss a potential contracting process. Discussions focused on education about the medical and mental health services provided in school based health centers, and the benefits of contracting with SBHC for services provided to their members. The Pro Bono Partnership in Hartford has accepted CASBHC's request for legal assistance with the commercial insurance contracting process, in response to the passage of SB 400.

Improving School Based Resources

- CASBHC secured a Connecticut Health Foundation Grant focusing on organizational capacity building, advocacy, and technical assistance and training for SBHC.

- CASBHC secured a DPH Emergency Preparedness Grant to implement emergency preparedness in SBHC. Funds were used to support training, community collaboration

with preparedness networks, the acquisition of necessary pandemic influenza supplies, and the development of emergency operations plans.

- CASBHC secured a two-year DSS Grant to implement an oral health improvement project. The project focused on oral health training for SBHC medical practitioners, resource development in local programs, implementation of dental services in SBHC sites, and the development of partnerships with local dental providers, key statewide stakeholders, and oral health advocates.

Identifying Geographic Areas of Need

- The DPH Primary Care Office worked in collaboration with HRSA's National Health Service Corps and Shortage Designation Branch to approve seven existing SBHC sites for participation in the federal loan repayment program for critical health professionals. Seven clinicians are participating in the program.

Other Topics

- CASBHC secured a Perrin Family Foundation Grant to support an evaluation of SBHC data by the University of Connecticut (UCONN) School of Nursing for 2007-2008 and 2008-2009. The CASBHC Data Committee worked to define the outcomes that can be achieved from the data analysis. A final report will be used during the legislative session to strengthen CASBHC's advocacy efforts.

- CASBHC conducted a Student Satisfaction Survey in 2009 to collect and utilize data that could illustrate the impact of SBHC services and care on student health. The survey was randomly distributed to students in grades 6-12, ages 11-19 who utilized the SBHC. Surveys were completed by 1,005 students in 28 schools (in 15 communities), representing a sample size of 5% of all students who utilize SBHC services (Appendix D: CT Association of School Based Health Centers Student Satisfaction Survey 2009*)*.

- DPH sponsored an internship for two graduate students from the Southern CT State University Master of Public Health program to benchmark with other states to identify what is currently being used as school based health centers outcome measures, develop new contract language, and help revise reporting tools.

- DPH met with the Executive Director of CASBHC on March 19, 2010 to discuss potential performance measures, future collaborations and the study being conducted by the UCONN School of Nursing.

- DPH invited the Executive Director of CASBHC to participate in the MCHBG stakeholders' group to review state MCH Needs Assessment findings and select priority areas for the next 5 years.

- DPH staff met with the Appropriation's Health and Hospital Sub-Committee and representatives from CASBHC on 3/8/2010 to discuss the budget and SBHC services.

- DPH and CASBHC co-sponsored a conference entitled, *Putting Prevention into Practice: Successful Strategies for Keeping Students Safe and Healthy* for SBHC staff. Two hundred thirty individuals attended.

- The Connecticut (CT) Department of Mental Health and Addiction Services (DMHAS) received a federal grant from the Substance Abuse Mental Health Services Administration (SAMHSA) Center for Mental Health Services (CMHS) to develop the CT Youth Suicide Prevention Initiative (CYSPI) in 2006. The Assessing Depression and Preventing Suicide in Adolescents (ADAPSA) Program served middle-school-aged youth (7^{th}-9^{th}-graders) attending the St. Francis' Adolescent and Young Health Program, the Hartford Public School's Quirk Middle School (Quirk) and Hartford High School (Hartford High) School-Based Health Centers (SBHC). The program was implemented for the period 1/07-10/09 (Appendix E: The Connecticut Department of Mental Health and Addiction Services CT Youth Suicide Prevention Initiative June 2006-May 2010).

Committee members will identify and choose priorities for the group to address for the remainder of the fiscal year.

APPENDIX A

Substitute Senate Bill No. 317

Public Act No. 06-195

AN ACT CONCERNING REVISIONS TO DEPARTMENT OF PUBLIC HEALTH STATUTES.

Excerpt

Sec. 51*. (*Effective from passage*) (a) The Commissioner of Public Health shall establish an ad hoc committee for the purpose of assisting the commissioner in examining and evaluating statutory and regulatory changes to improve health care through access to school based health centers, particularly by persons who are underinsured, uninsured or receiving services under the state Medicaid program. The committee shall hold its first meeting not later than July 15, 2006. The committee shall focus on improving school based resources, facilitating access to school based health centers and identifying or recommending appropriate fiscal support for the operational and capital activities of school based health centers. The committee shall also assess the current school based health center system, with particular focus on (1) expansion of existing services in order to achieve the school based health center model, (2) supportive processes necessary for such expansion, including the development and use of unified data systems, (3) identifying geographical areas of need, (4) financing necessary to sustain an expanded system, and (5) availability of services under the current system and under an expanded system. Other topics may be included at the discretion of the commissioner and the committee.

(b) (1) The ad hoc committee shall consist of the Commissioners of Public Health and Social Services, or their designees, and the following members appointed by the Commissioner of Public Health (A) two employees of the Department of Public Health, (B) one employee of the Department of Mental Health and Addiction Services recommended by the Department of Mental Health and Addiction Services, (C) one employee of the Office of Policy and Management recommended by the Office of Policy and Management, and (D) three school based health center providers recommended by the Connecticut Association of School Based Health Centers.

(2) The Commissioner of Public Health may expand the membership of the ad hoc committee to include representatives from related fields if the commissioner decides such expansion would be useful.

(c) On or before December 1, 2006, the Commissioner of Public Health shall submit, in accordance with section 11-4a of the general statutes, the results of the examination, with specific recommendations for any necessary statutory or regulatory changes, to the Governor and the joint standing committee of the General Assembly having cognizance of matters relating to public health.

* Not codified

APPENDIX B

COMMITTEE ON SCHOOL-BASED HEALTH CENTERS

Excerpt

Sec. 19A-61 The committee established under section 51 of public act 06-195 shall meet at least once every calendar quarter and report annually to the joint standing committees of the General Assembly having cognizance of matters relating to public health and education, in accordance with the provisions of section 11-4a of the general statutes, on recommended statutory and regulatory changes to improve health care through access to school-based health clinics.

APPENDIX C

Ad Hoc Committee Members
2008-2009 (7/1/09)

Department of Public Health	
Rosa Biaggi	Section Chief, Family Health Section
Janet Brancifort	Public Health Services Manager, Family Health Section
Sharon Tarala	Supervising Nurse Consultant, Primary Care and Prevention Unit, Family Health Section
Meryl Tom	Social Work Consultant, Primary Care and Prevention Unit, Family Health Section
Jill Kentfield	Legislative Liaison, Office of Government Relations Office of Government Relations
School Based Health Centers	
Deborah Poerio	Integrated Health Services, East Hartford
Melanie Bonjour	City of Danbury
JoAnn Eaccarino	Child &Family Agency of Southeastern Connecticut
Carlos Ceballos	New Haven Public Schools
Jesse White-Fresé	Connecticut Association of School Based Health Centers
Office of Policy and Management	
Anne Foley	Senior Policy Advisor
Department of Children and Families	
Marilyn E. Cloud	Behavioral Health Clinical Manager
State Department of Education	
Stephanie Knutson	Health Promotion Consultant
Department of Social Services	
Nina Holmes	Medical Policy Consultant
Department of Mental Health and Addiction Services	
Andrea Iger-Duarte	Behavioral Health Program Manager

APPENDIX D

Connecticut Association of School Based Health Centers

Student Satisfaction Survey 2009

Background
The Connecticut Association of School Based Health Centers, Inc. (CASBHC) was formed in 1994 and serves as the voice of school based health care in Connecticut. The Association represents School Based Health Centers (SBHCs) in nineteen communities in more than seventy-five schools.

The Method
The Association recognized the need to collect and utilize data that could illustrate the impact of SBHC services and care on student health. CASBHC wanted information that could assess student-identified behavior change in addition to demographic data, number of visits, and top diagnoses. Although SBHCs perform patient satisfaction assessments as part of traditional quality assurance plans, this survey was designed to collect information on the role and impact of the SBHC in the health care of the user.

The survey was distributed randomly to users of the SBHC's services at the time that they came for an appointment. When the surveys were collected, they were sent to the CASBHC office and were aggregated into the data that is presented in this report.

The Purpose
The purpose of the survey was to collect data on the impact of the SBHC on the user's health care.

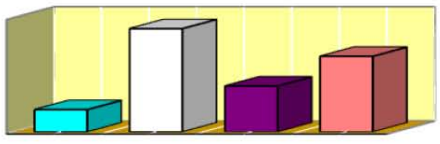
The Sample
The sample was composed of students in grades 6 -12, ages 11 – 19. The number of respondents was 1005 students in 28 schools in fifteen communities, representing a sample size of 5% of all users of services. Surveys were completed by students using SBHC services during the month of May and first week of June, 2009. Seventeen of nineteen communities with SBHCs (89%) administered the survey and reported the results.

Findings
- Of the 1005 respondents, 327 (33%) students were male, 632 (64%) students were female, and 33 (3%) students did not answer. Student visits to the SBHC were to: Nurse Practitioner (65%), Social Worker (29%), Dental Hygienist (2%), Dentist (1%), Other (3%). (Dental services are provided in 5 of 19 communities).

- In response to the question, "How would you rate the care you received at the Health Center today?":
  - **778** of **992** students responded, and rated the care they received as **"Excellent." (78%)**
  - **174** students rated the care they received as **"Good." (18%)**
  - **30** students rated the care they received as **"Ok." (3%)**
  - **1** student rated the care they received as **"Poor." (<1%)**
  - **9** students **did not answer** the question. **(<1%)**

Satisfaction With SBHC Services

Number of Individual Student Visits to SBHC



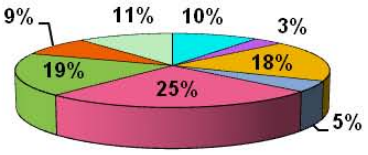
- Each student was asked to estimate their annual number of visits to their SBHC.
  - **88** Students said that it was their **1st** visit
  - **407** Students said they had made between **2-5** visits
  - **181** Students estimated **6-10** visits
  - **298** Students estimated **10+** annual visits

Impact on Student Health Behaviors

One of the most important findings of this survey was the impact that SBHC services and staff had on student health behaviors. The students reported that they have learned new health behaviors as a result of their visits to the SBHCs, and most significantly, have changed some of their behaviors after visiting the SBHCs and interacting with the staff. For example, when responding to "I've learned that some things I do may cause my health problems, 77% were able to say, "Yes, that is true". In terms of prevention, the fact that 81% stated that "I have learned some new health habits through my visit here" illustrates the impact the SBHC can have on positive health behaviors. The responses to the questions are illustrated below.

Health Behavior Questions	Yes
I have learned some new health habits through my visit(s) here	81%
I have changed some of my behaviors by coming to the Health Center	70%
I've learned that some things I do may cause my health problems	77%
I have learned how to take care of my teeth and gums **	51%
I have learned how to better manage my problems	81%
Using the Health Center has improved my overall health	78%
Coming here has been helpful to me	92%

**Few SBHC sites have dental services; oral health education initiated in additional sites in the spring of 2009



25% Wouldn't know what to do/done nothing
19% Try to find a community provider
18% Would have gone home/stayed out of school
11% Didn't answer question
10% Would go to school nurse
9% Would have gotten worse without SBHC
5% Talked to a friend or adult
3% Called home/get medicine/talked to school

Accessibility of Services in the School Based Health Center

Students were asked, "If the Health Center was not here in school, what would you have done today about your health problem?" Of the 981 students that wrote a response, 25% stated that "they didn't know what they would do without the health center", or "they would have done nothing about their health problem". 18% of the students would have gone home, or would have stayed home from school, while 19% responded that they would try to find a provider in the community. Significantly, 9% of the students stated that their health problem would have gotten worse without access to their SBHC, commenting that they "would have suffered through it", they "would get in fights" or "would have stayed in school in pain".

Conclusions

This survey illustrates that students in schools use School Based Health Centers for their healthcare. Without the presence of an SBHC in their school, initiation of treatment for a health problem would have been delayed in many cases. Delaying or forgoing treatment can have a substantial impact on health, especially for behavioral health problems leading to poor academic functioning and truancy.

Most significantly, this survey demonstrates that children who use SBHCs and receive health education and health services take the initiative to change behaviors to improve their health and well-being. The positive responses indicated in the table above illustrate the students' capacity to change old behaviors and improve their overall health as a result of the comprehensive, accessible care provided to them through their School Based Health Centers.

For more information, contact CASBHC at info@ctschoolhealth.org, or call 203-230-9976

Connecticut Association of School Based Health Centers

Healthy Kids Make Better Learners

www.ctschoolhealth.org

Survey results were aggregated by Joseph P. Culligan, University of Hartford student, August 2009.

Appendix E

Department of Mental Health and Addiction Services
CT Youth Suicide Prevention Initiative June 2006-May 2010
Support for Integrated Mental and Physical Health in School-Based Health Centers

Background

In June 2006, the Connecticut (CT) Department of Mental Health and Addiction Services (DMHAS) received a federal grant from the Substance Abuse Mental Health Services Administration (SAMHSA) Center for Mental Health Services (CMHS) to develop the *CT Youth Suicide Prevention Initiative (CYSPI).* Building upon the state's existing youth suicide prevention infrastructure, CYSPI goals and objectives were to implement, evaluate, and sustain statewide suicide prevention and early intervention programs and services for youth ages 10-24 years old from various urban, suburban, and rural areas of the state in accordance with the federal Garrett Lee Smith (GLS) Memorial Act.

The CYSPI encompassed a variety of components addressing youth suicide including the:
1) Connecticut Urban Middle School Indicated Early Intervention Project: Assessing Depression and Preventing Suicide in Adolescents (ADAPSA); 2) Connecticut High School Universal Suicide Prevention Project: Signs of Suicide (SOS); 3) Connecticut State University Suicide Prevention Project;
4) CYSPI Training and Workforce Development; and 5) Statewide Youth Suicide Prevention Education and Awareness Campaign.

DMHAS worked collaboratively with the CT Youth Suicide Advisory Board (YSAB), managed by the CT Department of Children and Families (DCF), the University of Connecticut Health Center (UCHC) Institute for Public Health Research as the Evaluator, and other local, state and national agencies, organizations, groups, systems, schools, and individuals in order to carry out the CYSPI. These collaborations contributed to the success of the Initiative and the capacity to sustain most of its efforts beyond the initial funding period.

Connecticut Urban Middle School Indicated Early Intervention Project: Assessing Depression and Preventing Suicide in Adolescents (ADAPSA)

There were four primary goals of the CYSPI and many objectives, but the results of Goal 2, Objective 6, support the integration of mental and physical health in School-Based Health Centers:

Goal 2: To implement selected youth suicide prevention/early intervention strategies.

Objective 6: Design and pilot implementation of a model program to increase the availability and accessibility of mental health treatment by embedding services in school-based health clinics, which may be replicated in other CT communities.

Research Questions: Will embedding services in school clinics improve treatment outcomes, and how will a school clinic compare to a hospital-based clinic in providing services?

DMHAS contracted with St. Francis Hospital and Medical Center to implement the *ADAPSA Program,* which served middle-school-aged youth (7^{th}-9^{th}-graders) attending the St. Francis' Adolescent and Young Health Program, the Hartford Public School's Quirk Middle School (Quirk) and Hartford High School (Hartford High) School-Based Health Centers (SBHC). ADAPSA integrated select youth suicide prevention/early intervention depression screening and brief mental health treatment with primary care in an effort to provide early identification and treatment of youth at risk for suicide. In addition, the local evaluation studied variations in service provision and youth treatment adherence between the St. Francis hospital/community-based site and the Quirk and Hartford High School-based sites.

Each site provided mental health assessments using the Reynolds Adolescent Depression Scale, version 2, (RADS 2), the Behavior Rating Profile (BRP) (Pro-Ed 2007) that assesses family, peer and school support, and a coping sub-scale of from the Oregon Youth Authority (OYA) Questionnaire, which monitors student functioning on an ongoing basis. Participating youth were evaluated by a clinical interview following the screening. When appropriate, youth who met screening criteria or assessment by clinician were offered brief psychological services (up to 6 sessions) by mental health clinicians employed at each site or referred on to other community mental health agencies. Youth who received treatment were reassessed at three, six, and 12, 18, and 24-months. All services and evaluations were performed only with youth who had active parental consent, as was required by the GLS Act.

The initial intent of the ADAPSA Program was to serve middle school aged youth (7^{th}-9^{th} grade), but at times older high school youth were also served. Therefore, a total of 1,016 youth grades 6^{th}-12^{th} were screened for depression as part of well child visits at the three ADAPSA sites, and from this group 166 screened positive for depression. The total number of middle school youth 7^{th}-9^{th} grades screened was 806, of which 117 screened positive for depression. All positive youth were provided with brief treatment.

Only 7^{th}-9^{th} grade youth with consent were allowed into the local evaluation. Therefore, of the 806 middle school youth 388 received consent to participate, 69 of which screened positive for depression on the RADS-2 with a score of 77 or above and/or endorsed self-injury. These youth had a mean RADS-2 score of 82. Students with 12-month follow-up data had an average screening score at that time of 60.3; significantly lower than their baseline average score of 76.3, showing that the services they received significantly helped to reduce their risk associated with suicide.

Our results suggest that the provision of mental health services in school-based health clinics could lead to increased rates of identification of depressed students and better access to students for the provision of counseling services. Efforts to reach young at-risk urban students, securing consent for evaluation, and providing mental health services were far more successful in school-based health centers than in an outpatient, hospital based pediatric clinic. Youths seen at the school-based health clinic also were seen more frequently for mental health appointments and received more follow-up screenings, even though the school-based clinics were only available for the 10 months of the school year while the community clinic was open year round. The proportion of kept appointments was quite high for a community outpatient clinic, particularly one serving younger clients from a largely Latino Population (Kruse, Rholand, & Wu, 2002; Donaldson, Spirito & Esposito-Smythers, 2005). Our findings support conclusions made by other researchers who have examined the accessibility and efficacy of school-based mental health services (Kataoka et al 2003; Flaherty et al 1996; Flaherty & Weist, 1999). However, follow-up rescreening rates were low in both the school and hospital contexts, suggesting that targeted efforts to improve tracking and follow-up procedures are warranted in order to document and hopefully improve student outcomes.

The adoption of screening as part of the standard of care at all three sites may potentially serve as a model for the 41 of 59 school-based health clinics in Connecticut which serve middle and/or high school students. This effort would be consistent with the 2005 Connecticut Comprehensive Suicide Prevention Plan (DPH, CT State Judicial Branch). The stated goal to “conduct rapid assessment and planning of care for children and youth; promote system changes to expand the scope of services in schools and assess utilization of school-based mental health services” may be well served by the adoption of a standard of care in which all youth utilizing school-based health clinics are screened for depression.

Summary of Findings

Middle School Outcomes:

- A total of 806* 7th-9th-grade youth were screened at all three sites, 117* of which screened positive at-risk for suicide. A total of 388 youth had consent to participate in the study, 69 of which screened positive at-risk for suicide.
- All youth who screened positive were offered on-site brief mental health treatment services for up to 6 sessions. However, when comparing St. Francis and Quirk, students at Quirk were provided about 3 times as many appointments and kept almost all of the appointments offered. Although the brief treatment model was to offer services for 4-6 sessions, the average number of clinical appointments was more than double that target at the Quirk SBHC.
- Consented students with 12-month follow-up data had an average screening score (60.3) that was significantly lower than the baseline average score (76.3) showing that the services they received significantly helped to reduce their risk.
- Treatment adherence was significantly greater for youth at the school-based sites versus the hospital/community-based site, primarily due to youth access and staff outreach, leading to conclude that SBHC are in a unique position to provide mental health screening, referral and treatment to youth.

*CT state law doesn't require parental consent for screening or brief treatment, but the federal act funding the grant does for study participation. Consequently services were provided to all youth, but only those with consent were in the study.