LiveWell Kershaw

Case Studies and Success Stories

Year 1 - Year 3

Community Health Worker Case Studies

Pamela

Moving to a new area can present challenges in many different ways. Pamela, a new Kershaw County resident, is currently experiencing many of those challenges. Now living with her mother, Pamela and her two daughters, along with her boyfriend are struggling to live off of her mother's disability income while searching for employment. In addition, the entire family is in need of medical care. After Pamela visited the LiveWell Kershaw team, she was able to work with Beckie, a CHW, to get set up with several different benefits and also get some information on an employment opportunity with Jobworks through the Goodwill. After over an hour and a half of coordination, Beckie was able to help Pamela complete applications for Medicaid and SNAP benefits. In total, the estimated amount of benefits for their household of five totals about $1,000. In addition, Pamela is now a patient of the Community Medical Clinic and can received medical care there until she is approved for Medicaid. Pamela was grateful to the LiveWell team for their help and communicated that she did not know of anything like this in Pennsylvania. Pamela also noted that in order to have the same amount of services, she would have had to go to several different locations if it had not been for the LiveWell team.

Craig

Craig, a 41-year old native of Cassatt, recently began receiving services through LiveWell Kershaw. After Craig became unemployed in February and moving in with his parents, he sought out LiveWell Kershaw for assistance with his health issues. Because he has Type 2 Diabetes, it is imperative that Craig be regularly seen by a physician to receive insulin and be able to check his blood sugar levels regularly. However, without any income, all medical bills have become his parent's responsibility. Therefore, Craig's primary care physician referred him to LiveWell Kershaw in order to alleviate the financial burden that has been placed on his parents. Craig is grateful to LiveWell Kershaw and says, "...I would probably go without my medicines if it weren't for y'all helping me out because I don't want that pressure on my parents…I actually might not be alive right now if it weren't for LiveWell or I may have lost a limb by now…" Through LiveWell, Craig was able to have blood work done, get his blood sugar under control, and obtain the medications that he needed. In fact, Craig is glad that he can go to Camden and get his test strips for $5 instead of paying an outrageous amount in-stores. When asked if there is anything that the LiveWell team should improve on he says, "Nope, everything's been great…they're a God-send." In addition, If Craig could describe the LiveWell team in one word, he would use the word, "lifesaver." Craig looks forward to continuing to receive LiveWell Kershaw services to keep his diabetes under control.

Jenny

In September, Beckie Tompkins, a Community Health Worker at the time, made a call to an individual from the ER call list to let her know that the LiveWell team could help her with medical care and social determinant issues. That individual was Jenny.

Jenny's story begins three years prior when her husband passed away and she was left without a source of income. Since moving to the North Central area, Jenny has been living off of a small amount of life insurance from her husband's passing but that money was quickly dwindling and she wasn't sure what next steps to take. When Beckie called her, Jenny indicated that was a patient of CMC and also suffered from some mental health issues. However, Beckie was able to inform her of the clinic satellites that exist in the community. Jenny was then able to schedule her appointments at Refuge instead of having to drive to Camden to be seen for medical care. This would reduce the amount of travel cost incurred by Jenny so that she could utilize her remaining funds for other necessities.

Through the help of Beckie and Jodi Rogers, another Community Health Worker, Jenny was able to complete applications for both SNAP and Medicaid, as well as charity care for her most recent ER visit that she does not have the funds to cover. That application is pending the Medicaid denial letter. In addition, Jenny has applied for Social Security Disability as a possible source of income. That application is currently pending. While Jenny is now receiving almost $200 a month in SNAP benefits, she is also receiving additional food from the food truck that visits DeKalb once a month.

Even though Jenny's story is just beginning to take shape, both Jodi and Beckie have already witnessed a transformation in her demeanor and her interactions with others. Jenny has developed from a withdrawn, depressed nature and into a more outgoing and joyful spirit. Over the holiday's Jenny delivered baked goods to the Refuge satellite as thanks to the LiveWell team. On another occasion, Beckie was ran into Jenny at the grocery store shopping with a friend and proceeded to give Beckie a hug.

While there is still more to come from Jenny's relationship with the LiveWell team, she is already improving emotionally and mentally as she develops relationships in her new community. Beckie and Jodi look forward to continue working with her.

G. Johnson

Mr. G. Johnson, 52 years old and a longtime resident of Bethune, SC, began visiting the Sandy Level Baptist Church satellite site in March 2015. He heard about LWK by 'word of mouth' from Kershaw Hospital. The initial reason for his visit was acid reflux. Mr. Johnson stated that CHW Karen Baker initially assisted him by directing him to community services, and CHW Rachael Sladek continued to help him on his follow-up visits at Sandy Level. As Rachael followed up to help Mr. Johnson navigate the healthcare system, he needed to get his identification (ID) card to be able to attend his disability hearing. At the time the only

piece of identification he had was his social security card. After a few weeks of making phone calls and working with the documentation that Mr. Johnson had, Rachael was able to help him secure his birth certificate and obtain his state-issued ID. He was finally able to attend his disability hearing where he was approved for Supplemental Security Income (SSI) in October. Since then, he has received Medicaid and visits his doctor regularly. He also received a mobile phone from Safelink to stay in better contact with his doctors and lawyer. Mr. Johnson stated that "Rachael is his angel." She never gave up working with him to get what he needed to take better care of himself. Mr. Johnson continues to work on his self-management goals in collaboration with his doctors and the CHWs. He plans to get his vision checked in the next two weeks.

Susan

Last April, "Susan" received assistance in getting a primary care doctor from CHW Karen Baker (see previous case study). Susan, who is continuing her journey to better health, previously had a blockage in her brain. She is no longer able to work, and filed for disability in February. She has been consistent in her follow-up with Karen at the Refuge Baptist Church satellite site. After receiving prior assistance from Karen, Susan needed to have a special test done on her brain. Because she was still waiting for Social Security, Disability and Medicaid, Susan postponed the test until a better time. With Karen diligently working on Susan's behalf, supplying requested documentation to the Social Security and Medicaid offices, Susan was approved for SSI benefits including Medicaid in July. Once she received the news of her approval, Susan was able to have the cerebral angiogram test done in October and received favorable results. With Susan's continued trust in LWK and Karen, she has been able to receive more help than she ever imagined. Susan has since expressed to Karen just how important LWK is and how it has changed her life.

Sylvie

"Sylvie," a 53-year-old female, benefits from joint Case Management Meetings at the Community Medical Clinic. Sylvie became a patient with the Community Medical Clinic on June 5, 2013. Over the past three years, she has worked with numerous medical providers and volunteers to help manage her comorbidities. In addition, Sylvie also visited case managers at Access Kershaw for continued care coordination. Diagnoses for Sylvie include: hypertension, leiomyoma of uterus, embolism and thrombosis of the arteries of the lower extremities, iron deficiency, GERD, cardiac murmur and obesity. Sylvie is a portrait of a medically complex patient. In June of 2016, Sylvie arrived at the Emergency Room of Kershaw Health in immense pain. A pelvic MRI revealed she needed to have a hysterectomy soon. However, with a blood clot, the needed surgery could not be scheduled immediately. After being discharged from the hospital, Sylvie followed up with medical providers at the Community Medical Clinic and also visited a specialist in Columbia. After much discussion, the Community Medical Clinic medical team decided that Lovenox would be the best medication for Sylvie, despite not being on the preferred list for the Prescription Assistance Program. The Executive Director decided to utilize $2,000 of a medication fund at the Community Medical Clinic to pay for Lovenox. In September, Sylvie successfully recovered from her hysterectomy and now continues to receive follow up care with the medical team at the Community Medical Clinic and Access Kershaw. Today, Sylvie feels "100% better" and speaks very highly of the team at the Community Medical Clinic and Access Kershaw. She shared that "everybody has a smile on their face" and is extremely friendly. Sylvie now advocates for others like her, in pain and suffering from health issues, to visit the Community Medical Clinic. Unlike some other places, Sylvie noted that "they really, really help you." Behind the scenes, the Executive Director convened three case management meetings over the summer to make sure that Sylvie was getting the best coordinated care possible. Joint face-to-face meetings were held with the entire medical team of the Community Medical Clinic as well as the nurse case managers of Access Kershaw to discuss Sylvie's medical situation and to make sure all appropriate follow-up was being taken. Leigh Reed, LPN, believes that there are many more "Sylvies" in Kershaw County with diverse and complicated medical needs that require a team based approach. Jeana Johnson, a Community Care Coordinator, found the joint case management meetings invaluable and notes that this "really helps with continuity of care and improving outcomes for the patient." The Executive Director will continue to have monthly joint case management meetings to discuss the individual needs of their patient population and has expanded the group to include LiveWell Kershaw Community Health Workers. By working and talking together about each patient, the team is believes that improved patient outcomes will become a reality for the uninsured and underinsured residents of Kershaw County.

Jodi

Patients recognize that they will receive quality medical care at a LiveWell Kershaw Mobile Clinic. When "Jodi" needed to be seen for a medical issue, she contacted the Community Medical Clinic for an appointment. A volunteer informed her that she could be seen more quickly if she went to Sandy Level Mobile Clinic. Jodi had no hesitation about the Mobile Clinic because she knew she would receive the same level of care provided by the CMC. As a result, Jodi has been coming to Sandy Level since September 2015. When it comes to solving her medical issues, Jodi says, "they don't let grass grow under their feet!" The mobile clinic staff does not waste any time when it comes to solving her medical issues. As a result, Jodi expects to undergo a much needed surgery arranged with help from LiveWell Kershaw.

Mr. Jones

Mr. Jones meets with a Nurse Practitioner on a monthly basis during mobile clinic days at Refuge Baptist. He has lived in Bonetown since 2009. Mr. Jones is employed by the Camden Walmart. Rachael Sladek, CHW, recently assisted Mr. Jones in applying for Welvista benefits. In order to apply, Mr. Jones needed to submit check stubs. This presented a challenge because his paychecks are only available online. Having no access to internet or a computer, Mr. Jones was unsure of how to get this information. Rachael was able to walk Mr. Jones through the process of creating an online account through his employer to obtain a hard copy of his income to include with his Welvista application. Thanks to Rachael's efforts, Mr. Jones now receives his medications mailed to his home through Welvista. He is very appreciative of the time that Rachael has spent assisting him. Mr. Jones has also worked with Community Health Worker, Beckie Tompkins. Mr. Jones now has a primary care home thanks to Beckie, who guided him through the Community Medical Clinic's enrollment process. Beckie continues to help him through the lengthy application process to obtain catheters at no charge.

Caleb

"Caleb" is a trained painter from Asheville, NC, who moved back to Westville, SC, to care for his aging parents. After suffering a heart attack and an arm injury, he has been unable to find work. After discharge from the hospital, Caleb was contacted by Community Health Worker, Beckie Tompkins. Beckie used this phone call to share information about the LiveWell Kershaw program with Caleb. He has been working with LWK ever since. Utilizing LWK services has been critical to Caleb's recovery as he has worked with both Community Health Workers and Nurse Practitioners to obtain necessary medication and lab work. The integrated team approach to treating the "whole person" has truly benefitted Caleb. Caleb really believes in the program and that the best way to share with others in the community is through word of mouth.

Ronny

Convenience plays a large role in whether or not a patient will seek medical care. Amount of miles to travel and lack of transportation are often barriers to accessing quality medical care. Ronny, a patient at the Sandy Level Mobile Clinic in Bethune, has been receiving care at this location for over two years. Ronny heard about this Mobile Clinic from a few of his friends and decided to stop by since it is within a few miles of his home. His sister drives him to his appointments. When asked how he feels about this clinic, Ronny says, "I love coming here! It works out great!"

Linda

One day, Linda, a 54-year-old from Cassatt, received a call from Rachael Sladek, a Community Health Worker with LiveWell Kershaw. Unsure of why she was being contacted, Rachael explained to that she knew Linda had been in the Emergency Room of Kershaw Health earlier that week and wanted to know how she was doing and if she needed assistance with medical needs. In addition, Rachael explained her role in helping individuals obtain medical attention and other social services if they are needed and the individual qualifies. Linda stated that she normally goes to the Emergency Room whenever she is hurting because does not have insurance or a primary care provider. Rachael informed her that she could be seen by a Nurse Practitioner at Cassatt Baptist Church on Mondays at no charge. As a result, Linda now has a medical home with the Community Medical Clinic.

The next Monday, Linda came in to see Rachael and completed all the necessary paperwork to be seen, as well as an application to obtain Medicaid and SNAP benefits. Linda explained to Rachael that she is constantly in pain and always has

difficulty walking. The following Monday, Linda came back to be seen by Vicky Craig, the Nurse Practitioner. Upon examination and the results of lab work ordered by Vicky, it was determined that Linda was suffering from Rheumatoid Arthritis. According to Vicky, her Rheumatoid factor levels were off the charts. Linda knew that she was in pain, but didn't really realize that anything was seriously wrong. Vicky was able to give her validation for the pain that she was having. Linda was then sent to the hospital for a steroid shot to help with the pain and inflammation.

Since this first encounter, Linda has been approved for SNAP benefits and Medicaid Healthy Checkup. The LiveWell team was also able to find Linda a Rheumatologist that would accept Christian Community Ministries vouchers. As a result, Linda is currently receiving follow-up care from this Rheumatologist.

The LiveWell satellite team worked together to coordinate not only the social services that Linda needed but also the medical care that she so desperately required. Linda is the perfect example of an emergency room list "cold call" that resulted in an individual who previously utilized emergency services regularly that now has a primary care provider and a specialist for her arthritis.

Stephanie's Story

Stephanie is a 38-year-old, mother of two that lives in Cassatt. Stephanie's journey with LiveWell Kershaw began in May 2016 with a visit to the Community Medical Clinic to see Community Health Worker, Rachael Sladek. Stephanie heard about LWK from her mother that transports her mother to the Refuge Baptist Church satellite. Stephanie came in because she did not have a Primary Care Provider and typically visited Elgin Urgent Care for any medical issues; located over 40 minutes from her home. Stephanie has several chronic conditions, including Lupus. However, her main concern at this time is a lump in her breast. "Kershaw Health said that they will not do the mammogram because I have no income or health insurance," said Stephanie. Rachael was able to screen Stephanie that same day to determine if she was eligible to become a patient of the Community Medical Clinic.

Since then, Stephanie has been a part of the Best Chance program and is now eligible for a mammogram at no cost. To Stephanie's relief, she discovered that the lump in her breast was not cancerous. Other services utilized by Stephanie included visits with CMC's mental health counselor, Christie Derrick, and help completing social service applications such as Welvista, SNAP, Medicaid, and Kershaw Health Financial Assistance. In addition, Stephanie has been connected to the Mobile Food Pantry through United Way that visits Cassatt Baptist Church every 3rd Tuesday each month.

Beginning in March 2017, Stephanie no longer had transportation to get to her appointments at CMC in Camden but realized that she could receive the same medical care and social service assistance at the Cassatt Baptist Church satellite location. "I love having a mobile clinic nearby. Cassatt Baptist Church is only about three miles from my home," says Stephanie. The only issue that Stephanie has is related to the fact that Christie is unable to see patients at the satellite locations. Stephanie hopes this will change soon. Stephanie attributes her decreased anxiety levels to the biweekly appointments she had scheduled with Christy. "She really helped my anxiety issues because I had a person to help me talk through any issues I had," says Stephanie.

Community Health Worker Rachael Sladek has continually worked with Stephanie on paperwork and getting approvals for various benefits. In March 2017, Stephanie was denied for SNAP benefits because she lives in her ex-husbands home with her two children and had to report his income, even though she is not receiving any of it. Through collaboration with the rest of the LiveWell Kershaw team, Rachael was able to enlist the help of Jodi Rogers, another CHW for LiveWell Kershaw. Jodi was able to make contact with a connection she has at SNAP to determine the protocol for obtaining a Fair Hearing for Stephanie to appeal her SNAP denial. This hearing is now pending as a result of her efforts. Stephanie is appreciative of Rachael's efforts to think outside the box when it comes to removing barriers.

"If she [Community Health Worker] doesn't have the answer, she will find it. If I need help with something and she can't, she leads me in the right direction and helps me get in contact with someone who can," says Stephanie.

Before receiving help from LiveWell Kershaw, Stephanie had gone years without medical attention for her chronic conditions because she had no insurance and could not qualify for disability. Stephanie is now able to manage her Lupus through the medications she receives from Welvista and regular medical appointments with Vicky Craig, LiveWell's Nurse Practitioner.

Not only has Stephanie received the benefits of working with LiveWell Kershaw team members but her fiancé is now receives medical care for his high cholesterol and triglycerides at Cassatt Baptist Church as well. Because of the care that both she and her fiancé have received, Stephanie believes that her future is much brighter.

Case Management Case Study—Joseph

Brandi Thompson, a Community Care Coordinator, has been working with Joseph, a gentleman diagnosed with Type II Diabetes in late September 2016. Joseph was referred to LiveWell through his Primary Care Physician after receiving his Type II diagnosis a few months ago. When he first met with Brandi, Joseph's A1C level measured at 16 and a glucose level that maxed out at 555. Immediately, Brandi began working with Joseph on bringing his levels to a more manageable state. In order to do so, Brandi worked with him on reviewing his medications, discussing portion control, and making healthy choices when dining out. In addition, they went over the benefits of exercising and increasing physical activity levels. "She helped me look at menus and came up with an eating plan for me," says Joseph. One area that Brandi focused on was helping Joseph learn how to read product labels when purchasing items from the store. In order to keep track of food intake and glucose levels, Joseph kept logs and used the glucometer that Brandi provided him. In his logs, he wrote down his blood sugar levels and what he was consuming throughout each day. Brandi meets with Joseph every couple of weeks and calls him weekly to check in and see how he is progressing. At last measure, his A1C levels had gone from 16 to 5.2. While Joseph has not reported much weight loss yet, he says, "I feel much better and my clothes are fitting better." Brandi will continue to work with Joseph on his self-management and ensure sustainability of his new lifestyle. We look forward to seeing the additional strides that Joseph will make in the coming months.

Transitional Care Case Studies

Patient Perspective - "James"

James is 44-year-old male that has lived in Camden, SC his entire life. Due to complications with diabetes, James has found himself in the hospital at Kershaw Health several times over the past few months. He was admitted once in March 2016 and again more recently, at the end of July for a 10-day hospital stay for uncontrolled high blood sugar. During his most recent hospital stay, it was discovered that an infection in his knee was the culprit of the elevated blood sugar levels. James' knee infection stems from a work related injury from several years ago that did not heal properly. While in the hospital, James was visited by Sheri Baytes and Jeana Johnson, Community Care Coordinators with the Transitional Care team that began coordinating care for James post-discharge. James has benefited greatly from the coordination of transitional care. The team assists him with keeping track of his appointments and making sure he has the medications he needs. Sheri has visited James at home on several occasions to bring him more test strips to check his blood sugar and a walker that now allows him to get around more easily. In addition, Beckie Tompkins, a Community Health Worker, sits in on all of James' medical appointments and is able to keep "everything straight" for him. As a byproduct of this team approach, James feels valued as a person and as a patient. James says that, "Sometimes when people help you, they put too much pressure on you because they are helping you out…but they [transitional care team] are not like that. When they call you they say they want to come check on you, if it's not a problem." When asked if he anticipates being hospitalized in the future, James says, "I'm hoping not." His knee is still slightly swollen which is a cause for concern but his doctors believe the swelling will reside after completion of antibiotics.

Even so, James feels that his transitional care team has placed him on the right track to stay out of the hospital. He says, “They work with you and let you know that they are concerned with what’s going on with you.”

Community Care Coordinator Perspective- Sheri

“The good thing about James being with transitional care is that he has someone to guide him…sometimes things can fall through the cracks,” says Sheri Baytes, the Community Care Coordinator. It can become overwhelming at times, trying to remember all the medications that need to be taken and appointments that need to be attended. Therefore, patients can be more successful in their recovery efforts by having a team behind them to provide appointment and medication reminders. “We can help him get focused,” says Sheri. For example, Sheri spoke with James just recently to check on his medications when he informed her that he needed more of one particular medication. James had taken his last dose that morning and would need another dose that evening. Sheri was able to make sure that he would have more medication for that evening. Additionally, the transitional care team works with the patients to educate them on how to take care of themselves in order to prevent readmission into the hospital. While James was readmitted into the hospital after his admission in March, he was admitted in late July for a different reason, the infection in his knee. However, since the infection is now controlled, the transitional care team believes that it will be much easier for James to control his blood sugar levels. While transitional care aims to keep patients out of the hospital, Sheri says that they also educate patients on when it is appropriate to go to the hospital. “Some people will hold out on going to the ER and will wait until the last minute, so that’s one thing we emphasize…if you need to go, go,” says Sheri. Moving forward, the transitional care team is also educating James on signs and symptoms of infection, as well as how to take care of the site where his PICC line was recently removed from. By encouraging James to stay on top of his medications, checking for signs of infection, and testing his blood sugar regularly, the transitional care team can lessen the likelihood that James will be readmitted into the hospital.

Kershaw Health’s Hospital Perspective

A close, trusting relationship between the Community Medical Clinic and Kershaw Health is vital for the transitional care piece to run smoothly. A Nurse Practitioner, a case manager, and a care team member at Kershaw Health shared their perspectives on working with the transitional care team and the impact this service has had on patients. “I think it’s awesome…the fact that they coordinate the patient’s care,” says Judy. She then went on to describe how a diabetic patient was recently able to get a glucometer through the help of the transitional care team, so that he can now check his blood sugar levels. Judy believes that if transitional care was not in Kershaw Health, there would definitely be more patients readmitted into the hospital. “There is nothing else like this at the hospital,” says Cynthia, a Nurse Practitioner. It’s been reassuring to patients that they will have medical help after they are discharged from the hospital. The care team at Kershaw Health believes that in a perfect world, there would be more access to equipment that patients could use, such as walkers. The equipment that the transitional care team has been able to provide patients has been a blessing.

Tim

Tim has been under the care of the transitional care team since July of 2016**,** when he underwent surgery for Cellulitis at Kershaw Health**.** Tim is currently staying in an older, run-down home that his sister is letting him use. His daughter and two grandchildren live upstairs in this same home and none of the family has access to transportation. Therefore, Tim depends on others to drive him to his doctor appointments. In addition, Tim does not have a telephone but his daughter has agreed to let Debbie Davis, transitional care team member and Community Care Coordinator text her phone weekly to check on Tim’s progress. Because Kershaw Health’s home health only visited three times a week for the first two weeks after Tim’s surgery, Tim’s daughter has had the responsibility of changing his dressings twice daily and then once daily as time went on. Debbie has visited their home multiple times to provide test strips for his glucometer, as well as gauze and saline for Tim’s dressing changes. The materials that Debbie is able to provide have been donated by the Community Medical Clinic (CMC). “Surgical site infection is always a big risk in a home setting, as well as in a hospital, but the daughter is doing a great job with the

dressing changes," says Debbie. Debbie went on to say, "…by helping his wounds heal, we decrease the number of specialty surgeon visits, a possible readmission into the hospital, and allows the patient to feel better and able to focus more on controlling his chronic conditions." Tim is also receiving Ensure, a protein drink, from CMC that he takes on a daily basis along with a multivitamin. Because of this, Tim has been able to put on some much needed weight and is gaining his color back as a result of the care that he has received since being out of the hospital. Tim has now been out of the hospital for **five** months.

Jimmy

Jimmy, who suffers from heart disease and diabetes, entered transitional care once he was discharged from Kershaw Health in July 2016. Once working with the transitional care team, Debbie Davis was able to work with Jimmy on getting the medications that he needed. With the help of the Community Care Coordinator, Jimmy was able to apply for a medication program to help cover the cost of the medicines prescribed while at the hospital. While working with him, Debbie quickly realized that monitoring his elevated blood pressure levels would be a challenge. Debbie educated Jimmy about the effect his diet has on his blood pressure and diabetes. In addition, Jimmy's heart specialist had recommended that he keep a log to record his blood pressure throughout the day. In another instance, Debbie was able to determine the reason behind Jimmy's continued high blood pressure even while being on medication. After much investigation and information provided by Home Health, Debbie discovered that Jimmy had not told his cardiologist that he had Welvista and once his prescriptions were sent to Walmart, he was not able to afford them. Therefore, Jimmy was going without his blood pressure medication resulting in unchecked elevated blood pressure levels. With help from Mary Lee Addis, the Nurse Practitioner at CMC, Debbie was able to obtain free medication for Jimmy until his Welvista medications came in. Debbie fully expects Jimmy's blood pressure to drop to normal levels once he begins taking his medications as prescribed.

On another occasion, Jimmy's blood pressure monitor broke and he promised to purchase a new one. However, Jimmy was not comfortable disclosing that he could not afford one and as a result, his blood pressure went unchecked for some time. Once Debbie realized what was happening, she was able to work with United Way partner, KARE, to obtain a blood pressure monitor for him. Debbie explained to Jimmy the importance of monitoring his blood pressure as it will help make sure that his medications are working, keep him out of the hospital, prevent him from having a stroke, and keep him around for his wife.

Mary Lee Addis, Nurse Practitioner at the Community Medical Clinic, also recalls working with Jimmy to get his blood pressure and blood sugar levels under control. Once Home Health was able to go into Jimmy's home, they were able to discern whether or not he was taking his blood pressure medication and monitoring his blood sugars. While Jimmy works and tries to maintain an independent lifestyle, Mary Lee noted that it was important to have Home Health available to help him out. As of today, Jimmy's blood pressure has stabilized to a normal level and his blood sugars are improving but are still a work in progress. Mary Lee is optimistic that with continued guidance from transitional care team and with help from the endocrinologist Jimmy has been referred to, that his conditions will continue to progress to more stabilized levels.

Jimmy's story is one that showcases the importance of having a team consisting of a Community Care Coordinator and a Nurse Practitioner. Debbie and Mary Lee were able to have frequent contact with Jimmy in order to understand the root causes of the health issues Jimmy was experiencing. Both Debbie and Mary Lee worked to find the real reasons behind why Jimmy was having difficulty controlling his blood pressure. Once they discovered what was really going on, they found a solution to fix the issue and get Jimmy on the right track.

Margie

Margie is a 51-year-old female that lives with her mother and her disabled adult son. Margie's journey with transitional care began when she was admitted to the hospital in August 2016 with Epiglottitis. Over the past 12 months, Margie reports going to the emergency room over ten times. She eventually came off of transitional care but was recently placed back in the program when she was admitted again in January for Epiglottitis.

Epiglottitis is a serious medical condition that can result in death if not treated quickly. This flap of tissue keeps food from going into the trachea and windpipe during swallowing. When this flap becomes infected, it can close off the windpipe, which can be fatal. This condition can occur as a result of environmental factors, trauma, or respiratory infection. Margie is a smoker and also lives in a home with no working air conditioning; both contributors to her health condition.

Margie was referred to transitional care for the second time by the discharge nurse at Kershaw Health. Since then, Debbie Davis, Community Care Coordinator, has been working with her to keep her out of the emergency room. In order to do this, Margie would need to undergo a Tracheostomy. Prior to hospital admission for the surgery, Debbie worked with her to complete a Medically Indigent Assistance Program Application to cover costs. In addition, she was able to help Margie obtain Medicaid Healthy Checkup coverage.

After Margie's surgery, Debbie did a home visit to check on her and make sure that she had enough supplies for her trach, as well as provide education about tracheostomy care. Education on care reduces the likelihood of infection and additional hospital admissions for Margie. Debbie also provided education and encouragement to Margie regarding smoking cessation. Since the surgery, Margie had not smoked any. Behind the scenes, Debbie knew that Margie would be low of supplies so she worked to secure additional materials. Home Health was able to bring these additional supplies on their courtesy visit.

Since then, Debbie has made several follow-up calls to Margie to see how she is doing. While Margie has since began smoking again because she believes that it helps with her coughing, she is smoking much less than her previous daily intake. Home Health educated Margie on replacing her trach and on how to sterilize them, as they can be reused.

Appropriate and consistent follow up with patients is key to transitional care success. In this case, Debbie is continuing to provide ongoing education and support to Margie to ensure that her tracheostomy is a success and that she does not return to the emergency room for issues related to the chronic Epiglottitis that she is having. Thus far, Margie is doing well and is scheduled for an appointment at the Medical University of South Carolina in April to further evaluate her chronic Epiglottitis. The LiveWell Kershaw team attributes Margie not being re-admitted to the hospital to the transitional care program. Margie has a support system and a medical home at the Community Medical Clinic.

Rhonda's Story

Rhonda, a 46-year-old resident of Camden, has been experiencing several hardships over the past couple months. During this time, Rhonda has been dealing with the deaths of two of her close friends. These deaths have taken a toll on her mental health and interpersonal relationships. In addition, she has recently become unemployed after an argument with a significant other that resulted in imprisonment. On top of this, her physical health has been impacted as well. Over the course of one week, Rhonda's world was turned upside down. One Friday morning in the shower, Rhonda noticed a cyst that had developed almost overnight. Because she was a member of the Community Medical Clinic, Rhonda scheduled an appointment to be seen the following Monday.

Rhonda was seen by Mary Lee Addis, a Nurse Practitioner at CMC who immediately referred her to Dr. Christenberry at Kershaw Health Surgical Associates to assess the cyst that was becoming an abscess. The abscess on her abdomen was determined to be staphylococcus aureus. These types of infections can turn deadly if the bacteria spreads deeper into the body and enters the bloodstream. Therefore, timeliness of treatment is very important. Because of the severity of the infection, Dr. Christenberry was unable to perform any draining of the abscess in his office and scheduled a surgery at Kershaw Health. Rhonda has no health insurance so the thought of incurring additional medical debt was another stressor that affected her. However, this procedure was necessary for her health.

After surgery and in recovery, Rhonda was greeted by Community Care Coordinator, Debbie Davis, who took time to explain the Transitional Care program and how she could benefit from its services. Rhonda described Debbie's presentation and interaction as "comfortable" and that she felt at ease throughout the conversation. Rhonda was elated to have the opportunity to participate in this program and interact with individuals that could coordinate her medical care and assist with social determinant needs such as the medical bills that she would incur as a result of the surgical procedure and subsequent

hospitalization. “I was able to focus on the medical side of this,” says Rhonda, “even a distant thought that there might be some help out there with the financial side…I was able to relax and be more at ease and focus in on feeling secure.” Rhonda also saw Christie Derrick, the mental health counselor, for four sessions to process her thoughts and feelings and learn appropriate coping techniques.

Thus far, Rhonda has been able to receive help with completing Kershaw Health Financial Assistance applications, medical education on the healing process of a wound, and assistance with receiving medications. At her follow-up appointment at the Community Medical Clinic, Rhonda met with Community Health Worker, Jodi Rogers, who sat in on her appointment with Mary Lee. Rhonda was happy to have another person on her care team to see her through this challenging time and assist her with recalling details from appointments. Dealing with personal, medical, and financial issues can be overwhelming for anyone. However, these issues in conjunction with loss of employment can hinder proper healing. The goal of transitional care is to provide the proper support and resources to lessen the stress associated with hospitalization. The team will continue to work with Rhonda as she recovers from surgery and regain control of her personal life and employment status.

Integrative Medicine Case Studies

Sally’s Story

Sally is a 38-year-old African American female who began receiving primary care services at the clinic in November 2015. One Friday night in April, she was robbed at gunpoint. Earlier that month, Sally had received a flier in the mail announcing the arrival of a new counselor that would be serving the clinic. So the following Monday, Sally came to the clinic so tearful and distraught the volunteer receptionist had trouble understanding what she was saying. The receptionist knew she was a regular patient and was finally able to determine that Sally was requesting an appointment with the new mental health counselor.

The counselor saw Sally immediately and conducted a thorough assessment. Sally confirmed she was having standard trauma responses: little sleep fraught with nightmares, easily startled, flashbacks of the gun in her face with thoughts that she was going to die, increased anxiety and fearfulness, and a loss of appetite. During the interview, the counselor learned that Sally already had an extensive trauma history from childhood to the present. A year ago she was homeless for about eight months.

The counselor asked Sally if she felt safe in her home and had adequate support from family, friends and coworkers. Sally said she was staying with a friend. Her family did not live nearby but her friends and co-workers were being supportive.

Sally did not want any medication to help her deal with the stress and sleep problems. She preferred dealing with problems by talking about them and trying to keep herself busy. The counselor respected Sally’s desire to address her distress in a holistic way, and showed Sally how to take deep breaths to calm herself. The counselor explained how her symptoms were common responses to experiencing danger. The counselor reassured Sally that there was hope and scheduled Sally’s next appointment in a week.

Over the course of five months, the counselor met with Sally every week. Like most trauma survivors, Sally struggled with frequent triggers which would bring on new symptoms or exacerbate old ones. During her treatment, she was relieved when her assailant was arrested but then relived the life-threatening event as she watched news of the Orlando and Dallas shootings.

Sally learned more relaxation techniques from her counselor so she didn’t need medicine to fall asleep and feel safe in her home. She learned how to monitor the tension in her body as the first line of defense in managing the stress. She also learned to visualize a comforting place in her mind where she could find a break from the onslaught of friends asking details of the robbery, nightly news of other violent crimes in nearby communities, how to handle a new employer who had become verbally abusive, and how to prepare for court where she would have to view video of the robbery.

Her counselor continued to encourage her by acknowledging her progress, normalizing her setbacks, and reminding her that healing is not always linear. Sally made a daily routine of practicing her relaxation exercises. When her stress level increased, she used these exercises more.

Repeatedly, Sally expressed appreciation to her counselor and amazement at how such simple techniques could make such a profound impact on her stress level. She now reports improved sleep and appetite, and even joy on many days. The counselor is providing updates to the clinic's Nurse Practitioner and is continuing to work with Sally as she moves forward.

Manuel's Story

Manuel is a 28 year old husband and father of two exuberant children, all under the age of seven. Several years ago, he was in an accident and suffered a serious head injury. He has never had health insurance and lost his job because he required two years of physical, speech, occupational and psychiatric therapy.

Shortly after losing his job, Manuel and his wife began coming to the Community Medical Clinic of Kershaw County (CMC) for their primary care. For two years, Manuel had to travel to Columbia to receive treatment for Post-Traumatic Stress Disorder (PTSD). Now he and his entire family receive weekly counseling at the clinic. The clinic's Family Nurse Practitioner prescribes medications to help manage his PTSD.

Like most people diagnosed with PTSD, Manuel is bombarded daily with multiple triggers. These triggers can profoundly disrupt his day leaving him feeling bewildered and hopeless. For instance, whenever he hears loud noises he still has flashbacks of being flown by helicopter from the scene to an area trauma center.

His movement remains restricted on one side. He is often tearful, anxious, withdrawn, and suffers from insomnia. Nevertheless, he tries hard to be a good husband and father by continually putting pressure on himself to continue to be the primary provider for his family – working 40 hours a week at odd jobs.

The accident and his illness didn't just affect Manuel. His whole family fights to cope with the monumental changes they must overcome to remain together. His wife is stoic when discussing the demands of caring for two small children and a husband who suffers from physical and emotional scars.

The children don't understand why their Papa doesn't have the energy to play with them like he did before the accident. They also don't understand why they had to move from their comfortable home where they each had a room, to a much smaller house that has few of their own personal belongings and toys. The oldest child acknowledged worrying about being homeless. Both parents comfort their children with hugs, kisses, and promises that they will never end up on the street but you can see the strain and worry on their own faces. Manuel and his family will continue to be seen at the Community Medical Clinic for both primary care and mental health services. They feel that the clinic is a very safe place and are encouraged by the small milestones they all are making to improve their quality of life as a family.

Philip's Story

Philip is a 40 year old, single, Caucasian male who lives with and cares for his 78 year old mother in Cassatt, SC. They live in a modest home in rural Kershaw County. Philip's two sisters work and live with their families elsewhere in the county. Philip never finished school but was able to work odd jobs for many years. Like many men, Philip felt best when he could contribute to the household income and had a place to go each day where he felt valued as a worker.

Philip came to the Community Medical Clinic for his first appointment in July, 2016. It was his first physical in 22 years. Like many residents of SC, Philip grew up on a diet rich in saturated fat and salt. He subsequently developed high blood pressure and cholesterol. Philip began smoking when he was 12 years old.

In October, 2016 Philip suffered a heart attack. As a result of LiveWell Kershaw, Philip does not have to drive to Camden anymore and began have his primary care visits at Cassatt Baptist Church. The Nurse Practitioner and Community Health Care

Worker were able to get him enrolled in a cardiac rehabilitation program. While he was recuperating from his heart attack Philip lost his job in November, 2016. He started smoking a pack of cigarettes a day. He began feeling depressed and useless as a man and as part of his family.

In December, 2016 Philip was encouraged to attend a stress reduction workshop held at Cassatt Baptist Church. During the workshop, Philip disclosed he was having regular thoughts of suicide. The counselor then met privately with Philip and talked with him about how difficult the past year has been. She reminded him of how important he was to his mother and her being able to stay in her own home instead of going into a nursing facility.

The counselor explained how depression often accompanies heart attacks and encouraged Philip to begin counseling. Philip responded that two of his doctors had told him counseling could help him get healthier. He agreed to start therapy.

That same day, the counselor and Nurse Practitioner discussed an expanded care plan that included counseling and anti-depressant medication. Philip is scheduled for his first therapy appointment next week.

Dottie's Story

This case study highlights the integration between all parts of the LiveWell Kershaw team within the Community Medical Clinic and how collaboration is used to care for the whole patient, not simply one component of their health. Involved in the care of Dottie, a 57 year old female, we find a Nurse Practitioner, Mary Lee Addis, a mental health counselor, Christie Derrick, and Patient Navigator, Yolanda Roary. Each team member plays a role in helping Dottie to restore her health to its former status prior to a heart attack. While one team member addresses her physical health, another takes an in-depth look at her mental health, discovers that Dottie needs financial assistance and refers her to another member of the team to address that issue. The LiveWell team will continue to work with Dottie to help address any and all issues that impact her health.

Dottie is a 57 year old, African American female that lives in Camden, SC and has been a patient at the Community Medical Clinic of Kershaw County since 2012. This past January, Dottie suffered a heart attack and was hospitalized for four days.

When she met with Family Nurse Practitioner, Mary Lee Addis on March 28, 2017 she was agitated and expressed anxiety over the medical bills she incurred from her heart attack and hospitalization. She also expressed sadness and worry over lost independence and a slow recovery. Mary Lee referred her immediately to the mental health counselor, Christie Derrick. Christie was able to see her right away.

Dottie talked to Christie about riding in the helicopter that transported her and recalled the noise of the hospital while also not being full aware of what was happening to her during that time. Dottie spoke of her fears of having another heart attack, noting that her own mother had died of cardiac arrest six years prior.

Dottie also recalled the times she woke in the middle of the night to find her heart racing, feeling both alone and afraid. She also expressed concern about how she would be able to pay off medical bills incurred from this hospital visit while also taking care of her regular monthly expenses as her cardiologist has not approved her to return to work at this time.

Christie explained to Dottie that she might benefit from weekly counseling sessions to learn relaxation exercises and work on a plan to help her recover from her heart attack. At this point, Christie explained that there was someone else who could help address her concerns about her bills. Christie asked Dottie if she could call someone on the CMC team who could help with these medical expenses. Dottie didn't realize that this type of assistance was available. Before Dottie left the clinic Christie offered a prayer for Dottie's health and healing.

While Dottie was driven home by a friend Christie talked with Yolanda Roary, the Patient Navigator located at Access and explained the situation. Once Dottie had made it back home, Yolanda gave her call and made her aware of how she could help alleviate the financial stress.

When Dottie experienced her heart attack, she was initially taken to Kershaw Health and then later transferred to Providence Hospital in Columbia, SC. Yolanda was able to contact Providence and find out what assistance they could offer Dottie because they do have patient assistance that covers hospital stays for low income patients. Upon investigation, Yolanda discovered that the billing department had been trying to contact Dottie but had not been successful. Yolanda was able to provide the billing department with updated demographics for Dottie and requested that they make contact again, as well as mail her an application for their patient assistance.

When Yolanda spoke with Dottie, she made her aware that she would be receiving a call, as well as the packet. She instructed her to complete the packer and return it to Providence Hospital as soon as possible, to which Dottie agreed and was extremely appreciative. Yolanda also mailed Dottie a Kershaw Health Charity application to complete in order to have her stay there covered as well.

When Dottie returned to the clinic the next week for her counseling session with mental health counselor, Christie Derrick, she said, “a huge weight was lifted from my shoulders when I learned I could get help with my medical bills.” Her tears were replaced with smiles. “I feel someone is in my corner,” she explained. The team will continue to work with Dottie as long as she feels that needs assistance. However, Christie Derrick notes that Dottie may be close to discharge from mental health counseling because of the stress of the financial burden is being alleviated. Each member of the team fully understands how stress can impact the mental health status of an individual. Moving forward, the team will continue to work with Dottie for as long as she needs assistance.

School Based Health Center Success Stories

Felipe’s Story

Mental Health Counselor Perspective

Over the summer, Felipe, a 10th grader at North Central High School, came into CMC to be seen for chest pains and dehydration that he was having. Felipe’s mother brought him in to the clinic because she was already being seen at CMC for her primary care needs and because the SBHC was closed for the summer. Christie, the mental health counselor at CMC, was able to meet with Felipe and his mother in a joint session to discuss the root cause of the dehydration and chest pains that he was having. Because of a language barrier between Christie and the mom, Mariana, a CNA at both the clinic and the SBHC, was able to interpret during the session. Felipe is young and healthy, Christie noted, so she found it unusual that he was experiencing chest pains. However, through discussion, Christie was able to determine that Felipe was drinking excessive amounts of energy drinks and then later uncovered that he had been drinking alcohol and participating in other risky behaviors. Christie is continuing to work with Felipe, but has referred him to see Cameron for mental health counseling now that the SBHC is open for the new school year.

Certified Nursing Assistant Perspective

Mariana is a CNA that works at both CMC and the SBHC at NCHS. She was able to interact with Felipe during his visit to CMC over the summer while she served as an interpreter between Felipe’s mom and Christie. Because of their interactions and the language commonality, Felipe felt at ease around Mariana and developed a sense of trust in her. Felipe was referred by Christie to see Cameron at the SBHC once school was back in session. Mariana noted that it wasn’t long after school started that Felipe popped his head in to say that he hadn’t heard from Cameron and really wanted to meet with him. That same week, he was able to meet with Cameron for mental health counseling. Mariana could tell that Felipe was hungry for help. The mental health integration works well because “Cameron and Christie are able to collaborate on information and progress regarding this student and how to guide him,” says Mariana. While Mariana notes that Felipe still has some high blood pressure issues, she is encouraged by the work that Christie and Cameron are doing regarding his alcohol use and other high risk behaviors. Felipe is getting the mental help he needs through both the clinic and the SBHC.

Ricky's Story

Ricky, a 10th grader at North Central High, has dealt with respiratory issues his entire life. So on a normal school day in September when he was experiencing trouble breathing, he thought it was going to be just another day.

Jodi Rogers, a Community Health Worker, had noticed that her friend Teresa's son Ricky was not enrolled in the School-Based Health Center in August of this year. Concerned, Jodi called Teresa and let her know what the SBHC could offer her son if he were to experience any sickness at school. Teresa immediately enrolled her son, not realizing that he would be in desperate need of medical help.

In September, Ricky was sitting in math class and found it difficult to breathe and quickly notified the teacher. After a visit to the school nurse, Ricky was then referred on to Vicky Craig, the Nurse Practitioner in the SBHC. Upon arrival, Vicky listened to listened to Ricky's lungs and determined that there was limited airflow and that his oxygen saturation levels were at 72. A normal saturation reading for someone of Ricky's age should be 98. After two breathing treatments from Vicky, Ricky's saturation levels were still only in the low 80s. While airflow was somewhat improved, Ricky was still not doing well and seemed to be worsening. Vicky knew that action should be taken immediately and that he needed a steroid shot from his doctor's office. After learning that Teresa, his mother, was out of town, Vicky then contacted Ricky's grandfather to come pick him up and take him to the doctor. As time passed, Vicky continued to monitor his worsening condition. "I was ready to put him in my car and take him because I knew we could not wait until the ambulance got here," said Vicky. Ultimately, the grandfather was able to get Ricky to the doctor for the steroid shot and then went on to the emergency room. Ricky's mother and family, credit Vicky and the SBHC team with recognizing Ricky's respiratory distress and saving his life through quick action.

This case study involved a network of caregivers that worked together to create a positive outcome for the student. This story began with concerned CHW, Jodi, getting the student enrolled into the SBHC and led to the teacher referral and then the school nurse who then involved Nurse Practitioner, Vicky. In Ricky's case, a hospital visit was unavoidable because it was the treatment that he needed. It is fortunate the acute care services Ricky needed were only a few steps from his classroom.

Adam

Adam, a 10th grader at NCHS, was referred to the School Based Health Center by the school nurse. Adam was not feeling well and presented with symptoms of abdominal pain. Susan G. brought him in for examination and concluded that he may be experiencing increased gas production as a result of habitual consumption of acidic drinks. The Nurse Practitioner then coordinated plans with his grandmother to send Adam home and to treat the problem with over the counter medication and reduced consumption of orange juice. Susan G. also informed the front office staff (Ms. Ham, Ms. Bowers, and Ms. Helms) that Adam would be going home and that his absence would be medically excused. The efforts of the SBHC helped Adam finish his day in a more comfortable state.

Marquis

Marquis, a 16-year-old student, at North Central High School visited the SBHC on a Thursday morning for a sports physical. When he arrived, Marquis told Susan G. that he had not been able to start football practice with pads on Monday because he had not yet had a physical exam. After having his physical completed by Susan G., Marquis said that going to the School Based Health Center is "way easier" than trying to get an appointment with his doctor. He said that he would not have been able to get a physical from his doctor until June 2nd, and football practice started on May 9th. Marquis is also a part of the Quest program -the step before being sent to the Department for Juvenile Justice. Therefore having the ability to play the sport that he loves may keep Marquis on the right track and out of the juvenile justice system. Marquis had his physical completed within thirty minutes of his arrival. After he left, Susan G. informed his coach that Marquis was ready for practice.

Bobby Joe

Bobby Joe is an 11th grader at North Central High School and plays several different sports including basketball and soccer. On a Friday evening, Bobby Joe was playing in a basketball game when she suffered a concussion after being hit in the head. She had a CT scan at an urgent care center and was evaluated. However, she was not cleared to play in her soccer game the following week unless medically released by a healthcare professional. Bobby Joe stopped by the SBHC and was seen by Susan G. who was able to release her to play in her soccer game. When asked if she liked the SBHC Bobby Joe said, "I love it, just knowing that I have people to come to if something happened to me. I wish I had this place in the 7th grade when I sliced my hand open dissecting a chicken wing in class. My mom had to get off work to come get me."

Henry

One Thursday morning, Susan G. received a call from the school nurse who reported that she was bringing "Henry" down to the SBHC in a wheelchair. He had reportedly dropped 180 pounds of weight onto his chest after another student dared him to lift that much in the weight room. Susan G. recalled a similar situation happening with Henry not too long ago. Several weeks earlier, Henry had dropped 90 pounds on his leg and was brought to the SBHC. Because he was not enrolled at the time, he needed several documents completed, as well as a parent ID. Henry's mother came but had no form of identification, and became very upset at the situation. Susan G. told the mother, "We are just here to help you, I know you are under a lot of stress." Henry has also been identified as a truant student (a student becomes truant after missing five blocks of any class). Susan G. is able to identify whether or not a student truly needs to miss school due to a health issue, which can help reduce truancy. Henry entered the SBHC looking sweaty and shaken from his experience. After taking Henry into the exam room, the school nurse asked Susan G., "Do I need to call EMS?" After examining Henry and speaking with school administrators, Susan G. determined that Henry was physically fine and only shaken from an adrenaline rush, so EMS was not needed. Henry thought he might need to leave school to have X-rays taken but the Nurse Practitioner assured both Henry and his mother, after she arrived, that he was fine and only experiencing some tenderness. In the end his mother took Henry home, but Susan G. was able to prevent unnecessary medical costs associated with an ambulance ride and ER visit. This situation involved several individuals: the school nurse, Susan G., Mariana H., three administrators, a stressed mom, and Henry. Susan G. was able to work with all persons in this scenario and determine the best course of action. On this particular day the nurse had to leave Henry at the SBHC in order to treat a diabetic student at the middle school. Susan G. was able to take the lead and handle this situation without the need for emergency services. In addition, Henry would have been able to stay in school for the remainder of the day if his mother had not decided to take him home. The SBHC played a role in reducing unnecessary healthcare costs and made a brave attempt to prevent truancy at North Central High School.

Eli

In January, Eli, a senior at North Central High School, had been playing baseball when he injured his finger. Knowing something was wrong with it by the amount of swelling, bruising, and pain, Eli showed his father. His father said, "There isn't anything wrong with your finger." Still concerned and hoping to get a second opinion, Eli decided to go to the SBHC the following morning at school just to be sure. Because he was already enrolled in the clinic, Eli was able to be seen by Vicky Craig, the Nurse Practitioner. Upon examination, Vicky determined that the finger was most likely broken from the impact of jamming the finger at baseball practice. After this discovery, Vicky coordinated for Eli's mom to take him to Elgin Urgent Care to be seen. Until then, Vicky advised Eli to take Ibuprofen and ice the finger. Eli confirmed later that day that the finger was fractured.

About a week later, Eli was back in the SBHC for the same issue. Another broken finger as a result of injury at baseball practice and in the same situation with a parent denying that anything is wrong with the finger. Again, Vicky was able to assess the injury and determine that it was indeed broken again. This case is an example of the benefit of having a Nurse Practitioner within the school that is qualified to determine the extent of an injury from participating in sports. Not only can the School Based Health Center provide sports physicals and see children for sick visits, but also assess injuries and provide treatment options for injuries sustained from participating in sports.

Katie

Katie, a junior at North Central High School, recently utilized the School Based Health Center after suffering a panic attack while taking a test at school. Common panic attack symptoms can include rapid breathing, irregular heartbeat, dizziness, sweating, and chills. Panic attacks can be very frightening; especially when you are not sure what exactly is happening to your body but knowing that you are not in control.

When Katie presented at the SBHC to be seen by Nurse Practitioner, Vicky Craig, her blood pressure was 198/120. A normal blood pressure is considered to be 120/80. Vicky knew that next steps would include calling EMS to take Katie to the Emergency Room. When EMS arrived, Katie's blood pressure had already climbed to 240/120. It was under the care of Emergency Room providers that Katie was diagnosed as having a panic attack and released from the hospital. She was then referred to Cardiology, who after further assessment diagnosed Katie with hypertension and cardiac issues. Katie is now being treated for these medical conditions.

When a seemingly healthy and active student has medical issues, such as a panic attack, it can be confusing for the student, their parents, and school administration. Katie, a cheerleader and active member of the student body at North Central High School, suffered a panic attack during the administration of a test. This incident brings to the surface how stress can affect the body and also bring underlying health conditions to light. The SBHC and the quick reaction of Nurse Practitioner, Vicky Craig, was well equipped to deal with a situation such as this. As a result, Katie has now being treated for her underlying health conditions, hypertension and cardiac problems. She is extremely grateful that her school has a school-based health center.

Tim

Tim is a 14-year-old freshman at North Central High School (NCHS) referred to the LiveWell School-Based Health Center (SBHC) towards the end of the academic year. His referral to the mental health counseling component of the SBHC came following a district hearing Tim had regarding threatening comments he made towards other students. The Assistant Principal at NCHS was notified about several journal entries that included violent and angry content, written by Tim earlier in the school year. Another student had found these journal entries, which led to a confrontation between Tim and the student.

The Assistant Principal was required to bring Tim before a disciplinary board; however, she suspected that Tim was experiencing some emotional disturbances beyond just anger and believed the mental health team could help figure out what was going on. Upon assessment, it was revealed that Tim's home life was chaotic and stressful, fueling his negative mood and angry feelings. Adding to his emotional turmoil, Tim had recently experienced some unhealthy interpersonal relationships which exacerbated his depression and hostility. The journal entries were a method for Tim to cope with some of these feelings and never intended for others to see, so when another student found them Tim was obviously upset and confronted the student, leading to the district's disciplinary action.

The SBHC counselor was able use the information obtained during the initial assessment to work with school personnel to help everyone understand that Tim's anger was a result of extreme negative events at home rather than a result of maliciousness on his part. Counseling sessions began immediately to help Tim find short-term behavioral solutions that he can use to help keep himself safe while in the school setting, such as avoiding students who might serve as triggers for his anger, identifying "safe" authority figures such as teachers and principals he can go to when he is feeling upset, and choosing actions that will de-escalate situations rather than escalate them. Since the referral came so late in the year, the SBHC counselor also helped Tim identify other community resources that might be of service during the summer, with the expectation that services would continue through the LiveWell SBHC in the fall.

John

John is a 16 year-old, white male who lives at home with both his mother and father. He was referred to LiveWell mental health services due to low motivation in school, which resulted in him repeating the 9th grade for a second time. John reported having support from friends in the school environment and also having a strong relationship with both his nuclear and extended family.

When initially meeting with Alexandra Golden, a doctoral student in Psychology at the University of South Carolina, John told her that he while he is interested in obtaining his high school diploma, but that he was not concerned with doing so within the typical four years. Over the course of this initial session, he also informed the therapist that he was interested in installing

speaker systems as a job option after high school. This discussion with the therapist validated reports from the Vice Principal pertaining to John's lack of motivation towards school.

After the completion of four sessions, the therapist noted that John's motivation had improved significantly. John expressed interest to both Alexandra, the therapist, and school officials that he would like to enroll in a course that would allow him to make up missed credits. John stated that after a conversation with his father, he realized that receiving his high school diploma was critical for his ability to gain employment following high school. In this same session, John also expressed that due to his parent's limited education he would need a mentor to help him attain the skills that would aid in pursuing his diploma.

During treatment, Alexandra worked effectively with both John and his teacher to identify John's progress in his coursework. Additionally, through working on communication skills and relaxation techniques, John's relationship with his teacher has improved. John's teacher has also noted significant improvement in John's progress and has expressed that he is impressed with John's behavior. Therapist will continue working with John and his teacher to improve their communication and empower John to pursue information on his course performance and trajectory from both his teacher and his counselor.

Deshawn

Deshawn is a sophomore at North Central High school who was referred to the School Based Health Care Center initially due to issues controlling his anger at home and in the classroom. Deshawn would often get into yelling matches with his parents to the point where he would threaten to harm himself and others. This behavior would also occur at school, where he would often make vague threats of harm to students who he felt were disrespectful to him. Complicating matters, Deshawn is also identified as intellectually disabled, with very low cognitive abilities. Part of what was initially discovered during the early assessments with the LiveWell mental health team, specifically Cameron Massey, a doctoral student in Psychology at the University of South Carolina is that he is unable to understand how comments made in anger have lasting effects and consequences. Deshawn's family struggles to make ends meet and does not have access to reliable transportation in the community, therefore receiving services at the SBHC is truly and ideal situation.
Initial treatment focused on helping Deshawn how his words were interpreted by others and how they often got him in trouble. Clinicians at the SBHC used concrete examples and strategies to help Deshawn associate his threatening language with the negative consequences of getting in-school suspensions and detentions, as well as alienating him from many of his peers. While Deshawn was learning to understand how his actions affected those around him, the clinician working with him began to introduce anger management strategies tailored to meet his special circumstances. **To date, Deshawn has gone 9 months without a discipline referral at the school, has engaged in no disruptive behaviors in the classroom setting, has passed all of his classes this academic year, and recently received an award through the school for his respectful and positive attitude.**

While Deshawn has experienced some positive changes in the academic environment, he does continue to struggle with his home life. Over the recent semester break, Deshawn's arguments with his parents escalated to the point of Deshawn needing to be hospitalized for three days. While this represented a setback in terms of treatment, the SBCH clinician was able to adjust their role from a direct provider of mental health services to more of a care coordinator, facilitating and supporting the treatment Deshawn is now obtaining through enhanced services through the Department of Mental Health. The LiveWell Kershaw clinician is still able to help Deshawn in school, which he is still maintaining his positive behavioral and academic gains, while at the same time helping to coordinate his family care through additional community resources.