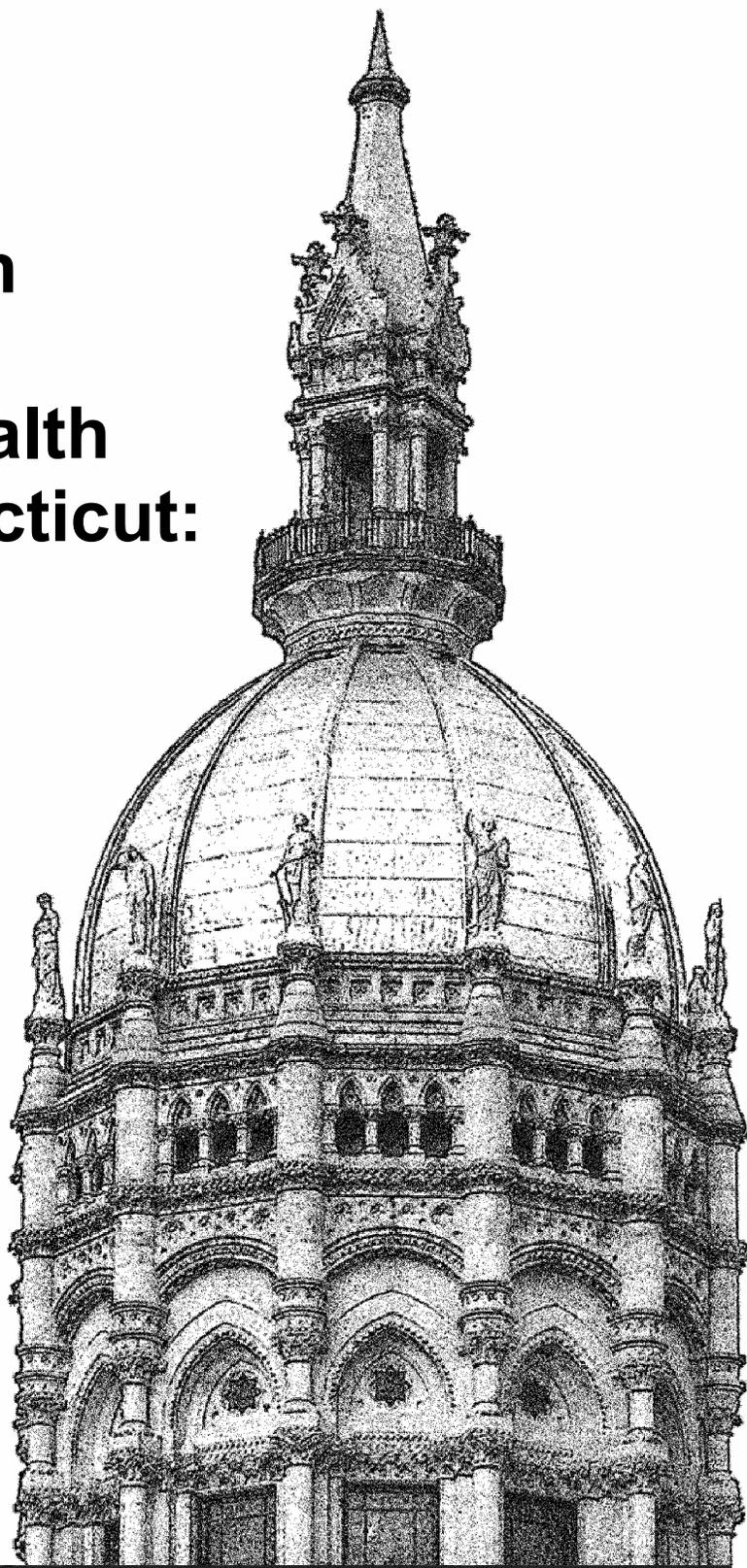


Adolescent Health Coordination and School-Based Health Centers in Connecticut: RBA Project 2011

March 2012



PRI

**Legislative Program Review and
Investigations Committee**

Connecticut General Assembly

**CONNECTICUT GENERAL ASSEMBLY
LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE**

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& INVESTIGATIONS COMMITTEE

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in Connecticut:
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Executive Summary

Adolescent Health Coordination and School-Based Health Centers in Connecticut: RBA Project 2011

The Legislative Program Review and Investigations Committee (PRI) authorized a study of adolescent health in Connecticut using a results-based accountability (RBA) approach in March 2011. The study scope focused on evaluating state-funded services for meeting the health care needs of youth ages 10 to 19, including those supported through Medicaid and the Children's Health Insurance Program (CHIP). The extent of parental involvement in adolescent health care also was identified and compared with practices cited in national literature and followed in other states.

At the committee's May 25, 2011, meeting, it was clarified that while the study scope included review of parental involvement policies and practices, the program review staff would not be proposing any actions concerning state law on parental notice or consent for the medical treatment of minors. Committee members also endorsed a staff proposal to concentrate the program evaluation portion of the study on primary and preventive care for 10 to 19 year olds in two areas: school-based health centers (SBHCs); and teen reproductive health services.

The PRI committee reached consensus on study findings and staff proposed improvements concerning the state school-based health center program and several overarching system issues. The final adolescent health report approved by the committee on March 16, 2012, contains 22 recommendations for increasing the efficiency and effectiveness of state-funded SBHCs and helping the state better progress toward desired health results for Connecticut's entire adolescent population.

Main Findings

Overall, the program review committee found Connecticut compares well with other states and national data on most key indicators of child and youth well-being. In general, Connecticut ranks among the top states on many specific measures of adolescent health, including teen death and teen birth rates, and on national ratings of overall system performance. At the same time, as the national assessments point out, even high performing states like Connecticut have room for improvement.

The broad, complex nature of health care for young people involves many programs and agencies representing a wide range of medical, behavioral, and social services. Connecticut is fortunate to have many public and private resources available for meeting the physical, behavioral, and oral health care needs of its adolescent population. However, statewide planning and service delivery for adolescent health is fragmented.

In addition, there is no concerted state effort at present to address barriers to better health outcomes for all Connecticut youth. Like previous assessments of state adolescent health, the program review committee study revealed significant disparities in health status and in access to care for youth of specific racial and ethnic groups, and by age, gender, and geographic location.

A high quality state strategic adolescent health plan, along with a well-designed collaborative way to implement it, has been in place since 2005 but essentially ignored. A multi-agency, widely representative council created by the legislature in 1992 to coordinate adolescent health was eliminated in the last legislative session after years of inactivity. It is not completely clear why these efforts failed to sustain momentum, but a lack of dedicated staff resources and high level agency commitment were among the problems.

In preparing the RBA report card on school-based health centers funded by the state Department of Public Health (DPH) for this study, multi-year data related to individual center and aggregate program performance were examined, including four core outcome measures: access (enrollment and utilization); health status; school attendance; and cost-effectiveness. The performance information in the report card indicates SBHCs in Connecticut generally have been successful in making essential primary and preventive care accessible to adolescents, particularly those who are uninsured or underinsured, and low-income. Based on national research, SBHCs also appear to have high cost-savings potential; among the centers' benefits are reduced hospitalizations/emergency department visits (e.g., for asthma), more coordinated case management, and fewer transportation and missed work time issues for parents.

Committee Recommendations

The committee study identified several ways to strengthen the state adolescent health care system through more effective coordination and planning, stronger leadership, and improved data and data analysis. PRI recommendations call for establishing an adolescent health workgroup of state agency and community partners to oversee and direct planning and coordination in collaboration with the currently active Coordinated School Health initiative. In addition, adolescent health coordinators should be designated within each of the agencies with key roles in promoting the well-being of Connecticut youth.

With the assistance of the new workgroup, the public health department should update and keep current the state's strategic plan for adolescent health. Greater statewide attention also should be given to making primary and preventive care accessible to and used by adolescents, especially older teens participating in HUSKY A and B, the state Medicaid and Children's Health Insurance Programs. The committee also recommends the adolescent health coordination workgroup track the state's progress in improving the health of its young people and result data be integrated into the existing statutory children's report card project overseen by the legislature's Select Committee on Children.

Several ways to improve the state's SBHC program, a critical system component for the most at-risk teens in the state, were identified by the committee's research. First, a more streamlined reporting and management information system at the Department of Public Health to permit fuller evaluation, based on targeted measures, of how school-based health centers are improving health outcomes for the students they serve is recommended. The department also needs to refocus its SBHC grant allocation process on actual results, and more clearly summarize and use center performance data for program accountability purposes.

As a result of the study, it became clear to the committee that more research and analysis are needed to assess the long-term impact of state adolescent health care services. Data should be gathered and analyzed to determine whether SBHC and other currently funded teen health services are: 1) helping to reduce disparities in access and outcomes; and 2) cost-effective approaches for improving the health status of all adolescents.

Taken together, the corrective actions recommended in this report can become a solid foundation for achieving better health results for all Connecticut youth and ensuring more effective investment of state adolescent health care resources. A complete list of the program review committee adolescent health recommendations, which were adopted by a unanimous vote, follows.

Coordination and Leadership

- 1. A workgroup composed of representatives of state agency and community partners with major responsibilities for adolescents in Connecticut should be established to oversee and direct planning and coordination of policies, programs, resources, and data related to adolescent health in Connecticut. The adolescent health coordination workgroup should operate in collaboration with the state Coordinated School Health initiative.**
- 2. An adolescent health coordinator should be designated in each agency with a key role in promoting the health and well-being of Connecticut youth; at a minimum, there should be coordinators at the Departments of Public Health, Education, Children and Families, and Social Services and the Court Support Services Division of the Judicial Branch.**
- 3. The Department of Public Health, with the assistance of the workgroup, should update and continue to keep current, the state adolescent health strategic plan. Strategic planning for adolescent health should be a central component of the department's present federally driven, comprehensive state health plan process, Healthy People 2020.**

Access and Utilization

- 4. State agencies and state-funded community providers serving adolescents should make getting and keeping their teen clients insured a priority. The Department of Social Services, as part of its new information technology improvement projects, should ensure clear, correct, and complete information on its health insurance programs are available on-line.**
- 5. DSS should also take all steps necessary to simplify application and renewal procedures and address the causes of administrative errors that result in gaps in coverage for adolescents.**

6. The adolescent health coordination workgroup recommended earlier should make increasing EPSDT participation among adolescents, particularly older teens, a top goal. Among the strategies the group should consider are ways to:
 - a. improve the health literacy of adolescents, such as ensuring schools are providing a comprehensive, quality health education curriculum, so teens are aware of the short and long-term benefits of primary and preventive care; and
 - b. expand school- and community-based primary and preventive care services for adolescents.

Adequate Accountability Data

7. The adolescent health coordination workgroup should track the state's progress in achieving desired health results for Connecticut youth ages 10 to 19.
8. The adolescent health population report card prepared for this study should be continued, with the assistance of the workgroup, and integrated with current children's report card initiative being carried out by the legislature's Select Committee on Children under P.A. 11-109.
9. Data analysis capacity for the HUSKY programs and other state-funded health services provided to adolescents should be ensured and possibly expanded by:
 - a. continued funding for the program monitoring and evaluation work of Connecticut Voices for Children; and
 - b. pursuing DSS participation in CHIN and a research partnership between the department and the UConn Health Center Institute of Public Health Research.
10. As part of the adolescent health data development and research agenda,
 - a. a cost effectiveness analysis of school-based health centers in Connecticut should be conducted as recommended below (see #22); and
 - b. the current status of Electronic Health Records among the state's public schools, including how many districts have automated their school health assessment forms, should be determined along with an estimate of the resources needed for implementation statewide.

School-Based Health Centers

11. The federal definition of school-based health center contained within the Social Security Act should be codified in Connecticut. Included in this

definition should be the definition of primary care as defined by the Connecticut Office of Health Care Access in its Statewide Healthcare Facilities and Services Plan.

12. The Committee on School-Based Health Clinics established under C.G.S. Sec. 19a-6i should continue its work on crafting a more formal definition of school-based health center to include standards around overall comprehensiveness of operations (e.g., staffing types and levels, hours of availability) and the types and level of services provided by such centers.
13. School-based health center grant allocations by the public health department should be tied to center performance, including staffing levels, services provided, and student health outcomes. Within this process, the Department of Public Health should develop a formal protocol for allocating state grants based on specific, measurable outcomes that ultimately determine whether the program is making a difference in the overall health of students. Beginning in 2014, state funding for school-based health centers should be based on a competitive application process as developed by the public health department. At minimum, prospective grantees must demonstrate student health care needs at the school site and why state funding is necessary to support the school-based health center at that site.
14. The Department of Public Health should conduct a full analysis of the cost per visit by individual state-funded school-based health centers. The results should be used by the department as one factor for determining the funding levels for centers.
15. The Department of Public Health should establish formal performance goals for state-funded school-based health centers, including increased access to health care for uninsured/underinsured students, the provision of preventive care to students, and the degree to which centers increase student attendance and academic achievement. The department should develop standardized measures used to evaluate school-based health center performance against the goals.
16. The program's current data collection and reporting requirements should be replaced with a Results-Based Accountability-style report card for each center based on the newly-developed performance measures and targeted outcomes. A report card summarizing the annual performance of the department's school-based health center program also should be developed. At minimum, the department should post the summary report card on its website.
17. The Department of Public Health and key stakeholders should develop short- and long-term plans for replacing the current automated management

information system with one that collects the most relevant automated data for program management purposes based on specific program goals and performance measures established by the department. As part of this process, the department should work with the current ad-hoc committee on school-based health centers, and elicit feedback from all centers, as to what data are most relevant and collectable for program performance purposes.

18. The Department of Public Health should begin collecting, maintaining, and analyzing information about licensed, non-state funded health centers in public schools. The information collected should be relevant to helping the department establish a full profile of the physical, mental, and dental health resources provided in schools by state-licensed entities to improve students' overall health.
19. DPH should continue providing technical assistance and training to school-based health center staff, and, to the extent possible, use webinars, e-conferences, and frequently updated website information to provide such assistance. A frequent review of centers' technical assistance needs should be conducted.
20. The department should serve as a clearinghouse for innovative and promising practices for school-based health centers, and disseminate best practice information to centers on a regular basis. Included in this effort should be assistance to sponsoring agencies to maximize their funding resources outside of state funding and working with centers in transitioning to electronic medical records.
21. The department should fully evaluate SBHCs and their role/ability to serve within the medical home model for students.
22. A comprehensive, longitudinal analysis should be completed showing the relationship between Connecticut's state-funded school-based health centers and health outcomes of students using such centers. A comparative analysis between school-based health center users and nonusers regarding their academic performance and school absenteeism, tardiness, and discipline issues should be done. The study also should include a cost-benefit analysis of school-based health centers in Connecticut. The public health department should determine the overall parameters of the study.

Adolescent Health in Connecticut

In March 2011, the Legislative Program Review and Investigations Committee (PRI) authorized its staff to conduct a study of adolescent health in Connecticut, using the principles of results-based accountability (RBA). Results-based accountability is a data-driven performance evaluation tool that was developed by a national consultant to help improve government programs and promote community well-being. RBA techniques have been used by the appropriations committee of the Connecticut legislature for budgeting purposes since 2005. It has been employed on a pilot basis by the program review committee for two recent studies.¹

The main purpose of this study, the committee's third RBA project, was to evaluate how health care services funded with state resources, including those provided through Medicaid and the state's Children's Health Insurance Program (CHIP), are meeting the needs of adolescents in Connecticut. The study also identified the extent of parental involvement in adolescent health care programs, comparing Connecticut practices with those followed in other states and cited in the national literature.

Background

Protecting and enhancing the overall health and well-being of adolescents is of interest for all levels of government. While most teens are healthy and thriving, many engage in risky behaviors or develop habits that can adversely affect their immediate and long-term well-being. Lifestyle choices made during adolescence, such as eating nutritiously, exercising regularly, and not smoking or abusing drugs and alcohol, can reduce the risk of chronic diseases in adulthood. Federal, state, and local agencies, therefore, currently invest significant public resources in trying to prevent death, injury, and disease among young people and to support healthy, positive development.

A national effort to improve adolescent health was initiated in 2004 by the U.S. Department of Health and Human Services (HHS) as part of the federal government's broader Healthy People 2010 program.² With the help of an advisory panel of experts and stakeholders, a set of 21 critical objectives corresponding to the most serious physical and mental health issues for adolescents and young adults was identified. The national critical objectives for adolescent health address five areas of most concern: mortality/unintentional injury (reduce teen deaths/accidents); violence (increase safety of schools and neighborhoods); substance use and mental health (abstain from illicit drug use; ensure access to timely, appropriate behavioral

¹ Based on its RBA pilot project experience, mandated by P.A. 09-166, PRI found the results-based accountability method to be a promising practice for legislative oversight work. The committee decided to continue using it for other projects, including its 2011 adolescent health study. Additional background on RBA and its application in Connecticut is provided in Appendix B.

² See: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Adolescent and School Health, *Improving the Health of Adolescents & Young Adults: A Guide for States and Communities*, 2004.

health care); reproductive health (reduce teen pregnancies; support healthy sexuality); and chronic disease prevention (avoid tobacco use; adopt healthy nutrition, fitness behaviors).

Building on the federal initiative, the Connecticut Department of Public Health (DPH) issued a state strategic plan for adolescent health in 2005 aimed at achieving the following vision: “Connecticut adolescents develop healthy lifestyles, are fully engaged, and reach their full potential.”³ The DPH plan included recommendations for a broad-based implementation approach, recognizing active participation and support from government agencies and officials, businesses, healthcare and educational organizations, and teens, their families and communities would be required for success. The interagency group that helped develop the strategic plan considered it to be a blueprint for improving the health of the state’s population aged 10 to 24 over the next decade.

The program review committee was interested in determining the results of the state’s current adolescent health strategies and the progress made toward the health goals for Connecticut youth envisioned in the DPH plan. By conducting an RBA assessment, the committee could examine: how well state adolescent health policies and programs now in place are working; and possible statutory, budgetary, or administrative changes, particularly low- and no-cost improvements, for achieving better physical, behavioral, and oral health outcomes for young people ages 10 to 19.

Scope

For the purposes of the program review committee study, adolescents were defined as youth ages 10 to 19.⁴ Young persons in this age range in Connecticut account for 13.8 percent of the state’s population, or just under 485,000 individuals, according to the latest U.S. Census data (2009). Forty-eight percent (230,700) are younger adolescents, ages 10 through 14, and 52 percent (253,900) are 15 to 19 years old.

Initially, the study scope approved by the committee emphasized examining the full spectrum of state programs for improving the physical health status of youth ages 10 to 19, including but not limited to community and school-based health centers, teen pregnancy and sexually transmitted disease prevention initiatives, nutrition counseling, injury prevention, and violence reduction projects. Program review staff later proposed the committee focus the program performance evaluation portion of the study on just two areas: 1) state-funded school-based health centers (SBHCs); and 2) state-supported primary and preventive reproductive health services for teens. Concentrating on these program areas would keep the study scope manageable given available staff resources, yet still permit examination of a comprehensive

³ See: Connecticut Department of Public Health, *Adolescent Health Strategic Plan*, May 2005.

⁴ Definitions of adolescence vary and there is not full agreement among providers, researchers, and policy makers about what age bracket to use to demarcate the adolescent population. After reviewing the literature on adolescent health, PRI staff adopted the same definition (those aged 10-19) used by the National Research Council Committee on Adolescent Health Care Services and Models of Care for Treatment, Prevention, And Health Development for its 2009 report, *Adolescent Health Services: Missing Opportunities* (accessible at the National Academy of Science website: http://www.nap.edu/catalog.php?record_id=12063).

cross-section of services provided to adolescents and many important health care issues involving Connecticut youth.

At the committee's May 25, 2011, meeting, as noted in the minutes, committee members endorsed the staff proposal for narrowing the study scope. The committee also clarified that while the study would include a review of parental involvement policies and practices regarding adolescent health care, program review staff would not be proposing recommendations about what the state law should be concerning parental notification or consent for the medical treatment of minors.

After reviewing the final staff work on the study, PRI committee members reached consensus on findings and proposed legislative and administrative changes concerning the state school-based health center program and several overarching adolescent health system issues. The adolescent health report approved by the committee on March 16, 2012, contains 22 recommendations intended to increase the efficiency and effectiveness of state-funded SBHCs and help the state make better progress in achieving desired health outcomes for Connecticut's entire adolescent population.

Research Methods

Committee staff research began with a review of relevant state laws and policies as well as much of the extensive literature on recognized best practices for adolescent health care. Other major tasks included determining: what program performance and client outcome data were readily available for the purposes of the study; what information could be developed within the study timeframe; and what items should be considered for data development and future research. Available data on the status of adolescent health in Connecticut to assess overall results for the population of youth ages 10 to 19 were identified, compiled, and analyzed.

A primary information source for this study was committee staff interviews conducted with personnel from the main state agencies involved with adolescent health, other key stakeholders, and experts. Over the course of the study, PRI staff met with:

- agency leadership and key program managers at the state education, public health, children and families, and social services departments;
- several provider organizations (the Connecticut Association of School-Based Health Centers, Planned Parenthood of Southern New England, and A Better Choice Women's Center); and
- local advocacy groups including the Family Institute of Connecticut, Connecticut Voices for Children, and Connecticut Center for Children's Advocacy.

Committee staff visited school-based health center sites in Branford, Bridgeport, East Hartford, Hartford, New Haven, Norwich, and Windham, and observed a board meeting of the state SBHC association. Interagency work group meetings for the state's Coordinated School Health program and meetings of the SBHC ad hoc committee also were observed. PRI staff went to a seminar about confidentiality in adolescent health care and promoting access to care sponsored by the Center for Children's Advocacy in May 2011, and met several times with the

center's staff. Staff also attended a pregnant and parenting teen conference sponsored by the state education department in June 2011.

On June 21, 2011, the program review committee held an information forum with a panel of invited experts that was followed by a public hearing about adolescent health in Connecticut. Materials from the forum and testimony from public hearing are available at the committee staff office website (http://www.cga.ct.gov/pri/2011_ahct.asp). Appendix C contains a synopsis of the major themes discussed during the committee's adolescent health forum and public hearing.

PRI staff had several follow-up meetings with public health department staff about contracting and licensing procedures for school-based health centers and state-funded family planning services. Staff also compiled and analyzed available program data for teen reproductive health services funded by DPH and DSS, which involved a number of conversations with state agency staff and providers. Personnel from the University of Connecticut Health Center Family Planning Center, who serve as consultants to DSS for the Teen Pregnancy Prevention Initiative, also were interviewed.

Arrangements were made to obtain the public health department's electronic data for the school-based health centers it funds. Committee staff created a comprehensive SBHC database that included these data and other descriptive and outcome information gathered through a review of SBHC reporting documents, a survey of all school-based health center sponsoring agencies in the state, and SBHC site visits. Committee staff also relied on assistance from the University of Connecticut's Institute of Public Health Research for school-based health center data management and analysis of over 130,000 enrollment records and 300,000 client visit records. State public health department staff also assisted with organizing the school-based health center data for the study.

Efforts by committee staff to obtain and analyze Medicaid program data from the Department of Social Services for youth ages 10 to 19 continued throughout the study process but were only partially successful. For example, obstacles to obtaining assistance in linking SBHC and Medicaid data from the Connecticut Health Information Network (CHIN) in order to learn more about state-supported adolescent health outcomes could not be resolved during the study timeframe.⁵

Data limitations. Staff encountered some significant challenges in gathering and analyzing information for this study. As discussed more fully later, reliable, complete data about health status, access to care, and types, amount, and sources of services for adolescents, even those served by state Medicaid and CHIP programs, are not readily available. Often, there are long lags in the reporting of national and state level data and many times, definitions (e.g., age range of adolescence, race/ethnicity) are inconsistent across sources.

⁵ CHIN, a legislatively mandated partnership between the University of Connecticut Health Center (i.e., its Center for Public Health and Public Health Policy) and a number of state health and social service agencies, is charged with developing a computer network linking databases across agencies. The goal of the network is to help inform policy decisions and program development by integrating and analyzing public health data, including health outcome information for various target populations over time. (See CHIN website: <http://publichealth.uconn.edu/CHIN.php>)

A central data issue for researchers, nationally and in Connecticut, is the definition of adolescent. As much as possible, PRI staff used the age range 10 to 19 (meaning through age 18) to define adolescents. However, many statistics, especially those regarding reproductive health matters, use other age categories. The age of a minor, for example, can vary for certain situations and across states, making accurate comparisons difficult. There is no easy remedy to improve consistency across data sources so care must be used when information on adolescent health needs and outcomes is reviewed.

Another factor complicating analysis of adolescent health matters is that much of the available data are based on surveys of public high school students. It is likely the health needs, behaviors, and status of the highest risk groups (e.g., teens who have dropped out of school, are incarcerated, or are in another institutional setting) are not being captured.⁶ Also, much of the national health survey data is based on parent-reported information gathered through telephone surveys. Finally, in Connecticut and probably other states, agency resources for data collection and analysis are very limited, a situation that compromises both the quality and quantity of available adolescent health information.

Report Organization

An overview of the committee's RBA approach to the adolescent health study and the results-based accountability framework developed for the study are presented in Chapter I. A report card on the state's progress in improving the health of its adolescent population, based on nine key indicators, also is included in this chapter. Program review committee findings and recommendations addressing the overarching adolescent health issues revealed by the assessment of key indicator data are discussed in Chapter II.

Chapter III provides performance evaluation information about the school-based health centers funded by DPH in a results-based accountability program report card format. The SBHC report card also contains committee proposals for low- and no-cost ways to improve program efficiency and achieve better health outcomes for the adolescents who use these state-supported primary and preventive care services.

Information about state laws on parental involvement and minors' rights concerning health care is provided in Chapter IV. It includes summaries of how consent, notification, and confidentiality practices regarding medical, behavioral (substance abuse and mental health), and reproductive health care treatment provided to adolescents in Connecticut compare with those followed in surrounding states and nationally.

Agency response. It is the policy of the Legislative Program Review and Investigations Committee to provide state agencies that are the subject of a study an opportunity to review and comment on committee findings and recommendations prior to their publication in a final report

⁶ Under an arrangement between program review committee staff and the University of Connecticut public policy department to augment PRI staff efforts in this study, a team of graduate students is conducting a study of health services provided to adolescents at the Department of Correction Manson Youth Institution as their final public administration ("Capstone") project. Information developed through the project, which will be completed in May 2012, may be used to supplement the committee's final report on adolescent health.

document. Written responses for this study were solicited from the four agencies with primary responsibility for adolescent health: the Departments of Children and Families, Education, Public Health, and Social Services. Each one submitted formal comments and copies of all four agency responses are provided in Appendix A.

RBA Assessment of Adolescent Health: Framework and Key Indicators

Results-based accountability is a way of evaluating the efficiency and effectiveness of state programs, agencies, or systems within a larger context of the broad quality of life goals they are intended to help achieve. It is program review committee practice for studies using the RBA approach to develop a one-page framework to guide data collection and analysis concerning both program and higher level population accountability (see below, Figure I-1). When completed, the RBA accountability framework for a program review study outlines:

- desired *quality of life results*, in the form of a positive statement about population-level outcomes, to which the program, agency, or system under review is intended to make a major contribution;
- key population-level *indicators* for tracking statewide progress toward those results;
- the main public *strategies* for achieving high-level results and the *partners*, public and private, with significant roles in implementing those strategies;
- the *major state programs* and activities undertaken to carry out those roles and strategies; and
- core *performance measures* for assessing outcomes for the clients/customers directly served by the program(s) subject to in-depth evaluation.

Population results. As part of the committee’s RBA approach, program review staff compile and assess key indicator data related to the broad, population-level results of the selected topic area. The extent of staff analysis of population-level indicators, however, depends on the study timeframe and available resources. The results-based accountability framework and key indicator information developed for the committee’s study of adolescent health are described later in this chapter.

The state’s progress in improving overall adolescent health outcomes, as measured by nine key indicators, is summarized below in a population accountability report card, a format created over the past several years by the program review committee staff. It is important to keep in mind that responsibility for these population-level results is shared by the all major partners involved in adolescent health and not any single state agency or organization. The committee’s recommendations for addressing the overarching issues raised by its analysis of trends in the key indicators of adolescent health are discussed in Chapter II.

Program results. Performance information about school-based health centers, an adolescent health program examined in depth by the PRI study, is summarized in Chapter III. It is presented in another report card format developed by committee staff for performance results data gathered through the RBA program evaluation process. The data collected and analyzed to assess program-level performance under the results-based accountability approach are related to three main performance questions and include:

- Outputs on quantity of effort (*How much did we do?*)
- Outcomes about quality of effort or process results (*How well did we do it?*)
- Outcomes about results for clients/those served by the program (*Is anyone better off?*)

Accountability for program results, in contrast to population-level outcomes, rests primarily with managers in the administering agency, including agency leadership.

The information compiled to answer the RBA program accountability questions is used to: determine trends in performance; understand the reasons for identified trends and current conditions; and find ways to improve program performance, especially in terms of better end results for those served. PRI committee recommendations for improving the state's school-based health center program also are included in Chapter III.

Accountability Framework for Adolescent Health

The results-based accountability framework prepared by program review staff for adolescent health in Connecticut is provided in Figure I-1. It is based on:

- a literature review of model adolescent health care policies and practices;
- discussions with various state agency staff responsible for planning and administering adolescent health services; and
- input provided by experts attending the committee's information forum.

PRI staff, with assistance from various stakeholders, refined the framework, as well as related key indicator and performance measure data, throughout the study. Each of the main elements of the framework is described briefly below.

Quality of life results statement. In applying the RBA method, staff developed the following statement about desired quality of life results for adolescent health: "*Connecticut's adolescents have the health care services, supports, knowledge, and skills that promote optimal physical and mental well-being and success in life.*" The statement, shown at the top of the framework in Figure I-1, is based on the mission contained in the state's current (2005) strategic plan for adolescent health. It also reflects the goal of the state's new coordinated school health initiative, as well as objectives for adolescent health and well-being of some national advocacy groups (e.g., Child Trends, Annie E. Casey).

The statement's target population, Connecticut adolescents, is defined for the purposes of this study as young people ages 10 to 19. Definitions of adolescence vary and there is some debate about what age bracket to use. However, this age range is used by state health department for planning purposes and, as noted earlier, is endorsed by the adolescent health committee of the National Research Council.

Key indicators of progress. Under the RBA approach, indicators that capture critical, measurable aspects of population-level outcomes are developed to track progress toward the

FIGURE I-1. RBA FRAMEWORK: CONNECTICUT ADOLESCENT HEALTH

POPULATION LEVEL ACCOUNTABILITY

QUALITY OF LIFE RESULTS STATEMENT:

“Connecticut adolescents have the health care services, supports, knowledge, and skills that promote optimal physical and mental well-being and success in life.”

KEY INDICATORS

of Progress Toward Population Level Results

Mortality (Accidental and Intentional Death) 1. Teen Fatalities: All Causes	Morbidity (Disease, Chronic Conditions) 2. Physical: Obesity 3. Behavioral: Depression 4. Oral: Untreated Cavities	Risk Factors (Unhealthy Behaviors) 5. Binge Drinking 6. Illegal Drug Use 7. Tobacco Use 8. Teen Births	Protective Factors (Conditions Promoting Health) 9. Insurance coverage
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MAJOR STATE STRATEGIES

for Achieving Results Statement

<i>Increase access to appropriate, timely, cost-effective care</i>	<i>Promote use of primary and preventive care</i>	<i>Promote healthy behaviors and positive youth development</i>	<i>Better coordinate and integrate services and supports</i>	<i>Enhance data collection, research, information-sharing, accountability</i>
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MAIN PARTNERS

Sharing Responsibility for Achieving Results Statement

Congress and Federal Agencies (ED, HHS – CDC/HRSA/SAMSHA, IOM) Connecticut General Assembly and State Agencies (CSSD/JUD, DCF, DOC, DDS, DOL, DMHAS, DMV, DPH, DSS, DOT, OCA, OPM, SDE)	Municipal agencies (e.g., local police, health departments, YSBs) Community-Based Organizations (e.g., YMCAs/YWCAs) Public and Private Schools, Local Churches Health Care Professionals and Providers	Parents, Guardians, Families, Youth Advocacy Groups (e.g., CVC, CCA)/Foundations Health Advisory Groups (e.g., Medicaid Care Oversight Council, CBHAC)
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PROGRAM LEVEL ACCOUNTABILITY

MAIN STATE AGENCY PROGRAMS (PRI STUDY FOCUS PROGRAM IN RED)

Health Care Services				Health Education	Prevention	Nutrition & Fitness
Physical	Behavioral	Oral	Reproductive			
<ul style="list-style-type: none"> - SBHCs (DPH) - CHCs (DPH) - CSH (DPH/SDE) - CYSCHN (DPH) - Asthma (DPH) - Family/MCH(DPH) - HUSKY/Medicaid LIA (DSS) - School Health-public & nonpublic (SDE) 	<ul style="list-style-type: none"> - HUSKY- BHP/ Medicaid LIA (DSS) - State mental health & substance abuse services and facilities for all under 18 (DCF) & 18-19 (DMHAS) - SBHCs (DPH) - CHCs (DPH) - CSH (DPH/SDE) - CYSCHN (DPH) - School Behavioral Health (SDE) 	<ul style="list-style-type: none"> - HUSKY DHP/ Medicaid LIA (DSS) - Oral Health Office (DPH) - SBHCs (DPH) - CHCs (DPH) - CSH (DPH/SDE) - CYSCHN (DPH) 	<ul style="list-style-type: none"> - SVIP (DPH) - STD Control (DPH) - Fam. Planning (DPH and DSS) - TPPI (DSS) - SPPTP (SDE) - PREP (DPH) - Preg. & Parenting Girls (DCF) - SBHCs (DPH) - CHCs (DPH) - CSH (DPH/SDE) - HUSKY/ Medicaid LIA (DSS) 	<ul style="list-style-type: none"> - School Health Ed. (SDE) - SBHCs (DPH) - CHCs (DPH) - CSH (DPH/SDE) - HHS (DPH) 	<ul style="list-style-type: none"> - Youth Suicide Advisory Comm. (DCF) - Healthy Start (DSS) - NFN (DSS) - Youth Service Bureaus (SDE) - HIV Prev. (DPS) - Tobacco (DPH) - Immunizations (DPH) - SBHCs (DPH) - CHCs (DPH) - CSH (DPH/SDE) - Medicaid EPSDT (DSS) 	<ul style="list-style-type: none"> - School Nutrition (SDE) - School Physical Ed. (SDE) - SNAP (DSS) - WIC (DPH) - NPAO (DPH) - SBHCs (DPH) - CHCs (DPH) - CSH (DPH/SDE)

CORE PROGRAM PERFORMANCE MEASURES (FOR FOCUS PROGRAM):

School-Based Health Centers

- | | |
|---|---|
| <ul style="list-style-type: none"> • Access to primary and preventive care (e.g., enrollment rates, particularly for uninsured/underinsured students) • Improved health status (e.g., receive screenings, chronic conditions managed) | <ul style="list-style-type: none"> • Better school attendance (e.g., fewer absences/tardy, higher return to class rate) • Cost-effectiveness (e.g., reduced use of emergency departments) |
|---|---|

Acronyms Used in Adolescent Health RBA Framework (Figure I-1)

State Agencies	
• CSSD/JUD	Court Support Services Division, Judicial Branch
• DCF	Dept. of Children and Families
• DOC	Dept. of Correction
• DDS	Dept. of Developmental Services
• DOL	Dept. of Labor
• DMHAS	Dept. of Mental Health and Addiction Services
• DMV	Dept. of Motor Vehicles
• DPH	Dept. of Public Health
• DSS	Dept. of Social Services
• DOT	Dept. of Transportation
• OCA	Office of the Child Advocate
• OPM	Office of Policy and Management
• SDE	State Dept. of Education
Federal Agencies	
• ED	U.S. Dept. of Education
• HHS	U.S. Dept. of Health and Human Services
○ CDC	HHS/Centers for Disease Control and Prevention
○ HRSA	HHS/Health Resources and Services Administration
○ SAMHSA	HHS/Substance Abuse and Mental Health Services Administration
• IOM	Institute of Medicine of the National Academies
Advocacy /Advisory Groups	
• CBHAC	CT Children's Behavioral Health Advisory Council
• CVC	CT Voices for Children
• CCA	CT Center for Children's Advocacy
Other	
• YSBs	Youth Service Bureaus
State Programs	
• BHP	Behavioral Health Partnership
• CHC	Community Health Center
• CSH	Coordinated School Health
• CYSHCN	Children and Youth with Special Health Care Needs
• DHP	Dental Health Partnership
• EPSDT	Early Periodic Screening, Diagnosis and Treatment (comprehensive preventive care program under Medicaid for children up to age 21)
• LIA	Low Income Adult
• MCH	Maternal and Child Health
• NFN	Nurturing Family Network
• NPAO	Nutrition, Physical Activity and Obesity
• PREP	Personal Responsibility Education Program
• SBHC	School-Based Health Center
• SNAP	Supplemental Nutrition Assistance Program (formerly Food Stamps)
• SPPTP	Support for Pregnant and Parenting Teens Project
• STD	Sexually Transmitted Disease
• SVIP	Sexual Violence Intervention and Prevention program
• WIC	Women, Infant, and Children program

desired results. Ideally, three to five key indicators (sometimes called “headline” indicators), are used to monitor and report on areas of primary importance. Depending on the complexity of the results statement, additional primary indicators may be needed but usually no more than 10 are recommended. Any number of secondary indicators also may be selected to capture additional aspects of how the state is doing in achieving a results statement.

As shown in Figure I-1, PRI staff identified four broad areas for primary indicators related to adolescent health:

- mortality (frequency of death, life expectancy);
- morbidity (incidence of disease and chronic conditions);
- risk factors (behaviors that jeopardize immediate and future health); and
- protective factors (conditions that promote good health now and in the future)

Rates of mortality and morbidity are traditional markers of the overall health of a population. For adolescents, health and health care services can be heavily influenced by the presence or absence of certain risk and protective factors.

Six health-risk behaviors have been found to have a major influence on adolescent mortality and morbidity. They include: behaviors that contribute to unintentional injury and violence; tobacco use; alcohol and other drug use; sexual behaviors that contribute to unintended pregnancy and sexually transmitted diseases (including human immunodeficiency virus/acquired immune deficiency syndrome or HIV/AIDS); unhealthy dietary behaviors; and physical inactivity.⁷

Among the most important protective factors for adolescent health is regular access to quality health care services, which is supported by health insurance coverage. Other significant factors for protecting adolescent well-being that are regularly monitored by state and federal surveys (e.g., the Connecticut School Health Survey) include: two parent households; adult supervision; adult guidance; family love and support/connection with a caring adult; family meals; hours of sleep; and organized activities outside of school.

Program review committee staff developed nine key indicators of state progress on adolescent health results:

- one for mortality (teen fatality rate);
- three for morbidity (one each for physical, behavioral, and oral health – rates of teen obesity, depression, and untreated cavities);
- four related to risk factors (rates of teen binge drinking, drug use, births, and tobacco use); and
- one that addresses protective factors (health insurance coverage).

⁷ According to the Centers for Disease Control, as cited in *2009 Connecticut School Health Survey Youth Behavior Component*, Connecticut Department of Health (in collaboration with Connecticut State Department of Education), April 2011.

The best available trend data for each indicator are summarized in the committee's population accountability report card for adolescent health presented later in this chapter and detail are provided in D.

Strategies. The committee's RBA framework outlines five major strategies employed by the state to achieve desired adolescent health results. They are: increasing access to, and use of, appropriate health care services; promoting healthy behaviors among adolescents; better coordinating services and supports; and enhancing accountability through improved use of data. Responsibility for implementing some or all of these strategies is shared, to varying degrees, by the many public and private partners shown in the middle of the framework.

Partners. Entities in Connecticut with significant responsibilities for adolescent health include: state, federal, and municipal agencies; various youth advocacy groups; schools; and community-based organizations that serve teens and their families. A wide range of health care professionals and providers, along with parents, guardians, families, and teens themselves, also share accountability for making progress toward the state's desired adolescent health results.

Main state agency programs. Major components of the state adolescent health system shown in Figure I-1 include: health care services – physical, behavioral (mental health and substance abuse), oral, and reproductive; health education; prevention; and nutrition and fitness. Another important dimension, positive youth development, encompasses health, safety, and social support programs intended to build the attributes young people need to be successful. Some common positive youth development efforts in Connecticut are anti-bullying initiatives, dropout prevention, mentoring, and transition-to-adulthood services.

Given study resource constraints, program review staff decided to concentrate on system components with the most direct impact on physical, behavioral, and oral health outcomes for young people. Positive youth development, therefore, was excluded from this framework and reserved for possible study at another time⁸.

The major programs carried out by state agencies within each direct component of adolescent health are listed in the lower part of the framework. Some programs appear more than once because they provide a wide range of health care for adolescents. A chart showing the programs PRI staff identified as making up the state adolescent health infrastructure is contained in Appendix E. It includes some recent budget and client data for most of the programs.

A comprehensive calculation of all state resources allocated to adolescent health services could not be prepared within the study timeframe. One complicating factor is many state health programs serve both adults and youth and costs by type of client are rarely available. However, PRI staff estimated that readily identifiable state spending on health care for adolescents totaled over \$244 million during 2011.

Most of this amount (about 93 percent) was HUSKY A and B program expenditures for clients ages 10 to 19. The remainder was state funding for services provided to adolescents in

⁸ Major state agency roles beyond operating or funding adolescent health programs, such as systemwide planning and coordination, evaluation, or regulation, also are not represented in this framework. PRI findings and recommendations concerning overarching issues like coordination, however, are included in the following chapter.

this same age group by SBHCs and five other agency programs included in the committee's infrastructure chart.⁹

As Figure I-1 indicates, four state agencies have primary roles for adolescent health in Connecticut at present: the Departments of Children and Families, Education, Public Health, and Social Services (DCF, SDE, DPH, DSS). None has a lead role; instead, each has responsibility for certain aspects of the adolescent health system and/or particular subgroups of the age 10 to 19 population.

DCF. The Department of Children and Families oversees state behavioral health care services for all Connecticut children (legally defined as under age 18). It has direct responsibility for meeting all health care needs of the all youth in its custody (e.g., juvenile justice and child welfare clients). Pregnancy and STD prevention education is provided to girls in DCF-funded juvenile residential treatment programs. The agency also funds some residential care and support services programs for adolescent mothers in its care.

SDE. The state education department oversees a number of health programs carried out in public elementary, middle, and high schools across the state including: school health/school nurses; school behavioral health (e.g., guidance, counseling, social work); health education; physical education; and school nutrition. At present, SDE funds two programs specifically for pregnant and parenting teens. Under a federally funded cooperative agreement, the department, in partnership with DPH, also administers "*Improving Health and Educational Outcomes of Young People*," the state's coordinated school health initiative designed to align health and education efforts to improve physical, mental, and developmental outcomes for students of all ages.

DPH. The Department of Public Health conducts or supports a wide range of disease prevention, health promotion, epidemiological and other research, and health services delivery activities that serve all ages, including Connecticut adolescents. DPH administers the state's grant program for school-based and community health centers and oversees contract compliance for the centers it funds. The department funds or directly provides a number of reproductive health services such as family planning, sexually transmitted disease prevention and treatment, and sexual violence intervention that are used by Connecticut youth and adults.

In 2005, the department, in collaboration with a working group of representatives of other state agencies, organizations, and providers that serve adolescents, issued a state adolescent health strategic plan. It included a summary of the health status and trends of the population ages 10 to 19 and identified priority issues, goals, and strategies for improving the health of Connecticut youth over the next decade. Steps for putting the plan into action also were recommended, but have not been implemented by DPH or any of its partner agencies to date.

DSS. The Department of Social Services administers Medicaid and a number of other public health care coverage programs that serve Connecticut youth including those ages 10 to 19.

⁹ The programs in Appendix E with identifiable adolescent health expenditures are: HUSKY A and B (\$18.9 million in payments for April 2011, extrapolated to \$227 for the year); SBHCs (\$7.7 million, the amount of total state grant funding apportioned for clients ages 10- 19) ; Children and Youth with Special Health Needs (\$2.1 million); Young Parents (\$0.2 million); Support for Pregnant and Parenting Teens Project (\$1.9 million); Youth Service Bureaus (\$3.6 million); and Teen Pregnancy Prevention Initiative (\$1.8 million).

According to DSS, one of every five children and one of every three pregnancies in Connecticut is covered by a department health care plan. In Connecticut, eligible children up through age 18 are provided health care services through HUSKY A, the state's Medicaid program for low-income families and pregnant women. Children under 18 in families with incomes too high for Medicaid can be provided health care coverage through HUSKY B, Connecticut's Children's Health Insurance Program (CHIP).

Certain low-income adults, including 19 year old adolescents, can receive health services through the department's recently created Medicaid Low Income Adult (LIA) program. Adolescents over age 18 also can participate in the Charter Oak Program, the DSS managed health care program started in 2008 for uninsured adults not otherwise eligible for federally supported health coverage

In addition to services funded through the state HUSKY programs, DSS supports some targeted reproductive health care for its clients. The department allocates a portion of its federal social service block grant monies to help subsidize community-based family planning services for low-income state residents including adolescents. It also administers the only state-funded teen pregnancy prevention program, the Teen Pregnancy Prevention Initiative.

Other agencies. Several other state agencies, as noted in Appendix E, provide health care services to segments of the adolescent population (i.e., the Department of Correction, the Department of Mental Health and Addiction Services, and the Court Support Services Division of the Judicial Branch). The adolescents served by these agencies – youth involved in the criminal/juvenile justice system and older teens with serious behavioral health problems – often have special health needs and care issues that merit further examination. As another way of keeping the study scope manageable, these two subgroups, and the health care services they receive, were excluded from current review efforts.

Focus on core program performance measures. Given the size and complexity of Connecticut's adolescent health care system, assessment of all or even most of the programs supported with state funding was not possible within the study timeframe. Instead, the report's in-depth performance evaluation focused on one critical system component: school-based health centers. Background information on school-based health centers in Connecticut and in general is presented in Appendix F.

As noted earlier, the RBA approach measures program performance with information about outputs (how much was done?), process outcomes (how well was it done?) and client outcomes (is anyone better off?). Three to five core measures are selected to monitor the most critical program results for the clients served. Four core measures of SBHC performance are highlighted at the bottom of the RBA framework: access to care; health status; school attendance; and cost.

Core and supplemental performance measure data compiled and developed by program review committee staff are summarized within the school-based health center program report card contained in Chapter III. The program report card also provides some additional descriptive information about the SBHCs funded with the state public health department grants.

Population Accountability Report Card: Key Indicators of Adolescent Health

Program review committee findings about population level results from the state's adolescent health system are presented below in an RBA report card format (Figure 1-2). The first section of the report card ("How Are We Doing") summarizes how the state is doing in achieving the results statement "Connecticut adolescents have the health care services, supports, knowledge, and skills that promote optimal physical and mental well-being and success in life," based on the nine key indicators of progress.¹⁰ This can be considered a "snapshot" of the overall health status of the state's population of young people ages 10-19.

In a second section, called the "Story Behind Data," trends in the indicators are discussed in more detail, emphasizing the outcomes of efforts undertaken by four state agencies with major roles in addressing the health needs of Connecticut youth – the Departments of Public Health, Social Services, Education, and Children and Families (DPH, DSS, SDE, DCF). It is intended to highlight successes and challenges of the current state adolescent health infrastructure and strategies. It also serves as the foundation for committee recommendations to achieve better overall adolescent health results (or, to use RBA terminology, statewide actions to "turn the curve") that are presented in the next chapter, "Overarching Issues" (Chapter II).

Indicator data. Recommended criteria for selecting indicators include: easy to understand; objective and reliable; representative and balanced; and data are collected regularly, reliably, and rigorously. High quality data, however, frequently are lacking for meaningful indicators of progress toward many quality of life results governments want to achieve. RBA assessments often must rely on the best available "proxy" indicators for measuring overall progress while better alternatives are made part of a data development and research agenda. Setting priorities for development of new outcome data is a critical component of the results-based accountability approach.

There are a number of limitations and challenges with current indicator data shown in the adolescent health report card, making it very much a "work in progress." For example, some core vital statistics (e.g., teen fatalities and teen births) lag as much as two to three years. Data for other indicators, such as those based on national child health and youth behavior surveys, are only gathered every other or every four years. Delays and gaps in available health status information make it difficult to assess current conditions and project future trends.

In most cases, indicator data are not readily available for the age range of adolescence adopted for the PRI study (ages 10 to 19); some are collected just for high school students. Such inconsistencies can make comparative analysis difficult. For some indicators, like overweight and obesity rates, regular data collection began relatively recently, so only short-term trends are known. Also, a considerable amount of national child and adolescent health information either is not available or not easily accessible at an individual state level. The better indicators related to oral health, for example, are not reported by on a state-by-state basis.

¹⁰ As noted earlier, each key indicator is described in more detail, with separate data trend charts, in Appendix D. Possible secondary indicators for future data development also are noted.

Figure I-2. RBA Population Accountability Report Card

Adolescent Health in Connecticut 2011

Desired Quality of Life Results Statement:

“Connecticut adolescents have the health care services, supports, knowledge, and skills that promote optimal physical and mental well-being and success in life.”

HOW ARE WE DOING?

Progress on Key Adolescent Health Indicators:

+ Positive trend **-** Negative trend **↔** Little/no change or mixed **?** Cannot be determined

Key Indicators*	Progress	Most Current Data for Connecticut
Mortality: Adolescent deaths, accidental and intentional, are minimized.		
<p><u>All Causes</u></p> <p>1. Teen fatality rate declining</p>	-	<ul style="list-style-type: none"> Between 2003 and 2007, the most current available data, the state’s death rate for youth ages 15 – 19 rose from 40 to 44 per 100,000. Teen fatality rates vary substantially by gender and race/ethnicity; deaths among black youths age 15-19 in Connecticut were double the rate for white teens in 2006. Connecticut ranked 7th lowest on teen deaths among all states in 2007.
Morbidity: Diseases, including chronic conditions, and injuries among adolescents are prevented.		
<p><u>Physical</u></p> <p>2. Percent of youth overweight or obese decreasing</p>	↔	<ul style="list-style-type: none"> Over one-quarter of Connecticut youth ages 10-17 were overweight or obese in 2007 (26%), compared with nearly one-third (32%) nationally. The statewide rate changed only slightly – about one percent -- between 2003 and 2007. Disparities in Connecticut high school student obesity rates by gender and race/ethnicity are substantial.
<p><u>Behavioral</u></p> <p>3. Percent of adolescents experiencing depression declining</p>	↔	<ul style="list-style-type: none"> About 25% of high school students in Connecticut and in the U.S. reported they felt persistently sad or hopeless in 2009. Prevalence rates of adolescent depression since 2005 have changed very little at state or national levels. Rates of depression among teens are substantially higher for females than males, and also vary by race/ethnicity in Connecticut and the U.S.
<p><u>Oral</u></p> <p>4. Percent of youth with untreated dental cavities decreasing</p>	?	<ul style="list-style-type: none"> Data for most oral health indicators, particularly trend data, are not available by state at this time. Nationally, rates of untreated cavities among youth ages 12-17 declined from 19% in 1999 to 12% in 2008. Nearly 85% of all children in Connecticut, compared with 78% nationally, had a preventive dental visit in 2007.

HOW ARE WE DOING?		
Progress on Key Adolescent Health Indicators		
+ Positive trend	- Negative trend	↔ Little/no change or mixed
? Cannot be determined		
<i>Key Indicators*</i>	<i>Progress</i>	<i>Most Current Data for Connecticut</i>
Health Risk Factors: Adolescent behaviors associated with poor health outcomes, particularly those with long-term negative consequences, are avoided.		
<u>Alcohol Use</u> 5. Binge drinking rate for youth declining	↔	<ul style="list-style-type: none"> The binge drinking rate for high school students in Connecticut in 2009 -- 24.2% -- was the same as the national average. Between 2004 and 2009, there has been little change in binge drinking rates for either Connecticut youth ages 12-17 (13%) or young adults ages 18-25 (47-50%).
<u>Drug Use</u> 6. Rate of illicit drug use (other than marijuana) for youth declining	↔	<ul style="list-style-type: none"> Between 2004 and 2009, the use of illicit drugs among adolescents ages 12-17 decreased from 5% to 4% in both Connecticut and the U.S. After steadily dropping since 2004, rates for youth ages 18-25, increased to 9% from 8% in 2009 in Connecticut but stayed the same nationally (8%).
<u>Tobacco Use</u> 7. Cigarette smoking rate for youth declining	+	<ul style="list-style-type: none"> Cigarette use among Connecticut and U.S. teens and young adults is nearly the same; between 2004 and 2009, smoking rates declined for both age groups. Smoking rates for 12-17 year olds are much lower than rates for 18-25 year olds; rates in 2009 nationally and in Connecticut were about 9% for the younger group and around 36-37% for the older group.
<u>Sexual Activity</u> 8. Teen birth rate declining	+	<ul style="list-style-type: none"> Connecticut's 2008 teen birth rate of 23 per 1,000 females ages 15-19 was 4th lowest in the U.S.; the national average was 41 per 1,000. Teen birth rates in Connecticut and the nation were lower in 2008 than in 2004. Rates vary substantially by race/ethnicity; in 2008, births to Hispanic teens were almost three times the state average in Connecticut and nearly twice the U.S. average.
Health Protective Factors: Conditions that contribute to positive health outcomes for adolescents are promoted.		
<u>Insurance</u> 9. Percentage youth without health insurance decreasing	↔	<ul style="list-style-type: none"> From 2005 through 2009, the rate of uninsured children and youth ages 6-17 in Connecticut fluctuated between 6 and 7%. Connecticut's rate of uninsured children under 18 is substantially lower than the national rate -- 6.5% versus 9.8% in 2010. Adolescents ages 12-17 nationwide are more likely than young children to have gaps in coverage; uninsured rates also are higher for Black and Hispanic children overall, and for children under 18 living in poverty .
*Details regarding each key indicator are contained in Appendix D.		

STORY BEHIND THE DATA

Connecticut Adolescent Health Successes and Challenges

The above PRI summary of population level performance shows *Connecticut compares well with national data on nearly all key indicators* presented in the report card. Teen fatality and birth rates in this state are among the lowest in the country. The portion of the adolescent population that is overweight or obese is below the U.S. average and the percent of children without health insurance is smaller in Connecticut than in most states. State rates of adolescent depression, binge drinking, and drug and tobacco use are about the same as national averages. State-level data about teen oral health are limited, making Connecticut's comparative performance in that area difficult to assess at present.

Other National Assessments

A number of national organizations periodically review and report on state performance on various aspects of child and adolescent health. Recent results for Connecticut from four major national assessments are highlighted below. *In general, Connecticut ranks among the top states on ratings of overall system performance, and on many specific indicators of adolescent health and well-being.*

KIDS COUNT profile. Each year, the Annie E. Casey Foundation publishes its KIDS COUNT Data Book that tracks the well-being of children and youth at national, state, and local levels.¹¹ Ten key indicators, which are used to monitor trends and compare state performance in important health and safety areas for children, have been followed for two decades.

Connecticut's composite ranking in 2011 on all 10 KIDS COUNT key indicators was sixth. The three best states were New Hampshire, Minnesota, and Massachusetts; the three lowest ranked states were: Mississippi, Louisiana, and Alabama. Connecticut consistently compares well with other states; it has ranked as high as three and no lower than 11 since 2002.

The state's complete Data Book profile for 2011 is provided in Appendix G. It shows Connecticut ranks in the top 10 states for all four KIDS COUNT key indicators specific to adolescents (with 1=best): teen death rate (7th); teen birth rate (4th); percent teens not in school and not high school graduate (3rd); percent teens not attending school and not working (2nd).

Commonwealth Fund scorecard. The Commonwealth Fund is a private foundation that supports independent research and provides grants to improve health care practice and policy, particularly for the most vulnerable groups in society. One of the fund's ongoing projects is compiling a scorecard that assesses core dimensions of national and state health care system performance to help policymakers and other stakeholders assess progress and identify areas in need of improvement.

¹¹ Annie E. Casey Foundation, *2011 KIDS COUNT Data Book: State Profiles of Child Well-Being*, 2011.

The current *State Scorecard on Child Health System Performance*, released in February 2011, examines 20 key indicators across the following three dimensions: access and affordability of care; receipt of preventive care and treatment; and the potential to lead healthy lives. A fourth dimension incorporates a measure of system equity in terms of differences in performance on other selected indicators associated with the income, insurance type, and race or ethnicity of children and their families. The scorecard data generally cover all children under 18; while not specific to adolescents, the scorecard still provides some of the best available comparative information on how well state health care systems are meeting health care needs of children and youth.

Connecticut ranks 9th among all states in overall child health system performance. All the New England states are in the top quartile although the others rank higher than Connecticut. Massachusetts, tied with Iowa, is first; Vermont is third, Maine fourth, New Hampshire fifth, and Rhode Island 6th.

The five best performing states overall also were in the top quartile on all four dimensions of the scorecard. Connecticut's child health care system did very well on three of the four, ranking 6th both for potential for children to lead healthy lives and for equity, and 8th on access and affordability of care. However, the state placed 26th on the prevention and treatment dimension.

A copy of Connecticut's 2011 scorecard is provided in Appendix H. It shows, regarding preventive care and treatment, that Connecticut had higher rates of unmet needs for children with special health care needs and higher hospital admissions for pediatric asthma than many states. Also, the state's rates for screenings and immunizations (which are just for younger children as adolescent measures are not captured by the scorecard) were below the national median.

Connecticut rank high on some other indicators in this dimension. Its rate of children receiving needed mental health treatment was second best among all states. The percent of those under 18 who had a preventive dental or medical care visit in the past year ranked 4th and 5th, respectively.

The scorecard report points out *all states, even high performers like Connecticut, have room for improvement*.¹² For example, top-ranked states still may not be achieving satisfactory results. Nearly a third of children under age 18 lack access to health care meeting the definition of a medical home in the states rated best on that measure.¹³ Similarly, while between 82 and 96 percent of children under 18 in every state had health insurance coverage, significant numbers still lack access to quality preventive medical and dental care and do not receive recommended screenings and immunizations.

¹² The Commonwealth Fund, *Securing a Healthy Future: State Scorecard on Child Health System Performance, 2011*, February 2011.

¹³ The American College of Physicians, the American Academy of Family Physicians, the American Academy of Pediatrics, and the American Osteopathic Association have jointly defined the "medical home" as a model of care where each patient has an ongoing relationship with a personal physician who leads a team that takes collective responsibility for patient care.

NSCH portrait of states. The National Survey of Children’s Health (NSCH) is conducted every four years by the National Health Statistics Center of the Centers for Disease Control and Prevention, under the direction of the U.S. Maternal and Child Health Bureau (MCHB). The survey asks a representative sample of parents about multiple aspects of their children’s physical and mental health, health care, and social well-being, as well as aspects of their family and neighborhood that can affect health.

NSCH provides a comprehensive source of basic state-level information on health status and risk and protective factors for both children and youth. Most survey data information, however, is reported for all children under 18 or by school-age and preschool categories; little is specific to the adolescent population.

National and state level survey results are analyzed and reported by the Child and Adolescent Health Measurement Initiative (CAHMI), a research center based out of the Department of Pediatrics of Oregon Health and Science University. For 2007, key state level indicators were compared with national statistics in individual profiles, which were combined to provide a “portrait” of the health and well-being of U.S. children. In what it calls “snapshot” reports, CAHMI also examines disparities within state and national performance indicators, in terms of differences by income, race and ethnicity, insurance type, and groups with special health needs.¹⁴

Key indicators from the 2007 NSCH data that are most relevant to adolescent health are summarized for Connecticut and the U.S. overall in Table I-1. As pointed out by CAHMI, findings are encouraging nationwide in several areas – a large majority of children, about 85 to 90 percent, according to parents’ reports: are in excellent or very good health; have received an annual preventive health care check-up; and are currently insured.

Connecticut’s performance on each NSCH indicator in Table I-1 is better than the overall performance for the U.S. For 2007, nearly 95 percent of children under 18 in the state were currently insured and under 10 percent lacked consistent coverage during the year. About 95 percent of Connecticut children had an annual medical preventive care visit, almost 85 percent had an annual oral preventive care visit, and nearly 80 percent who needed mental health care received it. A very high proportion of children (88.2 percent) are in excellent or very good health, according to parents’ reports. Oral health was excellent or very good for a smaller portion, but still a large majority, 76.4 percent. Fewer than five percent of Connecticut children ages 6-17 missed 11 or more days of school in 2007.

One area of concern at both the state and national levels is the portion of children who receive care in a medical home. Only about 62 percent of children under 18 in Connecticut, and a slightly smaller portion nationwide (57.5 percent), have a regular source of medical care

¹⁴ Children and youth with special health care needs (CYSHCN) are defined by federal law as having one or more ongoing physical, developmental, behavioral or emotional condition that require more than routine care. Under the federal CYSHCN program, states receive funding that can be used to provide care coordination, advocacy, and other supports to eligible families. In 2007, children with special health needs represented about 21 percent of the Connecticut population under 18, slightly more than the national rate (19 percent). DPH administers Connecticut’s program.

meeting all medical home criteria (i.e., accessible, continuous, comprehensive, coordinated, compassionate, and culturally sensitive).

Table I-1. Selected Child Health and Well-Being Indicators from NSCH 2007: Connecticut and U.S.			
Indicator	Explanation (Percent of Children:)	CT %	U.S. %
Child Health Status	<i>in excellent or very good health</i>	88.2	84.4
Oral Health Status	<i>with excellent or very good oral health</i>	76.4	70.7
Missed School Days	<i>aged 6-17 who missed 11 or more days of school in past year</i>	4.6	5.8
Current Health Insurance	<i>currently insured</i>	94.6	90.9
Insurance Coverage Consistency	<i>lacking consistent coverage in past year</i>	9.1	15.1
Preventive Health Care	<i>with a preventive medical visit in past year</i>	95.2	88.5
Preventive Dental Care	<i>with preventive dental visit in past year</i>	84.9	78.4
Mental Health Care	<i>aged 2-17 with problems requiring counseling who received mental health care</i>	78.8	60.0
Medical Home	<i>who received care in a medical home</i>	62.4	57.5

Source of Data: U.S. DHSS, Health Resources and Services Administration, Maternal and Child Health Bureau, *The National Survey of Children's Health 2007*, Rockville, MD, 2009.

Further, performance on the medical home indicator and the key NSCH indicators, at both the national and state levels, vary substantially by race, ethnicity, and family income. CAHMI analysis shows White children generally have better health outcomes and services than children of other races. Also, low-income children overall are less likely to have positive survey findings (e.g., be in excellent or very good health, have consistent insurance coverage, receive care in a medical home).

NCCP adolescent profile. As part of an ongoing project called “Improving the Odds for Adolescents,” the National Center for Children in Poverty (NCCP) at Columbia University compiles information about state policy choices that affect the health and well-being of adolescents. In a recent report (June 2011), the center examined whether states have adopted the policies its research has shown promotes adolescent access to high quality health, mental health, violence and injury prevention, and positive youth development services.¹⁵

According to NCCP, such policies include the following steps states have taken to:

- expand public health insurance coverage to reach more youth in need of care;
- push schools to adopt evidence-based health promotion curricula and programs;

¹⁵ National Center for Children in Poverty, Mailman School of Public Health, Columbia University, *Connecticut Adolescent Profile*, Updated June 1, 2011.

- mandate a coordinated school health approach;
- invest in SBHCs and other best practices shown to improve health and academic outcomes;
- explicitly extend consent and confidentiality rights to adolescents around sensitive topics (e.g., mental health, reproductive health);
- empower adolescents to protect themselves from violence and abuse (e.g., access to protection orders, bullying and cyberstalking legislation);
- encourage public-private collaborations to expand internships, mentoring, and other growth opportunities; and
- invest in programs that enable adolescents, particularly vulnerable youth, to successfully transition to independent adulthood (e.g., vocational and independent living skills training, counseling).

Based on the adolescent profile for the state in the center's 2011 report, Connecticut has adopted about two-thirds of 78 specific state policies and practices associated with improved access to and quality of health services for adolescents.

The majority of policies associated with access to quality health care (21 of 27), some of which are funding school-based health centers, providing continued Medicaid eligibility for youth aging out of the foster care system, and laws allowing minors to consent to various reproductive health services, are in place in Connecticut. About half the policies identified by NCCP as promoting mental health care access and quality (6 of 11), such as requiring certification of school behavioral health staff and mandating drug and alcohol use prevention as part of school health education curriculum, also are in place in the state.

Connecticut also has adopted half (11 of 22) of the violence and injury prevention policies outlined in the NCCP report, including a graduated driver licensing system as well as a ban on cell phone use by novice adolescent drivers. Most of the policies concerning positive development (10 of 13), which range from various supports for foster youth transitioning to adulthood to a mandatory minimum high school completion age of 18, are state law or established practice in Connecticut.

Previous State Assessments

Findings from two prior state efforts to evaluate adolescent health in Connecticut, a strategic planning initiative and an advisory council review, are highlighted below. For the most part, the *issues, priorities, and proposed changes identified by the council more than 15 years ago are echoed in the strategic plan prepared about 10 years later.*

State adolescent health strategic plan. The last comprehensive assessment of adolescent health in Connecticut was carried out as part of a state adolescent health strategic planning process completed in May 2005. The planning process, led by the Department of Public Health, was undertaken in response to the National Initiative to Improve Adolescent Health by 2010.

The department received assistance from an outside consultant and a committee of key stakeholders, including representatives from six state agencies with major roles in adolescent health, the legislature's Medicaid council, various types of health care providers, and several children and youth advocacy organizations. In addition to helping the committee prepare the plan, the consultant conducted a needs assessment and a best practices review, and compiled an inventory of existing adolescent health system assets.

A key finding from the planning process was: *“Overall, Connecticut adolescents do well on many health factors compared to the nation, with trends generally improving. However, significant disparities exist for youth of specific racial and ethnic groups, age groups, or gender for particular health issues, suggesting that there are important opportunities to further improve adolescent health in the state.”*¹⁶

The 2005 strategic plan found Connecticut has available a wide range of programs and services, public and private, addressing adolescent health. However, many challenges to effective coordination of policies and programs, such as limited opportunities for exchanging information or collaborating on service delivery, also were found. It was noted no suitable mechanism for sharing confidential health care information across providers and agencies was in place.

In addition, a number of data deficiencies that impede effective planning and accountability were identified by the strategic planning process. Much of the available data about adolescent health needs and services were incomplete, outdated, and not representative; mental health data were particularly limited. Few if any data were systematically collected about the health of youth who were homeless or not in school, the most at-risk group for poor outcomes. A central data warehouse and centralized process for monitoring program and system effectiveness also were found missing.

In the final state strategic plan, the department and the planning committee identified the following three issues and associated goals as top priorities for supporting adolescent health and positive development in the coming decade:

- 1. *Provide the support, options, and resources adolescents need to successfully transition to adulthood.***
 - Teens empowered to assume responsibility for health and behavior.
 - Access to timely, affordable, appropriate health and mental health services ensured.

- 2. *Enhance communication, coordination, collaboration among stakeholders in adolescent health.***
 - Data and information, particularly on lessons learned, best practices, challenges and successes, shared across programs/service providers and agencies.

¹⁶ Connecticut Department of Public Health, *Connecticut Adolescent Health Strategic Planning Initiative: A Report on Adolescent Health Needs, Assets and Best Practices* (prepared by Policy Studies Inc.), May 2005, p. 4.

- All health services adolescents receive coordinated and integrated.
- Appropriate data collected and made available to inform decision-making at program and system levels.

3. *Improve adolescent health and well-being.*

- **Obesity and healthy lifestyles:** healthy nutrition/fitness promoted.
- **Mental health:** prevention/positive mental health programs available; access to and use of appropriate services when needed ensured.
- **Substance abuse:** youth abstain from drug/alcohol use; ensure access to timely, affordable, appropriate treatment when needed.
- **Reproductive health:** youth adopt behaviors that support healthy sexuality.
- **Violence:** adolescents' neighborhoods and schools are violence-free.

The strategic plan contains other proposed systemic improvements and specific interventions, as well as a general framework for implementation. Recognizing success is dependent on a collective effort by all partners, especially the state education department, the framework calls for: establishment of an implementation group with general oversight responsibilities for moving the plan forward; formation of teams to develop action plans and monitor progress on each priority and strategic issue; and the appointment of a strategic planning coordinator to facilitate implementation efforts.

Some efforts to organize the implementation group and develop action teams did occur soon after the plan was completed in 2005; however, to date there has been no comprehensive follow up. At this time no one within the public health department or any other state agency is assigned to monitor implementation or update the current adolescent health strategic plan.

Adolescent health council report. The State-Wide Adolescent Health Council was established by the legislature in 1992 (P.A. 92-107) to advise and consult with the commissioners of public health, social services, education, and children and families, about teen health needs and coordination of service delivery. Council members included heads of the various state agencies involved with adolescents, chairs of the legislature's public health and human services committees, and representatives of a number of provider groups, social service agencies, and advocacy organizations that serve adolescents.

The adolescent health council also was charged with examining issues related to high risk behaviors, such as teen pregnancy, substance abuse, AIDS, and violence, and making recommendations to address these and other health needs of Connecticut adolescents. As mandated by law, the council issued a report to the legislature in 1994 that contained its findings and recommendations about adolescent health in Connecticut.

In its report, *the council identified a number of problems with adolescent health in Connecticut* and the U.S., including the following main findings:

- Adolescent health services have not been a public policy priority due to the false impression teens generally are healthy; nationwide, adolescents are the only age group for whom life expectancy is declining.

- Multiple barriers impede access to health services, including lack of providers trained in adolescent health care, lack of information on available services, and teens' concerns about confidentiality.
- Adolescents do not seek timely care when they cannot pay for it, easily reach it, or believe providers might inform their parents against their wishes for privacy.
- Significant numbers of adolescents lack health insurance coverage (one in seven at the time); many private insurance plans do not cover services youth need, such as treatment for mental health and substance abuse problems or preventive services such as contraception.
- Despite research findings showing adolescent health problems often are multi-faceted (e.g., physical, behavioral, social) and require comprehensive approaches to care, most state policies and funding for adolescent health services is categorical (focused on a single problem, e.g., substance abuse, risky sexual activity, smoking).
- Adolescent health issues are currently addressed by multiple agencies, providers, and a wide range of community-based organizations with little evidence of effective cooperation and coordination. There is no locus for oversight of adolescent health planning and program development and no "voice" for adolescent health issues in health care debates.
- Health trends for adolescents are not tracked for the purposes of efficient health policy planning and evaluation; available indicators of teen health often lag three to four years and some critical data are not available at all.

To address these problems, *the council made five main recommendations: 1) improve access to health services; 2) ensure adequate financial reimbursement and insurance coverage for health services; 3) establish and evaluate comprehensive preventive services; 4) centralize planning and oversight responsibilities; and 5) establish an adolescent health index to track trends.* The 1994 report also outlined the council's immediate priorities for specific actions by state agencies and policymakers within each of these areas, including:

- expansion of school-based health centers;
- support community-based services for hard-to-reach populations (e.g., school dropouts, homeless youth);
- expansion of Medicaid coverage to more low-income youth and support for efforts that can increase adolescent participation in EPSDT ;
- fund comprehensive prevention programs aimed at reducing all targeted risk behaviors and developed via inter-agency collaboration;

- mandate accurate and comprehensive K-12 health education that emphasizes risk reduction skills;
- establish the council as the central entity responsible for coordinating services, increasing communication and collaboration, advocating for adolescent health, developing a comprehensive state plan for adolescent health care, and making recommendations to public health and other state agencies for enhancing adolescent health; and
- establish one standardized statewide data collection system for monitoring incidence and prevalence of adolescent health issues, analyzing trends, assessing risk and protective factors, and tracking service utilization to identify gaps and priorities.

It appears the council issued no further reports (and was not required to) and there are no records of meetings or other activities following submission of the 1994 report. The council had been defunct for a number of years at the time PRI began this study and its enabling legislation was repealed during the 2011 regular legislative session (P.A. 11- 242).

HUSKY Program Monitoring and Evaluation Results

Two programs administered by the Department of Social Services are the major publicly funded source of health care services for Connecticut adolescents:

- HUSKY A, the state’s Medicaid program for low-income children up through age 18 (and their caregivers, as well as certain pregnant women); and
- HUSKY B, Connecticut’s Children’s Health Insurance Program (CHIP) for uninsured children not eligible for Medicaid but whose family income is below thresholds set by the state.

According to DSS, *one of every five children in Connecticut is covered by the state HUSKY programs or another department health plan.* An estimated 117,000 adolescents ages 10-19 are covered by HUSKY A; about another 9,000 youth in this age group are enrolled in HUSKY B.

Every child and adolescent on Medicaid is eligible for Early Periodic Screening, Diagnosis and Treatment (EPSDT) up to age 21. EPSDT is a federally mandated program of comprehensive preventive health services provided in accordance with American Academy of Pediatrics guidelines (i.e., “Bright Futures”). The program’s goal is early identification and treatment of conditions that can impede children’s healthy growth and development and avoidance of the costs, human and financial, of long-term disability.

EPSDT services include required well-child checkups with a variety of screenings (medical, dental, vision, and hearing), assessments of physical and behavioral/developmental status, and appropriate immunizations. States also must provide diagnostic and treatment services for all medically necessary health needs identified by EPSDT, whether or not the services are covered benefits of their Medicaid programs. As a result, Medicaid coverage for

children is more comprehensive than the benefits provided for adults or through typical private insurance plans.

High enrollment in Medicaid and CHIP programs and full participation in EPSDT are crucial ways for states to achieve good health results for children and youth and a cost-effective public health care system. In Connecticut, ensuring access to, and utilization of, the HUSKY programs is a central strategy for meeting the health needs of the state's most vulnerable children and youth (e.g., low-income, uninsured, involved in the child welfare or juvenile justice systems).

Since 1994, the statutory Medicaid Medical Assistance Program Oversight Council (originally known as the Medicaid Managed Care Council), has been responsible for advising on development and overseeing implementation of Connecticut's Medicaid, and later CHIP, health services programs for children and families. Current council membership consists of legislators, state agencies, consumers, advocates, and health care providers. Representatives of the state's contracted managed care organizations (MCOs) and administrative services organizations (ASOs) for HUSKY and other DSS medical assistance programs also serve on the council.

Under legislation enacted in 2011 the council's oversight role was expanded to encompass the programs covering all Medicaid enrollees in the state (P.A. 11-44). The council also was given responsibility for monitoring and advising DSS on matters related to the end of all managed care arrangements on January 1, 2012, and transition to an ASO model for all medical services. (Behavioral health and dental services for Medicaid enrollees already are administered through contracted administrative services organizations.)

Since it was established, the Medicaid council, often through various working committees, has regularly reviewed HUSKY and other program performance data provided by the department and the contracted program managers and administrators. It has requested preparation of special reports and held forums on issues of concern, including, in the early 2000s, adolescent underutilization of EPSDT services.

The council also receives the reports and research briefs prepared by the department's contracted, independent HUSKY program evaluator, Connecticut Voices for Children (CVC). Recent council and CVC monitoring and evaluation results related to how well the HUSKY programs are meeting adolescent health needs are described briefly below. Some supplemental performance information provided to committee staff by DSS also is included.

Findings related to two key aspects of accessibility – enrollment and utilization rates – for youth ages 10 to 19 are highlighted. Overall, these *data underscore the importance of initiatives that have been shown to improve adolescent access to, and utilization of, primary and preventive care such as school-based health centers and other community-based general and reproductive health care (e.g., provided at community health centers, family planning clinics).*

Enrollment. Data presented by Connecticut Voices for Children at the program review committee's June information forum showed in 2009 (the most recent available data during the committee study), a total of 126,899 children ages 10 -19 were enrolled in HUSKY at least one point; 65 percent were enrolled for the entire year. While the average period of enrollment for

this group was 10 months, the CVC analysis found older adolescents were less likely to be continuously enrolled and had shorter average enrollment periods.

Research conducted by CVC in 2010 showed that some of the gaps in coverage for older teens can be the result of administrative error by the Department of Social Services.¹⁷ Based on data from 2006-2007, one in six of children turning 18 (15.9 percent) lost HUSKY A program coverage, a disenrollment rate eight times higher than for youth ages 10 or 15. It appears in some cases disenrollment of the older teens was triggered incorrectly due to age. Prior to 1996, eligibility ended at 18 for children not enrolled in school; however, subsequent rule changes provide children with HUSKY coverage until their 19th birthday. Some reasons given for mistaken disenrollment are long-standing problems at DSS: outdated technology, inadequate procedures, and confusing notification forms.

Utilization. An October 2000 study of EPSDT services by the department's external quality review contractor (Qualidigm) found very low utilizations by adolescents in the HUSKY program. While in 1998 and 1999 participation rates were in the mid-60 percent range for children up to age 10, they dropped precipitously to between 30 and 40 percent for older youth. The study also found, based on 1998 data, only 28 percent of youth ages 12 to 21 had a well care visit during the year; 33 percent had documentation of an acute care visit only; and 16 percent had no service documentation.

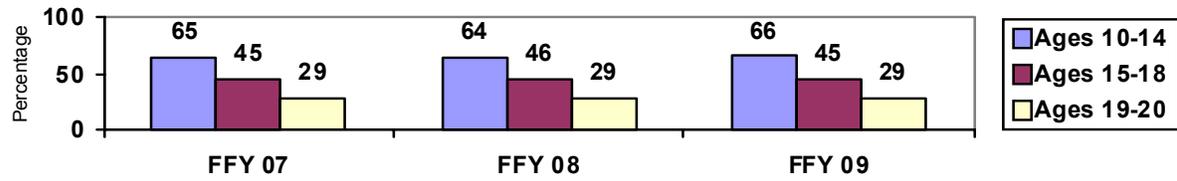
In response to these findings, the Medicaid council organized a work group focused on increasing adolescent EPSDT participation and making teen well care visits more comprehensive. During 2002 and 2003, the group worked with HUSKY program MCOs and the department to develop action plans for improving access to and quality of adolescent preventive care services. Final plans were presented and favorably reviewed by the council at its May 2004 meeting.

However, recent data on adolescent EPSDT participation rates, provided by the Department of Social Services at the committee's June 2011 information forum indicated no improvement has occurred since the 2000 study findings. As Figure I-3 on the following page shows, participation rates remain at 64 to 66 percent for young adolescents (ages 10-14) and between 30 and 40 percent for older teens (ages 15-20). The department cautions against trying to interpret these data any further without a full understanding of the limitations of the EPSDT measures and adolescent health care utilization patterns

Connecticut Voices for Children presented the most recent available information on the use of preventive care by adolescents enrolled in HUSKY also at the program review committee's June forum. Based on its analysis of 2008 Medicaid claims data provided by DSS, CVC found 83 percent of children ages 10 to 19 had visited a primary care provider that year but only 50 percent had received had a routine check up or "well-care" visit. According to CVC analysis, even fewer of the HUSKY-enrolled adolescents, just 44 percent, had received preventive dental care in 2008.

¹⁷ Connecticut Voices for Children, *Husky Program Coverage for 18 Year Olds: Recommendations for Avoiding Gaps or Loss of Coverage*, October 2010.

**Figure I-3. EPSDT Participations Rates
Connecticut Husky Program (Percent)**



Source of Data: DSS PowerPoint Presentation to PRI, June 21, 2011.

Use of preventive care, in Connecticut as is the case nationally, declines with age and varies by gender. The Connecticut Voices for Children research found during 2008 significantly fewer teens over 16, particularly males, compared with younger adolescents, had routine check-ups with primary care providers. Further, one in three of adolescents ages 13 to 20 enrolled in HUSKY had received emergency care, with utilization rates even higher for older teens. *CVC found one in four adolescents with any emergency care in 2008 was treated for a condition that could have been prevented or treated by a primary care provider.*

The most recent available information on inpatient care received by HUSKY teens, provided by DSS at the committee's June information forum, is summarized in Table I-2. It also indicates more can be done to ensure adolescents use primary and preventive services, such as EPSDT, particularly in the areas of reproductive and behavioral health.

Table I-2. HUSKY Members Ages 13-20: Top 5 Categories of Inpatient Care CY 2009

Major Diagnostic Category	No. Admissions	% Total Admissions	Total Payments (\$ millions)
HUSKY MCO INPATIENT DATA – PHYSICAL HEALTH ONLY			
Complications of Pregnancy & Childbirth	2,843	58	\$10.364
Digestive System Disease	395	8	\$ 1.984
Injury & Poisoning	353	7	\$ 1.921
Respiratory System Disease	239	5	\$ 1.252
Blood Disease	134	3	\$ 1.444
<i>Total all categories</i>	<i>4,866</i>		<i>\$22.958</i>
HUSKY FFS INPATIENT DATA - COMBINED PHYSICAL & BEHAVIORAL HEALTH			
Mental Disorders	2,434	63	\$33.645
Complications of Pregnancy & Childbirth	628	16	\$ 2.331
Injury & Poisoning	174	5	\$ 1.762
Digestive System Disease	143	4	\$.677
Respiratory System Disease	80	2	\$.611
<i>Total all categories</i>	<i>3,848</i>		<i>\$42.172</i>

Source of Data: DSS PowerPoint Presentation to PRI, June 21, 2011.

The top part of the table shows the five categories for inpatient physical health services provided in 2009 to adolescents ages 13-20 who are enrolled in HUSKY MCOs. Complications of pregnancy and childbirth accounted for well over half of all admissions (58 percent) and \$10 million of the total \$23 million in payments.

The bottom part of Table 2 presents similar information for the department's fee-for-service (FFS) medical assistance programs that serve youth, which includes all behavioral health services. In 2009, over 2,400 adolescents covered by HUSKY received inpatient care for mental disorders at a cost of almost \$34 million. The top physical health reason for inpatient admissions within this group of teens was complications of pregnancy and childbirth.

Adolescent Health: Critical Elements for Success

As discussed earlier, Connecticut's current policies and existing adolescent health infrastructure are achieving good results, based on available data, relative to other states and national statistics. Furthermore, *the state has made some steady progress on several key indicators of adolescent health.* Connecticut teen birth rates and rates of cigarette use by teens have been dropping. Also, with the availability of state HUSKY programs, the portion of children without health insurance in Connecticut has declined significantly over the past decade.

In other indicator areas, however, progress seems stalled. Rates of adolescent depression, binge drinking and illicit drug use among youth, and teen overweight and obesity rates, have shown little change in the past few years. Perhaps more troubling is the increase between 2003 and 2007 in the state's teen fatality rate. Persistent and substantial racial and ethnic disparities within most key indicators of adolescent health, while not unique to Connecticut, are of concern.

To better understand the reasons for plateaus and variations in performance, as well as ways to achieve better results, PRI staff reviewed the recent research about effective adolescent health policies and systemic practices.¹⁸ Elements considered by experts to be critical for successful state adolescent health systems were identified from three main sources: a 2009 report by the National Research Council and Institute of Medicine (IOM); a 2008 American Academy of Pediatrics (AAP) policy statement; and a conceptual framework developed by the Association of Maternal and Child Health Programs (AMCHP) in collaboration with the National Network of State Adolescent Health Coordinators (NNSAHS).¹⁹

¹⁸ Informally, these elements might be referred to as "best practices" for adolescent health. However, for purposes of this study, staff decided to limit use of that term, as suggested by the National Adolescent and Young Adult Health Information Center (NAHIC), to evidence-based strategies, activities, and/or approaches shown through accepted scientific research to be effective. A number of evidence-based adolescent health programs and services are in use in Connecticut. However, system-level approaches to service planning, management, and delivery have not been subject to the rigorous research and evaluation required for formal best practice designation.

¹⁹ See: 1) National Research Council and Institute of Medicine. *Adolescent Health Services: Missing Opportunities.* Washington, DC: The National Academies Press (2009); 2) American Academy of Pediatrics. *Policy Statement: Achieving Quality Health Services for Adolescents.* Pediatrics Volume 121, Number 6, June 2008; and 3) Collaborative Project of the Association of Maternal and Child Health Programs and the National Network of State Adolescent Health Coordinators, with support from the Annie E. Casey Foundation. *A Conceptual Framework for Adolescent Health* (May 2005).

The concepts and themes emphasized by all three sources vary mainly in presentation. Critical elements for quality adolescent health are outlined as five objectives by the Institute of Medicine, seven criteria by the American Academy of Pediatrics, and 10 guiding principles by AMCHP/NNSAHS. However, taken together, they can be summed up in three broad categories: accessibility; coordination; and quality.

Accessibility. *Research shows for adolescents, the key determinants for accessing health care services are convenience, cost, and confidentiality.* Offering affordable care in times and places accessible to youth is crucial to adolescent health program success.

Confidentiality issues have been shown to be significant barriers to teens obtaining necessary services in a timely way. Adolescents who want to keep sensitive health care concerns private from parents may withhold information from providers, delay entry into care, refuse care or not even seek it. Health care professionals and other experts strongly believe adolescents should be encouraged to involve their families in health decisions. However, balance also is needed to ensure confidentiality when necessary to protect an adolescent's health and well-being.

Other elements of accessibility include making care acceptable to youth by ensuring services are culturally competent, family centered, and community-based. Flexibility, within services, staff, and sites, is needed to address developmental, cultural, ethnic, and social diversity among adolescents. Above all, systems must be equitable, meaning eligibility and service delivery is unrestricted.

Coordination. To meet the health needs of adolescents, services must be comprehensive, combining health promotion, disease prevention, and youth development approaches. *Best results are achieved when health services are interdisciplinary, linked, and coordinated.* This requires collaboration and partnerships across providers and within communities. Effective coordination is dependent on comprehensive strategic planning and a commitment to improving adolescent health and well-being.

Quality. For adolescents, quality means strong primary care that emphasizes development, behavioral health, and disease prevention. Quality also means a basic level of service that fulfills their needs is provided to all youth. Care provided should be scientifically supported and appropriate. *Sound data and strong analytic capacity are essential to high quality programs, services and delivery systems for adolescent health.*

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Overarching Issues: Achieving Better Adolescent Health Results

The state's adolescent health report card presented in the previous chapter shows the overall outcomes for Connecticut adolescents equal or exceed national performance data for key indicators of child and youth well-being. Further, many elements regarded as critical for achieving good health outcomes for teens are in place in this state. National studies consistently rank Connecticut as one of the top states for child and adolescent health system performance.

However, the indicator data presented in the report card also show there is room for improvement. Clearly, more attention to reducing the significant racial and ethnic disparities in health outcomes among Connecticut youth is needed from all partners responsible for adolescent health results. Increasing access to and utilization of primary and preventive care, particularly by low-income and minority youth, also must be made a priority.

The program review committee study revealed system weaknesses centering around: coordination and leadership; access and utilization; and adequate data for planning and accountability. Deficiencies in each area have been overarching issues identified by previous studies and continue to be obstacles to better health results for all adolescents in the state. Committee proposals for addressing the state system's persistent problems in these areas are discussed below.

Coordination and Leadership

A concerted effort among many public and private partners is needed to provide quality care and improve health outcomes for all adolescents in Connecticut. At a minimum, DPH, SDE, DSS, and SDE need to be working together to meet the health needs of youth ages 10 to 19. Ideally, the Judicial Branch, Department of Mental Health and Addiction Services, and the Department of Higher Education also should be actively involved in planning and implementing state adolescent health strategies.

However, as cited in previous studies, and discussed at the program review committee's June information forum and public hearing, *there is no strong coordinating mechanism for adolescent health in Connecticut. Also, an up-to-date, comprehensive planning document and overarching policies to guide implementation of state strategies are lacking. Further, there is no ongoing, systematic way to track progress and hold agencies and programs accountable for achieving desired health results for youth ages 10 to 19.*

Past efforts to foster coordination and promote leadership for adolescent health have not been sustainable. The legislature created the multi-agency, widely representative Adolescent Health Council in 1992 to direct and oversee comprehensive and coordinated state policies and programs for teen health and well-being. However, it accomplished little following publication of its 1994 report and after years of inactivity, the council was eliminated in 2011.

A comprehensive strategic plan for improving adolescent health, and well-designed collaborative way to implement it, was released by DPH in 2005. To date, it has essentially been ignored. It is not completely clear why these efforts failed to sustain momentum, but a lack of dedicated staff resources and high level agency commitment are among the problems

Within the public health department, there has been little focus on the state population of 10 to 19 year olds as a whole since the strategic plan was prepared. At this time, the DPH position of adolescent health coordinator is inactive. (In conversations with committee staff, the commissioner, who had been with the department less than one year at the time of the PRI study, indicated she plans to give increased attention to several adolescent health issues in the future.) Responsibility for teen physical, behavioral, and oral health matters is diffused across various units, divisions, and offices within numerous state agencies.

To meet the complex health needs of adolescents, services must be comprehensive, combining health promotion, disease prevention, and youth development. As discussed in the previous chapter, *coordination and leadership are central to an effective adolescent health system*. Best results are achieved when services are interdisciplinary, linked, and coordinated. This requires collaborations and partnerships across agencies, programs, and providers and within communities. Effective coordination is dependent on comprehensive strategic planning and a commitment to improving adolescent health and well-being.

In recent years, with federal funding from the national Centers of Disease Control and Prevention (CDC), Connecticut and a number of other states have been carrying out Coordinated School Health (CSH) programs. Their purpose is to align school health and education efforts to improve both academic achievement and physical, mental and developmental outcomes for students. Strategies are based on research that shows health and academic achievement are directly connected, and a student's health is one of most significant influences on learning and achievement.

In partnership, the state departments of education and public health, with a small number of staff funded through the state's federal grant, are carrying out Connecticut's coordinated school health initiative, which is known as "Healthy Connections." The main goals of the state CSH effort are:

- link school health education, physical education, health services, mental health and social services, nutrition services, and activities related to a healthy and safe environment, family and community involvement, and staff wellness in every community;
- build partnerships and teamwork among school health and education professionals;
- eliminate gaps and reduce redundancies among initiatives and funding streams;
- build collaboration and communication among public health, school health, other health and education professionals in community; and
- help students engage in protective, health enhancing behaviors, avoid risk behaviors.

To date: a strategic coordinated school health plan and guidelines for schools have been developed; leadership teams for coordinated school health have been established in many districts; and related training and technical assistance is being provided to schools and community groups. An active interagency working group and a network of stakeholders and interested parties have been established to promote the goals of Healthy Connections.

A more broadly representative group that includes agencies and groups that work with adolescents who are not part of the school population, such as the Court Support Services Division of the Judicial Branch, the departments of corrections and mental health and addiction services, and community agencies involved in positive youth development, workforce development, teen pregnancy prevention and young parent supports, could build on the success of Healthy Connections. Connecticut's CSH organization and activities could be expanded to better coordinate planning and implementation of state strategies to improve health outcomes for youth within and outside of the school environment.

To provide a vehicle and framework for a concerted, fully statewide effort to improve the health of all Connecticut adolescents, the PRI committee recommends:

- **A workgroup composed of representatives of state agency and community partners with major responsibilities for adolescents in Connecticut should be established to oversee and direct planning and coordination of policies, programs, resources, and data related to adolescent health in Connecticut. The adolescent health coordination workgroup should operate in collaboration with the state Coordinated School Health initiative.**
- **An adolescent health coordinator should be designated in each agency with a key role in promoting the health and well-being of Connecticut youth; at a minimum, there should be coordinators at the Departments of Public Health, Education, Children and Families, and Social Services and the Court Support Services Division of the Judicial Branch.**
- **The Department of Public Health, with the assistance of the workgroup, should update and continue to keep current, the state adolescent health strategic plan. Strategic planning for adolescent health should be a central component of the department's present federally driven, comprehensive state health plan process, Healthy People 2020.**²⁰

²⁰ Healthy People 2020 is the third 10-year national agenda set by the U.S. DHHS for improving the health of all Americans. The science-based, measureable goals and objectives of the Healthy People initiatives are intended to be a framework for: identifying health promotion and disease prevention priorities; tracking progress; and reducing disparities. While not federally mandated or funded, many states, including Connecticut, carry out parallel efforts. At present, DPH is coordinating "Healthy Connecticut 2020" with an internal workgroup; a coalition of major stakeholders to advise and assist the agency is being formed. More information about current and prior Healthy Connecticut work is available at the agency website: <http://www.ct.gov/dph/cwp/view.asp?a=3130&q=458600>. The department also has hired a consultant with funding received through the federal Affordable Care Act to conduct a statewide health needs assessment and related health improvement plan, which is expected to support Health Connecticut planning. DPH additionally intends to better coordinate its many existing data collection and program planning efforts, including those related to adolescent health, in the coming months.

Access and Utilization

It is widely recognized that a key way to make progress toward better adolescent health outcomes overall and reduce disparities is to have quality primary and preventive care accessible to and used by teens. A critical first step is ensuring children and families have adequate health insurance coverage.

As noted in the previous chapter, the rate of children and youth with health insurance coverage in Connecticut is relatively high (almost 94 percent in 2010), making access to care less of a problem than in most states. However, *the fact as many as 49,000 children under 18 were without coverage for the entire year in 2010 needs more attention, given the broad availability of HUSKY and other state assistance programs.*²¹ *Research also shows continuity of coverage seems to be an ongoing problem, particularly for older adolescents enrolled in HUSKY.*²²

A recent study by the American Academy of Pediatrics shows the percent of Connecticut children eligible for Medicaid and CHIP who are enrolled was 69.2 percent in 2008.²³ This is about the same as the national rate (68.8 percent). However, other New England states had much higher rates: Maine was 82.4 percent and Massachusetts was 81.0 percent. Reasons for their better performance should be explored by state social services department staff to determine if there are additional low or no cost steps that could be taken to improve participation rates.

Connecticut has been involved in ongoing efforts to increase participation in HUSKY and make eligibility “seamless.” For example, the state used federal funding for outreach worker positions in the community and recently mandated schools to identify children without health insurance and provide their parents with information about the availability of HUSKY A and B (P.A. 07-2). Funding targeted for outreach, however, ended as of September 2011.

Community-based agencies as well as schools, school-based health centers, and other health services providers will continue to provide clients with HUSKY program information and application assistance with existing resources. A statewide coalition called “Covering Connecticut’s Kids and Families,” which is sponsored by the nonprofit advocacy group Connecticut Voices for Children and funded by the Connecticut Health Foundation, also will continue to serve as a clearinghouse on HUSKY program information for providers and the public.

²¹ Connecticut Voices for Children, *Uninsured Children in Connecticut: 2011*, October 2011.

²² A report on insurance coverage for children by Connecticut Voices for Children based on analysis of the most recently released U.S. Census data was issued in December 2011. In that report, CVC estimated 24,000 children under 18 in Connecticut were uninsured at the time of the census survey in 2010. The analysis showed the state has been successful in enrolling children and families in HUSKY programs, especially during the recent economic downturn; however, it also found retention of coverage remains problematic.

²³ American Academy of Pediatrics, *State Reports: Children’s Health Insurance Status and Medicaid/CHIP Eligibility and Enrollment: 2008*, September 2009.

At the time of the committee study, DSS was pursuing a Medicaid family planning expansion option that should increase the number of young people eligible for state coverage of their primary and preventive reproductive health services. (Costs will be 90 percent federally reimbursed.) As part of the option, providers such as community health centers, family planning centers, and school-based health centers, will be permitted to do point-of-service Medicaid enrollment.

In recent years, state and federally funded outreach efforts along with simplified application procedures have helped the state make significant progress in reducing the numbers of uninsured children and youth and achieve its low uninsured rate relative to the national average. Connecticut, in fact, was one of 23 states awarded a bonus from the U.S. Department of Health and Human Services last year for efforts to enroll more children in the HUSKY A Medicaid program. Given Connecticut's strong performance in providing health care benefits for nearly all children and youth in the state, it is hard to understand why a number of low-income adolescents still lack or lose HUSKY program or other Medicaid coverage.

Further, ensuring adolescents have health coverage, unfortunately does not guarantee they will seek or receive necessary health care services. Connecticut, like other states, continues to have problems with underutilization of primary and preventive care services by teens who are enrolled in HUSKY and other Medicaid programs.

As described in the prior chapter, while youth covered by Medicaid are eligible for comprehensive primary and preventive health services through the federally mandated Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program, teen participation rates in Connecticut are low. The state's EPSDT participation rates for adolescents ages 10-14 average about 65 percent, are between 30 and 40 percent for older teens (ages 15 through 19), and have shown no improvement since 2000. There is general agreement increasing EPSDT participation should be a central strategy for reducing health outcome disparities experienced by many low-income and minority youth

Critical elements for increasing the use of services by teens are convenience and cultural competence. *Research shows providing services in schools and other community settings are among the most effective ways to increase access for and utilization by teens, particularly low-income and minority youth.* In Connecticut, publicly funded community health centers, school-based health centers, and family planning health centers are major sources of affordable, quality primary and preventive health care that can improve health outcomes for low-income adolescents.²⁴ Further, ensuring students have access to and receive quality health care can help address the academic achievement gap and promote positive youth development.

As additional ways to increase health care access and utilization for Connecticut adolescents, the program review committee recommends:

²⁴ PRI staff was not able to include an examination of services provided to adolescents through the state's network of community health centers within the scope of this study. The latest data available from DPH show a substantial number of teens receive care from such facilities. In 2006, Connecticut's 10 federally funded community health centers served a total of 211,700 patients; teens ages 13 through 19 accounted for 13% (27,521) and all school-age children, ages 5 through 19, made up 29% (61,393) of total patients.

- **State agencies and state-funded community providers serving adolescents should make getting and keeping their teen clients insured a priority. The Department of Social Services, as part of its new information technology improvement projects, should ensure clear, correct, and complete information on its health insurance programs are available on-line.**
- **DSS should also take all steps necessary to simplify application and renewal procedures and address the causes of administrative errors that result in gaps in coverage for adolescents.**
- **The adolescent health coordination workgroup recommended earlier should make increasing EPSDT participation among adolescents, particularly older teens, a top goal. Among the strategies the group should consider are ways to:**
 - **improve the health literacy of adolescents, such as ensuring schools are providing a comprehensive, quality health education curriculum, so teens are aware of the short and long-term benefits of primary and preventive care; and**
 - **expand school- and community-based primary and preventive care services for adolescents that are provided through high performing SBHCs, community health centers, and family planning centers.**

Adequate Accountability Data

Currently available data on adolescent health are inadequate for determining how well the state is meeting the health needs of youth ages 10 to 19 or how to make better progress. Like prior assessments of adolescent health in Connecticut, this study found existing data sources for most indicators and measures have a number of shortcomings and certain information is not even collected.

Some deficiencies, such as the need for more frequent national surveys and better consistency in age groupings, are being addressed by the federal level. Other steps, such as automation of existing school health assessment forms and better linkages of state data systems can be undertaken by state agencies.

None of the state agencies with significant roles in adolescent health have strong internal capacity for data collection and analysis. DSS, for example has few agency staff resources for Medicaid data analysis and only one position is dedicated to preparing customized reports related to the HUSKY programs.

Department research efforts also are hampered by antiquated technology, although anticipated system improvement over the coming months are expected to help. Both factors, however, contribute to current data quality problems and long lags in reporting on program information. Even the work of the department's contractor for HUSKY program performance, Connecticut Voices for Children, is impeded by data delays; the most recent Medicaid data it was provided by the department during the committee's study was three years old.

PRI staff made extensive attempts throughout the study to obtain and analyze data from the Medicaid and CHIP programs, and link it with data available for state-funded school-based health centers. Several options were pursued to achieve this purpose, including using the resources of CHIN and the Institute for Public Health Research of the University of Connecticut Health Center (UCHC), which were available at no cost.

However, the many administrative, technical, and legal considerations involved in each possibility for assistance with data analysis could not be resolved before the study concluded. In the end, committee staff was unable to evaluate access to and utilization of primary and preventive care across different groups of adolescents covered through the HUSKY program and by source of services, including school-based health centers.

DSS made serious efforts to respond to PRI staff requests for Medicaid data that could inform analysis of the amounts, types, sources, and when available, outcomes of primary and preventive care provided to adolescents through the HUSKY programs. The agency was able to provide only a small portion of requested information within the study timeframe; it noted in a letter to the PRI committee staff director that with current resources and existing database challenges: “Under the best of circumstances, a request of this complexity would take several months to compile.”

Connecticut Voices for Children has been a critical resource for analysis of HUSKY program performance data; it has been a primary source of quantitative information for this study. Under its current contract, it is paid up to \$238,000 per year, which is 50 percent federally reimbursable. The program review committee believes this is a sound investment of resources for quality data analysis of services that cost around \$20 million per month just for adolescents in the HUSKY programs.

DSS expects the quality and quantity of HUSKY and other health program data will increase as the state’s new Administrative Services Organization (effective on January 1, 2012) and, eventually, a new eligibility management system are fully implemented. However, the skills, experience, and independence of CVC staff are valuable and low-cost assets for program accountability. It is also possible analytical capacity of state agencies and the legislature could be significantly increased with minimal cost by pursuing a partnership with the UConn Health Center’s public health research institute.

At this time, no state entity is responsible for systematically tracking the well-being of the adolescent population. It is intended that the adolescent health workgroup recommended earlier take on this role. Even with more centralized oversight, however, more data and data sharing will be needed to determine whether Connecticut youth are better off because of the state-supported health care they receive. Therefore, the PRI committee recommends:

- **The adolescent health coordination workgroup should track the state’s progress in achieving desired health results for Connecticut youth ages 10 to 19.**
- **The adolescent health population report card prepared for this study should be continued, with the assistance of the workgroup, and integrated with**

current children’s report card initiative being carried out by the legislature’s Select Committee on Children under P.A. 11-109.

- **Data analysis capacity for the HUSKY and other state-funded health services provided to adolescents should be ensured and possibly expanded by :**
 - **continued funding for the program monitoring and evaluation work of Connecticut Voices for Children; and**
 - **pursuing DSS participation in CHIN and a research partnership between the department and the University of Connecticut Health Center Institute of Public Health Research.**

- **As part of the adolescent health data development and research agenda,**
 - **a cost effectiveness analysis of school-based health centers in Connecticut should be conducted as recommended in Chapter III; and**
 - **the current status of Electronic Health Records among the state’s public schools, including how many districts have automated their school health assessment forms, should be determined along with an estimate of the resources needed for implementation statewide.²⁵**

²⁵ Under state law (C.G.S. Section 10-26(d) and 10-204a), school students in Connecticut must have primary immunizations and a health assessment by a qualified health care provider prior to school entrance, and updates in 6th or 7th grade, and in 9th or 10th grade. Students participating on school sports teams must have health assessments every year. The SDE form required for these assessments (Health Assessment Record), commonly referred to as “the blue form,” contains information on: the student’s primary care provider and health insurance status; health history; and current medical evaluation including physical exam results (e.g., height, weight, BMI), results of vision and other screenings, immunization record, chronic disease (such as asthma or diabetes) assessment, and any conditions that may affect his or her educational experience. Automation of the SDE forms would facilitate collection and analysis of extensive data about the current health status and health trends of Connecticut’s school-age population.

State statute also requires schools to maintain consistent documentation (written or electronic) of each student’s health history (including but not limited to Health Assessment Records) in a Cumulative Health Record. While the number of schools with Electronic Health Records is growing, many school nurses still rely on labor intensive manual documentation to complete student health records. SDE is supportive of efforts to automate school health forms and data but lacks resources to help with implementation. According to state education department staff, about two-thirds of local school districts had some electronic student health records as of January 2012. The most commonly used software for student health information (which can be used to automate all assessment records) costs about \$1,000 per site (school building); an estimated 500 schools statewide have no type of health record software at this time.

School-Based Health Centers: RBA Program Performance Report Card

Information on school-based health center (SBHC) performance in Connecticut is highlighted below in a program review committee RBA program report card format (Figure III-1). Some brief background information about SBHCS is provided first, followed by a summary of key performance measure data related to each of the three main RBA program accountability questions – *How Much Did We Do? How Well Did We Do It? Is Anyone Better Off?* The last section (“Story Behind the Data and Actions to Turn the Curve”) contains more detailed performance findings and PRI committee recommendations for improving health outcomes for the adolescents served by the state’s school-based health center program.

Figure III-1. RBA Program Report Card

<p style="text-align: center;"><u>School-Based Health Centers (SBHCs) 2011</u></p> <p style="text-align: center;">Contribute to the Quality of Life Results Statement: <i>“Connecticut adolescents have the health care services, supports, knowledge, and skills that promote optimal physical and mental well-being and success in life.”</i></p> <p>Main Contribution: Provide school-aged children greater and easier access to free primary care, mental health care, and dental care (in some cases), by making care available where children spend a large portion of their time: in school. Services are geared toward students/families who are uninsured, underinsured, or have public health insurance. Offering health care services within a school environment has been shown to increase academic achievement and reduce costly emergency department utilization.</p> <p>Primary Partners: State agencies (DPH, DSS, SDE, DCF); health care institutions and professionals (medical, dental, mental health, and substance abuse treatment providers); local schools/districts; local health departments; community-based, non-profit health and social service agencies; advisory and advocacy groups and associations for adolescent health care; parents/families, and students.</p>
<p style="text-align: center;"><u>BACKGROUND</u> (Additional SBHC background information is provided in Appendix F)</p>
<ul style="list-style-type: none">• School-based health centers are located in schools or on school grounds and offer free primary care, mental health care, and in some cases dental care, to students. Parents must enroll their children in a center for the student to receive services, which are confidential. Some school-based health centers, at the time of enrollment, allow parents to opt-out of particular services offered through the health center.• School-based health centers are integrated into the school environment and staffed with multi-disciplinary teams of state-licensed medical professionals, mental health professionals, and dental professionals. Each school-based health center must have a medical director (i.e., state-licensed medical doctor) available for consultation who is located either on-site at the center or within contact if not on-site. Centers must offer 24-hour referral to care.• Health care services provided through school-based health centers are in addition to the services provided by school nurses and other staff. Coordination of students’ health care typically occurs

among school-based health center staff, school nurses, counselors, teachers, and administrators, along with other community service providers. School nurses, working in conjunction with SBHCs, refer students to school-based health centers for care when necessary.

- A sponsoring agency (e.g., nonprofit agency, community health center, local health department, school district, or hospital) is responsible for overseeing the operations of a school-based health center. School-based health centers – through their sponsoring agencies – must be licensed by the Department of Public Health either as an outpatient clinic or hospital satellite.
- A state grant program administered by DPH supports 71 school-based health centers established in elementary, middle, and high schools throughout Connecticut, many of which (57) primarily serve adolescents (see Appendix F for a list of their locations). An estimated 37 other entities licensed either as outpatient clinics or hospital satellites provide school-based care but are not state-funded SBHCs.
- The state also provides funds for expanded student health services at 10 schools in 3 communities. Additional, targeted services (e.g., mental health counseling) are offered at those sites but not the full range of primary care (physical, behavioral, and in some cases dental health services) available through comprehensive school-based health centers.
- In FY 2008-09 (the most current year automated enrollment and encounter information is available from DPH), 33,413 adolescents (ages 10 to 19) were enrolled in school-based health centers; of those, 15,672 (47%) received services through a SBHC at least once during the year, resulting in 77,675 visits.
- State grant allocations for school-based health centers totaled \$10.3 million in FY 2011; funding for the 57 centers identified as primarily serving adolescents totaled \$8.3 million. An additional \$288,100 in federal funding through the Maternal and Child Care block grant was distributed to four sponsoring agencies. School-based health centers also receive funding and in-kind contributions from other sources, including foundations, local school districts, sponsoring agencies, and through public and private insurance reimbursements.

SBHC (State-Funded) Program Performance Summary

Symbols Used to Denote Progress (on Measures of How Well and Better Off):

+ Positive trend - Negative trend ↔ Little/no change or mixed ? Cannot be determined

I. How *Much* Did We Do?

Centers Available

- In FY11, the state funded 71 SBHCs in Connecticut, 57 of which served adolescent students (youth ages 10 to 19).
- In total, 17 sponsoring agencies oversee the operations of state-funded school-based health centers in 20 towns throughout the state; 16 sponsoring agencies in 18 towns primarily serve adolescents.

Clients Served (Enrollment and Use)

- Between FYs 2006-09, on average, 33,000 adolescents were enrolled in SBHCs over the four-year period.
- 43,100 students of all ages were enrolled in school-based health centers statewide in FY 2009; 33,400 (78%) were adolescents ages 10 to 19.

- For FYs 2006-09, 7.5% of all public school students in Connecticut were enrolled in a school-based health center; 5.8% were among those ages 10 to 19.
- An average of 16,700 adolescents visited a school-based health center for service at least once in each of the four years, 50% of all adolescents enrolled in a SBHC. The annual average number of SBHC visits for adolescents was 4.8.
- Of the total 132,355 adolescents enrolled in school-based health centers during FYs 2006-09:
 - 58% were 14-17 years old, with 17-year olds making up the largest percentage of enrollees (16%)
 - 52% were female, and 48% male
 - White (37%); Black (30%); Hispanic (13%); Asian (4%); other (4%); unknown (13%)
 - 60% were in grades 9-12 (traditional high school), and just over 30% were in grades 6-8 (traditional middle school)
- Of the adolescents who received services during FYs 06-09:
 - 57% were 14-17 years old; 16-year olds made up the largest percentage of all adolescents using school-based health center services (15%)
 - 56% were female, and 44% male
 - White (34%); Black (32%); Hispanic (13%); Asian (3%); other (5%); unknown (13%)
 - 57% were in grades 9-12, and 33% were in grades 6-8

Funding

- FY 2011 state grant funding for the 57 SBHCs primarily serving adolescents totaled \$8.3 million; \$10.3 million was available for all centers.

II. How Well Did We Do It?

KEY MEASURES	PROGRESS	CURRENT DATA
Serve intended population (students most in need of primary and preventive care, i.e., uninsured, underinsured/underserved)	+	<ul style="list-style-type: none"> • The state's poorest socioeconomic communities identified as having the greatest need for primary care, mental health care, and dental care services have at least one school-based health center in their school districts to serve adolescents, but not every school within each district has a center. • Approximately two-thirds of adolescents using SBHCs either were uninsured or insured through Medicaid, which remained consistent over a four-year period analyzed.
High enrollment and utilization	↔	<ul style="list-style-type: none"> • An average of 52% (33,100 students) of all eligible adolescents enrolled in their school-based health centers between FYs 06-09. • The trend in the overall enrollment rate remained relatively constant, ranging between 51-53%; there was a 2.8% enrollment increase over the period. • The rate of adolescents using SBHC services to enrolled adolescents ranged between 47-54%. SBHC utilization by adolescents averaged close to 16,700 per year for FYs 06-09. The number of service users remained relatively steady, between 15,700-17,500. • PRI staff survey results on how SBHCs view their capacity levels are mixed: 34% over capacity; 43% at capacity; 11% near capacity; and roughly 13% under capacity.
Meet overall primary health care needs	+	<ul style="list-style-type: none"> • SBHCs offer free care to students. The number of state-funded school-based health centers primarily serving adolescents increased to 57 since the 1980s, when centers

		<p>were first funded in Connecticut.</p> <ul style="list-style-type: none"> • Adolescent visits to SBHCs for preventive health reasons increased between FYs 2006-09: immunizations (+56%) and exams/follow-up (+9%). The most frequent visits were for mental health reasons (32%), followed by treating/managing chronic conditions (26%). • PRI staff survey results show 46% of SBHCs believe they are “very effective” in meeting adolescents’ overall health needs and 54% are “effective.” The service areas reported in need of most improvement are substance abuse, reproductive health, and dental care. • Centers coordinate referral service with community providers. • Results of a student satisfaction survey conducted by the Connecticut Association of School-Based Health Centers (2009) show 96% of the 992 respondents (ages 11-19) rated the care they received at their SBHC either as “excellent” (78%) or “good” (18%), indicating care met students’ needs. An additional 92% said coming to the center was helpful, and 78% said the center improved their overall health. • On average, during FY 11, school-based health centers remained open almost 2½ hours longer per week than normal school operating hours, providing students more access to centers; full summer hours are lacking across most centers.
<p>Individual center performance satisfactory</p>	<p>↔</p>	<ul style="list-style-type: none"> • Most centers are not staffed with both a medical and mental health professional for all their open hours. For FY 11, medical professionals (e.g., APRN or PA) were on-site an average of 33 hours per week, when centers were open 35.8 hours; mental health professionals (e.g., LCSW) were available an average of 32.7 hours; and dental professionals (e.g., dentist/dental hygienist) an average of 17.1 hours at limited sites. • 55% of individual centers met or exceeded the average hours/week for medical professional staffing and 55% met or exceeded mental health professional staffing (although not necessarily the same centers.) • 26 of the 58 centers analyzed for FY 09 were above the average enrollment rate; 35 centers had utilization rates above the average. • Based on state grant allocations, the average state cost per adolescent user of SBHC services for FY09 was \$109; 43% of school-based health centers had a per-visit cost below the average.
<p>State-level program management efficient and effective</p>	<p>↔</p>	<ul style="list-style-type: none"> • There have been three program supervisors in last several years. • Improvements are necessary to refocus the SBHC program to better determine outcomes based on specific program measures. The department is making improvements, including working in collaboration with key stakeholders, to increase the overall efficiency and effectiveness of school-based health centers.

		<ul style="list-style-type: none"> • Additional work is also needed to develop a standardized protocol for distributing state grant funding to school-based health centers.
Proper Oversight and Quality Assurance	-	<ul style="list-style-type: none"> • Determination of individual center performance based on current, accurate data and targeted measures is lacking; information about nonstate-funded school-based health centers is not formally tracked. • The current management information system no longer supports the program and must be replaced; enrollment and encounter data used for program management purposes lags by two years, heightening issues with oversight, quality assurance, and proper data-driven program management. • Efforts are underway within DPH for designing a replacement automated data collection system. • SBHCs submit numerous reports throughout the year containing vast amounts of information and program data; analysis of the information for program oversight does not occur in a targeted manner focused on program results. • There is no overarching summary unifying performance measures, program data, and outcomes, making overall program effectiveness difficult to determine. • No standardized process using formal criteria exists at the state level to determine where to locate SBHCs or at what level to fund centers; little information exists about nonfunded entities providing school-based health for use in broader adolescent health planning. • Contract monitoring site visits occur, but not on a standardized basis. Additional work is necessary to connect site visits with performance outcomes. Coordination exists between the DPH contract monitoring and licensing functions. •

III. Is Anyone Better Off?

KEY MEASURES	PROGRESS	CURRENT DATA
Improved health outcomes for students served	+?	<ul style="list-style-type: none"> • The mere ability to receive free physical and mental health care on site at schools, where students spend a large portion of their time, increases students' access to care – especially in communities having the greatest need for accessible, affordable, quality health care – and improves adolescents' chances of receiving care they need for improved health. • Results from a CT Association of School-Based Health Centers satisfaction survey (2009) of over 1,000 students who used SBHC services in Connecticut show 78% said using the center improved their overall health, 34% said they would not know where to go for care or their condition would have gotten worse without the SBHC, and 18% said they would have gone home from school or stayed home if care was not available in school. • National research indicates students who used SBHCs are more satisfied with their health and engaged in a greater

		number of health-promoting behaviors than students who do not use SBHCs.
Increased academic achievement	+?	<ul style="list-style-type: none"> • SBHCs' performance of returning adolescents to class is positive -- a four-year average of 92% of adolescents receiving services from a school-based health center returned to class the same day, although no clear annual trend emerged for the period analyzed. • National research shows improved academic performance on the part of students who use SBHCs compared with students who do not, yet additional work is needed in Connecticut to fully understand the impact of state-funded SBHCs on students' overall academic performance.
Cost effectiveness	+?	<ul style="list-style-type: none"> • National literature says use of school-based health centers can save an estimated \$970 per person in avoided hospitalization/ED use, and up to \$35 per child in Medicaid costs. • It is unclear how many adolescents in Connecticut avoided emergency room visits because they used SBHC services; determining the extent to which SBHCs reduce overall health care costs in the state needs further analysis. • Potential cost-saving benefits of SBHC care include: parents not having to miss work to care for a child; fewer transportation issues/ costs associated with finding care outside of SBHC; ability for more consistent and easier follow-up service; and more coordinated case management and referral services.

Story Behind the Data and Actions to Turn the Curve

The school-based health center model is a strategy for increasing access to free primary health care for school-aged children.²⁶ School-based health centers operate as medical clinics (or pediatricians' offices) located within or on the grounds of a school. SBHCs offering comprehensive services are staffed with licensed physical and mental health professionals and, at times, dental professionals.

According to the National Assembly on School-Based Health Care, the following seven principles provide guidelines to: 1) define the essential elements of a school-based health center; 2) benchmark SBHC programs; and 3) provide a framework for accountability and continuous improvement of school-based health centers.²⁷ The principles also help form a national standard

²⁶The draft Connecticut Department of Public Health Office of Health Care Access Statewide Healthcare Facilities and Services Plan defines primary care as: *...that care provided by licensed independent practitioners specifically trained for and skilled in comprehensive first contact and continuing care to address personal health care needs including but not limited to prevention, care of chronic illness, routine care and not limited by problem origin (biological, behavioral, or social), organ system or diagnosis.* (As of 2-3-12)

²⁷ National Assembly on School-Based Health Care:
<http://www.nasbhc.org/site/c.ckL0KbOVlK6E/b.7697107/apps/s/content.asp?ct=10860609>

of care provided by school-based health centers. Specifically, a school-based health center should:

- *Support the School:* The SBHC is built upon mutual respect and collaboration between the school and the health provider to promote the health and educational success of school-aged children.
- *Respond to the Community:* The SBHC is developed and operated based on continual assessment of local assets and needs.
- *Focus on the Student:* Services involve students as responsible participants in their health care, encourage the role of parents and other family members, and are accessible, confidential, culturally sensitive, and developmentally appropriate.
- *Deliver Comprehensive Care:* An interdisciplinary team provides access to high quality, comprehensive, physical and mental health services emphasizing prevention and early intervention.
- *Advance Health Promotion Activities:* The SBHC takes advantage of its location to advance effective health promotion activities to students and the community.
- *Implement Effective Systems:* Administrative and clinical systems are designed to support effective delivery of services incorporating accountability mechanisms and performance improvement practices.
- *Provide Leadership in Adolescent and Child Health:* The SBHC model provides unique opportunities to increase expertise in adolescent and child health, and to inform and influence policy and practice.

School-based health centers were implemented in Connecticut in the early 1980s with the overriding purpose of offering a range of health care services where students spend a large amount of their time: school. The SBHC model is further designed to: 1) improve access to affordable, accessible quality primary and preventive health care; 2) ensure primary and preventive health services to children of various ages are developmentally appropriate; and 3) improve academic performance by treating students' physical and mental health needs on-site, allowing them to stay in school.

The types of primary and preventive health care offered at comprehensive school-based health centers include:

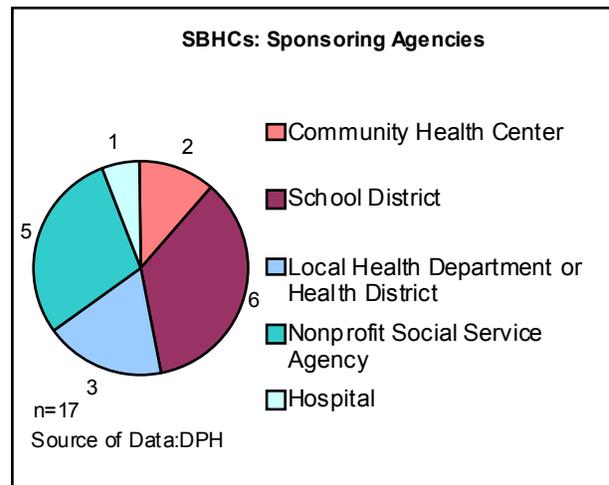
- physical examinations, follow-up exams, and immunizations;
- diagnosis and treatment of acute medical conditions;
- management of chronic conditions;
- referrals to and follow-up for specialty care;

- basic laboratory tests;
- vision and hearing screening; and
- nutrition services.

Specific mental health care services available include: outreach to identify students with potential mental health concerns; screening for mental health needs; offering students mental health assessments, crisis intervention, counseling, treatment, and referral; and case management, including coordinating services with local mental health providers. If offered, oral health services may include school-wide and individual oral health education; screening for oral health needs; providing fluoride, sealant, and cavity care; making referrals to community oral health providers or bringing dental providers to the school-based health center to provide oral health services; or establishing dental facilities, including mobile and portable operations, at the school-based health center.

Primary care professionals staff SBHCs, and typically include a nurse practitioner or physician assistant, and a mental health clinician. Health center staff must be overseen by a medical doctor; any overseeing physician who is not on-site must have direct contact with the medical professional at the center, and 24-hour backup care must be available to enrollees. Additional center staff may include social work professionals, dental professionals, and support/administrative staff.

School-based health centers in Connecticut must be affiliated with a sponsoring agency, generally a community health center, hospital, local health department, or local board of education. The sponsoring agency is the entity licensed by the Department of Public Health either as an outpatient clinic or hospital satellite to operate a school-based health center. The sponsoring agency must also develop an advisory board for general oversight of the program.



As the figure shows, almost two-thirds of the sponsoring agencies for all SBHCS in Connecticut were either non-profit agencies or school districts, while community health centers and local health departments account for almost 30 percent. Sponsoring agencies may subcontract with other entities (e.g., community health centers, hospitals, nonprofit agencies) to actually operate one or more of the school-based health centers under their control, which several do.

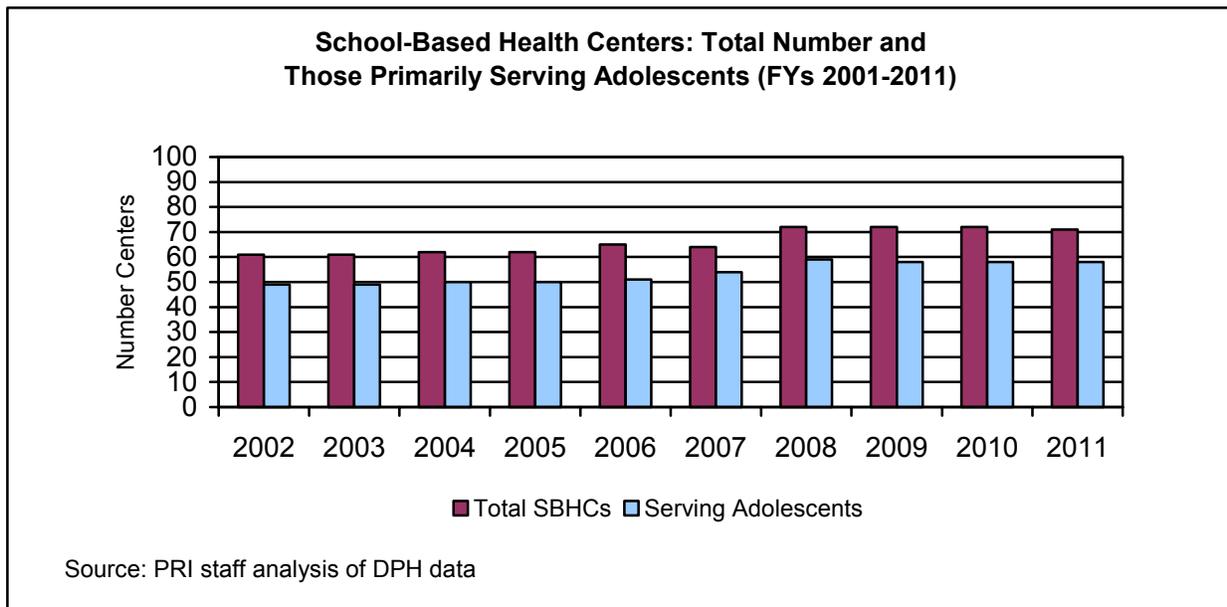
RBA Question I: How Much Did We Do?

- State-funded SBHCs offered access to free primary and preventive physical and mental health services, and dental services at some sites, through 71 schools in FY 11.
- FY 11 grant allocations for SBHCs totaled \$10.3 million; grants of \$8.3 million were provided to 57 centers identified as primarily serving adolescents. An additional 10 schools received state funding to

provide additional, targeted services, such as mental health counseling. An estimated 37 nonfunded centers were also licensed in the state to provide school-based health care.

- Annual adolescent enrollment in SBHCs between FYs 06-09 averaged almost 33,100 students, or 52% of the total student population in the schools where school-based health centers were located.
- On average, just under 16,700 adolescents visited school-based health centers for a total of 80,145 visits over the four-year period.

Measure 1: Number of School-Based Health Centers

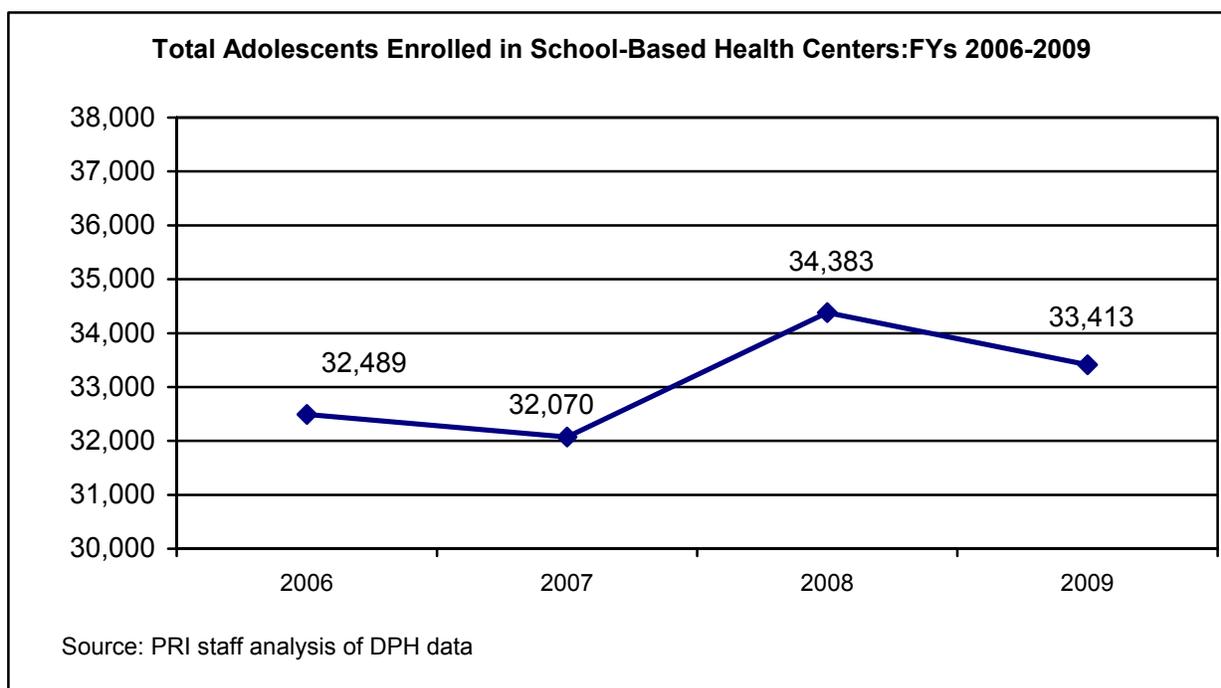


- In FY 11, 71 state-funded school-based health centers operated throughout the state to provide primary and preventive physical and mental health care to students. Of those centers, 57 were in schools where the majority of students were adolescents, as identified by the committee.²⁸
- The growth in the number of school-based health centers for the ten-year period of FYs 2002-11 was 16 percent – 61 to 71 centers. Centers identified as primarily serving adolescents increased 16 percent during that time – from 49 to 57 centers. Additional funding was provided by the legislature in 2008 to expand services provided by the existing centers, and was awarded to several centers based on a competitive application process. The yearly number of SBHCs otherwise fluctuates due to openings and closings.

²⁸ Note: primary schools with SBHCs in Bridgeport and New Haven are mixed elementary and middle schools, and typically serve students in grades K-8. Those schools were included in committee staff’s analysis of schools primarily serving adolescents because excluding them would result in a large portion of adolescents in grades 6-8 in those major cities not being counted.

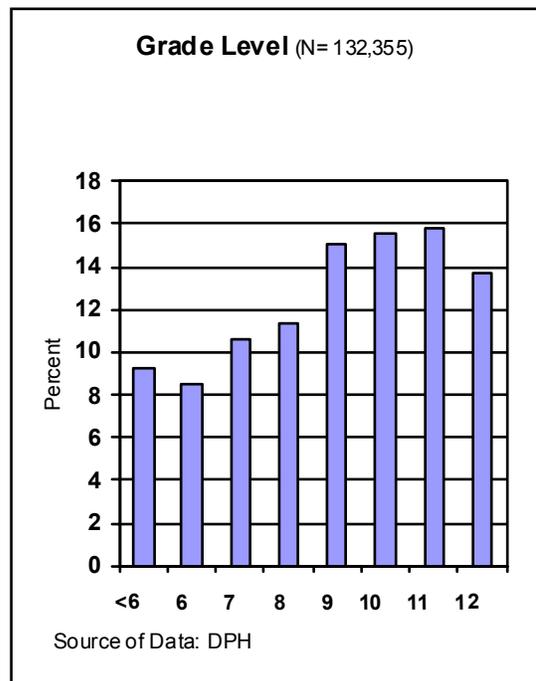
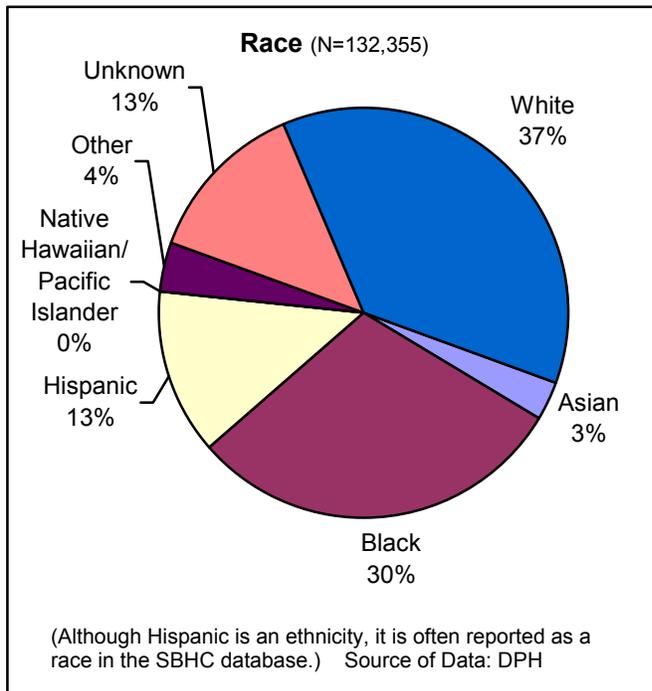
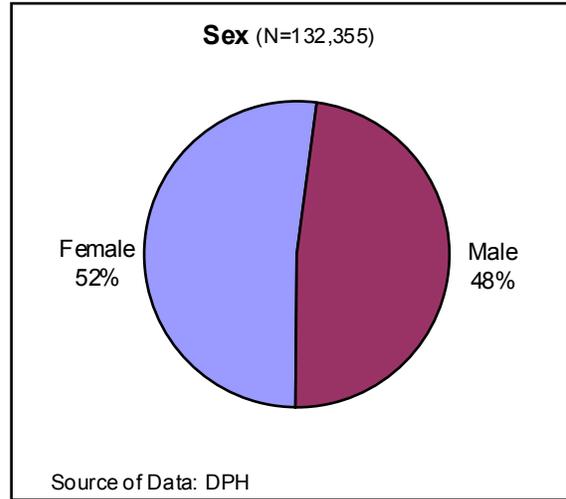
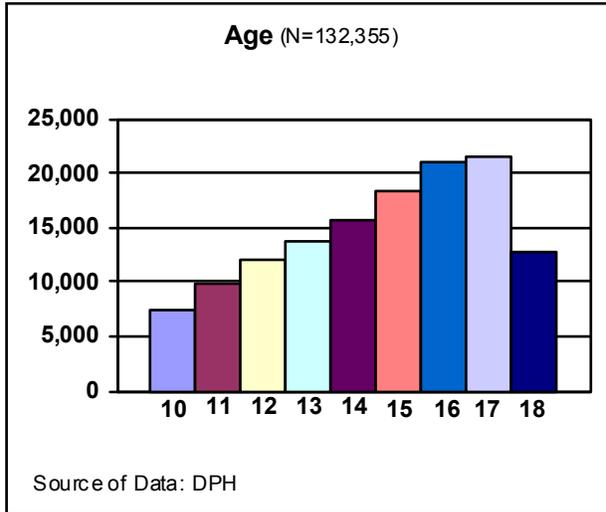
- Ten schools in three districts received just over \$256,000 in FY11 to ‘expand’ existing school health services to students. The sites do not provide the comprehensive array of primary physical and mental services that the centers provide, but they offer individual services, such as mental health counseling or physical health. (Information about ‘expanded’ sites is *not* included in committee staff’s analysis to the extent feasible).

Measure 2: Adolescent Student Enrollment



- The total number of adolescents enrolled in school-based health centers ranged from 32,070 to 34,383 during the four-year period of FYs 2006-09. Adolescents generally accounted for just over three-fourths of SBHC enrollment for all students.
- An annual average of just under 33,100 adolescents enrolled in state-funded school-based health centers over the four-year period. (Additional analysis comparing ratios of adolescents enrolled in school-based health centers with overall student population is provided later in this chapter.)
- There was no consistent up or down trend in enrollment over the four-year period analyzed.
- Over the four-year period, the number of adolescents enrolled in SBHCs increased 2.8%, with the largest increase occurring between FY07 and FY08 (7.2%). The exact reasons for the fluctuations in enrollment are unknown, although there was a relatively substantial increase in state funding in FY08.

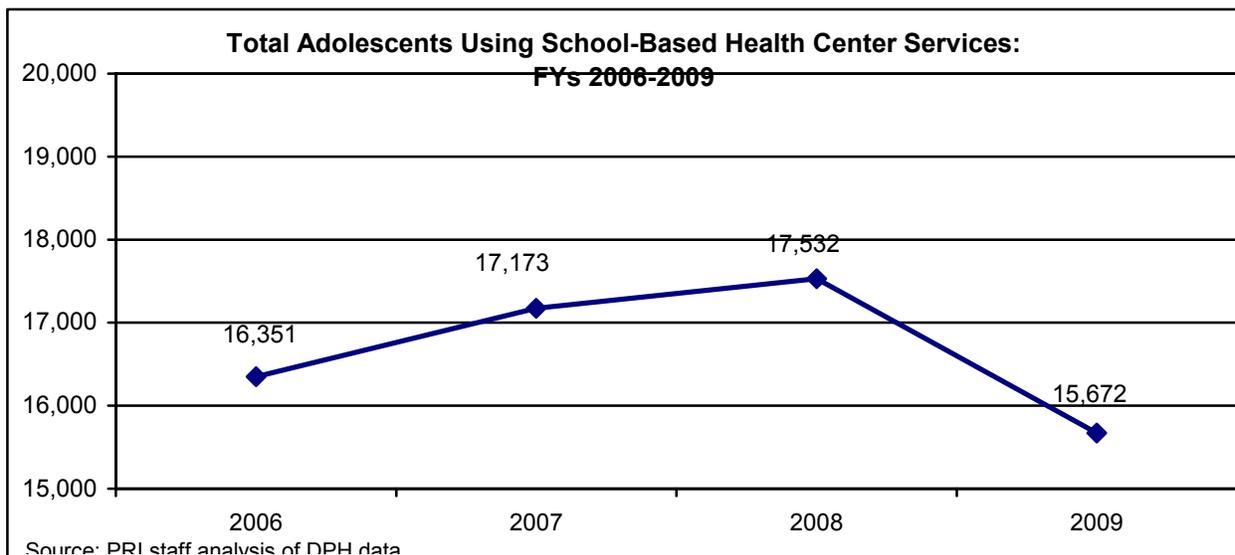
Measure 3: Demographics of Enrolled Adolescents (FYs 2006-09)



- 58% of enrollees were 14-17 years old, with 17-year olds making up the largest percentage (16%). One interesting factor in the age distribution of enrolled adolescents is the drop-off for 18-year olds. This could be a result of the way age is calculated within the DPH data. The cut-off date to determine a student’s age is January 1 of the fiscal year. As a result, those adolescents turning 18 after that date, or students graduating at age 17, is not included in the overall number for that specific fiscal year which would account for roughly half of the year.

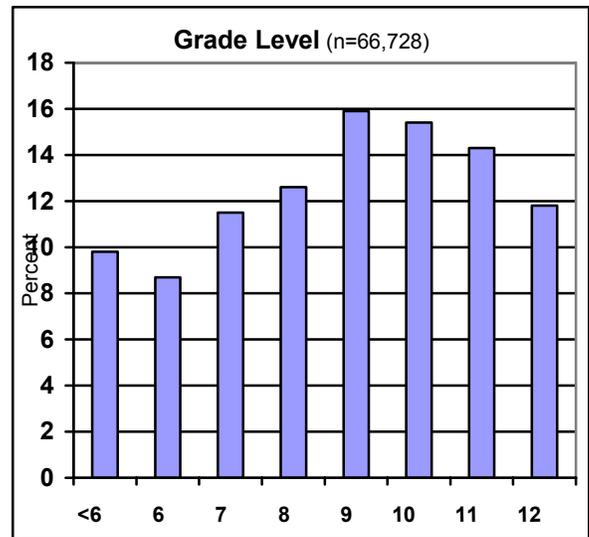
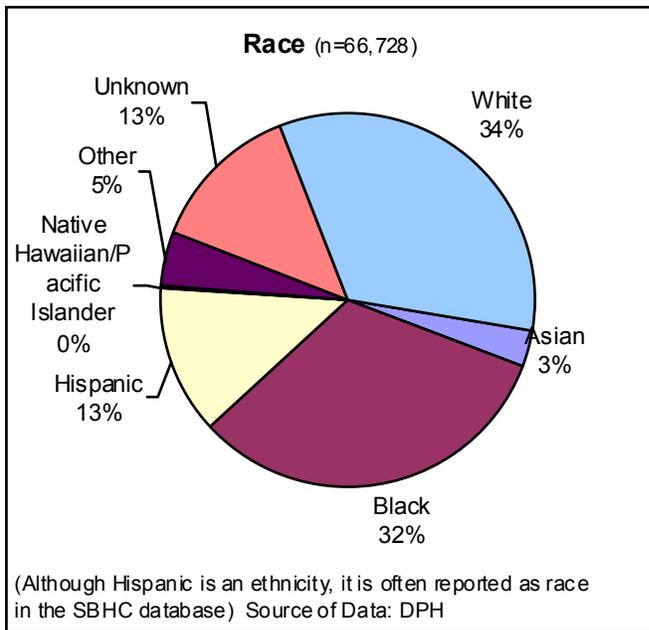
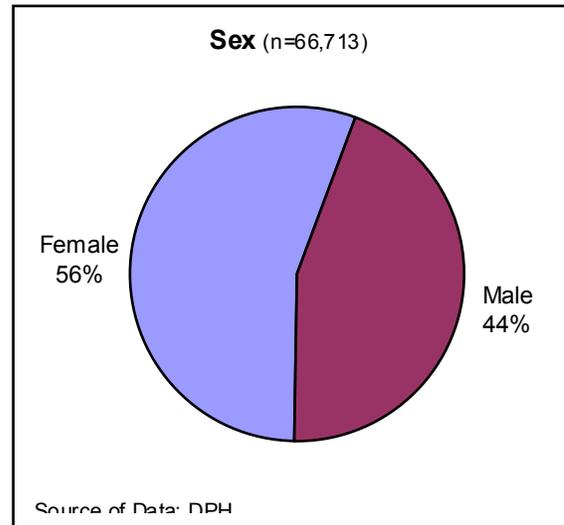
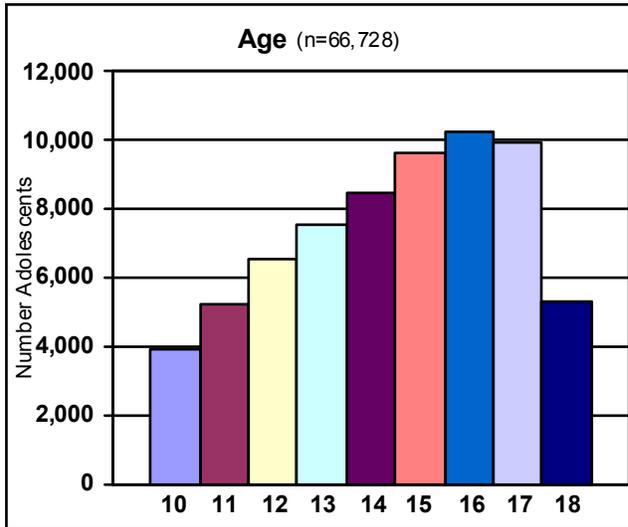
- Females accounted for 52% of adolescent enrollees, and males 48%.
- White (36%); Black (30%); Hispanic (13%); Asian (13%); other (4%); unknown (4%).
- The vast majority of adolescents (60%) enrolled in SBHCs were in grades 9-12; 30% were in grades 6-8. Just over 9% were in grades below 6th grade, which includes ten-year olds in grades 4 and 5. (Roughly 900 students included in the DPH database have a grade level below grade 4, or the information is missing altogether.)

Measure 4: Adolescent Service Users



- The number of adolescents annually receiving services from a school-based health center averaged 16,682, and ranged from 15,672 to 17,532.
- After a steady increase through FYs 2006-08, the number of adolescents receiving services declined 10.6% in FY 2009 to 15,672. The reason(s) for the decrease is unclear, although the decline corresponds with a roughly three percent drop in the total number of adolescents enrolled in FY09 from the previous year. As mentioned, the decrease also may be attributed to the way age is calculated in the DPH database as 18 year-olds only being counted for half of FY09 since the date age was determined was January 1 of the fiscal year.

Measure 5: Demographics of Adolescent SBHC Users (FYs 2006-09)

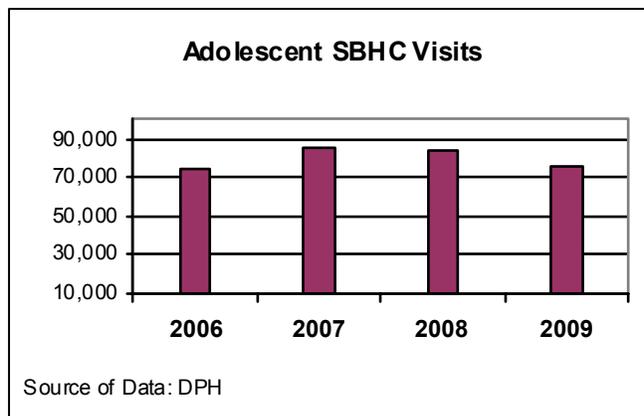


- 57% of adolescents using SBHC services were 14-17 years old, with 16-year olds making up the largest percentage (15%) of all adolescents. The age distribution of adolescents using school-based health center services is almost identical to that of adolescents enrolled in SBHCs.
- 56% were female and 44% were male.
- Adolescents using school-based health center services were: White (34%); Black (32%); Hispanic (13%); other (5%); or unknown (13%).

- Over half (57%) of adolescents using SBHCs were in grades 9-12; 33% were in grades 6-8. Roughly 10% were in grades below grade 6.

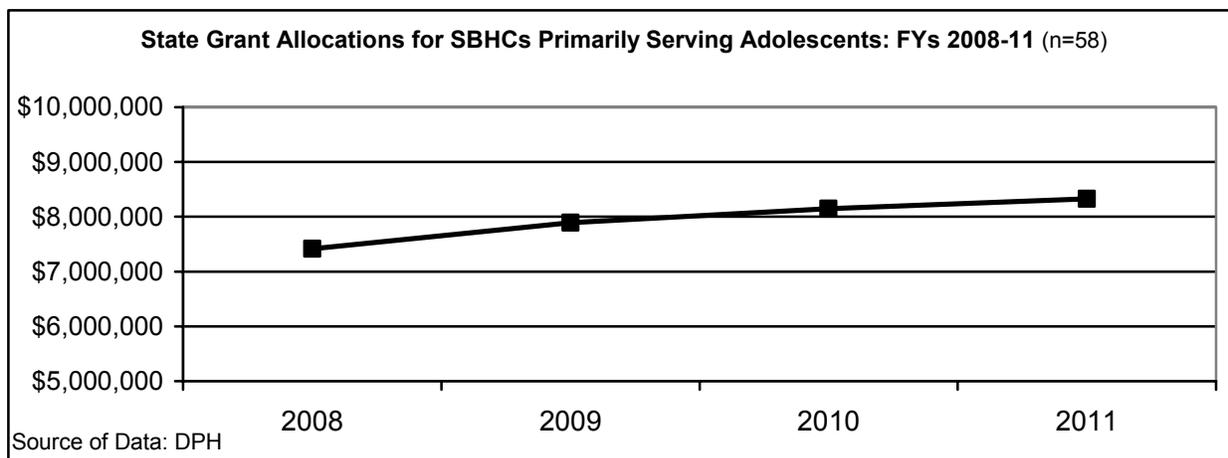
Measure 6: Total Service User Visits

- The number of adolescents visiting a school-based health center at least once in a year during FYs 06-09 increased 3.4%, from 75,090 to 77,675. Between FYs 06-08, there was a 12.3% increase. Reasons for the trends are unclear. (Note: visit information does not include “collateral contacts,” such as phone calls to parents or other health providers to obtain information, because DPH does not classify such contacts as actual clinic visits.)



- The average number of SBHC visits by unique adolescent service user over the four year period was 4.8 visits.

Measure 7: State SBHC Funding

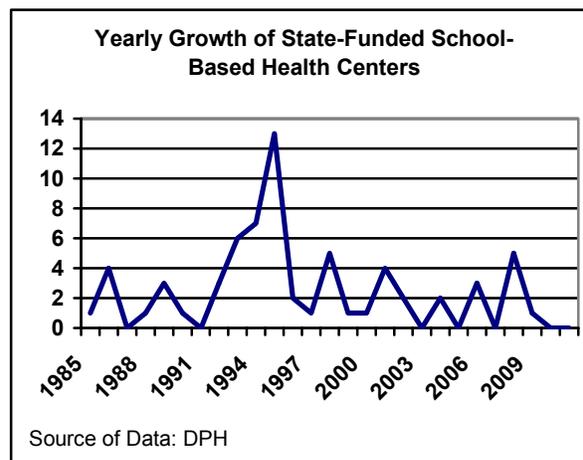
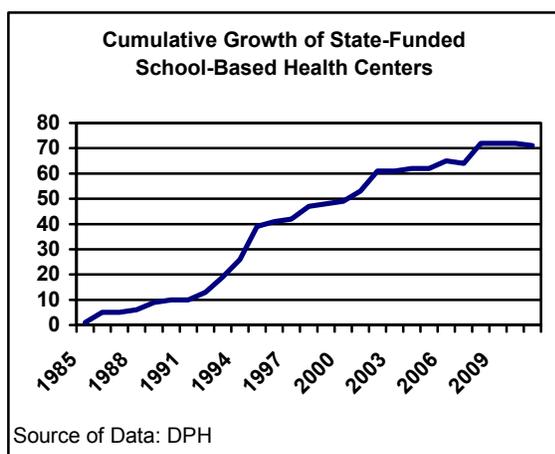


- State grant funding for SBHCs is distributed through contracts between DPH and each school-based health center’s sponsoring agency. PRI was able to isolate state grant allocations for the SBHCs primarily serving adolescents for FYs 2008-11. Annual funding amounts averaged just under \$8 million, or approximately \$137,000 per center.²⁹

²⁹ Not included in the funding analysis is funding received by SBHCs from other sources, including: federal Maternal and Child Health Block Grant funding totaling \$288,000 available to Bridgeport, Hartford, New London, and New Haven; insurance claims; private sources; or in-kind services. As best determined through PRI staff survey responses, the average amount of funding from other sources across per center was an estimated \$38,500 in FY11.

- There was an upward trend in state grant funding for centers over the four-year period analyzed. Overall, funding was up 12.2% during FYs 2008-11. Annually, funding increased 10.6% between FYs 2008-09, decreased by .8% in FY10, and increased 2.2% in FY11.
- In FY08, the legislature appropriated an additional \$2.5 million to expand state-funded school-based health centers. Within the appropriation, \$1.03 million was earmarked for creation and/or expansion of specific school-based health centers, and the remaining \$1.47 million was distributed through a competitive application process to help augment services at existing state-funded sites.

Connecticut began funding school-based health centers in the mid-1980s. Since that time, 71 centers have been established in schools throughout the state. The figures below show the overall increase in state-funded school-based health centers in Connecticut since their inception: the first figure shows the cumulative number of centers, while second figure shows the number of new centers by year. A map showing all current state-funded SBHC locations throughout the state is provided in Appendix I.



Narrowing the number of school-based health centers to just those serving adolescents is challenging given the age range for adolescents used in this study (10 to 19) and the grade configurations of various schools. Essentially, any school-based health center in an elementary school could serve students who were younger adolescents in terms of age, although those adolescents would not account for the majority of students in the elementary school. In addition to traditional elementary schools, several large districts in the state combine elementary and middle schools serving students in grades K-8. This type of school encompasses a lot of adolescents in grades 6-8, but also includes adolescents and non-adolescents in the lower grades. Neither school configuration – an elementary school or a mixed elementary and middle school – lends itself particularly well to isolating adolescents ten to nineteen for analysis purposes, as do middle and high schools with traditional grade levels.

The “how much” information presented above is for all adolescents ages 10 to 19, regardless of the type of school they attended. The data were obtained from the Department of Public Health’s automated database, called Clinical Fusion, for FYs 2006-09 and derived from

the student age variable within the database (that calculates age as of January 1.)³⁰ This means students may still be in elementary schools, but were included in the analysis because they fell within the specific age range for adolescent. The FY 09 data is the most current automated data released by the department. DPH continues to check the automated data submitted by school-based health centers for FYs 10-11 to ensure the overall quality of the information. Additional analysis of the department's automated management information system is provided later in this chapter.

Analysis of individual center performance outcomes is also challenging because of school configuration and the age range of adolescent used in this study. As such, PRI narrowed its analysis of individual center performance to FY 09 and identified a total of 58 school-based health centers as primarily serving adolescents. This includes middle schools (and in some cases, mixed elementary and middle schools), mixed middle and high schools, and high schools.

Where trend information is presented, PRI accounted for changes in the overall number of school-based health centers serving adolescents in a given year. The annual number of centers funded may fluctuate for various reasons, including the addition of a newly funded center(s) or centers opening or closing because of schools being reconstituted to include different grade levels than the previous year, school mergers, or school closings. A summary of school-based health centers and their yearly funding levels was provided by DPH for FYs 2008-11; information about centers from previous years was derived from various DPH documents.

In addition to the total state-funded school-based health centers, ten schools in Madison, Meriden, and Region 11 (Chaplin) received state funding in FY11 to expand existing school health services to students. The sites offer targeted services, such as mental health counseling, health education, or oral health care. A state license is not required for these sites, since they do not provide the full range of physical and mental health services as comprehensive school-based health centers and thus are not considered outpatient clinics or hospital satellite programs. As best as possible, those centers were not included in the analysis, nor were the other estimated 37 school-based health centers licensed by DPH as outpatient clinics or hospital satellites but not receiving state funding.³¹

The definition of what constitutes a school-based health center has been a topic of discussion among stakeholders in Connecticut for several years. The key issue is whether certain standards should be in place to differentiate school-based health centers in such areas as operations (e.g., types of staff, staffing levels, and hours open) and types of service provided to students. Specific standards would distinguish among state-funded centers with comprehensive staffing and service levels (e.g., physical and mental health, and possibly dental services), state-funded centers providing targeted services (i.e., expanded sites), and state-licensed entities providing health services in schools without state funding.

³⁰ The University of Connecticut's Institute for Public Health Research assisted committee staff with data management and analysis of over 132,000 enrollment records and 300,000 encounter records from the DPH Clinical Fusion database for FYs 2006-09. DPH also provided assistance.

³¹ PRI staff identified non-state funded health clinics operating in schools from licensing information provided to committee staff by the DPH licensing unit. The department does not specifically track information about nonstate-funded school-based health centers. As such, licensed facilities with the term 'school-based health center' in their title not receiving state funding, were counted as non-funded centers by committee staff.

In 2006, the legislature created the Ad Hoc Committee to Improve Health Care Access to examine and evaluate statutory and regulatory changes to improve health care through access to school-based health centers, particularly students who are uninsured, underinsured, or have Medicaid as their health insurer.³² The committee discussed the services and staffing levels necessary for a SBHC to be considered a “Level V” center (i.e., the highest standard for staffing and services).³³ Following the expiration of the Ad Hoc Committee, a subsequent ad hoc stakeholder group has been meeting.³⁴ A large part of the group’s discussions has been whether Connecticut should adopt a formal definition of school-based health center and the details of such definition, although no formal definition has been developed.

The Children’s Health Insurance Program within the federal Social Security Act defines “school-based health center” (see Appendix J for the definition).³⁵ The National Assembly on School-Based Health Care has also developed its own position on a national definition of school-based health center.³⁶

Creating a state definition of a school-based health center, particularly in statute, has licensing ramifications. Currently, school-based health centers are licensed by the state either as outpatient clinics or hospital satellites. Requiring school-based health centers to follow specific requirements, such as staffing levels, would most likely mean making adjustments to the Public Health Code (a more detailed discussion of licensing is provided later in this chapter). At the same time, however, more clarification as to what a SBHC actually is would exist if state law contained a formal definition.

Actions to Turn the Curve

The committee believes there needs to be a more uniform definition as to what constitutes a school-based health center in Connecticut, and more specific standards need to be in place when primary and preventive health care is provided in schools by licensed entities beyond the services provided by school nurses. Therefore, the committee recommends: **the federal definition of school-based health center contained within the Social Security Act should be codified in Connecticut. Included in this definition should be the definition of primary care as defined by the Connecticut Office of Health Care Access in its Statewide Healthcare Facilities and Services Plan.**

PRI further recommends the Committee on School-Based Health Clinics established under C.G.S. Sec. 19a-6i should continue its work on crafting a more formal definition of school-based health center to include standards around overall comprehensiveness of

³² P.A. 06-195

³³ “Level V” is a term used within the Ad Hoc Committee to Improve Health Care Access 2006 report to describe a standard by which school-based health centers are considered comprehensive, including specific type and levels of staffing, services provided, and operational requirements. The standard is not used by DPH for funding or licensure purposes.

³⁴ C.G.S. Sec. 19a-6i

³⁵ Social Security Act, Title XXI, State Children’s Health Insurance Program (42 U.S.C. 1397jj(c)(9), Sec. 2110(c)(9)(A)). See: http://www.ssa.gov/OP_Home/ssact/title21/2110.htm#act-2110-c-9

³⁶ See: http://ww2.nasbhc.org/RoadMap/PUBLIC/Advocacy_SBHCdefinition.pdf

operations (e.g., staffing types and levels, hours of availability) and the types and level of services provided by such centers.

The recommendations create a basic statutory framework for school-based health centers in Connecticut. The level of detail specific to the school-based health center model is a matter best left to DPH, the relevant stakeholders on the current ad hoc group on school-based health centers, and ultimately the legislature. PRI believes the current ad-hoc school-based health center group should continue discussing whether changes to the current school-based health center construct are necessary beyond the federal definition. Moreover, there may be more than one model of school-based health center the group needs to define (e.g., state-funded, nonfunded, expanded). Regardless of what the ad hoc group decides about recommendations further defining the school-based health center model in Connecticut, a key result of the discussions should be greater ease in measuring the overall level of service provided by school-based health centers and their impact on students' overall health.

RBA Question II: How Well Did We Do It?

- State-funded school-based health centers are located in communities throughout the state identified as having the greatest need for accessible quality health care; centers in these communities serve adolescents, although not all schools within the districts have a school-based health center.
- Adolescents either with no health insurance or with Medicaid insurance (i.e., HUSKY) consistently made up the bulk of SBHC users, although the percent of adolescents served with private insurance rose each year between FYs 06-09.
- State funding for school-based health centers has increased since FY 08, but there needs to be a more formal process within the public health department to distribute grant funding based on specific performance measures and desired outcomes.
- The trend in the overall school-based health center enrollment rate remained relatively constant for FYs 06-09, averaging 52%; there was a 2.8% increase in enrollment over the four-year period.
- Utilization of school-based health center services by adolescents also remained relatively steady, between 15,700-17,500. The rate of adolescent service users among enrolled adolescents ranged from 47-54%.
- Adolescent visits to SBHCs for preventive health reasons increased between FYs 2006-09: immunizations (+56%) and exams/follow-up (+9%). The most frequent visits were for mental health reasons (32%), followed by treating/managing chronic conditions (26%).
- On average, SBHCs were open longer during the week than schools; differences in professional medical and mental health staffing coverage exist among centers.
- DPH reporting and data collection requirements of school-based health centers need to be streamlined; more targeted analysis of program performance based on standardized goals needs to occur; and the current automated management information system no longer supports the school-based health center program. DPH is aware of most problems and is actively taking steps for improvement.

AGGREGATE SCHOOL-BASED HEALTH CENTER PERFORMANCE

Measure 1: Serving Intended Population (see Appendix K for full analysis)

- State-funded school-based health centers are located in areas where students’ access to affordable and appropriate health care may be impeded for several reasons, including a lack of health providers or inadequate health insurance. SBHCs primarily serving adolescents are located in all but one of the top seven of the communities identified as having the greatest need for health care for adolescents based on various indicators. (Additional analysis of how well individual centers meet the overall need of adolescents is provided later in this chapter.)

- Areas identified as having a strong need for health care services may be served by other health care providers who provide access to care either in lieu of or in addition to, state-funded school-based health centers (e.g., community health centers, school-based health centers not receiving state funding, or private providers). An important question is whether adolescents will use those other types of care or if a school-based health center will be their primary source of health care because of its location.

Measure 2: Enrollment Rate

SBHC Adolescent Enrollment Rates: FYs 2006-09				
	FY 2006	FY 2007	FY 2008	FY 2009
Total Adolescents Enrolled in SBHCs	32,489	32,070	34,383	33,413
Total Students Eligible to Enroll	62,593	63,002	65,739	64,238
Percent Adolescents Enrolled Out of Students	51.9%	50.9%	52.3%	52.0%
<small>Note: Total Adolescents Enrolled includes <i>all</i> adolescents 10 to 19 enrolled in a state-funded school-based health center, regardless of school type. Total Eligible to Enroll includes total student populations of schools with a school-based health center, including those students not within the 10-19 age range (namely younger students.) The percent of students enrolled is most likely lower than if a precise annual comparison was made of only adolescent students enrolled with adolescent students eligible to enroll, rather than the aggregate information used in the table. Source: PRI staff analysis of DPH and SDE data.</small>				

- All students in schools with a state-funded school-based health center are eligible to enroll in the health center. In each of the four years analyzed, more than half of all adolescents annually enrolled in their school’s SBHC.

- On average, 52% (33,100) of adolescents were enrolled in state-funded school-based health centers.

- The percent of adolescents enrolled in SBHCs remained relatively consistent over the four-year period, ranging from a low of 51% in FY07 to a high of 52% in FY 09. At the same time, the overall enrollment rate for adolescents increased over the time span by 2.8%.

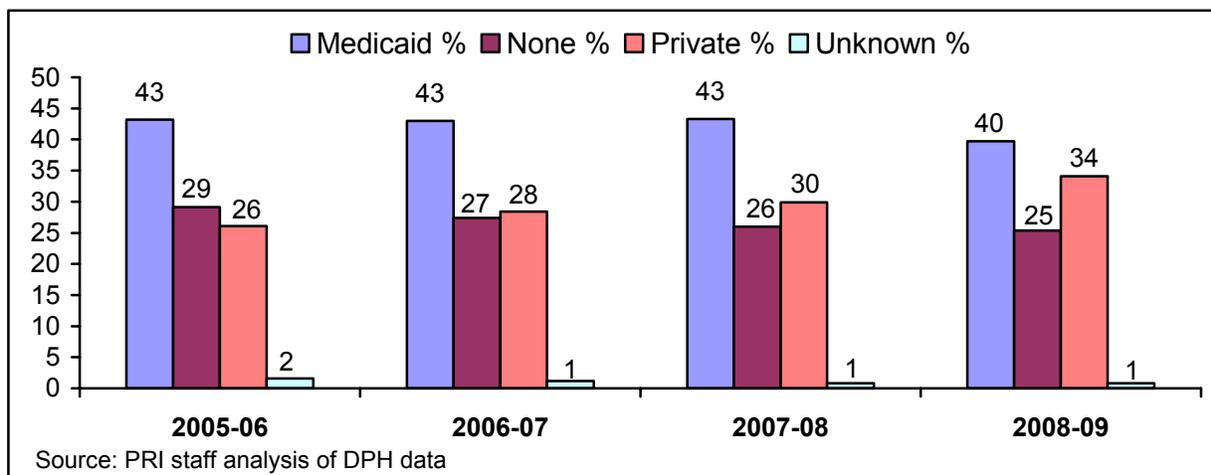
Measure 3: Utilization Rate

Adolescent SBHC Utilization Rates and % Difference from Previous Year: FYs 2006-09				
	FY 2006	FY 2007	FY 2008	FY 2009
Adolescents Enrolled	32,489	32,070 (-1.3%)	34,383 (+7.2%)	33,413 (-2.8%)
Adolescent Service Users	16,351	17,173 (+5.0%)	17,532 (+2.1%)	15,672 (-10.6%)
% of Adolescents Enrolled who Used SBHC Services	50.3%	53.5%	51.0%	46.9%

Source: PRI staff analysis of DPH data.

- The table provides information in several ways: 1) the number (and percent change from previous year) of adolescents enrolled in school-based health centers; 2) the number (and percent change) of adolescents using services; and 3) the number (and percent change) of enrolled adolescents who utilized a SBHC at least once during the year.
- On average, just over half (50.4%) of all students age 10-19 enrolled in state-funded school-based health centers used the centers’ services at least once in a given year. Although there was no clear trend in the percent of adolescents using services, there was a decrease in service users between FYs 2008-09. The reason(s) for the decline is not fully clear; however, one explanation could be that due to the way age is calculated in the DPH database, 18 year-olds were only counted for half of FY 09 since the date age was determined was January 1 of the fiscal year, which ends June 30.

Measure 4: Insurance Status



- Over the four-year period analyzed, on average, adolescents using school-based health center services had the following types of health insurance:

- Medicaid: 42.4%
 - Private insurance: 29.5%
 - No insurance coverage: 26.8%
 - Insurance coverage unknown: 1.3%
- The percent of adolescents with Medicaid insurance was steady for FYs 06-08 at 43% and then declined to 40% in FY09 (a 7% drop). The percent of students with private insurance increased each of the four years analyzed, from 26% to 34%, for an overall rise of 31%. Conversely, the percent of adolescents with no insurance dropped each year, from 29% to 25% (a 14% decline).

Measure 5: Reasons for Visits

Top Ten Reasons for Adolescent Visits: FYs 2006-09				
	FY 2006	FY 2007	FY 2008	FY 2009
Acute Conditions	25.3%	28.1%	25.5%	25.8%
Asthma	2.0%	2.0%	1.7%	2.4%
Exam/Follow-up	8.7%	7.6%	8.5%	9.5%
Health Education	2.9%	2.0%	2.1%	2.5%
Immunization	2.5%	2.9%	4.1%	3.9%
Injury	7.3%	6.6%	7.4%	6.7%
Mental Health	30.1%	32.1%	31.6%	34.3%
Oral Health	3.8%	4.5%	3.9%	3.3%
Reproductive Health	8.0%	7.0%	7.8%	5.2%
Screens	3.3%	2.6%	2.6%	3.2%

Note: Data for STD diagnoses are not included in the category of reproductive health, and are tracked separately. The remaining reasons for visits were categorized by DPH as: administrative, chronic/other, diabetes, deferred diagnosis, obesity, transportation/ advocacy.
Source: PRI staff analysis of DPH data.

- The public health department’s school-based health center database combines all service users initial diagnoses into 17 diagnosis categories. Data for FYs 06-09 were analyzed based on unique SBHC visits by adolescents. The top ten diagnoses categories were then identified by year, as shown above. (None of the four years analyzed includes any of the other remaining seven diagnosis categories not listed in the table.)
- Adolescents visit school-based health centers most often for mental health purposes. Mental health was consistently the top diagnosis category over the four-year period examined, with an average of 32% of all visits by adolescents to school-based health centers. In addition to mental health reasons, adolescents mainly visited SBCHs for: acute conditions (26%), exams/follow-up (9%), reproductive health (7%), injury (7%), and immunizations (7%).
- No diagnosis category showed a continual increase or decrease over the four-year period. There was a 14% overall increase in mental health diagnoses for the period, and a 56% increase in immunizations; overall, there was a 32% decrease in reproductive health diagnoses.

Measure 6: Staffing

School-Based Health Centers: Staffing Hours (FY 2011)	
	Mean Hours Per Week
School Hours Open (n=50)	33.5
SBHC Hours Open (n=55)	35.8
Primary/Preventive Care – Physical (n=49)	
Primary Care Providers (e.g., APRN, PA)	33.0
Primary/Preventive Care – Mental Health (n=47)	
Mental Health Providers (e.g., LCSW, MSW)	32.4
Dental Care (n=8)	
Dental Providers (dentist, dental hygienist)	17.3
Other	
Other Health/Allied Health (e.g., RN, nutrition)	n/a
Support Staff (e.g., medical asst, dental asst., clerk) (n=34)	24.5
Total number of SBHCs serving adolescents (57) Source: PRI staff analysis of DPH data.	

- For FY 2011, school-based health centers primarily serving adolescents were open an average of 35.8 hours per week, while their host schools were open an average of 33 hours per week. This indicates, for FY11, SBHCs were open an average of two hours and twenty minutes longer per week than their host schools' normal operating hours. Ten centers were open fewer weekly hours than their schools.
- Although school-based health centers were open an average of just under 36 hours per week, professional primary care staff averaged 33.0 hours; 62% of the centers met or exceeded the average weekly hours of medical professional coverage.
- Mental health care professionals were on-site an average of 32.7 hours; 64% met or exceeded the average weekly hours for mental health professional coverage.
- In the few SBHCs with dental programs, dental providers were available an average of 17.3 hours.

As discussed in Chapter I, Connecticut's adolescents rank near the top in many indicators regarding overall health when compared to other states. This means the health care system within the state meets the needs of adolescents for the most part. At the same time,

approximately 49,000 children in the state are without health care insurance, thus jeopardizing their overall health in comparison with children who have health care insurance coverage.

School-based health centers were created as a mechanism for helping students access quality, affordable health care. In theory, school-based health centers should be strategically located in schools where the need for accessible, quality health care is the greatest. The overall number of SBHCs and their locations, however, are balanced with the public policy decision to fund centers and at what level. As more fully discussed later in this chapter, national research shows school-based health centers provide children of all ages with greater access to comprehensive, cost effective health care they need.

There are numerous ways of identifying where health care is needed most. As highlighted in Appendix K, several key socioeconomic indicators were selected for analysis traditionally signifying barriers to accessing primary and preventive physical and mental health care.

Although the analysis shows communities with the greatest need for health care based on the indicators are served by state-funded school-based health centers, any expansion and/or reallocation of state resources for school-based health centers must take into account the overall accessibility to health care of students in areas of the state where accessible health care is an issue. In addition to determining the most appropriate sites for SBHCs, the process to fund centers is important. Since the 1980s, the legislature has provided grant funding for the state's school-based health center program, and at times designates funding amounts to specific school-based health centers. The legislature also provides funding to DPH for allocating grants to school-based health centers.

Actions to Turn the Curve

Since care at state-funded SHBCs is provided at no cost to students or their families, the number and locations of school-based health centers is a public policy decision that should balance need with state resources. Decisions on where to locate school-based health centers and at what level to fund the centers, should be based a formal process using standardized criteria, as discussed earlier in the report. At the same time, the committee finds grants to centers seem primarily based either on historical allocations provided to the centers over time from when they were originally funded or specific legislative appropriation amounts, and not on specific performance measures or outcomes, and recommends:

School-based health center grant allocations by the public health department should be tied to center performance, including staffing levels, services provided, and student health outcomes. Within this process, the Department of Public Health should develop a formal protocol for allocating state grants based on specific, measurable outcomes that ultimately determine whether the program is making a difference in the overall health of students. Beginning in 2014, state funding for school-based health centers should be based on a competitive application process as developed by the public health department. At minimum, prospective grantees must demonstrate student health care needs at the school site and why state funding is necessary to support the school-based health center at that site.

Requiring school-based health centers to seek state funding through a competitive application process is not a new concept. The 2006 Ad-Hoc Committee to Improve Health Care Access made a similar recommendation for state grants to all new sites. As noted earlier in this chapter, additional funding for SBHCs in 2008 was dispersed using an RFP process. In addition, legislation introduced in 2007 would have required DPH to establish the parameters of, and implement, a competitive grant program to award grants to municipalities to establish and operate new SBHCs.³⁷ The legislation, although unsuccessful, would have required the department to consider various municipal indicators for determining grants, including: percentage of public school children eligible to receive free or reduced-price meals; number of students attending school in the area to be served by the SBHC; status of the school as a priority school district; designation as a health professional shortage or medically underserved area; and community support for SBHCs. Given the state's limited funding resources, the committee believes allocating grants to school-based health centers on a competitive basis would ensure such resources are used for centers demonstrating the greatest need, while showing the best outcomes regarding students' health.

INDIVIDUAL CENTER PERFORMANCE (see Appendix L for full analysis)

In summary:

- Various measures of individual school-based health center performance for FY 09 were analyzed. The total student population of the schools identified by the committee as primarily serving adolescents (including mixed elementary/middle schools) was 58,007, which equates to all the students eligible to enroll in their school-based health centers. Of those, 31,712 (54.7%) enrolled, and 14,878 (47% of enrollees) used their school-based health center at least once during the year (i.e., unique service user). Thirty-five centers (60%) had utilization rates higher than the average.
- State grants to school-based health centers totaled \$7.9 million in FY 09. Adolescents made a total of 72,346 visits to their school-based health centers, at an average per visit cost of \$109. Of the total 58 centers analyzed, 25 (43%) had per visit costs below the average cost; per visit costs ranged from \$44 to \$735. The per-visit cost for one center was high in relation to the other centers, and additional analysis is needed to determine the reason(s) why.
- SBHC staffing information was available from DPH for FY 11 and was analyzed by PRI. The committee determined the average number of weekly hours medical and mental health professionals were available at the centers and compared the weekly staffing hours of individual centers against the average. Results show 31 centers (55%) were at or above the average number of weekly hours for medical professionals; the same number/percentage of centers met the average number of weekly hours for mental health professionals, although they were not necessarily the same centers.

³⁷ sHB 7366, 2007.

Actions to Turn the Curve

The Department of Public Health is the state agency responsible for ensuring the state's \$10 million investment in school-based health centers is worthwhile based on positive results. As such, the overall performance of state-funded school-based health centers rests in large part with the department's having specific practices in place for overseeing the SBHC program. And recommendations are put forth in this report for the department to increase its use of performance measures targeted to specific outcomes. Within the analysis of individual centers, one measure needing further analysis from the department to determine why performance variations may exist across centers is the overall cost per service user for school-based health center. The committee believes this is a strong indicator of center performance, and recommends:

The Department of Public Health should conduct a full analysis of the cost per visit by individual state-funded school-based health centers. The results should be used by the department as one factor for determining the funding levels for centers.

SBHC PROGRAM MANAGEMENT

PRI examined various factors within the department's operations for managing the school-based health center program. The following areas were reviewed: program performance monitoring and oversight, including contract management and compliance practices; the management information system used for school-based health centers; the department's responsiveness to the overall technical assistance needs of school-based health centers; and internal organization.

Monitoring and Oversight

DPH requires information from school-based health centers through a variety of reports, contract monitoring processes, and use of an automated system. The overall goal of the information is to help the department better understand the activities of state-funded school-based health centers.

The various reports required of SBHCs include quarterly activity reports, mid-year activity reports, year-end reports, staffing reports, aggregate budget/billing statements, grant contract, quality improvement plans, and enrollment and encounter data submitted through an automated system. The department also conducts site visits to school-based health centers for contract monitoring purposes, which include the centers completing a pre-visit administrative review report which the department uses to request additional information, including whether enrollment and visits increased/decreased from the previous year, what quality assurance measures the center has in place, and what data collection and management efforts are in place. In addition, the department's licensing unit conducts on-site regulatory visits of school-based health centers, since SBHCs' sponsoring agencies must be licensed by the department.

The committee reviewed the various information-collection documents and concludes the department collects a lot of information and data from school-based health centers applicable to monitoring the centers' overall performance, although the reporting requirements should be

streamlined. Moreover, the information is not fully coordinated or synthesized in a comprehensive manner to determine the overall performance of each center or the SBHC program as a whole. Although the grant contracts, various reports, and the quality improvement plans required by the department contain reference to performance measures, there is no unifying document or process summarizing the overall performance of state-funded school-based health centers based on relevant measures. School-based health centers submit a lot of information about their programs, yet the sources of such information are numerous and not analyzed in any comprehensive manner for performance monitoring purposes.

Committee staff also conducted a survey of the various sponsoring agencies for state-funded school-based health centers to more fully understand their satisfaction with the overall administration of the SBHC program. A key area where respondents thought the department should improve its performance is in sharing data analysis, with 62 percent either “dissatisfied” or “very dissatisfied.” Regarding the question of whether the department sets appropriate performance objectives, eight percent of respondents were “dissatisfied” and 67 percent were “somewhat satisfied.”

The committee believes the department needs to streamline its SBHC data collection requirements and target the information collected to performance measures pertinent to the state’s desired outcome(s) for the centers it funds – namely, increasing students’ access to health care to ensure their overall health and well-being – and recommends:

The Department of Public Health should establish formal performance goals for state-funded school-based health centers, including increased access to health care for uninsured/underinsured students, the provision of preventive care to students, and the degree to which centers increase student attendance and academic achievement. The department should develop standardized measures used to evaluate school-based health center performance against the goals.

The program’s current data collection and reporting requirements should be replaced with a Results-Based Accountability-style report card for each center based on the newly-developed performance measures and targeted outcomes. A report card summarizing the annual performance of the department’s school-based health center program also should be developed. At minimum, the department should post the summary report card on its website.

The current ad-hoc advisory workgroup could be an excellent source to help the department determine the revamped reporting requirements and to develop applicable performance measures. DPH already serves as part of this group, which includes relevant stakeholders of the school-based health center program and state agencies. In addition, the department developed an RBA report card for the legislature several years on the school-based health center program and department staff has been trained in RBA techniques, so there is experience in this area.

Management Information System

One of the most pressing issues within the school-based health center program is the management information system used to support the program. The system – Clinical Fusion – contains two components critical to program oversight: 1) enrollment data containing relevant demographic information, including insurance status, of all students enrolled in school-based health centers; and 2) encounter data: a record of each visit to a SBHC, including diagnosis information, referral data, and end result of the visits. School-based health centers are required to submit the information to DPH on an annual basis.

The Clinical Fusion system is a licensed product created by a private developer for school-based health centers throughout the country. Centers pay an annual fee to the company, which in turn provides technical help and software updates to the centers to support the system. However, the company recently announced it will no longer issue system software updates or technical support for its product as of July 1, 2012. Consequently, the current management information system used by the state’s school-based health center program will become obsolete in a few months.

The absence of an automated SBHC enrollment and encounter data system only exacerbates the problem of the department not having adequate data for program management purposes. At present, the enrollment and encounter data available through the automated system is not current. As automated information comes in from SBHCs, it is reviewed by the department and checked for completeness and accuracy, a process that lags by two years.

DPH is fully aware of the management information system issue it faces and continues to work toward finding a solution for replacing the current system. PRI believes the department and stakeholders are at a critical juncture to comprehensively examine and identify what automated data are most relevant to collect and analyze for determining how well the state-funded SBHC program is performing and whether the overall level student health is improved through state funding for the program. PRI recommends:

The Department of Public Health and key stakeholders develop short- and long-term plans for replacing the current automated management information system with one that collects the most relevant automated data for program management purposes based on specific program goals and performance measures established by the department. As part of this process, the department should work with the current ad-hoc committee on school-based health centers, and elicit feedback from all centers, as to what data are most relevant and collectable for program performance purposes.

PRI believes the department’s management information system planning should give full attention to the implementation of electronic health records by school-based health centers. Most SBHCs are already transitioning to electronic health records (EHRs), or will be in the near future. Committee staff survey results show over three-fourths of SBHCs sponsoring agencies either currently use EHRs (23%) or plan full implementation of EHRs within three years (54%).

Licensing

School-based health centers must be licensed by DPH either as outpatient clinics or hospital satellites, and so must meet specific quality standards to be licensed. Entities providing care within schools or on school grounds must be licensed regardless of whether they receive state funding. Of the current 71 school-based health center sites, 87 percent are licensed as outpatient clinics.

Meetings were held with DPH licensing staff to better understand the licensing processes for outpatient clinics and hospital satellites - both which incorporate licensure for school-based health centers (committee staff did not fully review either process to determine its efficiency or effectiveness.) During the discussions, the department noted licensing deficiencies or compliance problems are not common with school-based health centers. Moreover, the current level of interaction and coordination between DPH's licensing staff and SBHC contract monitoring staff seems adequate.

A key topic being discussed within the current ad hoc committee group, and previously with the original ad hoc committee in 2006, is whether current regulations for outpatient clinics and hospital satellites should be modified to further define a comprehensive school-based health center. Part of the debate is whether SBHCs should have their own licensing designation under the umbrella of an outpatient clinic or hospital satellite license.

Several points have been made within the ad hoc group's discussions: 1) any changes to the current licensing standards for school-based health centers would most likely involve changes to the licensing regulations; 2) what specific changes should be made and what the ultimate goal of the changes is; and 3) making school-based health centers a distinct licensure category may have a currently unknown impact on insurance reimbursement.

PRI believes the ad hoc committee is the proper forum to discuss any potential recommendations to change SBHC licensure. At the same time, if the goal of the group is to "brand" the comprehensive school-based health center model, then regulatory changes may be necessary, but more work by the group is required. The ad-hoc committee should continue to vet the issue, determine the pros and cons of implementing any changes, and make suggested recommendations as part of its statutory requirement to annually report to the legislature. As part of any proposed changes to licensing of school-based health centers, the ad hoc committee is encouraged to: 1) fully examine coordination between the licensing and SBHC contract monitoring units to avoid any duplication of effort; 2) implement best practices for the administration of SBHCs wherever possible; and 3) increase the state's ability to study clinical outcomes through the licensing and contract monitoring functions to the extent feasible.

PRI believes better coordination between the licensing unit and the contract monitoring unit should occur in the area of obtaining information about licensed SBHCs not receiving state funding. During its review, the committee found information about the operations of nonfunded school-based health centers is not collected by DPH, either routinely or as part of any overall school-health planning efforts. Little information exists about nonfunded school-based health centers beyond the ability to identify them through the name on their license. Information about the services they provide, the number of students served, and the results achieved to better

students' overall health, is not known. The committee understands resources are necessary to obtain such information, but believes at least a basic understanding of those entities is needed to fully assess school-based health care in the state. PRI recommends:

The Department of Public Health should begin collecting, maintaining, and analyzing information about licensed, non-state funded health centers in public schools. The information collected should be relevant to helping the department establish a full profile of the physical, mental, and dental health resources provided in schools by state-licensed entities to improve students' overall health.

The committee believes the data collection efforts should be in a manner and interval that best fits within the department's current resources. The process should be a joint effort between the public health department's licensing and school-based health center programs, and include any other state agency or entity that can assist the department with its efforts. At minimum, the information collected should include: operations (staffing policies, hours of operation, physical space); enrollment (number, insurance status); visits (number, reason for visits, diagnoses); and finances (budget, funding sources).

Organization

Internal organization and supervision of the school-based health center program within DPH has undergone changes in the past several years. There has been supervisory staff turnover, with three program supervisors in the past three years. The experience levels of the key program staff also vary and, until recently, one experienced full-time program analyst and two part-time analysts have overseen the program, along with a DPH manager who has additional responsibilities. The department recently reorganized the program and moved it to the new Child and Adolescent Health unit with a new program supervisor, and added another full-time staff person, which PRI believes are positive moves and should give the program organizational and supervisory stability. Moreover, the new supervisor has experience with other public health programs, including the medical home model of care.

Under the new organizational and supervisory structure of the program, the committee believes three program components should receive focus: technical assistance to school-based health centers in such areas as outreach efforts, data collection, funding opportunities in lieu of state funding, and information system management; best practices; and working with centers around the medical home model of care. PRI recommends:

DPH should continue providing technical assistance and training to school-based health center staff, and, to the extent possible, use webinars, e-conferences, and frequently-updated website information to provide such assistance. A frequent review of centers' technical assistance needs should be conducted.

The department should serve as a clearinghouse for innovative and promising practices for school-based health centers, and disseminate best practice information to centers on a regular basis. Included in this effort should be assistance to sponsoring agencies to maximize their funding resources outside of state funding and working with centers in transitioning to electronic medical records.

The department should fully evaluate SBHCs and their role/ability to serve within the medical home model for students.

The school-based health center program currently provides assistance to centers on an as-needed basis and via its on-site contract monitoring visits with centers. The recommendations above would require the department to remain current with school-based health center issues and best practices, including SBHCs' role in the medical home model of care, be proactive in evaluating SBHCs' issues, and use various electronic means to communicate and assist centers efficiently.

RBA Question III: Is Anyone Better Off?

How effective school-based health centers are is a multi-faceted question. Centers function to help students with a myriad of issues, including mental health, physical health, injuries, chronic illness, reproductive health, and interpersonal problems. Focusing on one aspect of school-based health center outcomes, such as their effect on lowering teenage pregnancy rates, is beneficial, but does not provide an overall examination of the ways adolescents may be better off because of SBHC care.

Very little empirical research has been done to determine Connecticut's school-based health centers' effect on adolescent health. As a result, the committee mostly relied on findings from published studies for three key performance measures to determine whether students who used school-based health centers were "better off."

Measure 1: Improved Health Outcomes

- Results from a Connecticut Association of School-Based Health Centers satisfaction survey (2009) of over 1,000 students who used SBHC services in the state show:
 - 78% said using the center improved their overall health;
 - 34% said they would not know where to go for care or their condition would have gotten worse without the SBHC; and
 - 18% said they would have gone home from school or stayed home if care was not available in school.

The ability of students to receive free physical and mental health care on site at schools, where they spend a large portion of their time, increases students' access to care and improves adolescents' chances for better health – especially in communities having the greatest need for accessible, affordable health care. Although there is a dearth of data on the direct impact of Connecticut's school-based health centers on student health outcomes, national research from numerous studies indicate positive health outcomes for students who used SBHCs: they are more satisfied with their health and engaged in a greater number of health-promoting behaviors than students not using SBHCs. Examples of the national study findings include the following results:

- A three-year longitudinal evaluation of middle and high school students with access to school-based health centers in Michigan found that students who used SBHCs had greater satisfaction with their health, engaged in more physical activity, had greater self-esteem, ate more healthy foods, and had greater family involvement. The overall student population in schools with SBHCs engaged in fewer individual risks, had fewer threats to achievement, had less emotional discomfort, and had fewer negative peer influences.³⁸
- Within a safety-net system, school-based health centers augment health care access and quality for underserved adolescents compared with traditional care.³⁹
- Adolescents were up to 21 times more likely to visit a school-based health center for mental health services than other types of care, and almost twice as likely to visit for health maintenance reasons.⁴⁰
- A two-year study examining the direct and indirect effects of school-based health centers on the health and health behaviors of middle and high school students found students who used school-based health centers were more satisfied with their health and engaged in a greater number of health-promoting behaviors than nonusers.⁴¹
- A somewhat dated study by the U.S. General Accounting Office concluded school-based health centers represent a unique health care delivery option that gives children, especially those who are poor or uninsured, easy access to health care services and can improve children's access to care by removing financial and nonfinancial barriers.⁴²

³⁸ McNall MA, Lichty L, Mavis B, Bates, L., *The Michigan Evaluation of School-Based Health*, Community Evaluation and Research Collaborative, Michigan State University, December 2010.

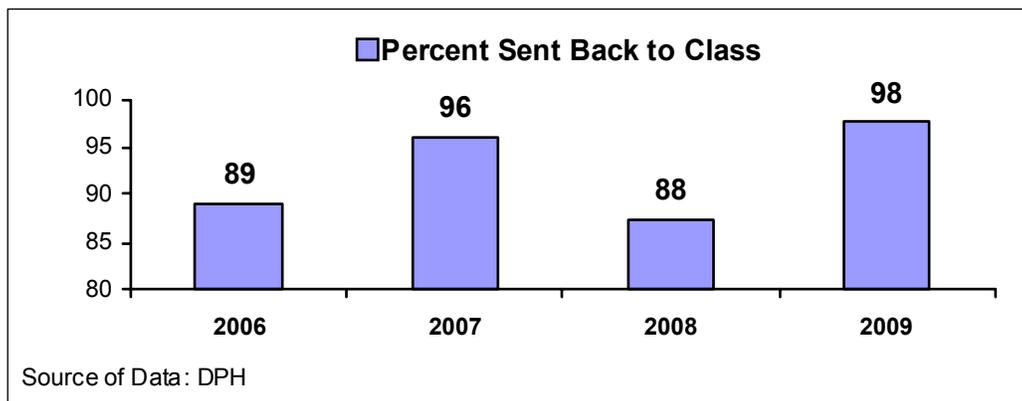
³⁹ Allison MA, Crane LA, Beaty BL, Davidson AJ, Melinkovich P, Kempe A., School-based health centers: improving access and quality of care for low-income adolescents. *Pediatrics: Journal of the American Academy of Pediatrics*, 2007; 120(4); e887-e894.

⁴⁰ Juszczak L, Melinkovich P, Kaplan D., Use of health and mental health services by adolescents across multiple delivery sites, *Journal of Adolescent Health*, 2003; 32S:108-118.

⁴¹ McNall MA, Lichty LF, and Mavis B., The Impact of School-Based Health Centers on the Health Outcomes of Middle School and High School Students, *American Journal of Public Health*, September 2010, 1604-10.

⁴² U.S. General Accounting Office, Health Care Reform: School-Based Health Centers Can Promote Access to Care, May 1994.

Measure 2: Increased Academic Achievement



- State-funded SBHCs' performance of returning adolescents to class, as an indicator of academic achievement, is positive. A four-year average of 92 percent of the adolescents receiving services from a school-based health center returned to class the same day, although no clear trend emerged for the four-year period analyzed.
- The 2009 National Youth Risk Behavior Survey shows students with higher grades are less likely to engage in health-risk behaviors than their classmates with lower grades.⁴³ Although there is no student health outcome data specific to Connecticut on how state-funded SBHCs affect students' academic achievement beyond the disposition immediately after a SBHC visit, national research shows improved academic performance on the part of students who use SBHCs compared with those who do not:
 - SBHC use was associated with academic improvements over time for a high-risk group of users. There was a significant increase in attendance for students who used school-based health centers for medical reasons compared to those who did not. Increases in grade point average over time occurred for students using SBHCs for mental health reasons compared to nonusers. Discipline incidents, however, were not found to be associated with SBHC use.⁴⁴
 - Students enrolled in a SBHC gained three times as much classroom seat time as students not enrolled, and school-based health centers significantly reduced the number of early dismissals from school in comparison with students who received school nursing services alone.⁴⁵
 - The presence of a SBHC is associated with greater academic expectations, higher school engagement, and more communication, than in schools without a school-based health center.

⁴³ Centers for Disease Control and Prevention, Health-Risk Behaviors and Academic Achievement, *National Youth Risk Behavior Survey 2009*.

⁴⁴ Walker SC, Kerns SE, Lyon AR, Bruns EJ, Cosgrove TJ., Impact of school-based health center use on academic outcomes, *Journal on Adolescent Health*. 2010 March;46(3):251-257.

⁴⁵ Van Cura M., The relationship between school-based health centers, rates of early dismissal from school, and loss of seat time, *Journal on School Health*. 2010, August: 80(3): 371-377.

SBHCs in urban schools enhanced certain aspects of the learning environment for students and parents, such as providing school/community health liaisons to engage parents and students.⁴⁶

- A longitudinal analysis found low to moderate use of school-based health centers reduced dropout rates for high school students in an urban school district compared with non-SBHC users. The association between SBHC use and prevention of dropout was greatest for higher-risk students.⁴⁷

Measure 3: Cost effectiveness

- PRI staff calculated the average SBHC per visit cost for adolescents in FY 09 was \$109; more detailed information about the overall cost effectiveness, including potential long-term benefits, of school-based health center care in Connecticut is not available.

As noted earlier in the report, analysis of SBHC user data with Medicaid data for adolescents in part to determine cost outcomes for care provided through the two systems was attempted. This analysis could not be conducted for various reasons; thus national information was examined regarding the overall cost effectiveness of school-based health centers, as highlighted below:

- A longitudinal study of SBHCs in Ohio found SBHCs to be cost beneficial to both the Medicaid system and society, and increased health care utilization for African American and disabled students and closed the gaps of health care disparities. The estimated net social benefits of the SBHC program in four districts were \$1.3 million over three years; the estimated savings to Medicaid was approximately \$35 per student per year for students who used school-based health centers.⁴⁸
- SBHC programs increase the proportion of students who receive mental health services, and SBHC students with mental health problems had lower total Medicaid reimbursements compared with non-SBHC students.⁴⁹
- Accessible, prevention-oriented health care provided in a SBHC can decrease the utilization of episodic health care in an emergency department.⁵⁰

⁴⁶ Strolin-Goltzman J. The relationship between school-based health centers and the learning environment, *Journal on School Health*, 2010; 80: 153-159.

⁴⁷ Kerns S.E., Pullman MD, Cusworth Walker S, Lyon A.R., Cosgrove T.J., Bruns E.J. Adolescent use of school-based health centers and high school dropout. *Archives of Pediatrics and Adolescent Medicine*. 2011 July; 165(7): 617-623.

⁴⁸ Guo JJ, Wade TJ, Pan W, Keller K, School-Based Health Centers: Cost-Benefit Analysis and Impact on Health Care Disparities, *American Journal of Public Health*, September 2010; 100(9) 1617-23.

⁴⁹ Guo JJ, Wade TJ, Keller KN, Impact of school-based health centers on students with mental health problems. *Public Health Rep*. 2008 Nov./Dec.; 123(6):768-80.

⁵⁰ Key JD, *Journal of Adolescent Health*, April 2002; 30(4):273-278.

- A study of SBHCs in New York found asthma-related emergency room visits were more than halved for students with school-based health centers compared to those in schools with no school-based health centers.⁵¹
- The risk of hospitalization and emergency department visits for children with asthma decreased significantly with SBHC programs. The potential cost-savings for hospitalization was an estimated \$970 per child.⁵²

Actions to Turn the Curve

Additional research is necessary in Connecticut to evaluate the overall health and academic achievement outcomes school-based health centers might hold for adolescents, along with the overall cost effectiveness of centers. A detailed analysis comparing the outcomes of students served by state-funded school-based health centers with those not served by SBHCs is necessary to more fully answer the question of whether adolescents are “better off” in Connecticut because of the services they receive from school-based health centers funded by the state. The committee recommends:

A comprehensive, longitudinal analysis should be completed showing the relationship between Connecticut’s state-funded school-based health centers and health outcomes of students using such centers. A comparative analysis between school-based health center users and nonusers regarding their academic performance and school absenteeism, tardiness, and discipline issues should be done. The study also should include a cost-benefit analysis of school-based health centers in Connecticut. The public health department should determine the overall parameters of the study.

⁵¹ Webber MP, Carpiniello KE, Oruwariye T, Yungtai L, Buron WB, Appel DK. Burden of asthma in elementary school children: Do SBHCs make a difference? *Archives of Pediatric and Adolescent Medicine*, 2003; 157: 125-129.

⁵² Guo JJ, Jang R, Keller, KN, McCracken AL, Pan W, Cluxton RJ. Impact of school-based health centers on children with asthma. *Journal of Adolescent Health*. October 2005;37(4):266-274.

Parental Involvement and Minors' Rights

Overview

The level of parental or guardian involvement in an adolescent child's health care decisions is a topic often debated in particular areas of adolescent care. Advocates for involving parents and guardians to the greatest degree possible in their child's health care decisions maintain such involvement is the right as parents. They believe parents know the health needs of their minor children best and should be fully responsible for those needs. Others, however, maintain that minors – particularly older adolescents – are able to make decisions about their own health care and might or will not seek the care they need if they know there is a possibility or requirement their parents will be notified before or after care. They further believe some level of confidentiality is necessary.

Over the past half century, the rights of minors to determine their own health care have broadened in Connecticut and the other states. Difficulty still remains, however, among balancing the rights and responsibilities of parents regarding the health care of their adolescent children, the level of immaturity and vulnerability of adolescents, and adolescents' rights to make their own health care decisions free from parental involvement, particularly for time-sensitive health issues where the need for prompt treatment may outweigh the need for parental involvement. As a result, a mix of laws and practices exists, some more clear-cut than others, so that no overriding statements about rights of minors and parents with regard to medical treatment can be made. At the same time, a key goal of states' adolescent health care policies should be to balance the rights, interests, and responsibilities of minors, parents, and health care professionals, while protecting public health.

Various topic areas regarding parental involvement are discussed below. Table IV-1 provides a summary of Connecticut's requirements, and how this state's policies compare with other states, namely in the areas of: contraceptives; emergency contraceptives; pregnancy testing and care; pregnancy termination (abortion); STD testing and treatment; HIV/AIDS testing and treatment; mental health inpatient and outpatient care; alcohol and drug treatment; and mental health outpatient care.⁵³ For all areas, the Connecticut age of majority is 18, unless otherwise stated.⁵⁴

⁵³ The primary source of information is the Guttmacher Institute, unless noted otherwise.

⁵⁴ A Connecticut minor age 16 or 17 may be emancipated through court, which means among other things that the minor may consent to medical, dental, or psychiatric care, without parental consent, knowledge or liability. In FY 10, 36 minors were granted emancipation.

TABLE IV-1. ADOLESCENT HEALTH CARE: PARENTAL INVOLVEMENT AND MINORS' RIGHTS IN CONNECTICUT

	Definition of Minor (Age)	Parental Notice and/or Consent Required	Other Requirements	Legal Basis for Age of Consent and/or Patient Confidentiality	Requirements in Other States*
Medical/Surgical Treatment (Procedure Requiring Informed Consent)	Under 18	Yes (unless emergency or emancipated minor)	<ul style="list-style-type: none"> • Legal guardian (including DCF) can consent • Kinship caretaker with appropriate court order providing legal status of the minor to the caretaker can consent 	Common law (no direct state statute)	Age of Majority: <ul style="list-style-type: none"> • 18 (46 states, plus District of Columbia) • 19 (2 states) • 21 (2 states)
PROTECTED CONFIDENTIAL CARE / STATUTORY AND CONSTITUTIONAL EXCEPTIONS					
Substance Abuse					
<i>Alcohol & Drug Treatment</i>	Under 18	No	<ul style="list-style-type: none"> • No access to drug treatment records without minor's consent, unless serious threat to life/well-being that can be diminished by disclosure to parents • Minor liable for treatment costs 	State Statute: 17a-688(d)	Surrounding States <ul style="list-style-type: none"> • MA: minors 12 and older found drug dependent by at least two physicians may consent to substance abuse treatment except for methadone maintenance therapy(B) • RI: minor may consent(C) • NY: minor may consent only if requiring parental consent would have a detrimental effect on treatment, or consent is denied and physician finds treatment necessary and in the best interest of the child(D)

TABLE IV-1. ADOLESCENT HEALTH CARE: PARENTAL INVOLVEMENT AND MINORS' RIGHTS IN CONNECTICUT

	Definition of Minor (Age)	Parental Notice and/or Consent Required	Other Requirements	Legal Basis for Age of Consent and/or Patient Confidentiality	Requirements in Other States*
					Surrounding States <ul style="list-style-type: none"> Nearly 40 states permit a minor to consent; almost 25% of those states require minor to be a certain age(E) If treatment/rehab facility federally funded, follow requirements of federal Public Health Services Act(F)
Reproductive Health					
<i>Contraceptive Services</i>	Under 18	No	<ul style="list-style-type: none"> Signs of sexual intercourse or activity (e.g., use of birth control) by minor under age 13 mandates clinical provider send child abuse/neglect report to DCF or law enforcement 	Constitutional(1) (privacy grounds)	Surrounding States: <ul style="list-style-type: none"> MA: explicitly allows all minors to consent to contraceptive services (state funds a statewide program giving minors access to confidential contraceptive care) RI: no explicit policy NY: explicitly allows all minors to consent to contraceptive services (state funds a statewide program giving minors access to confidential contraceptive care) All States <ul style="list-style-type: none"> 21 states (plus D.C.) explicitly allow all minors to consent to contraceptive services

TABLE IV-1. ADOLESCENT HEALTH CARE: PARENTAL INVOLVEMENT AND MINORS' RIGHTS IN CONNECTICUT

	Definition of Minor (Age)	Parental Notice and/or Consent Required	Other Requirements	Legal Basis for Age of Consent and/or Patient Confidentiality	Requirements in Other States*
					<ul style="list-style-type: none"> • 25 states explicitly permit minors to consent to contraceptive services in one or more circumstances • 4 states have no explicit policy
<i>Emergency Contraception</i>	Under 17	No	<ul style="list-style-type: none"> • Prescription required if under 17 (available over the counter if 17 or older) • Licensed health care facilities required to provide emergency contraception to victims of sexual assault upon her request (a hospital may contract with independent medical professional in order to provide EC services) 	FDA order 4/2009 (per federal court order)	<p>Surrounding States:</p> <ul style="list-style-type: none"> • MA: emergency rooms required to provide information about EC and dispense upon request • RI: no explicit policy • NY: emergency rooms required to provide info. about EC and dispense upon request <p>All States</p> <ul style="list-style-type: none"> • 12 states require hospitals to dispense EC to sexual assault victims (including CT)
<i>Pregnancy Testing & Care (routine prenatal, delivery, postpartum)</i>	Under 18	No	<ul style="list-style-type: none"> • Whether parental consent needed for invasive procedures (e.g., epidural, amniocentesis, c-section) unsettled 	Constitutional (privacy grounds)	<p>Surrounding States</p> <ul style="list-style-type: none"> • MA: minor may consent to prenatal care but parent must be notified if minor's health/or life at risk • RI: no explicit policy

TABLE IV-1. ADOLESCENT HEALTH CARE: PARENTAL INVOLVEMENT AND MINORS' RIGHTS IN CONNECTICUT

	Definition of Minor (Age)	Parental Notice and/or Consent Required	Other Requirements	Legal Basis for Age of Consent and/or Patient Confidentiality	Requirements in Other States*
					<ul style="list-style-type: none"> • NY: minor may consent to prenatal care <p>All States</p> <ul style="list-style-type: none"> • 36 states (and DC) explicitly allow some minors to consent to prenatal care; 13 of those states allow, but do not require, physicians to inform parents their minor daughter is seeking or receiving prenatal care when they deem it in the best interests of the minor
<i>Pregnancy Termination (Abortion)</i>	Under 16	No (if 16 or older, considered adult, so no parental notice or consent required)	<ul style="list-style-type: none"> • Counseling required if under age 16. Physician or counselor must: 1) explain choices to minor and that the information given is not intended to coerce, persuade, or induce a decision; 2) state alternatives; and 3) discuss possibility of involving parents in the decision-making process.** 	State Statute: 19a-600	<p>Surrounding States</p> <ul style="list-style-type: none"> • MA: minor<18; one parent consent or judicial bypass resulting in order for minor • RI: : minor<18; one parent consent or judicial bypass resulting in order for minor • NY minor <18; no parental consent/notification/judicial bypass requirement <p>All States</p> <ul style="list-style-type: none"> • 37 states require parental involvement (consent and/or notification) <ul style="list-style-type: none"> • 22 states require at least one parent to <i>consent</i> to the procedure, with

TABLE IV-1. ADOLESCENT HEALTH CARE: PARENTAL INVOLVEMENT AND MINORS' RIGHTS IN CONNECTICUT

	Definition of Minor (Age)	Parental Notice and/or Consent Required	Other Requirements	Legal Basis for Age of Consent and/or Patient Confidentiality	Requirements in Other States*
					judicial bypass <ul style="list-style-type: none"> • 11 states require parental <i>notification</i> to at least one parent, with judicial bypass. • 4 require both notification and consent; • 7 states (plus DC) do not require parental consent or notification (includes CT and Maine) • 6 states with laws currently enjoined
<i>STD Testing & Treatment</i>	Under 18	No	<ul style="list-style-type: none"> • DCF must be notified if child 12 or under (exam, care, treatment remain confidential but investigation of abuse/neglect may proceed) • Minor responsible for all costs 	State Statute: 19a-216	Surrounding States <ul style="list-style-type: none"> • MA: minor may consent; parent must be notified if minor's health/life at risk • RI: minor may consent • NY: minor may consent All States <ul style="list-style-type: none"> • All 50 states and DC explicitly allow minors to consent; 11 states require minor to be a certain age of consent • 18 states allow physicians to inform a minor's parents that minor is seeking or receiving STD services

TABLE IV-1. ADOLESCENT HEALTH CARE: PARENTAL INVOLVEMENT AND MINORS' RIGHTS IN CONNECTICUT

	Definition of Minor (Age)	Parental Notice and/or Consent Required	Other Requirements	Legal Basis for Age of Consent and/or Patient Confidentiality	Requirements in Other States*
<i>HIV/AIDS Testing & Treatment</i>	Under 18	No, <u>but</u> may treat without parental consent only if provider determines notification will result in denial of treatment or minor will not seek and pursue treatment as result of the notification	<ul style="list-style-type: none"> At the time of communicating test results, provider must work toward goal of involving minor parents and counsel minor about need to notify parents; also if necessary, assist in notifying partners Minor responsible for all costs; if consents, bill may be sent to parents 	State Statute: 19a-582(a-d)	<p>Surrounding States</p> <ul style="list-style-type: none"> MA: minors may consent(A) RI: Minors may consent NY: minors may consent to testing; does not include right to consent to treatment <p>All States</p> <ul style="list-style-type: none"> 31 states explicitly include HIV testing and treatment in the package of STI services to which minors may consent 18 states allow physicians to inform minor is seeking or receiving STI services No state but one <i>requires</i> parental notice in the case of a positive HIV test
Mental Health					
<i>Inpatient Care (Hospitalization)</i>	Under 16	Yes, but 14 or 15 year olds can be admitted on own and parent (or nearest relative) must be notified after 5 days following admission (if 16 or older, no parental consent or notice required)	<ul style="list-style-type: none"> Uninformed parents not liable for costs (minor responsible) 	State Statute: 17a-75, 17a-79, 17a-504(d),	<p>Surrounding States</p> <ul style="list-style-type: none"> MA: Minors 16 and 17 may consent to admission at a mental health treatment facility without notifying parent; a provider may choose to provide mental health treatment without notifying minor's parent per

TABLE IV-1. ADOLESCENT HEALTH CARE: PARENTAL INVOLVEMENT AND MINORS' RIGHTS IN CONNECTICUT

	Definition of Minor (Age)	Parental Notice and/or Consent Required	Other Requirements	Legal Basis for Age of Consent and/or Patient Confidentiality	Requirements in Other States*
<i>Outpatient Care</i>	Under 18	No <u>if</u> professional counselor** determines notification or consent would be seriously detrimental to minor; <i>and</i> whether to notify parent and secure consent must be evaluated initially and reevaluated after every sixth session	<ul style="list-style-type: none"> • Uninformed parents not liable for costs (minor responsible) 	State Statute: 19(a)-14c(b-d)	MA mature minor rule(I) <ul style="list-style-type: none"> • Rhode Island: No explicit policy for outpatient(J) All States <ul style="list-style-type: none"> • Aggregate information not specifically available for other states

* Primary information source: Guttmacher Institute

**Definitions: Professional Counselor (psychiatrist, psychologist, independent certified social worker, licensed marriage and family therapist (19a-14c(b)); Counselor (psychiatrist, licensed clinical social worker, licensed marriage and family therapist, ordained clergy member, licensed physician's assistant, nurse-midwife, certified guidance counselor, registered nurse or practical nurse (19a-600)).

(I) Constitutional authority granting minors confidentiality and autonomy over reproductive health care decisions: see *Roe v. Wade* (1973), *Carey v. Population Services Int'l* (1977); *Bellotti v. Baird* (1979)

(A) Consent to Medical Treatment by Minors in Massachusetts, A Guide for Practitioners. Juvenile Rights Advocacy Project, Boston College School of Law (2006)

(B) Ibid

(C) National Center for Children in Poverty, Adolescent Mental Health Variables http://nccp.org/profiles/RI_profile_56.html#8 accessed 2/20/12

(D) Ibid

(E) Amy L. McGuire, J.D., Ph.D. and Courtenay R. Bruce, J.D., *Keeping Children's Secrets: Confidentiality in the Physician-Patient Relationship*, 8 Houston Journal of Health and Law Policy 315-33, p. 323 (2008)

(F) Ibid

(G) Juvenile Rights Advocacy Project

(H) National Center for Children in Poverty

(I) Ibid

(J) Houston Journal

Age of Majority and Minor Consent

In every state, persons below a certain age cannot receive health care without the permission of their parents or guardians for most medical procedures because they are legally minors. In Connecticut and most states, the age of majority is 18, and persons at that age are legally adults.⁵⁵ The rationale for requiring parental consent for minors is founded on two principles: 1) minors are not yet competent in making their own decisions and need to be protected from the consequences of uninformed, immature decisions; and 2) the authority for parents to make medical decisions for their minor children is based on a legal presumption that parents will act in the best interests of their children and on the constitutional right of privacy in family matters.

At the same time, federal and state policies, including those in Connecticut, provide exceptions allowing minors to provide their own consent to certain sensitive health-related services or lowering the age of majority (and still provide for minor consent). These exceptions, often referred to as minor-consent laws, include such carve-outs as drug and alcohol treatment, reproductive health, and inpatient/outpatient mental health services.

The age of majority and right to minor consent in Connecticut differs depending on the type of health care/procedure sought. As discussed below, the state has determined the age of a minor is below 16, rather than under 18, in two specific health care areas. Connecticut law also is silent in certain areas, implicitly maintaining a minor's confidentiality by not explicitly requiring parental notification or consent, if not already protected under federal law.

The requirements pertaining to minor consent in Connecticut for general medical treatment and other health care areas are discussed below. Also discussed are Connecticut's specific carve-outs in which minors control their own health care decisions for drug and alcohol treatment and rehabilitation, mental health counseling, reproductive health, and HIV/AIDS services. A comprehensive description of parental involvement and minors' rights in adolescent health care, including the legal status of adolescent decision making in certain health care situations in Connecticut and other states is detailed later in this chapter.

Emancipation of Minors

Connecticut's *emancipation* statute⁵⁶ provides a process that legally releases a resident minor who is at least 16 years old from all parental involvement requirements providing them legal status as an adult, including consenting to their own medical, dental, or psychiatric care. For emancipated minors, the laws about minor consent discussed here are not applicable.

Under Connecticut's emancipation law, any minor who is at least 16 years old and resides in the state - or the minor's parents or legal guardian - can petition the juvenile or probate court to determine whether the child should be emancipated. Legal notice must be given to the

⁵⁵ Nationally, 46 states specify 18 as the age of majority. Alabama and Nebraska, have set the age at 19, while Pennsylvania and Mississippi use 21 as the age of majority (see: Law Information Institute: Cornell University Law School; and Age of Majority by State, Department of Defense Financial Management Regulation, Volume 7B, Appendix H, February 2010.)

⁵⁶ C.G.S. 46b-150

minor and the minor’s parents or guardian requiring them to attend a hearing, after which the judge will rule on the emancipation petition. A judge is required to make the decision about emancipation, and once the decision is made, it cannot be reversed.

The statutory grounds for emancipation in Connecticut are: 1) the minor has entered into a valid marriage, even if the marriage has since terminated by dissolution; 2) active duty in the U. S. military; 3) the minor willingly lives apart from his/her parents or guardians (with or without their consent) and is managing his/her own financial affairs, regardless of the lawful source of the income; or 4) a good cause showing that emancipation is in the best interests of the minor, the minor’s child, or the minor's parents or guardian. Minors who have a child can make medical decisions for their child, but are not automatically emancipated themselves. Table IV-2 below shows the annual number of emancipated minors in Connecticut has been no more than 60 for the past five years.

Table IV-2. Minors Granted Legal Emancipation in CT: 2006-2010		
Year	# Minors Emancipated Granted: Juvenile Court	# Minors Emancipated Granted: Probate Court
2006	19	31
2007	22	*
2008	18	42
2009	18	27
2010	8	28
*Figure not available due to Probate Court central office database conversion. Data Sources: Superior Court for Juvenile Matters; Office of the Probate Court Administrator		

Medical or Surgical Treatment (General)

Under Connecticut law, anyone at age 18 has reached the age of majority and is a legal adult, and anyone under the age of 18 is considered a minor, except if the law provides for a different age.⁵⁷ No specific state statute governs the age of consent for medical and surgical treatment, but under common law, the minimum age for people to make their own health care choices without parental consent in the state is 18, reflecting the general statutory age of majority. As such, minors in Connecticut cannot give informed consent in the area of health care, unless permitted through law. Informed consent acknowledges the patient voluntarily agrees to a procedure, has the capacity to consent, and has been made aware of alternative procedures and the possible consequences resulting from those procedures.⁵⁸ Informed consent must be obtained before any procedure, unless attaining consent is not reasonable, such as in emergencies.

Clearly consent, in particular, informed consent, and whoever is deemed appropriate to provide it, is a key requirement for medical treatment. The Public Health Code in Connecticut

⁵⁷ C.G.S. Sec. 1-1d.

⁵⁸ Adolescent Health Care: Legal Rights of Teens, Fourth Edition, Center for Children’s Advocacy: Medical-Legal Partnership Project, 2010, p.6.

requires each hospital in the state ensure its bylaws, rules, or regulations pertaining to the hospital's medical staff include the requirement that, except in emergency situations, the responsible physician must obtain proper informed consent as a prerequisite to any procedure or treatment for which it is appropriate and provide signed evidence of consent by the patient or a written statement signed by the physician on the patient's hospital record.⁵⁹ The extent of information to be supplied by the physician to the patient must include the specific procedure or treatment (or both), the reasonably foreseeable risks, and reasonable alternatives for care or treatment.

Mature minor doctrine. The *mature minor doctrine* is a legal principle based on common law that provides a minor who is not legally separated from his or her parents may possess the maturity to choose or reject medical treatment without the knowledge or agreement of the minor's parents, and should be permitted to do so. States may codify the doctrine in statute, or simply follow the doctrine based on common law. Connecticut does not follow the mature minor doctrine nor has there been a legal case in this area.⁶⁰

Under the mature minor doctrine, the court must consider various factors in determining whether a minor is sufficiently mature, including the minor's age, evidence of maturity, education, and judgment to consent knowingly to medical treatment.⁶¹ The minor must be able to understand and appreciate the nature and consequences of a medical procedure. A judicial procedure determines whether an adolescent is deemed mature.

While the mature minor doctrine may be considered a form of patients' rights by allowing minors to make their own health care decisions under certain circumstances, it also could be viewed as a way of protecting health care providers from legal action by parents of minors. Under the doctrine, when a minor has the capacity to give informed consent for care and voluntarily gives such consent as long as the care is within mainstream medical practice and is not provided in a negligent manner, a health care provider will not be liable for relying on the minor's consent or for not obtaining the consent of a parent for the care.

Drug or Alcohol Treatment

Connecticut law provides that minors (under age 18) may give their own consent to receive treatment or rehabilitation for drug or alcohol dependency, without parental involvement.⁶² The fact that a minor sought treatment or rehabilitation for drug or alcohol dependence cannot be reported to the minor's parents or guardian without the consent of the minor. Care for drug or alcohol dependence must come from a facility licensed to treat drug or alcohol dependence or a facility operated by the Department of Mental Health and Addiction Services.

Minors are afforded full confidentiality of their records when seeking or receiving alcohol or drug treatment/rehabilitation, including no third-party billing. By law, however,

⁵⁹ Conn. State Regs. Sec. 19-13-D3(d)(8)

⁶⁰ Per 8/29/11 meeting with Center for Children's Advocacy, University of Connecticut School of Law.

⁶¹ Keeping Children's Secrets: Confidentiality in the Physician-Patient Relationship, Amy L. McGuire and Courtenay R. Bruce, *Houston Journal of Health Law and Policy*, 327, 2008.

⁶² C.G.S. Sec. 17a-688(d).

minors are financially liable for any costs and expenses associated with any drug or alcohol treatment or rehabilitation they request.

If a minor receives a drug test as part of a routine examination, Connecticut law is silent as to whether a physician must report the test results to the minor's parent or guardian.⁶³ As such, physicians are bound by their ethical duty to ensure patient confidentiality, regardless of the patient's age. American Medical Association guidelines, however, say such confidentiality may be broken if the minor is in serious harm and/or such breach enables a parent to make an informed decision about their minor's treatment.⁶⁴

When a minor seeks drug or alcohol treatment from a licensed substance abuse counselor, state law parallels the federal Public Health Services Act (PHSA) regarding patient confidentiality. Facts relevant to reducing a threat to the life or physical well being of the minor or any other individual may be disclosed to the parent or guardian if the program director determines: a) because of extreme youth or mental or physical condition to make a rational decision on whether to consent to disclose information to his or her parent or guardian; and b) the minor's situation poses a substantial threat to the life or physical well being of the minor or any other individual, which may be reduced by communicating relevant facts to the minor's parent or guardian.⁶⁵

Reproductive Health Care

Contraception services. The federal constitutional right to privacy serves as the basis for a woman's right to receive confidential contraceptive services. The United States Supreme Court has extended this right in matters relating to the use of contraception to minors, as well. For this reason, federal or state government cannot restrict a minor's access to reproductive health services, such as contraception, without a compelling reason. To date, Connecticut has not imposed any such legal restrictions.

Although Connecticut law provides no statutory right for minors to obtain birth control without parental consent (beyond the rights conferred to emancipated minors), U.S. Supreme Court rulings in cases such as *Carey v. Population Services Int'l*⁶⁶ have established that minors' access to confidential contraceptive services is protected under constitutional privacy rights. State law also is silent as to whether parents or guardians must be notified prior to their minor child obtaining birth control.

Mandatory reporters in Connecticut (including health care practitioners), notwithstanding minors' constitutional rights, must report sexual activity of minors under age 13 if there is knowledge or suspicion of a minor engaging in sexual activity or intercourse, including the use of birth control.⁶⁷ Moreover, health care providers, including clinics, may request minors inform their parents/guardians about the contraception use, but no law exists requiring such notification.

⁶³ Adolescent Health Care: Legal Rights of Teens, Fourth Edition, Center for Children's Advocacy: Medical-Legal Partnership Project, 2010, p.10.

⁶⁴ *Id.*

⁶⁵ 42 C.F.R. 2.14(d)

⁶⁶ *Carey v. Population Services International*, 431 U.S. 678.

⁶⁷ *Id.*, p.15.

Nationally, states' policies regarding contraceptive services and their availability to minors vary:⁶⁸

- 21 states and the District of Columbia explicitly allow all minors to consent to contraceptive services;⁶⁹
- 25 states explicitly permit certain minors to consent to contraceptive services in *one or more* circumstances;⁷⁰
 - 3 states allow minors to consent to contraceptive services if a physician determines that the minor would face a health hazard if she is not provided with contraceptive services
 - 21 states allow a married minor to consent to contraceptive services (Connecticut confers right/responsibilities of adulthood to married minors once emancipated)
 - 6 states allow a minor who is a parent to consent
 - 6 states allow a minor who is or has ever been pregnant to consent to services
 - 11 states allow a minor to consent if the minor meets other requirements, including being a high school graduate, reaching a minimum age, demonstrating maturity or receiving a referral from a specified professional, such as a physician or member of the clergy; and
- 4 states have no explicit law on minors' authority to consent to contraceptive services.⁷¹

Emergency contraception. Parental consent and/or notification are not required for minors to obtain emergency contraception.⁷² The federal Food and Drug Administration (FDA), pursuant to a 2009 court order, has stated anyone age 17 or older may acquire emergency contraception without a prescription.⁷³ The FDA has also said emergency contraception without parental notification or consent is available from a pharmacy with a prescription to anyone under 17 years old.

Connecticut law further provides any licensed health care facility that provides emergency treatment to any victim of a sexual assault must provide the victim with accurate and objective information about emergency contraception, inform the victim of the availability of

⁶⁸ Guttmacher Institute: State Policies in Brief, *Minors Access to Contraceptive Services*, September 2011.

⁶⁹ Alaska, Arizona, Arkansas, California, Colorado, Georgia, Idaho, Iowa, Kentucky, Maryland, Massachusetts, Minnesota, Montana, New Mexico, New York, North Carolina, Oregon, Tennessee, Virginia, Washington, Wyoming

⁷⁰ Alabama, Connecticut, Florida, Illinois, Indiana, Louisiana, Maine, Michigan, Mississippi, Missouri, Nebraska, Nevada, New Jersey, Oklahoma, Pennsylvania, South Carolina, South Dakota, Texas, Utah, Vermont, West Virginia

⁷¹ North Dakota, Ohio, Rhode Island, Wisconsin. (Note: Connecticut is defined by Guttmacher as a state explicitly allowing emancipated married minors to consent to medical services, of which Guttmacher considers contraceptive services. For purposes of this study, Connecticut is a state with no explicit policy regarding minors and contraceptive services beyond the emancipation provision.)

⁷² Emergency contraception is used as a back-up birth control method to prevent pregnancy after unprotected sexual intercourse, sexual assault, or a contraceptive failure. The FDA has approved one type of emergency contraception (*Plan B One Step*) made available without a prescription to anyone 17 or older.

⁷³ See: <http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/2009/ucm149568.htm>, accessed 9/10/11

emergency contraception, and provide emergency contraception to the victim at the victim's request, unless the victim has been determined to be pregnant by an FDA approved pregnancy test.⁷⁴ Twelve states, plus D.C., require emergency rooms to dispense emergency contraception at the request of the minor.⁷⁵ Connecticut has such a requirement, but a hospital may contract with an independent medical professional to provide the emergency contraception services.⁷⁶

Pregnancy testing and related care. Minors do not need parental consent to obtain a pregnancy test or routine gynecological care for pregnancy. Connecticut law is silent on this topic, but minors are able to consent to such care based on their constitutional right to privacy. At the same time, Connecticut law specifically states a married minor or a minor parent can consent to medical, dental, health, and hospital services for his or her child and is liable for the costs of that care.⁷⁷

One area of law in Connecticut that remains unsettled is if a minor needs permission from a parent or guardian to obtain invasive procedures associated with pregnancy, including amniocentesis and epidurals.⁷⁸ On one hand, such procedures are viewed as confidential in that they are part of reproductive health care and affect reproductive rights, thus falling under the right to privacy for pregnancy matters. At the same time, these examples may be construed as medical procedures, which would require parental consent under the theory that the minor does not have the legal capacity to provide such consent.

Abortion. In general, Connecticut's laws related to parental involvement in adolescent health care are fairly similar to those in a number of other states, with the exception of pregnancy termination. In 37 states, a minor is required to obtain consent from or provide notice to one or both parents before terminating her pregnancy, or file for a judicial bypass. A judicial bypass is an expedited proceeding that requires a judge to rule: 1) whether the minor is mature enough to make the termination decision on her own; or 2) absent a finding of maturity, if termination is otherwise in her best interest.

Connecticut does not require a minor to seek parental consent/notification, and thus has no judicial bypass process. By statute, Connecticut does require minors seeking abortions to first receive counseling, the substance of which is set out in statute and requires discussing the possibility of involving the minor's parents (a minor for pregnancy termination purposes is defined to be under age 16 in Connecticut.)⁷⁹ As prescribed by law, the following licensed

⁷⁴ C.G.S. Sec. 19a-112e(6)(b)(3).

⁷⁵ California, Connecticut, Massachusetts, Minnesota, New Jersey, New Mexico, New York, Oregon, South Carolina, Utah, Washington, Wisconsin

⁷⁶ C.G.S. Sec. 19a-112e

⁷⁷ C.G.S. Sec. 19a-285

⁷⁸ *Adolescent Health Care: Legal Rights of Teens*, Fourth Edition, Center for Children's Advocacy: Medical-Legal Partnership Project, 2010, p.16.

⁷⁹ As with many areas of public policy, laws and practices concerning parental involvement are, for the most part, developed to reflect the values and norms of local communities. It is widely accepted among health professionals and children's advocates that involving parents in adolescent health care decisions is good practice. Connecticut providers and others interviewed by committee staff said teens should be encouraged to communicate with their parents and families to the extent feasible. PRI staff did not identify any definitive scientific evidence regarding the positive or negative impact of various parental notification and consent policies, nor are there generally accepted research-based best practices about parental involvement.

professionals are considered appropriate counselors: psychiatrist; psychologist; clinical social worker; marital and family therapist; ordained minister of the clergy; physician assistant; nurse-midwife; certified guidance counselor; registered professional nurse; and licensed practical nurse; although not included in the statutory definition of “counselor,” physicians can provide information and counseling.⁸⁰

When counseling a minor prior to the performance of an abortion, the following information must be explained, as specified in statute:

- information given to the minor is provided objectively and is not intended to coerce, persuade or induce the minor to choose to have an abortion or to carry the pregnancy to term;
- the decision to have an abortion may be withdrawn at any time before the abortion is performed or may reconsider a decision not to have an abortion at any time within the time period during which an abortion may legally be performed;
- alternative choices are available for managing the pregnancy, including: 1) carrying the pregnancy to term and keeping the child; 2) carrying the pregnancy to term and placing the child for adoption, placing the child with a relative, or obtaining voluntary foster care for the child; and 3) having an abortion, and explaining that public and private agencies are available to assist the minor with whichever alternative she chooses and that a list of these agencies and the services available from each will be provided if the minor requests;
- public and private agencies are available to provide birth control information and that a list of these agencies and the services available from each will be provided if the minor requests;
- involving the minor's parents, guardian or other adult family members in the minor's decision-making concerning the pregnancy is a possibility and whether the minor believes that involvement would be in her best interests; and
- adequate opportunity for the minor to ask any questions concerning the pregnancy, abortion, child care, and adoption, and provide information the minor seeks or, if the person cannot give the information, to indicate where the minor can receive the information.

Once a minor receives the necessary information, the counselor is required to have her sign and date a form stating she has received the information contained in the above points. The person providing the counseling also must sign and date the form, and provide other information on the form. The signed form must be kept in the minor’s medical record. A copy must be given to the minor and the minor’s attending physician.

The statutory counseling provision does not apply when, in the best medical judgment of the minor’s physician, a medical emergency exists that so complicates the pregnancy or the

⁸⁰ C.G.S. Sec. 19a-600(1)

health, safety, or well-being of the minor as to require an immediate abortion. Such medical emergency must be documented in the minor's record.

Nationally, states have various requirements as to parental involvement regarding abortion and minors.⁸¹ Overall:

- 37 states require some type of parental involvement in a minor's decision to have an abortion
 - 22 states require one or both parents to *consent* to the procedure⁸²
 - 11 states require parental *notification* only; 1 of which requires both parents⁸³
 - 4 states require both parental *consent* and *notification*⁸⁴
- 6 states have laws that are enjoined, meaning policy not in effect⁸⁵
- 2 states (Connecticut, Maine) and the District of Columbia have laws giving minors authority to obtain abortions without parental notification or consent – Maine requires written consent from the minor and one parent, guardian, or adult family member⁸⁶
- 37 states that require parental involvement have an alternative process for minors seeking an abortion
 - 37 states include a judicial bypass procedure, which allows a minor to obtain approval from a court⁸⁷
 - 6 states requiring parental involvement permit minor to obtain an abortion if a grandparent or other adult relative is involved in the decision
- Most states that require parental involvement make exceptions under certain circumstances
 - 32 states permit a minor to obtain an abortion in a medical emergency
 - 16 states permit a minor to obtain an abortion in cases of abuse, assault, incest or neglect

In *Bellotti v. Baird*, the U.S. Supreme Court said that if states require parental consent as a condition for minors seeking abortions they must also “provide an alternative procedure whereby authorization for the abortion can be obtained.”⁸⁸ The ruling declared that a pregnant

⁸¹ Guttmacher Institute: http://www.guttmacher.org/statecenter/spibs/spib_PIMA.pdf, accessed 9/2011 and 2/2012.

⁸² Alabama, Arizona, Arkansas, Idaho, Indiana, Kansas, Kentucky, Louisiana, Massachusetts, Michigan, Mississippi, Missouri, Nebraska, North Carolina, North Dakota, Ohio, Pennsylvania, Rhode Island, South Carolina, Tennessee, Washington, and Wisconsin

⁸³ Alaska, Colorado, Delaware, Florida, Georgia, Iowa, Maryland, Minnesota, New Hampshire, South Dakota, West Virginia

⁸⁴ Oklahoma, Texas, Utah, Wyoming

⁸⁵ California, Illinois, Montana, Nevada, New Jersey, New Mexico

⁸⁶ M.R.S. Title 22, Chapter 263-B, Sec. 1597-A(2)

⁸⁷ New Mexico's abortion law is enjoined; state is shown in Guttmacher information as not having an alternative procedure.

⁸⁸ *Bellotti v. Baird*, 443 U.S. 622 (1979), pp. 642-644

minor is entitled to such a proceeding to show either: 1) she is mature enough and well enough informed to make her abortion decision, in consultation with her physician, independently of her parents' wishes; or 2) even if she is not able to make this decision independently, the desired abortion would be in her best interests.

Each state currently with parental consent and/or notification requirements before a minor can undergo an abortion has a judicial bypass option, as a requirement of the U.S. Supreme Court ruling.⁸⁹ Judicial bypass allows a minor to go to court for a judicial hearing when her parents refuse to consent to an abortion. As noted above, this option allows minors to request a judge waive parental consent requirements, when the court finds the minor is mature or that it would be in the best interest of the minor not to involve her parents in the abortion decision.

Additional data about pregnancy terminations and the patient's state of residence are set out in Table IV-3. The sources of these data are the annual *DPH Statistical Summary of Legal Induced Abortions Occurring in Connecticut* for 2006-2010, which are based on reports that health care providers are required to submit to DPH. There is some interest in these data because Connecticut does not require a minor to either notify her parents or obtain parental consent in order to terminate a pregnancy, while two neighboring states, Massachusetts and Rhode Island each have such a requirement in place, along with a judicial bypass provision. (The other neighboring state, New York, does not have a parental consent or notice requirement.)

The top half of the table shows the total number of reported abortions for patients of all ages in Connecticut over five years, and provides a breakdown by the state within which the person obtaining the abortion resides. As shown, the numbers of out-of-state patients range from 408 in 2010 to 462 in 2009, averaging 434 a year, or approximately three percent of all abortions.

The bottom half of the table shows the out-of state resident abortion numbers by age. The annual average number of abortions for women 19 and under, and not Connecticut residents, was 126, for the five years shown. Using 2010 numbers, the abortions for persons 19 and under not living in Connecticut represented 0.68 percent of all the abortions performed that year. DPH has no information on the reasons why these residents of neighboring states, some of whom were minors, terminated their pregnancies in Connecticut.

Table IV-4 : Legal Induced Abortions in Connecticut: By Patient's State of Residence and Age 19 and Under					
Abortions in Connecticut by Patient's Specific State of Residence (all ages)					
	<u>2006*</u>	<u>2007*</u>	<u>2008*</u>	<u>2009*</u>	<u>2010*</u>
Total	14,112	14,534	14,442	13,732	13,438
State of Residence					

⁸⁹ State Policies in Brief, *Parental Involvement in Minors' Abortions*, Guttmacher Institute, September 1, 2011.

CT	13,694	14,091	14,005	13,270	13,030
MA	178	165	154	136	135
RI	79	107	105	124	99
NY	125	126	122	160	129
Other	36	45	56	42	45
<i>Total Non-CT Residents</i>	<i>418</i>	<i>443</i>	<i>437</i>	<i>462</i>	<i>408</i>
Abortions in Connecticut By Patient's Age and Residence In or Out of Connecticut					
CT Resident & Age 19 and Under	2,592	2,621	2,504	2,280	2,068
Non-CT Resident & Age 19 and Under**	141	149	138	108	92
Non-CT Resident & Age 20 and Up	277	294	299	354	316
*There are records with missing age data as follows for each year: 2006, 314; 2007, 373; 2008, 615; 2009, 321; and 2010, 260.					
**Available information that reports both age and state of residence combines ages into groups (e.g. 15-19, <15) and state of residence in two categories: CT and non-CT. Thus specific resident state-to-age comparisons were not possible.					
Source of Data: DPH Statistical Summaries of Legal Induced Abortions Occurring in Connecticut (for 2006-2010).					

Sexually Transmitted Disease (STD) Testing and Treatment

Connecticut law provides that minors may be examined and provided treatment by any municipal health department, state institution or facility, licensed physician, or public or private hospital or clinic for sexually transmitted diseases.⁹⁰ Consent of the minor's parent or guardian is not required as a prerequisite to the consultation, examination, and treatment of the minor. Minors are personally liable for all costs and expenses relating to such consultation, examination, and treatment.

Information regarding the consultation, examination and treatment of a minor for a sexually transmitted disease is confidential and must not be revealed by the facility or physician conducting the services, including through sending a bill, to any person other than the minor. One exception to this is compliance with the statutory requirement of making a report to DPH based on the list of reportable diseases and laboratory findings developed by the department. Another exception is through the facility or physician must report the name, age and address of

⁹⁰ C.G.S. Sec. 19a-216

such minor to DCF if the minor is under 13. In addition, any provider who believes a minor either cannot take care of him/herself or is endangering their own health, has an ethical duty to inform a responsible adult of the situation.

Nationally, every state and the District of Columbia allow all minors to consent to sexually transmitted infections (STI).⁹¹ Eighteen states allow, but do not require, a physician to inform a minor's parents that the minor is seeking or receiving STI services, when the physician determines such disclosure is in the best interest of the minor. Moreover, several states have established specific minimum ages for a minor to consent to STI services.

HIV/AIDS. A minor can be tested for Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) without parental consent.⁹² Health care providers may give counseling, as needed, at the time the lab results are presented to the tested person. Such counseling includes coping with the emotional consequences of learning the result and information about available medical treatment and services. HIV testing is voluntary, and minors also may choose, without parental involvement, not to be tested.

Physicians examining and/or treating a minor may do so without parental consent if the physician determines: 1) notification of the minor's parents or guardian will result in denial of treatment; or 2) the minor will not seek, pursue, or continue treatment if the parents or guardian are notified, and the minor requests that his or her parents not be notified.⁹³ All lab results must be sent directly to the person ordering the HIV/AIDS test. Insurance billing is confidential and must not be divulged without the minor's consent to any person other than the minor, until the physician consults with the minor regarding the sending of a bill. A minor is personally liable for all costs and expenses for any HIV/AIDS services received.

⁹¹ State Policies in Brief, *An Overview of Minors' Consent Laws*, Guttmacher Institute, September 1, 2011.

⁹² C.G.S. Sec. 19a-582(a)

⁹³ C.G.S. Sec. 19a/592(a)

Inpatient Mental Health Care

For purposes of admitting a minor to a hospital for diagnosis or treatment of a mental disorder, minor is defined under Connecticut law as someone less than 16 years old.⁹⁴ Under Connecticut law, anyone 16 or older can commit to inpatient hospitalization for treatment of a mental disorder. Further, a minor who is 14 or 15 years old may be admitted for inpatient mental health services without consent of his or her parents if such child consents in writing.⁹⁵ If this occurs, parents must be notified within five days of such admission. If the parents cannot be located, then the child's nearest relative must be notified. Hospitals can admit minors upon the written request of the child's parent.

If a parent or guardian requests written release of his or her minor child who has been voluntarily self-committed to a hospital for mental health services, the hospital either must release the child or commence commitment proceedings in accordance with state statute. The hospital may detain the child for five business days, in order to allow an application to be filed.

If an application is filed to commit the 14 or 15 year old child to a hospital, the child must remain hospitalized for an additional period of time to allow the application to be heard. The hospital may detain the child until the application for commitment is heard or 25 days, whichever is longer.

Children in DCF custody cannot be admitted for diagnosis or treatment unless: 1) requested by the commissioner; 2) legal counsel appointed by the court for juvenile matters or probate court provides written agreement to the admission; and 3) the child, if 14 years old or over, consents to admission. The same parental notification and additional detainment requirements outlined above apply.

Minor patients who signed themselves into a hospital may sign themselves out of a hospital as long as they pose no threat to themselves or others in the community.

Outpatient Mental Health Care

Outpatient mental health treatment means the treatment of mental disorders, emotional problems or maladjustments with the objective of: a) removing, modifying or retarding existing symptoms; b) improving disturbed patterns of behavior; and c) promoting positive personality growth and development. Treatment for mental health outpatient care does not include prescribing or otherwise dispensing any medication.⁹⁶

A licensed psychiatrist, independent social worker, or a marital and family therapist may provide outpatient mental health treatment to a minor without the consent or notification of a parent or guardian at the request of the minor, if: 1) requiring the consent or notification of a parent or guardian would cause the minor to reject such treatment; 2) the provision of such treatment is clinically indicated; 3) the failure to provide such treatment would be seriously detrimental to the minor's well-being; 4) the minor has knowingly and voluntarily sought such

⁹⁴ C.G.S. Sec. 17a-75

⁹⁵ C.G.S. Sec. 17a-79

⁹⁶ C.G.S. Sec. 19a-14c

treatment; and 5) in the opinion of the provider of treatment, the minor is mature enough to participate in treatment productively.⁹⁷

After the sixth session of outpatient mental health treatment, the provider must notify the minor that the consent, notification or involvement of a parent or guardian is required to continue treatment. This must occur unless the provider determines parental involvement would be seriously detrimental to the minor's well-being, which must be documented in the minor's record. Reevaluation must occur after every sixth session. Minors who voluntarily seek outpatient mental health treatment without parental notification are responsible for the costs associated with the treatment.

The treatment providers must document in the minor's clinical record the reasons for the determination to treat the minor without parental or guardian consent or notification. This includes a written statement signed by the minor, stating he or she has: a) voluntarily sought such treatment; b) discussed with the provider the possibility of involving his parent or guardian in the decision to pursue such treatment; c) determined it is not in his best interest to involve his parent or guardian in such decision; and d) been given adequate opportunity to ask the provider questions about the course of his treatment.⁹⁸

⁹⁷ *Id.*

⁹⁸ *Id.*

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APPENDICES

- A. Agency Responses
 - Department of Children and Families
 - Department of Social Services
 - Department of Education
 - Department of Public Health (with PRI staff annotations)
- B. Results-Based Accountability (RBA) Background
- C. PRI Information Forum and Public Hearing on Adolescent Health, June 21, 2011: Summary of Main Themes
- D. Key Indicators: Adolescent Health in Connecticut
- E. Connecticut Adolescent Health Infrastructure
- F. Background: School-Based Health Centers in Connecticut
- G. KIDS COUNT Profile: Connecticut (2011)
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- I. Locations: Connecticut School-Based Health Centers (State-Funded)
- J. Federal Definition: School-Based Health Center
- K. Need Indicators: School-Based Health Centers
- L. PRI Staff Analysis of State-Funded School-Based Health Centers

APPENDIX A

Agency Responses

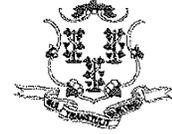
It is the policy of the Legislative Program Review and Investigations Committee to provide state agencies that are the subject of a study with the opportunity to review and comment on committee findings and recommendations prior to publication in a final PRI report document. Written responses for this study were solicited from the four agencies with primary responsibility for adolescent health: the Departments of Children and Families, Social Services, Education, and Public Health. Each agency submitted a formal response; copies are included in this appendix. Clarifying comments from PRI staff were added to the DPH response.



Joette Katz
Commissioner

DEPARTMENT of CHILDREN and FAMILIES

Making a Difference for Children, Families and Communities



Dannel P. Malloy
Governor

May 24, 2012

Ms. Carrie E. Vibert, Director
Legislative Program Review and Investigations Committee
State Capitol, Room 506
HARTFORD, CT 06106

Dear Ms. Vibert:

I appreciate the opportunity to respond to the Program Review and Investigations study entitled *Adolescent Health Coordination and School-Based Health Centers in Connecticut: RBA Project 2011*.

After reviewing your report and recommendations, I commend you on your good work, and agree with your recommendations. Some of those recommendations, in particular: development of a multi-agency oversight, planning and coordination group; an adolescent health coordinator assigned by each agency; multi-agency strategic planning for adolescent health; prioritizing health insurance for teen clients; and improving the health literacy of adolescents; are recommendations that require DCF participation. I strongly agree with these recommendations, and if these recommendations are accepted, I will assign appropriate DCF staff members to cooperate in these efforts.

I am also in agreement with your recommendation that the adolescent health population report card prepared for this study should be continued, and integrated with the current children's report card in which DCF participates.

Sincerely,

Joette Katz
Commissioner

Cc: J. Howroyd
A. McIntyre-Lahner
F. Wolman



RODERICK L. BREMBY
Commissioner

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May 31, 2012

Carrie E. Vibert
Director
Legislative Program Review and Investigations Committee
State Capitol, Room 506
Hartford, CT 06106

Dear Ms. Vibert:

Thank you for sharing the draft copy of the Legislative Program Review and Investigation Committee's final report titled *Adolescent Health Coordination and School-Based Health Centers in CT: RBA Project 2011* and for the invitation for the Department of Social Services (DSS) to comment on the report.

The report finds that although Connecticut's teens, defined as those aged 10 – 19 years, have better access to health services than most teens nationwide, those in Connecticut are still underserved, under utilize preventive care, and participate in risky health behaviors at alarming rates. Further, the report finds that there is no concerted state effort to address barriers faced by Connecticut teens to access health care and to narrow the disparities in health status across different segments of the teen population. The department agrees with these findings as well as with the Committee's recommendations that focus on re-invigorating the adolescent health strategic planning process, with strengthened coordination and leadership by the Department of Public Health and with DSS serving as one of the agencies intimately involved in the effort.

We note that the report calls for improved and expanded collection and analysis of HUSKY and other state-funded health program data, specifically through DSS participation the Connecticut Health Information Network (CHIN) and pursuit of a research partnership with the University of Connecticut Institute for Public Health Research. While the department does not dispute the need for greater capacity to conduct meaningful data analysis, we remind the committee that the department's ability to share data with outside entities is limited by the bounds of state and federal law, as we explained at length in our November 22, 2011 letter.

Any other actions recommended by the committee that would impact HUSKY or other publicly funded programs could only be undertaken within available appropriations and subject to the requirements of applicable federal rules and approvals.

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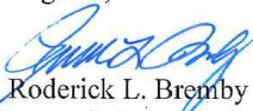
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Ms. Carrie E. Vibert
May 31, 2012
Page 2

Thank you for your comprehensive review and thoughtful recommendations on this important and often overlooked topic. It was a pleasure to work with your professional and accommodating staff and we look forward to our continued work together on the Committee's 2012 studies.

Regards,


Roderick L. Bremby
Commissioner

cc: Jill Jensen, LPRIC
Brian Beisel, LPRIC
Robert Zavoski, M.D.



STATE OF CONNECTICUT
DEPARTMENT OF EDUCATION



May 29, 2012

Ms. Carrie E. Vibert, Director
The Legislative Program Review
and Investigations Committee
The State Capitol, Room 506
Hartford, CT 06106

Dear Ms. Vibert:

The Connecticut State Department of Education (CSDE) has reviewed the *Adolescent Health Coordination and School-Based Health Centers in CT: RBA Project 2011*. While this report focuses mainly on adolescent health coordination and school-based health centers in Connecticut, the report provides a comprehensive review of adolescent health and the CSDE supports the final recommendations.

Sincerely,

Cheryl Resha, Ed.D.
Education Manager
Bureau of Health/Nutrition, Family Services
and Adult Education

CRs

cc: Stefan Pryor, Commissioner
Charlene Russell-Tucker, Chief Operating Officer
Sarah Hemingway, Legislative Liaison
Bonnie Edmondson, Education Consultant

AGENCY RESPONSE FROM
Connecticut Department of Public Health (May 25, 2012)
Annotated with PRI Staff Comments

**Adolescent Health Coordination and School-Based Health Centers in Connecticut:
RBA Project 2011**

(DPH Note: Language directly from the draft is in bold; comments from the Department of Public Health are unbold).

Coordination and Leadership

1. **A workgroup composed of representatives of state agency and community partners with major responsibilities for adolescents in Connecticut should be established to oversee and direct planning and coordination policies, programs, resources, and data related to adolescent health in Connecticut. The adolescent health coordination workgroup should operate in collaboration with the state Coordinated School Health initiative.**

DPH: Who is the lead for this workgroup? What are the logistics? The Coordinated School Health grant is coming to an end; therefore, will this new workgroup be a stand-alone workgroup? What is the purpose of this workgroup? Clarify which state agencies should be involved.

PRI Staff Comment: As explained on pages 34-35 of the report, the workgroup is intended to provide a vehicle and framework for a concerted, statewide effort to improve the health of Connecticut adolescents, something found crucial for progress, but lacking, by the PRI and all prior studies. As the state's health agency, it is logical that DPH would take a leadership role among the many partners responsible for achieving better health results for all the state's youth. These partners include multiple state agencies, as specified on page 33. It would be unfortunate if the collaborative work of the coordinated school health initiative ceases when federal grant funding ends, but the adolescent health coordination workgroup clearly could and should continue to operate on its own.

2. **An adolescent health coordinator should be designated in each agency with a key role in promoting the health and well-being of Connecticut youth; at a minimum, there should be coordinators at the departments of public health, education, children and families and social services and the Court Support Services Division of the Judicial Branch.**

DPH: DPH is the state's health agency, so "an adolescent health coordinator" should reside within the DPH. Other state agencies may have "adolescent services coordinators". The relationship of these coordinators is not clear.

PRI Staff Comment: Although DPH clearly is the state's lead health agency, multiple state agencies, as discussed on pages 12-14 of the report, have major responsibilities for the physical, behavioral, and oral health of the adolescent clients they serve. Officially assigning a staff person within each agency the duty of coordinating adolescent health matters internally and across agencies can facilitate interdisciplinary communication, collaborative service delivery, and effective partnerships. All of these efforts are necessary, as national research shows, to meet the

multi-faceted and complex needs of teens. The department could refer to the framework developed for implementation of the 2005 Adolescent Health Strategic Plan as guide for the roles and relationships of the PRI recommended adolescent health coordinators and workgroup.

- 3. The Department of Public Health, with the assistance of the workgroup, should update and continue to keep current, the state adolescent health strategic plan. Strategic planning for adolescent health should be a central component of the department's present federally driven, comprehensive state plan process, Healthy People 2020.**

DPH: We must work comprehensively to address child and adolescent health –rather than just adolescent- and make meaningful efforts to address gaps? Are we using the Healthy People 2020 objectives? (Note: Healthy People 2020 is not a plan. The document is a compendium of specific health objectives for the nation). Producing or even just updating yet another strategic plan may not be as meaningful in addressing the gaps. We propose utilizing and –as necessary –revise/update the needs assessments that guide programs for children and adolescents (i.e., Maternal and Child Health Services Block Grant, and the Maternal, Infant and Child Home Visiting Program). These are examples of dynamics documents that really guide the programming of service delivery for the target populations.

PRI Staff Comment: Healthy People 2020, as noted on p. 35 of the report, is not a plan per se but a national agenda with science-based goals and objectives intended to be a framework for identifying priorities and tracking progress. The department's current Healthy Connecticut 2020 planning process is a parallel effort to the national initiative, which seems well-suited for updating and further developing a comprehensive approach for meeting the distinct health needs of the state's adolescents as well as other target populations. Existing, separate DPH needs assessments, while important, are not a substitute for a cohesive, measurable set of strategic statewide actions to improve health outcomes for those ages 10 to 19.

Access and Utilization

- 4. State agencies and state-funded community providers serving adolescents should make getting and keeping their teen clients insured a priority. The Department of Social Services, as part of its new information technology improvement projects, should ensure clear, correct, and complete information on its health insurance programs are available on-line.**
- 5. DSS should also take all steps necessary to simplify application and renewal procedures and address the causes of administrative errors that result in gaps in coverage for adolescents.**

DPH: 4-5 DPH will partner with the Department of Social Services as necessary.

- 6. The adolescent health coordination workgroup recommended earlier should make increasing EPSDT participation among adolescents, particularly older teens, a top goal. Among the strategies the group should consider are ways to:**
 - a. Improve the health literacy of adolescents, such as ensuring schools are providing a comprehensive, quality health education curriculum, so teens are**

**aware of the short and long-term benefits of primary and preventive care;
and**

- b. Expand school- and community-based primary and preventive care services for adolescents.**

DPH: Early Periodic Screening, Diagnosis, and Treatment (EPSDT) will be included in contract language. Health education curricula are for the schools (local Boards of Education) to decide.

PRI Staff Comment: Including performance measures related to EPSDT participation in department contracts with relevant providers such as School-Based Health Centers, could be an effective strategy for increasing adolescents' use of primary and preventive health care services. While local districts have ultimate authority over health education curricula, it seems DPH, as the state's lead health agency, also has a role in recommending possible content standards and best practices that can improve health literacy.

Adequate Accountability Data

- 7. The adolescent health coordination workgroup should track the state's progress in achieving desired health results for Connecticut youth ages 10 to 19.**
- 8. The adolescent health population report card prepared for this study should be continued, with the assistance of the workgroup, and integrated with current children's report card initiative being carried out by the legislature's Select Committee on Children under P.A. 11-109**

DPH: #7: DPH will work with this workgroup as needed. However, 7-8 may be out of sync with each other. In #8, what is the current age group? Is the Select Committee on Children already addressing health? If yes, through who, and what would be the purpose of creating yet another Report Card?

PRI Staff Comment: Recommendations 7 and 8 actually are complimentary. At present, the children's report card project being carried out by the legislature's Select Committee on Children incorporates state policies and programs aimed at ensuring all Connecticut children (individuals under age 18) live in stable environments, and are safe, healthy, and ready to succeed. A number of primary and secondary indicators of the health of Connecticut's children and youth have been developed and will be refined as the project continues. Expanding the scope of the current statutory report card to include information about the state's young adult population (ages 19 to 25) is under consideration. The intent of the recommendation is to supplement the information about the health of Connecticut's children and youth contained in the current report card, not create another, separate population report card.

- 9. Data analysis for the HUSKY programs and other state-funded health services to adolescents should be ensured and possibly expanded by:**
- a. Continued funding for the program monitoring and evaluation work of Connecticut Voices for Children; and**
- b. Pursuing DSS participation in CHIN and a research partnership between the department and the UConn Health Center Institute of Public Health Research.**

DPH: No comments; this pertains to the Department of Social Services.

10. As part of the adolescent health data development and research agenda,
 - a. A Cost effectiveness analysis of school-based health centers in Connecticut should be conducted as recommended below (see #22); and
 - b. The current status of Electronic Health Records among the state's public schools, including how many districts have automated their school health assessments forms, should be determined along with an estimate of the resources for implementation statewide.

DPH: for "a." see #22. For "b." this is the responsibility of the State Board of Education.

School-Based Health Centers

11. The federal definition of school-based health center contained within the Social Security Act should be codified in Connecticut. Included in this definition should be the definition of primary care as defined by the Connecticut Office of health Care Access in its Statewide Healthcare Facilities and Services Plan.

DPH: The DPH supports this idea; taking appropriate action is the responsibility of the Legislature.

PRI Staff Comment: DPH should seek legislation in the 2013 session to implement this recommendation.

12. The Committee on School-Based Health Clinics established under C.G.S. Sec. 19a-6i should continue its work on crafting a more formal definition of school-based health center to include standards around overall comprehensiveness of operations (e.g., staffing types and levels, hours of availability) and the types and level of services provided by such centers.

DPH: The School-Based Health Centers Advisory Committee can work on this in collaboration with the DPH.

13. School-based health center grant allocations by the public health department should be tied to center performance, including staffing levels, services provided, and student health outcomes. Within this process, the Department of Public Health should develop a formal protocol for allocating state grants based on specific, measurable outcomes that ultimately determine whether the program is making a difference in the overall health of students. Beginning in 2014, state funding for school-based health centers should be based on a competitive application process as developed by the public health department. At minimum, prospective grantees must demonstrate student health care needs at the school site and why state funding is necessary to support the school-based health center at that site.
14. The Department of Public Health should conduct a full analysis of the cost per visit by individual state-funded school-based health centers. The results should be used by the department as one factor for determining the funding levels for centers.

15. **The Department of Public Health should establish formal performance goals for state-funded school-based health centers, including increased access to health care for uninsured/underinsured students, the provision of preventive care to students, and the degree to which centers increase student attendance and academic achievement. The department should develop standardized measures used to evaluate school-based health center performance against the goals.**
16. **The program's current data collection and reporting requirements should be replaced with a Results-Based Accountability-style report card for each center based on the newly-developed performance measures and targeted outcomes. A report card summarizing the annual performance of the department's school-based health center program also should be developed. At minimum, the department should post the summary report card on its website.**
17. **The Department of Public Health and key stakeholders should develop short and long-term plans for replacing the current automated management information system with one that collects the most relevant automated data for program management purposes based on specific program goals and performance measures established by the department. As part of this process, the department should work with the current ad-hoc committee on school-based health centers, and elicit feedback from all centers, as to what data are most relevant and collectable for program performance purposes.**

DPH: 13-17 are all related. Historically, the DPH has allocated funds to SBHC following language in the state budget (#13). Provided flexibility for the DPH, we will develop an allocation process taking into account cost per visits (#14) among other components. It is the intent of the DPH to establish performance goals and standardized measures to evaluate effectiveness (#15). However, we have capacity limitations -81 state-funded SBHCs vs. limited staff (2 FTE). In addition, the 2012-2013 state budget includes increased funding for SBHCs, with a mandate to establish at least twenty (20) new sites. Additional resources must accompany this budget increase to help DPH reach adequate staff capacity. This means adding resources to fund at least one FTE for Epi support (data analysis and evaluation) and one FTE for contract monitoring and oversight.

An automated data collection system is being developed and will be launched for use beginning the 2012-2013 academic-year. Reporting requirements will be reconsidered, but it is not the intent of the DPH to replace them with the RBA Report Card (#16 and #17). We propose to require that each SBHC site develops a Report Card as part of their reporting to DPH, but not in lieu of information that is critical for evaluation purposes. Report Cards from state-funded SBHCs **must** include Health Equity as one of the primary indicators.

PRI Staff Comment: As noted on p.65 of the PRI report, grants to centers primarily have been based on historical allocations provided to the centers over time from when they were originally funded or specific legislative appropriation amounts, and not on specific performance measures or outcomes. Decisions on where to locate school-based health centers and at what level to fund the centers, should be based on a formal process using standardized criteria. Thus, it is

imperative the department begin developing appropriate measures to adequately determine how well school-based health centers are performing, and performance information from centers should be reported to the department in the most useful and efficient manner possible. If the department determines it needs more staff resources to support the additional school-based health centers approved by the legislature, it should make such a request. Moreover, if DPH wants to include "Health Equity" as part of the SBHC report card format, committee staff believes that works within the overall intent of the recommendations, although it seems more suitable as a measure of center performance than a primary indicator of adolescent health progress. (As suggested in Appendix D, disparity in health outcomes at the population level should be tracked by examining indicator data disaggregated by race/ethnicity, gender, income, and other demographics.)

- 18. The Department of Public Health should begin collecting, maintaining, and analyzing information about licensed, nonfunded health centers in public schools. The information collected should be relevant to helping the department establish a full profile of the physical, mental, and dental health resources provided in schools by state-licensed entities to improve student's overall health.**

DPH: We are currently doing this through a student intern, but we can only expect these sites to volunteer information. SBHCs that are not state-funded, do not have an obligation to provide DPH with this information. DPH has no programmatic authority over SBHC that are not our contractors.

PRI Staff Comment: As state's lead agency for public health licensing and the coordinator of the school-based health center program, DPH has the ability and responsibility to obtain fundamental information from state-licensed school-based health centers regardless of whether they receive state funding. An understanding of at least the location of nonstate-funded centers, their basic staffing levels, and the services they provide would help the department better identify where children are receiving their health services in the state and the types of service they receive. Such information would be very useful from a public health planning perspective.

- 19. DPH should continue providing technical assistance and training to school-based health center staff, and, to the extent possible, use webinars, e-conferences, and frequently-updated website information to provide such assistance. A frequent review of centers' technical assistance needs should be conducted.**
- 20. The department should serve as a clearinghouse for innovative and promising practices for school-based health centers, and disseminate best practice information to centers on a regular basis. Included in this effort should be assistance to sponsoring agencies to maximize their funding resources outside of state funding and working with centers in transitioning to electronic medical records.**

DPH: For #19-20, we propose to create a page embedded in the DPH website for information on School Age Children (#19). We propose and plan to increase the TA offered to SBHC state-funded sites by: a) assessing their TA needs; b) allowing SBHC to recommend speakers; c) inviting them to share their best practices with others. We will do this through monthly conference calls and quarterly contractors' meetings.

- 21. The department should fully evaluate SBHCs and their role/ability to serve within the medical home model for students.**

DPH: SBHCs are not medical homes by definition. This is DSS' role; DPH can work with DSS and the SBHC contractors who are interested in pursuing the medical home model designation. Some sites will need to partner with community resources. We will invite SBHCs contractors to participate in the Medical Home Advisory Council (MHAC) where information about linking consumers to community resources is presented. We will add a link in the DPH website to an on-line curriculum on Medical Homes, which will be soon released by the A.J. Pappanikou Center for Excellence in Developmental Disabilities (UConn).

PRI Staff Comment: PRI understands school-based health centers currently are not medical homes by definition. The intent of the recommendation on p.72 of the report is DPH, along with the SBHC Advisory Committee, continue to work with DSS to determine whether school-based health centers under certain circumstances would meet the definition of "medical home."

22. A comprehensive longitudinal analysis should be completed showing the relationship between Connecticut's state-funded school-based health centers and health outcomes of students using such centers. A comparative analysis between school-based health center users and nonusers regarding their academic performance and school absenteeism, tardiness, and discipline issues should be done. The study also should include a cost-benefit analysis of school-based health centers in Connecticut. The public health department should determine the overall parameters of the study.

This is a very ambitious goal which will require significant time, financial and human resources. In addition, this is pure research, which falls outside of our mission. Therefore, we will contract with an academic institution or a competent research consultant should the resources become available for a study of this magnitude.

Other comments

1. Title: Adolescent Health Coordination and School-Based Health Centers in Connecticut: RBA Project 2011

DPH: It was understood that School Based Health Centers would be used as a sample of the work related to adolescent work, and that reproductive health was also going to be examined. However, the final title of the report - **Adolescent Health Coordination and School-Based Health Centers in Connecticut: RBA Project 2011** –implies that this was an exhaustive study on SBHC in CT. This may be misleading. The document is a report of findings, not an analysis of coordination. Furthermore, the report only refers to state-funded SBHCs, which is not a clear depiction of SBHCs in Connecticut. There are at least thirty (30) SBHCs in operation in the state that are not state-funded. Information about these SBHCs is not included in the report.

PRI Staff Comment: As discussed in the introduction to the report, the committee conducted this study as a results-based accountability assessment of how well state adolescent health policies and programs are working and what statutory, budgetary, or administrative changes might achieve better physical, behavioral, and oral health outcomes for young people ages

10 to 19. The final report findings, which are based on PRI staff analysis of key adolescent health indicators and echo the results from previous adolescent health assessments, show more effective coordination and planning is needed to improve health outcomes for the population aged 10 to 19 years. Stronger leadership and improved data analysis also are required to address the significant health disparities revealed by the staff analysis of the study's key indicator data.

To keep the study scope manageable with available staff resources, the program evaluation portion was concentrated on state-funded SBHCs. This program was selected for the study's in-depth performance review because it still permitted examination of a wide range of services and many important adolescent health issues, both programmatic and overarching. (Staff also evaluated some teen reproductive health services, although the committee was unable to reach consensus on findings and recommendations related to those programs so they were not included in the final report.) While all SBHCs are licensed by DPH, the department does not collect operations or outcome data from centers that do not receive state grant funding. PRI staff attempted to gather such information but was unable to do so within the study timeframe.

2. Appendix L:

Data included in Appendix L is not consistent. It makes State-funded SBHC look underutilized and expensive, which is not an accurate reflection of SBHCs activities.

PRI Staff Comment: The data used to prepare Appendix L came directly from DPH. The analysis, although indicating disparities in cost and utilization among certain school-based health centers that raise further questions, is the most detailed examination of state-funded school-based health centers in Connecticut, since the department's 2007 annual report on the program.

The Department of Public Health requires state-funded school-based health centers to submit a variety of activity information through numerous reporting requirements, as discussed in the committee report beginning on page 67. The department's last effort to comprehensively analyze the reported data was for the 2006-2007 school year, which was published in 2009. At present, enrollment and encounter data used for program management purposes lags by two years, heightening issues about adequate oversight, quality assurance, and data-driven program management. As noted on page 47 of the PRI report, the department's current management information system no longer supports the SBHC program and must be replaced.

As DPH continues to develop and implement its new management information system for school-based health centers, it has an ideal opportunity to create a system that captures relevant performance data. It can then use the system to fully evaluate the performance of individual centers and the results of the program as a whole.

APPENDIX B

RESULT-BASED ACCOUNTABILITY (RBA): BACKGROUND

Results-Based Accountability was developed in the 1990s by a nationally known public policy and administration consultant (Mark Friedman) to help managers and policymakers focus on end results – positive outcomes for clients – of the public programs, agencies, and service systems they oversee. In Connecticut, results-based accountability is defined by state law as “... the method of planning, budgeting, and performance measurement of state programs that focuses on the quality of life results the state desires for its citizens....” (P.A. 09-166)

RBA uses data to measure progress made toward desired results and, most important, to develop corrective actions that can improve performance of programs, agencies, and systems. Data collection and analysis has several purposes: establish a baseline that shows trends in performance and programs toward quality of life results; understand the reasons for those trends (known in RBA terminology as the “story behind the data”); and identify changes that could improve trends over time, or in RBA terms, “turn the curve.” Information produced through an RBA approach is presented primarily in charts, often in a report card format.

Unlike other evaluation tools, RBA also requires data gathering and analysis for two levels of accountability: population and program. Population accountability examines progress toward the outcomes desired for a whole community (e.g., an entire city, state, region, the nation, or some target population, e.g., all youth ages 10 to 19). Success at this level involves shared responsibility among many entities, public and private, and depends on their forming partnerships. Progress is tracked through broad indicators of the well-being of population.

Program accountability, the scope of traditional PRI committee work, centers on outcomes for clients directly served by a particular program, agency or system. Primary responsibility for effective program performance rests with those managing the program (or agency or system). Under the RBA approach, measures of program performance address three main questions: How much did we do? How well do we did it? Is anyone better off?

Typically, the first step of an RBA assessment is to determine why the program or agency under review exists. Specifically, what ultimate state goal, framed as a positive statement about desired quality of life results, is it intended to help achieve? Next, key indicators for tracking progress, the primary strategies for achieving the population-level results, and the main contribution made by the program or department – and all other significant partners – are identified.

Once this overall framework is created, the measures critical for assessing and addressing program-level performance can be determined and evaluated. To determine what changes may be needed, the following questions should be asked: What will happen if we don’t do something different? What would it take to achieve success? What do we know works, or could work, to do better? What actions – including low-cost/no-cost ideas – will we take to make a difference?

Information developed through this process can be used for RBA’s primary purpose: taking action to improve performance and achieve better results for clients. Another essential step is outlining the additional or better quality data needed to fully assess program and

APPENDIX B
RESULT-BASED ACCOUNTABILITY (RBA): BACKGROUND

population level outcomes and prioritizing their development. Creation of data development and research agendas is central to any RBA project.

More details about RBA concepts and the PRI results-based accountability process can be found in the committee's two completed pilot project reports. (See: *RBA Pilot Project Study of Selected Human Services Programs (P.A. 09-166)*, Final Report to the Appropriations Committee January 15, 2010, and *RBA Pilot Project 2010: Department of Transportation Project Delivery*).⁹⁹

⁹⁹ Final RBA project reports and all related documents are available at the PRI committee staff office website: http://www.cga.ct.gov/pri/2009_RBA.asp (2009); http://www.cga.ct.gov/pri/2010_RBA.asp (2010)

APPENDIX C

PRI JUNE 21, 2011 INFORMATION FORUM AND PUBLIC HEARING ON ADOLESCENT HEALTH IN CONNECTICUT : MAIN THEMES

Information Forum Group Discussion Summary

Legislators Attending: PRI – Reps. Rowe, Becker, Urban, Guiliano; Sens. Kissel, Markley, Coleman; also Sens. Gomes and Gerratana

Invited Panelists (9 adolescent health experts from state agencies and the community):
Dr. Ryan, Dr. Schichor (adolescent medicine specialists); Dr. Lee (CT Voices for Children); Ms. Poiero (CT Association School Based Health Centers); Atty. Sicklick (CT Center for Children’s Advocacy); Dr. Wolman (DCF); Dr. Zavoski (DSS); Dr. Resha (SDE); and Ms. Biaggi (DPH)

- *Health care issues for adolescents differ from those of young children and adults*
 - *Mostly a healthy population but undergoing many cognitive and developmental changes; faced with decisions that have short- and long-term consequences on health and well-being*
 - *High risk behaviors a problem: unintentional injury is cause of half of all adolescent deaths; intentional injury (e.g., suicide, homicide) another 25%; teen pregnancy, STDs of concern*
 - *Many in difficult family/community situations that impact health status and health care; higher poverty rates than adults*
 - *Troubling trends in some chronic diseases, conditions (asthma, obesity)*
 - *Significant racial/ethnic disparities in health status, access to quality care*
 - *Need emphasis on promoting health, healthy lifestyles, and helping youth learn to manage own care*
 - *Early, ongoing education on health, positive development and presence of competent, caring adult in life important to adolescent health and success*
 - *Teens more likely to seek care and share information when services convenient, confidential, and respectful*
 - *Adolescent privacy rights outlined in constitution, state statute, case law but not always clear*
- *Adolescent typically thought of as age 12 or 13 to 21 but population can be defined to include as young as 10 to as old as 25*
 - *More comprehensive definition results in better health care planning and policymaking for young, middle, and older adolescents and young adults*
- *Tension between parental involvement and teen confidentiality (as well as provider ethical obligations and mandatory reporting requirements) complicates service delivery*
 - *School-based primary and preventive care appear effective way of providing convenient and confidential services*
 - *A number of parents, providers, and family advocates concerned about Connecticut’s parental notification policies for teen reproductive health care, (e.g., minors can obtain abortion without parental notice or consent), believing*

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PRI JUNE 21, 2011 INFORMATION FORUM AND PUBLIC HEARING ON ADOLESCENT HEALTH IN CONNECTICUT : MAIN THEMES

adolescents are better off with guidance from their parents when making important life decisions

- *Major challenges are: making sure adolescents 1) have access to and 2) use prevention and primary care*
 - *HUSKY (A and B) available to all regardless of income but many who are eligible not enrolled*
 - *HUSKY data shows utilization of preventive care declines with age, especially for male teens*
 - *Mental health and substance abuse needs especially underserved*
 - *Estimated 1 in 5 adolescents has diagnosable mental health disorder but less than 20 percent of those in need get adequate behavioral health care*
 - *SBHCs appear to be cost-effective way to improve access, provide primary and preventive care to teens, particularly disadvantaged and at-risk youth*
- *Implementation of overarching state plan and policy on adolescent health lacking; collaboration among providers, school, family, and community central to improved quality, cost-effective care*
- *Better collection and analysis of data on adolescent health needed statewide to identify needs, ensure quality care, allocate scarce resources to most effective programs and services*

Public Hearing Testimony Summary

A total of 28 individuals including 3 legislators presented or submitted testimony on a range of adolescent health issues including but not limited to parental involvement, confidential access to care, inadequate behavioral health services and health education programs, and special needs of certain high risk groups.

In summary:

- **Sen. McLachlan and eight members of the public**, including two family practice physicians who also work with pregnancy resource centers and several persons speaking for themselves or as members of Connecticut Right to Life and Silent No More: *support of mandatory parental notification for a minor's abortion*
- **Rep. Ritter**: *requested that the study examine three particularly grave issues: mental health and substance abuse, STDs and complications from a lack of education and treatment, and complications of obesity for teens and young adults*
- **Rep. Lyddy**: *suggested the committee should look carefully at adolescent substance abuse and treatment*
- **Child Advocate Jeanne Milstein**: *cabinet for adolescent health could address problems of fragmentation; youth in foster care need special attention as at greater risk for unintended pregnancy, STDs*

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PRI JUNE 21, 2011 INFORMATION FORUM AND PUBLIC HEARING ON ADOLESCENT HEALTH IN CONNECTICUT : MAIN THEMES

- **Association of School Nurses CT (ASNC):** *school health services need to be adequately funded and staffed; care coordination effective practice but not funded*
-
- **City of Hartford Public Health Office:** *need to recognize and address the many social determinants of health (e.g., poverty); better coordination, e.g., pediatricians and school-based health centers, would improve services*
- **CT Association of School-Based Health Centers (CASBHC):** *SBHCs provide barrier-free access to care at low cost, help reduce inappropriate emergency room use, and keep kids healthy and in school*
- **CT National Alliance on Mental Illness (NAMI):** *access to community-based mental health prevention and treatment lacking; SBHCs play critical role in delivering mental health services; better data collection and monitoring of teens transitioning to adult mental health system needed*
- **CT Sexual Assault Crisis Services (CONNSAC):** *teens' rights regarding sexual assault evidence need to be clarified*
- **CT Speech Language Hearing Association (CSHA):** *increasing prevalence of hearing loss among teens needs attention; insurance coverage for hearing aids for 13-18 years should be mandatory as for younger children*
- **Get in Touch Foundation:** *provided information on their (free) breast self-exam program for schools, important health issue for young women*
- **Hartford Gay and Lesbian Health Coalition (HGLHC):** *lesbian, gay, bisexual, transgender, and queer youth at greater risk for poor health outcomes; their special needs require more attention*
- **Six individuals,** including two nurse practitioners, one from a school-based and one from a community health center, four representatives from NARAL Pro-Choice CT, Planned Parenthood Southern New England (PPSNE) and HGLHC *supported Connecticut's current law and policy regarding adolescent health care confidentiality*
- **Eight individuals,** including seven representatives from CASBHC, CONNSACS, NARAL, PPSNE, and HGLHC, *supported comprehensive health education, including sex education, for young people*

APPENDIX D

Adolescent Health in Connecticut: Key Indicators

Nine key indicators of adolescent health in Connecticut were developed for the program review committee’s 2011 RBA project. Data trends and sources for each key indicator are briefly described in the following charts, which are organized by major topic: mortality; morbidity; risk factors; and protective factors. The charts contain the best data currently available for tracking state progress toward the PRI study’s quality of life results statement: “*Connecticut’s adolescents have the health care services, supports, knowledge, and skills that promote optimal physical and mental well-being and success in life.*” Also noted are limitations of the key indicators, which should be addressed as part of on-going RBA data development efforts, along with possible secondary indicators to supplement future reports on adolescent health results in Connecticut.

INDICATOR AREA: MORTALITY

1. Teen Fatalities

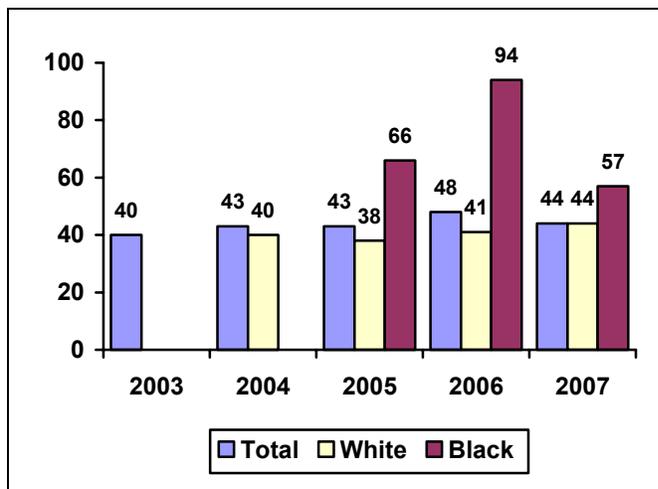
Teen death rate per 100,000 age 15-19 all causes

Data Source: CDC, National Center for Health Statistics as published by KIDS COUNT 2011 (2003 – 2007)

Teen fatality rates are widely used indicators of adolescent well-being. Nationally, accidental and intentional injuries cause nearly 80% of deaths among adolescents aged 15-19. Motor vehicle crashes and other unintentional injuries, homicide, and suicide are the leading causes of death for youth and young adults aged 10-24 in the U.S. and Connecticut. Fatality rates overall and by cause vary by race/ethnicity and gender. One limitation of current teen fatality information is the lag time (over four years at present) in reporting of national and state-level comparative data.

Possible Secondary Indicators: fatalities by cause (motor vehicle crashes, other unintentional injuries, homicide, suicide) – all by gender, race/ethnicity

**Connecticut Teen Death Rate
(per 100,000 ages 15-19)**



- Between 2003 and 2007, the most recent available data, Connecticut’s overall teen fatality rate rose from 40 to 44 per 100,000 youth ages 15-19.
- Fatality rates for Black youth ages 15-19 are substantially than for White teens nationally and in Connecticut; the state rate for Black teens was double that of White teens in 2006.
- Among all states in 2007, Connecticut ranked 7th lowest on teen deaths per 100,000; the state with lowest rate was Vermont (35) and highest was Alaska (100).

APPENDIX D
Adolescent Health in Connecticut: Key Indicators

INDICATOR AREA: MORBIDITY
PHYSICAL, BEHAVIORAL, AND ORAL HEALTH CONDITIONS

2. Obesity (Physical Health)

Percent youth ages 10-17 overweight or obese by gender

Primary data source: Child Trends analysis of National Survey of Children's Health data (2003, 2007)
as published by KIDS COUNT 2011

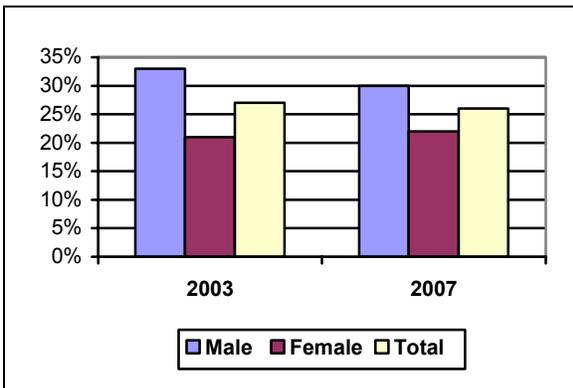
Being overweight or obese can have both immediate and long-term negative consequences for adolescent health. In addition to the psychosocial impact on teens, obesity increases risks for many diseases and conditions later in life, including diabetes, stroke, heart disease, arthritis, and certain cancers. The national survey categorizes children between the 85th and 95th percentile BMI-for-age as overweight, and children at or above the 95th percentile BMI-for-age as obese.

According to the most recent National Health and Nutrition Examination Survey, the prevalence of obesity among U.S. children ages 6 – 17 increased from 6% in 1980 to 19% as of 2007-2008. Rates vary by race/ethnicity, and, in Connecticut, also differ by gender.

Data gathered through national health surveys have several limitations. Most information about adolescents, including data on weight, physical activity, and nutrition, is collected through telephone interviews with parents. Intervals between national surveys are as long as four years. Current state adolescent health surveys is gathered just every two years, through written questionnaires administered to a sample of 9th through 12th graders; only data from students attending public high schools is captured.

Possible Secondary Indicators: obese, overweight (separate measure), physical activity/inactivity, diet quality – all by gender, race/ethnicity

Percent Connecticut Youth (ages 10-17) Overweight or Obese



- Over one-quarter (26%) of Connecticut youth were overweight or obese in 2007; nationally, 32% of 10-17 year olds were.
- Between 2003 and 2007, rates in Connecticut changed only slightly; down just one percentage point overall, up one percent for girls and down three percent for boys.
- According to the 2009 Connecticut School Health Survey, among high school students:
 - Girls are much less likely than boys to be obese (7% vs. 14%)
 - Black girls are 2.5 times more likely to be obese than White girls (12% vs. 5%)
 - Hispanic boys are twice as likely as White boys to be obese (24% vs. 12%).

APPENDIX D
Adolescent Health in Connecticut: Key Indicators

INDICATOR AREA: MORBIDITY
PHYSICAL, BEHAVIORAL, AND ORAL HEALTH CONDITIONS

3. Depression (Behavioral Health)

Percent high school students felt sad or hopeless for two weeks in a row

Data source: CT DPH, Connecticut School Health Survey Youth Behavioral Component (2005, 2007, 2009)

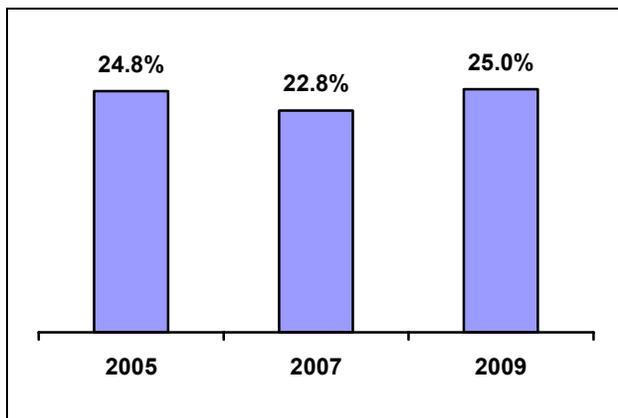
Adolescent depression can cause severe problems at home, school/work, and socially as well as adversely impact other health conditions such as asthma and obesity, and general physical well-being. Youths experiencing the psychiatric diagnosis Major Depressive Episode (MDE)* are more likely than other teens to attempt suicide and initiate alcohol and other substance use. Teen depression rates and suicidal behaviors vary by gender, race/ethnicity, and region of the country. During 2008-09, the prevalence of MDE was about 8% for adolescents ages 12-17 in Connecticut and the U.S. as a whole state rates ranged from a high of 10% (Wyoming) to a low of 7% (Maryland).

Comprehensive, longitudinal information about adolescent mental health is lacking at both state and national levels. At present, definitions are inconsistent, reporting is sporadic, and most available data reflect only portions of adolescent population (e.g., public high school students, incarcerated youth). Several federal efforts to improve health data collection and reporting related to all populations are underway, including some being carried out by CDC through its latest national strategic planning initiative, Healthy People 2020.

Possible Secondary Indicators: received treatment for depression, seriously considered suicide, attempted suicide – all by age category gender and race/ethnicity

* MDE is defined as a period of at least two weeks of a depressed mood or loss of interest or pleasure in daily activities plus at least four additional symptoms of depression (such as problems with sleep, eating, concentration, energy).

Percent Connecticut High School Students Sad or Hopeless Two Weeks or More in A Row



- In 2009, one in four high school students in Connecticut felt persistently sad or hopeless, virtually same rate as in 2005 and comparable to U.S. rates.

- Adolescent girls have significantly higher depression rates than boys; the rates for Connecticut high school students in 2009 were 32.9% vs. 17.2%.
- Prevalence of teen depression also differ by race and ethnicity, with Hispanic girls having the highest rates; in Connecticut, 33.3 % of Hispanic high school students compared to 22.1% of White students experienced depression symptoms in 2009.
- In 2009, 14.1% of Connecticut high school students seriously considered attempting suicide in the past 12 months; 7.4% actually attempted suicide at least once. U.S. suicidal behavior rates were nearly the same (14% and 6%).

APPENDIX D

Adolescent Health in Connecticut: Key Indicators

INDICATOR AREA: MORBIDITY PHYSICAL, BEHAVIORAL, AND ORAL HEALTH CONDITIONS

4. Untreated Cavities (Oral Health)

Percent youth ages 12-17 with untreated dental caries (cavities)*

Primary data source: America's Children: Key National Indicators of Well-Being, 2011 (Federal Interagency Forum on Child and Family Statistics)

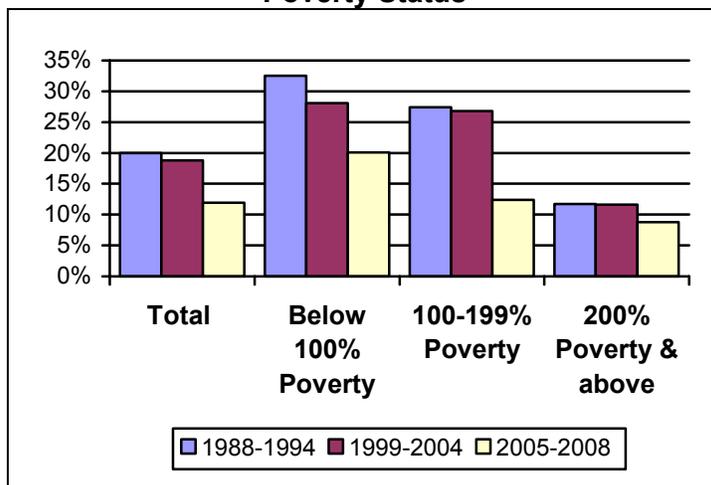
Oral health is an integral component of overall well-being, particularly for children and adolescents. Regular dental visits and good self-care can prevent and promote treatment of oral diseases and conditions, including dental caries (cavities), the most common childhood disease. Based on national data, prevalence rates for untreated caries have dramatically declined among school-age children because of community prevention efforts (e.g., fluoridated water) but cavities remain a problem among some racial and ethnic groups and those living in poverty.

Information on the oral health of young people, particularly at the state level, is limited at present. Connecticut has just started to gather and analyze data about dental care provided to children and youth through the state Medicaid and CHIP programs. Increased awareness of the importance of good dental care, its link with academic performance and impact on health in later life is prompting efforts at state and national levels to develop better measures of children's oral health.

Possible Secondary Indicators: Dental visit within the past year, EPSDT dental screening -- all by race/ethnicity, poverty status

* U.S. data only presented in chart as comparable state-level data unavailable at this time.

Percent U.S. Youth Ages 12-17 with Untreated Cavities by Poverty Status



- One source of state data about oral health, the 2007 National Survey of Children's Health, shows 84.9% of all children in Connecticut, compared with 78.4% of children in the U.S., had a preventive dental visit in the past year according to parents participating in the survey.

- Nationwide, between 1999 and 2008, the percent of youth ages 12-17 with untreated cavities dropped from 19% to 12%.
- The percentage with untreated cavities among 12-17 year olds living in poverty also declined significantly during this time period.
- However, during 2005-2008, percentage of youth with untreated cavities living in poverty was twice that of 12-17 year olds with family incomes at or above 200% poverty.

APPENDIX D
Adolescent Health in Connecticut: Key Indicators

INDICATOR AREA: RISK FACTORS
DRINKING, DRUG USE, TOBACCO USE, SEXUAL ACTIVITY

5. Binge Drinking

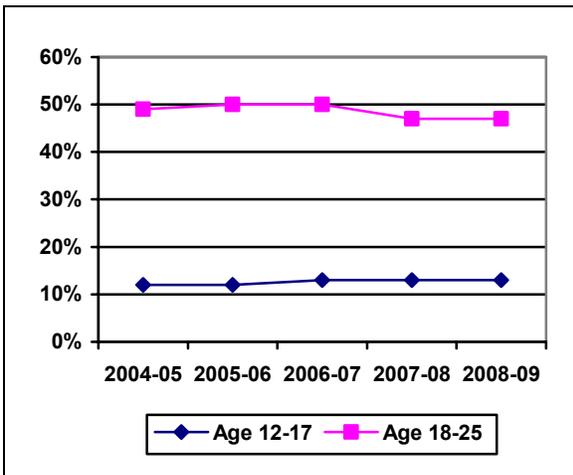
Percent binge alcohol use by age group

Primary data Source: State Estimates from National Survey on Drug Use and Health (2004-05 – 2008-09)
as published by KIDS COUNT 2011

Alcohol use is associated with many negative outcomes for adolescents including injuries and death from motor vehicle accidents, fighting, and reckless behavior, as well as problems in school, the workplace, home, and community. Heavy drinking (binge alcohol use) increases the likelihood of these negative outcomes and can have serious long-term health consequences. Binge drinking for the purpose of the national survey is defined as having five or more drinks on the same occasion on at least one day in the prior 30 days. One limitation of the national survey data on alcohol and other drug use is the long lag time in reporting results (i.e., latest available information is about three years old). Age categories used by the national survey to report results also make it difficult to isolate data for the overall adolescent population (if defined as ages 10 – 19).

Possible Secondary Indicators: Current alcohol use, First drink before age 13, drinking and driving -- all by gender, race/ethnicity

Binge Drinking Rates of Connecticut Youth and Young Adults (Percent by Age)



- In recent years, 13% of those ages 12-17 and around half (47-50%) of those 18-25 year old binge drink.

- Binge alcohol use rates have changed very little among Connecticut youth (age 12-17) and young adults (age 18-25) between 2004 and 2009.
- According to the Connecticut School Health Survey, among the state's high school students in 2009.
 - 26% of girls and 22.5% of boys had five or more drinks in a row (binge drinking).
 - 43.5% had at least one drink on at least one day during the month before they were surveyed.
- In 2009, the overall binge drinking rate for high school students in Connecticut and the U.S. was the same – 24.2%.

APPENDIX D
Adolescent Health in Connecticut: Key Indicators

INDICATOR AREA: RISK FACTORS
DRINKING, DRUG USE, TOBACCO USE, SEXUAL ACTIVITY

6. Drug Use

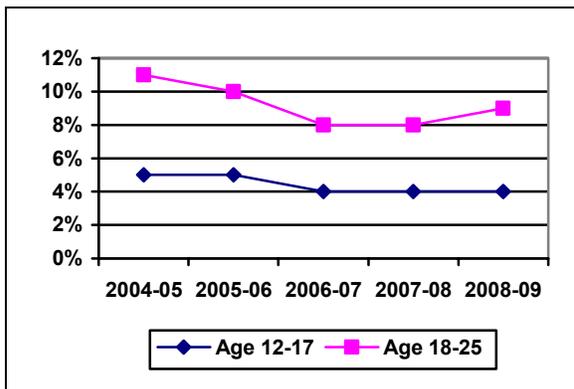
Percent illicit drug use other than marijuana in the past month by age group

Data Source: State Estimates from National Survey on Drug Use and Health
as published by KIDS COUNT 2011

Use of illegal drugs (e.g., hallucinogens, cocaine, heroin, and other narcotics, amphetamines, barbiturates or tranquilizers not under doctor's orders) can have immediate and long-term health and social consequences for adolescents. Health problems vary with the types and amounts of drugs used, but range from heart attack and stroke, to impaired pulmonary functioning, cognitive damage, and memory loss, to premature death. Like alcohol use, the use of illicit drugs has the potential for increasing teens' risky behaviors. As noted in the prior key indicator chart descriptions, limitations of the national survey data on drug use are: the long lag in reporting results (i.e., latest available information is about three years old); and the age categories used (12 – 17 and 18 -25 rather than an overall adolescent category of ages 10 – 19).

Possible Secondary Indicators: Marijuana use, lifetime illicit drug use, lifetime over-the-counter and prescription drug abuse -- all, by age, gender, race/ethnicity

Illicit Drug Use Rates (other than Marijuana) of Connecticut Youth and Young Adults (Percent by Age)



- From 2004 to 2009, illicit drug use (other than marijuana) declined from 5% to 4% among Connecticut adolescents ages 12-17.
 - The drug use rate for older youths (18-25), which is about double that of young teens, increased between 2008 and 2009 from 8% to 9%.
 - For both groups, Connecticut rates are comparable to U.S. rates.
- According to the Connecticut School Health Survey, among the state's high school students in 2009:
 - Rates for ever using cocaine, ecstasy, methamphetamines or heroin all were similar to those among U.S. high school students.

APPENDIX D

Adolescent Health in Connecticut: Key Indicators

INDICATOR AREA: RISK FACTORS DRINKING, DRUG USE, TOBACCO USE, SEXUAL ACTIVITY

7. Tobacco Use

Percent any cigarette use in the past month by age group
Primary data Source: State Estimates from National Survey on Drug Use and Health
as published by KIDS COUNT 2011

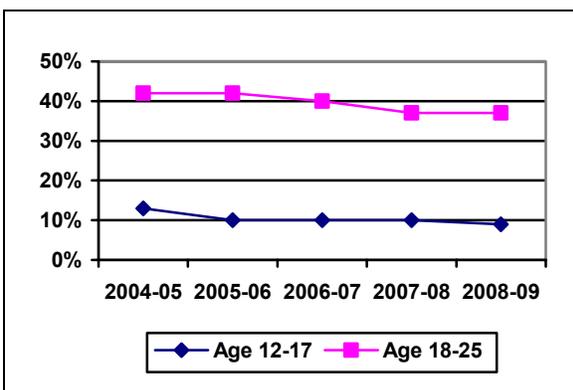
Cigarette smoking has serious long-term consequences including the risk of premature death and smoking-related diseases. Smoking causes many types of cancer, heart disease, stroke, chronic obstructive pulmonary disease (COPD) like emphysema, asthma, hip fractures, and cataracts. After a rapid increase in teen smoking in the early 1990s, rates of cigarette use among adolescents have steadily dropped in recent years. However, certain subgroups still are more likely than others to smoke.

The most recent available data show nationally, 19.5% of high school students smoked cigarettes on one or more days in the past 30 days in 2009. In the U.S. and in Connecticut, male high school students are more likely than females to smoke; black high school students are significantly less likely than White or Hispanic students to be frequent cigarette smokers. Limitations of national survey data, as noted in previous charts, include: a long lag in reporting results (i.e., latest available information is about three years old); and the age categories used (12 - 17 and 18 - 25 rather than an overall adolescent category of ages 10 - 19).

Possible Secondary Indicators: Current and frequent cigarette smoking by high school students – by gender, race/ethnicity*

* Distinctions are made both in the Connecticut and national survey of youth health-risk behaviors between current use (smoked cigarettes at least once in past month) and frequent use (smoked cigarettes on 20 or more of the past 30 days).

Cigarette Smoking Rates Connecticut Youth and Young Adults (Percent by Age)



- Cigarette use among Connecticut youth ages 12–17 dropped from 13% to 9% between 2004 and 2009.
 - The cigarette smoking rate for young adults, which includes 18- and 19 -year olds, was significantly higher (37% in 2008-09) but also declined over time.
 - U.S. and Connecticut rates are nearly the same.

- According to the 2009 Connecticut School Health Survey, among the state’s high school students:
 - Almost 18% smoked cigarettes at least once in the past month
 - 19% of boys and 16.5% of girls were current smokers.
 - 20.3% of White students, 15.5% of Hispanic students, and 9.6% of Black students were current cigarette smokers.

APPENDIX D

Adolescent Health in Connecticut: Key Indicators

INDICATOR AREA: RISK FACTORS

DRINKING, DRUG USE, TOBACCO USE, SEXUAL ACTIVITY

8. Sexual Activity

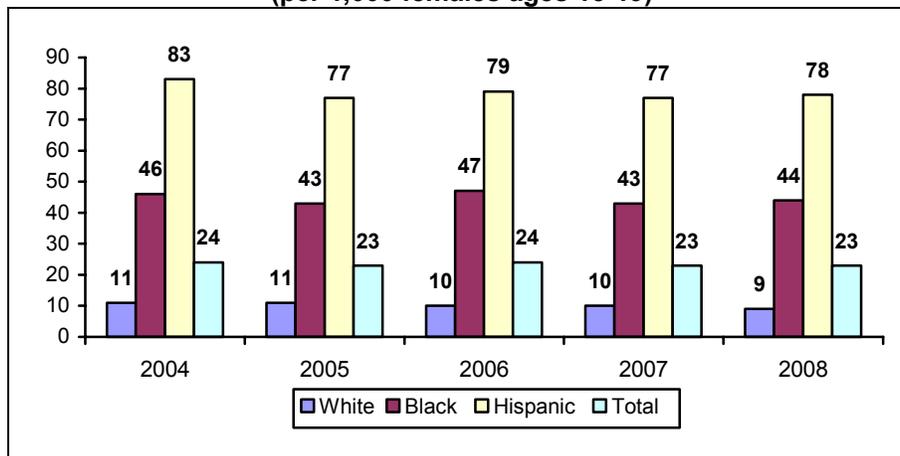
Teen birth rate per 1,000 females ages 15-19

Data Source: CDC, National Center for Health Statistics as published by KIDS COUNT 2011

Adolescent sexual activity can pose significant emotional and physical health risks. Youth who engage in risky sexual behaviors can become pregnant and contract infections and diseases, including some with lifetime consequence. Teen pregnancy is associated with a number of long-term negative consequences, for both the child and the mother. Babies born to adolescent mothers compared with older mothers are at higher risk for low birth weight and infant mortality. Teenage mothers are more likely to experience pregnancy complications and are at high risk of dropping out of school and of living in poverty. While state and national data on teen pregnancy and other measures of adolescent sexual activity are fairly comprehensive, there are long delays in reported information (e.g., most recent available teen birth rates generally lag three years).

Possible Secondary Indicators: Teen pregnancy rates, teen births to women already mothers, STD rates, Sexual contact/intercourse, birth control use – all by race/ethnicity

**Connecticut Teen Birth Rates by Race
(per 1,000 females ages 15-19)**



- The teen birth rate in Connecticut declined from 24 to 23 per 1,000 females ages 15-19 between 2004 and 2008; after a two-year increase, the U.S. teen birth rate dropped to 41 births per 1,000 in 2008.
- Connecticut's 2008 teen birth ranked 4th lowest among all states; Massachusetts and New Hampshire had the lowest state rate (20 per 1,000) and Mississippi had the highest (66 per 1,000).
- Teen birth rates vary substantially by race/ethnicity:
 - Nationwide, rates for Hispanic females ages 15-19 are consistently highest and were nearly twice the U.S. average for all teens in 2008 (78 vs. 41).
 - In Connecticut, the 2008 birth rate for Black teens (44 per 1,000) was almost twice the state average; the Hispanic teen birth rate (78 per 1,000) was more than three times higher.
 - Of the 2,789 Connecticut teen births in 2008, nearly half (1,353) were to Hispanic mothers.

APPENDIX D

Adolescent Health in Connecticut: Key Indicators

INDICATOR AREA: PROTECTIVE FACTORS

9. Health Insurance Coverage

Percent Children Ages 6-17 Without Health Insurance

Data Source: Census Bureau, Current Population Survey as provided by KIDS COUNT 2011

*A regular and accessible source of quality health care is critical to ensuring the well-being of children and youth. Adolescents with insurance coverage, private or public (e.g., Medicaid), are more likely to obtain the preventive and primary care they need to promote and maintain good physical, behavioral, and oral health. Given the importance of adequate coverage for good health outcomes, the U.S. Census collects data on children's insurance status in several ways.**

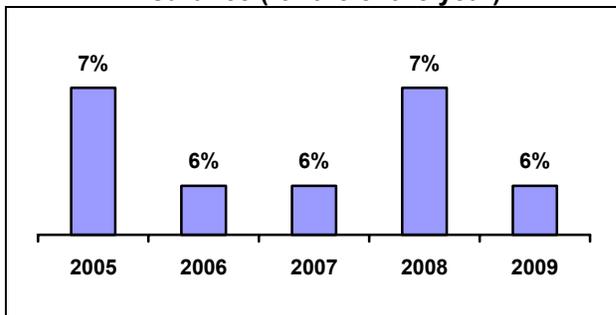
Nationally and in Connecticut, rates of uninsured children declined following creation of federal Children's Health Insurance Programs (CHIPs), such as Connecticut's HUSKY B program, in 1997. By 2008, just under 10% of all U.S. children under 18 were without health insurance for the entire year. Insurance status and adequacy of coverage, however, can vary significantly by race, ethnicity, family income, and age. National data from 2007 show adolescents ages 12-17 are more likely than young (aged 6-11) and very young (aged 0-5) children to lack adequate health insurance coverage (26.3%, 25.1%, 19.2%, respectively).

The latest Current Population Survey data show in 2010, 9.8% of all U.S. children under 18 (7.3 million) were uninsured for the entire year. According to an October 2011 Connecticut Voices for Children research brief, nationally, the children most likely to be uninsured in 2010 were 12 to 17 year olds (10.9%), Hispanic (16.3%) or Black children (11.0%) and children living in poverty (15.4%). An analysis by the Center for Budget and Policy Priorities found rates of uninsured children under 18 in 2009-2010 for all New England states including Connecticut were well below the national average (CT 6.4%, ME 4.2%, MA 3.4%, NH 4.4%, RI 6.0%, VT 4.4%).

Possible Secondary Indicators: HUSKY enrollment by age, race/ethnicity, Usual source of care/Have primary care physician, Adolescent vaccination rates, by gender, race/ethnicity, family income

* Based on U.S. census bureau Current Population Survey (CPS) data, annual estimates of those without health insurance for the entire year are prepared by age group for each state. The bureau's annual American Community Survey (ACS) provides estimates of those uninsured at the time of the survey by age group, county, and for certain cities. Data from the different surveys, therefore, are not directly comparable; complicating state-by-state and trend analysis.

Percent Connecticut Children Ages 6-17 Without Health Insurance (for the entire year)



- The rate of uninsured children in Connecticut ages 6-17 fluctuated between 6% and 7% from 2005 through 2009. Approximately 36,000 Connecticut children ages 6-17 were uninsured for the whole year in 2009.

- Nationwide, the rate of children ages 6-17 without health insurance for the whole year was 10% in 2009. State rates for 2009 ranged from a low of 4% (Massachusetts, Vermont, New Hampshire, Hawaii) to a high of 18% (Nevada, Texas).
- Connecticut's 2010 uninsured rate for all children under 18 is substantially lower than the U.S. average – 6.5% versus 9.8%; for the New England region, however, this state rate is the highest while the Massachusetts rate (3.4%) is lowest.
- The total number of children under 18 in Connecticut without health insurance dropped from about 58,000 in 2005 to 52,000 in 2009.

APPENDIX E

STATE ADOLESCENT HEALTH CARE INFRASTRUCTURE (Dec. 2011)							
STATE AGENCY	MAJOR COMPONENTS						
	Physical Health Care	Behavioral Health Care	Oral Health Care	Reproductive Health Care	Health Education	Prevention	Nutrition & Fitness
DPH	<ul style="list-style-type: none"> • School-Based Health Centers – SBHCs [School year 2008-09, 41,749 students (K-12) enrolled; \$10.3 million state funds SFY11] • Community Health Centers – CHCs [2009 served almost 290,000 patients all ages statewide; \$5.1 million fed. funding] • Coordinated School Health – CSH (Healthy Connections, in partnership with SDE) [total served all ages 74,073; \$100,000 federal funding annually] • Children and Youth with Special Health Care Needs – CYSHCN [Served 3,140 ages 10-18; \$2.1 million] • Primary Care Office – PCO [all ages; federal funding \$199,830] • Asthma [e.g. Easy Breathing – 1,529 children treated; Annual state funding \$500,000] • InfoLine (contracted referral/screening services) • Family/maternal and child health care programs, e.g., Pregnancy Risk Assessment Tracking (PRATS) [all postpartum women; federal funding \$100,000] • Sexual Violence Intervention and Prevention – SVIP [\$990,000 all ages] • Sexually Transmitted Disease (STD) Control programs [9 clinics serve 6,000 all ages annually; \$990,000] 	<ul style="list-style-type: none"> • SBHCs • CHCs • CSH • CYSHCN • PCO • InfoLine • PRATS • SVIP • Injury Prevention Program – Child Sexual Abuse [745 children served; Annual state funding \$255,287] 	<ul style="list-style-type: none"> • SBHCs • CHCs • CSH • PCO • InfoLine • PRATS • Oral Health Office 	<ul style="list-style-type: none"> • SBHCs • CHCs • CSH • InfoLine • PRATS • SVIP • STD • Family Planning [FY09: \$1.04 million; served 39,473 clients though 12 clinics operated by statewide contractor (Planned Parenthood)] • Personal Responsibility Education Program – PREP (in partnership with DCF, SDE, DMHAS) [5 year expected federal funding \$2.9 million; HIV, STD, teen pregnancy prevention for DCF youth starting in 2011] 	<ul style="list-style-type: none"> • SBHCs • CHCs • CSH • InfoLine • PRATS • Asthma • NPAO • SVIP • STD • Hartford Healthy Start – HHS [412 enrolled low income pregnant and postpartum women in Hartford; federal funding \$750,000] 	<ul style="list-style-type: none"> • SBHCs • CHCs • CSH • CYSHCN • InfoLine • PRATS • SVIP • STD • NPAO • HHS • CT School Health Survey • HIV Prevention • Immunizations [2011 target pop. ages 10-18 = 422,262; \$40.0 million for vaccines] • Tobacco Use [20,345 students served; FY10 \$500,000 –none FY11] • Comprehensive Cancer Prev. and Control Program (women age 19+) 	<ul style="list-style-type: none"> • SBHCs • CHCs • CSH • InfoLine • HHS • Nutrition, Physical Activity and Obesity program – NPAO • Communities Putting Prevention to Work [12 schools; fed. stimulus funds \$120,000] • WIC (Women, Infants, & Children) nutrition program
DSS	<ul style="list-style-type: none"> • HUSKY (A & B) *see below • Medicaid LIA (covers 19 yr. olds)** 	<ul style="list-style-type: none"> • HUSKY (A & B Behavioral Health Partnership – BHP) • Medicaid LIA 	<ul style="list-style-type: none"> • HUSKY (A & B Dental Health Partnership – DHP) • Medicaid LIA 	<ul style="list-style-type: none"> • HUSKY/Medicaid • Teen Pregnancy Prevention Initiative - TPPI [FY11: \$1.8 million state; 690 capacity total] • Family Planning (through SSBG) [FY11: \$0.9 million; 5,802 served] 		<ul style="list-style-type: none"> • TPPI • Family Planning • Healthy Start • Nurturing Family Network 	<ul style="list-style-type: none"> • SNAP (nutritional counseling)

APPENDIX E

STATE ADOLESCENT HEALTH CARE INFRASTRUCTURE (Dec. 2011)							
STATE AGENCY	MAJOR COMPONENTS						
	Physical Health Care	Behavioral Health Care	Oral Health Care	Reproductive Health Care	Health Education	Prevention	Nutrition & Fitness
DCF	<ul style="list-style-type: none"> DCF-involved covered by HUSKY/Medicaid [approx. 11,800 in A & B as of May 2011; if remain voluntarily after age 18, stay on HUSKY to 21; over age 18 who do not may qualify for Medicaid LIA] DCF provides some direct care in facilities its operates (i.e., Riverview, CT Juvenile Training School, CCP) 	<ul style="list-style-type: none"> DCF-involved covered by HUSKY (BHP)/ Medicaid For all under 18, DCF operates/funds mental health and substance abuse services: <ul style="list-style-type: none"> Riverview Hospital CT Children's Place Residential/ group homes EMPS Intensive In-home Extended Day Outpatient/ community-based Care Coordination Family advocacy and support (Age 18 and over served by DMHAS) 	<ul style="list-style-type: none"> DCF-involved covered by HUSKY (DHP)/Medicaid 	<ul style="list-style-type: none"> DCF-involved covered by HUSKY/Medicaid DCF funds: <ul style="list-style-type: none"> Reproductive care in JJ Girls Res. Programs [5 providers statewide] Pregnant & Parenting Girls Programs [5 providers statewide] 	<ul style="list-style-type: none"> School Health Ed (through DCF U.S.D. #2) 	<ul style="list-style-type: none"> Youth Suicide Advisory Committee 	
SDE	<ul style="list-style-type: none"> School Health Care (School RN) [included in general state and local education funding] Health Services to Pupils in Nonpublic Schools [FY10: \$4.8 million] Coordinated School Health –CSH (Healthy Connections, in partnership with DPH) 	<ul style="list-style-type: none"> School Behavioral Health (Guidance, Counseling, Social Work) [included in general state and local education funding] CSH 	<ul style="list-style-type: none"> CSH 	<ul style="list-style-type: none"> CSH Young Parents [2000-10 SY: \$229,330; 191 teens served] Support for Pregnant and Parenting Teens Project (SPPTP) [FFY11: \$1,999,99; 5 large urban school districts] 	<ul style="list-style-type: none"> School Health Ed. [included in general state and local education funding] CSH 	<ul style="list-style-type: none"> Youth Service Bureaus [FY10: \$3.6 million; 40,213 youth served] CHS 	<ul style="list-style-type: none"> School Nutrition [school breakfast/lunch funding] School Physical Education [included in general state and local education funding] CSH
<p>OTHER STATE AGENCIES that provide health care services to segments of the adolescent population: Judicial Branch/Court Support Services Division (CSSD) - Juvenile detention population (under 18 currently; under 17 as of July 2012); Dept. of Correction (DOC) - Ages 14-19 incarcerated in adult correction system; Dept. of Mental Health and Addiction Services – State behavioral health services for young adults including 19 year olds</p>							
<p>* HUSKY A = Medicaid for children up to age 19 and their parents/certain adult caregivers and pregnant women: \$998 million total expended (est.) FY11 (60% federal reimbursement; returns to 50% July 1, 2011), with about 117,000 adolescents ages 10-19 enrolled (256,808 ages 0-19 enrolled as of 2/2011). Under the Medicaid program EPSDT (Early and Periodic Screening, Diagnosis, and Treatment), there are specific federal requirements for timely well-care, early detection and treatment, health education, and other primary and preventive care for children and young adults under age 21. HUSKY B = Connecticut's Children's Health Insurance Program (CHIP) for uninsured/not Medicaid eligible children up to age 19; \$36.6 million (est.) expended FY11 (85% federal reimbursement) with 15,000 total enrolled (Feb 2011). ** Medicaid LIA = Low Income Adult, formerly SAGA, for those over age 18 (and not aged, blind, or disabled).</p>							

APPENDIX F

School-Based Health Centers (SBHCs) in Connecticut

This appendix augments the program report card information about state-funded SBHCs presented in Chapter III. It provides background on the history, development, and current structure and administration of school-based health centers in Connecticut.

History and Overview

In Connecticut, school-based health centers are not defined within current state law. Under the federal Social Security Act, however, a school-based health center is a health clinic: 1) located in or near a school facility; 2) organized through school, community, and health provider relationships; 3) administered by a sponsoring agency; 4) providing primary health services to children through health professionals; and 5) satisfying all applicable state requirements.¹⁰⁰

Although school-based health centers currently serve many purposes, their overarching goal is the same as it was over 40 years ago when the SBHC concept was first established: to increase access to health care to school-aged children and adolescents who are uninsured, underinsured, or not receiving proper health care due to various reasons. With an emphasis on prevention, early intervention, and risk reduction, school-based health centers also counsel students on healthy habits and how to prevent injury, violence, and other threats.

Viewed as the precursor to school-based health centers, in 1967, the director of Maternal and Child Health for the Cambridge, Massachusetts health department assigned a nurse practitioner to work in an elementary school and deliver primary medical care to the children enrolled in the school. Four additional health clinics were opened in Cambridge schools in the years that followed.¹⁰¹

In the early 1970s, school-based health centers staffed with nurse practitioners and part-time physicians were established in Texas and Minnesota.¹⁰² In 1977, the Robert Wood Johnson Foundation (RWJF) funded its first large initiative – the *School Health Services Program* – to increase health care access to school-aged children.¹⁰³ The seven-year program brought nurse practitioners into multiple elementary schools in four states (Colorado, New York, North Dakota, and Utah).

From 1986 through 1993, RWJF supported a national initiative – *School-Based Adolescent Health Care Program* – a large-scale demonstration project designed to determine: 1) whether health centers in secondary schools could deliver comprehensive medical and mental health care to teenage students across the nation; 2) whether communities and local institutions could be persuaded to provide long-term support for school-based health centers; and 3) the feasibility of school-based health centers as a means of improving adolescent access to appropriate services. The program worked with 23 SBHCs nationwide.

¹⁰⁰ Social Security Act, Title XXI, State Children’s Health Insurance Program (42 U.S.C. 1397jj(c)(9), Sec. 2110(c)(9)(A)).

¹⁰¹ The Robert Wood Johnson Foundation Anthology, *School-Based Health Clinics*, Paul Brodeurk, 2000.

¹⁰² *Id.*

¹⁰³ Robert Wood Johnson Foundation National Program Report – Making the Grade: State and Local Partnerships to Establish School-Based Health Centers

APPENDIX F

School-Based Health Centers in Connecticut: Background

Between 1993 and 2001, the Robert Wood Johnson Foundation established another national program: *Making the Grade: State and Local Partnerships to Establish School-Based Health Centers*.¹⁰⁴ The \$25.2 million program was based on two components: 1) planning grants for 12 states; and 2) implementation grants for several states.¹⁰⁵ Connecticut was one of three states meeting their planning objectives in one year and receiving a \$2.3 million implementation grant the following year to help create four school-based health centers.

The key goals of the *Making the Grade* program were to help states and their local partners increase the availability of comprehensive school-based health services for children with unmet health care needs, and support state-local collaborations designed to expand comprehensive school-based health services for children and adolescents.¹⁰⁶

Nationally, 1,909 health clinics and programs connected with schools nationwide were identified during the 2007-08 school year.¹⁰⁷ In Connecticut, the state's first SBHC opened at New Haven's Wilbur Cross High School in the early 1980s through the proceeds of a Robert Wood Johnson Foundation grant.¹⁰⁸ In 1985, the first state Department of Public Health (DPH) funded SBHC opened at Bassick High School in Bridgeport. Since then, the number of SBHCs around the state has increased to the current total of 71, located in 20 communities, as shown in Table F-1.

Administrative Models (Sponsoring Agency)

In Connecticut, the decision to establish and operate a SBHC is determined by local capacity and need. For state funding and licensing purposes, each SBHC must have a sponsoring agency (i.e., operator) responsible for obtaining the proper license and entering into funding contracts. Moreover, the host-school district where the center is located must have a formal agreement/contract with a qualified medical provider to provide services.

Administrative models involving a variety of sponsoring agencies exist to operate school-based health centers. These include private nonprofit human service agencies, local health departments, hospitals, community health centers, school systems, private nonprofit mental health agencies, and private not-for-profit boards of directors. Sponsoring agencies serve as the administrative home for the school-based health center.

¹⁰⁴ The Robert Wood Johnson Foundation Anthology, *School-Based Health Clinics*, Paul Brodeurk, 2000.

¹⁰⁵ The 12 states participating in the *Making the Grade* program's initial planning phase were Colorado, Connecticut, Delaware, Hawaii, Louisiana, Maryland, New York, North Carolina, Oregon, Rhode Island, Tennessee, and Vermont; the nine states receiving implementation grants were: Colorado, Connecticut, Louisiana, Maryland, New York, North Carolina, Oregon, Rhode Island, and Vermont.

¹⁰⁶ Robert Wood Johnson Foundation National Program Report – *Making the Grade: State and Local Partnerships to Establish School-Based Health Centers*, p.4.

¹⁰⁷ *School-Based Health Centers: National Census, School Year 2007-08*, National Assembly on School-Based Health Care.

¹⁰⁸ *School-based Health Centers*, Office of Legislative Research, 2001-R-0313, John Kasprak, Senior Attorney.

APPENDIX F
School-Based Health Centers in Connecticut: Background

Table F-1. State Funded School-based Health Centers by Location and School Type (2011)				
	Elementary School (inc. Pre-K)	Middle School	High School	Mixed School*
Ansonia			1	
Bloomfield				1
Branford	1	1	1	
Bridgeport			3	7
Danbury		2	1	
East Hartford	1	1	1	
Groton	2	2	1	
Hamden			1	
Hartford	1		2	1
Middletown	1	2		
New Britain		1	1	
New Haven			2	9
New London	5	2	1	
Norwalk			3	
Norwich	1	2	1	
Stamford		2	2	
Stratford		1		
Waterbury	1			
Waterford	1			
Windham		1	1	
20 Towns	14	17	22	18
*Combined elementary/middle school or middle/high school. Source of data: DPH				

School-based health centers generally function as freestanding outpatient clinics of their sponsoring agencies, as discussed more below. In addition to outpatient clinic licensing requirements, grant contracts for centers receiving state funding require centers to comply with national standards for pediatric preventive care, identified in the American Academy of Pediatrics *Guidelines for Adolescent Preventive Services* and the National Association of Social Workers *Standards for Social Work Practice in Health Care Settings*.

Physical site preparation, utilities, and maintenance costs of a school-based health center usually are the local school district's responsibility. Sponsoring agencies, however, often provide some sort of in-kind services for the center(s). An applicant for a state SBHC grant also must demonstrate the services to be provided by the center do not duplicate existing services available to students.

APPENDIX F

School-Based Health Centers in Connecticut: Background

Services Provided

Regardless of the administrative model, the basic mission of school-based health centers is the same: provide convenient access to health care services for students through comprehensive primary, acute, and preventive care for physical and mental health conditions in school settings. Moreover, school-based health centers try to work in conjunction with school nurses, counselors, classroom teachers, coaches, principals, and physical, speech and occupational therapists to offer a broad array of coordinated services to students. Services offered by school-based health centers vary by location, but can include:

- physical exams;
- health screening, diagnosis, and treatment of acute and chronic illness (e.g., asthma, injuries, high blood pressure, and strep throat);
- mental health and social services including crisis intervention, and individual, group, and family counseling;
- diagnosis and treatment for illness and injury;
- referral for follow-up services, diagnostic procedures, and treatment of conditions beyond the scope of service provided by the center;
- crisis intervention and advocacy;
- health education;
- limited on-site clinical and laboratory testing;
- nutrition education, counseling, and treatment (e.g., weight management and eating disorders);
- prevention services (e.g., substance abuse, HIV/AIDS, unintended pregnancy, violence, sexually transmitted disease, and child abuse and neglect. Some centers offer contraceptives, but this is a community decision based on local need);
- outreach to at-risk students;
- case management;
- advocacy and referral for services (e.g., child care, housing, and job training);
- consultation and training to parents and school staff; and
- dental services (preventative and restorative dental health).

Health care services are generally provided during school hours, with some centers offering extended hours. Most centers operate only during the school year, while several remain open during the summer months. Others may open before the start of each school year to conduct student physicals for sports, school, or health center enrollment. (The Connecticut Association of School-Based Health Centers provided data to committee staff showing seven centers open for some portion of time beyond the school year.)

Enrollment

Prior to any student receiving services from a school-based health center in Connecticut, the student's parent or guardian must sign a written consent form for the student allowing the student to enroll in the SBHC. Once the parent signs the consent form, the health center will

APPENDIX F

School-Based Health Centers in Connecticut: Background

provide any services the student needs, if offered by the center, or refer the student for additional services, when necessary. Parents may indicate if they do not want the child to receive a specific service by writing the name of the service in the appropriate space on the center-specific form.

Although the health center will attempt to keep parents informed of the services their child receives, signing the center's consent form gives it permission to provide medical and behavioral health services to the child without contacting the parent each time the child visits the center. No child is treated, counseled, or referred without a consent form first signed by a parent, except in an emergency situation. In emergencies, a SBHC will attempt to call the parent, but parental consent is not required prior to treatment.

Enrollment policies at SBHCs around the state vary. Some districts allow students to enroll once for the entire time they are at a particular school (e.g., grades 6-8), while other centers required students to enroll each year. School-based health centers visited by committee staff each had a rolling enrollment process, whereby students can enroll at any time during the school year, not just at the beginning of the year.

Staffing

Staffing at school-based health centers in Connecticut varies. Centers are typically staffed with some combination of licensed health care professionals, including physicians (either full- or part-time), advanced practice nurse practitioners (APRN), physician assistants, clinical social workers, and/or psychologists or psychiatrists. Dental care providers may also be on the staff of a school-based health center, although rare, since dental services generally are provided on a limited basis. Health centers also included administrative staff, typically an administrator and a medical office assistant. All centers must have a medical director to oversee their operations.

School nurses. School nurses provide daily management of most traditional school health services. Services provided by school nurses include documenting immunization status, conducting screening examinations for vision, hearing and other indicators that may affect students' academic performance, helping enroll students in public health insurance programs (i.e., HUSKY A/B), providing case management to students involved with several public agencies, caring for disabled students and students with chronic health conditions, and providing first aid and emergency care. In combination with SBHC staff, the two should work toward offering a comprehensive approach to ensuring optimal health of students. Staff of the school-based health centers visited by PRI staff noted that school nurses are vital to the overall health and safety of students, and services provided by nurses and SBHCs do not overlap.

Funding

Funding for school-based health centers in Connecticut comes from a variety of sources. As discussed below, SBHCs receive their funding from third party payers (insurance), federal, state, and local government funds, and private contributions.

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Insurance. A key source of income for centers is billing public and private insurance providers for their services. The two sources of public insurance are Medicaid (i.e., HUSKY A) and the State Children’s Health Insurance Program (i.e., HUSKY B). If a student is not covered either by public or private health insurance, the SBHC will use its other funds to help offset any incurred costs.

Public Act 10-118, enacted in 2010, requires each Connecticut licensed health insurer, at the request of one or more school-based health centers, to offer to contract with the center or centers to reimburse covered health services to the insurer's enrollees. This offer must be made on terms and conditions similar to contracts offered to other health care service providers.

Federal funding. School-based health centers can receive federal grant funding through several key funding sources: Maternal and Child Health Block Grant, Drug Free Schools; and Communities Act Funds-High Risk Youth Component. For the first time School-Based Health Centers were recognized at the federal level in the reauthorization of the children’s health insurance program (SCHIP) in February 2009.

Passage of the federal Patient Protection and Affordable Care Act in March 2010 created opportunities for communities to develop new school-based health centers; when funded, the ability to expand capacity and services at existing health centers.¹⁰⁹ The federal act authorized \$200 million for the new School-Based Health Center Capital Program from 2010 through 2013 to address capital needs in school-based health centers. In July 2011, the federal Department of Health and Human Services (HHS) began awarding its first of a series of competitive grants: \$95 million to 278 school-based health center programs across the country to help centers expand and provide more health care services at schools (Table F-2 shows seven Connecticut centers received just under \$2 million). In awarding grants, HHS must give preference to school-based health centers that serve a large population of children eligible for medical assistance under Medicaid.

State funding. Connecticut has funded school-based health centers in part since 1985. State grants serve as base funding essential for school-based health centers due to the number of uninsured and underinsured patients. SBHCs in Connecticut receive state grants via contracts between the state and a center’s sponsoring agency. The level of SBHC funding for recent years is provided in the SBHC report card earlier in the report.

Criteria for awarding state funds to local school-based health center initiatives in Connecticut most likely include socioeconomic needs of the community, lack of access to health services by the adolescent student population, community support, working relationship between the health and education agencies, and likelihood of SBHC sponsors fulfilling service goals and objectives. This is borne out by Appendix I, which shows the location of school-based health centers in relation to the state education department’s District Reference Group classifications.¹¹⁰

¹⁰⁹ Public Law 111-148, Section 4101(a, b)

¹¹⁰ District Reference Group (DRG) is a classification system in which districts having public school students with similar socioeconomic status and need are grouped together. DRGs are based on the following seven

APPENDIX F
School-Based Health Centers in Connecticut: Background

Table F-2. Connecticut School-based Health Centers Receiving Federal Patient Protection and Affordable Care Act Grants (2011)		
Sponsoring Agency	District	Amount
1) Charter Oak Health Center, Inc.	Hartford	\$500,000
2) Child and Family Agency of Southeastern, Inc.	New London	\$436,237
3) Family Centers, Inc.	Greenwich	\$150,524
4) Optimus Health Care, Inc.	Bridgeport	\$309,429
5) Yale-New Haven Hospital	New Haven	\$392,460
6) Quinnipiac Valley Health District	North Haven	\$15,739
7) Southwest Community Health Center	Bridgeport	\$166,338
Note: not all the above school-based health centers receive state funds. Source: http://www.hhs.gov/news/press/2011pres/07/20110714grantee.html		

Other. Other sources of funding for SBHCs include foundations, private donations, local funds, community agency contributions, and in-kind contributions from host schools/districts.

State Oversight

Oversight of state-funded school-based health centers is the responsibility of the Department of Public Health (DPH). Oversight occurs through the department’s contract monitoring and licensing functions.

Contracts. As noted earlier, state grants are provided through DPH via contracts with health centers’ sponsoring agencies. The department’s Family Health Section and Grants Management Section are responsible for ensuring contracts are initiated correctly and monitored for performance purposes.

Grant contracts are executed for each sponsoring agency receiving state funding in a given fiscal year. The contracts specify grant amounts, performance requirements, and reporting requirements, along with other legal language.

variables: income, education, occupation, family structure, poverty, home language, and district enrollment. They include nine groups, from group A (low-need, high socioeconomic districts) to group I (high-need, low socioeconomic districts). Charter schools, Connecticut Technical High Schools, and Regional Educational Service Centers are not given DRGs. See: <http://www.sde.ct.gov/sde/lib/sde/PDF/DEPS/Student/NutritionEd/SWP/5PhysicalEducation.pdf>

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Examples of grant contract requirements include: cultural competence (services encompassing a set of behaviors, skills, attitudes, and policies promoting awareness, acceptance, and respect for diverse cultures); enrollment thresholds to meet; identifying objectives; developing an annual quality improvement work plan; and submitting standardized performance reports. DPH also conducts on-site contract monitoring.

DPH maintains a school-based center database (known as Clinical Fusion). Individual SBHCs collect and enter specific data each student enrolled, and utilization/diagnostic information around students' visits to centers. The information is then transmitted to DPH via the centralized database. The department ensures the accuracy of the data and maintains the information for oversight purposes. All but two sponsoring agencies use the department's database; the others submit their data electronically to DPH, which then converts the information over to its centralized system.

Licensing. Because federal Medicaid regulations do not define school-based health centers as participating entities within the program, if a state is to develop special Medicaid-related funding strategies for the centers, the state Medicaid program needs to define the centers as reimbursable ambulatory care provider-type facilities (i.e., a particular health care delivery system unit that can be shown to meet specific standards).¹¹¹ Examples of ambulatory care providers include out-patient clinics, hospital-sponsored clinics, federally qualified health centers, and rural health centers.

SBHCs in Connecticut are licensed through DPH either as free standing outpatient clinics or hospital satellite clinics (hospital satellites have a hospital as their sponsoring agency and fall under the hospital's state license). At present, 115 school-based health centers are licensed in the state, and 71 of those are state funded. Of the total 115 SBHCs, 104 (90 percent) are licensed as outpatient clinics, with the remaining 11 are licensed as hospital satellite clinics. (DPH does not have the capability to maintain licensing data for years previous to the current year, thus licensing trends for SBHCs could not be developed.) Licensing and contract compliance are separate functions within DPH.

State licensing requirements specify only students who attend the school where the school-based health center is physically located are permitted to access the center for care. In other words, if a school district operates than one school, but a school-based health center is located in only one of those schools, technically, the center is only supposed to enroll students from that particular school and not from any of the other schools within the district.

DPH licensing inspectors are required to inspect SBHCs using an inspection protocol at least once during the duration of the center's particular license, which must be renewed every four years for outpatient clinics and every two years for hospital satellite clinics. If deficiencies are found, the SBHC is responsible for making the necessary corrections and reporting back to DPH when the deficiencies have been corrected.

¹¹¹The Center for Health and Health Care in Schools, *Issues in Financing School-Based Health Centers: A Guide for State Officials*, September 1995.

APPENDIX F
School-Based Health Centers in Connecticut: Background

Ad Hoc Committee

In 2006, the legislature required DPH to establish an ad hoc committee to assist the department in examining and evaluating statutory and regulatory changes to improve health care through access to school-based health centers, particularly for students who are uninsured and underinsured.¹¹² The committee was designed as a partnership of key state agencies involved in child health care and SBHC coordinators.

The committee was required to focus its efforts on improving school-based resources, facilitating access to their SBHC services, and identifying or recommending appropriate fiscal support for the operational and capital activities of school-based health centers. The committee was further asked to assess school-based health centers in terms of: 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.

The ad hoc committee met six times before releasing a report with its findings and recommendations in December 2006.

¹¹² See: Public Act 06-195 (Sec. 51).

2011 KIDS COUNT Data Book

The Annie E. Casey Foundation

6

OVERALL RANK

Connecticut

4

IMPROVED

3

WORSENER

1

UNCHANGED

KEY INDICATORS	STATE TREND		NATIONAL TREND		NATIONAL RANK
Percent low-birthweight babies	2000 7.4 2008 8.0	8%	2000 7.6 2008 8.2	8%	21
Infant mortality rate (deaths per 1,000 live births)	2000 6.6 2007 6.6	0%	2000 6.9 2007 6.8	-1%	22
Child death rate (deaths per 100,000 children ages 1-14)	2000 15 2007 12	-20%	2000 22 2007 19	-14%	3
Teen death rate (deaths per 100,000 teens ages 15-19)	2000 47 2007 44	-6%	2000 67 2007 62	-7%	7
Teen birth rate (births per 1,000 females ages 15-19)	2000 31 2008 23	-26%	2000 48 2008 41	-15%	4
Percent of teens not in school and not high school graduates (ages 16-19)	2000 11 2009 4	-64%	2000 11 2009 6	-45%	3
Percent of teens not attending school and not working (ages 16-19)	2000 N.A. 2009 6	—	2000 N.A. 2009 9	—	2
Percent of children living in families where no parent has full-time, year-round employment	2000 N.A. 2009 26	—	2000 N.A. 2009 31	—	13
Percent of children in poverty (income below \$21,756 for a family of two adults and two children in 2009)	2000 11 2009 12	9%	2000 17 2009 20	18%	2
Percent of children in single-parent families	2000 27 2009 30	11%	2000 31 2009 34	10%	12

Find more state and community-level data at the KIDS COUNT Data Center: datacenter.kidscount.org/CT

PERCENT CHANGE OVER TIME

GETTING BETTER

GETTING WORSE

N.A.: Comparable data not available for 2000 for these indicators. Find more information and the definitions and data sources for indicators at: datacenter.kidscount.org/databook/2011

APPENDIX H

Commonwealth Fund State Scorecard on Child Health System Performance, 2011

CONNECTICUT

Overall and Dimension Rankings	
OVERALL	9
Access & Affordability	8
Prevention & Treatment	26
Potential to Lead Healthy Lives	6
Equity ^a	6

Summary of Indicator Rankings	
	Count
Total number of indicators	20
Top 5 States	6
Top Quartile	10
2nd Quartile	4
3rd Quartile	2
Bottom Quartile	4
Bottom 5 States	0

Dimension and Indicator	2011 State Scorecard on Child Health System Performance					
	Year	State Rate	All States Median Rate	Top 5 States Average Rate	Best State Rate	Rank
ACCESS & AFFORDABILITY						8
Percent of children ages 0–18 insured	2008–09	93.2	91.4	95.6	96.7	13
Percent of parents ages 19–64 insured	2008–09	88.8	83.7	92.5	95.6	9
Percent of currently insured children ages 0–17 whose health insurance coverage is adequate to meet needs	2007	76.9	77.0	81.5	83.8	28
Average total premium for employer-based family coverage as percent of median income for family household	2009	13.9	18.6	14.4	13.9	1
PREVENTION & TREATMENT						26
Percent of children ages 0–17 with a medical home	2007	62.4	60.7	67.5	69.3	18
Percent of young children (ages 19–35 months) received all recommended doses of six key vaccines	2009	71.4	74.4	81.7	84.1	36
Percent of children ages 0–17 with a preventive medical care visit in the past year	2007	95.2	87.8	96.7	97.7	5
Percent of children ages 1–17 with a preventive dental care visit in the past year	2007	84.9	79.1	85.8	86.9	4
Percent of children ages 2–17 needing mental health treatment/counseling who received mental health care in the past year	2007	78.8	63.0	77.5	81.5	2
Percent of young children (ages 10 months–5 years) received standardized developmental screening during visit	2007	16.6	18.8	35.8	47.0	39
Hospital admissions for pediatric trauma per 100,000 children ages 2–17 ^b	2006	172.4	128.7	55.8	44.1	33
Percent of children with special health care needs ages 0–17 who had no problems receiving referrals when needed	2005–06	76.0	80.3	87.7	89.8	40
Percent of children with special health care needs ages 0–17 whose families received all needed family support services	2005–06	64.0	72.8	81.4	83.0	46
POTENTIAL TO LEAD HEALTHY LIVES						6
Infant mortality, deaths per 1,000 live births	2006	6.2	6.8	5.0	4.7	18
Child mortality, deaths per 100,000 children ages 1–14	2007	12.0	20.0	11.0	9.0	3
Percent of young children (ages 4 months–5 years) at moderate/high risk for developmental or behavioral delays	2007	22.7	25.8	19.2	18.6	13
Percent of children ages 10–17 who are overweight or obese	2007	25.7	30.6	24.7	23.1	5
Percent of children ages 1–17 with oral health problems	2007	23.6	25.8	21.5	20.0	9
Percent of high school students who currently smoked cigarettes ^c	2009	17.8	18.3	12.6	8.5	19
Percent of high school students not meeting recommended physical activity level ^d	2009	54.8	56.0	50.4	46.4	18

^a The equity dimension was ranked based on gaps between the most vulnerable group and the U.S. national average for selected indicators. Refer to supplemental *State Scorecard/Data Tables* available online <<http://www.commonwealthfund.org/Content/Publications/Fund-Report/2011/Feb/State-Scorecard-Child-Health.aspx>> that show data by income, insurance, and racial/ethnic groups and gaps for equity indicators.

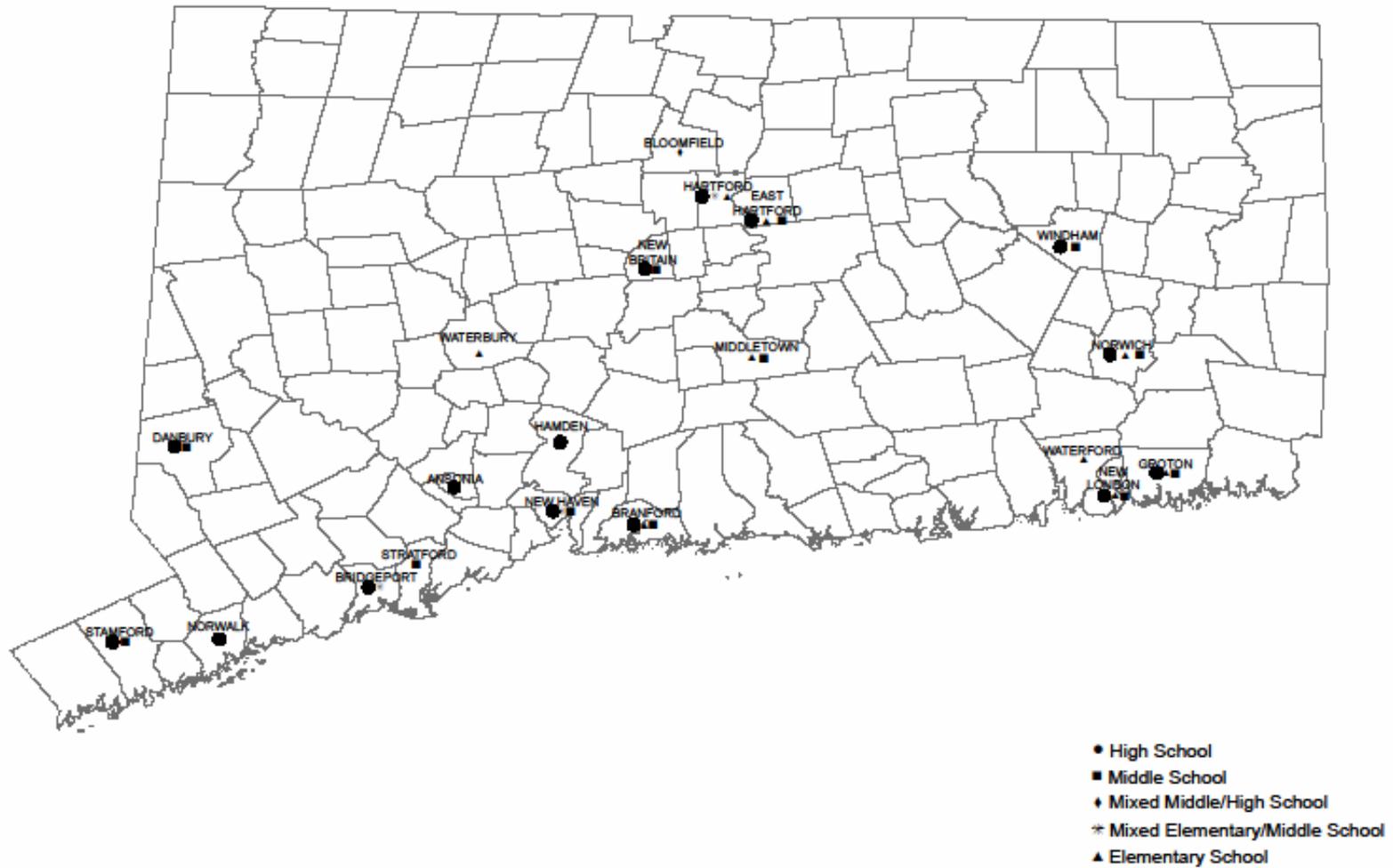
^b Data available for 39 states.

^c Data available for 42 states.

Note: Refer to Appendix B in the *State Scorecard on Child Health System Performance* <<http://www.commonwealthfund.org/Content/Publications/Fund-Report/2011/Feb/State-Scorecard-Child-Health.aspx>> for indicator descriptions, data sources, and other notes about methodology.

APPENDIX I

State-Funded School-Based Health Centers



N=71
As of February 2012
Source: PRI Staff

APPENDIX J

Federal Definition of School-Based Health Center

The term “school-based health center” means a health clinic that:

- is located in or near a school facility of a school district or board or of an Indian tribe or tribal organization;
- is organized through school, community, and health provider relationships;
- is administered by a sponsoring facility; provides through health professionals primary health services to children in accordance with State and local law, including laws relating to licensure and certification; and satisfies such other requirements as a State may establish for the operation of such a clinic.

The term “sponsoring facility” includes any of the following:

- hospital;
- public health department;
- community health center;
- nonprofit health care agency;
- local educational agency (as defined under Section 9101 of the Elementary and Secondary Education Act of 1965); or
- program administered by the Indian Health Service or the Bureau of Indian Affairs operated by an Indian tribe or a tribal organization.

Source: Social Security Act, Title XXI, State Children’s Health Insurance Program (42 U.S.C. 1397jj(c)(9), Sec. 2110(c)(9)(A)).

APPENDIX K
Need Indicators: School-Based Health Centers

TOWN BY DRG (1)	% All Children in Poverty (2)	% All Children Uninsured (3)	%HUSKY A Ages 10-19(4)	% Children Eligible for Free/Reduced Lunch Program(5)	HPSA(6)	MUA/P (7)	# SBHCs Primarily Serving Adolescents(8)
DRG I							
Bridgeport*	28.6	7.2	8.7	98.3	PMD	X	10
Hartford*	44.2	5.2	10.7	92.9	PMD	X	4
New Britain*	32.2	4.4	4.8	72.4	PMD	X	2
New Haven*	33.7	6.2	7.8	73.4	PMD	X	11
New London*	26.0	7.6	1.5	70.4	PMD	X	3
Waterbury*	32.6	5.8	7.9	74.9	PMD	X	0^
Windham*	34.6	7.3	1.5	71.6	PMD	X	2
DRG H							
Ansonia*	17.6	--	0.8	54.6	PM*D		1
Danbury*	8.6	10.7	2.1	29.4	PMD	X	3
Derby	19.1	--	0.5	47.2			0
East Hartford*	23.2	4.0	2.6	61.0	PD	X	2
Meriden*	21.7	3.0	3.0	59.0	PD		0^
Norwalk*	12.3	6.2	2.0	30.4	MD	X	3
Norwich*	22.2	5.7	1.9	64.1	PMD	X	3
Stamford*	12.7	9.3	2.7	43.4	PMD	X	4
West Haven	14.3	2.9	2.1	47.1	D	X	0
DRG G							
Bloomfield	4.7	4.8	0.6	46.2			1
Bristol	11.5	2.3	1.9	36.7	PD	X	0
East Haven	13.8	3.1	0.8	32.7			0
Groton	9.9	5.4	0.8	29.5	P*MD		3
Hamden	6.3	2.2	1.3	33.6			1
Killingly	12.8	--	0.7	38.6	P*M*		0
Manchester	12.4	3.1	2.1	43.5	D		0
Middletown	13.0	5.0	1.4	36.6	D	X	2
Naugatuck	9.4	3.6	1.0	37.0			0
Plainfield	14.1	--	0.6	31.3	M		0
Putnam*	21.5	--	0.4	53.4	M		0
Stratford	4.3	7.1	1.4	24.3	P	X	1
Torrington	14.8	2.0	1.2	32.2	PMD	X	0
Vernon	9.0	0.0	0.8	25.1	PD		0
Winchester	10.8	--	0.4	43.0	M		0

APPENDIX K

Need Indicators: School-Based Health Centers

Notes:

* Indicates Priority School District: school districts identified by SDE as demonstrating the greatest academic need

^ Waterbury is served by a state-funded school-based health center at Driggs Elementary School. Ten schools in Meriden receive state funding to serve as 'expanded' sites offering select services, not a combination of primary and mental health care similar to other state-funded school-based health centers.

1. District Reference Group: developed by SDE to enable educators to fairly compare groups of districts with similar characteristics. The state's local school districts and three academies have been divided into nine groups based on socioeconomic status and indicators of need. The groups are classified by the most affluent/low need districts (DRG A) to the poorest/most needy districts (DRG I).

2. Connecticut Voices for Children, Family Well-being Indicators for Connecticut Cities and Towns: Summary of 2008-2010 American Community Survey Census Data, January 2012. (Information does not include health insurance status.)

3. Connecticut Voices for Children, Poverty, Income, and Health Insurance in Connecticut Cities and Towns: Summary of 2008-2010 Data from the American Community Survey, November 2011. (Information is only available for towns/cities with populations of 20,000 or more; of children uninsured does not necessarily mean eligible for HUSKY median family income.)

4. Department of Social Services

5. Annie E. Casey Foundation, *Kids Count Data Center, Connecticut Students Eligible for Free- or Reduced-Price School Lunch Program (Percent), 2008*. (See:

<http://datacenter.kidscount.org/data/bystate/Rankings.aspx?state=CT&loct=10&by=a&order=a&ind=4549&dtm=13508&tf=35>)

6. A Health Professional Shortage Area (HPSA) is designated as having a critical shortage of either primary care, dental or mental health providers. Each type of HPSA is further classified as being a specific geographic area, a specific population group, or in some cases, a specific facility. There is also an automatic designation for community health centers meeting a set of standard requirements. Once declared, a HPSA designation is valid for a period of three years. (see: <http://datawarehouse.hrsa.gov/hpsadetail.aspx#Reports>). Also, HPSA designation is pending in Ansonia (mental health), Groton (primary care), and Killingly (primary care and mental health care).

7. Medically Underserved Area/Population (MUA/P) is a designation determined by the U.S. Department of Health and Human Services (Health Resources and Services Administration) identifying areas as having a shortage of personal health services, including primary care providers, hospital beds, or medical resources, population groups of persons who face economic, cultural, or linguistic barriers to health care. (see: <http://muafind.hrsa.gov/index.aspx>)

8. Figures are for FY09. A total of 57 SBHCs have been identified as primarily serving adolescents, including mixed elementary/middle schools mainly in Bridgeport and New Haven; 14 additional state-funded school-based health centers are located in elementary schools. Two school-based health centers primarily serving adolescents in Branford are not included because the school district is classified as DRG 'D.'

Source of Table: PRI staff.

APPENDIX L
Analysis of Individual School-Based Health Centers

Center	School Pop.	SBHC Enrolled	Rate Enrolled	Clients	Rate Utiliz.	Budget (DPH funds)	Total Visits	Cost/visit (DPH funds)	Weekly SBHC Hours >= School Hours*	Meets Medical Staffing Hourly Mean*	Meets Mental Health Staffing Hourly Mean*
Ansonia											
Ansonia HS	717	608	85%	317	52%	\$118,203	873	\$135	Y	N	N
Bloomfield											
Metro. LC	683	538	79%	237	44%	\$77,260	510	\$151	Y	Y	N
Branford											
Walsh Intern	1,083	691	64%	360	52%	\$106,792	1,524	\$70	m	m	m
Branford HS	1,111	696	63%	268	39%	\$126,948	1,175	\$108	m	m	m
Bridgeport											
Columbus	629	211	34%	56	27%	\$125,038	193	\$648	m	m	m
Marin	854	397	46%	100	25%	\$47,453	425	\$112	m	m	m
Read	919	321	35%	124	39%	\$175,799	304	\$578	Y	Y	N
Roosevelt	550	248	45%	79	32%	\$147,198	207	\$711	Y	Y	N
Blackham	1,059	394	37%	169	43%	\$164,512	538	\$306	m	Y	N
Dunbar	397	105	26%	42	40%	\$71,732	183	\$392	m	m	m
JFK	1,327	266	20%	15	6%	\$62,758	19	\$3,303	Y	m	m
Bassick HS	1,257	905	72%	240	27%	\$103,818	605	\$172	Y	Y	N
Central HS	2,287	784	34%	388	49%	\$118,294	1,134	\$104	Y	N	N
Harding HS	1,652	485	29%	203	42%	\$147,080	747	\$197	m	m	m
Danbury											
Broadview MS	1,105	988	89%	434	44%	\$178,277	1,808	\$99	Y	Y	Y
Rogers Park MS	1,020	534	52%	277	52%	\$130,000	1,608	\$81	Y	Y	Y
Danbury HS	2,839	1,830	64%	530	29%	\$188,690	1,624	\$116	Y	Y	Y
East Hartford											
E. Hartford MS	967	487	50%	291	60%	\$116,125	1,836	\$63	Y	N	Y
E. Hartford HS	1,898	1,566	83%	495	32%	\$385,090	2,419	\$159	Y	N	Y
Groton											
Fitch MS	432	209	48%	128	61%	\$125,000	855	\$146	N	N	N
West Side MS	265	249	94%	206	83%	\$94,565	1,704	\$55	Y	Y	N
Fitch HS	1,388	705	51%	449	64%	\$115,303	2,213	\$52	Y	Y	Y
Hamden											
Hamden HS	2,113	510	24%	169	33%	\$122,094	1,258	\$97	N	N	N

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Hartford											
M.D.Fox ES	783	325	42%	202	62%	\$128,072	1,011	\$127	Y	Y	N
Quirk MS	568	700	123%	541	77%	\$157,098	3,516	\$45	n/a	n/a	n/a
Hartford Pub. HS	1,541	772	50%	373	48%	\$220,494	2,057	\$107	Y	Y	Y
Weaver HS	874	360	41%	186	52%	\$155,925	903	\$173	Y	N	N
Middletown											
Keigwin MS	375	179	48%	167	93%	\$130,000	2,403	\$54	Y	N	Y
Woodrow Wilson MS	729	423	58%	395	93%	\$127,999	2,770	\$46	Y	Y	Y
New Britain											
Roosevelt MS	477	242	51%	218	90%	\$130,000	2,193	\$59	Y	Y	Y
New Britain HS	2,972	1,242	42%	805	65%	\$149,062	3,416	\$44	Y	Y	Y
New Haven											
Barnard	478	129	27%	68	53%	\$126,938	251	\$506	Y	Y	N
Clinton Ave.	546	229	42%	109	48%	\$145,489	583	\$250	Y	N	Y
Mauro	318	155	49%	91	59%	\$100,564	451	\$223	Y	Y	Y
Truman	554	244	44%	138	57%	\$79,311	995	\$80	Y	N	Y
Fair Haven	562	224	40%	136	61%	\$100,850	448	\$225	N	N	Y
Sheridan	195	165	85%	154	93%	\$135,020	1,209	\$112	Y	Y	Y
Troup	550	157	29%	101	64%	\$95,688	435	\$220	Y	N	N
King/Robinson	441	114	26%	37	32%	\$98,336	260	\$378	Y	Y	Y
Clemente	387	177	46%	81	46%	\$154,445	210	\$735	Y	Y	Y
Wilbur Cross HS	1,662	591	36%	296	50%	\$122,140	1,247	\$98	Y	N	Y
Hillhouse HS	1,016	699	69%	338	48%	\$90,101	1,269	\$71	Y	Y	Y
New London											
Bennie Jackson MS	622	471	76%	268	57%	\$110,241	1,212	\$91	Y	Y	Y
New London HS	870	602	69%	367	61%	\$140,515	1,609	\$87	Y	Y	Y
ISAAC	180	102	57%	97	95%	\$130,000	579	\$225	N	N	N
Norwalk											
Norwalk HS	1,515	999	66%	540	54%	\$116,274	2,152	\$54	N	N	N
Briggs HS	106	143	135%	85	59%	\$65,348	592	\$110	Y	N	N
McMahon HS	1,708	856	50%	583	68%	\$117,628	2,561	\$46	N	Y	N

APPENDIX L
Analysis of Individual School-Based Health Centers

Center	School Pop.	SBHC Enrolled	Rate Enrolled	Clients	Rate Utiliz.	Budget (DPH funds)	Total Visits	Cost/visit (DPH funds)	Weekly SBHC Hours >= School Hours*	Meets Medical Staffing Hourly Mean*	Meets Mental Health Staffing Hourly Mean*
Norwich											
Kelly MS	678	415	61%	346	83%	\$131,238	2,262	\$58	Y	Y	Y
Teachers' MS	472	284	60%	206	73%	\$78,743	632	\$125	Y	Y	Y
Norwich Free Acad.	2,489	1,197	48%	728	61%	\$292,256	3,121	\$94	Y	Y	Y
Stamford											
Dolan MS	636	479	75%	121	25%	\$149,132	631	\$236	N	Y	N
Rippowam MS	746	789	106%	236	30%	\$205,903	963	\$214	Y	N	Y
Stamford HS	1,662	889	53%	280	31%	\$168,643	1,637	\$103	N	Y	Y
West Hill HS	2,339	2,010	86%	368	18%	\$172,891	1,419	\$122	N	N	Y
Stratford											
Wooster MS	571	328	57%	202	62%	\$163,207	1,297	\$126	N	N	Y
Windham											
Windham MS	926	629	68%	202	32%	\$176,342	988	\$178	Y	Y	Y
Windham HS	907	665	73%	236	35%	\$178,605	1,302	\$137	Y	Y	Y
TOTAL	58,007	31,712	54.7%	14,878	47%	\$7,892,527	72,346	\$109	* KEY for FY11 Staffing Information: Y=Yes; N=No; m=Missing; n/a=Not Applicable		
SOURCE: PRI staff analysis											